TARANAKI
District Health Board

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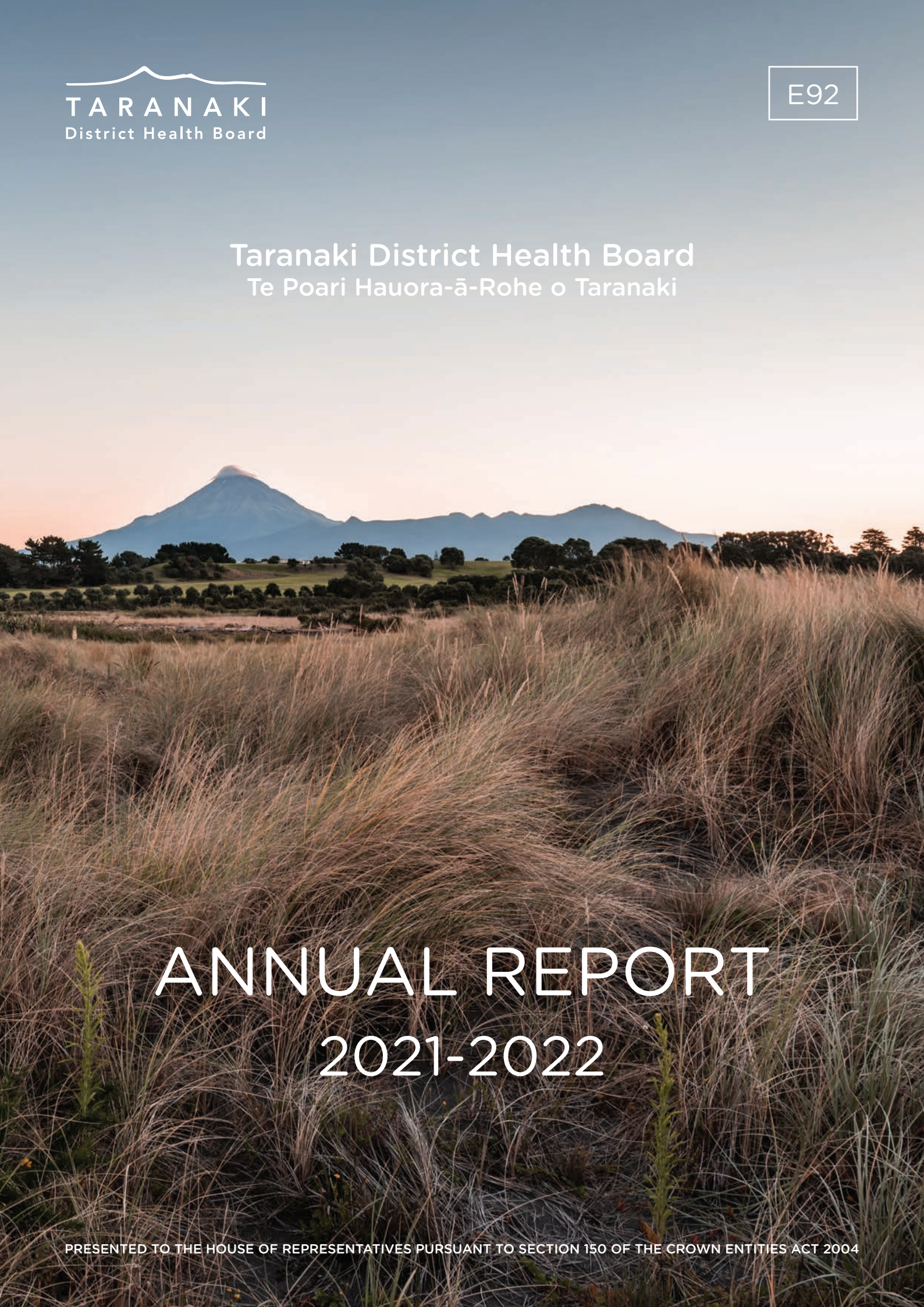
Taranaki District Health Board
Te Poari Hauora-ā-Rohe o Taranaki



ANNUAL REPORT
2021-2022

PRESENTED TO THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 150 OF THE CROWN ENTITIES ACT 2004

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Contents

NGĀ KIKO

Haere Mai

WELCOME

E ngā mana, e ngā reo, e ngā karangatanga maha tēnā ra koutou katoa

E ngā mate huhua, kua riro atu ki te Pō
haere, haere, haere atu ra.
Oti atu koutou ki te Pō, nau mai Te Ao
Tihei mauri ora ki a tātou

On behalf of the former Taranaki District Health Board, I am presenting the Board's Annual Report for the financial year ending June 30, 2022.

This last year saw our Taranaki health services join in the most significant transformation in New Zealand's health service to date as we started the transition from being a district health provider to becoming part of Te Whatu Ora – Health New Zealand on July 1.

Joining this team of teams meant that a number of our most senior enabling, and clinical managers were seconded into national roles to steer the transition. This included Rosemary Clements, whose role of as our CEO concluded on June 30 enabling Rosemary to take up a position as interim lead, People and Culture for the new organisation.

Our Board was also dissolved on July 1, and the Taranaki health team would like to thank the dedicated service that Rosemary and our Board members have shown us in the last, and in previous years.

Despite the pressures and restrictions from the COVID-19 pandemic easing through the first part of the 2022, the long tail of COVID, added to winter illnesses created a very challenging winter for our health staff. Our hospitals were under capacity pressures, and our clinical managers worked hard to ensure staffing numbers matched these high demands.

In our last financial year, our dedicated team of more than 2,400 health professionals completed more than

3,408 elective surgeries, helped give birth to 1,334 babies, and attended to more than 47,280 patients through our ED departments.

And they did all this through a pandemic. It hasn't been easy for them. Yet they worked together as a team to deliver the best health service we can. Because that is our focus. To deliver the best health service.

On behalf of the Taranaki Executive Leadership Team, I'd like to offer our sincere thanks for the efforts of all our staff to keep our hospitals and health services running in the most difficult of conditions. I am very proud to work alongside such a professional team.

Our Project Maunga hospital rebuilding programme continued at pace through the year with the construction of the New East Wing Building - a 20,000 square metre, six-storey building which will house many of Taranaki Base Hospital's acute clinical services including ED, ICU, Maternity, Primary Birthing, Neonatal, Radiology, Laboratory and a roof-top helipad.

As part of the Seismic Risk Management Plan (SRMP), Taranaki Base Hospital will see the construction of a new Renal Unit, Energy Centre, Computer Room and an upgrade to critical site wide infrastructure. These projects will be completed and commissioned by the end of 2022.

In 2023, we will see the commencement of a new, purpose-built Cancer Centre at Taranaki Base Hospital. This will house a new linear accelerator (LINAC) and bring all related oncology outpatient services under one roof. Chemotherapy patients will receive their treatment sessions in a new 12 chair department.

The centre will mean 70-80% of Taranaki cancer patients requiring radiotherapy, will be able to have the majority of their treatment provided locally.

To help provide necessary equipment for our hospitals, our funding partner, the Taranaki Health Foundation launched a new funding raising campaign during the last year – 'Taranaki deserves the best'.

The Foundation is aiming to raise another $25 million across emergency, ICU, maternity, neonatal and radiology to purchase key items, such as a dedicated CT scanner for the emergency department preventing delays for patients, and a new MRI machine for radiology.

This is an exciting new campaign and we are very grateful for every dollar the Foundation raises.

As we continue our transition to Te Whatu Ora – Health New Zealand, we are committed to bringing high quality, accessible and equitable health services to our Taranaki community.

E te huinga, e te tuingā, tēnā ra koutou katoa

Gillian Campbell
Interim District Director
Te Whatu Ora - Taranaki

Our Vision, Aims & Values

TE MATAKITE, NGĀ WHAINGA & TE AHU

Our Shared Vision / Te Matakite

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

Our Aims / Ngā Whainga

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

Our Values / Te Ahu

Partnership / Whanaungatanga
We work together to achieve our goals

Courage / Manawanui
We have the courage to do what is right

Empowerment / Mana motuhake
We support each other to make the best decisions

People matter / Mahakitanga
We value each other, our patients and whānau

Safety / Manaakitanga
We provide excellent service in a safe and trusted environment

TE AHU
TARANAKI DHB VALUES

Our People

TE HUNGA MAHI

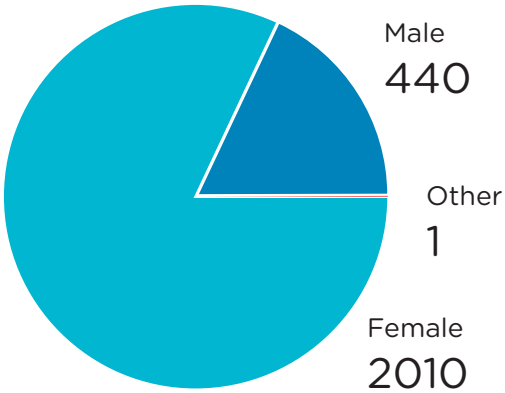
Healthcare is about people helping people.

In Taranaki we have a great team of health professionals and support staff all working together for our community. The make up of our team as at 30 June 2022 is as follows:

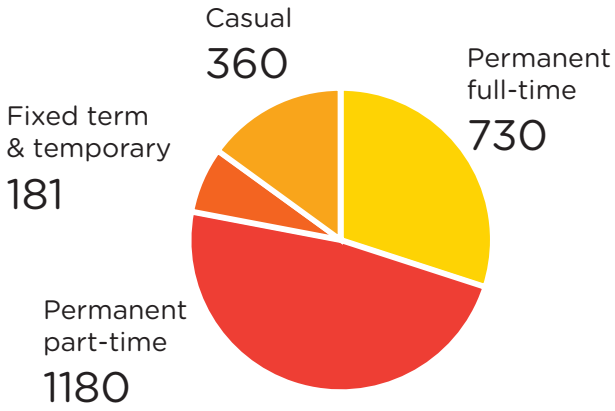
TOTAL STAFF

2451

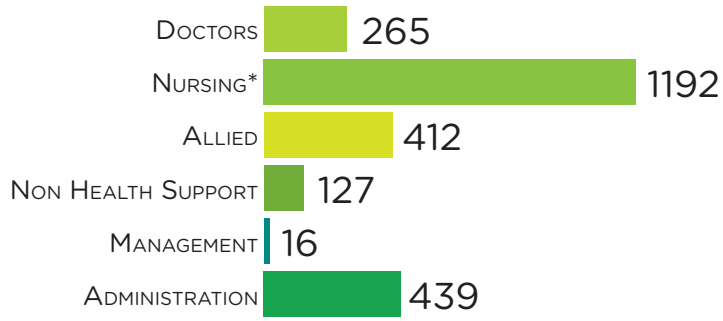
GENDER



TYPE OF EMPLOYMENT

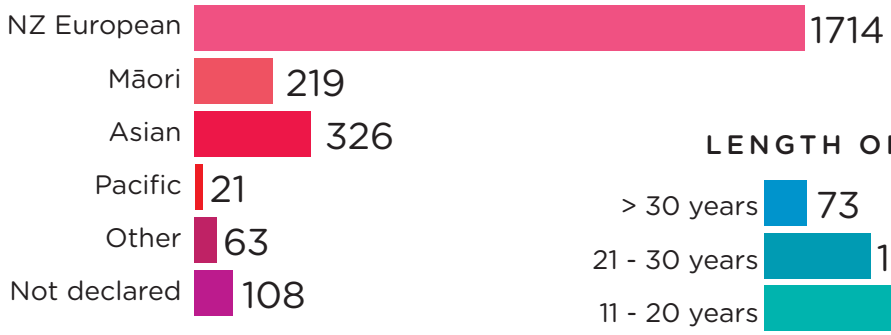


POSITION TYPE

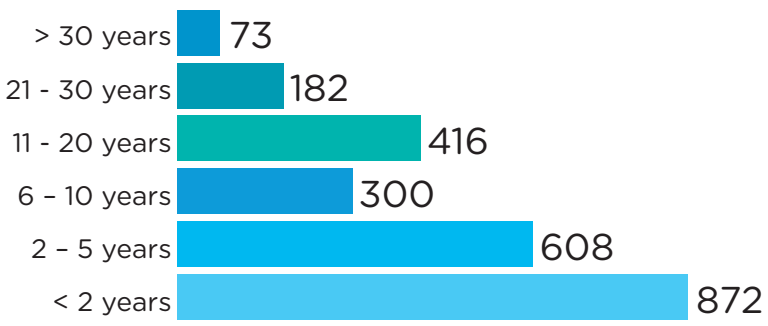


* (Includes midwives and health care assistants)

ETHNIC GROUP



LENGTH OF SERVICE



Reporting on 'Good Employer' Practices

PŪRONGO WHANONGA KAIMAHI PAI

Taranaki DHB's role in workforce planning and development is to identify strategic actions and mechanisms that when implemented will contribute to the organisation having health workers with appropriate clinical and 'soft' skills now and into the future. Actions identified are from a perspective of the DHB being a planner and a funder, a major employer, and a provider of health services in our district.

In addition to these sector wide responsibilities, Taranaki DHB is the largest single employer of health employees in Taranaki. The DHB ensures good employer practices are provided to staff, such as excellent leadership, people, culture, relationships and processes. The table below is a summary of those human resources practices that assist the organisation to be a good employer for its employees, with a patient-centric focus to its people management.

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken

Leadership, Accountability and Culture	• Code of Conduct
	• Equal Employment Opportunities (EEO)
	• Taranaki DHB Values documentation
	• Performance Review (My Feedback) Policy
	• Unprofessional Behaviour Policy & Procedure
		• Employee Engagement Survey (July 2017, Dec 2018 and scheduled for Dec 22)
		• 'Te Ahu Taranaki' Values (2018 launch)
		• Formal management and management/ union meetings
		• New managers' and organisational induction
		• Leadership and Team Development,
		• Change Management & Continuous Improvement programme
		• Team development workshops to support our 'Te Ahu Taranaki' Values and effective team functioning
		• Wellbeing strategy for our workforce
			• Leadership and team development within a changing health reform context
			• 'Te Ahu Taranaki' Values to support the Taranaki way of working
			• COVID-19 Leadership Support
			• Leadership Coaching Opportunities
			• Culture Survey
			• Focus on all facets of wellbeing from individual to organisational incorporating Te Whare Tapa Wha
				• Leadership development undertaken with senior leaders across the organisation
				• The following have been implemented:
				  • Leadership and change management toolkit for leaders to ensure consistency
				  • Personal development and one-on-one coaching sessions
				• COVID-19 – Leadership Support plan
				• Culture Survey will replace engagement survey using the same provider but different framework

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken
Recruitment, Selection Induction	• Recruitment and Selection Policy • Recruitment Guideline Procedure • Induction and Orientation Policy • Worker Safety Check Policy and Procedures	• Comprehensive Induction Programme with elements online combining eLearning modules • Recruitment training for managers • Recruitment and Selection Toolkit • Scholarships across all disciplines • Schools Career Expo • Working with clinical schools to provide work experience placements • Police and Ministry of Justice criminal records checking • Behaviour-based recruitment	• Better management of the online talent pool to access suitable candidates • Use of social networking to target youth • Vulnerable Children's Act and the implementation of procedures relating to this legislation • Focus on hard to fill occupations to reduce re-advertising • Review of recruitment process to ensure it has an equity focus	• National Heath Careers website targeting students, return-to-work and international candidates • Continue to collaborate with the national Kiwi Health Jobs working group to promote the New Zealand health sector brand • Continue to collaborate with the Whakatipuranga Rima Rau project to place Māori into the health sector employment over 10 years • Implementation of Vulnerable Children's Act procedures • Electronic Onboarding – to improve the new hire experience • Use networks an sources to identify potential talent • Introduce Values-based questions into patterned interview formats; use of personality profiles in recruitment • Full review of recruitment tools for managers • Participation in national and regional international recruitment campaigns
Employee Development, Performance, Promotion and Exit	• Study, conference and course leave • Termination of Employment Policy and Procedure • Medical Incapacity Policy • Professional Development Policy • Performance Review Policy • Performance and Disciplinary Policy • Employment Agreements • Continuing Medical Education (CME) policy	• Exit interview and survey • Coaching available to all staff • Clinical supervision • Employee Assistance Programme (EAP) • Non-clinical skills training for employee • Professional development funding • National qualifications for non regulated workforces (e.g. orderlies, cleaners and health care assistants) • Annual calendar of educational events • Performance appraisal / My Feedback	• Continuing development of e-learning resources • Enabling technology for accessing learning tools • Further rollout of non-regulated workforce training – NZQA • Review of performance review tools and processes to increase feedback	• eLearning platform in operation, enabling greater access to eLearning resources. New clinical courses added. An increase number of courses for non-clinical staff. Site also to be used for e-portfolios • Professional Development Policy finalised • HCAs, orderlies, cleaners, dental assistants, newborn hearing technicians enrolled in NZQA (Careerforce) training • New Values-Based performance appraisal & development framework (launched 2019 and further developed) • Specific internal and external exit interview process implemented

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken
Employee Engagement	• Flexible Working - Request and Complaints Procedure • Collective employment agreements • Worker Engagement and Participation Agreement • Recognition framework – Values based (see below) • Wellbeing Framework Developed	• Work in conjunction with individuals and unions in consultative manner • Employee Well-being initiatives • Stress & Resilience resources for employees • Wellbeing strategy for our workforce	• Employee engagement assessment • Employee wellbeing • Recognition framework – Values based (see below)	• National (20 DHB's) Framework for Employee Wellbeing launched • Active Wellbeing programme in place • Values based Peer-to-Peer Recognition scheme in operation (launched 2018) • On-going provision of Stress & Resilience seminars & workshops • Employee Engagement – New format selected for 2021 Culture Survey
Remuneration, Recognition and Conditions	• Job Evaluation Procedure • Recognising Long Service Procedure • Collective employment agreements • Recognition framework – Values based	• Comprehensive Progression/Merit criteria via collective agreements	• Recognition framework – Values based	• Promoting employee benefits for all staff • As above, Values based Peer-to-Peer Recognition scheme in operation • Team trained to run in house job evaluation to support remuneration model
Stress and Resilience Support; Harassment and Bullying Prevention	• Unprofessional Behaviour Policy and Procedure (incorporates Bullying and Harassment) • Employee Assistance Programme (EAP) • Stress & Resilience Support initiatives • Wellbeing Framework Developed	• Interpersonal skills programmes • Coaching/training Union reps • Conflict resolution • Stress & Resilience training workshops provided for staff during restructures; 'lunch-n-learn' sessions for staff on stress, meditation, mindfulness etc. • Pink shirt day (bullying awareness) • Mental Health Awareness Week • EAP promoted regularly • After Critical Event Framework • Wellbeing strategy for our workforce	• Unprofessional Behaviour programme • Change Management training • COVID-19 – Support Plan for Employees & Leaders • Wellbeing	• Unprofessional Behaviour policy and procedure approved and implemented training • Education & communication programme underway • Teams at high risk of bullying identified and change programmes with these teams implemented • COVID-19 Supports Plans instigated for Leaders and Employees • Wellbeing Framework developed linking to National Initiatives • After Critical Event Framework implemented
Pay Gap – Pay Equity	• Recruitment and Selection Policy • Recruitment Guideline Procedure • Flexible Work Policy	• Participation in National 20-DHB initiatives, including pay equity claims being co-ordinated centrally by TAS	• Addressing gender pay gaps via National & Regional programmes	• Active participation in National & Regional pay equity programmes • In process of rolling-out administration / clerical pay equity claim

Element/ Measurement	Describe formal polices or procedures	Other Practices	Priority issues	Action taken
Equal Employment Opportunities	• Equal Employment Opportunities / Diversity Policy • Recruitment and Selection Policy • Recruitment Guideline Procedure • New Flexible Work guidelines	• Impartial selection of candidates in recruitment process • Recognition of employment requirements for Māori, ethnic or minority groups and persons with disabilities • WhyOra Maori recruitment programme • Engaging with Maori seminars to increase awareness of Māori culture, including recruitment, patient contact and working relationships • Complement of people permanently employed after participation in work skills development programme	• Increasing the number of Maori is a key strategic priority. 9% of employees are Māori vis-à-vis a Taranaki population of 19%. • Flexible work provides support for existing staff and assists with retention and assists with recruitment by widening options	• Through recruitment process, offering people the ability to have whanau present during an interview • Taranaki DHB, local iwi groups and community trusts fund the WhyOra Maori recruitment unit. This organisation provides programmes that support Maori to enter the health sector workforce in Taranaki. • New flexible work guidelines implemented
Safe and Healthy Environment	• Health and Safety specific policies and procedures • Risk management and compliance policies and procedures	• Health and Safety Programme • Pre-employment health Declaration for all staff, contractors and students • Health and Safety induction, orientation and compulsory refresher sessions • Health monitoring programme for applicable staff • Risk and Hazard registers • Input into renovation/ construction and purchase of new equipment decisions • Member of ACC's Accredited Employer Programme • Accident/incident/near miss reporting system • Employee Assistance Programme • Free staff vaccination programme that includes the annual influenza vaccination • Health and Safety Representative and Health and Safety Committee programmes • Bipartite Action Group • Quarterly reporting to the Taranaki DHB Board on Health and Safety matters • Wellness Committee • Security	• Accreditation maintained, and an active ACC partnership program is in place • Critical risks identified, and risk reviews underway to identify potential improvement areas. • Improving our health and safety reporting • Encouraging partnership by empowering the Health & safety Representative roles • Enhancing the worker rehabilitation program to promote early return to work practices • Strengthening our Contractor Management H&S framework • Improving our Hazardous Substances framework	• Stage 1 rep training provided to all new H&S Representatives • Health and Safety requirements in all job description templates and included in all staff performance reviews • Updating of existing health and safety procedures to ensure compliance with the Health and Safety at Work Act 2015 and associated regulations • Introduction of a Pre-Employment Health Declaration which includes improved health monitoring and vaccination processes. • Maintaining health monitoring and surveillance of staff exposed to workplace health risks • Hazardous Substances project commenced • Development of fire & emergency training package Security for Safety project commenced • Recreation society available to all staff • Improved presence of security on site

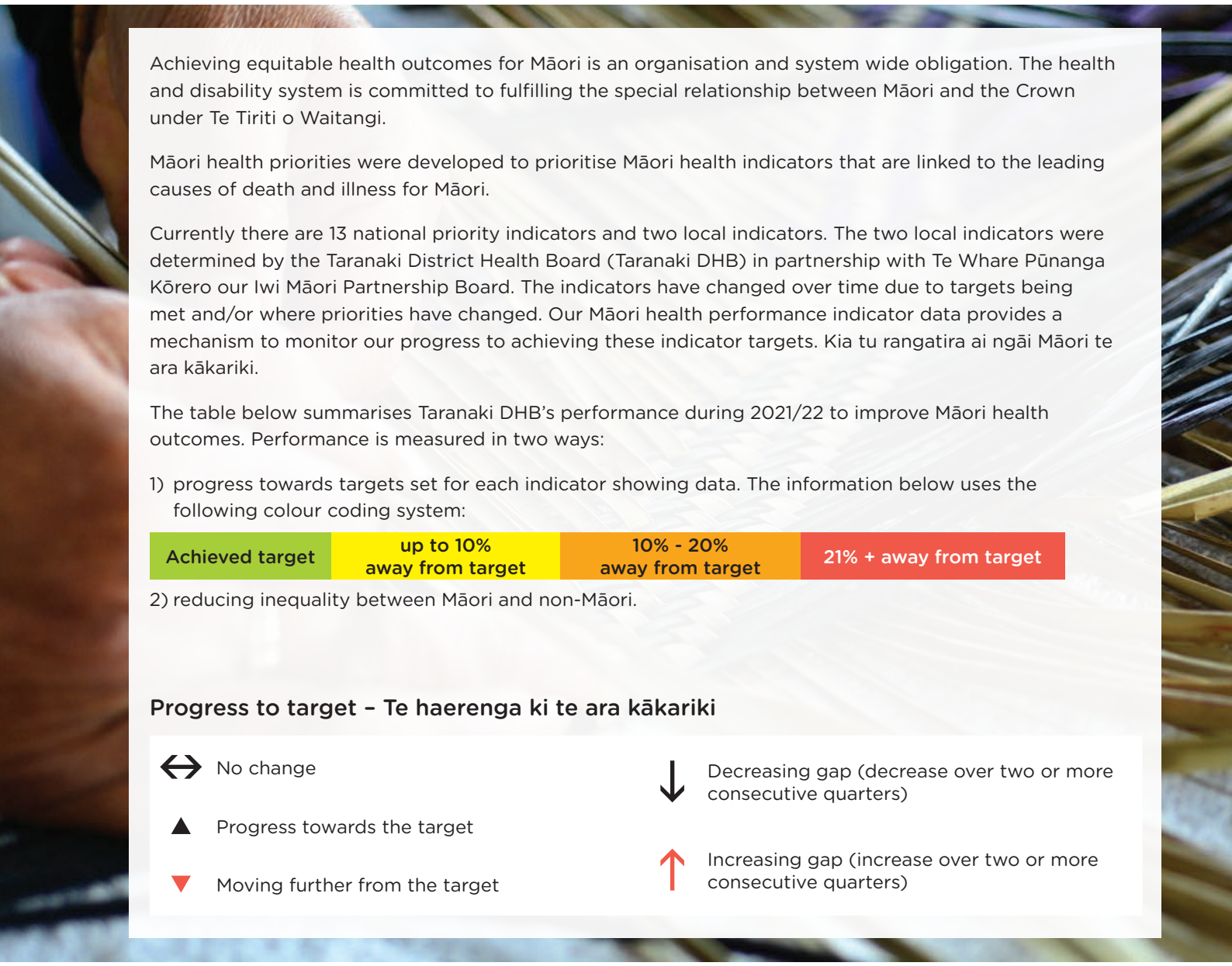
Māori Workforce

PAPA POUNAMU PRIORITY AREAS

Cultural competence	Addressing bias
Te Kawau Mārō Strategy Refresh 2020 outlines the DHB's commitment to delivering on its obligations under te Tiriti o Waitangi, in particular the principle of 'Options' under which it is required to ensure that all health care services are provided in a culturally appropriate way.	Mārama te Titiro: Cultivating cultural competency and a Tiriti-dynamic sys-tem, is an education package designed for completion by all employees. The education package focuses on exploring Te Tiriti o Waitangi (Te Tiriti), Māori health, and the concepts of racism, equity, cultural competency and cultural safety to increase authentic understanding and application to practice. • The training is designed to meet the requirements of Pae Ora and the New Zealand Health Strategy. • The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work. • The training provides a framework for doing this. It builds on the previously mandated Te Tiriti, TDHB and Me training.
Plan – the DHB plans to deliver a comprehensive cultural competency training programme which all staff will be required to complete over time. With regard to te reo Māori revitalisation, the TDHB's Te Reo Māori and Te Reo Māori Translation Policy commits the DHB to *"...using te reo Māori principally from a health literacy perspective of Māori, in ways that are appropriate to the intended audiences, and in ways that support tangata whenua to revitalise te reo o Taranaki."* The DHB is planning to incorporate a more comprehensive reo Māori curriculum within the cultural competency programme.	Support team members to participate in learning of Te Reo in the workplace.
Report – 615 DHB staff have attended either the Tiriti, DHB and Me workshops or Marama Te Titiro (cultural competency) since the programme has commenced. The impacts of both programmes are noticeable across hospital services in particular where pronunciation of te reo Māori has improved significantly and there is a higher demand for Māori staff to be involved in co-design of services. The DHB has been unable to meet the demand for enrolments on both courses. Consideration is currently being given to how the throughput of staff can be increased with the aim of getting all staff through the programme in three-yearly cycles.	The availability of staff limits the capacity to deliver two Marama te Titiro programmes per month to reach the target of ensuring all dhb staff receive the training the increase of new staff also has an impact on this, however all programmes are fully booked per month. Te Pa Harakeke staff members are also working with individual areas within dhb providing cultural training and development.

