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2019 Annual Report

Bay of Plenty District Health Board

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Ministerial Directions

BOPDHB complies with the following Ministerial Directions:

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

The Bay of Plenty District Health Board Annual Report 2019

Produced in 2019
by the Bay of Plenty District Health Board
PO Box 12024, Tauranga 3143
www.bopdhb.govt.nz

ISSN: 2230-6447 (Print)
ISSN: 2230-6455 (Electronic)

Photography by Brian Scantlebury and Andrew Warner

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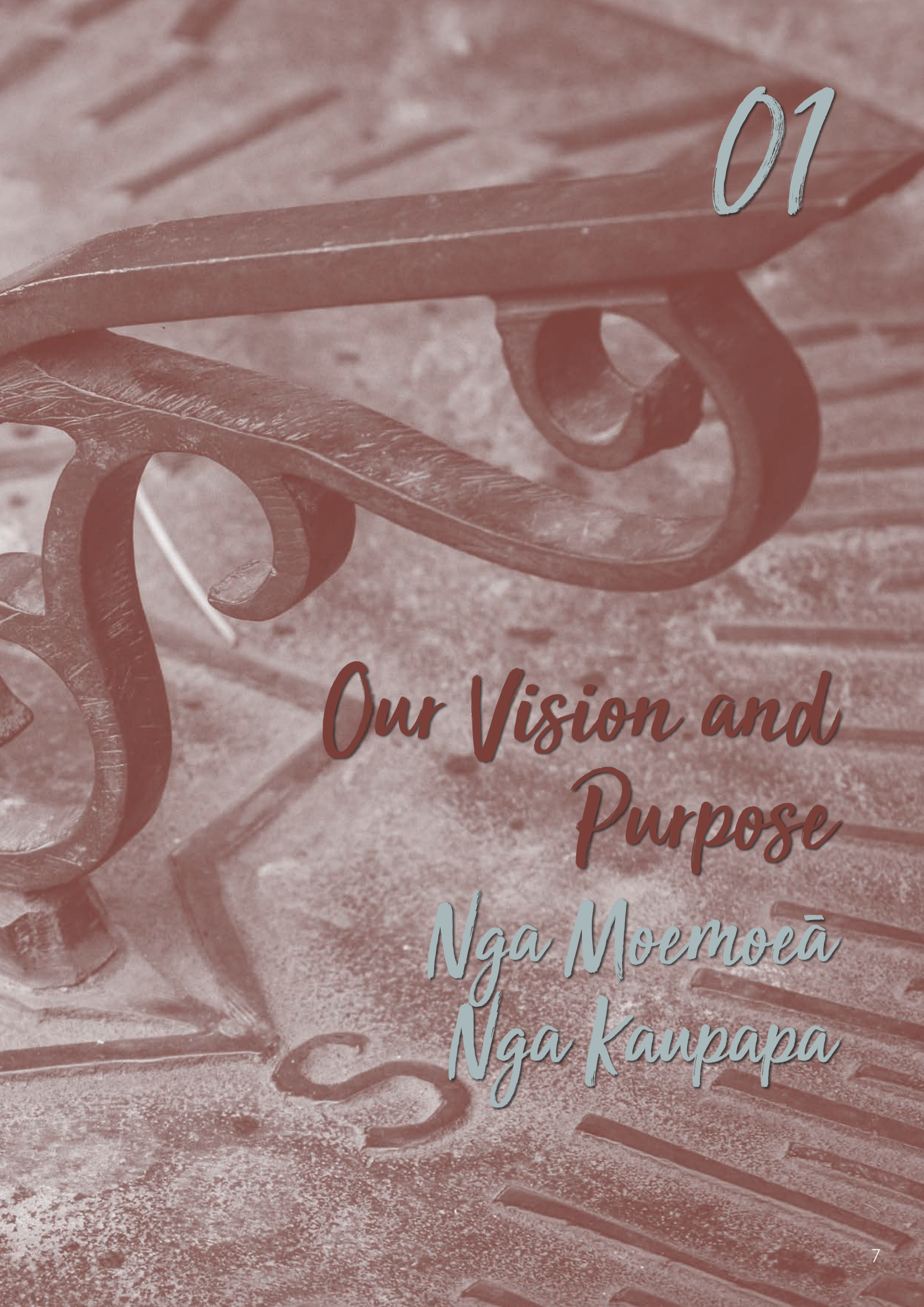


01

Our Vision and Purpose

Nga Moemoeā Nga Kaupapa

Our **VISION**

Tā Mātou Moemoea

Healthy, Thriving Communities – Kia Momoho Te Hāpori Oranga

Our **MISSION**

Tā Mātou Matakite

Enabling communities to achieve good health, independence and access to quality services.

Our **VALUES**

Ā Mātou Uara

Our CARE values underpin the way we work together to provide you with a better-connected health system that is patient and whānau centred.

He Pou Oranga Tangata Whenua Māori Determinants of Health Principles

Wairuatanga
Understanding and engaging in a spiritual existence.

Rangatiratanga
Positive leadership.

Manaakitanga
Show of respect or kindness and support.

Kotahitanga
Maintaining unity of purpose and direction.

Ukaipotanga
Place of belonging, purpose and importance.

Kaitiakitanga
Guardianship and stewardship over people, land and resource.

Whānaungatanga
Being part of and contributing collectively.

Pukengatanga
Teaching, preserving and creating knowledge.

CARE

Compassion **All-one-team** **Responsive** **Excellence**

The CARE values are aligned to our He Pou Oranga Tangata Whenua Māori Determinants of Health Principles.

Our District

One of 20 District Health Boards (DHBs) in New Zealand

The Bay of Plenty District Health Board (BOPDHB) was established under the New Zealand Health and Disability Act 2000. This Act sets out the roles and functions of DHBs[1].

The BOPDHB has a purpose of funding and providing personal health services, public health services and disability support services for the western and Eastern Bay of Plenty.

1. New Zealand Health and Disability Act 2000

BOPDHB's Population

The Bay of Plenty District Health Board (BOPDHB) is one of 20 DHBs in New Zealand, and one of five DHBs that make up the Midland region. We serve a population of 238,380 residents, for the major population centres of Tauranga, Katikati, Te Puke, Whakatāne, Kawerau and Ōpōtiki. Of this, 32% are under 25 and 25% identify as having Māori ethnicity, and like the national population, our population is ageing (currently 19% aged 65 or over, and forecast to reach 24% in 2026). Eighteen Iwi are located within our district.

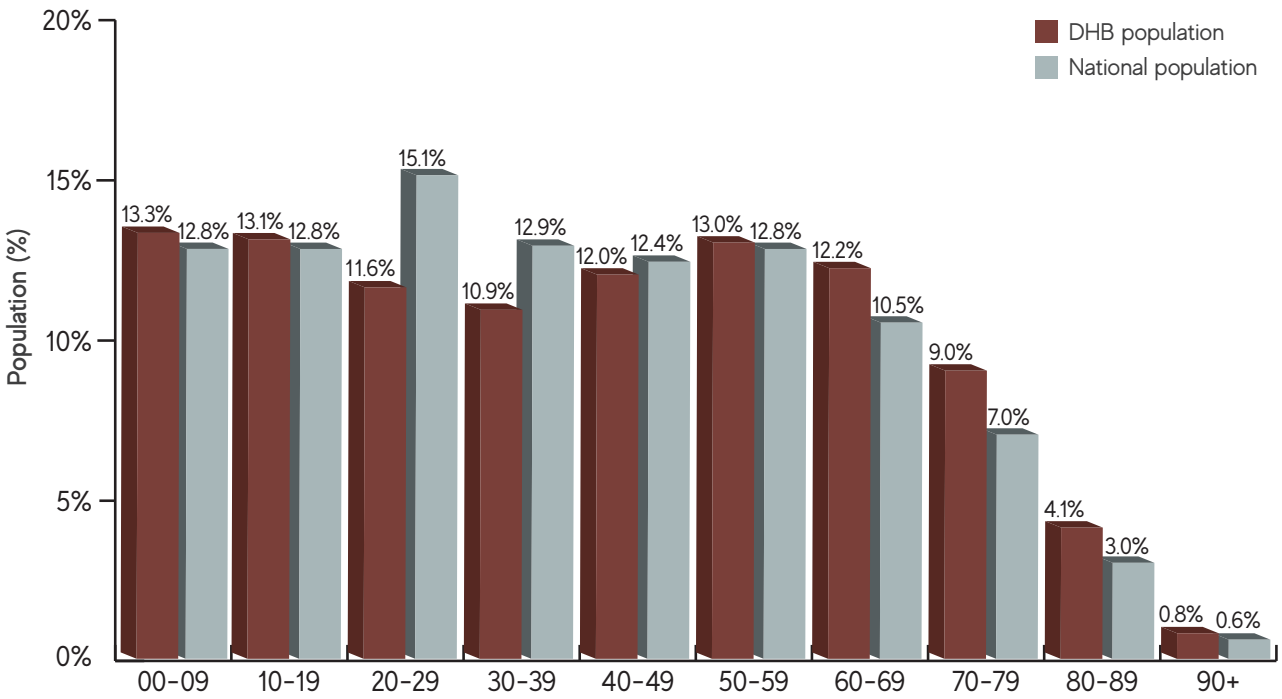
The Bay of Plenty is growing at a faster rate than the New Zealand population, as a whole. The forecast for population growth from 2016 to 2026 is 20.5% with the majority of the growth expected to be in the Western Bay of Plenty region (particularly Tauranga city) with the Eastern Bay of Plenty expected to experience a static or declining population. 77% of our population resides in the Western Bay of Plenty[2].

