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

Statement of Performance Expectations

2021/22

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga

The 2021/22 Annual Plan has yet to be agreed by the Minister of Health and the Taranaki District Health Board. The Statement of Performance Expectations (SPE) is an integral part of the Annual Plan. However, in order to meet the requirements of Section 149(L) of the Crown Entities Act 2004, we are pleased to present the following information which forms the Statement of Performance Expectations. The SPE may be subject to further change as a result of the process of finalising the DHB Annual Plan for 2021/22 with the Ministry of Health and all financials presented are provisional.

While our 2021/22 Annual Plan articulates the strategic direction and activities our DHB intends to take over the next few years, the information contained in this Plan supports the assessment of the activities outlined.

We have worked with other DHBs in the Te Manawa Taki region, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2021/22. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the range of outputs that we fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, we have included with each measure past performance as baseline data.

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

Signed:

Rosemary Clements
Chief Executive
Taranaki DHB
Dated: 30/06/2021

Signed:

Cassandra Crowley
Chair
Taranaki DHB
Dated: 30/06/2021

Signed:

Bridget Sullivan
Deputy Chair
Taranaki DHB
Dated: 30/06/2021

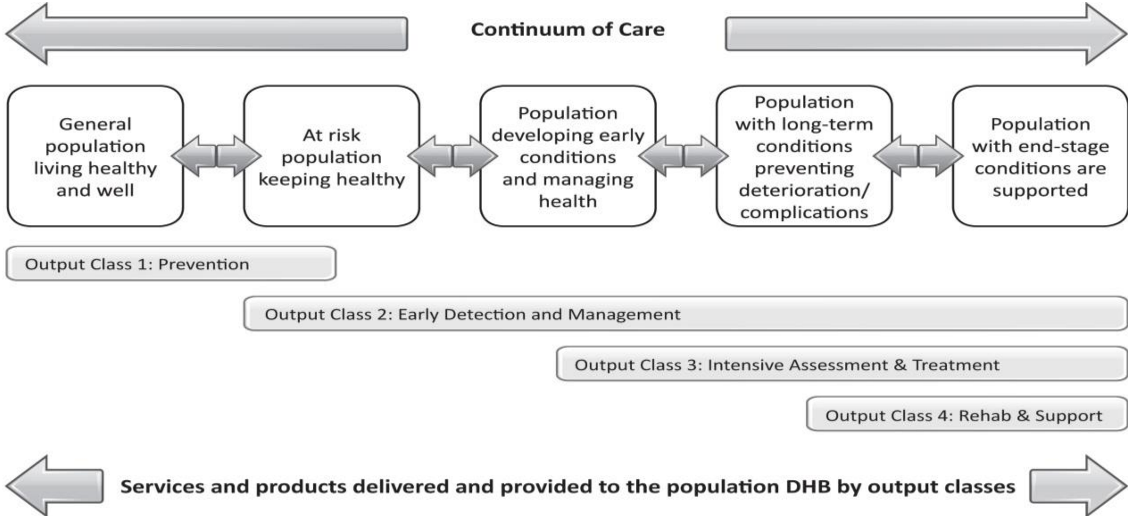
2021/22 Statement of Performance Expectations

We have worked with other DHBs in Te Manawa Taki, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2020/21. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, we have included with each measure past performance as baseline data.

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

Output Classes

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



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

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

Prospective Financial Performance by Output Class for the three years ended 30 June 2018, 2019 and 2020

Prospective Summary of Revenues and Expenses by Output Class	2021-22 Plan $000	2022-23 Plan $000	2023-24 Plan $000
Early Detection			
Total Revenue	107,572	111,411	116,051
Total Expenditure	115,819	118,435	123,516
Net Surplus / (Deficit)	**(8,247)**	**(7,025)**	**(7,465)**
Rehabilitation and Support			
Total Revenue	62,963	65,210	67,926
Total Expenditure	67,791	69,323	72,296
Net Surplus / (Deficit)	**(4,828)**	**(4,113)**	**(4,371)**
Prevention			
Total Revenue	9,893	10,246	10,673
Total Expenditure	10,651	10,892	11,359
Net Surplus / (Deficit)	**(758)**	**(646)**	**(686)**
Intensive Assessment and Treatment			
Total Revenue	287,625	297,889	310,296
Total Expenditure	309,677	316,672	330,257
Net Surplus / (Deficit)	**(22,052)**	**(18,783)**	**(19,962)**
Consolidated Surplus / (Deficit)	**(35,885)**	**(30,566)**	**(32,484)**

Guide to Reading the Statement of Performance Expectations

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

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

People are Supported to Take Greater Responsibility for their Health

Long Term Impact	People are supported to take greater responsibility for their health		
Intermediate Impacts	• Fewer people smoke	• Reduction in vaccine preventable diseases	• Improving health behaviours

