

TARANAKI DISTRICT HEALTH BOARD

ANNUAL REPORT 2015-16



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 Whānui, He Rohe Oranga

How we work together and with others

Nga Tikanga

Me Pehea nga mahi ngatahi me etahi atu

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

We will work together by:

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

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INTRODUCTION BY CHAIR AND CHIEF EXECUTIVE



Executive Management Team, 2015



Pauline Lockett congratulates Rosemary Clements on being appointed as Chief Executive

Welcome to the Annual Report for the Taranaki District Health Board for 2015/2016.

We would like to acknowledge and thank all the Board and committee members who have generously shared their skills and knowledge. We also acknowledge our Māori relationship partner, Te Whare Punanga Korero Trust representing the eight iwi of Taranaki, who have contributed to various planning activities, supporting the governance of the DHB, our goals of improving Māori health and reducing health inequalities.

The healthcare Taranaki DHB provides depends on the experience, skill, commitment and dedication of our staff and we want to acknowledge and recognise how hard working our people are at the outset of this report. The commitment and skills of our staff have resulted in a year of significant achievement and we thank them on behalf of our patients, their family/whānau and the community that we serve.

Throughout the year Taranaki DHB has funded services to the value of \$322m for the people of Taranaki. In a fiscally challenged environment, we have remained focused on improving performance, meeting national health targets, living within our means and ensuring access to high quality services for the community while reducing health inequalities.

Our approach to accelerating Māori health gain has been underpinned by Te Matakite Māori 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 Māori has enabled the DHB to reduce, some inequalities in access by Māori, to key services. Through a number of small projects carried out through the year the DHB was able to reduce the Māori rate of 'Did Not Attend' (DNAs) by 2% to 17%, and reduced the gap between Māori and non-Māori by 1 percentage point. However, we acknowledge there is a long road still ahead and we will need to sustain efforts to reduce even further towards the target of 5%.

During the later part of winter in 2015, Taranaki DHB faced the challenge of meeting the health needs of an unprecedented number of patients requiring our care and expertise. The commitment and skills of our staff, working together, ensured we were able to deliver high quality care and treatment throughout this difficult time. This year we have taken further measures and continue to look at how we organise services with a willingness to change to best suit our community. 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 once again on more elective surgeries, improving our target on shorter stays in our emergency departments, more people in Taranaki getting immunised, having 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 relatively new Faster Cancer Treatment 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.

We remain focused on engaging consumers and through an ongoing project called Health Together: Hauora Huihui, we are making service improvements to ensure Taranaki DHB provides patient and family/whānau-centred care. As part of this, a review of the Visitor Policy was completed this year and patients, families/whānau and general visitors were canvassed to find out what would be helpful and would improve the visitor experience. Projects like this have seen an increase in the number of patients and their whānau involved in service delivery planning and ensuring the changes we make are customer focused.



Pauline Lockett gets immunised against the flu



Rosemary Clements with the 2015 Taranaki DHB scholarship recipients

Taranaki DHB is an active partner with the Pinnacle (Midlands Health Network) – PHO. In the later part of the year we have been working together to develop a business case to assess the costs, benefits and implementation options of a new model of integrated care that will co-ordinate primary care (GP's), secondary care (hospitals) and community health services for the people of Taranaki. Important collaboration has also continued to ensure people receive prompt and appropriate acute care in our Emergency Departments and non urgent patients are redirected back to their General Practice.

We have continued to improve the planning and management of staffing costs while also increasing new graduate clinical staff. 23 scholarships were awarded for the 2016 study year and Taranaki DHB invested \$28,750 to support them through their studies. 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 financial year the Foundation was able to donate \$1,240,407 towards Taranaki DHB key projects. This has been achieved with the generous support of local businesses, community organisations and individuals.

Work continued on two new fundraising projects launched in 2014/15:

- The Mobility Garden enhancements to improve both patient and visitor experience at Taranaki Base Hospital.
- The WE HEART TARANAKI campaign 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 shared service company, HealthShare (of which Hauora Tairāwhiti, Bay of Plenty, Lakes and Waikato DHBs make up the complete

shareholding). Healthshare 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.

We continue to implement our Regional Services Plan with Healthshare facilitation 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. Examples of some of this great work include the implementation of a community oral health working group to improve dental enrolments for under fives, the WhyOra Secondary Schools Programme to increase the number of Māori working in the Taranaki health and disability sector, and the DNA Project to improve on the number of failed appointments.

The following pages provide a brief snapshot of some more 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.

And finally, a word from Taranaki DHB's newly appointed CE, "As the incoming Chief Executive (CE), I was three months into my new role when this report was written and would particularly like to acknowledge the support and advice I received from both Board and committee members, as well as the Executive Management team and Taranaki DHB staff, as I settled into the role."

Pauline Lockett
Chair

Rosemary Clements
Chief Executive

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 DEPARTMENT

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

Q1

94%

Q2

96%

Q3

94%

Q4

95%



IMPROVED ACCESS TO ELECTIVE SURGERY

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

Q1

115%

Q2

113%

Q3

114%

Q4

114%



FASTER CANCER TREATMENT

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.

Q1

70%

Q2

74%

Q3

84%

Q4

77%





Taranaki DHB staff members supporting Mōvever



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

91%

Q2

91%

Q3

94%

Q4

94%



BETTER HELP FOR SMOKERS TO QUIT

The target is 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. This target has a new definition shifting the focus to the entire enrolled population of people who smoke and not only those seen in primary care.

Q1

85%

Q2

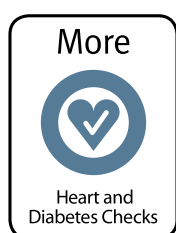
85%

Q3

86%

Q4

87%



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

92%

Q2

92%

Q3

92%

Q4

92%

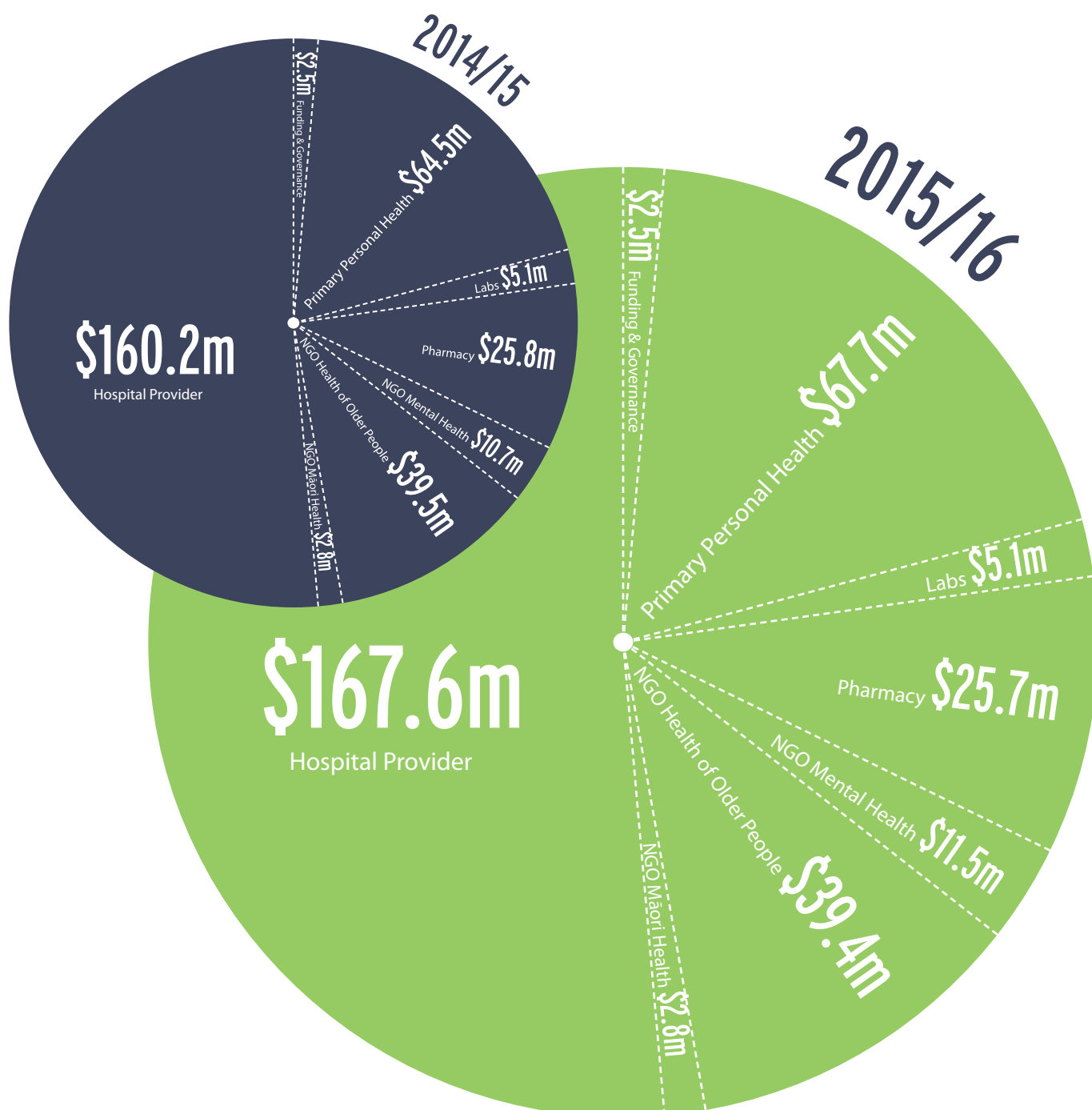


WHERE THE MONEY GOES

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

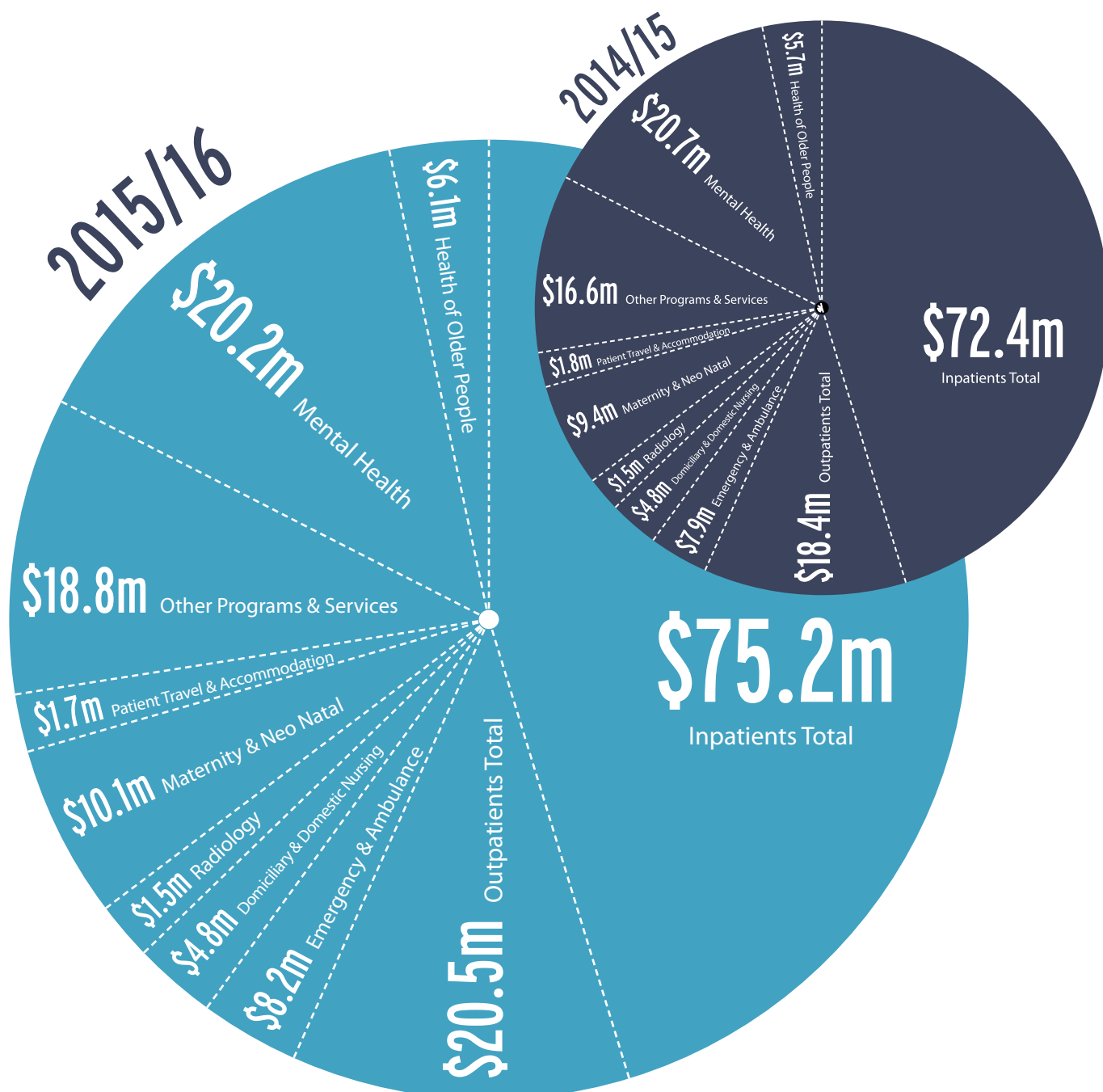
In 2015-16 the Planning and Funding division allocated it's funding of **\$322** million as follows:

» 2015/16 Taranaki DHB Planning and Funding Allocation



The **\$167** million allocated to the Hospital and Specialist Services was further allocated as follows:

» 2015/16 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 2015/16 Taranaki DHB served a population of 118,560* people.

The Maori 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 Maori, 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 19,896 (16.8%), with 6.7% of these being Maori.

A total of 38,545 people are under the age of 24 (32.5%), the number of Maori in this age group is 11,060 which represents 28.7% of Maori in the region.

Socio-Economic Indicators

The Taranaki population sits towards the centre of the socio-economic range.

Around 43% of Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Maori are over-represented in the wealthiest socio-economic deciles and Maori are over-represented in the lowest socio-economic deciles.

Within Taranaki, 32% of Maori live in the most deprived 20% of areas compared to 14% of non-Maori. In contrast, 7% of Maori live in 20% of the most affluent areas compared to 16.3% of non-Maori.

Māori in Taranaki have 6-7 years less life expectancy than non-Māori.

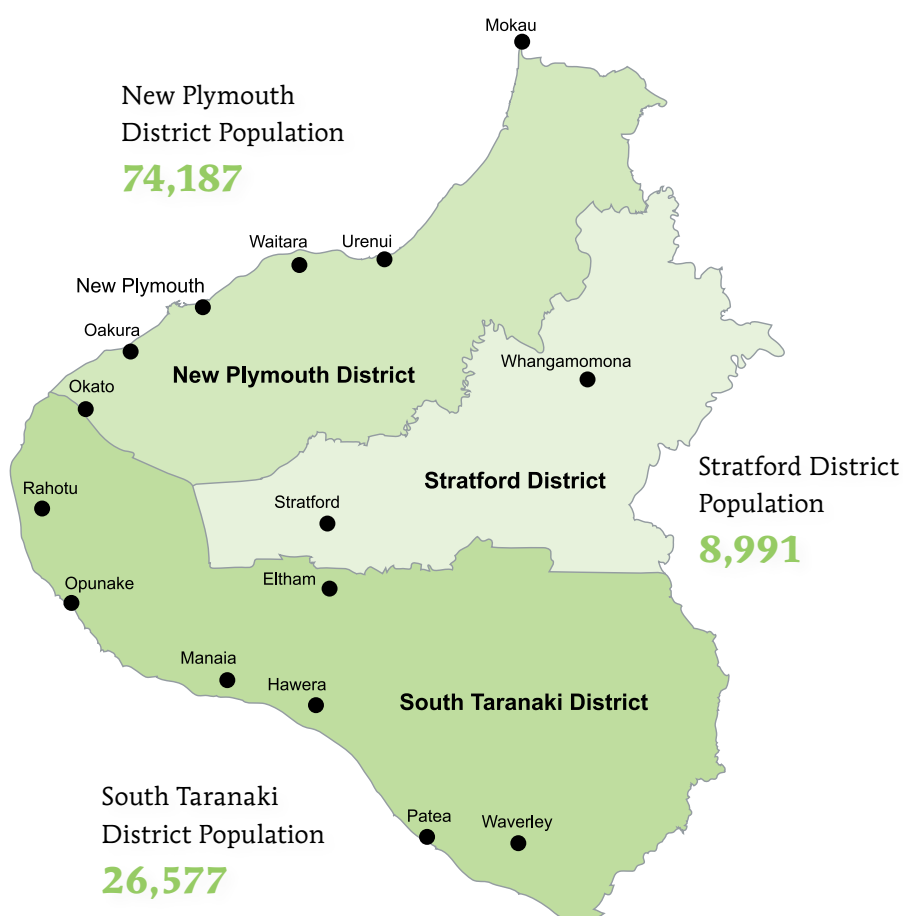
*Based on updated information received from Statistics New Zealand Population Projections released November 2014



We have...

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

- Relationships with 1 Primary Health Organisation
- 32 GP practices
- 21 dental practices
- 26 pharmacies
- 19 community personal health providers
- Providers of community laboratory services and radiology services
- 7 community based mental health, and alcohol & addictions service
- 1 Māori mental health and alcohol & addictions service provider
- Support services for people with disability, including 28 residential facilities
- 16 providers of community health for older people services
- Hospital provider - facilities include Taranaki Base Hospital, Hawera Hospital and five community health centres in Waitara, Stratford, Opunake, Patea and Mokau.





MĀORI HEALTH

Te Whare Punanga Korero Trust and Maori Health

Te Whare Punanga Korero Trust is the Māori Health Governance Group which works strategically with the Taranaki District Health Board (TDHB) to improve Maori 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 it has with the TDHB, exercises mana whenua status by providing kaitiakitanga or guardianship, for all Maori living in the region. Based on the 2013 NZ census, the 18,150 Maori 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 TDHB with regard to Maori health and connection with the Maori community.



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).

Te Whare Punanga Korero Trust and the Taranaki District Health Board met quarterly in August and November 2015, February and May 2016. The meetings focused on Maori Health performance as measured by the priorities of Te Matakite, Maori Health Plan 2015/16. Results are summarised below.

A highlight of the joint Board's agenda was to invite Professor Sir Mason Durie to discuss firstly with the joint Board's, its approach to achieving Pae Ora – Health Futures for Whanau - recently launched in the national Maori Health Strategy He Korowai Oranga 2014 Refresh. Professor Sir Mason gave inspirational insights into the meanings of Mauri Ora, Whanau Ora and Wai Ora as the key elements of Pae Ora. His challenge to the DHB was to focus on early intervention, whānau health literacy, the determinants of health, community collaboration and Maori models for wellness.



Sir Mason Durie

Professor Sir Mason also met with a number of key stakeholders together with the DHB, representing a wide range of cross sector interests including government agencies, providers and researchers. He again enlightened the audience with his insights on Pae Ora and challenged agencies with "A Scenario to Illustrate Possibilities" including that "by 2020 Health Taranaki had successfully promoted region-wide safe policies for fast food outlets, alcohol outlets, home insulation, health and financial literacy, and swimmable rivers". A key part of his message was encouraging and indeed challenging Taranaki Iwi leadership and including local and regional Councils, the DHB, PHOs, industry leaders, educational leaders, DoC, other Government ministries, voluntary agencies and health promotion interests to collaborate for collective impact on these key issues. During the year several discussions have taken place with interested groups to advance this kaupapa.

Maori Health Performance

The table below summarises the performance of the Taranaki DHB during 2015/16 to improve Maori health status, as measured by 18 national and three local performance indicators.

The national indicators link to leading causes of death and illness for Maori nationally. The local indicators relate to priorities identified specifically for Taranaki Maori. The data presented in this table is the data for 2015/16 available as at September 2016. The data periods are noted in the right hand column of the table.

INDICATOR LEGEND

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

SYMBOL	KEY
☒	No progress or worsening
?	Further info or work required
↑	Increasing gap
↓	Decreasing gap
😊	Eliminated gap

	Health Issue	Indicator(s)Target	Target	Māori	Non-Māori	12 Month Change	Progress To Target	Disparity Gap	Disparity Progress
National Priorities									
1	Data Quality	Ethnicity data accuracy in PHO registers	98%	83%	95.8%	0	◀▶	12.8%	☒
2	Access to care	Percentage of Māori enrolled in PHOs	98%	83%	95.8%	0	◀▶	12.8%	☒
		Ambulatory Sensitive Hospitalisations rates per 100,000 for the age group 0-4 years	95%	111.3%	78.2%	-27.7	▲	33.1%	↓
		Ambulatory Sensitive Hospitalisations rates per 100,000 for the age group 45-64 years	95%	206.1%	98.5%	+51.1	▼	107.6%	↑
3	Child health	Exclusive breastfeeding at six weeks	75%	54%	65%	-12%	▼	11%	↑
		Exclusive breastfeeding at three months	60%	39%	60%	-6%	▼	21%	↑
		Receiving some breast milk six months	65%	49%	68%	+3%	▲	19%	↑

	Health Issue	Indicator(s)/Target	Target	Māori	Non-Māori	12 Month Change	Progress To Target	Disparity Gap	Disparity Progress
4	Cardio-vascular disease	1. Percentage of Māori men 35-44 who have had their CVD risk assessed within the past five years (Health Target)	90%	89%	92%	-	-	3.5%	?
		2. 70 percent of high-risk patients will receive an angiogram within three days of admission. ('Day of Admission' being 'Day 0')	70%	50%	63%	-50%	▼	13%	↑
		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%	75%	94%	-25%	▼	19%	↑
5	Cancer	1. Breast Screening, among eligible population	70%	61.5%	74.8%	-0.5%	▼	13.3%	↓
		2. Cervical Screening, among eligible population	80%	68.4%	81.3%	+3.4%	▲	12.9%	↓
6	Smoking	Percentage of pregnant Māori women who are smokefree at two weeks postnatal	95%	71%	84%	New	New	13%	?
7	Immunisation	1 Percentage of infants fully immunised by eight months of age	95%	91.8%	94.9%	+1.8%	▲	3.1%	↑
		2 Seasonal influenza immunisation rates in eligible population	75%	No data available		-	-	-	?
8	Rheumatic Fever	Number and rate of first episode rheumatic fever hospitalisations for the total population	0.4/100,000	0%		0	◀▶	0%	😊
9	Oral Health	Preschool Dental Enrolments	90%	79%	101%	+20%	▲	22%	↓
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)	No target set	96	63	-18	No Target	33	↓
Local Priorities									
11	Access to Services	Did-Not-Attend (DNA) rate for outpatient appointments	5%	17%	6%	-4%	▲	11%	↓
12	Access to Services	Access by Taiohi Māori – receiving HEADSSS assessment from secondary school risk registers	No target set	111	79	No data available			
13	Workforce Development	Percentage of Māori employed by the TDHB	11%	8.55%	N/A	+0.04%	▲		N/A

Overall the results are poor with more than 40% of our indicators failing to progress positively towards the targets and disparities increasing or remaining the same on more than 50% of the indicators.