- The BOP is strongly bicultural with 25% of residents Māori.
- 20% of our residents are 65 or older. This is expected to grow to 25% by 2026. The over 85 age group in particular will grow from 5,580 to 8,280 people.
- The 2011-2014 New Zealand Health Survey recorded that 19.5% of the Bay of Plenty population are current smokers. This is higher than the national average of 17.7%.
- The rate of obesity in BOP is higher than the NZ average at nearly 32% of all adults.

The BOPDHB acknowledges these challenges and are refocusing their approach to achieving health outcomes. This will become more collaborative with community and agencies outside the health sector, with emphasis on Health in all Policies. Over the next thirty years, progressing to determinants of health approach, through a collective effort will be required to improve health of all New Zealanders[3].

Population by age 2018/19

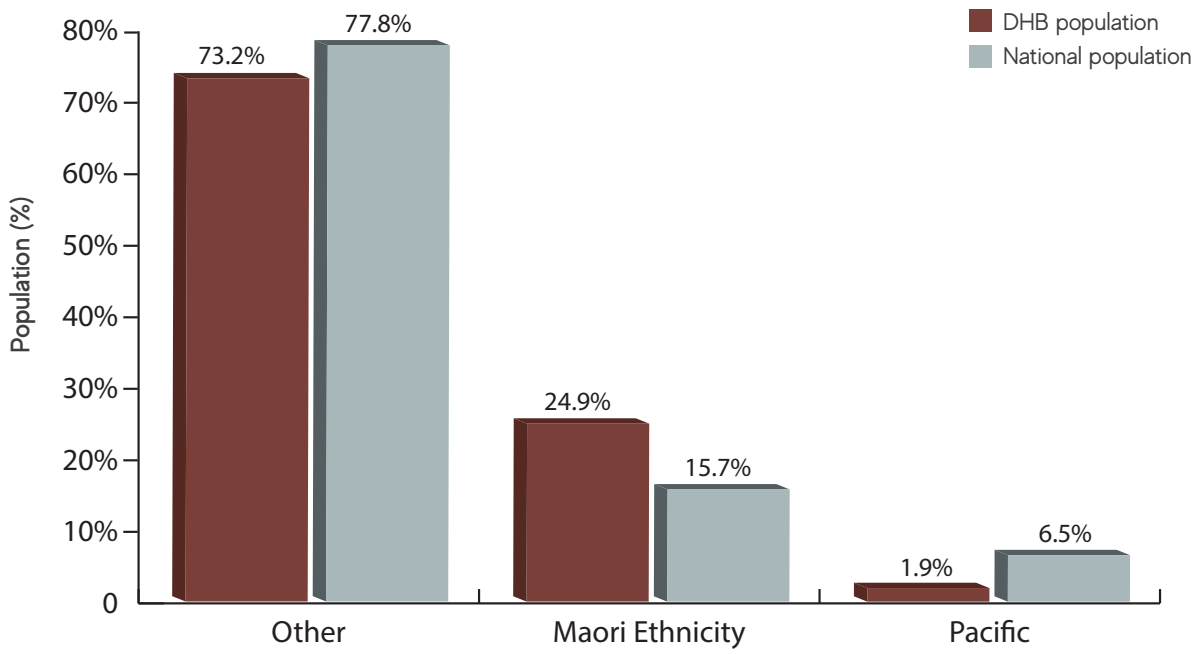
Bay of Plenty's population tends to be older than the national average[4].



2. http://www.bopdhb.govt.nz/your-dhb/about-your-dhb/
3. Mason Drury November 2015
4. Ministry of Health NZ

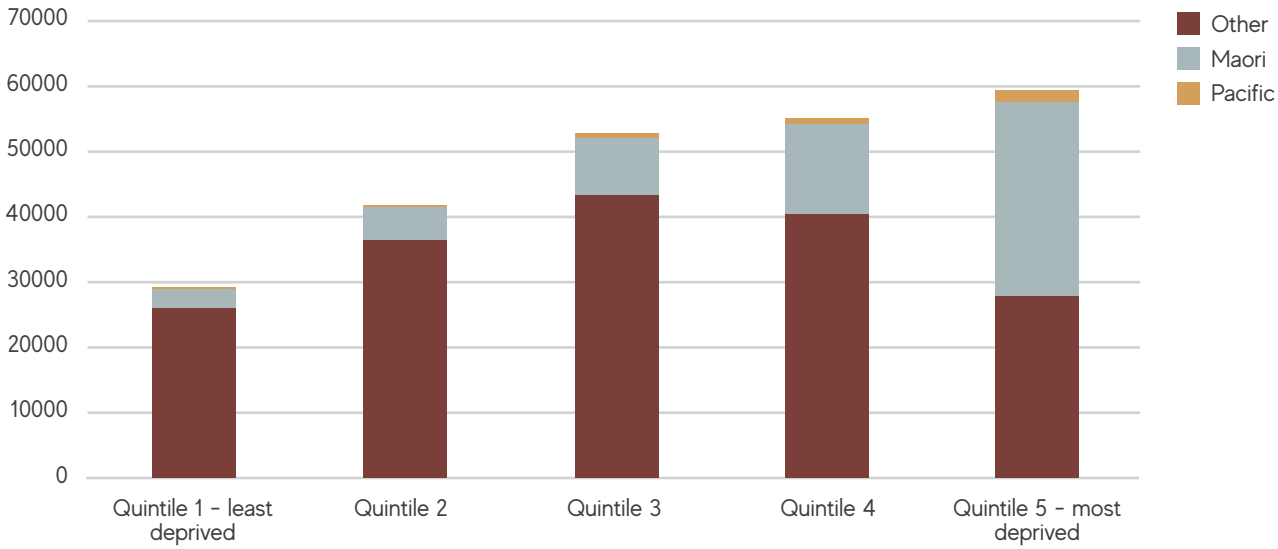
Ethnic mix 2018/19

Bay of Plenty has a higher proportion of Māori in comparison to the national average, and a lower proportion of Pacific people.



Deprivation 2018/19

Bay of Plenty has a higher proportion of Māori in comparison to the national average, and a lower proportion of Pacific people.



02

Our Priorities and Performance

Mahi Whakariterite

Board Chair and Chief Executive's Report

Chair and Chief Executive's year in review 2018/19

Foreword from the Chair and Chief Executive

Welcome to our 2019 Annual Report, where we are pleased to report on our organisational performance and progress towards achieving our vision – Kia Momoho te Hāpori Oranga, Healthy Thriving Communities. Te Tiriti o Waitangi is central to our identity and mission, and we acknowledge our partners in that journey, the DHB Māori Health Rūnanga.

Tēnā koutou katoa, e nau mai ki tā mātou Pūrongo a Tau 2019.
Ka waimarie mātou ki te whakapuaki i tō mātau whakahaere, ki te ānga whakamua kia tutuki te pae tāwhiti, Kia Momoho te Hāpori Oranga, Healthy Thriving Communities.
Ko te Tiriti o Waitangi te toka tū moana, ā e mihi ana mātou ki ō mātou nei tuakana ki runga i te Waka o Toi, arā ko te te Rūnanga Hauora o te Moana ā Toi.

We acknowledge the tribes of the Bay of Plenty, and their authority over this land that we work, live and play on. We remember those who have passed on in the past year. This report demonstrates what can be achieved together to ensure the health of our future generations.

E mihi kau ana matou ki ngā iwi o te Moana ā Toi, nō koutou te mana whenua. Kei te tangi te ngākau ki a rātou e wehe ai, e te hunga mate, e haere atu rā. E kui mā, e koro mā, ānei anō te ahua reka o te mahi tahi mō ngā mokopuna o anamata.

We acknowledge the many volunteers within our organisation and community who so generously give their own time and energy to enrich the lives of our people and help them flourish.

Ki ngā ringa raupā, tēnā koutou. Nō te ngākau māhaki, ka oranga ai te iwi, kia ea te Toi Ora.

