

Taranaki District Health Board

Annual Report

2016-2017

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga



Our Aims *A Matou Wawata*

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

How we work together and with others

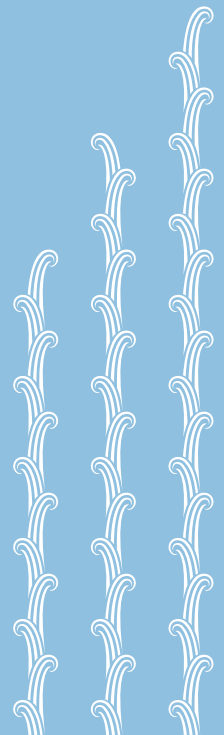
Nga Tikanga

Me Pehea nga mahi ngatahi me etehi atu

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

We will work together by:

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



Registered Office

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

Banker

TSB Bank
120 Devon Street East
New Plymouth 4310

Westpac
Po Box 8141
New Plymouth 4310

Advisors

Govett Quilliam
Private Bag 2013
New Plymouth 4342

Auditors

Office of the Controller
and Auditor-General
Agent - Deloitte Limited
PO Box 17
Hamilton 3240

Our shared vision / *Te Matakite*

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

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Kia Ora & Welcome

to the Annual Report for the Taranaki District Health Board for 2016-2017

We are pleased to present the Taranaki District Health Board (Taranaki DHB) Annual Report for the year 1 July 2016 to 30 June 2017.

Firstly, we would like to acknowledge and thank all the Board and committee members who have generously shared their skills and knowledge over the past year. 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, the governance of the DHB through the Board and Committees, and supported the DHB goals of improving Māori health and reducing health inequalities.

The healthcare Taranaki DHB supports and provides depends on the experience, skill, commitment and dedication of our providers and employees and we would like to take the opportunity to acknowledge and recognise how hard working all of our people are at the outset of this report. Thanks to them we have enjoyed a year of significant achievement and we thank them on behalf of our patients, their family/whānau and the community that we serve. We also acknowledge and thank all our volunteers who have given their time over the past year.

Throughout the year Taranaki DHB has funded services to the value of \$329m 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.

Taranaki DHB has maintained its performance in the majority of national health targets this year. A focus on the six key areas is important in order to continue to improve health, reduce inequalities and improve the quality of health services for the local population. This year we were one of the highest performing DHB's for the more elective surgeries target. Assisting in this result has been an ongoing focus on ensuring patients are well prepared for surgery and a continued reduction in day-of surgery-cancellations.

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.

This year the Board approved the implementation of the Taranaki Health Action Plan, which describes a 10-year vision for our local health system and how we're going to achieve this. At the centre of the vision are our patients, whānau and community, who depend on our expertise, care, compassion and support. The Plan was developed in partnership with our primary and community care providers and endorsed by Te Whare Punanga Korero Trust. It deliberately pursues a new approach that will bring fundamental changes through the adoption of new models of care, workforce roles and technologies. It recognises the strengths of the Taranaki health system, which provides a solid foundation for us to build on. It also recognises the challenges we face, particularly in making a difference to the persistent health inequalities faced by our Māori communities, and in responding to the increasing demand pressures on our health workforce in primary, community and secondary care.

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 has 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 enables the DHB to reduce some inequalities in access by Māori, to key services.

In December 2016 the Board confirmed its strategic intent to change the way Pathology and Laboratory Services are delivered in Taranaki. In order for Pathology and Laboratory Services in Taranaki to be clinically and financially sustainable in the long term, the DHB decided to implement a "whole of system" approach and has put plans in place to consolidate services into a single, large processing lab on DHB grounds, complemented by acute campuses. The move to a single service aims to provide a better experience for patients, increase



equity and improve health outcomes, deliver services closer to people's homes.

In late 2016 Taranaki DHB and Pinnacle Midlands Health Network (MHN) completed a business case that assessed a new model of integrated health care. The business case was approved by both Boards to move to the operational phase of the project. The vision for this project is for a patient centred and connected health service for Taranaki, where primary and secondary health services work together to achieve improved outcomes for our patients. Long term planning for implementation of this commenced in early 2017.

The redesign of the Te Puna Waiora Inpatient Mental Health unit situated on the Taranaki Base Hospital campus commenced in September 2016. The \$2.4million redesign will deliver environmental improvements and promote opportunities for engagement between staff and service users, while ensuring safety for both.

We have continued to improve the planning and management of staffing costs while also increasing new graduate clinical staff. The Taranaki health workforce has been strengthened 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.

Partnerships with other DHBs are 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.

Taranaki's new National Child Health Information Platform (NCHIP) and Child and Youth Coordination Service (CaY-C) was officially launched in July, providing a single online view for all practitioners involved in a child's health from birth to six years of age. It is a joint venture between Pinnacle MHN and Taranaki DHB which will improve the health of our children and enable early childhood health services to be delivered in a more coordinated way. Over 8,000 Taranaki children have had their key milestones entered onto the new system in the past year.



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. We have also officially joined forces with the Taranaki Area Police by signing an agreement based on the foundation of a positive working partnership between the two organisations.

Once again we have been very grateful for the work of the Taranaki Health Foundation, who make a real difference to our healthcare system's resources by raising funds and awareness for projects that improve quality patient care in the region. This year the Foundation was able to donate \$1,240,407 towards Taranaki DHB key projects, which included funds to complete the WE HEART TARANAKI campaign for a new Angiography Suite. The Health Foundation also officially launched The Open Minds Project, in March to support and raise funds for the Te Puna Waiora Inpatient Mental Health unit redesign. We also recognise the many community partners, businesses, donors and supporters who contribute to our campaigns and sincerely appreciate their support and generosity.

Within the DHB we have worked on two important employee projects. An IT Security Awareness campaign was launched to help our employees recognise and deal with a variety of information security threats. This was positively received by staff on all levels, giving them confidence in understanding cyber security and how to deal with individual situations. Taranaki DHB is also committed to its good employer obligations, in particular the fair and proper treatment of employees in all aspects of their employment and requiring good and safe working conditions. To assist with this we promoted the provision of an Employee Assistance Programme (EAP), a confidential counselling service for all hospital employees as a means of supporting them to improve their stress and resilience, and maintain the productivity and healthy functioning of the workplace.

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.

Pauline Lockett
Chair

Rosemary Clements
Chief Executive

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.



Community,
laboratory and
radiology services



Hospital services at Taranaki Base Hospital and Hawera Hospital

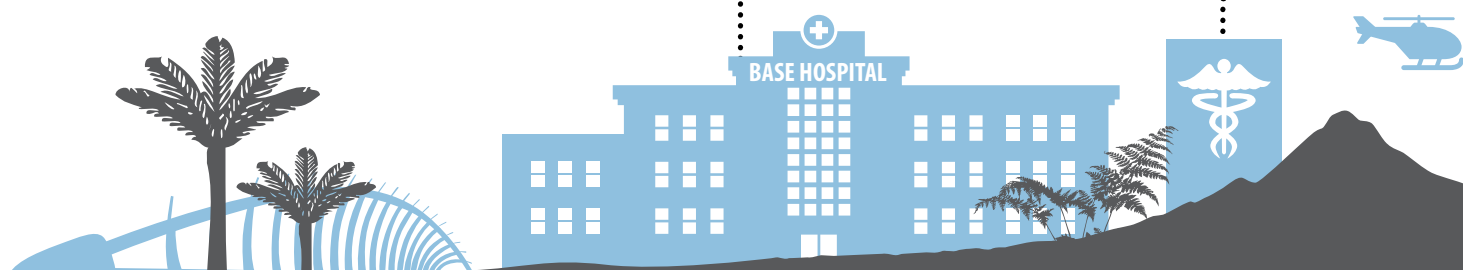


7

Community-based mental
health, and alcohol &
addictions service providers



26
pharmacies





Key relationship with Taranaki's Primary Health Organisation (PHO), Pinnacle Midlands Health Network, which oversees 32 aligned GP practices



Support services for people with disabilities including

28

residential facilities



Access to tertiary and more specialist hospital healthcare in other parts of New Zealand



16 Providers of Community Health for Older People Services



1 Māori Mental Health and Alcohol and Addictions Service Provider

19 Community Personal Health Providers

Community health centres in Mokau, Waitara, Stratford, Patea and Opunake

21 Dental practices



Population profile

According to Statistics New Zealand, in 2016/17 Taranaki DHB served a population of 118,110* people.

The Māori population is projected to increase to 22.5% of the total population by 2027. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2013 Census. Taranaki has 84.5% identified as European and other, 17.3% as Māori, 1.7% as Pacific and 3.7% as Asian.

Note: Where a person reported more than one ethnic group, they have been counted in each applicable grouping. As a result percentages do not add up to 100%.

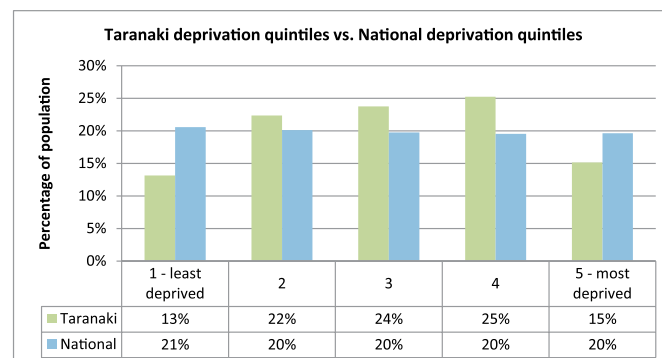
Age structure

Our population is ageing and older than the national average. The total number of people over the age of 65 is 20,370 (17.2%), with 7.1% of these being Māori.

A total of 38,005 people are under the age of 24 (32.2%), the number of Māori in this age group is 11,530 which represents 51.5% of Māori in the region.

Socio-economic indicators

The Taranaki population sits towards the centre of the socio-economic range with a greater proportion of people in the middle three deprivation quintiles than the national average.

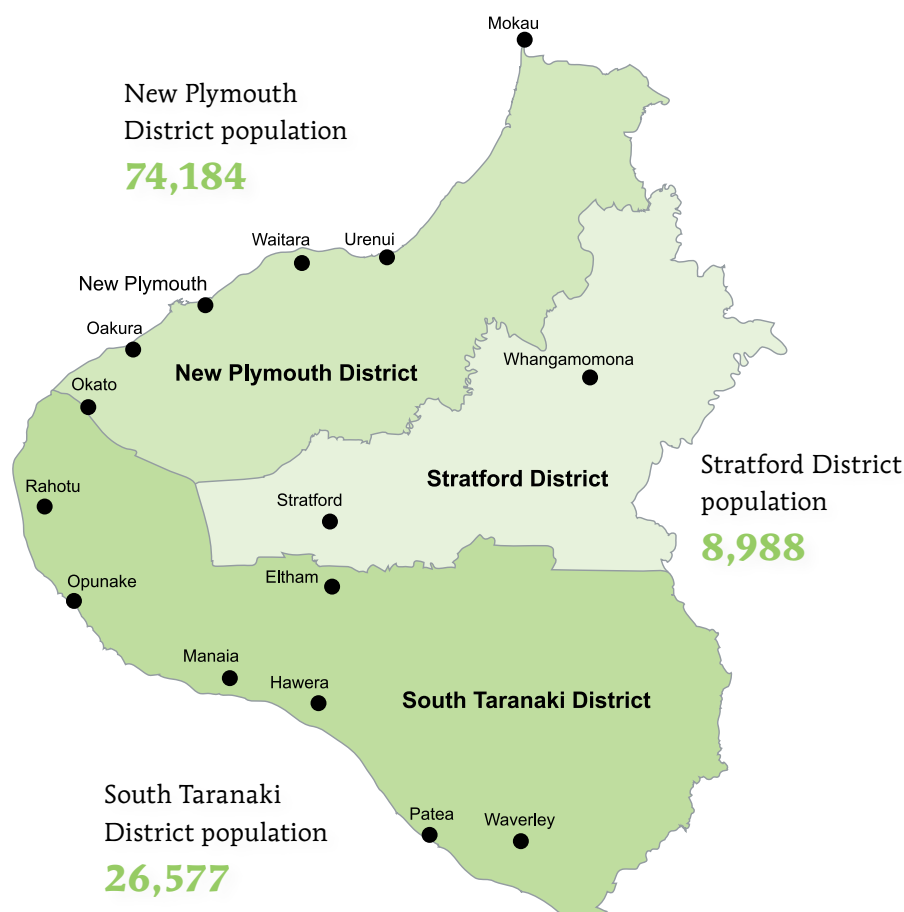


Source: Otago University index of deprivation 2013

Non-Māori are over-represented in the least deprived socio-economic quintile and Māori are over-represented in the most deprived quintile.

Within Taranaki, 32% of Māori live in the most deprived quintile compared to 14% of non-Māori. In contrast, 7% of Māori live in the least deprived quintile compared to 16.3% of non-Māori.

Life expectancy for non-Māori in Taranaki is 5-6 years longer than Māori.

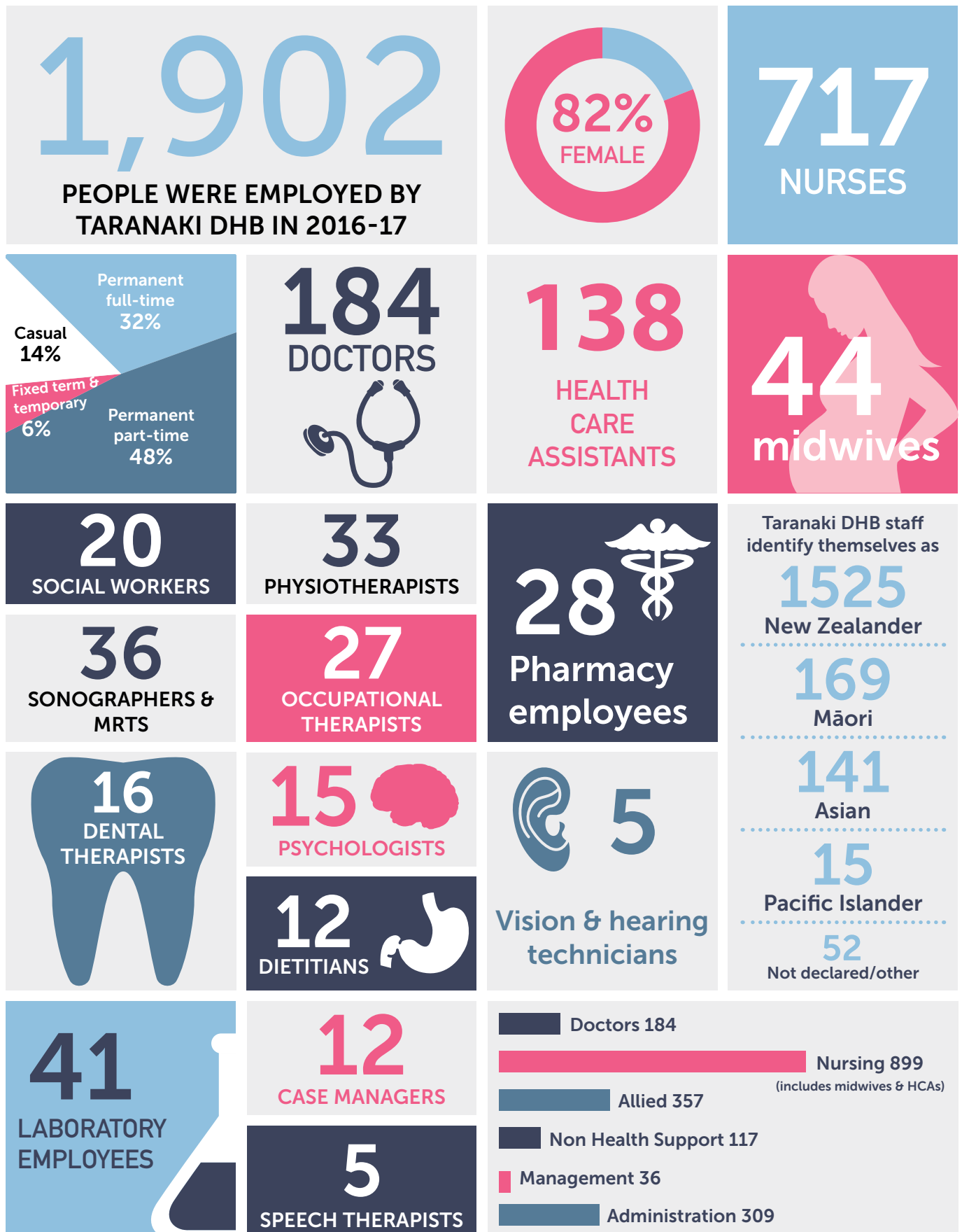


*Based on updated information received from Statistics New Zealand Population Projections released November 2015.

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.



Health Targets

ONTARGET

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.



1 Shorter stays in ED

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

Target 95%

Q1 94%

Q2 94%

Q3 92%

Q4 94%



2 Improved access to elective surgery

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

Target 100%

Q1 112%

Q2 112%

Q3 113%

Q4 114%



3 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.

Target 85%

Q1 74%

Q2 77%

Q3 72%

Q4 80%



4 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.

Target 95%

Q1 92%

Q2 93%

Q3 92%

Q4 90%



5 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.

Target 90%

Q1 86%

Q2 86%

Q3 86%

Q4 87%



6 Raising healthy kids

The target is that by December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Target 95%

Q1 28%

Q2 36%

Q3 61%

Q4 88%



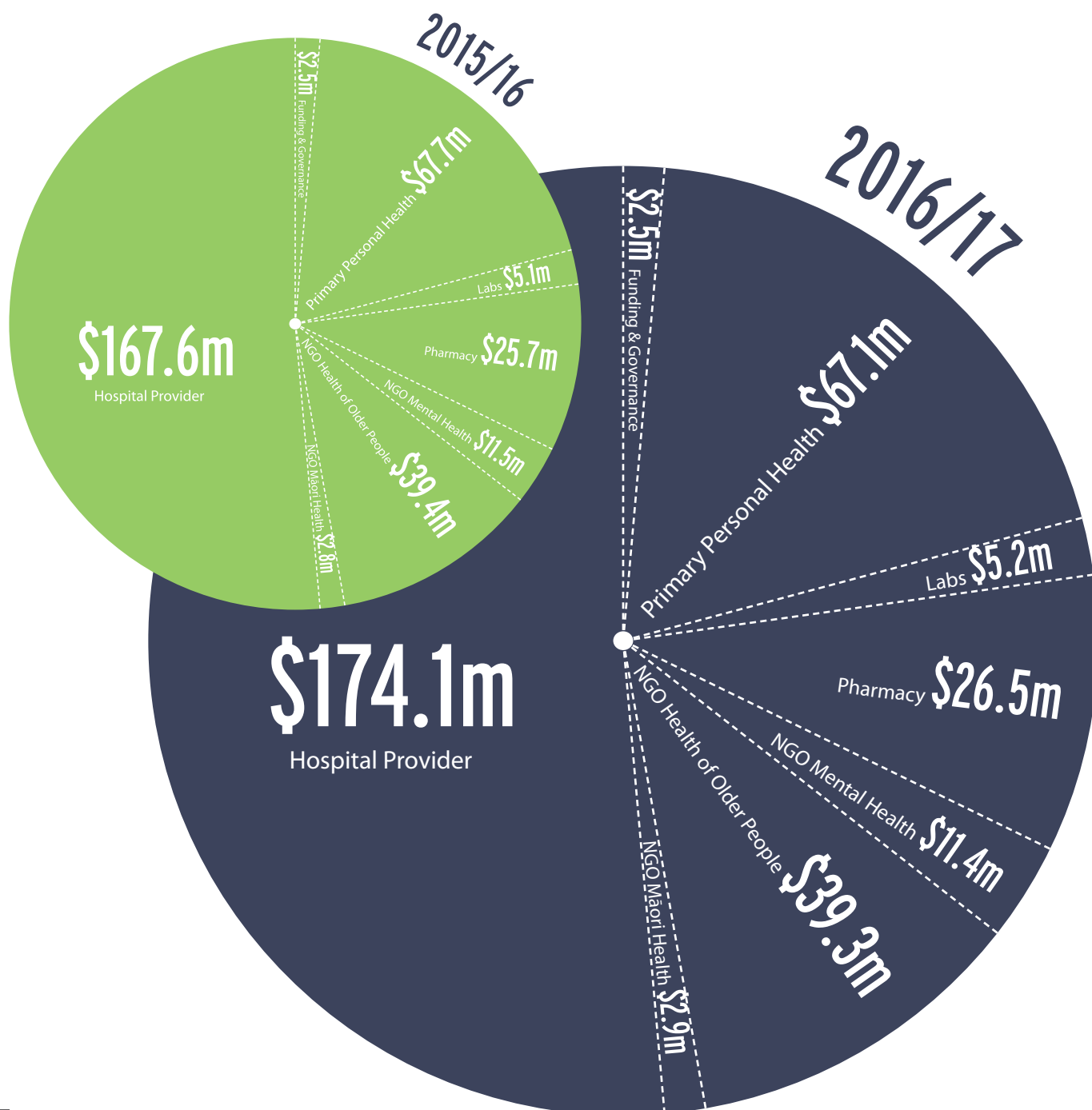
WHERE THE MONEY GOES

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



2016/17 Taranaki DHB Planning and Funding Allocation

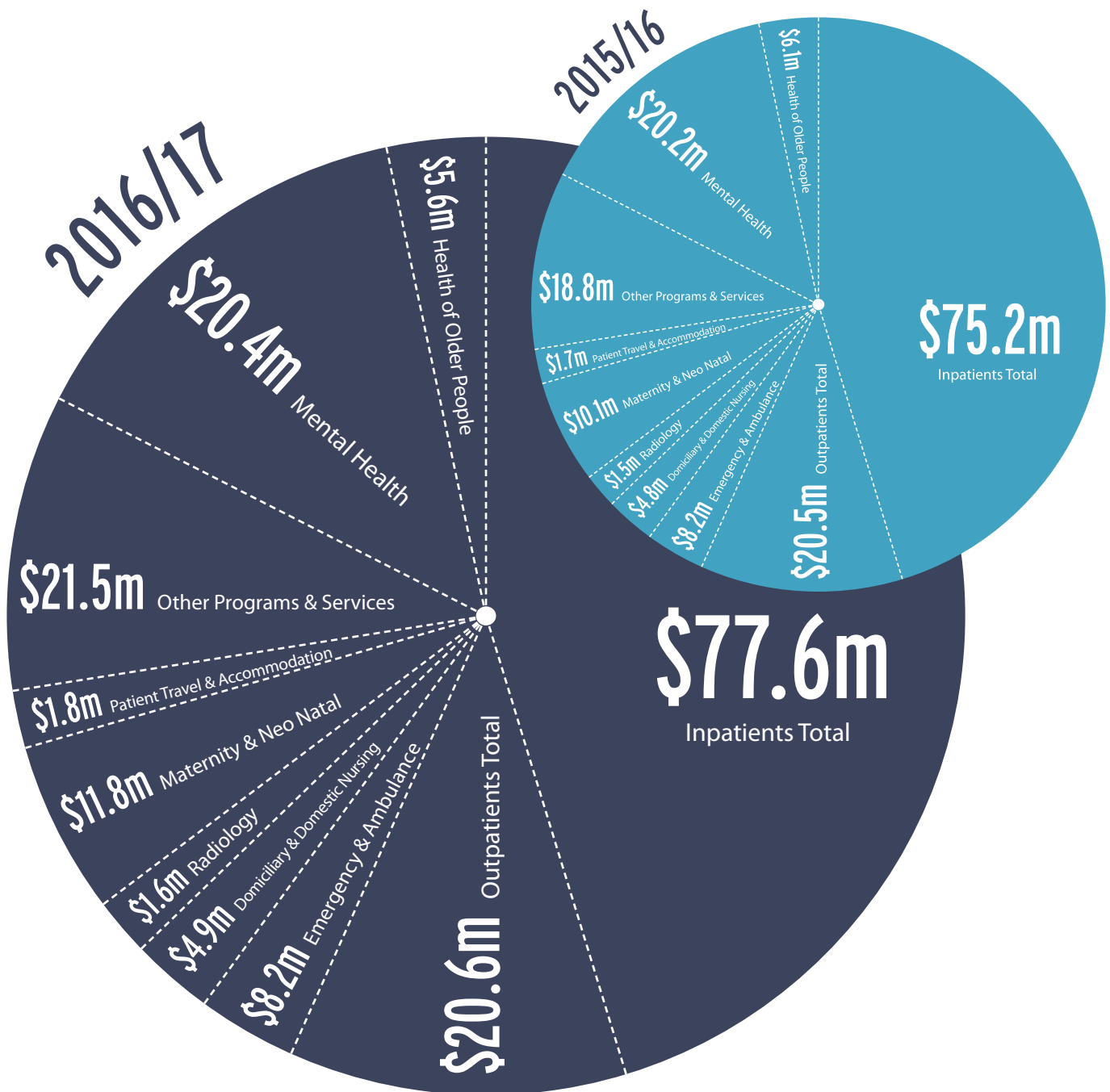
In 2016-17 the Planning and Funding division allocated its funding of **\$329 million** as follows:





2016/17 Hospital and Specialist Services Allocation

The **\$174 million** allocated to the Hospital and Specialist Services was further allocated as follows:



Māori Health Performance

The table below summarises Taranaki District Health Board's (TDHB) performance during 2016/17 in terms of improving Māori health status, reducing and eliminating health inequalities between Māori and non-Māori. Performance is tracked against national indicators that are linked to leading causes of death and illness for Māori across NZ including Taranaki. This enables a comparison of performance across DHB's, ability to identify best performers and sharing of successful interventions. Local indicators are priorities selected by Taranaki DHB for Taranaki.