Fewer People Smoke

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Percentage of Primary Health Organisations enrolled smokers offered advice to quit	Māori	1	qn/t	93%		86%	90%
	Total	1	qn/t	88%		90%	90%
Percentage of PHO enrolled patients identified as smokers	Māori	1	qn/t	20%	2017/18	New measure	5%
	Non-Māori	1	qn/t	10%	2017/18	New measure	5%
	Total	1	qn/t	12%	2017/18	New measure	5%

Reduction in Vaccine Preventable Diseases

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21

Percentage of eight-month olds fully immunised	Māori	1	qn/t	89%		85%	95%
	Total	1	qn/t	91%		89%	95%

Improving Health Behaviours

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Percentage of infants who are fully, exclusively or partially breastfed at 3 months	Māori	1	qn/t	47%		42%	70%
	Total	1	qn/t	55%		54%	70%
Reduce the rate of teenage terminations of pregnancy per 10,000	Māori	1	qn/t	179		58	<70
	Total	1	qn/t	125		55	<70
Reduce the teen birth rate per 10,000	Māori	1	qn/t	276		308	<84
	Total	1	qn/t	159		170	<84
The number of referrals to the GRx (Green Prescription) programmes – Adult	Māori	1	qn/t	361	2016/17	353	343
	Total	1	qn/t	1281		1448	1714
The number of referrals to the GRx (Green Prescription) programmes – Children	Māori	1	qn/t	60	2016/17	38	12
	Total	1	qn/t	80		78	60

People Stay Well in their Home and Communities

Long Term Impact	People Stay Well in Their Homes and Communities			
Intermediate Impacts	• An improvement in childhood oral health	• Long-term conditions are detected early and managed well	• Fewer people are admitted to hospital for avoidable conditions	• More people maintain their functional independence

An Improvement in Childhood Oral Health

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Percentage of adolescent utilisation of DHB funded dental services	Total	2	qn	54%		69%	85%

Percentage of children (0-4) enrolled in DHB funded dental services	Māori	2	qn	59%		78%	95%
	Total	2	qn	74%		104%	95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori	2	qn	4%		Not Available	10%
	Total	2	qn	2%		Not Available	10%

Long Term Conditions are Detected Early and Managed Well

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Percentage of eligible women (25-69) have a cervical cancer screen every 3 years	Māori	1	qn/t	64%		76%	80%
	Total	1	qn/t	79%		82%	80%
Percentage of eligible women (50-69) have a breast screen in the last 2 years	Māori	1	qn/t	61%		61%	70%
	Total	1	qn/t	74%		74%	70%
Percentage of population enrolled with a PHO	Māori	2	qn	84%		86%	90%
	Total	2	qn	95%		95%	90%
Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Total	2	qn	91%		90%	90%
Percentage of people enrolled in the PHO, aged 15-74 with HbA1c <64mmols	Māori	2	qn	68%	2017/18	New measure	60%
	Total	2	qn	78%	2017/18	New measure	60%

Fewer People are Admitted to Hospital for Avoidable Conditions

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Percentage of eligible population who have had their B4 school checks completed	High Needs	1	qn/t	87%		92%	90%
	Māori	1	qn/t	119.5%	2016/17	90%	90%
	Total	1	qn/t	91%		95%	90%
Percentage of Emergency Department presentations who are	Māori	2&3	qn	52%		New Measure	Reduction
	Total	2&3	qn	49%		New Measure	Reduction

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
triaged at levels 4 & 5 – Taranaki Base Hospital							
Percentage of Emergency Department presentations who are triaged at levels 4 & 5 – Hawera Hospital	Māori Total	2&3 2&3	qn qn	70% 69%		New Measure New Measure	Reduction Reduction
Percentage of Emergency Department presentations who are triaged at levels 4 & 5 – Total	Māori Total	2&3 2&3	qn qn	60% 55%		New Measure New Measure	Reduction Reduction
Number of Emergency Department presentations – Taranaki Base Hospital	Māori Total	2&3 2&3	qn qn	6,819 32,693		New Measure New Measure	Reduction Reduction
Number of Emergency Department presentations – Hawera Hospital	Māori Total	2&3 2&3	qn qn	4,988 15,641		New Measure New Measure	Reduction Reduction
Number of Emergency Department presentations – Total	Māori Total	2&3 2&3	qn qn	11,943 48,742		New Measure New Measure	Reduction Reduction
Number of Violence Intervention Programme (VIP) training sessions delivered	Total	1	qn	TBC		New Measure	Maintain
Ward 2B (Paediatric) VIP Routine Questioning Rates	Total	2	qn	80%	2018/19 H1	New Measure	85%
Ward 15 (Maternity) VIP Routine Questioning Rates	Total	2	qn	64%	2018/19 H1	New Measure	85%
Number of Oranga Tamariki reports of concern	Total	2	qn	TBC		New Measure	Maintain

More People Maintain their Functional Independence

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
% of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2020/21	Total	2	qn	2.2%	2017/18	New Measure	7.6%

