TARANAKI DISTRICT HEALTH BOARD

Statement of Intent

2009/10 – 2011/12

CONTENTS

1 EXECUTIVE SUMMARY

This Statement of Intent (SOI) outlines to Parliament and the general public the performance that Taranaki District Health Board (DHB) will deliver during 2009/10 and contains non-financial and financial forecast information for 2010/11 and 2011/12[1]. This document sets out our objectives and provides an overview of some of the services we deliver along with the performance targets we have set for ourselves for the period ahead. Due to the range of services delivered by our DHB, we have selected key priority areas for discussion in our SOI. The rationale for selecting and included these priority areas will be explained in later sections.

_____

Signature
John Young
Chairman

_____

Signature
Peter Catt
Deputy Chairman

_____

Signature
Tony Foulkes
Chief Executive

[1] To meet the requirements of section (s) 39 of the New Zealand Public Health and Disability Act 2000 and s 139 (1) of the Crown Entities Act 2004.

2 Context

2.1 Population

This section describes our DHB's external environment, including our geographical location and our population profile.

Total Population
Approximately 104,000 people live in the Taranaki DHB region. The district covers a geographical area of over 7,000 square kilometres, with a few densely populated areas such as New Plymouth, Stratford and Hawera. The rest of the population is scattered in and around small rural centres. Therefore ensuring equitable access to health and disability services by our population is both a priority and a challenge for the DHB.

Boundaries
Taranaki DHB boundaries are co-terminus with those of Taranaki Regional Council; and covers the three Territorial Local Authorities of New Plymouth District Council, Stratford District Council and South Taranaki District Council. This relationship enables focused and productive joint work with the Regional Council and TLA's on the wider determinants of health, particularly environmental, social and economic issues.

Ethnic Profile
In comparison to the New Zealand average, the Taranaki population has much smaller populations of Pacific and Asian people and a higher proportion of European people. The proportion of Maori people living in Taranaki is similar to the New Zealand average. There are a smaller proportion of Taranaki people who live in the most affluent and in the most socio-economically deprived areas. Within Taranaki, a higher proportion of Maori people live in the most socio-economically deprived areas in comparison to non-Maori. The DHB's approach to reducing inequalities for those people with the poorest health and highest need therefore focuses on Maori people.

Age Profile
The age profile of the Taranaki population differs from the New Zealand average in two key areas. Firstly the proportion of the population over the ages of 65 and 75 years is significantly higher. Provision of services to older people is therefore considered to be a strategic priority by the DHB. Secondly whilst the proportion of children between the ages of 5 and 14 years is higher than the national average, the proportion of young people between the ages of 15 and 24 years is significantly lower than the national average. This relative decline reflects the outward migration of young people for tertiary education and employment. Due to the direct relationship between education, employment and disposable income; which in turn has a direct relationship to health needs, young people in Taranaki could reasonably be expected to have relatively higher health needs.

Population Growth
The rate of growth of the Taranaki population is lower than the New Zealand average. This results in an ongoing projected decline in Taranaki DHB share of population based funding. The continued decline in population-based funding share, coupled with a higher proportion of older people presents significant challenges for the DHB to meet the health and disability needs of the population now and into the future. The DHB is therefore planning and implementing a programme of activities to refocus and re-prioritise resource allocation across the sector, to meet

the projected health and disability support service needs of our population within our projected future funding availability.

Detailed analysis of our population can be found in Taranaki DHB Health Profile 2007:
http://www.tdhb.org.nz/misc/document_library.shtml

2.2 Health Profile

What the HNA is

Taranaki DHB's health profile is generated through a comprehensive Health Needs Assessment (HNA)[2] that describes our population, its health status and identifies key strategic priorities. It was prepared in consultation with stakeholders and published in 2005. In 2009 the HNA was reviewed and a shorter updated Health Profile was published. We continue to expand the scope and quality of information as a normal part of our work.

How we use the HNA

The HNA's identification of health needs enabled us to develop a District Strategic Plan (DSP)[3] based on key priorities and containing long-term strategic outcomes to meet our population's needs. This adds a local flavour to the nationally driven requirements of the Public Health and Disability Act 2000, Ministry of Health priorities and Ministerial priorities that guide DHB's.

Key Priorities of Taranaki DHB:-

Chronic Disease

Cardiovascular disease, diabetes and respiratory diseases comprise three of the five main causes of ill health and death amongst our population. The impact of these chronic diseases is significantly higher for Māori than for non-Māori. In Taranaki rates of diabetes and rates of renal failure with concurrent diabetes, in both Māori and non-Māori women are higher than the overall New Zealand picture. Similar Māori men in Taranaki are more likely to be admitted to hospital for cardiovascular disease or chronic obstructive pulmonary disease.

Cancer

Cancer is the fourth main cause of ill health and death amongst our population. Non-Māori women are likely to have melanoma than women else where in New Zealand.

Mental Health and Addictions

Mental illness and addictions is the other main cause of ill health and death amongst our population.

Oral Health

Tooth decay is the most common chronic disease affecting our population. The average number of damaged (decayed, missing or filled) teeth for 5 year olds living in areas with a fluoridated water supply is 1.7 for non-Māori and 3.4 for Māori. The number of damaged teeth for those living in non-fluoridated areas of Taranaki is higher, 2.5 for non-Māori children and 3.9 for Māori children.

[2] Taranaki DHB HNA is available on our website at www.tdhb.org.nz
[3] The Taranaki District Strategic Plan can be accessed on our website www.tdhb.org.nz

2.3 Provider profile

Taranaki DHB funds a range of primary and community health services, hospital services. Just over half of our funding is used to provide services by the DHB.

Taranaki DHB provides services from two hospitals and five community health centres:

- Taranaki Base Hospital (236 beds)
- Hawera Hospital (31 beds)
- Health centres located in Waitara, Stratford, Opunake, Patea and Mokau

This network of facilities provides inpatient, outpatient and community base health services across emergency, critical care, surgery, medicine, oncology, radiology, laboratory, women's and child health, mental health, public health, disability support services for over 65 years, allied health and related support services.

The remainder of our funding is used to contract with a range of providers in the wider health sector. Locally services are delivered by 3 Primary Health Organisations, one GP unaligned with a PHO, 23 Dental Practices, 24 Community pharmacies, 19 Community Personal Health Providers, Community Laboratory and Radiology Providers, 17 community based mental health and addiction service providers (including 6 Māori providers) 31 providers of Age Related Residential Care, 6 providers of Home based support services for older people and 16 Māori Primary Health Care Providers.

We also fund more specialised (tertiary) services which are not available in Taranaki. These specialised services comprise cancer treatment, heart operations and other highly specialised surgical operations. These services are delivered by hospitals in Palmerston North, Hamilton, Auckland and Wellington.

3 Outcomes Framework

3.1 Government Priorities

Our SOI aligns with Ministry and Government Priorities and with Taranaki DHB's long term strategic intention to improve the health and well being of our community and reduce health inequalities.

DHB's fund and plan for services in accordance with national health and disability strategies, with a local context added through our strategic planning process (referred to earlier in section 2.2). Our District Strategic Plan[4] shows at a high level how we aim to change services to improve health status. DHB's prepare a District Annual Plan[5] based on the actions relevant to each year.

The Minister of Health writes a Letter of Expectations[6] in which he announces his specific expectations of DHB's for the coming year.

The Ministers Letter of Expectations for 2009/10 indicates that DHB's should:

Improve service and reduce waiting times	Increasing the volume of elective surgery undertaken
	Improve waiting times in Emergency Departments
	Improve cancer treatment waiting times
Improve clinical staff retention	Trusting, valuing and fully engaging health professionals in the planning and delivery of services
Foster Clinical Leadership	To drive improved patient care through new models of service delivery

A set of national Health Targets has been identified to follow the efforts of DHB's and make more rapid progress on key national priorities. These Health Targets are included within the selection of performance measures in this SOI; they are also included in section 5.1 of our DAP 2009/10.

[4] The Taranaki District Strategic Plan can be accessed on our website www.tdhb.org.nz
[5] http://www.tdhb.org.nz/nz/misc/document_library.shtml
[6] http://www/beehive.govt.nz/release/letter+expectations+dhbs+released

3.2 Outcomes

Based on these national priorities and local health needs, Taranaki DHB has developed a vision of "Taranaki together, a healthy community". Underlying this vision are three key outcomes:

Ability to meet current and future health needs within available resources	A health sector that has the people and infrastructure to meet the changing needs of our community. Services that are delivered through newer, more effective models of care which have been developed by clinical staff in primary, community and secondary care. These new services, the right people and infrastructure will improve productivity and enable our priorities to be met within available resources.
Improved health status	A community that adopts healthy lifestyles and individuals that take responsibility for their own health and the health of their family/whanau. Supporting people to be as healthy as they can be through promotion, prevention, early intervention and rehabilitation. A healthy Taranaki community will be able to contribute more productively to society and will reduce demand on health services especially the treatment of long term conditions.
Reduced inequalities	*Improved health status for Māori people and other groups with poor health status compared to the rest of our community.*

These outcomes are consistent with the purposed of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

3.3 Key Mechanisms for Intervention

As described earlier in section 2.3, Taranaki DHB:

FUNDS health and disability services through the contracts we have with providers

PROVIDES hospital and specialist services that covers medical and surgical services, mental health, older person's health

PROMOTES community health and wellbeing through health promotion, health education and population health programmes.

We want to ensure our interventions are relevant to our communities, coordinated and ensure best value for money. Before making funding, provider or promotion decisions we :

PLAN in consultation with key stakeholders (Iwi, PHOs and NGOs) and our community, the strategic direction for health and disability services within our district[7]

PLAN in collaboration with other DHBs, regional and national work.

[7] For more information on our strategic direction, you can view our District Strategic Plan (DSP) on our website www.namedhb.org/govt.nz

3.4 Intervention Logic

The interventions we choose are consistent with achieving the outcomes described in section 3.2. We use the intervention logic model in Table 1.

Table 1 DHB Intervention Logic Model

If we invest in ➡	And undertake ➡	Then we produce ➡	Which we group into ➡	That will achieve ➡	And contribute to
Inputs resources capability	**Activities** **Initiatives** **Projects**	**Outputs** services provided	**Output classes** public health services primary & community services hospital services support services	**Ministry of Health priorities** **MInister's expectations** **NDHB strategic goals**	**Improved health status** **Reduced inequalities**
		DHB enablers activities programmes projects	**DHB programmes** activities programmes projects		

Types of health need and interventions

How TDHB seeks to improve the health of the population depends on the type of health needs people have. To illustrate this, Table 2 describes the framework we have developed for dealing with chronic conditions. It categorises the population into four subgroups according to their health status and ability to function in society, and describes the typical types of services applied to each of the groups.

Table 2 also suggests an inverse relationship between health status and the cost of providing services. Healthy people require very few, if any, resources from the health system. Once people develop a long term condition they require ongoing monitoring and management. If it reaches a severe stage, expensive treatments are usually necessary.

Table 2 TDHB Long Term Conditions Framework

Principles which guide the framework					
Equity in outcomes	**Evidence-base practice**	**Efficient services**	**Person in charge clinicians support**	**Hospital Care is episodic**	**Emergency hospital admission and ED attendances are avoidable**

	Population subgroup			
	Level 1	**Level 2**	**Level 3**	**Level 4**
Who leads management of the condition?	**Person**	**Person**	**Person**	**Clinician**
Definition of group	People who have risk factors that will potentially lead to long term condition	People who have been diagnosed with one long term condition	People living in community with one or more long term conditions and co-morbidities. Condition is usually progressive with significant function impairment	Severe debilitation, major loss of functioning and eventual death.
Types of services (outputs) provided	Health promotion, screening, immunisation. Supporting people to stay healthy and reduce or eliminate risk factors	Level 1 and primary and community services. Early detection and intervention and treatment. Support to manage own condition	Level 1 and 2 episodic hospital care. Support for self management and regular clinical checks to maintain function for as long as possible	Hospital care and support services including palliative care
	Health status, ability to function		**Level of disability: cost of services**	

Implications of Table 2

Maintaining health

Long term conditions cannot be eliminated and tend to become more common as we age. The challenge is to maintain a reasonable level of health and fitness for as long as possible and 'compress' the disease phase into a minimal period towards the end. For DHBs, Table 2 suggests that investing in services that keep people healthy and prevent or delay the onset of disease is the most cost-effective approach. It enables the population to function better in their daily lives, increasing their ability to contribute to their families and to society as a whole. It also enables health funders to restrain the ever-rising cost of health services.