Te Hau Oranga Māori

MĀORI HEALTH PERFORMANCE



Achieving equitable health outcomes for Māori is an organisation and system wide obligation. The health and disability system is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi.

Māori health priorities were developed to prioritise Māori health indicators that are linked to the leading causes of death and illness for Māori.

Currently there are 13 national priority indicators and two local indicators. The two local indicators were determined by the Taranaki District Health Board (Taranaki DHB) in partnership with Te Whare Pūnanga Kōrero our Iwi Māori Partnership Board. The indicators have changed over time due to targets being met and/or where priorities have changed. Our Māori health performance indicator data provides a mechanism to monitor our progress to achieving these indicator targets. Kia tu rangatira ai ngāi Māori te ara kākariki.

The table below summarises Taranaki DHB's performance during 2021/22 to improve Māori health outcomes. Performance is measured in two ways:

1) progress towards targets set for each indicator showing data. The information below uses the following colour coding system:

Achieved target	up to 10% away from target	10% - 20% away from target	21% + away from target

2) reducing inequality between Māori and non-Māori.

Progress to target – Te haerenga ki te ara kākariki

↔ No change

▲ Progress towards the target

▼ Moving further from the target

↓ Decreasing gap (decrease over two or more consecutive quarters)

↑ Increasing gap (increase over two or more consecutive quarters)

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2021	Māori June 2022	Non-Māori June 2022	Progress to target	Disparity Gap June 2022	Disparity Progress
NATIONAL PRIORITIES									
1	Data quality	Ethnicity data accuracy in PHO registers	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Pinnacle Primary Health Organisation (PHO) use the enrollment audit data process, EDAT with voluntary quarterly randomly generated patient audits occurring successfully. Pinnacle PHO -Taranaki have championed the process in the Pinnacle Network and are making great progress. Audits have been completed by 11 practices and three more are scheduled.									
2	Access to care	Percentage of Māori enrolled in PHOs	90%	78.8%	78.1%	97.7%	▼	-19.6%	↑
Enrolment in a primary health organisation (PHO) is voluntary. The non- Māori population has met the target of 95% however the disparity continues to increase for the Taranaki Māori population. Te Whatu Ora Taranaki and Pinnacle PHO are currently creating an enrollment service to reduce the barriers to support whānau enrolling into the PHO.									
3	Access to care	Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for the age group 0-4yrs	5,200	4,715	5,649	5,410	▼	-4.3%	↑
The ASH rate targets have been met for the non-Māori Taranaki population however the rate for Māori continues to increase. Despite overall variations, the equity gap for this year has increased. The equity gap remains an opportunity to improve outcomes by addressing underlying determinants of health and access to quality primary care interventions, particularly for Māori									
4	Access to care	Ambulatory Sensitive Hospitalisation rates per 100,000 for the age group 45-64 yrs	4,990	8,266	8,333	4,641	▼	-56.9%	↓
Māori continue to have almost 50% more admissions than that of the total non-Māori. The rates for Māori are still significantly higher than the target. There is an opportunity in the new health system to have real targeted interventions for the conditions where Māori are overrepresented. Targeted Public Health campaigns, targeted co-commissioning, and targeted monitoring could help improve outcomes for Māori.									
5	Child Health	Exclusive breastfeeding at 3 months of age	70%	41.7%	49.5%	58.7%	▲	-9.2%	↓
There is a 7.8% increase in breastfeeding for Māori babies showing that almost half of the Māori babies (49.5%) being born are breastfed at 3 months compared to 58.7% of non-Māori babies. Hapū Wānanga continues to support mothers who attend, in their breastfeeding journey, with lactation support in attendance.									
6	Cancer	Cervical screening, among eligible population	80%	67.7%	64.3%	78.4%	▼	-14.1%	↑
Coverage rates for Māori women remain under target but are still above the national average. Post COVID-19 coverage rates decreased for all women screened, especially Māori women who already have lower rates of screening. The Regional Screening Unit continues to work with Māori health providers and Pinnacle PHO to promote and support community action and development for priority women in Taranaki. The National Cervical Screening Programme (NCSP) is changing the way cervical screening is undertaken in New Zealand. From July 2023 the primary test for cervical screening will change to a human papillomavirus (HPV) test. This new screening method will test for the presence of HPV, the cause for 99% of cervical cancers. Self-testing with clinical oversight will be an option for all participants and their whānau.								
7	Cancer	Breast screening among eligible population	70%	59.5%	56.4%	71.3%	▼	-14.9%	↑
Breast screening rates for Māori have decreased from the previous year with a continuing increase in disparity between Māori and non-Māori. A collaborative approach with all the screening providers could be advantageous.									
8	Immunisation	Percentage of infants fully immunised by eight months of age	95%	67.0%	71.4%	82.1%	▲	-10.7%	?
There has been a 4.4% increase in the percentage of Māori children immunised by eight months. Immunisation requires a collaborative and collective approach that is co- designed and co-led supported by Iwi. Once again there is an opportunity to improve outcomes by addressing underlying determinants of health and access to quality care interventions, particularly for Māori.									
9	Immunisation	Seasonal influenza immunisation rates 65+ year olds	75%	51.8%	48.4%	64.7%	▼	-16.3%	↓
Influenza rates have decreased by 3.4% in the 2021 influenza season. While the boarders were closed there was less flu active in the community. NB: These rates are calculated at the end of the previous year's flu season. Therefore the 2022 influenza season will be reported in 2023. A collective approach that is supported to deliver multiple approaches for whānau will be helpful as well as addressing underlying determinants of health and access quality interventions.									

Priorities	Health Issue	Indicator(s) Target	Target	Māori June 2021	Māori June 2022	Non-Māori June 2022	Progress to target	Disparity Gap June 2022	Disparity Progress
10	Rheumatic Fever	Number and rate of first episode rheumatic fever hospitalisations	0.3 / 100,000	0	0	0	↔	0	↔
There have been no first episode Rheumatic Fever hospitalisations in the past three years in Taranaki.									
11	Oral Health	Pre-school dental enrolments	95%	87.0%	87.4%	97.2%	▲	-9.8%	↓
Taranaki DHB achieved the target for the total population; however, we have not met the target for our Māori children. Despite this, the increase in enrolment for Māori children continues to increase which is encouraging.									
12	Mental Health	Mental Health Act Section 29 Community Treatment Orders (CTO)	115.2	288	289	101	▼	-96.4%	↓
There is a huge inequity for Māori regarding Section 29 CTOs. A lot of work is taking place within the hospital services and secondary services to change the way we support tangata whaiora as a result of the He Ara Oranga report of the Government Inquiry into Mental health and addiction. The aim is to reduce the inequity by 10% each year.									
13	SUDI	Five year average annualized SUDI infant deaths by DHB region	0	Not Available	Not Available	Not Available		Not Available	
Taranaki Tau te Moe, the Taranaki DHB safe sleep programme, continues to deliver safe sleep education and distribute safe sleep space to mothers and whānau who are most in need. Hapū Wānanga continues to be the largest distributer of safe sleep devices to Māori women. There are also opportunities in the smokefree space to support whānau.									
LOCAL PRIORITIES									
14	Access to care	Did not attend (DNA) rate for outpatient appointments	5%	12.4%	12.4%	5.6%	↔	-6.8%	↓
Total DNA (Did Not Attend) rates continue to decrease in number for non- Māori; however, they remain static for Māori. Effort is required from outpatient services to find ways to connect with Māori patients and decrease the DNA rates for Māori. Services need to be brave and change their approaches for Māori whānau.									
15	Workforce Development	Percentage of Māori employed by the DHB	18%	9.16%	9.13%		▼		↔
Te Whatu Ora Taranaki continues to stay stagnant in the number of Māori that are employed in the organisation. A workforce dashboard has been created which shows how many Māori are employed, the professions in which they are being employed, whether they are in leadership and how many staff leave each year. This investigation will be used to improve the retention rates of our Māori staff.									

PERFORMANCE SUMMARY

Performance to targets

- Performance improved on three indicators: Exclusive breastfeeding at three months of age; percentage of infants fully immunised by eight months of age; and pre-school dental enrolments.
- There were performance declines on eight of the indicators. The targets that declined were percentage of Māori enrolled in PHOs; ambulatory sensitive hospitalisation rates per 100,000 for the age group 4yrs; ambulatory sensitive hospitalisation rates per 100,000 for the age group 45-64yrs; cervical screening, among eligible population; breast screening among eligible population; seasonal influenza immunisation rates 65+year old; Mental Health Act Section 29 Community Treatment Orders (CTO); did not attend; and percentage of Māori employed by DHB.
- Data was absent for three of the targets; ethnicity data accuracy in PHO registers; number and rate of first episode rheumatic fever hospitalisations, and five-year average annualised SUDI infant deaths by DHB region.

Equity performance

- There was a reduced inequity gap on seven indicators: Ambulatory sensitive hospitalisation rates per 100,000 for the age group 45-64yrs; exclusive breastfeeding at three months of age; percentage of infants fully immunised by eight months of age; enrolments seasonal influenza immunisation rates 65+year old; pre-school dental; Mental Health Act Section 29 Community Treatment Orders (CTO); did not attend; and percentage of Māori employed by DHB.
- Increases in disparity occurred for four of the indicators: Percentage of Māori enrolled in PHOs; ambulatory sensitive hospitalisation rates per 100,000 for the age group 4yrs; cervical screening, among eligible population; and breast screening among eligible population.
- The disparity gap remained the same for one of the targets: percentage of Māori employed by the DHB.
- Data was absent for two of the targets; 5-year average annualised SUDI deaths by DHB region and ethnicity data accuracy in PHO registers.

Te Whatu Ora Taranaki (formally known as Taranaki DHB) have priority towards:

- Enabling Iwi Māori Partnership Board – Ngā Iwi o Taranaki Hauora Māori Partnership Board (formally known as Te Whare Punanga Kōrero) to represent local Māori perspectives on

  o Needs and aspirations of hauora outcomes

  o How health sector is performing

  o Design and delivery of services and public health interventions

- Te Whatu Ora Taranaki in partnership with whānau voice (local perspective) are considering the priorities for 2022-2023

MĀORI LANGUAGE PLANNING

Te Whatu Ora - Taranaki Te Reo Māori and Te Reo Māori Translation Policy commits to "using te reo Māori principally from a health literacy perspective of Māori, in ways that are appropriate to the intended audiences, and in ways that support tangata whenua to revitalise te reo o Taranaki".

Te Whatu Ora - Taranaki has continued the partnership with Te Whare Wānanga o Awanuiārangi to deliver Te Pokaitahi Reo, an Intermediate Level which includes 4 Oral Assessments totalling 60 Credits. This is attained over a 12-month period through 2.5-hour classes once a week plus two noho. The classes included a mixture of onsite and online learning. Due to the disruption of Covid-19, most of the classes were delivered on line which was a little unsettling for the students. A total of 75 staff enrolled in 2021 which is due to be completed in October 2022

Additional to the Level 3 programme, to support those entry level reo learners, Te Whare Wānanga o Awanuiārangi introduced Te waharoa ki te Reo Ace programme which started in July 2022. This 20-week basic online reo programme involves a 2.5 hour weekly online class and includes a 20-hour noho or 2, 10-hour wānanga. A total of 28 staff have started the programme.

Profiling Taranaki

TE AO HAUORA O TARANAKI

Taranaki DHB delivers health services in Taranaki and in the Mokau area, which is part of the Waikato District Health Board. The district covers more than 7,000 square kilometres.

There are a few densely populated centres in Taranaki such as New Plymouth, Stratford and Hāwera. The rest of the population is scattered in and around small rural centres.

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

THESE SERVICES INCLUDE:

- **19** dental practices
- **30** pharmacies
- **1** specialist palliative care provider
- **10** community based mental health, and alcohol & addictions services
- **2** specialist mental health service providers (including 1 kaupapa Māori provider)
- **3** Māori health service providers
- Relationship with one Primary Health Organisation (Pinnacle Midlands Health Network)
- **29** GP practices
- **1** provider of community laboratory services and radiology services
- Support services for people with disability, including 25 aged residential care facilities
- **2** hospitals - Taranaki Base Hospital and Hāwera Hospital. **5** community Health Centres in Waitara, Stratford, Opunake, Patea and Mokau
- access to tertiary and specialist hospital healthcare in other parts of New Zealand

POPULATION PROFILE

According to the 2018 Census, Taranaki DHB serves a population of 118,284 people[1]. This is approximately 2.5% of the New Zealand population.

Within Taranaki, the Māori population is projected to increase to 23.4% of the total population by 2033^. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2018 Census. Taranaki has 84.7% identified as European, 19.6% as Māori as compared to 16.2% nationally[1].

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

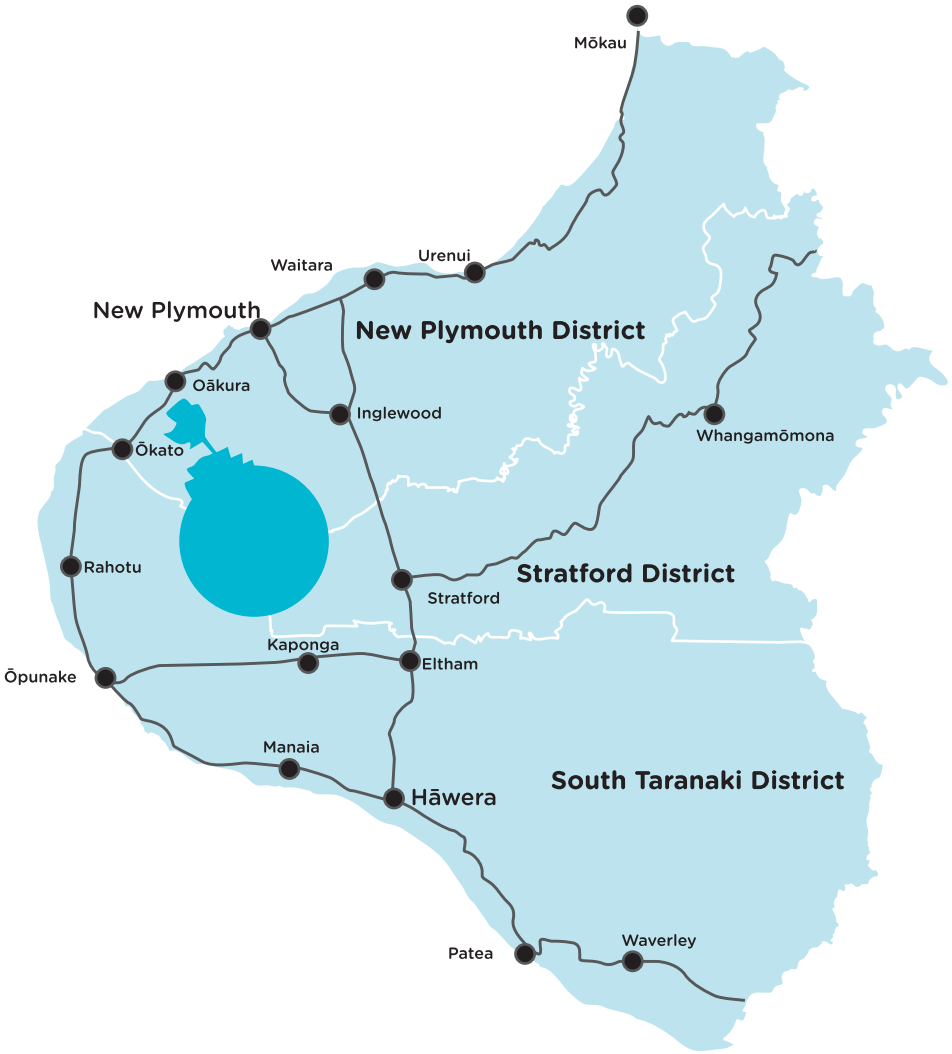
AGE STRUCTURE

Our population is ageing and older than the national average, and is expected to age further in the future. Based on the latest forecast, the total number of people over the age of 65 is 20,589 (17.4% of the population)[1].

Latest forecasts also show the total number of people 24 years or younger are 37,701 (31.9%), the number of Māori in this age group is 11,691 which represent 50.3% of Māori in the region. 34.5% of Māori population is under 15 years as compared to 20.9% of the total population[1].

SOCIO-ECONOMIC INDICATORS

Around 37.3% of the Taranaki population lives in NZDEP2018 Decile 1 to 5 compared to 48.5% nationally and 62.7% in Decile 6 to 10 compared to 51.5%.



New Plymouth District population
81,558[1]

Stratford District population
9,540[1]

South Taranaki District population
27,186[1]

[1] *Based on usually resident population, 2018 Census*

^ *Based on updated information received from Statistics New Zealand Population Projection released December 2020*

Governance Structure

TĀHUHU KĀWANATANGA

The governance structure for DHBs is set out in the NZ Public Health and Disability (NZPHD) Act 2000. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three-yearly local body election process (last held in 2019) and up to four are appointed by the Minister of Health.

The Board is responsible for the overall governance of Taranaki DHB. Within this role the functions carried out directly by the Board include:

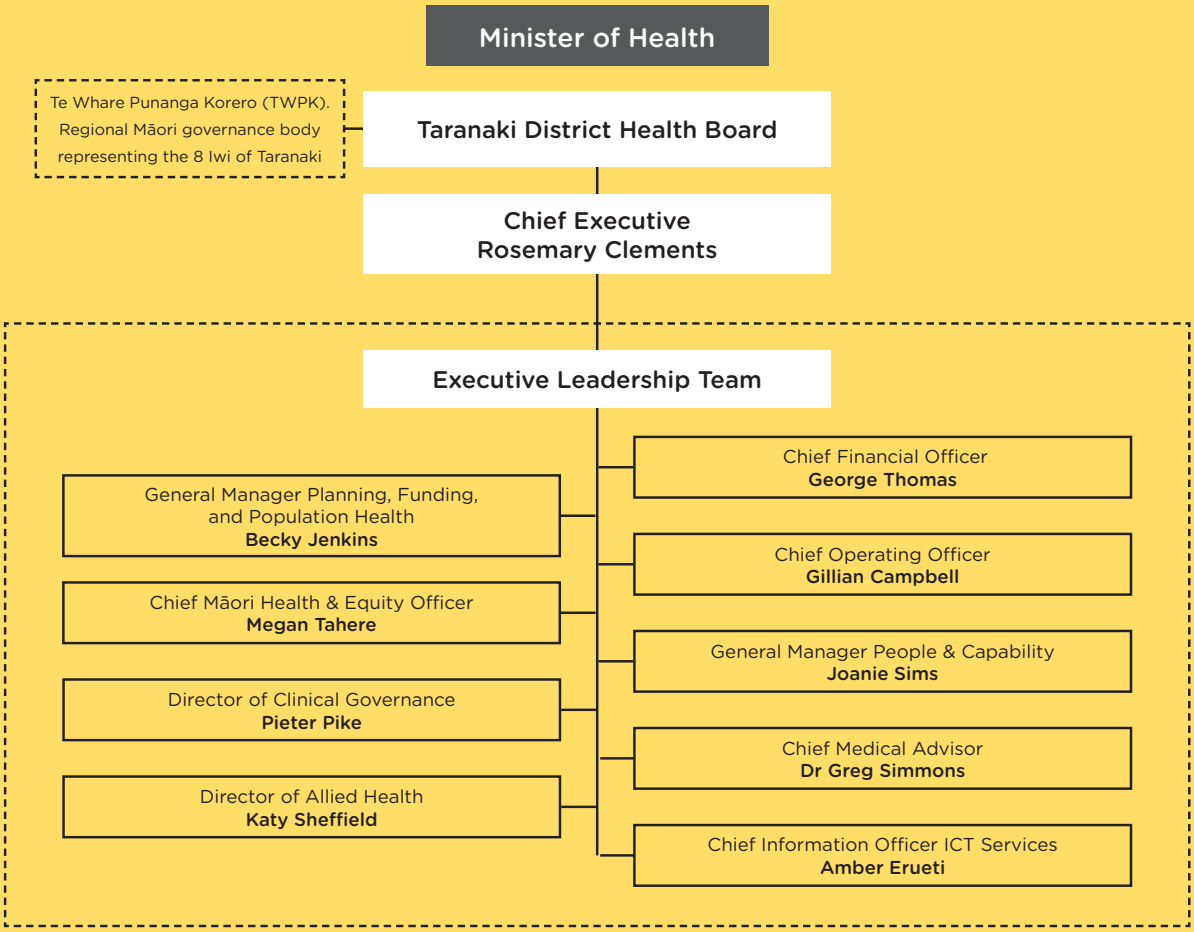
- Approving major strategic and policy documents including the District Strategic Plan, Annual Plan,
- Budget and considering recommendations on key issues.
- Monitoring the implementations of the Annual Plan and Budget.
- Monitoring the operating performance of the organisation.
- Maintaining and developing an effective working relationship with Te Whare Punanga Korero, its Iwi partner.
- Ensuring Taranaki DHB acts legally and responsibly.
- Appointing, evaluating and supporting the performance of the Chief Executive.

The governance of a District Health Board is a diverse and complex undertaking and the Board has established committees so that it can carry out its responsibilities effectively, recognising the requirements of the NZPHD Act 2000.

The balance of skills and experience of the Board is kept under regular review. Additional knowledge and expertise is recruited to assist where needed with the work of the advisory committees. The Board publishes when and where it or its advisory committees meet and members of the public are welcome to observe most of the meetings, other than items of a confidential or commercial nature.

GOVERNANCE STRUCTURE

(FROM 1 JULY 2021 TO 30 JUNE 2022)



Ministerial Directions

NGĀ TOHUTOHU A TE MINITA

Directions issued by a Minister during the 2016-17 financial year, or that remain up to 30 June 2022 are as follows:

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

Members of the Board

INTEREST REGISTER (AS AT 30 JUNE 2022)

Cassandra Crowley (Chair)

Director of:
- Aratu Forests Limited
- Maketū Foods Limited
- Ngāti Manawa Developments Limited
- Ngāti Manawa Gas Limited
- Ngāti Manawa Tokuwaru Asset Holding Company Limited
- The Skills Consulting Group
- Te Matai Water Scheme Limited
- Te Arawa Tipu Limited
- Western Institute of Technology at Taranaki

Chair of:
- District Health Board Chairs
- K.L.C Limited

Deputy Chair of:
- Waka Kotahi - New Zealand Transport Agency

Trustee of:
- Ngāti Manawa Developments Trust
- Narsha Nayolet Foundation Trust
- The Skills Foundation

Director & Shareholder of:
- Crescendi Group Limited
- Grand Debut Limited

Minority shareholder via nominee company of:
- Be Pure Health Limited
- Ossis Limited

Minority shareholder of:
- Zeffer Brewing Limited

Other:
- Board Member, Bledisloe Park Board
- Commercial Advisor, Te Arawa Management Limited
- Executive Member, Sacred Heart Girls' College New Plymouth Alumni Association
- Appointee – Interim Health New Zealand Board
- Relatives employed by Taranaki DHB
  - Consultant Rural Health, Hāwera Hospital
  - Registered Medical Officer, Taranaki Base Hospital
  - Duty Nurse Manager, Taranaki Base Hospital
  - Public Health Nurse, Taranaki District Health Board
  - Booking & Outpatient Department Admin/Reception, Hāwera Hospital

Bridget Sullivan (Deputy Chair)

- Employee of Ministry of Business, Innovation and Employment
- Partner is a member of the Toi Foundation and a Partner in Young, Carrington & Ussher Lawyers
- Family member employed by Taranaki DHB
- Trustee on Tiaki te Mauri o Parininihi

Mike Davey

- Elected councillor at Taranaki Regional Council - sits on Consents & Regulatory and Policy & Planning committees, plus member of Ordinary meeting
- Deputy Chair at Taranaki Electricity Trust
- Taranaki Health Foundation board member
- Relative employed by Taranaki DHB as a pharmacy technician
- Board Member – Ravensdown Ltd
- Director – Ravensdown Ltd
- Member – Federated Farmers New Zealand

Pauline Lockett

Trustee of:
- P Lockett Family Trust
- Taranaki Work Trust (no transactions and interest noted only)
- Te Hapai Hoe Trust

Other:
- Chairperson of Te Pai Pari Trust (Waitara Perpetual Fund currently known as 'The Board')
- Advisory Trust and Independent Contractor – Ngāti Te Whiti Whenua Topu Trust
- Board Member - Worksafe

MEMBERS OF THE BOARD - INTEREST REGISTER

Paul Verić

Director of:
- BTE Consulting Ltd
- PASS Ltd
- iPromise

Other:
- Board member of Kaitake Community Board
- Oakura School Board of Trustees
- Wife holds following positions which are connected to Taranaki DHB work:
  - GP at Vivian Medical Centre (partner)
  - On call doctor for Med SAC

Kevin Nielsen

- Adviser of Conductive Education Taranaki Trust
- President of New Plymouth Riding for the Disabled
- Lifetime Member, Hospice Taranaki Inc
- Committee Member, Flourish Charitable Trust

Alison Brown

- NZ Nurses' Organisation Honorary Life Membership
- Committee Member of Grey Power
- Board Member of Age Concern Taranaki
- Daughter is employed as a Registered Nurse by Capital & Coast, Wellington Hospital

David Lean

Chair of:
- Rahotu Dairy Ltd
- David Lean & Associates Ltd

Other:
- Deputy Chair of Taranaki Regional Council
- Trustee of Cameron Clow Trust
- Surf Life Saving New Zealand Life Member
- Daughter employed by Taranaki DHB

Member and Advisor:
- Westland Industries for Sustainable Environment (WISE) – Charitable Trust

Shareholder and Advisor:
- Return 2 Earth Ltd

Shareholder, Company Director and Advisor:
- Bioplant Manawatu NZ Ltd
- Bioplant Tairawhiti NZ Ltd
- Bioplant Waikato NZ Ltd
- Bioplant Hokitika NZ Ltd
- Bioplant Canterbury NZ Ltd

Te Pahunga (Marty) Davis (Chair for Te Whare Punanga Korero Trust (TWPK)

Chair of:
- Te Whare Pūnanga Kōrero Trust

Co-Chair of:
- Taumaruroa

Trustee of:
- Tuituia Trust
- Taranaki Māori Trust Board
- Ngāti Ruaiti Nukumaru Marae Trust
- Wai-o-Turi Marae Trust
- Meremere Marae Trust

Director of:
- Tumararoa Properties Ltd

Other:
- Co-chair of Mental Health & Addictions Cross Sector Group
- Member of Taranaki DHB Infrastructure & Planning Working Group

MEMBERS OF THE BOARD - INTEREST REGISTER

Carla White

Director of Health Literacy NZ Ltd working for health sector clients including:
- Essence the Health Agency/Johnson&Johnson; Janssen-Cilag Ltd
- Waitemata DHB
- Te Pou Limited
- ProCare (PHO Limited)
- CARI (Caring for Australians with Renal Impairment)
- University of Auckland
- PHARMAC
- Te Whare Pūnanga Korero Trust

Member of:
- TAS Pharmacy Expert Advisory Group

Other:
- Ministry of Health – project to improve gout management in primary care
- Health Quality & Safety Commission – rewrite of health literacy guidance for the health workforce
- Heart Foundation – training staff
- Health Hawkes Bay – training for Health Coach
- Pinnacle, Tui Ora, Ngaruahine Health – training for Diabetes Kaitautoko
- PHARMAC – writing and publishing new gout publication
- Problem Gambling Foundation – training staff

Harry Duynhoven

Patron of:
- Taranaki Disability Resource Centre
- Community Christmas Dinner Trust
- NP Model Aeroplane Club

Other:
- Board Member, Habitat Taranaki
- Member, Automobile Association (Taranaki) Council
- Board Member, NZCAA (NZ Civil Aviation Authority)
- Councillor, New Plymouth District Council
- Consultant – part-time
- President, NZ Federation of Motoring Clubs
- Board Secretary, Air Quality Asia (NGO based in USA)
- Member of several community organisations
- Beneficiary – family trust ownership part share in house and bach
- Independent member of two private Trusts providing for impaired individuals

Patsy Bodger (Pat)

Member of:
- NPDC Accessibility, Aged and Issues & Working Party
- Taranaki Nurses Scholarship Grant Trust

Trustee of:
- Manukorihi Hapū Charitable Trust
- Manukorihi Paa Reserve Trust
- Te Kowhatu Tu Moana (NPDC Land Act 2018)
- Te Tai Pari Board – Waitara Perpetual Community Fund (NPDC Land Act 2018)
- Te Hanataua Family Trust

Other:
- Te Atiawa representative of Te Whare Punanga Korero (TWPK)
- Board member of Hospice Taranaki Inc. Soc.