There were however a number of performance highlights, some of which are summarised on the next page.

Oral Health Preschool Dental Enrolments

A working group set up to review community oral health enrolments and engagement have been delighted with the results following changes to oral health enrolment for under fives. In the past families were asked to enrol their children with the oral health service. After some investigating we found that it made more sense to automatically enrol whanau into the service and so this was trialled with good results. While whanau have the choice of opting off enrolment, we have not had any whanau that have chosen to do so to date. Automatic enrolment of whanau has now been introduced as standard practise.

Ngaruahine Needs Analysis

The Ngaruahine Iwi Authority recently completed 'Nga Pae Tawhiti kei nga Riu o Te Iringa' a needs analysis for their rohe/ area in and around Manaia in South Taranaki. Supported by DHB's Public Health Unit, the Iwi Authority trained and used Ngaruahine community champions to conduct interviews with their wider whanau to build a picture of their needs and to prioritise those needs in the form of an Iwi Health and Social Strategy. The information was fed back to the community and was received well.

Transport issues were identified as one of the most common themes including rurality and the need to travel to access services, to work, study, do their shopping and engage in cultural activities. The cost of fuel, maintaining a car with warrant of fitness and registration, having a driver licence and access to vehicles were consistent issues that came through as barriers to accessing health and other services. The findings of the report will be key in informing new models of care currently being worked through to improve access to services by Ngaruahine and other high needs communities of South Taranaki.

WhyOra – Secondary Schools Programme

WhyOra is a joint venture between the Taranaki DHB, Ministry of Social Development and Te Whare Punanga Korero Trust (representing the iwi of Taranaki) and its role is to increase the number of Maori working in the Taranaki health and disability sector. Some of its achievements during 2015/16 included:

- 76 Maori were supported along various stages of their tertiary studies
- 44 Maori were helped into employment in the Taranaki health and disability sector
- Students from 13 secondary schools Taranaki-wide participated in the secondary schools programme of profiling health careers. This involved:

- o 46 year 13 students
- o 67 year 12 students
- o 42 year 11 students
- o 19 health careers were profiled by 'mentors'
- o 19 Taranaki DHB departments and two Community provider organisations contributed to career profiling through four workshops held throughout the year

Despite the excellent work of WhyOra supporting Maori through the workforce pipeline and the excellent engagement of the Taranaki DHB staff and departments in this work, the DHB ended the year 2.66% short of the target for June 2016 of 11%. In the year ahead more focus will be centred on the DHB's recruitment and retention approaches for Maori onto its staff.

Access to Services – Failed Appointments (DNA's - Did Not Attend)

In July 2015, 21% of Maori compared to 7% of non-Maori, did not attend "outpatient" appointments that had been made for them due to a health need. That represents a significant disparity in that three times more Maori than non-Maori did not access the services they needed. There are several negative impacts of that.

Through a number of small projects carried out through the year the DHB was able to reduce the Maori rate of DNA's by 4% to 17%, and reduced the gap between Maori and non-Maori by 3%. We will need to sustain efforts to reduce even further towards the target of 6%.

The following are examples of successful interventions that contributed to lowering the DNA rate.

A 6 year old child missed their first Audiology appointment in mid April. Kaimahi Hauora (DHB Maori Health Unit) were asked to follow up. Contact with child's mother was made shortly after when detailed information was given about the appointment, what to expect, importance of and ensuring there were no barriers to attendance. Mother rang the Booking Office to reschedule another appointment. Child and mother attended the new appointment and the child was able to be discharged.

On commencement of focus on Maori Audiology DNA's a 5 year old was identified as high risk having missed 8 x Audiology appointments in total. Further in-depth study identified that the patient had missed a total of 32 Outpatient Clinic appointments in total. Patient referred to Kaimahi Hauora (DHB Maori Health Unit) who immediately established positive engagement with his whanau. The patient and whanau have been supported to attend clinics and to navigate their way to obtaining support for this child to obtain hearing aids at minimal cost to the whanau. An excellent result that enables the child to participate and benefit fully from school life.



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 received a **Cold Cuddle Cot** in July thanks to a kind donation from Linda and Don Mackie via the Emerikus Land Foundation. This is the first of its kind at the Taranaki DHB and is a relatively new piece of equipment in New Zealand. The cot is designed to help Taranaki families who suffer the loss of a baby in pregnancy or early infancy to have the opportunity to spend more quality time with their deceased baby.

The cot is used in Taranaki Base Hospital's '**Willow Suite**', a facility that has been set up with the support of SANDS New Plymouth (a pregnancy, baby and infant loss support group). The suite provides a comfortable and private environment for parents who are grieving from the loss of a baby.

Taranaki DHB's **Why Ora Programme** gave 167 secondary school students the opportunity to get an insight into 21 different health careers through a series of workshops held in 2015. The programme was supported by a number of staff and departments within the DHB.

Why Ora is run by Whakatipuranga Rima Rau (WRR) with the financial support of TSB Community Trust, JR McKenzie Trust and Taranaki DHB, and is accessible to all secondary schools throughout Taranaki.

The vision of WRR is for Taranaki to have a competent, skilled Maori health and disability workforce equal in proportion to its population. The goal is to identify, facilitate and fill employment opportunities for Maori within the health and disability sector. A total of five cadets have been placed within Taranaki DHB, as well as 20 internships throughout the Taranaki health and disability sector.

The first ever Taranaki DHB **Parent Hub was erected at WOMAD 2016**, providing a relaxed and welcoming space where maternity staff were available to discuss any questions festival goers had about their baby or one that might be planned or on the way.

The Parent Hub, which supports the Breastfeeding Welcome Here initiative, was a collaboration with the Taranaki Arts Festival Trust to encourage parents to feed and rest with their babies in comfort. The hub provided a change table, toys and a lounge area with furniture and lamps kindly donated by Hospice Taranaki.

There was also a range of information available including the top five things to do when you discover you are pregnant as well as information on how to ensure your baby gets the best start in life.

The Taranaki DHB Health Protection team worked alongside New Plymouth Injury Safe to promote '**safety in the home**' at the popular Mitre 10 Mega Ladies Night in August.

The Health Protection exhibit promoted the identification and management of lead-based paint in the home, including advice on how to safely remove it.

The stall had a lot of positive feedback as many attendees were not aware of the issue, particularly those who were about to buy, or had just purchased their first home and were considering renovations.

Earlier this year dietitians Sara Knowles and Jill Nicholls from the Public Health Unit teamed up with the South Taranaki Diabetes Society, to hold a **virtual supermarket tour** for the people of Eltham.

The tour was promoted to both society members and the general public, and many of the participants had recently been diagnosed with diabetes and were not confident about reading food nutrition labels.

Participants were guided through a presentation which explained, among other things, processed food and their nutrition labels. They were also provided with packet food items to practice their label reading skills.

Feedback from the event was extremely positive, with most participants noting that their confidence in reading labels had increased and that they would change their shopping habits as a result of the information provided.

April Falls Awareness Week took place from 25 April - 1 May 2016. The campaign highlighted the issue of falls in our community.

Taranaki DHB partnered with New Plymouth Injury Safe and ACC as part of the Health Quality and Safety Commission's national campaign to highlight this issue and to promote falls prevention. This year our focus was building and maintaining strength and balance.

The committee ran a strength and balance challenge for staff to participate in, with prizes donated by Front Runner, Shoe Clinic, Cycle Inn, Taranaki Rugby Union and NPDC.

PHOTOS ON PAGE 20

- 1 Cuddle Cot donation for Taranaki DHB's Willow Suite.
- 2 Taranaki DHB's Parent Hub at WOMAD 2016
- 3 Dad Peter Caldwell reads to Everett, 4 months, and Wren, 3, in the Parent Hub at Womad 2016. (Photo from Taranaki Daily News)
- 4 Annabel Shaw from Taranaki DHB Health Protection team and New Plymouth Injury Safe's programme manager Teresa Gordon at the Mitre 10 Mega Ladies Night.



1

WORKING TOGETHER *Regionally*



2



3



4

PHOTOS

- 1 Taranaki DHB maternity staff celebrate the launch of the BreastFed NZ app and their achievements in the Ministry of Health's Maternity Quality & Safety Programme.
- 2 Stephanie Ayling with her mother and baby Ellia using the BreastfedNZ app.
- 3 Desiree Paulson, Mary Bird, Jacqui Herrett and Mike Broker with some of the speech bubbles written by visitors during Patient Safety Week.
- 4 Staying smokefree has paid off for this group of Countdown Vogeltown work colleagues who won a competition run by the Taranaki Smokefree Coalition.

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.

At the end of August the Midland Maternity Action Group (MMAG) launched a new app called **BreastFedNZ**, designed to help support and encourage women with their breastfeeding goals.

Maternity staff at Taranaki DHB celebrated the launch with an afternoon tea, which also served as a celebration of the team's achievements in the Ministry of Health's Maternity Quality & Safety programme, being one of only two DHB's in New Zealand to be classified in the 'Excelling Tier' for services provided.

The new app provides simple information, illustrations, photos, video clips, web links, and personal stories aimed at supporting pregnant women and new mothers.

Public health advocate, psychiatrist and Maori Health expert Sir Mason Durie visited Taranaki Base Hospital at the end of August to present the **Ministry of Health's Maori Health strategy, Pae Ora**.

Launched by the Ministry of Health in 2014, Pae Ora is the Government's vision for Maori health which emphasises the importance of whānau to good health and the expectations on health practitioners.

Sir Mason is respected nationally as both a medical practitioner and an expert on Maori health, education and development with more than 20 years of practical psychiatric experience.

One of his key messages was that Maori health gains will not be achieved by health services alone - it requires a wider community and regional response led by an iwi.

The Health Quality and Safety Commission's **National Patient Safety Week** (PSW) was held from 1 - 7 November, with a focus on communication and consumer engagement.

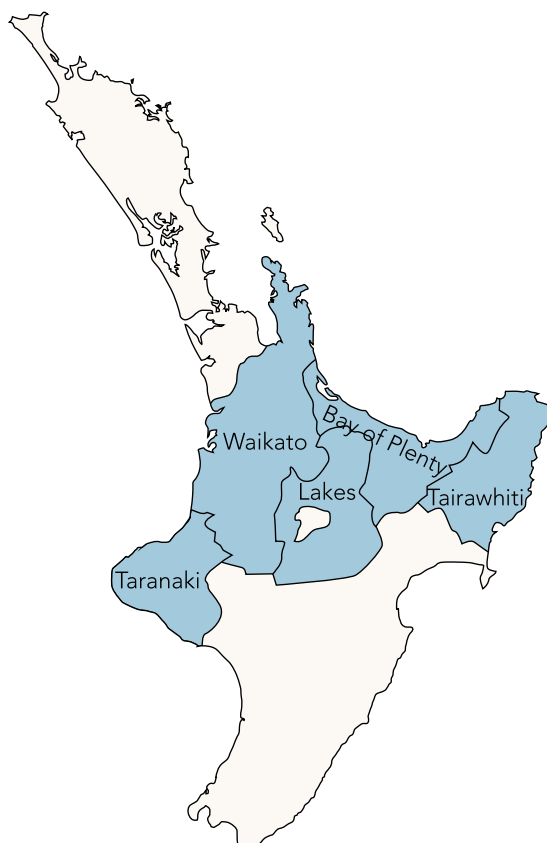
Led by Taranaki DHB Service Improvement Advisor, Jacqui Herrett and the PSW Committee, the week was full of activities and education for staff, patients and visitors at both Taranaki Base and Hawera Hospitals. Patient Safety education resources were also delivered to the Aged Residential Care sector, aligning with Advanced Care Planning in our region.

Visitors to our hospitals were asked to write what mattered to them in healthcare on coloured speech bubbles which were displayed in the front entrances. Over 500 members of the public responded, with communication a common theme.

As part of **World Smokefree Day** on 31 May the Taranaki Smokefree Coalition ran a company-wide stop smoking competition. The coalition includes members of the Heart Foundation, Cancer Society, Tui Ora, Ngati Ruanui Health, Pinnacle Midlands Health Network and Taranaki District Health Board.

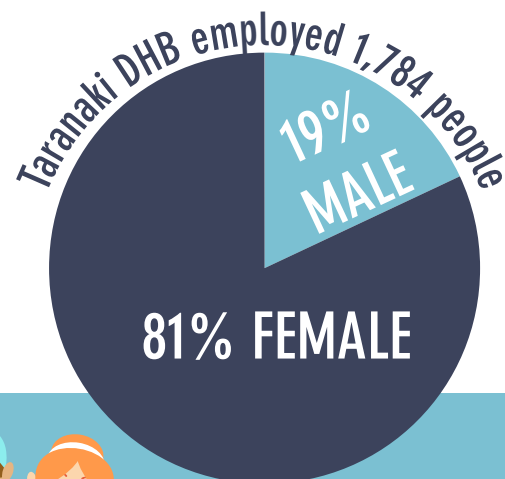
Eight women from Vogeltown Countdown supermarket took out the top prize of \$1,000 after working together as a group to stop smoking. The group's Quit Coach Jan Stewart of Pinnacle Midlands Health Network made herself available when needed, offering words of encouragement, nicotine replacement such as gum and patches, and smokerlyser readings which measures the carbon monoxide levels in a person's lungs.

Coach support runs for three months, ensuring they will be non-smokers for the long-term. Smoking cessation services are ongoing and provided through Tui Ora, Pinnacle Midlands Health Network and Ngati Ruanui (in South Taranaki).



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.





149 staff identifying themselves as Maori,
12 Pacific Islanders,
124 Asians,
1,199 New Zealanders

44 
Midwives



695
Nurses

 **172**
Medical
(Doctors) 

25 Occupational Therapists

34
Physiotherapists



 **128** Health Care Assistants

22 Social Workers




 **44**
Cleaners

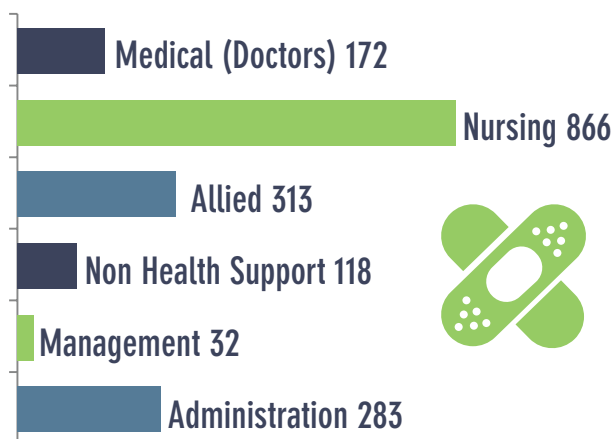
 **29**
Orderlies

25 Pharmacy employees 

18
Dental
Therapists



41 
Laboratory
Employees



Senior Medical Officer Recruitment

There continues to be success in recruiting senior medical officers into long term and permanent positions. Six senior medical officers started in the last 12 months, including:

- 1 Consultant General Surgeon
- 1 Consultant Psychiatrist
- 1 Consultant Emergency Medicine
- 2 Medical Officers Emergency Department
- 1 Medical Officer General Medicine

Scholarships Awarded

Taranaki DHB health scholarships were awarded to 23 students in 2016 studying a range of areas including dental surgery, dietetics, medicine, mental health and addictions support, midwifery, nursing, occupational therapy, oral health, pharmacy and physiotherapy.

Of the recipients, 60.9% identified as Maori.

TARANAKI HEALTH FOUNDATION

The Taranaki Health Foundation is a charitable organisation founded in 1998 in partnership with the Taranaki District Health Board. The shared vision of the partners is to enable the best possible healthcare via fundraising for key projects that will make a significant difference to our regional community.

Taranaki Health Foundation Board



In 2016, the Foundation welcomed Trustee Adrian Sole to the position of Chairperson. For the past two years Adrian has been a trustee on the Foundation and has now taken the helm from Michael Joyce.

A fifth-generation member of the Sole family, he says excellent health facilities and services are important to everyone in Taranaki.

"It's my way of contributing to the community and making sure that Taranaki continues to be the great place to work and live that it is. I firmly believe that," Adrian says.

"Without vital services, particularly equipment, like the angiography machine as a good example, we cannot attract the right specialists and healthcare outcomes."

When Adrian was the commercial development manager for the Taranaki Daily News, he was approached by the trust about the media organisation becoming a foundation partner for the Project Maunga and We Heart Taranaki campaigns. "To me, it was a no-brainer to support a community-focused trust."

Board members acknowledged out-going Chairperson Michael Joyce (who remains as Trustee), Kirsty Godfrey-Billy and Bruce Moller who resigned before year end, for their dedication and contribution to the Foundation's success. Completing the Board are Trustees: Murali Bhaskar, Cathy Katene, Pauline Locket, Peter McDonald and Philip Brown.

Taranaki Health Foundation Trustees



Acknowledgment of past Trustees:

Greg Simmons
John Doran
Mary Bourke
Kirsty Godfrey-Billy
Marise James
Nicola Luxton
Bruce Moller

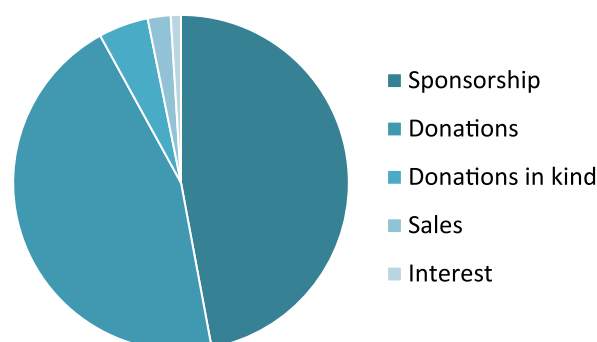
WHAT WE ACHIEVED IN 2015/16

The Taranaki Health Foundation has had much to celebrate in 2015/16, with new projects capturing the hearts of the Taranaki community. Our donors and partners deserve our thanks because without them we would not have achieved the stunning results we have to date.

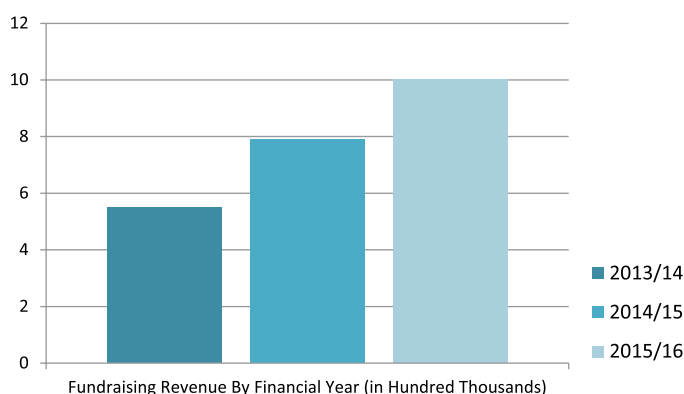
A financial highlight for the Taranaki Health Foundation at year end 2016 was raising over one million dollars in new pledges and donations. As a consequence, the Foundation was able to donate \$1,240,407 to the Taranaki District Health Board towards key projects. Total fundraising revenue for the period including pledged income (to be paid over several financial years) was \$1,022,312 with actual funds received, illustrated below. Public donations have significantly boosted revenue over the last two financial years with the introduction of the WE HEART TARANAKI campaign.

**Table 1. Taranaki Health Foundation Sources of Revenue
(Actuals Received)**

FUNDRAISING REVENUE 2015/16



**Table 2. Taranaki Health Foundation Fundraising Revenue
Streams (Pledged and Received)**



The Foundation received an unqualified audit in 2015 from Vanburwray Chartered Accountants Ltd and awaits the completion of the 2015/16 accounts. An Annual Report will be submitted to the Charities Service by 31 December 2016, and will meet all of the new 'Performance Reporting' standards for Tier 3 Charities. This new report will also include non-financial information which will collectively tell our charity's story over the financial year. The Foundation's Performance Report and Audited Accounts will be made available on the Charities Service www.charities.govt.nz late December 2016.



OUR FIRST COMMUNITY CAMPAIGN: WE HEART TARANAKI



Front and centre was the successful conclusion of the 'WE HEART TARANAKI' campaign which raised the final \$1.2 million dollars required for the new \$3.6 million dollar Angiography Suite. The 17 month campaign drew much public attention, with over 20 events and many engagement activities organised including: ladies lunches, charity golf games, bike rides, quiz nights, a fashion show and unique hospitality experiences. An astounding 30+ new business supporters joined our growing donor family and the Taranaki community got right behind the dream to enhance 'local' services, with over \$520,000 raised from public donations throughout the campaign.



MOBILITY GARDEN COMPLETION

In addition to completing the Angiography campaign the new Mobility Garden at Taranaki Base Hospital was also opened in December 2015. This new enhanced space has received much praise from the public, but also received national acclaim when local Architect and Trustee Murali Bhaskar of Boon Goldsmith Bhaskar Brebner won the Small Project Award from the New Zealand Institute of Architects.



