



TARANAKI DISTRICT HEALTH BOARD

STATEMENT OF INTENT

2019/20-2022/23

Incorporating the 2019/20 Statement of Performance Expectations

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004



Mihi

Ko Puanga te hua o te tau hou.
Ka rewa i te atatū, ko te uranga o te rā.
Ka haehae i te pō, ka takina te pō ki tua.
E matarikoriko ana ki te pae o tō rangi.
E wherawhera ana ki ō pae ki mua.

Tēnei rā te puanga mai o te ora e rewa nei ki te tihi o Taranaki.
Te kōhae nei, te korakora nei ki te pae o te tau ki mua.
He ahunga rau, he hokinga mahara atu i te tau kua hipa
Te maunutanga mai o te tau pai, ko te tau kei runga.
Kia piri, kia tata mai ki te whare o Tāne whakapiripiri
Kia ihiihi, kia wanawana mai ki te kura o Tāne te wānanga
Kia tū, kia oho ki te paepae tapu o Tāne te waiora.
Taranaki e, kia horapa te pai, he tūāpapa ki te ora

*Puanga heralds the new year.
Rising at early dawn, the prelude of a new day.
Vanquishing the night, leaving darkness behind.
Gleaming on the cusp of the horizon.
Revealing what new horizons are possible.*

*This statement for wellbeing is like that star that rises above Taranaki.
Gleaming and radiating, signalling the threshold of the forthcoming year.
Reflecting back also to the achievements and events of the year past
The year is launched forward with aspirations of new productivity and growth
To draw people closer together in mind and spirit, the essence of our connection
To invigorate and excite with knowledge and insight, the essence of our intellect
To strengthen and awaken with values and practice, the essence of our wellbeing
Taranaki, may compassion be widespread, and the foundation of health*

Mihi authored by Ruakere Hond

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Published by Taranaki District Health Board
Private Bag 2016, New Plymouth, 4342

This document is available on the Taranaki District Health Board website: www.tdhb.org.nz

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Note: The 2019/20 Annual Plan has yet to be agreed by the Minister of Health and the Taranaki District Health Board. The Statement of Intent (SOI) and Statement of Performance Expectations (SPE) is an integral part of the Annual Plan. However, in order to meet the requirements of Section 149(L) of the Crown Entities Act 2004, we are pleased to present the following information which forms the Statement of Intent and Statement of Performance Expectations. The SOI and SPE may be subject to further change as a result of the process of finalising the DHB Annual Plan for 2019/20 with the Ministry of Health.

SECTION 1: Overview of Strategic Priorities

1.1 Introduction

Taranaki DHB was established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD) and is one of 20 DHBs in New Zealand. DHBs were established as vehicles for the public funding and provision of personal health services, public health services and disability support services for a geographically defined population. Each DHB is categorised as a Crown Agent under the Crown Entities Act and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

Taranaki District Health Board's Statement of Intent 2019/20-2021/22 has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health. The Statement of Intent sets out our strategic goals and objectives, and describes what we aim to achieve in terms of improving the health of our population and ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year.

This Statement of Intent makes clear links to national, regional and district agreed priorities including the Taranaki Health Action Plan (2017-20) and Te Kawau Maro (Taranaki Māori Health Strategy, 2009-29). This document sets out our goals and objectives and what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the Taranaki health system over the coming three years.

This Statement of Intent can be read alongside the Taranaki DHB Statement of Performance Expectations and the Taranaki DHB Annual Plan (incorporating the Taranaki DHB Statement of Performance Expectations) which is updated annually.

This Statement of Intent is extracted from the Taranaki DHB's Annual Plan and presented to Parliament as a separate public accountability document to meet legislated submission timeframes.

In line with the New Zealand Health Strategy, Taranaki DHB has made a strong commitment to 'whole of system' service planning. We work in partnership with other service providers, and engage with individuals, their families and our community, to meet the needs of our population.

We recognise our role in actively addressing disparities in health outcomes for Māori and are committed to improving equity. We work with in partnership with iwi and Māori Health provider representatives in a spirit of communication and co-design that encompasses the principles of participation, partnership and protection outlined in the Treaty of Waitangi.

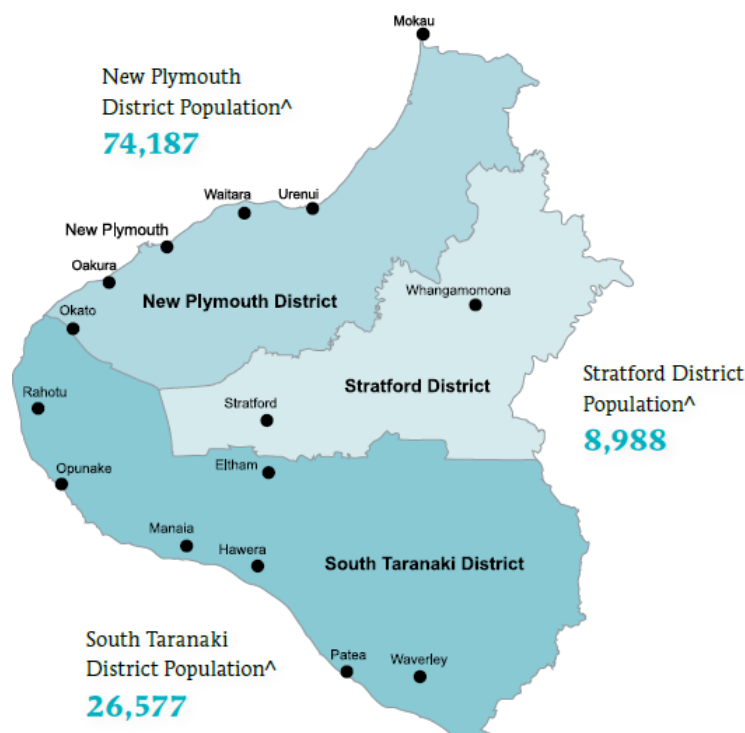
In order to achieve the planned outputs, impacts and outcomes as outlined in this Annual Plan, we may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or vary any current agreement for the provision or procurement of any health and disability support service. These agreements (or variations) may contain any terms or conditions acceptable to the DHB.

In signing this Statement of Intent, we are satisfied that it fairly represents our joint intentions and activity, and is in line with Government expectations for 2019/20.

1.2 Population Profile

The Taranaki region covers more than 7000 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.

According to Statistics New Zealand, in 2018/19 Taranaki DHB serves a population of 119,800¹ 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.



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

The district covers more than **7000** square kilometres.

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.

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.

This pattern is reflected in inequitable Māori health outcomes, particularly in the areas of non-communicable disease which is strongly linked to social determinants of health.

¹ Based on updated information received from Statistics New Zealand Population Projection released December 2018

[^] Based on usually resident population, 2013 Census

Mortality rates for Māori in Taranaki are significantly higher, age-standardised, than for non-Māori (3.4 times)². Nationally the difference between Māori and non-Māori is about 2.3 times. Nationally, males have a significantly higher mortality rate (1.4 times) than females. Both of these differences are linked to higher past smoking rates. Over the last 10 years, the hospitalisation rate for COPD has remained steady for NZ, but declined for Taranaki by about 1.4% despite an increasing number of COPD patients due to the ageing population.

Amenable mortality is decreasing in Taranaki but Māori continue to die earlier than non-Māori, and non-Māori in Taranaki die earlier than their peers in other Midland DHBs. Taranaki Māori residents are more likely to die for amenable reasons than non-Māori, although the gap is less than observed in other Midland Region DHBs and nationally. Taranaki non-Māori residents are also more likely to die for amenable reasons than their peers in other Midland Region DHBs or nationally. Around 80% of all amenable deaths in Taranaki are for non-Māori residents.

Ischaemic heart disease (IHD) is the leading cause of amenable mortality for Taranaki residents, as it was for NZ overall. Other leading causes of premature death in Taranaki and NZ are suicide, chronic obstructive pulmonary disease (COPD), cerebrovascular disease (stroke) and female breast cancer.

1.3 Role and Functions

Under the Health and Disability Act 2000, Taranaki DHB has a responsibility to improve, promote and protect the health of its people and communities. Additionally, there is a responsibility to promote the reduction of adverse social and environmental effects on health of people and communities.

As a DHB we:

- **Plan**, in partnership with key stakeholders and our community (i.e. clinical leaders, Iwi, Primary Health Organisations and non-Government organisations); and in collaboration with other DHBs and the National Health Board, regional and national work. the strategic direction for health and disability services in the Taranaki;
- **Fund** the provision of the majority of the public health and disability services in our district, through the contracts we have with providers (see also *Modules 5 and 7*);
- **Provide** hospital and specialist services primarily for our population; and
- **Promote, protect and improve** our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

Taranaki DHB is responsible for the provision (or funding the provision) of the majority of health services in our district. We collaborate with other health and disability organisations (such as our primary care alliance partners), key stakeholders and our community to identify what health and disability services are needed and how best to use the funding we receive from Government. Through this collaboration we aim to ensure that health and disability services are well coordinated and cover the full continuum of care, with the patient at the centre. We expect these collaborative partnerships to also allow the sharing of resources, reduction in duplication, variation and waste across the health system to achieve the best outcomes for our community.

Taranaki DHB recognises our responsibilities under the Treaty of Waitangi, and fulfils these through:

- Engagement with Te Whare Punanga Korero (TWPK) Trust, the Māori health governance group which works with the Board of Taranaki DHB in setting strategic direction
- Implementation of Te Kawau Mārō (the Taranaki Māori Health Strategy) through the DHB's Pae Ora Framework, and the principles of the Treaty of Waitangi.

² Note – population health data in this section is referenced from the Taranaki Health Action Plan (2017-20) available at <https://www.tdhub.org.nz/misc/documents/TDHB-Health-Action-Plan-2017.pdf>

- Working with our Māori health provider network, Te Kawau Mārō Alliance and Te Pa Harakeke, the DHB's Māori Health Unit
- Enabling Māori participation in decision-making at an executive level through the Chief Advisor Māori Health

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

- Relationship with one Primary Health Organisation (Pinnacle Midlands Health Network)
- 29 PHO aligned GP practices
- 21 dental practices
- 28 pharmacies
- 19 community personal health providers
- Providers of community laboratory services and radiology services
- 7 community based mental health, and alcohol & addictions service
- 3 Māori health service providers
- Support services for people with disability, including 26 aged residential care facilities
- Access to tertiary and specialist hospital healthcare in other parts of New Zealand

Hospital provider - facilities include Taranaki Base Hospital, Hawera Hospital and five community health centres in Waitara, Stratford, Opunake, Patea and Mokau.

1.4 Vision and Values

Our Shared Vision - Te Matakite

Taranaki Together, A Healthy Community

Taranaki Whanui He Rohe Oranga

Our Mission – Te Kaupapa

Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki

Our Values – Nga Tikanga

How We Work Together With Others – Ngā Tikanga

The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, Whānau, funded agencies, staff and members of the public. Therefore, we will work together by:

- Partnership / Whānaungatanga
- Courage / Manawanui
- Empowerment / Mana motuhake
- People matter / Mahakitanga
- Safety / Manaakitanga

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



1.5 Strategic Intentions/Priorities

1.5.1 National Context

The Treaty of Waitangi

The Treaty of Waitangi (*Te Tiriti o Waitangi*) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Taranaki DHB values the importance of the Treaty. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure).

The Taranaki DHB Annual Plan is underpinned by the Treaty of Waitangi principles of partnership, participation and protection. We acknowledge the special relationship between the Crown and *Tāngata Whenua* and will actively work with Māori to affirm Treaty of Waitangi principles.

New Zealand Health Strategy

The New Zealand Health Strategy outlines the high level direction of the New Zealand health system over the next 10 years along with a Roadmap of Actions. The Strategy identifies five strategic themes for the changes that will take us toward this future:

- People-powered
- Closer to home
- Value and high performance
- One team
- Smart system

The strategy has a ten-year horizon, so impacts on not just immediate planning and service provision but enables and requires DHBs and the sector to have a clear roadmap for future



He Korowai Oranga

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Pae Ora (Healthy Futures for Whānau) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments). DHBs in particular should implement He Korowai Oranga in their planning, and in meeting their statutory objectives and functions for Māori health.

Healthy Ageing Strategy

The Healthy Ageing Strategy presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. The Healthy Ageing Strategy vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities". It takes a life-course approach that seeks to maximise health and wellbeing for all older people. This Strategy is designed to ensure our health system provides the care, support and treatment that older New Zealanders need and that level of care is sustainable. It has a strong focus on prevention, wellness and support for independence, recognising the importance of Whānau and community in older people's lives.

The UN Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disabilities is the first United Nations human rights treaty of the 21st century. The Convention makes it explicit that member countries must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability. It will also help to ensure that mainstream services are inclusive of disabled people and delivered in non-discriminatory ways.

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018

To facilitate the delivery of high-quality health services that meet the needs of Pacific peoples, 'Ala Mo'ui has been developed. This builds on the successes of the former plan, 'Ala Mo'ui 2010–2014. It sets out the strategic direction to address health needs of Pacific peoples and stipulates new actions, to be delivered from 2014 to 2018.

National Inquiry into Mental Health & Addictions

The 2018 Inquiry into Mental Health and Addiction aimed to provide an accurate picture of how well New Zealand's current mental health and addiction services are working and to create a baseline from which a proposed pathway for improvements can be outlined. The Inquiry provides an opportunity to build consensus on the specific changes needed to enable improved and equitable outcomes for those with mental health and addiction needs. It also aims to set out a clear direction for the next five to ten years that Government, the mental health and addiction sector and the whole community can pick up and make happen.

The Inquiry sought to hear the voices of the community, particularly those impacted by mental health and addiction challenges, and to report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people experiencing those problems. The Inquiry also aimed to recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on achieving equitable outcomes. The Inquiry Report has been used to inform the Government's decisions on future arrangements for mental health and addiction and future investment priorities, which in turn is reflected in the actions outlined in our Annual Plan.

1.5.2 Regional Context

Midlands DHBs collaborate regionally to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Midland DHBs' shared services agency, is tasked with developing the Midland RSP on their behalf. This work is done in consultation with the Midland DHBs

Annual Plan Writers Group and DHB Executive Groups to ensure collaboration and alignment) between the region and DHB planning.

The guidance for 2019/20 outlines expectations that both the locally determined and nationally required priorities for the implementation element of the RSP will be in line with the legislative obligations of DHBs in improving Māori health. The guidance also includes clear expectations that RSPs identify how regional collaborative work programmes in general, and in the implementation section of the plan specifically, are supporting financial, clinical and service sustainability.

In addition to locally agreed priorities, the Ministry has identified the following priorities for regional service planning:

- Data & Digital – Regional ICT Investment Portfolio
- Workforce
- Hepatitis C
- Cardiac & Stroke
- Healthy Ageing

The Midland region has six regional strategic objectives that inform and support the direction of regional efforts:

- Health equity for Māori.
- Improve quality across all regional services.
- Integrate across continuums of care.
- Build the workforce.
- Improve clinical information systems.
- Efficiently allocate public health system resources.