Supporting people with long term conditions

Health services also have an obligation to provide treatment to people who develop diseases. Once a long term condition is acquired it can generally only be managed, not eliminated. The challenges are to persuade people to recognise when symptoms are significant, and to design services that detect conditions in their earliest stages while control is easiest. As conditions become more advanced, self management and regular visits to clinical services become increasingly important to maintain functionality for the individual and minimise impacts on health services.

3.4.1 Prioritisation of Key Interventions

Table 3 Examples of intervention logic

Diabetes				
If we invest in ➡	**And undertake** ➡	**Then we produce (outputs, enablers)** ➡	**That will achieve (impacts)** ➡	**& contribute to (outcomes)**
Primary care services.	Annual free checks (AFCs) of diabetics. Improvements to info systems that support diabetes management, including linkages between primary and secondary services.	Info on diabetics who are managing their condition well (% with blood sugar under the recommended level). Info identifying individual diabetics who have not had their AFCs. Info by ethnicity, deprivation level, and geography to identify at-risk groups of diabetics not receiving AFCs.	More people who are better managing their diabetes and have fewer complications. Identification and follow-up of those who have not had their AFC, thus adding to the above group. Planning for improved services to capture the at-risk groups who are 'missing out'.	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities.
Oral health services for youth				
If we invest in ➡	**And undertake** ➡	**Then we produce (outputs, enablers)** ➡	**That will achieve (impacts)** ➡	**& contribute to (outcomes)**
Oral health services.	A reorganised, seamless, community-based oral health service. Increases in the oral health workforce.	Higher attendances at oral health services by youth. More equitable coverage (reduce gaps by ethnicity, deprivation level, geography).	Improved oral health status (fewer teeth that are decayed, missing, filled).	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities.
*Rationale***.** While the oral health of children requires significant improvement, they are readily accessible to public oral health services through schools. Adolescents are harder to reach because traditionally once they reach secondary school they have come under private dentists, but it has been up to them to attend. There is scanty data on the oral health of adolescents, but we know intuitively it is poor. A single public oral health service covering ages 0-18 will help deal with many of these problems.				
Ageing in Place				
If we invest in ➡	**And undertake** ➡	**Then we produce (outputs, enablers)** ➡	**That will achieve (impacts)** ➡	**& contribute to (outcomes)**
Hospital Services Community Services Primary Care Services	Elective Service Planning Implementation of single point of access to health services for older people Flu advertising campaign Negotiation of agreements for respite care beds	More elective surgery Home based support services Intermediate care and treatment model Respite care beds Immunisations	Fewer older people hospitalised. Reduced impact of disability Support available for those who care for older people Older people are healthier	Ability to meet current and future health needs within available resources Improved health status Reduce inequalities

3.4.2 Development of measures

For each intervention TDHB develops measures to describe the changes taking place in services and the impacts these have on patients and clients – in other words, whether we are 'making a difference'. For each of the examples above, Table 4 describes the measure, the baseline level of performance from current or most recently available data, and improvement targets for 2009/10 and the two following years.

Table 4 Examples of measures

Outputs	Measures	Baseline	Targets		
			2009/10	2010/11	20011/12
Diabetes Annual Free Checks (AFCs)	% of diabetics receiving an AFC:				
	Maori	41%	59%	63%	67%
	Other ethnic groups	59%	71%	73%	75%
	Total population	56%	69%	71%	73%
	% of diabetics receiving AFCs with satisfactory or better diabetes management:				
	Maori	73%	74%	78%	82%
	Other ethnic groups	81%	85%	87%	89%
	Total population	80%	83%	85%	87%
A re-organised, seamless, community-based oral health service with an expanded workforce.	% of youth (Year 9 to ages 17) enrolled with oral health services:				
	Total population	60%	70%	80%	85%
More elective surgery	Additional discharges	3,921	844	977	1,115
	Additional caseweights	4,329	1,185	1,350	1,508

4 Statement of Forecast Serivce Performance (SFSP)

4.1 Introduction

Section 2

Section 2 of the SOI described the Taranaki population and its major health needs. It also explained that though the DHB is by far the largest health organisation in Taranaki, it is only one of many health service providers. Since the DHB does not directly control other providers, we must use other means to achieve progress such as negotiating and monitoring contracts, improving integration of services between the DHB and non-DHB providers, joint planning and collaborative ventures.

Section 3

Section 3 explained in a bigger-picture sense what Taranaki DHB is trying to achieve (priorities and outcomes), the thinking we use in designing services and programmes (our intervention logic) and gave some examples of how we measure progress.

Section 4: the SFSP

Section 4 takes the process a step further. It develops a Statement of Forecast Service Performance (SFSP) by applying the intervention logic and measurement process to a range of key activities. It explains the impacts these have, the outcomes they support, the measures we apply, describes baseline levels of performance and sets future targets.

Key selected activities only

The SFSP highlights a selection of activities that make key contributions to our outcomes and to national and local priorities. It does not attempt comprehensive coverage of Taranaki's health needs and health services (that is more the intent of our District Annual Plan mentioned in section 3.1).

Other accountability mechanisms

Taranaki DHB is accountable through mechanisms other than the SFSP, as explained in section 6.2.

4.2 Output Classes

Section 4 is organised around "output classes", broadly similar types of services grouped together for the purposes of the SOI to make it more understandable to audiences outside the health sector. Table 4 describes the four types of output classes.

Table 5 Output classes: description and who provides them

Output class	Description	Who provides	
		DHB	Non-DHB
Public health services *$7,026,492*	Services aimed at improving the health of the population as a whole (as distinct from personal health services delivered to individuals). They include health promotion, health protection, screening programmes (such as breast and cervical screening, B4 School Checks) and immunisation.	✓	✓
Primary and community services *$103,597,106*	Personal health services based in the community that people can access directly. They include general practitioners, Maori health providers, pharmacists, nurse practitioners, public health nurses, Plunket, midwives, health of older people services[8], and a host of others.	✓	✓
Hospital services *$169,167,074*	Services that are generally accessible only through a referral by a health professional, commonly a GP. There are two levels of service: (a) secondary (general hospital services), as provided at Base Hospital and Hawera Hospital; (b) tertiary (highly specialised services) mostly provided by Waikato, Auckland and Midcentral DHB's. More details on secondary and tertiary services are included in section 2.3 and the flowchart in section 4.5.	✓ secondary services	✓ tertiary services
Support Services *$20,734,328*	Services which are not easily classifiable into one of the above three categories, usually because they cover more than one of them. Examples include palliative care services and Needs Assessment and Service Coordination[9].	✓	✓

[8] These comprise age-related residential care, home-based support services and day services.

[9] NASC for short. An organisation contracted by the Ministry of Health or DHB to: (a) determine a person's eligibility and need for publicly-funded disability support services (= needs assessment); (b) allocate services which are then delivered by third party providers (=service coordination).

4.3 SFSP for Public Health Services

Table 6a Intervention logic for public health

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Public health services	Health promotion	Smoking Cessation Programme referrals in primary health care.	Fewer people smoking (short term). Reduced incidence of smoking-related disease (longer term).	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities (through a focus on high-need groups with poorer health status indicators)
		% of mothers exclusively and fully breastfeeding at 6 weeks, 3 months and 6 months.	Adequately nourished babies. Higher levels of protection against disease.	
	Health protection	Investigations of communicable disease notifications.	Early identification of people who have contracted disease and early action to prevent its spread.	
		Monitoring of water supplies.	Higher standards of water available to the public, lower rates of gastrointestinal disease.	
	Population screening	Cervical screens	Early detection of cancerous or pre-cancerous conditions.	
		B4 School Checks	Early detection of health problems in school new entrants.	

Table 6b SFSP for public health services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	**Data**	**2009/10**	**2010/11**	**2011/12**
Population Health	B4 School Checks	% of cohorts receiving B4SC: Total population	46% 646	80% 1200	80% 1200	80% 1200
		Maori Non-Maori	148 498	240 960	240 960	240 960
	Immunisations against HPV	% of Year 8 girls completing a course of immunisation against HPV: Total population Maori Non-Maori	 43% 30% 70%	 44% 35% 71%	 45% 40% 72%	 46% 45% 73%

4.4 SFSP for Primary and Community Services

Table 7a Intervention logic for primary and community services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
GP services	Diabetes Annual Free Checks (AFCs)	Info on diabetics who are managing their condition well (% with blood sugar under the recommended level). Info identifying individual diabetics who have not had their AFCs. Info on AFC coverage of the diabetic population (by ethnicity, deprivation level, geography) to identify at-risk groups of diabetics not receiving AFCs	More people who are better managing their diabetes and have fewer complications. Identification of those who have not had their AFC, thus adding to the above group. Planning for improved services to capture those who are 'missing out'.	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities.
	Cardiac monitoring	CVD[10] risk assessments. Lipid and glucose tests performed on people who have had CVD risk assessments.	Knowledge of the level of risk of developing CVD.	
	Primary care assessment and treatment services	Conditions managed appropriately in a primary care setting. Protocols to assist GPs to refer appropriately.	Fewer admissions to hospital that are avoidable or preventable by appropriate treatment in primary care. Earlier resolution of conditions for patients, less chance of complications, disease progression slowed.	
	Well child services	2-year-olds fully immunised. Year 8 girls immunised against HPV[11].	Higher level of protection against communicable diseases in the population.	
Taranaki Community services	A reorganised, seamless, community-based oral health service. Increases in the oral health workforce.	Higher enrolments (and therefore attendances) at oral health services by youth. More equitable coverage (reduce gaps by ethnicity, deprivation level, geography).	Improved oral health status (teeth that are decayed, missing, filled). Reduced impact on overall personal health status.	

[10] Cardiovascular disease, which comprises heart disease and strokes.

[11] Human Papilloma Virus, two strains of which are known to cause most cervical cancer, and which the HPV immunisation guards against.

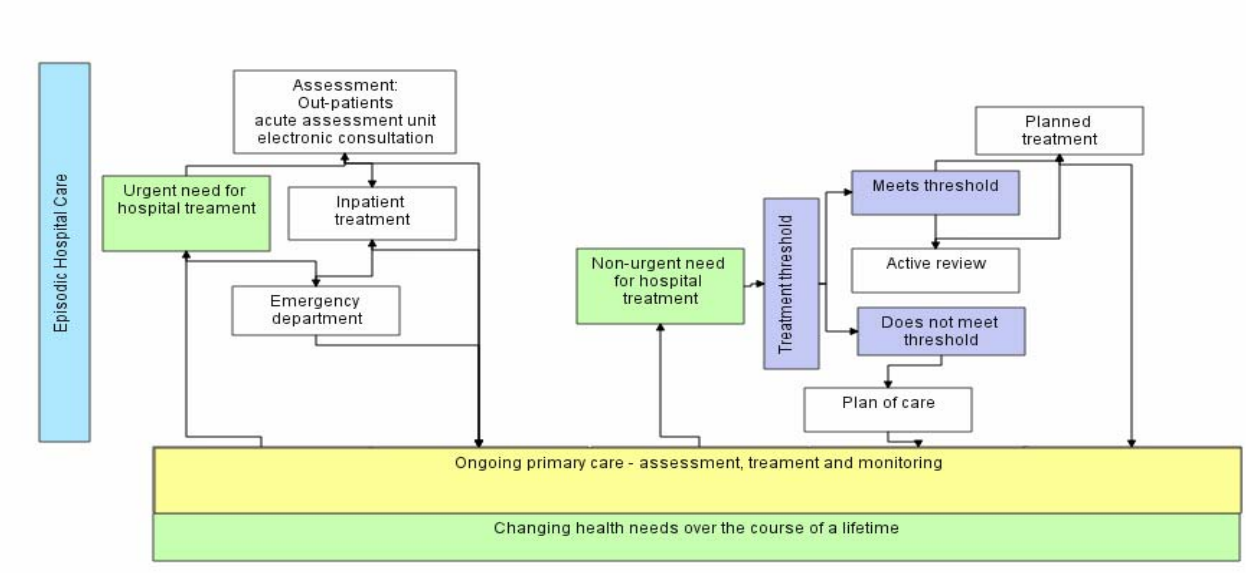
Table 7b SFSP for primary and community services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
GP services	Diabetes Annual Free Checks (AFCs)	% of diabetics accessing free annual checks:				
		Maori	41%	59%	63%	67%
		Other ethnic groups	59%	71%	73%	75%
		Total	56%	69%	71%	73%
		% on diabetes register who have satisfactory or better diabetes management level:				
		Maori	73%	74%	78%	82%
		Other ethnic groups	81%	85%	87%	89%
		Total	80%	83%	85%	87%
	CVD Risk Assessment	% of eligible adult population who have had CVD risk assessment in last 5 years:				
		Maori	47.1%	49.2%	51.2%	53.2%
		Pacific	50.0%	52.0%	54.0%	56.0%
		Other ethnic groups	66.9%	69.0%	71.0%	73.0%
		Total	62.8%	64.8%	66.8%	68.8%
	2-year-old immunisations	% of 2 year olds fully immunised:				
		Maori	70%	79%	90%	95%
		Total	78%	79%	90%	95%

4.5 Hospital Services

To clarify the differences between patients who are treated by primary care services and those treated by hospital services, Figure 1 explains the different patient pathways.