We join the people of the Bay of Plenty in acknowledging the many staff within the BOPDHB who go above and beyond for the benefit of our communities' wellbeing in every part of our region. There are few words to express our thanks for your tireless efforts.

Kia a koutou ngā kaimahi, ngā kaiāwhina, ngā pou, ngā rangatira o te Hauora ā Toi, ka rere ātiu te mihi mai i ngā Kurī ā Whārei ki Tihirau, tēnā koutou katoa. Kua kawea e koutou ngā rourou o te Hauora ā Toi ki tēnā kāinga, ki tērā kainga hei oranga mō te iwi. He mihi mutunga kore ki a koutou. Tēnā koutou, tēnā koutou, tēnā koutou katoa.

Welcome to the 2019 Annual Report for Hauora ā Toi, the BOPDHB. Here we report to our community, and the government, on our progress towards delivering on our vision – Kia Momoho te Hāpori Oranga, Healthy Thriving Communities, and our strategic aspirations to deliver on that vision. Over the last year we continued to aim to be a high performing healthcare system while meeting the needs of our community, and have undertaken many great initiatives, some of which are highlighted below.

Consumer Council

Since its establishment last year, the Bay of Plenty Health Consumer Council (BOPHCC) has been identifying areas where they can provide input from Bay of Plenty consumers, to help bring their perspective on health issues to the forefront of the BOPDHB. These areas include prevention and early detection programme/services, keeping children well and out of hospital, healthy, safe and supported youth, person and family/whānau centred care, a healthy start for all babies and improving lives of those with disabilities and/or long term need, and the effective use of health resources. Chair of the Council John Powell says the past 12 months have been an active time of learning for its 14 members who come from both the Eastern and Western Bay of Plenty, and that they hope to be a helpful and clear consumer voice to the BOPDHB.

Strategic Health Services Plan

Since the launch of our strategic health services plan, we have been adapting and innovating the way we provide services in order to reach our strategic outcomes: "Live well, Stay well, Get Well".

We continue to focus on improving the health of our priority populations; Māori, the first 1000 days of life, vulnerable children and youth, vulnerable older people, and people with long term mental health needs and / or addiction. Key Projects include:

Integrated care bundle

System-wide Community Care Co-ordination

Care co-ordination is a function that deliberately organises, communicates and shares information among patients family/Whānau and a range of health and social care agencies to support the patient and family/Whānau in their health and wellbeing.

Keeping Me Well

'Keeping Me Well', is an Integrated Community Enablement approach that aims to assist with early supported discharge and preventing hospital admissions and re-admissions. The Community Care Co-ordination will provide a single point of contact for all requests for care and support by community based allied health and nursing teams and identifying the best approach to resolving that request.

Health Care Homes and the Tangata Whenua Model of Care (Nuka)

The definition of a health care home (HCH) in Aotearoa is a primary care practice or practice hub that meets the HCH standards. It provides a comprehensive range of preventative and acute primary health based care, and connects Whānau with the broader health and social system. BOPDHB has funded an initial roll out of Health Care Homes across the district with a population coverage of 50,000 people, including 15,000 Māori. Seven practices are participating in the initial roll out for year one. Tangata Whenua Model of Care is about the transformation of the general practice team and its interconnecting partners to work together as one whole system. The DHB has entered into a contract with Nga Mataapuna Oranga PHO to lead the design and development of the new model within the Western Bay of Plenty.

Community Breast Feeding Support Services

A new integrated breastfeeding support service has been established in the community to deliver dual programmes for Te Ao Māori and mainstream. It includes co-ordinated Kaiāwhina roles working alongside lactation specialists. The service in the Eastern Bay has been launched as 'Whakamanahia te Waiu, Celebrating the Essence of life', and the service in the Western Bay has been launched as 'Mama Maia'.

Tamariki Healthy Lifestyle Service

The BOPDHB has initiated a procurement process to fill a service gap and design a new service to work with children who have been assessed as obese. The BOPDHB recognised that a service that was co-designed with tamariki, rangatahi and their whānau that was based on a Kaupapa Māori service delivery model was the best fit for our community. The procurement process is underway and a new service is expected to be up and running by September 2019.

Te Toi Ahorangi

Our newly endorsed Māori Health Strategy, Te Toi Ahorangi 2030, sets a clear direction for tangata whenua and our DHB to achieve Toi Ora, together. We are proud of this Treaty led approach to health and it is significant for our DHB and our eighteen iwi – our Te Tiriti o Waitangi partners, as we work towards strengthening our relationships. This will support Tangata Whenua to define, decide and determine their own wellness pathways, according to a Māori worldview.

Annual Plan

By the end of 2018/19 we achieved 2 of our 5 measures of our ambitious plan, this is a reflection of the immense pressure our system has been under this year, and even so, we were very close to achieving at least two more of our measures. Important achievements to note are:

Better help for smokers to quit:

96% of Hospitalised patients who smoke were offered help to quit smoking by a health care practitioner (target was 95%).

93% percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer, were offered brief advice and support to quit smoking (target was 90%).

Raising healthy kids

100% of obese children identified in the Before School Check (B4SC) programme, were offered a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (target was 95%).

Staff engagement and culture

Under the Creating our Culture strategic priority we've made some major steps forward in the last three years including workshops to explore together what we want our experience of work to be, evolving our CARE values, identifying the behaviours that are not ok with us, launching our handbook on workplace behaviours, encouraging people to talk through issues and resolve early, and establishing Speak up Safely programme.

Health Quality & Safety Service (HQSS) - Mana Marutau Hauora

BOPDHB is committed to providing high quality and safe health services; the right care at the right time in the right setting. Jerome Ng is our newly appointed Clinical Director/ Kaiwhakahaere Haumanu who will be leading the implementation of our people centred Clinical Governance Framework. This framework aligns with our C.A.R.E and He Pou Oranga Tangata Whenua values, and strategic plans. It is a guiding document for clarifying our roles and responsibilities to enable us to provide quality healthcare. Further on in the report is our Statement of Quality which details our quality achievements during the 2018/19 year.

Admissions

Both Tauranga and Whakatāne hospitals were extremely busy this year, with large admission numbers. This reflects the high incidence of sickness in the community and is also being reflected within our own staff's ranks. In turn this continues to provide a challenge for matching staffing levels with our current patient demand. Key leaders worked to coordinate both staff and patients across our hospitals, looking for alternatives to admission and reviewing work that might be deferred in order to support clinical delivery across both hospital sites.

Nurses strike

July 2018 NZNO saw a 24 hour complete withdrawal of labour by nurses, midwives and healthcare assistants nationally. Planning for this significant event was extensive and commenced in March 2018. Contingency planning was led by the Director of Nursing with support from all services and professions to ensure safe emergency care could continue to be provided for the community. Although the community was affected by deferment of planned care, emergency services were safely delivered for the 24 hour period. It was noted in the debrief that it truly felt like "All one Team". All staff contributed to the success of the planning and provision of safe care, medical staff based in wards, allied health working in the Emergency Department and the tremendous efforts by administration staff.

Allied Health

There have been some changes in the Allied Health Scientific and Technical (AHST) leadership in 2019, with Martin Chadwick taking up an exciting new role as Chief Allied Health Professions Officer in the Ministry of Health. Sarah Mitchell was appointed as his successor in March and is further developing the work started by Martin to ensure the AHST workforce is making a significant contribution to driving service improvement and sustainability across community and acute sectors. The breadth and depth of AHST skills and their reach across people's lives, communities and organisations makes them ideally placed to lead and support services towards a greater focus on prevention and early intervention.

Some exciting initiatives include:

- the community enablement project which focuses on delivering responsive services closer to peoples home,
- the orthopaedic transformation programme which focuses on providing specialist assessment and interventions within community settings,
- the Emergency Department musculoskeletal (MSK) initiative which focuses on physiotherapy assessment and intervention for people presenting with MSK conditions,
- the AWESOMM research initiative which focuses on improving the health and wellbeing of older adults,

2019 and beyond will see a shift of AHST services into the community as part of our ambition to provide services at the right time, in the right place to ensure true person centred and equitable support and enablement to the people across the Bay.

Information management

We were pleased to welcome Richard Li to the BOPDHB as the Chief Information Officer of our Information Management service. Key projects he will be leading include the delivery of the Information Management Strategy, as well as a number of local and regional projects.

Mental Health and Addictions Services

Ōtūmoetai's Kāhui Ako – Communities of Learning, which consists of 26 early childhood centres and nine schools, implemented a wellbeing programme with the Bay of Plenty District Health Board. This has resulted in a reduced rate of referrals to the Maternal, Infant, Child and Adolescent Mental Health Services from this cluster of schools compared to previous years. It is growing the awareness and early intervention for primary and intermediate aged children in the area and therefore aligned with the principles in He Ara Oranga. It has also been presented at National Leaders days and has received positive feedback, and was mentioned in the He Ara Oranga report as an example of innovative practise.