People Receive Timely and Appropriate Care

Long Term Impact	People receive timely and appropriate care			
Intermediate Impacts	• People receive prompt and appropriate acute and arranged care	• People have appropriate access to elective services	• Improved health status for people with a severe mental health illness and/or addiction	• More people with end-stage conditions are appropriately supported

People Receive Prompt and Appropriate Acute and Arranged Care

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Acute Re-admission rate	Total	3	ql/t	7.2%		12.1%	≤6.9%
Acute Re-admission rate 75+ years	Total	3	ql/t	10.5%		12.1%	≤10.9%
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	Māori	3	ql	14%	2015/16	18%	<18%
	Total	3	ql	20%		22%	<18%
Faster cancer treatment (62 day indicator)	Māori	3	ql/t	100%		80%	90%
	Total	3	ql/t	77%		71%	90%
Percentage of patients with a confirmed diagnosis of cancer who receive their first cancer treatment with 31 days of diagnosis	Total	3	ql/t	82%		93%	85%

People Have Appropriate Access to Elective Services

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Did-not-attend percentage for outpatient services	Māori	3	qn/t	19%		18%	5%
	Total	3	qn/t	9%		8%	5%
Number of elective surgical discharges under the Planned Care Initiative	Total	3	qn	5293		New Measure	5511
ESPI 1 Percentage of referrals appropriately acknowledged and processed within 15 days	Total	3	qn/t	100%		New Measure	100%

ESPI 2 Percentage of patients waiting longer than four months for their First Specialist Assessment	Total	3	qn/t	0%		16%	0%
ESPI 3 Percentage of patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold	Total	3	qn/t	0%		New Measure	0%
ESPI 5 Percentage of patients given a commitment to treatment but not treated within four months	Total	3	qn/t	0%		New Measure	0%
ESPI 8 Proportion of patients who were prioritised using approved nationally recognised processes or tools	Total	3	qn/t	100%		New Measure	100%

*ESPI = Elective Services Performance Indicator

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

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Percentage of Child and Youth clients discharged with a transition (discharge) plan.	Total	3	qn/t /ql	12%		32%	95%
Percentage of people referred for non-urgent addiction services are seen within 3 weeks	0-19 yrs	3	qn/t	71%		74%	80%
	20-64 yrs	3	qn/t	77%		67%	80%
	65+ yrs	3	qn/t	100%		92%	80%
Percentage of people referred for non-urgent mental health are seen within 3 weeks	0-19 yrs	3	qn/t	71%		54%	80%
	20-64 yrs	3	qn/t	69%		74%	80%
	65+ yrs	3	qn/t	87.3%		83%	80%

More People with End Stage Conditions are Supported Appropriately

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
A reduction in the percentage of palliative care clients who have had an inappropriate Emergency Department presentation	Māori					New Measure	
	Total	3	qn/t	0.6%	2017/18	New Measure	0%

Support Services

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2018/19	Target 2020/21
Improved wait times for diagnostic services - accepted referrals receive their CT scan within 42 days	CT	2	qn/t	86%		81%	95%
Improved wait times for diagnostic services - accepted referrals receive their MRI scan within 42 days	MRI	2	qn/t	45%		45%	90%
Histology reporting completed within 5 working days (tbc)	Total	2	qn	New measure		New measure	80%
Urgent community tests completed within 3 hours (tbc)	Total	2	qn	New measure		New measure	80%
Routine community tests completed within 24 hours (tbc)	Total	2	qn	New measure		New measure	90%
Percentage of Māori employed in the Health and disability workforce at the Taranaki DHB	Māori	4	qn	8.42%		9.3%	18%

Appendix A: Financial Performance Plan 2021-25

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)	2019/20 audited	Year 0 2020/21 forecast	Year 1 2021/22 plan	Year 2 2022/23 plan	Year 3 2023/24 plan	Year 4 2024/25 plan
TOTAL REVENUE	**419,924**	**456,870**	**468,053**	**484,756**	**504,945**	**527,241**
TOTAL OPERATING EXPENSES	**445,552**	**473,270**	**501,938**	**515,322**	**537,429**	**560,629**
Hospital Provider + Governance financial result	**-39,768**	**-33,600**	**-37,379**	**-25,984**	**-20,234**	**-13,837**
TDHB Funder financial result	**14,140**	**17,200**	**3,494**	**-4,582**	**-12,250**	**-19,551**
CONSOLIDATED result before extraordinary expenditure	**- 25,628**	**- 16,400**	**- 33,885**	**- 30,566**	**- 32,484**	**- 33,388**
EXTRAORDINARY EXPENDITURE						
* Holidays Act Remediation	**3,000**	**7,000**	**2,000**	-	-	-
CONSOLIDATED result after extraordinary expenditure	**- 28,628**	**- 23,400**	**- 35,885**	**- 30,566**	**- 32,484**	**- 33,388**

The net consolidated financial projections for the planning period 2021-25 are:

- 2021/22: Deficit $35.88M
- 2022/23: Deficit $30.57M
- 2023/24: Deficit $32.48M
- 2024/25: Deficit $33.39M

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

1. Key points from the Budgeted Financials: 2021-25

The 2021/22 Funding Package added $752.74M nationally compared to $990M in 2020/21.