Symbol	Key
☒	No progress or worsening (Increase over one quarter only, or stayed the same)
↑	Increasing gap (Increase over two or more consecutive quarters)
?	Further info or work required
↓	Decreasing gap (Decrease over two or more consecutive quarters)

	Health Issue	Indicator(s)Target	Target	Māori	Non-Māori	Progress to Target	Disparity Gap	Disparity Progress	Comments
National Indicators									
1	Data quality	Ethnicity data accuracy in PHO registers	100%	84	96	▲	12	↓	Ongoing support is given to all Pinnacle Midlands Health Network practices by the PHO to ensure accurate capture of ethnicity data on enrolment.
2	Access to care	Percentage of population enrolled with a Primary Health Organisation	97%	84	96	▲	12	↓	100 patient audits have been randomly completed for all practices in the past year. This audit included cross checking of enrolment forms completed by the patient that records ethnicity and ensuring that the information had been accurately entered into the Patient Management System. Practices are also required to complete an ethnicity audit as part of the RNZCGP accreditation programmes – again all PMHN practices are participating in either Foundation standards or Corner Stone accreditation. Ethnicity data accuracy and PHO enrolment figures are based on population projections. A matching of PMHN enrolment data with TDHB's NHI data indicated a close alignment in patient numbers. ED admissions are being screened for GP enrolment info and pts contacted where no GP identified, to assist with enrolment.
		Reduction in prevalence of Ambulatory Sensitive Hospitalisations (per 100,000) for 0-4 year olds	<7,174	7,188	6,697	▲	491	↓	110% of targeted B4SC were achieved. Additional resources have contributed to the catch up programme. Under 13 free access has been completed and monitoring is ongoing. Babies are automatically enrolled into the Oral Health Services at birth and a project is under way to ensure they attend scheduled clinics. On-going encouragement to use Map of Medicine pathways is occurring noting its use is discretionary.
		Reduction in prevalence of Ambulatory Sensitive Hospitalisations (per 100,000) for 45-64 year olds	<5,444	8,209	4,075	▼	4,134		Primary Options has been extended to include both acute care and non-acute care with the aim of more appropriate primary care being provided in the community. All PMHN staff are required to improve cultural competency as part of the PMHN quality programme. The latest available ASH data for 12 months to June 2016 identified an increase in avoidable hospital admissions for this age group. A PMHN PHO programme is under way to identify enrolled service users who are eligible and due for a screening to enable the practice to contact and schedule the patient for their assessments. A service improvement project focussing on improving outcomes for Māori and eliminating Māori / non-Māori disparities will be undertaken in 2017/18.
	Child health	Percentage of infants who are exclusively breastfed at 4-6 weeks	75%	49.6	66.7		17.1	↑	The latest available data is for 6 months ending June 2016. The Tiaki Ukaipo service has exceeded their referral targets for the 2016/17 year. We expect to see this reflected in up-to-date data. Taranaki DHB is preparing to support the roll out of 'Hapu Wananga', a programme to help pregnant and new mums be good parents and care for their pepi both ante and post natal. The programme was created by the Waikato DHB.
		Percentage of infants who are exclusively breastfed 3 months	60%	41.3	59.2		17.9	↓	
		Percentage of infants who are fully, exclusively or partially breastfed at 6 months	65%	49	68		19	↑	
4	Cancer	Percentage of eligible women (25-69) have a cervical cancer screen every three years	80%	73	82	▲	9	↓	Cervical Screening 25-69yrs (3yr) for Māori in Taranaki DHB reached 73.2% in the 2017 Q4 period. This represents a 5.4% difference since 2016 Q4 brought about by a commitment by key stakeholders TDHB National CS Programme, Pinnacle Midland Health Network PHO and Te Kawau Maro alliance of Māori providers Ngati Ruanui and Tui Ora in particular. Initiatives undertaken during the year included: PMHN and TDHB staff doing a data cleansing project which identified and corrected significant discrepancies in recording of ethnicity data. Ruanui Health Services ran evening and weekend clinics and used community-based Kaiawhina to track and refer South Taranaki Māori women who had not had the screens done Tui Ora ran Marae and community-based education events in North Taranaki. Monthly data comparisons are sent directly to PMHN to identify priority women from the National Screening Unit. Planning is under way with the assistance of the Regional Screening Unit to undertake a Cervical Screening month in July/ August/September 2017.
		Percentage of eligible women (50-69) have a breast screen every two years	70%	62	76.5	▼	15.4	↑	Breast Screen Aotearoa is undertaking a Health Equity assessment. Progress on this will be followed up.

5	Tobacco	Percentage of pregnant Māori women who are smokefree at two weeks postnatal	95%	66	84	▼	18	↑	A contract to support and strengthen referrals into the Taranaki Stop Smoking Service from the Primary Healthcare sector is now operational with Te Kāwau Maro Alliance. It is also anticipated that the Hapu Wananga Programme will impact positively on this measure.
6	Immunisation	Percentage of babies who are fully immunised at eight months of age	95%	90	92.3	▼	7	↑	A Health Equity Assessment has been scheduled to identify barriers to uptake of 8 month old infant immunisations. The assessment will be used to plan an approach to increase immunisations.
		Percentage of the population (>65 years) who have had the seasonal influenza immunisation	75%	42	54		12	?	
7	Rheumatic Fever	Rate of first episode rheumatic fever hospitalisations for the total population	0.3/100,000	0			0		There was one notified case of Rheumatic Fever in the year to June 2017.
8	Oral Health	Percentage of children (0-4) enrolled in DHB funded dental service	95%	81	101	▲	20	↓	A new project is being developed to ensure enrolled children aged 0 – 4 years are supported to fully engage with oral health services during this time. The project will be informed by a health equity assessment planned for August 2017.
9	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)	Reduction	113	63		50	?	Collation of the names of people identifying as Māori and receiving Mental Health services has commenced, specifically via the Section 29 or 30 (Long term) Mental Health Act. The capacity for the Mental Health Consumer Advisor to begin surveying Māori and whānau to capture the experience and thoughts of those affected is currently limited. Another Project Lead has been identified to commence this piece of work. Discussion re planning and implementation is ongoing.
10	SUDI	Most recent five year average annualised SUDI infant deaths by DHB region	0.4	1.91	0.58	New	1.33	?	No SUDI deaths recorded in Taranaki this year. Funding of Pepi Pods is an issue with the SUDI coordinator seeking funding opportunities to be able to ensure high risk families have access to Pepi Pods.
		Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact One	100%					?	"Hapu wananga" programme is anticipated to further strengthen knowledge and capabilities of parents in the future.

Local Indicators									
11	Access to Services	Did Not Attend (DNA) rate for outpatient services	5%	18	5.6	▼	12.4	↑	Further development of the dashboard has enabled us to determine which regions in Taranaki have the highest DNA rates so that we can focus our efforts. Two draft DNA letters are being sent to our survey group for feedback.
12	Access to Services	Access by tamariki and rangatahi to oral health services	New measure					?	No progress made during the year to address this priority. A HEAT Assessment of the Community Oral Health Service is planned in 2017/18 to inform a project to improve oral health outcomes for Taranaki tamariki and rangatahi.
13	Workforce Development	Percentage of Māori employed by Taranaki DHB	13%	8.89	N/A	▲		↓	Progress is slow but moving in the right direction. Efforts are increasing to ensure students supported by the 'WhyOra' programme are in turn supported into jobs with the TDHB and wider Taranaki health workforce. The TDHB has adopted a 'Position Impact Assessment' which assesses the impact of roles on Māori and triggers a stratified approach to Māori involvement in the recruitment process.

Performance Analysis

Of the 20 indicators:

- Māori health status improved in both progress towards targets and reduction of inequality on 40% (8) of the indicators
- Māori health status declined in both progress towards targets and increases in inequality on 30% (6) of the indicators
- No comparative data was available for 20% or four of the indicators
- One indicator, Rheumatic Fever has remained the same and target met
- One indicator relating to treatment of patients with Mental Health issues in the community, does not have a target set but TDHB's performance consistently ranked amongst the top five performing DHB's.

Although improvement on 40% of targets is positive, inequalities have increased on 30% of our indicators which is unacceptable. An intensified targeted service improvement approach is planned for 2017/18 to try to bring about sustainable performance improvements.

Highlights

WORKING

TOGETHER



Left to right: Rosemary Clements, Abysinia Sibanda, Jonathan Coleman (MP), Jonathan Young (MP) and Barbara Kuriger (MP) at the angiography suite launch.

Angiography Suite

In August, Minister of Health Jonathan Coleman formally opened Taranaki DHB's new angiography suite. There was a large turnout of fundraisers/donors who had contributed to the magnificent community campaign that fundraised \$1.2M towards the final cost of \$3.6M.

The Minister, local members of parliament and Rosemary Clements, Chief Executive, went on a tour of the new facility. Fulford Radiology's Head of Department, Dr Abysinia Sibanda demonstrated the new equipment and explained the range of procedures that are now available in Taranaki as a result of the new angiography suite.

Leadership in Practice Programme

The Leadership in Practice Programme (LIPP) brought together participants from all five Midlands DHBs for six day-long workshops over a period of nine months

Participants can be new and/or experienced managers, or those with leadership potential. The aim of the LIPP is to ensure that those in leadership roles:

- Have necessary leadership skills to perform in practice
- Network with others in their organisation and region
- Obtain coaching from their manager and peers

Participants graduate from the programme with a vast array of tools and knowledge to assist them as leaders.

Recovery Action Plan/ Health Passport

Taranaki's mental health services have been busier than usual this year, preparing for the launch of the Recovery Action Plan/Health Passport (RAP/HP), a free booklet designed to empower mental health service users in their own recovery and to help them identify when deterioration in health might be occurring/possible.

The RAP/HP was produced as a collaborative project between Taranaki's mental health service providers and a large group of project advisors who are, or were, service users.

The RAP/HP is ground-breaking for Taranaki as it is the first health care document that was created with input from patients and that is used across all service providers in the region.

Oranga Mokopuna

Over 900 tamariki, their teachers and families are inspired by healthy eating and fun exercise thanks to a programme called Oranga Mokopuna.

The programme is a collaboration between Tui Ora, Sport Taranaki, the Taranaki DHB Public Health Unit and the Heart Foundation. It is part of the Ministry of Health's maternal and infant physical activity and nutrition programme to address obesity in the developmental stages of life.

Since beginning, the programme has run in early childhood centres (ECE's), kōhanga reo and home-based carers throughout Taranaki.

It's helped to train kaimahi (staff) and focuses on healthy kai, the benefits of breastfeeding, physical activity and the importance of active movement.



NCHIP

Over 8000 Taranaki children have had all their key health milestones entered onto the new National Child Health Information Platform (NCHIP), with help from Child and Youth Coordination Services (CaY-C).

NCHIP began back loading health information on children aged 0-6 years in October and is now successfully up to date. This information includes midwife checks, Well Child/Tamariki Ora assessments, immunisations, hearing and vision checks, oral health checks and B4 School Checks.

Taranaki is the third Midland region DHB to implement NCHIP, with successful roll outs already in the Waikato and Tairāwhiti.

Prostate cancer diagnosis

A one-off partnership between Taranaki DHB and Rotary Taranaki means Taranaki men are now able to receive prostate cancer diagnosis and treatment much faster than before, thanks to the donation of a \$45,000 transrectal ultrasound (TRUS) machine.

Funding for the machine was provided by fundraising efforts from the Rotary Clubs of Taranaki, as well as a contribution from the Okato Lions Club. These organisations were approached by Taranaki DHB's Urology Department as part of a service improvement project aimed at speeding up the process of prostate cancer diagnosis and treatment.

The donation of the machine coincided with [Blue September](#), which is the Prostate Cancer Foundation's national awareness campaign.



Members of Rotary clubs and Taranaki DHB team with the transrectal ultrasound machine.

Whānau Pakari

Whānau Pakari is a whānau-based healthy lifestyle programme that supports Taranaki children and adolescents (aged 4 - 16) who are struggling with weight issues. Being whānau-based, the programme encourages lifestyle changes across the whole whānau to help support the child.

The programme is run by a multi-disciplinary team comprised of a healthy lifestyles co-ordinator, paediatrician, dietitian, health development advisor (focused on physical activity) and a psychologist to provide support on issues, such as how to change eating patterns and self esteem.

Popular activities include boxing classes at Box Office Gym in New Plymouth and the Taranaki Cycle Park out in Bell Block.

Recreational facilities in Taranaki such as the YMCA, Todd Energy Aquatic Centre, Powerco Aquatic Centre (Hawera), Air Zone Trampoline Park and more have shown their support by offering discounts to families participating in the programme. New Plymouth Boy's High School and Hawera High School have also supported Whānau Pakari by providing cooking rooms for the much anticipated cooking sessions during the term.



Whānau Pakari kids with Sam Rapira at Boxfit in New Plymouth.

Wahine Toa

Thanks to Taranaki DHB's Community Oral Health Service, young mothers who struggle to afford oral health care were recently treated to free routine dental care and advice.

Taranaki DHB dental therapist Deneille Walden recognised a need in the community, applied for a Wrigley Company Foundation grant and secured \$1600 towards an initiative to assist low income young mothers to visit the dentist. This special initiative in collaboration with Tui Ora is called the 'Wahine Toa Project.'

Taranaki area Police

Taranaki DHB and the Taranaki Area Police (Police) have officially joined forces and signed an agreement based on the foundation of a positive working partnership between the two organisations.

Police and DHB sector staff often work together in a range of capacities due to legislative requirements and the nature of their work. The relationship is a critical one and is recognised at a higher level by way of a memorandum of understanding between the New Zealand Police and the Ministry of Health.



Rosemary Clements - Taranaki DHB Chief Executive and Keith Borrell - Taranaki Police Inspector and Area Commander, sign the agreement between the Ministry of Health and New Zealand Police.



Patient Safety Week

The Health Quality and Safety Commission's (HQSC) National Patient Safety Week (PSW) was held from 30 October - 5 November 2016; the theme being 'Let's Talk', with a focus on communication and consumer engagement.

A highlight of the week was the great support received from the community, including our Board members, local politicians, councillors and general community members. It also included support from the Royal New Zealand Navy and the crew from HMNZS ENDEAVOUR.

The week was also supported by our staff and very generous sponsors who donated prizes, including a Hurricane's training jersey signed by Beauden Barrett.

The Open Minds Project

The Taranaki Health Foundation has launched a new community campaign called 'The Open Minds Project', which helped to raise funds for enhancements to Taranaki's Mental Health inpatient unit, currently under renovation.

The secure inpatient unit supports people during times of severe psychiatric need; times when they may hurt themselves or others. Over 500 people use the facility each year and since it was last renovated 16 years ago it has become out-dated. The renovations will provide Taranaki with an up-to-date mental health unit that aligns with a modern-day model of care for people suffering psychiatric issues.

The image above was posted on the Royal New Zealand Navy Facebook page during PSW with the following comment: "During HMNZS ENDEAVOUR's home port visit to New Plymouth over Labour weekend, the crew heard about #TDHBPatientSafetyWeek. As safety is the utmost priority in any workplace, ENDEAVOUR's Ship's Company wanted to get stuck in and show their support."

Come Hear Project

In 2007 the Ministries of Health and Education introduced the Universal Newborn Hearing Screening Programme in all DHBs.

In April 2016, Taranaki DHB's audiology and Māori health teams launched the Come Hear Project, which aimed to improve health outcomes for Māori children by reducing DNA (Did Not Attend) rates at DHB audiology clinics to less than 10% by October 2016.

The project team developed a new process to identify children at risk/high risk of not attending (DNA) their booked audiology appointments, and implemented an organised attendance pathway.



The Come Hear Project team.

Mental Health Awareness Week

During Mental Health Awareness Week a Whānau Fun Day was held at Puke Ariki. The fun day in New Plymouth marked the end of a great week for the mental health team who worked alongside Pathways, Progress to Health and Supporting Families to arrange a week of mostly outdoor activities to capture the spirit of the 2016 theme: connecting with nature.

Advance Care Planning

Advance Care Planning (ACP) is the process of thinking about, discussing, and writing down your wishes about the type of medical care and treatment you want to receive in the future. In particular, towards the end of your life or when you are not able to make your own decisions.

Taranaki DHB and Hospice Taranaki teamed up to help promote 'Conversations that Count' Day where ACP was highlighted to patients, visitors and staff at Taranaki Base Hospital.

Regionally the aim is to promote ACP and encourage health professionals to engage in these conversations with patients.

HPV vaccine

Taranaki public health nurses and general practices have been busy protecting a new group of young New Zealanders against HPV-related cancers, with changes to the National Immunisation Schedule now providing free HPV immunisation for everyone aged 9–26, including boys and young men for the first time.

Taranaki DHB public health nurses have been visiting Taranaki schools and speaking to parents and girls and boys about the HPV vaccine.

Tackling inequalities in health

Reducing inequalities is a priority for government, so Taranaki DHB's Public Health Unit has used the Health Equity Programme (HEP) to apply an equity lens over our organisation's services for the past six months. The HEP aims to put health inequalities at the forefront of all the work carried out within the DHB.

Health equity assessments help us to look critically at our programmes, policies and services. Assessments also help us identify the current inequity in different population groups in Taranaki and ways that we can influence change.

Health equity assessments have the potential to significantly transform the services we deliver and help us achieve health equity for Māori and other patient groups such as those on low income, rurally isolated or facing disabilities.



The HEP team working with members of the Childhood Immunisation Programme team during a HEAT workshop.

Immunisation

To celebrate Immunisation Week from 1 – 7 May 2017, a community pop up clinic was held at the Māori Women's Welfare League in Waitara, which proved very popular with local residents.

The clinic was a collaborative initiative between Taranaki DHB, Tui Ora Ltd, the Māori Women's Welfare League and Pinnacle Midlands Health Network to help raise awareness of the importance of immunisation in the community.

Over 70 people utilised the free immunisation service, which gave free influenza vaccinations, childhood and pregnancy immunisations for protection against influenza, whooping cough, measles mumps and rubella (MMR).



WhyOra

WhyOra continues to run workshops at Taranaki Base and Hawera Hospitals for secondary school students in the region. The workshops give Taranaki rangatahi (youth) from years 11, 12 and 13 insight into what it's like to work in health and to encourage them to take up careers or study in this sector.



Cultural Health Index

The Cultural Health Index (CHI) is a tool that Māori can use to assess the cultural and biological health of waterways in their area. The CHI tool was recently used during an initiative between Taranaki DHB and local iwi, Ngati Mutunga, on a project called Nga Puna Waiora. This project has a focus on increasing food security and reducing food-borne illness for Māori communities.

A wananga (workshop) hosted by Ngati Mutunga in February 2017 focussed on monitoring of the Urenui River, which is a major waterway of this tribal area and is used for a diverse range of activities.



Smokefree Aotearoa

To help combat alarming statistics the Taranaki Smokefree Coalition Group (with members from Taranaki DHB, Taranaki Cancer Society, Tui Ora's Taranaki Stop Smoking Service and WITT) took their 'Smokefree New Zealand 2025' plight to New Plymouth District Council (NPDC) to ask for more smokefree areas around the city.

NPDC and the Taranaki Smokefree Coalition Group will continue to explore other options to further support clean air in public spaces, including making smokefree signage a priority to clearly identify current smokefree areas and the possibility of supporting private businesses to provide smokefree outdoor dining through an incentive scheme.



Taranaki Health Foundation

The Board

The Foundation has enjoyed a very stable governance group for the last few years and was thrilled to welcome two new high calibre Trustees who bring a wealth of experience and enthusiasm for the kaupapa: Dr Gregory Simmons and Brian Ropitini.

Dr Greg Simmons has recently re-joined the Foundation in March 2017, after a short hiatus as a Trustee. He provides a wealth of knowledge and experience to the Board as he is the Chief Medical Advisor at Taranaki District Health Board.



Brian Ropitini has recently joined the Board in April 2017, and brings a fresh approach to Trust business and fundraising. As the Director of Manufacturing for Methanex NZ, Brian



manages the operations at the three methanol plants at Motunui and Waitara Valley and leads health and safety for over 250 employees and numerous contractors. Methanex NZ produces up to 2.4 million tonnes of methanol per year, which is a significant contributor to Methanex's total worldwide output as well as generating \$650 million for New Zealand's annual GDP.

Brian says, "I'm thrilled to join the board and support the work of the Foundation, helping provide great healthcare in Taranaki through fundraising for key projects, which will benefit the region. Good health care has the ability to make such a difference to peoples' lives and it's important to give back to the community for me personally."

The Trust also warmly acknowledged outgoing Trustees: Cathy Katene and Philip Brown for their dedication and contribution to the Foundation's success. Completing the Board are Trustees: Adrian Sole (Chair), Murali Bhaskar, Pauline Lockett, Peter McDonald and Michael Joyce.



Performance reporting

The Foundation received an unqualified audit in 2015/2016 and awaits the completion of the 2016/17 accounts. An Annual Report will be submitted to the Charities Service by 31 December 2017, and will meet all of the new 'Performance Reporting' standards for Tier 3 Charities. This 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 website www.charities.govt.nz early January 2018.

What we achieved in 2016/17

The Taranaki Health Foundation has had much to celebrate in 2016/17, with new projects capturing the hearts and minds 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.

WE  TARANAKI
TOUCHING HEARTS · SAVING LIVES



Barbara Kuriger (MP), Brian Ropitini (Major sponsor Methanex and new Trustee in 2017), Rosemary Clements (Chief Executive, Taranaki DHB), Brian Jeffares (Cornerstone Funder, TET), Hon. Dr Jonathan Coleman (Minister of Health), Jonathan Young (MP) and Adrian Sole (Chairperson, Taranaki Health Foundation).

WE HEART TARANAKI: Angiography Suite Opening

On Friday 26 August 2016, the Foundation and Taranaki DHB were pleased to welcome Hon. Dr Jonathan Coleman, Minister of Health to officially open the Angiography Suite at Base Hospital. This event was joined by our key sponsors and community donors who had contributed to the campaign and made this project a reality for the region.

The official opening concluded a whirlwind of fundraising activities and presentations to community stakeholders on the value of the project to the region. The Taranaki Health Foundation raised over \$1.2 million in new pledges and donations for the WE HEART TARANAKI campaign. This complemented the pledge of \$1.2 million from the Taranaki Electricity Trust and \$1.2 million invested by the Taranaki District Health Board.



From Hardship to Hope Kids Health Fund

Launched in October 2016, this new project was developed to 'strengthen Taranaki families throughout their children's medical journeys, ensuring they are better placed to cope and help their children heal'.

The need for this fund arose from hospital staff that highlighted the many challenges faced by patients/families that experienced stress and hardship because of the medical journeys they find themselves on.