Work programmes are developed by the regional clinical networks and action groups; the regional enablers, and also by services provided by HealthShare (the Midland DHBs' shared services agency), i.e. Third Party Provider Audit & Assurance Service, the Regional Internal Audit Service. Alignment with national and regional strategic direction is provided against each work programme's initiatives, i.e. the New Zealand Health Strategy's five strategic themes; the national System Level Measures, and Midland's six regional strategic objectives. Resourcing for delivery of approved work programmes is regionally agreed, budgeted and approved.

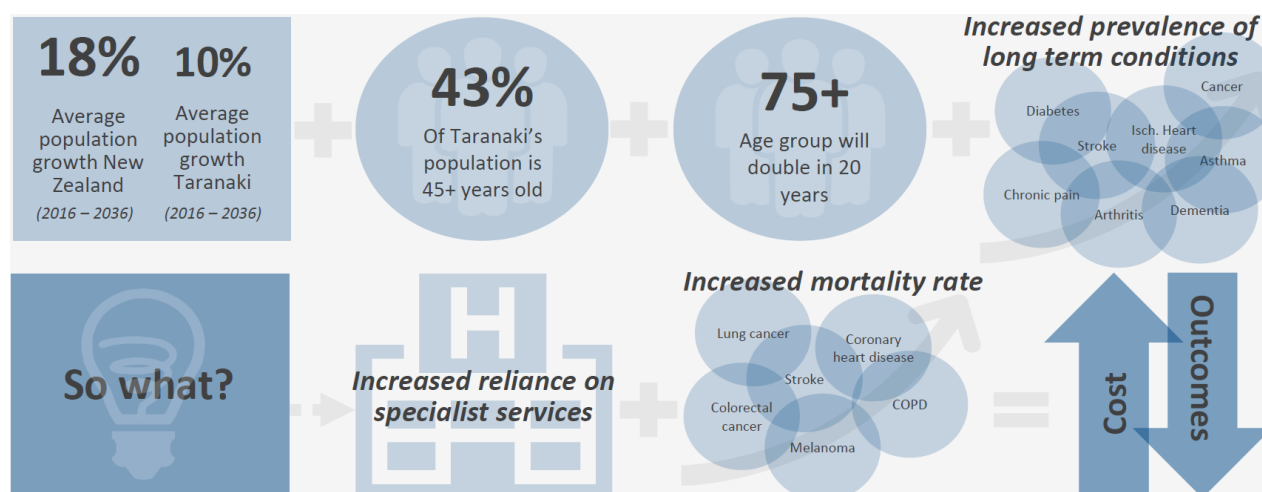
In the case of cancer service planning, Taranaki DHB is aligned to the Central Cancer Network (CCN) rather than the Midlands Cancer Network. CCN is one of four Regional Cancer Networks in New Zealand whose overall aim is to take a proactive leadership, facilitation and coordination approach to ensure all providers of cancer care in the network area work together to reduce the incidence and impact of cancer, reduce health inequalities and improve the journey of cancer patients and their family/Whānau through the cancer care pathway.

1.5.3 Taranaki Context

Local Challenges

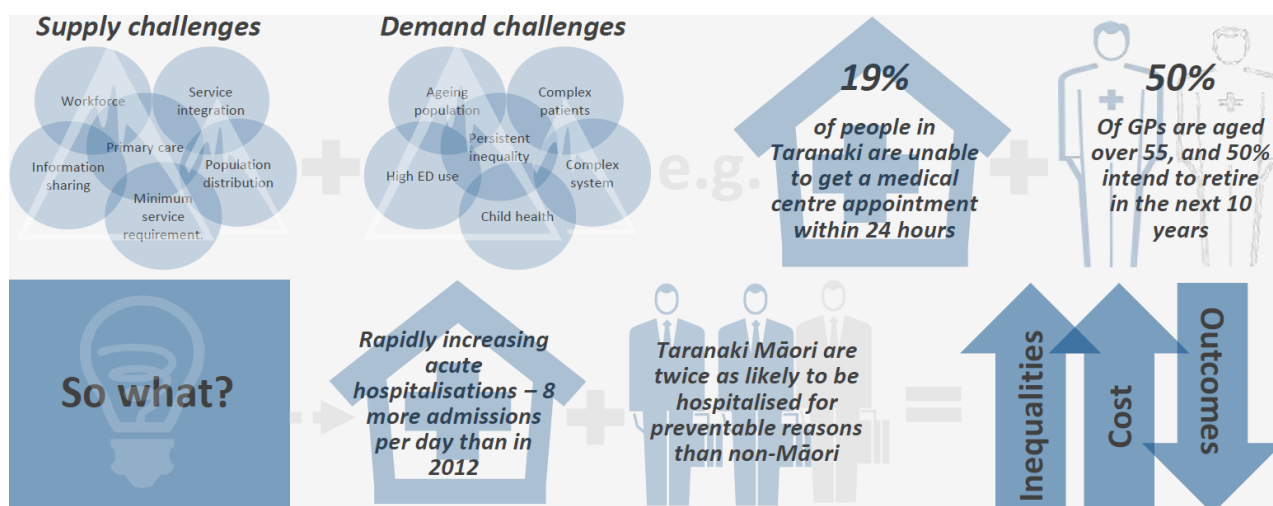
Like the New Zealand health system as a whole, Taranaki's health system is facing intensifying supply and demand pressures that are impacting on clinical and financial sustainability. Key pressures in Taranaki include an ageing population, increasing patient complexity, persistent health inequalities for Māori, an increased reliance on specialist services (including high use of ED) and small scale primary care. These pressures exist within the context of slow growth in funding, an existing DHB deficit and an increase in quality and safety expectations. However, our population is predicted to grow slowly, impacting on our

funding. At the same time complexity of patient needs is increasing due to the impacts of ageing and long term conditions.

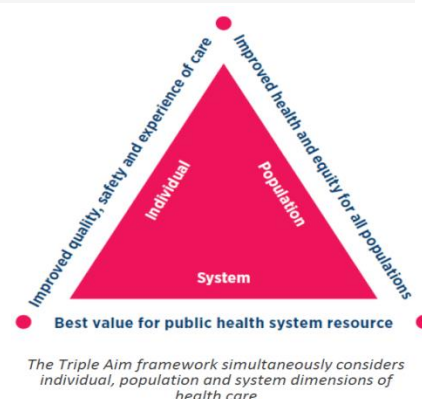


Analysis of evidence and stakeholder perspectives on the most important issues facing the Taranaki health system have prioritised a number of focus areas. These focus areas take into consideration national, regional and local priorities and initiatives. These priority areas have been identified as follows:

- **Acute demand** – Taranaki has a relatively high rate of hospitalisation and a very high rate of ED attendance. There is some evidence that this is partly attributable to access barriers in primary care. Reducing unplanned visits to hospital services through more timely interventions in primary and community care will improve health outcomes and quality of life for patients while also enabling the system to make better use of resources –impacting on system costs
- **GP workforce** – The most frequent reason Taranaki residents report as a barrier to primary care access is being unable to make an appointment with 24 hours with their usual practice. This is higher than the national average and puts pressure on our hospital services. This likely reflects the characteristics of the Taranaki primary care sector: a low number of GP FTEs per capita and a large number of solo-GP practices. Capacity pressures are expected to intensify over coming years given workforce ageing. Finding new ways of working is therefore fundamental for supporting the sustainability of the Taranaki health system
- **Population health risk factors** – While Taranaki residents can expect to live on average the same number of years as other New Zealanders, there remain opportunities to improve the quality of people's lives through reducing the prevalence of long term conditions and other factors that lead to early deaths. This requires addressing the social determinants of health through cross-sector and agency collaboration to ensure that health care needs are being addressed holistically for the well-being of individuals, communities and whānau
- **Māori** – Taranaki still has a considerable way to go to address persistent health inequalities for Māori in terms of access and outcomes. Systemic barriers to care underlie these inequalities including the unconscious bias of health care professionals and the systems and structures the sector operates in
- **Mental health and addictions** – More people with complex mental health and addiction needs are presenting acutely to Taranaki hospital services
- **Health of older persons** – The Taranaki population is already older than the national average, and the population aged 75 years and over is expected to double over the next 20 years. Ensuring that the right services are in place to support people to age in healthy ways will be critical for their outcomes and the sustainability of the health system



In response to these sustainability challenges, local health systems are redesigning their models of care and service configurations and Taranaki is no exception. The strategic direction of the New Zealand Health Strategy (NZHS) provides the system-level framework for redesign of models of care. The NZHS recognises that fundamental changes are needed, which place power in the hands of patients, enable care to be delivered close to home, integrate care across settings, and effectively deploy new technologies to improve access to high-quality care. The NZHS has strong linkages with other government strategies (such as Pae Ora and social investment). These strategies include the health system playing a key role in delivering more effective social services to all New Zealanders, but in particular, individuals and whānau who are most vulnerable to poor outcomes.



Taranaki Health Action Plan 2017-20

The strategic direction for Taranaki DHB, and our response to the challenges highlighted above, is outlined in the Taranaki Health Action Plan 2017-20. The Plan describes the transformational journey the Taranaki health system will take to redesign how care is delivered in the district to ensure the sustainable achievement of improving health outcomes. It acknowledges that in order for the Taranaki health system to improve population health outcomes, a system-wide approach must be taken aligned to the national and regional strategic priorities, with collaboration across health and social services, and measured against Triple Aim indicators.

In addition the Health Action Plan has utilised Pae Ora, a conceptual framework to inform the Health Action Plan, recognising the multifaceted needs of Māori through a holistic approach with three interconnected elements:

- Mauri ora (healthy individuals)
- Whānau ora (healthy families)
- Wai ora (healthy environments)

In improving Māori health using a Pae Ora approach, we have engaged with local stakeholders to understand how we can better collaborate with Taranaki Māori to improve equity of access and outcomes, and ensure that Māori are involved in both decision-making and service delivery.

The Health Action Plan provides an overarching framework for the Taranaki health system, with a 10-year vision, underpinned by a targeted three-year programme of work that will position the system to achieve its long term vision.

The Health Action Plan identifies six focus areas that will deliver on Taranaki's vision for the future, "Taranaki Together, A Health Community". These are aligned to the NZHS, and the desired strategic outcomes of Te Kawau Mārō, Taranaki's Māori Health Strategy.

Our six strategic focus areas are:

1. Helping our people to live well, stay well and get well through health literacy and 'health in all policies' approaches
2. Integrating our care models through a one team, one system approach, starting with adults with physical health needs and health of older people, and then extending to mental health and addiction services
3. Using our community resources to support hospital capacity to enable a sustainable hospital infrastructure matched to population needs and models of care
4. Using analytics to drive improvement in value through improved performance, efficiency and quality of care
5. Developing a capable, sustainable workforce matched with health need and models of care
6. Improving access, efficiency, and quality of care through managed uptake of new technologies – supporting changes in models of care

Through achieving the objectives of the six focus areas and their related actions, the following benefits are expected:

Enhanced patient experience	Improved population health and equity	Improved value for money	Strengthened system resilience
Our population will understand how, when and where to access the right health services and is supported with information to achieve their health goals. Patients will receive integrated services – centred around their needs.	Services are targeted at those most likely to benefit, with the workforce matched to population needs and enabled to support better health outcomes.	Prevention and earlier intervention activities has reduced demand, and more services are offered in community settings at lower system cost. Hospital services are more focused, with clearly defined care pathways to guide safe and effective patient journeys.	Primary health care capacity has increased, providing better access and better quality services. The system is supported by a stronger evidence base that informs clinical decision-making and enhances patient care.

The Health Action Plan has a medium to long-term view for transforming the Taranaki health system that reflects the fact that effective transformational change may take several years.

In addition to the above, and in response to discussions with the Ministry of Health about the strategic direction for 2019/20, it has been agreed that the following specific areas of work are considered high level priority areas for the Taranaki DHB in the 2019/20 year:

- Primary care
- Mental health
- Child health
- Acute demand
- Project Maunga

These priority areas will be supported by principles of equity, enhanced patient experience, value for money and strengthened resilience.

1.6 Message from the Chair

The New Zealand health system continues to face a number of challenges, and Taranaki's health system is no exception. An increasing number of older people are living longer, the burden of long term conditions is growing and our health system faces the financial challenges associated with the need to invest in new technologies and innovative health treatments. We continue to see disparities in health outcomes for some populations, notably Māori and those with mental health conditions, and people with disabilities. Our DHB is therefore faced with increasing demand for health services in the context of an increasingly challenging financial environment.



While acknowledging the financial constraints we work within, in 2019/20 we will continue to deliver the strategic direction for Taranaki DHB that is outlined in the Taranaki Health Action Plan. The Plan describes the transformational journey the Taranaki health system is taking to redesign how care is delivered in the district to ensure the sustainable achievement of improved health outcomes. As well as developing systems to ensure health information can be shared safely across a wider range of health professionals; we continue to seek further opportunities to deliver services closer to home as part of a wider health system that works collaboratively with councils and other agencies to address the wider determinants of health.

The New Zealand health system continues to face a number of challenges, particularly in relation to achieving equity of access and outcomes for Māori. Health Equity remains a top priority for the Taranaki DHB - it is a key focus of the Taranaki Health Action Plan 2017-2020 and a consistent theme through this Annual Plan and the TDHB Public Health Unit Plan. We work closely with our Iwi governance group both directly and via the Māori Health team (Te Paharakeke) to ensure integration of the themes of Pae Ora and Whanau Ora. Similarly, we recognise that equitable health outcomes are only possible where Councils and the wider community also share a role in achieving health and continue to work closely with our Public Health Unit to support a Health in All Policies approach as we progress forward.

As well as addressing the disparities in health outcomes and social determinants of health for disadvantaged populations, the DHB is tasked with managing the pressures and significant service demands which in turn significantly challenge health budgets. This requires DHBs to consider the impact of its funding decisions on achieving equitable outcomes. Building on the work undertaken in 2018/19, we have included specific Equity Outcome Actions (EOA) in the 2019/20 Annual Plan that aim to enable the achievement of health equity for all populations, including Māori.

The role of Taranaki DHB governance is to provide strategic oversight of the management of our DHB to ensure we deliver on our fundamental objective – i.e. of working within allocated resources to improve, promote and protect the health of the Taranaki population, and to promote the independence of people who experience a disability. In doing this we will continue to strive to achieve health equity and achieve our vision.

A handwritten signature in black ink that reads "P. Lockett".

PAULINE LOCKETT
Chair

1.7 Message from the Chief Executive

The strategic direction of the New Zealand Health Strategy (NZHS) and our Taranaki Health Action Plan 2017-2020 has provided a strong base from which we continue to build the enabling environment required for achieving transformational change within our health system. Empowering and partnering with patients; providing care closer to home; enabling integrated care across settings; and effectively utilising new technologies to improve access to high-quality care are critical success factors as we work towards this goal.



