

Taranaki District Health Board
Te Poari Hauora-ā-Rohe o Taranaki

ANNUAL REPORT

Pūrongo ā-tau

2018-2019



TARANAKI
District Health Board

Our Shared Vision / Te Matakite

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



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WELCOME

Haere mai

Kia Ora and welcome to the Annual Report for Taranaki District Health Board for 2018-2019.

We are pleased to present the Taranaki District Health Board (Taranaki DHB) Annual Report for the year 1 July 2018 to 30 June 2019.

We would like to acknowledge and thank all the Taranaki DHB 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.

Taranaki DHB depends on the experience, skills, 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. We could not have made it through this year without everyone going the extra mile and working above and beyond to provide the care patients need around the clock. We also thank the work of our community partners, NGOs, PHOs, volunteers and support groups who work tirelessly to improve the health services and outcomes for our community.

While the year has had its challenges we have also made some significant achievements. Throughout the year Taranaki DHB has funded services to the value of \$368 million 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. It deliberately pursues a new approach that will bring fundamental changes through the adoption of new models of care, workforce roles and technologies. 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 endorsed by Te Whare Punanga Korero Trust. 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.

Improving patient access and population health outcomes continue to be a priority for our DHB. We have seen some tangible results from the implementation of Project Connect - the Community Health Integration Centre (CHIC) referral programme as it continues its work to better connect primary, community and secondary services for our high needs patients. It enables adult referrals to be managed from one single point to better coordinate services. Last year the focus was on sorting out how to centralise referrals, improve referral criteria and processes, and improve

risk stratification and more. This year we have operationalised this work to coordinate community services and provide more support for patients who have high needs or are at risk, ensuring a much more patient centred care approach. A strong emphasis has also been placed on developing collaborative relationships with the local communities and health and social agencies to strengthen the support for patients and their family/whānau.

We have continued to improve the planning and management of staffing costs while also increasing new graduate clinical staff. The Taranaki health workforce continues to be strengthened through collaboration with Health Workforce New Zealand, the Midland Regional Training Network and with local partners such as The Western Institute of Technology and Whakatipuranga Rima Rau (WhyOra). WhyOra continues to do an excellent job of preparing students from year nine through to tertiary studies to train and move into the local health and disability workforce. WhyOra received a prestigious Philanthropy NZ, AMP People's Choice Award for a kaupapa Maori initiative that is achieving excellent results in its community.

Hawera Hospital's postgraduate Rural Hospital Medicine training programme for registrars received accolades this year. Dr Emma Davy was awarded the James Reid award for Excellence and Innovation in Rural Health for her work to set up and run rural health training programmes for rural hospital medicine registrars and fifth year medical students at Hawera Hospital.

Taranaki Base Hospital's first patient to have an Endo Vascular Aortic Repair (EVAR) in Taranaki took place this year. Prior to this, Taranaki patients with this type of aneurysm were sent to Waikato for surgery but thanks to a team of Taranaki DHB specialist doctors and other staff, as well as the hospital's state-of-the-art angiography suite, the patient was treated and was able to recover in Taranaki.

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).

Our approach to accelerating Māori health gain has been underpinned by Te Matakite Māori Health Plan together with a nationally standardised set of performance measures and monitoring framework. The Midland region is recognised as having a much higher proportion of Māori than any other region in New Zealand. Therefore, raising the profile of Māori health and eliminating health inequities has been a focus for the five DHBs. In June 2019 a Memorandum of Understanding (MoU) was signed between the Midland Region Governance Group (MRGG) and the Midland Iwi Relationship Board. The MoU formalises a longstanding partnership between our two governance groups and reinforces our shared commitment to supporting the delivery of quality, patient centred care.

Taranaki already has a number of successful health and wellbeing initiatives working for families in the community. Examples of these are Taranaki Toa, Hapū Wānanga and Whānau Pakari. This year Whānau Pakari founder, Paediatrician Dr Yvonne Anderson's thesis about the programme aiming to improve health equity was selected for a Liggins Institute Vice-Chancellor's Prize for the Best Doctoral Thesis.

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. Taranaki DHB's Public Health Unit (PHU) worked closely with the New Plymouth District Council (NPDC) over a few months to improve the health of the community, starting with installing more drinking water fountains in public areas.

We acknowledge the wonderful work of the Taranaki Health Foundation and are very grateful for the difference the Trust makes to our healthcare system's resources. During this year the Trust raised \$425,000 for the DHB

and this will go towards improving 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.

This year we received the final engineering reports and recommendations about the earthquake prone status of its buildings at Taranaki Base Hospital. The reports provided further validation for the DHB's plans, already underway to improve the structural integrity of the hospital campus including the new east wing acute hospital building to be completed 2023 or sooner. In September the Ministry of Health's Capital Investment Committee (CIC) advised the DHB they support the progression of Project Maunga - Stage two of the Taranaki Base Hospital Redevelopment Project and gave us the green light to develop the Indicative Business Case which was submitted in May. If approved we will proceed to the Detailed Business Case which will be completed by the end of 2019. Thank you to those involved in the project. It's an exciting step for Taranaki DHB and the community and its going to be exciting to see this gain momentum in the coming year.

The MORE Award, an ongoing staff peer to peer recognition programme to acknowledge "Moments Of Recognition Everyday." was launched this year. The MORE Award is designed to promote behaviour that demonstrates Te Ahu Taranaki DHB Values by recognising the people who are living the values every day at work, including: Partnership/Whanaungatanga, Courage/Manawanui, Empowerment/Mana motuhake, People matter/Mahakitanga, Safety/Manaakitanga. Since its launch it has been positive to see a number of staff acknowledging the hard work and success of others and giving awards to those people who are going the extra mile at work.

The following pages provide a brief snapshot of some more exciting developments underway, and the busy life and achievements of our health sector from the past year.

We would like to say a big thank you to everyone who plays a part in working tirelessly day and night for our patients and community. We look forward to working with and for the people of Taranaki in the year ahead.



Pauline Lockett
Chair



Rosemary Clements
Chief Executive



Te Pahunga (Marty) Davis
Chair, Te Whare Punanga Korero Trust



OUR PEOPLE

Te hunga mahi

Healthcare is about people helping people.

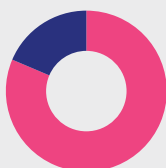
In Taranaki we have a great team of health professionals and support staff all working together for our community.

**figures as at 30 June 2019*

2,101 employees

Gender

1,711 Female
390 Male



Type of employment

973 permanent part-time
649 permanent full-time
327 casual
152 fixed term & temporary



792

Nurses



238

Doctors



Position type

1,021 Nursing
(includes midwives and health care assistants)
347 Allied
320 Administration
238 Doctors
130 Non Health Support
45 Management

184

Health care
assistants



45

Midwives



44

Laboratory
employees



31

Physiotherapists



Ethnic group

1,630 New Zealand European
196 Asian
195 Māori
38 Other
26 Not declared
16 Pacific Islander



PROFILING TARANAKI

Te ao hauora o 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

29
aligned GP
practices



26

Aged residential care facilities



Community,
laboratory
and radiology
services

30
pharmacies



19
Dental
practices

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



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



5
Providers of
Community
Health for
Older People
Services



3
Māori Health
Service
providers

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



POPULATION PROFILE

According to Statistics New Zealand, in 2018/19 Taranaki DHB served a population of 119,800* people.

The Māori population is projected to increase to 21.7% 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, and is expected to age further in the future. The total number of people over the age of 65 is 20,980 (17.5%), with 7.8% of these being Māori.

A total of 38,440 people are under the age of 24 (32.1%), the number of Māori in this age group is 11,780 which represents 52.3% of Māori in the region.

SOCIO-ECONOMIC INDICATORS

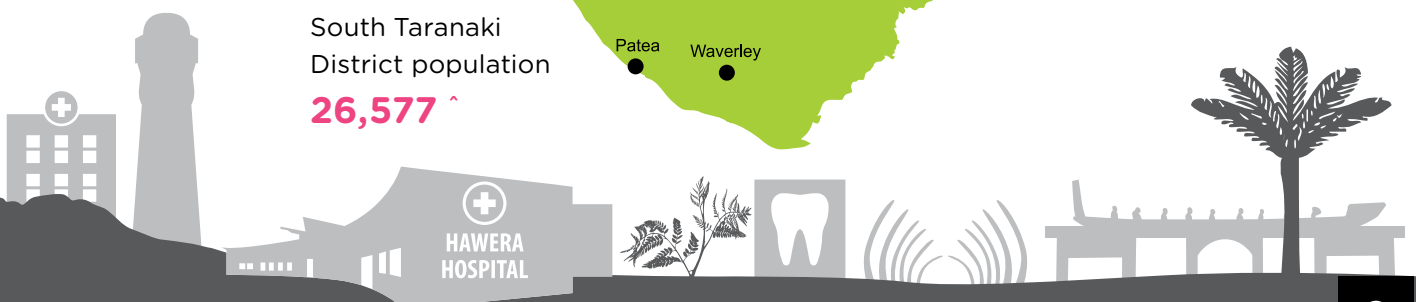
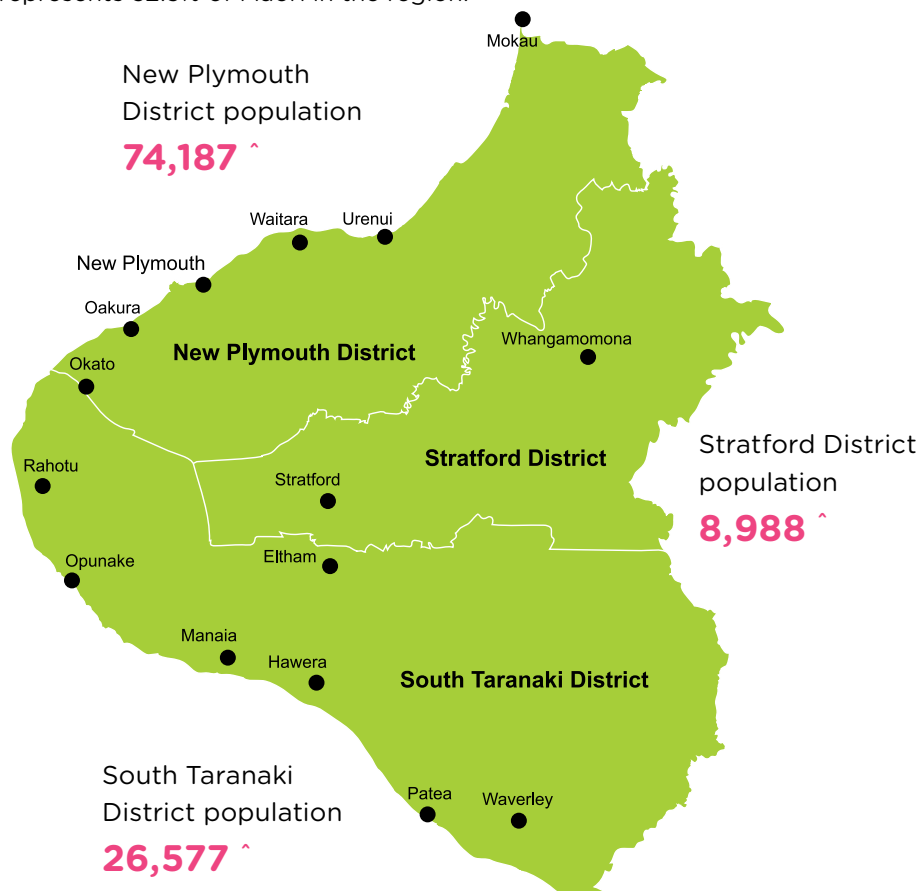
The Taranaki population sits around the centre of the socio-economic range.

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 socioeconomic 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 2018*

^ Based on usually resident population, 2013 Census



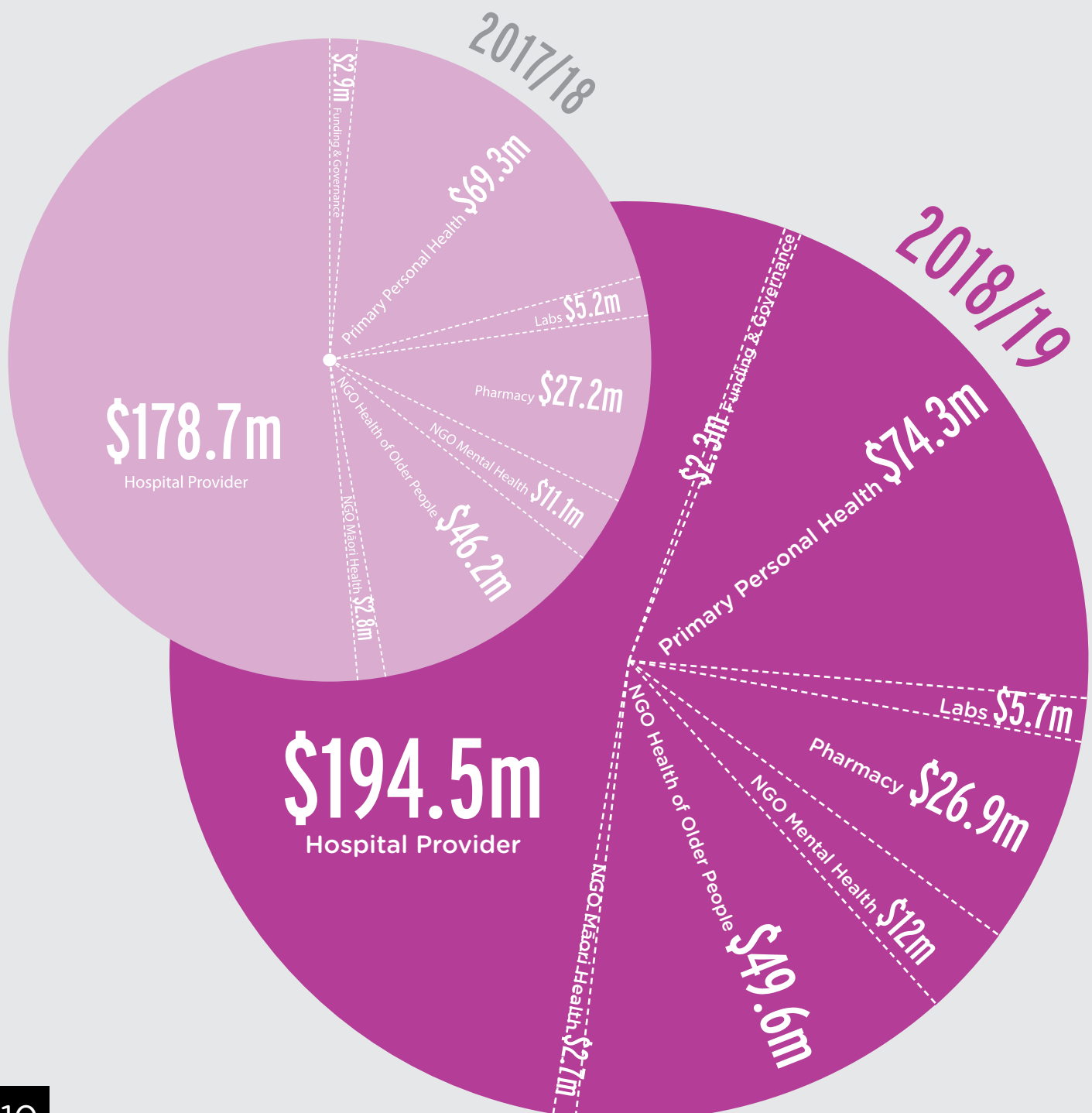
WHERE THE MONEY GOES

Te tohanga pūtea

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

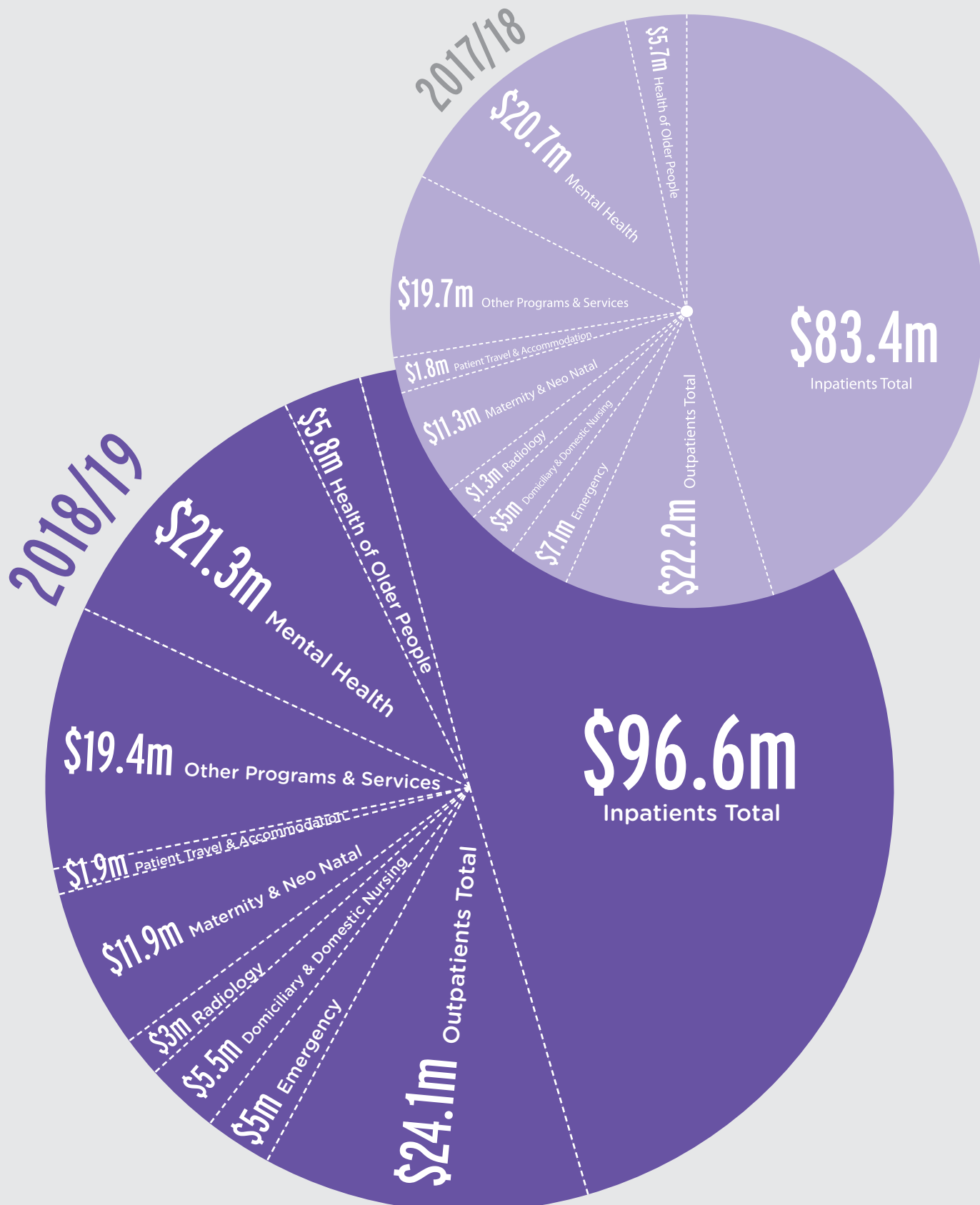
Taranaki DHB Planning and Funding allocation

In 2018/19 the Planning and Funding division allocated its funding of \$368 million as follows:



Hospital and Specialist Services allocation

The \$194.5 million allocated to the Hospital and Specialist Services during 2018-19 was further allocated as follows:



*Figures have been rounded.

MĀORI HEALTH PERFORMANCE

Te hau oranga Māori

Achieving equity in access and outcomes for Māori is a priority for Taranaki DHB. This is supported in the Taranaki Health Action Plan and highlighted in the DHB's Annual Plan in the form of 'Equity Outcome Actions'.

Championed by its iwi-based strategic partner Te Whare Punanga Korero Trust, the DHB endorsed the commitment to "Kia tū rangatira ai ngāi Māori ki te ara kākārīki", journey to the greens, a symbolic reference to transforming the dashboard of Māori health priority indicators from red to green according to the colour chart below. It is anticipated that 'Equity Outcome Actions' if successful, will accelerate progress towards achieving equity of access and outcomes for Māori.

The table below summarises Taranaki DHB's performance during 2018/19 against the Māori health priority indicators 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 2018	Māori June 2019	Non Māori June 2019	Progress to target	Disparity Gap June 2019	Disparity Progress
NATIONAL PRIORITIES									

1	Data Quality	1. Ethnicity data accuracy in PHO registers	Not available	Not available	Not available	Not available	Not available	Not available	Not available
There is no formal indicator definition or data available for this indicator.									