DONOR RECOGNITION

Visitors to the hospital will notice new donor recognition projects which serve to promote key health messages, share the Taranaki health story, and also acknowledge the generous support of sponsors and donors. At Taranaki Base Hospital new digital screens can be found in the foyer, fixed signage at the entrance and in whanau lounges in the new wards.

2016/17 FOCUS

Whilst we have been focusing on key projects, we remain 100% committed to our big picture - achieving 'the best possible healthcare within our region', not only to meet current health needs but to future-proof Taranaki with the best possible technology, infrastructure and services.

We cannot do this alone, so we wish to acknowledge the support of Taranaki DHB, the general public who have backed our campaigns and the many partnerships we have forged this year. Together with our supporters, we are always looking for innovative ways to raise funds and build awareness for projects that improve quality patient care.

With your help, our vision of making a positive difference to our people and our communities is becoming a reality. Thank you so much for your support.

GOVERNANCE



GOVERNANCE STRUCTURE

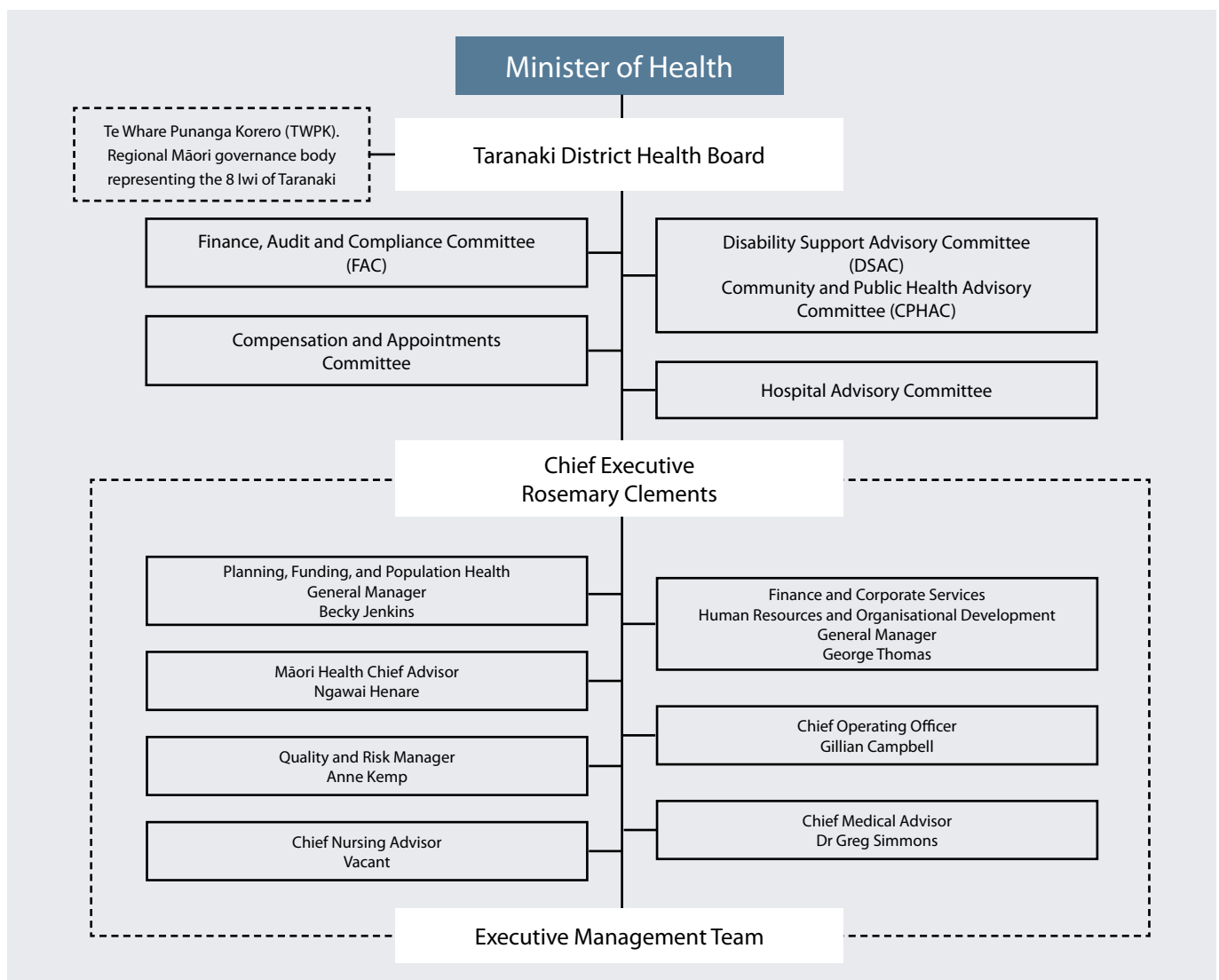
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process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



Pauline Lockett (Chair)

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

Interest Register: PN Lockett Family Trust, Landcorp Director, Trustee of Taranaki Work Trust and 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, member Health Workforce NZ.



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.

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 1994. 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 General Manager of Masterton Medical Ltd, the largest private GP practice in New Zealand with over 22,000 enrolled patients. 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, Chair of Fulford Radiology Services Ltd.



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 Health Trust, Board member - YMCA.



Te Aroha Hohaia

Te Aroha was appointed to the Taranaki District Health Board in 2013. She is a member of the Health Advisory Committee and the Chairperson for the Disability Services and the Community & Public Health Advisory Committees.

Te Aroha has professional and personal interests in community governance and local decision-making, and is especially interested in the wellbeing of our next generations. 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, Te Ara Pae Trust – Trustee & Chairperson, Access Radio Taranaki Trust – Trustee & Chairperson, Hohaia van Paassen Limited Principal, Louise Rauhuia Manuera Hohaia Whānau Trust – Responsible Trustee, School of Government Victoria University of Wellington – PhD Candidate, Te Korowai o Ngāruahine Trust – Trustee, Waiokura Marae & Reserves Trust – Responsible Trustee.



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 14 years. He has been an executive member of Hospice New Zealand for 9 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

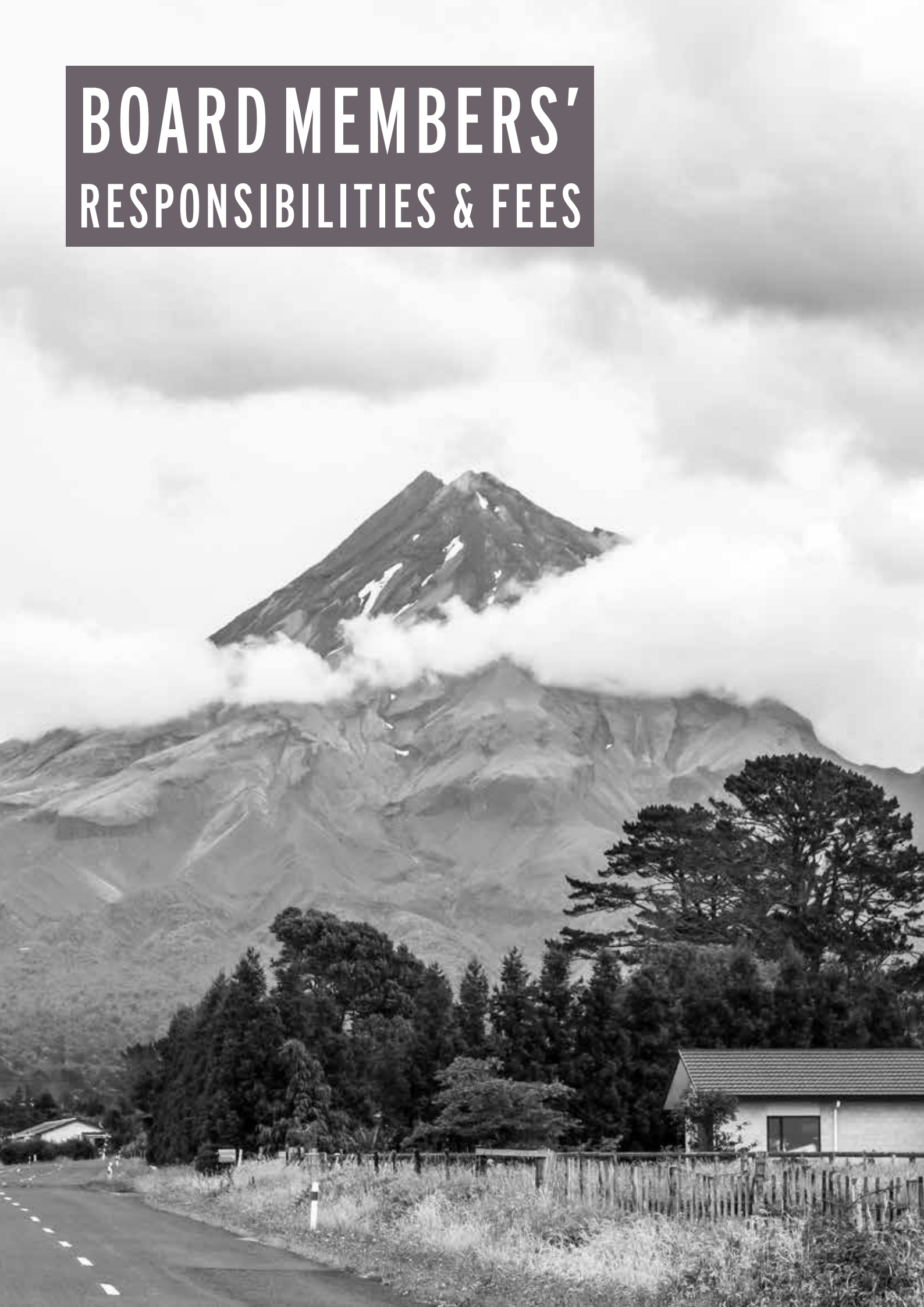


Rosemary Clements (Chief Executive)

Interest Register: Director HealthShare Ltd. Husband Cancer Society employee. Trustee of a family Trust affiliated to Carefirst Trust Limited. (No pecuniary benefits).



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 (\$)
Board Members									
Pauline Lockett	*10 of 11	7 of 9	2 of 6	9 of 11	✓				43,600.00
Sally Webb	^9 of 11	6 of 9		^8 of 11	✓				27,586.96
Alex Ballantyne	8 of 11	7 of 9	4 of 6	9 of 11					23,620.00
Karen Eagles	8 of 11	^6 of 9	3 of 6						21,182.50
Flora Gilkison	11 of 11	8 of 9	5 of 6	11 of 11			✓		25,057.50
Richard Handley	11 of 11	9 of 9	5 of 6	*11 of 11	✓				25,807.50
Te Aroha Hohaia	10 of 11	8 of 9	6 of 6						22,557.50
Kevin Nielsen	10 of 11	*8 of 9	6 of 6	10 of 11					25,370.00
Alison Rumball	10 of 11	8 of 9	4 of 6						22,120.00
Aroaro Tamati	9 of 11	7 of 9	3 of 6	10 of 11					24,370.00
Co-opted Committee Members									
David Tamatea (CPHAC/ DSAC Member)			4 of 6						1,250.00
Te Urumairangi Ritai		6 of 9							1,500.00
Pat Leary (CPHAC/ DSAC Member)			3 of 6						750.00
Other Directors									
Rosemary Clements, Chief Executive (Appointed April 2016)								✓	
Simon Barrett, Group Financial Manager						✓	✓		
Tony Foulkes, Chief Executive (Resigned February 2016)								✓	

Key:

* = Chairperson

^ = Deputy Chairperson

✓ = Both Flora Gilkison and Te Aroha Hohaia were Chair and Deputy Chair for three months each.

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 2016

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 appropriations, of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 71 to 99, that comprise the statement of financial position as at 30 June 2016, 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 38 to 67.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 71 to 99:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2016; 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 the performance information of the Health Board for the period ended 30 June 2016, 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 38 to 67.

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, 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 appropriations; 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 27 October 2016. 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.

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;
- 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.

A handwritten signature in blue ink that reads "B Dente".

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

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

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

We built our performance framework for 2015/16 by grouping our activities into the population long and medium term impacts we intended to influence.

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

Notes:

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

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

STATEMENT OF PERFORMANCE

Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2015/16

Output Class	Planned Revenue (\$000's)	Actual Revenue (\$000's)	Planned Expenditure (\$000's)	Actual Expenditure (\$000's)
Prevention	7,637	7,970	7,636	7,926
Early Detection and Management	86,572	86,696	86,562	76,543
Intensive Assessment and Treatment Services	206,837	207,122	206,117	223,857
Rehabilitation and Support	53,593	53,662	53,586	50,792
TOTAL	354,639	355,449	353,901	359,118

Our Performance Story

Our Vision and Mission	
<p>Vision: Taranaki Together, a Healthy Community – Taranaki Whānui He Rohe Oranga</p> <p>Mission: Improving promoting, protecting and caring for the health and wellbeing of the people of Taranaki</p>	

Our Outcomes	
To improve the health of our population	To reduce or eliminate health inequalities

Our Strategic Priorities				
Meeting Health Targets	Addressing Māori health/disparities	Supporting older people to live well within their community	Addressing a system wide approach to integrated services	Supporting wellness and managing chronic conditions

Long Term 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"> Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> People receive prompt and appropriate acute and arranged care People have appropriate access to elective services Improved health status for people with a severe mental health illness and/or addiction More people with end-stage conditions are appropriately supported

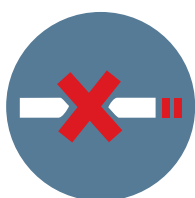
Outputs
Statement of Performance Measures

STATEMENT OF PERFORMANCE

Long Term Impact 1:

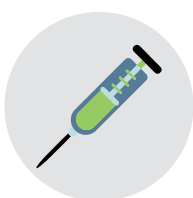
People are supported to take greater responsibility for their health

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.



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 6.



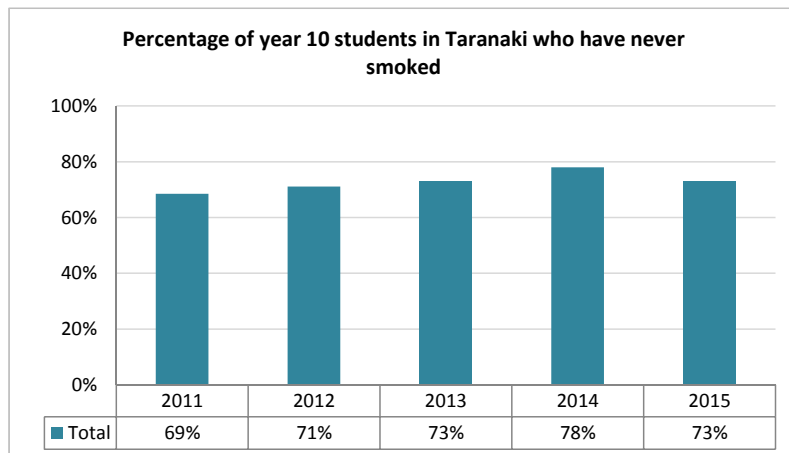
Improving Healthy Behaviours

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



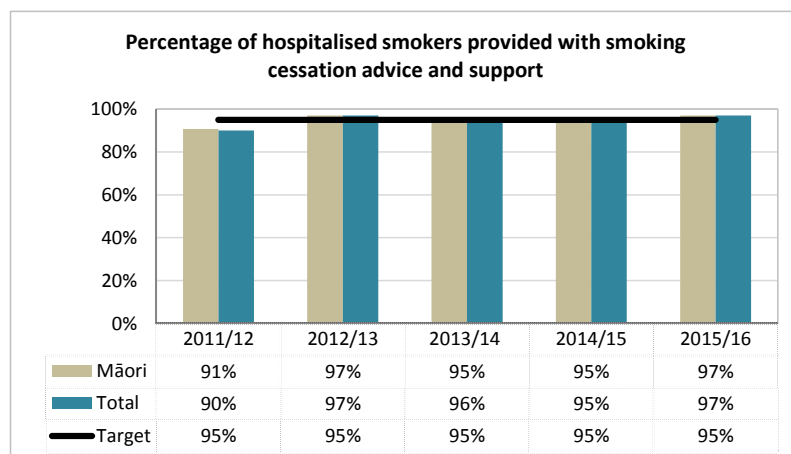
Target for 2015 was to increase on 2014 result of 78%

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 that surveys around 30,000 students every year on their smoking behaviour and attitudes. The survey has been conducted throughout the country for 17 years and is one of the largest youth smoking surveys in the world. Each calendar year Action on Smoking and Health (ASH) publish a summary of reports showing youth smoking trends. Taranaki had a slight decrease of year 10 students results who are recorded as never having smoked but continued planning and monitoring at a local level for Rangatahi will assist in more youth recording their status as never having smoked.

Output Measures



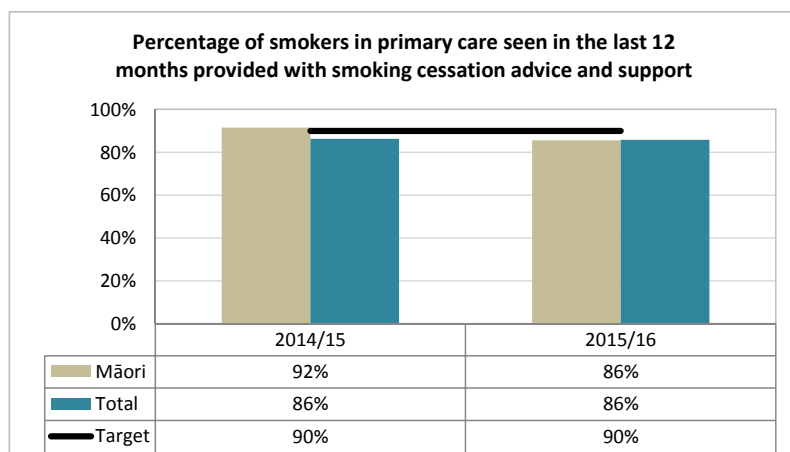
Data Source: Taranaki DHB Patient Management System

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

Māori	Target Achieved
Total	Target Achieved

The reported result is an average percentage of information received over 2015/16. The 95% target has been met by the Taranaki DHB for both Māori and Total population for 2015/16. Reporting has been developed to monitor the use of nicotine replacement therapy provided at the DHB to ensure patients are well supported to assist with smoking cessation. Smokefree coordination and facilitated education and support is provided across the Taranaki DHB.

STATEMENT OF PERFORMANCE



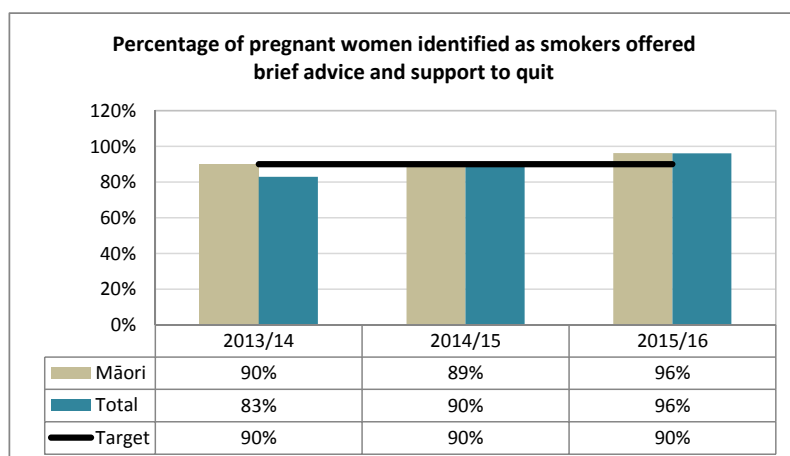
Data Source: MOH Integrated Performance and Incentive Framework (IPIF)

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

Māori	Target Not Achieved
Total	Target Not Achieved

The reported result is an average percentage of information received over 2015/16. Taranaki DHB has not achieved this health target in 2015/16 for either Māori or Total population (based on the average of quarterly results). Quarterly performance results for both groups have fluctuated over the year, although the average annual result for the total population figure has remained static while the average annual result for the Māori population has decreased from 92% to 86%.

Despite this disappointing result, Taranaki DHB has seen an improvement quarter by quarter and expects that we will achieve an improved result over time.



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

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 Achieved
Total	Target Achieved

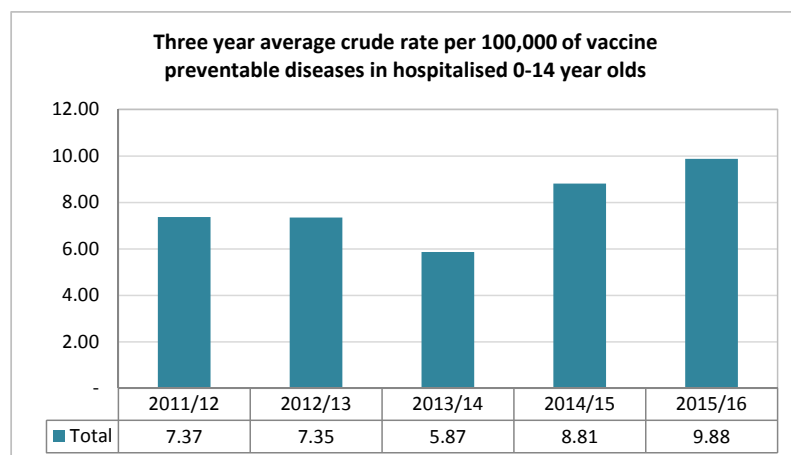
The reported result is an average percentage of information received over 2015/16. Taranaki DHB has achieved the target for both Māori and total population results and it is pleasing to note the level of improvement in both from the previous year.