Rosemary Clements - Chief Executive

- Family trust affiliated to Carefirst Trust Ltd

Jane Parker-Bishop – Board Observer

- Trustee of Sport Taranaki Board
- Member of Leadership Group – Te Ara Whakamua o Waitara
- Co-Chair – Consumer Engagement Council

Board Members' Responsibilities & Fees

Board members, committee members and directors schedule

Name	Board Members to June 2022	Allied Laundry Services Ltd	HealthShare Ltd	Fees Paid ($)
Board Members – 2021/22				
Cassandra Crowley (Chair)	8 of 8			50,402.92
Bridget Sullivan (Deputy Chair)	8 of 8			32,962.96
Patsy Bodger	8 of 8			27,170.92
Alison Brown	8 of 8			27,170.92
Mike Davey	6 of 8			27,170.92
Te Pahunga (Marty) Davis **	5 of 8			5,750.00
Harry Duynhoven	8 of 8			27,170.92
David Lean	8 of 8			27,170.92
Pauline Lockett	7 of 8			26,670.92
Kevin Nielsen	8 of 8			27,170.92
Paul Verić	8 of 8			27,170.92
Carla White	8 of 8			27,170.92
Jane Parker-Bishop ***	7 of 8			1,500.00
Other Directors				
Rosemary Clements, Chief Executive			✓	
Simon Barrett, Group Financial Manager		✓		

Key:

** Co-opted Board / Committee members

*** Board Observer

Te Kāhui o Te Whare Punanga Kōrero

TE WHARE PŪNANGA KŌRERO TRUST

Te Whare Pūnanga Kōrero Trust(TWPK) is the Iwi Māori Partnership Board which works strategically with the Taranaki District Health Board (DHB) to improve Māori health and reduce and eliminate Māori health inequalities. The members of the Trust represent the eight iwi of Taranaki – Ngā Rauru Kītahi, Ngāti Ruanui, Ngā Ruahinerangi, Taranaki, Te Atiawa, Ngāti Maru, Ngāti Mutunga and Ngāti Tama – and in terms of the Memorandum of Understanding it has with Taranaki DHB, exercises mana whenua status by providing kaitiakitanga or guardianship, for all Māori living in the region. Based on Statistics NZ population projections Māori made up 19.6% of the Taranaki population of 118,284.

Governance

a) The TWPK Chair participates on behalf of the Trust in all Taranaki DHB Board meetings, including confidential meetings. The Taranaki DHB Board acknowledges the value of having the specifically iwi/Māori lens contributing to its discussions at this strategic level;

b) TWPK Chair was appointed to and is a fully participating member of the Infrastructure and Planning Committee;

c) TWPK Chair participated as a member of Te Manawa Taki Region Governance Group alongside four other DHB Iwi Māori Relationship Board Chairs and the five Manawa Taki DHB Board Chairs;

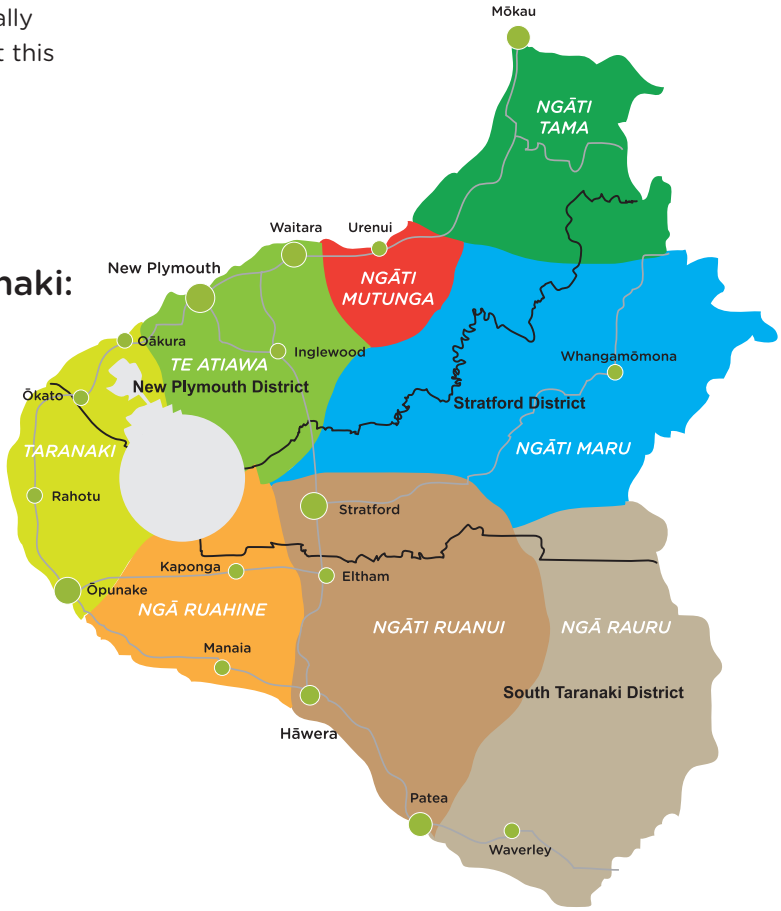
Executive Management

a) The TWPK Chair and Taranaki DHB Chief Executive have had an open door policy to enable discussions as and when needed;

b) The General Manager Planning, Funding and Population Health and Chief Operating Officer attended TWPK meetings on request to provide briefings on planning and/or performance in addressing Māori health issues.

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

Mana Whenua Iwi	Representative
Ngā Rauru Kītahi	Te Pahunga Martin William Davis
Ngāti Ruanui	Ngapari Nui
Ngāruahine	Te Oti Katene *(untill 12 May 2022)* Linda Georgina Elgar *(from 13 May 2022)*
Taranaki iwi	Leanne Kuraroa Horo
Ngāti Maru	Eileen Sandra Hall
Te Atiawa	Patricia Maria Bodger
Ngāti Mutunga	Howie Tamati
Ngāti Tama	Greg White



Project Maunga Stage Two

PROJECT MAUNGA
BASE HOSPITAL REDEVELOPMENT

It was an exciting year for Project Maunga Stage Two as construction work began at the Renal Building and the Energy Centre sites, as well as enabling works on the New East Wing Building (NEWB) site.

AUGUST 2021
Drilling and piling work for NEWB begins

With the NEWB site established, the first drilling begins. This was an exciting time as staff and patients could now see the scale of the new six-storey, 22,000m2, building compared to the Acute Services Building (ASB) completed as part of Project Maunga Stage 1.

SEPTEMBER 2021
Removal of main entrance

As part of the enabling works for NEWB, the main entrance had to be demolished. The old main entrance has been reopened for the duration of the construction period, and will be replaced by a new entrance way leading into the central atrium of the new building.

NOVEMBER 2021
Renal Building progressing well

Framing is nearing completion and some outer wall linings are in place, giving patients and visitors a better idea of how the unit will look on campus once completed.

MARCH 2022
First concrete pour on NEWB site

A great deal has been achieved in a few short months, with the retaining wall on the east, west and south sides now in place and the first foundations beginning to appear.

APRIL 2022
Energy Centre progress

The generator hall pre-cast panels were installed at the Energy Centre. The generator hall will accommodate two new generators as part of the Seismic Risk Management Plan response to strengthen the hospital infrastructure in preparation for a natural disaster such as the eruption of Mount Taranaki.


Drilling


Main entrance sign comes down


Renal Building


Energy Centre

Parking initiatives launched

A significant number of staff car-parks were no longer available as NEWB got underway, so several initiatives were launched to help ease the pressure.

The first initiative, pairing DHB workers with nearby residents with daytime driveway spaces, received a positive response with around 20 match-ups.

The second was a park and ride programme using 83 available spaces near the Cool Stores in Motorua. A shuttle service transports staff between the site and the Taranaki Base Hospital between 7am - 10am and 3pm - 6pm Monday to Friday.

Some existing parking areas were reconfigured to provide more staff carparks on the hospital campus itself, and a new direct morning bus service from New Plymouth CBD to the hospital provided another alternative option.

Pedestrian red path installed

The changes in the configuration of the campus required a new public walkway – known as the red path due to its bright colour – to be built.

The walkway runs from the Lyn Street entrance (now the main vehicular entrance to the hospital) to the Renal (C Block) corridor entrance. This gives access to the ASB building and the public wards via the temporary link corridors, as well as renal, radiology and cardiology services.

Environmental sustainability award

Taranaki DHB received an award from Taranaki Regional Council for its commitment to sustainability, which included the way Project Maunga Stage Two's new buildings are being constructed.

The six-storey, New East Wing Building (NEWB) will be the country's first public hospital building to be 5-star Green Star certified, and the Renal Building will be one of the first net zero energy healthcare buildings under the Living Future Net Zero Energy standard.

Project Maunga Stage Two

Renal Building

A new, purpose-built Renal facility is being built on David Street. The new facility is a single storey, timber building of approximately 800m2 and will have a distinctly non-clinical feel in comparison to the existing department. The building will target Net Zero Energy Certification, meaning that the total energy use over a year will be neutral. This will be achieved by reducing the energy consumption and utilising roof mounted solar panels to generate energy. A pedestrian connection will link the Renal Unit to the main Base Hospital campus.

New East Wing Building (NEWB)

The New East Wing Building (NEWB) will enable the relocation of the following core clinical services: Emergency Department, Radiology, Laboratory, Maternity services, Neonatal, and Intensive Care Unit, incorporating High Dependency Unit and Coronary Care Unit.

A rooftop helipad will aid faster, safer patient transfers and the building will also house purpose-built maternity facilities including a Primary Birthing Unit, Delivery Suite, Postnatal Ward and Neonatal Unit. There will also be a dedicated Tūpāpaku viewing room.

In addition, site-wide infrastructure upgrades, now largely completed, improve the resilience of the campus with the addition of two emergency power generators, increased water storage, replacement and expansion of the oxygen storage facility, provision of a new services routes for critical building services and the replacement of the secondary computer server room.

The expected outcomes for Project Maunga Stage Two and the Seismic Risk Management Plan include:

- compliance with Earthquake Prone Building Amendment Act
- compliance with NZ Building Code
- reduced clinical risk
- improved resilience of Taranaki Base Hospital, including post-disaster provision of emergency medical and surgical response
- improved models of care that enable Te Whatu Ora Taranaki to manage acute demand by the improvement of patient pathways in ED
- the development of an Acute Assessment Unit to reduce hospital admissions
- improved equity of access for Māori via the inclusion of a Primary Birthing Unit adjacent to the Secondary Care Maternity Unit
- improved patient transfer times with the inclusion of a rooftop helipad with direct access to ED, ICU and theatres.

Taranaki Health Foundation

TE PUNA HAUORA O TARANAKI

Taranaki Health Foundation

2021/2022: BRINGING OUT THE BEST IN THE COMMUNITY

A word from the general manager...

It has been a busy year for Taranaki Health Foundation as we continue our work to raise funds to bring healthcare enhancements across the region after being impacted and delayed by the COVID-19 pandemic. Our conversations during this time with local businesses have shown us there is a clear understanding that Taranaki needs the support of its community to bring its people the healthcare they deserve.

Our relationship with Taranaki DHB has remained strong, and we look forward to working with them further now they have become Te Whatu Ora Taranaki. We also continue to appreciate the input from our valued board of Trustees, chaired by Brian Ropitini, which has navigated us through some challenging times. We bid a reluctant farewell to long-standing trustee Murali Bhaskar in May as he chose to stand down from his position.We wish Murali and his family all the best in their new home in Okato!

Our focus remains on raising $25 million to provide enhancements to the New East Wing Building (NEWB), currently under construction at Taranaki Base Hospital .

Brad Kisby has joined the THF team as our donor relationship manager, supporting Grant Carter in developing fundraising opportunities across the region as we work towards this goal. Brad brings a wealth of experience to the foundation, is the managing director for Fortius Group and has many ties with the building and construction industry. He is also passionate about improving healthcare in Taranaki and is already making a significant contribution to our endeavours.

As the fundraising task for Project Maunga is such a challenge, it is vital we have the tools in place to manage our donor relationships. This has included implementing a new customer relationship management (CRM) tool, partnered with email marketing and social media management tools, improving our administration systems and reviewing how we manage the day-to-day tracking of our interactions with donors.

We have also made considerable improvements to our website, providing a better user experience, as well as enabling online donations. The upgrade has also improved our digital capabilities, with the functionality to set up peer-to-peer donation pages and events. With this groundwork laid, we are well on our way to becoming more efficient and effective in our fundraising.

Leighs project manager Nathan Hawkins shows Adrian Sole and Grant Carter some of the base isolators on the Project Maunga site.

TARANAKI DESERVES THE BEST

We continued to build worthwhile relationships with various groups and businesses across the region. We know from experience how amazing the community is at supporting local causes, but even so we have been delighted by the enthusiasm from civic groups such as Rotary and Lions International. Without exception they have shown great interest in Project Maunga and the hospital redevelopment and expressed a deep desire to help. There has also been a fantastic response from businesses across the region, and we are in the process of finalising agreements with some major donors for the project.

The first Project Maunga community campaign was launched in June, raising awareness of which departments will be houses in NEWB and the project in general. To make the most of the campaign and reach the widest audience, we have developed relationships with many different media channels that are either giving us advertising space in-kind or have agreed to preferential rates.

CHAIRS FOR HEALTH

The festive season is always a time of generosity that we aim to take advantage of to bring vital enhancements to the hospital. Our 2021 Christmas campaign was Chairs for Health. The aim for this campaign was to provide specialised La-Z-Boy recliner chairs for the general surgery wards, supplied by R J Eagar at a discounted cost of $2,500 each.

These chairs were chosen due to their incredible durability and comfort, with options to go from a zero-gravity reclining position to a forward-tilt to help recovering patients stand easily. They are exactly the types of healthcare enhancements that are difficult to justify providing from the hospital's budget, but make a major contribution to a patient's recovery.

Our community responded, donating enough to enable 11 chairs to be purchased. We are looking forward to seeing them in use at Taranaki Base Hospital very soon.

LOVE OUR KIDNEYS (RENAL UNIT)

The Inglewood Lions have continued to support the outfitting of the Renal Building at Taranaki Base Hospital, with a popular firewood raffle We have been told that this activity will garner a donation of at least $10,000, for which we are very grateful. Our relationships with local groups like these are so rewarding, as their grassroots efforts will directly translate into improving the patient experience for those people who actually buy the tickets.

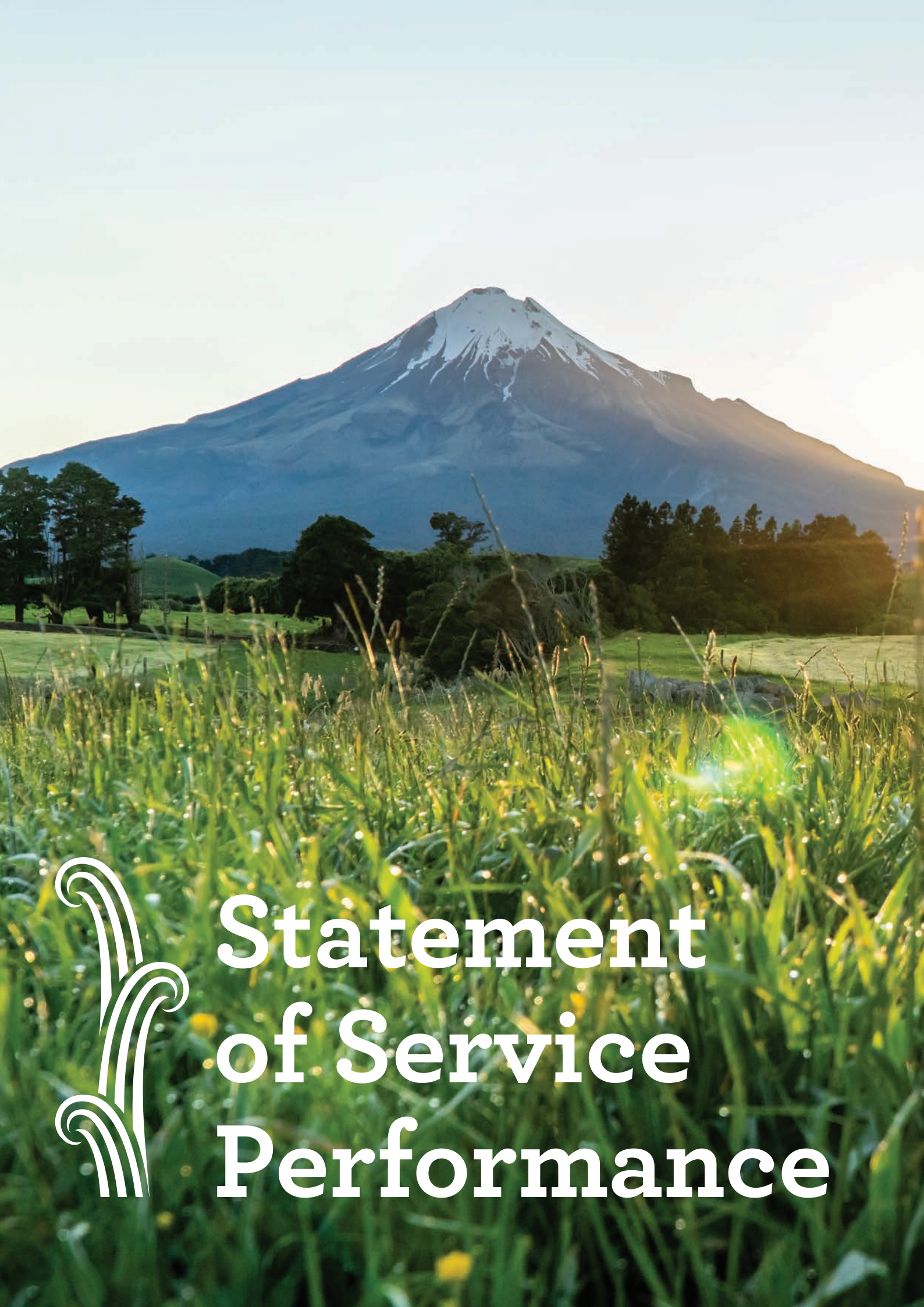
L-R: Kevin Knowles, George Buchanan, Grant Carter, Tiny Austin, Hendrik Hofstee and Melisa Bedford. A big thank you to Chooks Pumping & Engineering for providing the 1st prize of a 7x4 trailer to the Inglewood Lions Firewood Raffle.

Acknowledgements

Finally, I must acknowledge everyone we have worked with this past year; local charities, Taranaki businesses large and small, community-minded organisations such as Venture Taranaki and district and regional councils, and our fellow trusts, for their support, enthusiasm and generosity, both of spirit and pocket!

I would also like to thank the THF team for their hard work and dedication to the cause – your efforts are appreciated. Together we will deliver the very best healthcare possible our Taranaki community deserves.

Ngā mihi nui,
Adrian Sole - Taranaki Health Foundation General Manager



Statement of Service Performance

Statement of Service Performance

NGĀ WHANAKETANGA RATONGA

Overview

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

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

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

We built our performance framework for 2021/22 by grouping our activities into the population long and medium term impacts we intended to influence.

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

Notes:

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

Taranaki DHB Planned and Actual Revenue and Expenditure Allocated to Output Classes 2021-22

Output Class	Planned Revenue ($000's)	Actual Revenue ($000's)	Planned Expenditure ($000's)	Actual Expenditure ($000's)
Prevention	9,937	15,426	10,695	16,796
Early Detection and Management	108,041	120,968	116,288	112,137
Intensive Assessment and Treatment Services	288,880	323,445	310,932	368,413
Rehabilitation and Support	63,238	70,806	68,066	74,428
TOTAL	**470,096**	**530,645**	**505,981**	**571,775**

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

OUR PERFORMANCE STORY

Our Vision	Taranaki Together, a healthy Community – Taranaki Whānui He Rohe Oranga				
Our Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Our Strategic Priorities	Meeting Health Targets	Addressing Māori health/ disparities	Supporting older people to live well within their community	Addressing a system wide approach to integrated services	Supporting wellness and managing chronic conditions
Long Term Outcome	**1. People are supported to take greater responsibility for their health**		**2. People stay well in their homes and communities**		**3. People receive timely and appropriate specialist care**
Intermediate Impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours		An improvement in childhood oral health Long-term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence		People receive prompt and appropriate acute and arranged care People have appropriate access to elective services Improved health status for people with a severe mental health illness and/or addiction More people with end-stage conditions are appropriately supported
Outputs[2]	Percentage of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking Percentage of eight months olds who will have their primary course of immunisation on time Number of people referred to the Green Prescription programmes		Percentage of children (0-4) enrolled in DHB funded dental services Percentage of population enrolled with a PHO Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months		Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours Acute re-admission rate Elective and arranged day surgery rate Improving the percentage of long-term clients with up to date relapse prevention/ treatment plans
Output Classes	Prevention services	Early detection and management services	Intensive treatment and assessment	Rehabilitation and support services	Module 3

[2] The outputs described are examples only.

OUTCOME 1

People are supported to take greater responsibility for their health

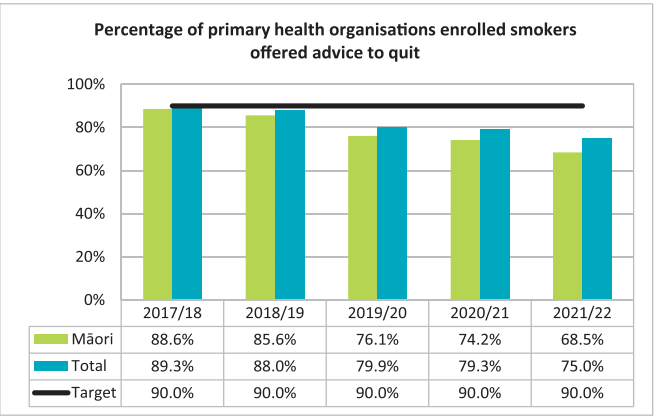
Expectation

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. These programmes create health-promoting physical and social environments which support people to take more responsibility for their own health and make healthier choices.

Fewer people smoke

Smoking and exposure to second-hand smoke causes 4,500 to 5,000 premature deaths annually and impacts directly on those who smoke and also through the effects of passive smoking on children and others who spend time with smokers. Tobacco smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Cancer is the leading cause of death in New Zealand (29.8%), and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Māori experiencing a higher incidence (20% +), higher mortality and higher stage at presentation. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say "no" to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	88.6%	85.6%	76.1%	74.2%	68.5%
Total	89.3%	88.0%	79.9%	79.3%	75.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

Data Source: Ministry of Health PHO enrolment Collection

Percentage of primary health organisations enrolled smokers offered advice to quit

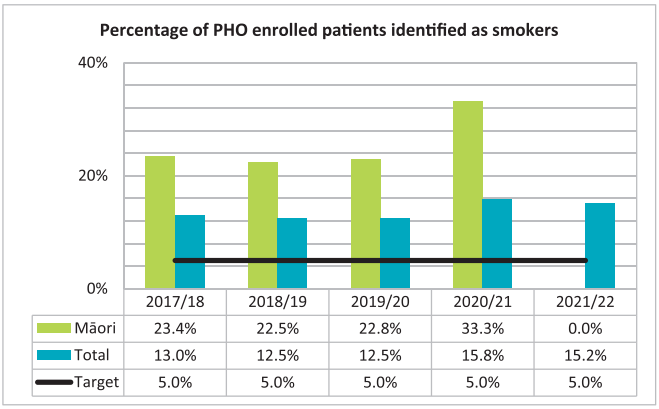
Māori **Not Achieved**

Total **Not Achieved**

The nature of GP workload continues to be in flux with workforce shortages, responding to COVID-19 and now influenza season. This means some core functions such as smoking cessation have not been delivered to target levels.

Taranaki DHB has a workforce and enrolment plan in place to stabilise the Primary care service delivery which should see core services such as stop smoking advice resume.

Te Pā Harakeke (Taranaki DHB's Māori health directorate) are working at pace alongside Planning and Funding to raise the priority of smoking cessation amongst all services within priority populations including mental health, pregnant women and Māori whānau.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	23.4%	22.5%	22.8%	33.3%	0.0%
Total	13.0%	12.5%	12.5%	15.8%	15.2%
Target	5.0%	5.0%	5.0%	5.0%	5.0%

Data Source: Ministry of Health PHO enrolment Collection

Percentage of PHO enrolled patients identified as smokers

Māori **Not Available**

Total **Not Achieved**

Work continues with the PHO and the Taranaki Stop Smoking Service to improve quit rates and thereby reduce the number of enrolled patients who identify as smokers. The Taranaki Stop Smoking Service continues to prioritise referrals for Māori, Pasifika, Hapū Māmā and people with mental health conditions but remains available to the general population.