The Taranaki health system is no different to the New Zealand health system as a whole, in that it is facing intensifying supply and demand pressures that are impacting on clinical and financial sustainability. The strategic direction for Taranaki DHB is outlined in the Taranaki Health Action Plan. The Health Action Plan provides an overarching framework for the Taranaki health system, with a 10-year vision, underpinned by a targeted three-year programme of work that will position the system to achieve its long term vision. As Taranaki DHB enters into the third year of implementation of this Plan, we acknowledge the work that has already been achieved by those working in our complex health system. However we also recognise the additional work that will be required to achieve the transformational change required to ensure long-term sustainability of the Taranaki health system and the best health outcomes for our community. Progress against the deliverables in this Plan continues and we remain confident that we have the capability and capacity to deliver on our promises.

Improving patient access and population health outcomes continue to be a priority for our DHB. The Taranaki DHB acknowledges that Māori are the main population group that are affected by health inequity in Taranaki and we therefore have a particular focus on improving equity for Māori. In line with this, our DHB remains committed to to “Kia tū rangatira ai ngāi Māori ki te ara kākārīki” – a “journey to the greens” - which symbolises our commitment to transforming our dashboard of Māori health priority indicators from red to green. Working in partnership with our Iwi governance group, Te Whare Punanga Korero, and our local Māori Health providers towards eliminating health inequalities between Māori and non-Māori is a priority focus for our DHB, and the Equitable Outcome Actions (EOA) outlined in this Annual Plan are a sign of our commitment to achieving this.

With the support of strong governance, clinical and executive leadership and capability across the health sector, Taranaki DHB remains committed to meet the significant challenges the New Zealand public health system as a whole continues to face.

A handwritten signature in black ink, appearing to read 'R. Clements'.

ROSEMARY CLEMENTS
Chief Executive

1.8 Message from the Chair - Te Whare Punanga Korero

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



Achieving equity in access and outcomes for Māori is a priority for the Taranaki DHB and a key focus of the Taranaki Health Action Plan. Te Whare Punanga Korero Trust is committed to supporting the DHB towards achieving this goal, lofty as it may seem in an environment in which ‘the reds’ dominate Māori health indicator dashboards, the demands of a growing youthful population at one end of the life course, and a growing elderly population at the other, place increasing pressures on the DHB to respond.

Te Whare Punanga Korero sees the challenges ahead as opportunities and is committed to continuing its role of monitoring progress against the activities outlined in this Plan, particularly those tagged as ‘Equity of Access for Māori’ actions. These are the activities that the Taranaki DHB and Te Whare Punanga Korero in partnership, have prioritised to accelerate towards eliminating health inequalities between Māori and non-Māori.

The DHB is committed to “Kia tū rangatira ai ngāi Māori ki te ara kākāriki”, journey to the greens, a metaphoric reference to transforming the dashboard of Māori health priority indicators from red to green. Te Whare Punanga korero will continue to be the iwi monitor and to work with the Taranaki DHB strategically on that journey.

The following whakawai given prominence by Te Whiti o Rongomai, aptly captures the perspective of the iwi:

He puāwai au nō runga i te tikanga

I am a descendant from righteous endeavour

He rau rengarenga nō roto i te Raukura

A healing herb from within the sacred emblem

Ko taku Raukura, he manawa nui ki te ao,

My sacred emblem is a symbol of my unwavering dedication,

He manawa nui ki te ao, he manawa nui ki te ao.

of prosperity, good health and well-being.

Na, Te Whiti O Rongomai

A handwritten signature in black ink, appearing to read 'Marty Davis'.

TE PAHUNGA (MARTY) DAVIS
Chair - Te Whare Punanga Korero Trust

SECTION 2: Delivering on Priorities and Targets

2.1 Māori Health

The New Zealand and Public Health and Disability Act 2000, Part 1, makes explicit that Treaty of Waitangi provisions require District Health Boards to establish mechanisms to enable Māori to contribute to decision making and participate in the design and delivery of health and disability services, and to work with the Treaty of Waitangi-based principles of Partnership, Participation and Protection.

Taranaki DHB recognises our responsibilities under the Treaty of Waitangi, and fulfils these through:

- Engagement with the Te Whare Punanga Korero (TWPK) Trust, the Māori health governance group which works with the Board of Taranaki DHB in setting strategic direction
- Implementation of the principles of the Treaty of Waitangi and Te Kawau Mārō (the Taranaki Māori Health Strategy) through the Pae Ora Framework.
- Working in partnership with local Māori Health Providers and Te Pa Harakeke, the DHB's Māori Health Unit to enable the delivery of culturally appropriate services to Māori by Māori
- Supporting with building capacity of the Māori Health workforce through training, development and other initiatives aimed at building cultural competence of the local health workforce and supporting initiatives to attract more Māori into the health workforce
- Enabling Māori participation in planning and funding decision-making at an executive level through the Chief Advisor Māori Health role
- Establishing and maintaining processes that enable Māori to participate in, and contribute to, strategies for Māori Health improvement at both a governance level and service development level

Taranaki DHB's obligation to establish and maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement is specifically outlined in He Korowai Oranga, National Māori Health Strategy refresh 2014, in particular the four pathways, as well as in Te Kawau Mārō, the Taranaki Māori Health Strategy 2009-2029.

Te Kawau Mārō is a strategic framework that seeks the attainment of Whānau Ora over a twenty-year time span. It identifies five strategic priorities to achieve this:

- Improving access
- Building Māori capacity
- Improving mainstream services
- Strategic Relationships, and
- Monitoring performance

The Pae Ora framework (outlined in the diagram below) was formally adopted by Taranaki DHB in 2015. The Framework includes existing policy directives that provide the platform for Taranaki DHB to advance Pae Ora. The Treaty of Waitangi principles and the Whānau Ora Goals within the framework provide common ground to advance collaboration with other sectors in order to address the determinants of health.

The Framework acknowledges that "Pae Ora – healthy futures" can only be achieved through collective action towards Whānau Ora – healthy families; Mauri Ora – healthy lives; and Wai Ora – healthy environments. It provides a conceptual basis upon which to make planning, funding and service decisions in a Pae Ora context and identifies a range of mechanisms to implement it locally. It provides staff and others working with the Taranaki DHB a shared understanding of the DHB's concept of Pae Ora, the elements that contribute to it, and how it may be applied in practice.

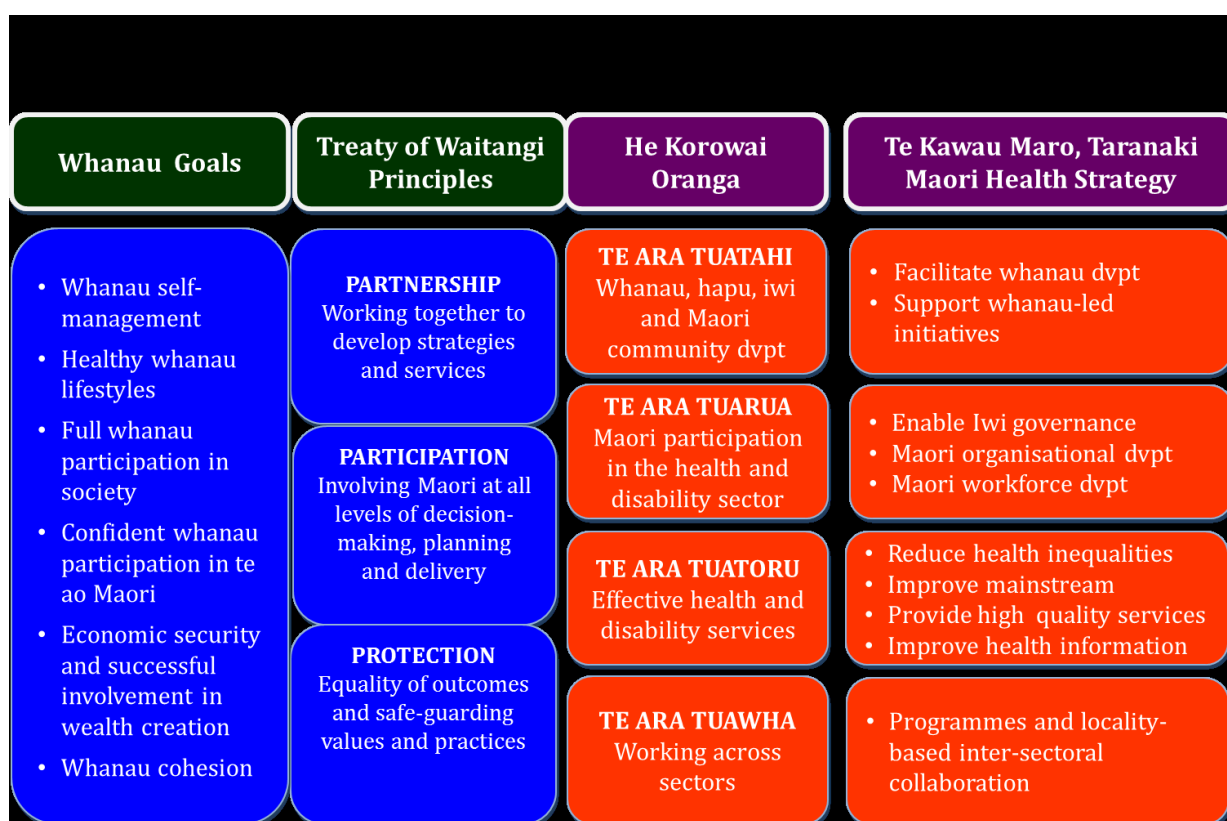


Figure 1 - Taranaki DHB Pae Ora Policy Framework

2.1.1 Health Equity

Health inequalities are disparities in health status between various groups within population that are unnecessary, avoidable, unfair and unjust. Disparities may occur in age, gender, socio-economic status, geographical region, and ethnicity. Ethnicity plays a significant part in health inequalities. Studies show that disparities in overall Māori health persist even when factors such as poverty, education and location are eliminated. In New Zealand there is clear evidence of wide and enduring inequalities between the health status of Māori and non-Māori. Taranaki DHB acknowledges that Māori are the main population group that are affected by health inequity in Taranaki and, as a result, a key focus of the Taranaki Health Action Plan 2017–2020 is to improve access and outcomes for Māori.

The Ministry of Health (MoH) released a document in September 2018 entitled ‘Achieving equity in health outcomes’³ which provides an overview of the international literature and context. The MoH used this research to come up with a working definition of ‘equity’ as follows:

“In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.”

As the above document states: “The concept of equity in health is an ethical principle, closely related to human rights, in particular, the right of all humans to experience good health”. The highest attainable standard of health is a reflection of the standard of health enjoyed in the most socially advantaged group within a society. This indicates a level of health that is biologically attainable and the minimum standard for what should be possible for everyone in that society.

³ Ministry of Health. 2018. *Achieving Equity in Health Outcomes: Highlights of important national and international papers*. Wellington: Ministry of Health

Taranaki DHB has included a number of Equitable Outcome Actions (EOA) in this Annual Plan that will help support the achievement of greater health equity for all our populations, including Māori. Activities in Section 2 of this Plan that demonstrate Taranaki DHB's commitment to reducing and eliminating inequities between Māori and non-Māori are clearly identified with the acronym [EOA] immediately following the activity. A full list of the Equitable Outcome Actions are also documented in Appendix C of this plan.

Health Equity has also been identified as one of four strategic priorities for the Taranaki Public Health Unit (PHU). The PHU will demonstrate leadership by continuing to work in collaboration with other agencies on the social determinants of health as well as championing the provision of high quality health care that delivers equitable health outcomes for Māori. A key strategy for this work is supporting the application of the Ministry of Health's Health Equity Assessment Tool (HEAT) to PHU and DHB programmes, working with Te Pa Harakeke, our Māori Health Team to support the DHB to integrate the use of HEAT into service planning, service improvement and evaluation.

2.1.2 Health Equity Tools

Taranaki DHB is committed to creating a fairer society where everyone has the opportunity for good health and where our health care system meets the needs and aspirations of Māori. Eliminating health outcome differences which are unnecessary and avoidable, but in addition are considered unfair and unjust, is a core theme of our work. We are committed to working in collaboration with other agencies through a Health in All Policies approach to address the social determinants of health as well championing the provision of high-quality health care that delivers equity of health outcomes for Māori.

A key strategy for this work will be through the continued use of health equity assessment tools in the planning, development and evaluation of local health services. Taranaki DHB identifies the Ministry of Health's '*Health Equity Assessment Tool*' as its preferred methodology for undertaking Health equity assessment and guidance on its use is available from the DHB's Public Health Unit (PHU) and Te Pa Harakeke.

The DHB has a two-pronged approach to applying health equity assessment. Firstly the Taranaki PHU Plan 2019/20 outlines a number of actions that demonstrate how the Health Equity Assessment Tool will be used to support service planning and decision making in the DHB in 2019/20. This includes a commitment to carry out two comprehensive Health Equity Assessments of Taranaki DHB services by June 2020 and continuing to monitor the effectiveness of Health Equity Assessment in influencing service changes that lead to improved Māori Health outcomes. Secondly Te Pa Harakeke Māori Health Unit applies a health equity lens through service improvement methodology on projects that target Māori health outcomes as measured by Māori health priority indicators. The projects are embedded throughout the Annual Plan and are summarised in the schedule of Equity Outcome Actions at Appendix C. Service improvement methodology requires close monitoring of the impact of interventions on improvement measures and involves the spread of successful interventions more widely. This process aims to build capability of service teams to apply and embed health equity practice into their daily routines

2.2 National Planning Priorities

The Taranaki DHB Annual Plan 19/20 will continue to focus on the key activities that reflect the specific planning priorities the Minister has identified, as outlined in the Minister's Letter of Expectation (December 2018), as follows:

- Strong fiscal management
- Child wellbeing
- Mental health and addiction care
- Strong and equitable public health and disability system

- Public health and the environment
- Primary care and prevention

The Annual Plan also provides line of sight to the system outcomes, to three of the Government's twelve priority outcomes, *Support healthier, safer and more connected communities, Make New Zealand the best place in the world to be a child and Ensure everyone who is able to, is earning, learning, caring or volunteering* and to the Government's theme *Improving the well-being of New Zealanders and their families*. Each of the sections within Section 2 of the Plan have been aligned to the most appropriate health system outcome and Government priority outcome.



2.3 Local Planning Priorities

With the agreement of the Ministry of Health about the strategic direction for 2019/20, it has been agreed that the following areas of work are key priority areas for the Taranaki DHB:

- Primary care
- Mental health
- Child health
- Acute demand
- Project Maunga

These priority areas will be supported by principles of equity, enhanced patient experience, value for money and strengthened resilience.

The tables below outline the actions that will be undertaking to deliver against the above local and national priorities in 19/20. Where activities are relevant to more than one section of the plan, the activity is listed in the section that it most strongly links to and a reference highlighting the other section(s) it links to is noted in italics in order to avoid repetition of activities. A note cross-referencing the linkage has also been added in the corresponding section to which the activity relates.