Taranaki population growth rate is lower than the country as a whole.
Taranaki growth in population numbers is estimated at 1.16% compared to 2.64% nationally.
The Population Based Funding (PBF) share for 2021/22 for Taranaki has reduced more than planned. It is confirmed at 2.61% in 2021/22, a reduction from the last year share of 2.65%.
Taranaki has received a 2.81% increase on 2020/21 revised baselines – this is the lowest growth DHB in the country along with South Canterbury DHB.
The funding package adds $11.40M to Taranaki DHB compared to last year. For comparison, in 2020/21 Taranaki received a 7.98% increase on 2019/20 revised baselines, an additional $29.57M from the funding packages.
The change in demographic assumptions has resulted in a significant reduction to planned revenue.

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Against this backdrop, the Board has planned for a consolidated operating financial deficit for Yr.1 (2021/22) of $30.08M. After extraordinary expenditure, the consolidated deficit is $ 35.88M (Forecast 20/21 deficit: $23.40M). Future periods also carry financial deficits.

The financial plan will require the Board to actively work to restrain costs growth and also requires potential service changes to achieve a sustainable financial result in the out years.

- The Hospital Provider Arm will carry a cost to funding gap resulting in operating deficits in each year covered by this plan. These financial projections indicate that expenditure in the hospital provider operations is growing year on year and is significantly in excess of its funding, leaving residual deficits in its wake. The continuing operating deficits have impacted the DHB's cashflow, such that that it has had to seek deficit funding support from the Ministry in June 2019 ($13.60M) and February 2020 ($18M), and has planned for additional deficit support in fiscal 2021/22 ($35M).

- The hospital provider budget for Year 1 is *after* targeted cost reductions and budget rationalisation (Please refer Sec: 8 - Sensitivity Analysis for details). The cost reductions have to be bridged through savings and initiatives. (Please refer Section 6: Savings Plan).

- The surplus generated in the DHB Funder operations has significantly reduced to $3.50M in 2021/22 (2020/21 surplus: $17.20M) – reflecting the direct impact of the reduction in the funding package received for 2021/22.

- The DHB Funder operations are carrying risks in its budget which will present challenges for it to deliver to plan (Please refer Sec: 8 - Sensitivity Analysis for details).

- Collectively, the total cost budgeted in 2021/22 for Taranaki DHB to provide operational support to national and regional agencies (NZHPL, Health Share and TAS) is circa $2.70M – and increasing year on year. This is in addition to capital investment required to support regional and national projects. The operating budget is very limited in its ability to absorb these new (and increasing) costs arising across different fronts – noting that any benefits are likely to accrue only in future periods.

In the final analysis;

The Board is faced with:

1. *A significantly reduced funding increase in 2021/22.*
2. *Increasing demand for services and resources.*
3. *A continuing core deficit in its Hospital Provider operations, a much reduced surplus in the DHB Funder operations and, a consolidated financial deficit in each year of the plan period.*
4. *An aggressive and challenging Savings Plan for its hospital operations.*
5. *Additional financial exposure in its expense budgets + the inability to absorb unplanned costs in a fiscal period.*
6. *The financial recovery for its Hospital Provider operations being largely dependent on cost reductions incidental to services rationalisation, capacity and work force management.*
7. *Its limitation to make structural changes (to the extent practical and permissible) and re-align service configurations in its hospital service operations to restrict its current deficit.*
8. *Its Funder operations having to reduce investment in community services during the period the hospital operation is going through this transition.*

Provisional

The Board notes:

a) That the DHB is faced with increasing demand for health services and operating costs, therefore targeted changes within its operating framework (including the non-hospital sector) are necessary.
b) The need to focus and inject equity across the whole spectrum of its services - both within the hospital operations and community services.
c) The operating cost to funding gap in the Hospital Provider operations cannot be bridged by marginal changes and short term measures.
d) That structural and service change will have to be pursued if the Hospital Services arm is to remain financially viable and sustainable when faced with increased costs on several fronts.
e) That these changes will take time, will need to transcend political sensitivities and communal expectations in a collaborative (and time challenged) manner.
f) Consequently, a 12 month annual plan time line is impracticable for capturing the financial impacts of structural reforms - and will require sustained investment over a longer period to undertake targeted transformational change.

The variability in year-on-year growth assumptions is significant. The movement from high growth to low growth scenario in one year due to funding changes makes planning very challenging.

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

2. The DHB operations

2.1 Taranaki DHB’s Funder Operations

2.1.1 Population Based Funding

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

Taranaki DHB population estimates are shown below. The 2021/22 allocation is based on a population estimate of 125,840 people resident in Taranaki (Table 1). The population growth rate of 1.17% for Taranaki DHB is lower than the national growth rate of 2.64%.

