

Taranaki District Health Board

Annual Report

2017-2018

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



Our Aims / Ngā Whainga

- ☞ 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

Our Values / Te Ahu

Partnership / Whanaungatanga

We work together to achieve our goals

Courage / Manawanui

We have the courage to do what is right

Empowerment / Mana motuhake

We support each other to make the best decisions

People matter / Mahakitanga

We value each other, our patients and whānau

Safety / Manaakitanga

We provide excellent service in a safe and trusted environment

TE AHU

TARANAKI DHB VALUES



Our Shared Vision / Te Matakite

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

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Pauline Lockett,
Chair



Rosemary Clements,
Chief Executive

Kei ngā kawekawenga o rua tupua, kei ngā torotoronga o rua tawhito, tēnā koutou katoa. Tēnei hoki rā te au mihinga ki ngā māeroero o Taranaki hauhunga e hāpai nui ake i te mana o ngā uri, nō te pari marutuna o Parininihi, ki Taranaki tuawhenua, ki te awa ngūnguru o Waitōtara, tēnā koutou, tātou tahi.

Welcome to the Annual Report for the Taranaki District Health Board for 2017-2018.

We are pleased to present the Taranaki District Health Board (Taranaki DHB) Annual Report for the year 1 July 2017 to 30 June 2018.

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 inequities.

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. While the year has had its challenges we have also made some significant achievements 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 \$343m for the people of Taranaki. In a fiscally challenged environment, we have remained focused on improving performance, living within our means and ensuring access to high quality services for the community while reducing health inequalities.

We have continued this year with 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 is working in partnership with our primary and community care providers and is 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.

Taranaki DHB and Pinnacle Midlands Health Network's (MHN) continues to work together on Project Connect - the integration project aiming to better connect primary, community and secondary services for our high needs patients. The project gained some momentum in late 2017 and the Community Integration Health Centre (CHIC) was established. The CHIC is key as it will enable adult referrals to be managed from one single point to coordinate services and provide more support for patients who have high needs or are at risk. In early 2018 a small team was appointed with the aim to create a single point of access for all community referrals by early 2019. Achieving patient centred care and connected health services for Taranaki is not without its challenges and will take time.

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 WhyOra. Our graduating doctors ranked Taranaki DHB second most preferred hospital and employer to work for in 2017, which is largely due to the hard work our team puts into the training and support of junior doctors who all attend the innovative first year doctor's Acute Skills Teaching Programme when they arrive to work at Taranaki DHB.

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.

In early June, a new hi-tech simulator called Oscar (an acronym for Organised Simulated Care and Response) was introduced at Taranaki DHB to help train surgical teams to deal with real life patients. Oscar is one of several highly realistic manikins that are central to a world-leading simulation programme called NetworkZ. This programme has been developed by Auckland University and is being rolled out in DHBs throughout the country and aims to provide better outcomes in acute care.

Our approach to accelerating Māori health gain has been underpinned by Māori Health priorities 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 supports the DHB's endeavour to eliminate inequalities in access by Māori, to key services.

Taranaki DHB's Māori Health Team Te Pa Harakeke launched an exciting Kaupapa Māori birth education programme in early June 2018 for pregnant women and their whānau called Hapū Wānanga. This pilot programme offers free workshops to pregnant women around Taranaki to help them better understand pregnancy, birth and raising tamariki and has received huge interest. We look forward to seeing this programme grow and flourish throughout our Māori community over the next 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. These partnerships were put to the test when New Plymouth's water supply was potentially contaminated and a boil water notice was put in place for over a week in February 2018. Taranaki DHB's Public Health Unit worked closely with New Plymouth District Council and Civil Defence to highlight the importance of boiling water and distributed FAQs using a cross agency approach to spread the information far and wide.

Taranaki already has a number of successful health and wellbeing initiatives working for families in the community. Examples of these are Taranaki Toa and Whānau Pakari, which have gained national recognition. In April 2018 the

health of Taranaki children was at the heart of an Activity and Nutrition Aotearoa (ANA) regional forum that aimed to connect people together in addressing the food and physical environment of children and young people in the region. A range of delegates attended including parents, education, health, district council, hospitality and local iwi as well as nationally and internationally acclaimed experts.

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. 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 launched our new organisational values, Te Ahu Taranaki, which have been embraced by many of our DHB employees who are incorporating these into their daily work lives. The five values - Partnerships / Whanaungatanga, Courage / Manawanui, Empowerment / Mana Motuhake, People Matter / Mahakitanga and Safety / Manaakitanga - define who we are as an organisation, the way we work with each other, our patients, whānau and external partners.

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.

*He puāwai au nō runga i te tikanga
He rau rengarenga nō roto i te Raukura
Ko taku Raukura, he manawa nui ki te ao,
He manawa nui ki te ao, he manawa nui
ki te ao.*

Na, Te Whiti O Rongomai



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.



Hospital services at Taranaki Base Hospital and Hawera Hospital



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



Support services for people with disabilities including

26

residential facilities



Community, laboratory and radiology services

27

pharmacies

29

aligned GP practices



8

Providers of Community Health for Older People Services

19

Community Personal Health Providers

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



21

Dental practices



1 Māori Mental Health and Alcohol and Addictions Service Provider



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

7

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



Population profile

According to Statistics New Zealand, in 2017/18 Taranaki DHB served a population of 118,965* people.

The Māori population is projected to increase to 22.6% of the total population by 2028. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2013 Census. Taranaki has 83.9% identified as European and other, 17.1% as Māori, 1.7% as Pacific and 3.6% as Asian.

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

Age structure

Our population is ageing and older than the national average. The total number of people over the age of 65 is 20,715 (17.4%), with 7.5% of these being Māori.

A total of 38,330 people are under the age of 24 (32.2%), the number of Māori in this age group is 11,690 which represents 51.3% of Māori in the region.

Socio-economic indicators

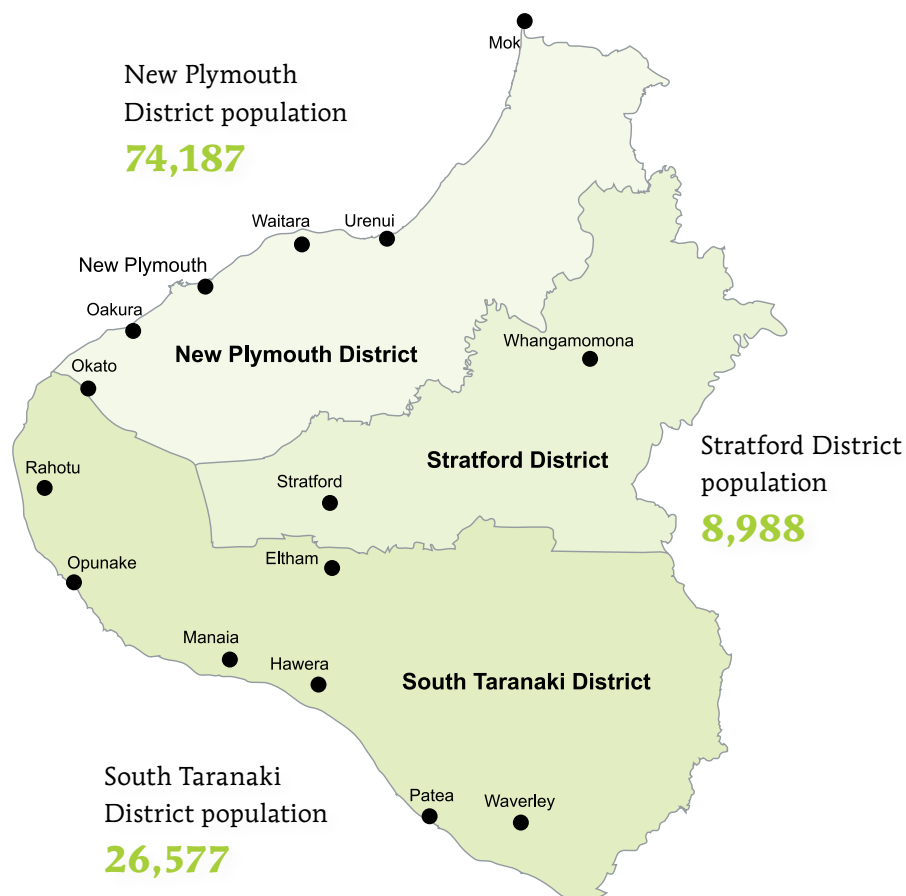
The Taranaki population sits around the centre of the socio-economic range.

Around 38.8% of the Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Māori are over-represented in the wealthiest socio-economic deciles and Māori are over-represented in the lowest socio-economic deciles.

Within Taranaki, 32% of Māori live in the most deprived 20% of areas compared to 13% of non-Māori. In contrast, 7% of Māori live in 20% of the most affluent areas compared to 17% of non-Māori. Māori in Taranaki have five to six years less life expectancy than non-Māori.

* Based on updated information received from Statistics New Zealand Population Projection released December 2016

^ Based on usually resident population, 2013 Census



OUR PEOPLE

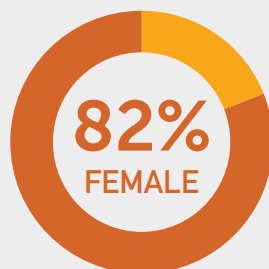


Healthcare is about people helping people.

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

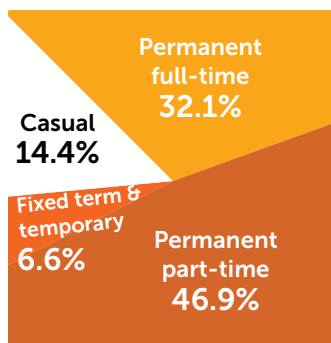
1,973

PEOPLE WERE EMPLOYED BY
TARANAKI DHB IN 2017-18



753

NURSES



208

DOCTORS



148

HEALTH
CARE
ASSISTANTS

46

midwives

19

SOCIAL WORKERS

36

PHYSIOTHERAPISTS

30



Pharmacy
employees

32

SONOGRAPHERS & MRTS

25

OCCUPATIONAL THERAPISTS

16

DENTAL
THERAPISTS

14



PSYCHOLOGISTS



Vision &
hearing
technicians

11

DIETITIANS



13

CASE MANAGERS

5

SPEECH THERAPISTS

42

LABORATORY
EMPLOYEES

Taranaki DHB staff identify
themselves as

1560

New Zealand European

185

Māori

161

Asian

14

Pacific Islander

24

Not declared

29

Other

Doctors 208

Nursing 941

(includes midwives & HCAs)

Allied 350

Non Health Support 115

Management 43

Administration 316

HEALTH TARGETS

ON TARGET

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

		Target	Quarter 1 results	Quarter 2 results	Quarter 3 results	Quarter 4 results
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.	95%	91.7%	92.2%	90.7%	91.1%
2	Improved access to elective surgery The target is an increase in the volume of elective surgery by at least 4000 discharges per year.	100%	122.5%	123.7%	119.7%	118.9%
3	Faster cancer treatment The target is 90 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.	90%	90.2%	90.9%	97.3%	88.9%
4	Increased immunisation The target is 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	95%	91.8%	90.6%	87.6%	87.2%
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 and 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	90%	88%	90.8%	88.9%	89.9%
6	Raising healthy kids The target is 95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	95%	92.3%	93.8%	98.2%	97.5%



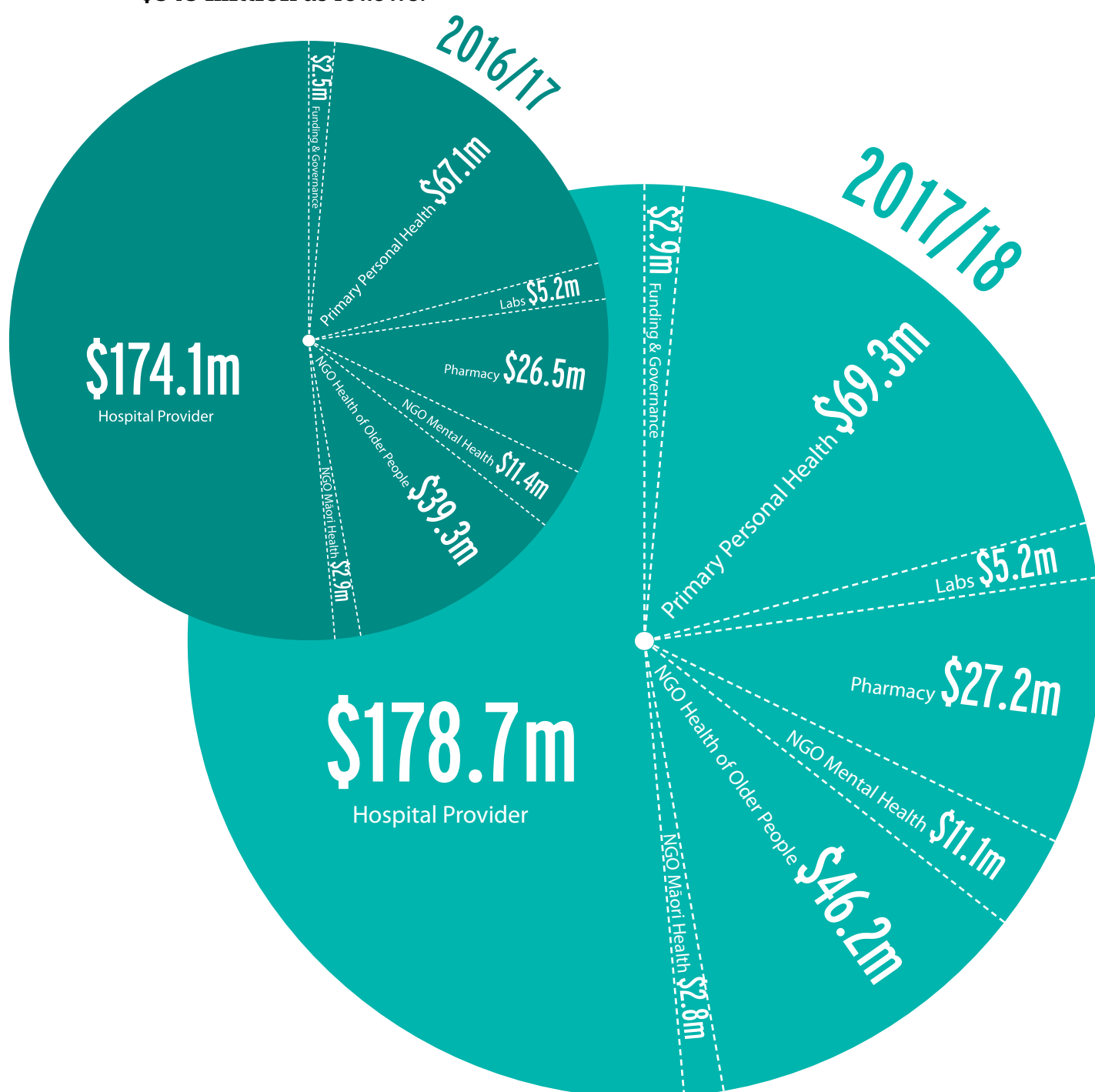
WHERE THE MONEY GOES

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



2017/18 Taranaki DHB Planning and Funding Allocation

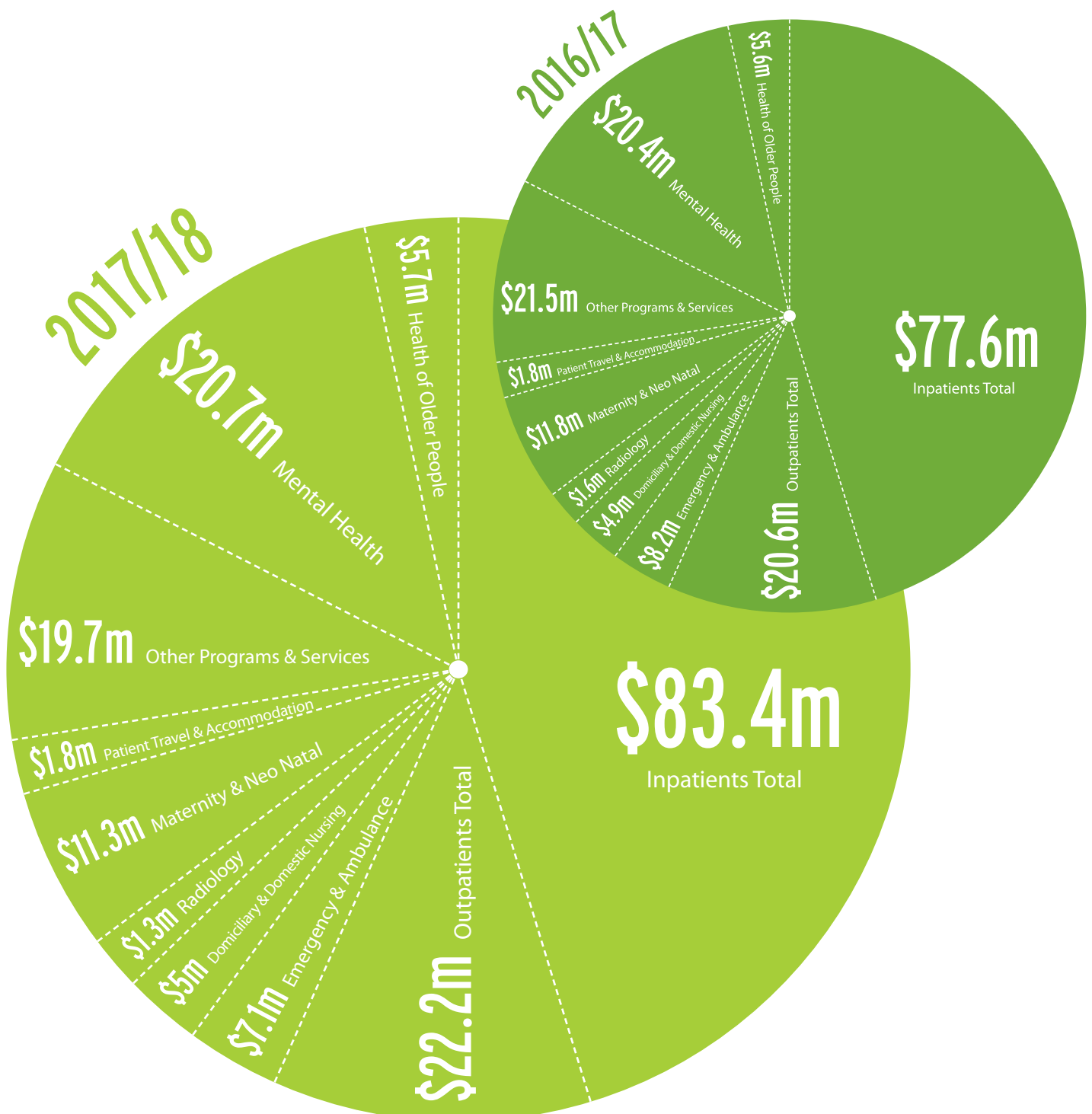
In 2017-18 the Planning and Funding division allocated its funding of **\$343 million** as follows:





2017/18 Hospital and Specialist Services Allocation

The **\$178 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 2017/18 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 DHBs, ability to identify best performers and sharing of successful interventions. Local indicators are priorities selected by Taranaki DHB for Taranaki.

Progress to target

Target met	Within 10% of Target	10 -20% away from Target	More than 20% from the Target
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?	Further information or work required
↔	No change
▲	Progress towards the target
▼	Moving further from the target
↓	Decreasing gap (Decrease over two or more consecutive quarters)
↑	Increasing gap (Increase over two or more consecutive quarters)

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2017	Māori June 2018	Non Māori June 2018	Progress to target	Disparity Gap June 2018	Disparity Progress	Comments
NATIONAL INDICATORS										
1	Data Quality	1. Ethnicity data accuracy in PHO registers	100%	84%	87.1%	95.8%	▲	-8.7%	↔	No new projects known to check or improve ethnicity data accuracy however there is ongoing support given to Pinnacle Health Network practices by the PHO to ensure accurate capture of ethnicity data on enrolment. Ethnicity data accuracy is based on PHO enrolment figures which are based on enrolments as a proportion of population projections.
2	Access To Care	2. Percentage of Māori enrolled in PHOs	97% (2017 target was 100%)	84%	87.1%	95.8%	▲	-8.8%	↓	Location of a Kaimahi Hauora in ED during the year enabled a focus on identifying Māori who were not enrolled with a GP. This contributed to the small but significant increase in PHO enrolments by 3% to 87% for the year. A further improvement of 3%, or 659 Māori, is needed to reach the national target of 90%. (Trendly) A goal for all planned activities to incorporate a check on enrolment of patients with the PHO has not had the desired results during 2017/18. More emphasis will be put on this through Māori health priority actions during 2018/19.