The activities listed in the tables below also have strong alignment to the Taranaki PHU Annual Plan 19/20 and the System Level Measures (SLM) Plan 19/20. In order to demonstrate this linkage, where the same activity also appears in the PHU Plan or SLM Plan a reference note (in italics) highlights this and specifies the section number of the Plan that it relates to.

The Annual Plan 19/20 is also seen as an important delivery mechanism for achieving the objectives of the Taranaki Health Action Plan 2017-20. As described in Section 1, the Health Action Plan sets out the transformational journey the Taranaki health system will take to redesign how care is delivered in the district to ensure the sustainable achievement of improving health outcomes. Where specific activities in the Annual Plan 19/20 are also identified in the Health Action Plan, this is highlighted with a note referencing the relevant section number.

The explicit cross-referencing of Annual Plan activities to other DHB plans is intended to highlight the strategic linkage across our work plans as well as demonstrating the inter-relationships between our multiple work programmes.

2.4 Financial Performance Summary

This section will include the consolidated statement of comprehensive income (previous year's actual, current year's forecast and three years plan), and the prospective summary of revenue and expenses by output class for the next three years.

(For further detail refer to Appendix A 2019-23 Financial Performance Plan - Page 105)

Prospective Statement of Financial Performance (Comprehensive Income) for the four years ended 30 June 2020, 2021, 2022 and 2023

	Audited	Actual		Planned			
	2017/18	2018/19		2019/20	2020/21	2021/22	2022/23
Revenue							
Devolved Funding	356,708	375,687		390,822	401,870	412,918	423,966
Non-Devolved Contracts	6,549	6,574		6,568	6,613	6,659	6,706
Inter-DHB & Interprovider Revenue	5,056	5,250		5,461	5,687	5,922	6,167
Other Revenue	13,117	12,747		10,628	10,788	10,992	11,200
Total Revenue	381,430	400,258		413,479	424,958	436,491	448,039
DHB Provided Expenditure							
Personnel	142,651	158,574		158,725	165,052	171,630	178,476
Outsourced Personnel & Support	2,777	2,416		2,079	2,121	2,163	2,206
Outsourced Clinical Services	13,032	12,249		9,280	9,558	9,845	10,140
Clinical Supplies	30,924	34,377		34,999	35,931	36,888	37,871
Infrastructure & Non-Clinical Supplies	38,194	44,902		45,470	44,793	44,132	43,481
Total DHB Provided Expenditure	227,578	252,518		250,553	257,455	264,658	272,174
Other Providers							
Personal Health	64,882	68,636		73,662	75,635	77,549	79,399
Mental Health	10,590	11,476		12,617	12,985	13,353	13,720
Public Health	693	542		906	928	951	975
DSS	44,205	47,570		49,262	50,492	51,754	53,046
Maori Health	2,887	2,752		2,662	2,729	2,798	2,868
IDFs	38,884	40,134		41,840	43,158	44,515	45,915
Total Other Providers	162,141	171,110		180,949	185,927	190,920	195,923
Total Expenditure	389,719	423,628		431,502	443,382	455,578	468,097
Total Consolidated Result	(8,289)	(23,370)		(18,023)	(18,424)	(19,087)	(20,058)
By Arm							
Provider	(25,879)	(36,094)		(31,823)	(32,373)	(33,179)	(34,293)
Governance	5	(29)		0	0	0	0
Funder	17,585	12,753		13,800	13,949	14,092	14,235
TDHB Consolidated	(8,289)	(23,370)		(18,023)	(18,424)	(19,087)	(20,058)

Prospective Financial Performance by Output Class for the Three Years Ended 30 June 2019, 2020 and 2021

Prospective Summary of Revenues and Expenses by Output Class	2019-20	2020-21	2021-22
	Plan \$000	Plan \$000	Plan \$000
Early Detection			
Total Revenue	95,234	97,878	100,534
Total Expenditure	99,385	102,122	104,931
Net Surplus / (Deficit)	(4,151)	(4,244)	(4,397)
Rehabilitation and Support			
Total Revenue	61,544	63,252	64,969
Total Expenditure	64,226	65,994	67,810
Net Surplus / (Deficit)	(2,682)	(2,742)	(2,841)
Prevention			
Total Revenue	8,721	8,963	9,207
Total Expenditure	9,101	9,352	9,607
Net Surplus / (Deficit)	(380)	(389)	(400)
Intensive Assessment and Treatment			
Total Revenue	247,980	254,864	261,781
Total Expenditure	258,790	265,913	273,230
Net Surplus / (Deficit)	(10,810)	(11,049)	(11,449)
Consolidated Surplus / (Deficit)	(18,023)	(18,424)	(19,087)

SECTION 3: Service Configuration

3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under Section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. Taranaki DHB may, pursuant to Section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

Taranaki DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2019/20.

3.2 Service Change

Taranaki DHB has developed a Health Action Plan which will lead change from a health system perspective. The following table identifies emerging service issues other than what is already covered in this plan or described within the context of the Midland Regional Service Plan. Taranaki DHB wishes to signal its intention to review and/or evaluate these services in the coming year.

Change	Description of Change	Benefits of Change	Change for Local, Regional or National Reasons
Midland Regional Services Plan	As part of the Regional Services planning process action groups or networks are in place for a number of identified areas	<ul style="list-style-type: none">• Reduce duplication of effort enabling DHBs to collectively develop sustainable solutions• Develop integrated approach to recruitment and retention within the global marketplace• Standardised planning, evaluation and procurement of new technology solutions within a clinical environment	This work is consistent with the continuing national expectation of an increased focus on regional approaches, and with the strong focus on regionalisation agreed across the Midland DHBs
Taranaki Integrated Health System	Implementation of the Taranaki Health Action Plan and Project Connect	<ul style="list-style-type: none">• Implementing new service models for adult physical health and health of older people• Developing locality based services to be delivered within the resources available	Local and National
Managing Acute Demand	New options for acute demand and urgent primary care	<ul style="list-style-type: none">• Support achievement of ED Health Target• Increase options available in primary care after hours• Increased enrolment of patients with PHOs	Local

Change	Description of Change	Benefits of Change	Change for Local, Regional or National Reasons
Mental Health	Initiation of whole system services redesign and more targeted changes associated with defined services	<ul style="list-style-type: none"> • Whole system services redesign • Review of existing services and models of care • Care Closer to Home • Improved performance 	Local
Community Pharmacy	Implement the national pharmacy contracting arrangements and develop local services once agreed.	<ul style="list-style-type: none"> • More integration across the Primary Care team. • Improved access to Pharmacist services by consumers • Consumer empowerment • Safe supply of medicines to the customer • Improved support for vulnerable populations • More use of Pharmacists as a first point of contact within Primary Care. 	National and local process
Pathology and Laboratory Services	Implementing options for the future direction of Laboratory and Pathology Services	<ul style="list-style-type: none"> • Co-ordinated services across whole systems • Improved performance 	Local
Child Health	Implementation of responsive and appropriate models of care for Antenatal Education and other child health determinants	<ul style="list-style-type: none"> • Increase access to services • Great emphasis on equity of access and appropriate service provision • Culturally responsive services 	Local
Fracture Liaison Service	Implementation of options from the Fracture Liaison Service into primary care	<ul style="list-style-type: none"> • Increase access to services • Alignment with other Primary Care based Falls Prevention Services 	Local
Non Secure Psycho-geriatric Service Pilot	Continuation of pilot residential care service for older people with mental health conditions requiring specialised care in a non secure service following service review	<ul style="list-style-type: none"> • Responding to an identified service gap • Improved support for older people with complex needs 	Local
Mental Health - Independent Living Pilot	Continuation of pilot independent living pilot and implementation of evaluation findings	<ul style="list-style-type: none"> • Improved outcomes 	Local
Mental Health Vocational/ Employment Support	To implement the findings of the service review, including implementing an evidence based model of service delivery which strengthens	<ul style="list-style-type: none"> • Reduce duplication between current DHB funded vocational services and MDS employment support 	Local

Change	Description of Change	Benefits of Change	Change for Local, Regional or National Reasons
Services	working relationships with MSD to support good employment outcomes for people with mental health conditions	services <ul style="list-style-type: none"> • Increased access to services in rural areas • Delivery of evidence-based services that focus on achieving equity-based outcomes 	
Mental Health – Adult Community Support Services	To implement the findings of the review of Adult Community Support Services to ensure appropriate out of hours service coverage in rural areas	<ul style="list-style-type: none"> • Responding to an identified service gap • Improved support for people with mental health conditions living in the community 	Local
Primary Mental Health Initiative (Taranaki Primary Connections)	Implementation of the recommendations of the PMHI review 2018 to extend availability of psychological therapies to people with moderate to severe mental health conditions	<ul style="list-style-type: none"> • Responding to an identified service gap • Increased access to services in rural areas • Improving service quality • Improved support for people with mental health conditions living in the community • Innovation in mental health care 	Local
Mental Health Crisis and Planned respite (South Taranaki)	Re-orientation of crisis and planned respite service in South Taranaki to respond to rural staffing and sustainability issues and ensure continued service coverage	<ul style="list-style-type: none"> • Responding to service coverage issue and sustainability concerns • Ensuring continued access to care for people with mental health conditions requiring respite • Consideration of alternative service models to provide care closer to home 	Local
Taiohi wellness service (youth mental health)	Evaluation of the Taiohi wellness service may lead to some service change depending on evaluation findings	<ul style="list-style-type: none"> • Identify and respond to potential service gaps • Improved service quality • Service delivery is more responsive to service users' needs 	Local

Table 1: Service Issues 2019/20

Service coverage exceptions and service changes must be formally approved before they are included in Annual Plans. It has yet to be determined that there is a proven need for all changes to take place. Should the DHB consider in due course that a change is warranted, a formal service change process as outlined under the Operating Policy Framework (OPF) will be followed to ensure service coverage and the Minister's and the Ministry's requirements are met.

SECTION 4: Stewardship

As part of their stewardship role DHBs have statutory responsibilities to improve, promote and protect the health of people and communities. Taranaki DHB is committed to working in partnership with the Public Health Unit in their work on health promotion; delivering services that enhance the effectiveness of prevention activities in other parts of the health system; working within a Health in All Policies framework; and undertaking regulatory functions.

This section provides an outline of the arrangements and systems that Taranaki DHB has in place to manage our core functions and to deliver planned services. This Annual Plan also incorporates Taranaki DHB's three-yearly Statement of Intent.

4.1 Managing our Business

Organisational Performance Management

Taranaki DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at various level(s) of the organisation. These may be reported daily, weekly, fortnightly or monthly as appropriate.

The Ministry of Health monitors our performance on behalf of the Minister. The mechanisms currently in place to achieve this are outlined in the following table.

Table: External Reporting Framework

Reporting	Frequency
Information requests	Ad hoc
Financial reporting	Monthly
National data collections	Monthly
Risk reporting	Quarterly
Health target reporting	Quarterly
Crown funding agreement non-financial reporting	Quarterly
DHB Non-financial monitoring framework	Quarterly
Annual Report and audited accounts	Annual

Funding and Financial Management

Taranaki DHB's key financial indicators are outlined in the table below:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	\$M	\$M	\$M	\$M	\$M	\$M
	AUDITED	ACTUAL	PLANNED	PLANNED	PLANNED	PLANNED
Revenue	381.43	400.26	413.48	424.96	436.49	448.04
Net Surplus/(Deficit)	(8.29)	(23.37)	(18.02)	(18.42)	(19.09)	(20.06)
Total Fixed Assets	220.05	216.52	213.57	209.62	205.61	201.61
Crown Equity	187.47	176.74	172.76	168.38	163.33	157.32
Term Borrowings and Provisions	0.90	1.10	1.16	1.18	1.21	1.23

Taranaki DHB's key financial indicators are a consolidated operating deficit of \$ 18.02m for 2019/20 which comprises a deficit of \$ 31.82m in the hospital provider, a financial breakeven for the DHB Governance & Funding Administration and a surplus of \$ 13.80m in the DHB Funder operations.

These are assessed against and reported through Taranaki DHB's performance management process to the Board and Finance, Audit and Compliance Committee on a monthly basis.

Further information about Taranaki DHB's planned financial position for 2019/20 and out years is contained in Appendix A (Financial Performance Plan).

We report monthly to the Ministry of Health against the financial templates. We report on our financial performance monthly to our Board. This report includes commentary and financials as well as actions planned to improve financial performance.

As part of our financial reporting we include full time equivalent (FTE) reporting. This covers areas such as:

- Contracted/Accrued FTE
- FTE categories ie. Medical, Nursing, Allied Health, Support and Management & Administration FTEs.
- Out Sourced Services FTE

The information on our financial performance is one of the tools used by the organisation to identify issues and inform decision-making to improve our performance.

These are assessed against and reported through Taranaki DHB's performance management process to our senior management, Board and Ministry of Health on a regular basis.

Investment and Asset Management

All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across Government, the Investment Management and Asset Management Performance (IMAP) system.

Shared Service Arrangements and Ownership Interests

HealthShare Limited (HSL), established in 2001, is a regional Shared Services Agency jointly owned by Waikato, Bay of Plenty, Lakes, Taranaki, and Tairāwhiti District Health Boards. HSL has continued to take on an expanded role as a regional provider of non-clinical service and now provides operational support in a number of areas identified as benefiting from a regional solution.

The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk Management

Taranaki DHB has a formal risk management and reporting system, which utilises an electronic integrated quality and risk system called Datix, implemented in 2017. Reporting to the Taranaki DHB Board, Executive Management Team and other key committees occurs on a regular basis. The Taranaki DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality Assurance and Improvement

Taranaki DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best

value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

4.2 Building Capability

As part of their stewardship role DHBs have statutory responsibilities to improve, promote and protect the health of people and communities. Taranaki DHB is committed to working in partnership with the Public Health Unit in their work on health promotion; delivering services that enhance the effectiveness of prevention activities in other parts of the health system; working within a Health in All Policies framework; and undertaking regulatory functions.

This section provides an outline of the arrangements and systems that Taranaki DHB has in place to manage our core functions and to deliver planned services, which also forms part of our Statement of Intent for the next three years.

Capital and Infrastructure Development

Baseline capital expenditure during 2019/20 is forecast at \$15.65M. This includes \$7.0M investment in Information and Communication Technology (ICT) besides \$5.0M in clinical and theatre. Outlay for minor site redevelopment expenditure is \$3.0M.

Scoping and planning for Stage 2 of Project Maunga is well advanced, with preliminary works in progress. Early documentation (Risk assessment, Point of Entry, Strategic Assessment) had been submitted to Treasury and CIC during 2018. TDHB has been advised by CIC to progress the Indicative Business case (IBC). The IBC is scheduled for submission in August 2019, under an accelerated business approval and delivery programme. The estimated capital cost based on the preliminary scope is between \$272M - \$310M, which is likely to be finalised only once the scope is approved, detailed design undertaken and cost estimates become more definitive. The planning and resources required to progress the business case through the different stages leading to approval have been established.