Mental Health have more than doubled our intake of new grads into specialist practice (NESPS), acknowledging the difficulty of recruiting staff into Mental Health field and specifically into rural areas like Whakatane. This also gives us the opportunity to actively recruit Māori staff and this year we had more NESPS identifying as Māori than non-Māori.

Clinical campus update

Whakatāne and Tauranga hospitals are fortunate to be amongst the top sites in New Zealand for medical students to select as placements and for work, and recognition of BOPDHB staff in the 2018/19 year, demonstrated the effort made to ensure students are well supported.

Six Bay of Plenty District Health Board (BOPDHB) staff members were recognised for their supervision, teaching and care of medical students in 2018. Amongst the recipients were Chief Medical Officer Dr Hugh Lees and Oncologist Dr Richard North, who were awarded Distinguished Clinical Teacher Awards from the University of Auckland's School of Medicine.

Others to be recognised with AUMSA (Auckland University Medical Students Association) staff-student awards include: Student Placement Coordinator Leonie Alley, Student Programme Coordinator Matt Sinton and Academic Coordinator Yvonne Boyes. Dr North also received an AUMSA staff-student award. Student Placement Coordinator Leonie Alley has received awards recognising her care and dedication in each of the last four years.

Our five week Rural Health Interprofessional Programme (RHIP) in Whakatāne (run six times a year), has grown substantially, and nurtures students in the programme to help ensure many choose to return to a rural hospital environment. There will be 76 students in 2019, compared to 39 in RHIP's first year, 2013.

Also honoured was Te Kaha GP Dr Rachel Thompson who won the Dennis Pickup Clinical Teaching Award for her work with medical students on placement at the rural practice.

University of Auckland student numbers at the BOPDHB have increased significantly from 10 (6th year students) in 2012 to 68 (4th, 5th and 6th year medical students) in 2019.

Workforce development

BOPDHB has endorsed the Te Tumu Whakarae Position Statement on Increasing Māori Participation in the Workforce, and has endorsed the targets to support the Position Statement being realised. Our Māori workforce has increased to 13% of our total workforce.

Public Health

This year the board signed off the Toi Te Ora Public Health and DHB led Travel Plan for the BOPDHB. This was developed by a Travel Plan group as a way of promoting a sustainable approach to transport, reducing sole occupancy vehicle use and maximising active transport options such as walking, cycling and public transport. It's an ambitious plan, and it's important to state that we're not going to be able to achieve it all immediately, but there are a lot of very good ideas within it, and many of these will help us with our ongoing work around sustainability and carbon reduction.

Facilities & Business Operations

Facilities & Business Operations (FBO) is the new name given to the service formed following a joint review of Property Services (PS) and Hospital Support Services (HSS). Over time, Tauranga and Whakatāne Hospitals have grown in size and complexity and the scope of services managed by PS and HSS increased. Our new service is comprised of a dedicated team specialising in facilities management, project management, clinical engineering, security, non-clinical support services and sustainability.

Sustainability

The Minister's Letter of Expectations highlighted the importance of DHBs doing what they can to reduce their carbon emissions. This year we have created a Sustainability Coordinator role to help implement a sustainability strategy and travel plan. As well as this we have recently procured three new Hybrid fleet cars for Community Allied Health, in our journey towards a cleaner greener fleet. We will continue to look at better ways to respond to climate change over the next year to achieve the global goal of carbon neutrality by 2050.

Summary

Moving into 2020, we are continuing to improve and reshape our health system and the services we deliver, looking at best use of resources to support our communities to be healthy and thriving.

We will:

- increase the pace of change of system integration between our primary and secondary services,
- strengthen our mental health and addictions service so it is easy to navigate,
- improve the health and wellbeing of infants, children, young people and their whānau, and
- continue to re-design how we work to enable the evolution of our system.

The impact of population growth and the increased complexity of the conditions people require support for, has meant there has been very high demand for all health services delivered in the Bay of Plenty. We would like to thank our dedicated, professional and resilient staff working within the BOPDHB, and for our many community and primary care providers, who work hard to deliver professional and compassionate care. We look forward to the year ahead here in Te Moana ā Toi.

Looking ahead to the triennial elections later this year, the Board wish to thank their health partners and the community for the dedication and support over the last three years. It has been an honour to serve our community here in the Bay of Plenty.

Sally Webb
Board Chair

Helen Mason
Chief Executive

Māori Health Rūnanga Year in Review

"In the now is all time. This means that what we do today matters for our tomorrow.

We must work together to ensure we leave flourishing legacies for our future generations"

Te Rūnanga Hauora Māori o Te Moana ā Toi aims to restore the balance of power and reset our relationship with the crown. Te Toi Ahorangi strategises how we as iwi will determine our own health and wellbeing as tangata whenua.

Te Rūnanga exists to optimise the total wellbeing of whānau, hapū and iwi of Te Moana ā Toi.

As tangata whenua, we acknowledge that when we are able to determine, define and decide our own health and wellbeing; as well as the direction and shape of our own institutions, communities and development - we will flourish.

We acknowledge that we have essential strengths derived from our ancestors and in turn a level of resilience from our experience as a colonised people. Te Toi Ahorangi is a reflection of our aspiration to see our people flourishing, shifting from kahupō to Toi Ora. In this generation, our pēpi will be valued, inspired and raised to realise their ultimate potential, strong in their identity and confident in their rights as tangata whenua.

Our Iwi

Our unique composition as a collective of seventeen iwi within the Bay of Plenty District Health Board (BOPDHB) region gives effect to our status as Te Tiriti o Waitangi partners and as mana whenua, mana moana and mana tangata of our respective tribal regions. The Māori Health Rūnanga provides a platform for Ngāi Tai, Ngāi Te Rangi, Ngāti Awa, Ngāti Mākino, Ngāti Manawa, Ngāti Pūkenga, Ngāti Ranginui, Ngāti Rangitihi, Ngāti Tūwharetoa ki Kawerau, Ngāti Whakahemo, Ngāti Whakaue ki Maketū, Ngāti Whare, Tapuika, Te Whānau a Apanui, Te Whānau ā Te Ēhutu, Waitahā and Whakatōhea to influence the decision-making processes of the BOPDHB Board.

MĀORI HEALTH
RŪNANGA

Pouroto Ngaropo
Chair
I Te Rūnanga Hauora Māori o Te Moana ā Toi

Our leadership | Te tira hou

Tēnei te tira hou, tēnei hara mai nei!

Our executive team continues to maintain a strong and influential partnership with the Board on behalf of the tangata whenua of Te Moana ā Toi.

Pouroto Ngaropo
Chair
Ngāti Awa

Punohu McCausland
Deputy Chair
Waitaha

Rutu Maxwell-Swinton
Member
Tapuika

Linda Steel
Member
Ngai Tai

Māori Health Rūnanga membership

Iwi	Member
Te Whānau a Apanui / Te Whānau ā Te Ēhutu	Astrid Tawhai
Ngai Tai	Linda Steel
Ngāti Awa	Pouroto Ngaropo (Chair)
Whakatōhea	Dickie Farrar
Ngāti Manawa	John Porima
Ngāti Tūwharetoa ki Kawerau	Karilyn Te Riini
Ngāti Whare	Wikitoria Hona
Ngāti Mākino	Stewart Ngatai
Ngāti Whakaue ki Maketū	Manuhuia Pene
Tapuika	Rutu Maxwell-Swinton
Waitahā	Punohu McCausland
Ngāti Pūkenga	Titihuia Pakeho
Ngai Te Rangi	Kipouaka Pukekura-Marsden
Ngāti Ranginui	Phillip Hikairo
Ngāti Whakahemo	Margaret Hinepo Williams
Ngāti Rangitihi	Robin Cheung

Revitalising He Pou Oranga

Tangata Whenua determinants of wellbeing

We look to our ancestors as archetypes of wellness. Our tūpuna are demonstrations of what it means to be flourishing.

He Pou Oranga Tangata Whenua (Te Rūnanga Hauora Māori o Te Moana ā Toi, 2007) protects tangata whenua values that lead to Toi Ora. Ngā Pou Mana o Io, the five cornerstones of He Pou Oranga Tangata Whenua - Mana Atua, Mana Tūpuna, Mana Whenua, Mana Moana and Mana Tangata underpin a tangata whenua worldview.

These cornerstones orient us towards our ancestral teachings, principles and knowledge systems that are in alignment with our own māramataka, rongoā, kawa, tikanga, reo and mātauranga. He Pou Oranga supports us to lead flourishing lives as Māori. By seeing our world through our own eyes, we are able to articulate how optimum spiritual, mental, social, emotional and physical wellbeing can be realised.

When we support our people to exercise their mana, we encourage their mauri to flourish.