2	Access To Care	2. Percentage of Māori enrolled in PHOs	90% (2018 target was 97%)	87.1%	86.4%	97.4%	▼	-11%	↑
<p>An improvement of 3.6% or 849 more Māori is needed to reach the national target of 90.0% in Taranaki.</p> <p>The rate is lower than it potentially could be in part due to one general practice and its patients not being enrolled in the PHO, and also people in the Waverley and surrounding districts being enrolled with a general practice that is based in Taranaki but registered with Whanganui PHO. That would likely account for only a small number of Māori non-enrolments.</p> <p>The increase in Māori enrolment rates from previous years reflects some targeted enrolment promotion work undertaken by the Māori Health Unit in 2017/18. Efforts will be intensified during 2019/20 to improve these results including reinstating the location of a Pou Hapai in ED to amongst other things identify Māori presenting at ED who are not enrolled with a GP and supporting them to enroll.</p>									

		3. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for the age group 0-4yrs	5,200 (2018 target was 6,437)	8,929	8,863	6,842	▲	-22%	↓
<p>The ASH target for Taranaki has changed again this year reducing from 6,437 to 5,200. Taranaki continues to be well short of the target despite having improved over the 12 month period.</p> <p>A number of interventions were initiated this year with the following targeting Māori specifically:</p> <ul style="list-style-type: none"> A referral pathway was developed and trialed from Ward 2B Children's Ward to WISE Better Homes home insulation programme with the aim of increasing insulation of homes of children admitted for respiratory conditions. The pathway once settled will be extended across other wards and services to increase home insulation as much as possible as an effective prevention/early intervention strategy Hapū Wānanga, a kaupapa Māori-based antenatal parenting education programme continued to be delivered Taranaki-wide. It has been highly successful in increasing reach to Māori hapu wahine. A wide range of information is shared on ante and postnatal care of pepi and whānau. The aim is to build Hapū Wānanga as the primary medium for educating and raising awareness on Māori health priority issues including breastfeeding, immunisation, safe sleep, smoking, oral health, GP enrolment and accuracy of ethnicity data. Wise better homes referrals and education sessions were held within the scope of Hapū Wānanga. This has proven to be a successful approach in terms of reach to whānau in need. <p>The System Level Measure ASH 0-4 yrs group is considering a range of interventions that will be implemented 2019/20 with the aim of reducing the ASH 0-4yrs rates further (see SLM plan in the Taranaki DHB Annual Plan 2019/20).</p>									

		4. Ambulatory Sensitive Hospitalisation rates per 100,000 for the age group 45-64 yrs	5,166 (2018 target was 4,160)	9,239	9,920	4,686	▼	-52.8%	↑
<p>The difference in ASH rates per 100,000 between Māori and non-Māori (aged 45-64) has worsened between 2017/18 and 2018/19.</p> <p>ASH 45-64 rates increased in the winter of 2016, and have remained at that level since. The equity gap between Māori and non-Māori has generally remained similar, with a slight increase in the last quarter.</p> <p>The reasons for this general increase are complex and multifactorial. Taranaki DHB has been focusing on a refreshed acute demand strategy that will further help manage patients at the right time and the right place. However, this success has been dwarfed by significant increases in higher acuity patients presenting to ED. From a conditions perspective, we continue to see angina and chest pain as the dominant ASH presentation. As such, the 2018/19 year has seen us focus on increasing the range of acute primary options made available to general practice, develop a more closely aligned and focused respiratory service that keep patients out of hospital, implementation of the Health Care Homes model across Taranaki general practices and integration of the fracture liaison service with the PHO falls prevention service to reduce the likelihood of further injury and related hospitalisation.</p> <p>In addition the establishment of the Community Health Integration Centre (CHIC), aims to help patients receive more consistent, timely and coordinated care through better navigation and coordination of the health services they receive (e.g. fewer referrals lost in the system, more appropriate referrals, more timely responses from services, comprehensive health assessments and MDT care plans, more appropriate onward referral to key services). Te Kāwau Maro Māori provider alliance are key stakeholders in these developments.</p>									

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2018	Māori June 2019	Non Māori June 2019	Progress to target	Disparity Gap June 2019	Disparity Progress
NATIONAL PRIORITIES									
3	Child Health	5. Exclusive breastfeeding at 4-6 weeks	75%	58.9%	Not available	Not available	Not available	Not available	Not available
		6. Exclusive breastfeeding at 3 months	70%	45.5%	41.7%	58.6%	▼	-16.9%	↓
		7. Receiving some breast milk at 6 months	60%	Not available	Not available	Not available	Not available	Not available	Not available
<p>Improving breastfeeding rates and reducing the inequity that persists between Māori and non-Māori, continues to be a challenging priority for Taranaki DHB. The result for 2018/19 is disappointing as this demonstrates that breastfeeding rates at three months have dropped for both Māori and non-Māori despite the delivery of a number of initiatives aimed at supporting breastfeeding mothers. The equity gap has closed slightly by 0.3% since last year.</p> <p>In recent months a comprehensive review of lactation consultant and breastfeeding support services in our region has been undertaken to identify ways to improve our breastfeeding rates in future. In addition to this, over the last year we have continued to operate a Lactation Consultant Scholarship Programme and have attracted two new Māori kaimahi with strong links to the Māori community to undertake this training. We have also recently extended community Lactation Consultant support services in South Taranaki in order to target greater support to those areas where we have identified lower breastfeeding rates and higher deprivation.</p> <p>Hāpu Wānanga is a relatively new programme which includes kaupapa Māori based antenatal education regarding breastfeeding. The impact of Hāpu Wānanga coupled with access to more lactation consultancy support once current trainees become fully competent, is expected to become evident in 2019/20.</p> <p>Data is not available for breastfeeding at six weeks and six months. These indicators were discontinued during the year.</p>									
4	Cancer	8. Cervical screening, among eligible population	80%	76.3%	76%	82.8%	▼	-6.8%	↑
<p>Cervical screening 25-69yrs (three year) for Māori in Taranaki DHB reached 76% in the January - March 2019 period. This represents a 0.6% decline and 0.4% increase in disparity since 2018. An improvement of 4.0% or 191 more Māori women need to be screened to reach the national target of 80.0%.</p> <p>For 2019/20 to achieve 80% coverage for all ethnic groups and overall, the plan is to:</p> <ul style="list-style-type: none"> Work in partnership with local health providers to improve access to cervical screening services to ensure participation for at least 80% of women aged 25-69 years in the most recent 36 month period with a priority focus on Māori women. Activities will include a funded health promotion programme targeting Māori and delivered by kaupapa Māori health provider(s) that aims to increase uptake of cervical screening rates and improve equity for Māori through promotion at community events, targeted media advertising, networking with iwi providers and engagement in professional development activities. Work with Pinnacle Midlands Health Network (PHO) to identify opportunities for enhancing data and enrolment systems in order to improve targeted communication to Māori and other high risk/vulnerable populations such as Asian women for due and overdue screening. 									
		9. Breast screening among eligible population	70%	61.4%	60.8%	75.3%	▼	-14.6%	↓
<p>Disparity has decreased slightly from -15.1% now -14.6</p> <p>Breast screening 50-69 years for Māori in Taranaki DHB reached 61.4%. This represents a 0.3% decline 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).</p> <p>Activities to make an improvement in the screening rates and to improve equity outcomes for Māori was the initiation of a HEAT review in Q3/Q4 of breast screening services across Taranaki and to uncover the pertinent issues regarding the service provided by Taranaki Breast Screening Coast to Coast (BSC2C) and the role and purpose of health providers involved in this part of the health system. We aim to work with those who hold the contracted services within BSC2C to address the findings of the Health Equity Assessment of breast screening services in Taranaki to identify needs and service gaps and to inform the development and implementation of strategies that will improve equity of access and outcomes for Māori and Pacifica women.</p>									
5	Tobacco	10. Proportion of babies who live in a smokefree household at six weeks post natal <i>New Ministry of Health denominator</i>	73%	Not available	19.9%	46.7%	Not available	-26.8%	Not available
<p>This indicator has changed from "Percentage of pregnant Māori women who are smokefree at two weeks postnatal" to "Proportion of babies who live in a smokefree household at six weeks post natal".</p> <p>New data standards for this measure came into effect in January 2019 and accuracy of the data for 2018/19 may be impacted. It is expected that data quality and accuracy will improve over time as WCTO providers implement the new standards. .</p> <p>Tui Ora Ltd continues to work with priority GP practices to ensure Māori patients are prioritised for referral into the Taranaki Stop Smoking Service. Tui Ora staff also attends Hāpu Wānanga to provide information and support to the hapū māma and their whānau.</p>									

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2018	Māori June 2019	Non Māori June 2019	Progress to target	Disparity Gap June 2019	Disparity Progress
NATIONAL PRIORITIES									
6	Immunisation	11. Percentage of infants fully immunised by eight months of age	95%	81.3%	89.1%	91.7%	▲	-2.6%	
<p>Immunisation (eight months) for Māori infants in Taranaki DHB reached 89.1% representing a 7.8% improvement on the 2017/18 result and a reduction in disparity to 2.6%. Immunisation of an additional eight Māori infants is needed to achieve the target of 95%.</p> <p>Efforts to improve immunisation rates were focused on implementing Health Equity Assessment recommendations centred on improving primary care access, increasing GP-midwife engagement, enhancing local PHO administration systems and understanding the map of immunisation services within Taranaki. Better opportunities for health providers to immunise children when in other roles was also addressed (such as B4 School Check).</p>									
		12. Seasonal influenza immunisation rates in eligible population	75%	42.3%	43.3%	58%	▲	-14.7%	↑
<p>Increase in the gap from 11.5% to 14.7%</p> <p>There is a low influenza rate currently across New Zealand. More pharmacies are now providing this service.</p>									
7	Rheumatic Fever	13. Number and rate of first episode rheumatic fever hospitalisations	0.3/100,000	0	0	0	↔	0	↔
There have been no first episode Rheumatic Fever hospitalisations in the past three years in Taranaki.									
8	Oral Health	14. Pre-school dental enrolments	95%	78.7%	78.1%	116%	▼	-37.9%	↑
<p>Whilst the total population has met the target, there has been a slight decline in enrolment for Māori pre-school children. This has been looked at as part of the 0-4 year dental treatment Did Not Attend (DNA) project which indicates that Māori are un-enrolled from the oral health services where they DNA. Improvement in oral health DNAs is expected to impact enrolment rates as well.</p> <p>This accuracy of data for preschool dental enrolments may be impacted due to ongoing reporting issues with the dental software.</p>									
9	Mental Health	15. Mental Health Act Section 29 Community Treatment Orders (CTO)	89	190	233	94	▼	59.7%	↑
<p>Section 29 of the Mental Health Act for Māori in Taranaki DHB reached 233 per 100,000 per year for the 12 months ending Year to March 2019. This represents use of Section 29 with 54 Māori individuals (Trendly).</p> <p>Taranaki DHB initiated a project to reduce CTOs through:</p> <ul style="list-style-type: none"> Discharge planning Introducing flexible packages of care for community-based services with secondary contracts. <p>Midlands Region undertook a review of the reduction in Section 29 Compulsory Treatment Order Project in which Whaiora were reported as having predominantly expressed positive experiences as they transitioned from across the continuum of care. They identified components of the transition where things could have assisted them on their journey. The review contains a number of recommendations to address these issues which are being considered by the regional mental health network.</p>									
10	SUDI	16. Five year average annualised SUDI infant deaths by DHB region	0	1.9	1.9	0.6	↔	69.6%	↔
<p>The most current data is from Quarter 2 2016/17.</p> <p>A SUDI prevention/maternity smokefree coordinator was recruited this year to look at safe sleep practice and referrals to smoking cessation. Since October, 39 referrals were made for safe sleep spaces.</p> <p>Hapū Wānanga has a safe sleep component with parent participation. Participants receive safe sleep resources such as Wahakura and safe bedding (wool and cotton).</p> <p>There is insufficient disparity data to make the comparison of inequality at this stage.</p>									

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2018	Māori June 2019	Non Māori June 2019	Progress to target	Disparity Gap June 2019	Disparity Progress
LOCAL PRIORITIES									

11	Access to services	1. Did not attend (DNA) rate for outpatient appointments	5%	16.5%	18.1%	5.1%	▼	-13.0%	↑
<p>DNAs continue to be a challenging priority for the DHB. Our focus remains on oral health services for children 0-4 years and diabetes clinics which together account for approx half of the DHB's outpatients DNA rate.</p> <p>A Health Equity Assessment (HEA) that looked at the barriers for 0-4 year olds has been completed and is currently informing a Hawera/South Taranaki DNA project to improve attendance rates. 0-4 year DNAs are un-enrolled from the oral health services thereby impacting the enrolment target, so improvement here will likely impact enrolment rates as well.</p> <p>In terms of Diabetes Education services, a health literacy review was completed.</p>									

12	Workforce Development	2. Percentage of Māori employed by the DHB	18%	9.4%	9.3%	N/A	▼	8.7% to target	↑
<p>The proportion of Māori recruited by Taranaki DHB hasn't increased this year despite increasing numbers of Māori being recruited. This is due to the increase in total FTE that has occurred.</p> <p>WhyOra continues to do an excellent job of filling the workforce pipeline from Year 9 through to tertiary studies and into the local health and disability workforce. WhyOra received a prestigious AMP People's Choice Award for a kaupapa Māori initiative that is achieving excellent results in its community, from Philanthropy NZ. This is outstanding testament to the work WhyOra is doing and to the success of its unique model.</p> <p>Taranaki DHB's chief executive announced the DHB's commitment to recruiting 100% of Māori nursing graduates that successfully complete their training requirements. This makes nursing as a career a strong platform for WhyOra to champion nursing as an attractive option for secondary students to pursue.</p> <p>Te Pa Harakeke continues 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>Te Pa Harakeke also began targeted delivery of cultural competency 'Treaty DHB & Me' training to improve the organisational response to the needs of Māori.</p>									

Performance analysis

Of the 14 national (excluding breast feeding six weeks and six months) and two local indicators:

- There has been minimal progress towards targets, having improved on three only – ASH 0 to 4 years, immunisation at 8 months and influenza vaccinations for 65+ year olds.
- Progress towards targets has declined on ten of the national targets and both local targets.
- Inequality reduced on four, increased on seven and stayed the same on two national priorities.
- Inequality increased on the two local priorities despite that absolute numbers improved.

There is insufficient data to be able to make a comparison on one national indicator (SUDI) while the two breastfeeding targets that were withdrawn during the year are not included in this analysis.

HIGHLIGHTS

Ngā hua o te tau

The following pages provide a snapshot of some of the collaborative work and highlights that have taken place within Taranaki DHB in the 2018-19 year.



Taranaki DHB's Cancer Coordination team from left to right: Sophie Cunningham, Sue Piper, Jenny Corban, Fran James and Nikki Spedding.



Antenatal classes in a cultural setting

Māori women and their whānau have enjoyed better access to antenatal classes based on kaupapa Māori practices and principles, thanks to birth education programme Hapū Wānanga which was launched by Taranaki DHB in 2018.

Over the past year Hapū Wānanga has offered 10 free workshops around Taranaki to help pregnant women better understand pregnancy, birth and raising tamariki. A total of 106 women attended throughout the year, 96 who were of Māori descent.

The workshops have incorporated a new feature for fathers-to-be this year with the introduction of a Mana Tāne panel, where prominent Taranaki men share their experiences as fathers. Whānau are also benefitting from an eco-friendly education session to learn about the correct disposal of nappies, wipes and general household products. Education also focusses on increasing the use of reusable materials to have a more positive impact on Papatūānuku, our earth.

Cancer team more coordinated

Taranaki DHB's Cancer Coordination team has increased its staff to help improve the service for Taranaki patients suspected of having cancer.

The team has gone from having one member only to a multidisciplinary team of specialist nurses, social workers, psychologists and administration staff. Together they work to ensure patients receive the best quality and equitable oncology care within accepted timeframes. This means working closely with GPs, hospital doctors, nurses, cancer society, referrals, the booking centre and most importantly patients and their family/whānau.

To overcome location limitations for people living with cancer in Taranaki, the team has started virtual clinics with Palmerston North radiation oncologist Dr Claire Hardie. This allows Taranaki patients to see their consultant and have a specialist nurse in the room without having to travel away from home.

Another new development this year is the Taranaki men's exercise group – Proactive, supported by the Cancer Society. The DHB offers the group exercise, education and 'mateship' for men in the region who have or are receiving treatment for cancer, most commonly prostate cancer.

New monitors for Taranaki Base and Hawera hospitals

In September eight new monitors the DHB purchased were installed into the Emergency Department's resuscitation rooms and high acuity areas at Base and Hawera hospitals.



Hawera Hospital Emergency Department team with one of the new monitors



Taranaki benefits from more water fountains

Taranaki's Public Health Unit (PHU) collaborated with New Plymouth District Council this year to increase the number of drinking water fountains in public areas, after a PHU study revealed a lack of accessible free water in parks, playgrounds and major walkways in the region.

The Ministry of Health recommends that plain water should be the beverage of choice for children and adults. Medical Officer of Health Dr Jonathan Jarman says "The installation of more public water fountains will help with a number of child health issues that Taranaki faces, including childhood obesity and dental decay. Taranaki is the second most affected region in New Zealand for childhood obesity – almost 20 per cent, or 4,500 children."

The first two water fountains have been installed at Ngamotu Domain and Kawaroa Playground, with more fountains planned in the following year to help ensure the healthy choice is the easy choice.

Hawera doctor wins award for setting up rural medicine training programmes

Dr Emma Davey won the James Reid award for Excellence and Innovation in Rural Health for her work to set up and run rural health training programmes for rural hospital medicine registrars and fifth year medical students at Hawera Hospital. She said she was humbled to receive the award and have the programmes, which are the result of a strong collaborative effort from across many different areas of the hospital, recognised on a national level.

Hawera Hospital is an accredited teaching hospital and runs the DHB's postgraduate Rural Hospital Medicine training programme for registrars. The rural hospital medicine programme was established in 2008 to train doctors to be rural generalists in hospitals or as GPs.



Stand up, speak out and act to prevent violence

Taranaki DHB staff wore white ribbons and black and white t-shirts to show they do not condone violence towards women for White Ribbon Day on 25 November.

This year's theme was Stand up, speak out and act to prevent violence. A provocative scene of an unhealthy relationship was displayed at Taranaki Base Hospital to highlight intimate partner violence as a form of social entrapment. The display urged people to think and talk about how abuse can be emotional, physical or sexual. Staff members of the Violence Intervention Programme were able to have valuable conversations with patients and hospital visitors who took interest in the White Ribbon Day display.

Project Connect - the Community Integration Health Centre is up and running

Taranaki DHB's Community Integration Health Centre (CHIC) continues its work to better connect primary, community and secondary services for our high needs patients. Improving our management of referrals from one central point is really important to improving access to DHB services for patients. In late March 2019 the CHIC unit was established and started receiving referrals from community, allied and some specialist services. Once a referral is received by the CHIC, the team provides an initial holistic assessment of the referral. This includes ensuring that a patient's health needs are cared for in the most appropriate setting. The CHIC clinical assessors maintain a proactive approach with the aim to create a seamless experience for the patient. Referrals and enquiries will continue on a forward path rather than returned with no outcome or plan offered. The CHIC also assists with referrer and patient enquiries, providing accurate and timely information. Alongside this, the CHIC is placing a strong emphasis on developing collaborative relationships with the local communities, health and social agencies to strengthen the support for patients and their family/whānau.



Director of the Liggins Institute at the University of Auckland Professor Frank Bloomfield (left) and Taranaki DHB CE Rosemary Clements celebrate the achievements of Dr Yvonne Anderson (right).

Yvonne Anderson achieves top honours for Whānau Pakari PhD

Six years of hard graft have paid off for Dr Yvonne Anderson who has graduated with high praise from the Liggins Institute at Auckland University for her Whānau Pakari research. Yvonne's thesis about the programme, titled 'Whānau Pakari: a multi-disciplinary intervention for children and adolescents with weight issues', was one of five thesis' selected out of 392 doctoral degrees awarded in 2018 for a Vice-Chancellor's Prize for the Best Doctoral Thesis.

In 2012 Yvonne's work with childhood obesity led to her founding the community-based, family-centred Whānau Pakari programme and then to studying its effects. "We realised we needed to do some scientific study or process and that led to me doing the PhD," she says.

The programme supports children and their whānau wanting to overcome weight issues and make healthy lifestyle choices by providing physical assessments, fun activities, one-on-one and family support, cooking sessions, virtual supermarket tours and input from dietitians and psychologists.

Dr Anderson says, "It's been really exciting to be part of something that's improving health equity".

Woman of Influence

Dr Yvonne Anderson was nominated for the Women of Influence Awards, recognising and celebrating women from all walks of life who make a positive difference in the lives of their fellow New Zealanders. Dr Anderson's passion for working to improve the health and wellbeing of all children led her to be a finalist in the Innovation and Science category for her work with child obesity. Dr Anderson was one of 83 New Zealanders short listed for the awards which were held in September 2018.