Figure 1. Patient flows between primary care and hospital services.



4.5.1 Acute Services

Acute services are for illnesses that have an abrupt onset. It is usually of short duration, rapidly progressive, and in need of urgent care.

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Primary care services	Effective management of long term conditions with the patient taking responsibility for their health	More conditions treated appropriately in the primary care setting.	Illnesses detected and treated ASAP. Fewer admissions to hospital. Reduced costs to the health system. Higher patient satisfaction.	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities.
Quality Hospital systems	Systematic review and redesign of hospital processes	Clarity about how details of the treatment process work and how improvements can be made.	Shorter, safer, higher quality acute treatment processes. Fewer resources used. Less stressful experiences for patients.	
Mental health services.	Planning with clients, their families and significant others.	Relapse plans for all clients with long term mental health conditions.	More stable lives for people with mental health conditions, their families and significant others. Fewer demands on mental health secondary services.	

Table 8b SFSP for acute hospital services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Cancer services	Radiation oncology treatments	% of patients waiting less than 6 weeks between first specialist assessment and the start of radiation oncology treatment[12].	100%	100%	100%	100%

[12] Includes patients in category A (urgent, within 24 hours), B (curative, within 2 weeks) and C (palliative) but excluding D (combined radiotherapy and chemotherapy).

4.5.2 Elective services

Elective services are for illnesses where treatment can be planned for a future date.

Table 9a Intervention logic for elective services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Elective services	Improvements to processes and systems. Additional funding for additional procedures.	More elective procedures.	Lower level of illness and disability in the population. People whose ability to function is increased and who are more able to contribute to society.	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities.

Table 9b SFSP for elective services

Services provided	Outputs	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Elective services	Improvements to processes and systems.	ESPIs[13]:				
		1 DHB services that appropriately acknowledge and process all patient referrals within ten working days.	92%	92%	92%	92%
		2 Patients waiting longer than six months for their first specialist assessment (FSA).	1.6%	1.6%	1.6%	1.6%
		3 Patients waiting without a commitment to treatment whose priorities are higher than actual treatment threshold (ATT).	4.0%	4.0%	4.0%	4.0%
		4 Patients without clarity of treatment status.	0.0%	0.0%	0.0%	0.0%
		5 Patients given a commitment to treatment but not treated within six months.	4.0%	4.0%	4.0%	4.0%
		6 Patients in active review who have not received a clinical assessment within the last six months.	12.0%	12.0%	12.0%	12.0%
		7 Patients who have not been managed according to their assigned status and who should have received treatment.	4.0%	4.0%	4.0%	4.0%
		8 The proportion of patients treated who were prioritised using nationally recognised processes or tools.	92.0%	92.0%	92.0%	92.0%
	Additional funding for additional procedures.	Increase in the number of elective service discharges				
		Estimated elective discharges	3,921	4,765	4,898	5,036
		Elective CWDs[14]	4,329	5,514	5,679	5,837

[13] Elective Service Patient flow Indicators, measures of system performance at 8 critical points. A full explanation of the abbreviated wording in the table is available at http://www.electiveservices.govt.nz/indicators.html

[14] As well as the number of elective discharges, their complexity is also important (the more complex, the longer they take to treat and the fewer procedures are possible). Cost-Weighted Discharges attempt to allow for this complexity factor.

4.5.3 Emergency services

Table 10a Intervention logic for emergency services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
Emergency services	Redesigned data systems. Redesigned patient flow models.	Reduced length of stay in EDs. Reduced time from an ED request for an inpatient bed to admission onto a ward.	More efficient use of resources. Faster attention to needs for non-urgent patients. Less stressful experiences for patients.	Ability to meet current and future health needs within available resources Improved health status. Reduce Equalities

Table 10b SFSP for emergency services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
	Shorter stays in ED	95% of patients will be admitted, discharged, or transferred from an ED within 6 hours	85%	95%	95%	95%

4.6 SFSP Support Services

Taranaki DHB's aim is to have a fully inclusive community, where people are supported to live with independence and can participate in their communities.

Table 11a Intervention logic for support services

If we invest in ➡	And undertake ➡	Then we produce (outputs, enablers) ➡	That will achieve (impacts) ➡	& contribute to (outcomes)
NASC (Needs Assessment and Service Coordin-ation)	Needs assessment: determining eligibility and need for publicly-funded disability support services. Service coordination: allocating services to third party providers.	Packages of care aligned to clients' disability support needs. More regular client reviews. Informal carer impact assessment.	Timely access to appropriate services. Reduction in ED presentations and avoidable hospital admissions (falls especially). People living in their own homes longer. Less impact on informal carers.	Ability to meet current and future health needs within available resources Improved health status. Reduced inequalities.
Palliative care	Palliative Care Liaison with Secondary Services[15]	Earlier referrals to palliative care services in the curative stage of cancers.	Reduced impacts of conditions on patients and their families.	
Health of Older People Services	Respite Care	Respite care beds available across Taranaki	Carers able to support older people in their own homes	

Table 11b SFSP for support services

Services provided	Outputs, enablers	Baseline measure		Targets		
		Description	Data	2009/10	2010/11	2011/12
Health of older people services	**Respite Care**	Dedicated respite care bed days	0	2,400	2,400	2,400

[15] A new service for both Northland and NZ, provided in hospital by by an NGO palliative care provider, to provide support to people with cancer in the earlier curative stages to improve quality of life for patients.

4.7 Financial Performance

4.7.1 Financial Statements

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

($'000)	2007/08 audited	Year 0 2008/09 forecast		Year 1 2009/10 plan	Year 2 2010/11 plan	Year 3 2011/12 plan
Hospital Provider + Governance Funding (including other income)	156,290	158,647		166,434	171,577	177,359
Non Hospital Provider Funding (NGO)	115,268	128,380		131,988	136,080	140,707
TOTAL FUNDING	**271,558**	**287,027**		**298,422**	**307,657**	**318,066**
Hospital Provider + Governance Operating Expenses	159,507	166,252		172,534	177,045	181,149
Payments to Non Hospital Providers (NGO)	112,751	121,030		125,790	130,550	136,424
TOTAL OPERATING EXPENSES & PAYMENTS	**272,258**	**287,282**		**298,324**	**307,595**	**317,573**
Hospital Provider + Governance Operating Surplus/(Deficit)	(3,217)	(7,605)		(6,100)	(5,468)	(3,790)
TDHB Funder - Surplus/(Deficit)	2,517	7,350		6,198	5,530	4,283
OPERATING RESULT FOR THE FISCAL PERIOD	**(700)**	**(255)**		**98**	**62**	**493**
Expenditure against prior period surpluses (TDHB Funder)						
** Mental Health services*	*-*	*-*		*(837)*	*(364)*	*-*
** Workforce Development*	*(562)*	*(300)*		*(500)*	*(233)*	*(100)*
** Mâori Health Gains project*	*(31)*	*(50)*		*(864)*	*(1500)*	*(500)*
** Hospital Provider strategic projects*	*-*	*-*		*-*	*(100)*	*(100)*
NET CONSOLIDATED SURPLUS/(DEFICIT)	**(1,293)**	**(605)**		**(2,103)**	**(2,135)**	**(207)**

Notes:

A: The net consolidated financial result is AFTER recognising the:

I. expenditure against ring fenced Mental Health surpluses carried forward from prior financial periods,
II. expenditure on account of Workforce Development initiatives (an appropriation against retained surpluses),
III. expenditure on Mâori Health gains project (an appropriation against retained surpluses), and
IV. expenditure on strategic Hospital Provider projects (an appropriation against retained surpluses)

The consolidated operating result BEFORE the appropriations against prior period retained surpluses is a financial breakeven position , with an operating surplus of $0.098M, $0.062M and $ 0.49M for the plan periods 2009/10, 2010/11 and 2011/12 respectively.

B: Expenditure against prior period surpluses: These relate to short to medium term investment in strategic services and operations viz. Workforce development ($ 2.5 Million) and Maori Health inequalities ($ 3.0 M). These investments were committed by the Board, and will span more than one financial period, and are outside the core annual operating budget. The investment is to be funded out of carried forward surpluses from prior periods. Due to timing, if this committed outlay does not eventuate or is less than what was planned for the period, the financial results of the DHB Funder operations will be favourable to that extent, as also the DHB consolidated result. The Mental Health (MH) expenditure relates to ring fenced surpluses arising from MH services in prior periods that are being expended from carried forward surpluses/reserves (Please also refer to 7.5.1).

C: It is also to be noted that expenditure ($ 1.44M towards capital charge and depreciation) incidental to the revaluation of assets (per FRS3 - land and buildings) carried out on 30 June 2008 is charged against the hospital provider. This extraordinary expenditure has had a material impact on TDHB's financial and cash positions. No confirmation or commitment for funding this expenditure has been received (this was funded on a cost neutral basis during previous revaluation exercises). The corresponding funding if/when received will improve the hospital provider and also the consolidated financial results by $ 1.44M in each of the financial periods 2008/09 and plan years 2009/2012 - a significant improvement in the financial results of the DHB.

C: These financial results are to be read with the accompanying notes and assumptions.

Key Points from the Budgeted Financials 2009 – 2012

In principle, the Board has planned for a consolidated financial breakeven result in each year of the plan period. However, this financial breakeven goes against the emerging trend across the entire planning period 2009-2012, which clearly indicates that cost growth in the hospital provider operations is significantly in excess of funding received, leaving residual operating deficits. The consolidated surplus is primarily on account of the surpluses generated in the Funder operations during each of the fiscal periods under consideration.

1. The Hospital Provider Arm is facing a budgetary cost to funding gap resulting in operating deficits in each year covered by this plan. This financial gap could increase to $8.40M in 2009/10 if other identified risks and associated costs (estimated at $ 2.30M) were to materialise fully. With the residual risk estimated at $1.70M, the resultant financial gap could be in the region of $7.75M.

2. In applying the stated budgetary assumptions, it is evident that current cost structures in the Hospital Provider have little to offer by way of savings, unless there are structural changes in some of its services, workflows and staffing levels. In view of the increasing

cost pressures and risks, the financial budget for the provider arm hinges on the delivery of a number of efficiency initiatives, service changes and staffing movements, which are expected to generate approximately $3.5M of reduced operating costs during 2009/10. (Please refer the "Efficiency & Productivity Improvements" section for details).

3. Additionally, it is carrying unbudgeted financial risks in many of its cost structures that are likely to materialise in part or full during the plan period.

4. The Board therefore recognises that the operating cost to funding gap in the Hospital Provider operations will need to be addressed through options that could result in changes to service configurations, models of care and re-alignment of services within funding available. It acknowledges these changes are essential if the hospital services arm is to remain financially viable and sustainable when faced with increased costs on several fronts.

5. In context of increasing cost structures and continuing operating deficits, it is to be noted that Taranaki DHB is about to embark on a staged redevelopment of the Base Hospital inpatient facilities. There are several compelling reasons to undertake the redevelopment, but non more compelling than the fact that the current hospital layout and structures are not conducive for delivery of complex clinical pathways and modern models of care. Consolidation of specialist services and improved models of care and pathways will result in more efficient use of clinical resources and thereby reduction in core operating costs. The redevelopment will pave the way for a recovery plan for the hospital services to align itself more efficiently – both clinically and financially. The impact will be evident post redevelopment of the base hospital facilities.