Table 1: DHB Population Variance

Year	2020/21	2021/22	Increase
2019 Population Series	124,380	125,215	835
2020 Population Series	125,100	125,840	740
Change	720	625	1,460

The Taranaki DHB PBFF (including Rural, Overseas and unmet need) share in 2021/22 is confirmed in the Funding advice as 2.61%. The PBFF share is forecast to reduce over time (refer Table 2 and Table 3). PBFF share has reduced further from the 2020/21 assumption of 2.65% to 2.61%.

Provisional

Table 2: PBFF Share from 2020/21 Planning Package

Year	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Taranaki	2.7	2.69	2.68	2.67	2.66	**2.65**	2.64	2.63

Table 3: PBFF Share from 2021/22 Planning Package

Year	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Taranaki						2.62	**2.61**	2.61

2.1.2 PBFF Change and Variability

- Taranaki population growth rate is lower than the country as a whole.
- Taranaki growth in population numbers is estimated at 1.16% compared to 2.64% nationally.
- The Population Based Funding (PBF) share for 2020/21 for Taranaki has reduced more than planned. It is confirmed at 2.61% in 2021/22, a reduction from last year from 2.65%.
- In 2020/21 the DHB received transitional funding of $4,350,513, in 2021/22 this has reduced to $3,079,989, a reduction of $1.27M.
- Taranaki has received a 2.81% increase on 2020/21 revised baselines – this is the lowest growth DHB in the country along with South Canterbury DHB. The funding package adds $11.4M to Taranaki DHB compared to last year. For comparison, in 2020/21 Taranaki received a 7.98% increase on 2019/20 revised baselines, an additional $29.57M from the funding packages.
- The change in demographic assumptions has resulted in a significant reduction to planned revenue.
- Revenue from PBFF is significantly lower than planned by a minimum of $12M.

2.1.3 Key Pressures

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

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

Whilst the level of funding for Taranaki DHB under the PBFF regime is equitable when compared to the proposed increases for other DHBs, the level and quantum of increase is significantly lower than the cost and service pressures faced by the DHB Funder and Provider Arm. The quantum of funding for 2021/22 and future periods require the Board to actively work to restrain costs growth and also requires potential service changes, for which appropriate service change processes will need to be adopted. Importantly, the need to carry funds for investment in services and improvements is equally necessary – requiring a sustainable and positive financial position.

2.2 Taranaki DHB's Hospital Provider Operations

1. The DHB's Hospital Provider operations continue to face a cost to funding gap. The gap between funding and real cost growth has resulted in a budgetary deficit of $33.58M for 2021/22 (before

Provisional

extraordinary expenses) after considering all current efficiencies and a savings plan of $8M, and carries other financial risks as noted earlier.
The hospital services will continue to carry deficits for the entire plan period.

2. Cost pressures are particularly evident in the following areas:

   a) Wages – MECA settlement impacts
   b) Safe staffing (CCDM) cost
   c) Outsourced clinical staff
   d) Diagnostics and Pharmaceuticals
   e) Acute services including mental health inpatient services and emergency department
   f) Increasing cost impacts of statutory compliances, quality and accreditation deficits and numerous legislative requirements
   g) Information and communication technology (ICT) - capital investment and increased annual operating costs for projects, network infrastructure and software licences. By far, this is one area of operations that has witnessed quantum increases YoY - and continuing
   h) Cost contributions to national and regional agencies + capital investment and participation in national and regional initiatives and business cases have added to existing cashflow pressures.

   Overall, the Hospital Provider's financial plan for the planning period is tight and has little flexibility to accommodate unplanned cost movements. Its operating budget carries financial risks and it is highly dependent on the realisation of targeted savings within planned timelines to meet its 2021/22 and out year financial targets.

3. Indicative savings through reduced pricing from collective procurement projects, All of Government (AOG) initiatives and other collaborative efforts have been factored into clinical supply and consumable costs over the plan period. Likewise, operating expenditure outflow to support these national initiatives have been provided to the extent known.

4. Taranaki DHB's share in supporting the approved Te Manawa Taki projects and contribution to HealthShare (the regional shared services entity) has been budgeted. Investment in the Te Manawa Taki MCP (Midland Clinical Portal) programme will be prioritised along with other national and local IT projects.

5. In applying the budgetary assumptions we have recognised ongoing quality improvements and those compliance costs of which Taranaki DHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or costs resulting from clinical compliance expectations and legislative changes.

6. With over 95% of its revenue derived from health funding (via DHB Funder and the Ministry of Health), the Hospital Provider has few alternative income streams for revenue growth. In 2021/22 there is a marginal increase in ACC revenues. Miscellaneous income assumes $2.00M to be raised through community donations.

7. During the plan period 2021-25, baseline capital expenditure will be contained within depreciation provisions, so that any additional equity injection to support cashflow levels is minimised.

8. In the final analysis, the gap between funding and the realistic cost model for services has resulted in a very sensitive financial budget for 2021/22 and out years.

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3. Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the four year planning period 2021-25.