From left: Dr Aysinia Sibanda, Heather Holdaway and Mr Murray Cox.

EVAR surgery performed in Taranaki for the first time

Taranaki Base Hospital's first patient to have an Endo Vascular Aortic Repair (EVAR) or Aneurysm surgery in Taranaki took place in May 2019. Prior to this, Taranaki patients with this type of aneurysm were sent to Waikato for surgery but thanks to a team of Taranaki DHB specialist doctors and other staff, as well as the hospital's state-of-the-art angiography suite, the patient was treated and was able to recover in Taranaki. The EVAR technique had been widely used for the last 20 years, but Taranaki had never had the right team or equipment to be able to carry out the operation. There are many advantages to having the procedure performed locally. One is patient convenience, two is there are some cost savings, and three is it maintains and develops the skills of staff members in the radiology suite.

Taking prime care of whānau

Three services sit under Tui Ora's community nursing team: Asthma Support, Cancer Navigation and Long-Term conditions which is diabetes, cardiac and lung conditions. All three prioritise Māori and high needs clients who face barriers to receiving adequate service.

Tui Ora's approach is unique. The key to success is due to the team taking a whole person-whole whānau approach, making it different from other similar services in the region. While clinicians focus on diagnosis and are responsible for a patient's treatment pathway, the community nursing team can provide support by being responsive and having the flexibility to go into a client's home. This model of care helps to break down barriers and involve the whole whānau to make decisions that will support a person to live to the best of their ability with their illness or diagnosis.

Taranaki DHB is the largest funder of health service contracts and we contract Tui Ora Ltd to provide a range of services through the Te Kawau Māro alliance, who hold the single contract for Māori health services in Taranaki.



Te Puna Hauora o Taranaki

TARANAKI HEALTH FOUNDATION BOARD

The Foundation has enjoyed a very stable governance group for the last few years and celebrated its 20th birthday this year. We have undergone strategic planning processes throughout the year to ensure we are geared for fundraising excellence over the next few years.

Board Members include: Adrian Sole (Chairperson), Brian Ropitini (Deputy Chairperson), Murali Bhaskar, Pauline Locket, Peter McDonald, Antony Rhodes and Greg Simmons. The Board is supported by General Manager - Bry Kopu and Foundation Administrator, Vivian Lewis.

WHAT WE ACHIEVED IN 2018/19

The Taranaki Health Foundation has had much to celebrate this financial year, with new projects capturing the hearts and minds of the Taranaki community. Our donors and partners deserve our gratitude because without them we would not have achieved the stunning results we have to date. During this financial year we were able to transfer \$425,000 to the DHB in both sponsorship, gifts in-kind and donations.

PERFORMANCE REPORTING

The Foundation received an unqualified audit in 2018 and awaits the completion of the 2018/19 accounts. An Annual Report will be submitted to the Charities Service by 31 December 2019, 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 in December 2019 and made available on the Charities Service www.charities.govt.nz early January 2020.

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

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. From Hardship to Hope Fund is positively supporting families in need and is going from strength to strength with renewed sponsorship and new projects picked up each year.

THE FUTURE

Whilst we have been focusing on many 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.

COUNTDOWN KIDS HOSPITAL APPEAL 2018

In 2018, we received \$52,000 from Countdown Supermarket following a successful regional fundraising effort that will have on-going benefits for Paediatric care of Taranaki children and young people. The grant provided new portable equipment to monitor patients acute respiratory conditions in both Hawera and Base Hospitals, a new hoist for our Child and Adolescent Community Centre to support our most vulnerable patients with disabilities and a new art wall planned in the dedicated TSB Children and Young Person Ward.



Events that supported our fundraising included a Charity Golf Day, Special Quiz Night, Raffles and Bake Sales and Runway for a Reason, outlined below.



RUNWAY FOR A REASON 2018

New Plymouth teenager Emma Kingi, 17, worked with the Foundation to conceptualise Runway for a Reason, a fashion show featuring the latest spring and summer fashion trends. Kingi was the force behind the fashion fundraiser to support the health needs of children and youth in Taranaki. Kingi organised over 40 volunteers of all ages to model, dance and prepare for the sold out show. This was a unique youth led event that raised over \$3000.

SUPPORTING SAFE SLEEP IN TARANAKI

The Foundation continues to engage the community with handicrafts that connect families with natural bedding for babies that promote safe sleep practices. Donations of wool, cotton sheets and knitted blankets and clothing are donated annually to hundreds of families in need.

Safe Sleep Day in December 2018, encouraged more than 300 people to gather and hear safe sleep messages at a Teddy bear's picnic at Brooklands Zoo. This annual event is co-organised by the Foundation and the Taranaki DHB Safe Sleep coordinator, Beki Madden. The goal of the day is to celebrate National Safe Sleep Day, adults and youngsters, received messages to promote safe sleep and smokefree practices and celebrate our volunteers.



GOVERNANCE STRUCTURE

Tāhuhu kāwanatanga

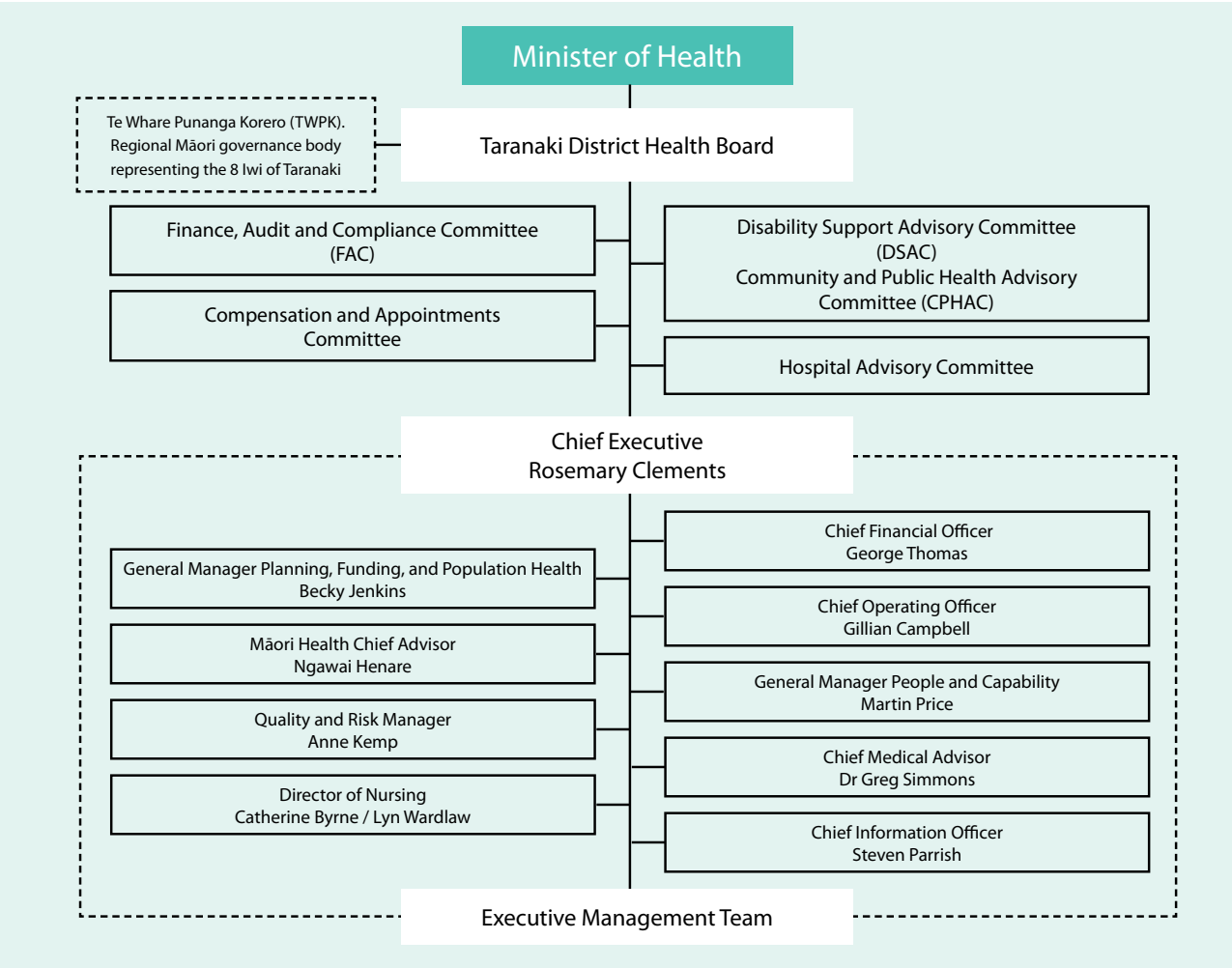
The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process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

The Board is responsible for the overall governance of 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 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

Ngā kainoho Poari

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 2019): 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 ten 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 2019): 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; 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 25 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, completing 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.

Interest Register (as at 30 June 2019): 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; Health Research Council Ngā Kānohi Kitea, Recipient; Ngāti Moeahu Hapū, Secretary; Parihaka Papakāinga Trust, Secretary; Te Paepae o Te Raukura Incorporated, Parihaka, Secretary; 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 2017. 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 2019): 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 2019): 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 2019): Board Member of Age Concern Taranaki; 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 2019): 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. Inspired by her mokopuna, she is especially interested in the wellbeing of our future generations. 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 2019): Access Radio Taranaki Trust – Trustee & Chairperson; Bashford Nicholls Charitable Trust – Trustee; Bishop's Action Foundation – Trustee; Hohaia van Paassen Limited – Principal Consultant, Shareholder & Director, also contracted to Te Puni Kōkiri for project facilitation services to the Parihaka Papakāinga Trust; 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; Trinity Home & Hospital Limited – Director; Waiōkura Marae & Reserves Trust – Trustee

Bev Gibson



Bev is a practicing registered nurse, an engagement consultant with Māori clients/whānau and case managers for ACC. She has extensive years of knowledge in primary, secondary, tertiary and community health. Bev has a Bachelor of Arts majoring in Nursing and Education, a Postgraduate Diploma in Health Service Management and a Masters in Management. She is an advocate of high-quality early intervention/prevention programmes and a promoter of self-care physical/mental health wellbeing.

Interest Register (as at 30 June 2019): Independent Contractor – ACC Cultural/Clinical Advisor; Director of Quality Visions Limited (QVL); Director of the Parininihi Ki Waitotara (PKW); Chair of PKW Human Resource Committee; Chairman of Te Korowai O Ngāruahine Trust; Director of Te Kiwai Maui O Ngāruahine Limited; Chair of Mahia Mai a Whai Tara Kaumatua Service, Trustee of Tamariki Pakari and Independent Trustee of Lantern Trust.

David Lean



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

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

Interest Register (as at 30 June 2019): Daughter is a TDHB employee; Deputy Chair Taranaki Regional Council; Chair – Rahotu Dairy Ltd; Chair – David Lean & Associates Ltd; Surf Life Saving New Zealand – Life Member; Trustee – Cameron Clow Trust.

Harry Duynhoven



Harry is New Plymouth-born and bred and is married to Margaret, with whom he has three adult children. He has served the community in many different roles, including Member of Parliament, Mayor and is currently on the New Plymouth District Council. He was appointed a member of the NZ Civil Aviation Authority board in June 2019. 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 is a member of Ngamotu Rotary Club.

Interest Register (as at 30 June 2019): 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).

Te Pahunga (Marty) Davis



Born in Hawera and schooled in Taranaki and Auckland and have been residing in Whanganui since 1976.

Worked 30 years in Agriculture and Fisheries including 10 years in management.

Returned to work for Ngā Rauru Kītahi Iwi for 10 years as its CEO and Chief Negotiator before becoming the CEO of Ngāti Ruanui Iwi in Hawera for four years and concurrently elected to the pre-settlement board of Ngāruahine and joined their negotiation team.

At the beginning of 2014 I returned to Whanganui and was elected the Tumu Whakarae of Te Kāhui o Rauru Trust and in 2018

Although “retired” I remain the chair of Te Whare Punanga Korero and Te Whakatipuranga Rima Rau Trust and a Trustee of Tuituia Trust and the Taranaki Māori Trust Board and a Taranaki Maunga negotiator

I am a trustee at Ohangai, Waioturi and Tauranga Ika Pā and whakapapa to Ngā Rauru Kītahi, Ngāti Ruanui, Ngā Wairiki Ngāti Apa and Ngāruahine.

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

Interest Register (as at 30 June 2019): 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	HealthShare Ltd	Fees Paid (\$)
Board Members - 2018/19								
Pauline Lockett	*11 of 11	6 of 6	4 of 5	11 of 11	✓			44,100.00
Neil Volzke	^11 of 11	6 of 6	5 of 5	11 of 11				29,149.46
Alison Brown	10 of 11	6 of 6	5 of 5	10 of 11				24,120.00
Rose Bruce	9 of 11	3 of 6	2 of 5	Not a member				20,120.00
Harry Duynhoven	10 of 11	4 of 6	4 of 5	Not a member				20,870.00
Bev Gibson	9 of 11	5 of 6	✓ 4 of 5	Not a member				21,245.00
Richard Handley	10 of 11	6 of 6	4 of 5	✓ 10 of 11	✓			24,495.00
Te Aroha Hohaia	8 of 11	2 of 6	✓ 3 of 5	8 of 11				22,307.50
David Lean	11 of 11	6 of 6	5 of 5	11 of 11				24,370.00
Kevin Nielsen	10 of 11	✓ 6 of 6	4 of 5	✓ 10 of 11	✓			24,245.00
Aroaro Tamati	8 of 11	✓ 3 of 6	3 of 5	Not a member				10,612.50
Te Pahunga (Marty) Davis	8 of 11							2,000.00
Patsy Bodger		3 of 6	5 of 5					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 Kāhui o Te Whare Punanga Kōrero

Te Whare Pūnanga Kōrero Trust is the Māori Health Governance Group which works strategically with the Taranaki District Health Board (DHB) to improve Māori health and reduce and eliminate Māori health inequalities. The members of the trust represent the eight iwi of Taranaki – Ngā Rauru, Ngati Ruanui, Nga Ruahinerangi, Taranaki, Te Atiawa, Ngati Maru, Ngati Mutunga and Ngati Tama - and in terms of the Memorandum of Understanding it has with Taranaki DHB, 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 Taranaki DHB Board activities throughout the year:

- Two joint meetings of the TWPK and Taranaki DHB Boards at which the main focus of discussion was progress against the Māori Health Plan 2018/19
- 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 Taranaki DHB Board members

Participation in these activities enables TWPK to influence the DHB's decisions in a strategic capacity.

Te Whare Pūnanga Kōrero Trust representing the eight iwi of Taranaki:



Back row: **Te Oti Katene** (Ngaruahinerangi), **Rawinia Leatherby** (Taranaki iwi), **Eileen Hall** (Ngati Maru), **Ngapari Nui** (Ngati Ruanui)

Front row: **Greg White** (Ngati Tama), **Te Pahunga (Marty) Davis** (Ngaa Rauru), **Patsy Bodger** (Te Atiawa), **Howie Tamati** (Ngati Mutunga)

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF TARANAKI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2019

The Auditor-General is the auditor of Taranaki Health Board (the Health Board). 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 Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 61 to 90, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 32 to 57.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the *Basis for our qualified opinion* section of our report:

- the financial statements of the Health Board on pages 61 to 90:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2019; 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 Health Board on pages 32 to 57.
 - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, 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 29 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we draw out 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.

Basis for our qualified opinion

As outlined in note 24 on page 85, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of \$0.95 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

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

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

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosure made on page 65 that outline the financial difficulties being experienced by the Health Board in relation to operating and cash flow forecasts. The Health Board has determined that it is a going concern, because it has obtained a letter of support from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

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

The Board is responsible on behalf of the Health Board 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 Health Board for assessing the Health Board'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 Health Board 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 Health Board'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 Health Board'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 Health Board'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 Health Board'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 Health Board 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 communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 28, page 60 and pages 91 to 94, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

We are independent of the Health Board 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 Health Board.



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

STATEMENT OF SERVICE PERFORMANCE

Ngā whanaketanga ratonga

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 2018/19 by grouping our activities into the population long and medium term impacts we intended to influence.

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

Notes:

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

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

Taranaki DHB planned and actual revenue and expenditure allocated to output classes 2018/19

Output Class	Planned Revenue (\$000's)	Actual Revenue (\$000's)	Planned Expenditure (\$000's)	Actual Expenditure (\$000's)
Prevention	8,318	8,460	8,608	8,541
Early Detection and Management	90,444	91,991	93,600	84,014
Intensive Assessment and Treatment Services	241,829	245,964	250,268	271,628
Rehabilitation and Support	52,938	53,843	54,786	59,538
TOTAL	393,529	400,258	407,262	423,721

Our performance story

Our Vision	Taranaki Together, a healthy Community – Taranaki Whānui 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
Outputs ²	<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

² The outputs described are examples only.

OUTCOME 1

People are supported to take greater responsibility for their health

Expectation

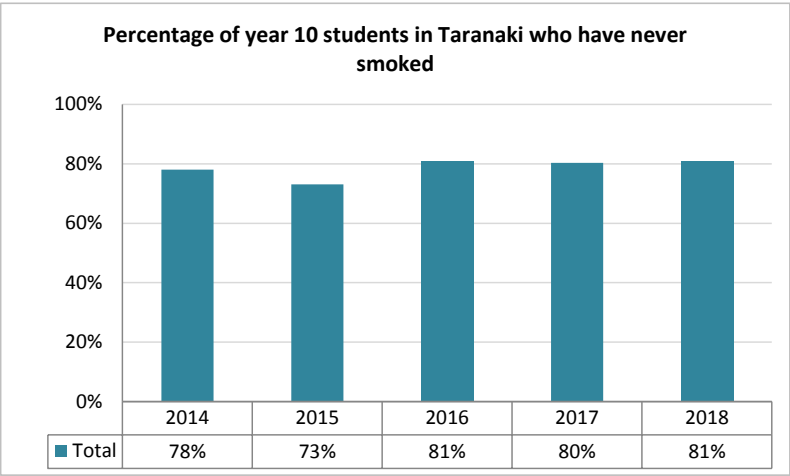
Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. These programmes create health-promoting physical and social 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.

Impact Measures



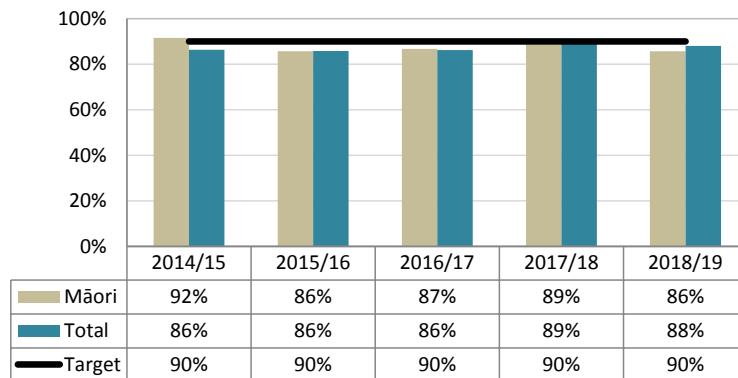
Data Source: Action on Smoking and Health (ASH) annual survey.
2018 Data is based on preliminary results and is subject to change

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

It is pleasing to see an overall increase in Year 10 Taranaki students who have never smoked. This is in line with a declining national trend in young people initiating smoking as measured by the Action for Smokefree 2025 (ASH) Year 10 Survey. Taranaki youth that are recorded as never having smoked remain consistently over 70%. 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 smokers in primary care seen in the last 12 months provided with smoking cessation advice and support



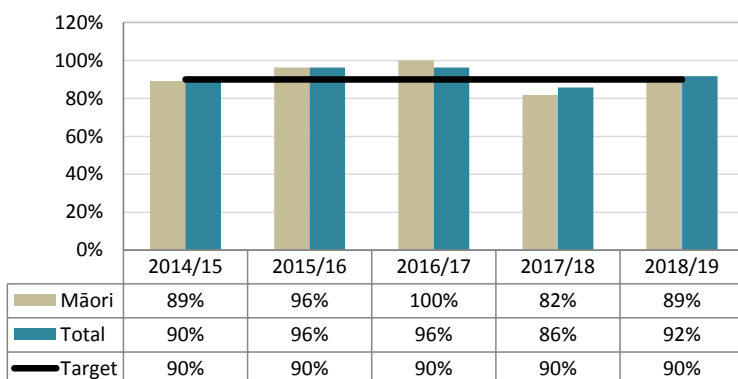
Data Source: MOH

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

88% percent of people in Taranaki, and 86% of Taranaki Māori, received smoking cessation advice and support. This is below the national target of 90%. Pinnacle Midlands Health Network (PHO) uses their data management systems to identify smokers and support practices to provide support and advice to their patients. In 2019/20 greater emphasis is being placed on both the number and the quality of engagement with people who smoke to ensure that more people, particularly priority populations such as Māori and pregnant women, are referred to and receive support to quit through our Taranaki Stop Smoking Service (TSSS).