Mana Atua

Our creation from Io Matua Nui and our connection to the spiritual world, influences how we interact with our Atua who are embodied within the natural world.

Mana Tūpuna

Our connection to our ancestors unites us all as tangata whenua through our whakapapa, strengthening our collective spirit and guiding our ultimate direction.

Mana Whenua

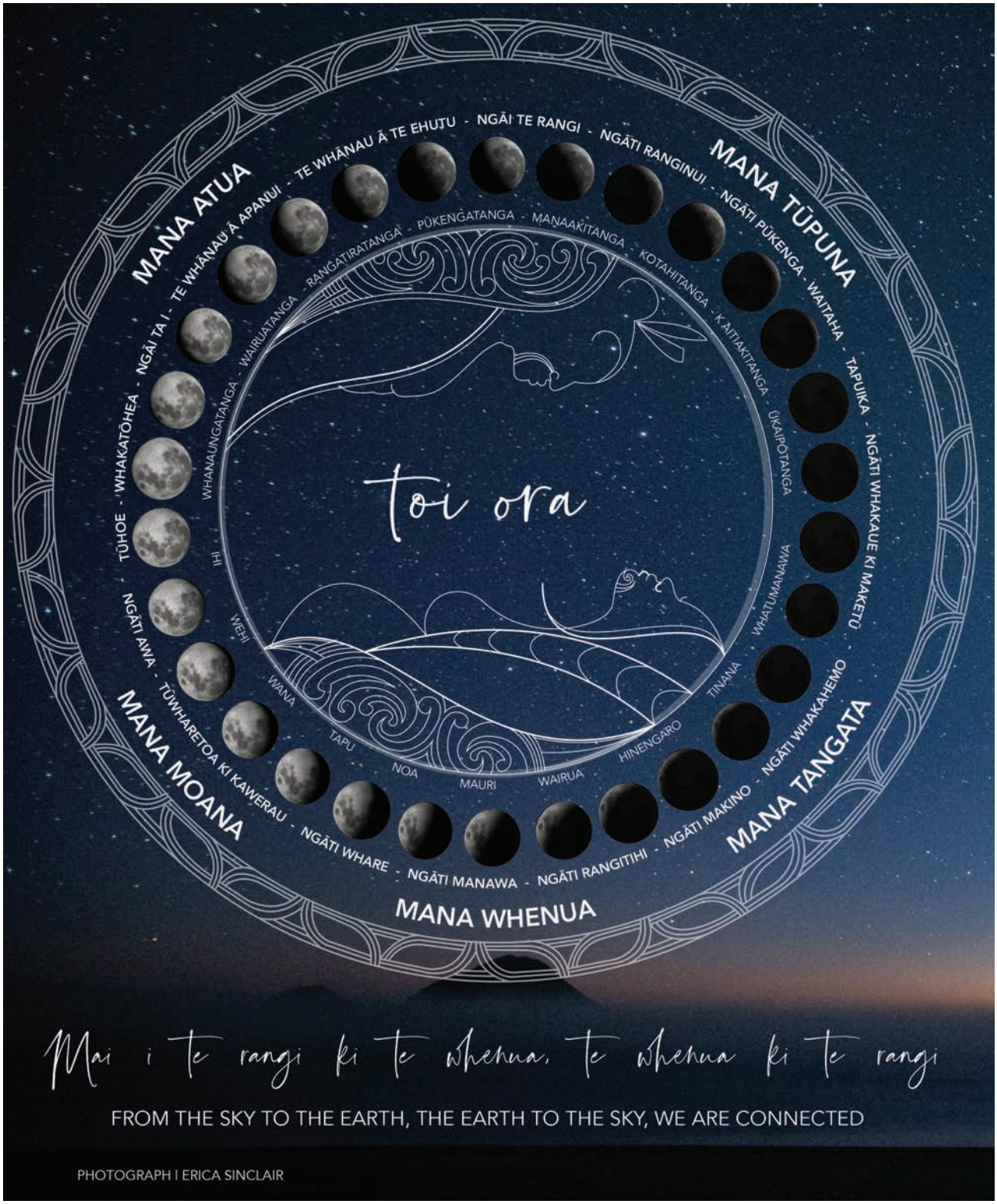
Our conception connects us to our tūrangawaewae that affirms our rights to be self-determining over our ancestral lands and waterways.

Mana Moana

Our connectedness to Te Moana ā Toi affirms our wayfinding legacies and our unique relationship to Tangaroa, including our responsibilities as kaitiaki.

Mana Tangata

Our unique identity, qualities and attributes as human beings, and as tāne and wahine, affirm our special place and purpose within our whānau, hapū and iwi.



Māori Health Gains and Development report

We want to be the first genuinely Te Tiriti led District Health Board in Aotearoa.

'When we whakamana whānau and uphold the sacred mana and mauri of all mokopuna - the whole of Te Moana ā Toi will flourish. It's about aroha and every decision made must work towards restoring balance and mana to tangata whenua'

Tricia Keelan
General Manager, Māori Health Gains and Development

Wayfinding Toi Ora

Te Toi Ahorangi 2030

Over the last year we have developed Te Toi Ahorangi, in partnership with Te Rūnanga Hauora o te moana a Toi. Inspired, driven and led by tangata whenua, Te Toi Ahorangi affirms our unified vision, voice and intention to drive toward a whole of system transformation to Toi Ora that will improve the wellbeing of the 56,490 Maori that live in Te Moana a Toi. Making up 25% of the total Bay of Plenty population, the wellbeing of tangata whenua is integral to the prosperity of our entire region.

We acknowledge the leadership of the Runanga, the Board, iwi, hapū, whānau, and, everyone within the DHB and our communities that contributed to the development of the strategy. This document is ground-breaking in that it calls for authentic Tiriti o Waitangi partnership and provides a voice for tangata whenua aspirations and determination.

Maori Health Gain and Development will prioritise the needs and aspirations of our people utilising a Toi Ora wellness approach that aligns with a Maori worldview of population health and prevention. Our approach will focus specifically on improving the lives of our most disadvantaged whānau, and shifting resources from acute illness centred services - towards upstream wellness preventative approaches in alignment with He Pou Oranga Tangata Whenua.

Our priorities for Toi Ora

Toi Oranga Mokopuna Flourishing Mokopuna

Whakamana whānau to nurture the sacred mana and mauri of all mokopuna and address harm to our mokopuna in all its forms.

Toi Oranga Ngakau Flourishing Hearts

Improve the lives of our whānau who are impacted by mental health and addictions.

Toi Oranga Ake Accelerating Flourishing

Address inequity, systemic issues and innovate for population and environmental health improvement.

Our success will be measured in improvements in the lives of our people. The solutions and pathways to Toi Ora lie with whānau, and iwi. We can transform the system, but the most important transformation must occur within whānau themselves. They will grow our sacred way finders of tomorrow.

Toi Tū Te Tini o Toi!

Our year's highlights

He Pou Mana - He Pou Oranga

Reimagining our narratives to influence campus design
Our reigniting of He Pou Oranga Tangata Whenua and development Te Toi Ahorangi has included a commitment to ensuring that our narratives are expressed in our work and work environments.

Te Whare Whakamana

We partnered with mana whenua in bringing to life our aspirations for He Pou Oranga in the design and build of Te Whare Whakamana – the new building for Te Teo Herenga Waka. We were grateful for the leadership of Tamati Tata (Ngāi Tamarāwaho) who supported us at each stage of the design and build.

We also worked with artist Stu McDonald (Ngāti Hē, Ngāti Tapu) who developed the art work for Te Whare Whakamana, reimagining the narrative of Taurikura, an ancestral kōrero of Ngāi Tamarāwaho. From the striking carved pou in the front of the building to the internal design, Te Whare Whakamana demonstrates the warm space that can be created when working with our iwi in design.

Our wayfinding compass

Kaupapa Ward

This year saw the first stage of the redesign of our Kaupapa Ward. Inspired by the view of Mauao from its northern windows, the Kaupapa Ward now has a magnificent entrance of bush and forest and the story of the journey of Mauao is recorded for all to reflect on in their time in our ward. As part of our commitment to bilingual signage, all signage is now in both te reo Māori and English. Further developments are planned to continue to create an indigenous ward space.

Community garden

Māori Health Gains and Development has partnered with Service Improvement to bring He Pou Oranga Tangata Whenua to life in a community garden space on Tauranga campus. The design includes a physical representation of the pou oranga and includes the practical use of our Maramataka in the planting and harvesting. Spaces are designed to encourage a communal experience and to highlight rongoā Māori and traditional Māori foods.

Mana Reo - Mana Māori

Te Reo Māori language classes delivered onsite.