Since January 2017, the fund has assisted 50 families with food and/or petrol vouchers to reduce the financial stress, caused by the cumulative stress/pressures of having an acutely sick child in hospital. Hospital transfer is the second area of need, which has been very important to support families leaving the region for 'special' treatment.

A joint Taranaki Health Foundation and Taranaki DHB Committee has been established to ensure donor accountability and transparency over funds raised and distributed.



THE OPEN MINDS PROJECT

The fundraising campaign was officially launched in March 2017 by New Plymouth Mayor Neil Holdom, to complement the \$2.4 million renovation of Te Puna Waiora Inpatient Mental Health Unit. The focus of the Foundation is on the following potential 'enhancement' areas:

- Garden zones
- Fitness zone
- Dedicated 'adolescent' area – youth friendly
- Whānau Room
- Meeting room/training room
- Sensory modulation resources
- Artwork and video/images.

A number of exciting fundraising activities have been held to build awareness and raise funds. A smaller campaign for the 'garden zone' completion is currently underway and hoped to be resolved by early 2018.

SAFE SLEEP PROJECT, NEW PARENT'S ZONE AND ARTWORK PROJECT

The Foundation has also been working on three other smaller projects with key Taranaki DHB staff to build awareness and improve patient/whānau/visitor experience. All of which will be resolved in 2017/18:

1. Safe Sleep Project - Pepi Pod and Community Blanket Project
2. The renovation of the new Parent's Zone
3. Artwork Project for the TSB Children and Young People's Ward.



Where to next. Focus 2017/18

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 staff, 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 Structure

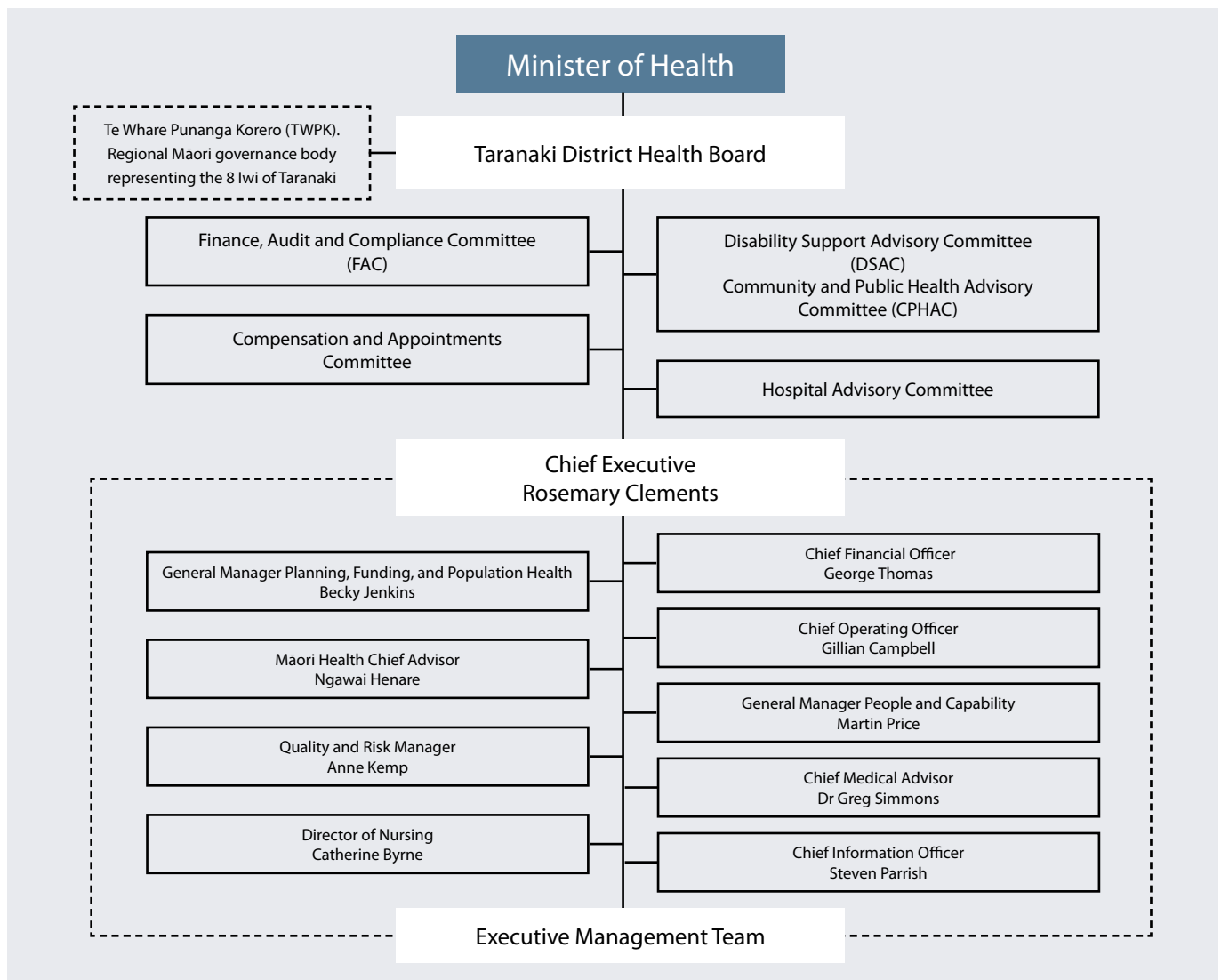
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (last held in 2016) 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.



Members of the Board

Pauline Lockett - Chair



Pauline Lockett has lived in New Plymouth since 1981. She was appointed to the Taranaki District Health Board in 2010 and was appointed as the Chair in 2013 and again in 2016. She is a member of all the DHB's committees. Pauline is a director of Landcorp Farming Limited and is the Chair of the Finance, Audit and Compliance Committee.

Interest Register (as at 30 June 2017): Trustee P Lockett Family Trust, Landcorp Director, Taranaki Work Trust – Trustee, Taranaki Health Foundation Trust – Trustee and Fellow Chartered Accountant.

Neil Volzke - Deputy Chair



Neil has resided in Stratford most of his life and has had a varied and challenging working career. This includes 18 years as a radiographer and nine years as the Chief Executive of two central Taranaki rest home facilities. Neil was elected to the Stratford District Council in 2001 and became District Mayor in 2009, a position he currently holds.

Neil has a good insight into how health services are delivered in the smaller towns and rural parts of the region, with a particular focus on timely access to core services. He views the retention of GP services as a genuine concern for smaller communities and recruitment needs to be actively encouraged. As a board member he is in touch with community health needs and expectations, helping to ensure decisions made deliver the best possible services equally, to everyone.

During his time as a Mayor, Neil has become well aware of the difficulties many families have to endure especially around housing, employment and health issues. He supports a whole of community approach to improving the overall well-being of people and would like to see more collaboration between councils, Government agencies and the DHB to achieve that goal.

Interest Register (as at 30 June 2017): Citizens Award Committee – Chair, Executive Committee – Chair, Sport NZ Rural Travel Fund Committee – Member, Stratford Health Trust – Chair, Taranaki Civil Defence Management Group – member, Taranaki Disaster Relief Trust – Trustee, Taranaki Regional Land Transport Committee – member, Stratford District Licensing Committee – member, Age Care Central Ltd – Chief Executive, Stratford Business Association – member, Stratford Senior Citizens Association – patron, Taranaki Justice of the Peace - Stratford Branch – member, Volzke Family Trusts Partnership – Trustee, Music Innovation Trust of Taranaki – Settlor, Central Police Blue Light Committee – member and TET Holdings Limited – Chief Executive.

Aroaro Tamati



Aroaro was first appointed to the Taranaki 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 & Public Health Advisory Committee 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, having enrolled in a PhD in public health through the University of Otago.

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. She also supports the monthly gatherings held at Parihaka to honour the legacy of Tohu Kākahi and Te Whiti o Rongomai, and is a director of Mataara Ltd.

Interest Register (as at 30 June 2017): Te Kōpae Piripono-KM Immersion ECE – Co Director, Mataara Ltd – Director, Te Paepae o Te Raukura Inc, Parihaka – Secretary, PHD Candidate, Otago University, Te Kāhui o Taranaki Trust – Trustee, Te Pou Tiringa Inc – Board Member, HRC, Nga Kanohi Kitea – Recipient, Ngati Moeahu Hapū – Secretary, Husband CEO Sport Taranaki, Parihaka Papakainga Trust – Secretary.

Kevin Nielsen



Kevin is an elected member of the Taranaki District Health Board and is also chair of the Hospital Advisory Committee. He spent 36 years of his working life at Taranaki Newspapers - the last 16 as General Manager, and was chief executive of Hospice Taranaki until his retirement in August. Kevin's top priority is to minimise financial deficit of Taranaki hospitals whilst not compromising on primary healthcare. He wants all Taranaki people to benefit from quality health services.

Interest Register (as at 30 June 2017): CEO – Hospice Taranaki.

Rose Bruce



Rose is a local GP who is an advocate for online healthcare services in the future. She wants to help Taranaki DHB evolve to this new environment and is keen to be part of this change. Rose believes in delivering high quality care in innovative ways and hopes her role as a GP can offer some of this insight.

Interest Register (as at 30 June 2017): Contracted GP working at MediCross (not a Director), interest in an STI app but currently it is an idea not a financial startup, previously locumed at Opunake, Parklands, Vivian, WITT as a GP/locum, ex husband is a private practising orthopaedic surgeon, unpaid member of NZ Alcohol Action Alliance, occasional paid blogger/writer NZ Doctor magazine, previously a Trustee of Arthouse Cinema – now in liquidation, Family Trust called 'Retrotrust' (has zero shares). Partner owns a house in Okato, recently contracted (6/2017) locum GP at Waitara Health 10-12 hours/week, recently contracted (6/2017) Police doctor at New Plymouth Police station, GP spokesperson for NZ Vaping Alliance.

Alison Brown



Alison is an elected member of the Taranaki District Health Board and a member of the Taranaki DHB Health of Older Persons Reference Group.

During her 40 years of service with Taranaki DHB in various nursing roles she has had close association with management both nationally and locally as a lead advocate for nurses and a strong campaigner for patients and their rights. She was awarded Honorary Life Membership to the NZ Nurses Organisation for services to nursing.

Alison has close ties to the rural sector and extensive knowledge and understanding of health services from both community/rural and hospital perspectives. In her view a strong Health Board should be transparent, and should consult with and listen to the community it serves.

Interest Register (as at 30 June 2017): Employee Taranaki DHB – Casual Health Assistant, Taranaki DHB Health of Older Persons Consumer Reference Group, Grey Power Committee, NZ Nurses Organisation – Honorary Life Membership.

Richard Handley



Richard's career includes 15 years in international and domestic banking, followed by Chief Executive positions at Lakeland Health, the Human Rights Commission, and in tertiary education as Deputy Chief Executive of Unitec and Chief Executive of WITT. Richard is also Chair of Taranaki DHB's Finance, Audit and Compliance Committee.

Interest Register (as at 30 June 2017): Councillor New Plymouth District Council, Board Member - Taranaki Youth Health Trust, Board Member - YMCA, Secretary/Treasurer Taranaki Retreat Trust, Board Member - St Mary's Diocesan School, Vestry Member - St Mary's Cathedral, Executive Committee - St Mary's Cathedral Project.

Te Aroha Hohaia



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

Interest Register (as at 30 June 2017): TSB Community Trust - Trustee, TSB Group Ltd - Director, Access Radio Taranaki Trust - Trustee & Chairperson, Hohaia van Paassen Limited - Principal Consultant, Shareholder & Director, School of Government Victoria University of Wellington - PhD Candidate & Research Assistant, Waiokura Marae & Reserves Trust - Trustee, Louise Rauhuia Manuera Hohaia Whānau Trust - Responsible Trustee, Te Korowai o Ngaruahine Trust - Trustee, Chair of Finance, Audit & Risk Committee, Te Ara Pae Trust - Trustee & Chair.

Harry Duynhoven



Harry is New Plymouth-born and bred and is married to Margaret, with whom he has three adult children. He has serviced the community in many different roles, including Member of Parliament, Mayor and is currently on the New Plymouth District Council. Through these roles he has assisted many people to access the healthcare they needed.

Harry believes timely access to healthcare services is vital for Taranaki people, especially as the ageing population grows. Harry also does consultancy, charity and voluntary work, is an honorary member of two international advocacy organisations and is a board member of Habitat Taranaki and New Plymouth Rotary.

Interest Register (as at 30 June 2017): Patron of Taranaki Disability Resource Centre, Patron of Community Christmas Dinner Trust, Board of Habitat Taranaki, Member of several community organisations, Beneficiary of Nistelrode Trust - family trust ownership part share in house & bach, Councillor New Plymouth District Council, Consultant - Part-time, President NZ Federation of Motoring Clubs, Patron NP Model Aeroplane Club and Patron of Taranaki Disabilities Information Centre Trust.

David Lean



David has a proven record of community leadership and governance experience in Taranaki, having been New Plymouth Mayor from 1980-92, serving as Civil Defence controller for more than three decades and leading Sport Taranaki as chairperson for 20 years.

David is keen to make a positive difference in the region's future health care and believes focus on health promotion and education is vital to community wellbeing. David is also currently Deputy Chairman of the Taranaki Regional Council.

Interest Register (as at 30 June 2017): Daughter is a Taranaki DHB employee, Deputy Chair Taranaki Regional Council, Chair - Rahoitu Dairy Ltd, Chair - David Lean & Associates Ltd, Surf Life Saving New Zealand - Life member, Trustee - Cameron Clow Trust, Executive member - NPOB Surf Lifesaving Club.

Bev Gibson



Bev is a registered nurse, engagement consultant and health auditor with a wealth of experience in the health sector. She has a Bachelor of Arts degree majoring in nursing and education, a Postgraduate Diploma in health service management and a Masters in Management. Bev is a promoter for quality early intervention/prevention programmes. She is also an advocate of self-health, physical/mental wellbeing for all persons particularly Māori, the elderly and families.

Interest Register (as at 30 June 2017): Independent Contractor – ACC Cultural Advisor, Daughter is the Kai Rangahau Tautoko, a research assistant in the Whānau Pakari programme, Chairman of Mahia Mai a Whai Tara, a kaumatua service based in Waitara, Independent Trustee of Lantern House Trust, Committee of management – Parininihi Ki Waitotara, Director of Quality Visions Limited (QVL), Committee member of Lotteries Taranaki.

Te Pahunga (Marty) Davis



Te Pahunga was born in Hawera and on marrying moved to Whanganui 42 years ago. Te Pahunga was employed in the Ministry of Agriculture and Fisheries (MAF) for 30 years with the last 10 years in various management positions. In 1999 Te Pahunga returned to work for his Iwi Ngaa Rauru Kaitiaki as its first CEO and Chief Negotiator where settlement was reached in 2005. In 2009 Te Pahunga took up the position of CEO for the South Taranaki Iwi Ngaati Ruanui for 4 years before returning to Whanganui. At the same time Te Pahunga was elected a Board Member of Ngaa hapuu o Ngaruahine and also joined their negotiation team. In 2014 Te Pahunga was elected Tumu Whakarae (Chair) of the post settlement governance entity Te Kaahui o Rauru and is the current Chair of Te Whare Punanga Korero. Te Pahunga is an avid road cyclist, a musician and a very ordinary golfer – teenaa ra koutou katoa.

Interest Register (as at 30 June 2017): Te Pahunga is a Trustee at Meremere, Waiohau and Tauranga Ika marae and has Iwi affiliations to Ngaa Rauru Kaitiaki, Ngaati Ruanui, Ngaa Wairiki Ngaati Apa and Ngaruahine.

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 and fees

Board members, committee members and directors schedule

Name	Board Members to November 2016	Board Members from December 2016	Hospital Advisory Committee to November 2016	Hospital Advisory Committee from December 2016	Community and Public Health and Disability Support Advisory Committee to November 2016	Community and Public Health and Disability Support Advisory Committee from December 2016	Finance Audit and Compliance Committee to November 2016	Finance Audit and Compliance Committee from December 2016 (**)	Compensation & Appointments Committee	Allied Laundry Services Limited	Fulford Radiology Services Limited	HealthShare Limited	Fees Paid (\$)
Board Members – 2016 and 2017													
Pauline Lockett	*4 of 5	*5 of 6	3 of 3	2 of 3	1 of 2	1 of 2	4 of 5	5 of 6	✓				42,850.00
Neil Volzke		^6 of 6		3 of 3		2 of 2		6 of 6					16,509.06
Alison Brown		6 of 6		3 of 3		2 of 2		6 of 6					13,757.50
Rose Bruce		5 of 6		1 of 3		1 of 2		2 of 2					12,007.50
Harry Duynhoven		6 of 6		2 of 3		2 of 2		2 of 2					12,507.50
Bev Gibson		6 of 6		3 of 3		√2 of 2		2 of 2					12,757.50
Richard Handley	5 of 5	6 of 6	3 of 3	2 of 3	2 of 2	2 of 2	√5 of 5	√6 of 6	✓				24,557.50
Te Aroha Hohaia	4 of 5	5 of 6	2 of 3	2 of 3	√2 of 2	√2 of 2		5 of 6					22,370.00
David Lean		6 of 6		3 of 3		2 of 2		6 of 6					13,757.50
Kevin Nielsen	5 of 5	6 of 6	√3 of 3	√3 of 3	1 of 2	2 of 2	5 of 5	√6 of 6	✓				24,245.00
Aroaro Tamati	4 of 5	6 of 6	2 of 3	√3 of 3	2 of 2	2 of 2	4 of 5	2 of 2					22,620.00
Alex Ballantyne	0 of 5		0 of 3		0 of 2		0 of 5						7,862.50
Karen Eagles	4 of 5		√2 of 3		1 of 2								8,612.50
Flora Gilkison	4 of 5		1 of 3		√2 of 2		4 of 5				✓		9,612.50#
Alison Rumball	3 of 5		2 of 3		1 of 2								8,612.50
Sally Webb	^5 of 5		2 of 3				√5 of 5						11,577.90

Co-opted Board / Committee Members													
Te Pahunga (Marty) Davis		3 of 4											750.00
David Tamatea (CPHAC/DSAC Member)					1 of 2	1 of 1							500.00
Patsy Bodger				1 of 1									250.00
Greg White			3 of 3										750.00

Other Directors													
Rosemary Clements, Chief Executive											✓		
Simon Barrett, Group Financial Manager									✓	✓			

Key:

* = Chairperson Board

^ = Deputy Chairperson Board

√ = Chair/Deputy Committees

(**) = All Board members were members of FACC for December 2016 + February 2017 # = Excludes Fulford Radiology Services Limited

Te Whare Punanga Korero Trust

Te Whare Punanga Korero Trust is the Māori Health Governance Group which works strategically with the Taranaki District Health Board (TDHB) to improve Māori health and reduce and eliminate Māori health inequalities. The members of the trust represent the eight iwi of Taranaki – Ngaa Rauru, Ngati Ruanui, Nga Ruahinerangi, Taranaki, Te Atiawa, Ngati Maru, Ngati Mutunga and Ngati Tama - and in terms of the Memorandum of Understanding it has with the TDHB, exercises mana whenua status by providing kaitiakitanga or guardianship, for all Māori living in the region. Based on Statistics NZ population projections Māori made up 18.9% of the Taranaki population, 22,370 from a total population of 118,110.

In its representative capacity the TWPK Trust participated in the following TDHB Board activities throughout the year:

- Two joint meetings of the TWPK and TDHB Boards at which the main focus of discussion was progress against the Māori Health Plan 2016/17
  - TWPK member on the Community and Public Health and Disability Support Advisory Committee which met six times during the year
  - TWPK member on the Hospital Advisory Committee which met six times during the year
  - TWPK members participated in the Midland Region DHB Board's two-day training event
  - TWPK and TDHB members participated in a workshop on Institutional Racism facilitated by Dr Heather Came
  - TWPK members have participated in workshops entitled "Engaging Effectively With Māori" along with TDHB Board members
- Participation in these activities enables TWPK to influence the DHB's decisions in a strategic capacity.

Members of TWPK

**Te Urumairangi
Ritai**



Te Atiawa (July 2016
- December 2016)

Pat Bodger



Te Atiawa
(January 2017 -
current)

Tamzyn Pue



Ngati Maru

Greg White



Ngati Tama

Ngapari Nui



Ngati Ruanui

David Tamatea



Taranaki Iwi

Te Oti Katene



Nga Ruahinerangi

**Te Pahunga
(Marty) Davis**



Ngaa Rauru Kaitahi

Vicki Kershaw



Ngati Mutunga



INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF TARANAKI DISTRICT HEALTH BOARD'S GROUP FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2017

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

We have audited:

- the financial statements of the Group on pages 67 to 93, that comprise the statement of financial position as at 30 June 2017, 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 Group on pages 33 to 64.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Group on pages 67 to 93:

- present fairly, in all material respects:
  - its financial position as at 30 June 2017; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand 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 in the prior year

In respect of the 30 June 2016 comparative information only, some significant performance measures of the Group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators, relied on information from third-party health providers, such as primary health organisations. The Group's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the Group's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the Group on pages 33 to 64

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2017, including:
  - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - 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; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 26 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Group or there is no realistic alternative but to do so.

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.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these 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.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.



- We obtain an understanding of internal control relevant to the audit 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 Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieved fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 28, page 66 and pages 94 to 96, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): *Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the Group.

A handwritten signature in black ink, appearing to read "B Dente".

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



STATEMENT OF PERFORMANCE

Overview

As an effective District Health Board we need to demonstrate accountability¹ 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 2016/17 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).

Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2016-17

Output Class	Planned Revenue (\$000's)	Actual Revenue (\$000's)	Planned Expenditure (\$000's)	Actual Expenditure (\$000's)
Prevention	7,715	7,706	7,757	7,909
Early Detection and Management	87,629	87,526	88,109	76,264
Intensive Assessment and Treatment Services	217,039	216,787	218,228	230,898
Rehabilitation and Support	52,651	52,590	52,940	51,208
TOTAL	365,034	364,609	367,034	366,279

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>

Our Performance Story

Our Vision	Vision: Taranaki Together, a healthy Community – Taranaki Whanui He Rohe Oranga				
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 Outcome	People are supported to take greater responsibility for their health		People stay well in their homes and communities		People receive timely and appropriate specialist care
Intermediate Impacts	- Fewer people smoke - Reduction in vaccine preventable diseases - Improving health behaviours		- An improvement in childhood oral health - Long-term conditions are detected early and managed well - Fewer people are admitted to hospital for avoidable conditions - More people maintain their functional independence		- People receive prompt and appropriate acute and arranged care - People have appropriate access to elective services - Improved health status for people with a severe mental health illness and/or addiction - More people with end-stage conditions are appropriately supported
Outputs¹	- Percentage of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking - Percentage of eight months olds who will have their primary course of immunisation on time - Number of people referred to the Green Prescription programmes		- Percentage of children (0-4) enrolled in DHB funded dental services - Percentage of population enrolled with a PHO - Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years - Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months		- Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours - Acute re-admission rate - Elective and arranged day surgery rate - Improving the percentage of long-term clients with up to date relapse prevention/ treatment plans
Output Classes	Prevention Services	Early detection and management services	Intensive treatment and assessment	Rehabilitation and support services	Module 3

¹ The outputs described are examples only.



Key Measure of Performance

The following outcomes and impacts described below, outline the rationale for delivery the DHB's programmes and services as outlined in the 2016/17 Annual Plan.

Following each outcome statement are the measures that the DHB and the MoH agreed we would monitor in order to assess the DHB's achievements in contributing towards the outcomes.

OUTCOME 1

People are supported to take greater responsibility for their health

Expectation

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.