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2017	Māori June 2018	Non Māori June 2018	Progress to target	Disparity Gap June 2018	Disparity Progress	Comments
		3. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for the age group 0-4yrs	85.1% 6,437 (2017 target was 95% / 7,174)	95.1% 7188	118% 8929	88.73% 6480	▼	-29.27%	↓	The following activities have taken place: <ul style="list-style-type: none"> review of acute admissions with possible unhealthy homes as a factor attempts to identify admissions with respiratory illness conducted whānau interviews through paediatric contact to identify housing needs. Further work in 2018/19 will be progressed through the SLM for children 0-4 to address housing issues. ASH data is constantly changing as the conditions that contribute to ASH, change. The data fluctuates therefore, and to an extent it can be unhelpful/inappropriate to compare current with past data. This indicator should be read in this context.
		4. Ambulatory Sensitive Hospitalisation rates per 100,000 for the age group 45-64 yrs	4,160 (2017 target was 5,444)	8,209	9239	4,648	▼	-49%	↓	A number of activities were carried out during the year with the aim of managing acute demand including: <ul style="list-style-type: none"> Care Capacity Demand Management rolled out across the hospital to improve patient management New ED nurse staffing model was implemented to improve ED response to acute demand Heart Failure service project to improve understanding of patient flow issues from Taranaki to Waikato to prevent geographical inequity going forward Ethnicity data has been embedded in all cardiology and national reporting to regularise equity reporting Based on the fact that progress to target declined by year end these activities have failed to produce the desired results or the impact of their implementation has yet to take hold. The conditions that make up this indicator are variable and complex therefore it is difficult to get traction. The target and data also fluctuate therefore comparing changes over time can also be misleading.
3	Child Health	5. Exclusive breastfeeding at 4-6 weeks	75%	49.6%	58.9%	73.6%	▲	14.7%	↑	The TKM alliance Oranga MokoPuna and Tiaki Ukaipo services made a significant increase in the breastfeeding māma this year. Despite this, the improvement is still too slow. The Hapū Wānanga antenatal service for Māori women has begun in which information on breastfeeding technique and value is greatly improved. There will be on-going intensive monitoring to see the impact of this on women actually breastfeeding. The continuous/ service improvement approach will be applied. Of concern is that the disparities between Māori and non-Māori are widening on at least two of the three indicators, indicative of the need to target Māori women.
		6. Exclusive breastfeeding at 3 months	70% (2017 target was 60%)	41.3%	45.5%	62.7%	▲	17.2%	↑	
		7. Receiving some breast milk at 6 months	60%	46.1%	Not Available	Not Available	?	Not Available	?	
4	Cancer	8. Cervical Screening, among eligible population	80%	73%	76.3%	82.8%	▲	-6.5%	↑	Cervical Screening 25-69 years (3yr) for Māori in Taranaki DHB reached 76.3%. This represents a 3.3% difference since June 2017 which earned Taranaki DHB the ranking as top performing DHB for this indicator. An improvement of 3.7 % is needed to reach the national target of 80.0%. This would require screening an additional 173 Māori. (Trendly) Despite the good progress towards target the equity gap is widening, i.e. improvement for non-Māori is happening at a faster rate than for Māori. The 2018/19 Annual Plan includes an action to undertake a health equity assessment to assess the effectiveness of existing services and to come up with ways of improving the uptake of cervical screens by wahine Māori.
		9. Breast screening among eligible population	70%	61.74%	61.4%	76.5%	▲	-15.1%	↓	Breast Screening 50-69 years for Māori in Taranaki DHB reached 61.4%. This represents a 0.3% difference since July 2017. An improvement of 8.6% is needed to reach the national target of 70%. This would require screening an additional 152 Māori. (Trendly)

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2017	Māori June 2018	Non Māori June 2018	Progress to target	Disparity Gap June 2018	Disparity Progress	Comments
5	Tobacco	10. Percentage of pregnant Māori women who are smokefree at two weeks postnatal.	95%	66%	Not Available	Not available	?	Not Available	?	Tui Ora Ltd continues to work with priority practices to ensure Māori patients are prioritised for referral into the Stop Smoking Service. Tui Ora staff also attend Hapū Wānanga to provide information, and support to the hapū māmā and their whānau. Unfortunately the comparative data is still not available for 2016/17 or 2017/18.
6	Immunisation	11. Percentage of infants fully immunised by eight months of age	95%	85.3%	81.3%	90.6%	▼	-9.3%	↑	Immunisation for Māori infants at 8 months old in Taranaki DHB reached 80.7%. An improvement of 14.3% is needed to reach the national target of 95%. This would require an additional 16 Māori infants.(Trendly) The Public Health Unit completed a comprehensive Health Equity Assessment of Immunisation services during the year. The focus in 2018/19 is on implementing recommendations that came out of the assessment. There is strong emphasis in the Annual Plan to improve immunisation rates as the decline in progress towards target and increasing inequality must be reversed.
		12. Seasonal Influenza immunisation rates in eligible population	75%	42%	42.3%	53.8%	▲	-11.5%	↑	Q1 17/18 The Ministry of Health 'Immunisation Week' campaign was used to focus on older people and increase uptake of flu vaccine. There is a low influenza rate currently across New Zealand. Nine pharmacies are now providing this service. The 2018/19 Annual Plan signals initiatives to improve the uptake of flu vaccination among 65+ year-olds.
7	Rheumatic Fever	13. Number and rate of first episode rheumatic fever hospitalisations	0.3/100,000	0	0	0		0	0	Q4 17/18 There have been no first episode hospitalisations in Taranaki.
8	Oral Health	14. Pre school Dental enrolments	95%	81%	78.7%	98.6%	▼	-19.9%	↔	A Health Equity Assessment that looks at the barriers to 0-4 year olds attending the Community Oral Health Service is in draft stage. The findings will be used to inform future service improvement initiatives in oral health service. Te Pa Harakeke is working with the Community Oral Health team to look at a service improvement method. Pre Calling on the day before appointments was identified as the first initiative. This has been implemented recently and there is not enough evidence as yet to draw conclusions re its effectiveness.
9	Mental Health	15. Mental Health Act section 29 Community Treatment Orders	89	113	190	91	▲	52%	↑	A transition document that is used prior to discharge is being reviewed for effectiveness. Post discharge care is closely monitored to ensure key workers meet within seven days in aid of preventing relapse, ensuring adequate support and reducing the need for Sec 29 CTO. A consumer advisor has been appointed to assist with Sect 29 project for 2018/19. Sec 29 for Māori reached 190 per 100,000 per year or 43 Māori individuals for the 12 months ending March 2018. (Trendly)
10	SUDI	16. Five year average annualised SUDI infant deaths by DHB region.	0.4	1.91	1.9	0.6	↔	1.3	?	Hapū Wānanga has a Safe Sleep component with parent participation. Participants also receive safe sleep resources such as Wahakura and safe bedding (wool and cotton). There is insufficient disparity data to make the comparison of inequality at this stage.
		17. Caregivers provided with SUDI prevention information at WCTO Contract 1	70%	-	50%	33.2%	?	16.8%	?	

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2017	Māori June 2018	Non Māori June 2018	Progress to target	Disparity Gap June 2018	Disparity Progress	Comments
LOCAL INDICATORS										
11	Access to services	1. Did not attend (DNA) rate for outpatient appointments	5%	18%	16.5%	5.6%	▲	-10.9%		<p>A Health Equity Assessment (HEAT) that looks at the barriers to 0-4 year olds attending the Community Oral Health Service is in draft stage. The findings will be used to inform future service improvement initiatives in oral health service. Te Pa Harakeke is working with the Community Oral Health team to look at PDSA rounds of Pre Calling on the day before appointments. Not enough conclusive evidence at this stage as it is only early on in the initiative.</p> <p>A Health literacy review has also been completed for the DNAs in the diabetes education clinics with the action plan still to be developed. Both pieces of work will have the service improvement methodology applied in 2018/2019.</p>
12	Workforce Development	2. Percentage of Māori employed by the DHB	18%	8.89%	9.4%	N/A	▲	8.6% to target		<p>Progress to increase the DHB's Māori workforce is heartening. The increase is small but significant, with actual numbers increasing by 17 over the year compared to previous single figure increases.</p> <p>WhyOra continues to fill the workforce pipeline and supports the recruitment processes for new graduate nurses in the DHB.</p> <p>Te Pa Harakeke has also increased regular circulation of DHB vacancies through Māori networks and is taking a more intensive approach to providing recruitment support for vacancies that are assessed as being of high impact on Māori.</p> <p>2018/19 will continue to support WhyOra and look for opportunities to increase its capacity to do more. In addition Te Pa Harakeke will increase its support of the DHB's recruitment processes through more intensive focus on those roles that are assessed (using the Position Impact Assessment form) as having high impact on Māori and/or communities.</p> <p>Te Pa Harakeke is also increasing and targeting delivery of cultural competency training to improve the organisational response to the needs of Māori.</p>

Performance Analysis

Of the 17 national and two local indicators:

On the positive side:

- Overall, progress towards targets improved on eight of the national and both of the local indicators;
- Inequality reduced on four of national and both local indicators.

On the negative side:

- Progress towards targets has declined on four of the national targets.
- Inequality increased on six of the national targets and stayed the same on two.

There is insufficient data to be able to make a comparison on four of the national indicators.

Overall this performance is summarised as mediocre at best, perhaps indicative of the challenges we have faced as a DHB in the past year.

HIGHLIGHTS 2017/18



The following pages provide a snapshot of some of the collaborative work and highlights that have taken place within Taranaki DHB in the past year.

Obesity programme for children has promising results

A healthy lifestyle programme for kids and teens with obesity has had promising results, with children reporting better physical and emotional health after just a year. The programme called Whānau Pakari is for 5-16 year olds and is a collaboration between the Taranaki DHB and Sport Taranaki.

Taranaki DHB paediatrician and Liggins Institute researcher, Dr Yvonne Anderson lead the study which took healthcare out of hospitals and into people's homes and communities, and involved the whole family/whānau. The valuable weekly group sessions taught people about cooking, virtual supermarket tours, sports and physical activity, making persistent lifestyle changes and self-esteem.

Patient Safety Week 2017

Taranaki DHB's annual Patient Safety Week (PSW) ran from 6 – 10 November 2017. It was a great success, with plenty of staff, patients and visitors throughout the region taking part in activities and helping us promote important medication safety messages.

All patients discharged from both hospitals received a new discharge flyer with important information they need to know about filling their prescriptions and availability of pharmacy services in the region.

Medication safety support was also available through the 'medication hot desk' and displays in the main foyers of both hospitals. People were able to ask hospital staff any questions they have about their medicines, and enter a 'true or false' quiz with prizes such as grocery hampers, coffee vouchers and a Huawei smart phone kindly donated by Spark.



Patient Safety Week

Whānau Pakari collaborates with Return 2 Earth

Families involved with the Whānau Pakari programme have been learning to grow their own fresh green produce, with assistance from the Whānau Pakari Dietitians and Physical Activity Advisor.

Parents and children have been utilising the garden beds located at Sport Taranaki to grow a variety of vegetables so they can reap the benefits of the seeds they plant.

With help from local company Return 2 Earth, the gardens have been revived this summer thanks to a generous donation of high quality compost to boost the nutrition in the beds.



Whānau Pakari Dietitian, Niamh O'Sullivan, shows the children how to plant their seeds.

Taranaki DHB ranked second most preferred hospital by graduating doctors

Taranaki Hospitals (Taranaki DHB) came second in a survey that ranks graduating doctors' most preferred hospitals to work in.

Every year, graduates of New Zealand medical schools rank their preferences for which hospital they wish to start work at as a qualified doctor (Resident Doctor or RMO). The number of graduating doctors choosing which hospital as 'number one' against the number of positions available for employment gives a consistent measure of the popularity of hospitals amongst the newest doctors.

Using this method, Taranaki Base Hospital has taken the number two spot as preferred employer for 2017.

Less sugary drinks available to students before school

Six local retail stores in Westown have supported Taranaki DHB's Tap into Water project by choosing not to sell sugar sweetened beverages (SSBs) to children on their way to school this year.

Westown shop retailers Little Fed, Subway, Westown Hot Bread Shop, Tukapa and Westown Dairies, and Park Dairy on Clawton St joined in the bid to prevent children having access to sugary drinks before 9am on school days. It is not recommended that children start their school day with the amount of high sugar that SSBs contain as it can interfere with concentration, learning and problem behaviour.



Westown retailers who support the Tap into Water Project (L-R) Subway employees Kate Spencer and Jess Prater, Little Fed manager Jeremy Webbing and Westown Bakery manager Steve Lorth.

Pandemic border health exercise demands multi-agency response

To ensure our region is ready for a potential life threatening human illness, a simulated pandemic border health exercise was rolled out in March by Taranaki DHB's Public Health Unit in conjunction with Port Taranaki.

The goal was to determine each border health agencies capacity and ability to undertake actions which would aid in the prevention and protection of the 'health' of New Zealanders from the risks associated with ill-travellers.

Port Taranaki was at the centre of the pandemic exercise based on a maritime vessel arriving from China with a number of ill crew members on board experiencing "severe influenza like symptoms."

The exercise required a multi-agency response which included assistance from Taranaki DHB (both public health and general hospital services), Port Taranaki, Ministry for Primary Industry, Customs New Zealand, St John Ambulance, Police and shipping agent Phoenix.

Port Taranaki



Base Hospital's new Parent Zone for whānau and staff

Revamping the old existing parenting room for whānau and staff at Taranaki Base Hospital required a community effort. As a result we have a fabulous new and private space for families to enjoy, where they can offer their babies and children the support they need.

Style advice was given by Cat Glass and Jeremy Hill, who featured on TV3's The Block 2015, and sponsorship secured through a local partnership with RJ Eagar, a well-known Taranaki-owned furniture and home design store. Securing the sponsorship allowed many of the large ticket items to be achieved, including new carpet, new furniture and window treatments.

New visitors will find the Parent Zone located off the main corridor on Level 2, between the Outpatients and Maternity departments.



Mother Maree Vesseur and daughter Remi (born 13 May 2018) using the Parent Zone.

White Ribbon Day 2017

White Ribbon Day support was loud and clear at Taranaki DHB in November, with large white ribbons on the outside of Taranaki Base Hospital, and both the Silent Shoes and Spiral of Violence displays promoting that violence towards women and children is never OK.

Taranaki DHB staff held a morning tea in support of White Ribbon Day (25 November) and got involved with several events to help promote this year's theme 'Raise Our Boys', which focussed on ensuring our dads have the skills and confidence to talk to their sons about respectful relationships.



Whānau Hāpai uplifts families

Iwi have been working together to turn around the lives of Taranaki whānau with young children through a service called Whānau Hāpai. The service has seen Tui Ora, Ngāti Ruanui and Ngā Ruāhine collaborating to make a difference.

Whānau Hāpai focuses on whānau in Taranaki with children aged between 0-5 years - particularly those with high and complex needs. It looks at ways to build healthy, engaged whānau so pepi and tamariki have the best start in life.

To do that, three new staff called kai hāpai, support and manaaki the whānau who often face barriers in accessing health and social services.

Once the whānau are ready to opt in and make long-term changes they are supported on their journey by the Comprehensive Pathway, which is a plan that sets out targets and milestones.

Oscar the simulated manikin

Surgical teams at Taranaki DHB have been using a new hi-tech simulator called Oscar to improve team communication skills to help them deal with real life patients.

Oscar (an acronym for Organised Simulated Care and Response) is one of several highly realistic manikins that are central to a world-leading simulation programme called NetworkZ. This programme has been developed by Auckland University, funded by ACC and is being rolled out in DHB's throughout the country.

Oscar provides high level training that focusses on teamwork and communication for nurses, anaesthetists, anaesthetic technicians and surgeons in real time. Oscar is very realistic – he bleeds, breathes, blinks, has a heartbeat and can even talk. He plays a vital role in helping to improve the safety and efficiency of care for our patients, and will continue to offer our staff up to date research and training in theatre.

Te Ahu Taranaki DHB Values

Taranaki DHB launched brand new organisational values this year which better define who we are as an organisation, the way we work with each other, our patients, whānau and external partners.

Our new Te Ahu Taranaki DHB Values are: *Partnerships / Whanaungatanga, Courage / Manawanui, Empowerment / Mana Motuhake, People Matter / Mahakitanga and Safety / Manaakitanga.*

Te Ahu, which means 'the way', represents the way Taranaki DHB lives the values. Local Māori artist, Hemi Sundgren, helped create the circular values design. The kowhaiwhai designs on each of the five values represent the movement and direction towards the centre (inner being) and an attention to foster and nurture wellbeing. This reflects our values coming together around one central focus – the patient.

The new values also link to the ways in which we recognise each other and how we recruit for new positions through to how we discuss our performance, goals and aspiration's.



TE AHU TARANAKI DHB VALUES



The Midland Clinical Portal – One patient, one record

The Midland Clinical Portal (the Portal) was launched across the five Midland DHBs in July 2017. It has been in development since 2016. The Portal is an initiative for eSpace and a clinician led programme that provides a single point of access for patient information across the midland region.

This means that health professionals now have a consistent view of patient records in one place. In the future this is where dispensing and prescription information will also be available.

To date more than 1.5 million patient's records have been registered on the Portal since October 2017.

Collaboration key to cervical screening improvements

Over the last three years Taranaki DHB's Regional Screening Unit has worked alongside contractor Tui Ora, Ngati Ruanui and other health providers to broaden the awareness of cervical screening in Taranaki and increase uptake, especially for Māori women, where we've seen a significant increase in priority smears over the last three years.

Increased collaboration enabled the unit to reach new networks and work in communities which they'd never had access to before. Māori, Pacific and Asian women were also given more opportunities to be screened for free.

Nurses phoned, visited, provided transport to clinics, sent promotional letters and made clinic bookings for women. A night clinic was also offered which was hugely popular and the biggest success of the project.



Regional Screening Unit from left: Jodi Spencer, Kerryn Smith, Wendy McCormick, Calyn James, Robyn Maxwell

New immunisation signage

Taranaki DHB cars in South Taranaki are sporting new immunisation signage thanks to sponsorship from the Ethyl Gray Charitable Trust. The Trust represents Ethyl Gray, who was a courageous and well-respected nurse who contracted polio from a young patient when she worked at Stratford Hospital in the 1940s. Sadly, she and many others died after two polio outbreaks in the 40s and 50s before a vaccine was developed. The Trust works to promote the importance of immunisation in Taranaki.



Free car seat clinics

Taranaki DHB is collaborating with Kid Safe Taranaki to provide free car seat clinics and help people fit their children's car seats correctly. The clinics were held every month in New Plymouth, Hawera, Stratford and Waitara and a qualified car seat technician is available to help.



Free WiFi for Base and Hawera Hospitals

Free Wi-Fi is now available at both Taranaki Base and Hawera Hospitals thanks to the generosity of PrimoWireless, the Taranaki owned and operated internet service provider company.

PrimoWireless is a community minded organisation who worked closely with our Taranaki DHB IT department to come up with a wireless hotspot network for both hospitals. The free Wi-Fi has made a huge difference for our patients, who can now connect with friends and whānau while they recover in hospital.

Deciding to provide free Wi-Fi at Taranaki DHB was personal for Matthew Harrison, PrimoWireless Managing Director, who spent over \$3000 trying to run his business from hospital when he spent almost six months of his life in Ward 3 at Taranaki Base.



Ward 2B play specialist Sharon Luque talks to PrimoWireless about the benefits of free Wi-Fi for the children in hospital

Hapū Wānanga launched

Taranaki DHB's Māori Health team has launched an exciting kaupapa Māori birth education programme for pregnant women and their whānau called Hapū Wānanga. Independent midwives Tawera Trinder and Sharron Wipiti will facilitate the workshops, offering information about pregnancy, birth and raising tamariki based on Māori practices and principles.



Introducing...Super Mama!

As part of the Ministry of Health's "better public service" target, Taranaki DHB developed an informative video for young mothers on how to keep themselves and their baby healthy during pregnancy.

The video features a Māori super hero named Super Mama, who offers important advice for women in the first trimester of pregnancy and beyond. This includes five top tips – get a midwife early in pregnancy, take supplements through pregnancy, be aware of hormones, avoid unhealthy habits during pregnancy and whilst breastfeeding, and eat and exercise well.

The video is also relevant for women who are yet to get pregnant as it provides an important insight into how they can provide the best start possible for a child, should they get pregnant.

The Super Mama video can be viewed on the Taranaki DHB website – tdhb.org.nz.



Community unites to improve health of Taranaki children

The health of Taranaki children was at the heart of an Activity and Nutrition Aotearoa (ANA) regional forum held in New Plymouth in April this year.

A range of delegates attended the forum called 'Taranaki: where healthy children can flourish,' including parents, education, health, district council, hospitality and iwi from around the maunga as well as nationally and internationally acclaimed experts from outside the region.

The ANA regional forum brought people together to address the food and physical environment of children and young people in the region.

Project Connect – the integration project connecting Taranaki health services

Project Connect was set up by Taranaki DHB and Pinnacle Midlands Health Network in 2017. This large programme of work aims to provide the people with the care they need, when they need it, in the right place, while also improving the experience for patients with high needs. This means better coordination of primary care (GPs), secondary care (hospitals) and community health services.

As part of this broad integration project the Community Health Integration Centre (CHIC) has been established and is led by operations manager Lydia Rae and administrator Nicole Mancner.

The CHIC is a key part of the service because it will enable adult referrals to be managed from one single point to better coordinate services and provide more support for patients who have high needs or are at risk, ensuring a much more patient centred care approach. In 2017 the focus was on sorting out how to centralise referrals, improve referral criteria and processes, and improve risk stratification and more.

In 2018 we are now working to operationalise this work. Achieving a patient centred and connected health service for Taranaki is an exciting project but not without its challenges. We still have a lot of work to do and it is important to get it right.

PROJECT CONNECT
The integration project connecting Taranaki health services

TARANAKI HEALTH FOUNDATION



The Board

The Foundation has enjoyed a very stable governance group for the last few years and was thrilled to welcome new Trustee Antony Rhodes to the board. As the Communications Manager at Venture Taranaki, Antony's wealth of experience and professional expertise in public relations is proving to be a huge benefit to the Trust in both development and implementation of fundraising and community campaigns. Antony is committed to the Taranaki Health Foundation kaupapa and brings a fresh approach to Trust business and fundraising.



The Trust also warmly acknowledged outgoing Trustee and ex-Chairperson Michael Joyce, for his dedication and contribution to the Foundation's success. His commitment to excellence and wise counsel will sincerely be missed around the table. Completing the Board are Trustees: Adrian Sole (Chairperson), Murali Bhaskar, Pauline Locket, Peter McDonald, Brian Ropitini and Greg Simmons. The Board are supported by General Manager - Bry Kopu and Foundation Administrator, Vivian Lewis.

What we achieved in 2017/18

The Taranaki Health Foundation has had much to celebrate in 2017/18, 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.

Our focus

Our primary focus is on fundraising with a difference. We strive to build partnerships and provide opportunities for communities to support projects that will enhance health and well-being in Taranaki. As we prepare for larger projects in the near future, we have been very proud to work on smaller projects that encourage a culture of giving, enable people to donate time, talent and resources that can enhance the health and well-being of patients and families requiring health support. The next few pages showcase some of our 2017/18 highlights.

Performance reporting

The Foundation received an unqualified audit in 2017 and awaits the completion of the 2017/18 accounts. An Annual Report will be submitted to the Charities Service by 31 December 2018, 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 ratified at our AGM on 15 December 2018 and made available on the Charities Service www.charities.govt.nz early January 2019.