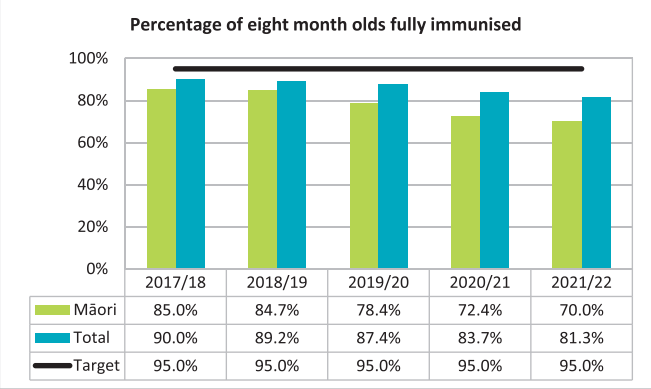
** Māori figures for the year 2021/22 were not received in the toolkit data.**

Reduction in vaccine preventable diseases

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). These diseases are entirely preventable.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	85.0%	84.7%	78.4%	72.4%	70.0%
Total	90.0%	89.2%	87.4%	83.7%	81.3%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: National Immunisation Register

Percentage of eight month olds fully immunised

Māori **Not Achieved**

Total **Not Achieved**

COVID-19 has continued to impact childhood immunisations this year with primary care service stretched, workforce challenges and whānau being hesitant to engage with health services. In response to these challenges Taranaki immunisations have focused on;

Increasing the workforce through supporting COVID-19 provisional vaccinator workforce to become authorised vaccinators; actively working through recall lists of whānau who have missed an vaccination event; and supporting partner organisations with vaccination workforce.

An Immunisation Steering Group has also been established to understand, prioritize and co-ordinate the delivery of immunisations in Taranaki, working collaboratively with partner providers. This steering group will see accelerated focused on immunisations in the coming year.

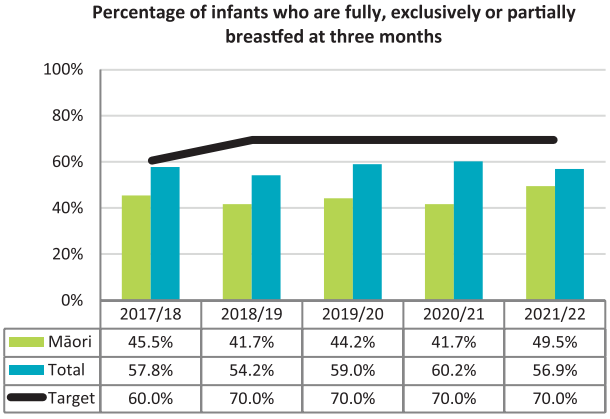
Improving health behaviours

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

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

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

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	45.5%	41.7%	44.2%	41.7%	49.5%
Total	57.8%	54.2%	59.0%	60.2%	56.9%
Target	60.0%	70.0%	70.0%	70.0%	70.0%

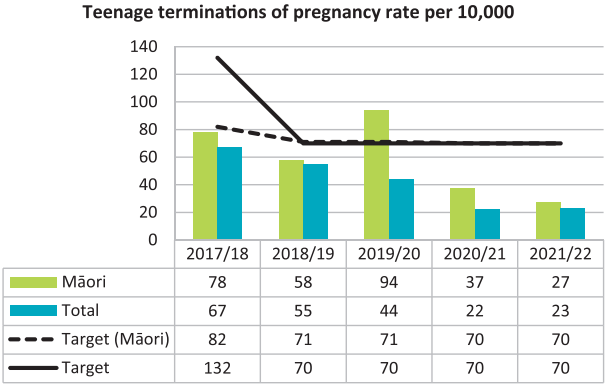
Well Child / Tamariki Ora Quality Improvement Framework Indicators data

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

Māori **Not Achieved**

Total **Not Achieved**

Hapū Wānanga and Āhuru Mōwai links expectant Māmā with lactation consultants before the birth of pēpi to ensure Māmā are aware of the supports available to enable successful breastfeeding outcomes. Delivery of this programme alongside strengthen Māori leadership for the F2000days work programme are being established to increase the support Taranaki whānau on their breastfeeding journey.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	78	58	94	37	27
Total	67	55	44	22	23
Target (Māori)	82	71	71	70	70
Target	132	70	70	70	70

Data Source: Ministry of Health National Minimum Dataset

Reduce rate of teenage terminations of pregnancy rate - per 10,000

Māori **Achieved**

Total **Achieved**

There is a continued effort to ensure young people have access to sexual health services, including long acting contraception and self-referral clinics. The extension of services in schools, alternative education and primacy care mental health all contribute to ensure young people are engaged with health services.

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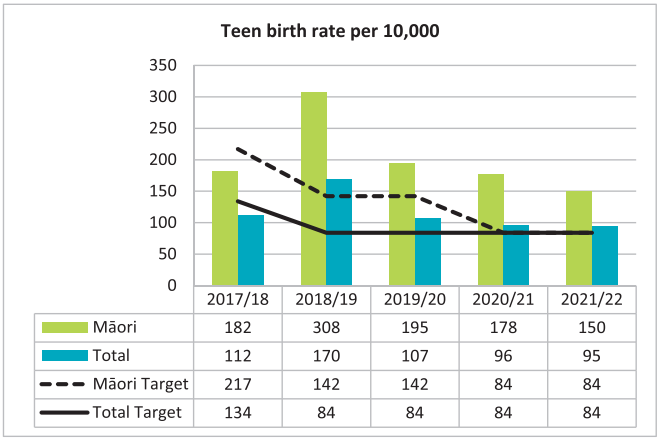


	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	182	308	195	178	150
Total	112	170	107	96	95
Māori Target	217	142	142	84	84
Total Target	134	84	84	84	84

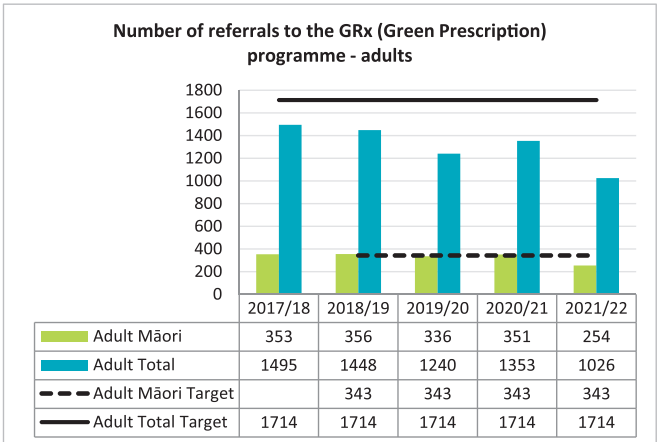
Data Source: Ministry of Health National Minimum Dataset

Reduce the teen birth rate per 10,000

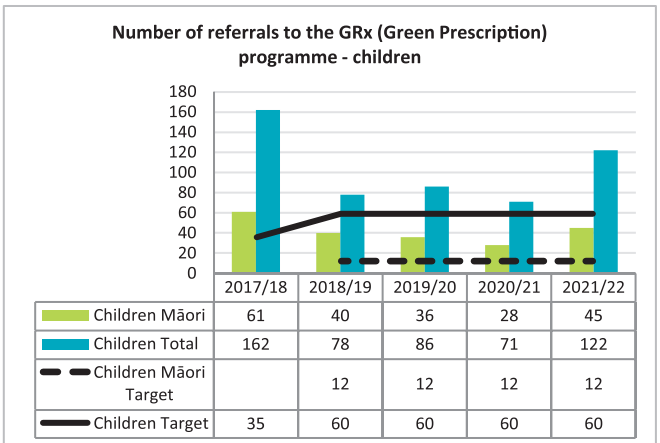
Māori **Not Achieved**

Total **Not Achieved**

Te Pā Harakeke is working along maternity services to strengthen antenatal educational, maternity services and wrap around to support that young people access through their pregnancy journey. This work compliments the work to ensure that young people are able to access timely and appropriate sexual health information including contraception.



	2017/18	2018/19	2019/20	2020/21	2021/22
Adult Māori	353	356	336	351	254
Adult Total	1495	1448	1240	1353	1026
Adult Māori Target		343	343	343	343
Adult Total Target	1714	1714	1714	1714	1714



	2017/18	2018/19	2019/20	2020/21	2021/22
Children Māori	61	40	36	28	45
Children Total	162	78	86	71	122
Children Māori Target		12	12	12	12
Children Target	35	60	60	60	60

Data Source: Sports Taranaki Performance Monitoring Report 2021/22
Taranaki DHB Performance Monitoring Report 2021/22

The number of referrals to the GRx (Green Prescription) programme

Adult Māori **Not Achieved**

Adult Total **Not Achieved**

Children Māori **Achieved**

Children Total **Achieved**

This year 2022 has seen the implementation of a new green prescription service that is focussed on priority communities including Māori, Pacifica, diabetics and patients with co-morbidities. As this service change is embedded more of our priority groups will be engaged in the service and improve our results against the target. The children's service has changed to the Whānau Pakari service. Whānau Pakari are multi-disciplinary with a strong equity focus and include a Paediatrician, Dietician, Psychologist and Activity Coordinator delivering a family based nutrition, activity and lifestyle intervention.

*The 2019/20 Māori target for children has been altered from the number published in the previous annual report as an error was identified. Targets now correctly line up with the agreed annual plan figures.

OUTCOME 2

People stay well in their homes and communities

Expectation

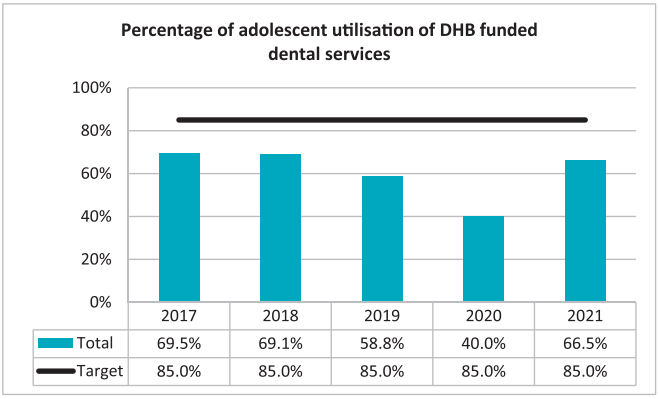
Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better managing their illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness. They also support people to regain their functionality after illness and to remain healthy and independent.

An improvement in childhood oral health

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

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

OUTPUT MEASURES



	2017	2018	2019	2020	2021
Total	69.5%	69.1%	58.8%	40.0%	66.5%
Target	85.0%	85.0%	85.0%	85.0%	85.0%

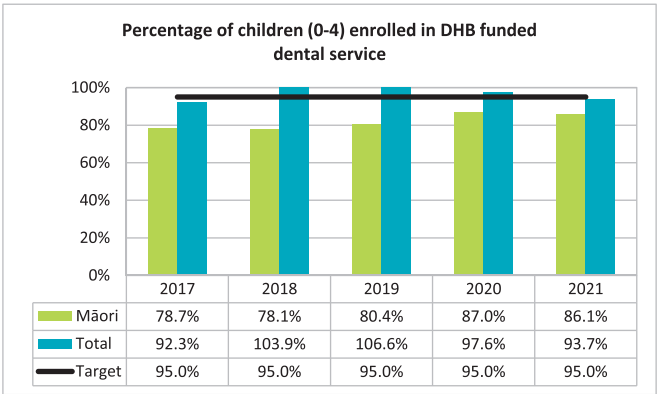
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2021 calendar year.

Percentage of adolescent utilisation of DHB funded dental services

Total **Not Achieved**

Inequity in access to adolescent oral health has been identified as a significant challenge. In 2021/22 year a Health Equity Assessment has been completed. This highlighted a range of opportunities to improve outcomes. The first recommendation involves development of a coordination function which is currently in planning.

While significant improvement was observed in 2021, much of this involves catch-up following a year of COVID-19 disruption in 2020. Initiatives included a temporary increased age limit for adolescent to accommodate those who turned 18 years old during the impacted period.



	2017	2018	2019	2020	2021
Māori	78.7%	78.1%	80.4%	87.0%	86.1%
Total	92.3%	103.9%	106.6%	97.6%	93.7%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

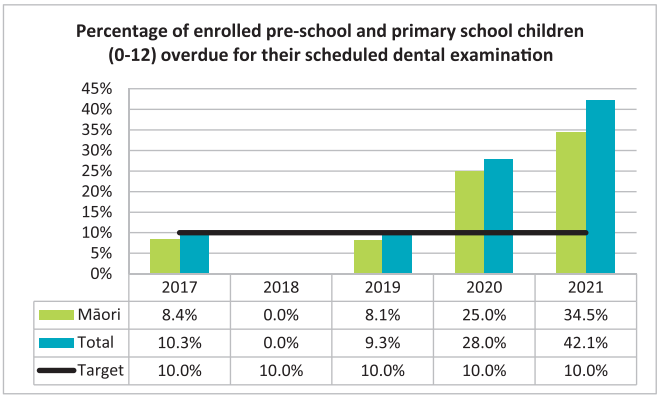
Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2021 calendar year.

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

Māori **Not Achieved**

Total **Not Achieved**

It is disappointing that Taranaki DHB did not meet the target for preschool enrolment in 2020. A contributing factor may be preschool children residing in Waverley have been historically enrolled with Taranaki DHB, however in 2021 Whanganui DHB has enrolled all children residing from Waverley to the Whanganui border with the Whanganui Community Oral Health Service. This is because most new-born children residing in these areas are more often than not born in Whanganui Hospital. Waverley whānau tend to receive all their GP services in Whanganui and the parents of children receive their own dental treatment in Whanganui. This change in practice may have contributed to a reduction in enrolment numbers in Taranaki, but is expected to improve engagement with oral health services for these whānau. The Kaiawhina working with South Taranaki whānau and staff has had a positive impact assisting with service-whānau engagement, and it is disappointing that this is not reflected in this data. Earlier this year (2022) COHS started a data clean-up of all preschool aged children with a Taranaki residential address, and we expect the results of this to be reflected in the data for 2022. In addition, it is not fully known the impact COVID-19 has had on the population of Taranaki and on the denominator used to determine population numbers.



	2017	2018	2019	2020	2021
Māori	8.4%	0.0%	8.1%	25.0%	34.5%
Total	10.3%	0.0%	9.3%	28.0%	42.1%
Target	10.0%	10.0%	10.0%	10.0%	10.0%

Data Source: Taranaki DHB Dental Patient Management System - Titanium. Statistics New Zealand Population Projection 2018. Data is for the 2021 calendar year.

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

Māori **Not Achieved**

Total **Not Achieved**

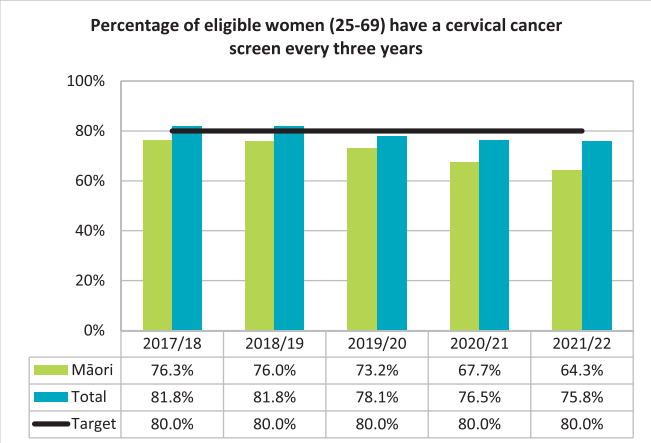
The impact of COVID-19 continued to provide disruption to provision of dental services in 2021. Along with a brief lockdown in 2021 which resulted in the COHS staff being redeployed to support other hospital departments, the NZ Dental Council continued to issue restrictions and guidelines regarding providing dental care in a pandemic during Alert levels 1, 2, 3 + 4 which affected the number of dental appointments which were able to be offered in all Alert levels. Chronic vacancies in the Therapy workforce also impacted the number of dental appointments which were able to be offered in 2021.

*No data for 2018 *

Long-term conditions are detected early and managed well

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to "contain costs" we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and specialist care, enabling more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage Cardiovascular Disease (CVD or heart disease). It is one of the largest causes of death in New Zealand, and disproportionately higher for Māori. Often by the time heart problems are detected, the underlying cause of atherosclerosis (arterial disease) is usually well advanced. Our aim is to either prevent the disease by modifying risk factors such as healthy eating, exercise and avoiding smoking, or early detection and management.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	76.3%	76.0%	73.2%	67.7%	64.3%
Total	81.8%	81.8%	78.1%	76.5%	75.8%
Target	80.0%	80.0%	80.0%	80.0%	80.0%

Data Source: National Screening Unit

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

Māori **Not Achieved**

Total **Not Achieved**

2021/22 coverage rates for Māori and Asian women remained under target but well above the national average. Post COVID-19 coverage decreased for all women screened especially Māori and Asian who already have lower rates of screening.

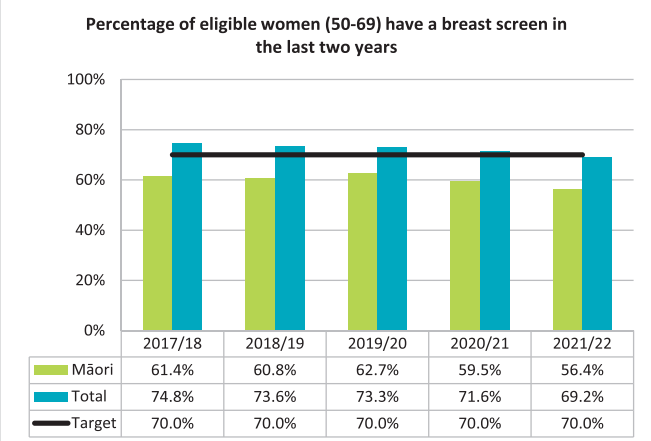
While we know the response is ongoing, we are focusing attention on approaches that will support recovery. We are progressing work on sharing data to assist recovery planning and will be working with providers to identify further opportunities.

The NCSP are planning two initiatives to support an equitable recovery for Māori and Pacific women.

1) An advertising campaign to be launched in 2022.

2) HPV primary screening and self testing which is expected to begin in 2023 with preparation of new a NCSP Register underway.

Work continues to work with Māori health providers and the PHO to promote and support priority women in Taranaki.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	61.4%	60.8%	62.7%	59.5%	56.4%
Total	74.8%	73.6%	73.3%	71.6%	69.2%
Target	70.0%	70.0%	70.0%	70.0%	70.0%

Data Source: Breast Screening Aotearoa

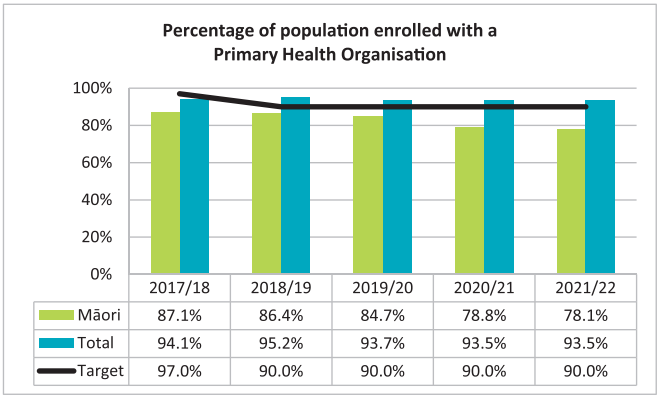
Percentage of eligible women (50-69) have a breast screen in the last two years

Māori **Not Achieved**

Total **Not Achieved**

Breast screening rates are similar to previous years with continuing disparity between Māori and non-Māori screening rates being evident. Funding and operational support for this target is with Breast Screening coast to coast and Pinnacle. Neither are commissioned via Taranaki DHB.

2020/21 Data provided is only for the period to 31 December 2020. Our provider continues to actively promote breast screening and cervical screening awareness at all local Māori/Iwi functions that they attend. Local knowledge and door knocking with wāhine who have not attended appointments or responded and it is hoped this will drive more equitable performance.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	87.1%	86.4%	84.7%	78.8%	78.1%
Total	94.1%	95.2%	93.7%	93.5%	93.5%
Target	97.0%	90.0%	90.0%	90.0%	90.0%

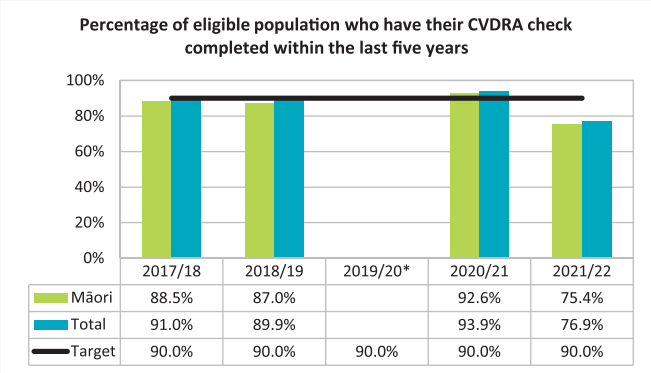
Data Source: Ministry of Health PHO enrolment Collection. Statistics New Zealand Population Projection 2018

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

Māori **Not Achieved**

Total **Achieved**

Overall PHO enrolment remains steady however there has been gradual decline in enrolment rates for Māori. A project has been initiated with the PHO to specifically focus on increasing Māori enrolment.



	2017/18	2018/19	2019/20*	2020/21	2021/22
Māori	88.5%	87.0%		92.6%	75.4%
Total	91.0%	89.9%		93.9%	76.9%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

Data Source: Pinnacle (PHO) quarterly reporting until 2018/19. Pinnacle Diabetes Dashboard since 2020/21

Percentage of eligible population who have their Cardiovascular Disease Risk Assessment (CVDRA) assessed in the last five years

Māori **Not Achieved**

Total **Not Achieved**

In Taranaki we are currently using BPAC tool, which has different implementations between regions.

The below initiatives are in place to engage Māori and Pacific patients eligible for CVDRA:

(a) CVDRA recalls for all patients with Maori starting at the younger age to adjust for their higher risk.

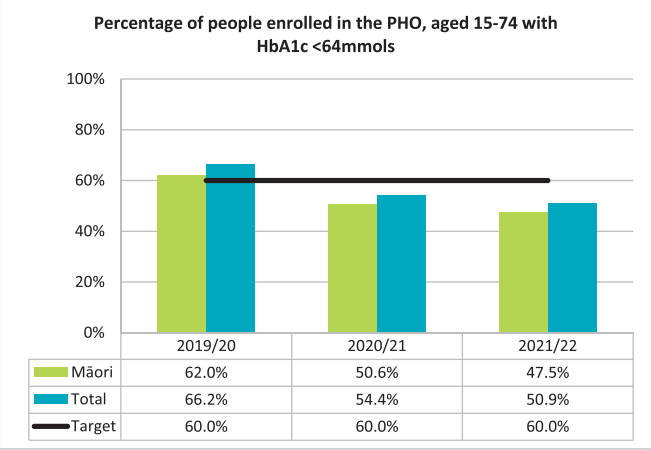
(b) BPAC dashboard highlighting if patient is due screening.

(c) Quality points for achieving % of CVDRA with specific target for high needs groups.

(d) HIPs in some practices. Can help engage high needs patients that otherwise may have barriers to proactive wellness screening and healthcare

(e) Nurse training for diabetes available. Also a funded certificate through Waikato university was recently run and well attended by Dr and nurses in primary care.

2019/20 data was not available as MOH no longer provided the data. Data source changed for 2020/21



	2019/20	2020/21	2021/22
Māori	62.0%	50.6%	47.5%
Total	66.2%	54.4%	50.9%
Target	60.0%	60.0%	60.0%

Data Source: Pinnacle (PHO) Diabetes Dashboard
*Data refers to the diabetic population only

Percentage of people enrolled in the PHO, aged 15-74 with HbA1c <64mmols

Māori **Not Achieved**

Total **Not Achieved**

HBA1C in control has decreased for a second year, we believe this continues to be a COVID-19 impact. A Diabetes Integrated Team has been established in the 2021/22 year. In 2022/23 we anticipate this team will have a significant focus on improving these results.

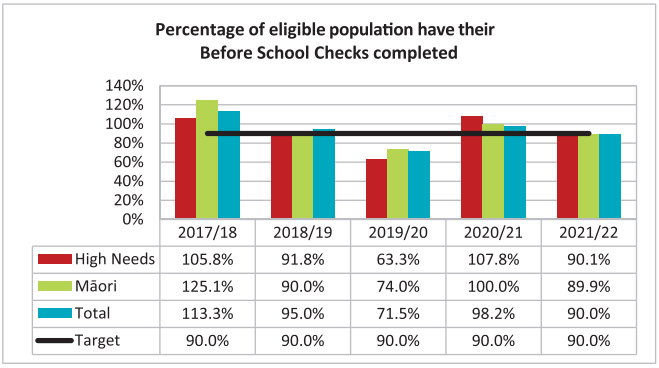
Fewer people are admitted to hospital for avoidable conditions

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

A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases and deliver on the Government's priority of "better, sooner, more convenient" healthcare.

The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Improving people's access to, and the effectiveness of, primary care will facilitate early interventions, particularly among Māori and Pacific people, which supports improving our population's health outcomes and reducing health inequalities for Māori.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
High Needs	105.8%	91.8%	63.3%	107.8%	90.1%
Māori	125.1%	90.0%	74.0%	100.0%	89.9%
Total	113.3%	95.0%	71.5%	98.2%	90.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

Data Source: National Immunisation Register

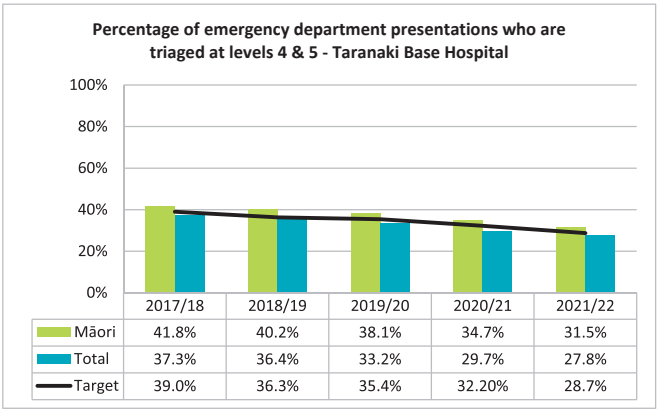
Percentage of eligible population have their Before School Checks completed

High Needs	**Achieved**
Māori	**Not Achieved**
Total	**Achieved**

This has been another challenging year with COVID-19 disrupting services. Despite these challenges the Before School Check programme in Taranaki has delivered to a higher percentage of Māori and Pacific young people than other ethnicities.

This has been the result of collectively effort from our Māori health partners and Public Health Nurse Team (PHN) working together. The team have run clinics in Kohanga reo focusing on high deprivation areas and Māori Health partners have delivered outreach services.