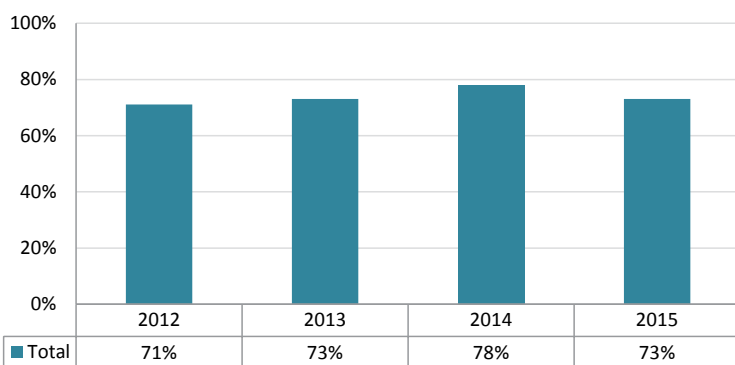
Intermediate Impacts

Fewer people smoke

Smoking and exposure to second-hand smoke causes 4,500 to 5,000 premature deaths annually and impacts directly on those who smoke and also through the effects of passive smoking on children and others who spend time with smokers. Tobacco 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 and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Māori experiencing a higher incidence (20% +), higher mortality and a higher degree of cancer infiltration when they present for treatment. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori. See Health Targets pages 10-11.

Impact Measures

Percentage of year 10 students in Taranaki who have never smoked



Target for 2016 was to increase on 2015 result of 73%

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

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

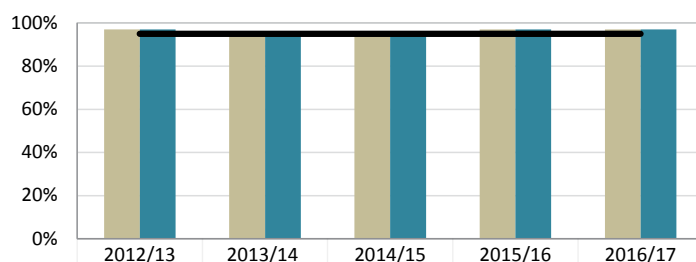
NB: Action for Smokefree 2025 (ASH) has not been able to provide the national or DHB level results of the 2016 Annual Year 10 Snapshot Survey, so the latest results are from the 2015 collection.

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see an increase in this measure to reflect an improving health outcome in our population.

The ASH Year 10 Survey is an annual survey of around 30,000 Year 10 students throughout New Zealand. It has been running for over 17 years and provides valuable insights into tobacco trends for youth. Taranaki youth that are recorded as never having smoked remain consistently over 70%. As such, supporting people to quit smoking is a national and local priority, especially with the focus on New Zealand being smokefree by 2025.

Output Measures

Percentage of hospitalised smokers provided with smoking cessation advice and support



Māori	97%	95%	95%	97%	97%
Total	97%	96%	95%	97%	97%
Target	95%	95%	95%	95%	95%

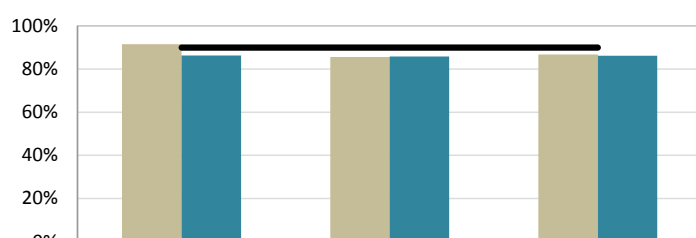
Data Source: Taranaki DHB Patient Management System

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

Māori	Target Achieved
Total	Target Achieved

This target has been consistently achieved. The Ministry of Health has indicated a shift in tobacco control targets to more outcomes focused. With this in mind, referral pathways from the Taranaki DHB into stop smoking services will need to be strengthened in the 2017/18 year.

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



Māori	92%	86%	87%
Total	86%	86%	86%
Target	90%	90%	90%

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

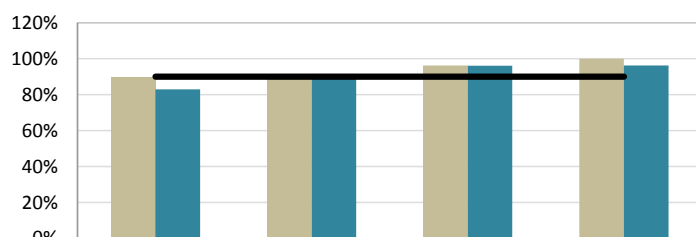
90% of smokers in primary care seen in the last 12 months are provided with cessation advice and support to quit

Māori	Target Not Achieved
Total	Target Not Achieved

Taranaki DHB has not achieved this health target in 2016/17 for either Māori or Total population (based on the average of quarterly results). However, the quarterly performance results for both groups have improved since 2015/16. There also continues to be very little disparity between Māori and the Total population results.

The Taranaki DHB continues to work towards meeting this health target and has contracted the Taranaki Stop Smoking Service to implement a Primary Healthcare programme that will support GP practices to increase referrals into the quit service.

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



Māori	90%	89%	96%	100%
Total	83%	90%	96%	96%
Target	90%	90%	90%	90%

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 Taranaki DHB has achieved this target for both Māori and the Total population. Māori population results have improved on the results of the previous year. The DHBs maternity department have nominated a Smokefree Champion and they have been strengthening the relationship with the newly established Taranaki Stop Smoking Service.

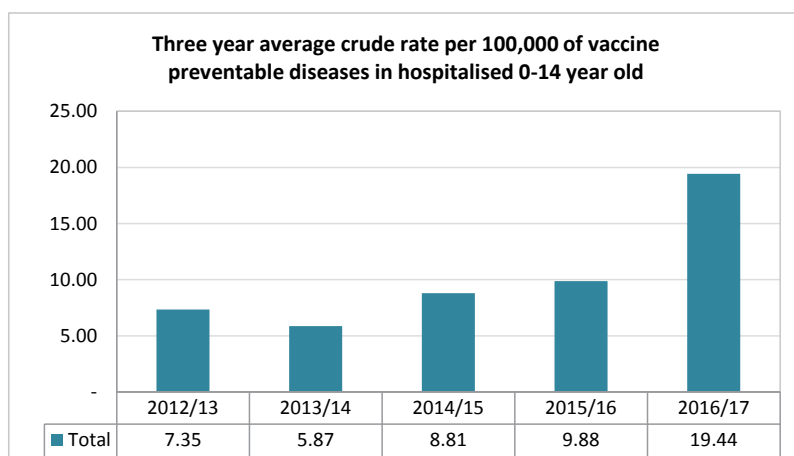


Reduction in vaccine preventable diseases

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 pages 10-11.

Impact Measures



Data Source: Ministry of Health National Minimum Dataset

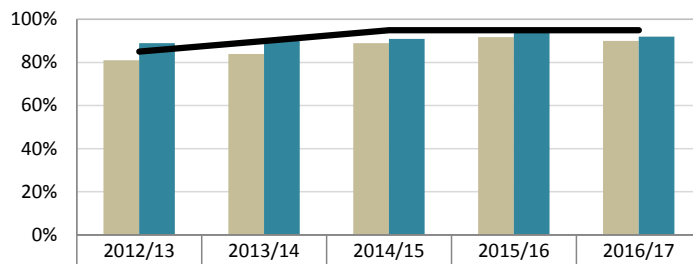
Reduction in vaccine preventable diseases

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see a decrease in this measure to reflect an improving health outcome in our population.

The major driver for the increased vaccine preventable diseases hospitalisations for children in Taranaki during 2016/17 was an outbreak of pertussis. During this period there were a total of 94 notifications to the Medical Officer of Health. It is worthy to note that only two pertussis notifications were children aged less than one year which is likely to be due to a high vaccination coverage in this age group. The outbreak has now ceased with no cases notified in June and July 2017.

Output Measures

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



Māori	81%	84%	89%	92%	90%
Total	89%	90%	91%	94%	92%
Target	85%	90%	95%	95%	95%

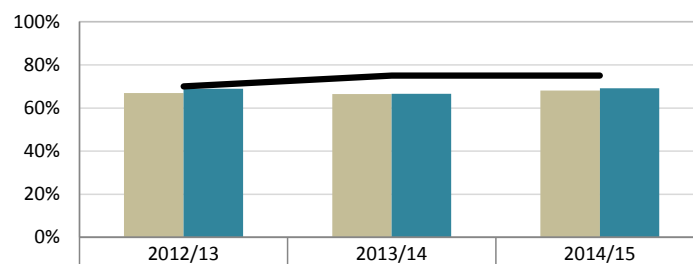
Data Source: National Immunisation Register

95% of babies are fully immunised at eight months old

Māori	Target Not Achieved
Total	Target Not Achieved

Taranaki DHB did not reach the target for either Māori or Total Population, we continue to work closely from a strategic and operational level to improve this. We have developed systems within Taranaki DHB to remind all providers to have the immunisation conversations at each contact point with the family and to offer opportunistic vaccination wherever appropriate.

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



Māori	67%	67%	68%
Total	69%	67%	69%
Target	70%	75%	75%

Data Source: Primary Health Organisation Performance Programme (PPP)

No Data available for 2015/16 nor 2016/17

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

Māori	No longer reportable
Total	No longer reportable

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

This measure is now part of the Ministry of Health's national performance indicator suite and data will be provided in September 2017 from the National Immunisations Register.

Improving health behaviours

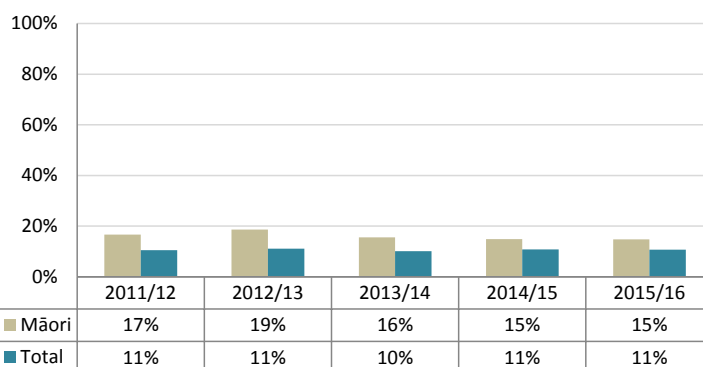
In 2016 Body Mass Index (BMI) is expected to overtake tobacco as the leading preventable risk to New Zealanders' health, thus in October 2015 the Ministry of Health (MoH) released the Childhood Obesity Plan which aims to prevent and manage obesity in children and young people up to 18 years of age. The focus of the Plan is on food, the environment, and being active at each life stage starting during pregnancy and early childhood bringing together government agencies, the private sector, communities, schools, and whānau across 22 initiatives.

Development of the Plan drew on recent evidence including the World Health Organisation's (WHO) Commission for Ending Childhood Obesity and Professor Peter Gluckman's, Chief Science Advisor to the Prime Minister and co-chair of the WHO Commission, research indicating that pre-conditions for obesity are set very early and the best intervention point is maternal and infant nutrition (including breastfeeding) and physical activity.

Increased physical activity and improved nutrition will impact rates of obesity and other conditions including high cholesterol, high blood pressure, heart disease, some cancers and mobility disorders however a multi-faceted approach is needed. Obesity disproportionately affects Māori, Pacific, and low socio-economic groups across New Zealand, thus Taranaki DHB's interventions will be targeted to Māori to decrease this disparity. See Health Targets pages 10-11.

Impact Measures

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



Data Source: New Zealand Health Survey 2015/16

Percentage of New Zealand population who are obese

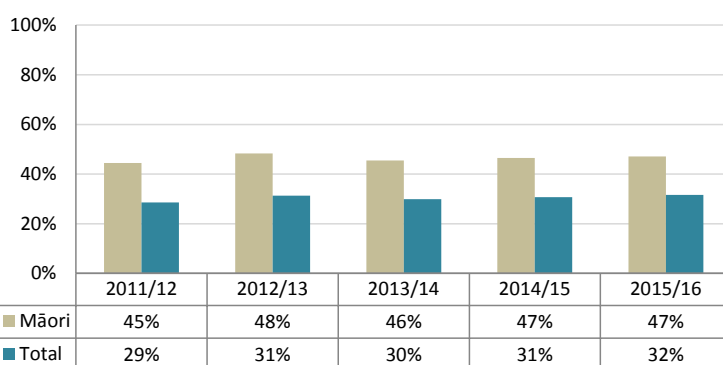
Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see a decrease in these measures to reflect an improving health outcome in our population.

According to the Ministry of Health, obesity rates have increased in all ages, genders and ethnic groups over the last 30 years, with those born more recently becoming obese at a younger age. The Ministry of Health states "high body mass index (BMI) has now overtaken tobacco as the leading risk to health in New Zealand".

Taranaki DHB funds a Green Prescription (GRx) programme, that is available to adults, and GRx Active Families, that is available for 5-18 year olds. The GRx programme involves health professional (usually GP or practice nurse) issuing their patient with a Green Prescription, and enters the GRx programme. The programme also involves a GRx Support Person that supports the patient to become more active through activities such as monthly telephone calls or group support in a community setting.

Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of premature onset of illness. It can also affect a child's immediate health, educational attainment and quality of life. To that end the Ministry of Health has established the Raising Healthy Kids Target in the 2016/17 year. The Taranaki DHB has worked to establish the referral pathway for those children identified as obese in the Before School Check (B4Sc). Those children who are identified as obese in the B4Sc check are referred into the DHB funded programme Whānau Pakari. Whānau Pakari is an extension of the GRx Active Families programme and provides support to children and their whānau from a multi-disciplinary team and weekly nutrition and physical activity sessions.

Percentage of New Zealand population who are obese 15 years and older

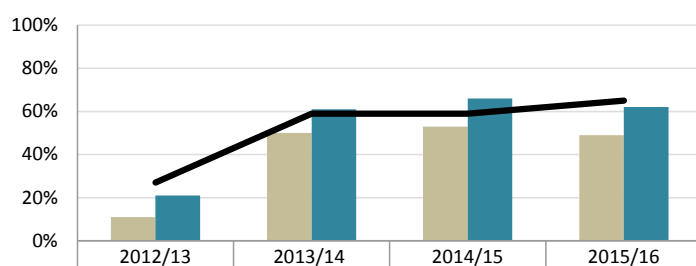


Data Source: New Zealand Health Survey 2013/14



Output Measures

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



Data Source: National Plunket Data

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

Māori	Not reportable
Total	Not reportable

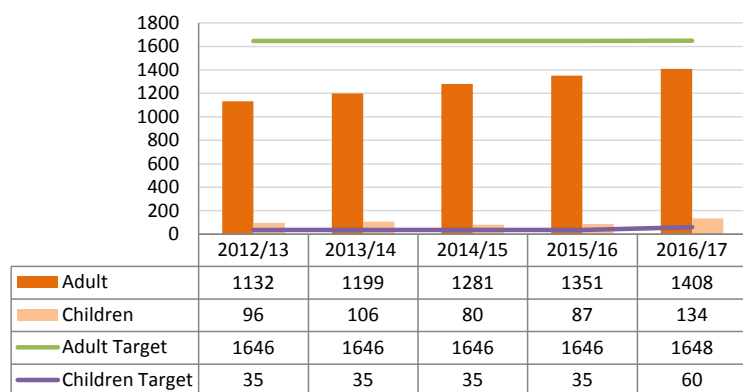
NB: Breastfeeding results have not been published by the Ministry of Health since December 2015. The Ministry has advised they are currently working on publishing historical breastfeeding results.

Breastfeeding results for Taranaki remain below the target despite significant activity in this space. Activity in the 2016/17 year included;

- The Taranaki DHB participated in the development of the Midlands DHB Breastfeeding Framework.
- The Public Health Unit undertook a Health Equity Analysis (HEA) of the Breastfeeding Welcome Here (BFWH) programme. While the HEA was primarily focused on the BFWH programme, analysis across the system enabled some identification of gaps, but also the positive mahi that aims to enhance and protect breastfeeding.
- The Mama Pepi Hauora programme including the Tiaki Ukaipo Service continues to exceed referral numbers for the community Lactation Consultants.

There are opportunities to further enhance breastfeeding support activity in Taranaki DHB in 2017/18 through the Sudden Unexplained Death of an Infant (SUDI) prevention programme and the establishment of the Hapu Wananga curriculum, a kaupapa Māori antenatal/parenting education programme.

Number of referrals to the GRx (Green Prescription) programme



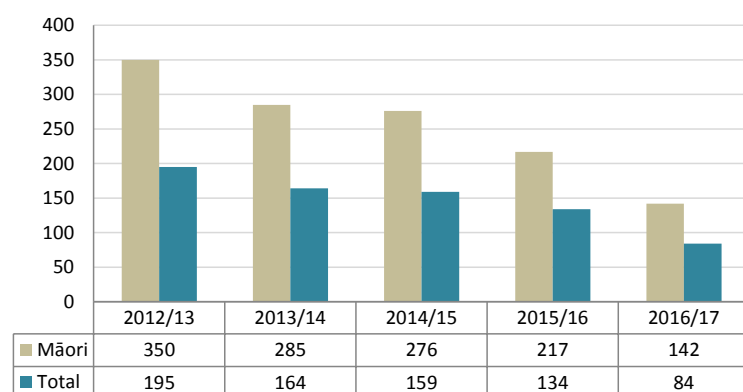
Number of referrals to the GRx (Green Prescription) programme

Adult	Target Not Achieved
Children	Target Achieved

Although Sport Taranaki did not quite reach the annual referral target for adults, they managed to achieve over 80% (85%) as required in their contract. Referrals for diabetes have remained consistent for the 2016/17 year and make up over 20% of referrals. Referrals from LMCs have remained low. Similarly to 2015/16, 78% of all those referred in 2016/17 went on to participate or complete the service, which is an excellent result for a behaviour change intervention.

Active Families has exceeded their annual referral target. The new Raising Healthy Kids Health Target has meant Active Families/Whānau Pakari have had a rise in under 5 year old referrals. The Active Families and Whānau Pakari teams have developed an under 5s programme to accommodate the increase in those referrals.

Teen birth rate per 10,000



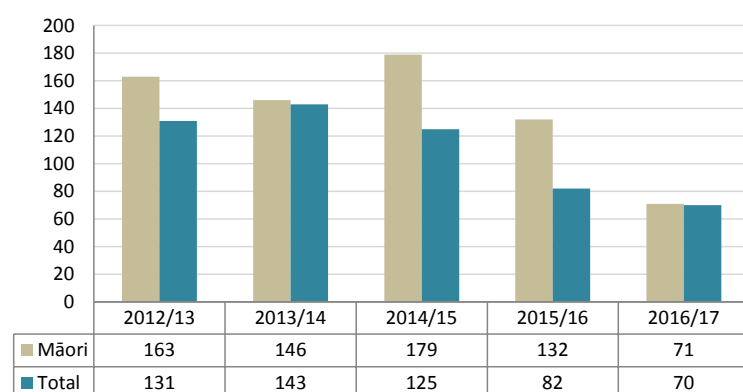
Target: Māori <276; Total population <159

Teen birth rate per 10,000

Māori	Target Achieved
Total	Target Achieved

The teen birth rate continues to fall in the Taranaki Region. We continue to maintain services to the adolescent population as described in the Annual Plan, such as Medical Termination of Pregnancy (TOP) and provision of Long Acting Reversible Contraceptives (Jadelles). Public Health Nurses (PHNs) ensure that adolescents have access to self referral clinics for contraception and referral to TOP services.

Teenage terminations of pregnancy rate per 10,000



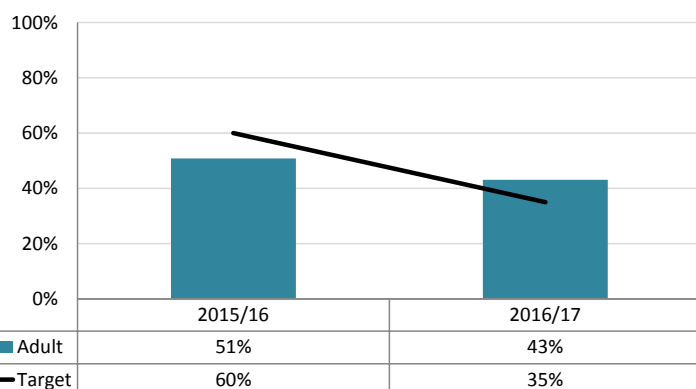
Target: Māori <163; Total population <125

Teenage terminations of pregnancy rate - per 10,000

Māori	Target Achieved
Total	Target Achieved

We continue to see a decline in the numbers of teenage terminations. This is due to the ready availability of contraception via self referral clinics to all adolescents in school and alternate education settings.

Adult Green Prescriptions programme participation



Data Source: Sport Taranaki: GRx Adults Quarterly Report

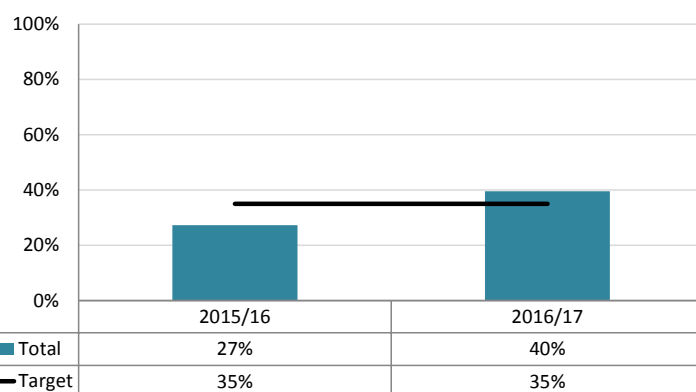
Percentage of adult quarterly referrals currently participating in Green Prescriptions programme

Adult Target Achieved

This is a new output measure for 2016/17 and was consequently not reported on in 2015/16 although data was collected.

A significant proportion of referrals to the Adult GRx participated in the programme and for the 2016/17 year the target for participation in the programme has been exceeded.

Active Families programme participation



Data Source: Sport Taranaki: GRx Active Families Quarterly Report

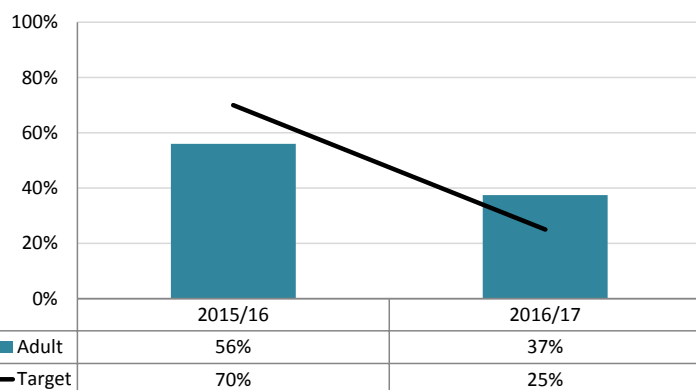
Percentage of Active Families quarterly referrals currently participating in programme

Total Target Achieved

This is a new output measure for 2016/17 and was consequently not reported on in 2015/16 although data was collected.

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%.

Completed adult Green Prescriptions discharges



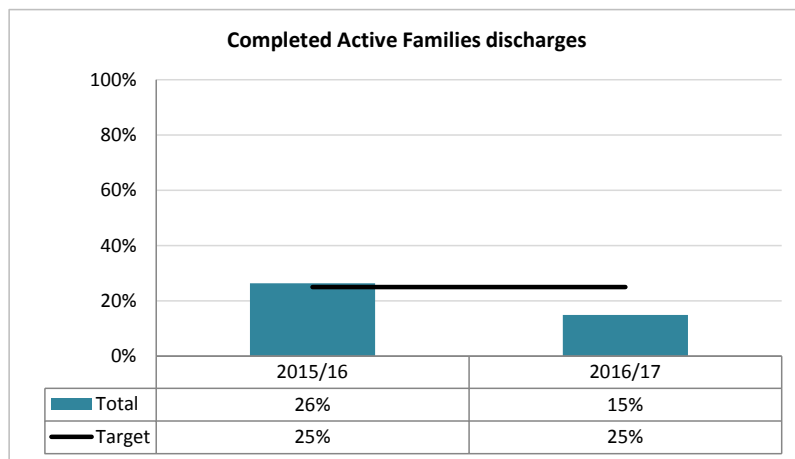
Data Source: Sport Taranaki: GRx Adults Quarterly Report

Of the total adults discharged from the Green Prescriptions programme for the year to date, the percentage discharged as complete

Adult Target Achieved

This is a new output measure for 2016/17 and was consequently not reported on in 2015/16 although data was collected.

Adult GRx have exceeded the target for discharges.