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



Data Source: Ministry of Health National Minimum Dataset

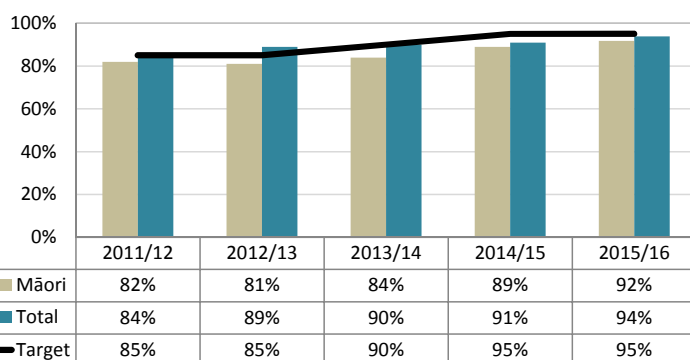
Reduction in vaccine preventable diseases

The number of admissions that could have been avoided through administration of a vaccine has increased, albeit within a low number of admissions involved. A system wide approach to preventing/reducing vaccine preventable admissions continues (for example, opportunistic immunisations are being facilitated in the paediatric wards and ED for all children who present there and are due to have an immunisation).

STATEMENT OF PERFORMANCE

Output Measures

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



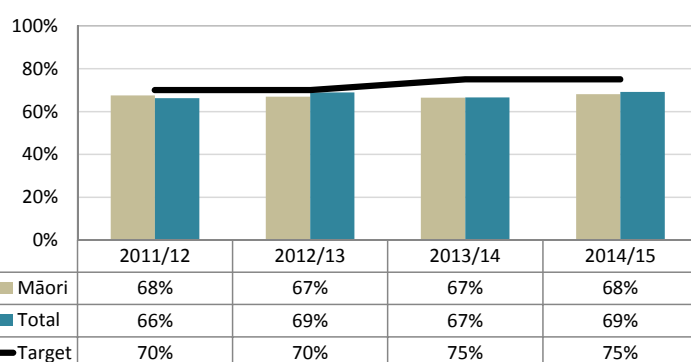
Data Source: National Immunisation Register

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 several 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. The required numbers to meet the target are low, with only three children below what was required to meet the threshold. The new National Childrens Health Information Platform (NCHIP), being launched in 2016/17, will provide another way to consolidate the information available on babies and children receiving services and increase opportunities for tracking and tracing.

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	Not reportable
Total	Not reportable

NB: Seasonal influenza results have not been published by the Ministry since Q1 2015/16. The Ministry have advised that a new report is currently in development - Taranaki DHB is unable to obtain results after September 2015.

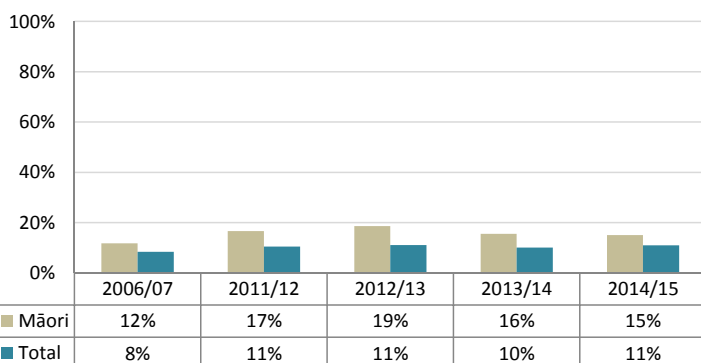
Efforts will be undertaken in 2016/17 to obtain the reporting framework required to be able to report against this measure. Due to the success of the previous year the DHB funder approved funding for 160 influenza vaccines to be administered in outreach immunisation clinics during Immunisation Awareness Week. This was an initiative in partnership with the Māori Woman's Welfare League (MWWL) and was held during Immunisation Awareness Week.

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

According to the New Zealand Health Survey, rates of childhood obesity in Taranaki have marginally reduced over the past two years. The data is released 12 months following the period reported and so the most recent information we hold is for 2014/15. Māori children continue to be more likely to be obese than non-Māori, but it is pleasing to see a slight shift (reduction in percentage in the 2014/15 year).

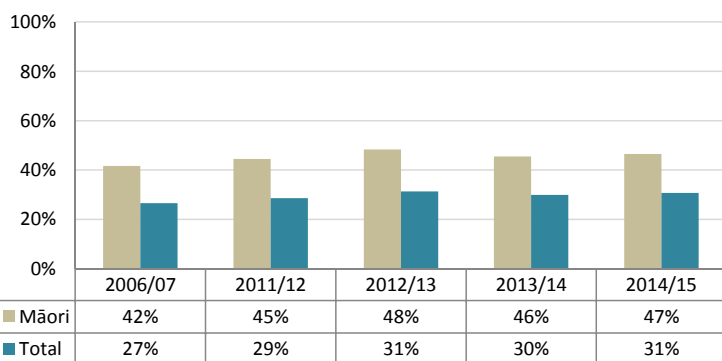
Nationally the proportion of adults who are obese and are being less active is increasing. In Taranaki the adult rates have remained fairly consistent over the past two years.

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 Whānau Pakari Programme as an extension of the GRx Active Families service, this provides wrap around multi-disciplinary support to referred children and their families including six monthly clinical assessments for a year, support from a Dietitian and a Psychologist, and weekly health education and physical activity sessions.

In 2016/17 Taranaki DHB will be focusing of the new child obesity health target and measuring the proportion of obese children identified via Before School Checks (B4SC) referred for clinical assessment and a family based lifestyle intervention. Much of 2015/16 has been spent refining this pathway inclusive of Whānau Pakari.

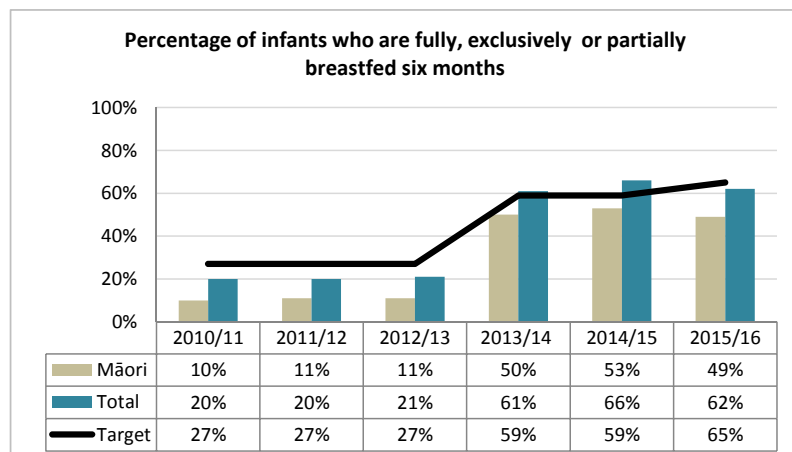
**Percentage of New Zealand Population who are obese 15 years
and older**



Data Source: New Zealand Health Survey 2013/14

STATEMENT OF PERFORMANCE

Output Measures



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 Not Achieved

Breastfeeding data is reported six monthly, and at the time of writing this report the most recent data available was the Q2 2015/16 result.

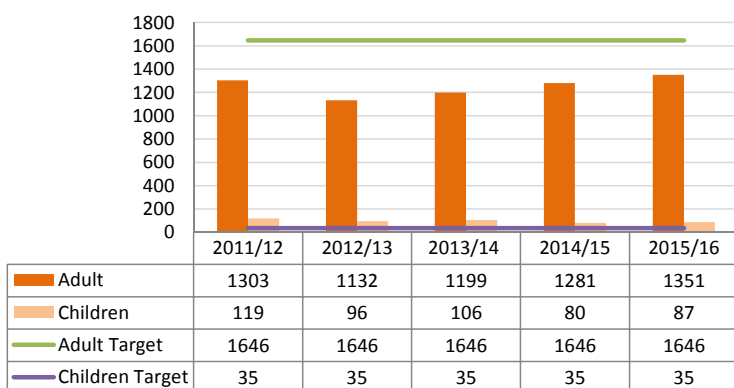
Breastfeeding results for Taranaki remain below the target despite significant activity in this space. Taranaki DHB have been working with the Tui Ora and Plunket to:

- Deliver the Mama Pepe Hauora Community Breastfeeding Support Service (including Lactation Consultants and Peer Support Counsellors)
- Accredited Early Childhood Education settings as Breastfeeding Welcome Here
- Provide group breastfeeding education to expecting and new mothers
- Maintain annual education standards with three Baby Friendly Community Initiative providers.

Taranaki DHB continues to maintain its Baby Friendly Hospital Initiative standard across both facilities. The MoH is now providing combined breastfeeding data to Taranaki DHB on a six monthly basis, this will allow us a full picture of breastfeeding for the region. It has been agreed that this data will now also be used to report against the Māori Health Plan.

STATEMENT OF PERFORMANCE

Number of referrals to the GRx (Green Prescription) programme



Target: Adult 1646; children 35

Number of referrals to the GRx (Green Prescription) programme

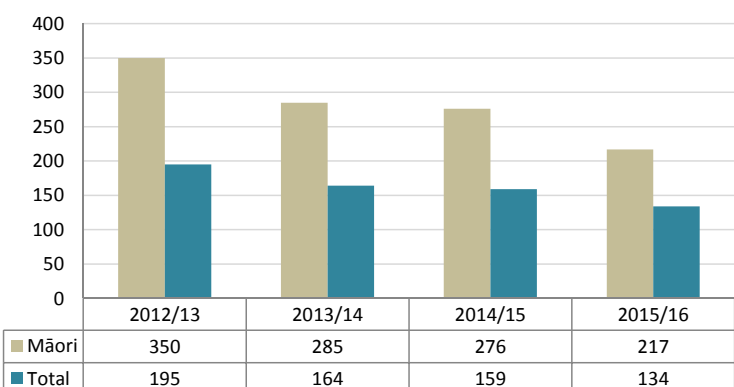
Adult	Target Not Achieved
Children	Target Achieved

Sport Taranaki is one of only two GRx providers that has achieved all nine of the annual KPIs for seven consecutive years.

Although Sport Taranaki did not quite reach the annual referral target for adults they managed to achieve over 80% as required in their contract. Referrals for diabetes and from Lead Maternity Carers (LMCs) are slowly increasing. However 79% of all those referred in 2015/16 went on to participate or complete the service which is an excellent result for a behaviour change intervention.

Active Families continues to exceed their annual referral target with the wrap around support provided by Whānau Pakari. Both programmes have a high referral and participation rate by Māori, in excess of 20%.

Teen birth rate per 10,000



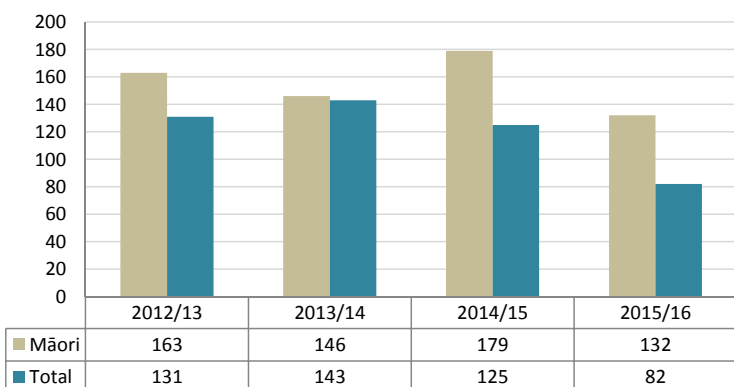
Target: Māori <285; Total population <164

Teen birth rate per 10,000

Māori	Target Achieved
Total	Target Achieved

The teen birth rate has reduced year on year for the past four years for Māori and non-Māori. The introduction of medical terminations has meant that the procedure is more accessible to all women across Taranaki. In addition, the introduction and increased uptake of Jadelle as a contraception option and Public Health nurses having standing orders/prescribing rights for emergency contraceptive and contraceptives has impacted on the teen birth rate. Informed patient choice and greater education around contraception is likely to have also reduced the number of pregnancies.

Teenage terminations of pregnancy rate per 10,000



Target: Māori <146; Total population <131

Teenage terminations of pregnancy rate - per 10,000

Māori	Target Achieved
Total	Target Achieved

The termination rate for both Māori and non-Māori has reduced in the past year. While access to this service remains available, it is pleasing to see that less young women have required it. It is also pleasing to note that the reduction of terminations has not necessarily resulted in an increase of teen births. Informed patient choice and greater education around contraception is likely to have also reduced the number of pregnancies.

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.



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 6. 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

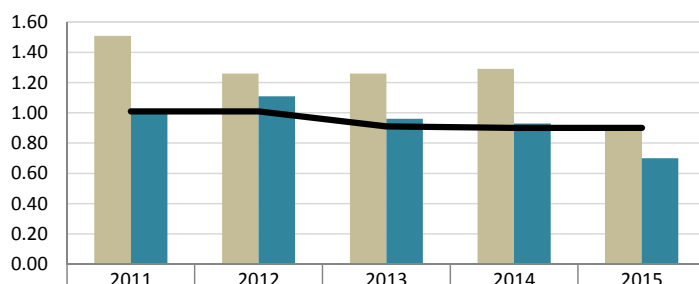
If we are to deliver on our twin goals of improving health outcomes, and reducing or eliminating health inequalities, for our older population, we aim to support people to maintain functional independence. With an increasing and ageing population, as this cohort increases, so does demand on our constrained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

Mean Decayed Missing or Filled Teeth (DMFT) score at year 8



	2011	2012	2013	2014	2015
Māori	1.51	1.26	1.26	1.29	0.89
Total	1.00	1.11	0.96	0.93	0.70
Target	1.0	1.0	0.9	0.9	0.9

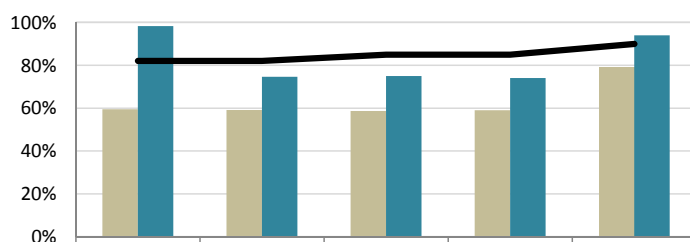
Reduction in the mean Decayed Missing or Filled Teeth (DMFT) score at year 8

The mean DMFT at year continues to decline with Māori continuing to have a higher rate than non Māori although the gap is reducing. Please note that this information is published for each year at the end of Quarter three (end of March each year).

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2015

Output Measures

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



	2011	2012	2013	2014	2015
Māori	60%	59%	59%	59%	79%
Total	98%	75%	75%	74%	94%
Target	82%	82%	85%	85%	90%

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

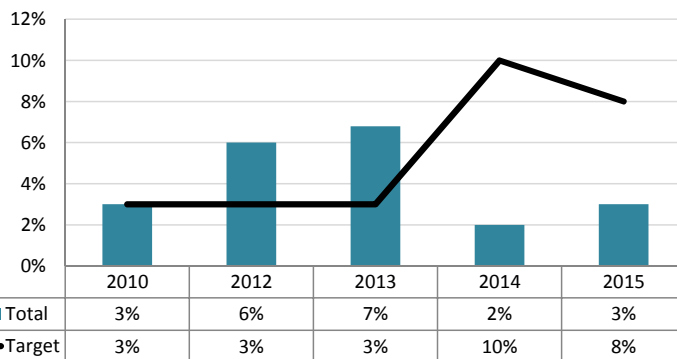
Māori	Target Not Achieved
Total	Target Achieved

Taranaki DHB has achieved this target for non-Māori and has made significant improvement in the enrolment of Māori children. Please note that this information is published for each year at the end of Quarter three (end of March each year).

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2015

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 2015

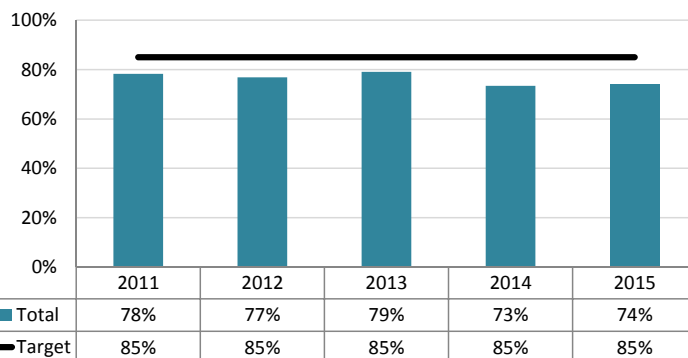
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination

Total Target Achieved

Taranaki DHB continues to measure this indicator to assess the service coverage for children between the ages of 0-12 years. Please note that this information is published for each year at the end of Quarter three (end of March each year).

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 lower 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 20135

Percentage of adolescent utilisation of DHB funded dental services

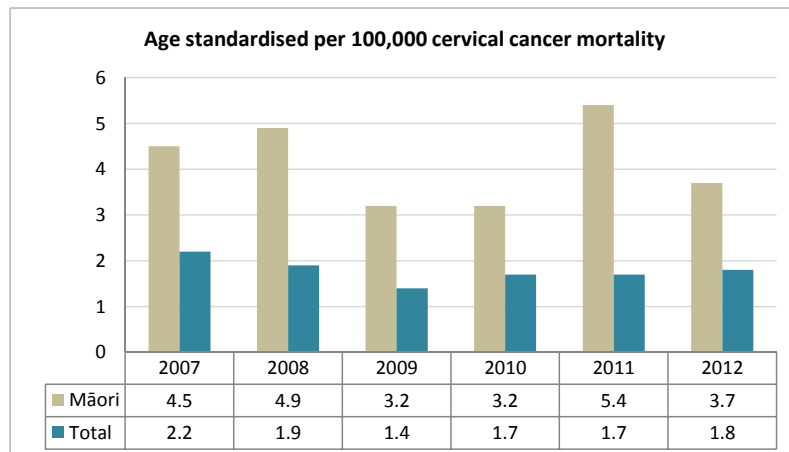
Total Target Not Achieved

Taranaki DHB continues to work to improve the percentage of adolescents receiving publicly funded oral health care. The service is delivered by both private dentists through the CDA and the Taranaki DHB Community Oral Health Service.

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.

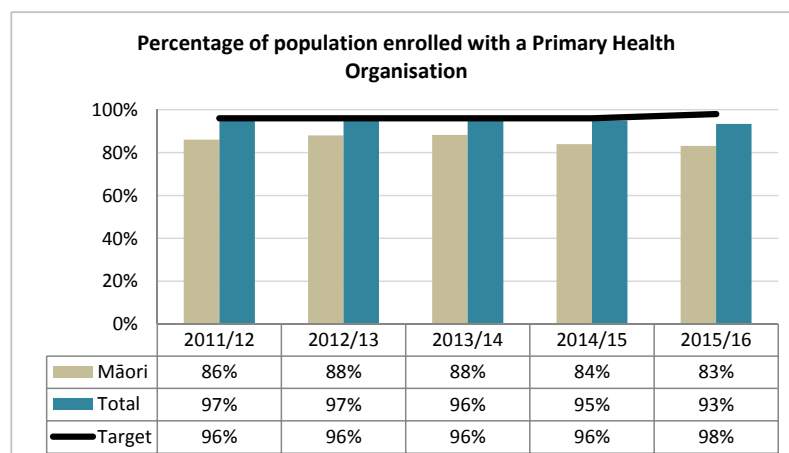
Cervical cancer mortality - age standardised per 100,000

This measure was last published in 2015 via the NZ Cancer Registry and Mortality data collection and relates to the 2012 period. Unfortunately this level of information is not available on a more timely basis.

Please note that the data used in this report are national results, not Taranaki DHB specific, however Taranaki DHB obviously contributes to the overall national outcome. As a system wide impact measure, it is important from a New Zealand perspective to look at the impact of cancer interventions across the country and the resulting health of our population. The latest annual results show a slight deterioration in the Total result and a noticeable improvement for Māori.

Our objective continues to be a reduction in cervical cancer mortality rates both locally and as part of the national health system.

Output Measures



Data Source: Ministry of Health PHO Enrolment Collection

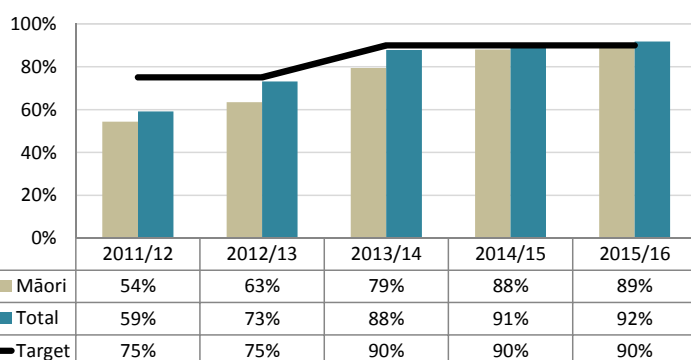
Percentage of population enrolled with a Primary Health Organisation (PHO)

Māori	Target Not Achieved
Total	Target Not Achieved

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. While enrolled within a PHO, it is of note that a significant number of people in the South Taranaki Area (e.g. Waverley and surrounding districts) enrol with a Whanganui PHO.

STATEMENT OF PERFORMANCE

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



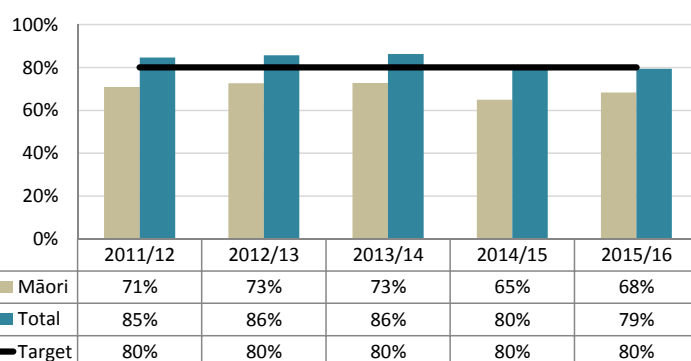
Data Source: Primary Health Organisation Performance Programme (PPP)

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

Taranaki DHB has continued to improve the percentage of eligible Māori and non-Māori who have had a CVDRA completed in the last five years. We continue to work with our Primary partners to achieve this indicator for our Māori population and maintain the current results for our non-Māori population.

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 Not Achieved

It is disappointing to note the decline in overall coverage rate. While Taranaki has seen a slight improvement in the percentage of eligible Māori women, overall we wish to see improvements in all women over the next year.