The team have been highly resourceful to ensure services are focused on priority populations.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	41.8%	40.2%	38.1%	34.7%	31.5%
Total	37.3%	36.4%	33.2%	29.7%	27.8%
Target	39.0%	36.3%	35.4%	32.20%	28.7%

Data Source: Taranaki DHB Patient Management System. Statistics New Zealand Population Projection 2018

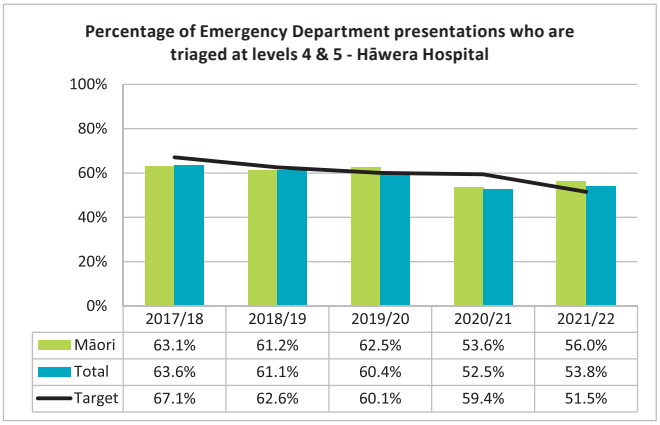
Percentage of emergency department presentations who are triaged at levels 4 & 5 - Taranaki Base Hospital

Māori	**Not Achieved**
Total	**Not Achieved**

Taranaki DHB continues to see a reduction in triage 4 & 5 Emergency Department (ED) presentations at Taranaki Base Hospital for both Māori and total population.

Initiatives that provide alternatives to ED admission for those with minor health issues have continued for 2021/22. Similarly to previous years public communications/education drives, re direction to GP services (including funded voucher systems) and primary options pathways continue.

Māori continue to present at slightly higher rates than non-Māori, the reasons for which is likely multifactorial, however the rate of presentations continues to reduce which is promising. Implementation of a Manaaki Mana based role in ED was initiated to assist with enrolment and appropriate re-direction of Māori.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	63.1%	61.2%	62.5%	53.6%	56.0%
Total	63.6%	61.1%	60.4%	52.5%	53.8%
Target	67.1%	62.6%	60.1%	59.4%	51.5%

Data Source: Taranaki DHB Patient Management System. Statistics New Zealand Population Projection 2018

Percentage of Emergency Department presentations who are triaged at levels 4 & 5 - Hāwera Hospital

Māori **Not Achieved**

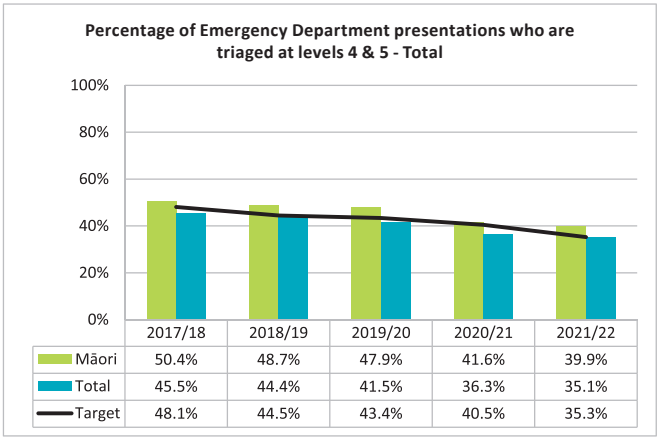
Total **Not Achieved**

The Hāwera Emergency Department has had a decrease in the number of triage 4 and 5 patient presentations overall. However, the percentage of triage 4 and 5 presentations has increased and has not met the target of 51.5%. The Māori presentation rate also increased from 53.6% to 56%.

The increase may be due to difficulty in seeing own practitioner, health care worker illness and vacancies, and an increased demand on health care due to the global pandemic.

Public education campaigns, and ED-redirection initiatives are ongoing. The South Taranaki Rural Health GP enrolled population has increased to approximately 2600 providing the community in South Taranaki primary care access.

Māori continue to present at slightly higher rates than non-Māori, the reasons for which is likely multifactorial (e.g. social determinants, affordability)



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	50.4%	48.7%	47.9%	41.6%	39.9%
Total	45.5%	44.4%	41.5%	36.3%	35.1%
Target	48.1%	44.5%	43.4%	40.5%	35.3%

Data Source: Taranaki DHB Patient Management System. Statistics New Zealand Population Projection 2018

Percentage of Emergency Department presentations who are triaged at levels 4 & 5 - Total

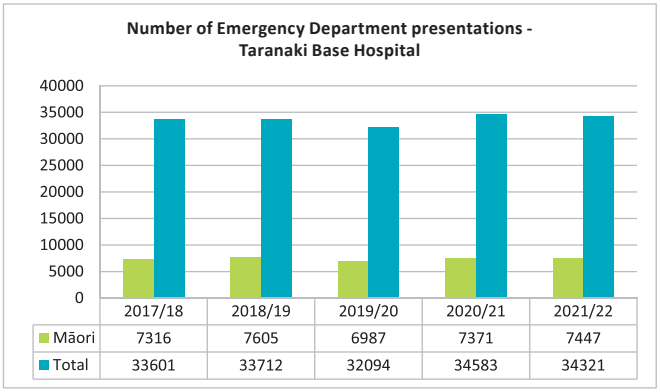
Māori **Not Achieved**

Total **Not Achieved**

Taranaki DHB continues to see a reduction in triage 4 & 5 Emergency Department (ED) presentations at Taranaki Base Hospital for both Māori and Total population.

Initiatives that provide alternatives to ED admission for those with minor health issues have continued for 2021/22. Similarly to previous years public communications/education drives, re direction to GP services (including funded voucher systems) and primary options pathways continue.

Māori continue to present at slightly higher rates than non-Māori, the reasons for which are likely multifactorial, however the rate of presentations continues to reduce which is promising. Implementation of a Manaaki Mana based role in ED was initiated to assist with enrolment and appropriate re-direction of Māori.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	7316	7605	6987	7371	7447
Total	33601	33712	32094	34583	34321

Data Source: Taranaki DHB Patient Management System

Number of Emergency Department presentations - Taranaki Base Hospital

Māori **Not Achieved**

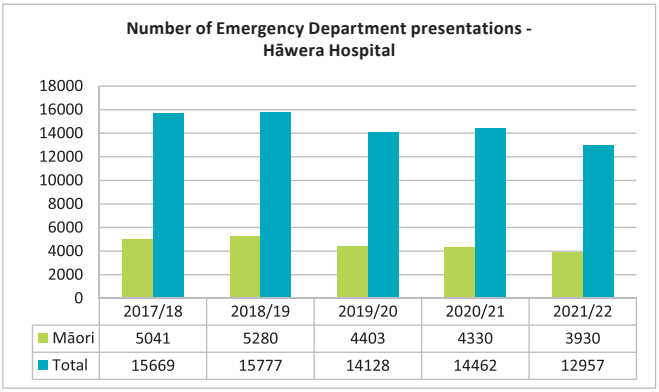
Total **Achieved**

The number of ED presentations has decreased slightly from 2021/22, this may have been due to the impact of COVID-19 and reluctance of people to present to secondary services in times of lock down or increased telehealth options in the primary setting.

The overall trajectory has seen an increase in Māori presentations and this may be attributed to a lower primary care enrolment rate or non related due to slight increase only.

The Taranaki region will continue to explore alternative models of care and care pathways that enable community based care where possible with a focus long term conditions initially.

Target = reduction from the previous year.



Data Source: Taranaki DHB Patient Management System

Number of Emergency Department presentations - Hāwera Hospital

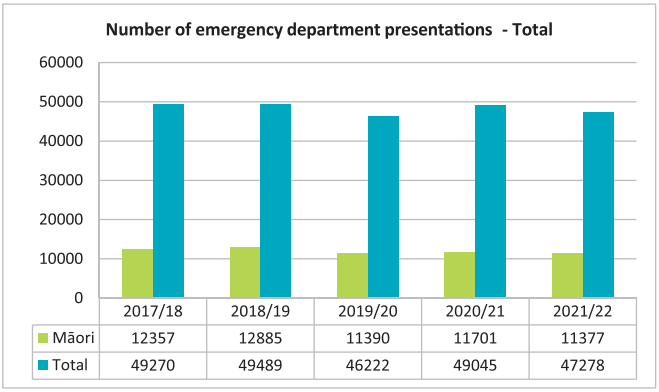
Māori **Achieved**

Total **Achieved**

There has been an overall decrease in patient presentations to Hāwera Emergency Department. The triage 3 patients are the outlier as the only cohort that has shown an increase.

The overall decrease can be attributed to the ongoing public education campaigns, and ED redirection to other relevant health care providers (including for example, own GP, South Taranaki Rural Health GP practice, pharmacy). The walk-in service continues to develop and will further ease the burden on the ED by providing an alternative service/access point for GP appropriate patients.

Target = reduction from the previous year.



Data Source: Taranaki DHB Patient Management System

Number of Emergency Department presentations - Total

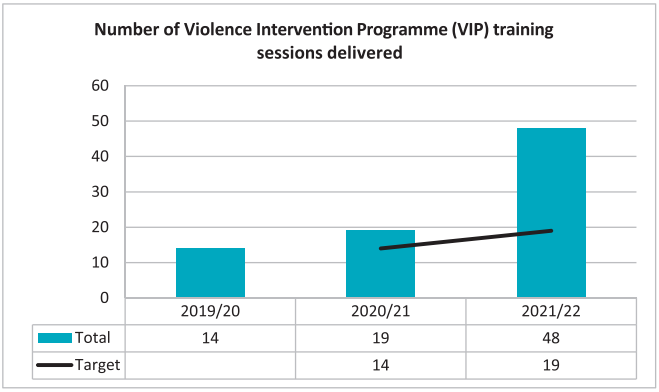
Māori **Achieved**

Total **Achieved**

The number of ED presentations has decreased both for Māori and overall from 2021/22, this may have been attributed to COVID-19, national lock downs and a reluctance from the general public to seek out help when the awareness that COVID-19 cases are in the hospital.

The Taranaki region will continue to explore alternative models of care and care pathways that enable community based care where possible.

Target = reduction from the previous year.



Data Source: Violence Intervention Programme Office records, Taranaki DHB

Number of Violence Intervention Programme (VIP) training sessions delivered

Total **Baseline being established**

During the 2021/22, the Taranaki DHB Violence Intervention Programme (VIP) has trained 116 clinical staff in Core VIP response and 43 clinical staff in the Safeguarding of Older Adults and Vulnerable Adults from Abuse and Neglect. 12 other staff received Advanced VIP training and seven GP registrars received a short training in an appropriate family violence response in General Practice.

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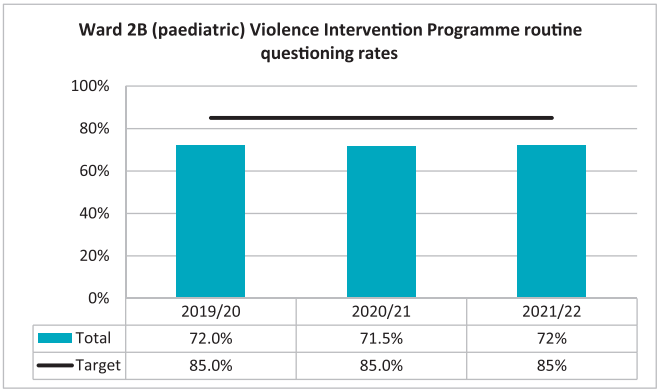
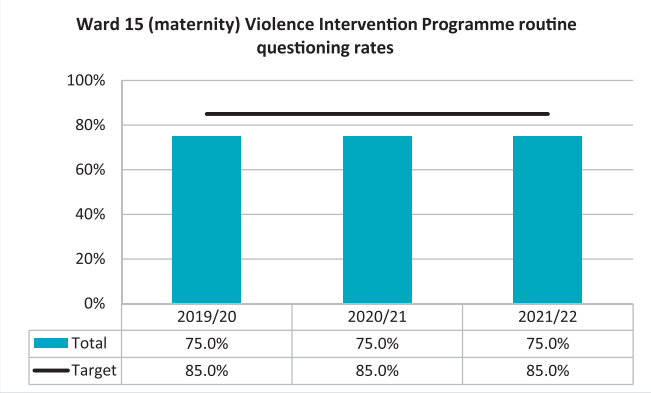


Data Source: Violence Intervention Programme Office records, Taranaki DHB

Ward 2B (paediatric) Violence Intervention Programme routine questioning rates

Total **Not Achieved**

Taranaki DHB has not completed routine audits of family violence routine questioning (FVRQ) in Ward 2B due to the Pandemic and limitations to access to the ward. We maintained the training of all clinical staff to ask FVRQ and to respond appropriately to a positive disclosure of family violence.

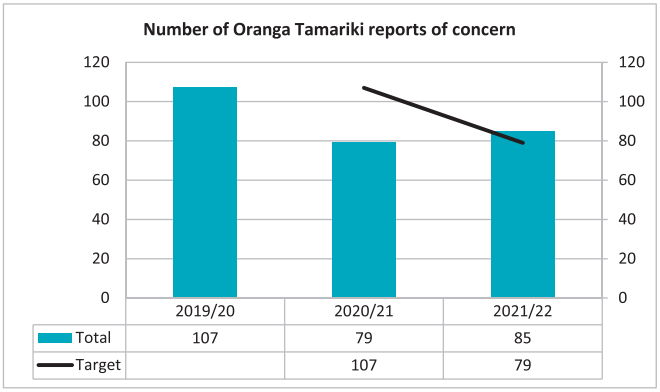


Data Source: Violence Intervention Programme Office records, Taranaki DHB

Ward 15 (maternity) Violence Intervention Programme routine questioning rates

Total **Not Achieved**

We have not completed routine audits of family violence routine questioning (FVRQ) in Ward 15 due to the pandemic and staff changes/shortages. We maintained the training of all clinical staff to ask Family Violence Routine Questions (FVRQ) and to respond appropriately to a appositive disclosure of family violence. Despite the target not being achieved we are confident that VIP outcomes in this area are being achieved.



Data Source: Violence Intervention Programme Office records, Taranaki DHB

Number of Oranga Tamariki reports of concern

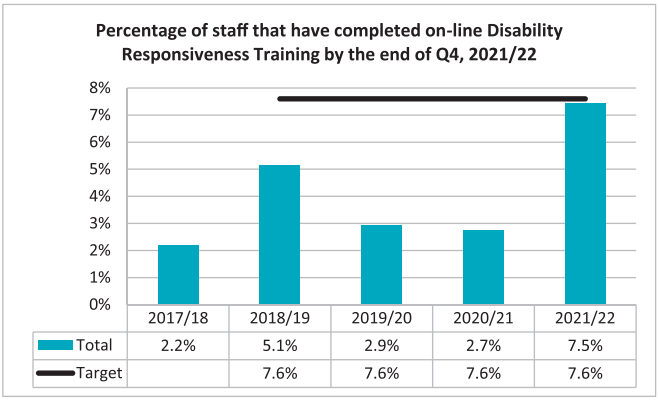
Total **Achieved**

85 Report of Concerns were made from Health Professionals to Oranga Tamariki. Health Professionals in all clinical areas receive child protection training to respond to vulnerable children

More people maintain their functional independence

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

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Total	2.2%	5.1%	2.9%	2.7%	7.5%
Target		7.6%	7.6%	7.6%	7.6%

Data Source: Taranaki DHB

Percentage of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2021/22

Total **Not achieved**

Over the 2021/22 period Taranaki DHB introduced new Disability Equity Training as an online e-learning module.

There were 463 staff who completed the training during this period. An increase of more than double the participation rate from last year.

Disability Equity Training is now mandatory for staff and included as part the induction package.

A new employee must complete the module within the first three months of their respective start date.

While the target was not met in 2021/22, it was within 0.1% of target and has improved over prior years.

OUTCOME 3

People receive timely and appropriate specialist care

Expectation

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

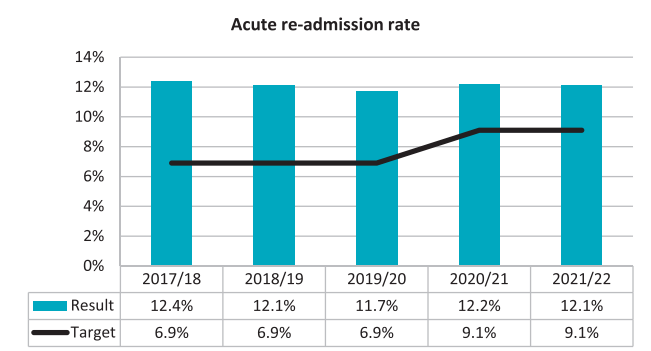
This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

People receive prompt and appropriate acute and arranged care

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

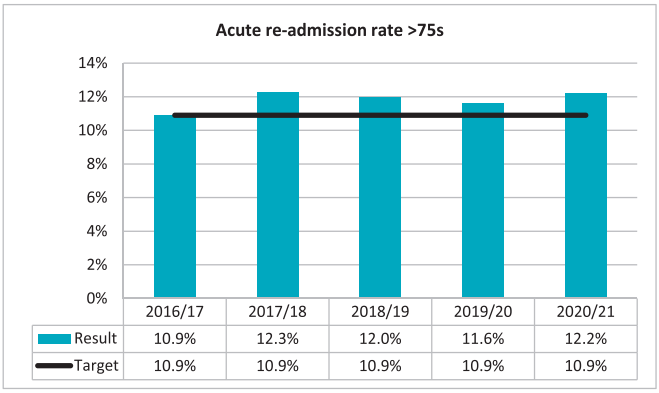
The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentations, the effectiveness of services provided in ED and the hospital and community services provided following exit from ED. Reduced waiting time in ED is indicative of a coordinated 'whole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

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Result	12.4%	12.1%	11.7%	12.2%	12.1%
Target	6.9%	6.9%	6.9%	9.1%	9.1%

Data Source: National Minimum Dataset (NMDS)



	2016/17	2017/18	2018/19	2019/20	2020/21
Result	10.9%	12.3%	12.0%	11.6%	12.2%
Target	10.9%	10.9%	10.9%	10.9%	10.9%

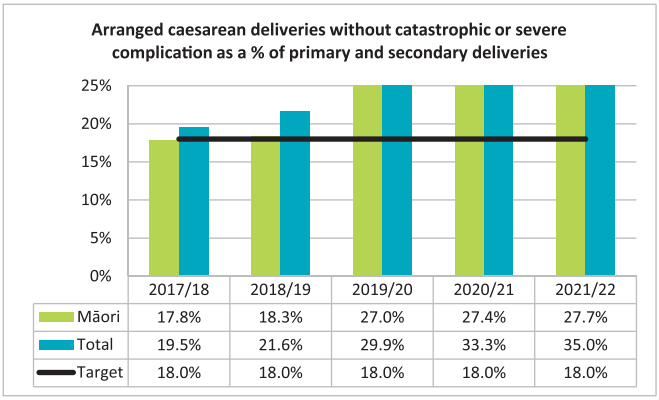
Data Source: National Minimum Dataset (NMDS)

Acute re-admission rates

Acute re-admission rate	**Not Achieved**
Acute re-admission rate >75s	**Not Achieved**

Acute re-admission rates remain above target, largely as a result of increasing levels of acute demand and complexity of patient conditions. The over 75 age group are also more at risk of frailty, and tend to have a higher risk of acute re-admission. Planned activity and projects that could have impacted this measure in the 2021/22 year were significantly impacted by COVID-19, with energy and resourcing going heavily to keeping services open and running. Going forward, the surgical directorate is putting greater emphasis on improving the pre-operative patient journey to ensure that patients are well prepared for their elective procedures, which for this cohort at least should result in lower re-admission rates.

The medical directorate continues to direct energies into long term condition community support, especially Lung, diabetes and cardiac care. Rehab and community education groups continue in the region and the diabetes model of care is moving out of the secondary setting to ensure people get care closer to home and have appropriate support as a first line response.



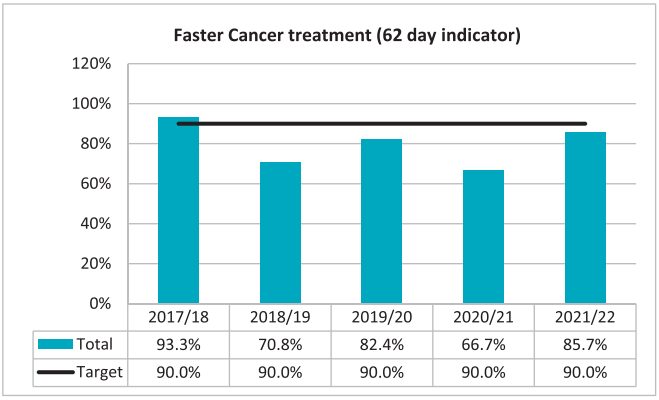
Data Source: National Minimum Dataset (NMDS). Desired outcome is below the target rate

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

Māori **Not Achieved**

Total **Not Achieved**

Taranaki DHB remains committed to reducing the number of elective caesarean sections in our region. The indications for elective caesarean sections are multifactorial and includes factors such as higher risk women, co-morbidities in pregnant women, workforce issues and local availability of testing that continues to clinically drive these rates. A project has been established to implement a new induction of labour (IOL) protocol using Misoprostol. Using Misoprostol at other hospitals have reported up to a 10% reduction in caesarean section rate.



Data Source: National Cancer data set

Faster Cancer treatment (62 day indicator)

Total **Not Achieved**

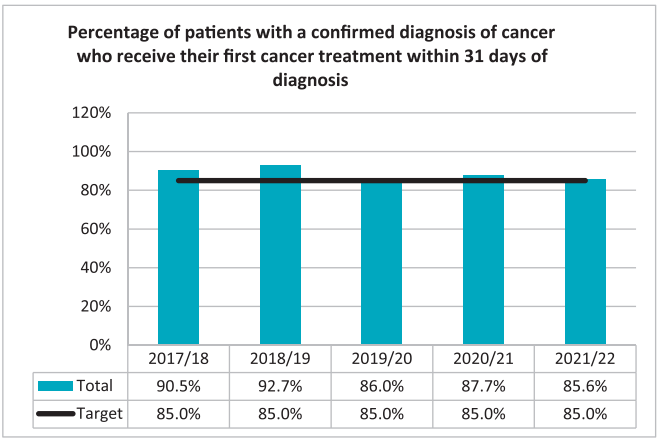
Taranaki has not met the target of 90% of all cancer patients receiving their first treatment within 62 days. An improvement has been observed since 2020/21 and part of this is attributed to the additional employment of an oncology medical officer (on site) and a cancer nurse coordinator.

However inability to reach the target is still hindered by complex diagnostic procedures which require intervention outside of the region (CT guided lung biopsy - Waikato). Availability of on site specialists, especially for ENT services. Continued reliance on visiting specialties (lung) also prolonged appointment time frames.

A breach analysis report continues to be maintained for the Taranaki region to improve processes where able.

Continued work with te Aho o Te Kahu will ensure consistency .

The Taranaki Faster Cancer Treatment (FCT) governance group is well established and includes wide representation.



Data Source: National Cancer data set

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

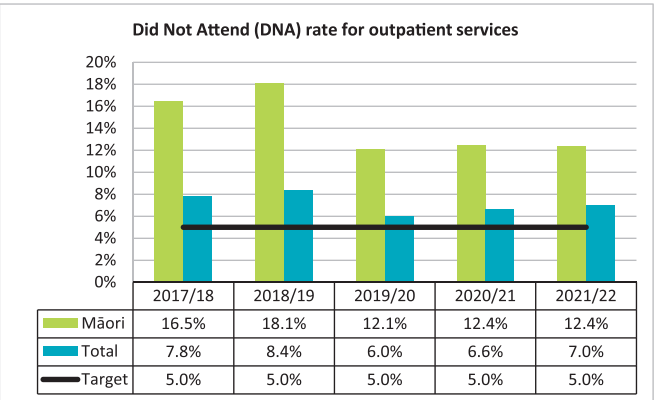
Total **Achieved**

The target of 85% of its patients receiving their treatment in 31 days has been achieved. Ongoing monitoring and promotion of staff awareness of this target will be undertaken to ensure this target continues to be met. A breach analysis report is maintained to allow the Taranaki region to improve processes where able. An additional cancer nurse coordinator could have attributed to achieving this result as well as national support via Te Aho o Te Kahu.

People have appropriate access to elective services

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services. Improved performance on targets in this area are reflective of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	16.5%	18.1%	12.1%	12.4%	12.4%
Total	7.8%	8.4%	6.0%	6.6%	7.0%
Target	5.0%	5.0%	5.0%	5.0%	5.0%

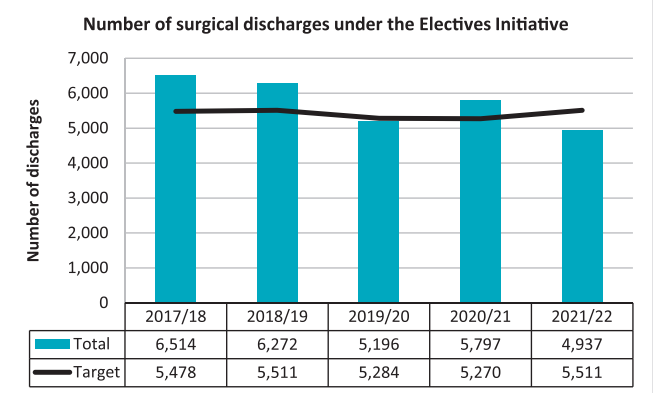
Data Source: National Non-admitted Patient dataset. Desired outcome is below the target rate

Did Not Attend (DNA) percentage for outpatient services

Māori **Not Achieved**

Total **Not Achieved**

Total DNA rates declined in the 2021/22 year. Te Pā Harakeke continue to work with all specialties to assist patients to navigate through the health system. Patient centred booking, virtual consultations, telehealth and other patient centred initiatives are being considered to overcome some of the barriers to attendance. Taranaki DHB will continue to monitor DNA rates and look for ways to improve engagement of patients in health services. The DNA policy and letters project continue on track and should near completion end 2022.



	2017/18	2018/19	2019/20	2020/21	2021/22
Total	6,514	6,272	5,196	5,797	4,937
Target	5,478	5,511	5,284	5,270	5,511

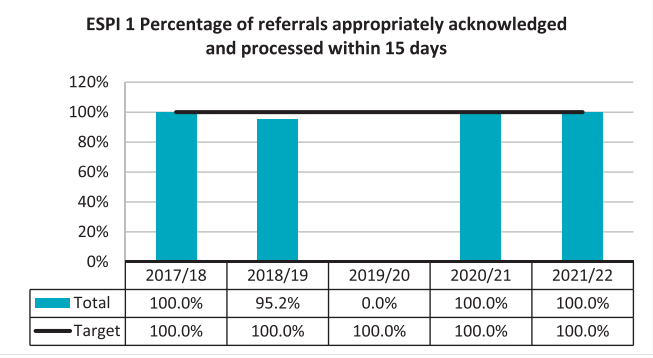
Data Source: National Minimum Dataset (NMDS)

Number of surgical discharges under the Electives Initiative

Result **Not Achieved**

Taranaki DHB did not achieve this in 2021/22. This is due to the substantive challenges in theatre productivity and bed availability along with periods heavily impacted by COVID-19.