Information Technology and Communications Systems

Taranaki DHB's information technology and communication systems goals align with the national and regional strategic direction for IT. Further details about Taranaki DHB's current IT initiatives are contained in the Midland Region Information Services Plan 2017–2021 which aligns with the 2019/20 Midlands Regional Service Plan, and the Data & Digital table in Section 2 of this Plan.

Workforce

Below is a short summary of Taranaki DHB's organisational culture, leadership and workforce development initiatives. Further detail about the Midland regional approach to workforce is contained in the 2019/20 Midland Regional Service Plan.

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Key focus areas for Taranaki DHB will be:

- Enhancing capacity through increasing the use and span of workforce data to inform workforce planning and modelling and committing to implementing the pre-vocational medical training programme
- Enhancing diversity through identifying ways to increase representation of Māori in the health workforce

- Enhancing succession planning, including a programme focused on frontline leadership and supporting national DHB initiatives in leadership and talent management
- Implementation of the HR Strategic Plan (3 year focus)
- On-going implementation of new Taranaki DHB Values
- On-going Implementation of the Taranaki DHB Recognition framework
- Implementation of the 'My Feedback' performance appraisal and individual development framework
- Team development, collaboration and business partnering professional development programme (external training) and a team development module run by internal staff that will help develop teamwork both within and amongst our local teams
- Employee wellbeing initiatives, including supporting national DHB programmes
- Taranaki DHB 2018 Staff Survey results benchmarked against Midland DHB results
- Bullying prevention and awareness programme
- Culture development support for the implementation of the Clinical Governance programme

Care Capacity Demand Management

Taranaki DHB is committed to implementing Care Capacity Demand Management (CCDM) by June 2021 through a phased delivery approach to accommodate appropriate recruitment and establishment processes.

For the 2019/20 year, the following actions are planned:

- CCDM council and working parties fully established and operational
- Validated patient acuity tool developed and data analysis completed to inform FTE, forecasting and planning
- CCDM implementation workplan developed and agreed

Co-operative Developments

Taranaki DHB collaborates with a number of external organisations and entities to work towards supporting and building the capacity and capability of the wider health system. Many of the initiatives are being progressed through collaboration and co-operative developments between the DHB and its community including other agencies. We believe these other agencies and sectors can help address complex problems involving the social determinants of health, and improving the capability of family/Whānau, through health literacy, to self-manage their health and well-being.

Taranaki DHB works through its established formal alliances, including the Midland Health Network Alliance and the Taranaki Alliance Leadership Team, in addition to other work programmes.

The Whakatipuranga Rima Rau Trust (WRR) is an independent charitable trust established by Taranaki District Health Board, Ministry of Social Development and Te Whare Punanga Korero Trust. WRR was created to build an integrated approach focusing on increasing the Māori health and disability workforce to equal the proportion of Māori in the Taranaki population. Its role is to fill the Māori workforce development pipeline with Māori pursuing health workforce careers. This is an innovative multi-agency and multi funder model which introduces a range of initiatives to address Māori workforce development through collaboration.

SECTION 5: Performance Measures

5.1 2019/20 Performance Measures

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention.
- Better population health outcomes supported by strong and equitable public health services
- Better population health outcomes supported by primary health care.

Each performance measure has a nomenclature to assist with classification as follows:

Code Dimension

CW Child wellbeing

MH Mental health and addiction care

PV Prevention

SS Strong and equitable public health and disability system

PH Primary health care

PE Public health and the environment

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2019/20.

Child Wellbeing

Performance measure	Performance expectation	
CW01: Children caries-free at 5 years of age	Year 1	61%
	Year 2	61%
CW02: Oral Health - Mean DMFT score at Year 8	Year 1	0.61
	Year 2	0.61
CW03: Improving the number of children enrolled and accessing the Community Oral health service	Year 1	95% of children (0-4) enrolled
		≤10% (0-12) not examined according to planned recall
	Year 2	95% of children (0-4) enrolled
		≤10% (0-12) not examined according to planned recall
CW04: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	Year 1	≥85%
	Year 2	≥85%
CW05: Immunisation coverage		
Focus Area 1: Immunisation coverage at 8-months of age	95% of 8-month-olds fully immunised	
Focus Area 2: Immunisation coverage at 5-years of age	95% of 5-year-olds fully immunised	
Focus Area 3: HPV coverage	75% of eligible girls and boys fully immunised – HPV vaccine	
	Report on activities in the Annual Plan	

Focus Area 4: Influenza immunisation at age 65 years and over	75% of 65+ year olds immunised – flu vaccine	
CW06: Child Health (breastfeeding)	70% of infants are exclusively or fully breastfed at three months.	
CW07: Improving newborn enrolment in General Practice	55% of newborns enrolled in General Practice by 6 weeks of age	
	85% of newborns enrolled in General Practice by 3 months of age	
CW08: Increase Immunisation (2-year-old coverage)	95% of 2-year-olds fully immunised	
CW09: Better help for smokers to quit (maternity)	90% of pregnant women who identify as a smoker upon registration with DHB-employed midwife or Lead Maternity Carer offer brief advice and support to quit	
CW10: Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	
CW11: Supporting child well-being	Report on activities in the Annual Plan.	
CW12: Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement <i>Youth Health Care in Secondary Schools: A framework for continuous quality improvement</i> in each school (or group of schools) with SBHS.	
	Initiative 3: Youth Primary Mental Health. As reported through MH04.	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
CW13: Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever hospitalisations	<2.8 per 100,000 total population

Mental health and addiction care

Performance measure	Performance expectation	
MH01: Improving the health status of people with severe mental illness through improved access	Age 0-19	3.78%
	Age 20-64	4.02%
	Age 65+	3.50%
MH02: Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
	95% of audited files meet accepted good practice.	
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental health provider arm	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
	Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
MH04: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.	
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	

Prevention

Performance measure	Performance expectation
PV01: Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.
PV02: Improving cervical screening coverage	80% coverage for all ethnic groups and overall.

Strong and equitable public health and disability system

Performance measure		Performance expectation	
SS01: Faster cancer treatment (31 days)		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
SS02: Ensuring delivery of Regional Service Plans		Provision of a progress report on behalf of the region agreed by all DHBs within that region.	
SS03: Ensuring delivery of Service Coverage		Provide reports as specified	
SS04: Delivery of actions to improve Wrap Around Services for Older People		Provide reports as specified	
SS05: Ambulatory sensitive hospitalisations	0-4	See System Level Measure Improvement Plan	
	45-64	Total: 5294/100,000	
SS07: Planned Care			
Measure 1: Planned Care Interventions		6,869 planned care interventions delivered	
Measure 2: Elective Service Patient Flow Indicators (ESPI)	ESPI 1	100% of services report yes (that >90% of referrals within the services are processed in ≤15 calendar days)	
	ESPI 2	0% of patients waiting >4 months for FSA	
	ESPI 3	0% of patients in Active Review with a priority score above the actual Treatment Threshold (aTT)	
	ESPI 5	0% of patients are waiting >120 days for treatment	
	ESPI 8	100% of patients prioritised using an approved national or nationally recognised prioritisation tool	
Measure 3: Diagnostic waiting times	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography receive their scan and results within 6 weeks	
	Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan and results within 6 weeks	
	Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan and results within 6 weeks	
Measure 4: Ophthalmology Follow-up Waiting time		No patient will wait more than or equal to 50% longer than the intended time for their appointment.	
Measure 6: Acute readmissions		9.1%	
SS08: Planned care three year plan		Provide reports as specified	
SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections			
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (duplication)		>1% and ≤3%
	Recording of non-specific ethnicity in new NHI registrations		>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with non-specific value		>0.5% and 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1		>76% and ≤85%
	Invalid NHI data updates		TBC
Focus Area 2: Improving the quality of data	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures.		≥90% and <95%

submitted to National Collections	National Collections completeness	≥94.5% and <97.5%
	Assessment of data reported to NMDS	≥75%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified about data quality audits.
SS10: Shorter stays in Emergency Departments		95% of patients admitted, discharged, or transferred within six hours
SS11: Faster cancer treatment (62 days)		90% of patients with a high suspicion of cancer receive their first cancer treatment (or other management) within 62 days
SS12: Engagement and obligations as a Treaty partner		Reports provided and obligations met as specified
SS13: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.	
Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care.	
	Ascertainment of people enrolled in the PHO aged 15-74	95-105% and no inequity
	The percentage of people enrolled in the PHO, aged 15-74 with HbA1c <64mmols	60% and no inequity
	The percentage of people enrolled in the PHO, aged 15-74 with no HbA1c result	7-8% and no inequity
Focus Area 3: Cardiovascular health	The percentage of people assessed as high risk who have received an annual review.	Provide reports as specified
	The percentage of people assessed as high risk who have a blood pressure measurement of 130/80 mmHg or better.	Provide reports as specified
	The percentage of people assessed as high risk with low density lipoproteins (LDL) less than 1.8 mmol/L.	Provide reports as specified
Focus Area 4: Acute heart service	>70% of high-risk patients receive an angiogram within 3 days of admission.	
	>95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days and 99% within 3 months.	
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	
	Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes). (expected target for 2019/20 is 85%)	
	≥99% of patients who have pacemaker or cardiac defibrillator implantation/replacement have completion of ANZACS QI device forms within 2 months of procedure	
Focus Area 5: Stroke services	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	
	10% or more of potentially eligible stroke patients thrombolysed 24/7.	
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	
	60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team ie RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.	
SS15: Improving waiting times for colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less	
	70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less	
	95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.	

SS16: Delivery of collective improvement plan	TBC – subject to confirmation
SS17: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.

Primary Health Care

Performance measure	Performance expectation
PH01: Delivery of actions to improve system integration and SLMs	Provide reports as specified
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).
PH03: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.
PH04: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke are offered help to quit in the past 15 months

Annual Plan Actions – Status Update Reports

Performance measure	Performance expectation
Annual plan actions – status update reports	Provide reports as specified

TARANAKI DISTRICT HEALTH BOARD

STATEMENT OF PERFORMANCE EXPECTATIONS 2019/20

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga



The 2019/20 Annual Plan has yet to be agreed by the Minister of Health and the Taranaki District Health Board. The Statement of Performance Expectations (SPE) is an integral part of the Annual Plan. However, in order to meet the requirements of Section 149(L) of the Crown Entities Act 2004, we are pleased to present the following information which forms the Statement of Performance Expectations. The SPE may be subject to further change as a result of the process of finalising the DHB Annual Plan for 2019/20 with the Ministry of Health.

While our 2019/20 Annual Plan articulates the strategic direction and activities our DHB intends to take over the next few years, the information contained in this Plan supports the assessment of the activities outlined.

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2019/20. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, we have included with each measure past performance as baseline data.

Activity not mentioned in this module will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and/or our Board on our performance related to this activity.

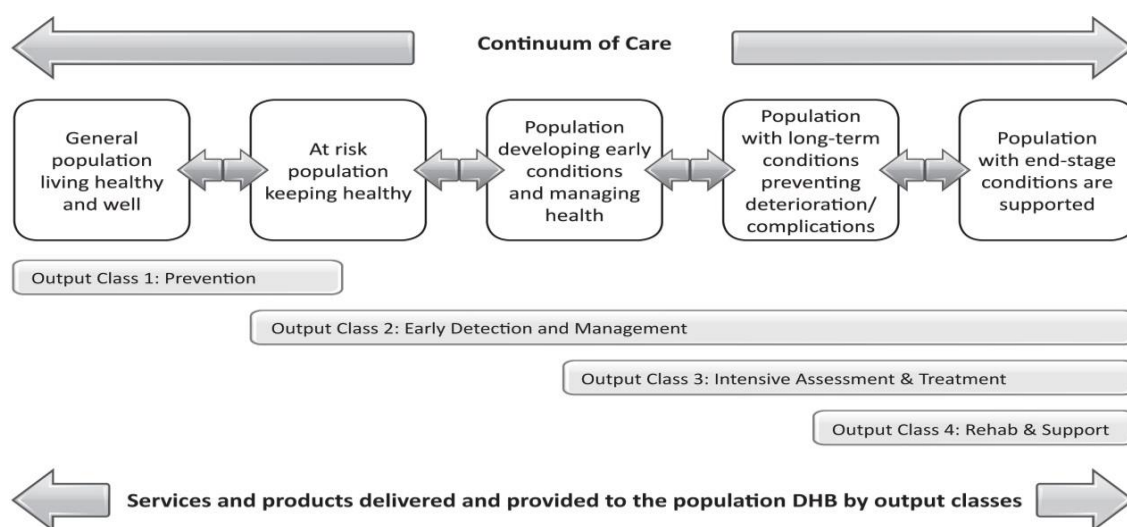
2019/20 Statement of Performance Expectations

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Activity not mentioned in this module will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and/or our Board on our performance related to this activity.

Output Classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. There are four output classes that have been agreed nationally. They represent a continuum of care, as follows:



Output Class	Definition
Prevention	Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.
Early Detection	Early detection and management services are delivered by a range of health and allied

Output Class	Definition
and Management	health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.
Intensive Assessment and Treatment Services	Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. They include: Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services, Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services, Emergency Department services including triage, diagnostic, therapeutic and disposition services. On a continuum of care these services are at the complex end of treatment services and focussed on individuals.
Rehabilitation and Support	Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum on care these services provide support for individuals.