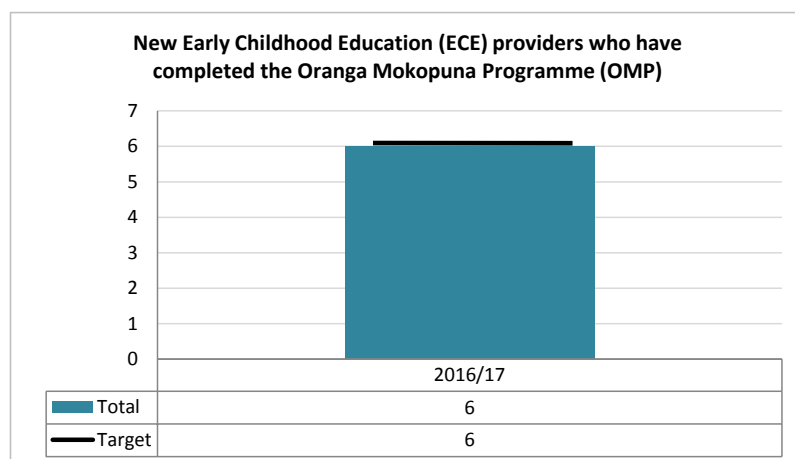
Data Source: Sport Taranaki: GRx Active Families Quarterly Report

Of Active Families annual referrals, the percentage discharged as complete

Total	Target Not Achieved

This is a new output measure for 2016/17 and was consequently not reported on in 2015/16 although data was collected.

While the target for discharges was not met, there were a good proportion of referrals that were either in-processing or actively participating in the programme.



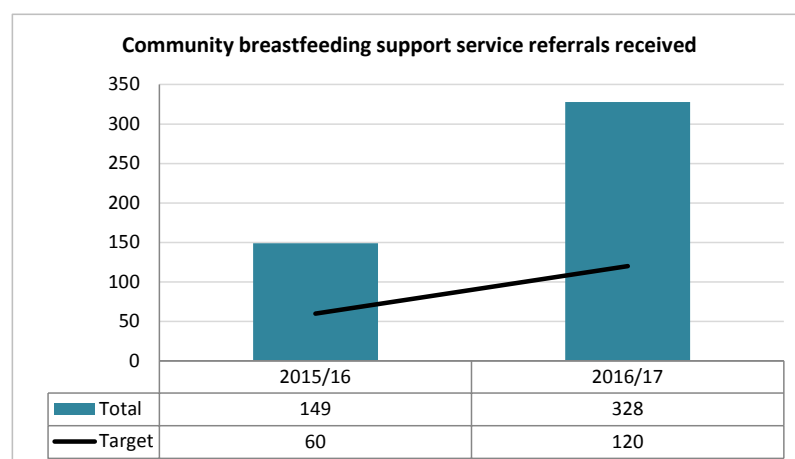
Data Source: Tui Ora Mama Pepe Hauora Contract Report

Number of new Early Childhood Education (ECE) providers who have completed the Oranga Mokopuna Programme (OMP)

Total	Target Achieved

This output measure was initiated in 2016/17 and data was not captured nor reported in prior years.

The Oranga Mokopuna (OMP) team have actively engaged six new ECE into the programme and have supported them to work towards completing the activities to achieve the levels 1-3 of the programme.



Data Source: Tui Ora Mama Pepe Hauora Contract Report

2015/16 target and results were not provided in the 2015/16 Annual Report as this is a new measure.

Number of community breastfeeding support service referrals received

Total	Target Achieved

The Community Breastfeeding service has exceeded the target for referrals. The Community Lactation Consultant (LC) service in particular has received significant referrals, highlighting the value the Community LCs holds for the referring services. It is noted however the referrals and utilisation of the peer supporters could be enhanced to alleviate the pressure of high numbers through the LC service.



OUTCOME 2

People stay well in their homes and communities

Expectation

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.

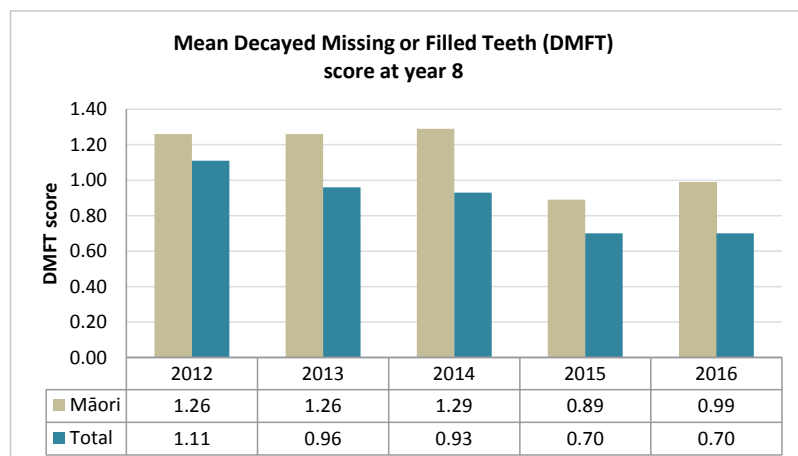
Intermediate Impacts

Children and adolescents have better oral health

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

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

Impact Measures



Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2016. Data is for the 2016 calendar year.

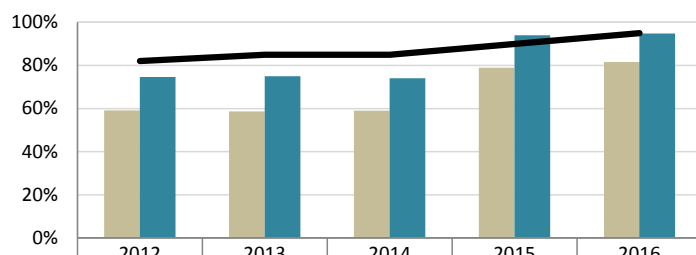
Reduction in the mean Decayed Missing or Filled Teeth (DMFT) score at year 8

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see a decrease in this measure to reflect an improving health outcome in our population.

The mean DMFT at year end has remained steady over 2016. It is unfortunate to see that Māori rates have increased slightly. Some of this rise may be contributed to by the increased number of Māori Children actually enrolled in the service (thereby enabling an improvement in dental decay).

Output Measures

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



Māori	59%	59%	59%	79%	81%
Total	75%	75%	74%	94%	95%
Target	82%	85%	85%	90%	95%

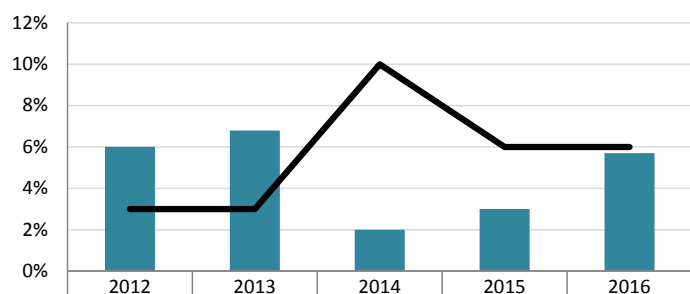
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2016. Data is for the 2016 calendar year.

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 the total population and while we have not achieved the Māori enrolment target, we have made on-going improvements in this area and anticipate continued improvement to address the inequality over time.

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



Total	6%	7%	2%	3%	6%
Target	3%	3%	10%	6%	6%

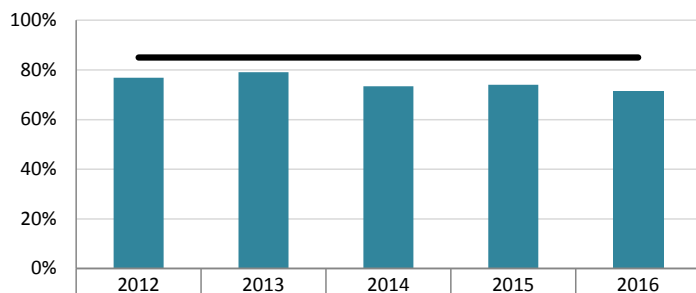
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2016. Data is for the 2016 calendar year.

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 tamariki between the ages of 0-12 years. We hope to reduce this percentage over time with the help of greater emphasis on attending dental services.

Percentage of adolescent utilisation of DHB funded dental services



Total	77%	79%	73%	74%	72%
Target	85%	85%	85%	85%	85%

Data Source: DHB Provider Claims plus Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2016. Data is for the 2016 calendar year.

Percentage of adolescent utilisation of DHB funded dental services

Total	Target Not Achieved

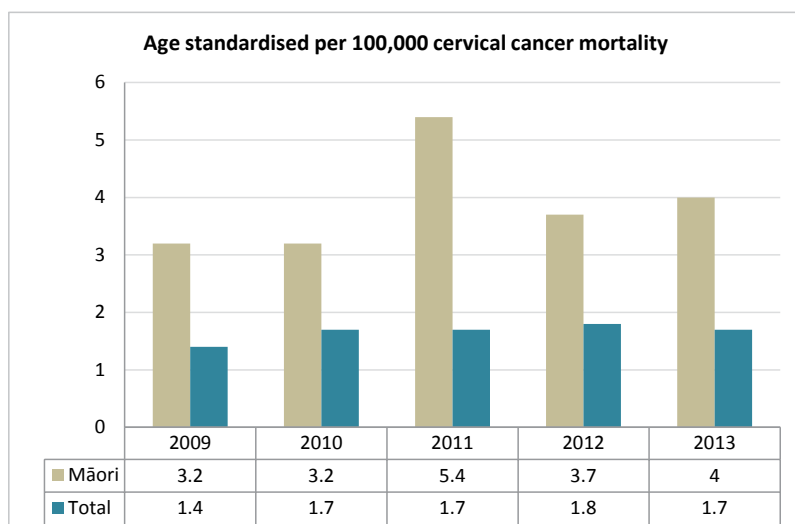
Taranaki DHB continues to work to improve the percentage of adolescents receiving publicly funded oral health care. The service is delivered by both private dentists through the Combined dental Agreement (CDA) and the Taranaki DHB Community Oral Health Service.



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.

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

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see a decrease in this measure to reflect an improving health outcome in our population.

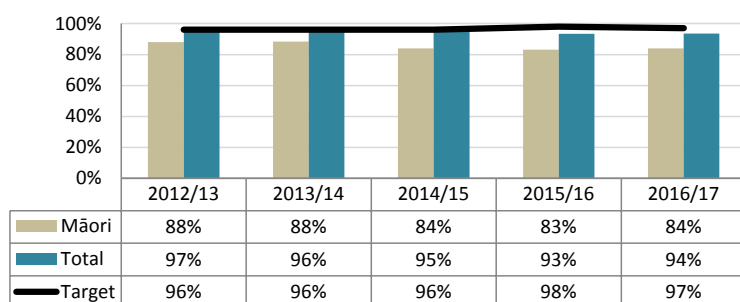
This measure was last published through the NZ Cancer Registry and Mortality data collection in 2016 and is the latest available data. Due to the complexity to collate and report national information, the data held by the national registry is not able to be more current than reported.

The information does however provide important and useful information regarding changes over time for the population and looks at the impact of cancer interventions across the country (and the resulting health of our population). That is why it has been chosen as a long term impact measurement - rather than a annual activity measure.

The latest annual results show a slight deterioration in the results for Māori, and a slight improvement for the Total population. Our objective continues to be a reduction in overall cervical cancer mortality rates.

Output Measures

Percentage of population enrolled with a Primary Health Organisation



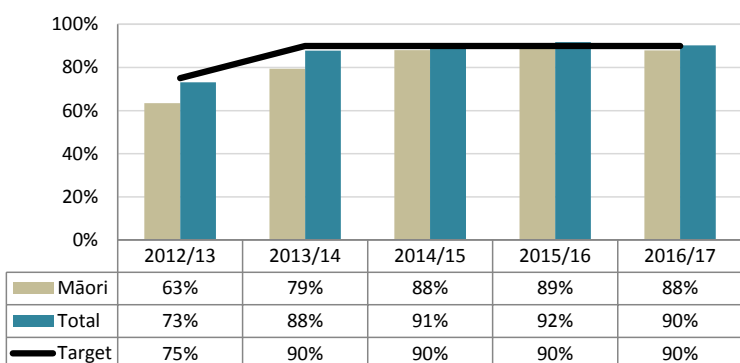
Data Source: Ministry of Health PHO Enrolment Collection

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

Māori	Target Not Achieved
Total	Target Not Achieved

PHO enrolment has improved between 2015/16 and 2016/17 with Taranaki DHB having a small percentage of the population not enrolled with a PHO. This is in part due to one GP practice (and resulting enrolled patients) remaining independent of the PHO and a significant number of people in the Waverley and surrounding districts enrolled with a Whanganui PHO (which decreases the numerator while the denominator is not adjusted). Some work has been undertaken by the Taranaki PHO to identify areas of the Taranaki DHB region that have low rates of PHO enrolment. This will enable a targeted approach in these low enrolment areas.

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



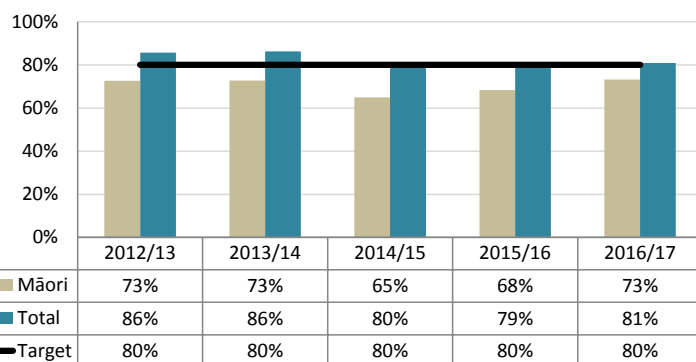
Data Source: Primary Health Organisation Performance Programme (PPP)

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 see a high percentage of eligible Māori and non-Māori have their 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. Some initiatives from 2016/17 include supporting Primary providers to develop a Māori Health Plan to target the health needs of their Māori population, developing a Māori health dashboard as a set of indicators for Primary practices to understand health trends and progress Māori health outcomes and developing new systems of supporting practices to identify their high needs patients and collecting practice based data stratified by ethnicity and gender. These initiatives are planned to continue into 2017/18.

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



Data Source: National Screening Unit

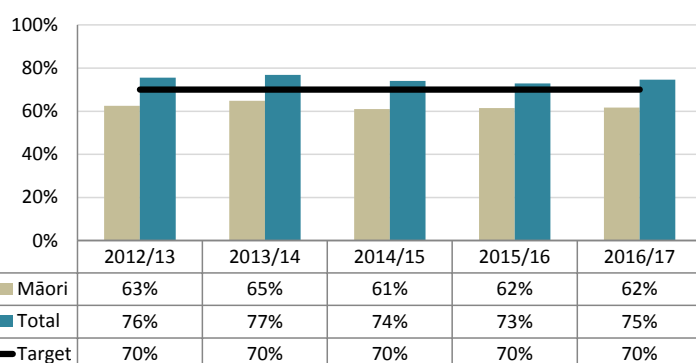
Percentage of eligible women (25-69) have a cervical cancer screen every three years

Māori	Target Not Achieved
Total	Target Achieved

Historically coverage for "total eligible population" in Taranaki has been maintained at over 80% (target). Coverage rates for Māori and Asian women remain under target but well above the national average for Māori and Pacific woman. Taranaki continues to make an improvement in coverage especially for Māori woman since the population adjustment in 2014. Coverage is now based on the ethnicity recorded on the National Health index prior to this the information was based on the National Cervical Screening Programme (NCSP). The Regional Screening Unit (RSU) are working closely with Health Promotion to improve coverage with Asian women.

The RSU in partnership with one of Taranaki high needs practices undertook an initiative to screen their priority women during September. The outcome was very successful and further plans to undertake the same initiative with three other centres in 2017/2018. Data matching occurs on a monthly basis between PHO and NCSP. The Taranaki Steering group has been dis-established due to ongoing low attendance.

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



Data Source: Breast Screening Aotearoa

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

Māori	Target Not Achieved
Total	Target Achieved

Tui Ora have been engaging in a number of activities to increase Māori women's participation in the breast screening programme. This includes utilising the Kaiarahi role to support women to attend screening appointments and following up Did Not Attend (DNAs). Tui Ora are also ensuring the screening bus is located in areas of high Māori population and high socio-economic deprivation.

Fewer people are admitted to hospital for avoidable conditions

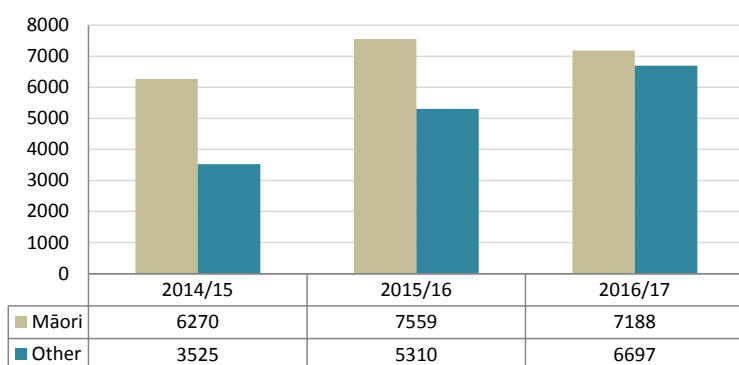
There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care.

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.

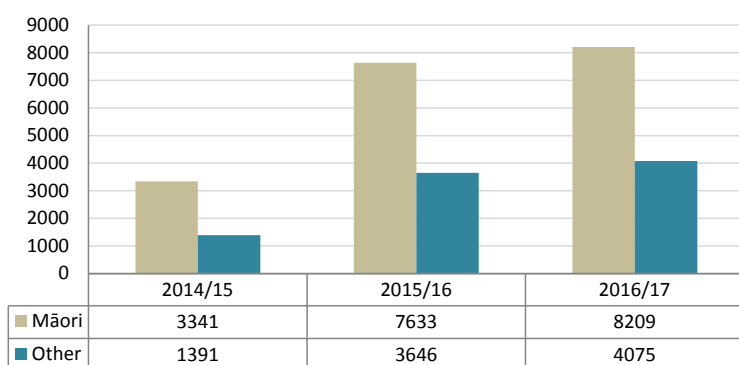
Impact Measures

Reduction in prevalence of Ambulatory Sensitive Hospitalisations (per 100,000) for 0-4 year olds



Data Source: Ministry of Health National Minimum Dataset

Reduction in prevalence of Ambulatory Sensitive Hospitalisations (per 100,000) for 45-64 year olds



Data Source: Ministry of Health National Minimum Dataset

Reduction in prevalence of Ambulatory Sensitive Hospitalisation (ASH)

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see a decrease in these measures to reflect an improving health outcome in our population.

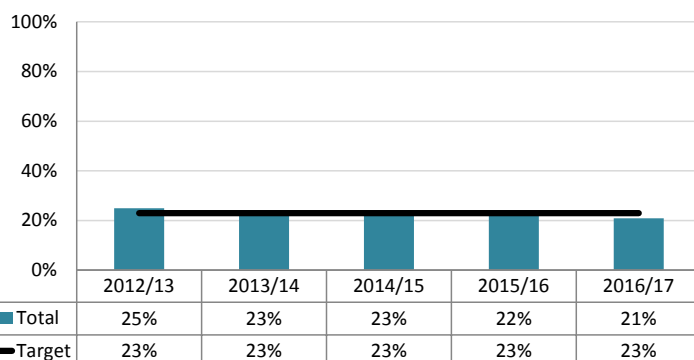
This measure is important in identifying the effectiveness of Primary Care services and adds to the evidence that we need to work with our Primary partners to reduce these Ambulatory Sensitive Hospital(ASH) admissions, with a particular emphasis on reducing ASH rates for Māori to bring them in line with the rest of the population.

Ambulatory Sensitive Hospitalisations for 0-4 year olds was part of the System Level Measures framework in 2016/17, where Primary Health Organisations and DHBs work together to increase healthy outcomes. As such, this measure was put under greater scrutiny for 0-4 year olds and there were a range of actions put in place to try and reduce the prevalence of Ambulatory Sensitive Hospitalisations and the disparity between Māori and Non-Māori. While Māori Ambulatory Sensitive Hospitalisations have decreased during 2016/17, non-Māori Ambulatory Sensitive Hospitalisations has continued to deteriorate. The System Level Measure framework for 2017/18 is again focusing on Ambulatory Sensitive Hospitalisations for 0-4 year olds and there are a number of actions that have been identified that will aim to reduce the Ambulatory Sensitive Hospitalisation rate for 0-4 year olds in 2017/18.

An integration Project between primary and secondary care is underway with the aim that stakeholders work together to ensure co-ordinated care is delivered closer to the patient's home, as it is better for the patient, better for the population and better for the health system. Work on setting up a single point of access has already commenced along with data analysis regarding referral patterns to secondary care.

Output Measures

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



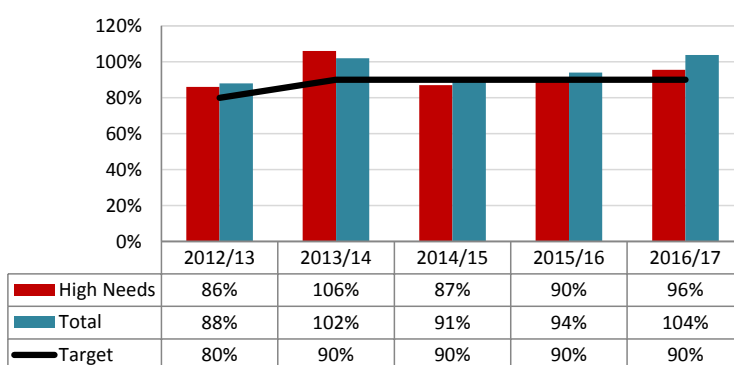
Data Source: National Non-admitted Patient Collections. Statistics New Zealand Population Projection 2013

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

Total	Target Achieved

Our ED presentation numbers of triage 4 and 5 patients have been steadily decreasing due to ongoing public education campaigns, primary option pathways and primary redirection.

Percentage of eligible population have their Before School Checks completed



Data Source: National Immunisation Register

90% of eligible population have their Before School Checks completed

High Needs	Target Achieved
Total	Target Achieved

Each year Taranaki consistently deliver above the national target for both High Needs and Total Population. For quarter four, an increase in resources was put in place, as Taranaki DHB was an outlier in the timing for the age that the checks were commenced. The intention is to rebase the start age for the checks earlier to align with national best practice. This has meant that more children have been checked as the age for the checks has moved from roughly four and half years old, to a couple of months after they turn four. This has resulted in over 100% of the intended cohort receiving a check for 2016/17. This is not seen as sustainable in out years.

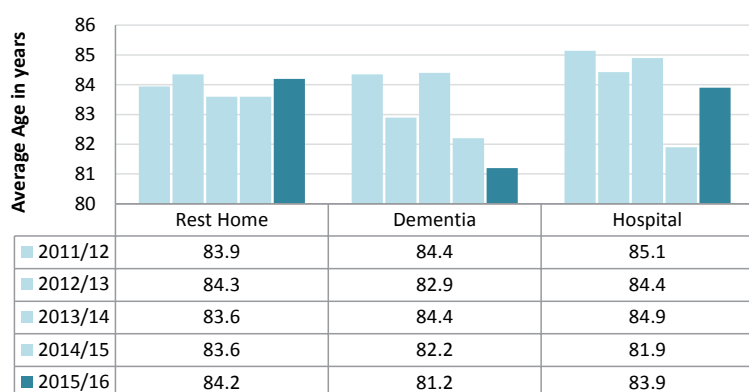


People maintain functional independence

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.

Impact Measures

Average age of entry into rest homes (by level of care)



Data Source: Inter District Flow files

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

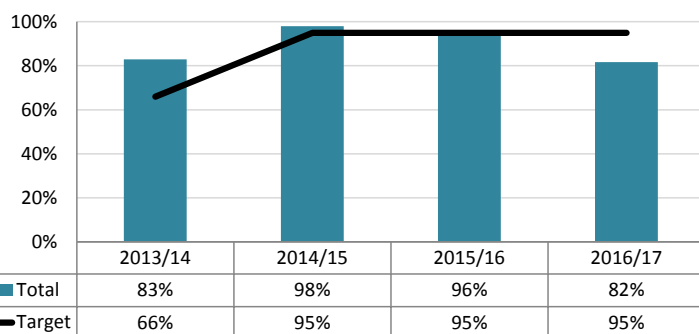
NB: The reported data is only available 12 months in arrears. Consequently, we are reporting the final results for 2015/16.