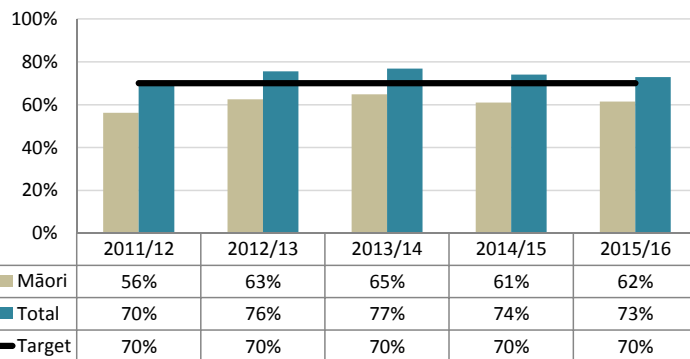
The data used for reporting is matched between PHO and the National Cervical Screening Programme, with the benefit of being able to identify and work with high needs practices to screen priority women.

Ethnicity data cleansing of 28,000 individuals against PHO data is being undertaken.

New initiatives continue with our Māori Health providers to promote and support community action development to priority women and work collaboratively with all health providers and groups. A steering group has been formed with stakeholders.

STATEMENT OF PERFORMANCE

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



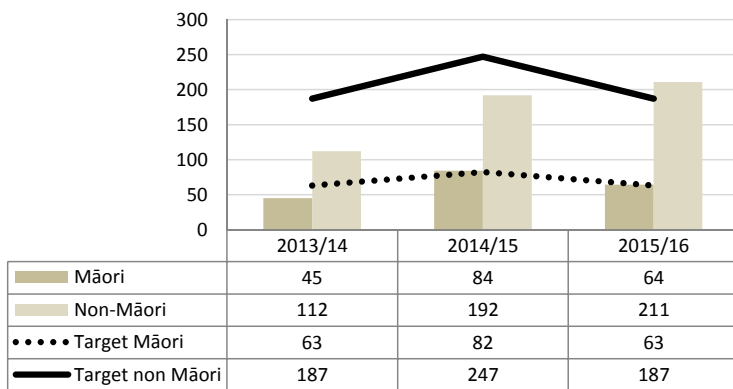
Data Source: Breast Screening Aotearoa

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.

Number of packages of care available to youth under PMHI



Data Source: Contract Reporting

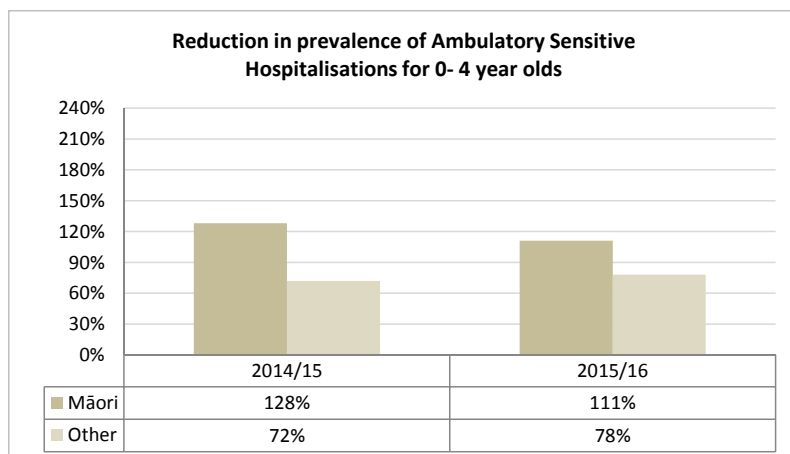
Increase the number of packages of care available to youth under the Primary Mental Health Initiative (PMHI)

Although the numbers of Māori accessing the youth PMHI services have decreased, the target was met. The PMHI is one of many ways that young people can access services when needed. Although the Social Sector Trial was exited in South Taranaki, the agencies and organisations involved are committed to continuing with services that had been embedded as part of the Trial.

STATEMENT OF PERFORMANCE

FEWER PEOPLE ARE ADMITTED TO HOSPITAL FOR AVOIDABLE CONDITIONS

Impact Measures



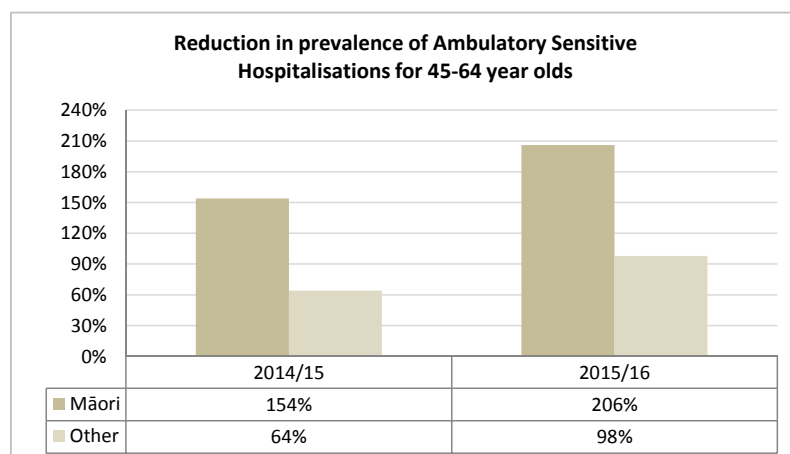
Target was to reduce on previously reported hospitalisations

Data Source: Ministry of Health National Minimum Dataset

Reduction in prevalence of Ambulatory Sensitive Hospitalisation (ASH)

The 2015/16 Annual plan outlined the impact measure of Ambulatory Sensitive Hospitalisations (ASH) being measured for the age band 0-74 years. However, the Ministry of Health stopped providing the data for this age band and instead are reporting two separated age bands (0-4 years and 45-64 years) now presented in the two separate graphs. This measure is important in identifying the effectiveness of Primary Care services and adds to the evidence that we need to work with our Primary partners to reduce these Ambulatory Sensitive Hospital(ASH) admissions, with a particular emphasis on reducing ASH rates for Māori.

Taranaki DHB and Pinnacle Midlands Health Network are working on a joint project to develop a new seamless model of co-ordinated health care which will be focussed on those people in the population with complex needs. The aim of this new model of care is that Taranaki patients are at the centre of health care so that the right person receives the right care and support from the right person at the right time. Care must be accessible and appropriate and reduce health inequalities. A strong focus for this project is to reduce avoidable hospital admissions.



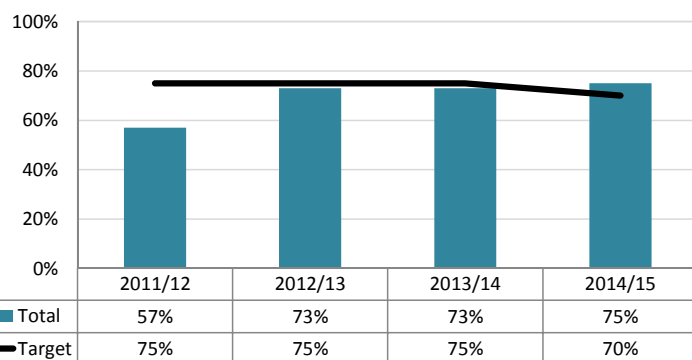
Target was to reduce on previously reported hospitalisations

Data Source: Ministry of Health National Minimum Dataset

STATEMENT OF PERFORMANCE

Output Measures

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



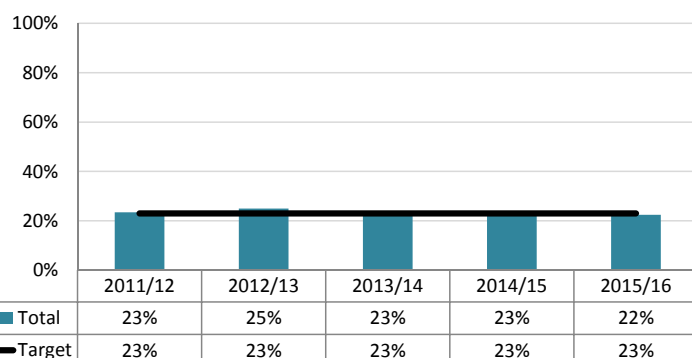
Data Source: Ministry of Health DHB claiming data

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

Total Not reportable

NB: Following advice from ACC, data for 2015/16 is unreliable, therefore unable to report on this measure.

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



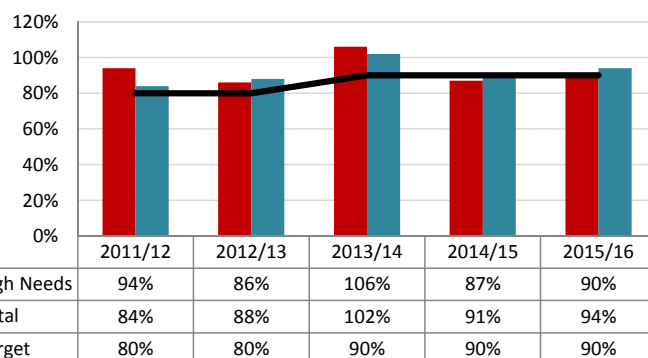
Data Source: National Non-admitted Patient Collections. Statistics New Zealand Population Projection 2013

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

Total Target Achieved

Taranaki DHB has achieved this target for 2015/16. Taranaki DHB are working with the primary sector to encourage triage 4 and 5 patients to present to their primary care provider rather than the Emergency Department. Triage 4 and 5 presentations are redirected back to primary care if appropriate. Ongoing public education has taken place to encourage patients to reconnect with their primary health provider to ensure continuity of care occurs.

Percentage of eligible population have their Before School Checks completed



Data Source: National Immunisation Register

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

High Needs Target Achieved

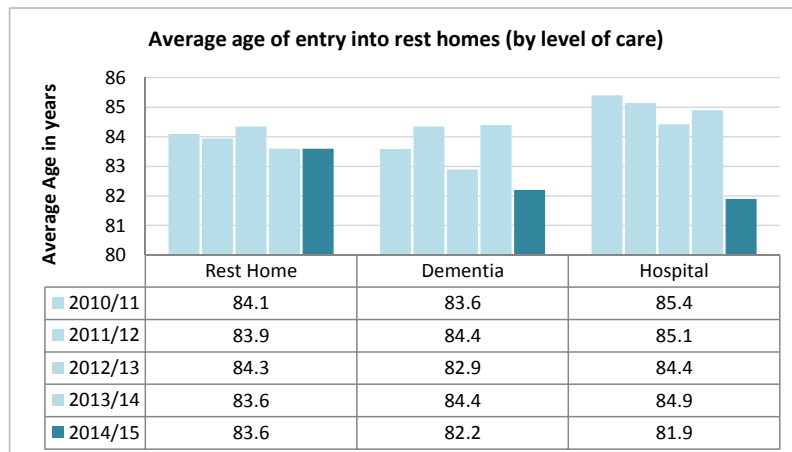
Total Target Achieved

Taranaki DHB met the targets for both high needs and total population. Detailed analysis is able to be undertaken on those not receiving the checks to assess the demographic profile and enable a more targeted approach to ensure that those most in need have a B4SC completed.

STATEMENT OF PERFORMANCE

MORE PEOPLE MAINTAIN THEIR FUNCTIONAL INDEPENDENCE

Impact Measures

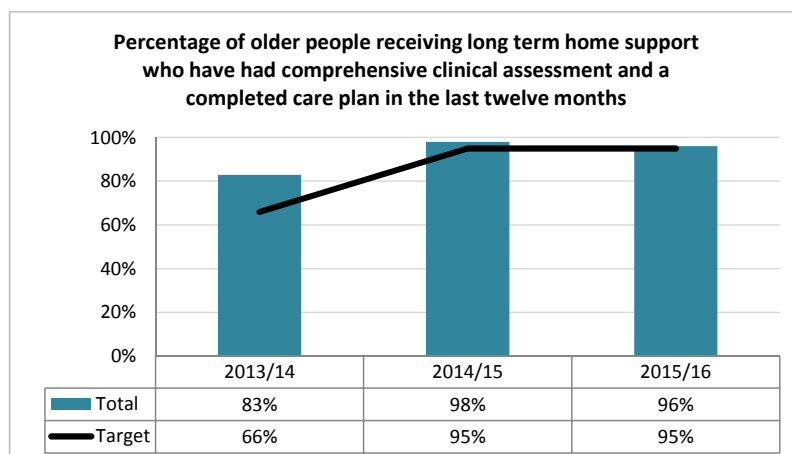


Data Source: Inter District Flow files

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

NB: The reported data is available 12 months in arrears from the national database for this measure. Consequently we are reporting the final results for 2014/15. We continue to manage expected growth in demand by improved models of care that support people to remain independent for as long as possible. Average age of entry to aged residential care is used as a proxy indicator for average length of stay in a residential care 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. Achievement of this target provides assurance that older people requiring home based support service have received a comprehensive clinical assessment of their needs.

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	2015/6
HBSS:ARC	1:2.45	1:2.34	1:2.41	1:2.58	1:2.57

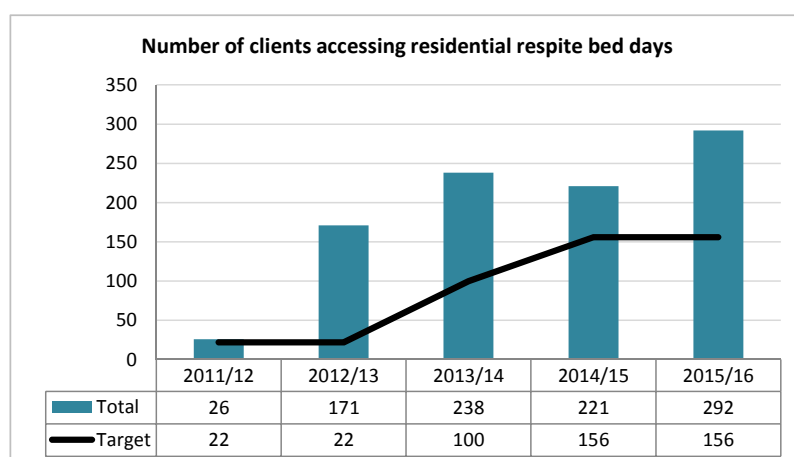
Target: to reduce the cost of rest home level of care funding compared to home based support services funding

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

Result	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. Although this target was achieved, it is important to note that the ratio can be influenced by a number of other factors (e.g. asset and income thresholds, aged residential care bed day prices, and proportion of individuals at different levels of care), so cannot be relied on as a sole indicator of effectiveness of home based support services.



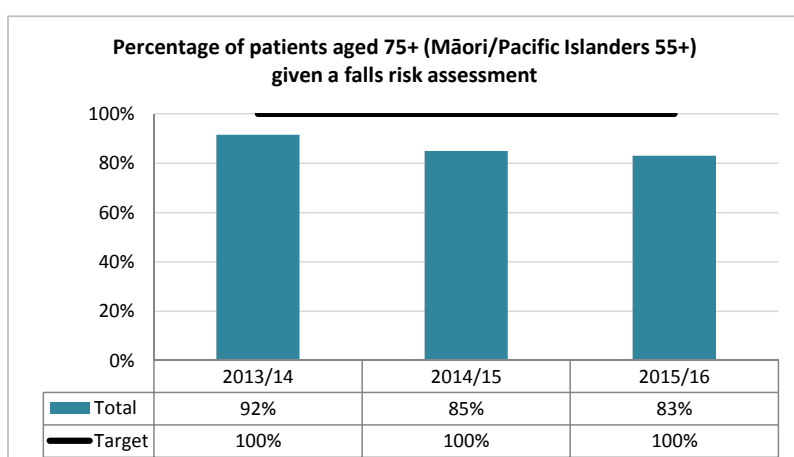
Target: increase the utilisation of respite services (2014/15 >156)

Data Source: Ministry of Health DHB Claiming data

Number of clients accessing residential respite bed days

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

Taranaki DHB has continued to significantly exceed its target for a number of clients accessing residential respite services during 2015/16. 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 (unlike carer support) does not require clients to pay a top up fee. We also have a number of other respite care options that our Needs Assessment and Service Coordination service promotes to carers to encourage them to take regular respite breaks.



Data Source: Taranaki DHB

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

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

The current target for this measure was a self-imposed target of 100% (compared to the international best practice rate of 90%) which was not achieved. It would be reasonable for us to consider revising our target in future to match the international best practice rate which allows for clinical variance in assessment processes (e.g. where other assessments take priority over a falls assessment due to clinical need) and recognises that 100% is very difficult to achieve in practice.

The DHB's Falls Prevention Committee continues to monitor compliance with this and other key quality and safety markers. Monthly review of the data has identified contributing factors and these have been fed back to individual areas resulting in tangible improvement in the last quarter of 2015/16 year. All of our areas where falls are high risk continue to exceed this marker.

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.



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 6). 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

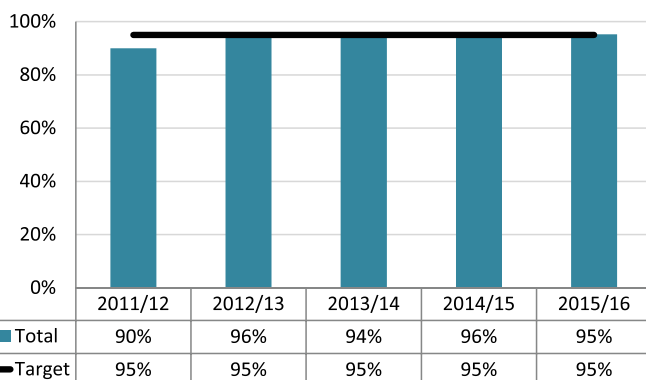
For people in our population who have end stage conditions, it is important that they, their family and Whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life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



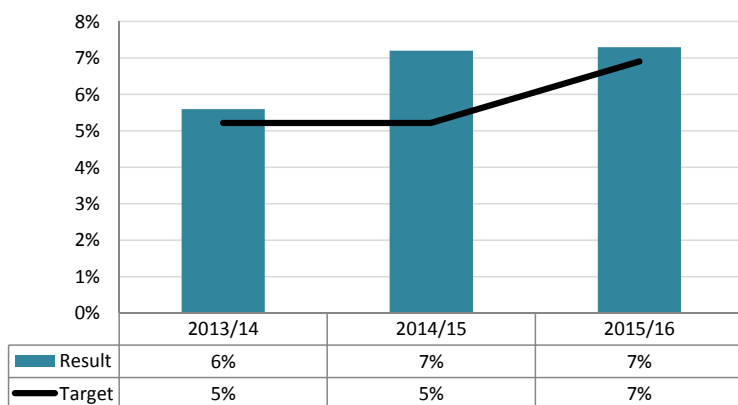
Data Source: Taranaki DHB Patient Management System

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

While this measure is reported within the National Health Targets, we believe that it also serves as an important impact measure for overall progress around managing acute care across both the primary and secondary services. Taranaki DHB has met this target for 2015/16. There has been significant work between the hospital and the primary sector on prevention of low acuity patients presenting to the Emergency Department. This has resulted in a decreased number of triage 4 and 5 patients presenting to the Emergency Department and has enabled more effective and timely care to be provided to the higher acuity patients.

Output Measures

Acute re-admission rate



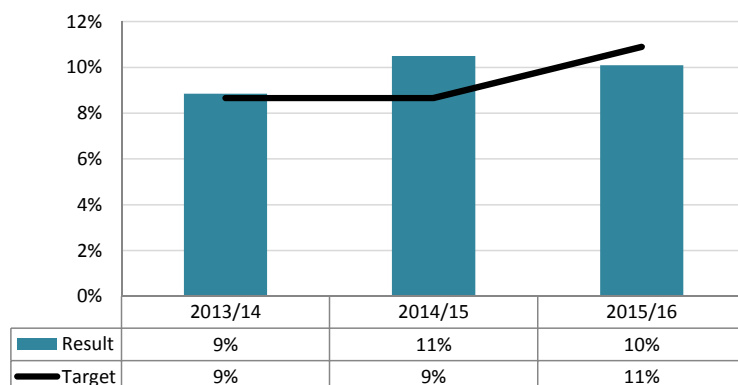
Data Source: National Minimum Dataset (NMDs)

Acute re-admission rate

Acute re-admission rate	Target Not Achieved
Acute re-admission rate (over 75 years)	Target Achieved

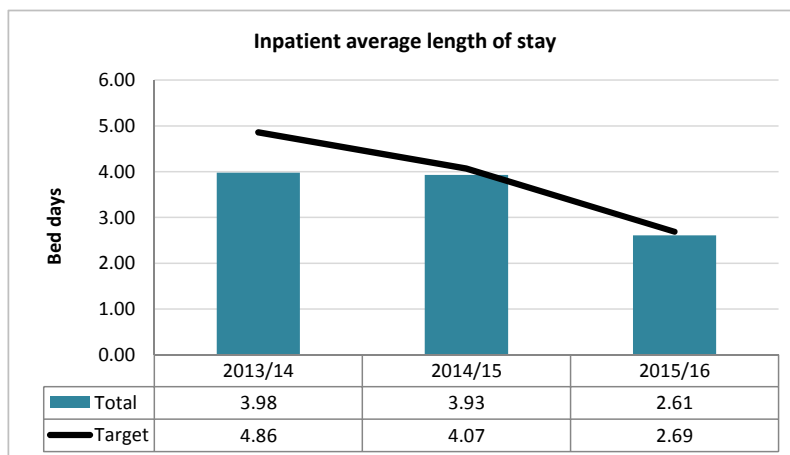
There are a number of unavoidable acute hospital readmissions which could be expected within our patient cohort. Good patient assessment and discharge planning can ensure the number of readmissions is reduced and we continue to monitor our readmission rates and diagnoses to identify trends and make improvements in this area.