The Foundation also wishes to acknowledge the wonderful Taranaki DHB staff that have assisted the development and implementation of Partnership projects with Taranaki DHB. In particular, the Communications Team, Mary Lawn, Lydia Rae and the fantastic Social Work Team, Mary Bird, Ronel Marais, Ross Ek Dahl and the Te Puna Waiora Team, Deb Riley (Procurement), Steve Berendsen, The Safe Sleep Coordinator - Beki Madden and the wonderful volunteers from passionate hospital teams.

The OPEN MINDS Project

The Open Minds Project was launched in 2017, to fundraise for acute mental health recovery, healing and well-being. The campaign was designed to complement the renovation of the Acute Inpatient Unit in Te Puna Waiora. The Foundation worked with staff to look at small projects or resources that would enhance the environment, with the goal of increasing staff and patient engagement and provide a more welcoming space for whānau and other visitors to the unit.

We raised over \$85,000 in the period with activities supported by Foundation Partner Methanex NZ, sponsorships and events that raised the profile of the campaign Mental Health Awareness with well-known champions lending their support.



Left: National Mental Health Ambassador and WORLD Owner Denise L'Estrange-Corbet and Terry Parkes helped raise \$15,000 at this special luncheon. This event sold out in four days and was also supported by nationally acclaimed artist Reuben Paterson.



Right: Television personality, chef, gastronomad, and supporter of the Taranaki Health Foundation, Peta Mathias helped raise \$12,000 at another sell out fundraiser.

The Parent Zone

The Foundation worked with Taranaki DHB staff and sponsors to complete a 'make-over' to create a new Parent Zone at Base Hospital. This small project has made a significant difference to this family-friendly space enabling privacy for breastfeeding parents and a quiet respite zone for visitors with children. Fully equipped with baby change facilities, books, play equipment, new wall coverings, drapes, carpet and furniture. We wish to thank our major sponsor Michael Eagar (RJ Eagar).



Left: Major Sponsor Michael Eagar (RJ Eagar) and Adrian Sole (Chair, Taranaki Health Foundation) celebrate the completion of the Parent Zone.



Electronic Whiteboards at Hawera Hospital

Finger-tip technology is helping staff at Hawera Hospital to check on patients at a glance. Three touch-screen whiteboards have been donated to the hospital by the Taranaki Health Foundation, thanks to support from two south Taranaki trusts. These are the Isobel Bremer Medical Services Trust and Fred and Eunice Rodie Trust, administered by Halliwells law firm.

The electronic whiteboards are located in the hospital's emergency department, co-location area and in-patient ward.

Left: Hawera Hospital clinical manager Cathy Thomson and Trustee Michael Joyce.

International Social Workers Day

International Social Workers Day, supported both Mental Health and From Hardship to Hope Kids Health fund, by hosting artist and guest speaker Paul Rangiwhia at a special lunch for staff.

Taranaki DHB staff embraced Social Workers' Day by issuing a gold coin challenge to all hospital departments, with proceeds going to the From Hardship to Hope kids' health fund, which helps Taranaki DHB social workers to support families in need. Paul Rangiwhia, who has created a number of artworks called 'Mental WOF' which highlight how simple messages in art can help you live a happier, more stress free life.

Right: Taranaki DHB social worker Lydia Rae, artist Paul Rangiwhia and Taranaki Health Foundation general manager Bry Kopu.





From Hardship to Hope

Our special Kids Health Fund is going from strength to strength with a major new sponsor Tamarind NZ, secured in 2017 and thousands of dollars donated in goods, services and donations. Our focus is to strengthen Taranaki families throughout their children's medical journeys, ensuring they are better placed to cope and help their children heal. This fund provides very practical support when families are faced with acutely ill children in hospital. If there is hardship, families can be supported in multiple ways by staff with the FHTH fund providing vouchers for groceries and petrol to ease financial stress and burden of extra travel and expenses in and out of the region.

We received over 450 knitted wool blankets for the Safe Sleep Programme and many knitted garments for families in need from volunteers in the community. We were also able to provide Pepi Pods and woven wahakura to Taranaki DHB to support the valuable work being done to encourage safe sleep practices with new parents.

We are currently working on cot size blankets and sheet sets for pods.

Left: Viv Lewis, Beki Madden (Safe Sleep Coordinator) and Bry Kopu.

Safe transport for Taranaki's youngest patients

In the last 12 months Taranaki Patriotic Trust has donated \$30 000, which has paid for not one, but two specially-designed, high-tech baby pods to transport ill babies by air to hospitals around the country for treatment.

One pod is based in New Plymouth and the other in Hawera, where it will safely transport babies from South Taranaki to New Plymouth's Taranaki Base Hospital by road, as well as being used by Taranaki Air Ambulance for transport.

New ambulances are arriving in the region in the next few months but it is understood that existing (older) incubators cannot fit in these vehicles. Having done more than 220 flights in the last seven years as a neonatal flight nurse, Evelyn Kelly said the demand for the new pods was certainly there.

"This generous donation makes transporting infants by air ambulance so much easier. The new pods can be securely strapped on top of a stretcher and don't rely on power to keep babies warm and in a stable condition during transport," she added.

Taranaki Health Foundation general manager Bry Kopu, told the trusts it was "a true Taranaki community collaboration".

"We acknowledge these wonderful trusts for their



Above: Evelyn Kelly, a registered neonatal nurse at Taranaki DHB, demonstrates the features of the baby pods to Taranaki Patriotic Trust and Taranaki Air Ambulance Trust (TAAT) trustees.

commitment to improving patient safety in Taranaki. This new equipment will make it so much easier for staff to care for patients in transit."

In 2015 the Patriotic Trust also donated \$200,000 to St John for a new ambulance in Taranaki, and in 2017 donated \$100,000 towards the new angiography machine at Taranaki Base Hospital, \$25,000 to Taranaki Hospice and the Taranaki Rescue Helicopter Trust.

The future

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

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

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

GOVERNANCE STRUCTURE

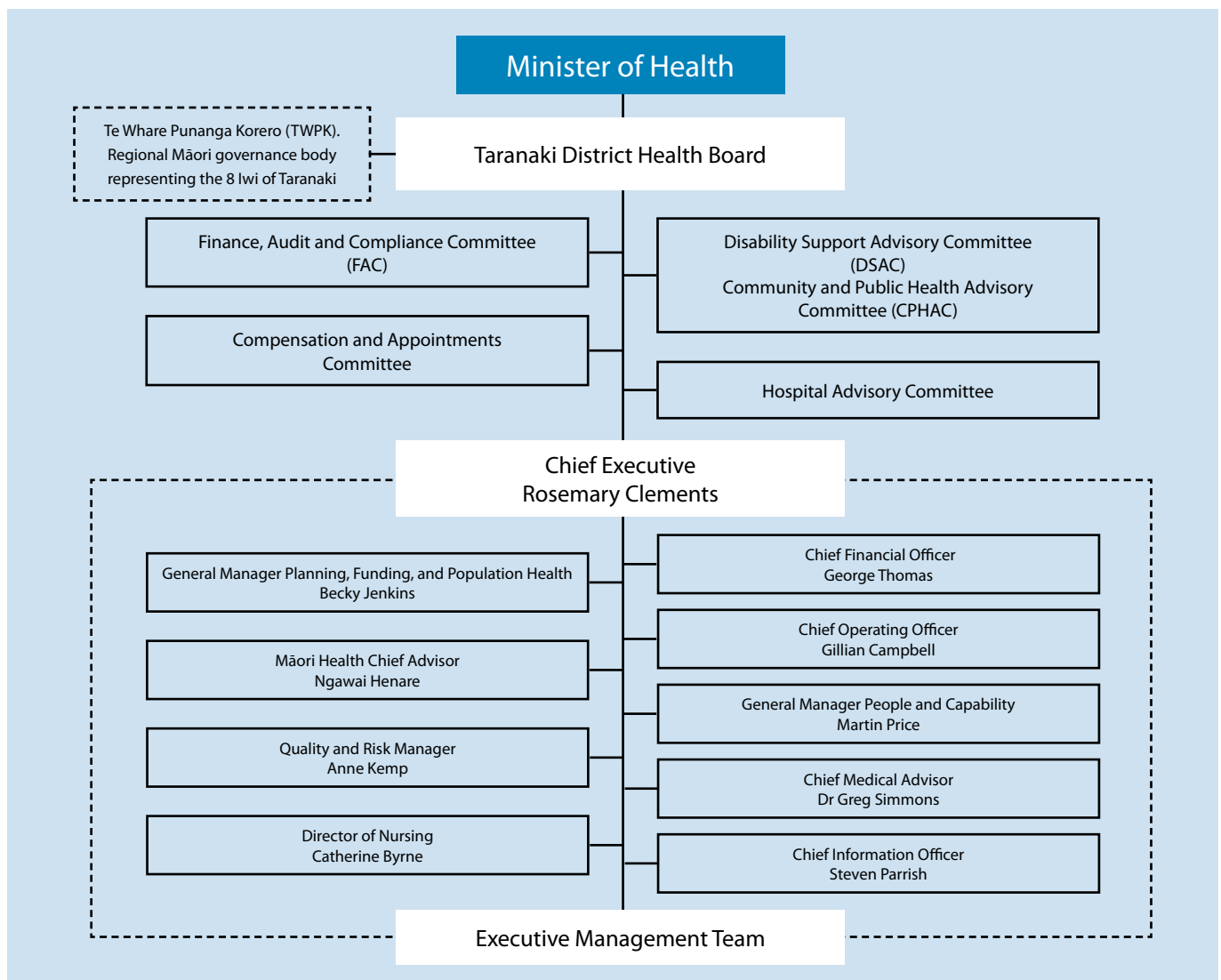
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (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 New Zealand Health Partnerships Ltd and Chairperson of the Ngati Te Whiti Whenua Topu Trust along with having other appointments as detailed in the Interest Register.

Interest Register (as at 30 June 2018): Trustee P Lockett Family Trust; Trustee of Taranaki Work Trust; Trustee of Taranaki Health Foundation; Member of Greypower; Chairperson of the Ngati Te Whiti Whenua Trust; Chairperson of the Midland Regional Governance Group; Director of NZ Health Partnerships Ltd, from 1.7.2018; a member of the District Health Boards Executive.

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 GPs and other health 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 2018): Stratford District Council Mayor. Council Relationships include – 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 Assoc – 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; 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 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 24 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 psychology through the University of Otago.

Aroaro is active in the Taranaki Māori community. She is secretary of Ngāti Moeahu Hapū, secretary of Parihaka Papakāinga Trust, secretary of one of Parihaka's three active marae - Te Paepae o Te Raukura - and trustee of 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 2018): Te Kopae Piripono Kaupapa Māori Immersion ECE, Co-Director; Mataara Ltd, Director; PHD Candidate, Otago University; Te Kāhui o Taranaki Trust, Trustee; Te Pou Tiringa Incorporated, Board Member; HRC, Ngā Kānohi Kitea, Recipient; Ngāti Moeahu Hapū, Secretary; Parihaka Papakāinga Trust, Secretary; Te Paepae o Te Raukura Incorporated, Parihaka, Secretary; Husband CEO Sport Taranaki; Daughter TDHB employee, working as a House Officer since November 2017.

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 2018): Conductive Education Taranaki Trust – Adviser; President New Plymouth Riding for Disabled.

Rose Bruce



Rose is a local GP who strongly believes in online healthcare. She is active in delivering free prescriptions to children enrolled with Lance O'Sullivan's iMOKO and is advocating for quality care delivered in new ways.

Interest Register (as at 30 June 2018): Contracted GP working at Medicross not a Director; interest in an STI app pilot in Taranaki; occasional locum GP; previous husband is a private orthopaedic surgeon; member of NZ Alcohol Action Alliance; blogger NZ Doctor (paid); trustee of Arthouse Cinema (liquidation); Retro Trust; NZ Police GP; END Smoking NZ; Otago University Student studying NZ Rural GP Diploma.

Alison Brown



Alison is an elected member of the Taranaki District Health Board. 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 2018): TDHB Health of Older Persons Consumer Reference Group; NZ Nurses Organisation – Honorary Life Membership; Grey Power Committee.

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. Professional affiliations with The Chamber of Commerce, membership of NZ Society of Accountants and NZ Institute of Directors.

Interest Register (as at 30 June 2018): Councillor New Plymouth District Council; Board Member – Taranaki Youth Health Trust; Board Member – YMCA; Secretary/Treasurer Taranaki Retreat Trust; Member Greypower; Chair – Audit & Risk Committee – NPDC.

Te Aroha Hohaia



Te Aroha is an elected member of the Taranaki District Health Board and is the 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 2018): Access Radio Taranaki Trust – Trustee & Chairperson; Hohaia van Paassen Limited – Principal Consultant, Shareholder & Director; Louise Rauhuia Manuera Hohaia Whānau Trust – Responsible Trustee; Te Ara Pae Trust – Trustee & Chair; Te Kiwai Maui o Ngāruahine Limited – Director; Te Korowai o Ngāruahine Trust – Trustee; TSB Community Trust – Trustee; TSB Group Ltd – Director; Waiōkura Marae & Reserves Trust – Trustee.

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 2018): 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; Member of Automobile Association Council (Taranaki), Secretary of Board – Air Quality Asia (NGO, based in USA).

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 2018): Daughter is a TDHB 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.

Bev Gibson



Bev is a registered nurse, an engagement consultant with Māori clients/whānau and case managers for ACC and a quality systems health auditor. She has a Bachelor of Arts majoring in Nursing and Education, a Postgraduate Diploma in Health Service Management and a Masters in Management. Bev is an advocate of quality early intervention/prevention programmes and promotes self-care physical/mental health wellbeing.

Interest Register (as at 30 June 2018): Independent Contractor–ACC Cultural/Clinical Advisor; Director of Quality Visions Limited (QVL); Director of the Parininihi Ki Waitotara (PKW) Committee of Management; Chair of PKW Human Resource Committee; Chairman of Te Korowai O Ngaruahine Trust; Director of Te Kiwai Maui O Ngāruahine Limited; Chair of Mahia Mai a Whai Tara Kaumatua Service; Independent Trustee of Lantern Trust; daughter is Kai Rangahau Tautoko, a research assistant for the Whānau Pakari programme.

Te Pahunga (Marty) Davis



Born in Hawera and on marrying moved to Whanganui in 1976. Employed with Agriculture and Fisheries for 30 years including 10 years in management. In 1999 returned to work for Ngaa Rauru Kītahi as its first CEO and Chief Negotiator with settlement completed 2005. In 2009 took up the position of CEO Ngāti Ruanui for four years before returning to Whanganui. Concurrently elected a board member of Ngaa hapuu o Ngaruahine and joined their negotiation team. Current Taranaki Maunga negotiator.

In 2014, elected Tumu Whakarae of Te Kaahui o Rauru Trust. Current chair of Te Whare Punanga Korero and Te Whakatipuranga Rima Rau Trust and Trustee of Tuituia Trust. Current Trustee of Taranaki Māori Trust Board since 2016. Also a trustee at Ohangai, Waioturi and Tauranga Ika Paa and whakapapa to Ngaa Rauru Kītahi, Ngaati Ruanui, Ngaa Wairiki Ngaati Apa and Ngaaruahine.

A sometimes road cyclist, musician and a very ordinary golfer – teenaa ra koutou katoa.

Interest Register (as at 30 June 2018): TWPK – Chair).

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 - TDHB Board meeting	Hospital Advisory Committee	Community and Public Health and Disability Support Advisory Committee	Finance Audit and Compliance Committee	Compensation & Appointments Committee	Allied Laundry Services Ltd	Fulford Radiology Services Ltd	HealthShare Ltd	Fees Paid (\$)
Board Members – 2017 /18									
Pauline Lockett	*11 of 11	5 of 6	4 of 5	11 of 11	✓				43,850.00
Neil Volzke	^11 of 11	5 of 6	5 of 5	10 of 11					28,336.96
Alison Brown	10 of 11	6 of 6	5 of 5	10 of 11					24,120.00
Rose Bruce	10 of 11	6 of 6	4 of 5	Not a member					21,370.00
Harry Duynhoven	11 of 11	6 of 6	3 of 5	Not a member					21,120.00
Bev Gibson	11 of 11	5 of 6	✓ 5 of 5	Not a member					21,370.00
Richard Handley	10 of 11	5 of 6	4 of 5	✓ 10 of 11	✓				24,245.00
Te Aroha Hohaia	10 of 11	4 of 6	✓ 5 of 5	10 of 11					23,932.50
David Lean	11 of 11	6 of 6	3 of 5	11 of 11					23,870.00
Kevin Nielsen	11 of 11	✓ 6 of 6	5 of 5	✓ 11 of 11	✓				24,807.50
Aroaro Tamati	6 of 11	✓ 3 of 6	3 of 5	Not a member					17,475.00
Co-opted Board / Committee Members									
Flora Gilkison							✓		5,625.00
Te Pahunga (Marty) Davis	3 of 11								750.00
Patsy Bodger		5 of 6	3 of 3						2,000.00
Other Directors									
Rosemary Clements, Chief Executive								✓	
Simon Barrett, Group Financial Manager						✓	✓		

Key:

* = Chairperson Board

^ = Deputy Chairperson Board

✓ = Chair/Deputy Committees

TE WHARE PŪNANGA KŌRERO 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 – Ngā Rauru, Ngāti Ruanui, Nga Ruahinerangi, Taranaki, Te Atiawa, Ngāti Maru, Ngāti Mutunga and Ngāti 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 five 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 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

Pat Bodger



Te Atiawa
(January 2017 -
current)

Tamzyn Pue



Ngāti Maru

Greg White



Ngāti Tama

Ngapari Nui



Ngāti Ruanui

David Tamatea
(till late 2017)



Taranaki Iwi

Rawinia Leatherby
(from late 2017)



Taranaki Iwi

Te Oti Katene



Ngā Ruahinerangi

Te Pahunga
(Marty) Davis



Ngā Rauru Kaitahi

TWPK representative for Ngāti Mutunga is currently vacant and has been vacant since April 2017.

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 2018

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.

Opinion

We have audited:

- the financial statements of the Group on pages 65 to 93 that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue & 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 34 to 61.

In our opinion:

- the financial statements of the Group on pages 65 to 93:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2018; 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; and
- the performance information of the Group on pages 34 to 61:
 - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2018 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; and
 - 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 25 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to a matter in relation to compliance with the Holidays Act 2003. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Compliance with Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosures about this matter in Note 32 on page 93. Our opinion is not modified in respect of this matter.

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 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.

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 achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the group audit. We remain solely responsible for our audit opinion.

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 30 and page 64, and pages 94 to 97, but does not include the financial statements and the performance information, and our auditor's report thereon.

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.



Bruno Dente
Partner

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

STATEMENT OF SERVICE 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 2017/18 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 2017-18

Output Class	Planned Revenue (\$000's)	Actual Revenue (\$000's)	Planned Expenditure (\$000's)	Actual Expenditure (\$000's)
Prevention	7,970	8,010	8,012	8,474
Early Detection and Management	88,922	89,366	89,391	80,488
Intensive Assessment and Treatment Services	224,916	226,040	226,101	243,581
Rehabilitation and Support	57,726	58,014	58,030	57,176
TOTAL	379,534	381,430	381,534	389,719

¹ The 2004 Crown Entities Act requires under section 153 that a Statement of Performance be complete. 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	1. People are supported to take greater responsibility for their health		2. People stay well in their homes and communities		3. People receive timely and appropriate specialist care
Intermediate Impacts	<ul style="list-style-type: none"> Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours 		<ul style="list-style-type: none"> An improvement in childhood oral health Long-term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence 		<ul style="list-style-type: none"> People receive prompt and appropriate acute and arranged care People have appropriate access to elective services Improved health status for people with a severe mental health illness and/or addiction More people with end-stage conditions are appropriately supported
Outputs¹	<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> 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 outline the rationale for delivery the DHB's programmes and services as outlined in the 2017/18 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.

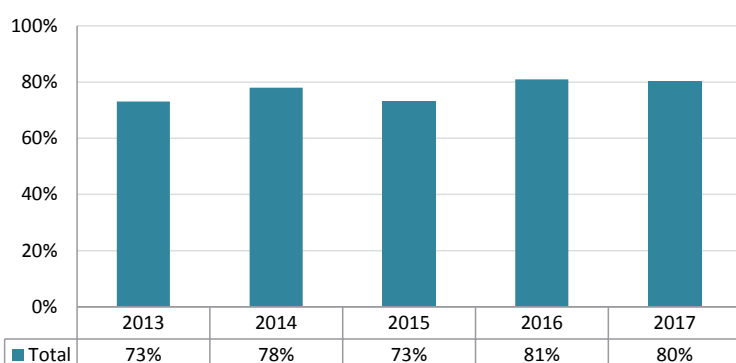
Intermediate Impacts

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 (29.8%), and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Māori experiencing a higher incidence (20% +), higher mortality and higher stage at presentation. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori. See Health Targets page 9.

Impact Measures

Percentage of year 10 students in Taranaki who have never smoked



Target for 2017 was to maintain the 2016 result of 81%

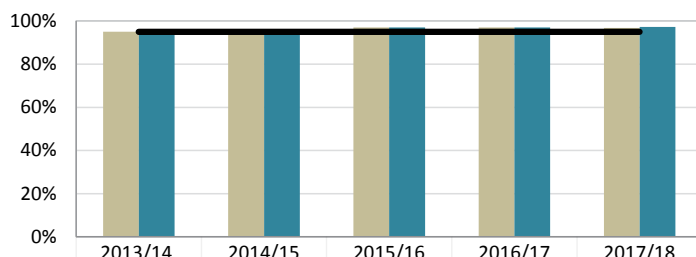
Data Source: Action on Smoking and Health (ASH) annual survey

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

Even with a 1% decrease from 2016, it is pleasing to see a 7% increase from 2015 to 2017 in Year 10 Taranaki students who have never smoked. The Action for Smokefree 2025 (ASH) Year 10 Survey is undertaken annually throughout New Zealand and has shown a declining national trend in young people initiating smoking. 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	95%	95%	97%	97%	97%
Total	96%	95%	97%	97%	97%
Target	95%	95%	95%	95%	95%

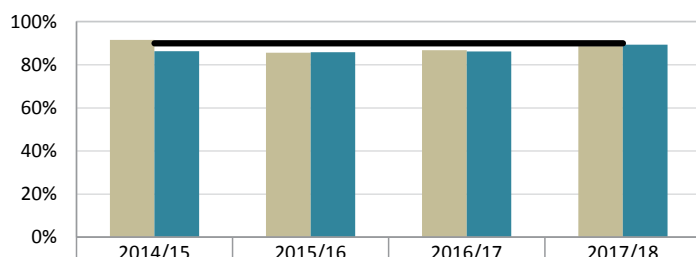
Data Source: Taranaki DHB Patient Management System

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

Māori	Target Achieved
Total	Target Achieved

The practice of providing cessation advice to smokers is well embedded into Taranaki DHB (District Health Board) hospital services. It is positive to see there is no disparity between Māori and total population results. Pathways into smoking cessation services from the hospital however still require further development and this will be one of the areas of focus for our Tobacco Control work in 2018/19. Ongoing promotion of the local smoking cessation service and the positive outcomes they are achieving for both Māori and Non-Māori clients is an important means of achieving this, along with specific actions that champion brief intervention and referral to smoking cessation services such as the recent recruitment of a Maternity Services Smokefree Coordinator position.