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see an increase in this measure to reflect an improving health outcome in our population.

We continue to take steps to manage growth in demand for aged residential care by offering a range of alternative care and support options including respite care, short-term post-discharge residential rehabilitation services (aimed at older people with re-hab potential) and short term "enhanced" home & community support services. Expenditure on long term aged residential care was lower in 2016/17 than it was in the previous year, in contrast to historical trends, suggesting that more older people are being supported to remain independent in their own home despite the lower average age of entry to aged residential care in 2016/17.

Output Measures

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



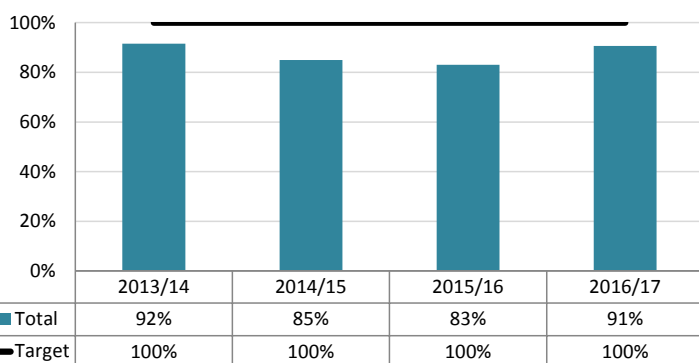
Data Source: InterRAI and Ministry of Health DHB Claiming data

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 Not 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 approved, so the true result for this client group is more likely to be 100%. Due to changes in contracting processes, in particular the merger of our short-term and long-term Home & Community Support Sector contracts, we have had some issues with our data reporting systems (with short-term clients, who are not required to have an interRAI assessment, now being included in the data used as the denominator for this result). Prior to this change, Taranaki DHB was achieving over 95%. If the short-term clients were able to be extracted from the data set, this figure would be expected to be closer to 100% as all older people receiving long-term support services are required to be interRAI assessed in practice (Taranaki DHB does not use any other assessment tool for this client group).

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



Data Source: Taranaki DHB

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

Total Target Not Achieved

Overall for the 16/17 year we have achieved the Health Quality & Safety Commission target of 90% although there has been variance across individual months. The self imposed target of 100% is not appropriate given the international best practice rate, as endorsed by the Health Quality & Safety Commission. This allows for the small percentage of patients where other assessments and interventions are a clinical priority over a falls risk assessment.

The DHB's Falls Prevention Committee continues to monitor compliance with this and other key quality and safety markers. Monthly reviews of the data has identified contributing factors and these have been fed back to individual areas resulting in tangible improvement, e.g. The new ED Casualty cards now include a Falls Risk assessment to identify falls risk and mitigate as early as possible. In 17/18 monthly audits and feedback will continue. Variances will be discussed at the monthly falls meeting and continuous quality improvement will occur to maintain and improve this rate.



OUTCOME 3

People receive timely and appropriate specialist care

Expectation

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.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

Intermediate Impacts

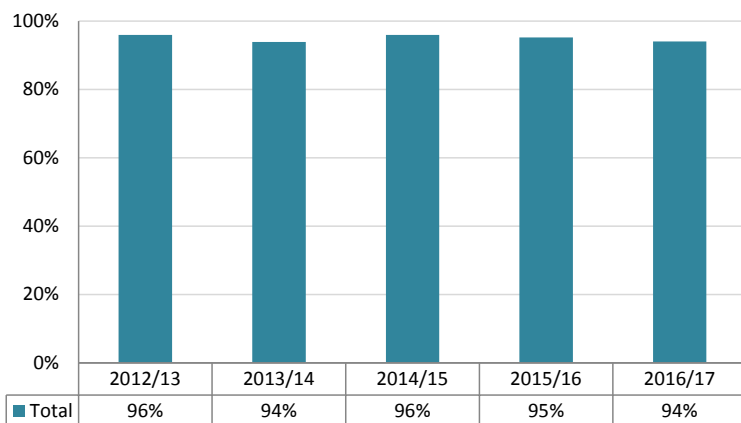
People receive prompt and appropriate acute care

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.

The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentations, the effectiveness of services provided in ED and the hospital and community services provided following exit from ED. Reduced waiting time in ED is indicative of a coordinated 'whole of system' response to the urgent needs of the population. See Health Targets pages 10-11.

Impact Measures

Percentage of patients that are admitted, discharged, or transferred from an emergency department within six hours



Data Source: Taranaki DHB Patient Management System

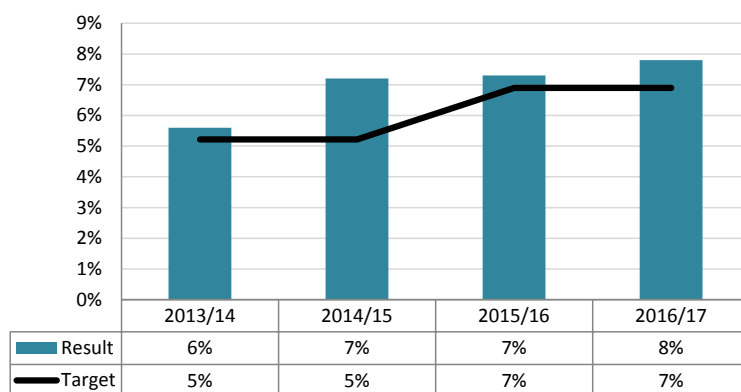
Percentage of patients that are admitted, discharged, or transferred from an emergency department within six hours

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see an increase in this measure to reflect an improving health outcome in our population.

Although our triage 4 & 5 patient numbers are continuing to decline, our ED triage 1-3 patient numbers have increased which has put pressure on our target. The roll out of capacity at a glance screens and variance response update is due by October 2017 and this will assist to identify early any capacity issues or delays and enable a response to improve patient flow. The new IT ED dashboard is currently being tested and rolled out and this enables the improved monitoring of mandatory and non mandatory measures in accordance with the ED Quality Framework. This IT dashboard also provides an insight into the ED patient journey and this will allow specific improvements as a result of any identified delays.

Output Measures

Acute re-admission rate



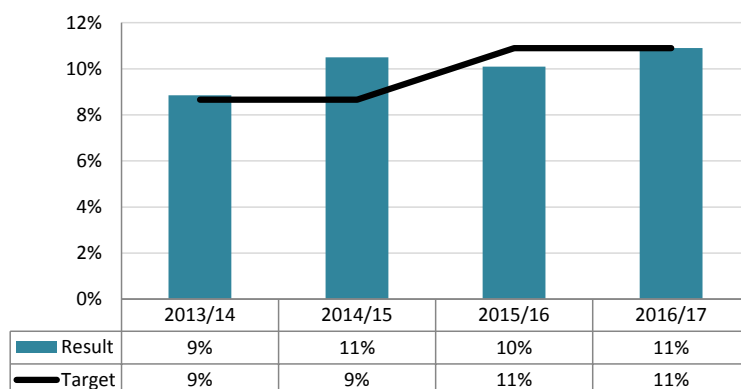
Data Source: National Minimum Dataset (NMDs)

Acute re-admission rate

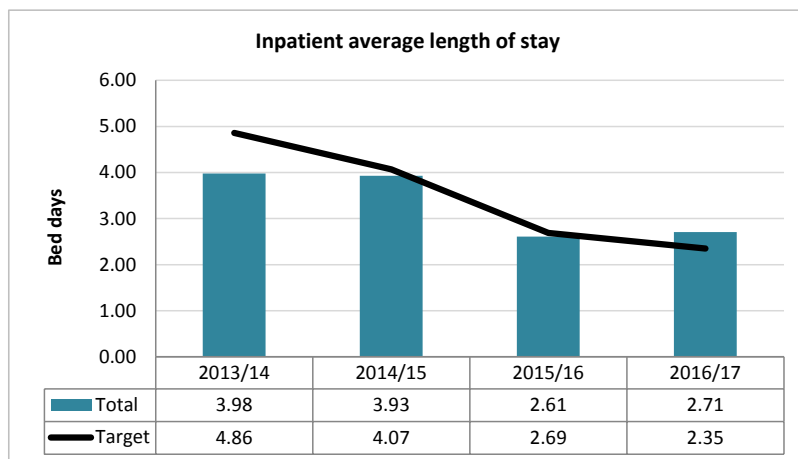
Acute re-admission rate	Target Not Achieved
Acute re-admission rate (over 75 years)	Target Achieved

The hospital readmission rate has increased this financial year, in part due to the increased acuity and complexity of our patients presenting and being admitted to hospital. Currently TDHB have our Integration Project underway and this is working toward developing greater levels of clinical integration across the primary and secondary sectors. This will ensure proactive and co-ordinated care is delivered closer to the patient's home which will prevent hospital admissions and allow for earlier, safe discharge from hospital and the prevention of readmissions.

Acute re-admission rate >75s



Data Source: National Minimum Dataset (NMDs)

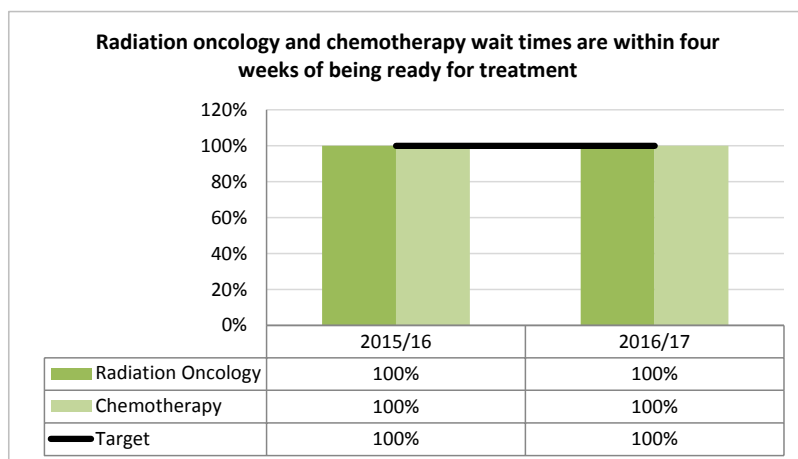


Data Source: National Minimum Dataset (NMDS). Desired outcome is below the target rate

Acute Inpatient average length of stay reduced

Total	Target Not Achieved

Acute Length of Stay (LOS) has increased slightly, this is disappointing for Taranaki DHB as there is significant ongoing work occurring to maintain the improvements gained and reach out target. We have had vacancies in our case management team that has contributed to this along with an exceptionally busy winter with some very ill elderly patients. Ongoing work continues in relation to early assessment, treatment and planning for discharge within the inpatient wards.

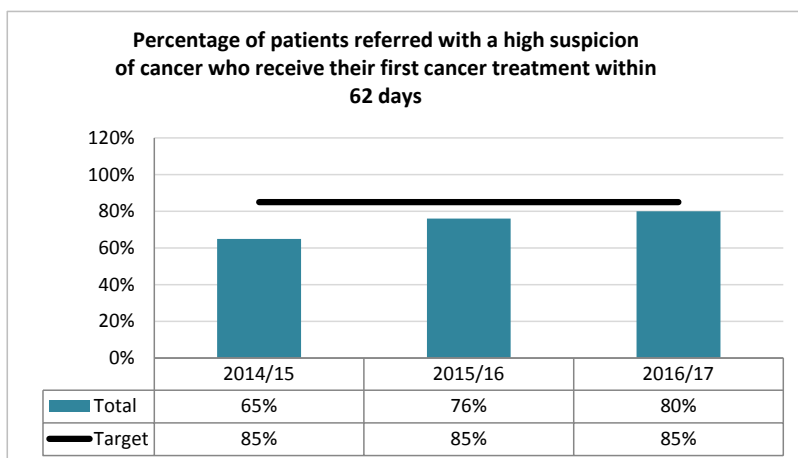


Data Source: Mid-Central DHB Patient Management System

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

Radiation Oncology	Target Achieved
Chemotherapy	Target Achieved

Continue to work with Midcentral DHB to ensure our patients receive timely radiation oncology and chemotherapy treatment.



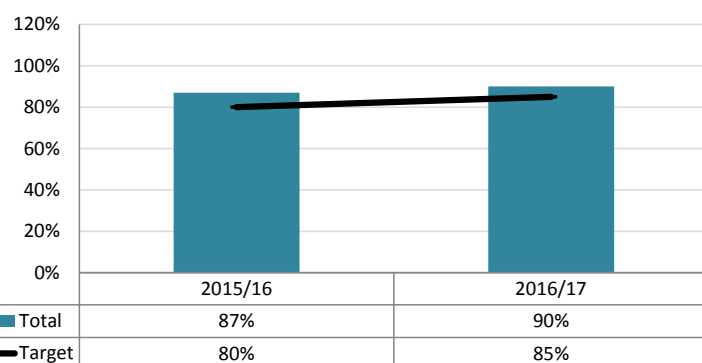
Data Source: Mid-Central DHB Patient Management System

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 continues to work closely with the Central Cancer Network (CCN) to implement quality improvements identified in the tumour reviews. There has been an improvement in the 62 day target throughout the year. An audit of cancer registrations has been carried out which has identified missing haematology patients and improvements are now in place to ensure improved capture. Haematology, Oncology and 62 day indicator pending reports are now available and are checked regularly by our Faster Cancer Treatment (FCT) administrator and coordinator. Daily breach reporting has been developed and monthly meetings are occurring to ensure each breach is analysed and processes are developed to prevent further breaches. Midcentral DHB have commenced weekly FSA and planning appointments to be carried out simultaneously in Palmerston North and this will lead to improvements in our FCT time frames. Improved FCT awareness by development of FCT Newsletters sent to all clinical staff and education of clerical staff to ensure compliance with targets. FCT Governance Group is working well and now includes a Physician representative.

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



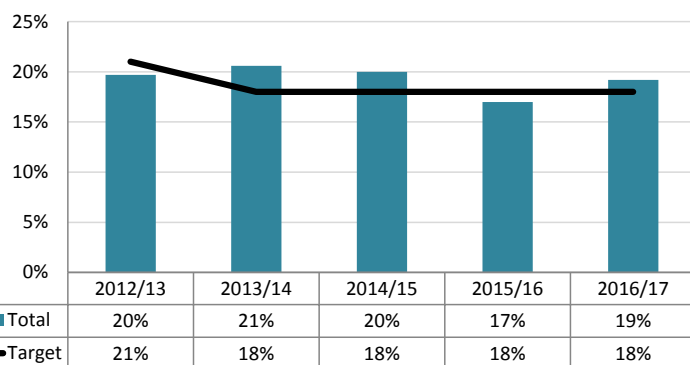
Data Source: Mid-Central DHB Patient Management System

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

Total Target Achieved

There has been consistent improvement in meeting the 31 day target. Improvements in raising Faster Cancer Treatment (FCT) awareness with all staff across the hospital and increased monitoring has ensured this target is continuing to be met.

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



Data Source: National Minimum Dataset (NMDs). Desired outcome is below the target rate

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

Total Target Not Achieved

Whilst we are committed to reducing the number of arranged caesarian sections in the Taranaki region it is noted by senior obstetricians that there are increased indications for elective caesarean sections, such as the birth of twins, suspected large babies and second caesarean sections when no more children are planned.



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 pages 10-11). 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.

Impact Measures

Elective services - standardised intervention rates per 10,000

Major joint replacement - target 21 per 10,000

Result: 22.95 Not significantly different to target

Cataract procedures - target 27 per 10,000

Result: 27.61 Not significantly different to target

Cardiac surgery - target 6.5 per 10,000

Result: 6.41 Not significantly different to target

Percutaneous revascularisation - target 12.5 per 10,000

Result: 8.81 Significantly below target

Coronary Angiography Services - target 34.7 per 10,000

Result: 39.07 Significantly above target

Data Source: Ministry of Health, Elective Services

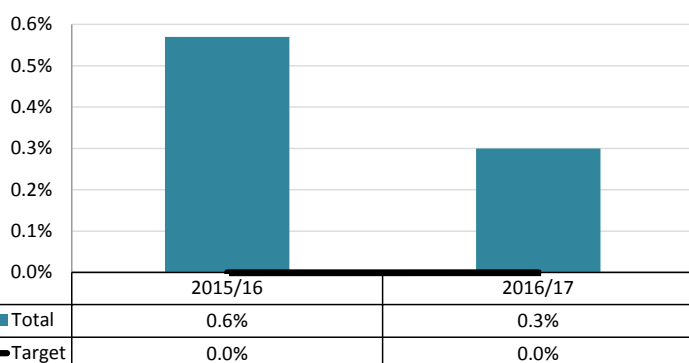
Elective services - standardised intervention rates per 10,000

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see an increase in these measures to reflect an improving health outcome in our population.

Standardised intervention rates are measured against nationally set targets to ensure that access to a variety of types of surgery is fair, and not dependent upon where a person lives. Taranaki DHB continues, as a secondary care hospital, to rely heavily on Waikato DHB's processes to support us meeting the national standardised intervention rates for this level of surgery. It was pleasing therefore to see that our standardised intervention rate for surgery was similar again to other DHB's across the country. The improvement gained in orthopaedics and cataract surgery has been sustained in the past 12 months. This is pleasing for Taranaki DHB.

Output Measures

ESPI 2 - No patients wait longer than four months for their specialist assessment



Data Source: National Booking Reporting System (NBRS)

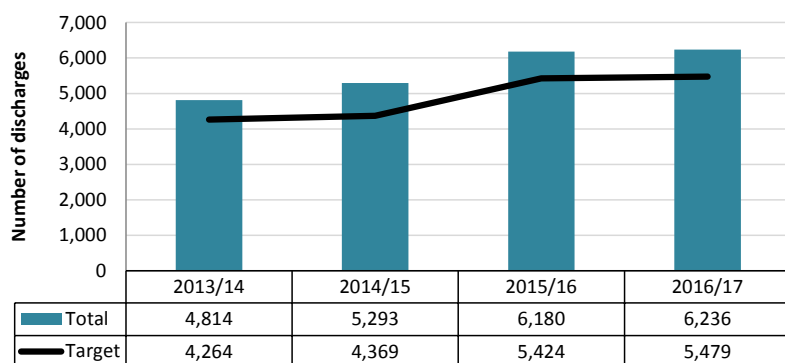
Extract of Elective Services Performance Indicators (ESPI) results

Result	Target Not Achieved

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.

Taranaki has generally been able to meet the ESPI indicators for 2016/17. There has however been a few months where TDHB has not been compliant resulting in the very small percentage non-compliant result. However this has not been sustained and managed back to compliance in a timely manner.

Number of Health Target elective surgical discharges



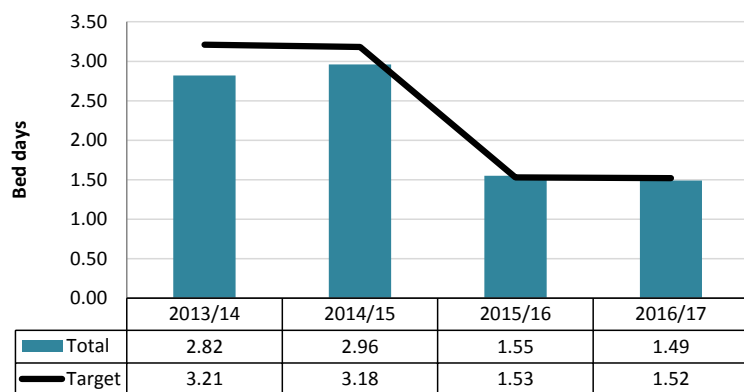
Data Source: National Minimum Dataset (NMDS)

Number of Health Target elective surgical discharges

Result	Target Achieved

It was pleasing to have Taranaki DHB achieve this target again. The teams have worked hard to ensure all surgery is undertaken within Ministry of Health guidelines and within contracted volumes. This hard work and effort with continue into 2017/18.

Elective inpatient length of stay



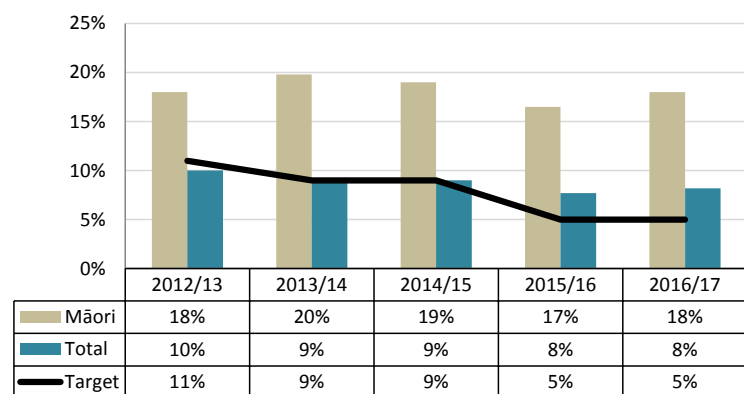
Data Source: National Minimum Dataset (NMDS). Desired outcome is below the target rate

Elective inpatient length of stay (LOS)

Total	Target Achieved

As the efficiency of the hospital increases we expect that the average length of stay (in bed days) would reduce. Our enhanced recovery after surgery project continues to again support Taranaki achieving the elective LOS target.

Did Not Attend (DNA) rate for outpatient services



Data Source: National Non-admitted Patient dataset. Desired outcome is below the target rate

Did Not Attend (DNA) rate

Māori	Target Not Achieved
Total	Target Not Achieved

Managing and monitoring the DNA rate of all patients and Māori patients in particular is an ongoing focus for us. Individual specialties are working on ways of improving this. The Māori health team have a project group that are working on initiatives to reduce the Māori DNA rates. Whilst we have not markedly increased in this target area, the planned and expected improvement has not been realised either. Work continues in this area for Taranaki DHB, in an effort to facilitate better attendance at OPD clinic appointments for all.

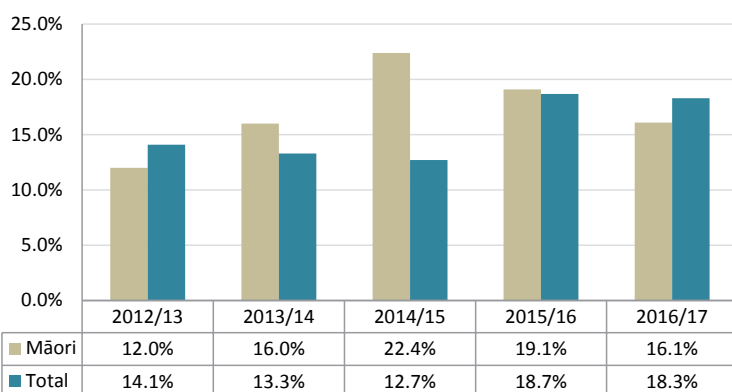


Improved access to mental health services

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.

Impact Measures

28 day acute readmission rate



Target range is between 10-20%

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

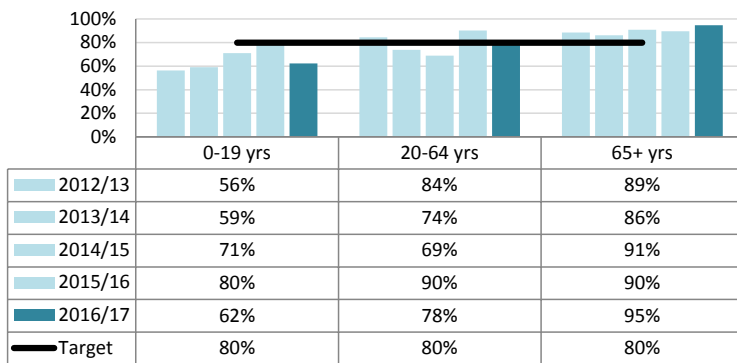
28 day acute readmission rate

Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB would ideally like to see a decrease in this measure to reflect an improving health outcome in our population.

Readmission rates are a national KPI for all Mental Health and Addiction Service (MHAS) Adult services. An audit was completed for 15/16 and this identified that readmission rates for specific diagnostic groups were trending up, although TDHB remains below the upper target alert. A quality improvement programme for the next six months will focus on discharge planning which in turn should assist with reducing the readmission rate.