6. Likewise, the DHB Funder operations is planning to reduce planned expenditure by $4 million to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2009/10. It is also faced with an overall exposure in its contracts estimated at around $1.0M for 2009/10, with a probability factor leaving a residual risk equating to about $0.50M. This is in addition to the financial risks carried by the Hospital Services operations.

7. In the final tally, though the Board is planning a financial breakeven it is faced with:

    a. a significant cost to funding gap in its Hospital provider operations for 2009/10 (and out years),
    b. additional financial exposure in its expense budgets which could materialise in part or full
    c. the possibility of having to change or re-align service configurations in its hospital service operations to manage the gap and other potential risks
    d. the financial recovery plan for its hospital provider operations being largely dependent on the redevelopment of the hospital facilities
    e. its Funder operations having to significantly reduce investment in additional services, besides carrying financial risks, and
    f. its consolidated residual financial exposure (besides the hospital provider operating deficit) being circa $2.20M for the planning period 2009/10, the overall exposure being around $3.30M

Recognising that additional risks continue to be carried both within and outside the financial budget, Taranaki District Health Board's financial risk assessment of the current District Annual Plan is potentially "medium to high risk" under the assumptions and risks as stated.

Key Financial Strategies

a. The Hospital Provider Arm is faced with an operating deficit of $ 6.1M in its 2009/10 operating budget + other financial risks. The hospital provider has identified a number of areas and developed a framework for effecting change. These include, amongst others, plans for:

   Integration of Health centre services/facilities with primary care and other providers.

   Selective capital investment in Information Technology aimed at improving work flows and processes and releasing FTEs.

   Development of regional networks to support effective local service delivery of vulnerable services.

   Effective and robust clinical pathways for after hours care.

   Focus on chronic disease management strategies.

   Service reviews.

   Staffing reviews aimed at improving productivity and reduction in core FTEs.

   Overall the approach will be to explore a range of practical options including re-configuration of services and facilities with the primary aim of reducing the overall cost of service delivery whilst maintaining access of core services to the people of Taranaki.

b. These options are being considered in conjunction with the redevelopment of the inpatient facilities at the Base Hospital. The facilities redevelopment is expected to deliver greater workflow efficiencies and an overall reduction in costs in several areas of its operations. Underpinning this redevelopment is the need to configure the facilities to meet the services profile for the future and achieve maximum efficiency and effectiveness of service delivery.

c. Considering the trends in demand for health services, it is obvious that longer term sustainability, both clinical and financial, will continue to be the key focus for Taranaki DHB. To achieve this balance, Taranaki DHB has embarked on the development of strategies and processes that involve:

   identifying and evaluating referred options to match costs with funding

   alignment towards a more sustainable clinical services model in line with funding

   internal cost controls and closer monitoring of operating budgets

   achievement of systems and process improvements, initiatives and efficiency gains

   technology driven solutions

   Sustained focus on longer term strategic plans, whilst continuing to proactively address immediate and medium term risks and issues

d. Investment and cash outlay for committed strategic initiatives such as Workforce Development, Mâori Health Gains and Hospital Provider services projects will continue to be funded below the line using prior period retained surpluses.

e. Primary sector cost pressures will be mitigated through management of demand driven services and integration of services with providers, while the secondary services align itself.

f. The hospital provider services will continue to pursue operational efficiencies through initiatives and measures to further reduce its service costs and/or increase non DHB funded revenue.

g. Cost containment together with focus on cost reduction in primary costs across the hospital provider operations such as staffing and operational overheads will continue to be pursued and managed through a Cost Management Plan.

h. During the plan period 2009/12, baseline capital expenditure is expected to be contained within annual depreciation accruals, so that additional equity injection or borrowing is not required. The only exception will be funding to support the stages of the hospital redevelopment programme in line with approvals received.

Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the three-year planning period 2009/12.

Application of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS)

The DAP financial template for the plan period 2009/12 and comparative years have been prepared in accordance with NZIFRS.

Equity and Borrowing

- The District Annual Plan 2009/12 has not assumed any additional Crown equity, other than the capital funding approved to undertake the rollout of the community oral health project ($ 3.04M) which is being treated as equity. or borrowing from CHFA during the plan period
- Term borrowing from the Crown Health Financing Agency (CHFA) to fund the first stage of the capital redevelopment programme proposed for the inpatient facilities at the Base Hospital has been included in the DAP 2009/12. Approval for Stage 1 (estimated cost: $ 80M) of the redevelopment was received in July 2008, which includes a CHFA funded borrowing of $ 45M.
- With the exception of the capital outlay envisaged on inpatient facilities redevelopment as noted above, base line capital expenditure outlay is expected to be contained within the level of depreciation for 2009/10 and the two years following
- Taranaki DHB is on “standard monitoring” status on the performance monitoring scale, and it is assumed that monthly funding will continue to be received in advance.

Wages and Operating Cost Growth

1. Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with the agreement (s) and in line with collective DAP assumptions agreed nationally.

2. Clinical supplies: average 3.0% for 2009/10 + estimated on activity levels + reduced for efficiencies and value for money (vfm) gains.

3. General operating expenditure: average 3.0% for 2009/10 + confirmed outflows + reduced for efficiencies and value for money (vfm) gains.

4. Value for Money (VFM) impacts: the potential impact of efficiencies and cost reductions generated by the national VFM programme has been estimated and built into the relevant operating budgets and expense lines. Other potential gains from local initiatives and projects have also been considered in the relevant expense budgets.

Mental Health Services and Strategic Initiatives Expenditure

Expenditure on strategic projects and initiatives viz. Workforce Development, Māori Health Gains and Hospital Services Strategic Projects are being funded from prior period retained surpluses and is in line with the strategic direction set by TDHB. In principle, this strategic spend

being outside the 12 month fiscal period may result in a financial deficit for the period, however no additional funding or deficit support is being requested by Taranaki DHB to progress these long term initiatives.

Interest Rates

Interest rates have been assumed along current monetary indicators and commitments and averaged as appropriate over the mix of funding streams and options as follows:

	Overdraft	CHFA loans (existing)	CHFA loans (new)	Deposits	Equity
Year 1 (2009/10)	8.00%	6.85%	-	4.00%	8.00%
Year 2 (2010/11)	8.25%	6.85%	5.50%	4.50%	8.00%
Year 3 (2011/12)	8.50%	6.85%	6.00%	5.00%	8.00%

Notes:

1. CHFA existing facility limit is $ 31M, with $ 29M drawn down. This is besides the $ 43M new term debt for Stage 1 of the base hospital redevelopment project approved by CHFA.
2. TDHB has transactional banking arrangements with ASB bank. Approved overdraft facilities are available on stand bye basis (uncommitted) with ASB. No financial covenants have been stipulated by ASB for transactional banking and stand bye overdraft arrangements.
3. TDHB currently has $ 29M in term deposits with Kiwi Bank and ASB Bank, which are available to bridge any shortfalls in working capital if required.

Asset Revaluation and its Impact

Under the provisions of FRS3, TDHB is required to undertake an asset revaluation exercise as at 30 June each year, and recognise any material increase in land and building values, and also its impact on depreciation and capital charge.

TDHB was required to revalue its land and buildings as @ 30 June 2008 and take into consideration the future carrying values of its buildings incidental to the redevelopment of its base hospital inpatient facilities. The impact of the revaluation was a net increase of $ 9.01M in its current land and building values, resulting in an increase in capital charge ($ 740K) and depreciation ($ 700K). The impact ($ 1.44M) is already being carried in the financial statements of 2008/09 (Year 0) with no corresponding funding from the MOH.

it is assumed that any movement in the asset base as at 30 June 2009 is not likely to be material, and accordingly no provision for changes in asset values and related costs have been made.

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

Financial Covenants and Ratios
There are no specific financial covenants stipulated by the Crown Health Financing Agency (CHFA) for its term lending to TDHB. No financial covenants have been stipulated by ASB for transactional banking and stand bye overdraft arrangements.

The following are some key financial ratios as derived from the consolidated financial statements for the period 2009 to 2012.

	Financial ratios	TDHB 2008/09	TDHB 2009/10	TDHB 2010/11	TDHB 2011/12
		forecast	plan	plan	plan
1	Revenue to net funds employed	4.57	2.85	2.08	2.16
2	Operating margin to revenue	4%	4%	3%	4%
3	Operating return on net funds employed	10%	10%	7%	8%
4	Debt to debt equity ratio	28%	28%	50%	50%
5	Interest cover ratio	4.57	5.08	5.10	6.09

Efficiency and Productivity Improvement

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. The DHB will also be faced with managing the redevelopment of its base hospital facilities scheduled to commence in the 2010/11 fiscal year. Under this capped environment, with increasing operating costs and demand for services, the hospital provider arm will need to achieve sustainability – both clinical and financial. Taranaki DHB recognises the need for continuous service improvements and efficiency gains while it attempts to re-position itself continually to meet the challenge.

The strategy is to pursue short term initiatives to provide immediate gains, while progressing a series of longer term initiatives to achieve sustainability.

The following key initiatives are expected to result in efficiency gains and reduced operating costs within the hospital provider arm during 2009/10:

	Initiative	**Proposal**	**Potential ($)**	**Impact**
1	Reduction of outsource service services costs	Bringing in-house services currently outsourced	$ 300K	Reduce service cos
2	Manage Clinical supply costs.	Efficiency reviews + contra negotiations + VFM initiativ	$ 300K	Contain cost growth
3	Staffing reviews and alignment of services to funding + FTE's.	Efficiency & process reviev + reduction of FTE's	$ 1,800K	Contain cost growth + FTE reduction
4	Reduce General Operating overheads	Internal cost controls + capped budgets	$ 200K	Contain cost growth
5	Management of FTE's through vacancies	Active review and FTE reduction by attrition.	$ 900K	Contain cost growth + FTE reduction
	TOTAL		**$ 3,500K**	

The DAP 2009/10 has recognised the efficiency and reduced cost impacts of the above initiatives in the financial budget. The gains from these initiatives are also expected to flow into future periods and have been recognised in the out years.

In parallel, the focus is on the redevelopment of the facilities. The primary aim of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint. This will in turn lend more flexibility and efficiency to operations. Overall, the project should generate more permanent and sustainable results**.**

Faced with a cost to funding gap in its operating budget, the hospital provider arm will continue to explore all practical options with the aim of reducing its overall cost of services delivery, whilst improving productivity and efficiency of operations. This financial recovery plan is an ongoing process, and is expected to span more than one fiscal year in view of their strategic components and broader implications.

4.7.2 Capital Expenditure

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

Capital Outlay	**Year 1 (2009/2010)**	**Year 2 (2010/2011)**	**Year 3 (2011/2012)**	**Total (2009/2012)**
Clinical Equipment	1,600	1,600	2,000	5,200
Other Equipment	500	350	450	1,300
Motor Vehicles	50	50	50	150
Minor Site Redevelopment (excluding prior year WIP)	1,350	500	500	2,350
Major Site Redevelopment: (Base Hospital - inpatient facilities)		See separate section for details	See separate section for details	
SUB - TOTAL	**3,500**	**2,500**	**3,000**	**9,000**
Information Technology (100% subsidiary - HIQ Ltd)	2,000	2,000	2,000	6,000
TOTAL (operational)	**5,500**	**4,500**	**5,000**	**15,000**
Community Oral Health Project	**2,871**	**171**	**-**	**3,042**
Base Hospital redevelopment project	**-**	**40,000**	**40,000**	**80,000**
GRAND TOTAL	**8,371**	**44,671**	**45,000**	**98,042**
Source of Funding				
Crown Equity	2,871	171	0	3,042
Bank Borrowing	0	0	0	0
CHFA Term Loans	0	40,000	5,000	45,000
Internal Cash Accruals	5,500	4,500	40,000	50,000

Note: Effective 01 July 2009, HIQ Ltd the JV between Capital & Coast DHB and Taranaki DHB (50/50 shareholding) for delivery of ICT services will change its structure and become a fully owned subsidiary of TDHB. Outlay on Information and Communication Technology (ICT) is related to capital investment in HIQ Ltd as a 100% subsidiary of TDHB.

Major Capital project: Base Hospital Inpatient Facilities Development Programme

The Base Hospital located in New Plymouth, like many of other contemporary hospitals across New Zealand is a conglomeration of buildings spread across the site with little relationship to patient flows and clinical processes. This coupled with capacity constraints and the urgent need to bring existing structures to the standards found in hospitals elsewhere in New Zealand as also in line with modern practices in clinical safety and patient care is the primary reason supporting the case for capital investment.