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



Māori	92%	86%	87%	89%
Total	86%	86%	86%	89%
Target	90%	90%	90%	90%

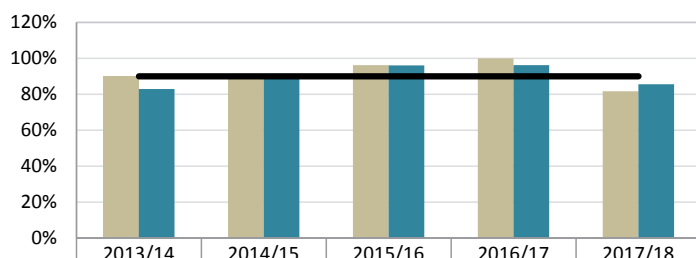
Data Source: MOH Integrated Performance and Incentive Framework (IPIF)

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

While the Taranaki DHB is 1% off meeting this target, there has been an improvement during this year. It is also pleasing to see there is no disparity between the results for Māori and the total population. The Primary Health Organisation (PHO) uses their data management systems to identify smokers and support practices to provide support and advice to their patients. Tui Ora has also led a programme of work to encourage and support primary health practitioners to have conversations about smoking cessation and to prompt referrals into face-to-face smoking cessation services.

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



Māori	90%	89%	96%	100%	82%
Total	83%	90%	96%	96%	86%
Target	90%	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 Not Achieved
Total	Target Not Achieved

There has been a decline in the number of identified pregnant women who smoke being offered advice and support. Specific training for Lead Maternity Carers (LMC) and other maternity workforce staff on the provision of brief advice and support to pregnant women who smoke has not been available for some time. The Auckland DHB's newly developed online training is now available and Taranaki DHB Maternity Services are actively promoting this training to the maternity workforce. This will be further facilitated by the recent recruitment of a Maternity Smokefree Coordinator position that aims to increase the percentage of pregnant women identified at the time of confirmation of pregnancy as smokers that are offered brief advice and support.

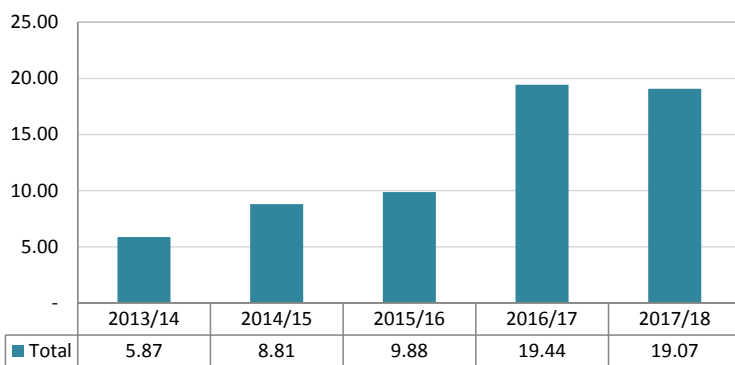
Reduction in vaccine preventable diseases

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 page 9.

Impact Measures

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



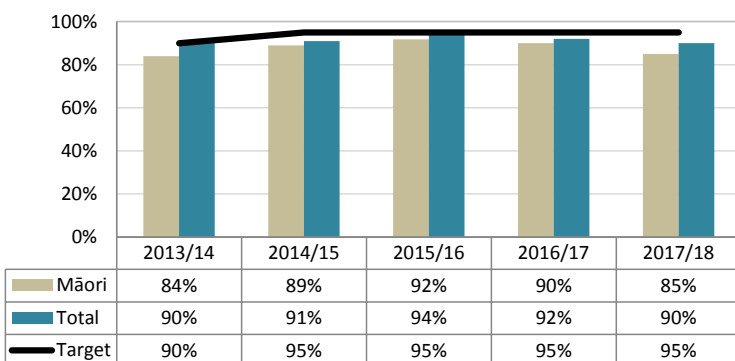
Data Source: Ministry of Health National Minimum Dataset

Reduction in vaccine preventable diseases

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. The three year average of 19.07 for 2017/18 is heavily influenced by the seven cases that occurred in the 2016/17 year, noting that Taranaki had the lowest proportion of cases across the Midlands region in 2017/18. A range of socioeconomic, health system and personal factors influence the hospitalisation of vaccine prevention disease in children and are most likely related to pertussis and/or influenza. Responding to this issue requires a wider health sector approach and has been identified as an area of focus for our work in 2018/19 within our System Level Measure (SLM) plan for child health.

Output Measures

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



Data Source: National Immunisation Register

95% of babies are fully immunised at eight months old

Māori	Target Not Achieved
Total	Target Not Achieved

Unfortunately the figures for 2017/18 show a reduction in rates of immunisation of babies at eight months. The 2017/18 year has also seen a widening of disparity between Māori and non-Māori immunisation rates across all four quarters. This appears to be influenced by a combination of high decline rates as well a reduction in Outreach Immunisation Service (OIS) delivery, the latter of which will be actively addressed in the 2018/19 year.

Overall, this has led to non achievement of the immunisation target for eight months old and may have contributed to vaccine preventable disease rates of pertussis in this age group. Taranaki District Health Board is developing a three year work plan based on the findings of a Health Equity Assessment undertaken in 2018 and a recent Systems mapping day to look at the mother-child immunisation journey. Addressing inequity between Māori and non-Māori by increasing rates of enrolment and engagement with families and whānau will be a major focus of our work in 2018/19.

Improving health behaviours

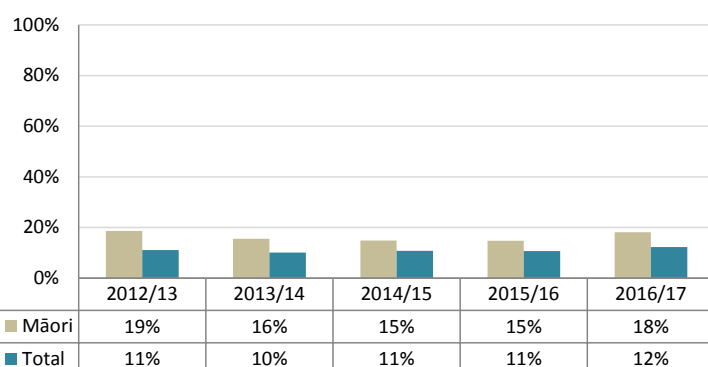
In 2016 Body Mass Index (BMI) is expected to overtake tobacco as the leading preventable risk to New Zealanders' health, thus in October 2015 the Ministry of Health (MoH) released the Childhood Obesity Plan which aims to prevent and manage obesity in children and young people up to 18 years of age. The 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 interventions will be targeted to Māori to decrease this disparity. See Health Targets page 9.

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

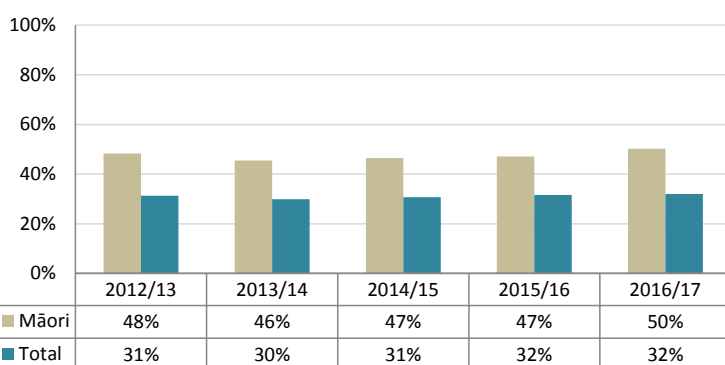
According to the Ministry of Health, obesity rates have increased in all ages, genders and ethnic groups over the last 30 years, with those born more recently becoming obese at a younger age. The Ministry of Health states that high body mass index (BMI) has now overtaken tobacco as the leading risk to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

Despite this, it is disappointing to see an increase in the percentage of children who are obese over the last year, along with an increase in inequity between Māori and the total population. We have continued to refer children who are identified as obese at the Before School Check to programmes and initiatives that provide nutrition and physical activity support 2017/18 will hopefully have an impact on obesity numbers in the coming years. Whānau Pakari, the service that provides support to Taranaki children, has seen a significant increase in children under five being referred to the programme and the programme has been adapted to suit this.

Adult obesity also has remained stable at 32%, however the increase in the percentage of the Māori population who are obese is of concern. The Health Sector recognises that obesity is a complex issue and it will take effort beyond the sector to address the underlying factors that contribute to obesity.

Taranaki DHB continues to seek opportunities to do cross-sector work to address obesity in our communities and our Public Health Unit is currently leading the development of a sector wide Childhood Obesity Prevention Action Plan that aims to reverse the obesity rate trend in future.

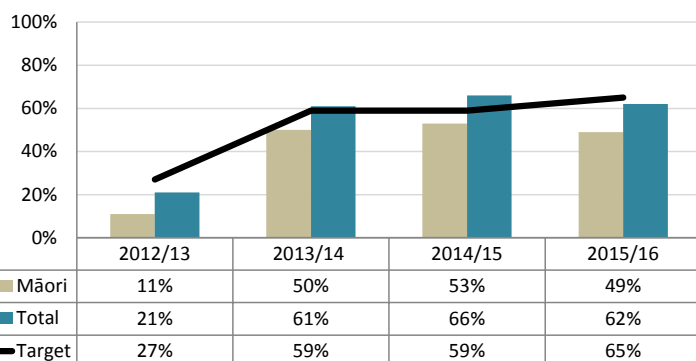
**Percentage of New Zealand population who are obese 15 years
and older**



Data Source: New Zealand Health Survey 2013/14

Output Measures

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



Data Source: National Plunket Data

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

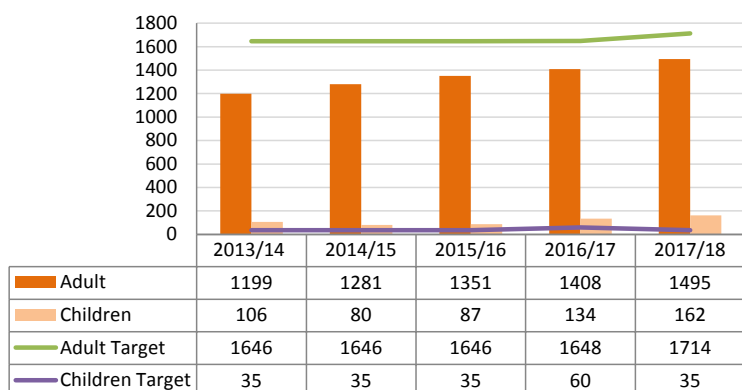
Māori	Not reportable
Total	Not reportable

Improving breastfeeding rates, and reducing the inequity that persists between Māori and non-Māori rates continues to be a priority for Taranaki DHB.

Taranaki DHB recently established a scholarship programme to encourage and support Lactation Consultant (LC) training in the Māori Health provider workforce. Two Kaimahi Māori who work in the Maternity Sector were awarded a scholarship to support them to become certified LCs. These qualified LC practitioners already have established working relationships with whānau in Taranaki communities and will contribute towards positive outcomes in future.

NB Data is no longer available through the Well Child Tamariki Ora framework.

Number of referrals to the GRx (Green Prescription) programme

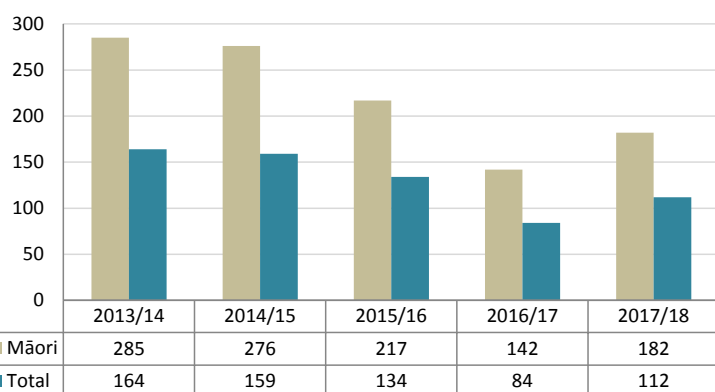


Number of referrals to the GRx (Green Prescription) programme

Adult	Target Not Achieved
Children	Target Achieved

Sport Taranaki did not reach the target for the number of referrals received for the Green Prescription adult programme. However they have exceeded the referral targets for the Active Families programme. The Green Prescription programme continues to achieve positive results for the population of Taranaki, with over 34% of those referred into the adult programme completing it. A high proportion of referrals into the adult programme are received from Primary Care providers. A significant proportion of the referrals into Active Families are now associated with the Raising Healthy Kids Target and the Active Families and Whānau Pakari teams have worked hard to ensure the programme meets the needs of those tamariki and their whānau.

Teen birth rate per 10,000



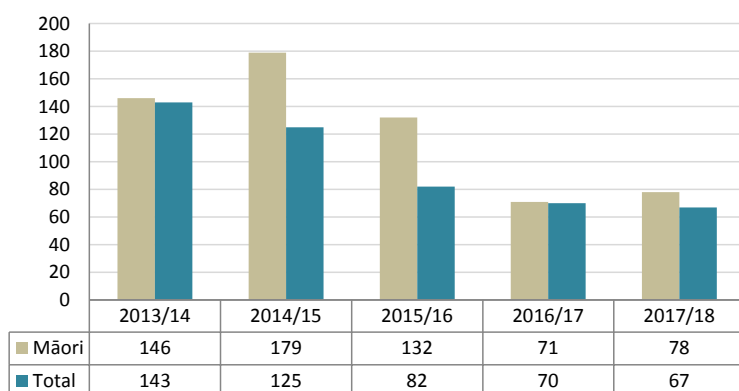
Target: Māori <217; Total population <134

Teen birth rate per 10,000

Māori	Target Achieved
Total	Target Achieved

While the teen birth rate increased in 2017/18, the overall trend appears to be downward. Taranaki DHB continues to maintain services to the adolescent population, 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. We also plan to implement free consultations for under 25's accessing the Emergency Contraceptive Pill (ECP) through community pharmacies in 2018/19 which it is hoped will reduce current cost barriers for young people accessing this service.

Teenage terminations of pregnancy rate per 10,000



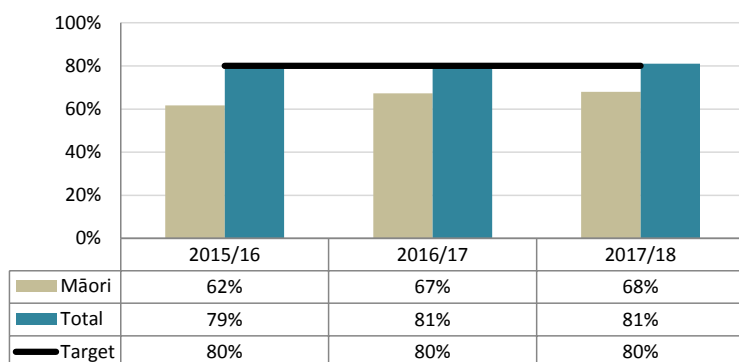
Target: Māori <132; Total population <82

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 of pregnancy overall. Although a slight rise is noted in the Māori Population, the result remains within the target. We continue to ensure that contraception is readily available through self referral clinics to all adolescents in school and alternative education settings.

Percentage of pregnant woman that are registered with an Lead Maternity Carer in the first trimester



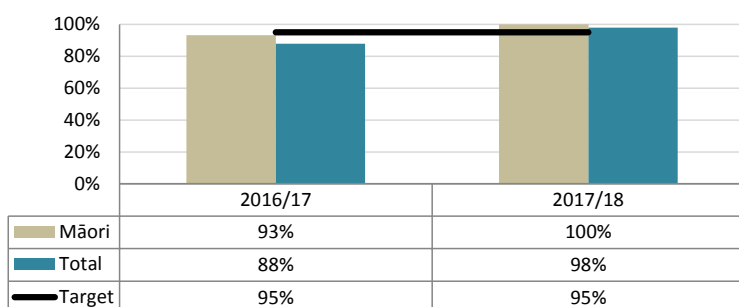
Data Source: Sport Taranaki: GRx Adults Quarterly Report

Percentage of pregnant woman that are registered with an Lead Maternity Carer in the first trimester

Māori	Target Not Achieved
Total	Target Achieved

While the total population have reached the target for registering with Lead Maternity Carers (LMC) in a timely way, the result shows ongoing evidence of inequity of access for Māori populations. Taranaki DHB has a planned programme of work within our the System Level Measure Plan for 2018/19 that aims to explore some of the barriers Māori women are facing in registering with LMCs in the first trimester and to identify what actions could facilitate early registration.

Percentage of obese children identified in the Before School Check (B4SC) Programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention



Data Source: Sport Taranaki: GRx Active Families Quarterly Report

Percentage of obese children identified in the Before School Check (B4SC) Programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention

Māori	Target Achieved
Total	Target Achieved

Taranaki DHB exceeded target in 2017/18 with 98% of the total population and 100% of the Māori population who are identified as obese in the Before School Check being offered a referral into the DHB's clinical assessment and intervention service (Whānau Pakari). Although this health target has now been removed for 2018/19, the practice of referring obese children to Whānau Pakari is now embedded into the Before School check programme and will continue.

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.

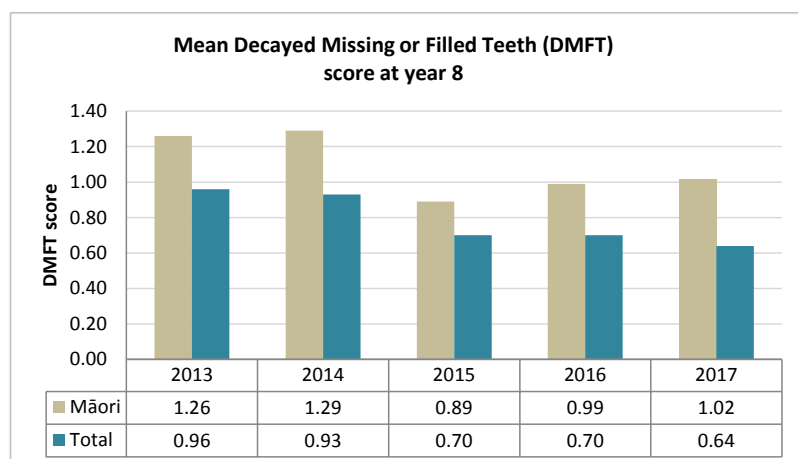
Intermediate Impacts

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 2017. Data is for the 2017 calendar year.

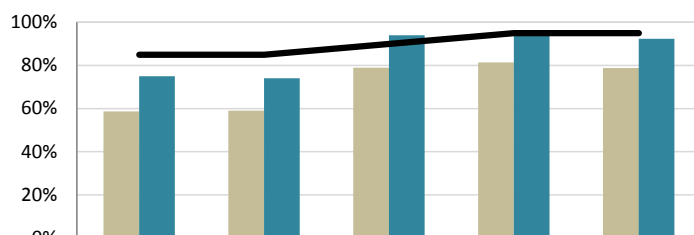
Reduction in the mean Decayed Missing or Filled Teeth (DMFT) score at year 8

Overall mean DMFT scores continue to improve in Taranaki, in part due to increased clinical measures such as topical fluoride and good oral health promotion. However the result for non-Māori being under target and Māori being well over target demonstrates a widening inequity between Māori and non-Māori, which is disappointing.

Taranaki DHB undertook a Health Equity Assessment in 2018 as part of a wider service improvement project aimed at reducing Māori 0-4 years Did Not Attend (DNA) rates in community oral health services. The recommendations arising from this report will be incorporated into a service improvement project that will be led by the DHB Māori Health Unit in 2018/19.

Output Measures

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



Māori	59%	59%	79%	81%	79%
Total	75%	74%	94%	95%	92%
Target	85%	85%	90%	95%	95%

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2017. Data is for the 2017 calendar year.

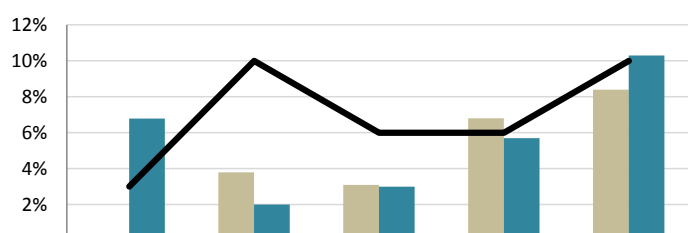
Percentage of children (0-4) enrolled in DHB funded dental service

Māori	Target Not Achieved
Total	Target Not Achieved

Taranaki DHB has not achieved this target for the total population and the Māori enrolment result has dropped also. The lower Māori enrolment result may be partly explained by anomalies in ethnicity data however we are also aware that persistent inequity continues between Māori and non-Māori for dental service enrolment.

Taranaki DHB intend to undertake a service improvement project in 2018/19 aimed at reducing Māori 0-4 years Did Not Attend (DNA) rates in community oral health services and it is hoped that this will also help identify way we can improve Māori 0-4 years enrolment rates in future. Meanwhile, we maintain close links with all preschool health service providers who use our online enrolment form to enrol new preschoolers to the area.