Prospective financial performance by output class for 3 years ending 30 June 2021, 2022 and 2023

Prospective Summary of Revenues and Expenses by Output Class	2019-20	2020-21	2021-22
	Plan \$000	Plan \$000	Plan \$000
Early Detection			
Total Revenue	95,234	97,878	100,534
Total Expenditure	99,385	102,122	104,931
Net Surplus / (Deficit)	(4,151)	(4,244)	(4,397)
Rehabilitation and Support			
Total Revenue	61,544	63,252	64,969
Total Expenditure	64,226	65,994	67,810
Net Surplus / (Deficit)	(2,682)	(2,742)	(2,841)
Prevention			
Total Revenue	8,721	8,963	9,207
Total Expenditure	9,101	9,352	9,607
Net Surplus / (Deficit)	(380)	(389)	(400)
Intensive Assessment and Treatment			
Total Revenue	247,980	254,864	261,781
Total Expenditure	258,790	265,913	273,230
Net Surplus / (Deficit)	(10,810)	(11,049)	(11,449)
Consolidated Surplus / (Deficit)	(18,023)	(18,424)	(19,087)

Guide to Reading the Statement of Performance Expectations

The following points provided should be kept in mind when reading the Statement of Performance Expectations:

- Baseline figures for the output performance measures are for the 2014/15 financial year unless otherwise stated
- National/Regional Result figures show the 2016/17 national or regional average for the output performance measure (where available)
- Most measures have been adopted regionally
- Some measures fall across more than one impact. Where this is the case they have only been included once
- Measurement type key:
 - qn = Quantity
 - t = Timeliness
 - ql = Quality
- There are some services we provide that support the rest of the health system so we have included these in a “Support Services” section of our performance story

People are Supported to Take Greater Responsibility for their Health

Long Term Impact	People are supported to take greater responsibility for their health		
Intermediate Impacts	<ul style="list-style-type: none"> Fewer people smoke 	<ul style="list-style-type: none"> Reduction in vaccine preventable diseases 	<ul style="list-style-type: none"> Improving health behaviours

Fewer People Smoke

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of Primary Health Organisations enrolled smokers offered advice to quit	Māori	1	qn/t	93%		89%	90%
	Non-Māori	1	qn/t	86%		91%	90%
	Total	1	qn/t	88%		90%	90%
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	Māori	1	qn/t	89%		82%	90%
	Non-Māori	1	qn/t	91%		90%	90%
	Total	1	qn/t	90%		86%	90%
Percentage of PHO enrolled patients identified as smokers	Māori	1	qn/t	20%	2017/18	New Measure	5%
	Non-Māori	1	qn/t	10%	2017/18	New Measure	5%
	Total	1	qn/t	12%	2017/18	New Measure	5%

Reduction in Vaccine Preventable Diseases

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of eight month olds fully immunised	Māori	1	qn/t	89%		81%	95%
	Non-Māori	1	qn/t	93%		91%	95%
	Total	1	qn/t	91%		88%	95%

Improving Health Behaviours

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of infants who are fully, exclusively or partially breastfed at 3 months	Māori	1	qn/t	47%		46%	70%
	Non-Māori	1	qn/t	58%		63%	70%
	Total	1	qn/t	55%		58%	70%
Reduce the rate of teenage terminations of pregnancy per 10,000	Māori	1	qn/t	179		78	<71
	Non-Māori	1	qn/t	106		62	<70
	Total	1	qn/t	125		67	<70
Reduce the teen birth rate per 10,000	Māori	1	qn/t	276		182	<142
	Non-Māori	1	qn/t	117		80	<58
	Total	1	qn/t	159		112	<84
The number of referrals to the GRx (Green Prescription) programmes – Adult	Māori	1	qn/t	361	2016/17	353	343
	Non-Māori	1	qn/t	1047	2016/17	1142	1371
	Total	1	qn/t	1281		1495	1714
The number of referrals to the GRx (Green Prescription) programmes – Children	Māori	1	qn/t	60	2016/17	61	12
	Non-Māori	1	qn/t	74	2016/17	101	48
	Total	1	qn/t	80		162	60
% contracts with a Healthy Food and Drink Policy reported as a proportion	Total	1	qn/t	0%	2018/19	New Measure	100%

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
of total contracts							

People Stay Well in their Home and Communities

Long Term Impact	People Stay Well in Their Homes and Communities			
Intermediate Impacts	<ul style="list-style-type: none"> An improvement in childhood oral health 	<ul style="list-style-type: none"> Long-term conditions are detected early and managed well 	<ul style="list-style-type: none"> Fewer people are admitted to hospital for avoidable conditions 	<ul style="list-style-type: none"> More people maintain their functional independence

An Improvement in Childhood Oral Health

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of adolescent utilisation of DHB funded dental services	Total	2	qn	54%		70%	85%
Percentage of children (0-4) enrolled in DHB funded dental services	Māori	2	qn	59%		79%	95%
	Non-Māori	2	qn	81%		99%	95%
	Total	2	qn	74%		92%	95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori	2	qn	4%		8%	10%
	Non-Māori	2	qn	1%		11%	10%
	Total	2	qn	2%		10%	10%

Long Term Conditions are Detected Early and Managed Well

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
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Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of eligible women (25-69) have a cervical cancer screen every 3 years	Māori	1	qn/t	64%		76%	80%
	Non-Māori	1	qn/t	81%		83%	80%
	Total	1	qn/t	79%		82%	80%
Percentage of eligible women (50-69) have a breast screen in the last 2 years	Māori	1	qn/t	61%		61%	70%
	Non-Māori	1	qn/t	75%		77%	70%
	Total	1	qn/t	74%		75%	70%
Percentage of population enrolled with a PHO	Māori	2	qn	84%		87%	90%
	Non-Māori	2	qn	95%		96%	90%
	Total	2	qn	95%		94%	90%
Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Māori	2	qn	88%		89%	90%
	Non-Māori	2	qn	92%		92%	90%
	Total	2	qn	91%		91%	90%

Fewer People are Admitted to Hospital for Avoidable Conditions

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of eligible population who have had their B4 school checks completed	High Needs	1	qn/t	87%		106%	90%
	Total	1	qn/t	91%		113%	90%
Percentage of Emergency Department presentations who are triaged at levels 4 & 5 – Taranaki Base Hospital	Māori	2&3	qn	52%		New Measure	Reduction
	Non-Māori	2&3	qn	48%		New Measure	Reduction
	Total	2&3	qn	49%		New Measure	Reduction
Percentage of Emergency Department presentations who are triaged at levels 4 & 5 – Hawera Hospital	Māori	2&3	qn	70%		New Measure	Reduction
	Non-Māori	2&3	qn	69%		New Measure	Reduction
	Total	2&3	qn	69%		New Measure	Reduction
Percentage of Emergency	Māori	2&3	qn	60%		New Measure	Reduction

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Department presentations who are triaged at levels 4 & 5 – Total	Non-Māori	2&3	qn	54%		New Measure	Reduction
	Total	2&3	qn	55%		New Measure	Reduction
# Violence Intervention Programme (VIP) training sessions delivered	Total	1	qn	TBC		New Measure	Maintain
Ward 2B (Paeds) IPV RQ (Routine Questioning) Rates	Total	2	qn	80%	2018/19 H1	New Measure	85%
Ward 15 (Maternity) IPV RQ (Routine Questioning) Rates	Total	2	qn	64%	2018/19 H1	New Measure	85%
# Oranga Tamariki reports of concern	Total	2	qn	TBC		New Measure	Maintain

More People Maintain their Functional Independence

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of inpatients that complete the National Inpatient Patient Experience Survey.	Total	4	ql	19%		New Measure	30%
% of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2019/20	Total	2	qn	2.2%	2017/18	New Measure	7.6%

People Receive Timely and Appropriate Care

Long Term Impact	People receive timely and appropriate care			
Intermediate Impacts	<ul style="list-style-type: none"> People receive prompt and appropriate acute and arranged care 	<ul style="list-style-type: none"> People have appropriate access to elective services 	<ul style="list-style-type: none"> Improved health status for people with a severe mental health illness and/or addiction 	<ul style="list-style-type: none"> More people with end-stage conditions are appropriately supported

People Receive Prompt and Appropriate Acute and Arranged Care

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Acute inpatient average length of stay	Total	3	ql/t	3.93 days		2.68 days	2.3 days
Acute Re-admission rate	Total	3	ql/t	7.2%		12.4%	≤6.9%
Acute Re-admission rate 75+ years	Total	3	ql/t	10.5%		12.3%	≤10.9%
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	Māori	3	ql	14%	2015/16	18%	<18%
	Non-Māori	3	ql	18%	2015/16	20%	<18%
	Total	3	ql	20%		20%	<18%
Faster cancer treatment (62 day indicator)	Māori	3	ql/t	100%		100%	90%
	Non-Māori	3	ql/t	70%		100%	90%
	Total	3	ql/t	77%		100%	90%
Percentage of patients with a confirmed diagnosis of cancer who receive their first cancer treatment with 31 days of diagnosis	Total	3	ql/t	82%		91%	85%

People Have Appropriate Access to Elective Services

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Did-not-attend percentage for outpatient services	Māori	3	qn/t	19%		17%	5%
	Non-Māori	3	qn/t	6%		6%	5%
	Total	3	qn/t	9%		8%	5%
Number of surgical discharges under the elective initiative	Total	3	qn	5293		6,514	5511
Percentage of patients waiting longer than four months for their first	Total	3	qn/t	0%		0.4%	0.0%

specialist assessment							
Elective inpatient length of stay	Total	3	ql/t	2.96 days		1.50 days	1.45 days

Improved Health Status for those with Severe Mental Illness and/or Addictions

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Percentage of Child and Youth clients discharged with a transition (discharge) plan.	Total	3	qn/t/q	12%		29%	95%
Percentage of people referred for non-urgent addiction services are seen within 3 weeks	0-19 yrs	3	qn/t	71%		83%	80%
	20-64 yrs	3	qn/t	77%		69%	80%
	65+ yrs	3	qn/t	100%		67%	80%
Percentage of people referred for non-urgent mental health are seen within 3 weeks	0-19 yrs	3	qn/t	71%		48%	80%
	20-64 yrs	3	qn/t	69%		73%	80%

More People with End Stage Conditions are Supported Appropriately

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
A reduction in the percentage of palliative care clients who have had an inappropriate Emergency Department presentation	Total	3	qn/t	0.6%	2017/18	New Measure	0%

Support Services

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2017/18	Target 2019/20
Improved wait times for diagnostic services - accepted referrals receive their CT scan within 42 days	CT	2	qn/t	86%		78%	95%
Improved wait times for diagnostic services - accepted referrals receive their MRI scan within 42 days	MRI	2	qn/t	45%		50%	90%

Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Cat 1 within 24 hours	2	qn/t	100%		100%	90%
	Cat 2 within 96 hours	2	qn/t	100%		100%	90%
	Cat 3 within 72 hours	2	qn/t	90%		91%	90%
Percentage of Māori employed in the Health and disability workforce at the Taranaki DHB	Māori	4	qn	8.42%		9.36%	18%

APPENDIX A: 2019-23 Financial Performance Plan

The consolidated financial summary below includes the Hospital Provider (Personal Health, Mental Health, Public Health and DSS), DHB Governance & Funding Administration, and the DHB Funder operations.

(\$'000)	2017/18 audited	Year 0 2018/19 unaudited	Year 1 2019/20 plan	Year 2 2020/21 plan	Year 3 2021/22 plan	Year 4 2022/23 plan
TOTAL REVENUE	381,430	400,258	413,479	424,958	436,491	448,039
TOTAL OPERATING EXPENSES	389,719	423,628	431,502	443,382	455,578	468,097
Hospital Provider + Governance Operating Deficit	-25,874	-36,123	-31,823	-32,373	-33,179	-34,293
TDHB Funder surplus	17,585	12,753	13,800	13,949	14,092	14,235
CONSOLIDATED FINANCIAL RESULT	-8,289	-23,370	-18,023	-18,424	-19,087	-20,058

The net consolidated financial projections for the planning period 2019-23 are:

- 2019/20: Deficit \$ 18.02M
- 2020/21: Deficit \$ 18.42M
- 2021/22: Deficit \$ 19.09M
- 2022/23: Deficit \$ 20.06M

These financial projections are to be read with the accompanying notes and assumptions.

1. Key points from the Budgeted Financials: 2019-23

Taranaki DHB's PBFF share has reduced from 2.66% (2016/17) to 2.64% in 2017/18 to 2.63% in 2018/19 and has further reduced to 2.61% in 2019/20. Population estimates indicate that Taranaki DHB's population in 2019/20 will show an increase of 1.17% or an increase of 1,410 from the 2017/18 population projection. With such a low population growth rate, Taranaki DHB will continue to be in transitional funding for 2019/20 and has received only minimum growth on funding allocation. The longer term forecast is that the DHB's PBFF share will continue to reduce (please refer to Section 2.1 for details).

The increase in core funding for 2019/20 over 2018/19 is the fourth lowest level of increase amongst the 20 DHBs in New Zealand.

The quantum of funding for 2019/20 will require the Board to actively work to restrain costs growth and also requires potential service changes. Equally, the ability to retain funds for investment in services and improvements is severely impacted.

- Against this backdrop, the Board has planned for a consolidated financial deficit, albeit increasing, for each of the 4 fiscal planning periods.

- The longer term forecast is that Taranaki DHB PBFF share will continue to reduce. The Government has made no decision on out-year funding. To ensure consistency across all DHBs, Taranaki DHB has prepared the Annual Plan using the planning guidance provided that funding increases in out-years will be of the same nominal value as 2019/20.
- *These financial projections reflect a common trend across the entire planning period 2019-23; clearly indicating that cost growth in the hospital provider operations is growing year on year and is significantly in excess of its funding, leaving operating deficits in its wake. With the low levels of funding YOY over the past four fiscal periods, the compounding effect of deficit increases is to be expected - and real.* Further, the surplus generated in the Funder operations is not sustainable, nor ideal for strategic health services planning for the local community.
- The Hospital Provider Arm is facing a significant cost to funding gap resulting in operating deficits in each year covered by this plan. The hospital provider budget for Year 1 is *after* targeted cost reductions and budget trimming – primarily in wages and clinical supplies (Please refer Sec: 8 - Sensitivity Analysis for details). In addition, there is a cost to funding gap of \$7.00M which is required to be bridged through savings and initiatives. (Please refer to the Section 6: Cost & Efficiency Initiatives section for details).
- The Hospital Provider (and consolidated) financial result in Year 1 (2019/20) and out years continues to be materially influenced by the flow on cost impacts of Project Maunga Stage 1 – depreciation, cost of borrowing and loss of interest income on deposits (circa \$6.60M).
- The DHB Funder operations is planning to reprioritise funding and drive strategic initiatives to enable the DHB Funder operations to manage its costs down and deliver the operating result planned for 2019/20 and years following. Like the hospital provider, the DHB funder is carrying risks in its budget which will present challenges for it to deliver to plan (Please refer Sec: 8 - Sensitivity Analysis for details).
- Collectively, the total cost budgeted in 2019/20 for Taranaki DHB to provide operational support to national and regional agencies (NZHPL, Health Share, TAS) is circa \$1.45M – and increasing year on year. This is besides any capital investment required to support regional and national projects. The operating budget is very limited in its ability to absorb these new (and increasing) costs arising on different fronts – noting that any benefits are likely to accrue only in future periods.

In the final analysis;

The Board is faced with:

1. *Continuing low levels of funding year on year against increasing demand for services and operating costs.*
2. *A continuing core deficit in its Hospital Provider operations in each of the plan years.*
3. *An increasing consolidated deficit in each of the plan years, with consequential impacts on cash flow and investment potential.*
4. *Additional financial exposure in its expense budgets + the inability to absorb unplanned costs during a fiscal period.*
5. *The financial recovery for its Hospital Provider operations being largely dependent on cost reductions incidental to services rationalisation, capacity and work force management.*
6. *Its limitation to make structural changes (to the extent practical and permissible) and re-align service configurations in its hospital service operations to restrict its current deficit.*
7. *Its Funder operations having to reduce investment in community services during the period the hospital operation is going through this transition.*

The Board notes:

- a) *That the quantum of annual funding increases received by TDHB is grossly inadequate to support its current services and infrastructure. Operating deficits are inevitable – and will increase year on year at forecast funding levels. Operating cash flow will be impacted, and will result in additional equity funding to support liquidity. The DHB has limited ability to invest in change or service improvements.*
- b) *That the DHB is faced with increasing demand for health services against a backdrop of nominal annual funding increases, therefore targeted changes within its operating framework (including the non-hospital sector) are necessary.*
- c) *The operating cost to funding gap in the Hospital Provider operations cannot be bridged by changes along the margins and short term measures, and*
- d) *that structural and service changes will have to be pursued if the Hospital Services arm is to remain financially viable and sustainable when faced with increased costs on several fronts, and*
- e) *that these changes will take time, will need to transcend political sensitivities and communal expectations in a collaborative (and time challenged) manner, and*
- f) *consequently, a 12 month annual plan time line is impracticable for capturing the financial impacts of structural reforms - and will require injection of new equity funding to undertake targeted transformational change.*

In summary, the financial risk assessment of the current Annual Plan is rated “medium to high” risk under the assumptions and risks stated.