This year has seen a renewed commitment to developing and growing capability in te reo me ona tikanga, within Māori Health Gain and Development and across the DHB. Mihi whakatau and pōwhiri are becoming more normalised

as processes for welcoming new staff and visitors to our space. Karakia and kapa haka are gaining more interest from staff, and broad interest in te reo Māori has seen informal and formal learning grow exponentially. This demand has supported our new initiative with Te Whare Wānanga o Awanuiārangi, who now deliver Māori language classes for staff onsite.

Toi Oranga Ngākau

Creating our future with Toi Oranga Ngākau – flourishing hearts

The Tumu Whakarae submission to the Government's Mental Health and Addiction Inquiry was endorsed by the DHB Board and Runanga. It is agreed that the recommendations and approaches within this submission best meet the needs of our Māori communities which are over presented in poor mental health outcomes. As part of the Maori Health Gain ad Development change process, the mental health portfolio manager position was redesigned to create the Toi Oranga Ngākau - Flourishing hearts - Change Leader role. The focus of this role is to review and redesign services using mahitahi approaches to achieve Toi Ora outcomes which align to the aspirations of Te Toi Ahorangi.

We are now launching Creating our future and aspire to authentic partnerships between iwi, hapū and whānau, Te Teo Herenga Waka, Kaupapa Māori and NGO organisations and our provider arm services to change the mental health landscape in Te Moana ā Toi. Key challenges shared by our Māori communities include; high rates of suicide, high methamphetamine use, complexities of pēpi born with methamphetamine addiction, access to, and retention of appropriate housing for whānau with mental health compounding recovery and maintenance of wellbeing. We are collectively committed to transforming towards Toi Ora underpinned by the aspirations and strategic goals in Te Toi Ahorangi. The submission is available on our website: **https://www.bopdhb.govt.nz/media/61843/final-submission_tumu-whakarae_govt-inquiry-mha_august-2018-3-.pdf**

Partnering for outcomes

Building Awesome Whānau

Māori Health Gains and Development has been exploring intersectoral relationships and partnering opportunities outside of the health sector, with other government agencies as well as representatives from private, voluntary and non-profit groups to yield population health improvement for Tangata Whenua.

An example of this approach focusing on the First 1000 days is a dialogue with Bay Brighter Futures funding collaborative to progress a partnership to co-design, commission and fund a parenting programme with Parenting Place – "raising awesome whānau". Bay Trust and Tauranga Energy Consumer Trust (TECT) have agreed to look to partner with BOPDHB to fund the Parenting Place "Building Awesome Whānau" co-design project for 3 years. All funders including BOPDHB are conducting due diligence and a result re-funding won't be known until later in September 2019.

Health Quality Safety Commission (HQSC) Partnership

Reducing patient deterioration

The HQSC's Patient Deterioration Program aims to reduce the harm of failures to recognise, or respond to, acute physical deterioration of adult inpatients.

The program involves three key work streams:

1. Standardised recognition and response systems i.e. EWS system.
2. Patient. Family and whānau escalation– Kōrero mai.
3. Shared goals of care.

Kōrero Mai involved four DHB's, BOPDHB is one of these DHB's, the commission requesting that the Kaupapa Ward be involved in the national program so that the commission could understand what whānau escalation looked like in a kaupapa model of care context.

Patients, families and whānau often recognise subtle signs of patient deterioration even when vital signs are normal. Failures to adequately respond to concerns raised by patients, and whānau are commonly highlighted in adverse event reports from the Health and Disability Commissioner associated with clinical deterioration.

Understanding what was in place to support escalation of whānau were a critical component of our partnership with HQSC in the Kaupapa Ward for phase one of Kōrero mai. From a Te Ao Māori perspective, the current dominant biomedical model of deterioration is limited because it does not consider all of the domains which constitute wellness for Māori. The maintenance of wellbeing or preventing deterioration for Māori needs to take into consideration; mind, body, spirit perspectives, if a patient and or their whānau have access to healers and or Tohunga. In addition two significant and fundamental aspects to the prevention of deterioration for Māori is Whānau/ whakapapa and whenua considerations.

> "Communication failure is the most common theme identified in an analysis of clinical deterioration related to serious adverse events"

In the first phase of Kōrero Mai, a survey's of staff and patients and observational studies (interactions between staff and patients) were performed.

The findings from phase 1 were:

1. Most patients on the Kaupapa Ward (85% of total sample) are aware of escalation protocols. Whānau awareness of the tools for escalation (using the bell or talking with a nurse) was the same for Māori and non-Māori.
2. Out of the total number of patients surveyed, 75% would escalate their concerns if they felt their condition was getting worse. However 25% of those surveyed would not escalate because they did not want to be a 'hoha'. Escalation behaviour in the Kaupapa ward is similar to overall patient behaviour in the other DHB's undertaking this section of the program.
3. All Whānau we surveyed would escalate their concerns for a whānau member.

Whānau recommendations for improving Māori confidence to escalate included:

- **Information Sharing** – ensuring whānau are fully informed of ward procedures (kawa).
- **Accessibility and responsiveness** of staff.
- **Process for regular patient and whānau feedback** whilst they are on the ward, timely and constant dialogue.
- **Whānaungatanga** – consistency 24 hours per day as required.
- **Addressing the 'don't want to be a hoha mindset'**, removing those barriers.
- **Staff demonstration of Tikanga Māori** – all staff who are on the ward.

BOPDHB Kōrero Mai phase 2 will commence on August 12th, 2019. Phase 1 data will inform a mahitahi design of a Kaupapa Māori escalation process and tools.

A mahitahi is a Te Ao Māori approach to co-design and is our preferred approach because at the core it is Te Tiriti o Waitangi based and uses He Pou Oranga Tangata Whenua determinants to keep our designs holistic and Whānau centred. He Pou Oranga principles inform and work harmoniously with all the steps of HQSC co-design element model.

The principles from He Pou Oranga Tangata Whenua and the aspirations of Te Toi Ahorangi that guide our Mahitahi process are:

- **Te Tiriti o Waitangi** – acknowledge the rights of Whānau as descendants of Toi to exercise their rangatiratanga and our responsibility as the crown to work in authentic partnership.
- **Rangatiratanga** –whānau in phase 2 will be in authentic partnership with the project team; meaning their ideas for design are valued and listened to and decision making cannot occur without them.
- **Mana** – whānau are experts in their lives and wellbeing. Ensure a balance of power in this process.
- **Whānaungatanga** – engage whānau representatives in a way which foster relationships with the Kaupapa ward and builds trust in the design process and outcomes.
- **Manaakitanga** – hosting whānau representatives for phase 2 meetings so that all barriers to participate are removed and that they feel safe and welcome. Using this principle privileges Tangata Whenua voice.
- **Ako** – mutually reinforcing learning, distribute the power and control.

The principles in He Pou Oranga Tangata Whenua ensure the intervention we design would be utilised by whānau and or the patient and support the removal of barriers which shifts the 'don't want to be a hoha mindset'.

Toi Ora target performance

Measurable Improvements in Performance BOPDHB's goals for improved health system performance for the Māori population it serves continue in Te Toi Ahorangi. The DHB's ongoing focus on measurable improvements in performance and health outcomes have been demonstrated by continued investment in personnel assigned to health target improvement, and the funding of performance improvement change initiatives. Coupled with reporting accountability to Executive Leadership and the Board, the DHB's efforts have seen several highlights over the past year and, these are discussed in the Statement of Performance.

General Manager Corporate Services Report

This financial year we achieved a deficit result of $17.37m on total revenue of $840.8m. Our result was $6.89m off our targeted deficit of $10.48m. This result represents deterioration from last year's deficit result of $9.86m.

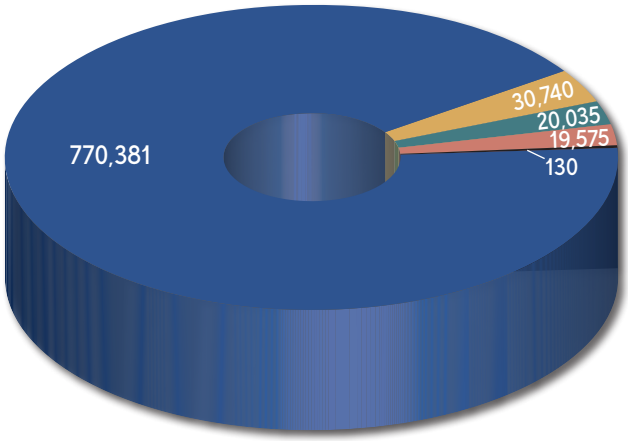
Our cash position has held at $21.28m in cash and investments available at year end ($21.97m in 2017/18).

As with other DHB's, we continue to face increasing demand for health and disability services across our district. The Bay of Plenty has experienced sustained growth in our population, and our demography continues to age.

This growth includes the treatment and discharge of 12,101 elective patients against a target of 11,269, (prior year: 12,112), 83,238 visits to our emergency departments (prior year: 80,693), whilst ensuring that 93% (Target: 95%) of our emergency department patients were admitted, discharged or transferred within six hours.