3.1 Application of Public Benefit Entity Accounting Standards

The DAP financial template for the plan period 2021-25 and comparative years has been prepared in accordance with NZ GAAP. They comply with Public Benefit Entity Standards which include the Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

3.2 Equity and Borrowing

a) The District Annual Plan 2021-25 has assumed the need for deficit funding support + Crown equity to support investment in capital projects. The continuing deficit and that forecast for 2021/22 will drive the need for cash injection, and $35M has been provided in the plan. Crown equity relates to capital funding to support the following approved capital programmes:

- Stage 2 (Project Maunga) : $336M
- Taranaki Cancer Centre: $25M
- Mental Health upgrade: $8M

Approval for quarterly drawdown of project funding has been received for Stage 2.

3.3 Operating Expenditure assumptions:

a) Wage costs: In general;
- Wage budgets for employee groups covered by national MECA settlements are essentially in accordance with current agreement(s) and in line with collective planning assumptions
- MECA's which are yet to be settled have a budgetary provision of 1.50% for wage increases - which presents a risk should final settlement exceed the provision
- IEA increases have been restricted to 0% to 1% and 0% for employees earning in excess of $100K pa.

The budget has only partially provided for recruitment to new positions and critical front line vacancies carried in the 2020/21 FY, besides provision for overtime, one on one care etc.

b) Clinical supplies: increases have been assumed in 2021/22 based on estimated activity levels, reduced for local efficiencies and procurement gains. There is a potential risk in this line due to demand growth exceeding planned assumptions.

c) General operating expenditure: increase noted primarily in ICT costs, this service has seen YoY increases above the average and will continue to put pressure on costs and cashflow as more ICT projects come on stream. Local efficiencies and cost controls have been built in to balance inflationary impacts.

d) Value for Money (VFM) impacts: Cost reductions and gains likely to ensue from the collective procurement contracts undertaken by MBIE/NZHPL programmes, AOG contracts and regional arrangements have been recognised. Gains from local initiatives and projects have been built into the relevant expense budgets.

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e) Other expenditure reductions: the 2021/22 expense budget has applied cost reductions arising from the following - and present a financial risk:

- FTEs.
- Care Capacity Demand Management (CCDM).
- Bowel Screening Programme.
- Contracts renewal and renegotiation.
- Acute demand and capacity management.

4. Budgetary Outlay and Assumptions

4.1 Mental Health Services

In keeping with the guidelines on treatment of "Mental Health Ring fence surplus" the amount of any under-expenditure carried forward from previous accounting periods has been reported as a surplus in Taranaki DHB's Statement of Financial Performance in the year the surplus is generated. Based on expenditure to date and forecasts, no surplus is likely to remain on 30 June 2021. No surpluses from Mental Health services are envisaged during the 2021-25 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

4.2 Interest Income and Payment

Interest on overdraft (usually at month end) is netted off against interest income on overnight deposits under the sweep arrangement of the collective banking and treasury programme, resulting in net interest income for 2021/22 and out years.

4.3 Asset Revaluation and its Impact

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

Taranaki DHB conducted a full asset valuation as at 30 June 2018 in accordance with the stipulated cycle and the impacts were incorporated in the accounts as appropriate. Taranaki DHB has undertaken a desktop assessment as at 30 June 2021. The draft valuation report indicates an increase of $15.70M (Land: $3.50M, Buildings: $12.20M), driving the need to revalue these assets. Correspondingly the increase in depreciation for buildings was $0.39M (capital charge being neutral). The draft budget has not included this increase in depreciation, and this will be absorbed within the operating budget.

4.4 Depreciation

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

4.5 Capital Charge

Capital charge has been calculated in line with existing methodology, adjusted for donations and closing balance of shareholders funds. Capital charge on equity investment for strategic capital projects follows the guidelines issued by Treasury.

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4.6 Leasing

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

4.7 Changes in Accounting Policies

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

4.8 Capital Investment

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

Capital Outlay ($'000)	Year 1 (2021-22)	Year 2 (2022-23)	Year 3 (2023-24)	Year 4 (2024-25)	Total (2021-25)
Operating					
Clinical Equipment	5,000	4,000	4,000	4,000	17,000
Other Equipment	500	500	500	500	2,000
Motor Vehicles	150	150	300	300	900
Minor Site Redevelopment (including MH upgrade - $8M)	12,000	3,000	3,000	3,000	21,000
Information Technology	7,000	7,000	8,000	8,000	30,000
TOTAL - Operating	**24,650**	**14,650**	**15,800**	**15,800**	**$ 70,900**
Strategic					
A: Base Hospital redevelopment. Project Maunga – Stage 2	Site preparation + Renal unit + seismic works.	Construction	Construction	Construction + commissioning	$336M
B: LINAC + Bunker	Business case + Preliminary works	Construction	Construction + commissioning	-	$25M
TOTAL - Strategic	**-**	**-**	**-**	**-**	**$361M**
Sources of Funding ($ M)					
Crown Equity	92,000	84,000	84,000	84,000	**369M (*1)**
Bank Borrowing	0	0	0	0	**0**
DMO/MOH Term Loans	0	0	0	0	**0**
Internal Cash Accruals	16,650	14,650	15,800	15,800	**62.90M**

Note: 1: Includes $8M approved Crown capital funding for the Mental Health upgrade.