2. Key Risks

2.1 Taranaki DHB’s Funder Operations

2.1.1 Population Based Funding

DHB funding is based on a Population Based Funding Formula (PBFF) which allocates the total Vote Health funding to DHBs on the basis of the total resident population, with adjustments applied for ethnicity, rurality, age profile, socio-economic deprivation and the number of overseas visitors. Whilst other factors impact on the PBFF share weighting the total population number is the most significant factor.

DHB population estimates are shown below. The 2019/20 allocation is based on a population estimate of 121,460 people resident in Taranaki (Table 1). The growth rate of 1.17% is one of the lowest of the DHBs and as such indicates that the Taranaki population is growing much slower than the country as a whole (Table 2).

PBFF is based on 2013 Census population as Census 2018 is not yet available.

Table 1: DHB Population Variance

Year	2018/19	2019/20	Increase
2017 Population Series	120,050	120,690	640
2018 Population Series	120,455	121,460	1,005
Change	405	770	1,410

2.1.2 POPULATION BASED FUNDING SHARE

The Taranaki DHB PBFF share in 2019/20 is 2.61% The longer term forecast is that Taranaki DHB PBFF share will continue to reduce over time (refer Table 3).

Table 3: PBFF Share

Year	2014/ 15	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/ 23
Taranaki	2.71%	2.68%	2.66%	2.64%	2.62%	2.61%	2.59%	2.57%	2.56%

Whilst the level of funding for Taranaki DHB is equitable when compared to the proposed increases for other DHBs, the level and quantum of increase is considerably lower than the cost and service pressures faced by the DHB Funder and Provider Arm. The quantum of funding for 2019/20 will require the Board to actively work to restrain costs growth and also requires potential service changes, for which appropriate service change processes will need to be adopted. Importantly, the ability to carry funds for investment in services and improvements is severely impacted.

2.1.3 Key Pressure

The range of pressures that the Taranaki Health System is experiencing is interdependent as noted below:

- ✓ Cost Pressures in Hospital and Specialist Services
- ✓ Cost Pressures in NGO Sector
- ✓ Strategic Investment to progress the Health Action Plan

2.1.4 Resource Allocation

The allocation of resources is a pragmatic approach to investment given the information available at this time and reflects prioritisation in line with DHB funding responsibilities and the Minister's Letter of Expectation. In order to partially offset planned deficits in the Provider Arm, the Funder is required to achieve surpluses. For 2019/20 the planned Funder surplus is \$ 13.80M. This presents a significant challenge for the Funder.

2.2 Taranaki DHB's Hospital Provider Operations

1. The Hospital Provider Arm is facing a significant and increasing cost to funding gap. This gap between funding and real cost growth has resulted in a budgetary deficit of \$31.82M for 2019/20, after considering all current efficiencies and cost savings, and carries other financial risks as noted earlier.
2. Cost pressures are particularly evident in the following areas:
 - a) Wages – MECA settlement impacts. There are gaps in funding received against pay out.
 - b) Outsourced clinical staff – primarily psychiatrists.
 - c) Diagnostics and Pharmaceuticals.
 - d) Acute services including mental health inpatient services and emergency department.
 - e) Increasing cost impacts of statutory compliances, quality and accreditation deficits and numerous legislative requirements.
 - f) Information and communication technology (ICT) capital investment and increased annual operating costs for projects, network infrastructure and software licences.
 - g) Increasing cost contributions to national and regional agencies + capital investment and participation in national and regional initiatives and business cases which contributes to existing cashflow pressures.

Overall, the Hospital Provider's financial plan for the planning period is highly geared and has no flexibility to accommodate unplanned cost movements. Its operating budget carries financial risks and it is highly dependent on the realisation of targeted savings within planned timelines to meet its 2019/20 and out year financial targets.

3. Indicative savings through reduced pricing from collective procurement projects, All of Government (AOG) initiatives and other collaborative efforts have been factored into clinical supply and consumable costs over the plan period. Likewise, operating expenditure outflow to support these national initiatives have been provided.
4. Taranaki DHB's share in supporting the approved Midland regional projects and contribution to HealthShare (the regional shared services entity) has been provided. Investment in the Midland e-Space programme will be prioritised along with other national and local IT projects.
5. In applying the budgetary assumptions we have recognised ongoing quality improvements and those compliance costs of which Taranaki DHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or increased costs resulting from clinical compliance expectations and legislative changes.
6. With about 94% of its revenue derived from health funding (via DHB Funder and the Ministry of Health), the Hospital Provider has few alternate income streams for revenue growth. In 2019/20 there is a reduction in ACC revenues due to exit of certain ACC contracts on grounds of negative contribution. Miscellaneous income assumes \$0.50M to be raised through community donations.
7. During the plan period 2019-23, baseline capital expenditure will be contained within depreciation provisions, so that any additional equity injection to support cashflow levels is minimised.
8. In the final analysis, the gap between funding and the realistic cost model for services has resulted in a very sensitive financial budget and is an increased financial deficit for the planning period 2019/23 and out years.

3. Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the four year planning period 2019-23.

3.1 Application of Public Benefit Entity Accounting Standards

The DAP financial template for the plan period 2019-23 and comparative years has been prepared in accordance with NZ GAAP. They comply with Public Benefit Entity Standards which include the Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

3.2 Equity and Borrowing

- a) The District Annual Plan 2019-23 has assumed the requirement for additional Crown equity.
- b) TDHB will be applying to the Capital Investment Committee (CIC) during 2019 in relation to capital funding to address Earthquake Probe Buildings (EPB) as part of its seismic risk management plan. This is being assessed and a separate business case will be forwarded to CIC in 2019/20.
- c) This (b above) is independent of the capital funding requested for Stage 2 of the hospital redevelopment, for which an Indicative Business Case has been submitted to the CIC in August 2019. Subject to approvals received in time, the indicative time line for delivery of Stage 2 is October 2023 or sooner (FY 2023-24)
- d) TDHB will be seeking additional equity injection to manage its cash shortfall and remain within its designated OD limit. It received equity support of \$ 13.60M in June 2019. The Annual Plan has assumed that PBFF funding in the out years is at the same level as the indicative funding for 2019/20, with operating expenditure materially outside the planned funding. Under this scenario, an equity injection of \$ 15M as deficit funding to support the cash flow has been built into each of the fiscal years 2019/20 through to 2023/24.

- e) Taranaki DHB is currently on “performance watch - remedial” status on the performance monitoring scale.

3.3 Operating Expenditure assumptions:

- a) Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with current agreement(s) and in line with collective planning assumptions. MECA's which are yet to be settled have a budgetary provision for wage increases - and presents a risk should final settlement exceed the provision. Additionally, as was noted in 2018/19, funding received for MECA increases have been much lower than the actual outlay - contributing to the operating deficit of the hospital provider. The budget has only partially provided for recruitment to new positions and critical front line vacancies carried in the 2018/19 FY, besides provision for overtime, specialising etc.
- b) Clinical supplies: an increase of circa 2% has been assumed in 2019/20 based on estimated activity levels, reduced for local efficiencies and procurement gains. There is a potential risk in this line.
- c) General operating expenditure: increase noted primarily in ICT costs, this service has seen YOY increases above the average and will continue to put pressure on costs and cashflow as more ICT projects come on stream. Local efficiencies and cost controls have been built in to balance inflationary impacts.
- d) Value for Money (VFM) impacts: Cost reductions and gains likely to ensue from the collective procurement contracts undertaken by MBIE/NZHPL programmes, AOG contracts and regional arrangements have been recognised. Gains from local initiatives and projects have been built into the relevant expense budgets.
- e) Other expenditure reductions: the 2019/20 expense budget assumes efficiencies and cost reductions arising from the following - and present a risk from a timing perspective:
 - FTES.
 - Models of Care and other programmes.
 - Length of stay and patient throughput.
 - Contract tracking + renegotiation + monitoring.
 - Acute demand and capacity management

4. Budgetary Outlay and Assumptions

4.1 Mental Health Services

In keeping with the guidelines on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure carried forward from previous accounting periods has been reported as a surplus in Taranaki DHB's Statement of Financial Performance in the year the surplus is generated. Based on expenditure to date and forecasts, no surplus is likely to remain on 30 June 2019. No surpluses from Mental Health services are envisaged during the 2019-23 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

4.2 Interest Income and Payment

Interest on term loans (\$74M) carried in previous periods is NIL in 2019/20 and out years on account of conversion of all term loans to equity in February 2017. Interest on overdraft (usually at month end) is netted off against interest income on overnight deposits under the sweep arrangement of the collective banking and treasury programme, resulting in net interest income for 2019/20 and out years.

4.3 Asset Revaluation and its Impact

Under the provisions of PBE IPSAS 17, Taranaki DHB is required to undertake an asset revaluation exercise as at 30 June each year, and recognise any material increase in land and building values, and also its impact on depreciation and capital charge. Taranaki DHB is required to undertake a full asset revaluation once every 5 years.

Taranaki DHB conducted a full asset revaluation as @ 30 June 2018 in accordance with the stipulated cycle. The summary impacts of the revaluation in the books and costs of the DHB are as under:

- Increase in value of Land & Buildings: \$ 49.09M
- Increase in Reserves: \$ 49.09M
- Increase in Depreciation due to revaluation impact: \$ 0.78M
- Increase in Capital charge due to revaluation impact: \$ 2.55M.

Provision has been made as appropriate in the 2019/20 financials and future periods for the impacts of asset revaluation noted above.

4.4 Depreciation

Depreciation has been calculated on a straight line method for all existing assets, less disposals and recognising additions.

4.5 Capital Charge

Capital charge has been calculated in line with existing methodology, adjusted for donations and closing balance of shareholders funds.

4.6 Leasing

The Annual Plan assumes certain items of plant and equipment will be leased after evaluation on a case-by-case basis. The Plan also assumes that operating leases will be explored for capital plant and equipment which have a short economic life or are prone to rapid changes in technology. Operating leases will adhere to current guidelines and tests to clearly differentiate these from finance leases.

4.8 Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements other than any changes brought about by the adoption of Public Benefit Entity Standards, including Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

4.9 Capital Investment

The capital investment planned during the Business Plan period and the proposed funding lines to finance the investment are as follows:

Capital Outlay (\$'000)	Year 1 (2019-20)	Year 2 (2020-21)	Year 3 (2021-22)	Year 4 (2022-23)	Total (2019-23)
Operating					
Clinical Equipment	5,000	4,000	3,000	3,000	15,000
Other Equipment	500	500	500	500	2,000
Motor Vehicles	150	150	100	100	500
Minor Site Redevelopment (including prior year WIP)	3,000	3,000	3,000	3,000	12,000
Information Technology	7,000	7,000	8,000	8,000	30,000

Capital Outlay (\$'000)	Year 1 (2019-20)	Year 2 (2020-21)	Year 3 (2021-22)	Year 4 (2022-23)	Total (2019-23)
TOTAL - Operating	15,650	14,650	14,600	14,600	\$ 59,500
Strategic					
A: Base Hospital redevelopment. Project Maunga – Stage 2	Scoping & development of IBC and DBC	Detailed design and implementation BC.	Procurement + start of construction	Construction phase.	Est. \$ 291M - subject to CIC approval
B: Seismic Risk Management Plan (strengthening of identified EPB buildings and relocation of services)	Single business case to CIC	Execution of strengthening works	Completion of strengthening works	-	\$ 56M - subject to CIC approval of BC.
TOTAL - Strategic	-	-	-	-	A+B : \$347M
Sources of Funding					(\$ M)
Crown Equity	0	0	0	0	347
Bank Borrowing	0	0	0	0	0
DMO/MOH Term Loans	0	0	0	0	0
Internal Cash Accruals	15,650	14,650	14,600	14,600	59.50M

Note: A: The strategic capital expenditure is in reference to the development of the business case for Stage 2 of Project Maunga. All preliminary work to inform the business case has been completed, and at the time of writing this draft Plan the DHB had submitted the Indicative Business Case (IBC) to the National Capital Investment Committee, and was awaiting to hear its decision - expected July/August 2019. The capital investment for Stage 2 is estimated at \$ 291M – subject to approval of the scope and design. Funding to support the build is expected to be largely from Crown equity, with an amount of \$ 25M being targeted from community support and local corporates - an ambitious target which carries a fair degree of risk.

B: The Seismic Risk Management Plan is a separate business case that seeks capital funding to address the critical seismic issues identified with Earthquake Prone Buildings (EPB) - options include relocation of services and strengthening of these EPB declared buildings. These are interim measures until Stage 2 of the hospital redevelopment is completed in 2023, and services within these EPB buildings relocated to the new facility.

4.10 Capital Divestment

The disposal of surplus assets proposed during the period 2019-23 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not material	0	2019-23
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2019-23
Total	0	0	0	

Taranaki DHB will ensure that disposal of any land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act 1993 will be subject to approval by the Minister of Health. Taranaki DHB will work closely with the Office of Treaty Settlements to ensure the relevant protection mechanisms that address

the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations to Māori sites of significance are addressed.

4.11 Personnel

a) Paid/Contracted/Core FTEs

The movement of "contracted/worked FTE" numbers across the Annual Plan period is assumed along the following lines.

	Average 2018/19		Yr 1 - 2019/20		Yr 2 - 2020/21		Yr 3 - 2021/22		Yr 4 - 2022/23	
	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued
* Medical	201	205	201	205	201	205	201	205	204	208
* Nursing	685	715	641	669	645	673	650	678	655	684
* Allied Health	260	260	263	263	264	264	264	264	265	265
* Support	105	107	99	101	100	102	100	102	102	104
* Mgt & Admin	286	291	285	291	286	291	286	291	288	293
* Gov & Funding	20	20	20	20	20	20	21	21	21	21
TOTAL	1557	1599	1509	1550	1516	1556	1522	1562	1535	1576

- Medical FTE count has seen an increase during 2018/19 to meet MECA conditions, primarily in relation to rosters, in addition to filling vacancies. Any increase planned for 2019/20 is on the assumption that vacancies are likely to be filled over the coming period in lieu of locum cover (with corresponding drop in locum costs).
- In general, nursing staff will show significant increases YOY in response to activity. Of particular note is the impact of the MECA settlement on staffing levels and CCDM commitments, which will see increases in core numbers and costs. However, there is a planned decrease in 2019/20, which is as a result of service reorganization and consolidation of positions as part of an efficiency/productivity initiative to rationalise FTE growth and the operating financial deficit. Future periods show a gradual increase linked to increase in activity, tempered by more efficient management of staffing and efficiencies from services reconfigurations and changing models of care within the hospital and mental health services.
- Movements in Allied Health and Support staff are likely to be contained and are constantly reviewed for efficiencies and optimum service delivery - any increase reflected in 2019/20 are related to vacant positions.
- Management and Administration staffs are expected to remain at current levels, with any increases solely driven by new funded projects. Capping FTE growth with improved productivity and more efficient and smarter workflows has been a key goal for Taranaki DHB to manage the cost growth and the deficit.
- In principle, the personnel budget has not planned for core FTE increases – other than FTEs required to deliver acute demand, locums converted to FTEs, vacancies filled, new projects and MECA driven requirements. The overall strategy is to contain FTE growth, albeit reduce the growth curve through changes to models of care and consolidation of positions as and when opportunities arise. There will be demand for clinical resources due to increase in activity levels – primarily acute demand as was witnessed during the recent fiscal periods. Additionally, as recent trends indicate, there has been an increase in specialising patients (one-on-one care) in ICU and Mental Health inpatient admissions. With introduction of staffing management tools and applications, Taranaki DHB will continue to aggressively pursue measures and initiatives to increase productivity of existing staff and reduce the demand for locums and casual staff within the hospital and specialist services.