Acute re-admission rate >75s



Data Source: National Minimum Dataset (NMDs)

STATEMENT OF PERFORMANCE



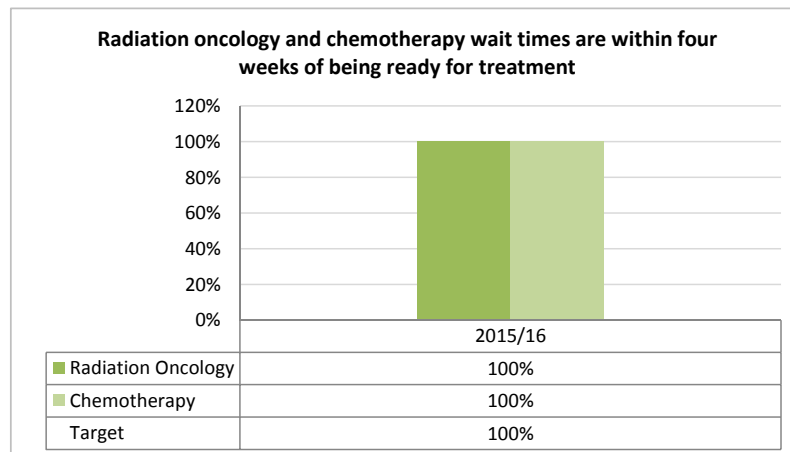
Data Source: National Minimum Dataset (NMDs)

Acute Inpatient average length of stay reduced

Total

Target Achieved

Please note that this information is published for each year at the end of Quarter three (end of March each year). A reduction in the length of stay has been achieved over the year. There is significant ongoing work occurring in the DHB to ensure early assessment, treatment and discharge occurs within the inpatient wards. Early case management and supporting patients to return home sooner may lead to a reduction in the rate of patient complications. The improved length of stay ensures that beds are available so patient flow across the hospital from the Emergency Department to the inpatients wards is unimpeded.



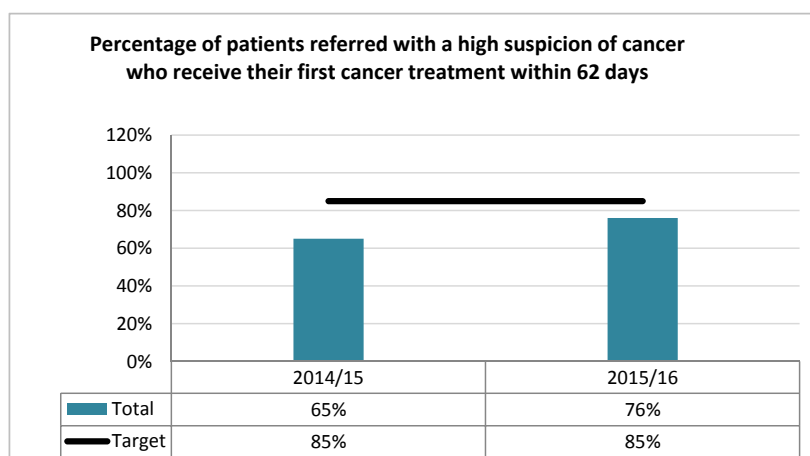
Data Source: Mid-Central DHB Patient Management System

100% radiation oncology and chemotherapy wait times are within 4 weeks of being ready for treatment

Total

Target Achieved

The results are now reported separately (as radiation oncology and chemotherapy) whereas previously they have been combined. Midcentral DHB provides both chemotherapy and radiotherapy for Taranaki patients. The two DHBs together continuously monitor the target to ensure all patients are seen within expected time frames. Some inpatient chemotherapy is provided locally at Taranaki Base Hospital.



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

Taranaki DHB is continuing to make good progress in achieving this target. Currently Taranaki DHB is fourth in the country for achieving Faster Cancer Treatment times and is ahead of the national average of 73.9%. The treatment time rates vary as we are dealing with very small numbers of patients and therefore one patient not meeting the target has a significant effect on the final number. There is considerable effort put into Faster Cancer Treatment timeframes and the patients' wellbeing is always at the forefront of anything that we do. Also, there are usually good reasons for patients not meeting the target and these are not always preventable, for example patient choice, clinical reasons, etc.

STATEMENT OF PERFORMANCE

New Measure

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

	2015/16
Result	87%
Target	80%

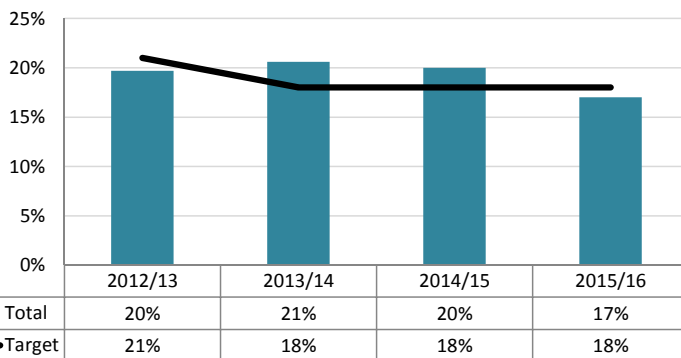
Data Source: Mid-Central DHB Patient Management System

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

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

Taranaki DHB is progressing well with the 31 day target. Although the number of patients tracked remains low, these patients have been identified as private breast cancer patients and therefore will not be captured in the data.

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



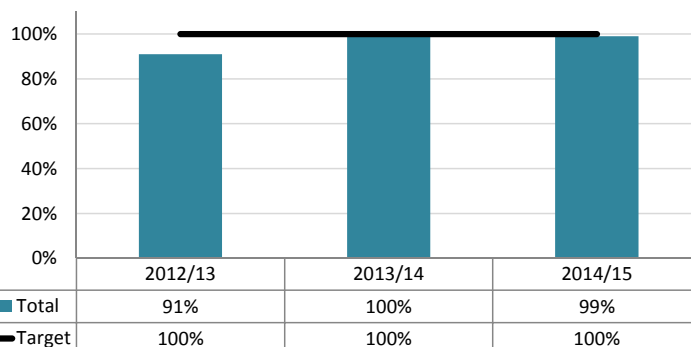
Data Source: National Minimum Dataset (NMDs)

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

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

Work continues in relation to reducing the caesarean section rate at Taranaki DHB. Whilst this has decreased we are motivated to reduce it further. The benefits to the women, baby and Taranaki DHB are great. All unexpected outcomes are reviewed by a case review committee. Antenatal clinics have been reviewed with the objective of increasing antenatal care for secondary care women, increasing education and reducing the caesarean section rate. In addition Taranaki DHB has increased access to incontinence clinics with the expectation that second delivery caesarean section rates are also reduced due to less disruption caused by this coexisting condition.

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	Not reportable
-------	----------------

The HQSC programme that required Taranaki DHB to collect and report on the WHO Surgical Safety Checklist, (including the blood clot statistics) ended in June 2015. Results are therefore not available to report for 2015/16. However, a new programme around Safe Surgery NZ quality and safety markers has been introduced and we are due to submit our first audit results in December 2016 for the period July - September 2016.

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 2015/16: 19.55	Not significantly different to target
Result 2014/15: 19.25	
Cataract procedures - target 27 per 10,000	
Result 2015/16: 32.64	Significantly above target
Result 2014/15: 33.39	
Cardiac surgery - target 6.5 per 10,000	
Result 2015/16: 5.67	Not significantly different to target
Result 2014/15: 5.86	
Percutaneous revascularisation - target 12.5 per 10,000	
Result 2015/16: 8.25	Significantly below target
Result 2014/15: 7.80	
Coronary Angiography Services - target 34.7 per 10,000	
Result 2015/16: 35.00	Not significantly different to target
Result 2014/15: 32.66	

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 percutaneous revascularisation 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. It is pleasing to see that Taranaki patients are receiving similar rates of access to the rest of the country. There has been a significant improvement in the orthopaedic joint replacement target and we continue to deliver a high rate of cataract operations.

Output Measures

Extract of Elective Services Performance Indicators (ESPI) results

ESPI 2 - No patients wait longer than four months for their specialist assessment	
Result: 0.57%	Not Achieved
Target: 0%	
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe	
Result: 0.96%	Not Achieved
Target: 0%	

Data Source: National Booking Reporting System (NBRS)

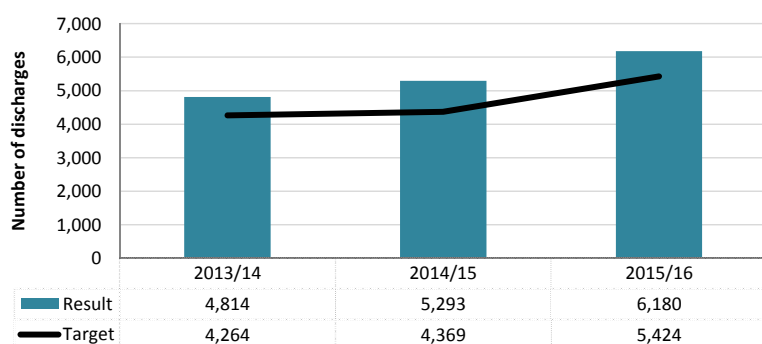
Extract of Elective Services Performance Indicators (ESPI) results

The Elective Services Performance 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 encompass when the person is first referred for specialist assessment, through to final treatment and/or discharged back to GP.

Taranaki DHB has largely achieved against all these indicators for 2015/16. There have been some months where there has been some non compliance however this has not been sustained.

STATEMENT OF PERFORMANCE

Number of Health Target elective surgical discharges



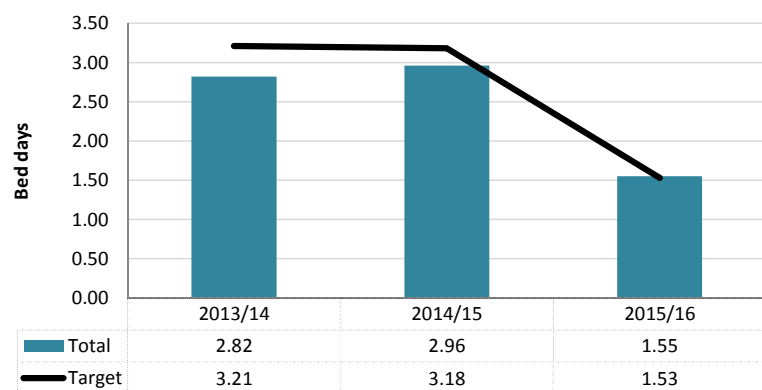
Data Source: National Minimum Dataset (NMDS)

Number of Health Target elective surgical discharges

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

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

Elective inpatient length of stay



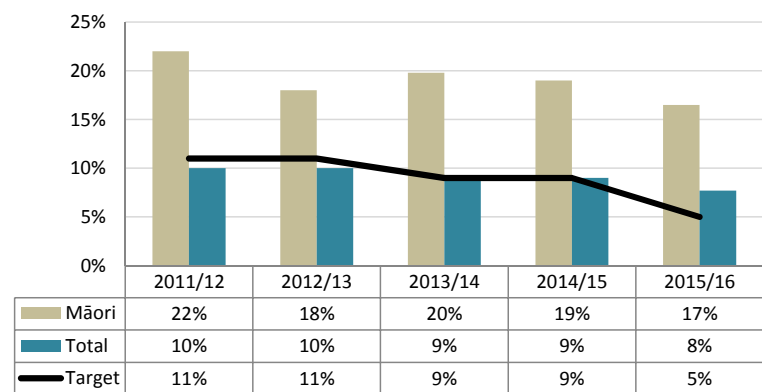
Data Source: National Minimum Dataset (NMDS)

Elective inpatient length of stay

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

Taranaki DHB continues to improve in this area however in this reporting period we have had to move to standardised length of stay for the first time and this has affected the target value. The project delivered for improving day procedure rates has been very successful and this group of patients has contributed to the reduction in length of stay (LOS) overall to 1.55 days which is only 0.02 days variance from the target.

Did Not Attend rate for outpatient services



Data Source: National Non-admitted Patient dataset

Did Not Attend (DNA) rate

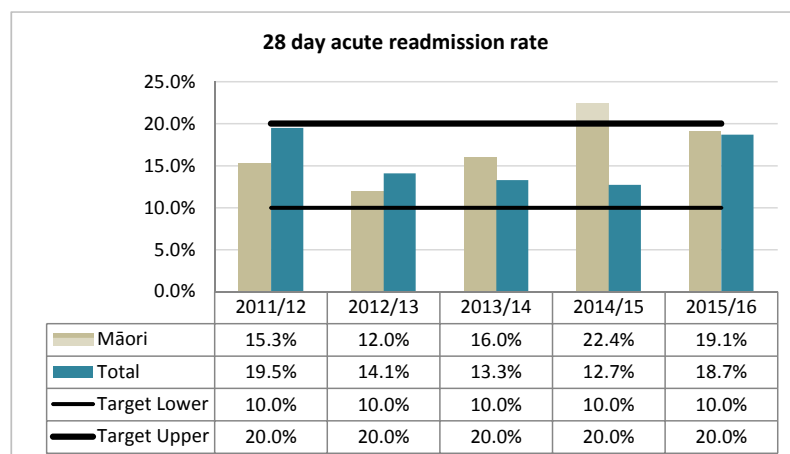
Māori	Not achieved
Total	Not achieved

Taranaki DHB has completed and is working on DNA projects within specific specialties. There have been improvements in some specialties and there is continuing work in this area. There is still significant inequity with Māori DNA rates and this is a continuing focus for the DHB. The Māori Health Unit is providing input into all of these projects to assist with the improvement in the Māori DNA rate. Ongoing monitoring and project work will be continuing in this area to ensure improvement occurs.

STATEMENT OF PERFORMANCE

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

Impact Measures



Target range is between 10-20%

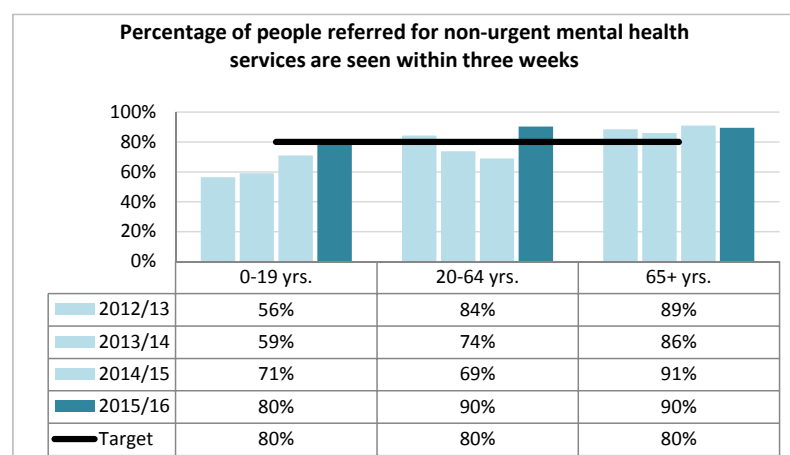
Data Source: Programme for the integration of Mental Health Data (PRIMHD)

28 day acute readmission rate

Readmission rates have been identified as a local KPI focus for the next two years.

A review of the service has been completed. An action plan will be developed and agreed in 2016/17 based on the identified themes from this review in order to seek a reduction in the number of readmissions within 28 days.

Output Measures



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

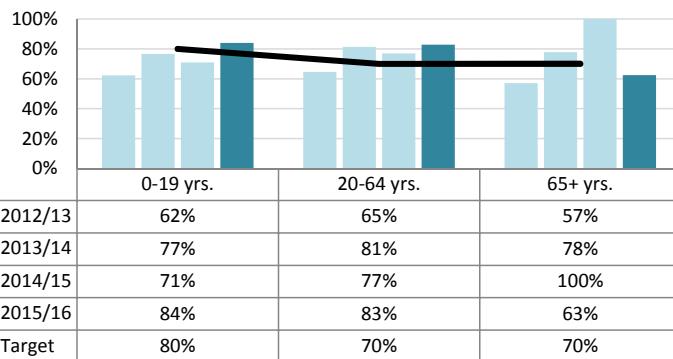
Improving the percentage of people referred for non-urgent mental health services are seen within three weeks

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

People seen in three weeks: The role of the Clinical Nurse Specialist (CNS) have been firmly embedded in the intake process and the reduced waiting time is a reflection of the higher degree of triage and decision-making that CNS are providing. Those that do not receive an assessment have a facilitated referral to a primary mental health agency that is ideally placed to meet the presenting needs of the individual, ensuring that the person has the right service address their needs.

STATEMENT OF PERFORMANCE

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



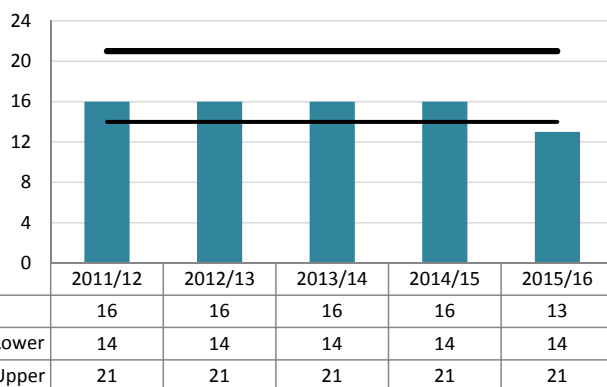
Data Source: Programme for the integration of Mental Health Data (PRIMHD)

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

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

As there are such small numbers any not seen within timeframe will affect the target percentage significantly. There were only eight non urgent addiction referrals for 65+ year group. The target of 70% required 5.6 people to be seen within that time frame. Five were seen within the three weeks. One person did not meet the target and two of the three not seen within that timeframe were seen within two days of the target.

Average length of stay for acute inpatients



Target: 14-21 days

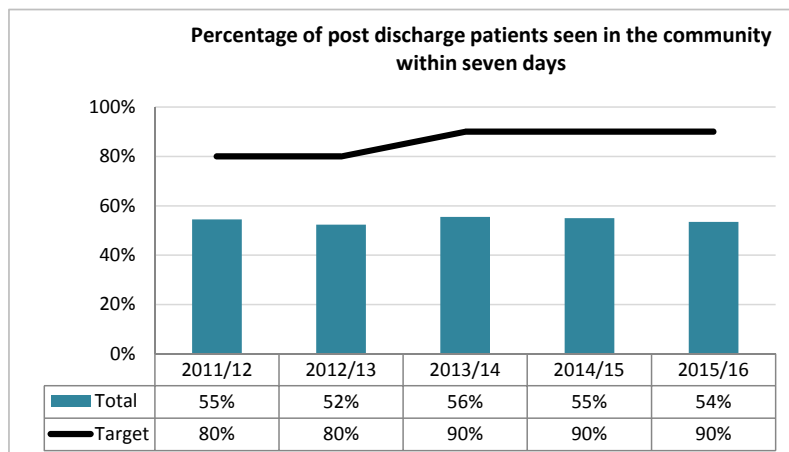
Data Source: Programme for the integration of Mental Health Data (PRIMHD)

Average length of stay for acute inpatients

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

Te Puna Waiora has had a number of long term clients residing in inpatient beds for long periods. This has been compounded by residential placement difficulties for this cohort meaning a high turn over in the other beds to ensure people in need are admitted. This has likely impacted on our readmission rate.

STATEMENT OF PERFORMANCE



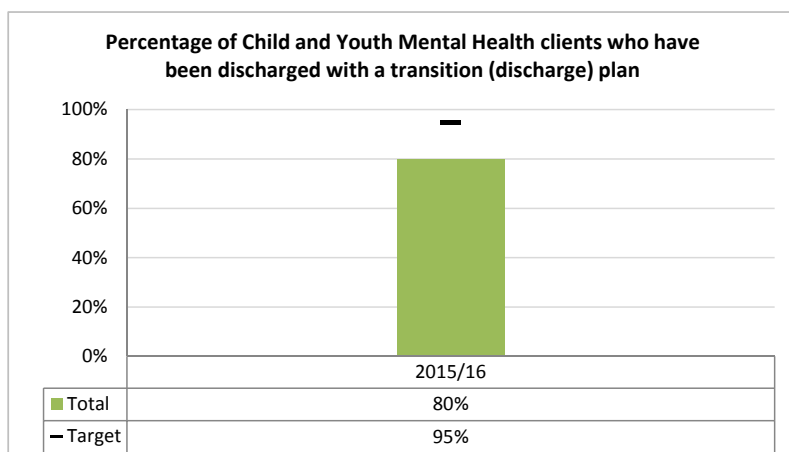
Target: 90-100%

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

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. This KPI is monitored in the Clinical Governance monthly meetings. 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.



Data Source: Mid-Central DHB Patient Management System

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

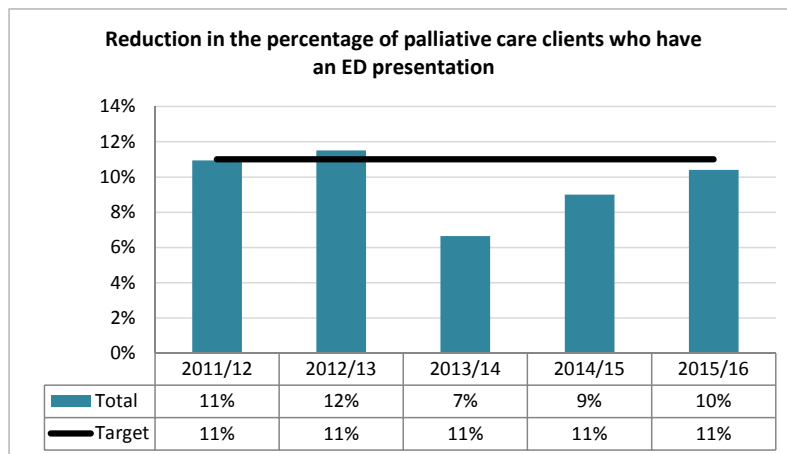
Total	Target Not Achieved
-------	---------------------

This reports on all routine discharges for the whole year. This process was newly introduced at the beginning of the period and while the target was not met for the full year it was met for the routine discharges in the final quarter.

STATEMENT OF PERFORMANCE

MORE PEOPLE WITH END-STAGE CONDITIONS ARE APPROPRIATELY SUPPORTED

Output Measures



Data Source: Taranaki Hospice

Reduction in the percentage of palliative care clients who have an Emergency Department (ED) presentation

Total	Target Not Achieved

While Taranaki DHB notes a slight increase in actual attendances, the overall result remains under our estimated target. We have therefore reported a not achieved as we did not reduce from the previous year's percentage.