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4.9 Capital Divestment

The disposal of surplus assets proposed during the period 2021-25 is as follows:

Asset	Book value ($)	Realisable Value ($)	Gain/(loss) On sale ($)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not material	0	2021-25
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2021-25
Total	**0**	**0**	**0**	

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

4.10 Personnel

a) Paid/Contracted/Core FTEs

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

DISTRICT ANNUAL PLAN 2021-25

	Average 2020/21		Yr 1 - 2021/22		Yr 2 - 2022/23		Yr 3 - 2023/24		Yr 4 - 2024/25	
	Contract	*Accrued*	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued
* Medical	*216*	*220*	223	227	225	230	225	230	228	233
* Nursing	*705*	*736*	721	753	725	757	728	760	730	762
* Allied Health	*290*	*290*	287	287	287	287	288	288	288	288
* Support	*100*	*102*	104	106	105	107	105	107	107	110
* Mgt & Admin	*302*	*307*	310	315	310	315	310	315	312	317
* Gov & Funding	*18*	*18*	23	23	23	23	23	23	23	23
TOTAL	**1631**	**1674**	**1668**	**1712**	**1675**	**1720**	**1679**	**1724**	**1688**	**1733**
% movement (total)			**2.27%**	**2.28%**	**0.42%**	**0.42%**	**0.24%**	**0.24%**	**0.54%**	**0.54%**

- Medical FTE count has seen an increase during 2021/22 to meet MECA conditions, partly in relation to rosters, besides filling vacancies and conversion of outsourced clinicians to employees.
- In general, nursing staff will show significant increases YOY in response to activity. Of particular note is the impact of the MECA settlement on safe staffing levels and CCDM commitments, which will see increases in core numbers and costs. Increase is also driven by the need for one on one care (specialling), and FTEs required by the Covid19 testing and vaccination programmes. Future periods show a gradual increase linked to increase in activity, tempered by more efficient management of staffing and efficiencies from services reconfigurations and changing models of care within the hospital and mental health services.
- Movements in Allied Health and Support staff are likely to be contained and are constantly reviewed for efficiencies and optimum service delivery - any increase reflected in 2021/22 are related to some vacant positions being filled.

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- Management and Administration staffs are expected mainly remain at current levels, with any increases solely driven by new funded projects + to support sustainability and health and safety initiatives. New positions have been provided to meet legislative and Ministry expectations in Health & Safety, promoting sustainability and green initiatives, and risk management besides strengthening some back office functions to meet growing operational demands. Capping FTE growth with improved productivity and more efficient and smarter workflows has been a key goal for Taranaki DHB to manage the cost growth vis-a-vis operational demands.
- In principle, the personnel budget has not planned for core FTE increases – other than FTEs required to deliver acute demand, locums converted to FTEs, safe staffing, vacancies filled, new projects and MECA driven requirements. The overall strategy is to contain FTE growth, albeit reduce the growth curve through changes to models of care and consolidation of positions as and when opportunities arise. There will be demand for clinical resources due to increase in activity levels – primarily acute demand as was witnessed during the recent fiscal periods. Additionally, as recent trends indicate, there has been an increase in specialling patients (one-on-one care) in ICU and Mental Health inpatient admissions. With introduction of staffing management tools and applications, Taranaki DHB will continue to aggressively pursue measures and initiatives to increase productivity of existing staff and reduce the demand for locums and casual staff within the hospital and specialist services.

5. Capital Expenditure: Strategic

5.1 Base Hospital Inpatient Facilities Development Programme

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

The other components of the programme are as follows:

Stages	Comprising	Estimated Cost	Timeline	Status
STAGE 1	Theatres, Ambulatory, Inpatient wards	$80M	Start: Aug 2011 Finish: June 2014	Completed.
STAGE 2	Maternity, Neonatal, ED, Radiology, Pathology, ICU/CCU/HDU.	$336M	Start: 2020 Finish: 2024	Approved. Preliminary works commenced. Includes seismic management.
STAGE 3	Ambulatory, OPD Administration.	$150M (estimate)	Tentative : 2026-2027	Supplementary business case to be progressed.
TOTAL		**$566M** (estimate)	**2011 – 2027**	

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5.1 Other Capital projects:

1. Taranaki Cancer Centre: Approval to proceed with installation of a new LINAC and bunker has been received at a capital outlay of $25M. A single stage business case is in a draft stage and scheduled to be lodged with the Capital Investment Committee in July. The preliminary works will commence in October 2021 and the facility is expected to be operational by end 2023.