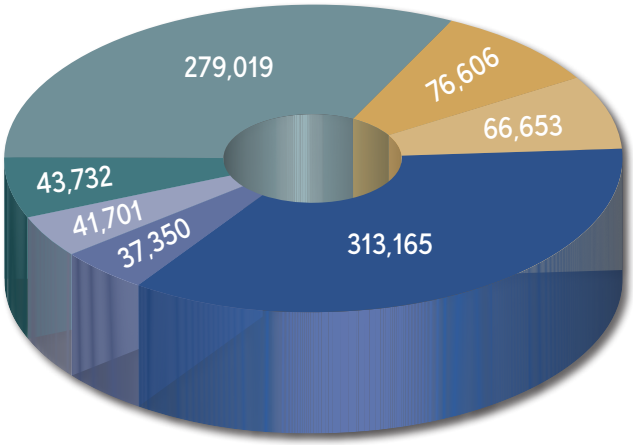
The 2018/19 financial year will continue to provide financial challenges as we service the health needs and demands of our growing population.

Revenue ($000s)



- Crown Funding
- Other MOH revenue
- Other Revenue
- Services to other DHB's
- Share of associate/JV surplus

Expenditure ($000s)



- Community Providers
- Depreciation, Interest & Capital Charge
- Infrastructure & Non-Clinical Supplies
- Outsourced
- Personnel
- Services from other DHBs
- Clinical Expenses

Owen Wallace

General Manager Corporate Services

Our Approach and Priority Populations

The BOPDHB are guided by strategies that are integral to achieving the national vision that "All New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system".

Our fresh approach for the Bay of Plenty Health System

CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

The Bay of Plenty health system's strategic direction

WHY?

- New Zealand Health Strategy
  All New Zealanders live well, stay well, get well
- Midland Region Strategic Direction
  Improve population health and eliminate health inequalities
- Bay of Plenty Strategic Health Services Plan 2017 - 27
  Healthy, Thriving Communities – Kia momoho Te Hāpori Oranga
- Bay of Plenty District Health Board Good to Great - Māori Health Strategy

WHAT?

Healthy individuals Mauri Ora	Healthy families Whānau Ora	Healthy environments Wai Ora
1. All people live healthy with a good quality of life. 2. All children have the best start in life. 3. People die in their place of choice.	1. Family/whānau live well with long-term conditions. 2. People are safe, well and healthy in their own homes and communities.	1. All people live, learn, work and play in an environment that supports and sustains a healthy life. 2. Our population is enabled to self manage. 3. All people receive timely, seamless and appropriate care.

HOW?

- Empower our populations to live healthy lives
- Develop a smart, fully integrated system to provide care close to where people live, learn, work and play
- Evolve models of excellence across all of our hospital services

Embedding patient and family centred care/Whānau Ora **Building effective partnerships**	**Developing our workforce** **Developing our facilities**	**Using information to improve value** **Making of the most of new technologies**

Redesigning funding and contracting models to better match care with need

Annual Plan

There were five key areas of focus for the BOPDHB for 2018/19, as agreed with the Ministry of Health. These areas align with the national direction and the strategic objectives in the Bay of Plenty Strategic Health Services Plan.

- Improving equity for Māori.
- Developing a high-performing primary care sector with strong leadership and capability with a particular focus on progressing enhanced primary care models such as health care homes.
- Responding to increasing service and acute demand.
- Improving mental health and addiction services across the Bay of Plenty considering the recommendations of the national review and looking at improved pathways for service users.
- Achieving financial sustainability.

Our six regional objectives

Improve Māori health outcomes

Integrate across continuums of care

Improve quality across all regional services

Build the workforce

Improve clinical information systems

Efficiently allocate public health system resources

Midland Regional Strategy 2018–2021

Improve the health of the Midland populations

Health and wellbeing is everyone's responsibility. Individuals and family and whānau are to actively manage their health and wellbeing; employers and local and central body regulators and policy makers are expected to provide a safe and healthy environment that communities can live within.

Achieve health equity

The New Zealand health service has made good progress over the past 75 years.

However, an ongoing challenge is to reduce ethnic inequalities in health outcomes for populations, particularly Māori and Pacific peoples. As a key focus Midland DHBs will work to support equitable health outcomes in its populations.

A core function of DHBs is to plan the strategic direction for health and disability services. This occurs in partnership with key stakeholders and our community (i.e. clinical leaders, iwi, Primary Health Organisations and Non-Government Organisations) and in collaboration with other DHBs and the Ministry of Health. Achieving health equity is the goal.

Public Health

Toi Te Ora Public Health (Toi Te Ora) is the Public Health Unit for the Bay of Plenty and Lakes DHBs. The role of Toi Te Ora is to deliver services that promote, protect and improve population wellbeing, prevent ill health and minimise the risk of disease through interventions at a population level. and focusses on action that protects our environments, prevents illness and injury and promotes health and wellbeing of communities.

Toi Te Ora continues to maintain the delivery of high quality services across our area of regulatory responsibilities, and wider health protection work as the service gives effect to its purpose of protecting and improving the health of the population with a focus on the achievement of health equity, in particular for Māori.

Toi Te Ora Public Health (Toi Te Ora) has maintained a focus on its three child-centred strategic goals throughout 2018/19, which were to reduce childhood infections, childhood obesity and the uptake of smoking by children. A number of key partners have continued to support Toi Te Ora with this work including the Bay of Plenty and Lakes District Health Boards (DHBs), primary care, a number of non-government organisations, and local and regional councils.

Toi Te Ora has now confirmed its new strategic direction for 2019-2029, which outlines six focus areas which build on the previous three goals and have been framed within the context of emerging public health issues and community priorities. Toi Te Ora has identified tamariki (children) as a population it will prioritise, alongside their whanau., with a focus on Māori, remain the priority population for Toi Te Ora.

The six priorities are:

Biophilic Public Health and Health in All Policies remain as the two strategic approaches that will support of our work within these focus areas. The new strategic plan and focus areas take effect from 1 July 2019.

Health Profile

BOP has steady population growth projected for Tauranga and West BOP, with negative population growth expected in East BOP. The largest proportionate growth is in older people, with the 75+ age group increasing at 3.6% per year, similar to the New Zealand average

75+
AGE GROUP INCREASING
3.6%
PER YEAR

25%
MĀORI

At 25%, BOP has a high proportion of Māori in the population compared to national data

The NZ Deprivation Index shows that on average, BOP is more deprived than the New Zealand average

The BOP population has a higher life expectancy than the New Zealand average, but has a higher amenable mortality. Males have a lower life expectancy than females

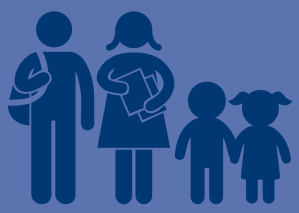
EAST BOP

WEST BOP

While heart disease and suicide are the largest causes of premature death, diabetes in East BOP and motor vehicle injury in West BOP showed higher mortality rates than other parts of BOP

Māori in BOP are comparable to Māori elsewhere in New Zealand on most health indicators. A large gap still exists in the majority of health indicators compared with non-Māori in BOP. Exciting opportunities exist for making rapid health gains for Māori in BOP

Children (0-14 years) and youth (15-24 years) are generally at higher risk than their national counterparts. Specific concerns include overcrowding, lack of home heating, child abuse, dental health, ambulatory sensitive hospitalisations, suicide and self harm



BOP has a higher rate of hazardous drinking than the national average

57,000
OBESE ADULTS

4,000
OBESE CHILDREN

The BOP population ranks relatively high on most risk factors compared to national data. It has 35,000 smokers and 57,000 obese adults 10,000 of whom are morbidly obese. Over 4,000 children are obese, with 21% consuming fizzy drinks 3+ times a week

MORE THAN
12,000
PEOPLE WITH DIABETES

More than 12,000 people in BOP have diabetes, and prevalence is growing

16% of adults have chronic pain, with many assessed for home care noting severe persistent pain. Rates of long term opioid use are high despite lack of effectiveness

16%
OF ADULTS WITH CHRONIC PAIN

GP

General practice coverage and quality is similar to the New Zealand average

Māori are lower users of primary care than indicated by their health status, raising equity concerns

Most hospital care is provided locally. Both unplanned and planned admission rates are above the New Zealand average

Overall, BOP's ambulatory sensitive hospitalisation rate for 2010-15 is higher than the national overall rate

Emergency department (ED) attendance rates are higher than national rates, and are particularly high at Whakatane Hospital. This may link to lower after-hours access to primary care