5. Capital Expenditure: Strategic

5.1 Base Hospital Inpatient Facilities Development Programme

The Base hospital Master Plan envisages a 3 Stage redevelopment of the Base Hospital core inpatient facilities and support systems, such that it is both financially and operationally feasible over a defined timeline. Stage 1 of Project Maunga - the redevelopment of the Base Hospital inpatient facilities with theatres and inpatient wards was delivered within budget and on time in June 2014 @ a cost of \$ 80M.

The other components of the programme are as follows:

Stages	Comprising	Estimated Cost	Timeline	Status
STAGE 1	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Aug 2011 Finish: June 2014	Completed.
STAGE 2	Maternity, Neonatal, ED, Radiology, Pathology, ICU/CCU/HDU.	\$291M (estimate)	Tentative: 2019-2023	Preliminary works commenced. Awaiting approval from CIC.
STAGE 3	Ambulatory, OPD Administration.	\$125M (estimate)	Tentative : 2026-2027	Supplementary business case to be progressed.
TOTAL		\$496M (estimate) <i>See notes</i>	2011 – 2027	

Notes:

1. Scoping and planning for Stage 2 of Project Maunga is well advanced, with preliminary works in progress. Early documentation (Risk assessment, Point of Entry, Strategic Assessment, Indicative Business case) has been submitted to the Capital Investment Committee (CIC) and approval is awaited. The estimated capital cost based on the preliminary scope is \$ 291M, which is likely to be finalised once the scope is approved, detailed design undertaken and cost estimates become more definitive. The planning and resources required to progress the business case through the different stages leading to approval have been established.
2. Independent of the above investment, the DHB has also submitted a Seismic Risk Management Plan to the CIC with a proposal to address seismic risks prevalent in Earthquake Prone Buildings within its campus. The capital estimate is \$ 56M. CIC approval is awaited.
3. Each of the stages can be visualised as standalone projects, yet forming part of one coherent facilities redevelopment programme for the Base Hospital in New Plymouth, thus enabling affordability to both Taranaki DHB and the National Health capital budget.
An updated Schedule of Capital Intentions has been submitted.

6. Cost and Efficiency Initiatives

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope, which has not seen any quantum increase over the recent periods and significantly falls short of annual operating expenditure. There is a growing financial gap. Under this capped environment, with increasing operating costs and demand for services, the Hospital Provider Arm will have to strive hard to achieve sustainability – both clinical and financial.

The following key initiatives are being considered within the Hospital Provider operations to generate efficiency gains, and bridge its cost to funding gap of \$ 7.0M if it has to meet its plan target for 2019/20 and contain its growing operating deficit.

Initiatives	Proposal	Potential Est. (\$)	Impact
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Internal cost controls: Campus wide cost management strategies to reduce discretionary costs	Target specific areas of cost for efficiency gains including review of service delivery and demand.	\$0.82M	Reduce operating costs
Outsourced services: Review of outsourced services.	Review and re-structure of outsourced services	\$0.44M	Reduce operating costs.
Clinical supplies: reduction in usage due to changes in models of care	Review of models of care with potential reduction in clinical supplies.	\$0.56M	Reduce operating costs
Contracts management: Review and re-negotiation of service contracts against delivery and measurable outcomes	Ongoing review of contracts in the DHB Funder and Hospital services.	\$1.00M	Reduce operating costs
Staff strategies: FTE vacancy management + other staffing initiatives	Range of FTE management and consolidation across the organisation.	\$4.18M	Rationalise FTE's + operating costs
TOTAL		\$7.00M	

The Annual Plan has identified a cost to funding gap of circa \$ 7.00M to arrive at its planned financial result for 2019/20, which has to be bridged by a range of saving initiatives and cost reduction plans as outlined. The services initiatives commenced in prior years will also progressively generate cost savings and have been recognised in current and out years.

Miscellaneous gains from local initiatives and cost reduction measures have been built into the relevant expense budgets.

The financial management plan is an ongoing process, will involve partnering with primary sector providers and is expected to span more than one fiscal year in view of their strategic components and broader implications. This is part of a broader primary secondary integration initiative currently under consideration.

7. Banking and Cash Flow

The primary assumptions carried in the financial plan 2019/20 are:

- Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective treasury and banking arrangement (currently with BNZ). Taranaki DHB has been in overdraft during most periods of 2018/19 primarily on the back of a sharp increase in its consolidated financial deficit from \$ 1.67M (2016/17) to \$ 8.29M for the year 2017/18 and increasing to \$ 23.37M in 2018/19. The deficit planned for 2019/20 is \$ 18.02M.
- It is expected that base line capital expenditure will be contained within the level of depreciation for 2019/20 and out years. Cash outflow will be closely managed by capital prioritisation and working capital management, the intention is to limit the overdraft.
- The continuing deficit and low levels of funding increases, year on year, is proving to be corrosive. The closing monthly cash balance over the recent months since December 2018 has been very close to the OD limit allowed for Taranaki DHB (\$ 18.04M). Additionally, TDHB has been funding the preliminary works and consultants (project management, QS, architects, health designer, structural engineers etc) required for development of the business cases for submission to the CIC for its Stage 2 building redevelopment and seismic management.
- Under the above scenario, TDHB will be seeking additional equity injection to manage its cash shortfall and remain within its designated OD limit. Accordingly, TDHB received \$ 13.60M in June 2019 as deficit support. The Annual Plan has assumed that PBFF funding in the out years is at the same level as the indicative funding for 2019/20, which will present cashflow problems considering the cost growth vis a vis funding received. Under this scenario, an equity injection of \$ 15M as

deficit funding to support the cash flow has been built into each of the fiscal years 2019/20 through to 2022/23.

8. Sensitivity Analysis: Budgetary Risks carried in Annual Plan 2019/20

The Annual Plan carries some key financial risks – *besides the \$7.00M cost to funding gap (see Sec: 6 – Cost & Efficiency Initiatives)*. While it is difficult to quantify all these risks with accuracy, the likely impacts on the bottom line if these were to materialise is factored below:

DHB Hospital Provider Operations – Key Risks in 2019/20

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
Wage budget (MECA impacts)	1.00	0.75	0.50	0.25	75%
Timing of gains from savings plan	2.00	1.50	1.00	0.50	50%
Clinical supplies	1.00	0.75	0.50	0.25	75%
General overheads	0.40	0.30	0.20	0.10	50%
Likely impact on 2019/20 planned financial result	\$4.40M	\$3.30M	\$2.20M	\$1.10M	\$2.70M

The overall risk is expected to be **\$4.40M** for 2019/20, while the probability factor is estimated to be around 60% leaving a residual risk equating to about **\$2.70M**. The risk is expected to be managed through a mix of:

- Internal cost controls
- Management of FTEs
- Operational savings in discretionary expense lines through capped budgets
- Gains from National procurement programmes and initiatives
- Fast tracking efficiency projects and service reviews

DHB Funder Operations – Key Risks in 2019/20

Unbudgeted financial risk	Est. risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
Hospital provider deficit increase	2.00	1.50	1.00	0.50	75%
IDF Above Plan	1.00	0.75	0.50	0.25	50%
Pharmaceuticals	0.50	0.38	0.25	0.13	25%
Health of Older People	0.50	0.38	0.25	0.13	25%
Potential impact on 2019/20 planned financial result	4.00M	3.00M	2.00M	1.00M	2.25M

The overall exposure is estimated at around **\$4.00M** for 2019/20, while the probability factor is estimated to be around 55% leaving a residual risk equating to about **\$2.25M**.

These risks are expected to be managed through contract monitoring.

9. Statement of Comprehensive Income

	Audited	Actual		Planned			
	2017/18	2018/19		2019/20	2020/21	2021/22	2022/23
Revenue							
Devolved Funding	356,708	375,687		390,822	401,870	412,918	423,966
Non-Devolved Contracts	6,549	6,574		6,568	6,613	6,659	6,706
Inter-DHB & Interprovider Revenue	5,056	5,250		5,461	5,687	5,922	6,167
Other Revenue	13,117	12,747		10,628	10,788	10,992	11,200
Total Revenue	381,430	400,258		413,479	424,958	436,491	448,039
DHB Provided Expenditure							
Personnel	142,651	158,574		158,725	165,052	171,630	178,476
Outsourced Personnel & Support	2,777	2,416		2,079	2,121	2,163	2,206
Outsourced Clinical Services	13,032	12,249		9,280	9,558	9,845	10,140
Clinical Supplies	30,924	34,377		34,999	35,931	36,888	37,871
Infrastructure & Non-Clinical Supplies	38,194	44,902		45,470	44,793	44,132	43,481
Total DHB Provided Expenditure	227,578	252,518		250,553	257,455	264,658	272,174
Other Providers							
Personal Health	64,882	68,636		73,662	75,635	77,549	79,399
Mental Health	10,590	11,476		12,617	12,985	13,353	13,720
Public Health	693	542		906	928	951	975
DSS	44,205	47,570		49,262	50,492	51,754	53,046
Maori Health	2,887	2,752		2,662	2,729	2,798	2,868
IDFs	38,884	40,134		41,840	43,158	44,515	45,915
Total Other Providers	162,141	171,110		180,949	185,927	190,920	195,923
Total Expenditure	389,719	423,628		431,502	443,382	455,578	468,097
Total Consolidated Result	(8,289)	(23,370)		(18,023)	(18,424)	(19,087)	(20,058)
By Arm							
Provider	(25,879)	(36,094)		(31,823)	(32,373)	(33,179)	(34,293)
Governance	5	(29)		0	0	0	0
Funder	17,585	12,753		13,800	13,949	14,092	14,235
TDHB Consolidated	(8,289)	(23,370)		(18,023)	(18,424)	(19,087)	(20,058)

10. Consolidated Statement of Financial Position

			2017/18 audited	2018/19 forecast		2019/20 plan	2020/21 plan	2021/22 plan	2022/23 plan
(\$'000)									
CURRENT ASSETS									
* Bank Account			317	391		399	625	841	399
* ST investments			2890	0		0	0	0	0
* Prepayments			1407	2144		1744	1544	1344	1144
* Debtors (net of provision)			14186	12786		11966	12061	12156	12251
* Inventory			3332	3477		3487	3492	3497	3502
			22132	18798		17596	17722	17838	17296
CURRENT LIABILITIES									
* Bank Account			4578	2036		634	0	0	312
* Creditors & other payables			21190	23011		24836	25690	26513	27337
* Term Loans (current portion)			0	0		0	0	0	0
* Provisions			31805	35656		37009	37319	37629	37939
			57573	60703		62479	63009	64142	65588
WORKING CAPITAL			-35441	-41905		-44883	-45287	-46304	-48292
NON CURRENT ASSETS									
* Net Fixed Assets			220052	216523		213570	209617	205614	201611
* Investments			2979	2501		4511	4511	4511	4511
* Trust funds			779	719		719	719	719	719
			223810	219743		218800	214847	210844	206841
NET FUNDS EMPLOYED			188369	177838		173917	169560	164540	158549
NON CURRENT LIABILITIES									
* Provisions - non current			901	1099		1159	1184	1209	1234
* Term Loans			0	0		0	0	0	0
			901	1099		1159	1184	1209	1234
CROWN EQUITY									
* Crown Equity			94290	106931		120973	135015	149057	163099
* Reserves			117319	117259		117259	117259	117259	117259
* Retained earnings			-24141	-47451		-65474	-83898	-102985	-123043
			187468	176739		172758	168376	163331	157315
NET FUNDS EMPLOYED			188369	177838		173917	169560	164540	158549

11. Consolidated Statement of Cashflow

(\$'000)	2017/18 audited	2018/19 forecast	2019/20 plan	2020/21 plan	2021/22 plan	2022/23 plan
OPERATING ACTIVITIES						
* MOH funding	358726	383730	398216	408388	419482	430577
* Other revenue	17644	17860	16083	16475	16914	17367
total receipts	376370	401590	414299	424863	436396	447944
* Payment of salaries & operating exp.	201630	231246	229222	237968	245202	252717
* Payment to providers & DHB's	162849	170151	180049	185427	190420	195423
total payments	364479	401397	409271	423395	435622	448140
NET CASHFLOW FROM OPERATIONS	11891	193	5028	1468	774	-196
INVESTING ACTIVITIES						
* Interest & Dividends Received	401	112	0	0	0	0
* Sale of fixed assets etc	121	48	0	0	0	0
* (Increase) / decrease in investments	-45	3428	-2010	0	0	0
* Capital expenditure	-12604	-13806	-15650	-14650	-14600	-14600
NET CASHFLOW FROM INVESTING	-12127	-10218	-17660	-14650	-14600	-14600
FINANCING ACTIVITIES						
* Equity injections	0	13600	15000	15000	15000	15000
* Equity repayments	-958	-959	-958	-958	-958	-958
* Borrowings	0	0	0	0	0	0
* Payment of debts	0	0	0	0	0	0
NET CASHFLOW FROM FINANCING	-958	12641	14042	14042	14042	14042
Total cash in	375412	414231	428341	438905	450438	461986
Total cashout	-376606	-411615	-426931	-438045	-450222	-462740
NET CASHFLOW	-1194	2616	1410	860	216	-754
Add: Cash (opening)	-3067	-4261	-1645	-235	625	841
CASH (CLOSING)	-4261	-1645	-235	625	841	87

12. Consolidated Statement of Movement in Equity

					2018/19 forecast	2019/20 plan	2020/21 plan	2021/22 plan	2022/23 plan
(\$'000)									
EQUITY AT THE BEGINNING OF PERIOD					187468	176739	172758	168376	163331
* Net results for the period					-23370	-18023	-18424	-19087	-20058
* Revaluation of Fixed assets					0	0	0	0	0
* Equity Injections / (repayments)					13600	15000	15000	15000	15000
* Other					-959	-958	-958	-958	-958
EQUITY AT THE END OF THE PERIOD					176739	172758	168376	163331	157315