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



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 Achieved

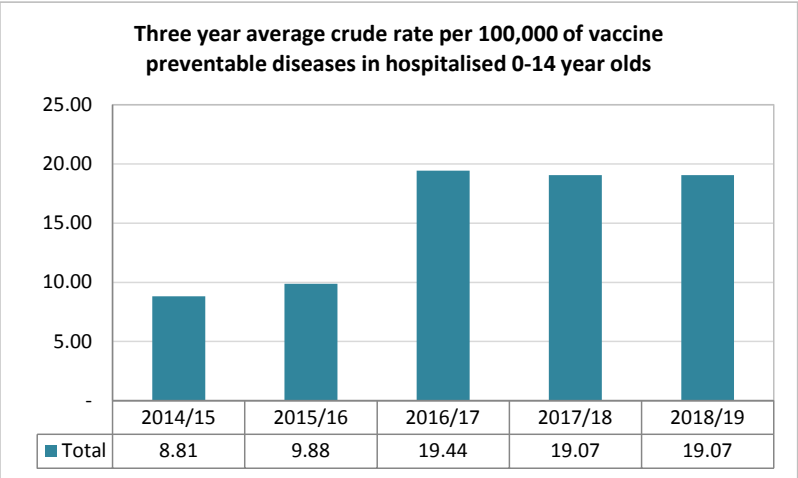
It is pleasing to see that a greater percentage of pregnant women who smoke are offered brief advice and support to quit. We are also seeing an increasing number of referrals of pregnant women to the Taranaki Stop Smoking Service and a subsequent increase in the number of pregnant women quitting smoking. The employment of a maternity smokfree coordinator has helped deliver this improvement, as has greater engagement of Māori women into Taranaki DHB's Hapū Wānanga programme.

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.

Impact Measures

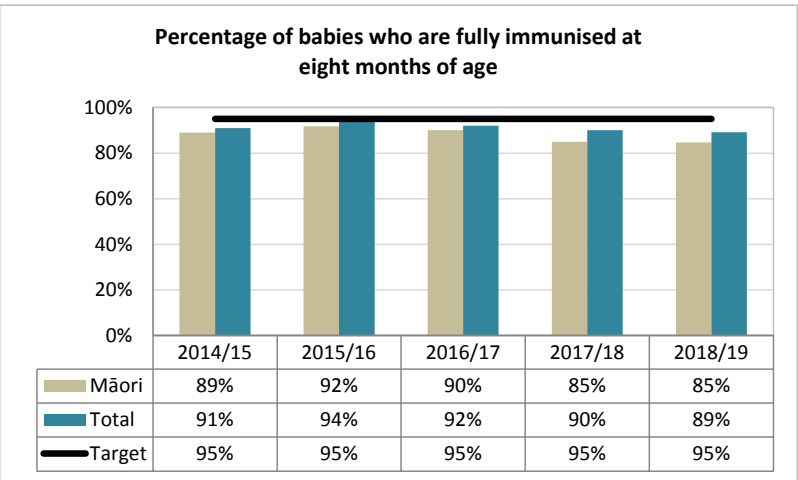


Data Source: Ministry of Health National Minimum Dataset

Reduction in vaccine preventable diseases

There has been no change in the 2018/19 vaccine preventable disease rate since 2017/18 despite the implementation of a number of activities throughout the year that aimed to improve immunisation rates for children. These included the development of an action plan to address the findings of a comprehensive Health Equity Assessment of community immunisation services. A range of socioeconomic, health system and individual factors influence the hospitalisation of children for vaccine preventable disease and are most likely related to pertussis and/or influenza. Responding to this issue requires a wider health sector approach. This continues to be an area of focus within our System Level Measure (SLM) plan for child health in which improving immunisation rates is key strategy.

Output Measures



Data Source: National Immunisation Register

95% of babies are fully immunised at eight months old

Māori	Target Not Achieved
Total	Target Not Achieved

Although the overall goal of meeting or exceeding 95% at eight months has not been achieved, the last quarter showed an improvement of the rates to 89.1% for Māori and 90.8% for the total population. This represents a reduction in the disparity between rates for Māori and non-Māori which is pleasing. Efforts to improve immunisation rates across Taranaki for 2018/19 were focused on implementing the recommendations of the 2017/18 Health Equity Assessment and were primarily centred on improving primary care access and engagement into primary care services, increasing GP-midwife engagement and enhancing primary care administration systems. A review of Outreach Immunisation Services was also conducted during the year and the findings will be used to inform and improve future outreach service delivery.

Improving health behaviours

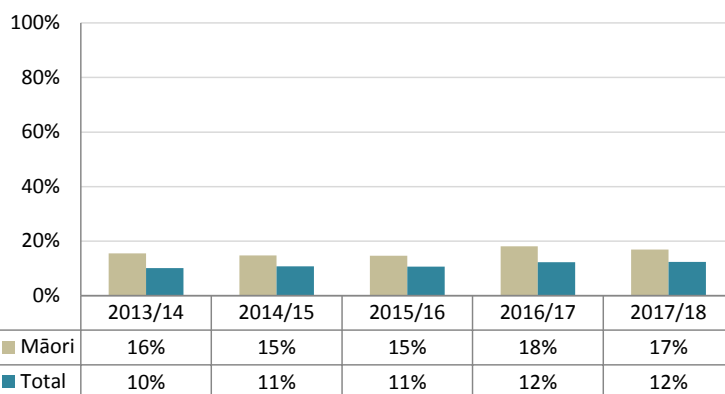
In 2016 Body Mass Index (BMI) has overtaken tobacco as the leading preventable risk to New Zealanders' health. In October 2015 the Ministry of Health (MoH) released the Childhood Obesity Plan which aims to prevent and manage obesity in children and young people up to 18 years of age. The focus of the 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.

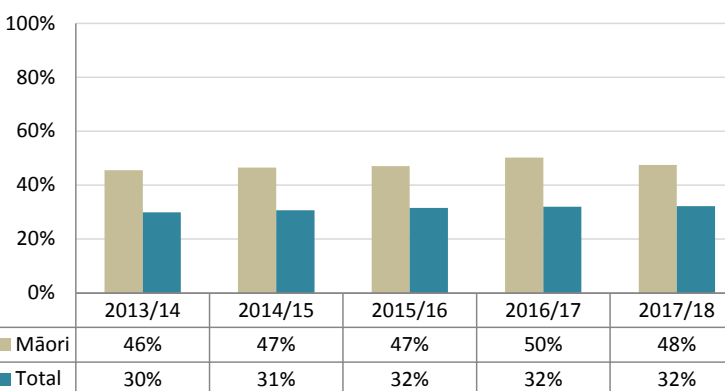
Impact Measures

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



Data Source: New Zealand Health Survey 2017/18

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



Data Source: New Zealand Health Survey 2017/18

Percentage of New Zealand population who are obese

According to the Ministry of Health, obesity rates have increased in all ages, gender and ethnic groups over the last 30 years. People are also 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.

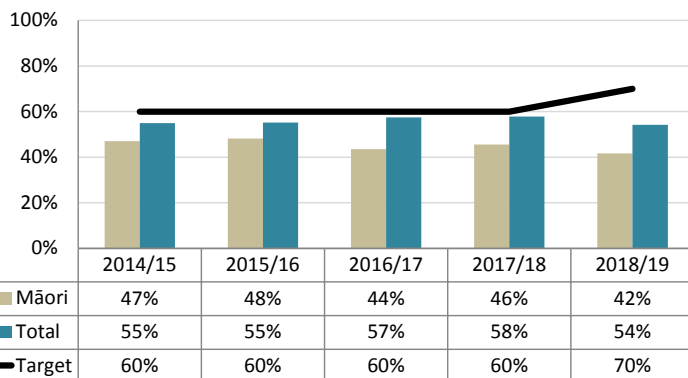
Taranaki DHB continues to deliver a number of initiatives at both an individual and a population health level, although we acknowledge that obesity prevention and management is a complex public health issue that requires a cross sectoral response in order to address the underlying factors that contribute to obesity.

In line with the concerning national trends in obesity prevalence, we continue to see significant inequity between Māori and non-Māori rates of obesity at a local level. After a worrying increase in obesity rates for Māori children (2-14 years) in 2016/17, the rate has slightly decreased in 2017/18 which is promising. Similarly the rate of Māori obesity in adults (15+ years) has slightly decreased in 2017/18. However, the significant disparity between Māori and non-Māori highlight the need for continued and targeted interventions aimed at improving equitable outcomes for Māori.

Taranaki DHB continues to refer children who are identified as obese at their Before Schools Check to our multidisciplinary programme - Whānau Pakari - that provides advice and intervention to the whānau on nutrition and physical activity advice. Our Public Health Unit also continues to deliver a number of population based initiatives aimed at preventing childhood obesity including working with schools to promote the implementation of water-only drink policies and advocating to local councils to support the development of health public policies that make healthier choices easier.

Output Measures

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



WCTO data

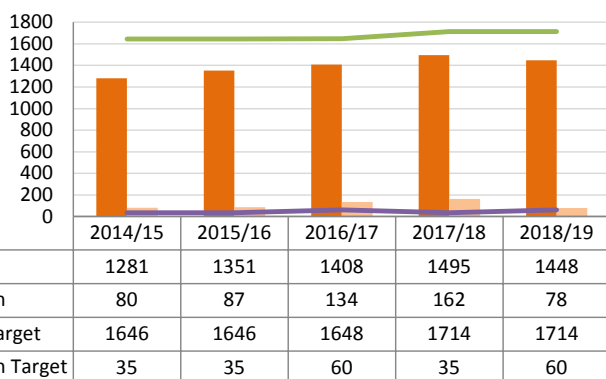
Increasing the number of infants who are fully, exclusively or partially breastfed at six months

Māori	Target Not Achieved
Total	Target Not Achieved

Improving breastfeeding rates, and reducing the inequity that persists between Māori and non-Māori, continues to be a priority for Taranaki DHB. The result for 2018/19 is disappointing as this demonstrates that breastfeeding rates at 3 months have dropped for both Māori and non-Māori despite the delivery of a number of initiatives aimed at supporting breastfeeding mothers.

Taranaki DHB is aware of declining breastfeeding rates in our region, and in recent months have undertaken a comprehensive review of Lactation Consultant and breastfeeding support services in our region to identify ways in which we can improve our breastfeeding rates in future. In addition to this, over the last year we have continued to operate a Lactation Consultant scholarship programme and have attracted two new Māori kaimahi with strong links to the Māori community to undertake this training. We have also recently extended community Lactation Consultant support services in South Taranaki in order to target greater support to those areas where we have identified lower breastfeeding rates and higher deprivation.

Number of referrals to the GRx (Green Prescription) programme



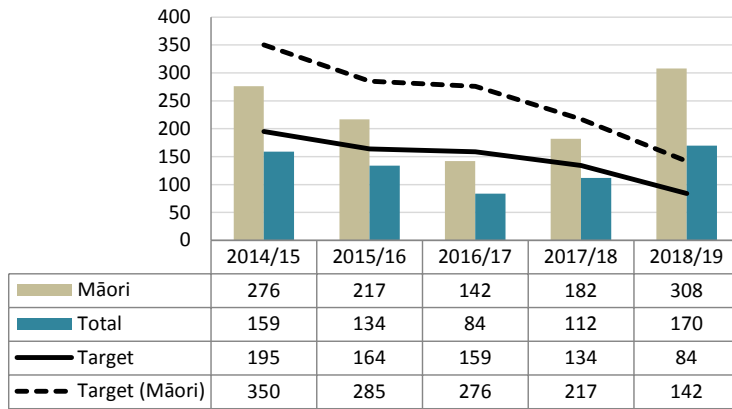
Number of referrals to the GRx (Green Prescription) programme

Adult	Target Not Achieved
Children	Target Achieved

Sport Taranaki did not reach the target for adult referrals in 2018/19 although they have exceeded the referral targets for the Active Families programme (aimed at children). The majority of those who are referred go on to participate in the Green Prescription programme and it continues to provide positive results for those who participate.

Sport Taranaki have a number of initiatives underway to promote the Green Prescription programme to referrers and this work is ongoing. The majority of referrals into the adult programme are received from primary care providers, followed by Allied Health professionals. A significant proportion of the referrals into the Active Families programme are received from the Whānau Pakari team and both services continue to work together to ensure that opportunities for high referrals are maximised and that the Active Families programme meets the needs of tamariki and their whānau.

Teen birth rate per 10,000



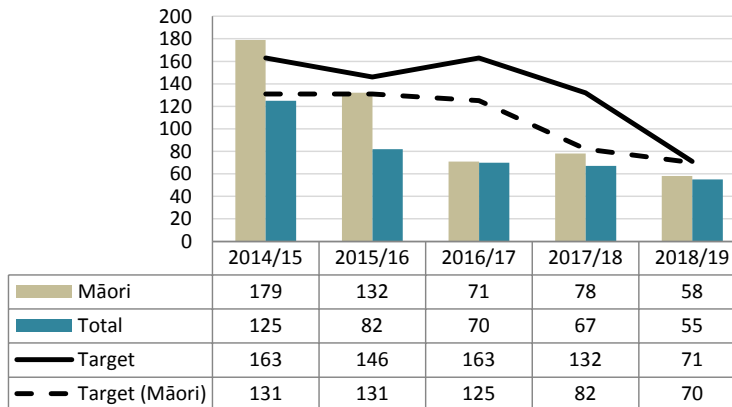
Target: Māori <142; Total population <84

Teen birth rate per 10,000

Māori	Target Not Achieved
Total	Target Not Achieved

While the teen birth rate increased in 2018/19. Taranaki DHB is committed to continuing 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 25s 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



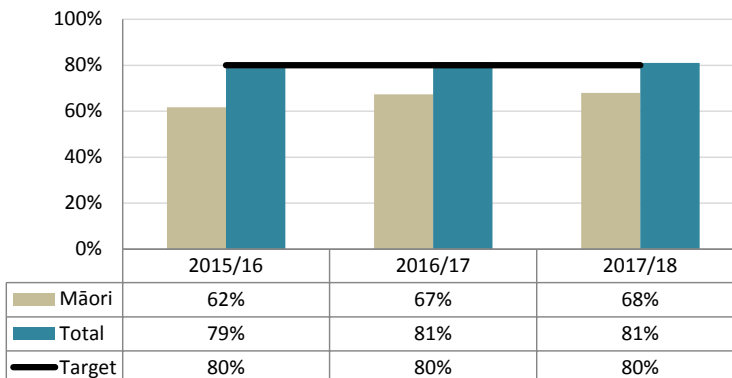
Target: Māori <71; Total population <70

Teenage terminations of pregnancy rate - per 10,000

Māori	Target Achieved
Total	Target Achieved

We continue to see the decline in teenage terminations of pregnancy. This is reflected in the Māori population as well as the total population. We will continue to ensure contraception is available through the adolescent clinics in schools and alternative education centres as well as continuing to offer low cost access through our community pharmacies.

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



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

Māori	Not available
Total	Not available

Data for 2018/19 is not available and data will not be available going forward. Alternative metrics are being considered for 2019/20.

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.

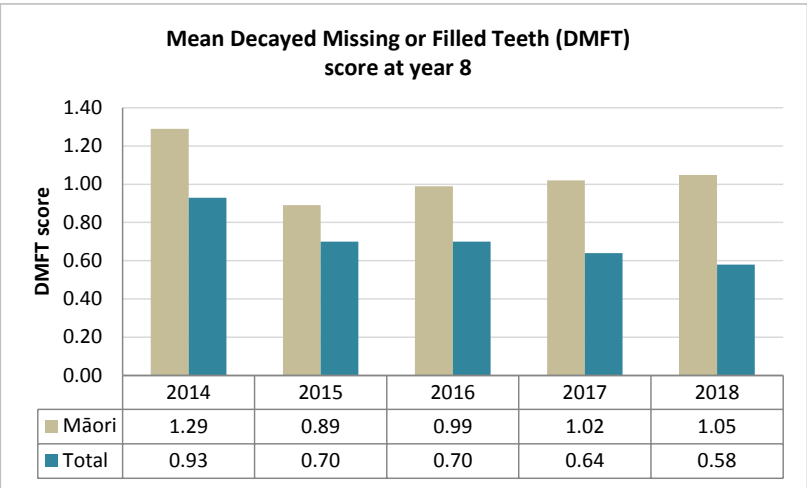
Intermediate impacts

An improvement in childhood oral health

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

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

Impact Measures



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

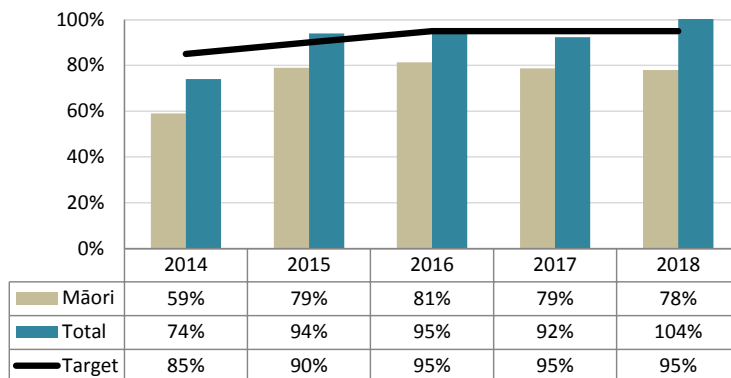
The overall DMFT score for the Total Year 8 cohort in Taranaki continues to improve. However the disparity in DMFT between Māori and non-Māori is continuing to increase.

In 2017 Taranaki COHS implemented a clinical preventive programme aimed at increasing preventive services being offered, to ensure all children who identify as Māori would benefit. The uptake was initially lower than expected, however in 2018 it increased, and it is expected that a marked improvement will be seen when those children's DMFTs are recorded as Year 8 children.

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2018 calendar year.

Output Measures

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



Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2018 calendar year.

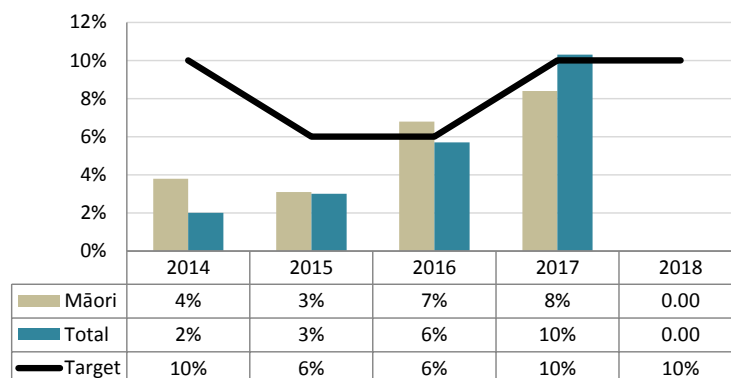
Percentage of children (0-4) enrolled in DHB funded dental service

Māori	Target Not Achieved
Total	Target Achieved

Whilst the Total population has met the target, there has disappointingly been a decline in enrolment for Māori preschool children enrolled. This data may also have some anomalies, as demonstrated by the very high Total result.

DNA (Did Not Attend) rates are a particular concern for Taranaki DHB, as whānau who consistently DNA are un-enrolled from this primary health care service. Taranaki DHB's Māori Health Unit are currently considering initiatives which will focus on improving attendance rates for Māori 0-4 year old children.

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



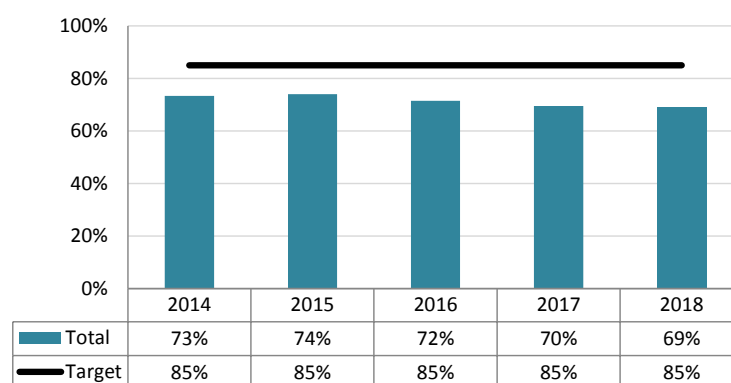
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2018 calendar year.

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

Māori	Not available
Total	Not available

2018 data was not available due to data issues.

Percentage of adolescent utilisation of DHB funded dental services



Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2018 calendar year.