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



Māori	0%	4%	3%	7%	8%
Total	7%	2%	3%	6%	10%
Target	3%	10%	6%	6%	10%

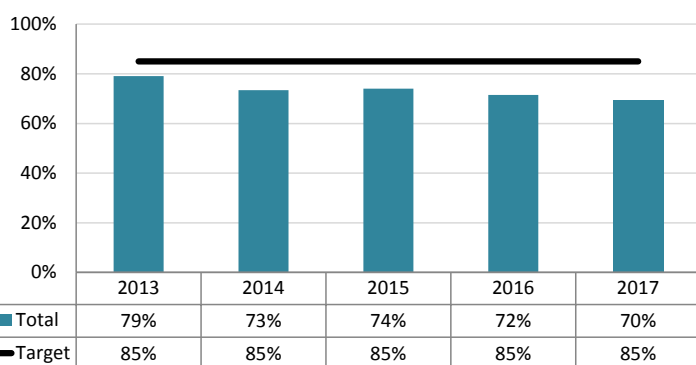
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2017. Data is for the 2017 calendar year.

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

Māori	Target Achieved
Total	Target Not Achieved

Taranaki DHB continues to measure this indicator to assess service coverage for tamariki between the ages of 0-12 years. Whilst Taranaki DHB is within the target of 10%, the increasing trend in overdue dental examinations is of concern. This will be reviewed in the 2018/19 year in order to identify opportunities for service improvement aimed at reducing the percentage of enrolled pre-school and primary school children overdue for their scheduled dental examination.

Percentage of adolescent utilisation of DHB funded dental services



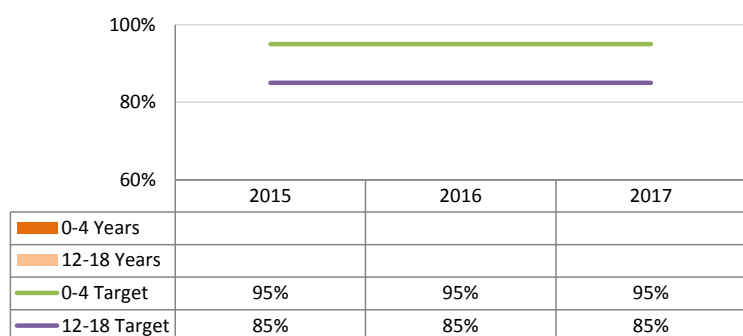
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2017. Data is for the 2017 calendar year.

Percentage of adolescent utilisation of DHB funded dental services

Total	Target Not Achieved
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Adolescent dental services are delivered by private dentists, through the Combined Dental Agreement (CDA), and the Taranaki DHB Community Oral Health Service. The Community Oral Health Service has 800 adolescents as part of the Service Specifications "Community Oral Health Services and Some Adolescents". These numbers make Taranaki DHB the largest provider of adolescent dental services. However it appears that fewer adolescents are accessing services through the CDA. Taranaki DHB continues to work to improve the percentage of adolescents receiving publicly funded oral health care.

Access by tamariki and rangatahi to oral health services: Proportion of tamariki and rangatahi that have annual oral healthcare plans in place



Access by tamariki and rangatahi to oral health services: Proportion of tamariki and rangatahi that have annual oral healthcare plans in place

0-4 Years	Not reportable
12-18 Years	Not reportable

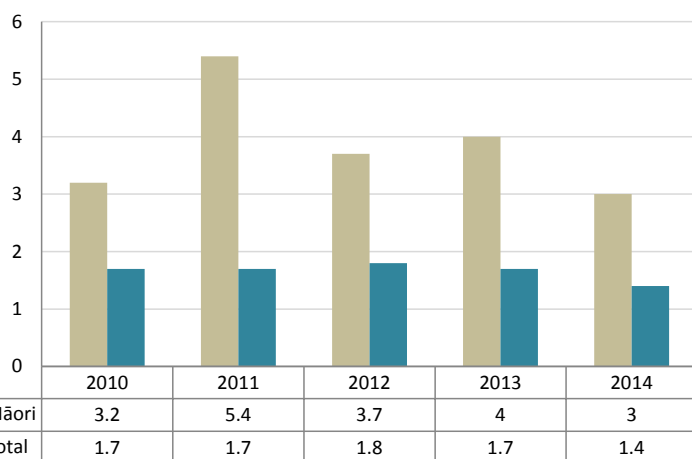
NB. Data has not been made available for this target.

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

Age standardised per 100,000 cervical cancer mortality



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

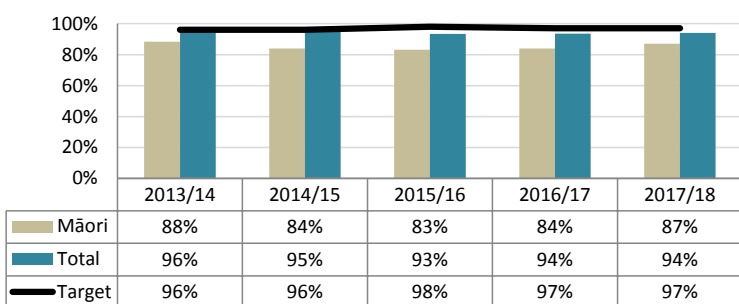
Cervical cancer mortality - age standardised per 100,000

Results for 2017/18 show an overall decreasing trend for Māori mortality since 2011 with 25% decrease from 2013 to 2014. This has reduced overall mortality rates and reflects a further reduction in the disparity of between Māori and total population rates. Cervical smear and colposcopy clinic procedure rates for Māori and total population are examples of interventions aimed at achieving favourable health outcomes in relation to cervical cancer.

Increasing vaccination rates for Human Papillomavirus (HPV) will also contribute to reduced cervical cancer mortality rates and will decrease the disparity between Māori and non-Māori over time. We are currently working closely with our service providers to target key population groups in the community in order to ensure continued improvements in health equity for Māori women in particular.

Output Measures

Percentage of population enrolled with a Primary Health Organisation



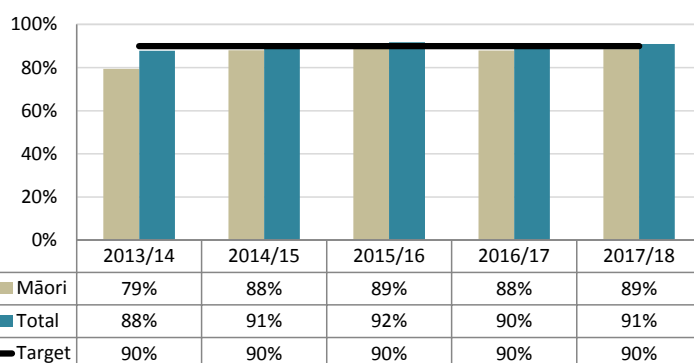
Data Source: Ministry of Health PHO Enrolment Collection

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

Māori	Target Not Achieved
Total	Target Not Achieved

Pinnacle Health Organisation (PHO) enrolment continues to be steady in Taranaki DHB, with only a small percentage of the population not enrolled with a PHO. This is due in part to one General Practice (and resulting enrolled patients) remaining independent of the PHO, and also due to a significant number of people in the Waverley and surrounding districts being enrolled with a General Practice that is based in Taranaki but registered with Whanganui PHO (which decreases the numerator while the denominator is not adjusted). The increase in Māori enrolment rates is pleasing and reflects some targeted PHO enrolment promotion initiatives undertaken by the Māori Health Unit in 2017/18.

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



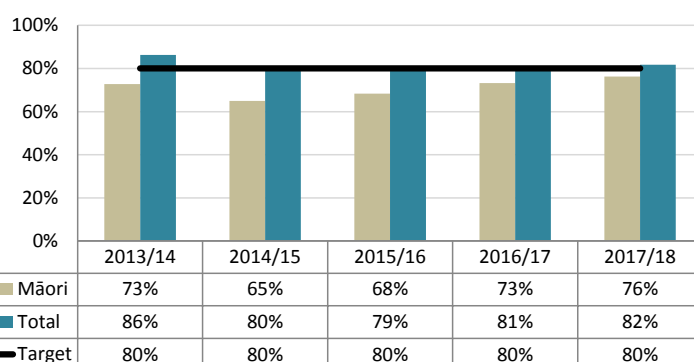
Data Source: Primary Health Organisation Performance Programme (PPP)

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 consistently achieved the 90% CVDRA target, however our rates for Māori remain below target despite an overall upward trend. In response to this, our System Level Measures (SLM) plan for 2018/19 has shifted focus to achieving equity for Māori against this measure. The Māori male 35-44 years old population has consistently underperformed against this target, and a number of actions to help improve this are identified in the 2018/19 SLM plan.

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



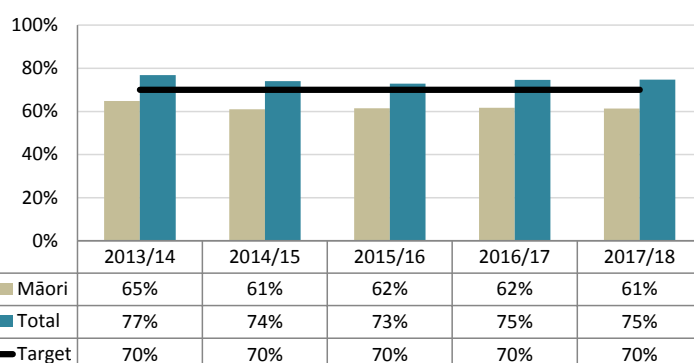
Data Source: National Screening Unit

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

Māori	Target Not Achieved
Total	Target Achieved

Results for 2017/18 show improved rate for Māori on prior year and a marginal increase in total rates. A reduced disparity gap as a consequence of increased Māori screening rates is also noted. We are maintaining and sustaining higher than National average rates for both Māori and overall. As expressed by Ministry of Health (MoH), Asian women will be a focus area to 2018/19 and we will be working with providers to address this area.

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

The patterns of breast screening uptake are similar to the previous year. Current service arrangements with Breast Screening Aotearoa and their mobile service remain the same but a health equity lens review is anticipated for 2018/19 which may elucidate some areas for improvement for Māori women aged 50 to 69 years. It is hoped that this will lead to reduced inequity and improved health outcomes in future.

Fewer people are admitted to hospital for avoidable conditions

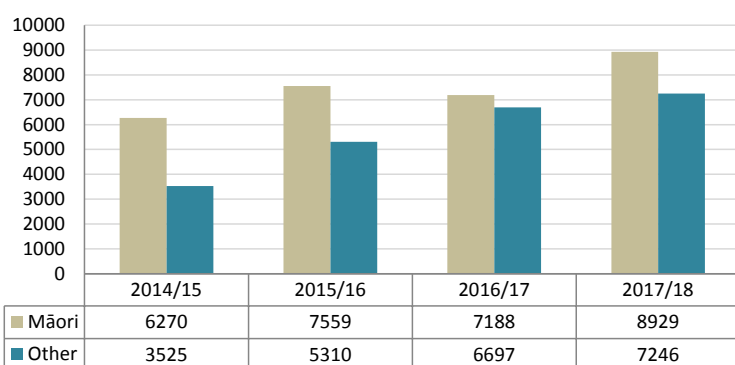
There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care.

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.

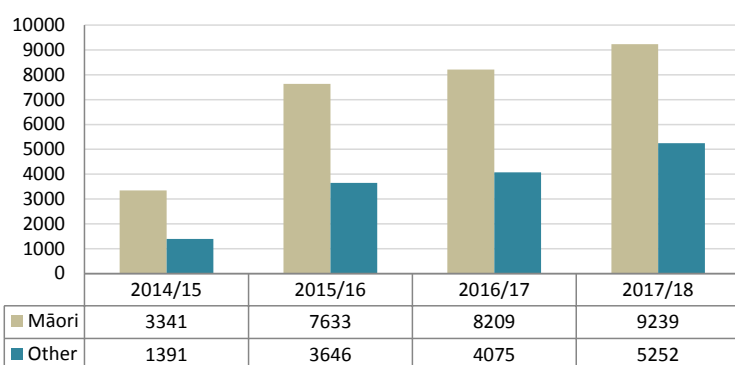
Impact Measures

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)

The 0-75 years Ambulatory Sensitive Hospitalisations (ASH) measure was removed in 2015/16 and has been replaced with results for 0-4 and 45-64 years.

The ASH measures are an example of an impact measure, which looks at changes to population health over a long period of time. The measures are an important indicator of the effectiveness of Primary Care and Community services. Taranaki DHB would ideally like to see a decrease in these measures, with a particular emphasis on improving equity between Māori and non-Māori, to reflect an improving health outcome in our population.

The 2017/18 year has seen some significant pieces of work such as the completion of a health equity assessment and programme of work looking at attendance rates for Māori in oral health services, research into healthy housing and its impact on hospital admissions and sharing of ASH and ED (Emergency Department) data with the Primary Health Organisation (PHO) for planning and education purposes in primary care.

Nevertheless, ASH rates for both 0-4 and 45-64 year olds in Taranaki DHB have been gradually increasing over the last five years, with the Māori rate consistently above the non-Māori rate and both rates considerably higher than target. The non-Māori rate is now above the national average. Taranaki DHB has the eighth highest ASH rates for total population and sixth highest ASH rates for Māori in New Zealand.

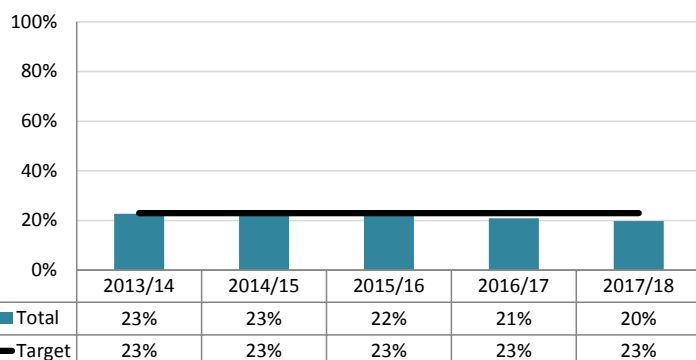
The most prevalent clinical conditions that contribute to Taranaki DHB's ASH 0-4 year old rate include respiratory conditions (infections and asthma), gastroenteritis and dental conditions.

The approach to System Level Measure (SLM) planning in 2018/19 has been significantly refreshed and identifies a number of actions to be tested and delivered throughout the year that are anticipated to reduce ASH rates.

In addition, Taranaki's integration project continues to gather momentum, with a particular focus the roll out of the Health Care Home initiative in general practices and the establishment of a single point of access for any patients requiring interventions not immediately available in primary care.

Output Measures

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



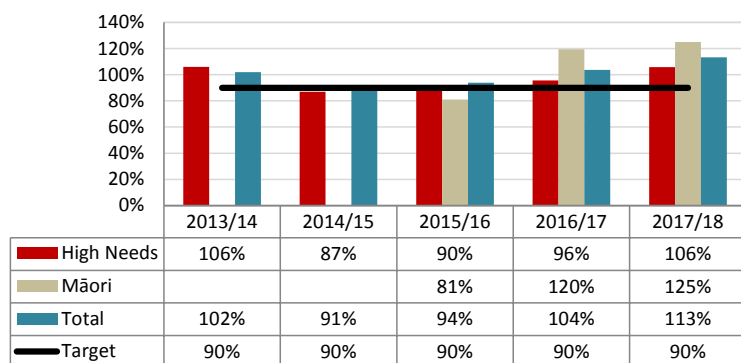
Data Source: National Non-admitted Patient Collections. Statistics New Zealand Population Projection 2013

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

Total	Target Achieved
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Taranaki DHB continues to see a reduction in our triage four and five numbers with use of our primary redirection and primary pathways as well as the ongoing public education programme.

Percentage of eligible population have their Before School Checks completed



Data Source: National Immunisation Register

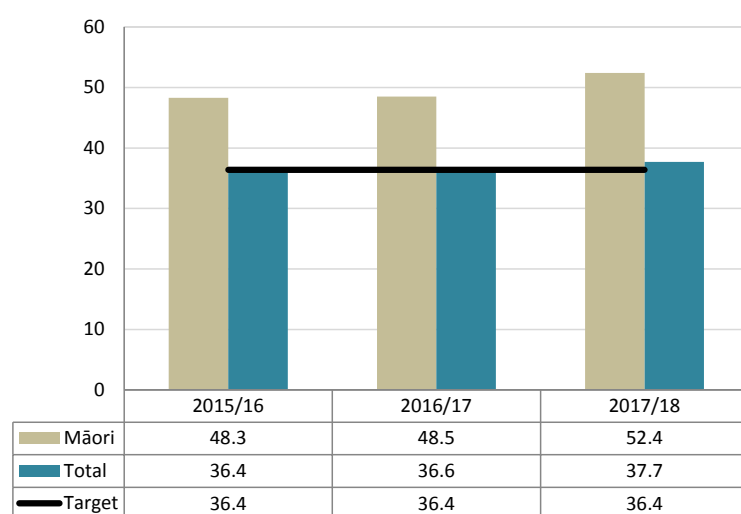
90% of eligible population have their Before School Checks completed

High Needs	Target Achieved
Māori	Target Achieved
Total	Target Achieved

Taranaki DHB has undertaken a successful programme aimed at improving the timeliness of the Before School Check. This programme has enabled an alignment of the start age of the Before School Check with national best practice guidelines. It has also impacted on the total number of checks delivered, with over 100% of the intended population receiving their check in 2017/18.

NB. Ethnicity results not available for 2013/14 and 2014/15.

Reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0-12 years old



Data Source: Ministry of Health National Minimum Dataset

Reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0-12 years old

Māori	Target Not Achieved
Total	Target Not Achieved

As with the Ambulatory Sensitive Hospitalisations (ASH) results, the most prevalent clinical conditions that contribute to Taranaki DHB's youth admission rate include respiratory conditions (infections and asthma), dermatological and dental conditions. The rate has risen for Māori in Taranaki and is slightly above the national rate.

The approach to System Level Measure (SLM) planning in 2018/19 for ASH should have some impact on the future results in this area as it specifically targets the 0-4 age group for early detection.

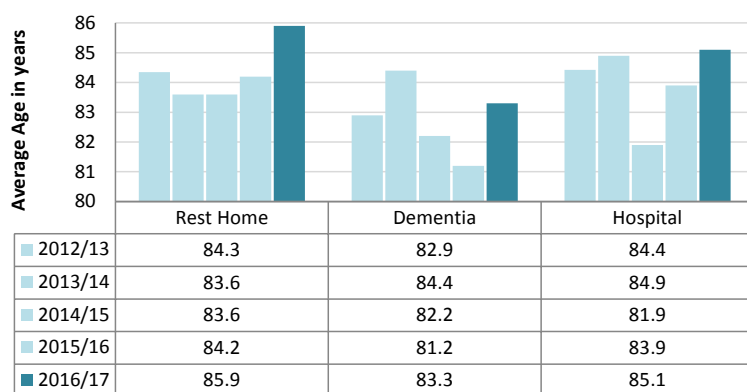
In addition, Taranaki DHB's integration project continues to gather momentum, with a particular focus the roll out of the Health Care Home programme in general practices and the establishment of a single point of access for any patients requiring interventions not immediately available in primary care.

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

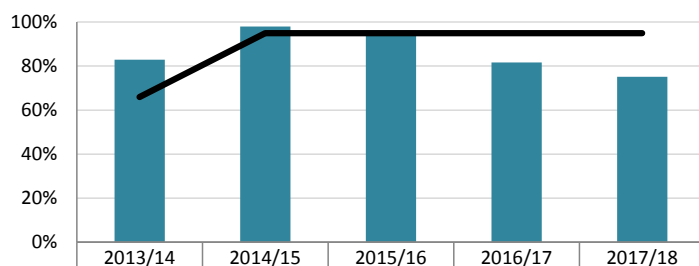
Impact measures look at changes to our population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is a result of the combined activities of multiple providers and services across the Taranaki region. Taranaki DHB has seen an increase in the average age of entry into rest homes which reflects an improved health outcome in our older 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 rehabilitation potential) and a range of home & community support services.

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

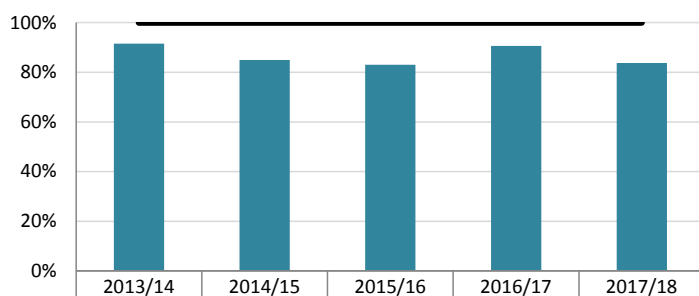
The percentage of older people receiving long term home support who have had comprehensive clinical assessment and a completed care plan in the last twelve months

Total **Target Not Achieved**

All older people referred to the Needs Assessment & Service Coordination (NASC) service who require long term supports should have a comprehensive clinical assessment (interRAI) and care plan completed before supports are allocated, and this is usual standard practice for the NASC.

This is unfortunately not reflected by the 2017/18 result for two reasons. Firstly, the merging of service contracts for home based support services in 2016 means that Taranaki DHB is no longer able to separate short term clients (who do not require an interRAI assessment) from long term clients for reporting purposes. Prior to this change, Taranaki DHB consistently met the 95% target as the figures for 2014/15 and 2015/16 show. Secondly, some recruitment challenges in the Needs Assessment Service Coordination (NASC) service in 2017/18 has led to some delays in assessment and care planning for low priority clients. The NASC service is now fully staffed and expects to exceed the 95% target in 2018/19 noting however that this will not be recognised in our reported data due to the ongoing reporting challenges arising from the merger of the short term and long term home based support service contracts.

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 2017/18 year Taranaki DHB averaged 84% compliance thus falling short of the Health Quality & Safety Commission's target of 90%. Consequently we did not meet our self imposed 100% target either. Note that international best practice rate (90%), set by the Health Quality & Safety Commission, allows for the small percentage of patients where other assessments and interventions take clinical priority over a falls risk assessment.

To enable improved compliance, a new nursing assessment and care planning document, that includes a Falls Risk Assessment, has been developed, trialled and was implemented in May 2018. The document includes a refined trigger tool to ensure that all appropriate patients are screened, with this being commenced in ED for acute admissions (a significant practice change). The risk assessment is linked to care bundles for falls prevention that enables the development of individualised care plans. Implementation includes a monitoring process and to date, results indicate increased compliance going into the 2018/19 year.