Output Measures

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



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

Desired outcome is below the target rate

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

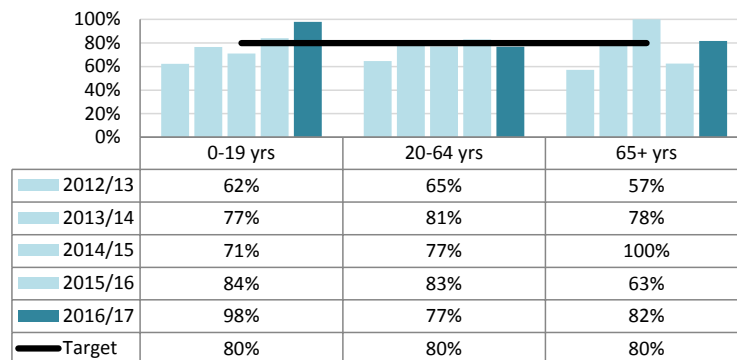
0-19 years	Target Not Achieved
20-64 years	Target Not Achieved
65+ years	Target Achieved

0-19yrs - 2016/17 saw an influx in referrals to the Child & Adolescent Mental Health and Addiction service. A revised model of care, improved response time to new referrals and recruitment to vacant positions is seeing an improvement for this target.

20-64yrs - Management of poor quality referrals and Did Not Attend (DNA) have had a significant impact on the services ability to see people in a timely fashion over this period. Work will be undertaken to work with referrers to assist in improving the quality of referrals and assessing/ advising alternative primary options.

65+yrs - Compliance remains above target.

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

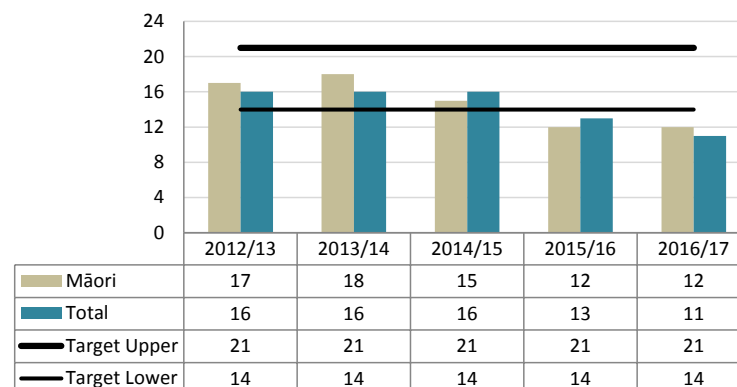
0-19 years	Target Achieved
20-64 years	Target Not Achieved
65+ years	Target Achieved

0-19yrs - Meeting performance target.

20-64yrs - Taranaki DHBs Addiction Services have seen an unprecedented rise in referrals which has precipitated longer waiting times for people with non urgent issues. The service is in the process of reviewing the current intake process, and will now be offering weekly group options for people presenting with non urgent problems.

5+yrs - Meeting performance target.

Average length of stay for acute inpatients



Target: 14-21 days

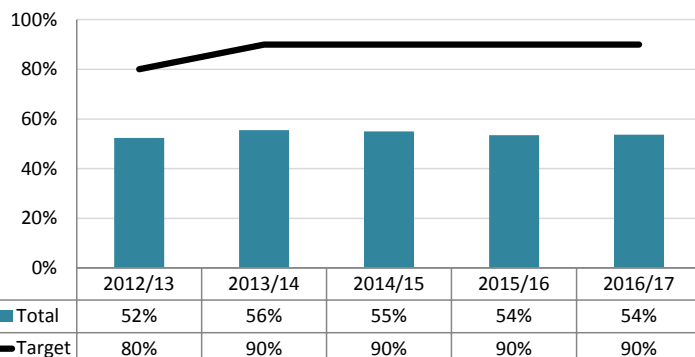
Data Source: Programme for the Integration of Mental Health Data (PRIMHD)

Average length of stay for acute inpatients

Total	Target Not Achieved

A revised nursing model has contributed to a reduction in length of stay which did not appear to impact on readmission or compromise patient care.

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



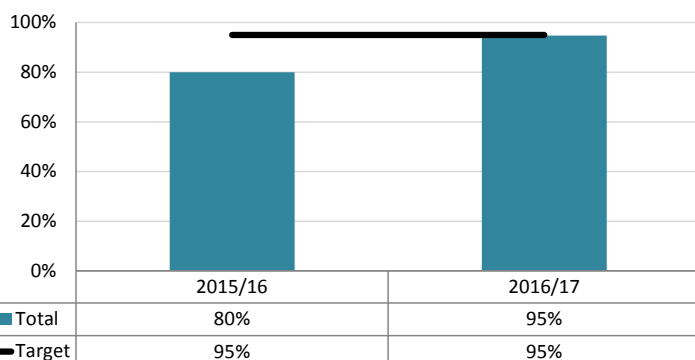
Data Source: Programme for the Integration of Mental Health Data (PRIMHD)

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

Total	Target Not Achieved

When this target is reviewed internally, protocol exclusions (eg. discharges to GP, corrections) are removed, which calculates to 84% of post discharge patients are seen in the community within seven days. We continue to discuss this KPI at the MHAS clinical governance forum and report to the Taranaki DHB Board with the intent to ensure all clients are seen within seven days.

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



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

Revised processes are continuing to ensure positive outcomes for the KPI.



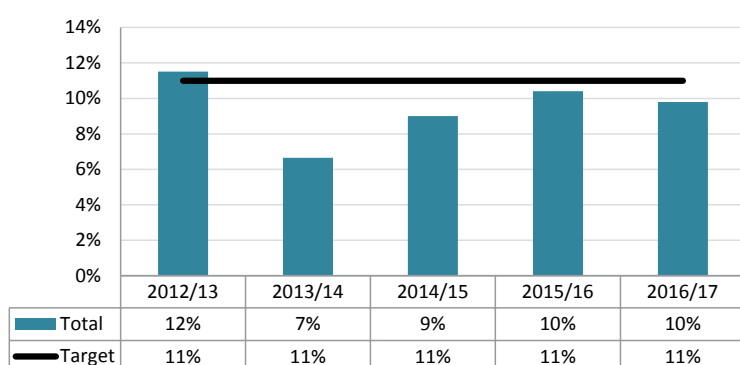
More people with end-stage conditions are appropriately supported

Why is this important?

It is important that people who have life threatening illness, along with their family and whānau, receive appropriate care and support to cope with their situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition that end of life is imminent and commencement of a palliative approach to care and support will heavily influence the quality of life individuals and their family experience during the dying process. Support services during this time include palliative care, aged residential care, respite care and home based support services. See Health Targets pages 10-11.

Output Measures

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



Data Source: Taranaki Hospice

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

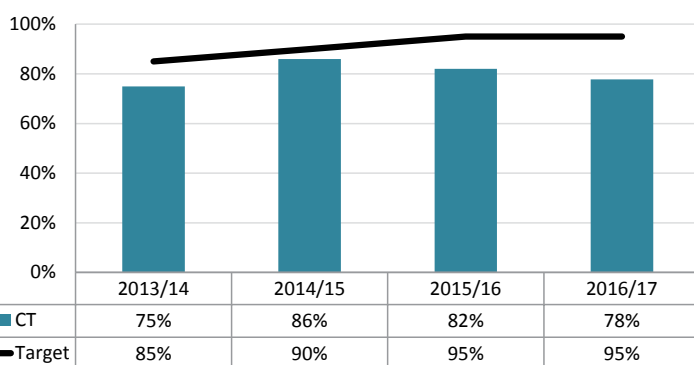
Total	Target Achieved

Hospice Taranaki introduced two new Palliative Care Clinical Nurse Specialists in 2016 whose role was focused on supporting aged residential care providers to build their skills and capacity to manage palliative residents in aged residential care and to reduce avoidable hospital admissions of palliative residents. The Palliative Clinical Nurse Specialists work closely with the Taranaki DHB Gerontology Clinical Nurse Specialist for aged residential care. Take up of this service by aged residential care has been high, and feedback to date has been excellent. The Palliative CNS service is due to be evaluated in 17/18, but it appears to have had a positive impact towards meeting targets for reduced ED presentations for palliative patients. We anticipate that this service will continue to contribute to the reduction of the reliance on ED services over time, enabling aged care facilities to better manage palliative conditions on site with support of Hospice Taranaki and primary care.

Support services

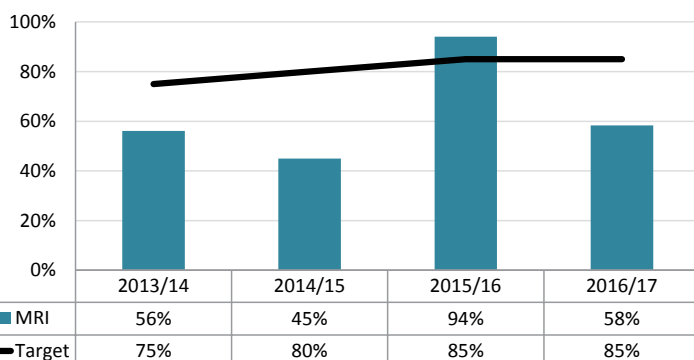
Output Measures

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



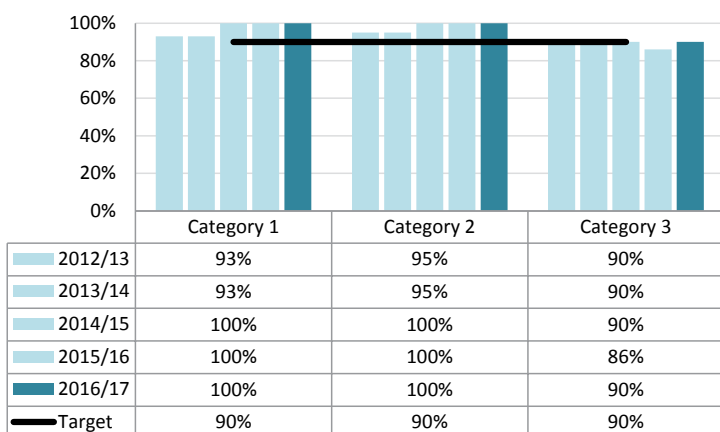
Data Source: Taranaki DHB

Percentage of people with accepted referrals for MRI 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

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

MRI	Target Not Achieved
CT	Target Not Achieved

CT scan requests have increased by 63% in the last three years while numbers of CT scans performed has increased by 40%. The proportion of (non-acute) CT scans measured in this indicator have fallen to 40% of the total referrals received and the proportion of acute and more urgent CT scan referrals has increased to 60% which explains the challenge in meeting this target. Clinical priority dictates that the urgent/semi-urgent scan request trumps the non-urgent scan.

For MRI, the acute and urgent scan requests have doubled over the last year along with increasing complexity and average scanning time, impacting on the waiting time for non-urgent scans. To address these challenges, we are trying to manage down the number of referrals received as well as increasing available scanning time to improve the number of scans performed across both modalities.

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

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

Timely diagnostic results are vital to ensuring the best possible health outcomes for patients. Taranaki DHB continues to work closely with its community laboratory services to ensure service remain readily available and reported in a timely manner.

Taranaki District Health Board and Group

FINANCIAL REPORT

2016-2017



- 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 2017, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.



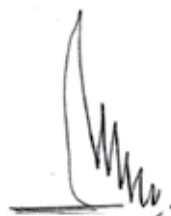
Pauline Lockett
Deputy Chairperson
26 October 2017



Neil Volzke
Deputy Chairperson
26 October 2017



Rosemary Clements
Chief Executive
26 October 2017



George Thomas
Chief Financial Officer
26 October 2017

Statement of Comprehensive Revenue & Expense For the Year Ended 30 June 2017

		Group and Parent		Group and Parent
		Actual	Budget	Actual
	Notes	June 2017	June 2017	June 2016
		Unaudited		
		\$000	\$000	\$000
Revenue	1	363,803	363,031	354,659
Other income	2	806	2,003	789
Total revenue		364,609	365,034	355,448
Employee benefit costs	3	131,137	131,036	123,087
Depreciation expense	13	16,429	17,011	15,521
Outsourced services		16,507	12,368	18,206
Clinical supplies		27,447	25,455	26,164
Infrastructure and non-clinical expenses		14,869	8,877	13,362
Payments to non-health board providers		152,607	162,149	152,539
Other expenses	4	1,437	2,394	1,872
Capital charge	5	4,347	5,407	5,822
Financing costs	6	1,457	2,337	2,660
Total expenses		366,237	367,034	359,233
(Loss) before share of associates		(1,628)	(2,000)	(3,785)
Share of surplus/(loss) of associates	12(c)	(42)	-	116
(Loss) after surplus of associates		(1,670)	(2,000)	(3,669)
Other comprehensive revenue and expense				
Total other comprehensive revenue and expense		-	-	-
Total comprehensive revenue and expense		(1,670)	(2,000)	(3,669)

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

Group and Parent					
Note	Public Equity	Accumulated Revenue and Expense	Asset Revaluation Reserve	Trust Fund Reserve	Total
	\$000	\$000	\$000	\$000	\$000
At 30 June 2015	23,164	(10,664)	67,450	800	80,750
Comprehensive revenue and expense					
(Loss) 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	29	(959)	-	-	(959)
	(959)	-	-	-	(959)
At 30 June 2016	22,205	(14,218)	67,450	815	76,252
Comprehensive revenue and expense					
(Loss) for the year	-	(1,670)	-	-	(1,670)
Transfer from/(to) Trust Funds Reserve	-	(29)	-	29	-
	-	(1,699)	-	29	(1,670)
Transactions with the Crown					
Debt converted to Equity	29	74,000	-	-	74,000
Equity repaid to the Crown	29	(959)	-	-	(959)
	73,041	-	-	-	73,041
At 30 June 2017	95,246	(15,917)	67,450	844	147,623

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

Statement of Financial Position

For the Year Ended 30 June 2017

		Group and Parent		Group and Parent
		Actual	Budget	Actual
	Notes	June 2017	June 2017	June 2016
		Unaudited		
		\$000	\$000	\$000
ASSETS				
Current assets				
Cash and cash equivalents	7	-	-	-
Trade and other receivables	8	13,173	15,450	13,026
Inventories	9	3,102	2,650	2,797
Other financial assets	10	2,890	2,890	2,890
Total current assets		19,165	20,990	18,713
Non-current assets				
Investments in subsidiaries	11	-	922	-
Investments in associates	12	1,395	1,351	1,437
Other financial assets	10	56	56	56
Property, plant and equipment	13	175,528	176,293	180,258
Intangible assets	14	1,934	1,418	1,418
Restricted assets & trust funds	15	844	800	815
Total non-current assets		179,757	180,840	183,984
TOTAL ASSETS		198,922	201,830	202,697
LIABILITIES				
Current liabilities				
Cash and cash equivalents	7	3,146	6,077	8,185
Trade and other payables	16	20,459	22,246	18,957
Interest bearing loans and borrowings	17	-	-	19,200
Employee benefits	18	26,690	25,145	24,624
Provisions	19	110	55	18
Total Current Liabilities		50,405	53,523	70,984
Non current liabilities				
Interest bearing loans and borrowings	17	-	74,000	54,800
Employee benefits	18	894	1,055	661
Total non current liabilities		894	75,055	55,461
TOTAL LIABILITIES		51,299	128,578	126,445
NET ASSETS		147,623	73,252	76,252
EQUITY				
Public equity		95,246	21,246	22,205
Retained (losses)		(15,917)	(16,243)	(14,218)
Asset revaluation reserve		67,450	67,449	67,450
Trust fund reserve	15	844	800	815
TOTAL EQUITY		147,623	73,252	76,252

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

For and on behalf of the Board, who authorised the issue of these financial statements on the 26th October 2017



Pauline Lockett
CHAIRPERSON



Neil Volzke
DEPUTY CHAIRPERSON

Statement of Cash Flows

For the Year Ended 30 June 2017

		Group and Parent		Group and Parent
		Actual	Budget	Actual
		June 2017	June 2017	June 2016
		Unaudited		
CASHFLOWS FROM OPERATING ACTIVITIES	Note	\$000	\$000	\$000
Cash was provided from:				
Receipts from Government and Public		364,798	364,542	356,645
Interest Received		359	292	345
GST (Net)		57	-	401
		365,214	364,834	357,391
Cash was disbursed to:				
Payments to Suppliers		212,946	204,337	211,707
Payments to Employees		128,838	130,281	122,413
Capital Charge Paid		4,347	5,407	5,822
Interest Paid		1,457	2,337	2,739
GST (Net)		-	-	-
		347,588	342,362	342,681
Net Cash Inflow from Operating Activities	20	17,626	22,472	14,710
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Dividends Received		2	-	2
Proceeds from Sale of Property, Plant & Equipment		143	-	84
		145	-	86
Cash was applied to:				
Purchase of Property, Plant & Equipment		11,744	15,200	13,304
Investments		-	-	437
Purchase of Intangible Assets		-	-	-
Restricted Assets		29	-	15
		11,773	15,200	13,756
Net Cash Outflow from Investing Activities		(11,628)	(15,200)	(13,670)
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Equity vested by Crown		-	-	-
Proceeds from Debt Financing		-	-	-
		-	-	-
Cash was applied to:				
Repayment of Equity		959	959	959
		959	959	959
Net Cash Outflow from Financing Activities		(959)	(959)	(959)
Net (Decrease)/Increase in Cash Held		5,039	6,313	81
Cash and cash equivalents at beginning of year		(8,185)	(12,390)	(8,266)
Cash and cash equivalents at end of year		(3,146)	(6,077)	(8,185)

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

Significant accounting policies for the year ended 30 June 2017**(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 PBEs 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% shareholding in Fulford Radiology Services Limited as it has full control. There is also a 18.25% shareholding in Allied Laundry Services Limited and a 20% shareholding in HealthShare Limited. These associated entities are included as an activity as Taranaki District Health Board has significant influence in those entities.

The financial statements of Taranaki District Health Board show the same results under both Group and Parent. This is because Crown Entities with subsidiaries are required to report through Group statements only.

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 2017. The financial statements were authorised for issue by the Board on 26 October 2017.

(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). These standards are based on international Public Sector Accounting Standards (IPSAS).

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

(i) Functional and presentation currency

The financial statements are presented in New Zealand dollars which is the functional currency of Taranaki District Health Board. All financial information presented in New Zealand dollars has been rounded to the nearest thousand (\$'000) unless stated otherwise.

(ii) Use of estimates and judgements

In preparing these financial statements Taranaki District Health Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Allowance for impairment loss on trade receivables (note 8)

A monthly assessment of non commercial debtors is made, with an impairment allowance being provided for based on the age of these debts. In June of each year all non commercial debts that are aged over 12 months that are not being paid off by the debtor is written off. Refer to note 8 for the amount per year of non commercial debt after the impairment allowance.

Estimation of employee entitlement accruals

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

Fair value of buildings

Taranaki District Health Board revalues land and buildings on either a five year cycle or when there is a material (10% or over) change between the independent valuation and the carrying value of the land and buildings. The independent valuation also determines the remaining life of buildings, and therefore the annual depreciation cost in future years.

Useful lives of property, plant and equipment

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

(iii) Changes in accounting policies

There have been no changes 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 13.

(c) Basis of consolidation**Subsidiaries**

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

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

In preparing consolidated financial statements, all intercompany balances and transactions, income and expenses and profit and losses resulting from intra-group transactions are eliminated in full. Crown entities with subsidiaries are required to report through Group statements only.

Taranaki District Health Board held a 100% shareholding in Fulford Radiology Services Limited as at 30 June 2017.

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 18.25% held
HealthShare Limited 20% held

Taranaki District Health Board's investment in its associates is accounted for using the equity method of accounting. The associates are entities over which Taranaki District Health Board has significant influences and that are neither subsidiaries nor joint ventures.

Taranaki District Health Board generally deems it has significant influence due to participation in commercial and financial policy decisions of the entities.

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, a demand fund held with NZ Health Partnerships Limited (NZHP), 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.

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.

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.

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), valuation technique using observable inputs (level 2), or (iii) valuation technique with significant non-observable inputs (level 3). Taranaki District Health Board does not have any financial instruments that are recognised at fair value in the statement of financial position.

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 Procurement Supply Chain, including National Oracle Solution

The Finance Procurement Supply Chain (FPSC), which includes the National Oracle Solution (NOS), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Taranaki District Health Board holds an asset at cost of capital invested by Taranaki District Health Board in the FPSC programme. This investment represents the right to access the FPSC assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the oncharging of depreciation and amortisation on the assets to the DHBs will be used, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

(m) Finance Leases

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

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

(n) Operating Leases

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

(o) Trade and Other Payables

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

All trade and other payables are exchange transactions.

(p) Interest-bearing Loans and Borrowings

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

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

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

All loans and borrowings were converted to equity in 2017. Refer to note 29 for further detail.

(q) Employee Leave Benefits

Short-term benefits

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

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

Long-term benefits

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

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

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

(r) Provisions

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

ACC Partnership Program

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

(s) Income Tax

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

(t) Goods and Services Tax (GST)

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

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

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

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

I REVENUE

	Group and Parent	
	2017	2016
	\$000	\$000
Health and disability services (Crown appropriation revenue)*	347,749	340,314
ACC revenue	7,003	5,757
Inter District Patient Inflows	4,566	4,021
Interest received	359	345
Dividends received	77	89
Bad debts recovered	5	5
Other revenue	4,044	4,128
	<u>363,803</u>	<u>354,659</u>

*Performance against this appropriation is reported in the Statement of Performance on pages 33-64. 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

	Group and Parent	
	2017	2016
	\$000	\$000
Non-exchange transactions	350,891	343,654
Exchange transactions	12,912	11,005
	<u>363,803</u>	<u>354,659</u>

2 OTHER INCOME

	Group and Parent	
	2017	2016
	\$000	\$000
Donations and bequests received	728	705
Gain on sale of property, plant and equipment	78	84
	<u>806</u>	<u>789</u>

(a) Other income from Exchange Transactions and non-exchange transactions

	Group and Parent	
	2017	2016
	\$000	\$000
Non-exchange transactions	728	705
Exchange transactions	78	84
	<u>806</u>	<u>789</u>

3 EMPLOYEE BENEFIT COSTS

Group and Parent

2017	2016
\$000	\$000

Wages and salaries	127,326	120,478
Contributions to defined contribution schemes	1,820	1,837
Increase in employee benefits provisions	1,991	772
	<u>131,137</u>	<u>123,087</u>

4 OTHER EXPENSES

Group and Parent

2017	2016
\$000	\$000

Impairment of trade receivables (bad and doubtful debts)	17	43
Loss on sale of property, plant and equipment	-	7
Audit fees - Deloitte (for the audit of the annual financial statements)	190	204
Audit fees - HSS Limited (ACC partnership plan)	6	4
Board and Advisory members fees	266	265
Board fees re Subsidiary Companies	8	7
Operating lease expenses	950	948
Goodwill written off	-	394
	<u>1,437</u>	<u>1,872</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 2017 was 6% (2016: 8%).

6 FINANCING COSTS

Group and Parent

2017	2016
\$000	\$000

Interest on loans - Third Parties	-	16
Interest on loans - Ministry of Health	1,457	2,644
	<u>1,457</u>	<u>2,660</u>

7 CASH AND CASH EQUIVALENTS

Group and Parent

2017	2016
\$000	\$000

Cash at bank and in hand	203	487
Demand funds with NZ Health Partnerships Limited	(3,349)	(8,672)
Short-term deposits maturing within 3 months of acquisition	-	-
Cash and cash equivalents	<u>(3,146)</u>	<u>(8,185)</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.

Working Capital Facility

Taranaki District Health Board is party to the "DHB Treasury Services Agreement" between New Zealand Health Partnerships Limited (NZHP) and the participating DHB's. The agreement enables NZHP to sweep DHB bank accounts and invest surplus funds.