In 2019/20 the Electives Initiative was relaunched as the Planned Care Initiative. The surgical discharge component remains comparable to previous years



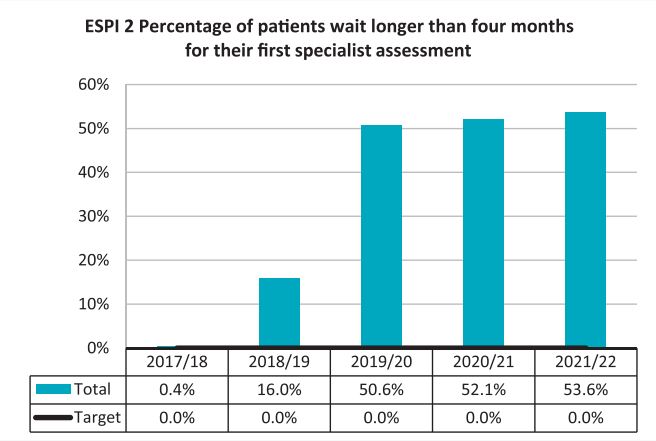
	2017/18	2018/19	2019/20	2020/21	2021/22
Total	100.0%	95.2%	0.0%	100.0%	100.0%
Target	100.0%	100.0%	100.0%	100.0%	100.0%

Data Source: National Booking Reporting System (NBRS)

ESPI 1 Percentage of referrals appropriately acknowledged and processed within 15 days

Result **Achieved**

Taranaki DHB continues to achieve this target.

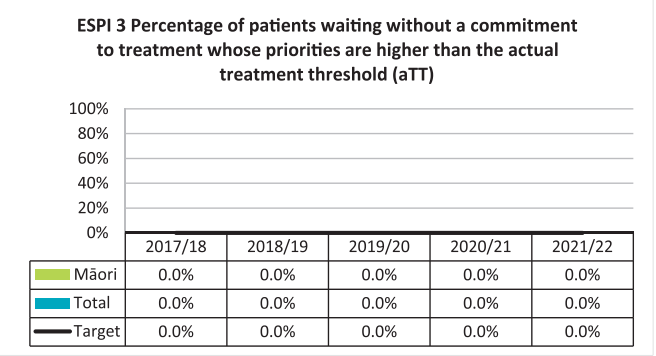


Data Source: National Booking Reporting System (NBRS)

ESPI 2 Percentage of patients wait longer than four months for their first specialist assessment

Result **Not Achieved**

ESPI2 performance continues to deteriorate, albeit at a slower pace than in the past. COVID-19 continues to have a substantial impact on waiting lists, through both a post-COVID-19 lockdown bounce in demand and reduced capacity due to staff illness and re-deployment to areas of greatest risk and need. This impact has been felt across all DHBs and a Planned Care taskforce been set up in Te Whatu Ora to try and tackle worsening back logs. Current activities to improve ESPI2 performance include regular reviewing of lists by bookers and SMOs, developing and maintaining appropriate thresholds to manage inflows, increasing capacity via additional clinics, locums, outsourcing and recruitment as and where able to increase production, and utilisation of alternative workforces where possible. Further work is planned in the surgical directorate to ensure leadership structures support optimising the patient pathway, roles are established or changed to focus more closely on patient flow and rapid discharging, and patients are more robustly prepared for surgery to reduce length of stay.

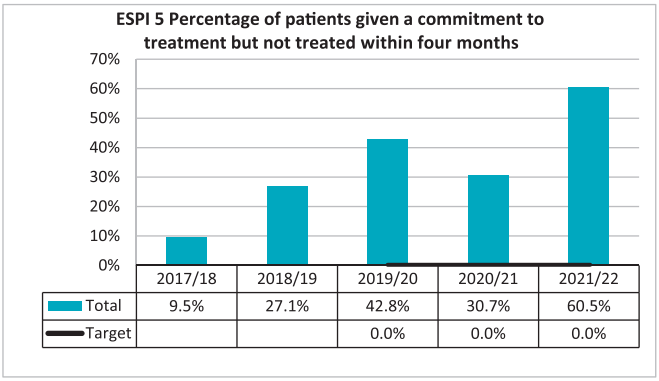


Data Source: National Booking Reporting System (NBRS)

ESPI 3 Percentage of patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)

Result **Achieved**

Taranaki DHB continues to achieve this target.

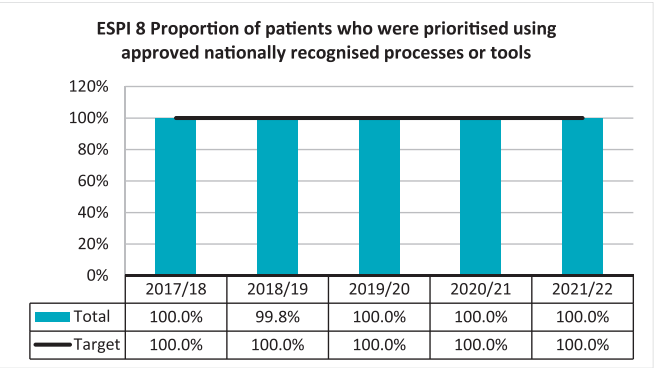


Data Source: National Booking Reporting System (NBRS)

ESPI 5 Percentage of patients given a commitment to treatment but not treated within four months

Result **Not Achieved**

ESPI 5 performance has deteriorated in 2021/22. This can be attributed to, in the earlier months, significant vacancy within the theatre team despite best efforts to recruit, coupled with reduced theatre productivity associated with safely managing patients with COVID-19 (i.e. infection control processes slowed theatre throughput). More recently, lack of bed availability due to very high occupancy associated with COVID-19, flu and other winter illnesses has resulted in theatre cancellations. Mitigations have included outsourcing where possible, a strong emphasis on recruiting, and trying to maximise current theatre productivity.



Data Source: National Booking Reporting System (NBRS)

ESPI 8 Proportion of patients who were prioritised using approved nationally recognised processes or tools

Result **Achieved**

Taranaki DHB uses all available nationally available processes or tools to facilitate prioritisation of patients requiring treatment.

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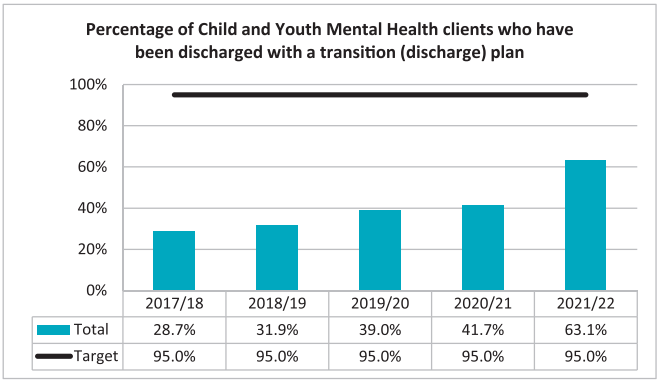
Improved health status for people with severe mental health illness

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

OUTPUT MEASURES



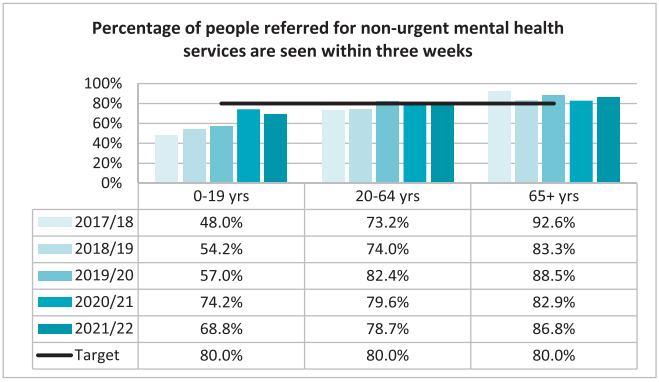
	2017/18	2018/19	2019/20	2020/21	2021/22
Total	28.7%	31.9%	39.0%	41.7%	63.1%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: Taranaki DHB mental health department records

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

Total **Not Achieved**

Improvement is being made but has been hampered with the level of vacancy currently with staff pulled into covering acute presentations.



	0-19 yrs	20-64 yrs	65+ yrs
2017/18	48.0%	73.2%	92.6%
2018/19	54.2%	74.0%	83.3%
2019/20	57.0%	82.4%	88.5%
2020/21	74.2%	79.6%	82.9%
2021/22	68.8%	78.7%	86.8%
Target	80.0%	80.0%	80.0%

Data Source: Programme for the Integration of Mental Health Data (PRIMHD). Desired outcome is below the target rate

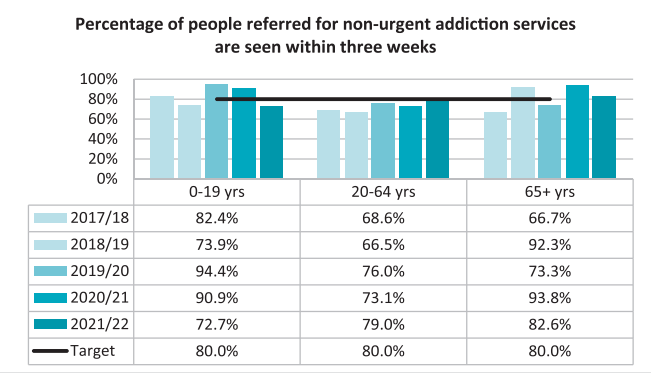
Percentage of people referred for non-urgent mental health services are seen within three weeks

0-19 yrs **Not Achieved**
20-64 yrs **Not Achieved**
65+ yrs **Achieved**

0-19yrs: Child and Adolescent services continue to see high referrals for acute needs and have been coping with a 40% vacancy rate for almost 6 months, hence a decline in performance seeing whai ora within three weeks.

20-64yrs: This age group was within 1.3% of achieving target.

65yrs+: Meeting KPI.



	0-19 yrs	20-64 yrs	65+ yrs
2017/18	82.4%	68.6%	66.7%
2018/19	73.9%	66.5%	92.3%
2019/20	94.4%	76.0%	73.3%
2020/21	90.9%	73.1%	93.8%
2021/22	72.7%	79.0%	82.6%
Target	80.0%	80.0%	80.0%

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

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

0-19 yrs **Not Achieved**
20-64 yrs **Not Achieved**
65+ yrs **Achieved**

0-19yrs: Dec 2021 our Youth AOD worker resigned and we have been unable to secure a replacement for this role as yet.

20-64yrs: This age group was within 1% of achieving target.

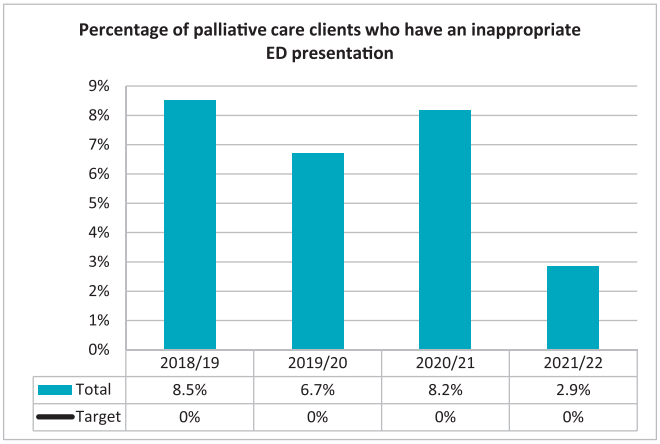
65yrs+: Meeting KPI.

0-19 yrs are referred to CAMHS (Child and Adolescents Mental Health Services) in the hospital and Tui Ora in the community. Also, there are community groups and agencies that provide child, youth and whanau support.

People with end stage conditions are supported

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

OUTPUT MEASURES



	2018/19	2019/20	2020/21	2021/22
Total	8.5%	6.7%	8.2%	2.9%
Target	0%	0%	0%	0%

Data Source: Taranaki Hospice

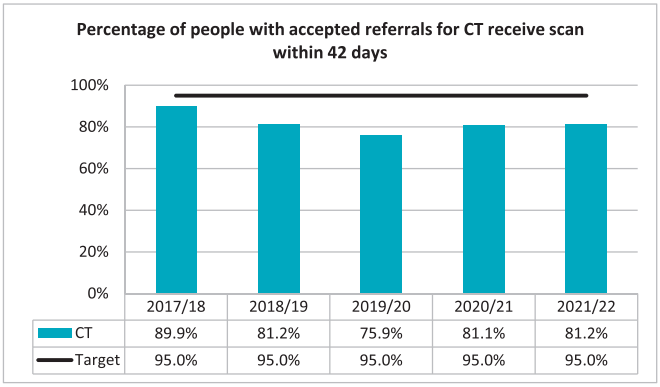
A reduction in the % of palliative care clients who have had an inappropriate Emergency Department (ED) presentation

Total **Not achieved**

There were a total of 140 ED presentations by patients registered with Hospice Taranaki in the 12 month period. This was less than the 208 who presented in the previous year. There were four presentations which were considered as inappropriate. The previous year, there had been 17. All patients are advised to ring the hospice service for advice before presenting to ED. This does not always happen. There were 2 admissions to hospital during the year where the hospice inpatient unit beds were full and the admission could not be managed.

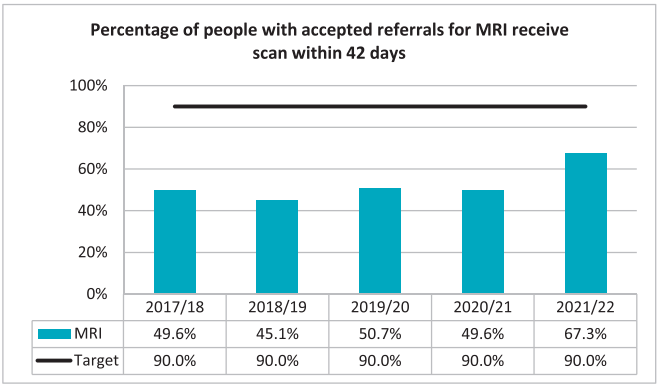
There is a higher number of patients registered with HTI in some months of this past year. The ED presentation schedule is reviewed by the clinical team each month and any trends are noted for discussion.

OUTPUT MEASURES



	2017/18	2018/19	2019/20	2020/21	2021/22
CT	89.9%	81.2%	75.9%	81.1%	81.2%
Target	95.0%	95.0%	95.0%	95.0%	95.0%

Data Source: Taranaki DHB



	2017/18	2018/19	2019/20	2020/21	2021/22
MRI	49.6%	45.1%	50.7%	49.6%	67.3%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

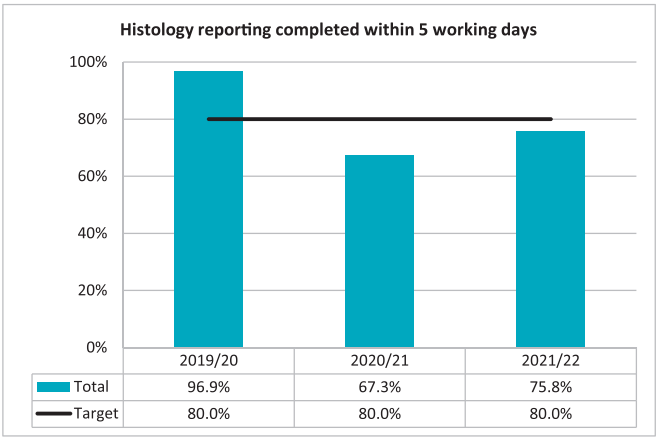
Data Source: Taranaki DHB

Improved wait times for diagnostic services - accepted referrals for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) within 42 days

CT **Not Achieved**

MRI **Not Achieved**

As with the previous year, we continue to experience rising referral rates for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI). Additionally, our current radiologist vacancy rate accounts for approximately one third of our budgeted FTE (we continue to actively recruit to these vacancies, exploring all options with our recruitment team). In order to respond to rising demands and provide timely services Taranaki DHB has undertaken outsourcing to our local community providers as well as extending hours on a voluntary basis. We have one CT machine which is well utilised with minimal downtime over the past year. Our MRI machine is around 20 years old and image acquisition rate on this machine is much slower than on modern machines (e.g., 50 minutes/scan versus 30 minutes/scan). We are currently undergoing procurement for early replacement of our MRI and CT machines as part of our new hospital build process with tentative installation dates for new equipment set for December 2021/January 2022. These upgrades will improve our service capacity. In the meantime, we are undertaking a significant service review including detailed productivity planning which will provide clear guidance on improvement processes for improving demand management including reviewing protocols, booking practices, rostering, and scheduling in order to maximize our available capacity.



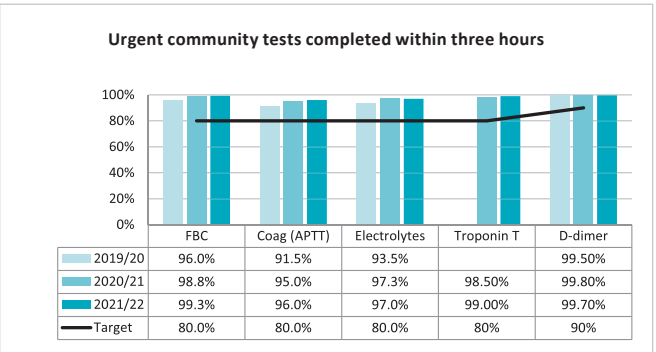
	2019/20	2020/21	2021/22
Total	96.9%	67.3%	75.8%
Target	80.0%	80.0%	80.0%

Data Source: Local contract Performance Monitoring

Histology reporting completed within five working days

Total **Not Achieved**

Histology reporting has largely been completed within the five working day target with results normally exceeding the 80% target. A significant decrease did occur for a period during 2021 as a lack of staff created pressure on timelines, this was remedied by bringing a locum in from Australia. This in itself was challenging as the COVID-19 pandemic made international travel difficult. A permanent long-term replacement has now been identified who will begin early in 2023.



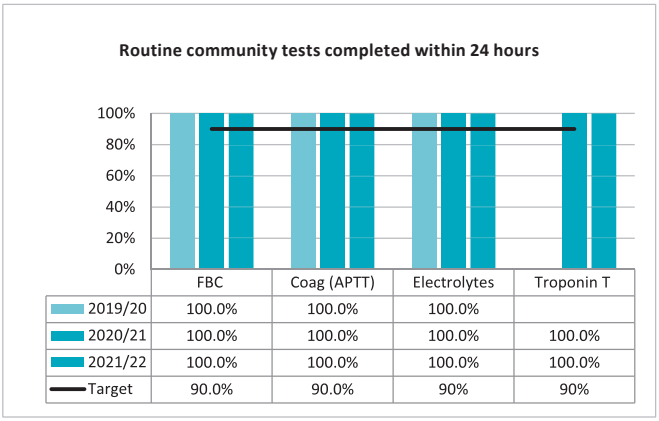
	FBC	Coag (APTT)	Electrolytes	Troponin T	D-dimer
2019/20	96.0%	91.5%	93.5%		99.50%
2020/21	98.8%	95.0%	97.3%	98.50%	99.80%
2021/22	99.3%	96.0%	97.0%	99.00%	99.70%
Target	80.0%	80.0%	80.0%	80%	90%

Data Source: Local contract Performance Monitoring

Urgent community tests completed within three hours

FBC	**Achieved**
Coag (APTT)	**Achieved**
Electrolytes	**Achieved**
Troponin T	**Achieved**
D-dimer	**Achieved**

Urgent community tests completed within three hours were consistently ahead of targets. D-dimer in particular performed at 100%, only dipping to 99% on one occasion with FBC performance almost as good sitting at between 95% and 99%. The gap in Troponin-T results in Q1 of 2020 was due to this being added a performance measure in Q1 2021.



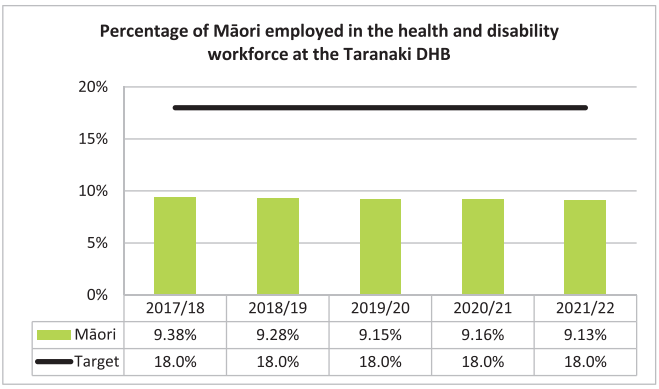
	FBC	Coag (APTT)	Electrolytes	Troponin T
2019/20	100.0%	100.0%	100.0%	
2020/21	100.0%	100.0%	100.0%	100.0%
2021/22	100.0%	100.0%	100.0%	100.0%
Target	90.0%	90.0%	90%	90%

Data Source: Local contract Performance Monitoring

Routine community tests completed within 24 hours

FBC	**Achieved**
Coag (APTT)	**Achieved**
Electrolytes	**Achieved**
Troponin T	**Achieved**

Exceptional performance has been seen for routine community laboratory tests with all milestones achieved at 100% levels (ahead of 90% targets). The gap in Troponin-T results in Q1 of 2020 was due to this being added a performance measure in Q1 2021.



	2017/18	2018/19	2019/20	2020/21	2021/22
Māori	9.38%	9.28%	9.15%	9.16%	9.13%
Target	18.0%	18.0%	18.0%	18.0%	18.0%

Data Source: Taranaki DHB HR system

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

Māori	**Not Achieved**

The Māori health workforce in Taranak DHB remained stable at around 9% of the total workforce, which remains significantly below the 18% target. In 2021 data indicates there were 208 people who identified as Māori employed at Taranaki DHB, and this figure has increased slightly to 225 currently. Introduction of new data collection and analysis revealed that within the previous six month period, a total of 23 people who identified as Māori commenced employment within the organisation, however it was also identified that 26 people who identified as Māori exited the organisation. Understanding this information is a priority and requires concentrated effort, as currently there is no consistent data capturing the reasons for these exits. Focus is being placed on monitoring recruitment and retention processes with the People and Capability team, including the introduction of processes to promote and facilitate exist interviews to enable insights. Te Pā Harakeke is also working with the ICT Team and the People and Capability team to develop a comprehensive Māori workforce data dashboard. This dashboard will provide data insights and will enable engagement with all Taranaki DHB employees who identify as Māori. Māori workforce hui are currently being planned. Relationships are being established between Te Pā Harakeke Māori Responsive Workforce and Research team and the People and Capability team to strengthen collective responsiveness in the People and Capability workstream of the organisation. Contract agreements have been renewed with Whakatipuranga Rima Rau to continue our partnered approach with Why Ora to the development of the Māori health workforce in Taranaki. The Why Ora programme supports Māori into the organisation, and a total of 9 Māori from the Why Ora programme were employed within Taranaki DHB between January 2022 – July 1 2022, including two first year Medical doctors.

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of 128,002, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[1]

1 www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[2] (HSU 2021 vs HSU 2020)

Year[3]	HSU 2021	HSU 2020
2020/2021	5.06%	5.31%
2021/2022	84.45%	88.52%
Total	**89.52%**	**93.83%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 89.52%, compared with 93.83% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Taranaki DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

	Primary course				
Year[4]	**Dose 1**	**Dose 2**	**Booster 1**	**Booster 2**	**Total[5]**
2020/21	9,790	5,188	0	0	14,978
2021/22	92,846	93,001	60,315	219	246,381
Total	**102,636**	**98,189**	**60,315**	**219**	**261,359**

By 30 June 2022, a total of 261,359 COVID-19 vaccinations had been administered, of which 94.3% were administered in 2021/22.

There are two similar, but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore, deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

2 Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.

3 Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

4 Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021 - 30 June 2022.

5 Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

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COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[6]

	Primary course				
Age group (years)[7]	**Dose 1**	**Dose 2**	**Booster 1**	**Booster 2**	**Total[8]**
0 to 11	5971	2853	0	0	8824
12 to 15	6765	6502	0	0	13267
16 to 19	5009	4963	1163	0	11135
20 to 24	5443	5388	2279	0	13110
25 to 29	5868	5790	2654	0	14312
30 to 34	6659	6636	3441	2	16738
35 to 39	6351	6385	3841	6	16583
40 to 44	6207	6253	4130	1	16591
45 to 49	6558	6648	4844	4	18054
50 to 54	6743	6838	5329	15	18925
55 to 59	6710	6919	5837	21	19487
60 to 64	6760	7053	6453	24	20290
65 to 69	5613	6267	5980	38	17898
70 to 74	4779	5565	5379	46	15769
75 to 79	3227	3876	3884	38	11025
80 to 84	2178	2642	2611	8	7439
85 to 89	1303	1538	1560	11	4412
90+	702	885	930	5	2522
Total	**92846**	**93001**	**60315**	**219**	**246381**

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

6 Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021 - 30 June 2022.

7 Age groupings in this table reflect the age of the person at the time of the vaccination being administered.

8 Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator. Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/22[9]

	Partial[11]		Primary course[12]		Booster course			
Age group[10] (years)	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
0 to 11	5006	24%	2441	12%	0	0%	0	0%
12 to 15	5841	80%	5179	71%	0	0%	0	0%
16 to 19	5576	92%	5493	91%	670	35%	0	0%
20 to 24	5504	84%	5441	83%	2211	39%	0	0%
25 to 29	5670	77%	5633	77%	2577	43%	0	0%
30 to 34	6591	79%	6597	79%	3329	48%	0	0%
35 to 39	6477	82%	6509	82%	3784	54%	0	0%
40 to 44	6173	82%	6226	82%	4023	61%	0	0%
45 to 49	6392	80%	6484	81%	4635	67%	0	0%
50 to 54	6811	83%	6936	84%	5319	72%	13	4%
55 to 59	6551	80%	6756	83%	5655	77%	25	6%
60 to 64	6961	84%	7234	88%	6473	83%	20	4%
65 to 69	5925	82%	6473	90%	6128	89%	35	9%
70 to 74	4838	79%	5569	91%	5374	92%	50	19%
75 to 79	3650	84%	4340	100%	4218	94%	40	20%
80 to 84	2344	81%	2836	98%	2789	96%	9	8%
85 to 89	1397	81%	1676	97%	1668	99%	12	20%
90+	843	80%	1038	99%	1054	102%	5	11%
Total	**92550**	**72%**	**92861**	**73%**	**59907**	**69%**	**209**	**9%**

9 Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

10 Age groupings in this table reflect age of the persons at end of financial year.

11 Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).