In addition, the key drivers that supplement this case are:

1. Theatre capacity – which will allow contracted volumes to be met and for models of care that optimise Day Surgery flows.
2. Ambulatory/outpatient service development – which will consolidate services and allow for the best models of care to be used.
3. Seamless integration between the primary and secondary healthcare settings – which will link primary and secondary models of care.
4. Consolidation of Emergency and Acute Assessment services – which will provide for the best models of care for disposition of ED patients between the primary and secondary sectors.
5. Services for the elderly/rehabilitation models – which will support early entry for assessment and discharge using modern models of care.
6. Consolidation of specialist services (Maternity, Paediatrics and NNU) – which will enable co-location of services and allow optimum efficiencies to be realised by bringing patients closer to the theatre area for urgent surgery situations.
7. Upgrade of inpatient accommodation and provision of sufficient beds over the next 10-15 years – which will enable modern models of care in purpose built inpatient wards.
8. The age and design features of the Clinical Services building indicate that their seismic performance is expected to be significantly below that required by current standards, and therefore it is quite likely that the building is Earthquake Prone. Legally, the Territorial Local Authorities are empowered by the Act to order strengthening or closing down of such buildings.

The primary focus of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint, which will lend more flexibility and efficiency to operations both in the immediate and long term. In doing so, it will also provide a more user friendly hospital and wellness environment to patients, staff and public.

This programme presents a staged redevelopment of the Base Hospital core inpatient facilities and support systems, such that it is both financially and operationally feasible over a defined timeline. The components of the programme are as follows:

	Stages	**Comprising**	**Estimated Cost**	**Construction Timeline**	**Status**
1	**STAGE 1**	Theatres, Ambulatory, Inpatient wards	$80M	Start: Jul 2010 Finish: Jun 2012	Approval received in July 2008.
2	**STAGE 2**	Maternity, Neonatal, Paediatrics, ED	$37M	Tentative: Jul 2013	Supplementary business case will be progressed later
3	**STAGE 3**	OPD, Laboratory, CSD, Administration	$28M	Tentative : Jul 2014	Supplementary business case will be progressed later
	TOTAL		**$145M**	**Jul 2010 – Dec 2015**	

Notes:

1. Approval and confirmation of funding has been received for Stage 1 only.

2. Stages 2 and 3 are discrete components of the overall Master Plan for the redevelopment of inpatient facilities at the Base Hospital.
3. Once Stage 1 is nearing completion it is envisaged that supplementary business cases will be developed for each of the remaining stages and forwarded to NCC for approval and funding.
4. In short, each of the stages can be visualised as stand alone projects, yet forming part of one coherent facilities redevelopment programme for the Base Hospital in New Plymouth, thus enabling affordability to both Taranaki DHB and the National health capital budget.

Financing Plan for Stage 1

The plan for financing Stage 1 is as follows:

		($M)	Notes
*	**Project capital cost**	**$80M**	QS estimate based on concept design.
*	Internally generated funds	$35M	- Free cash flows + retained surpluses
*	Net external borrowing	$45M	- Fresh borrowing as term debt
	Source:		
	Crown Health Financing Agency (CHFA)	$45M	- Un-utilised facility = $2.00M - New term debt = $43.00M
	NET EXTERNAL FUNDING	**$45 M**	**- equivalent to 56% of project cost**

Notes:

Project capital cost:

1. The cost of the project is based on the concept design, with the cost estimate prepared by Rider Levett Bucknall (Quantity Surveyors) as at August 2007.
2. The project capital includes the cost of site preparations, construction, building infrastructure, design and consultant fees, project management, fit-outs and the costs associated with decanting.
3. The above costs exclude capitalised interest. Interest will be capitalised at the relevant cost of borrowing up to the date of commissioning the facilities.
4. This cost estimate has an assessed accuracy under current building cost market conditions of +/- 20%, which is considered acceptable in the absence of detailed design drawings, projected timelines and architectural inputs.
5. This cost estimate has been independently reviewed and revisions incorporated as appropriate.

Internally generated funds:

6. TDHB has over the recent years built up cash reserves from its annual operating surpluses. These cash reserves together with base line depreciation reserves have enabled it to be an equal partner in this development. The internal investment of $35M (44% of project capital cost) is a combination of current cash reserves + future free cash flows + donations from local community trusts and organisations. TDHB is committed and confident of generating the necessary investment by the time the project reaches the active phase. Additionally, TDHB

will rationalise its annual base line capital expenditure over the immediate following financial periods with the aim of generating as much cash flow as possible to support the project.

Contingency cash lines are on standby in the form working capital facilities with ASB Bank. Whilst, it is acknowledged that this line of credit is not permitted for capital purposes, it nonetheless provides backup liquidity should it be required.

4.7.3 Disposal of Land

Taranaki DHB has planned for disposal of property identified as surplus to its requirements. Taranaki DHB will ensure that disposal of any land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act 1993 will be subject to approval by the Minister of Health. Taranaki DHB will work closely with the Office of Treaty Settlements to ensure the relevant protection mechanisms that address the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations to Māori sites of significance are addressed.

4.7.4 Other Financial Considerations

Measurement Basis
The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain assets as specified below.

Specific Accounting Policies
The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

Application of New Zealand Equivalents to International Financial Reporting Standards (NZIFRS)
The DAP financial statements for the plan period 2009/12 and comparative years have been prepared in accordance with NZ GAAP (generally accepted accounting principles). They comply with the New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards as applicable to public benefit entities.

Goods and Services Tax
The Financial Statements have been prepared exclusive of goods and services tax (GST) apart from gross 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.

Employee Entitlements
Provision is made in respect of Taranaki DHB's liability for annual leave, long service leave, retirement gratuities, parental leave and conference leave. Employee entitlements with the exception of long service leave have been calculated on an actual entitlement basis at current rates of pay. Long service leave is calculated taking into account the probability that the service years will be attained.

Taxation
Taranaki DHB 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 2004.

Basis of Consolidation
The Group Financial Statements represent the consolidation of Taranaki DHB and its subsidiaries (which are accounted for using the purchase method). Corresponding assets,

liabilities, revenues and expenses are added together on a line by line basis. All inter-company transactions are eliminated on consolidation.

Associate Companies
Associates are investees (but not subsidiaries or joint ventures) in which the Taranaki DHB has the capacity to affect substantially, but not unilaterally determine, the operating and/or financial policy decisions. The accounts of the associate companies have been reflected in these Financial Statements on an equity accounting basis, which shows the share of surplus/(deficit) in the Statement of Financial Performance and the share of post acquisition increases/decreases in net assets in the Statement of Financial Position. In the DHBs financial statements investments in associates are recognised at cost.

The associated companies are:

Fulford Radiology Services Limited – 50% held.
HIQ Limited – 15% held with 50% voting rights (until 30 June 2009).
Allied Laundry Services Limited – 25% held.
HealthShare Limited – 20% held.

Effective 01 July 2009, HIQ Ltd the JV between Capital & Coast DHB and Taranaki DHB (50/50 shareholding) for delivery of ICT services will change its structure and become a fully owned subsidiary of TDHB.

Accounts Receivable
Accounts receivable are stated at expected realisable value after providing for doubtful and un-collectable debts.

Inventories
Inventories are valued at the lower of cost, determined at weighted average value, and net realisable value. This valuation includes allowances for slow moving and obsolete inventories.

Property, Plant and Equipment
Property, Plant and Equipment transferred from Taranaki Healthcare Limited was initially valued at the cost at which it was transferred.

Property, Plant and Equipment acquired since the establishment of the DHB Assets, including assets capitalised under a finance lease, other than land and buildings acquired by the Board since its establishment are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation including materials, labour, and transport costs, but excluding any interest cost.

Revaluation of Land and Buildings
Land and buildings were re-valued as at 30 June 2008 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 Financial Performance. Any subsequent revaluation gains are written back through the Statement of Financial Performance only to the extent of past deficits written off. Value of land and buildings are assessed at the end of each financial year and any changes, if material, are recognised in the financial statements as appropriate.

Depreciation
Depreciation is provided 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.

The useful lives of major classes of assets have been estimated as follows:

Freehold Buildings	5 to 33 years	(3% - 20%)
Property, Plant, Equipment and Motor Vehicles	2 to 18 years	(5.5% - 48%)
Leased Assets Capitalised	5 years	(20%)
Motor vehicles	3 to 10 years	(10% - 33.3%)

Work in progress is not depreciated. The total cost of a project is transferred from work in progress to the appropriate asset class on its completion and is then depreciated.

Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, bank overdrafts and demand deposits which are invested as part of the day-to-day cash management.

Operating activities include cash received from all income sources and records the cash payments made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of non-current assets.

Financing activities comprise the change in equity and debt capital structure of the DHB.

Donations, Bequests and Trust Reserves

Donations and bequests received by the DHB are treated as revenue in the Statement of Financial Performance. They are subsequently appropriated to the Trust Reserve forming part of Equity. When expenditure is subsequently incurred in respect of those funds, it is recognised in the Statement of Financial Performance and an equivalent amount is transferred from the Trust Reserve component of Equity to Retained Earnings/Accumulated Deficit.

Financial Instruments

Taranaki DHB has adopted a policy of minimising exposure arising from its treasury activity. The DHB is not authorised by its Treasury policy to enter in to any transactions which are speculative in nature. Interest rate swaps, forward rate agreements, and options are entered into to manage the interest rate component of its term debt. As these items are hedges, their fair value is not recognised in the statement of financial position.

It is Government policy that DHBs do not borrow from the private sector except for certain capital facilities, although the New Zealand Public Health and Disability Act 2000 does allow for loans to be undertaken with the Minister of Finance's consent. The Crown Health Financing Agency (CHFA) is the Crown Agency (CA) for lending to DHBs.

Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements other than the changes brought about by the adoption of NZIFRS in the financial statements as stated earlier. All policies have been applied on a basis consistent with the previous period.

Where applicable, certain comparatives have been restated to comply with the accounting presentation adopted for the current year.

HIQ Ltd

Statement of Financial Performance ($'000)	2008/09 Plan	2008/09 Forecast	2009/10 Plan
Revenue	20498	22898	6200
Expenditure	20258	24298	6100
SURPLUS/(DEFICIT)	240	-1400	100
Statement of Financial Position			
Shareholders Funds	33347	31013	5035
Total assets	34847	38625	8000
Total liabilities	1500	7612	2965
NET ASSETS	33347	31013	5035
Statement of cash flows			
Cash Inflow (Outflow) from operating activities	15650	18300	6000
Cash Inflow (Outflow) from investing activities	-15631	-18225	-5800
Net increase / (decrease) in cash held	19	75	200
Plus: Opening cash	47	66	100
CLOSING CASH BALANCE	66	141	300
Statement of movements in equity			

	2008/09 plan	2008/09 forecast	2009/10 plan
EQUITY AT THE BEGINNING OF PERIOD	**33107**	**32413**	**4935**
* Net results for the period	240	-1400	100
* Other	0	0	0
EQUITY AT THE END OF THE PERIOD	**33347**	**31013**	**5035**

Note: Effective 01 July 2009, HIQ Ltd the JV between Capital & Coast DHB and Taranaki DHB (50/50 shareholding) for delivery of ICT services will change its structure and become a fully owned subsidiary of TDHB.

5 ORGANISATIONAL CAPABILITY

5.1 Accountability

The public are welcome to observe the meetings of the board and statutory committees. and Hospital Advisory Committee meeting. Board meetings and Hospital Advisory Committee meetings are held each month. Community & Public Health Advisory Committee and Disability Support Advisory Committee. Committee meetings are held every two months. Details of the meetings (such as agendas, minutes, membership of the committee, people who attended a meeting) are publicly available on http://www.tdhb.org.nz/dhb/meeting_information.shtml, at the public library, etc. Occasionally these groups have discussions where it is best if the public does not attend, and this is allowed for in the NZPHD Act 2000.

5.2 National and Regional Collaboration, and cross- sector Collaboration

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of Taranaki DHB in achieving the goals set out in our DSP. We are committed to sharing resources with regional DHBs and providers as well as collaboration with the Ministry, DHBNZ[16], NGOs[17] and other service providers in order to achieve specific outcomes.