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

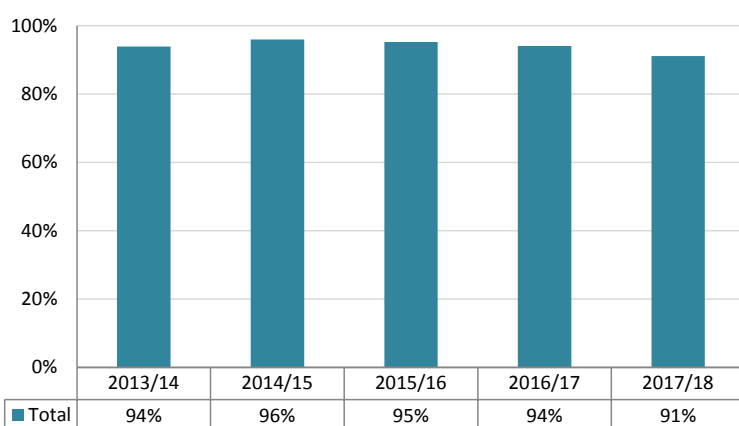
People receive prompt and appropriate acute care

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 page 9.

Impact Measures

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



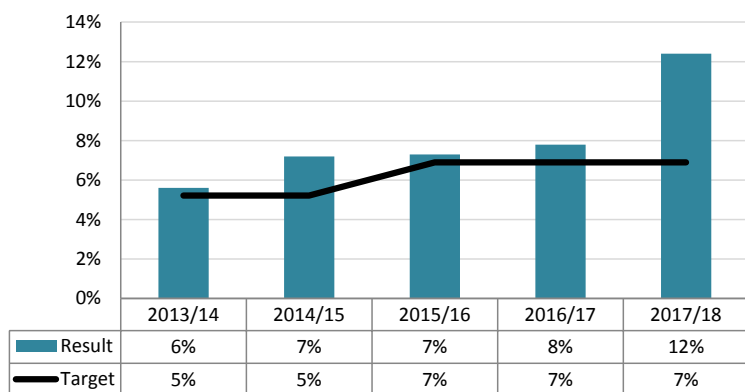
Data Source: Taranaki DHB Patient Management System

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

Continuing increased acute demand has impacted on our ability to manage the target of 95%. The Capacity at a Glance Screen initiative operating within our hospital services provides visual awareness of Emergency Department demand and this is already being used to promptly inform clinical teams about capacity or delay issues as they arise. The system also provides improved information in real time to assist with patient flow. The Emergency Department (ED) and Information Technology teams are now working on a variance response system for both medical and nursing staff to support improved management of ED patient flow in future.

Output Measures

Acute re-admission rate



Data Source: National Minimum Dataset (NMDS)

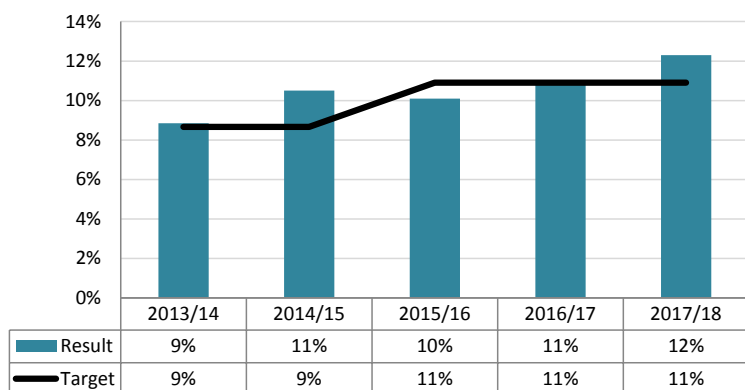
Acute re-admission rate

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

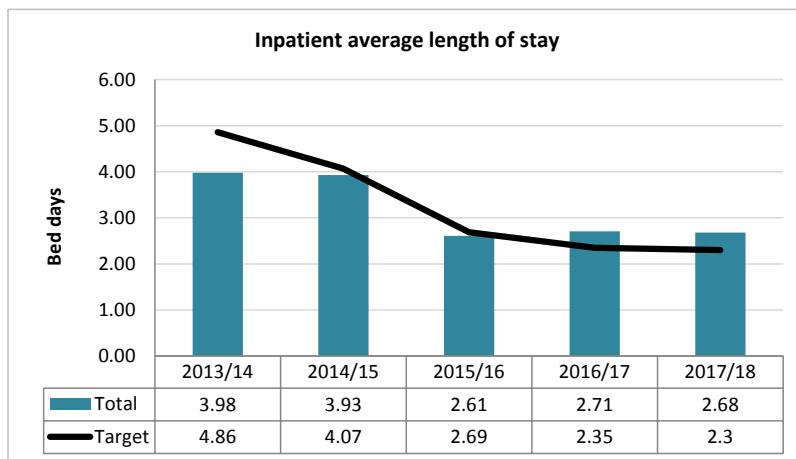
Taranaki DHB's acute re-admission rate continues to be over the target level. We have seen continuing, high acute demand in 2017/18 and this has significantly impacted on these rates. The DHB's integration project (Project Connect) is underway and includes a focus on better managing the referral process with an overarching objective of improved integration of primary and secondary services. It is hoped that this initiative will have a positive impact on reducing acute demand on hospital services in future.

NB: There has been a data definition change for the 2017/18 year. The current targets reflect the old data definition. Updated targets, based on the new data definitions, will be used in the 2018/19 year.

Acute re-admission rate >75s



Data Source: National Minimum Dataset (NMDS)

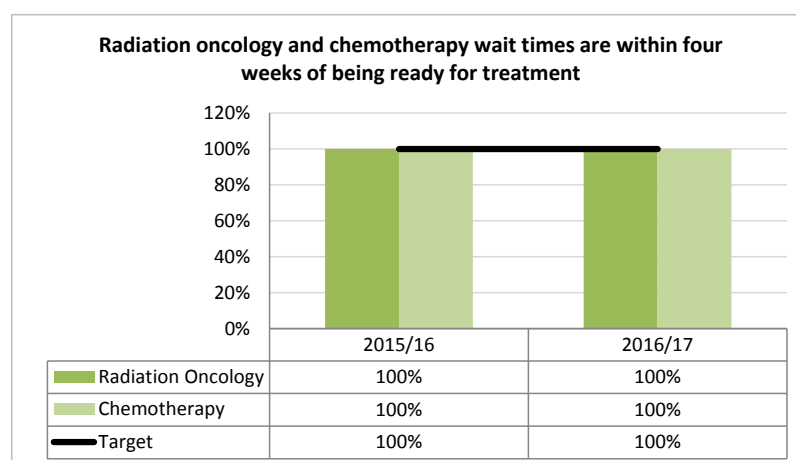


Data Source: National Minimum Dataset (NMDS). Desired outcome is below the target rate

Acute Inpatient average length of stay reduced

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

Despite a slight improvement since 2016/17, we have not met the target this year. Work is continuing to ensure that early assessment is completed to support improved discharge management and reduce length of stay (LOS) where appropriate. For example, we are working on providing clear pathways to ensure that patients are supported on discharge and that their LOS in the acute areas is not prolonged unnecessarily. The team are also focusing on reducing LOS for respiratory admission in particular.

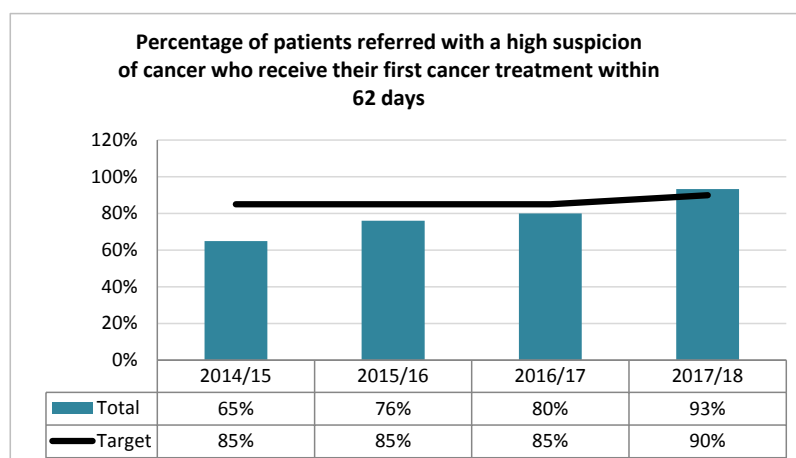


Data Source: Mid-Central DHB Patient Management System

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

Radiation Oncology	Not reportable
Chemotherapy	Not reportable

NB Midcentral DHB supply this service, however, Midcentral DHB are no longer supplying this data to Taranaki DHB.



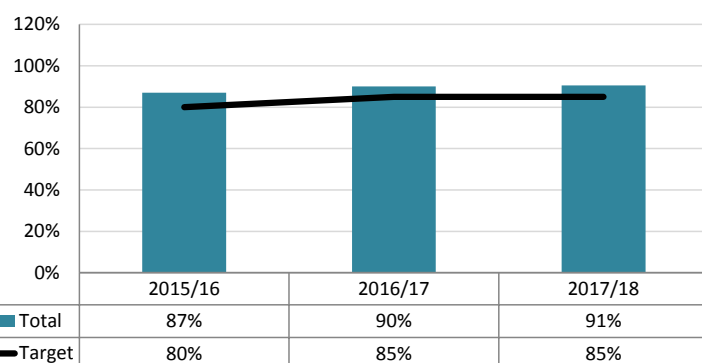
Data Source: Mid-Central DHB Patient Management System

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

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

Taranaki DHB's Faster Cancer Treatment (FCT) Governance Group is working well and now includes a physician representative. Taranaki DHB is pleased to have achieved the increased target of 90% of all cancer patients receiving their first treatment within 62 days.

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



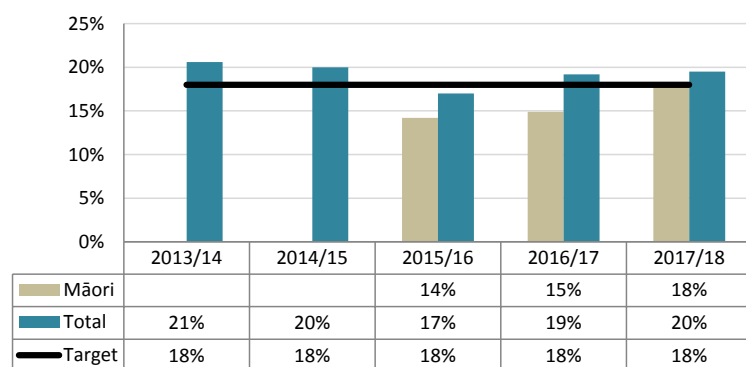
Data Source: Mid-Central DHB Patient Management System

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

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

Taranaki DHB is pleased to have exceeded the target of 85% of patients receiving their treatment in 31 days of diagnosis of cancer. Ongoing monitoring and promotion of staff awareness of this target will be undertaken to ensure this target continues 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

Māori	Target Achieved
Total	Target Not Achieved

Whilst we are committed to reducing the number of arranged caesarean 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 co-morbidities in pregnant women that clinically drive these rates.

People have appropriate access to elective services

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services (see Health Targets page 9). 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:	24.4	Significantly above target
Cataract procedures - target 27 per 10,000		
Result:	30.7	Significantly above target
Cardiac surgery - target 6.5 per 10,000		
Result:	6.3	Not significantly different to target
Percutaneous revascularisation - target 12.5 per 10,000		
Result:	11.5	Not significantly different to target
Coronary Angiography Services - target 34.7 per 10,000		
Result:	42.6	Significantly above target

Data Source: Ministry of Health, Elective Services

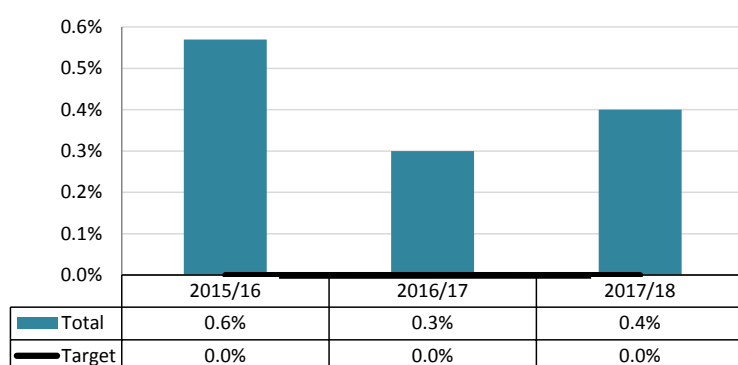
Elective services - standardised intervention rates per 10,000

It is pleasing for Taranaki DHB to see our results for Standardised Intervention Rates (SIR) at or above the national average. Taranaki DHB continues to work with our Tertiary partners to ensure that we can continue to meet our targets. Any further improvements in these measures will contribute toward better health outcomes for our local population.

SIRs are measured against nationally set targets to ensure access to a variety of types of surgery is fair and not dependant of the location of the patient.

Output Measures

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



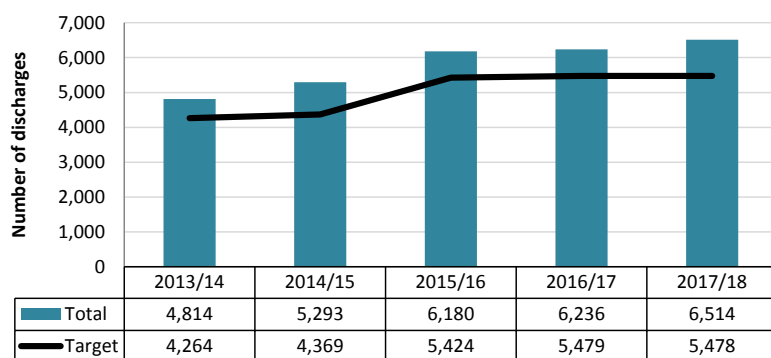
Data Source: National Booking Reporting System (NBRS)

Extract of Elective Services Performance Indicators (ESPI) results

Result	Target Not Achieved
--------	---------------------

Taranaki DHB continues to work hard to meet the Elective Services Performance Indicators (ESPI). The 2017/18 year has been challenging with a number of significant issues this year including increased acute demand and unplanned or emergency events (e.g. water supply restrictions caused by storm damage and the recent nurses strike). We have an increasing number of patients not meeting compliance timeframes for various reasons and we are working on processes to assist us to be compliant whilst ensuring that surgical prioritising tools are used accurately across all specialties.

Number of Health Target elective surgical discharges



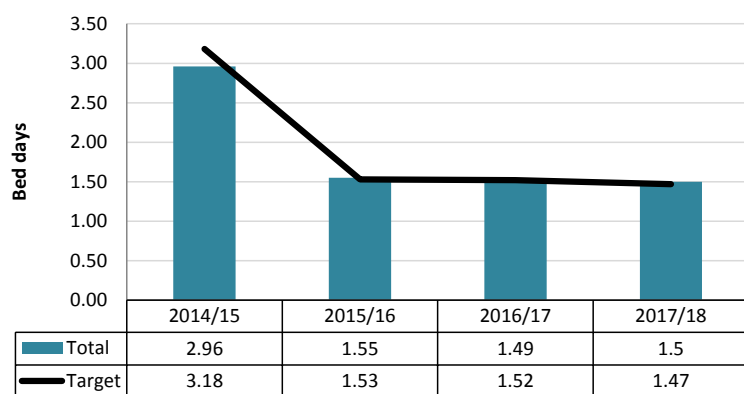
Data Source: National Minimum Dataset (NMDs)

Number of Health Target elective surgical discharges

Result	Target Achieved
--------	-----------------

Taranaki DHB has once again achieved this target. All specialty teams are working efficiently to ensure that the Ministry of Health guidelines are being achieved in relation to elective surgical discharges.

Elective inpatient length of stay



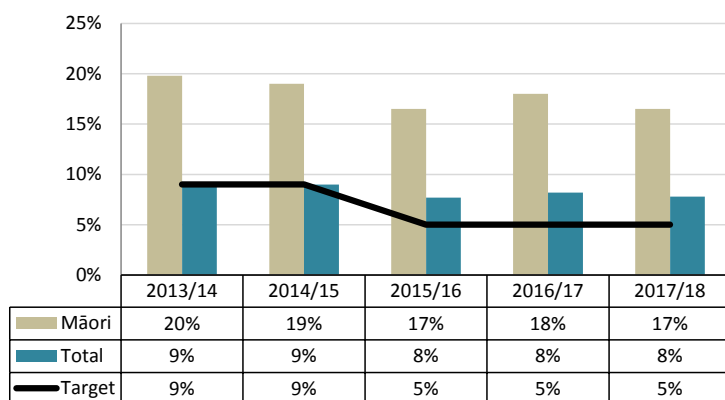
Data Source: National Minimum Dataset (NMDs). Desired outcome is below the target rate

Elective inpatient length of stay (LOS)

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

Taranaki DHB has continued to work hard on achieving this target. We continue to develop our Enhanced Recovery After Surgery (ERAS) project, refining this service in an effort to meet the elective inpatient length of stay 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

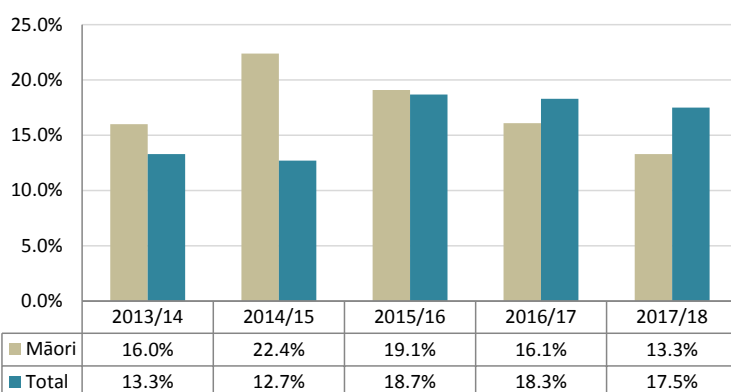
Managing our Did Not Attend (DNA) rate continues to be challenging and a focus for Taranaki DHB. Of particular importance to us and the Māori health team is the high DNA rates for Māori patients. The teams continue to work in supporting attendance at outpatient clinics (both first specialist and follow up appointments) and procedure clinics held in the outpatients department. There is a range of initiatives which are being initiated and trialled in an effort to facilitate better attendance for this group, including a number of specific service improvement projects planned for 2018/19.

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)

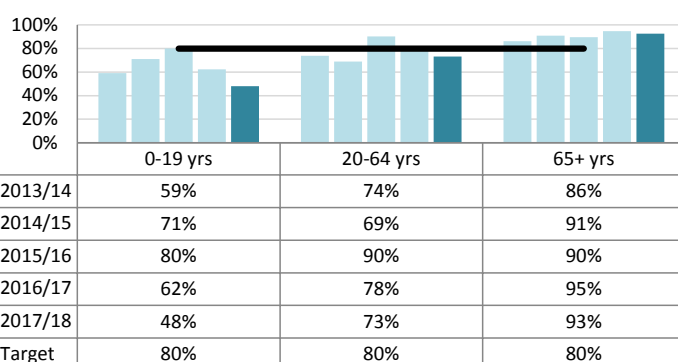
28 day acute readmission rate

While Taranaki DHB is below the upper target of 20% TDHB has implemented a transition document to replace discharge documentation with the aim of improving identification of biopsychosocial needs of the service user as well as interventions in place as well as identifying those that are needed to further decrease readmission rates to below the lower target of 10%.

The completion of this document will be reviewed and audited to ensure that clinical teams are acting upon identified needs of service users. Further work is to be conducted looking at transition processes to ensure that appropriate supports have been actioned to prevent readmission.

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).

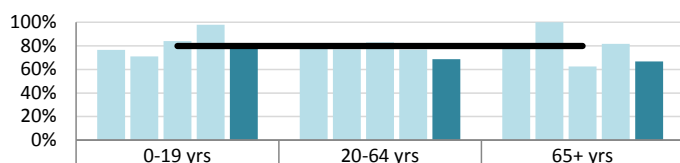
Desired outcome is below the target rate

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

0-19 years: Recruitment challenges in the child and youth mental health service has impacted on the teams ability to attend to non-urgent referrals within three weeks. The team has identified the need to develop a consult-liaison role within the service to work with community agencies to manage some of the issues preventing referrals to our service. Another initiative planned for 2018/19 is to develop a role that is dedicated to working on the non-urgent waiting list to allow non-urgent referrals to be seen in a more timely manner. Recruitment for specialist roles within the service is continuing.

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



	0-19 yrs	20-64 yrs	65+ yrs
2013/14	77%	81%	78%
2014/15	71%	77%	100%
2015/16	84%	83%	63%
2016/17	98%	77%	82%
2017/18	82%	69%	67%
Target	80%	80%	80%

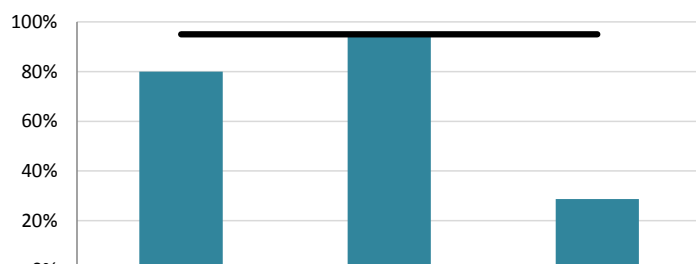
Data Source: Programme for the Integration of Mental Health Data (PRIMHD)

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 Not Achieved

Currently there is a systems review being undertaken in the addiction service to look at factors that delay people from being seen within three weeks. One issue is related to a population of Ministry of Justice referrals that are hard to contact, thus leading to extended times prior to contact. A new initiative will be trialed in 2018/19 to address these issues.

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



	2015/16	2016/17	2017/18
Total	80%	95%	29%
Target	95%	95%	95%

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
-------	---------------------

Taranaki DHB has launched a new initiative in the Child Youth Mental Health Service to identify and resolve the issues and barriers that have impeded this group of service-users from being discharged with transition plans. This initiative will continue in 2018/19 and it is hoped that this will positively impact on the percentage of child and youth mental health clients that are discharged with a transition plan in future.