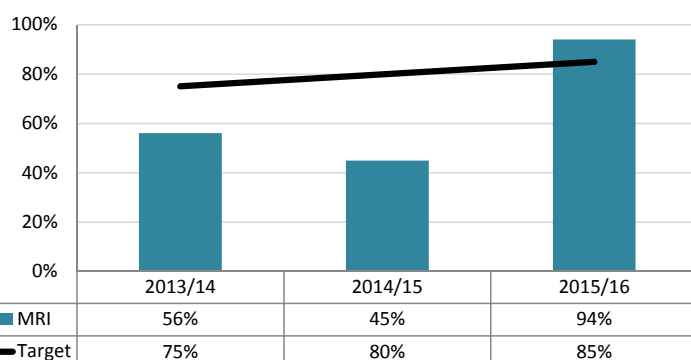
In February/March 2016, Hospice Taranaki (supported by Taranaki DHB) introduced two additional liaison staff to work with Aged Care providers as part of an additional initiative funded by the Ministry of Health. Also, Mokau and Inglewood District Nursing services have been further supported by the specialist palliative care team. We anticipate that these services will contribute to the reduction of the reliance on ED services over time.

STATEMENT OF PERFORMANCE

SUPPORT SERVICES

Output Measures

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



Data Source: Taranaki DHB

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

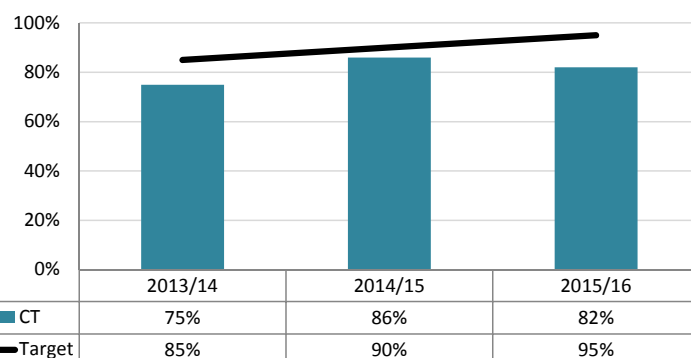
MRI	Target Achieved
CT	Target Not Achieved

Changes have been made to the provision of Radiology Services for Taranaki DHB. This has resulted in a marked improvement for MRIs which has seen us surpass the 85% target.

Work continues on meeting the CT target, a large increase in volume of referrals has meant we have not been able to meet the target.

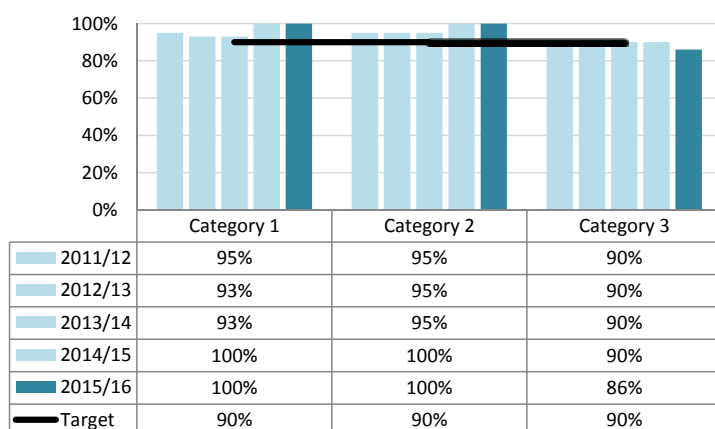
Please note that the reported data relates to results as at June 2016 rather than the full year.

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



Data Source: Taranaki DHB

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 Not Achieved

Category 1 = expected turnaround time within 24 hrs

Category 2 = expected turnaround time within 72 hrs

Category 3 = expected turnaround time within 96 hrs

Timely diagnostic results are vital to ensuring the best possible health outcomes for patients. Taranaki DHB is working closely with community laboratory services to understand why the target for 2015/2016 has not been met and how this can be addressed moving forward.

FINANCIAL REPORT

2015-2016





- 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 2016, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.




Sally Webb
Deputy Chairperson
27 October 2016



Richard Handley
Board Member
27 October 2016



Rosemary Clements
Chief Executive
27 October 2016



George Thomas
Chief Financial Officer
27 October 2016

Statement of Comprehensive Revenue and Expense

For the Year Ended 30 June 2016

	Notes	Actual June 2016 \$000	Budget June 2016 Unaudited \$000	Actual June 2015 \$000
Revenue	1	354,659	352,635	341,553
Other income	2	789	2,004	1,667
Total revenue		355,448	354,639	343,220
Employee benefit costs	3	123,087	115,901	114,826
Depreciation expense	13	15,521	15,770	16,046
Outsourced services		18,206	17,863	21,308
Clinical supplies		26,164	23,252	23,786
Infrastructure and non-clinical expenses		13,362	12,946	11,520
Payments to non-health board providers		152,539	157,130	148,736
Other expenses	4	1,872	2,079	1,672
Capital charge	5	5,822	6,089	6,230
Financing costs	6	2,660	2,872	3,065
Total expenses		359,233	353,902	347,189
(Loss) before share of associates		(3,785)	737	(3,969)
Share of surplus of associates	12(c)	116	-	182
(Loss) after surplus of associates		(3,669)	737	(3,787)
Other comprehensive revenue and expense				
Revaluation of land and buildings		-	-	-
Total other comprehensive revenue and expense		-	-	-
Total comprehensive revenue and expense		(3,669)	737	(3,787)

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

Statement of Changes in Net Assets / Equity

For the Year Ended 30 June 2016

	Note	Public Equity \$000	Accumulated Revenue and Expense \$000	Asset Revaluation Reserve \$000	Trust Fund Reserve \$000	Total \$000
At 30 June 2014		24,123	(6,835)	67,450	758	85,496
Comprehensive revenue and expense						
(Deficit) for the year		-	(3,787)	-	-	(3,787)
Other comprehensive income		-	-	-	-	-
Transfer from/(to) Trust Funds Reserve		-	(42)	-	42	-
		-	(3,829)	-	42	(3,787)
Transactions with the Crown						
Equity repaid to the Crown	30	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2015		23,164	(10,664)	67,450	800	80,750
Comprehensive revenue and expense						
(Deficit) for the year		-	(3,669)	-	-	(3,669)
Loss on consolidation of Subsidiary Company		-	130	-	-	130
Transfer from/(to) Trust Funds Reserve		-	(15)	-	15	-
		-	(3,554)	-	15	(3,539)
Transactions with the Crown						
Equity repaid to the Crown	30	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2016		22,205	(14,218)	67,450	815	76,252

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

Statement of Financial Position

For the Year Ended 30 June 2016

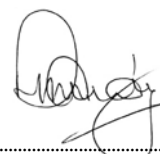
	Notes	Actual June 2016	Budget June 2016 Unaudited	Actual June 2015
		\$000	\$000	\$000
ASSETS				
Current assets				
Cash and cash equivalents	7	-	355	-
Trade and other receivables	8	13,026	10,970	14,651
Inventories	9	2,797	2,700	2,588
Other financial assets	10	2,890	-	2,890
Total current assets		18,713	14,025	20,129
Non-current assets				
Investments in associates	12	1,437	2,002	1,684
Other financial assets	10	56	56	56
Property, plant and equipment	13	180,258	187,423	182,483
Intangible assets	14	1,418	1,418	1,418
Restricted assets & trust funds	15	815	758	800
Total non-current assets		183,984	191,657	186,441
TOTAL ASSETS		202,697	205,682	206,570
LIABILITIES				
Current liabilities				
Cash and cash equivalents	7	8,185	-	8,266
Trade and other payables	16	18,957	23,982	18,883
Interest bearing loans and borrowings	17	19,200	-	19,200
Employee benefits	18	24,624	23,285	23,567
Provisions	19	18	10	60
Total Current Liabilities		70,984	47,277	69,976
Non current liabilities				
Interest bearing loans and borrowings	17	54,800	74,000	54,800
Employee benefits	18	661	1,025	1,044
Total non current liabilities		55,461	75,025	55,844
TOTAL LIABILITIES		126,445	122,302	125,820
NET ASSETS		76,252	83,380	80,750
EQUITY				
Public equity		22,205	22,149	23,164
Retained (losses)		(14,218)	(6,976)	(10,664)
Asset revaluation reserve		67,450	67,449	67,450
Trust fund reserve	15	815	758	800
TOTAL EQUITY		76,252	83,380	80,750

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 27th October 2016



Sally Webb
DEPUTY CHAIRPERSON



Richard Handley
BOARD MEMBER

Statement of Cash Flows

For the Year Ended 30 June 2016

		Actual June 2016	Budget June 2016 Unaudited	Actual June 2015
CASHFLOWS FROM OPERATING ACTIVITIES	Note	\$000	\$000	\$000
Cash was provided from:				
Receipts from Government and Public		356,645	353,754	339,162
Interest Received		345	525	517
GST (Net)		401	-	-
		<u>357,391</u>	<u>354,279</u>	<u>339,679</u>
Cash was disbursed to:				
Payments to Suppliers		211,707	213,963	214,069
Payments to Employees		122,413	115,006	113,718
Capital Charge Paid		5,822	6,089	6,230
Interest Paid		2,739	2,872	3,154
GST (Net)		-	-	113
		<u>342,681</u>	<u>337,930</u>	<u>337,284</u>
Net Cash Inflow from Operating Activities	20	<u>14,710</u>	<u>16,349</u>	<u>2,395</u>
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Dividends Received		2	60	62
Proceeds from Sale of Property, Plant & Equipment		84	-	-
		<u>86</u>	<u>60</u>	<u>62</u>
Cash was applied to:				
Purchase of Property, Plant & Equipment		13,304	15,350	8,559
Investments		437	-	-
Purchase of Intangible Assets		-	-	67
Restricted Assets		15	-	42
		<u>13,756</u>	<u>15,350</u>	<u>8,668</u>
Net Cash Outflow from Investing Activities		<u>(13,670)</u>	<u>(15,290)</u>	<u>(8,606)</u>
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds from Debt Financing		-	-	-
		<u>-</u>	<u>-</u>	<u>-</u>
Cash was applied to:				
Repayment of Equity		959	959	959
		<u>959</u>	<u>959</u>	<u>959</u>
Net Cash Outflow from Financing Activities		<u>(959)</u>	<u>(959)</u>	<u>(959)</u>
Net (Decrease)/Increase in Cash Held		81	100	(7,170)
Cash and cash equivalents at beginning of year		(8,266)	255	(1,096)
Cash and cash equivalents at end of year		<u>(8,185)</u>	<u>355</u>	<u>(8,266)</u>

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

Significant accounting policies for the year ended 30 June 2016**(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 100% 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 2016. The financial statements were authorised for issue by the Board on 27 October 2016.

(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.

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) Basis of consolidation**Subsidiaries**

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

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

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

Taranaki District Health Board held a 100% shareholding in Fulford Radiology Services Limited as at 30 June 2016.

Associates

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

- Allied Laundry Services Limited 19% held
- HealthShare Limited 20% held
- Fulford Radiology Services Limited nil (30 June 2015: 50%)

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 as a component of other income.

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

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

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

(d) Budget figures

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

Budget figures have not been audited.

(e) Revenue

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

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

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

(ii) ACC revenue

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

(iii) Inter district patient inflows

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

(iv) Interest received

Revenue is recognised using the effective interest method.

(v) Dividends received

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

(vi) Sale of goods

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

(vii) Rental revenue

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

(viii) Donation revenue

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

(f) Cash and cash equivalents

Cash and cash equivalents in the balance sheet comprise cash in hand, cash at bank, deposits held with an original maturity of three months or less.

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

(g) Trade and other receivables

Trade and other receivables are stated at amortised cost.

Trade receivables, which generally have 30 day terms, are recognised initially at fair value and subsequently measured at amortised cost less an allowance for impairment.

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

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.

(h) Inventories

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

All inventory purchased was acquired through exchange contracts.

(i) Investments and Other Financial Assets

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

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

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

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.

(j) Property, Plant and Equipment

Owned assets

Except for land and buildings, items of property, plant and equipment is stated at historical cost less any accumulated depreciation and any accumulated impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Leased assets

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

Land and buildings revalued

Land and buildings were revalued as at 30 June 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.

Class of Asset	Estimated life	Depreciation rate
Land	not depreciated	n/a
Buildings	4 to 60 years	3-25%
Plant and equipment	2 to 18 years	2-50%
Motor vehicles	3 to 10 years	10-33.3%

Impairment

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

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

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

(k) Intangible Assets

The shares held in NZ Health Partnerships Limited (NZ HPL), provide Taranaki District Health Board with rights to a finance procurement and supply chain (FPSC) under a service level agreement.

The intangible asset is recognised at the cost of the capital invested by the DHB in NZ HPL, who is the custodian of the FPSC Programme, a national initiative, facilitated by NZ HPL, whereby all 20 DHBs will move to a hosted services model for the provision of financial management system 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 NZ HPL 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.

(l) Finance Leases

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

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

(m) Operating Leases

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

(n) Trade and Other Payables

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

All trade and other payables are exchange transactions.

(o) Interest-bearing Loans and Borrowings

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

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

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

(p) Employee Leave Benefits

Short-term benefits

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

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

Long-term benefits

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

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

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

(q) Provisions

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

ACC Partnership Program

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

(r) Income Tax

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

(s) Goods and Services Tax (GST)

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

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

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

During the year there were no new mandatory standards, amendments and interpretations.

1 REVENUE

	2016	2015
	\$000	\$000
Health and disability services (Crown appropriation revenue)*	340,314	326,961
ACC revenue	5,757	5,188
Inter District Patient Inflows	4,021	3,594
Interest received	345	517
Dividends received	89	62
Bad debts recovered	5	7
Other revenue	4,128	5,224
	<u>354,659</u>	<u>341,553</u>

*Performance against this appropriation is reported in the Statement of Performance on pages 36-67. The appropriation revenue received by Taranaki District Health Board equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

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

	2016	2015
	\$000	\$000
Non-exchange transactions	343,654	329,802
Exchange transactions	11,005	11,751
	<u>354,659</u>	<u>341,553</u>

2 OTHER INCOME

	2016	2015
	\$000	\$000
Donations and bequests received	705	1,667
Gain on sale of property, plant and equipment	84	-
	<u>789</u>	<u>1,667</u>

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

	2016	2015
	\$000	\$000
Non-exchange transactions	705	1,667
Exchange transactions	84	-
	<u>789</u>	<u>1,667</u>

3 EMPLOYEE BENEFIT COSTS

	2016	2015
	\$000	\$000
Wages and salaries	120,478	112,385
Contributions to defined contribution schemes	1,837	1,658
Increase in employee benefits provisions	772	783
	<u>123,087</u>	<u>114,826</u>

4 OTHER EXPENSES

	2016	2015
	\$000	\$000
Impairment of trade receivables (bad and doubtful debts)	43	51
Loss on sale of property, plant and equipment	7	1
Audit fees - Deloitte (for the audit of the annual financial statements)	204	200
Audit fees - HSS Limited (ACC partnership plan)	4	4
Board and Advisory members fees	265	283
Board fees re Subsidiary Companies	7	-
Operating lease expenses	948	1,133
Goodwill written off	394	-
	<u>1,872</u>	<u>1,672</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 2016 was 8% (2015: 8%).

6 FINANCING COSTS

	2016	2015
	\$000	\$000
Interest on loans - Third Parties	16	-
Interest on loans - Ministry of Health	<u>2,644</u>	<u>3,065</u>
	<u>2,660</u>	<u>3,065</u>

7 CASH AND CASH EQUIVALENTS

	2016	2015
	\$000	\$000
Cash at bank and in hand	(8,185)	(8,266)
Short-term deposits maturing within 3 months of acquisition	-	-
Cash and cash equivalents	<u>(8,185)</u>	<u>(8,266)</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

	2016	2015
	\$000	\$000
Ministry of Health	4,981	6,330
Due from associates	555	207
Due from non-related parties	6,169	6,755
Prepayments	<u>1,417</u>	<u>1,411</u>
	13,122	14,703
Allowance for impairment loss (a)	<u>(96)</u>	<u>(52)</u>
Carrying amount of trade and other receivables	<u>13,026</u>	<u>14,651</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:

	2016	2015
	\$000	\$000
At 1 July	52	29
Charge for the year	68	51
Amounts written off	(24)	(28)
At 30 June	<u>96</u>	<u>52</u>
	2016	2015
	\$000	\$000
Total non commercial debt	164	124
Non commercial debt with no impairment allowance	68	72

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 2016 and 2015, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual		Actual	
	2016	2016	2015	2015
	Gross	Impairment	Gross	Impairment
	\$000	\$000	\$000	\$000
Taranaki District Health Board				
Not past due	12,498	-	14,066	-
Past due 1 - 30 days	106	-	125	-
Past due 31 - 60 days	51	(1)	134	(1)
Past due 61 - 90 days	51	(9)	3	(3)
Past due > 90 days	416	(86)	375	(48)
	<u>13,122</u>	<u>(96)</u>	<u>14,703</u>	<u>(52)</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

	2016	2015
	\$000	\$000
Non-exchange transactions	4,981	7,513
Exchange transactions	8,045	7,138
	<u>13,026</u>	<u>14,651</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 22.

(d) Credit Risk and Effective Interest Rate Risk

Details regarding the credit risk and effective interest rate of current receivables is disclosed in note 25.

9 INVENTORIES

	2016	2015
	\$000	\$000
Pharmaceuticals	467	471
Surgical and Medical Supplies	1,705	1,518
Other Supplies	625	599
	<u>2,797</u>	<u>2,588</u>

Inventory recognised as an expense for the year ended 30 June 2016 totalled \$10.873m (2015: \$10.026m)

The write-down of inventories held for distribution amounted to \$0.099m (2015 \$0.047m). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

	2016	2015
	\$000	\$000
Current portion		
Short-term deposits with maturities of 3-12 months	2,890	2,890
	<u>2,890</u>	<u>2,890</u>
Non-current portion		
Shares in CDC Pharmaceuticals Limited	56	56
	<u>56</u>	<u>56</u>

11 INVESTMENT IN SUBSIDIARY COMPANIES

	2016	2015
Investment details	\$000	\$000
Fulford Radiology Services Limited	-	n/a

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

Up until the 11th January 2016 Fulford Radiology Services Limited (FRSL) was a joint venture company formed by Taranaki District Health Board and Taranaki Radiologists Limited. On the 11th January 2016 Taranaki District Health Board purchased the shares owned by Taranaki Radiologists Limited. As a result of this Taranaki District Health Board owned 100% of FRSL. At 30 June 2016 the investment by Taranaki District Health Board in FRSL is valued at \$Nil.

12 INVESTMENT IN ASSOCIATE COMPANIES

	2016	2015
(a) Investment details	\$000	\$000
Allied Laundry Services Limited unlisted ordinary shares	1,150	750
Allied Laundry Services Limited Share of Retained Earnings	400	271
Fulford Radiology Services Limited unlisted ordinary shares	-	401
Fulford Radiology Services Limited Share of Accumulated Deficit	-	(239)
Fulford Radiology Services Limited loan to purchase assets	-	300
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	287	201
	<u>1,837</u>	<u>1,684</u>

Details of each Associate Company are as follows:

	Balance date	Interest held at 30 June 2016	Interest held at 30 June 2015
HealthShare Limited	30 June	20%	20%

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

Fulford Radiology Services Limited	30 June	100%	50%
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The principal activity of the associate is the provision of radiology services. On the 11th January 2016 Taranaki District Health Board purchased the 50% of shares not owned. Taranaki District Health Board now owns 100% of Fulford Radiology Services Limited effective the 11th January 2016 and its investment is now shown under Note 11 Investments in Subsidiary Company.

Allied Laundry Services Limited	30 June	19%	25%
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The principal activity of the associate is the provision of laundry services.

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

Summarised unaudited financial information - for the year ended 30 June 2016:

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	10,418	4,419	5,999	9,239	354
HealthShare Limited	14,962	13,688	1,274	11,979	(161)

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

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	6,022	1,422	4,600	8,002	757
Fulford Radiology Services Limited	3,323	2,956	367	13,760	43
HealthShare Limited	13,744	12,309	1,435	11,096	430

The above information has been extracted from the associate companies unaudited management accounts (2016) and audited financial statements (2015).

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

	2016	2015
	\$000	\$000
Balance at 1 July	1,684	1,502
Transfer of Associate Company Investment to Subsidiary Investment	(363)	-
Share of total recognised revenues and expenses	116	182
Balance at 30 June	1,437	1,684

13 PROPERTY, PLANT AND EQUIPMENT

	Freehold Land \$000	Freehold Buildings \$000	Plant and Equipment \$000	Motor Vehicles \$000	Work in Progress \$000	Total \$000
Year ended 30 June 2016						
Cost/revaluation 30 June 2015	8,860	149,612	82,839	3,185	5,949	250,445
Accumulated depreciation 30 June 2015	-	(13,620)	(51,688)	(2,654)	-	(67,962)
Carrying amount 30 June 2015	8,860	135,992	31,151	531	5,949	182,483
Current year additions	-	1,434	4,308	429	13,303	19,474
Current year work in progress capitalised	-	-	-	-	(6,171)	(6,171)
Current year disposals	-	-	(7)	-	-	(7)
Current year depreciation	-	(7,185)	(8,120)	(216)	-	(15,521)
At 30 June 2016 net of accumulated depreciation	8,860	130,241	27,332	744	13,081	180,258
At 30 June 2016						
Cost or fair value	8,860	150,892	84,387	3,122	13,081	260,342
Accumulated depreciation	-	(20,651)	(57,055)	(2,378)	-	(80,084)
	8,860	130,241	27,332	744	13,081	180,258

	Freehold Land \$000	Freehold Buildings \$000	Plant and Equipment \$000	Motor Vehicles \$000	Work in Progress \$000	Total \$000
Year ended 30 June 2015						
Cost/revaluation 30 June 2014	8,860	69,244	66,085	3,152	94,788	242,129
Accumulated depreciation 30 June 2014	-	(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	8,860	135,992	31,151	531	5,949	182,483
At 30 June 2015						
Cost or fair value	8,860	149,612	82,839	3,185	5,949	250,445
Accumulated depreciation	-	(13,620)	(51,688)	(2,654)	-	(67,962)
	8,860	135,992	31,151	531	5,949	182,483

In the year end 30 June 2016, there is a claim of \$1.502m (2015: \$1.600m) outstanding which relates to completed remedial work.