1. National

ACC District Health Board Relationship

ACC and DHBs are working together at district and national levels on projects of mutual interest and advantage to common clients as expressed in the Charter of Collaboration, which seeks to progress the relationship and seek opportunities to improve health outcomes for common clients.

In Taranaki the ACC and the Taranaki DHB engages on number of items and projects of interest to the hospital provider arm. Joint ACC-DHB prioritising of projects occurs yearly and in 2008/09 has included the provision of and changes to ACC Elective surgery; Mental Health project; Public Health Acute Services workshops and discussion; rewriting the Provider Handbook and DHB/ACC "Accident Services Who Pays?' guidelines; TDHB representatives on the Pain Contracts Workshops in order to rewrite more effective pain services contracts.

Future priorities might include updating equipment provision processes; further progress with electronic invoicing and reporting and ongoing collaboration in clinical pathway projects.

The wider DHB is also involved in projects such as the Implementation of the InterRAI Assessment Tool; encouraging DHBs to involve ACC in primary care after hours planning; joint funding of falls prevention programmes for elderly in the community and establishment of the ACC, Ministry and Police joint venture for Sexual Abuse Assessment and Treatment services.

The National Ambulance Sector Office (NASO), a joint venture between the Ministry of Health and ACC is charged with managing all ambulance related work for the two Crown agencies. There is ongoing work between NASO and the Taranaki DHB owned ambulance service towards determining linkages between the draft New Zealand Ambulance Strategy and other pieces of work such as the Inter Hospital Transfers project.

[16] DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.

[17] NGOs (Non-Governmental Organisations) for more information on NGOs go to http://www.moh.govt.nz/ngo

The ongoing commitment is that ACC and Taranaki DHB will continue to engage openly about opportunities that will benefit common clients and advance mutual outcomes.

DHB collective commitment to the National Quality Improvement Programme
Taranaki DHB will continue to work at both the national collective level and at the DHB level to deliver the QIC programme over the next 2-3 years.

Taranaki DHB continues with its commitment to actively work with the national collective to support the lead DHBs and to ensure that we as a DHB are prepared in terms of planning and resourcing to implement the results of these projects as they become available. We expect to be ready to start implementing outputs as we move into the implementation phase of 2009/10.

We note that many of the projects have a significant IT component that is yet to be funded. We will continue working with the Ministry of Health at the national collective level to ensure investment decisions are made in a timely manner.

2. Regional

Midland Region District Health Board's
Taranaki District Health Board is been an active participant in work undertaken by the Midland District Health Boards. A number of Regional Plans have been developed for specific clinical services including: mental health and addiction, diabetes and cardiac services.

The Midland group of DHBs have recently embarked on a Regional Clinical Services Plan. The Plan is sponsored by all 5 Chief Executives in the Midland region and focuses on what we intend to do clinically as a region in meeting the health needs of the regional population. The Plan describes a set of principles eg patient centric, targeting at risk groups, providing services close to the population so long as they are
clinically and financially viable which provide the focus for the collaboration. The Plan also acknowledges that within the region and outside it there are current cooperative ventures that need to be supported. Further, planning needs to be flexible to take in to account this approach in the future. The Plan is congruent with the Ministry's Long Term Sector Framework vision of greater regional collaboration

Central Region District Health Board's
Taranaki District Health Board is an active participant in the Central Region Cancer Network.

Improvements in patient and staff safety, practice service delivery and risk mitigation are supported by the Taranaki DHB, recognising that there needs to be a balance maintained between achieving the necessary improvements, mitigating risk and the costs of doing so.

The Taranaki DHB has an annual Taranaki DHB Quality and Risk Plan, located on the DHB's intranet, that is monitored through the DHB's committee structure with formal evaluation occurring at least annually. It is mainly focused on Taranaki DHB's Provider services and aims to facilitate the progressive achievement of the Taranaki DHB's vision by monitoring and continuously improving all services, processes and activities relevant to the quality of care, patient safety, risk mitigation and the service provided or funded. The plan facilitates the progressive achievement of the DHB's vision by outlining objectives and actions to be taken in relation to the 10 goals outlined in the Ministry of Health's IQ Action Plan: Supporting the Improving Quality Approach. It also links into the DHB's Strategic and District Annual Plans.

Key focus areas within the Taranaki DHB Quality and Risk Plan for the 2009-10 year will be addressing our corrective actions and recommendations received from the Provider Arm's recent certification and accreditation audit/survey respectively; progressing our commitment to the national Quality Improvement Committee programmes and progressing the recommendations from the Review of the Clinical Board Report received earlier this year.

3. Cross-Sector

Future Taranaki
Taranaki DHB is an active participant of the Future Taranaki Facilitation Group (FTFG) which was formed in 2004 out of a collaborative regional partnership between a wide and varied range of agencies. The FTFG member organisations currently comprise:

Taranaki District Health Board
Ministry of Social Development
Te Puni Kokiri
Venture Taranaki Trust
New Plymouth District Council
Stratford District Council
South Taranaki District Council
Taranaki Regional Council

The purpose of the group is to provide a framework through which these and other organisations can be encouraged to collaborate to deliver the seven community outcomes identified for the Taranaki region. These outcomes are:

Secure and Healthy: Region is a safe, healthy and friendly place to live, work or visit
Sustainable: Region appreciates its natural environment and its physical and human resources in planning, delivery and protection
Prosperous: Regional economy sustainable, resilient and innovative, prospering with the natural and social environment
Together: Region is caring and inclusive, works together and enables people to have a strong and distinctive sense of identity
Vibrant: Region provides high quality and diverse cultural and recreational experiences, and encourages independence and creativity
Connected: Region has accessible and integrated infrastructure, transport and communication systems that meet the needs of residents, businesses and visitors
Skilled: Region values and supports learning so all can play a full and active role in social, cultural and economic life

Three key projects are being undertaken by FTFG, all of which link to Taranaki DHB's strategic aims:

Working Together for a Smokefree Taranaki: Taranaki DHB is the lead agency for this project, which aims for Taranaki to become the first Smokefree province in New Zealand by Smokefree Day 2009
Safer Families, Safer Communities – Eliminating Family Violence in Taranaki: The Ministry of Social Development is the lead agency for this project, which aims to provide intervention, education and support in workplaces
Regional Skills Strategy: This project is led by Venture Taranaki Trust, with the New Plymouth District Council. The aim is to ensure that the region's supply of labour meets its potential demand

Taranaki Strategic Forum
The Taranaki Strategic Forum comprises Taranaki DHB, Ministry of Social Development and the Accident Compensation Corporation. The forum provides an opportunity for the major funders in the district to come together to share information, knowledge and expertise, identify duplications and gaps with a view to pooling resources to achieve greater gains.

5.3 Workforce Development and Organisational Health

Workforce development and strong organisation health are central to Taranaki DHB to ensure that the DHB provides access to and delivery of high quality, effective services and meet the continued challenges of the health needs of our community.

Taranaki DHB aims to continue to be recognised as an employer of choice and in so doing, the DHB connects with the community through a number of forums focusing on engagement in workforce, employment and career promotion. Taranaki District Health Board has a clear set of values which underpins the way we work with our employees, patients, communities, business partners and stakeholders. To this end, the DHB encourages and promotes flexibility and innovation; employee engagement, organizational and clinical leadership, career, learning and skill development opportunities.

As a 'good employer' Taranaki District Health Board has a number of policies and programmes that promote equity, fairness and a safe and healthy work environment. These include:

fair and transparent recruitment policies to ensure that the DHB meets current and future workforce needs and retain staff

strong induction, health checks and on-boarding practices to support and welcome new staff

flexible work practices are recognised and operated within the DHB. Taranaki DHB recognises the need for work-life balance and has implemented a number of initiatives to support staff

change management and consultation processes to ensure that employees are engaged in change processes

a zero-tolerance of all forms of harassment and bullying, supported by up-to-date policies, training, coaching and support

equitable training and development opportunities for all employees

a range of proactive policies and programmes focusing on health and safety. These include healthy living initiatives, exercise programmes, influenza vaccinations, Employee Assistance Programme, critical incident debriefing.

a wide range of discounts are provided to staff with the majority sought from local gyms, exercise programmes, massage and other health related fields.

Smokefree programmes and a program with TDHB caterers to provide healthy food choices.

post entry surveys are conducted with new employees after 3-months service to identify and address any employment related issues

exit interviews are offered to all departing employees to ascertain the effectiveness of employment practices and identify any areas for concern

the management and disclosure of adverse events to ensure a safe quality working environment.

implemented strong workforce planning programmes and has implemented a number of successful initiatives to improve service delivery and ensure continuity of staffing.

Taranaki District Health Board has developed a comprehensive workforce profile and has implemented a strong set of HR Key Performance Indicators to facilitate effective staffing. The DHB has an understanding the needs and expectations of its workforce. We are committed to improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki.

5.4 Quality and Safety

Improvements in patient and staff safety, practice service delivery and risk mitigation are supported by the Taranaki DHB, recognising that there needs to be a balance maintained between achieving the necessary improvements, mitigating risk and the costs of doing so.

The Taranaki DHB has an annual Taranaki DHB Quality and Risk Plan, located on the DHB's intranet, that is monitored through the DHB's committee structure with formal evaluation occurring at least annually. It is mainly focused on Taranaki DHB's Provider services and aims to facilitate the progressive achievement of the Taranaki DHB's vision by monitoring and continuously improving all services, processes and activities relevant to the quality of care, patient safety, risk mitigation and the service provided or funded. The plan facilitates the progressive achievement of the DHB's vision by outlining objectives and actions to be taken in relation to the 10 goals outlined in the Ministry of Health's IQ Action Plan: Supporting the Improving Quality Approach. It also links into the DHB's Strategic and District Annual Plans.

Key focus areas within the Taranaki DHB Quality and Risk Plan for the 2009-10 year will be addressing our corrective actions and recommendations received from the Provider Arm's recent certification and accreditation audit/survey respectively; progressing our commitment to the national Quality Improvement Committee programmes and progressing the recommendations from the Review of the Clinical Board Report received earlier this year.

The Taranaki DHB is committed to the delivery and funding of quality services by all health and disability providers within the district. Quality assurance systems and procedures are in place to ensure services undergo performance measurement (usually focused on service content, delivery specifications and patient/client outcomes). Continuous quality improvement is the response to this quality activity and supports the vision of the Board – Taranaki Together, a Healthy Community.

Improvements in patient and staff safety, practice service delivery and risk mitigation are supported by the Taranaki DHB, recognising that there needs to be a balance maintained between achieving the necessary improvements, mitigating risk and the costs of doing so. The tension and challenge lies in finding this balance. We continue to broaden our quality and risk management approach from the Taranaki DHB Hospital Provider as our key point of reference, to an approach that involves the entire health and disability sector in Taranaki, particularly engaging with clinicians and clinical services.

The annual Taranaki DHB Quality and Risk Plan facilitates the progressive achievement of the Taranaki DHB's vision by monitoring and continuously improving all services, processes and activities relevant to the quality of care and the service provided or funded. It outlines organisation wide goals and links into the Taranaki DHB's District Annual Plan and the Ministry of Health's IQ Action Plan: Supporting the Improving Quality Approach, provides direction for all health and disability services in Taranaki, building upon that successfully applied in the Taranaki DHB Provider services.

Key areas of focus within the Taranaki DHB Quality & Risk Plan for this DAP period will be addressing our corrective actions and recommendations received from our recent certification and accreditation audit/survey respectively; progressing our commitment to the National Quality Improvement Committee Programme and progressing the recommendations from the Review of the Clinical Board Report received earlier this year.

Indicators Level 2 – Risk Management

5.5 Building Capability

The DHB's approach to building capacity is outlined in the intervention logic diagrams "meeting needs with population share" on page 26.

The following technology developments will be initiated in 2009/10:

Medicine reconciliation tool

Clinical Portal

Referred services information system management

5.6 Information Services

The following technology developments will be initiated in 2009/10:

Medicine reconciliation tool

Clinical Portal

Referred services information system management

5.7 Associate Companies, JVs and Subsidaries

Taranaki DHB is a Crown entity in terms of the Public Finance Act 2004, owned by the Crown and domiciled in New Zealand.

Currently, the Taranaki DHB group consists of Taranaki DHB, a 50% investment in Fulford Radiology Services Ltd, a 15% investment in HIQ Ltd. (with 50% voting rights), a 25% investment in Allied Laundry Services Ltd. and a 20% investment in HealthShare Ltd.