8 TRADE AND OTHER RECEIVABLES

	Group and Parent	
	2017	2016
	\$000	\$000
Ministry of Health	4,881	4,981
Due from associates	342	555
Due from non-related parties	5,836	6,169
Prepayments	2,188	1,417
	<u>13,247</u>	<u>13,122</u>
Allowance for impairment loss (a)	(74)	(96)
Carrying amount of trade and other receivables	<u>13,173</u>	<u>13,026</u>

(a) Allowance for Impairment Loss

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

Movements in the allowance for impairment loss were as follows:

	Group and Parent	
	2017	2016
	\$000	\$000
At 1 July	96	52
Charge for the year	17	68
Amounts written off	(39)	(24)
At 30 June	<u>74</u>	<u>96</u>

	Group and Parent	
	2017	2016
	\$000	\$000
Total non commercial debt	168	164
Non commercial debt with no impairment allowance	94	68

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 2017 and 2016, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual		Actual	
	2017	2017	2016	2016
	Gross	Impairment	Gross	Impairment
	\$000	\$000	\$000	\$000
Taranaki District Health Board				
Not past due	12,499	-	12,498	-
Past due 1 - 30 days	90	-	106	-
Past due 31 - 60 days	12	-	51	(1)
Past due 61 - 90 days	14	-	51	(9)
Past due > 90 days	632	(74)	416	(86)
	<u>13,247</u>	<u>(74)</u>	<u>13,122</u>	<u>(96)</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

Group and Parent

	2017	2016
	\$000	\$000
Non-exchange transactions	4,881	4,981
Exchange transactions	8,292	8,045
	<u>13,173</u>	<u>13,026</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 24.

9 INVENTORIES

Group and Parent

	2017	2016
	\$000	\$000
Pharmaceuticals	512	467
Surgical and Medical Supplies	1,915	1,705
Other Supplies	675	625
	<u>3,102</u>	<u>2,797</u>

Inventory recognised as an expense for the year ended 30 June 2017 totalled \$23.942m (2016: \$10.873m)

The write-down of inventories held for distribution amounted to \$0.098m (2016 \$0.099m). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

Group and Parent

	2017	2016
	\$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**Investment details**

Fulford Radiology Services Limited

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

Taranaki District Health Board has a 100% shareholding in Fulford Radiology Services Limited. The balance date is 30 June (2016: June)

12 INVESTMENT IN ASSOCIATE COMPANIES

Group and Parent

(a) Investment details

	2017	2016
	\$000	\$000
Allied Laundry Services Limited unlisted ordinary shares	1,150	1,150
Allied Laundry Services Limited Share of Retained Earnings	(8)	-
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	253	287
	<u>1,395</u>	<u>1,437</u>

Taranaki District Health Board's share of retained earnings in 2017 relates to the year ended June 2016. This is due to final audited results for Associate Companies not been available at the time of finalising the current years result.

Details of each Associate Company are as follows:	Balance date	Interest held at 30 June 2017	Interest held at 30 June 2016
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.			
Allied Laundry Services Limited	30 June	18.25%	19%

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 2017:**

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	10,497	4,095	6,402	10,432	559
HealthShare Limited	14,909	13,420	1,489	13,682	222

Summarised audited 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	15,001	13,735	1,266	12,069	(169)

The above information has been extracted from the associate companies unaudited management accounts (2017) and audited financial statements (2016).

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

	2017	2016
	\$000	\$000
Balance at 1 July	1,437	1,684
Transfer of Associate Company Investment to Subsidiary Investment	-	(363)
Share of total recognised revenues and expenses	(42)	116
Balance at 30 June	1,395	1,437

13 PROPERTY, PLANT AND EQUIPMENT (GROUP AND PARENT)

	Freehold Land \$000	Freehold Buildings \$000	Plant and Equipment \$000	Motor Vehicles \$000	Work in Progress \$000	Total \$000
Year ended 30 June 2017						
Cost/revaluation 30 June 2016	8,860	150,892	84,387	3,122	13,081	260,342
Accumulated depreciation 30 June 2016	-	(20,651)	(57,055)	(2,378)	-	(80,084)
Carrying amount 30 June 2016	8,860	130,241	27,332	744	13,081	180,258
Current year additions	-	1,463	13,366	482	11,744	27,055
Current year work in progress capitalised	-	-	-	-	(15,311)	(15,311)
Current year disposals	-	-	(40)	(5)	-	(45)
Current year depreciation	-	(7,050)	(9,109)	(270)	-	(16,429)
At 30 June 2017 net of accumulated depreciation	8,860	124,654	31,549	951	9,514	175,528

At 30 June 2017

Cost or fair value	8,860	152,348	104,126	3,081	9,514	277,929
Accumulated depreciation	-	(27,694)	(72,577)	(2,130)	-	(102,401)
	8,860	124,654	31,549	951	9,514	175,528

	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

In the year end 30 June 2017, there are no claims (2016: \$1.502m) 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.

At June 2017 land and a sample of buildings valued at ODRC were compared against the carrying values of those assets, with the difference being not material. Therefore no revaluation exercise was undertaken, with a formal revaluation process occurring for 30 June 2018.

Impairment

The assessment of assets indicated no impairment for the year ended 30th June 2017 (2016: Nil).

14 INTANGIBLE ASSETS (GROUP AND PARENT)

	ePharmacy Licence \$000	Shares in NZ HPL \$000	Total \$000
Year ended 30 June 2017			
Carrying amount 30 June 2016	-	1,418	1,418
Reclassify ePharmacy licence from Prepayment	516	-	516
Amortisation charge for year	-	-	-
At 30 June 2017 net of accumulated amortisation	516	1,418	1,934
At 30 June 2017			
Cost or fair value	516	1,418	1,934
Accumulated amortisation and impairment	-	-	-
	516	1,418	1,934
	ePharmacy Licence \$000	FPSC Rights \$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

Finance Procurement Supply Chain, including National Oracle Solution

At 30 June 2017 Taranaki District Health Board had made payments totalling \$1,418k (2016: \$ 1,418k) in relation to the Finance, Procurement and Supply Chain (FPSC) programme. This is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHP).

In return for these payments, Taranaki District Health Board gained rights to access the FPSC asset, which includes the National Oracle Solution (NOS) programme. In the event of the liquidation or dissolution of NZHP, Taranaki District Health Board shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPSC/NOS rights that have been issued.

The FPSC/NOS rights have been tested for impairment by comparing the carrying value of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to Taranaki District Health Board's share of the DRC of the underlying FPSC/NOS assets.

The current expectation of the Board is that the FPSC/NOS programme will proceed as planned. In this scenario, the DRC of the FPSC/NOS rights is considered to equate to, in all material aspects, to the costs capitalised to date such that the FPSC/NOS rights are not impaired.

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.

	2017	2016
	\$000	\$000
Opening Balance	815	800
Funds Received	72	93
Interest Received	25	15
Funds Spent	(68)	(93)
Closing Balance Restricted Assets	<u>844</u>	<u>815</u>
	2017	2016
	\$000	\$000
Represented By:		
Cash at Bank	212	208
Short Term Deposits	625	600
Shares & Other	7	7
Total Restricted Assets	<u>844</u>	<u>815</u>

Restricted Assets and Trust Funds are shown as non current assets in the statement of financial position. This is because it is the intention of the Taranaki District Health Board Trust to not dispose of its investments, with revenue earned on those investments dispersed against funding requests.

16 TRADE AND OTHER PAYABLES

	Group and Parent	
	2017	2016
	\$000	\$000
Trade Payables	16,823	15,728
Capital Charge Payable	-	-
Income received in advance	1,736	429
Interest Payable	-	370
Owing to Associates	106	693
GST Payable	1,794	1,737
	<u>20,459</u>	<u>18,957</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

		Group and Parent	
		2017	2016
		\$000	\$000
Government Sector Borrowing		-	74,000
Total Loans		-	74,000
Less Current Portion		-	19,200
Term Portion		-	54,800
Interest Rates	2017		2016
Government Sector Borrowing	n/a		2.21% - 4.55%
		2017	2016
		\$000	\$000
Government Sector Borrowings			
Due for repayment:			
within one year		-	19,200
within two years		-	22,000
within three years		-	15,600
within four years		-	-
within five years		-	5,200
after five years		-	12,000
		-	74,000

The term loans of \$74 million financed by the Ministry of Health were converted to Equity in February 2017. Refer to note 29 for further detail.

FAIR VALUE OF GOVERNMENT BORROWING

The fair value of the \$0m (2016: \$74m) of Government Borrowing at 30 June 2017 was calculated at \$0m (2016: \$76.615m). This calculation is done by discounting the expected future cash flows at prevailing interest rates.

18 EMPLOYEE BENEFITS

		Group and Parent	
		2017	2016
		\$000	\$000
Salary & wages accrual		5,409	5,101
Annual Leave		17,594	15,755
Sick Leave		437	418
Long Service Leave		1,503	1,502
Retirement gratuities		683	671
Continuing Medical Education		1,665	1,602
Sabbatical Leave		293	236
		27,584	25,285
Made up of:			
Current		26,690	24,624
Non-current		894	661
		27,584	25,285

19 PROVISIONS

Group and Parent

2017 2016

\$000 \$000

Current provisions

ACC Partnership Programme

110	18
110	18

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2017. All outstanding claims by Taranaki District Health Board's employees are estimated by claim managers as at this point.

The private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting & analytics, people and processes.

Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of the annual report. Once the issues have been resolved the actual liability may be different. Taranaki District Health Board estimates the impact over the last six years to be \$0.65m.

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

Group and Parent

2017 2016

\$000 \$000

Net Loss	(1,670)	(3,669)
Add Non-Cash Items:		
Depreciation	16,429	15,521
Increase/(Decrease) in Provision for Doubtful Debts	(22)	44
Increase in Employee Entitlements	2,299	674
Reclassification of prepayment to intangible asset	(516)	-
	18,190	16,239
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	42	813
(Gain) / Loss on Disposal of Assets	(78)	(77)
	(36)	736
Movements in Working Capital:		
Decrease/(Increase) in Receivables & Prepayments	(50)	1,667
(Increase)/Decrease in Inventories	(305)	(209)
(Decrease) in Payables & Accruals	1,497	(54)
	1,142	1,404
Net Cash Inflow from Operating Activities	17,626	14,710

21 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	Group and Parent	
	2017	2016
	\$000	\$000
<i>Board Members</i>		
Remuneration	266	265
Full-time equivalent members	1.6	1.7
<i>Executive management</i>		
Remuneration	1,771	1,851
Full-time equivalent employees	9.0	7.0
Total key management personnel remuneration	2,037	2,116
Total full-time equivalent personnel	10.6	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.

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 \$347.749m from the Ministry of Health to provide health services to the Taranaki area (2016: \$340.314m). The amount outstanding at year end was \$4.881m (2016: 4.981m).

(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:

		Group and Parent		Group and Parent	
		Owed to TDHB		Income to TDHB	
		2017	2016	2017	2016
		\$000	\$000	\$000	\$000
TDHB Transactions					
Allied Laundry Services Limited	Dividend and rents received	269	148	93	105
Fulford Radiology Services Limited	Rent and services received	n/a	n/a	-	203
NZ Health Partnerships Limited	DHB national collective service agreements	-	-	-	-
Healthshare Limited	IT consultancy	73	407	513	747
		342	555	606	1,055

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

		Group and Parent		Group and Parent	
		Owed by TDHB		Expense to TDHB	
		2017	2016	2017	2016
		\$000	\$000	\$000	\$000
Allied Laundry Services Limited		93	85	1,035	1,060
Fulford Radiology Services Limited		n/a	n/a	n/a	1,992
NZ Health Partnerships Limited		130	54	702	583
Healthshare Limited		13	608	2,506	2,147
		236	747	4,243	5,782

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, together with fair values:

	Notes	Group and Parent		Group and Parent	
		Carrying amount	Fair value	Carrying amount	Fair value
		2017	2017	2016	2016
FINANCIAL ASSETS		\$000	\$000	\$000	\$000
Loans and receivables					
Cash and cash equivalents	7	-	-	-	-
Trade and other receivables	8	10,985	10,985	11,609	11,609
Other financial assets - current	10	2,890	2,890	2,890	2,890
Other financial assets - non current	10	56	56	56	56
Restricted Assets and Trust Funds	15	844	844	815	815
Total loans and receivables		14,775	14,775	15,370	15,370
		Group and Parent		Group and Parent	
		Carrying amount	Fair value	Carrying amount	Fair value
		2017	2017	2016	2016
FINANCIAL LIABILITIES	Notes	\$000	\$000	\$000	\$000
Financial liabilities at amortised costs					
Cash and cash equivalents	7	3,146	3,146	8,185	8,185
Trade and other payables	16	16,929	16,929	16,791	16,791
Interest bearing loans and borrowings	17	-	-	74,000	76,615
Total financial liabilities		20,075	20,075	98,976	101,591

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 and GST payable.

24 FINANCIAL INSTRUMENT RISKS (GROUP AND PARENT)

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% (2016: 97%) whilst it accounted for 94% (2016: 85%) 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**2017**

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	18,723	18,723	18,723	-	-	-
Loans and borrowings	-	-	-	-	-	-
	18,723	18,723	18,723	-	-	-

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

(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)	
	2017	2016
	\$000	\$000
+1% (100 basis points)	29	29
-1% (100 basis points)	(29)	(29)

25 CONTINGENT LIABILITIES

Taranaki District Health Board sometimes has claims that have been made by or against Taranaki District Health Board in the ordinary course of business. The Board Members do not consider the outcome of these claims will have a material adverse affect on the financial position of Taranaki District Health Board.

26 CAPITAL COMMITMENTS AND OPERATING LEASES

Group and Parent

2017 2016

\$000 \$000

Capital Commitments

Property, plant and equipment

907 2,252

907 2,252

Operating leases as lessee

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

Group and Parent

2017 2016

\$000 \$000

Not later than one year

893 493

Later than one and not later than two years

480 365

Later than two and not later than five years

415 184

Later than five years

145 178

1,933 1,220

27 MAJOR VARIATIONS FROM BUDGET (unaudited)**Income Statement Variances - Revenue**

Taranaki District Health Board recorded a deficit of \$1.67 million compared with a budgeted deficit of \$2.00 million.

A total of \$0.425 million reduced revenue over budget was received as follows (2016: \$0.809m):

	Variance	Variance
	2017	2016
	\$000	\$000
Health and disability services (Crown appropriation revenue)	(1,367)	932
Accident Compensation Revenue (ACC)	1,832	618
Inter District Flows	246	(8)
Inter Provider Revenue	229	37
Interest Received	159	(180)
Donations Received	(1,275)	(1,299)
Other	(249)	709
	<u>(425)</u>	<u>809</u>

Income Statement Revenue Explanations

Ministry of Health Funding

Loans to Ministry of Health repaid, so no funding received for ongoing interest charge

Accident Compensation Revenue (ACC)

Additional contracts and increased activity

Donations

Pledges not paid in year, but spread over a number of years

Income Statement Variances - Expenditure

A total of \$0.797m expenditure less than budget was incurred as follows (2016: over by \$5.331m):

	Variance	Variance
	2017	2016
	\$000	\$000
Employee Benefit costs	101	7,186
Depreciation Expense	(582)	(249)
Outsourced services	4,139	343
Clinical supplies	1,992	2,912
Infrastructure and non-clinical expenses	5,992	416
Payments to non-health board providers	(9,542)	(4,591)
Other	(2,897)	(686)
	<u>(797)</u>	<u>5,331</u>

Income Statement Expenditure Explanations

Outsourced expense

Increased acute activity and medical employee vacancies not filled

Clinical Supplies

Increased activity and additional electives delivered against contracts

Infrastructure and non-clinical expenses

Shortfall in realising efficiencies against a savings plan

Payments to non-health board providers

Reduced inter district flows and reduced aged residential care demand

Other

Capital charge rate reduction and repayment of Ministry of Health loans

	Variance 2017 \$000	Variance 2016 \$000
Balance Sheet Variances		
Cash and cash equivalents	2,931	(8,540)
Other financial assets	-	2,890
Property, plant and equipment	(765)	(7,165)
Trade and other receivables	(2,277)	2,056
Intangible assets	516	-
Employee benefits	1,384	975
Trade and other payables	(1,787)	(5,025)
Interest bearing loans and borrowings	(74,000)	-

Balance Sheet Explanations

Cash and cash equivalents	Capital expenditure deferral
Intangible assets	Reclassification of software licence from prepayments
Employee benefits	Additional employees and annual pay increases
Trade and other payables	Timing of payments to suppliers
Interest bearing loans and borrowings	Loans converted to Equity

28 AUDITORS' REMUNERATION

Group and Parent
2017 2016
\$000 \$000

Fees to principal auditor (Deloitte Limited)**Note**

Audit of annual financial statements

4

190 204

2017 2016
\$000 \$000

Other Audit Fees paid (non Deloitte Limited)**Note**

HSS Limited (ACC partnership program)

4

6 4

29 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.

During the year, the New Zealand Government has changed its policy on the capital financing of all District Health Boards. From 15 February 2017, DHB's no longer have access to Crown debt financing and funding of capital investment. Instead, the Crown contributions to DHB capital will now be solely funded via Crown equity injections. In addition the existing Crown debt held by DHB's have also been converted to Equity.

Pre 15 February 2017, Taranaki District Health Board had existing Crown borrowings of \$74 million, which were converted into Equity. The conversion of the borrowings into Equity changed Taranaki District Health Board's financial position increasing the crown equity balance and decreasing liabilities. This transaction was actioned via simultaneous accounting journals to convert Ministry of Health borrowings to equity. No cash payment was required to settle the transaction, with the exception of paying interest owing on the conversion date.

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 \$74m (2016: \$Nil) of Equity, as a result of converting Term Loans to Equity. Public equity of \$0.959m (2016: \$0.959m) was repaid to the Crown during the year. The repayments in both 2017 & 2016 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.

Prior to 15 February 2017 Taranaki District Health Board is not subject to external banking covenants.

30 EMPLOYEE REMUNERATION (GROUP AND PARENT)

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

Remuneration Range	Actual 2017	Actual 2016
100,000 - 110,000	42	32
110,001 - 120,000	16	22
120,001 - 130,000	11	5
130,001 - 140,000	11	5
140,001 - 150,000	13	8
150,001 - 160,000	2	5
160,001 - 170,000	7	5
170,001 - 180,000	6	11
180,001 - 190,000	7	6
190,001 - 200,000	6	8
200,001 - 210,000	6	7
210,001 - 220,000	7	6
220,001 - 230,000	5	2
230,001 - 240,000	5	3
240,001 - 250,000	4	1
250,001 - 260,000	2	3
260,001 - 270,000	4	3
270,001 - 280,000	2	4
280,001 - 290,000	11	6
290,001 - 300,000	3	5
300,001 - 310,000	-	4
310,001 - 320,000	1	2
320,001 - 330,000	2	2
330,001 - 340,000	2	2
350,001 - 360,000	5	1
390,001 - 400,000	-	-
460,001 - 470,000	-	1
470,001 - 480,000	-	1
	<u>180</u>	<u>160</u>
Clinicians	150	130
Non Clinical	<u>30</u>	<u>30</u>
Total	<u>180</u>	<u>160</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 224 (2016: 193).

31 TERMINATION PAYMENTS

For the period to 30 June 2017, 7 employees or former employees of Taranaki District Health Board received payment in respect of termination of employment for \$153,437 (2016: 1 payment totalling \$51,217).

32 EVENTS SUBSEQUENT TO BALANCE DATE

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

Reporting on 'good employer' practices

Taranaki DHB's role in workforce planning and development is to identify strategic actions and mechanisms that when implemented will contribute to the organisation having health workers with appropriate clinical and 'soft' 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. The DHB ensures good employer practices are provided to staff, such as excellent leadership, people, culture, relationships and processes. The table below is a summary of those human resources practices that assist the organisation to be a good employer for its employees, with a patient-centric focus to its people management.

Element/ Measurement	Describe formal policies or procedures	Other Practices	Priority issues	Action taken
Leadership, Accountability and Culture	- Code of Conduct - Equal Employment Opportunities (EEO). Taranaki DHB value statements – Nga Tikanga - Performance Review Policy	- Employee Engagement Survey (2017) 'Taranaki Way' values & behaviours - Organisational forum for all employees - Formal management and management/union meetings - New managers' induction - Workplace Behaviours Programme - National Leadership Domains Framework - National Talent Management Programme - Leadership in Practice (LIPP), Advanced Leadership (ALP) and Team Development & Collaboration programmes - Team workshops to support our Nga Tikanga values and effective team functioning	- Leadership and team development aligned with Taranaki DHB strategy - Refresh of values and behaviours to support Taranaki DHB strategy - Develop employee engagement	- LIPP for 25 leaders and aspiring leaders implemented - ALP for three senior leaders implemented - Implementation of National Leadership Domains - Team workshops rolled out around Taranaki DHB 'Taranaki Way' values and behaviours project for 2017/2018 - New suite of leadership & team development programmes for 2017/2018 - Employee Engagement Survey (2017)
Recruitment, Selection Induction	- Recruitment and Selection Policy - Recruitment Guideline Procedure - Induction and Orientation Policy - Worker Safety Check Policy and Procedures	- Comprehensive Induction Programme with elements online combining eLearning modules - Post-Entry Survey (three month) - 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	- 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	- 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 Whakatipuranga 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	• 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	• Exit interview and survey (2017) • Coaching available to all staff • Clinical supervision • Employee Assistance Programme (EAP) • 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) for nursing functions	• 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 tools and processes to increase feedback • Rollout of the OMA process for nursing functions	• New eLearning platform launched, enabling greater access to eLearning resources. New clinical courses added. Aim to increase number of courses for non-clinical staff. Site also to be used for e-portfolios • Professional Development Policy finalised • HCAs, orderlies, cleaners, dental assistants, newborn hearing technicians enrolled in NZQA (Careerforce) training • Held three month Awareness-Raising Programme on EAP • Commenced annual calendar of education events per department
Employee Engagement	• Flexible Working - Request and Complaints Procedure • Collective employment agreements • Worker Engagement and Participation Agreement	• Work in conjunction with individuals and unions in consultative manner • Organisational Mapping and Alignment Programme (OMA) for Nursing functions • Employee Well-being initiatives	• Employee engagement assessment • Employee wellbeing	• Employee Engagement Survey (2017) • Development of 2017/18 National Framework for Employee Wellbeing commenced
Remuneration, Recognition and Conditions	• Job Evaluation Procedure • Recognising Long Service Procedure • Collective employment agreements	• Comprehensive Progression/Merit criteria via collective agreements		• Promoting employee benefits for all staff
Harassment and Bullying Prevention	• Harassment Policy and Procedure • Employee Assistance Programme	• Interpersonal skills programmes • Coaching/training Union reps • Conflict resolution • Workplace Behaviours programme – training and educational resources	• Keep momentum around behaviours initiative and messages • Revise messages in the behaviours programme to enable organisational culture change • Launch revised Bullying and Harassment Policy	• Review of Workplace Behaviours project undertaken and further work commenced • Review of Taranaki DHB Bullying and Harassment Policy currently underway • Education sessions held in various departments
Safe and Healthy Environment	• Health and Safety specific policies and procedures • Risk management and compliance policies and procedures	• Health and Safety Programme • Pre-employment health questionnaire for all staff • Health and Safety induction, orientation and compulsory refresher sessions • Health monitoring programme for applicable staff • Risk and Hazard registers • Input into renovation/construction and purchase of new equipment decisions • Accredited employer with ACC's Partnership Programme • Accident/incident/near miss reporting system • Employee Assistance Programme • Free staff vaccination programme that includes the annual influenza vaccination • Health and Safety reps in designated areas • Health and Safety Committee • Bipartite Action Group • Quarterly reporting to the Taranaki DHB Board on Health and Safety matters • Wellness Committee	• Obtaining secondary level entry to the ACC Partnership at next audit (2018) • Implementation of an electronic risk register that includes health and safety risks and hazards • Strengthening our processes in relation to our joint responsibilities with other Persons Conducting a Business or Undertaking (PCBUs)	• ELearning HSWA for managers • Recreation society available to all staff • Wellness Committee has run and 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 • Review of existing health and safety policy and procedures to ensure compliance with the Health and Safety at Work Act 2015 • Working with Engineering Service staff on contractor management

Ministerial Directions

Directions issued by a Minister during the 2016-17 financial year, or that remain current are as follows:

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement , ICT and Property and the former two apply to DHBs
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction





TARANAKI
like no other