Percentage of adolescent utilisation of DHB funded dental services

Total	Target Not Achieved
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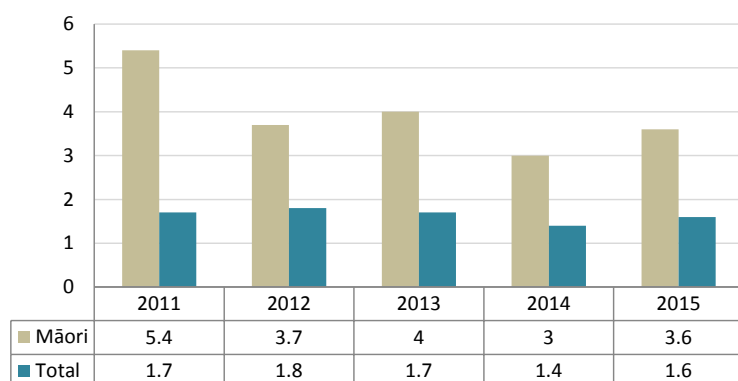
Adolescent dental services in Taranaki are provided by dentists in private practice through the combined dental agreement (CDA) contract. The Community Oral Health Service also provides some adolescent dental services in Taranaki. Given current challenges nationally and locally to recruit and retain dental and oral health therapists in Community Oral Health services, it will be important that we maximise youth uptake of oral health services through the CDA in order to deliver "good oral health for all, for life". Greater focus needs to be placed on proactively engaging with and navigating our youth to these services.

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

National Age standardised cervical cancer mortality (per 100,000)



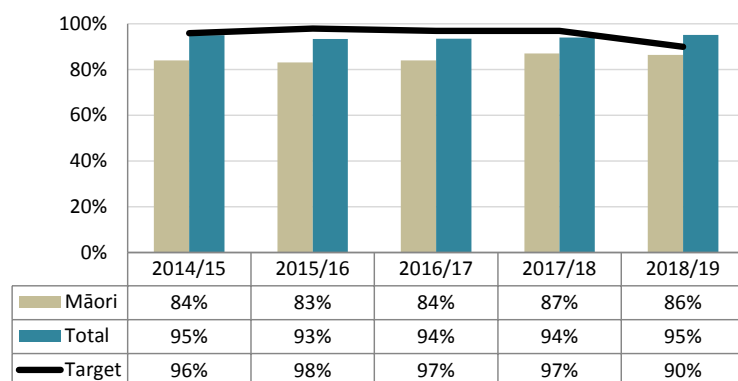
Data Source: New Zealand Mortality Collection - standardised to the WHO world standard population.

Cervical cancer mortality - age standardised per 100,000

Like 2014 results for 2015 show an overall trend of decreased rates of Māori mortality from cervical cancer since 2011. This has contributed to a fall in 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 direct and favourable health outcomes in relation to cervical cancer mortality.

Output Measures

Percentage of population enrolled with a Primary Health Organisation



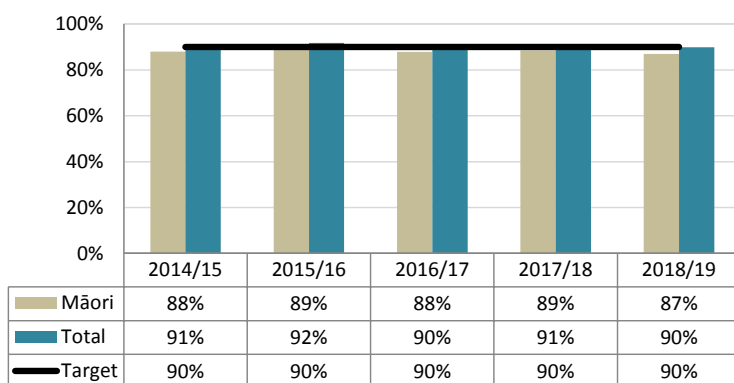
Data Source: Ministry of Health PHO Enrolment Collection

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

Māori	Target Not Achieved
Total	Target Achieved

Pinnacle Health Organisation (PHO) enrolment continues to be steady in Taranaki DHB, with 95% of the general population and 86% of Māori enrolled in the PHO. The rate is lower than it potentially could be in part due to one general practice and its patients not being enrolled in the PHO, and also 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



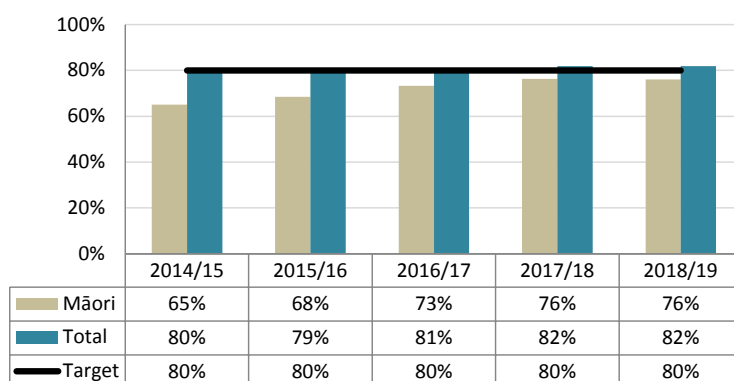
Data Source: Primary Health Organisation Performance Programme (PPP)

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% Cardiovascular Disease Risk Assessment (CVDRA) target, however rates for Māori remain below target despite an overall upward trend. The Ministry of Health recently updated the CVDRA guidelines and shifted focus to achieving equity for Māori males 35-44 years old in particular. Taranaki DHB is actively promoting the new guidelines with General Practices and encouraging them to proactively follow up with patients who have not engaged in their annual CVDRA screen.

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



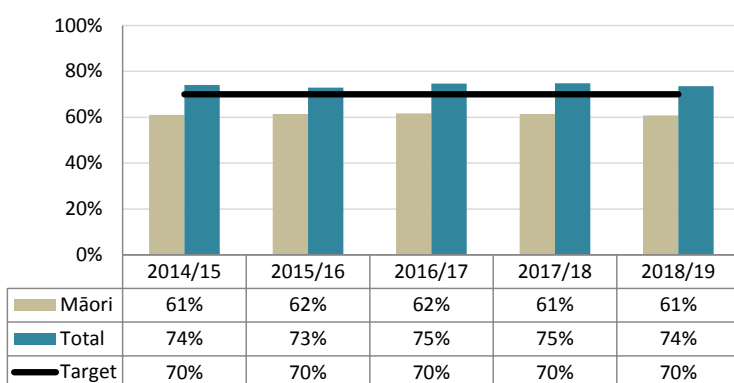
Data Source: National Screening Unit

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

Māori	Target Not Achieved
Total	Target Achieved

Taranaki cervical screening rates have remained consistent from 2017/18. Despite not meeting the 85% target, Taranaki DHB's cervical screening rates are highest in New Zealand for Māori and the total population. The DHB has continued to engaged with vulnerable and high risk population groups in the region as well as working closely with the local Primary Health Organisation (PHO) to increase screening rates for Asian women.

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

Breast screening rates are similar to 2017/18 with continuing disparity between Māori and non-Māori screening rates being evident. Screening services continue to be delivered by Breast Screening Coast to Coast (BSC2C) although the DHB intends to take a stronger equity focus next in future following the completion of a recent Health Equity Assessment of the service which has identified some opportunities for service improvement. It is hoped that this will lead to reduced inequity and improvement health outcomes for Māori in future.

Fewer people are admitted to hospital for avoidable conditions

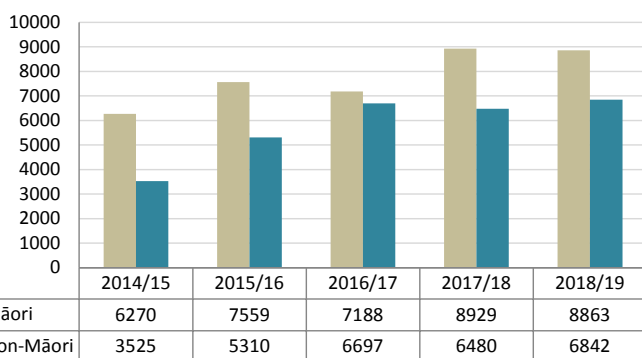
There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care.

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.

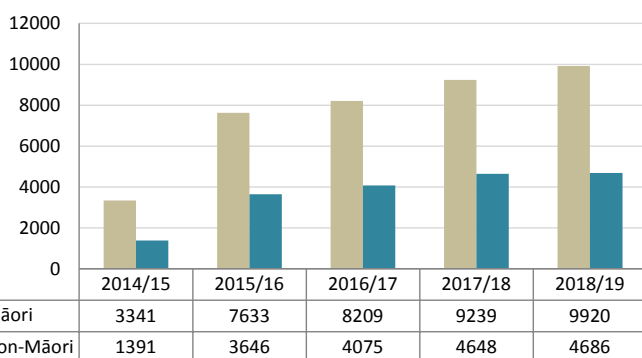
Impact Measures

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 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 outcomes in our population.

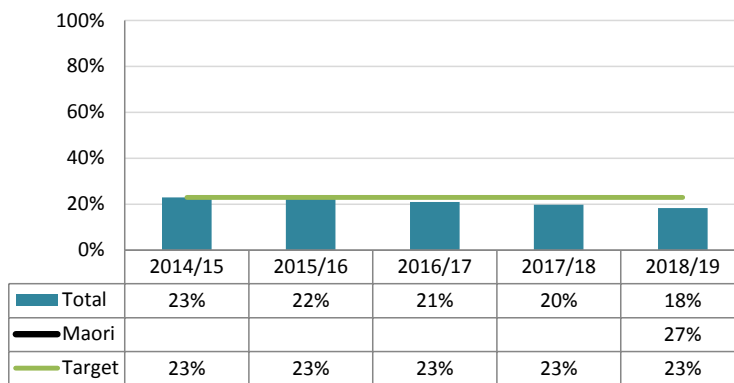
Ambulatory Sensitive Admission (ASH) 0-4 years rates have been relatively static since 2015 when looking at the data in more detail, and show a typical seasonal pattern with higher rates of admission during winter months. The equity gap between Māori and non-Māori also appears to be increasing. We know from our data that respiratory related presentations make up a significant portion of this total, and this is one of the fundamental drivers behind this pattern. As such, the 2018/19 year has seen the ASH System Level Measure group focus on increasing uptake of immunisations, more comprehensive assessment of children's home environment and associated support services such as home insulation schemes or smokefree homes, working with general practices to put plans in place to manage frequent hospital attendees, and building relationships between paediatric wards and our Māori Health team to improve engagement and coordination of care. It is too early to determine the success of this programme.

ASH 45-64 rates have slightly increased over 2017/18. The equity gap between Māori and non-Māori has generally remained similar, with a slight increase in the last quarter. The reasons for this general increase are complex and multifactorial. The Taranaki health system has been largely successful in ensuring lower acuity patients are managed in the primary and community setting. However, it appears that we may have

reached saturation point in this since 2018 and, as a result, we have been focussing on a refreshed acute demand strategy that will further help manage patients at the right time and the right place. However, this success has been dwarfed by significant increases in higher acuity patients presenting to ED. From a conditions perspective, we continue to see angina & chest pain as the dominant ASH presentation. As such, the 2018/19 year has seen us focus on increasing the range of acute primary options made available to general practice, develop a more closely aligned and focussed respiratory service that keep patients out of hospital, implementation of the Health Care Homes model across Taranaki general practices and integration of the fracture liaison service with the PHO falls prevention service to ensure all patients with osteoporosis, including those aged 55-64 years, access a comprehensive service and reduce the likelihood of further injury and related hospitalisation.

Output Measures

Triage level 4 and 5s presenting to the Emergency Department as a percentage of the population



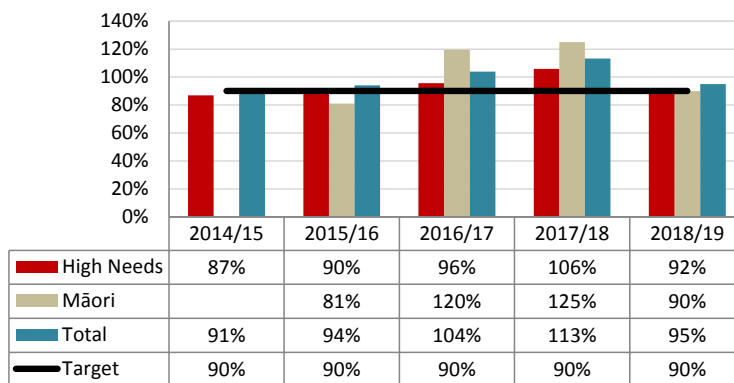
Data Source: National Non-admitted Patient Collections. Statistics New Zealand Population Projection 2018

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

Māori	Target Not Achieved
Total	Target Achieved

Taranaki continues to see an ongoing reduction in overall Triage 4 & 5 presentations into the Emergency Department (ED). This reflects the success of the continued use of the ED redirection service along with ongoing education to the public about appropriate use of ED services and the availability of alternative service options. Presentations of Māori remain slightly above target (27% vs 23%). The DHB remains committed to achieving equity within the population with activities ongoing to achieve this.

Percentage of eligible population have their Before School Checks completed



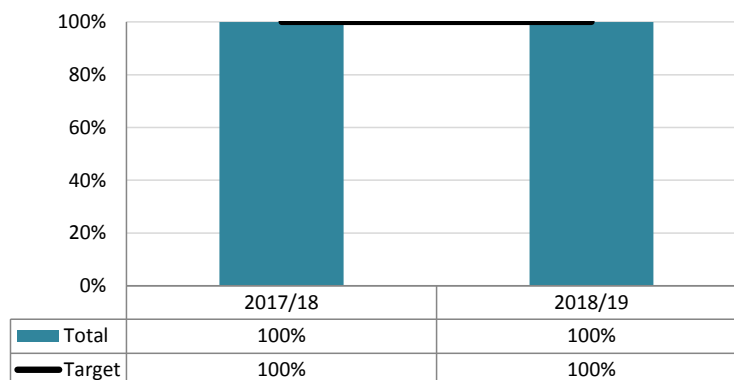
Data Source: National Immunisation Register

90% of eligible population have their Before School Checks completed

High Needs	Target Achieved
Māori	Target Achieved
Total	Target Achieved

Although the target of 90% was achieved for all populations the rates were less than the previous year (2017/18). In particular, the rate for high needs and Māori populations were lower than the 2017/18 rates which indicates a widening of disparity when compared to the total population. We will be working with the current Before School Checks providers over the next year to ensure that their services are accessible and numbers of checks increase.

100% of PHO practices in the Taranaki DHB region offer zero fees access to under 13/14 year olds



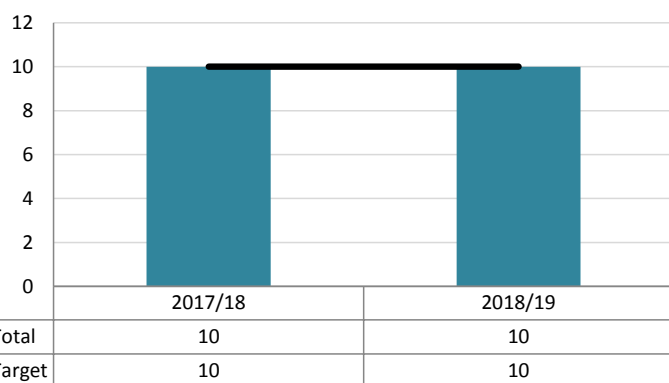
Data Source: Pinnacle Midlands Health Network

100% of PHO practices in the Taranaki DHB region offer zero fees access to under 13/14 year olds

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

All practices in Taranaki that are part of the Pinnacle Midlands Health Network have implemented zero fees access for under 14 year olds.

10 PHO practices in the Taranaki DHB region offer zero fees after hours care to under 13/14 year olds



Data Source: Pinnacle Midlands Health Network

10 PHO practices in the Taranaki DHB region offer zero fees after hours care to under 13/14 year olds

Total	Target Achieved
10	10

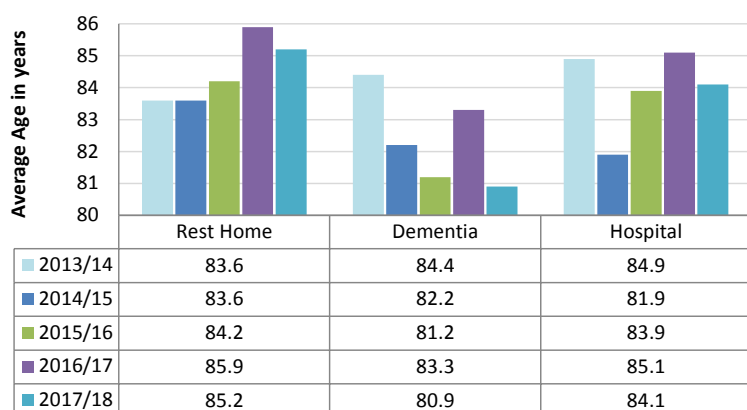
The goal of having ten practices providing access to zero fees after hours care to under 14 year olds has been achieved. This ensures that 95% of the eligible population of under 14 year olds have access to free after hours care within 30 minutes travel time.

More people maintain their functional independence

If we are to deliver on our twin goals of improving health outcomes, and reducing or eliminating health inequalities, for our older population, we aim to support people to maintain functional independence. With an increasing and ageing population, as this cohort increases, so does demand on our constrained funding. Aged Residential Care (ARC) is a specialist, high cost, and scarce resource. We are looking to manage the expected growth in demand, through an ageing population, by improved models of care that support people to remain independent for as long as possible.

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 are designed to evaluate population health over a long period of time, therefore specific targets are not set in any particular financial year. This impact measure is influenced by the combined activities of multiple providers and services across the Taranaki region.

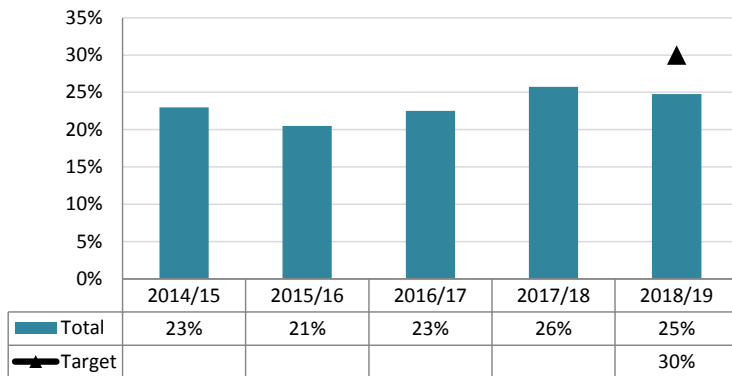
Between 2013/14 and 17/18 Taranaki DHB has seen a general increase in the average age of entry into rest homes which reflects an improved health outcome in our older population.

Steps continue to be taken 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 and community support services.

NB The reported data is only available 12 months in arrears. Consequently, we are reporting the final results for 2017/18

Output Measures

Mean Percentage of inpatients who complete the National inpatient Patient Experience Survey



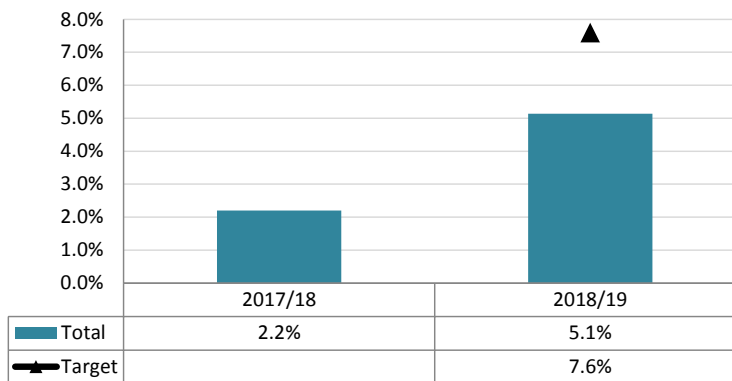
Data source: Health Quality & Safety Commission New Zealand

Percentage of inpatients who complete the National inpatient Patient Experience Survey

Total	Target Not Achieved
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Mean 2017/2018 Taranaki DHB responses rate for the National Inpatient Patient Experience survey was 26%. 2018/2019 Taranaki DHB responses rate for the National Inpatient Patient Experience survey is 25%. Quarterly reporting of survey results now occurs routinely and is shared widely with managers and staff. The DHB's Maori Health team has also been provided with access to survey results allowing this information to inform service improvement initiatives. In addition to this, the privacy statement on the DHB's Electronic Patient Details Form has been amended to safely enable increased email collection for survey purposes.

Percentage of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2018/19



Data Source: Taranaki DHB

Percentage of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2018/19

Total	Target Not Achieved
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While the target of 7.6% was not achieved, the percentage of staff completing the on-line Disability Responsiveness Training has more than doubled in 2018/19 suggesting that uptake of the training is improving. The DHB is now developing targeted training with specific information for different staff groups and will roll this out over the next year. A Disability Responsiveness Training and Education plan was also developed during 2018/19 and is in the process of being implemented.

OUTCOME 3

People receive timely and appropriate specialist care

Expectation

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.