Effective 01 July 2009, HIQ Ltd the JV between Capital & Coast DHB and Taranaki DHB (50/50 shareholding) for delivery of ICT services will change its structure and become a fully owned subsidiary of TDHB.

The financial statements of Taranaki DHB are prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Public Finance Act 2004.

HIQ Ltd
HIQ is a wholly owned subsidiary (from 1 July 2009) focused upon providing operational and strategic information systems support to Taranaki DHB. Through HIQ the DHB will be able to progress our Information Systems Strategic Plan including the required technology for the new hospital development.

HIQ also provides a good opportunity for further Inter DHB collaboration and shared information technology improvements. In the coming year HIQ will provide support to four other DHB's, on shared projects and also contribute to achieving national goals in this area.

HIQ support the Health Information Strategy for New Zealand. In particular, key initiatives are:

National Network Strategy: Through our ICT service provider, Health Intelligence, we are participating in the selection and implementation of a secure data network between regional DHBs.
eLabs: Implementation of a laboratory results repository accessible by multiple stakeholders in the region.
Chronic Care and Disease Management: We are actively investigating tools and decision support systems that will support chronic care initiatives.
National Collections/Strategies: TDHB have implemented the National Non-admitted Patient Collection (NNPAC) and are actively participating in the Primary Health Care Strategy workshops.

On 30 June 2009, HIQ Ltd will undergo a restructure, and effective 01 July 2009 HIQ Ltd will become a fully owned subsidiary of Taranaki DHB. The ICT operations of Capital & Coast DHB will become an in-house operation of the DHB.

Allied Laundry Services Ltd

Allied Laundry Services Ltd is a shared services arrangement between four District Health Boards for the provision of laundry and linen services. The participating District Health Boards are Hawkes Bay, MidCentral, Taranaki and Wanganui. This collaborative arrangement enables cost savings to be achieved in the delivery of laundry and linen services to the participating District Health Boards.

In pursuant of the provisions of Section 157 of the Crown Entities Act 2004, ALSL has received exemption to prepare an independent Statement of Intent (SOI), with an undertaking that one of the shareholding DHBs (MidCentral DHB) would provide appropriate information on ALSLs activities and operating plans in its SOI.

Fulford Radiology Services Ltd

Taranaki District Health Board has a 50% investment in Fulford Radiology Services which provides a comprehensive range of imaging services to the Taranaki population.

HealthShare

Each of the five Midland DHBs has a participatory interest in HealthShare Limited, a DHB joint venture company that specialises in both routine and issues-based quality-audit of service providers. The five DHB Chief Executives are Board members. The service level agreement between the five DHBs and HealthShare sets out the principles, targeted performance standards, and operational guidelines that underpin HealthShare's audit programme and framework ensuring alignment with both national and regional requirements.

HealthShare reports back to the participating DHBs throughout the year ensuring contractual obligations and standards are met by contracted providers.

HealthShare also manages the primary health regional fees review process for the Midland DHBs.

6 APPENDICIES

6.1 Appendix 1 : DHB Performance Reporting Framework 2009/10

6.1.1 Health Targets 2009/10 – Summary Reference Table

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95%	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	95%	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	Increase the National volume of elective surgery by an average of 4,000 discharges per year (compared with the recent average increase of 1400 per year).	129,000	additional elective surgical discharges	3,969	additional electives surgical discharges
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.	100%	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).	100%	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).
Increased immunisation	85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012	85%	of two year olds are fully immunised by July 2010	79%	of two year olds (Maori) are fully immunised by July 2010
				79%	of two year olds (Total) are fully immunised by July 2010

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Better help for smokers to quit	80 per cent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012. Introduce similar target for primary care from July 2010 or earlier, through the PHO Performance Programme.	80%	of hospitalised smokers are provided with advice and help to quit by July 2010	80%	of hospitalised smokers are provided with advice and help to quit by July 2010
Better diabetes and cardiovascular services NB All four of these targets are based on an increase of 2% of the actual achieved percentage this year not an increase on the targets set for 2008/2009. Ongoing discussions between the MOH, PHO's & Taranaki DHB to compare PHO Patient Management System data and the Laboratory Warehouse data	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Baseline 47.1%	49.2%	Increased percent of the eligible adult population (Maori) have had their CVD risk assessed in the last five years (suggestion is 2%)
			Baseline 50%	52%	Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last five years (suggestion is 2%)
			Baseline 66.9%	69%	Increased percent of the eligible adult population (Other ethnicity) have had their CVD risk assessed in the last five years (suggestion is 2%)
			Baseline 62.8%	64.8%	Increased percent of the eligible adult population (All ethnicities) have had their CVD risk assessed in the last five years (suggestion is 2%)
Better diabetes and cardiovascular services cont'd	Increased percent of people with diabetes attend free annual checks	Increased percent of people with diabetes attend free annual checks	Baseline 41%	59%	Increased percent of people with diabetes (Maori) attend free annual checks

Area	Long term Target	2009/10 National target		2009/10 DHB target	
			Baseline 21%	28%	Increased percent of people with diabetes (Pacific) attend free annual checks
			Baseline 59%	71%	Increased percent of people with diabetes (Other Ethnicity) attend free annual checks
			Baseline 56%	69%	Increased percent of people with diabetes (All Ethnicities) attend free annual checks
	Increased percent of people with diabetes have satisfactory or better diabetes management	Increased percent of people with diabetes have satisfactory or better diabetes management	Baseline 73%	74%	Increased percent of people with diabetes (Maori) have satisfactory or better diabetes management
			Baseline 81%	62%	Increased percent of people with diabetes (Pacific) have satisfactory or better diabetes management
			Baseline 81%	85%	Increased percent of people with diabetes (Other ethnicity) have satisfactory or better diabetes management
			Baseline 80%	83%	Increased percent of people with diabetes (All ethnicities) have satisfactory or better diabetes management

6.1.2 Level 2: Indicators of DHB Performance 2009/10 – Summary Reference Table

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
HKO – 01	Local Iwi/Maori are engaged and participate in DHB decision-making and the development of strategies and plans for Maori health gain	Reporting against 7 measures		✓		✓
HKO-03	Improving mainstream effectiveness	Reporting against 2 measures		✓		✓
HKO-04	DHBs will set targets to increase funding for Maori Health and disability initiatives	Reporting against 3 measures				✓
POP-04	Oral health – Mean DMFT score at year 8	Maori Fluoridated - 1.74 Maori Non-fluoridated - 1.94 Other Fluoridated - 1.26 Other non-fluoridated – 1.25			✓	
POP-05	Oral health – Percentage of children caries free at age 5 years	Maori Fluoridated – 47% Maori Non-fluoridated - 37% Other Fluoridated – 69% Other non-fluoridated – 60%			✓	
POP-06	Improving the health status of people with severe mental illness	0 – 19 years Maori 3.1% * 0 – 19 years Other 3.2%		✓		✓

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
		20 – 64 years Maori 5.2% 20 – 64 years Other 3.5% Over 65 years Maori 3.6% Over 65 years Other 3.6% *This target is aspirational but reflects our intend priority				
POP-07	Alcohol and other drug service waiting times	Reporting by ethnicity against 5 measures		✓		✓
POP-10	Chemotherapy treatment waiting times	Maximum 6 week wait for chemotherapy	monthly	monthly	monthly	Monthly
POP-11	Family violence prevention	Overall score of 70/100 in AUT audits for child abuse and partner abuse responsiveness				✓
POP-14	Utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years	Maori – Data not available All – 72% NB There are difficulties in obtaining an accurate baseline figure for 2008/09 and therefore this target may not be achieved.				✓
POP-15	Ambulatory sensitive (avoidable) hospital admissions	Remain below 95% of national average for Maori and other ethnicities for all age groups		✓		✓
POP-17	Improving mental health services	90% all long term consumers in all population groups will have up to date relapse prevention plans.		✓		✓
POP-18	Improving exclusive and fully breastfeeding rates	6 weeks Maori - 70.3% 6 weeks total - 74% 3 months Total - 54% 6 months Total – 22%	✓	✓	✓	✓
QUA-03	Improving the quality of data provided to National Collections	NHI duplications less than or equal to 3%		✓		✓

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Systems (NCS) – 09/10	Ethnicity not stated in the NHI less than or equal to 4% Standard v specific descriptor ratio of 5.0 or greater NMDS timeliness less than 5% records late				
RIS- 01	Service Coverage	Report progress towards resolution of exceptions to service coverage identified in DAP		✓		✓
SER-04	Continuous Quality Improvement – Elective Services Continuous Quality Improvement – Elective Services (cont'd)	Target minimum intervention rates per 10,000 population: Elective surgical 280 Target minimum intervention rates per 100,000 population: Major joint replacement 210 Hip replacement 105 Knee replacement 105 Cataract procedures 270 Cardiac procedures 59 Percutaneous revascularisation - maintain current rate	✓	✓	✓	✓
SER-07	Low or reduced cost access to first level primary care services	Reporting against 2 measures	✓	✓	✓	✓

6.1.3 Additional Reporting 2009/10 – Summary Reference Table

DHB Performance Reporting Framework	Additional Reporting 2009/10			
	Reporting occurring in Quarter			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reducing inequalities achievements (self assessment)		✓		✓
Oral Health			✓	
Delivery of DAP in key priority – confirmation and exception report		✓		✓
DHB Self Evaluation – Provider Arm Efficiency	✓	✓	✓	✓
Update report on delivery of Te Kokiri: the Mental Health and Addiction Action Plan			✓	
Delivery of Personal Health Services and Mental Health Service volumes	✓ mental health only	✓	✓ mental health only	✓
DHB confirmation and exception reports – risk management		✓		✓
Status Updates – Service changes and management of service risks	✓	✓	✓	✓
Global Trigger Tools	✓			✓
Longer Post Natal Stays		✓		✓
Primary Secondary Devolution		✓		✓

6.2 Appendix: Definitions

Definitions

Outcome	means a state or condition of society, the economy or the environment and includes a change in that state or condition. It normally describes a state or condition that is influenced by many different factors which may operate independently and where attributing change to the activities of one agency is very difficult. E.g. The life expectancy of infants at birth and at age one (Public Finance Act 1989)
Impact	means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g. The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations (Public Finance Act 1989)
Objectives	is not defined in the legislation but use recognises that not all outputs and activities are intended to achieve "outcomes" . E.g. *Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance…etc.*
Outputs	are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group
Output classes	are groups of similar outputs
Inputs	are the resources used to produce the goods and services (outputs) of the DHB. They include personnel, travel, motor vehicles, and land and buildings. Input information provides information about what the DHB has spent money on but not what the entity has produced.
Management systems	are the supporting systems and policies used by the DHB in conducting its business.
Processes	are the way the DHB converts inputs into outputs.
Internal outputs	also referred to as intermediate or management outputs) are: goods or services processed by one part of the DHB and delivered to another part of the same DHB; or steps along the way in the DHB's processes which contribute directly to the delivery of another output.
	Management systems, internal outputs and processes are needed to support the delivery of outputs to external parties. Although they are not outputs, information on them is needed for internal management purposes and may be useful for readers of general purpose financial statements.