Restrictions

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

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

Valuation

Land and buildings were independently valued as at 30th June 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 PBE IPSAS 17 as issued by External Reporting Board (XRB), and valuation guidelines for specialised items in the Health sector issued by Treasury.

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

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

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

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

Impairment

The assessment of assets indicated no impairment for the year ended 30th June 2016 (2015: Nil).

14 INTANGIBLE ASSETS

	Shares in NZ HPL \$000	Total \$000
Year ended 30 June 2016		
Carrying amount 30 June 2015	1,418	1,418
Current year additions	-	-
Amortisation charge for year	-	-
At 30 June 2016 net of accumulated amortisation	1,418	1,418
At 30 June 2016		
Cost or fair value	1,418	1,418
Accumulated amortisation and impairment	-	-
	1,418	1,418
	FPSC Rights \$000	Total \$000
Year ended 30 June 2015		
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 amortisation	1,418	1,418
At 30 June 2015		
Cost or fair value	1,418	1,418
Accumulated amortisation and impairment	-	-
	1,418	1,418

15 RESTRICTED ASSETS AND TRUST FUNDS

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

	2016 \$000	2015 \$000
Opening Balance	800	758
Funds Received	93	134
Interest Received	15	26
Funds Spent	(93)	(118)
Closing Balance Restricted Assets	815	800
Represented By:		
Cash at Bank	208	193
Short Term Deposits	600	600
Shares & Other	7	7
Total Restricted Assets	815	800

16 TRADE AND OTHER PAYABLES

	2016	2015
	\$000	\$000
Trade Payables	15,728	15,807
Capital Charge Payable	-	-
Income received in advance	429	460
Interest Payable	370	449
Owing to Associates	693	831
GST Payable	1,737	1,336
	<u>18,957</u>	<u>18,883</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.

17 INTEREST-BEARING LOANS AND BORROWINGS

	2016	2015
	\$000	\$000
Government Sector Borrowing	74,000	74,000
Total Loans	<u>74,000</u>	<u>74,000</u>
Less Current Portion	19,200	19,200
Term Portion	<u>54,800</u>	<u>54,800</u>

Interest Rates	2016	2015
Government Sector Borrowing	2.21% - 4.55%	3.03% - 4.55%

	2016	2015
	\$000	\$000
Government Sector Borrowings		
Due for repayment:		
within one year	19,200	19,200
within two years	22,000	-
within three years	15,600	22,000
within four years	-	15,600
within five years	5,200	-
after five years	12,000	17,200
	<u>74,000</u>	<u>74,000</u>

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

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

FAIR VALUE OF GOVERNMENT BORROWING

The fair value of the \$74m (2015: \$74m) of Government Borrowing at 30 June 2016 was calculated at \$76.615m (2015: \$75.254m). This calculation is done by discounting the expected future cash flows at prevailing interest rates.

18 EMPLOYEE BENEFITS

	2016	2015
	\$000	\$000
Salary & wages accrual	5,101	5,199
Annual Leave	15,755	14,600
Sick Leave	418	384
Long Service Leave	1,502	1,672
Retirement gratuities	671	898
Continuing Medical Education	1,602	1,649
Sabbatical Leave	236	209
	<u>25,285</u>	<u>24,611</u>
Made up of:		
Current	24,624	23,567
Non-current	661	1,044
	<u>25,285</u>	<u>24,611</u>

19 PROVISIONS

	2016	2015
	\$000	\$000
Current provisions		
ACC Partnership Programme	18	60
	<u>18</u>	<u>60</u>

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2016. All outstanding claims by Taranaki District Health Board's employees are estimated by claim managers as at this point.

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

	2016	2015
	\$000	\$000
Net Loss	(3,669)	(3,787)
Add Non-Cash Items:		
Depreciation	15,521	16,046
Increase in Provision for Doubtful Debts	44	23
Increase in Employee Entitlements	674	1,108
	<u>16,239</u>	<u>17,177</u>
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	813	(183)
(Gain) / Loss on Disposal of Assets	(77)	1
	<u>736</u>	<u>(182)</u>
Movements in Working Capital:		
Decrease/(Increase) in Receivables & Prepayments	1,667	(4,161)
(Increase)/Decrease in Inventories	(209)	17
(Decrease) in Payables & Accruals	(54)	(6,669)
	<u>1,404</u>	<u>(10,813)</u>
Net Cash Inflow from Operating Activities	<u><u>14,710</u></u>	<u><u>2,395</u></u>

21 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	2016	2015
	\$000	\$000
<i>Board Members</i>		
Remuneration	265	283
Full-time equivalent members	1.7	1.7
<i>Executive management</i>		
Remuneration	1,851	1,650
Full-time equivalent employees	7.0	7.0
Total key management personnel remuneration	2,116	1,933
Total full-time equivalent personnel	8.7	8.7

22 RELATED PARTY TRANSACTIONS

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

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the District Health Board would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Related Party Transactions and Balances

(a) Funding

Taranaki District Health Board received \$340.315m from the Ministry of Health to provide health services to the Taranaki area (2015: \$326.962m). The amount outstanding at year end was \$4.981m (2015: 6.330m).

(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	
		2016	2015	2016	2015
		\$000	\$000	\$000	\$000
TDHB Transactions					
Allied Laundry Services Limited	Dividend and rents received	148	62	105	81
Fulford Radiology Services Limited	Rent and services received	n/a	77	203	309
NZ Health Partnerships Limited	DHB national collective service agreements	-	-	-	-
Healthshare Limited	IT consultancy	406	68	747	491
		554	207	1,055	881

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	
		2016	2015	2016	2015
		\$000	\$000	\$000	\$000
Allied Laundry Services Limited		85	126	1,060	1,066
Fulford Radiology Services Limited		n/a	674	1,992	8,400
NZ Health Partnerships Limited		54	-	583	-
Health Benefits Limited		-	-	-	662
Health Benefits Limited - FPSC rights		-	-	-	67
Healthshare Limited		608	31	2,147	1,471
		747	831	5,782	11,666

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

23 FINANCIAL INSTRUMENT CATEGORIES

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

		2016	2015
		\$000	\$000
FINANCIAL ASSETS			
Loans and receivables			
Cash and cash equivalents	7	-	-
Trade and other receivables	8	11,609	13,240
Other financial assets - current	10	2,890	2,890
Other financial assets - non current	10	56	56
Restricted Assets and Trust Funds	15	815	800
Total loans and receivables		15,370	16,986

FINANCIAL LIABILITIES

Financial liabilities at amortised costs

	Notes		
Trade and other payables	16	18,528	18,423
Interest bearing loans and borrowings	17	74,000	74,000
Total financial liabilities		92,528	92,423

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 (note 17).

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

24 FAIR VALUE HIERARCHY DISCLOSURES

For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy:

- (i) Quoted market price (level 1) - Financial instruments with quoted prices for financial instruments in active markets.
- (ii) Valuation technique using observable inputs (level 2) - Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable.
- (iii) Valuation technique with significant non-observable inputs (level 3) - Financial instruments valued using models where one or more significant inputs are not observable.

The following table analyses the basis of the valuation of classes of financial instruments measured at fair value in the statement of financial position.

	Quoted market price	Observable inputs	Significant non- observable inputs	Total
	\$000	\$000	\$000	\$000
2016				
Financial assets	-	-	180,258	180,258
Financial Liabilities	-	-	-	-
2015				
Financial assets	-	-	182,483	182,483
Financial Liabilities	-	-	-	-

25 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% (2015: 97%) whilst it accounted for 85% (2015: 75%) 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**2016**

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
Non-derivative financial liabilities						
Trade and other payables	18,528	18,528	18,528	-	-	-
Loans and borrowings	74,000	80,608	121	21,115	40,116	19,256
	92,528	99,136	18,649	21,115	40,116	19,256

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	3-7 years \$000
Non-derivative financial liabilities						
Trade and other payables	18,423	18,423	18,423	-	-	-
Loans and borrowings	74,000	82,855	121	21,628	25,430	35,676
	92,423	101,278	18,544	21,628	25,430	35,676

(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)	
	2016	2015
	\$000	\$000
+1% (100 basis points)	29	29
-1% (100 basis points)	(29)	(29)

26 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.

27 CAPITAL COMMITMENTS AND OPERATING LEASES

	2016	2015
	\$000	\$000
Capital Commitments		
Property, plant and equipment	2,252	1,201
	<u>2,252</u>	<u>1,201</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	493	729
Later than one and not later than two years	365	259
Later than two and not later than five years	184	315
Later than five years	178	236
	<u>1,220</u>	<u>1,539</u>

28 MAJOR VARIATIONS FROM BUDGET (unaudited)

Income Statement Variances - Revenue

Taranaki District Health Board recorded a deficit of \$3.67 million compared with a budgeted surplus of \$0.74 million.

A total of \$0.809 million additional revenue over budget was received as follows (2015: \$5.050m):

	Variance unaudited	Variance unaudited
	2016	2015
	\$000	\$000
Ministry of Health Funding	932	3,399
Accident Compensation Revenue (ACC)	618	529
Inter District Flows	(8)	(395)
Inter Provider Revenue	37	34
Interest Received	(180)	17
Donations Received	(1,299)	(833)
Other	709	2,299
	<u>809</u>	<u>5,050</u>

Income Statement Revenue Explanations

Ministry of Health Funding	Additional services and initiatives for the Ministry of Health
Accident Compensation Revenue (ACC)	Utilisation of additional Theatre at Base rather than outsourcing
Donations	Timing difference between donation pledge and receipt
Other	Reassignment of a revenue contract from the Ministry of Health to a third party

Income Statement Variances - Expenditure

A total of \$5.331m additional expenditure over budget were incurred as follows (2015: \$8.084m):

	Variance Unaudited 2016 \$000	Variance Unaudited 2015 \$000
Employee Benefit costs	7,186	4,820
Depreciation Expense	(249)	14
Outsourced services	343	2,815
Clinical supplies	2,912	2,154
Infrastructure and non-clinical expenses	416	(2,250)
Payments to non-health board providers	(4,591)	669
Other	(686)	(138)
	<u>5,331</u>	<u>8,084</u>

Income Statement Expenditure Explanations

Employee Benefit costs	Higher levels of activity and consolidation of Fulford Radiology Services Limited
Clinical Supplies	Increased demand and inclusion of Fulford Radiology Services Limited
Payments to non-health board providers	Additional rebates from PHARMAC and lower expenditure for Health of Older People
Other	Decreasing interest rates, and reduced capital charge cost due to deficits

	Variance Unaudited 2016 \$000	Variance Unaudited 2015 \$000
Cash & S/T Deposits	(8,540)	(12,771)
Other Financial Assets	2,890	-
Property, plant and equipment	(7,165)	615
Receivables & Prepayments	2,056	6,701
Employee Entitlements	975	2,989
Payables	(5,025)	(5,459)

Balance Sheet Explanations

Cash & S/T Deposits	Two years of deficits and not utilising available short term deposits
Property, plant and equipment	Deferral of capital expenditure
Employee Entitlements	Inclusion of Fulford Radiology Services Limited employee entitlements
Payables	Timing of payments to suppliers

29 AUDITORS' REMUNERATION

		2016	2015
		\$000	\$000
Fees to principal auditor (Deloitte)	Note		
Audit of annual financial statements	4	204	200
		2016	2015
		\$000	\$000
Other Audit Fees paid (non Deloitte)	Note		
HSS Limited (ACC partnership program)	4	4	4

30 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 (2015: \$Nil). Public equity of \$0.959m (2015: \$0.959m) was repaid to the Crown during the year. The repayments in both 2016 & 2015 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.

31 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 2016	Actual 2015
100,000 - 110,000	32	29
110,001 - 120,000	22	12
120,001 - 130,000	5	5
130,001 - 140,000	5	8
140,001 - 150,000	8	4
150,001 - 160,000	5	11
160,001 - 170,000	5	8
170,001 - 180,000	11	3
180,001 - 190,000	6	5
190,001 - 200,000	8	10
200,001 - 210,000	7	4
210,001 - 220,000	6	4
220,001 - 230,000	2	4
230,001 - 240,000	3	1
240,001 - 250,000	1	4
250,001 - 260,000	3	4
260,001 - 270,000	3	7
270,001 - 280,000	4	4
280,001 - 290,000	6	2
290,001 - 300,000	5	2
300,001 - 310,000	4	3
310,001 - 320,000	2	2
320,001 - 330,000	2	1
330,001 - 340,000	2	-
350,001 - 360,000	1	-
390,001 - 400,000	-	1
460,001 - 470,000	1	-
470,001 - 480,000	1	-
	<u>160</u>	<u>138</u>
Clinicians	130	114
Non Clinical	<u>30</u>	<u>24</u>
Total	<u>160</u>	<u>138</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 193 (2015: 167).

32 TERMINATION PAYMENTS

For the period to 30 June 2016, 1 employee or former employee of Taranaki District Health Board received payment in respect of termination of employment for \$51,217 (2015: 0 payments totalling \$0m).

33 EVENTS SUBSEQUENT TO BALANCE DATE

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

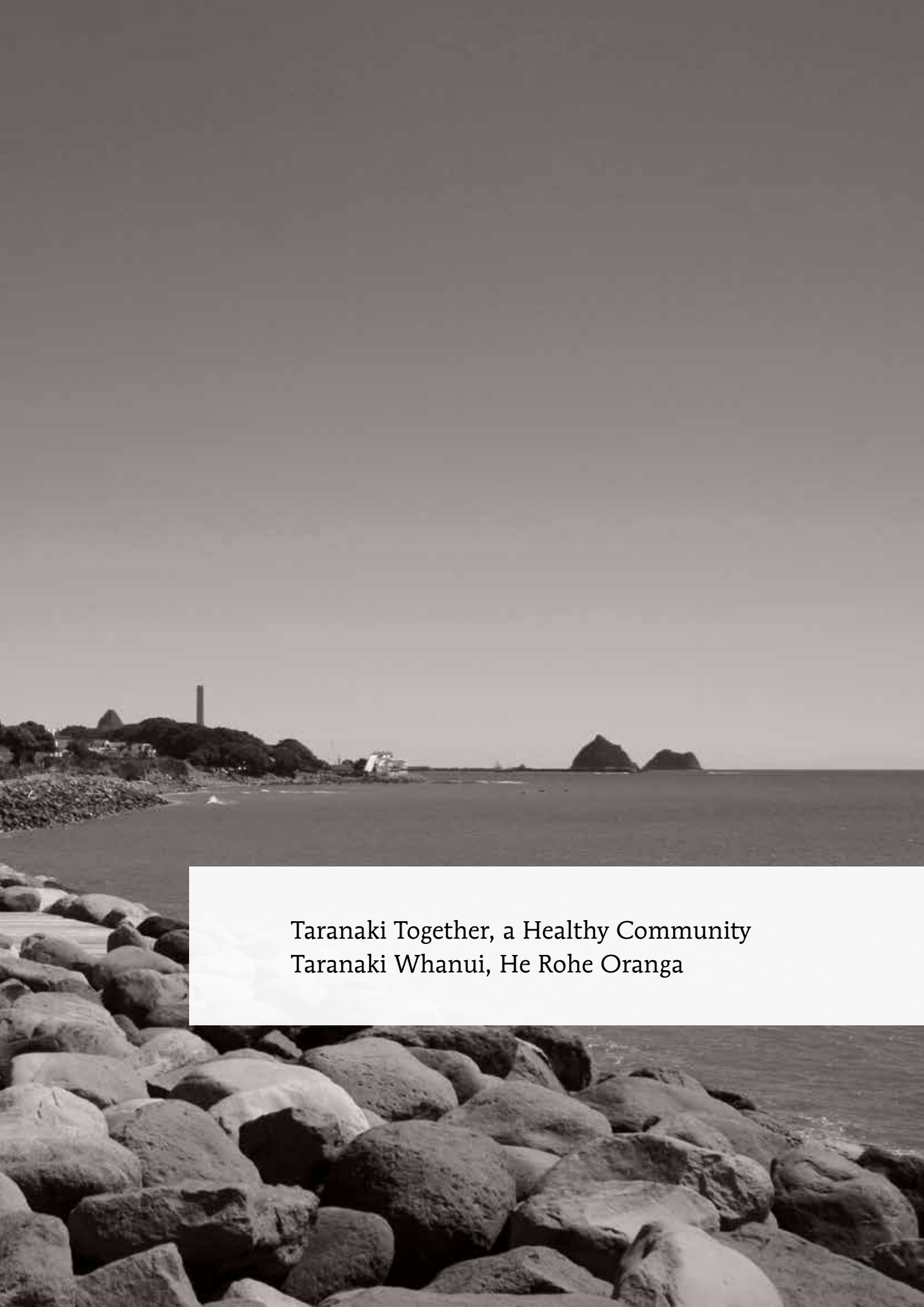
Reporting on 'good employer' practices

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"> Code of Conduct Equal Employment Opportunities (EEO). TDHB value statements – Nga Tikanga Performance Review policy 	<ul style="list-style-type: none"> Formal leadership programmes Suite of management development sessions Organisational forum for all employees. Formal management and management/union meetings New Managers' Induction Workplace Behaviours Programme National Leadership Domains Framework Succession planning and talent development programmes Clinical Leadership in Practice Programme Team workshops to support our Nga Tikanga values and effective team functioning 	<ul style="list-style-type: none"> Implementation of an Internal Leadership Development programme for new managers and aspiring leaders Embedding of talent development processes and outcomes 	<ul style="list-style-type: none"> Talent development programmes launched Implementation of National Leadership Domains Team workshops rolled out around Taranaki DHB
Recruitment, Selection	<ul style="list-style-type: none"> Recruitment and Selection Policy Recruitment Guideline Procedure Induction and Orientation Policy Worker Safety Check Policy and procedures 	<ul style="list-style-type: none"> Comprehensive Induction Programme with elements online combining eLearning modules Post-Entry Survey (3 months) Recruitment training for managers Recruitment and Selection Toolkit Scholarships across all disciplines. Schools Career Expo Working with clinical schools to provide work experience placements Police and Ministry of Justice criminal records checking 	<ul style="list-style-type: none"> Better management of the online talent pool to access suitable candidates. Use of social networking to target youth. Vulnerable Children's Act and the implementation of procedures relating to this legislation. Focus on hard to fill occupations to reduce re-advertising 	<ul style="list-style-type: none"> National Health Careers website targeting students, return-to-work and international candidates. Continue to collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand. Continue to collaborate with the Whakatipuanga Rima Rau project to place Māori into the health sector employment over 10 years. Implementation of Vulnerable Children's Act procedures Electronic Onboarding – to improve the new hire experience Use networks as sources to identify potential talent
Employee Development, Performance, Promotion and Exit	<ul style="list-style-type: none"> Study, Conference and Course Leave. Termination of Employment Policy and Procedure Medical Incapacity Policy Professional Development Policy Performance Review Policy Performance and Disciplinary policy Employment Agreements Continuing Medical Education (CME) policy 	<ul style="list-style-type: none"> Exit interview and survey Coaching available to all staff Clinical Supervision Employee Assistance Programme (EAP) Management development programmes Non-clinical skills training for employee Professional development funding National qualifications for non regulated workforces (e.g. Orderlies, Cleaners and Health Care Assistants) Annual Calendar of educational events Organisational mapping and alignment programme (OMA) Work in conjunction with individuals and unions in consultative manner Organisational Mapping and Alignment Programme (OMA) 	<ul style="list-style-type: none"> Revised education plan for 2017 Continuing development of e-learning resources Enabling technology for accessing learning tools Further rollout of non-regulated workforce training – NZQA Review of performance review system and processes to increase engagement Further rollout of the OMA process 	<ul style="list-style-type: none"> OMA programme commenced New eLearning platform launched, enabling greater access to elearning resources
Employee Engagement	<ul style="list-style-type: none"> Flexible Working - Request and Complaints Procedure Collective employment agreements Employee Participation Agreement 	<ul style="list-style-type: none"> Ageing workforce. Employee engagement survey/barometer Further rollout of the OMA process 	<ul style="list-style-type: none"> Regional collaboration to develop actions 	
Remuneration, Recognition and Conditions	<ul style="list-style-type: none"> Job Evaluation Procedure. Recognising Long Service Procedure Collective employment agreements 	<ul style="list-style-type: none"> Job Evaluation Committee. Comprehensive Progression/Merit criteria via collective agreements. 	<ul style="list-style-type: none"> Promoting employee benefits for all staff 	
Harassment and Bullying Prevention	<ul style="list-style-type: none"> Harassment Policy and Procedure. Employee Assistance Programme 	<ul style="list-style-type: none"> Interpersonal skills programmes Coaching / training Union Reps Conflict Resolution Workplace Behaviours programme – training and educational resources 	<ul style="list-style-type: none"> Keep momentum around behaviours initiative and messages Revise messages in the behaviours programme to enable organisational culture change Launch revised Bullying and Harassment Policy 	<ul style="list-style-type: none"> Review of Workplace Behaviours project undertaken and further work commenced. Review of Taranaki DHB Bullying and Harassment Policy currently underway
Safe and Healthy Environment	<ul style="list-style-type: none"> Relevant clinical policies and procedures 	<ul style="list-style-type: none"> Pre-employment Health Questionnaire for all staff. Employee Assistance Programme. Annual influenza vaccinations. Health and Safety Reps in each work area. Health and Safety orientation. Health and safety committee Wellness committee 	<ul style="list-style-type: none"> Quality and Risk Department responsible for majority of these procedures. Recreation society available to all staff. Wellness committee has run a number of wellness initiatives throughout the year Health and Safety requirements updated in Job description templates Health and safety competencies implemented in the performance review template 	





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

TARANAKI
like no other