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

Intermediate impacts

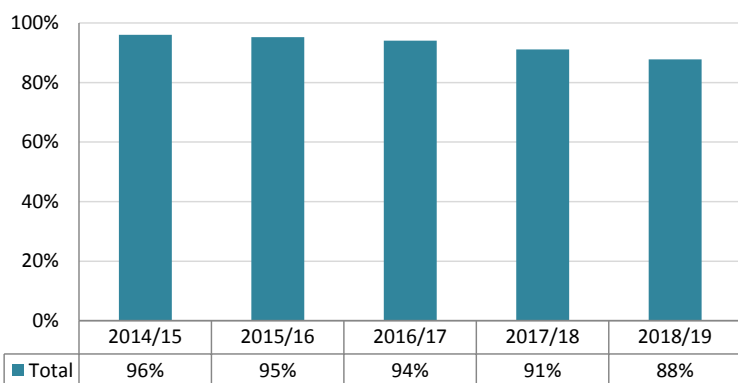
People receive prompt and appropriate acute and arranged care

Long stays in Emergency Departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in an ED improves the health services DHBs are able to provide.

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.

Impact Measures

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



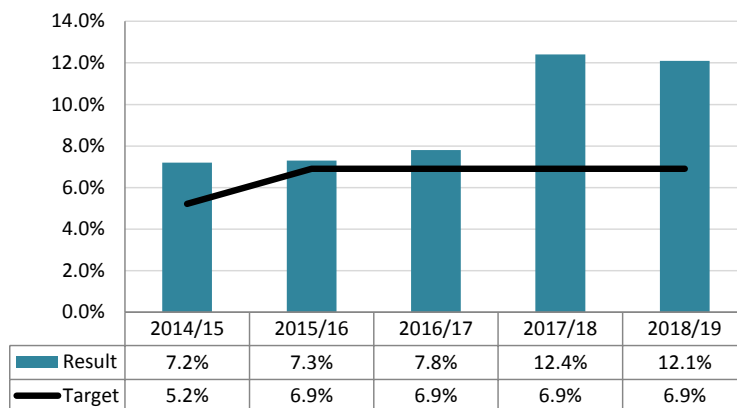
Data Source: Taranaki DHB Patient Management System

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

Continuing acute demand has made the achievement of this target very challenging. Work is ongoing on the Variance Response Management Plan. This plan has been developed as a response to fluctuations in demand and capacity. The capacity at a glance screen is being used to inform staff of key variance issues within the Emergency Department.

Output Measures

Acute re-admission rate



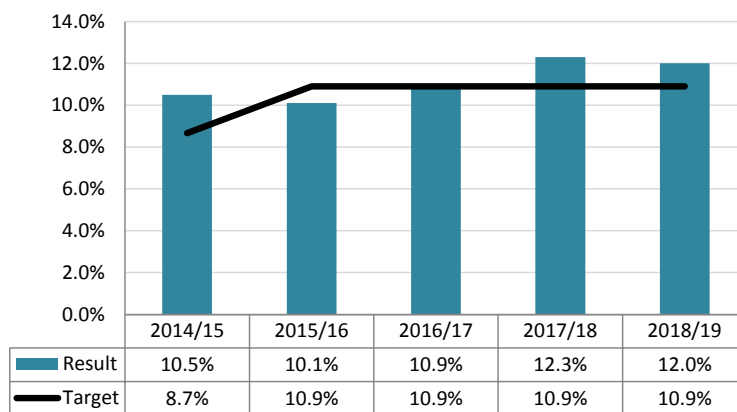
Data Source: National Minimum Dataset (NMDS)

Acute re-admission rate

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

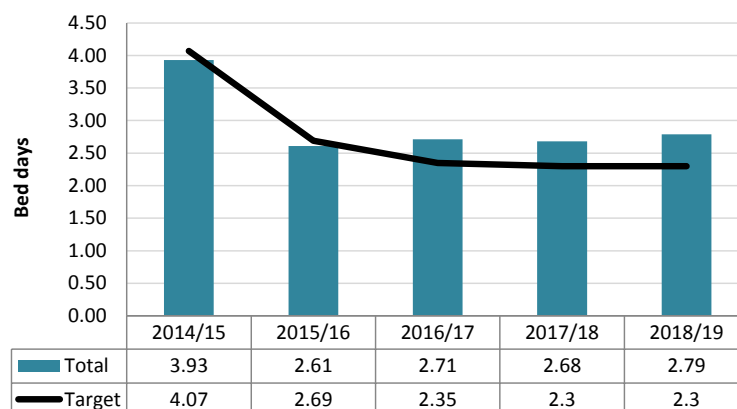
Acute re-admission rates continue to be above target. Acute demand has continued to put pressure on all aspects of patient pathways. The integration project has focused on better managing referrals once patients have been discharged ensuring that the appropriate resources are in place in the community to allow patients to return home and remain at home safely.

Acute re-admission rate >75s



Data Source: National Minimum Dataset (NMDS)

Inpatient average length of stay



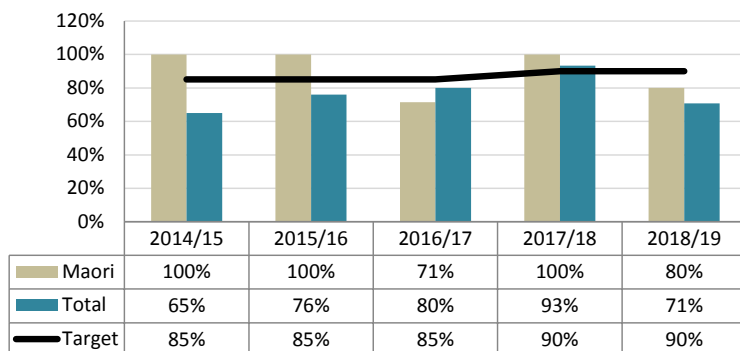
Data Source: National Minimum Dataset (NMDS). Desired outcome is below the target rate

Acute Inpatient average length of stay reduced

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

Taranaki DHB have not achieved this target and it remains a focus that discharge planning starts as soon as a patient is admitted, ensuring that complex cases are managed by our case managers and the multidisciplinary team. Respiratory patients' length of stay is an outlier and a full investigation into their care has been undertaken leading to formal recommendations to improve care pathways and reduce length of stay.

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



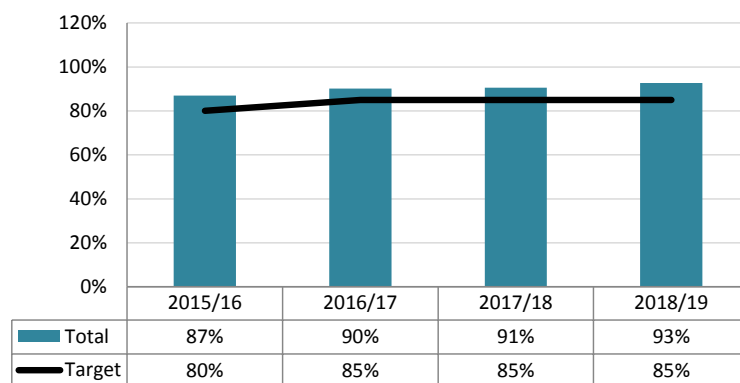
Data Source: Taranaki DHB and The Ministry of Health

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

Total Target Not Achieved

The reduction in rates since 2017/18 is a disappointing result and work is being undertaken with the Faster Cancer Treatment Governance Group to look into the reasons for the failure to achieve this target. Managing diagnostic tests in a timely manner is a focus and is essential to meeting the 62 day target.

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



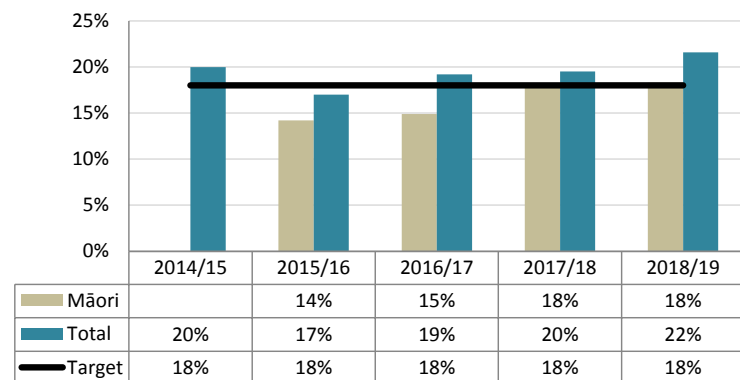
Data Source: Mid-Central DHB Patient Management System

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

The obstetric and maternity team remain committed to reducing the number of elective caesarean section births in Taranaki. Significant number of women have co-morbidities that indicate elective c section and this continues to be seen in the static results.

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. Improved performance on targets in this area are reflective 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

Major joint replacement - target 21 per 10,000

Result: 23.28 Not significantly different to target

Cataract procedures - target 27 per 10,000

Result: 31.03 Significantly above target

Cardiac surgery - target 6.5 per 10,000

Result: 5.71 Not significantly different to target

Percutaneous revascularisation - target 12.5 per 10,000

Result: 12.15 Not significantly different to target

Coronary Angiography Services - target 34.7 per 10,000

Result: 42.83 Significantly above target

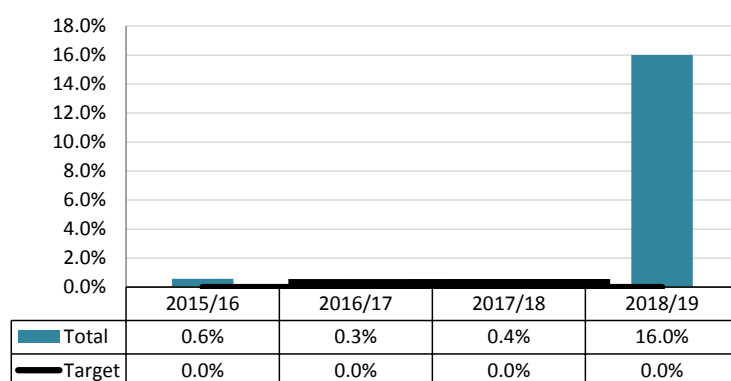
Data Source: Ministry of Health, Elective Services

Elective services - standardised intervention rates per 10,000

Taranaki DHB has continued to manage our elective procedures. We continue to work with our Tertiary centres to ensure that we have equality of access for our patients. It is pleasing for Taranaki DHB to see our results for Standardised Intervention Rates (SIR) at or above the national average. Any further improvements in these measures will contribute toward better health outcomes for our local population.

Output Measures

Percentage of patients wait longer than four months for their specialist assessment



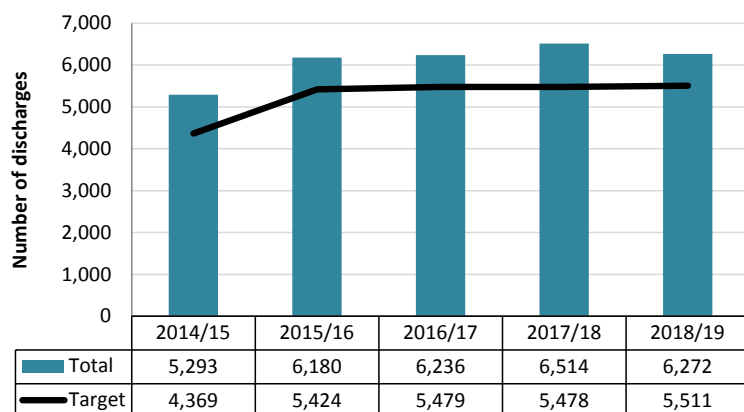
Data Source: National Booking Reporting System (NBRS)

Percentage of patients wait longer than four months for their specialist assessment

Result	Target Not Achieved
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Taranaki continues to work towards meeting this target. Throughout the 2018/19 year there have been significant factors which have impacted on our ability to meet this target. Once again we have seen a significant number of acute presentations. In addition to this, industrial action has impacted hugely on this target. We continue to monitor our Elective Services Performance Indicators (ESPI) numbers and are working towards seeing patients in a timely manner through improved productivity and coordinated care pathways.

Number of surgical discharges under the Electives Initiative



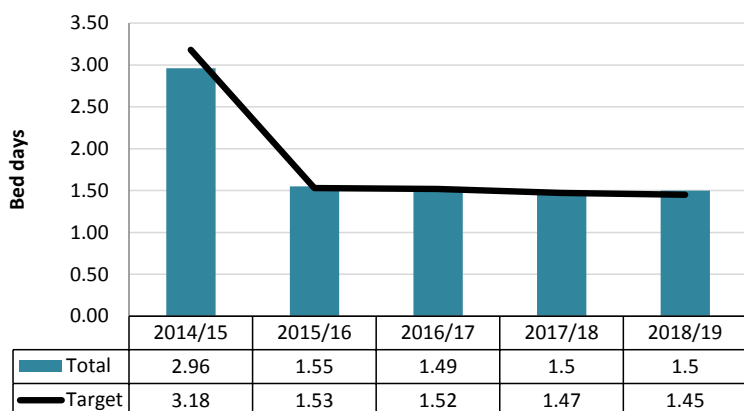
Data Source: National Minimum Dataset (NMDs)

Number of surgical discharges under the Electives Initiative

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



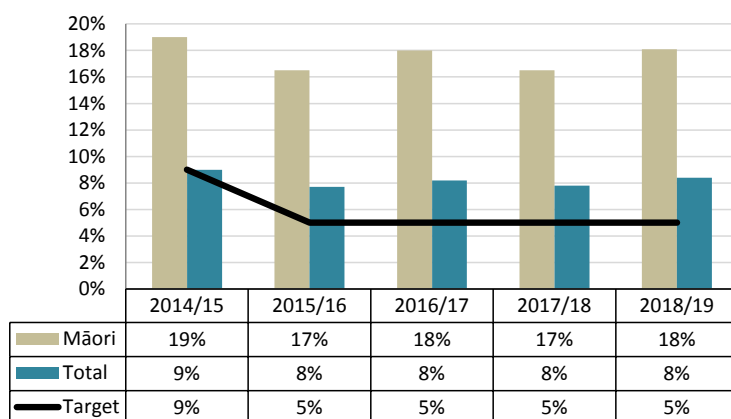
Data Source: National Minimum Dataset (NMDs). Desired outcome is below the target rate

Elective inpatient length of stay (LOS)

Total Target Not Achieved

Taranaki DHB continues to work towards achieving this target. Enhanced recovery after surgery is being utilised in the surgical wards and is working well. We are working towards using our case management and MDT teams to identify patients early who have complex needs and early identification of issues will allow for more resilient discharge planning

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

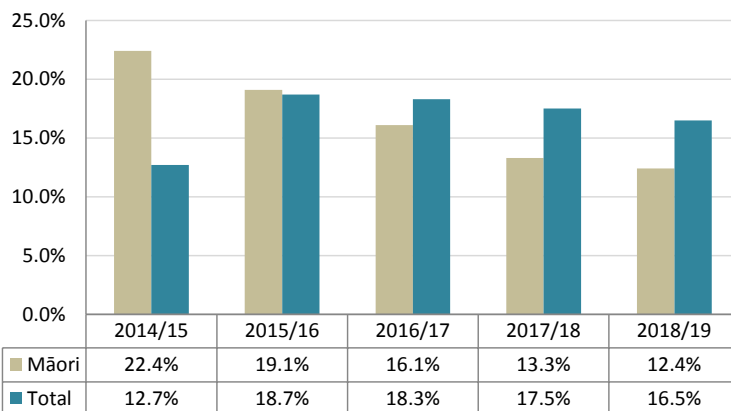
The Māori health team are working in conjunction with all specialties to assist patients to navigate through the health system. They are available for support with Outpatient Department and acute presentation. A new initiative is being considered with team members present in the Emergency Department to assist patients and families. Patient centred booking is being considered as we look to patient centred models of service delivery. This will allow more flexibility for patients to book appointments at a day and time which is more suitable to them.

Improved health status for people with severe mental health illness and/or addiction

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

Impact Measures

28 day acute readmission rate



28 day acute readmission rate

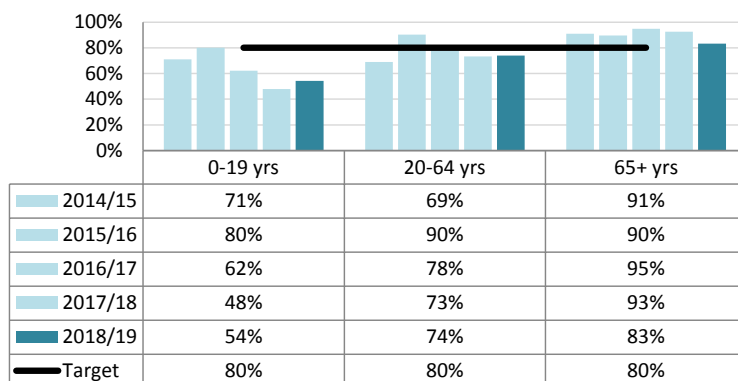
Taranaki DHB remains within the target range for readmissions and continues to trend down. The Transition Document piloted last year will be rolled out service wide to maintain and improve this performance

Target range is between 10-20%

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

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).

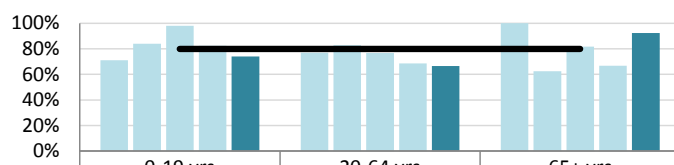
Desired outcome is below the target rate

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: The recruitment of workers into vacant positions in the child and youth mental health services has contributed to an increase in percentage this year although we have not met the target as yet, due to increased demands for services and also increased new and urgent presentations who require support. The increased demand influence also impacts on services meeting the health needs of those with severe mental illness and more work is planned in this region to design collaborative models of care with other providers to meet this need.

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



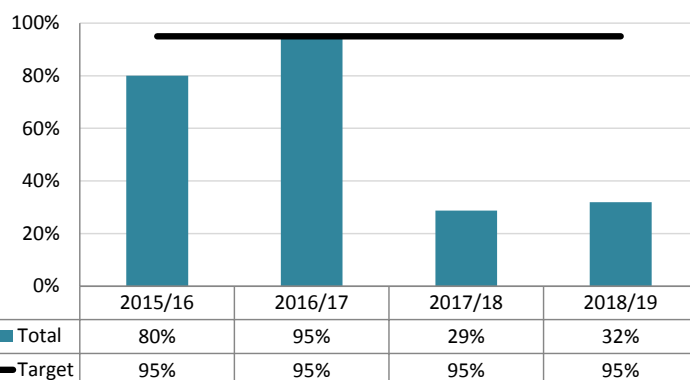
Data Source: Programme for the Integration of Mental Health Data (PRIMHD)

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

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

Work is occurring to assess influences on delays to people being seen from time of referral. Preliminary findings indicate that a high percentage of people change their mind or disengage in the period between referral and receiving an appointment to be seen, indicating a change in service model should be considered. More work is planned for the next quarter to definitively evidence the direction of more timely response and access to services.

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



Data Source: Mid-Central DHB Patient Management System

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

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

A Health Quality Safety Commission (HQSC) project has been undertaken in the Child and Youth Mental Health service which has resulted in the co-design of a new transition plan document to support good quality discharge planning. The new transition plan has been successfully utilised with existing clients and monitoring indicates that higher percentages are now being recorded which should improve our rates in the next quarter. Work is being undertaken with clinical teams to ensure improved compliance with the use of the new transition plan and the importance of meeting the percentage targets.

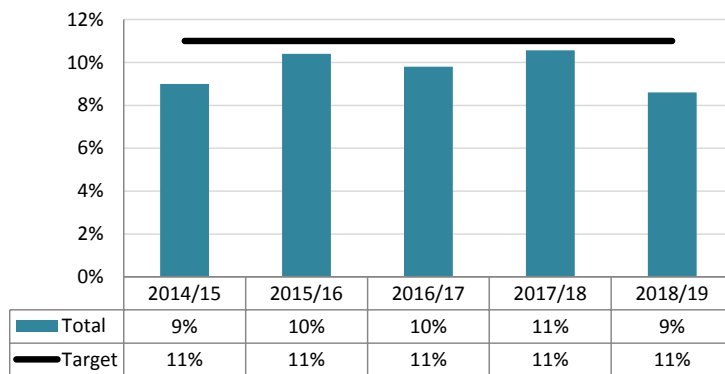
More people with end-stage conditions are supported

Why is this important?

It is important that people who have life threatening illness, along with their family and whanau, 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.