6.3 DAP Financial Summary

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009/12

($'000)

	Year -1	FORECAST		Year 0					Year 1	%
	Consolidated Audited 2007/08	Hosp+Gov Forecast 2008/09	Funder Forecast 2008/09	Consolidated Forecast 2008/09	Provider Plan 2009/10	Govt Plan 2009/10	Hosp+Govt Plan 2009/10	Funder Plan 2009/10	Consolidated Plan 2009/10	change
REVENUE										
* MOH funding	133961	141377		141377	149982	0	149982		149982	6.1%
	115268		124376	124376				127983	127983	2.9%
* Funding & Governance	2094	2163		2163	0	2230	2230		2230	3.1%
* ACC Revenue	8316	7828		7828	8629	0	8629		8629	10.2%
* CTA revenue	1274	1518		1518	1512	0	1512		1512	-0.4%
* Other revenue	10645	5761	4004	9765	4081	0	4081	4005	8086	-17.2%
TOTAL REVENUE	271558	158647	128380	287027	164204	2230	**166434**	131988	298422	4.0%
EXPENDITURE										
Personnel costs										
- medical	19483	21636		21636	24171	0	24171		24171	11.7%
- nursing	35705	35509		35509	36598	0	36598		36598	3.1%
- allied health	14636	15405		15405	15981	0	15981		15981	3.7%
- support	3617	3854		3854	4137	6	4143		4143	7.5%
- mgt & admin	13208	14150		14150	13788	1364	15152		15152	7.1%
total	86649	90554	0	90554	94675	1370	**96045**	0	96045	6.1%
Outsourced services										
- clinical services	18955	19396		19396	18140	0	18140		18140	
- other outsourced	3976	2948		2948	2158	200	2358		2358	
total	22931	22344	0	22344	20298	200	**20498**	0	20498	-8.3%
Clinical supplies										
- treatment disposables	7182	7177		7177	7229	0	7229		7229	0.7%
- diagnostic supplies	1140	1218		1218	1214	0	1214		1214	-0.3%
- instruments & equip	586	670		670	680	0	680		680	1.5%
- patient appliances	1066	1151		1151	1123	0	1123		1123	-2.4%
- implants & prostheses	2571	2779		2779	2596	0	2596		2596	-6.6%
- pharmaceuticals	3669	4422		4422	6576	0	6576		6576	48.7%
- other clinical & client costs	2237	2346		2346	2325	0	2325		2325	-0.9%
							0			
total	18451	19763	0	19763	21743	0	**21743**	0	21743	10.0%

Infrastructure & other op.costs										
- hotel services & laundry	2872	3196		3196	3450	0	3450		3450	7.9%
- facilities	3107	3149		3149	3407	0	3407		3407	8.2%
- transport	1103	1101		1101	1325	50	1375		1375	24.9%
- IT systems & telecom	5583	6529		6529	3410	0	3410		3410	-47.8%
- professional fees	1561	1283		1283	1401	166	1567		1567	22.1%
- other op.expenses	1978	1193		1193	2085	72	2157		2157	80.8%
- democracy	340	268		268	4	314	318		318	18.7%
- depreciation	7599	8350		8350	10444	0	10444		10444	25.1%
- interest	2036	2171		2171	2045	0	2045		2045	-5.8%
- associate company income	-24	0		0	0	0	0		0	
- Payment to - NGO providers										
- personal health	74265		79896	79896				83182	83182	
- mental health	6747		8444	8444				8368	8368	
- disability support services	30253		30619	30619				31994	31994	
- public health	32		203	203				301	301	
- maori health	1454		1868	1868				1945	1945	
total	138906	27240	121030	148270	27571	602	**28173**	125790	153963	3.8%
TOTAL OPERATING EXPENSES	**266937**	**159901**	**121030**	**280931**	164287	2172	**166459**	125790	292249	4.0%
SURPLUS before capital charge	**4621**	**-1254**	**7350**	**6096**	**-83**	**58**	**-25**	**6198**	**6173**	
- Capital charge	5321	6351		6351	6075	0	6075		6075	-4.3%
SURPLUS (before strategic exp)	**-700**	**-7605**	**7350**	**-255**	**-6158**	**58**	**-6100**	**6198**	**98**	
STRATEGIC EXPENDITURE										
Mental health Ring-fenced surplus	**0**		**0**	**0**				**837**	**837**	
Workforce Development	**562**		**300**	**300**				**500**	**500**	
Maori Health Gains Project	**31**		**50**	**50**				**864**	**864**	
Hospital Provider Strategic Projects	**0**		**0**	**0**				**0**	**0**	
NET SURPLUS/(DEFICIT) (after strategic expenditure)	**-1293**	**-7605**	**7000**	**-605**	**-6158**	**58**	**-6100**	**3997**	**-2103**	
Interest Cover ratio	**4.10**			**4.57**					**5.08**	
Revenue to Net Funds employed	**2.59**	**1.52**		**2.75**	**1.57**				**2.85**	
Operating margin to Revenue ratio	**3%**	**2%**		**4%**	**4%**				**4%**	
Op. return on Net Funds employed	**8%**	**3%**		**10%**	**6%**				**10%**	

TARANAKI DISTRICT HEALTH BOARD

DISTRICT ANNUAL PLAN : 2009/12

	Provider Plan 2010/11	Govt Plan 2010/11	Funder Plan 2010/11	Year 2 Consolidated Plan 2010/11	% change	Provider Plan 2011/12	Govt Plan 2011/12	Funder Plan 2011/12	Year 3 Consolidated Plan 2011/12	% change
REVENUE										
* MOH funding	154629	0		154629	3.1%	159894	0		159894	3.4%
			131950	131950	3.1%			136454	136454	3.4%
* Funding & Governance	0	2299		2299	3.1%	0	2377	0	2377	3.4%
* ACC Revenue	8888	0		8888	3.0%	9155	0	0	9155	3.0%
* CTA revenue	1557	0		1557	3.0%	1604	0	0	1604	3.0%
* Other revenue	4203	0	4129	8333	3.0%	4330	0	4253	8583	3.0%
TOTAL REVENUE	169278	2299	136080	307657	3.1%	174982	2377	140707	318066	3.38%
EXPENDITURE										
Personnel costs										
- medical	24896			24896	3.0%	25643	0		25643	3.0%
- nursing	37696			37696	3.0%	38827	0		38827	3.0%
- allied health	16462			16462	3.0%	16956	0		16956	3.0%
- support	4261	6		4267	3.0%	4389	6		4395	3.0%
- mgt & admin	14202	1405		15607	3.0%	14628	1447		16075	3.0%
total	97517	1411	0	98928	3.0%	100443	1453	0	101896	3.0%
Outsourced services										
- clinical services	18684			18684		19245	0		19245	
- other outsourced	2223	206		2429		2289	212		2502	
total	20907	206	0	21113	3.0%	21534	212	0	21746	3.0%
Clinical supplies										
- treatment disposables	7525			7525		7751	0		7751	
- diagnostic supplies	1250			1250		1288	0		1288	
- instruments & equip	700			700		721	0		721	
- patient appliances	1157			1157		1191	0		1191	
- implants & prostheses	2674			2674		2754	0		2754	
- pharmaceuticals	6773			6773		6976	0		6976	
- other clinical & client costs	2395			2395		2467	0		2467	
total	22474	0	0	22474	3.4%	23149	0	0	23149	3.0%

Infrastructure & other op.costs										
- hotel services & laundry	3554			3554		3617	0		3617	
- facilities	3509			3509		3114	0		3114	
- transport	1365	52		1416		1406	53		1459	
- IT systems & telecom	3512			3512		3618	0		3618	
- professional fees	1443	171		1614		1486	185		1671	
- other op.expenses	2146	74		2220		2274	76		2350	
- democracy	4	323		328		4	333		337	
- depreciation	10444			10444		10444	0		10444	
- interest	2026			2026		2011	0		2011	
- associate company income	0			0		0	0		0	
- Payment to - NGO providers										
- personal health			86664	86664				91183	91183	
- mental health			8628	8628				8919	8919	
- disability support services			32954	32954				33946	33946	
- public health			310	310				319	319	
- maori health			1993	1993				2056	2056	
total	28002	620	130550	159172	3.4%	27974	648	136424	165046	3.7%
TOTAL OPERATING EXPENSES	168901	2237	130550	301688	3.2%	173100	2313	136424	311837	3.4%
SURPLUS before capital charge	**377**	**62**	**5530**	**5969**		**1882**	**64**	**4283**	**6229**	
- Capital charge	5907	0		5907	-2.8%	5736	0	0	5736	-2.9%
SURPLUS (before strategic exp)	**-5530**	**62**	**5530**	**62**		**-3854**	**64**	**4283**	**493**	
STRATEGIC EXPENDITURE										
Mental health Ring-fenced surplus			**364**	**364**				**0**	**0**	
Workforce Development			**233**	**233**				**100**	**100**	
Maori Health Gains Project			**1500**	**1500**				**500**	**500**	
Hospital Provider Strategic Projects			**100**	**100**				**100**	**100**	
NET SURPLUS/(DEFICIT) (after strategic expenditure)	**-5530**	**62**	**3333**	**-2135**		**-3854**	**64**	**3583**	**-207**	
Interest Cover ratio				**5.10**					**6.09**	
Revenue to Net Funds employed	**1.15**			**2.08**		**1.19**			**2.16**	
Operating margin to Revenue ratio	**4%**			**3%**		**5%**			**4%**	
Op. return on Net Funds employed	**5%**			**7%**		**6%**			**8%**	

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009-12

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

($'000)

	2007/08 audited	2008/09 forecast		2009/10 plan	2010/11 plan	2011/12 plan
CURRENT ASSETS						
* Bank Account	5971	3104		3704	8704	13704
* Prepayments +ST investments	23142	30147		35147	35147	147
* Debtors (net of provision)	10167	10150		10150	11150	12150
* Inventory	2352	2395		2395	2495	2595
	41632	45796		51396	57496	28596
CURRENT LIABILITIES						
* Creditors & other payables	18365	19940		18830	10782	11581
* Term Loans (current portion)	216	244		244	244	54
* Provisions	18146	17257		18457	18957	19457
	36727	37441		37531	29983	31092
WORKING CAPITAL	4905	8355		13865	27513	-2496
NON CURRENT ASSETS						
* Net Fixed Assets	94760	90684		85740	114996	144752
* Investments	4681	4597		4597	4597	4597
* Trust funds	671	671		671	671	671
	100112	95952		91008	120264	150020
NET FUNDS EMPLOYED	**105017**	**104307**		**104873**	**147777**	**147524**
NON CURRENT LIABILITIES						
* Provisions - non current	592	580		580	580	580
* Finance Leases (Term portion)	480	387		185	53	7
* Term Loans	29000	29000		29000	74000	74000
	30072	29967		29765	74633	74587
CROWN EQUITY						
* Crown Equity	23898	23898		26769	26940	26940
* Reserves	52559	52576		52576	52576	52576
* Retained earnings	-1512	-2134		-4237	-6372	-6579
	74945	74340		75108	73144	72937
NET FUNDS EMPLOYED	**105017**	**104307**		**104873**	**147777**	**147524**
Debt: Debt equity ratio	28%	28%		28%	50%	50%

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2008-11

CONSOLIDATED STATEMENT OF CASHFLOWS

($'000)

	2007/08 audited	2008/09 forecast		2009/10 plan	2010/11 plan	2011/12 plan
OPERATING ACTIVITIES						
* MOH funding	250479	269571		281707	289536	299427
* Other revenue	15951	14740		15355	15820	16864
total receipts	266430	284311		297062	305356	316291
* Payment of salaries & operating exp.	150282	157539		160377	166451	170165
* Payment to providers & DHB's	112366	121236		129614	140559	136654
total payments	262648	278775		289991	307010	306819
NET CASHFLOW FROM OPERATIONS	**3782**	**5536**		**7071**	**-1654**	**9472**
INVESTING ACTIVITIES						
* Interest Received	3010	2852		1360	1401	875
* Sale of fixed assets etc	40	0		50	0	0
* (Increase) / decrease in investments	-4408	-6990		-5050	0	35000
* Capital expenditure	-4471	-4200		-5500	-39700	-40200
NET CASHFLOW FROM INVESTING	**-5829**	**-8338**		**-9140**	**-38299**	**-4325**
FINANCING ACTIVITIES						
* Equity injections / repayments	-853	0		2871	171	0
* Private sector borrowings	333	0		0	45000	0
* Payment of debts	-20	-65		-202	-218	-147
NET CASHFLOW FROM FINANCING	**-540**	**-65**		**2669**	**44953**	**-147**
Total cash in	265890	284246		299731	350309	316144
Total cashout	-268477	-287113		-299131	-345309	-311144
NET CASHFLOW	**-2587**	**-2867**		**600**	**5000**	**5000**
Add: Cash (opening)	8558	5971		3104	3704	8704
CASH (CLOSING)	**5971**	**3104**		**3704**	**8704**	**13704**

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009-12

CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY

	2008/09 forecast		2009/10 plan	2010/11 plan	2011/12 plan
EQUITY AT THE BEGINNING OF PERIOD	**74945**		**74340**	**75108**	**73144**
* Net results for the period	-605		-2103	-2135	-207
* Revaluation of Fixed assets	0		0	0	0
* Equity Injections / (repayments)	0		2871	171	0
* Other	0		0	0	0
EQUITY AT THE END OF THE PERIOD	**74340**		**75108**	**73144**	**72937**