12 Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

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COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[13] administered by ethnicity[14] (1 July 2021 – 30 June 2022)

	Primary course				
Ethnicity (Note 1, 2)	**Dose 1**	**Dose 2**	**Booster 1**	**Booster 2**	**Total[5]**
Asian	4398	4297	3044	8	11747
European/other	71780	72839	49983	182	194784
Māori	14826	14032	6142	22	35022
Pacific peoples	1245	1226	652	2	3125
Unknown	597	607	494	5	1703
Total	**92846**	**93001**	**60315**	**219**	**246381**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

13 This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.

14 Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[15]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed primary course (12+)	Completed primary course (12+) (% eligible)	Received first booster (18+)	Received first booster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
Asian	3932	82%	4084	85%	3031	73%	3	5%
Māori	13725	80%	13608	79%	6109	51%	21	8%
European/ other	68090	82%	70838	85%	49625	73%	178	9%
Pacific peoples	1146	81%	1188	84%	645	59%	2	17%
Unknown	651	87%	702	94%	497	62%	5	22%
Total	**87544**	**82%**	**90420**	**84%**	**59907**	**69%**	**209**	**9%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% HSU 2021)	Completed primary course (12+)	Completed primary course (12+) (% HSU 2021)	Received first booster (18+)	Received first booster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
Asian	4595	96%	4545	95%	3031	73%	3	5%
Māori	14847	87%	14234	83%	6109	51%	21	8%
European/ other	76081	92%	74950	90%	49625	73%	178	9%
Pacific peoples	1314	93%	1284	91%	645	59%	2	17%
Unknown	842	112%	828	111%	497	62%	5	22%
Total	**97679**	**91%**	**95841**	**90%**	**59907**	**69%**	**209**	**9%**

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.
Note 2 Partially Vaccinated counted for 12+ years old (age as at 30 June 2022)
Completed Primary Course counted for 12+ years old (age as at 30 June 2022)
Rec'd First Booster counted for 18+ years old (age as at 30 June 2022)
Rec'd Second Booster counted for 18+ years old (age as at 30 June 2022)
50+ age determined as at 30 June 2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30 June 2022

15 Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

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Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ:[16]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
   a. National population estimates (produced quarterly)
   b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
   a. Official national and subnational projections
   b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'[17]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

16 www.stats.govt.nz/methods/population-statistics-user-guide.

17 More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 127775 health service users in the HSU 2021. This is an increase of 4693 people from the HSU 2020 (an approximate 3.8% increase), and 1200 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.[18]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	23439	26600	3161
Pacific peoples	1820	1840	20
Asian	6213	6470	257
European/other	95491	91700	-3791
Unknown	812	0	-812
Total (Note 1)	**127775**	**126600**	**-1175**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison.

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[19]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	22303	25800	3497
Pacific peoples	1691	1790	99
Asian	5308	6390	1082
European/other	93285	91300	-1985
Unknown	495	0	-495
Total (Note 1)	**123082**	**125400**	**2318**

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

18 HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

19 HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

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COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[20] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Taranaki DHB by age group at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	0
50 to 59	2
60 to 69	5
70 to 79	8
80 to 89	10
90+	12
Total	**37**

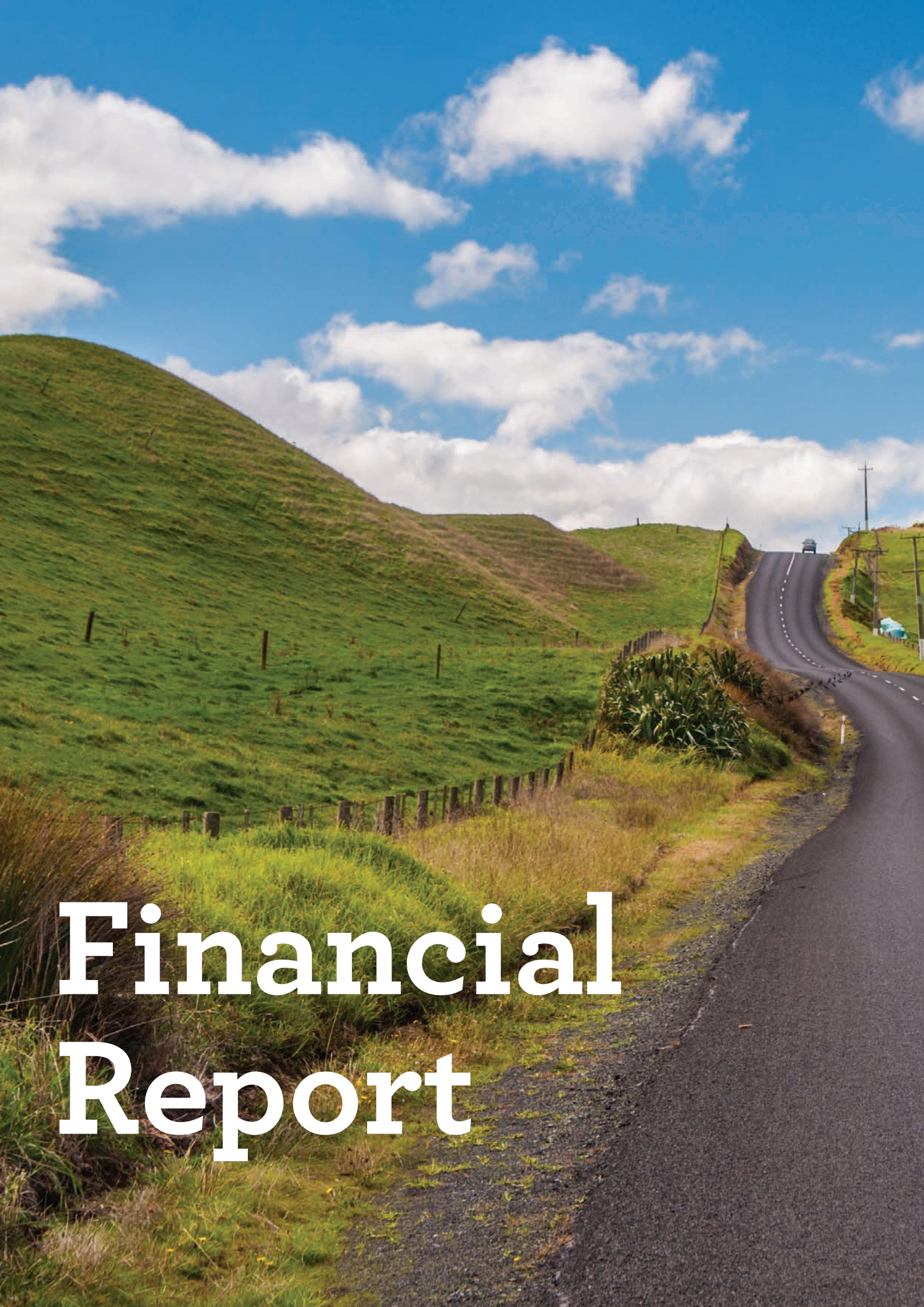
COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Taranaki DHB by the ethnicity of the individual (as at 30 June 2022).

Asian	0
European/other	30
Māori	6
Pacific peoples	1
Unknown[21]	0
Total	**37**

20 EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

21 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.



Financial Report

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Taranaki DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Taranaki District Health Board's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Taranaki DHB under section 19A of the Public Finance Act.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Taranaki District Health Board for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson
Acting Chair
28 April 2023

Hon Amy Adams
Board member
28 April 2023

	Notes	Actual June 2022 $000	Budget June 2022 Unaudited $000	Actual June 2021 $000
Revenue	1	529,820	468,096	460,411
Other income	2	825	2,000	2,346
Total revenue		530,645	470,096	462,757
Employee benefit costs	3	231,959	199,049	194,623
Depreciation expense	12	16,358	17,404	15,561
Outsourced services		23,513	11,473	16,082
Clinical supplies		44,797	39,313	38,847
Infrastructure and non-clinical expenses		25,265	24,267	17,618
Payments to non-health board providers		218,581	206,105	194,105
Other expenses	4	1,579	975	1,231
Capital charge	5	9,723	7,395	7,535
Financing costs	6	-	-	32
Total expenses		571,775	505,981	485,634
(Loss) before share of associates		(41,130)	(35,885)	(22,877)
Share of surplus/(loss) of associates	11(c)	(118)	-	115
(Loss) after surplus of associates		(41,248)	(35,885)	(22,762)
Other comprehensive revenue and expense				
Revaluation of land and buildings		-	-	15,561
Total other comprehensive revenue and expense		-	-	15,561
Total comprehensive revenue and expense		(41,248)	(35,885)	(7,201)

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

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	Note	Public Equity	Accumulated Revenue and Expense	Asset Revaluation Reserve	Trust Fund Reserve	Total
		$000	$000	$000	$000	$000
At 30 June 2020		123,972	(76,157)	116,541	797	165,153
Comprehensive revenue and expense						
Deficit support from Crown	25	32,968	-	-	-	32,968
(Loss) for the year		-	(22,762)	-	-	(22,762)
Change in asset revaluation reserve		-	-	15,561	-	15,561
Movements in restricted funds		-	85	-	(85)	-
		32,968	(22,677)	15,561	(85)	25,767
Transactions with the Crown						
Equity repaid to the Crown	25	(959)	-	-	-	(959)
		(959)	-	-	-	(959)
At 30 June 2021		155,981	(98,834)	132,102	712	189,961
Comprehensive revenue and expense						
Equity injections for Capital	25	69,119	-	-	-	69,119
Deficit support from Crown	25	30,000	-	-	-	30,000
(Loss) for the year		-	(41,248)	-	-	(41,248)
Change in asset revaluation reserve		-	-	-	-	-
Movements in restricted funds		-	43	-	12	55
		99,119	(41,205)	-	12	57,926
Transactions with the Crown						
Equity repaid to the Crown	25	(958)	-	-	-	(958)
		(958)	-	-	-	(958)
At 30 June 2022		254,142	(140,039)	132,102	724	246,929

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

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	Notes	Actual June 2022 $000	Budget June 2022 Unaudited $000	Actual June 2021 $000
ASSETS				
Current assets				
Cash and cash equivalents	7	8,403	442	401
Trade and other receivables	8	30,671	19,273	19,595
Inventories	9	4,891	4,091	4,132
Total current assets		43,965	23,806	24,128
Non-current assets				
Investments in associates	11	1,629	1,817	1,884
Other financial assets	10	1,018	792	192
Property, plant and equipment	12	310,718	337,944	253,930
Intangible assets	13	520	1,208	1,289
Restricted assets & trust funds	14	724	712	712
Total non-current assets		314,609	342,473	258,007
TOTAL ASSETS		358,574	366,279	282,135
LIABILITIES				
Current liabilities				
Cash and cash equivalents	7	-	6,279	5,764
Trade and other payables	15	31,105	30,239	29,982
Employee benefits	16	78,943	56,799	55,020
Provisions	17	133	33	33
Total Current Liabilities		110,181	93,350	90,799
Non current liability				
Employee benefits	16	1,464	1,375	1,375
Total non current liability		1,464	1,375	1,375
TOTAL LIABILITIES		111,645	94,725	92,174
NET ASSETS		246,929	271,554	189,961
EQUITY				
Public equity		254,142	273,460	155,981
Retained (losses)		(140,039)	(134,719)	(98,834)
Asset revaluation reserve		132,102	132,101	132,102
Trust fund reserve	14	724	712	712
TOTAL EQUITY		246,929	271,554	189,961

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

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	Note	Actual June 2022 $000	Budget June 2022 Unaudited $000	Actual June 2021 $000
CASHFLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Government and Public		508,003	470,364	461,049
Interest Received		271	15	35
GST (Net)		2,143	2,342	-
		510,417	472,721	461,084
Cash was disbursed to:				
Payments to Suppliers		303,323	284,197	260,261
Payments to Employees		207,849	197,195	182,906
Capital Charge Paid		9,723	7,395	7,535
Interest Paid		-	15	32
GST (Net)		-	-	1,239
		520,895	488,802	451,973
Net Cash Inflow/(Outflow) from Operating Activities	18	(10,478)	(16,081)	9,111
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Dividends Received		2	-	2
Proceeds from Restricted Assets		-	-	84
Proceeds from Sale of Property, Plant & Equipment		-	-	348
		2	-	434
Cash was applied to:				
Purchase of Property, Plant & Equipment		73,133	101,419	34,349
Investments		772	452	134
Purchase of Intangible Assets		-	-	154
Restricted Assets		12	-	-
		73,917	101,871	34,637
Net Cash Outflow from Investing Activities		(73,915)	(101,871)	(34,203)
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Capital equity injections from Crown		69,118	83,437	32,968
Deficit support received from Crown		30,000	35,000	-
		99,118	118,437	32,968
Cash was applied to:				
Repayment of Equity		959	959	959
		959	959	959
Net Cash Inflow from Financing Activities		98,159	117,478	32,009
Net (Decrease)/Increase in Cash Held		13,766	(474)	6,917
Cash and cash equivalents at beginning of year		(5,363)	(5,363)	(12,280)
Cash and cash equivalents at end of year		8,403	(5,837)	(5,363)

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

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Significant accounting policies for the year ended 30 June 2022

(a) Reporting entity

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

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

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

The Taranaki District Health Board financial statements comprise those of Taranaki District Health Board, a 16.67% shareholding in Allied Laundry Services Limited and a 20% shareholding in HealthShare Limited. These associated entities are included as an activity as Taranaki District Health Board has significant influence in those entities.

Taranaki District Health Board operates in Taranaki. It has three key roles, namely (i) Planning to determine the health needs of Taranaki and how these can be met, (ii) Funding organisations and individuals to provide specific health services and (iii) Providing specific health services to the Taranaki community.

The financial statements of Taranaki District Health Board are for the year ended 30 June 2022. The financial statements were authorised for issue by the Board on 28 April 2023

(b) Statement of compliance and basis of preparation

The financial statements have been prepared on a disestablishment basis, and the accounting policies have been applied consistently throughout the period.

The financial statements have been prepared in accordance with and comply with the Public Benefit Entity International Public sector Accounting Standards (PBE IPSAS) (Tier 1).

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System review.

The reforms wil replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services.

The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Taranaki District Health Board's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

(i) Operating and Cash flow forecast

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2022/23 financial year.

(ii) COVID-19

During the financial year, Taranaki District Health Board's operations have been significantly impacted by COVID-19.

August 2021, the DHB moved into Alert Level 4. In September the DHB moved to Alert Level 3, and then Alert Level 2. In December 2021 all of New Zealand moved to the COVID-19 Protection Framework and TDHB operated at the Orange setting for the remainder of the year.

While the DHB has received funding for cost directly related to the COVID-19 response, COVID-19 has caused inevitable disruption to the operational services of the DHB. It is difficult to determine the indirect operational and financial impact of COVID-19 during the financial year, or the longer-term impact which may have a material impact on the DHB.

Taranaki District Health Board will require continued monthly funding to pay for costs associated with the response, establishment and implementation of COVID-19 related programs.

Taranaki District Health Board have assessed the impact of the novel coronavirus as part of its impairment testing of assets on the Statement of Financial Position at 30 June 2022. Whilst the impact of COVID-19 has not had a significant financial effect on asset values it has had an impact to the services the District Health Board has been able to provide the local community. COVID-19 has caused inevitable disruption and delays in services which will have longer term consequences.

Government funding

The MOH provided funding of $37.2m to assist with the direct costs associated with the COVID-19 response. This included funding distributed through the DHB to Primary Health Organisations, pharmacies and aged care providers.

Personnel expenses
Personnel expenses have increased as temporary and casual staff were recruited to assist with the COVID-19 response. Further, we redeployed parts of the existing workforce into the planning and resourcing of a response to the outbreaks, including vaccinations, testing, awareness and patient care. Parts of the workforce not specifically redeployed to the COVID-19 response were still impacted, with additional duties, administration, reporting and responsibility incorporated into their 'business-as-usual' roles as a result of COVID-19. All areas of the workforce were impacted by staff becoming infected with COVID-19 and unable to work, preventative measures and restrictions due to lockdowns, quarantine and travel restrictions.

Other expenses
Supply chain issues resulting from global lockdowns have affected both the cost and availability of goods directly related to the COVID-19 response (e.g. PPE) but has also had a wider impact on other clinical supplies, building costs and consumables. The capacity of outsourced clinical services and the ability to recruit locums was also restricted due to capacity constraints and travel restrictions, having an immediate impact but also a future one as procedures were inevitably delayed. The COVID-19 response also resulted in an increase in administration expenses, including leasing additional premises, hygienic and sanitation supplies, pharmaceutical, security management, advertising, and communications.

Changes in accounting policies
There have been no changes in accounting policies during the financial year apart from the application of IFRIC interpretation on software-as-a-service (SaaS).

IFRIC released an agenda decision in April 2021 in relation to accounting for configuration and customisation costs incurred in implementing SaaS arrangements. SaaS arrangements are service contracts providing the DHB with the right to access the cloud provider's application software over the contract period. The agenda decision clarifies how current accounting standards should be applied to these types of arrangements.

The DHB's accounting policy has historically been to capitalise costs directly attributable to the configuration and customisation of SaaS arrangements as intangible assets in the Statement of Financial Position. Following the adoption of the above IFRIC agenda decision, current SaaS arrangements were identified and assessed to determine if the DHB has control of the software. For those arrangements where the DHB does not have control of the developed software, the configuration and customisation costs previously capitalised have been derecognised and prospectively these costs are now recognised as operating expenses when the services are received. Amounts paid to the supplier in advance of the commencement of the service period, including for configuration or customisation that are not distinct from the underlying SaaS, are treated as a prepayment. The impact on prior year has been considered to be not material and restatement of 2021 financial statements has not been made.

The financial statements have been prepared on a historical cost basis, with the exception of land and buildings and certain investments measured at fair value.

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

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

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

Estimation of employee entitlement accruals
The liability relating to back pay and long term employee benefits (long service leave, gratuities and sabbatical leave) is based on a number of assumptions in relation to the estimated length of service, the timing of release of the obligation and the rate at which the obligation will be paid to be applied in determining the present value. If any of these factors changed significantly, the actual outcome could be materially different to the estimate provided in the financial statements. The carrying value of the accruals has been disclosed in note 16.

Compliance with Holidays Act 2003
Many public and private sector entities, including Taranaki District Health Board, are continuing to investigate historic underpayment of holiday entitlements. For employers such as the Taranaki District Health Board that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

District Health Boards have taken a national approach and over the past few years the DHB's have been working with key stakeholders to define a baseline interpretation which is in place for the health sector. In December 2022, there were some remaining issues which was being resolved through legal advice. In 2022 this interpretation has been used by each DHB to systematically assess their liability. Taranaki District Health Board has included an estimated liability. Refer to note 16 which outlines the detail associated the compliance with the Holidays Act 2003.

Fair value of buildings
Taranaki District Health Board revalues land and buildings on either a five year cycle or when there is a material change between the independent valuation and the carrying value of the land and buildings. The independent valuation also determines the remaining life of buildings, and therefore the annual depreciation cost in future years. A fair value assessment was performed to ensure there is no material movement in the current year. Land and buiildings were last revalued at 30 June 2021.

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Useful lives of property, plant and equipment
Taranaki District Health Board reviews the estimated useful lives of property, plant and equipment at the end of each annual reporting period. In addition to this, at least every five years the land and buildings are revalued by an independent valuer, estimating the remaining life of these assets thus setting the annual depreciation to reflect this. Details of the above can be found in note 12.

(c) Basis of consolidation

Subsidiaries
Taranaki District Health Board did not have any subsidiaries included in their financial statements for the year ended 30 June 2022.

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

Allied Laundry Services Limited 16.67% held
HealthShare Limited 20% held

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

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

Under the equity method, investments in associates are carried in the statement of financial position at cost plus post-acquisition changes in the share of net assets of the associates. Goodwill relating to an associate is included in the carrying amount of the investment and is not amortised. After application of the equity method, Taranaki District Health Board determines whether it is necessary to recognise any impairment loss with respect to Taranaki District Health Board's net investment in associates. Goodwill included in the carrying amount of the investment in associate is not tested separately; rather the entire carrying amount of the investment is tested for impairment as a single asset. If an impairment is recognised, the amount is not allocated to the goodwill of the associate.

Taranaki District Health Board's share of associate's profits or losses is recognised in comprehensive revenue and expense, and its share of movements in other comprehensive income is recognised in other comprehensive income. The cumulative movements are adjusted against the carrying amount of the investment. Dividends receivable from associates are recognised in the parent entity's statement of comprehensive revenue and expense as a component of other income.

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

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

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

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

Budget figures have not been audited.

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

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

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

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

(iv) Interest received
Revenue is recognised using the effective interest method.

(v) Dividends received
Revenue is recognised when the right to receive payment has been established.

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

(vii) Rental revenue
Revenue is recognised in the income statement on a straight-line basis over the term of the lease.

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

(f) Cash and cash equivalents
Cash and cash equivalents in the statement of financial position comprise cash in hand, a demand fund held with NZ Health Partnerships Limited (NZHPL), cash at bank, deposits held with an original maturity of three months or less.

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

(g) Trade and other receivables
Trade and other receivables are stated at amortised cost.

Trade receivables, which generally have 30 day terms, are recognised initially at fair value and subsequently measured at amortised cost less expected credit losses.

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

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

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

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

All inventory purchased was acquired through exchange contracts.

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

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

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

For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy (i) quoted market price (level 1), valuation technique using observable inputs (level 2), or (iii) valuation technique with significant non-observable inputs (level 3). Taranaki District Health Board does not have any financial instruments that are recognised at fair value in the statement of financial position.

Taranaki District Health Board classifies its financial assets at amortised cost. Management determines the classification of its investments at initial recognition and re-evaluates this designation at every reporting date.

(j) Property, Plant and Equipment

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

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

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Land and buildings revalued
Land and buildings were revalued as at 30 June 2021 by an independent valuer on the basis of fair value. Changes in valuations are transferred to an asset revaluation reserve for that class of asset. Where such transfer results in a debit balance in the revaluation reserve the deficit is transferred to the statement of comprehensive revenue and expense. Any subsequent revaluation gains are written back through the income statement only to the extent of past deficits written off. Land and buildings are revalued every five years, unless the value of land and buildings materially alter prior to that date.

Additions
The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable the future economic benefits or service potential associated with the item will flow to Taranaki District Health Board and the cost of the item can be measured reliably. In most instances, an item of property, plant and equipment is recognised at its cost.

Subsequent costs
Subsequent costs are added to the carrying value of an item of property, plant and equipment when that cost is incurred if it is probable that the future economic benefits embodied with the item will flow to Taranaki District Health Board and the cost of the item can be measured reliably. All other costs are recognised in the statement of comprehensive revenue and expense, and expensed as incurred.

Disposals
An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal. Any gain or loss arising on derecognition of the asset (calculated as the difference between the net disposal proceeds and the carrying amount of the asset) is included in profit or loss in the year the asset is derecognised.

Depreciation
Depreciation is calculated on a straight line basis on all tangible property, plant and equipment other than freehold land, at rates which will write off the cost or valuation of the assets, less estimated residual values, over their estimated useful lives as follows:

Capitalised leases are depreciated over the shorter of the estimated life of the asset and the lease term if there is no reasonable certainty that Taranaki District Health Board will obtain ownership by the end of the lease term.

Class of Asset	Estimated life	Depreciation rate
Land	not depreciated	n/a
Buildings	4 to 100 years	1-25%
Plant and equipment	2 to 18 years	2-50%
Motor vehicles	3 to 10 years	10-33.3%

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

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

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

(k) Intangible Assets

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

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

(l) Finance Procurement Supply Chain, including Finance Procurement and Information Management System
The Finance Procurement Supply Chain (FPSC), which includes the Finance Procurement and Information Management System (FPIM), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Taranaki District Health Board holds an asset at cost of capital invested by Taranaki District Health Board in the FPSC programme. This investment represents the right to access the FPSC assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the oncharging of depreciation and amortisation on the assets to the DHBs will be used, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually. Refer to note 13 for details of any amortisation or impairment in the last 2 financial years.

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

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

(n) Operating Leases

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

(o) Trade and Other Payables

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

All trade and other payables are exchange transactions.

(p) Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Public equity
- Accumulated revenue and expenses
- Asset revaluation reserves; and
- Trust fund reserves

Public Equity

Public equity is the obtained from the Crown which includes either injecting equity for specific funding (including capital funding or deficit support) or requiring the DHB to repay equity as specified by the Crown.

Accumulated revenue and expenses

Accumulated revenue and expenses is the result of the surplus or deficit of the DHB.

Asset revaluation reserve

These reserves relate to the revaluation of property, plant, and equipment to fair value.

Trust fund reserves

This reserve records the unspent amount of restricted donations and bequests provided to the DHB. The restrictions generally specify how the donations and bequests are required to be spent in providing specified deliverables of the bequest. The receipt of, and investment revenue earned on, trust funds is recognised as revenue and then transferred to the trust funds' reserve from accumulated revenue and expenses. Application of trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated revenue and expenses from the trust funds' reserve.

(q) Employee Leave Benefits

Short-term benefits

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

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

Long-term benefits

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

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

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

(r) Provisions

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

ACC Partnership Program

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

(s) Income Tax

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

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(t) Goods and Services Tax (GST)

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

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

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

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

Amendment to PBE IPSAS 2 Cash Flow Statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment did not result in additional disclosures.

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

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has assessed that there will be little change as a result of adopting the new standard, as the requirements are similar to those contained in PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

1 REVENUE

	2022 $000	2021 $000
Health and disability services (Crown appropriation revenue)*	509,415	441,191
ACC revenue	8,834	8,170
Inter District Patient Inflows	6,906	6,148
Interest received	271	35
Dividends received	2	59
Bad debts recovered	3	6
Other revenue	4,389	4,802
	529,820	460,411

*Performance against this appropriation is reported in the Statement of Performance on pages 32-63. The appropriation revenue received by Taranaki District Health Board equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act.

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

	2022 $000	2021 $000
Non-exchange transactions	512,340	444,333
Exchange transactions	17,480	16,078
	529,820	460,411

2 OTHER INCOME

	2022 $000	2021 $000
Donations and bequests received	825	2,314
Gain on sale of property, plant and equipment	-	32
	825	2,346

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

	2022 $000	2021 $000
Non-exchange transactions	825	2,314
Exchange transactions	-	32
	825	2,346

3 EMPLOYEE BENEFIT COSTS

	2022 $000	2021 $000
Wages and salaries	205,576	179,497
Contributions to defined contribution schemes	1,719	2,300
Increase in holiday pay act 2003 provision	11,800	6,903
Increase in employee benefits provisions	12,864	5,923
	231,959	194,623

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4 OTHER EXPENSES

	2022 $000	2021 $000
Impairment for credit losses on receivables	36	121
Loss on sale of property, plant and equipment	11	-
Audit fees - Deloitte Limited (for the audit of the annual financial statements)	245	199
Audit fees - Deloitte Limited (for the overrun of the 2021 audit of the annual financial statements)	20	-
Audit fees - ACC Accreditation Audit	6	6
Board and Advisory members fees	333	332
Operating lease expenses	928	573
	1,579	1,231

5 CAPITAL CHARGE

District Health Boards are required to pay a capital charge to the Crown based on the greater of its actual or budgeted closing equity at year end, less adjustments for donated assets. The capital charge rate for the period ended 30 June 2022 was 5% (2021: 5%).