Output Measures

Percentage of palliative care clients who have an ED presentation



Data Source: Taranaki Hospice

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

Total

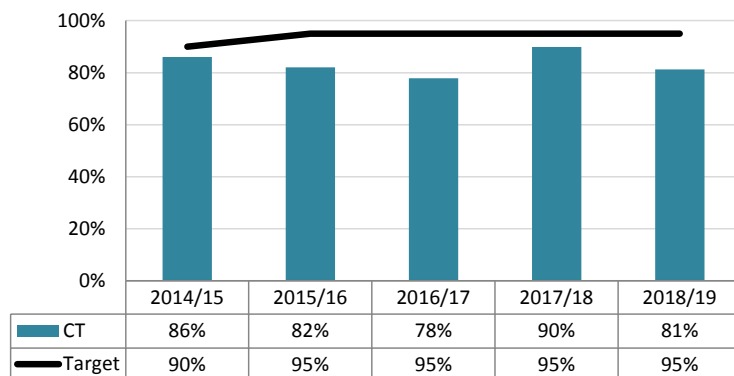
Target Achieved

Hospice Taranaki continues to deliver initiatives to reduce avoidable Emergency Department (ED) presentations of their patients. Hospice Taranaki monitor monthly ED admission statistics to identify trends and follow up on all inappropriate ED presentations of their clients. All Hospice clients are advised to contact hospice prior to going to ED, however the complex co-morbidities of their patients mean that an ED presentation is often unavoidable. Hospice Taranaki also continues to provide Palliative Care Clinical Nurse Specialist services to support residential aged care providers to build and maintain their skills and capabilities. This aims to improve their ability to manage end stage care for complex clients they are caring for within their facilities, thus reducing avoidable ED admissions wherever possible.

Support services

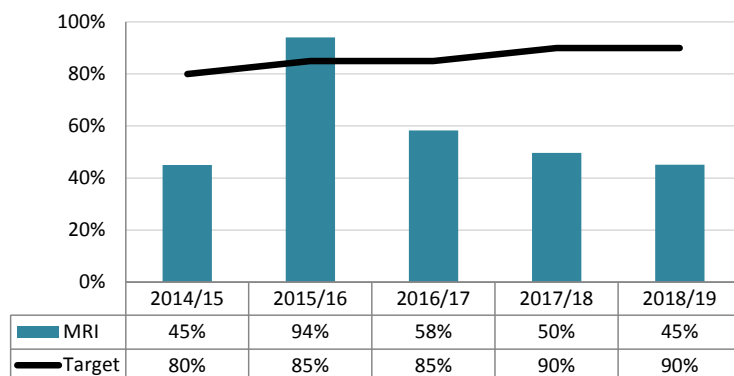
Output Measures

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



Data Source: Taranaki DHB

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



Data Source: Taranaki DHB

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

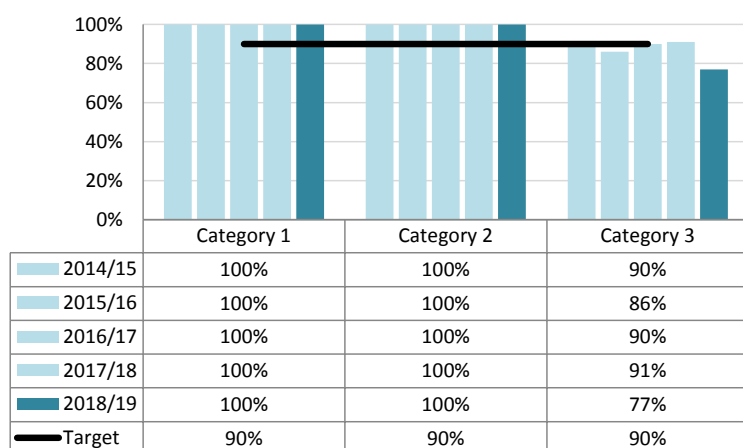
CT	Target Not Achieved
MRI	Target Not Achieved

There continues to be increasing numbers of Computed Tomography (CT) referrals with all referrals prioritised by consultants to ensure that urgent and semi-urgent scans are completed in a timely way. Strategies to respond to this include provision of extra CT sessions as well as exploring options to manage the demand for routine scans.

Magnetic Resonance Imaging (MRI) referrals are also reviewed by consultants and prioritised to ensure that urgent need is met. A number of extra sessions for MRI scanning have been delivered to meet high demand and, as with CT scans, options to manage routine demand for MRI scans is being explored.

The waitlist is continually monitored and those patients requiring investigations prior to scans are contacted to ensure that this is undertaken in a timely way.

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



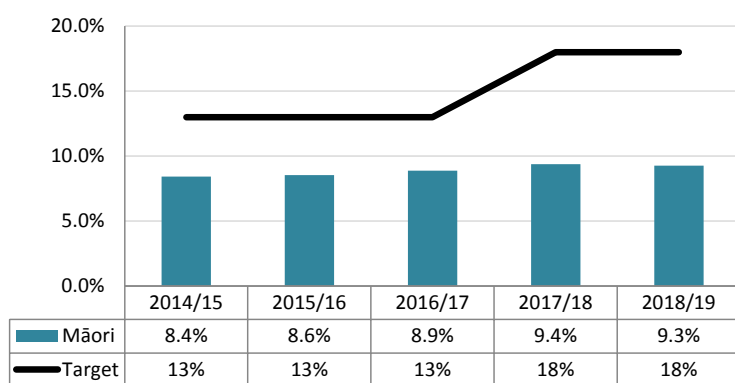
Data Source: Local contract Performance Monitoring

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

Category 1	Target Achieved
Category 2	Target Achieved
Category 3	Target Not Achieved

Timely diagnostic results are vital to ensuring the best possible health outcomes for patients. Taranaki DHB has been undertaking a procurement process for community laboratory services, and performance against a number of key performance indicators (KPIs) is a core requirement of the new contract.

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



Data Source: TDHB HR system

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

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

Although the 18% Māori workforce target has not been met (the end of year result was 9.3%) considerable progress has been made that is not reflected in this statistic.

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 who are being actively supported to enter the Taranaki health workforce in the next one to six years. 21 of these students will have completed study and will be ready for employment in 2020. This is an on-going programme that intensively supports students through their health career pathways and into the workforce.

This year, seven 'WhyOra' Māori nursing graduates were recruited by Taranaki DHB through the Nursing Entry to Practice (NETP) programme while a further 10 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

Pūrongo pūtea





- 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 2019, fairly reflect the financial position, operations, cash flows and service performance of the Taranaki District Health Board.



Pauline Lockett
Chairperson
29 October 2019



Neil Volzke
Deputy Chairperson
29 October 2019



Rosemary Clements
Chief Executive Officer
29 October 2019



George Thomas
Chief Financial Officer
29 October 2019

Statement of Comprehensive Revenue & Expense For the Year Ended 30 June 2019

	Notes	Actual June 2019 \$000	Budget June 2019 Unaudited \$000	Actual June 2018 \$000
Revenue	1	399,783	393,029	380,730
Other income	2	475	500	700
Total revenue		400,258	393,529	381,430
Employee benefit costs	3	158,574	148,186	142,650
Depreciation expense	13	17,332	18,899	17,134
Outsourced services		14,665	16,062	15,809
Clinical supplies		33,883	31,963	30,412
Infrastructure and non-clinical expenses		16,566	11,686	11,974
Payments to non-health board providers		171,110	167,877	162,141
Other expenses	4	1,197	2,014	1,490
Capital charge	5	10,367	10,575	8,226
Financing costs	6	27	-	27
Total expenses		423,721	407,262	389,863
(Loss) before share of associates		(23,463)	(13,733)	(8,433)
Share of surplus/(loss) of associates	12(c)	93	-	144
(Loss) after surplus of associates		(23,370)	(13,733)	(8,289)
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		(23,370)	(13,733)	40,802

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

Statement of Changes in Net Assets / Equity

For the Year Ended 30 June 2019

	Note	Public Equity	Accumulated Revenue and Expense	Asset Revaluation Reserve	Trust Fund Reserve	Total
		\$000	\$000	\$000	\$000	\$000
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						
Debt converted to Equity	28	-	-	-	-	-
Equity repaid to the Crown	28	(958)	-	-	-	(958)
		(958)	-	-	-	(958)
At 30 June 2018		94,288	(24,141)	116,541	779	187,467
Comprehensive revenue and expense						
Deficit support from Crown		13,600	-	-	-	13,600
(Loss) for the year		-	(23,370)	-	-	(23,370)
Change in asset revaluation reserve		-	-	-	-	-
Transfer from/(to) Trust Funds Reserve		-	60	-	(60)	-
		13,600	(23,310)	-	(60)	(9,770)
Transactions with the Crown						
Equity repaid to the Crown	28	(958)	-	-	-	(958)
		(958)	-	-	-	(958)
At 30 June 2019		106,930	(47,451)	116,541	719	176,739

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

Statement of Financial Position

As at 30 June 2019

	Notes	Actual June 2019 \$000	Budget June 2019 Unaudited \$000	Actual June 2018 \$000
ASSETS				
Current assets				
Cash and cash equivalents	7	391	405	317
Trade and other receivables	8	14,627	14,072	15,184
Inventories	9	3,477	2,927	3,332
Other financial assets	10	-	-	2,890
Total current assets		18,495	17,404	21,723
Non-current assets				
Investments in subsidiaries	11	-	-	-
Investments in associates	12	1,632	1,539	1,539
Other financial assets	10	56	56	56
Property, plant and equipment	13	216,525	215,047	220,052
Intangible assets	14	1,115	1,384	1,793
Restricted assets & trust funds	15	719	779	779
Total non-current assets		220,047	218,805	224,219
TOTAL ASSETS		238,542	236,209	245,942
LIABILITIES				
Current liabilities				
Cash and cash equivalents	7	2,036	7,674	4,578
Trade and other payables	16	23,196	21,855	21,355
Employee benefits	17	35,296	32,862	31,604
Provisions	18	176	100	37
Total Current Liabilities		60,704	62,491	57,574
Non current liability				
Employee benefits	17	1,099	941	901
Total non current liability		1,099	941	901
TOTAL LIABILITIES		61,803	63,432	58,475
NET ASSETS		176,739	172,777	187,467
EQUITY				
Public equity		106,930	93,332	94,288
Retained (losses)		(47,451)	(37,874)	(24,141)
Asset revaluation reserve		116,541	116,540	116,541
Trust fund reserve	15	719	779	779
TOTAL EQUITY		176,739	172,777	187,467

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

For and on behalf of the Board, who authorised the issue of these financial statements on the 29th October 2019



Pauline Lockett
CHAIRPERSON



Neil Volzke
DEPUTY CHAIRPERSON

Statement of Cash Flows

For the Year Ended 30 June 2019

		Actual June 2019	Budget June 2019 Unaudited	Actual June 2018
CASHFLOWS FROM OPERATING ACTIVITIES	Note	\$000	\$000	\$000
Cash was provided from:				
Receipts from Government and Public		401,476	396,214	377,756
Interest Received		112	330	401
GST (Net)		265	-	-
		<u>401,853</u>	<u>396,544</u>	<u>378,157</u>
Cash was disbursed to:				
Payments to Suppliers		236,077	230,086	219,904
Payments to Employees		154,515	146,781	137,730
Capital Charge Paid		10,367	10,575	8,226
Interest Paid		27	-	-
GST (Net)		-	-	107
		<u>400,986</u>	<u>387,442</u>	<u>365,967</u>
Net Cash Inflow from Operating Activities	19	<u>867</u>	<u>9,102</u>	<u>12,190</u>
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Dividends Received		161	58	71
Proceeds from Restricted Assets		61	-	65
Proceeds from Investments		2,890	2,890	-
Purchase of Intangible Assets		(240)	-	-
Proceeds from Sale of Property, Plant & Equipment		48	-	121
		<u>2,920</u>	<u>2,948</u>	<u>257</u>
Cash was applied to:				
Purchase of Property, Plant & Equipment		13,813	14,100	12,604
		<u>13,813</u>	<u>14,100</u>	<u>12,604</u>
Net Cash Outflow from Investing Activities		<u>(10,893)</u>	<u>(11,152)</u>	<u>(12,347)</u>
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Deficit support received from Crown		13,600	-	-
		<u>13,600</u>	<u>-</u>	<u>-</u>
Cash was applied to:				
Repayment of Equity		958	958	958
		<u>958</u>	<u>958</u>	<u>958</u>
Net Cash Inflow/(Outflow) from Financing Activities		<u>12,642</u>	<u>(958)</u>	<u>(958)</u>
Net (Decrease)/Increase in Cash Held		2,616	(3,008)	(1,115)
Cash and cash equivalents at beginning of year		(4,261)	(4,261)	(3,146)
Cash and cash equivalents at end of year		<u>(1,645)</u>	<u>(7,269)</u>	<u>(4,261)</u>

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

Significant accounting policies for the year ended 30 June 2019**(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 16.67% 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.

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 2019. The financial statements were authorised for issue by the Board on 29 October 2019.

(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.

Going Concern Assumption

The going concern assumption has been adopted in the preparation of these financial statements. The Board has a reasonable expectation that the District Health Board has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the District Health Board during the period of one year from the date of signing the 2018-19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in the current Statement of Intent). The key considerations are set out below.

(i) Operating and Cash flow forecast

The Board has considered the current year's deficit of \$ 23.4m and a forecasted deficit for next year together with forecast information relating to operational viability and cash flow requirements as well as the significant proposed capital spend in the future period. The Board expects that it will be able to use its working capital facility and access to additional funding, together with making adjustments to its capital spend to address the operational viability and cash flow for the coming year whilst still meeting expected patient demand and funding the required resources to deliver the relevant clinical services to meet such demand.

(ii) Borrowing covenants and forecast borrowing requirements

The District Health Board is subject to borrowing restrictions in the Ministry of Health Operations Policy Framework. The cash flow forecast for the next year prepared by the District Health Board reflects the equity funding or lease funding, together with the working capital facilities will be required to meet cash requirements. Whilst there is uncertainty regarding the mechanism that will be used to meet such cash requirements, the Board is confident that this can be achieved without breaching covenants or other borrowing restrictions.

(iii) Letter of comfort

The actions outlined above to address the operational viability and cash flow requirements are dependent on a combination of initiatives the Board intends taking over the next twelve months but there is still uncertainty of whether these actions will be successful and therefore the Board has requested a letter of comfort, dated 21 October 2019 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Changes in accounting policies

The District Health Board have adopted the following revisions to accounting standards during the financial year, which have only a presentational or disclosure effect:

PBE IFRS 9 Financial Instruments

The District Health Board has early adopted the standard for its financial statements for the year ended 30 June 2019. The District Health Board has applied PBE IFRS 9 retrospectively, but has elected not to restate comparative information. As a result, the comparative information provided continues to be accounted for in accordance with the District Health Boards previous accounting policy. On 1 July 2018 certain assets have been reclassified from "Loans and receivables" to "Financial assets at amortised cost". (refer to note 8).

The standard also introduced a new expected credit losses model that replaced the incurred loss impairment model used in PBE IPSAS 29 for calculating the provision for doubtful debts. The District Health Board has applied this expected credit losses model.

Accounting policies have been updated to comply with PBE IFRS 9. The main update is:

Trade and other receivables

This policy has been updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.

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:

Expected credit losses (note 8)

A monthly assessment of non commercial debtors is made, with expected credit losses 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 expected credit losses.

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. A fair value assessment was performed to ensure there is no material movement to the true carrying value in the current year.

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.

(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.

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 did not have any subsidiaries included in their financial statements for the year ended 30 June 2019.

Fulford Radiology Services Limited was removed from the Companies Register on the 25th October 2018. During the year ended June 2019 the company did not trade or incur any expenditure.

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 16.67% 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 (NZHPL), 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 expected credit losses.

Short term receivables are recorded at the amount due, less an allowance for credit losses. Taranaki District Health Board applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped together based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

Previous accounting policy for impairment of receivables

In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was objective evidence that the amount due would not be fully collected.

The amount of the expected credit loss 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 at amortised cost (previously loans and receivables). Management determines the classification of its investments at initial recognition and re-evaluates this designation at every reporting date.

(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 Finance Procurement and Information Management System

The Finance Procurement Supply Chain (FPSC), which includes the Finance Procurement and Information Management System (FPIM), 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 early adopted

In line with the Financial Statements of the Government, Taranaki District Health Board has elected to early adopt PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 8.

(v) Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective, that have not been early adopted are:

(i) Amendment to PBE IPSAS Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non cash flow changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Taranaki District Health Board does not intend to early adopt the amendment.

(ii) PBE IPSAS 34-38

PBE IPSAS 34-38 replace the existing standards for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019. Taranaki District Health Board will apply these new standards in preparing the 30 June 2020 financial statements. No effect is expected as a result of this change.

I REVENUE

	2019	2018
	\$000	\$000
Health and disability services (Crown appropriation revenue)*	382,262	363,258
ACC revenue	7,924	7,734
Inter District Patient Inflows	4,871	4,593
Interest received	112	401
Dividends received	71	71
Bad debts recovered	4	2
Other revenue	4,539	4,671
	<u>399,783</u>	<u>380,730</u>

*Performance against this appropriation is reported in the Statement of Performance on pages 32-57. 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

	2019	2018
	\$000	\$000
Non-exchange transactions	385,613	366,853
Exchange transactions	14,170	13,877
	<u>399,783</u>	<u>380,730</u>

2 OTHER INCOME

	2019	2018
	\$000	\$000
Donations and bequests received	427	612
Gain on sale of property, plant and equipment	48	88
	<u>475</u>	<u>700</u>

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

	2019	2018
	\$000	\$000
Non-exchange transactions	427	612
Exchange transactions	48	88
	<u>475</u>	<u>700</u>

3 EMPLOYEE BENEFIT COSTS

	2019	2018
	\$000	\$000
Wages and salaries	153,005	138,245
Contributions to defined contribution schemes	2,577	2,131
Increase in employee benefits provisions	2,992	2,274
	<u>158,574</u>	<u>142,650</u>

4 OTHER EXPENSES

	2019 \$000	2018 \$000
Impairment for credit losses on receivables	24	89
Loss on sale of property, plant and equipment	3	4
Audit fees - Deloitte Limited (for the audit of the annual financial statements)	201	195
Audit fees - ACC Accreditation Audit	6	5
Board and Advisory members fees	270	277
Board fees re Subsidiary Companies	-	6
Operating lease expenses	693	914
	<u>1,197</u>	<u>1,490</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 2019 was 6% (2018: 6%).

6 FINANCING COSTS

	2019 \$000	2018 \$000
Interest - NZ Health Partnerships Limited	<u>27</u>	<u>-</u>
	<u>27</u>	<u>-</u>

7 CASH AND CASH EQUIVALENTS

	2019 \$000	2018 \$000
Cash at bank and in hand	391	317
Demand funds with NZ Health Partnerships Limited	<u>(2,036)</u>	<u>(4,578)</u>
Cash and cash equivalents	<u>(1,645)</u>	<u>(4,261)</u>
Made up of:		
Asset	391	317
Liability	<u>(2,036)</u>	<u>(4,578)</u>
	<u>(1,645)</u>	<u>(4,261)</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

	2019	2018
	\$000	\$000
Ministry of Health	6,156	5,549
Due from associates	399	506
Due from non-related parties	6,334	8,258
Prepayments	1,841	998
	<u>14,730</u>	<u>15,311</u>
Allowance for credit loss (a)	(103)	(127)
Carrying amount of trade and other receivables	<u>14,627</u>	<u>15,184</u>

(a) Allowance for Credit Loss

Trade receivables are non-interest bearing and are generally on terms of 20th of month following invoice. An allowance for credit loss 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%).

30 June 2019

	Current	Receivable days past due			Total
		More than 30 days	More than 60 days	More than 90 days	
Expected credit loss rate	0.0%	0.0%	11.8%	46.1%	
Gross carrying amount (\$000)	14,491	3	17	219	14,730
Lifetime expected credit loss (\$000)	-	-	2	101	103

30 June 2018

	Current	Receivable days past due			Total
		More than 30 days	More than 60 days	More than 90 days	
Expected credit loss rate	0.0%	0.0%	66.7%	60.7%	
Gross carrying amount (\$000)	15,093	9	3	206	15,311
Lifetime expected credit loss (\$000)	-	-	2	125	127

	Actual	Actual
	2019	2018
	\$000	\$000
Allowance for credit losses as at 1 July calculated under PBE IPSAS 29	127	74
PBE IFRS 9 expected credit loss adjustment - through opening accumulated surplus/deficit	-	n/a
	<u>127</u>	<u>74</u>
Increase in loss allowance made during the year	25	89
Receivables written off during the year	(49)	(36)
	<u>103</u>	<u>127</u>

	2019	2018
	\$000	\$000
Total non commercial debt	196	237
Non commercial debt with no expected credit loss	93	110

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 2019 and 2018, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

(b) Receivables from exchange and non-exchange transactions

	2019	2018
	\$000	\$000
Non-exchange transactions	6,156	5,549
Exchange transactions	8,471	9,635
	<u>14,627</u>	<u>15,184</u>

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

(c) Related Party Receivables

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

(d) Credit Risk and Effective Interest Rate Risk

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

9 INVENTORIES

	2019	2018
	\$000	\$000
Pharmaceuticals	547	465
Surgical and Medical Supplies	2,253	2,216
Other Supplies	677	651
	<u>3,477</u>	<u>3,332</u>

Inventory recognised as an expense for the year ended 30 June 2019 totalled \$29.182m (2018: \$26.147m)

The write-down of inventories held for distribution amounted to \$0.085m (2018 \$0.073m). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

	2019 \$000	2018 \$000
Current portion		
Short-term deposits with maturities of 3-12 months	-	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

Fulford Radiology Services Limited was removed from the Companies Register on the 25th October 2018. During the year ended June 2019 the company did not trade or incur any expenditure.