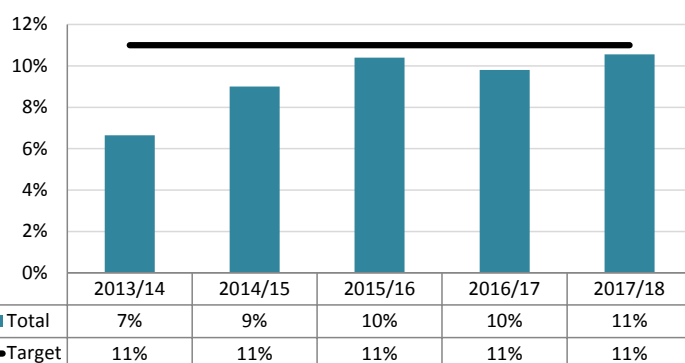
More people with end-stage conditions are appropriately supported

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 page 9.

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
-------	-----------------

This target was met in 2017/18 reflecting the ongoing initiatives that Hospice Taranaki have in place to reduce avoidable Emergency Department (ED) presentations by their patients.

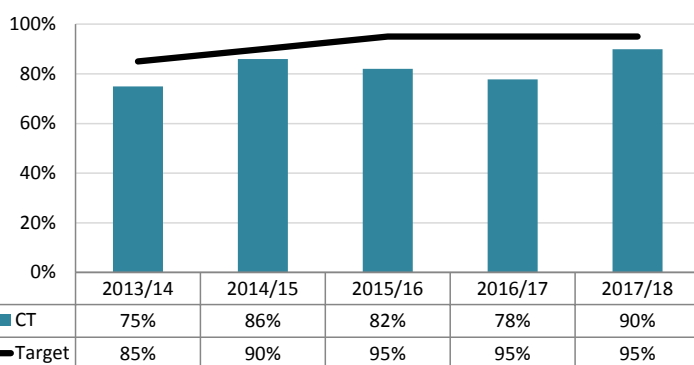
Hospice also continues to provide palliative care clinical nurse specialists whose role is supporting aged residential care providers to build their skills and capacity to manage palliative residents in aged residential care and to reduce avoidable hospital admissions of palliative residents.

The palliative clinical nurse specialists work closely with the Taranaki DHB gerontology clinical nurse specialist for aged residential care. Hospice Taranaki has had an increase of clients with complex co-morbidities, which can often lead to an ED presentation for a non-cancer condition. Hospice monitor monthly stats to identify trends and follow up on all inappropriate ED presentations of their clients so they can advise to contact Hospice prior to going to ED.

Support services

Output Measures

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



Data Source: Taranaki DHB

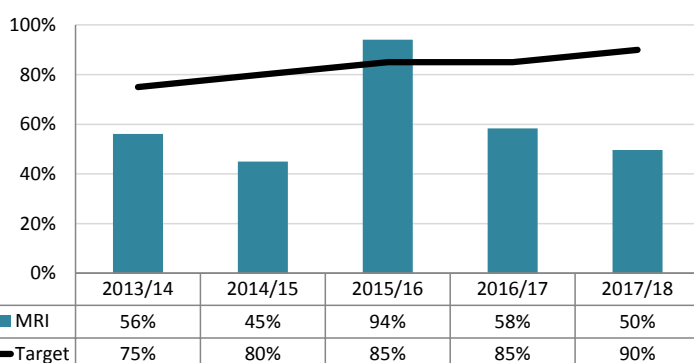
Improved wait times for diagnostic services - accepted referrals for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

CT	Target Not Achieved
MRI	Target Not Achieved

CT scan referrals have continued to increase, these are prioritised and urgent and semi urgent scans are completed. However, the wait time for non urgent diagnostic services continues. We have provided a number of extra sessions to assist in managing the increased number of referrals.

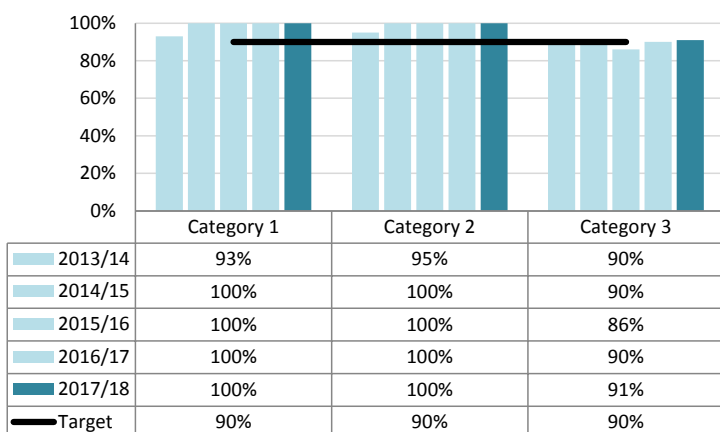
With MRI, the acute and urgent referrals for scans continues to be challenging. We have put a number of initiatives in place to manage this growing demand. Scan referrals are reviewed by specialist consultants to ensure referrals are clinically appropriate. Patients waiting on scans that require investigations prior to scanning are contacted and requested to have these completed so an appointment time can be arranged. Contact with paediatric patients who require a general anaesthetic for scanning is maintained to ensure that, once they meet the criteria, the scan can be performed. The MRI service have also had extra planned sessions on occasion to manage demand.

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

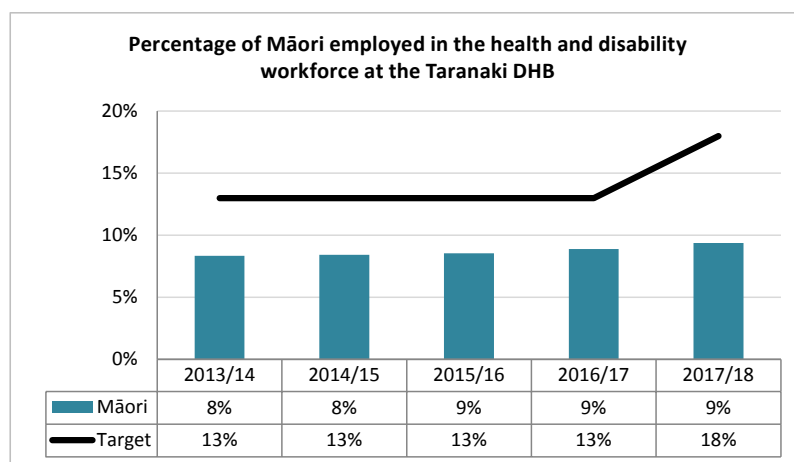


Data Source: Local contract Performance Monitoring

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 services remain readily available and reported in a timely manner.



Data Source: TDHB HR system

Percentage of Māori employed in the health and disability workforce at the Taranaki DHB

Māori	Target Not Achieved
-------	---------------------

The national target is to achieve a Māori workforce that equals the proportion of Māori to the total Taranaki population, which is currently 18%. Although the target has not been met, considerable progress has been made that is not reflected in the statistics reported. The 2016/17 year end baseline was 8.89% Māori while the end of year result for 2017/18 was 9.38%. This represents an increase in actual numbers from 169 to 185, a significant increase in the context of recent year trends.

The WhyOra Māori workforce programme, a joint venture between Taranaki DHB, Ministry of Social Development (MSD) and Taranaki iwi, continues to fill the health career pipeline with 85 Taranaki students in tertiary studies at year end and being actively supported to enter the Taranaki health workforce in the next one to six years. This is an on-going programme that intensively supports students through their health career pathways and into the workforce.

This year, six of the seven available 'WhyOra' Māori nursing graduates were recruited by the TDHB through the Nursing Entry to Practice (NETP) programme while a further 14 Māori from multiple clinical disciplines entered the wider Taranaki health workforce.

The DHB will continue to support the work of WhyOra as its major workforce development programme, and will also intensify the involvement of the DHB's Māori team in the DHB's organisation-wide recruitment programme to exert greater influence on recruitment decisions.



Taranaki District Health Board and Group

FINANCIAL REPORT

» 2017-2018



- 1 The Board and management of the Taranaki District Health Board accepts responsibility for the preparation of the Financial Statements and the judgements 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 2018, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.




Pauline Lockett
Chairperson
25 October 2018



Neil Volzke
Deputy Chairperson
25 October 2018



Rosemary Clements
Chief Executive Officer
25 October 2018



George Thomas
Chief Financial Officer
25 October 2018

Statement of Comprehensive Revenue & Expense For the Year Ended 30 June 2018

	Notes	Group and Parent		Group and Parent
		Actual	Budget	Actual
		June 2018	June 2018	June 2017
		Unaudited		
		\$000	\$000	\$000
Revenue	1	380,730	378,530	363,803
Other income	2	700	1,004	806
Total revenue		381,430	379,534	364,609
Employee benefit costs	3	142,650	136,728	131,137
Depreciation expense	13	17,134	17,658	16,429
Outsourced services		15,809	14,870	16,507
Clinical supplies		30,412	26,523	27,447
Infrastructure and non-clinical expenses		12,001	9,518	14,869
Payments to non-health board providers		162,141	165,657	152,607
Other expenses	4	1,490	2,277	1,437
Capital charge	5	8,226	8,303	4,347
Financing costs	6	-	-	1,457
Total expenses		389,863	381,534	366,237
(Loss) before share of associates		(8,433)	(2,000)	(1,628)
Share of surplus/(loss) of associates	12(c)	144	-	(42)
(Loss) after surplus of associates		(8,289)	(2,000)	(1,670)
Other comprehensive revenue and expense				
Revaluation of land and buildings		49,091	-	-
Total other comprehensive revenue and expense		49,091	-	-
Total comprehensive revenue and expense		40,802	(2,000)	(1,670)

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 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	28	74,000	-	-	-	74,000
Equity repaid to the Crown	28	(959)	-	-	-	(959)
		73,041	-	-	-	73,041
At 30 June 2017		95,246	(15,917)	67,450	844	147,623
Comprehensive revenue and expense						
(Loss) for the year		-	(8,289)	-	-	(8,289)
Change in asset revaluation reserve		-	-	49,091	-	49,091
Transfer from/(to) Trust Funds Reserve		-	65	-	(65)	-
		-	(8,224)	49,091	(65)	40,802
Transactions with the Crown						
Equity repaid to the Crown	28	(958)	-	-	-	(958)
		(958)	-	-	-	(958)
At 30 June 2018		94,288	(24,141)	116,541	779	187,467

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

Statement of Financial Position

As at 30 June 2018

		Group and Parent		Group and Parent
		Actual	Budget	Actual
	Notes	June 2018	June 2018	June 2017
		Unaudited		
		\$000	\$000	\$000
ASSETS				
Current assets				
Cash and cash equivalents	7	317	270	203
Trade and other receivables	8	15,184	10,423	13,173
Inventories	9	3,332	2,833	3,102
Other financial assets	10	2,890	2,890	2,890
Total current assets		21,723	16,416	19,368
Non-current assets				
Investments in subsidiaries	11	-	-	-
Investments in associates	12	1,539	1,395	1,395
Other financial assets	10	56	56	56
Property, plant and equipment	13	220,052	173,914	175,528
Intangible assets	14	1,793	1,418	1,934
Restricted assets & trust funds	15	779	815	844
Total non-current assets		224,219	177,598	179,757
TOTAL ASSETS		245,942	194,014	199,125
LIABILITIES				
Current liabilities				
Cash and cash equivalents	7	4,578	3,521	3,349
Trade and other payables	16	21,355	18,867	20,459
Employee benefits	17	31,604	26,242	26,690
Provisions	18	37	173	110
Total Current Liabilities		57,574	48,803	50,608
Non current liability				
Employee benefits	17	901	686	894
Total non current liability		901	686	894
TOTAL LIABILITIES		58,475	49,489	51,502
NET ASSETS		187,467	144,525	147,623
EQUITY				
Public equity		94,288	94,289	95,246
Retained (losses)		(24,141)	(18,028)	(15,917)
Asset revaluation reserve		116,541	67,449	67,450
Trust fund reserve	15	779	815	844
TOTAL EQUITY		187,467	144,525	147,623

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 25th October 2018



Pauline Lockett
CHAIRPERSON



Neil Volzke
DEPUTY CHAIRPERSON

	Note	Group and Parent		Group and Parent
		Actual	Budget	Actual
		June 2018	June 2018	June 2017
		Unaudited		
CASHFLOWS FROM OPERATING ACTIVITIES		\$000	\$000	\$000
Cash was provided from:				
Receipts from Government and Public		377,756	377,948	364,798
Interest Received		401	320	359
GST (Net)		-	-	57
		378,157	378,268	365,214
Cash was disbursed to:				
Payments to Suppliers		219,904	217,801	212,946
Payments to Employees		137,730	136,258	128,838
Capital Charge Paid		8,226	8,303	4,347
Interest Paid		-	-	1,457
GST (Net)		107	-	-
		365,967	362,362	347,588
Net Cash Inflow from Operating Activities	19	12,190	15,906	17,626
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Dividends Received		71	81	2
Proceeds from Restricted Assets		65	-	-
Proceeds from Sale of Property, Plant & Equipment		121	-	143
		257	81	145
Cash was applied to:				
Purchase of Property, Plant & Equipment		12,604	15,200	11,744
		12,604	15,200	11,773
Net Cash Outflow from Investing Activities		(12,347)	(15,119)	(11,628)
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was applied to:				
Repayment of Equity		958	959	959
		958	959	959
Net Cash Outflow from Financing Activities		(958)	(959)	(959)
Net (Decrease)/Increase in Cash Held		(1,115)	(172)	5,039
Cash and cash equivalents at beginning of year		(3,146)	(3,079)	(8,185)
Cash and cash equivalents at end of year		(4,261)	(3,251)	(3,146)

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

Significant accounting policies for the year ended 30 June 2018**(a) Reporting entity**

Taranaki District Health Board is a Health Board established by the New Zealand Public Health and Disability Act 2000. Taranaki District Health Board is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The financial statements of Taranaki District Health Board have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Finance Act 1989.

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

The Taranaki District Health Board financial statements comprise those of Taranaki District Health Board, a 100% shareholding in Fulford Radiology Services Limited as it has full control. There is also a 17.42% 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 2018. The financial statements were authorised for issue by the Board on 25 October 2018.

(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.

Taranaki District Health Board manages its cashflow to ensure that it operates within available banking facilities whilst it has an operating deficit. This includes ensuring replacement baseline capital expenditure is less than the free cash from depreciation.

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 17.

Fair value of buildings

Taranaki District Health Board revalues land and buildings on either a five year cycle or when there is a material 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) Change in accounting estimate

The only change to the previous years accounting estimates is to increase the estimated life of Buildings. This is to reflect the lives of existing buildings revalued at 30 June 2018.

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 2018.

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 17.42% 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 statement of financial position 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.

(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 2018 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, 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 100 years	1-25%
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**Software acquisition and development**

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Information technology shared services rights

Taranaki District Health Board has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of Taranaki District Health Boards share of investment.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the statement of comprehensive revenue and expense.

(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 28 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	
	2018	2017
	\$000	\$000
Health and disability services (Crown appropriation revenue)*	363,258	347,749
ACC revenue	7,734	7,003
Inter District Patient Inflows	4,593	4,566
Interest received	401	359
Dividends received	71	77
Bad debts recovered	2	5
Other revenue	4,671	4,044
	<u>380,730</u>	<u>363,803</u>

*Performance against this appropriation is reported in the Statement of Performance on pages 34-61. 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	
	2018	2017
	\$000	\$000
Non-exchange transactions	366,853	350,891
Exchange transactions	13,877	12,912
	<u>380,730</u>	<u>363,803</u>

2 OTHER INCOME

	Group and Parent	
	2018	2017
	\$000	\$000
Donations and bequests received	612	728
Gain on sale of property, plant and equipment	88	78
	<u>700</u>	<u>806</u>

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

	Group and Parent	
	2018	2017
	\$000	\$000
Non-exchange transactions	612	728
Exchange transactions	88	78
	<u>700</u>	<u>806</u>

3 EMPLOYEE BENEFIT COSTS

Group and Parent

2018	2017
\$000	\$000

Wages and salaries	138,245	127,326
Contributions to defined contribution schemes	2,131	1,820
Increase in employee benefits provisions	2,274	1,991
	<u>142,650</u>	<u>131,137</u>

4 OTHER EXPENSES

Group and Parent

2018	2017
\$000	\$000

Impairment of trade receivables (bad and doubtful debts)	89	17
Loss on sale of property, plant and equipment	4	-
Audit fees - Deloitte Limited (for the audit of the annual financial statements)	195	190
Audit fees - HSS Limited (ACC Partnership Plan)	5	6
Board and Advisory members fees	277	266
Board fees re Subsidiary Companies	6	8
Operating lease expenses	914	950
	<u>1,490</u>	<u>1,437</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 2018 was 6% (2017: 6%).

6 FINANCING COSTS

Group and Parent

2018	2017
\$000	\$000

Interest on loans - Ministry of Health	-	1,457
	<u>-</u>	<u>1,457</u>

7 CASH AND CASH EQUIVALENTS

Group and Parent

2018	2017
\$000	\$000

Cash at bank and in hand	317	203
Demand funds with NZ Health Partnerships Limited	(4,578)	(3,349)
Cash and cash equivalents	<u>(4,261)</u>	<u>(3,146)</u>
Made up of:		
Asset	317	203
Liability	(4,578)	(3,349)
	<u>(4,261)</u>	<u>(3,146)</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	
	2018	2017
	\$000	\$000
Ministry of Health	5,549	4,881
Due from associates	506	342
Due from non-related parties	8,258	5,836
Prepayments	998	2,188
	<u>15,311</u>	<u>13,247</u>
Allowance for impairment loss (a)	(127)	(74)
Carrying amount of trade and other receivables	<u>15,184</u>	<u>13,173</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	
	2018	2017
	\$000	\$000
At 1 July	74	96
Charge for the year	89	17
Amounts written off	<u>(36)</u>	<u>(39)</u>
At 30 June	<u>127</u>	<u>74</u>

	Group and Parent	
	2018	2017
	\$000	\$000
Total non commercial debt	237	168
Non commercial debt with no impairment allowance	110	94

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 2018 and 2017, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual		Actual	
	2018	2018	2017	2017
	Gross	Impairment	Gross	Impairment
	\$000	\$000	\$000	\$000
Taranaki District Health Board				
Not past due	15,051	-	12,499	-
Past due 1 - 30 days	42	-	90	-
Past due 31 - 60 days	9	-	12	-
Past due 61 - 90 days	3	-	14	-
Past due > 90 days	206	(127)	632	(74)
	15,311	(127)	13,247	(74)

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.

(b) Receivables from exchange and non-exchange transactions

Group and Parent
2018 2017
\$000 \$000

Non-exchange transactions	5,549	4,881
Exchange transactions	9,635	8,292
	15,184	13,173

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

(c) Related Party Receivables

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

(d) Credit Risk and Effective Interest Rate Risk

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

9 INVENTORIES

Group and Parent
2018 2017
\$000 \$000

Pharmaceuticals	465	512
Surgical and Medical Supplies	2,216	1,915
Other Supplies	651	675
	3,332	3,102

Inventory recognised as an expense for the year ended 30 June 2018 totalled \$26.147m (2017: \$23.942m)

The write-down of inventories held for distribution amounted to \$0.073m (2017 \$0.098m). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

Group and Parent	
2018	2017
\$000	\$000

Current portion

Short-term deposits with maturities of 3-12 months	2,890	2,890
	2,890	2,890

Non-current portion

Shares in CDC Pharmaceuticals Limited	56	56
	56	56

11 INVESTMENT IN SUBSIDIARY COMPANIES**Investment details**

Fulford Radiology Services Limited

The principal activity of the subsidiary was 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 (2017: 30 June).

Prior to 30 June 2018 all Fulford Radiology Services Limited staff had transitioned to become Taranaki District Health Board employees. Subsequent to year end the process of formally winding up Fulford Radiology Services Limited has begun.

12 INVESTMENT IN ASSOCIATE COMPANIES

Group and Parent	
2018	2017
\$000	\$000

(a) Investment details

Allied Laundry Services Limited unlisted ordinary shares	1,150	1,150
Allied Laundry Services Limited Share of Retained Earnings	14	(8)
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	375	253
	1,539	1,395

Taranaki District Health Board's share of retained earnings in 2018 relates to the year ended June 2017, plus \$88k for 20% share of HealthShare Limited's unaudited 2018 result.

Details of each Associate Company are as follows:

	Balance date	Interest held at 30 June 2018	Interest held at 30 June 2017
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	17.42%	18.25%

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

(b) Summary of financial information of associate companies (100%)**Summarised unaudited financial information - for the year ended 30 June 2018:**

	Assets	Liabilities	Equity	Revenues	Profit
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	10,506	3,673	6,833	10,590	540
HealthShare Limited	23,352	19,971	3,381	16,888	1,941

Summarised unaudited financial information - for the year ended 30 June 2017:

	Assets	Liabilities	Equity	Revenues	Profit
	\$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

The above information has been extracted from the associate companies unaudited management accounts (2018) and audited financial statements (2017).

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

This is based on an investment in HealthShare Limited of 20% (2017: 20%) and Allied Laundry Services Limited of 17.42% (2017: 18.25%)

	2018	2017
	\$000	\$000
Balance at 1 July	1,395	1,437
Share of total recognised revenues and expenses	144	(42)
Balance at 30 June	1,539	1,395

13 PROPERTY, PLANT AND EQUIPMENT (GROUP AND PARENT)

	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Work in Progress	Total
	\$000	\$000	\$000	\$000	\$000	\$000
Year ended 30 June 2018						
Cost/revaluation 30 June 2017	8,860	152,348	104,126	3,081	9,514	277,929
Accumulated depreciation 30 June 2017	-	(27,694)	(72,577)	(2,130)	-	(102,401)
Carrying amount 30 June 2017	8,860	124,654	31,549	951	9,514	175,528
Current year additions	-	4,348	6,447	717	12,604	24,116
Current year work in progress capitalised	-	-	-	-	(11,512)	(11,512)
Current year revaluations	3,695	45,396				49,091
Current year disposals	-	-	(9)	(28)	-	(37)
Current year depreciation	-	(7,078)	(9,815)	(241)	-	(17,134)
At 30 June 2018 net of accumulated depreciation	12,555	167,320	28,172	1,399	10,606	220,052
At 30 June 2018						
Cost or fair value	12,555	167,320	110,556	3,177	10,606	304,214
Accumulated depreciation	-	-	(82,384)	(1,778)	-	(84,162)
	12,555	167,320	28,172	1,399	10,606	220,052

	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

In the year end 30 June 2018, there are no claims (2017: \$Nil) 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 2018 by Ian D. Baker ANZIV, SNZPI, registered valuer Telfer Young (Taranaki) Limited.