2. Mental Health Upgrade: Approval has been received for an $8M upgrade of the Mental Health facilities, including the introduction of a new service to manage long term acute patients. The single stage business case has been approved and planning is underway. The upgrade is being delivered in stages and expected to be completed by end 2022.

An updated Schedule of Long term Capital Intentions has been submitted to the Health Infrastructure Unit (HIU) of the Ministry.

6. Savings Plan

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope, which falls short of annual operating expenditure. There is a financial gap. Under this capped environment, with increasing operating costs and demand for services, the Hospital Provider arm will have to strive hard to achieve sustainability – both clinical and financial.

The following key initiatives are being considered within the Hospital Provider operations to generate efficiency gains, and bridge its cost to funding gap and manage the risks arising from the budget setting and rationalisation process.

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Initiatives	Proposal	Potential Est. ($)	Impact
South Taranaki	Changed models of care.	$3.50M	Reduce operating costs and increase efficiency
Radiology project	Review of community radiology services.	$1.50M	Reduce operating costs.
Other initiatives	Review of models of care + theatre stores restructure + contracts + miscellaneous operating costs	$3.00M	Reduce operating costs
TOTAL		**$8.00M**	

The services initiatives commenced in prior years will also progressively generate cost savings and have been recognised in current and out years.

Miscellaneous gains from local initiatives and cost reduction measures have been built into the relevant expense budgets.
The financial management plan is an ongoing process, will involve partnering with primary sector providers and is expected to span more than one fiscal year in view of their strategic components and broader implications. This is part of a broader primary secondary integration initiative currently under consideration.

7. Banking and Cash Flow

The primary assumptions carried in the financial plan 2021/22 are:

a) Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective treasury and banking arrangement (currently with BNZ). Taranaki DHB has been in overdraft during most periods of 2020 and 2021 primarily on the back of a sharp increase in its consolidated financial deficit.

b) It is expected that base line capital expenditure will be contained within the level of depreciation for 2021/22 and out years. Cash outflow will be closely managed by capital prioritisation and working capital management, the intention being to limit the overdraft.

c) The continuing deficit and low levels of funding increases in recent years is proving to be corrosive. The closing monthly cash balance over the recent months since December 2018 has been very close to the OD limit allowed for Taranaki DHB ($19M). Additionally, Taranaki DHB has been funding the preliminary works and consultants (project management, QS, architects, health designer, structural engineers etc) required for development of the business cases for submission to the CIC for its Cancer Centre and Mental Health upgrade projects.

d) Operational realities and delays in business case approvals could dictate otherwise, in which event requests for cash advances will be triggered.

e) Taranaki DHB has sought equity injection to manage its cash shortfall and remain within its designated OD limit. Accordingly, Taranaki DHB received $13.60M in June 2019 and a further $18M in February 2020 as deficit support. Operational realities and delays in business case approvals could dictate otherwise, in which event requests for cash advances will be triggered.

f) The AP assumes a deficit support of $ 35M in 2021-22.

8. Sensitivity Analysis: Budgetary Risks carried in Annual Plan 2021/22

The Annual Plan carries a number of financial risks. While it is difficult to quantify all these risks with accuracy, the likely impacts on the bottom line if these were to materialise is factored below:

DHB Hospital Provider Operations – Key Risks in 2021/22

Unbudgeted financial risk	Est. risk ($M)	75% risk ($M)	50% risk ($M)	25% risk ($M)	**Probability factor (% risk)**
Wage budget (MECA + CCDM + activity)	2.80	**2.10**	1.40	0.70	**75%**
Timing of gains from savings initiatives	2.00	1.50	**1.00**	0.50	**50%**
Clinical supplies	0.40	**0.30**	0.20	0.10	**75%**
General overheads	0.40	0.30	**0.20**	0.10	**50%**
Likely impact on 2021/22 planned financial result	**$5.60M**	**$4.20M**	**$2.80M**	**$1.40M**	**$3.60M**

The overall risk is expected to be **$5.60M** for 2021/22, while the probability factor is estimated to be around 65**%** leaving a residual risk equating to about **$3.60M**. The risk is expected to be managed through a mix of:

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

DHB Funder Operations – Key Risks in 2021/22

Unbudgeted financial risk	Est. risk ($'M)	75% risk ($'M)	50% risk ($'M)	25% risk ($'M)	Probability factor (% risk)
Health of older people price increase – models of care	1.00	**0.75**	0.50	0.25	**75%**
IDF Above Plan	1.20	**0.90**	0.60	0.30	**75%**
Pharmaceuticals	0.60	0.45	0.30	**0.15**	**25%**
Bowel cancer screening	1.00	**0.75**	0.50	0.25	**75%**
Potential impact on 2019/20 planned financial result	**3.80M**	**2.85M**	**1.90M**	**0.95M**	**2.55M**

The overall exposure is estimated at around **$3.80M** for 2021/22, while the probability factor is estimated to be around 67**%** leaving a residual risk equating to about **$2.55M**.

These risks are expected to be managed through demand management and monitoring of service contracts against delivery.

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