12 INVESTMENT IN ASSOCIATE COMPANIES

	2019 \$000	2018 \$000
(a) Investment details		
Allied Laundry Services Limited unlisted ordinary shares	1,150	1,150
Allied Laundry Services Limited Share of Retained Earnings	39	14
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	443	375
	1,632	1,539

Taranaki District Health Board's share of retained earnings in 2019 relates to the year ended June 2018, plus \$68k for 20% share of HealthShare Limited's unaudited 2019 result.

Details of each Associate Company are as follows:	Balance date	Interest held at 30 June 2019	Interest held at 30 June 2018
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	16.67%	17.42%

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

(b) Summary of financial information of associate companies (100%)**Summarised financial information - for the year ended 30 June 2019:**

	Assets	Liabilities	Equity	Revenues	Profit
	\$000	\$000	\$000	\$000	\$000
Allied Laundry Services Limited	9,918	2,544	7,374	10,924	648
HealthShare Limited	26,525	24,309	2,216	17,390	340

Summarised 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

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

This is based on an investment in HealthShare Limited of 20% (2018: 20%) and Allied Laundry Services Limited of 16.67% (2018: 17.42%)

	2019	2018
	\$000	\$000
Balance at 1 July	1,539	1,395
Share of total recognised revenues and expenses	93	144
Balance at 30 June	1,632	1,539

*the share of total recognised revenue and expenses has been based on preliminary results and will differ slightly to actual results above.

13 PROPERTY, PLANT AND EQUIPMENT

	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Work in Progress	Total
	\$000	\$000	\$000	\$000	\$000	\$000
Year ended 30 June 2019						
Cost/valuation 30 June 2018	12,555	167,320	110,556	3,177	10,606	304,214
Accumulated depreciation 30 June 2018	-	-	(82,384)	(1,778)	-	(84,162)
Carrying amount 30 June 2018	12,555	167,320	28,172	1,399	10,606	220,052
Current year additions	-	842	4,432	454	13,813	19,541
Current year work in progress capitalised	-	-	-	-	(5,728)	(5,728)
Current year disposals	-	-	(8)	-	-	(8)
Current year depreciation	-	(7,913)	(9,125)	(294)	-	(17,332)
At 30 June 2019 net of accumulated depreciation	12,555	160,249	23,471	1,559	18,691	216,525
At 30 June 2019						
Cost or fair value	12,555	168,162	111,549	3,283	18,691	314,240
Accumulated depreciation	-	(7,913)	(88,078)	(1,724)	-	(97,715)
	12,555	160,249	23,471	1,559	18,691	216,525

	Freehold Land \$000	Freehold Buildings \$000	Plant and Equipment \$000	Motor Vehicles \$000	Work in Progress \$000	Total \$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

In the year end 30 June 2019, there are no claims (2018: \$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 2019 (2018: Nil).

14 INTANGIBLE ASSETS

	ePharmacy Licence \$000	Shares in NZ HPL \$000	Total \$000
Year ended 30 June 2019			
Carrying amount 30 June 2018	409	1,384	1,793
Additions for year	-	50	50
Depreciation and Loss on Sale of Assets	-	(271)	(271)
Impairment for year	-	(351)	(351)
Amortisation charge for year	(106)	-	(106)
At 30 June 2019 net of accumulated amortisation	303	812	1,115

At 30 June 2019			
Cost or fair value	747	1,658	2,405
Accumulated amortisation and impairment	(444)	(846)	(1,290)
	303	812	1,115

	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

Finance Procurement Supply Chain, including Finance Procurement and Information Management System

At 30 June 2019 Taranaki District Health Board had made payments totalling \$1,658k (2018: \$1,608k) 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 Finance Procurement and Information Management System (FPIM) 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/FPIM 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 2019 there is considered to be an accumulated impairment and amortisation of \$846k (2018: \$224k) to Taranaki District Health Board's share of the DRC of the underlying FPSC/FPIM assets.

Impairment of Finance Procurement and Information Management System Asset

The Finance Procurement and Information Management System (FPIM) asset is deemed to be a non-cash generating asset. This is on the basis that there are no cash flows directly linked to the asset. Rather, the benefit to each DHB is the potential cost savings from a negotiated national contract above the cost of each DHB negotiating a similar contract themselves. Therefore, the applicable accounting standard is PBE IPSAS 21 Impairment of Non-Cash-Generating Assets. PBE IPSAS 21 requires an annual test for impairment by comparing the asset carrying value with its recoverable service amount.

The FPIM Business Case approved by Cabinet 24 June 2019 materially changed from the FPIM Programme paused by the Cabinet decision of 28 June 2018 and the judgements that were assumed in assessing the FPIM Programme carrying value at 30 June 2018. Key changes being:

- * the Business Case has crystallised that only 10 DHBs are committing to a single system in the short to medium term;
- * the Business Case conservatively reduced the benefits to only identifiable procurement spend of \$ 642m by PHARMAC and \$ 102m by NZ Health Partnerships. This impacts on Net Present Value calculations which formed part of the assessment of carrying value of the asset and the requirement for any impairment;

* NZ Health Partnerships now have visibility of a working system, which has been operated since July 2018 at four DHBs, on which user feedback is available in evaluating the broader initial scope and activities capitalised under Health Benefits Limited ownership prior to June 2014. It has considered how much of that work still holds value for the pared back system that was finally deployed.

NZ Health Partnerships tested the FPIM asset for impairment by determining the asset's value in use based on its depreciated replacement cost (DRC).

Based on the information and assumptions known to it, NZ Health Partnership considers that, in all material respects, the FPIM asset costs capitalized now exceed the DRC. NZ Health Partnership therefore has recognised a further \$ 32.9m impairment of the FPIM asset in the Statement of Comprehensive Income for the year ended 30 June 2019, to a level that approximates its estimated future recoverable service amount.

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.

	2019	2018
	\$000	\$000
Opening Balance	779	844
Funds Received	23	80
Interest Received	14	20
Funds Spent	(97)	(165)
Closing Balance Restricted Assets	<u>719</u>	<u>779</u>
	2019	2018
	\$000	\$000
Represented By:		
Cash at Bank	176	139
Short Term Deposits	539	634
Shares & Other	4	6
Total Restricted Assets	<u>719</u>	<u>779</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

	2019	2018
	\$000	\$000
Trade Payables	20,072	18,417
Income received in advance	540	448
Owing to Associates	640	807
GST Payable	1,944	1,683
	<u>23,196</u>	<u>21,355</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

	2019	2018
	\$000	\$000
Salary & wages accrual	8,953	8,055
Annual Leave	21,765	19,078
Sick Leave	517	481
Long Service Leave	2,031	1,871
Retirement gratuities	692	686
Continuing Medical Education	2,132	2,160
Sabbatical Leave	305	174
	<u>36,395</u>	<u>32,505</u>
Made up of:		
Current	35,296	31,604
Non-current	<u>1,099</u>	<u>901</u>
	<u>36,395</u>	<u>32,505</u>

Compliance with Holidays Act 2003

Details regarding the provision for underpayments relating to this Act are disclosed in note 24.

18 PROVISIONS

	2019	2018
	\$000	\$000
Current provisions		
ACC Partnership Programme	<u>176</u>	<u>37</u>
	<u>176</u>	<u>37</u>

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at the 30th June 2019. 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 \$0.95m (2018: \$0.65m).

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

	2019	2018
	\$000	\$000
Net Loss	(23,370)	(8,289)
Add Non-Cash Items:		
Depreciation	17,332	17,134
Amortisation and impairment of Intangible assets	729	330
Increase/(Decrease) in Provision for Doubtful Debts	(24)	53
Increase in Employee Entitlements	4,059	4,920
	<u>22,096</u>	<u>22,437</u>
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	6	(334)
Net (Gain) / Loss on Disposal of property, plant and equipment	(45)	(84)
	<u>(39)</u>	<u>(418)</u>
Movements in Working Capital:		
(Increase) in Receivables & Prepayments	581	(2,064)
(Increase) in Inventories	(145)	(230)
Increase in Payables & Accruals	1,744	754
	<u>2,180</u>	<u>(1,540)</u>
Net Cash Inflow from Operating Activities	<u>867</u>	<u>12,190</u>

20 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	2019	2018
	\$000	\$000
<i>Board Members</i>		
Remuneration	270	277
Full-time equivalent members	1.7	1.6
<i>Executive management</i>		
Remuneration	2,506	2,261
Full-time equivalent employees	10.0	10.0
Total key management personnel remuneration	2,776	2,538
Total full-time equivalent personnel	11.7	11.6

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 \$382.262m from the Ministry of Health to provide health services to the Taranaki area (2018: \$363.258m). The amount outstanding at year end was \$6.156m (2018: \$5.549m).

(b) Inter-Group Transactions and balances:

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

		Owed to TDHB		Income to TDHB	
		2019	2018	2019	2018
		\$000	\$000	\$000	\$000
TDHB Transactions					
Allied Laundry Services Limited	Dividend and rents received	139	232	84	85
NZ Health Partnerships Limited	DHB national collective service agreements	-	-	-	-
Healthshare Limited	IT consultancy	260	274	563	716
		<u>399</u>	<u>506</u>	<u>647</u>	<u>801</u>

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

		Owed by TDHB		Payments by TDHB	
		2019	2018	2019	2018
		\$000	\$000	\$000	\$000
Allied Laundry Services Limited		89	91	1,128	1,088
NZ Health Partnerships Limited		194	46	833	424
Healthshare Limited		551	716	2,241	2,520
		<u>834</u>	<u>853</u>	<u>4,202</u>	<u>4,032</u>

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

22 FINANCIAL INSTRUMENT CATEGORIES

The carrying amounts of financial instruments categorised are as follows, together with fair values:

		Carrying amount	Fair value	Carrying amount	Fair value
		2019	2019	2018	2018
	Notes	\$000	\$000	\$000	\$000
FINANCIAL ASSETS					
Amortised cost					
Cash and cash equivalents	7	391	391	317	317
Trade and other receivables	8	12,786	12,786	14,186	14,186
Other financial assets - current	10	-	-	2,890	2,890
Other financial assets - non current	10	56	56	56	56
Restricted Assets and Trust Funds	15	719	719	779	779
Total amortised cost		13,952	13,952	18,228	18,228

		Carrying amount	Fair value	Carrying amount	Fair value
		2019	2019	2018	2018
	Notes	\$000	\$000	\$000	\$000
FINANCIAL LIABILITIES					
Financial liabilities at amortised costs					
Cash and cash equivalents	7	2,036	2,036	4,578	4,578
Trade and other payables	16	20,712	20,712	19,224	19,224
Total financial liabilities		22,748	22,748	23,802	23,802

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

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 98% (2018: 97%) whilst it accounted for 96% (2018: 96%) 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**2019**

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	22,656	22,656	22,656	-	-	-
	22,656	22,656	22,656	-	-	-

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	-	-	-

(e) Sensitivity Analysis

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)	
	2019	2018
	\$000	\$000
+1% (100 basis points)	-	29
-1% (100 basis points)	-	(29)

24 COMPLIANCE WITH HOLIDAY PAY ACT 2003 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 consider the outcome of these claims will not have a material adverse affect on the financial position of Taranaki District Health Board.

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 DHB's and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHB's. DHB's have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, Taranaki District Health Board recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHBs best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remains substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

Taranaki District Health Board has applied the intent of the Memorandum of Understanding in determining the provisioning of \$0.95 million of Holidays Act costs as at 30 June 2019. There is still work to be completed to finalise the value of the full cost.

25 CAPITAL COMMITMENTS AND OPERATING LEASES

	2019	2018
	\$000	\$000
Capital Commitments		
Property, plant and equipment	5,099	2,080
	<u>5,099</u>	<u>2,080</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.		
	2019	2018
	\$000	\$000
Not later than one year	356	485
Later than one and not later than two years	316	180
Later than two and not later than five years	179	286
Later than five years	78	111
	<u>929</u>	<u>1,062</u>

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

Taranaki District Health Board recorded a deficit of \$23.37 million compared to a budgeted deficit of \$13.73 million.

Revenue received during the year was \$6.73 million over budget as follows (2018 \$1.896m increased):

	Variance	Variance
	2019	2018
	\$000	\$000
Health and disability services (Crown appropriation revenue)	6,512	1,304
Accident Compensation Revenue (ACC)	(22)	514
Inter District Flows	17	31
Inter Provider Revenue	241	71
Interest Received	(218)	81
Donations Received	(73)	(392)
Other	272	287
	<u>6,729</u>	<u>1,896</u>

Income Statement Revenue Explanations

Ministry of Health Funding	Funding for collective employment settlements, safe staffing, and other additional funding programmes that were not budgeted
Inter Provider Revenue	Additional services provided to other DHB's that were not budgeted for
Interest Received	Shortfall against planned revenue due to reduced working capital

Income Statement Variances - Expenditure

Expenditure was \$16.459m in excess of budget as follows (2018: more by \$8.329m):

	Variance	Variance
	2019	2018
	\$000	\$000
Income Statement Expenditure Explanations		
Employee Benefit costs	10,388	5,922
Depreciation expense	(1,567)	(524)
Outsourced services	(1,397)	939
Clinical supplies	1,920	3,889
Infrastructure and non-clinical expenses	4,880	2,483
Payments to non-health board providers	3,233	(3,516)
Other	(998)	(864)
	<u>16,459</u>	<u>8,329</u>

Income Statement Expenditure Explanations

Employee Benefit costs	Additional staffing to meet increased acute demand, one on one patient care, compliance with MECA provisions, and increased wage settlements over budget assumptions
Depreciation expense	Due to timing of capital investment
Outsourced services	Bringing the services and personnel in house
Clinical Supplies	Increased activity, price increases and a pharmaceutical rebate now received by the Funder arm
Infrastructure and non-clinical expenses	Shortfall in realising efficiencies against a savings plan, increased operational costs over plan, and an impairment of investment
Payments to non-health board providers	Increase in demand and Inter District outflows

	Variance	Variance
	2019	2018
	\$000	\$000
Balance Sheet Variances		
Cash and cash equivalents	5,624	(1,010)
Trade and other receivables	555	4,761
Property, plant and equipment	1,478	46,138
Intangible assets	(269)	375
Trade and other payables	1,341	2,488
Employee benefits	2,592	5,577

Balance Sheet Explanations

Cash and cash equivalents	Impact of deficits on cashflow
Trade and other receivables	Annual wash ups and rebates not received
Intangible assets	Impairment of the Finance Procurement and Information Management System (FPIM)
Trade and other payables	Capital works with payments spread into future years
Employee benefits	Additional employees, unsettled collective agreements, and increased provision for the Holidays Pay Act 2003 liability

27 AUDITORS' REMUNERATION

		2019 \$000	2018 \$000
Fees to principal auditor (Deloitte Limited)	Note		
Audit of annual financial statements	4	201	195
		2019 \$000	2018 \$000
Other Audit Fees paid (non Deloitte Limited)	Note		
ACC Accreditation Audit	4	6	5

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 increased Equity by paying Deficit Support Funding of \$13.6m (2018: \$0m). Public equity of \$0.958m (2018: \$0.958m) was repaid to the Crown during the year. The repayments in both 2019 & 2018 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

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

Remuneration Range	Actual 2019	Actual 2018
100,000 - 110,000	68	46
110,001 - 120,000	35	35
120,001 - 130,000	31	18
130,001 - 140,000	18	8
140,001 - 150,000	8	6
150,001 - 160,000	9	6
160,001 - 170,000	8	7
170,001 - 180,000	4	9
180,001 - 190,000	7	10
190,001 - 200,000	8	7
200,001 - 210,000	7	5
210,001 - 220,000	8	3
220,001 - 230,000	5	9
230,001 - 240,000	5	6
240,001 - 250,000	6	8
250,001 - 260,000	5	3
260,001 - 270,000	5	1
270,001 - 280,000	5	4
280,001 - 290,000	3	2
290,001 - 300,000	4	7
300,001 - 310,000	5	3
310,001 - 320,000	4	3
320,001 - 330,000	1	3
330,001 - 340,000	3	1
340,001 - 350,000	2	5
350,001 - 360,000	4	-
360,001 - 370,000	2	2
370,001 - 380,000	4	1
380,001 - 390,000	4	1
400,001 - 410,000	1	1
470,001 - 480,000	-	1
	<u>279</u>	<u>221</u>
Clinicians	228	182
Non Clinical	<u>51</u>	<u>39</u>
Total	<u>279</u>	<u>221</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 403 (2018: 281).

30 TERMINATION PAYMENTS

For the period to 30 June 2019, 2 employees or former employees of Taranaki District Health Board received payment in respect of termination of employment for \$158,806 (2018: 4 payments totalling \$50,400).

31 EVENTS SUBSEQUENT TO BALANCE DATE

There were no events subsequent to the balance date.

REPORTING ON 'GOOD EMPLOYER' PRACTICES

Pūrongo whanonga kaimahi pai

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 Values documentation Performance Review Policy. 	<ul style="list-style-type: none"> Employee Engagement Survey (2017 & 2018) 'Te Ahu Taranaki' Values (2018 launch) Formal management and management/union meetings New managers' induction National Leadership Domains Framework National Talent Management Programme Front-line Leadership ('Leadership in Action'), Advanced Leadership (ALP) and Team Development & Collaboration programmes Change Management & Continuous Improvement programme Team development workshops to support our 'Te Ahu Taranaki' Values and effective team functioning. 	<ul style="list-style-type: none"> Leadership and team development aligned with Taranaki DHB strategy 'Te Ahu Taranaki' Values to support Taranaki DHB strategy Develop employee engagement. 	<ul style="list-style-type: none"> New suite of leadership & team development programmes for 2017/2018, continuing into 2019 & 2020. 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 and External Partnering (27 participants) Change Management and Continuous Improvement (120 participants) Launch of Te Ahu Taranaki new values (2018) Employee Engagement Survey (2017 & 2018). Teams identify employee engagement improvement actions, utilising engagement survey outcomes for their area.
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 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.

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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 Performance appraisal. 	<ul style="list-style-type: none"> Training Needs Analysis completed for 2019 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"> eLearning platform in operation, 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 New Values-based performance appraisal & development framework (launched 2019).
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 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 DHBs) Framework for Employee Wellbeing launched Active Wellbeing programme in place Values based Peer-to-Peer Recognition scheme in operation (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 As above, Values-based Peer-to-Peer Recognition scheme in operation.
Stress and Resilience Support; Harassment and Bullying Prevention	<ul style="list-style-type: none"> Harassment Policy and Procedure Employee Assistance Programme (EAP) Stress & Resilience Support initiatives. 	<ul style="list-style-type: none"> Interpersonal skills programmes Coaching/training Union reps Conflict resolution Stress & Resilience training workshops provided for staff during restructures; ‘lunch-n-learn’ sessions for staff on stress, meditation, mindfulness etc. Mental Health Awareness Week EAP promoted regularly. 	<ul style="list-style-type: none"> Launch revised Bullying and Harassment Policy and Anti-Bullying Programme Change Management training. 	<ul style="list-style-type: none"> Anti-Bullying programme underway New Bullying and Harassment Policy drafted for consultation Education & communication plan being developed Teams at high risk of bullying identified and change programmes with these teams being implemented Change Management training programme (120 participants).
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 MECAs and SECAs 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 whānau 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 six 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 Declaration for all staff, contractors and students • 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 Representative and Health and Safety Committee programmes • Bipartite Action Group • Quarterly reporting to the Taranaki DHB Board on Health and Safety matters • Wellness Committee • Security. 	<ul style="list-style-type: none"> • Maintaining entry in the ACC Accredited Employer programme • Maintenance of the 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 Strengthening our training especially at manager level in regard to expectations • Encouraging partnership by empowering the Health & safety Rep roles • Clarifying and strengthening the worker rehabilitation program. 	<ul style="list-style-type: none"> • Investigation training provided to managers and H&S Representatives • Health and Safety requirements in all job description templates and included in all staff performance reviews • Development of Incident management Policy and associated documents • Updating of existing health and safety policy and procedures to ensure compliance with the Health and Safety at Work Act 2015 and associated regulations • Introduction of a new Pre-Employment Health Declaration which includes improved health monitoring and vaccination processes. • Improvements to our follow up process in regard to new starters vaccination status • Improvements to the TB health surveillance and monitoring procedure • Continuing our hearing conservation program Asbestos Management Plan being finalised • 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.

MINISTERIAL DIRECTIONS

NGĀ TOHUTOHU A TE MINITA

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.



Te Poari Hauora-ā-Rohe o Taranaki
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