6 FINANCING COSTS

	2022 $000	2021 $000
Interest - NZ Health Partnerships Limited	-	32
	-	32

7 CASH AND CASH EQUIVALENTS

	2022 $000	2021 $000
Cash at bank and in hand	5	401
Demand funds with NZ Health Partnerships Limited	8,398	(5,764)
Cash and cash equivalents	8,403	(5,363)
Made up of:		
Asset	8,403	401
Liability	-	(5,764)
	8,403	(5,363)

Cash at bank earns interest at floating rates based on daily bank deposit rates. The carrying amounts of cash and cash equivalents represent fair value.

Working Capital Facility
Taranaki District Health Board is party to the "DHB Treasury Services Agreement" between New Zealand Health Partnerships Limited (NZHP) and the participating DHB's. The agreement enables NZHP to sweep DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the on-call interest rate received by NZHPL plus an administrative margin. The maximum working capital facility limit for Taranaki District Health Board at 30 June 2022 is $ 22.5m (2021: $ 20.9m).

8 TRADE AND OTHER RECEIVABLES

	2022	2021
	$000	$000
Ministry of Health	18,930	9,943
GST Refund Due	-	987
Due from associates	365	195
Due from non-related parties	9,617	7,161
Prepayments	1,838	1,485
	30,750	19,771
Allowance for credit loss (a)	(79)	(176)
Carrying amount of trade and other receivables	30,671	19,595

(a) Allowance for Credit Loss

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

30 June 2022

	Receivable days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	0.0%	32.0%	
Gross carrying amount ($000)	30,082	328	93	247	30,750
Lifetime expected credit loss ($000)	-	-	-	79	79

30 June 2021

	Receivable days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	Total
Expected credit loss rate	0.0%	0.0%	0.2%	61.4%	
Gross carrying amount ($000)	18,771	64	651	285	19,771
Lifetime expected credit loss ($000)	-	-	1	175	176

	2022	2021
	$000	$000
Allowance for credit losses as at 1 July	176	79
Increase in loss allowance made during the year	36	121
Receivables written off during the year	(133)	(24)
	79	176

	2022	2021
	$000	$000
Total non commercial debt	145	318
Non commercial debt with no expected credit loss	66	142

Non-commercial debt relates to amounts owing from individuals, rather than commercial entities.

Other balances within trade and other receivables do not contain impaired assets and are not past due. It is expected that these other balances will be received when due.

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(b) Receivables from exchange and non-exchange transactions

	2022	2021
	$000	$000
Non-exchange transactions	18,930	9,943
Exchange transactions	11,741	9,652
	30,671	19,595

Bulk funding received from the Ministry of Health is received in the month it relates to.

(c) Related Party Receivables

For specific amounts owing from related parties, including associate companies refer to note 20.

(d) Credit Risk and Effective Interest Rate Risk

Details regarding the credit risk and effective interest rate of current receivables is disclosed in note 22.

9 INVENTORIES

	2022	2021
	$000	$000
Pharmaceuticals	713	683
Surgical and Medical Supplies	2,812	2,355
Other Supplies	1,366	1,094
	4,891	4,132

Inventory recognised as an expense for the year ended 30 June 2022 totalled $ 30.368m (2021: $ 33.716m)

The write-down of inventories held for distribution amounted to $0.119m (2021 $0.164m). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities.

10 OTHER FINANCIAL ASSETS

	2022	2021
	$000	$000
Non-current portion		
Shares in CDC Pharmaceuticals Limited	56	56
Retentions held in Trust	962	136
	1,018	192

The retentions deducted from progress claims on Project Maunga stage 2 are held by Govett Quilliam, Taranaki District Health Board's solicitors trust account

11 INVESTMENT IN ASSOCIATE COMPANIES

	2022	2021
(a) Investment details	$000	$000
Allied Laundry Services Limited unlisted ordinary shares	1,150	1,150
Allied Laundry Services Limited Share of Retained Earnings	303	199
HealthShare Limited unlisted ordinary shares	-	-
HealthShare Limited Share of Retained Earnings	176	535
	1,629	1,884

Details of each Associate Company are as follows:	**Balance date**	**Interest held at 30 June 2022**	**Interest held at 30 June 2021**
HealthShare Limited	30 June	20%	20%

HealthShare Limited is a limited liability company registered in New Zealand. It is an unlisted company, and therefore there are no published market prices for this investment.

HealthShare Limited provides contract processing, auditing services and regional initiatives for the 5 Midland Region District Health Boards.

Allied Laundry Services Limited	30 June	16.67%	16.67%

Allied Laundry Services Limited is a limited liability company registered in New Zealand. It is an unlisted company, therefore there are no published market prices for this investment.

Allied Laundry Services Limited principal activity is the provision of laundry services.

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

Summarised financial information - for the year ended 30 June 2022:	**Assets**	**Liabilities**	**Equity**	**Revenues**	**Profit**
	$000	$000	$000	$000	$000
Allied Laundry Services Limited	13,539	4,839	8,700	13,776	295
HealthShare Limited	34,561	32,995	1,566	20,451	(1,800)

Summarised financial information - for the year ended 30 June 2021:	**Assets**	**Liabilities**	**Equity**	**Revenues**	**Profit**
	$000	$000	$000	$000	$000
Allied Laundry Services Limited	13,017	4,612	8,405	13,087	656
HealthShare Limited	37,274	33,909	3,365	21,352	1,205

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

This is based on an investment in HealthShare Limited of 20% (2021: 20%) and Allied Laundry Services Limited of 16.67% (2021: 16.67%)

	2022	2021
	$000	$000
Balance at 1 July	1,884	1,643
Share of total recognised revenues and expenses	(118)	115
Share of impairment	(137)	-
Dividends accrued per shareholders agreement not declared or paid	-	126
Balance at 30 June	1,629	1,884

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

12 PROPERTY, PLANT AND EQUIPMENT

	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Work in Progress	Total
	$000	$000	$000	$000	$000	$000
Year ended 30 June 2021						
Cost/revaluation 30 June 2021	17,335	160,799	117,781	3,235	56,975	356,125
Accumulated depreciation 30 June 2021	-	-	(100,226)	(1,969)	-	(102,195)
Carrying amount 30 June 2021	17,335	160,799	17,555	1,266	56,975	253,930
Additions	-	-	-	-	73,149	73,149
Work in progress capitalised	-	520	15,866	110	(16,496)	-
Revaluations	-	-	-	-	-	-
Disposals	-	(2)	(1)	-	-	(3)
Depreciation	-	(8,055)	(8,081)	(222)	-	(16,358)
At 30 June 2022 net of accumulated depreciation	17,335	153,262	25,339	1,154	113,628	310,718
At 30 June 2022						
Cost or fair value	17,335	161,317	132,461	3,346	113,628	428,087
Accumulated depreciation		(8,055)	(107,122)	(2,192)	-	(117,369)
	17,335	153,262	25,339	1,154	113,628	310,718

	Freehold Land	Freehold Buildings	Plant and Equipment	Motor Vehicles	Work in Progress	Total
	$000	$000	$000	$000	$000	$000
Year ended 30 June 2020						
Cost/revaluation 30 June 2020	13,809	169,743	115,025	3,330	29,634	331,541
Accumulated depreciation 30 June 2020	-	(15,911)	(93,825)	(1,910)	-	(111,646)
Carrying amount 30 June 2020	13,809	153,832	21,200	1,420	29,634	219,895
Additions	-	-	-	-	34,349	34,349
Work in progress capitalised	-	3,329	3,604	75	(7,008)	-
Revaluations	3,526	12,035	-	-	-	15,561
Disposals	-	(313)	(1)	-	-	(314)
Depreciation	-	(8,084)	(7,248)	(229)	-	(15,561)
At 30 June 2021 net of accumulated depreciation	17,335	160,799	17,555	1,266	56,975	253,930
At 30 June 2021						
Cost or fair value	17,335	160,799	117,781	3,235	56,975	356,125
Accumulated depreciation	-	-	(100,226)	(1,969)	-	(102,195)
	17,335	160,799	17,555	1,266	56,975	253,930

In the year end 30 June 2022, there are no claims (2021: $Nil) outstanding which relates to completed remedial work.

Restrictions

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

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

Valuation

Land and buildings were independently valued as at 30th June 2021 by Mike Drew BBS (VPM) ANZIV, MPINZ, registered valuer Telfer Young (Taranaki) Limited. There were no revaluations at 30 june 2022 as a fair value assessment indicated the carrying value approximated the fair value.

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

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

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

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

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

Impairment

The assessment of assets indicated no impairment for the year ended 30 June 2022 (2021: Nil).

13 INTANGIBLE ASSETS

	ePharmacy Licence	Shares in NZ HPL	Total
	$000	$000	$000
Year ended 30 June 2022			
Carrying amount 30 June 2021	89	1,200	1,289
Transfer to prepayments and Property, plant and equipment	-	(591)	(591)
Amortisation charge for year	(89)	(89)	(178)
At 30 June 2022 net of accumulated amortisation	-	520	520
At 30 June 2022			
Cost or fair value	747	2,230	2,977
Accumulated amortisation and impairment	(747)	(1,710)	(2,457)
	-	520	520

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	ePharmacy Licence	Shares in NZ HPL	Total
	$000	$000	$000
Year ended 30 June 2021			
Carrying amount 30 June 2020	196	1,230	1,426
Additions for year	-	154	154
Amortisation charge for year	(107)	(184)	(291)
At 30 June 2021 net of accumulated amortisation	89	1,200	1,289
At 30 June 2021			
Cost or fair value	747	2,230	2,977
Accumulated amortisation and impairment	(658)	(1,030)	(1,688)
	89	1,200	1,289

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

No impairment for the NZHPL Change Management and Supply Chain was recognised for the financial year ended 30 June 2022 (2020/21: Nil).

At 30 June 2022 Taranaki District Health Board had made payments totalling $2,230k (2021: $2,230k) in relation to the Finance, Procurement and Supply Chain (FPSC) programme. This is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHP).

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

The FPSC/NOS rights have been tested independently for impairment by comparing the carrying value of the intangible asset to its depreciated replacement cost (DRC). As at 30th June 2022 there is considered to be an accumulated impairment and amortisation of $ 1,710k (2021: $ 1,030k) to Taranaki District Health Board's share of the DRC of the underlying FPSC/FPIM assets.

14 RESTRICTED ASSETS AND TRUST FUNDS

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

	2022	2021
	$000	$000
Opening Balance	712	797
Funds Received	24	61
Interest Received	6	4
Income in Advance	55	-
Funds Spent	(73)	(150)
Closing Balance Restricted Assets	724	712

	2022	2021
	$000	$000
Represented By:		
Cash at Bank	120	107
Short Term Deposits	600	600
Shares & Other	4	5
Total Restricted Assets	724	712

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

15 TRADE AND OTHER PAYABLES

	2022 $000	2021 $000
Trade Payables	27,595	24,712
Income received in advance	2,194	3,864
Owing to Associates	160	1,406
GST Payable	1,156	-
	31,105	29,982
Payables under exchange transactions	27,845	26,209
Payables under non-exchange transactions	3,260	3,773
	31,105	29,982

Most trade and other payables are non-interest bearing and normally settled within 30 days.

16 EMPLOYEE BENEFITS

	2022 $000	2021 $000
Salary & wages accrual	18,410	11,728
Annual Leave	52,900	36,786
Sick Leave	718	552
Long Service Leave	2,726	2,501
Retirement gratuities	564	550
Continuing Medical Education	4,825	3,935
Sabbatical Leave	264	343
	80,407	56,395
Made up of:		
Current	78,943	55,020
Non-current	1,464	1,375
	80,407	56,395

Compliance with Holidays Act 2003

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2022/23 financial year.

As at 30 June 2022, in preparing these financial statements, TDHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. TDHB has included an estimated liability of $21.8m (2021: $10m) within this note.

The indicative liability as at 30 June 2022 was estimated across all employment groups and the most up to date guidance regarding the extent of the payroll components intended to be covered by the application of the Holidays Act. The project is uploaded to the National Collaboration Hub, ensuring visibility and confidence in milestones. The Remediation model has been consolidated and testing is underway, whilst the Assurance framework review is in progress. The tentative target date for remediation, assuming current project risks are managed appropriately, is 01 October 2023.

Taranaki District Health Board has applied the intent of the Memorandum of Understanding in determining the provisioning of $ 21.8 million of Holidays Act costs as at 30 June 2022 (2021: $ 10.0m).

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17 PROVISIONS

	2022	2021
	$000	$000
Current provisions		
ACC Partnership Programme	133	33
	133	33

The liability valuation on the ACC Partnership Program has been calculated by Aon New Zealand Limited as at 30 June 2022. All outstanding claims by Taranaki District Health Board's employees are estimated by claim managers as at this point.

18 RECONCILIATION OF NET LOSS WITH CASH OUTFLOW FROM OPERATING ACTIVITIES

	2022	2021
	$000	$000
Net Loss	(41,248)	(22,762)
Add Non-Cash Items:		
Depreciation	16,358	15,561
Amortisation and impairment of Intangible assets	768	291
Increase/(Decrease) in Provision for Doubtful Debts	(97)	97
Increase in Employee Entitlements and Employee provisions	24,110	11,718
	41,139	27,667
Add back items classified as investment/financing activities:		
Decrease/(Increase) in Investments Held	255	(185)
Net (Gain) / Loss on Disposal of property, plant and equipment	(11)	(32)
	244	(217)
Movements in Working Capital:		
(Increase) in Receivables & Prepayments	(11,966)	(3,277)
(Increase) in Inventories	(759)	(142)
Increase/(Decrease) in Income in Advance	(1,670)	1,610
Increase in Payables & Accruals	3,782	6,232
	(10,613)	4,423
Net Cash Inflow from Operating Activities	(10,478)	9,111

19 RELATED PARTIES - KEY MANAGEMENT PERSONNEL

	2022	2021
	$000	$000
Board Members		
Remuneration	333	332
Full-time equivalent members	1.4	1.4
Executive management		
Remuneration	2,753	2,182
Full-time equivalent employees	10.3	8.4
Total key management personnel remuneration	3,086	2,514
Total full-time equivalent personnel	11.7	9.8

20 RELATED PARTY TRANSACTIONS

Taranaki District Health Board is a wholly owned entity of the Crown.

Transactions with other government agencies are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Related Party Transactions and Balances

(a) Funding
Taranaki District Health Board received $ 509.415m from the Ministry of Health to provide health services to the Taranaki area (2021: $ 441.941m). The amount outstanding at year end was $ 18.930m (2021: $ 9.943m).

(b) Inter-Group Transactions and balances:
Taranaki District Health Board charged the following expenses during the year for services performed, administration, general facility services, and interest received and had the following balances at year end:

		Owed to TDHB		Income to TDHB	
		2022	2021	2022	2021
		$000	$000	$000	$000
	TDHB Transactions				
Allied Laundry Services Limited	Board fees	1	1	15	15
NZ Health Partnerships Limited	DHB national collective service agreements	-	-	-	-
Healthshare Limited	IT consultancy	364	193	976	889
		365	194	991	904

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

	Owed by TDHB		Payments by TDHB	
	2022	2021	2022	2021
	$000	$000	$000	$000
Allied Laundry Services Limited	138	133	1,420	1,321
NZ Health Partnerships Limited	-	77	829	1,041
Healthshare Limited	22	1,273	1,758	4,051
	160	1,483	4,007	6,413

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

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21 FINANCIAL INSTRUMENT CATEGORIES

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

		Carrying amount	Fair value	Carrying amount	Fair value
		2022	2022	2021	2021
FINANCIAL ASSETS	**Notes**	$000	$000	$000	$000
Amortised cost					
Cash and cash equivalents	7	8,403	8,403	401	401
Trade and other receivables	8	28,833	28,833	17,123	17,123
Other financial assets - non current	10	1,018	1,018	192	192
Restricted Assets and Trust Funds	14	724	724	712	712
Total amortised cost		38,978	38,978	18,428	18,428

Trade and other receivables does not include GST refunds due from the IRD

		Carrying amount	Fair value	Carrying amount	Fair value
		2022	2022	2021	2021
FINANCIAL LIABILITIES	**Notes**	$000	$000	$000	$000
Financial liabilities at amortised costs					
Cash and cash equivalents	7	-	-	5,764	5,764
Trade and other payables	15	27,755	27,755	26,118	26,118
Total financial liabilities		27,755	27,755	31,882	31,882

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

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

22 FINANCIAL INSTRUMENT RISKS

Taranaki District Health Board's activities expose it to a variety of financial instrument risks, including market risk, credit risk and liquidity risk.

(a) Market Risk

Fair value interest rate risk
Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Taranaki District Health Board's exposure to fair value interest rate risk is limited to bank deposits. However, because these deposits are not accounted for at fair value, fluctuations in interest rates do not have an impact on the surplus / deficit of Taranaki District Health Board or the carrying amount of the financial instruments recognised in the statement of financial position.

Cash flow interest rate risk
Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments issued at variable interest rates expose Taranaki District Health Board to cash flow interest rate risk.

Taranaki District Health Board deposits surplus funds with a spread of maturity dates to limit exposure to short term interest rate movements.

Currency risk
Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. Taranaki District Health Board is exposed to foreign currency risk on minor purchases for goods and services which require it to enter into transactions in foreign currencies. Transactions in foreign currencies are translated at the foreign exchange rate at the date of the transaction. As a result of this Taranaki District Health Board has limited exposure to currency risk.

(b) Credit Risk
Credit risk is the risk that a 3rd party will default on its obligations to Taranaki District Health Board, causing a loss to be incurred.

Due to the timing of its cash inflows and outflows, Taranaki District Health Board invests surplus cash into term deposits with registered banks.

Taranaki District Health Board maximum credit exposure for each class of financial instrument is represented by the total carrying amount of cash equivalents (note 7), net trade receivables (note 8) and other financial assets (note 10).

Taranaki District Health Board has no significant concentration of credit risk as government sourced revenue for Taranaki District Health Board was 98% (2021: 97%) whilst it accounted for 98% (2021: 97%) of receivables.

(c) Liquidity Risk
Liquidity risk is the risk that Taranaki District Health Board will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions.

In general, Taranaki District Health Board generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and can break term deposits with financial institutions if required.

(d) Contractual Liquidity Table

2022

The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 months	3-12 months	1-3 years	3-8 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
Trade and other payables	27,755	27,755	27,755	-	-	-
	27,755	27,755	27,755	-	-	-

2021

The following table sets out the contractual cash flows for all financial liabilities:

	Carrying value	Contractual Cash Flows	0-3 months	3-12 months	1-3 years	3-8 years
	$000	$000	$000	$000	$000	$000
Non-derivative financial liabilities						
Trade and other payables	26,118	26,118	26,118	-	-	-
	26,118	26,118	26,118	-	-	-

(e) Sensitivity Analysis
As at 30 June 2022, if floating interest rates had been 1% higher/lower, with all other variables being constant, the deficit for the year would have a minimal impact (2021: Minimal).

23 CAPITAL COMMITMENTS AND OPERATING LEASES

	2022	2021
	$000	$000
Capital Commitments		
Property, plant and equipment	317,763	64,654
	317,763	64,654

Project Maunga Stage 2 accounts for $ 317.76m (2021: $ 63.70) of the capital commitments as at 30 June 2022, with this projected to be all spent within the 2024-25 financial year.

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Operating leases as lessee

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

	2022 $000	2021 $000
Not later than one year	571	570
Later than one and not later than two years	344	321
Later than two and not later than five years	520	763
Later than five years	51	66
	1,486	1,720

24 MAJOR VARIATIONS FROM BUDGET (unaudited)

Income Statement Variances - Revenue

Taranaki District Health Board recorded a deficit of $ 41.25 million compared to a budgeted deficit of $ 35.89 million.

Revenue received during the year was $ 60.55 million over budget as follows (2021 $ 16.85m increased):

	Variance 2022 $000	Variance 2021 $000
Health and disability services (Crown appropriation revenue)	60,102	12,635
Accident Compensation Revenue (ACC)	1,404	1,533
Inter District Flows	203	477
Inter Provider Revenue	(110)	27
Interest Received	256	25
Donations Received	(1,175)	911
Other	(130)	1,241
	60,549	16,849

Income Statement Revenue Explanations

Health and disability services (Crown appropriation revenue)	Funding for Covid expenses and Payroll (MECA) settlements
Accident Compensation Revenue (ACC)	Increased activity over planned revenue.
Donations Received	Timing of Donations received related to Project Maunga

Income Statement Variances - Expenditure

Expenditure was $ 65.794m in excess of budget as follows (2021: $ 27.720m):

	Variance 2022 $000	Variance 2021 $000
Income Statement Expenditure Explanations		
Employee Benefit costs	32,910	18,741
Depreciation expense	(1,046)	(2,405)
Outsourced services	12,040	6,690
Clinical supplies	5,484	182
Infrastructure and non-clinical expenses	998	3,603
Payments to non-health board providers	12,476	2,244
Other	2,932	(1,335)
	65,794	27,720

Income Statement Expenditure Explanations

Employee Benefit costs	Primarily increased staff costs for the Covid pandemic, and wage settlements over budget assumptions.
Depreciation expense	Due to timing of capital investment
Outsourced services	Use of external consultants and locums to deliver clinical services and fill vacancies in clinical staffing.
Clinical supplies	The value of RAT tests and personal protective equipment issued by the Ministry of Health required due to COVID-19
Infrastructure and non-clinical expenses	Lower realisation of gains against the savings plan
Payments to non-health board providers	Costs relating to Covid management in the Community

	Variance 2022 $000	Variance 2021 $000
Balance Sheet Variances		
Cash and cash equivalents	1,682	1,749
Trade and other receivables	11,398	3,348
Property, plant and equipment	(27,226)	29,964
Intangible assets	(688)	(311)
Trade and other payables	866	3,693
Employee benefits	22,144	11,322

Balance Sheet Explanations

Trade and other receivables	Primariliy Covid related expenses reimbursement outstanding at year end.
Property, plant and equipment	Delays in the hospital redevelopment programme impacted by supply chain issues due to Covid.
Employee benefits	Increased provision for the Holidays Pay liability and for unsettled Pay agreements as at year end.

25 CAPITAL MANAGEMENT

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

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

From 15 February 2017, DHB's no longer have access to Crown debt financing and funding of capital investment. Instead, the Crown contributions to DHB capital will now be solely funded via Crown equity injections. In addition the existing Crown debt held by DHB's have also been converted to Equity.

Changes in public equity are as a result of the Crown either (i) injecting equity for specific funding, or (ii) requiring Taranaki District Health Board to repay equity as specified by the Crown.

During the year the Crown increased Equity by paying for Capital funding of $ 69.1m (2021 $ 33.0m) and Deficit Support Funding of $ 30m (2021: $ Nil). Public equity of $0.959m (2021: $0.958m) was repaid to the Crown during the year. The repayments in both 2022 & 2021 were to repay the Ministry of Health funding of additional depreciation expense on buildings revalued at 30 June 2006.

There have been no changes in Taranaki District Health Board's management of capital during the year. The DHB is still receiving in 2022/23 Equity Injections to fund major capital projects.

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26 EMPLOYEE REMUNERATION

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

Remuneration Range	Actual 2022	Actual 2021
100,000 - 110,000	142	111
110,001 - 120,000	91	52
120,001 - 130,000	71	37
130,001 - 140,000	37	22
140,001 - 150,000	28	14
150,001 - 160,000	16	10
160,001 - 170,000	10	10
170,001 - 180,000	8	10
180,001 - 190,000	12	9
190,001 - 200,000	7	8
200,001 - 210,000	5	8
210,001 - 220,000	3	6
220,001 - 230,000	9	10
230,001 - 240,000	11	5
240,001 - 250,000	6	2
250,001 - 260,000	9	8
260,001 - 270,000	3	7
270,001 - 280,000	7	4
280,001 - 290,000	5	4
290,001 - 300,000	4	5
300,001 - 310,000	4	8
310,001 - 320,000	3	2
320,001 - 330,000	6	4
330,001 - 340,000	1	3
340,001 - 350,000	3	5
350,001 - 360,000	1	4
360,001 - 370,000	3	3
370,001 - 380,000	1	-
380,001 - 390,000	3	2
390,001 - 400,000	4	2
400,001 - 410,000	-	3
410,001 - 420,000	3	3
420,001 - 430,000	1	1
430,001 - 440,000	1	1
440,001 - 450,000	1	1
450,001 - 460,000	1	-
460,001 - 470,000	1	-
490,001 - 500,000	2	1
	523	385
Clinicians	456	328
Non Clinical	67	57
Total	523	385

If the remuneration of part time clinical staff was grossed up to a full time equivalent (FTE) basis, the total of employees with salaries of $100,000 or more would be 908 (2021: 637).

27 TERMINATION PAYMENTS

For the period to 30 June 2022, 2 employees or former employees of Taranaki District Health Board received payment in respect of termination of employment for $ 34,748 (2021: 6 payments totalling $ 115,000).

28 EVENTS SUBSEQUENT TO BALANCE DATE

1. Health sector reforms

On 1 July 2022, Pae Ora (Healthy Futures) Act 2022, came into force, replacing the New Zealand Public Health and Disability Act 2000; and establishing Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority. District Health Boards were legally disestablished, and their assets and liabilities transferred to Te Whatu Ora on this date.

29 BREACH OF STATUTORY REPORTING DEADLINE

The 2021/22 annual report of Taranaki District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

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INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF

TARANAKI DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2022

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

We have audited:

- the financial statements of the Health Board on pages 67 to 94, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue & expense, statement of changes in net assets / equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 34 to 63.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the financial statements of the Health Board on pages 67 to 94, which have been prepared on a disestablishment basis:

- present fairly, in all material respects:
    - its financial position as at 30 June 2022; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 34 to 63:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriations; and
        - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

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Our audit of the financial statements and the performance information was completed on 28 April 2023. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to other matters. In addition, we outline the responsibilities of the Board of Te Whatu Ora – Health New Zealand and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

The financial statements are qualified due to uncertainties over the provision for holiday pay entitlements under the Holidays Act 2003

As outlined in note 16 on page 86, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes a provision of $21.8 million for the estimated amounts owed to current and past employees. Work on the provision is ongoing, due to the complex nature of health sector employment arrangements, and there is a high level of uncertainty over the amount of the provision. We have therefore been unable to obtain adequate evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain adequate evidence of the $10 million provision as at 30 June 2021. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2021.

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

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

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

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements.

The financial statements have been prepared on a disestablishment basis

Significant accounting policy (b) on page 71 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora - Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Impact of Covid-19

Significant accounting policy (b)(ii) on page 71 to the financial statements, which outline(s) the ongoing impact of Covid-19 on the Health Board.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Page 55 to 63 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 61 to 63. The notes outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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

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

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

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

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

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

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

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board of Te Whatu Ora.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

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Other Information

The Board of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 4 to 33 and 66, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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