The valuation process was undertaken in accordance with guidelines and recommendations contained within the New Zealand Property Institute (NZPI) Valuation Standard VS-3, the Accounting Standard PBE IPSAS 17 as issued by External Reporting Board (XRB), and valuation guidelines for specialised items in the Health sector issued by Treasury.

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

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

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

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

Impairment

The assessment of assets indicated no impairment for the year ended 30th June 2018 (2017: Nil).

14 INTANGIBLE ASSETS (GROUP AND PARENT)

	ePharmacy Licence \$'000	Shares in NZ HPL \$'000	Total \$'000
Year ended 30 June 2018			
Carrying amount 30 June 2017	516	1,418	1,934
Additions for year	-	190	190
Impairment for year	-	(224)	(224)
Amortisation charge for year	(107)	-	(107)
At 30 June 2018 net of accumulated amortisation	409	1,384	1,793

At 30 June 2018			
Cost or fair value	747	1,608	2,355
Accumulated amortisation and impairment	(338)	(224)	(562)
	409	1,384	1,793

	ePharmacy Licence \$'000	Shares in NZ HPL \$'000	Total \$'000
Year ended 30 June 2017			
Carrying amount 30 June 2016	623	1,418	2,041
Amortisation charge for year	(107)	-	(107)
At 30 June 2017 net of accumulated amortisation	516	1,418	1,934

At 30 June 2017			
Cost or fair value	747	1,418	2,165
Accumulated amortisation and impairment	(231)	-	(231)
	516	1,418	1,934

Finance Procurement Supply Chain, including National Oracle Solution

At 30 June 2018 Taranaki District Health Board had made or was liable for payments totalling \$1,608k (2017: \$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 independently for impairment by comparing the carrying value of the intangible asset to its depreciated replacement cost (DRC). As at 30th June 2018 there is considered to be an impairment of \$224k (2017: \$nil) to Taranaki District Health Board's share of the DRC of the underlying FPSC/NOS assets.

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.

	2018	2017
	\$000	\$000
Opening Balance	844	815
Funds Received	80	72
Interest Received	20	25
Funds Spent	(165)	(68)
Closing Balance Restricted Assets	<u>779</u>	<u>844</u>
	2018	2017
	\$000	\$000
Represented By:		
Cash at Bank	139	212
Short Term Deposits	634	625
Shares & Other	6	7
Total Restricted Assets	<u>779</u>	<u>844</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	
	2018	2017
	\$000	\$000
Trade Payables	18,417	16,823
Income received in advance	448	1,736
Owing to Associates	807	106
GST Payable	1,683	1,794
	<u>21,355</u>	<u>20,459</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 EMPLOYEE BENEFITS

Group and Parent

2018	2017
\$000	\$000

Salary & wages accrual	8,055	5,409
Annual Leave	19,078	17,594
Sick Leave	481	437
Long Service Leave	1,871	1,503
Retirement gratuities	686	683
Continuing Medical Education	2,160	1,665
Sabbatical Leave	174	293
	<u>32,505</u>	<u>27,584</u>

Made up of:

Current	31,604	26,690
Non-current	901	894
	<u>32,505</u>	<u>27,584</u>

Compliance with Holidays Act 2003

Details regarding the provision for underpayments relating to this Act are disclosed in note 32.

18 PROVISIONS

Group and Parent

2018	2017
\$000	\$000

Current provisions

ACC Partnership Programme	37	110
	<u>37</u>	<u>110</u>

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2018. 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 seven years to be \$0.65m (2017: \$0.65m).

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

	Group and Parent	
	2018	2017
	\$000	\$000
Net Loss	(8,289)	(1,670)
Add Non-Cash Items:		
Depreciation	17,134	16,429
Amortisation and impairment of Intangible assets	330	-
Increase/(Decrease) in Provision for Doubtful Debts	53	(22)
Increase in Employee Entitlements	4,920	2,299
Reclassification of prepayment to intangible asset	-	(516)
	<u>22,437</u>	<u>18,190</u>
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	(334)	42
Net (Gain) / Loss on Disposal of property, plant and equipment	<u>(84)</u>	<u>(78)</u>
	<u>(418)</u>	<u>(36)</u>
Movements in Working Capital:		
(Increase) in Receivables & Prepayments	(2,064)	(50)
(Increase) in Inventories	(230)	(305)
Increase in Payables & Accruals	<u>754</u>	<u>1,497</u>
	<u>(1,540)</u>	<u>1,142</u>
Net Cash Inflow from Operating Activities	<u>12,190</u>	<u>17,626</u>

20 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	Group and Parent	
	2018	2017
	\$000	\$000
<i>Board Members</i>		
Remuneration	277	266
Full-time equivalent members	1.6	1.6
<i>Executive management</i>		
Remuneration	2,261	1,771
Full-time equivalent employees	10.0	9.0
Total key management personnel remuneration	2,538	2,037
Total full-time equivalent personnel	11.6	10.6

21 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 \$363.258m from the Ministry of Health to provide health services to the Taranaki area (2017: \$347.749m). The amount outstanding at year end was \$5.549m (2017: \$4.881m).

(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	
		2018	2017	2018	2017
		\$000	\$000	\$000	\$000
TDHB Transactions					
Allied Laundry Services Limited	Dividend and rents received	232	269	85	93
NZ Health Partnerships Limited	DHB national collective service agreements	-	-	-	-
Healthshare Limited	IT consultancy	274	73	716	513
		506	342	801	606

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		Payments by TDHB	
		2018	2017	2018	2017
		\$000	\$000	\$000	\$000
Allied Laundry Services Limited		91	93	1,088	1,035
Fulford Radiology Services Limited		n/a	n/a	n/a	n/a
NZ Health Partnerships Limited		46	130	424	702
Healthshare Limited		716	13	2,520	2,506
		853	236	4,032	4,243

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

22 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
		2018	2018	2017	2017
FINANCIAL ASSETS		\$000	\$000	\$000	\$000
Loans and receivables					
Cash and cash equivalents	7	317	317	203	203
Trade and other receivables	8	14,186	14,186	10,985	10,985
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	779	779	844	844
Total loans and receivables		18,228	18,228	14,978	14,978
	Notes	Carrying amount	Fair value	Carrying amount	Fair value
		2018	2018	2017	2017
FINANCIAL LIABILITIES		\$000	\$000	\$000	\$000
Financial liabilities at amortised costs					
Cash and cash equivalents	7	4,578	4,578	3,349	3,349
Trade and other payables	16	19,224	19,224	16,929	16,929
Total financial liabilities		23,802	23,802	20,278	20,278

The fair value of all of the above financial instruments approximately equal their carrying value.

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

23 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 trade receivables (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% (2017: 97%) whilst it accounted for 96% (2017: 94%) 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**2018**

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	20,907	20,907	20,907	-	-	-
	20,907	20,907	20,907	-	-	-

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	-	-	-
	18,723	18,723	18,723	-	-	-

(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)	
	2018	2017
	\$000	\$000
+1% (100 basis points)	29	29
-1% (100 basis points)	(29)	(29)

24 CONTINGENT LIABILITIES

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

25 CAPITAL COMMITMENTS AND OPERATING LEASES

	Group and Parent	
	2018	2017
	\$000	\$000
Capital Commitments		
Property, plant and equipment	2,080	907
	<u>2,080</u>	<u>907</u>

Operating leases as lessee

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

	Group and Parent	
	2018	2017
	\$000	\$000
Not later than one year	485	893
Later than one and not later than two years	180	480
Later than two and not later than five years	286	415
Later than five years	111	145
	<u>1,062</u>	<u>1,933</u>

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

Taranaki District Health Board recorded a deficit of \$8.29 million compared to a budgeted deficit of \$2.00 million.

Revenue received during the year was \$1.896 million over budget as follows (2017: \$0.425m decreased):

	Variance	Variance
	2018	2017
	\$000	\$000
Health and disability services (Crown appropriation revenue)	1,304	(1,367)
Accident Compensation Revenue (ACC)	514	1,832
Inter District Flows	31	246
Inter Provider Revenue	71	229
Interest Received	81	159
Donations Received	(392)	(1,275)
Other	287	(249)
	<u>1,896</u>	<u>(425)</u>

Income Statement Revenue Explanations

Ministry of Health Funding	Funding for Pay Equity and additional Ministry of Health funding for programmes which was not budgeted
Accident Compensation Revenue (ACC)	Increased activity, offset by associated increased expenditure
Donations	Shortfall in donation receipts against budget

Income Statement Variances - Expenditure

Expenditure was \$8.329m in excess of budget as follows (2017: less by \$0.797m):

	Variance	Variance
	2018	2017
	\$000	\$000
Income Statement Expenditure Explanations		
Employee Benefit costs	5,922	101
Depreciation expense	(524)	(582)
Outsourced services	939	4,139
Clinical supplies	3,889	1,992
Infrastructure and non-clinical expenses	2,483	5,992
Payments to non-health board providers	(3,516)	(9,542)
Other	(864)	(2,897)
	<u>8,329</u>	<u>(797)</u>

Income Statement Expenditure Explanations

Employee Benefit costs	Additional staffing to meet increased acute demand, one on one patient care, to comply with MECA provisions, and increased wage settlements over budget assumptions
Depreciation expense	Deferral of capital expenditure, and the timing of investment
Outsourced services	Increased acute activity, increased ACC expenditure, and increased diagnostic costs
Clinical Supplies	Increased activity and additional electives delivered against contract
Infrastructure and non-clinical expenses	Shortfall in realising efficiencies against a savings plan, and increased operational costs over budget assumptions
Payments to non-health board providers	Positive inter district flow washups, and reduced demand for home based support and residential care

	Variance	Variance
	2018	2017
	\$000	\$000
Balance Sheet Variances		
Cash and cash equivalents	(1,010)	2,931
Trade and other receivables	4,761	(2,277)
Property, plant and equipment	46,138	(765)
Intangible assets	375	516
Trade and other payables	2,488	(1,787)
Employee benefits	5,577	1,384
Interest bearing loans and borrowings	-	(74,000)

Balance Sheet Explanations

Cash and cash equivalents	Impact of deficit on cashflow
Trade and other receivables	Positive year end wash ups, and rebates together with additional contract revenue to the Ministry of Health
Property, plant and equipment	Land & Building Revaluation
Intangible assets	Amortisation of ePharmacy licence, and impairment of shares in NZHPL
Trade and other payables	Capital works with payments spread over future years
Employee benefits	Additional employees and unsettled collective agreements

27 AUDITORS' REMUNERATION

		Group and Parent	
		2018	2017
		\$000	\$000
Fees to principal auditor (Deloitte Limited)	Note		
Audit of annual financial statements	4	195	190
		2018	2017
		\$000	\$000
Other Audit Fees paid (non Deloitte Limited)	Note		
HSS Limited (ACC Partnership Program)	4	5	6

28 CAPITAL MANAGEMENT

Taranaki District Health Board's capital is its equity, which comprises public equity, accumulated revenue and expense and asset revaluation reserve.

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

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.

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 \$0m (2017: \$74m) of Equity. Public equity of \$0.958m (2017: \$0.959m) was repaid to the Crown during the year. The repayments in both 2018 & 2017 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.

29 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 2018	Actual 2017
100,000 - 110,000	46	42
110,001 - 120,000	35	16
120,001 - 130,000	18	11
130,001 - 140,000	8	11
140,001 - 150,000	6	13
150,001 - 160,000	6	2
160,001 - 170,000	7	7
170,001 - 180,000	9	6
180,001 - 190,000	10	7
190,001 - 200,000	7	6
200,001 - 210,000	5	6
210,001 - 220,000	3	7
220,001 - 230,000	9	5
230,001 - 240,000	6	5
240,001 - 250,000	8	4
250,001 - 260,000	3	2
260,001 - 270,000	1	4
270,001 - 280,000	4	2
280,001 - 290,000	2	11
290,001 - 300,000	7	3
300,001 - 310,000	3	-
310,001 - 320,000	3	1
320,001 - 330,000	3	2
330,001 - 340,000	1	2
340,001 - 350,000	5	-
350,001 - 360,000	-	5
360,001 - 370,000	2	-
370,001 - 380,000	1	-
380,001 - 390,000	1	-
400,001 - 410,000	1	-
470,001 - 480,000	1	-
	<u>221</u>	<u>180</u>
Clinicians	182	150
Non Clinical	39	30
Total	<u>221</u>	<u>180</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 281 (2017: 224).

30 TERMINATION PAYMENTS

For the period to 30 June 2018, 4 employees or former employees of Taranaki District Health Board received payment in respect of termination of employment for \$50,400 (2017: 7 payment totalling \$153,437).

31 CHANGE IN ACCOUNTING ESTIMATE

Taranaki District Health Board reviewed the estimated useful lives of its fixed assets as part of the fair value assessment performed on land and buildings as at 30 June 2018. This review indicated that the actual lives of certain buildings were longer than the estimated useful lives used for depreciation purposes in the financial statements. As a result, effective 30 June 2018, Taranaki District Health Board changed its estimates of the useful lives of its buildings to better reflect the estimated periods during which these assets will remain in service. The estimated useful lives of the buildings that previously ranged 4 to 60 years were increased to a range of 4 to 100 years. The effect of this change in estimate will be prospectively applied, and will be to reduce depreciation expense and increase net income.

32 COMPLIANCE WITH HOLIDAYS ACT 2003

Many public and private sector entities, including Taranaki District Health Board, are continuing to investigate historic underpayment of holiday entitlements.

For employers such as Taranaki District Health Board that have workforces that include differential occupational groups with complex entitlements, non standard hours, allowances and/or overtimes, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

District Health Boards have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each District Health Board to systematically assess their liability.

Taranaki District Health Board has estimated its liability as at 30 June 2018 to be \$ 650k (2017: \$ 650k).

Taranaki District Health Board has undertaken internal assessments for payroll system compliance. Based on the sample tested and with further testing required Taranaki District Health Board has estimated a \$ 650k liability.

The estimate is based on the best information available to Taranaki District Health Board at balance date but, due to the uncertainties involved, the actual liability could be different.

33 EVENTS SUBSEQUENT TO BALANCE DATE

The winding up of Taranaki District Health Board's 100% subsidiary Fulford Radiology Services Limited commenced after 30 June 2018. Fulford Radiology Services Limited is not trading, and has no assets or liabilities at the 30 June 2018.

» 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	<ul style="list-style-type: none"> Code of Conduct Equal Employment Opportunities (EEO) Taranaki DHB value statements – Nga Tikanga Performance Review Policy 	<ul style="list-style-type: none"> Employee Engagement Survey (2017 & 2018) 'Te Ahu Taranaki' Values (2018 launch) 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 	<ul style="list-style-type: none"> Leadership and team development aligned with Taranaki DHB strategy New values and behaviours to support Taranaki DHB strategy Develop employee engagement undertaken in 2018 	<ul style="list-style-type: none"> New suite of leadership & team development programmes for 2017/2018. The following have been implemented: <ul style="list-style-type: none"> ➢ Advanced Leadership for a small number senior leaders ➢ 'Front-Line' Leadership (22 participants) ➢ Team Development, Collaboration & External Partnering (27 participants) Launch of Te Ahu Taranaki new Values (2018) Employee Engagement Survey (2017 & 2018). Programme to develop employee engagement by implementing engagement outcomes undertaken in 2018
Recruitment, Selection Induction	<ul style="list-style-type: none"> Recruitment and Selection Policy Recruitment Guideline Procedure Induction and Orientation Policy Worker Safety Check Policy and Procedures 	<ul style="list-style-type: none"> Comprehensive Induction Programme with elements online combining eLearning modules Post-Entry Survey (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 Behaviour-based recruitment 	<ul style="list-style-type: none"> Better management of the online talent pool to access suitable candidates Use of social networking to target youth Vulnerable Children's Act and the implementation of procedures relating to this legislation Focus on hard to fill occupations to reduce re-advertising 	<ul style="list-style-type: none"> National Health Careers website targeting students, return-to-work and international candidates Continue to collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand Continue to collaborate with the 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 Introduce Values-based questions into patterned interview formats; use of personality profiles in recruitment

Element/ Measurement	Describe formal policies or procedures	Other Practices	Priority issues	Action taken
Employee Development, Performance, Promotion and Exit	<ul style="list-style-type: none"> Study, conference and course leave Termination of Employment Policy and Procedure Medical Incapacity Policy Professional Development Policy Performance Review Policy Performance and Disciplinary Policy Employment Agreements Continuing Medical Education (CME) policy 	<ul style="list-style-type: none"> Exit interview and survey Coaching available to all staff Clinical supervision Employee Assistance Programme (EAP) 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 Performance appraisal 	<ul style="list-style-type: none"> Revised education plan for 2017 Continuing development of e-learning resources Enabling technology for accessing learning tools Further rollout of non-regulated workforce training – NZQA Review of performance review tools and processes to increase feedback Rollout of the OMA process for nursing functions 	<ul style="list-style-type: none"> 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 Launch of new performance appraisal framework (2018)
Employee Engagement	<ul style="list-style-type: none"> Flexible Working - Request and Complaints Procedure Collective employment agreements Worker Engagement and Participation Agreement Recognition framework – Values based (see below) 	<ul style="list-style-type: none"> Work in conjunction with individuals and unions in consultative manner Organisational Mapping and Alignment Programme (OMA) for Nursing functions Employee Well-being initiatives Stress & Resilience resources for employees 	<ul style="list-style-type: none"> Employee engagement assessment Employee wellbeing Recognition framework – Values based (see below) 	<ul style="list-style-type: none"> Employee Engagement Survey (2017 & 2018) and implementation (see above) National (20 DHB's) Framework for Employee Wellbeing launched Active Wellbeing programme in place Values based Peer-to-Peer Recognition scheme launched (2018) On-going provision of Stress & Resilience seminars & workshops
Remuneration, Recognition and Conditions	<ul style="list-style-type: none"> Job Evaluation Procedure Recognising Long Service Procedure Collective employment agreements Recognition framework – Values based 	<ul style="list-style-type: none"> Comprehensive Progression/ Merit criteria via collective agreements 	<ul style="list-style-type: none"> Recognition framework – Values based 	<ul style="list-style-type: none"> Promoting employee benefits for all staff Values based Peer-to-Peer Recognition scheme launched (2018)
Harassment and Bullying Prevention	<ul style="list-style-type: none"> Harassment Policy and Procedure Employee Assistance Programme 	<ul style="list-style-type: none"> Interpersonal skills programmes Coaching/training Union reps Conflict resolution Workplace Behaviours programme – training and educational resources 	<ul style="list-style-type: none"> Keep momentum around behaviours initiative and messages Revise messages in the behaviours programme to enable organisational culture change Launch revised Bullying and Harassment Policy 	<ul style="list-style-type: none"> Review of Workplace Behaviours project undertaken and further work commenced Review of Taranaki DHB Bullying and Harassment Policy commencing (2018) Education sessions to be held in various departments
Pay Gap – Pay Equity	<ul style="list-style-type: none"> Recruitment and Selection Policy Recruitment Guideline Procedure Flexible Work Policy 	<ul style="list-style-type: none"> Participation in National 20-DHB initiatives, including pay equity claims being co-ordinated centrally by TAS 	<ul style="list-style-type: none"> 93% of employees are covered by MECA's and SECA's so there is no gender pay gap for this group. 80% of staff are female. Limited evidence of gender pay gaps exists. 	<ul style="list-style-type: none"> Active participation in National & Regional pay equity programmes

Element/ Measurement	Describe formal policies or procedures	Other Practices	Priority issues	Action taken
EEO	<ul style="list-style-type: none"> Equal Employment Opportunities / Diversity Policy Recruitment and Selection Policy Recruitment Guideline Procedure Flexible Work Policy 	<ul style="list-style-type: none"> Impartial selection of candidates in recruitment process Recognition of employment requirements for Māori, ethnic or minority groups and persons with disabilities WhyOra Māori recruitment programme 'Subliminal Bias' training workshops Engaging with Māori seminars to increase awareness of Māori culture, including recruitment, patient contact and working relationships Complement of people permanently employed after participation in work skills development programme 	<ul style="list-style-type: none"> Increasing the number of Māori is a key strategic priority. 9% of employees are Māori vis-à-vis a Taranaki population of 19%. 	<ul style="list-style-type: none"> Through recruitment process, offering people the ability to have whanau present during an interview Taranaki DHB, local iwi groups and community trusts fund the WhyOra Māori recruitment unit. This organisation provides programmes that support Māori to enter the health sector workforce in Taranaki. Over the last 6 quarters the rate of Māori recruitment has improved to 13% compared to the existing employee percentage of 9%.
Safe and Healthy Environment	<ul style="list-style-type: none"> Health and Safety specific policies and procedures Risk management and compliance policies and procedures 	<ul style="list-style-type: none"> 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 Member of ACC's Accredited Employer 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 Security 	<ul style="list-style-type: none"> Retaining entry to the ACC Accredited Employer programme (against new standards) 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 Conduction a Business or Undertaking (PCBUs) Strengthening our health and safety reporting processes and outputs Strengthening our training especially at manager level in regard to expectations Utilising our Health & Safety Reps in day to day health and safety work 	<ul style="list-style-type: none"> ELearning HSWA for managers Health and Safety requirements in all job description templates and included in all staff performance reviews Updating of existing health and safety policy and procedures to ensure compliance with the Health and Safety at Work Act 2015 12 new Health & Safety reps have started in the last year and all have attended Stage 1 Rep training Have improved our new staff follow up process in regard to vaccination status A hearing conversation programme including training has commenced Continue to work with Engineering Service staff on contractor management – this will expand to other contractors in the 2018-19 year Asbestos survey undertaken and Asbestos Management Plan being finalised Due to emergency response activity in the last year, we are incorporating lessons learned in our planning and response actions. Recreation society available to all staff Wellness Committee has run and number of wellness initiatives throughout the year Commenced a programme of work to review and improve security for staff, patients and visitors

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