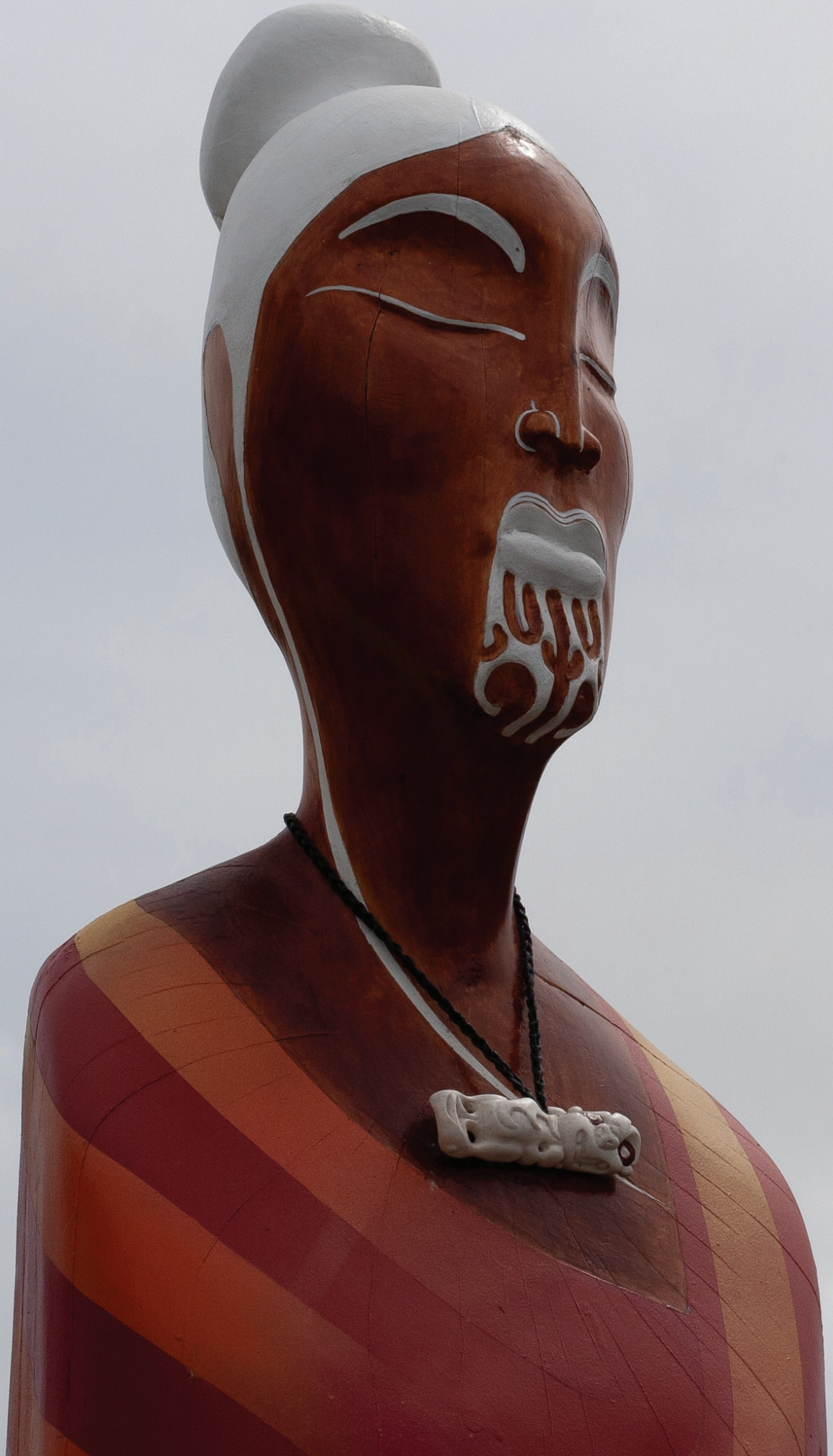
Older people (age 75+) appear to have good access to hospital and community-based services, with good ageing in place support

The birth rate is declining, but fertility remains higher than the NZ average. Obesity rates during pregnancy are similar to New Zealand rates. Caesarean section rates are relatively low

Access to mental health and addiction specialist services is similar to, or better than, the national average. Hospital level care may be overused compared with community-based support

SUICIDE RATE
HIGHER THAN NZ AVERAGE

Suicide and self harm rates are higher than the NZ average



A year in the life OF THE BAY OF PLENTY DISTRICT HEALTH BOARD

2019

913

people have received their first cancer treatment within 31 days

31

428

CONTRACTS

with health care providers for health services to the Bay of Plenty community

2,806

CHILDREN

received Before School Checks

Serves a population of **238,380**

- 25% IDENTIFY AS HAVING MAORI ETHNICITY
- 32% ARE UNDER 25 YEARS OF AGE
- 20% ARE AGED 65 OR OVER

24,056

people who smoke have been seen by a GP and provided with advice to quit smoking

3.61 MILLION

community pharmacy prescriptions

2,905 BABIES

delivered in birthing facilities

1,565,573

community

laboratory tests have been undertaken

School dental services to an enrolled population of **42,572**

83,238

attendances at the Emergency Departments

77%

of young people referred to alcohol and drug services are seen within 21 days

73%

of eligible women aged 50-69 received breast screens

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI


PHILIPS

03

Statement of Service Quality

Pūrongo Ratonga

Health Targets

There are five national health targets set by the Ministry of Health (MoH) to track how well district health boards are providing services to their communities. The targets include both preventative health and hospital service measures and are publically reported each quarter.

We have a number of programmes in place designed to help us meet the targets, however improving the target results will take an all of health sector approach. Because of this the DHB is building on its already strong relationship with primary and community-based healthcare providers. We are working proactively to ensure people are getting the services, check-ups and information they need to stay well.

Health Target	Target	2018/19 Q4 Results
95% of patients will be admitted, discharged, or transferred from an emergency department within six hours. 	95%	93%
90% of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months. 	90%	89%
90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2. 	90%	92%
95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. 	95%	100%
95% of 8-months-olds will have their primary course of immunisation (6 weeks,3 months and 5 months immunisation events) on time. 	95%	82%

Quality and Safety Markers

The Health Quality & Safety Commission (HQSC) is driving improvement in the safety and quality of New Zealand's healthcare through the national patient safety campaign Open for better care. The quality and safety markers (QSMs) help evaluate the success of the campaign nationally and determine whether the desired changes in practice and reductions in harm and cost have occurred. Below are our performance results as at 30 June 2019.

Marker Definition	New Zealand Goal	Q3 July to September 2018	Q4 October to December 2018	Q1 January to March 2019	Q2 April to June 2019
Falls: Percentage of patients aged 75 and over (Māori and Pacific Islanders 55 and over) that are given a falls risk assessment.	**90%**	**88%**	**77%**	**88%**	**84% TBC**
Falls: Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk.	**90%**	**89%**	**84%**	**94%**	**93% TBC**
Hand Hygiene: Percentage of opportunities for hand hygiene for health professionals.	**80%**	**81%**	**Data not available**	**76%**	**Data not available**
Surgical Site Infections: Percentage of hip and knee arthroplasty* primary procedures were given an antibiotic in the right time.	**100%**	**99%**	**100%**	**Data not available**	**Data not available**
Surgical Site Infections: Percentage of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose.	**95%**	**99%**	**100%**	**Data not available**	**Data not available**

Compared to other DHBs

Upper group Middle group Lower group

Fortnightly adult inpatient experience survey scores

Domain	National Average	Q1 Jul-Sep 18	Q2 Oct-Dec 18	Q3 Jan-Mar 19	Q4 Apr-Jun 19
Communication	8.4	8.4	8.1	8.5	8.6
Partnership	8.5	8.8	8.6	8.6	8.7
Coordination	8.3	8.9	8.6	8.5	8.6
Physical and Emotional Needs	8.6	9.1	8.9	8.8	8.9

Achieving our Vision of Healthy Thriving Communities

Patient centred

New clinic brings better support for people taking multiple meds

Helping elderly patients who take multiple medications stay safe and well is the aim of a new outpatients clinic at Tauranga Hospital.

For many older New Zealanders, polypharmacy (taking multiple medications for multiple conditions) is common. 35% of over 65s are prescribed five or more medications, and 8% of over 85s are on 11 or more. In the new clinic, these patients can talk to a pharmacist and, if needed, be assessed by a geriatrician.

"Taking multiple medications may be beneficial for quality of life and staying well, as long as it's carefully managed," said Bay of Plenty District Health Board (BOPDHB) Geriatrician Dr Vicky Henstridge. "Research shows 58% of people on five or more medications will suffer an adverse side effect. There's also a higher risk of falls and other age-related conditions that can lead to hospitalisation.

"Our new outpatient clinic allows people to bring along family or friends and spend up to an hour with a pharmacist discussing all their medications, prescribed and non-prescribed, their benefits, potential side effects and possible changes. At the same time, they can be seen by a geriatrician who may add to the recommendations, arrange appropriate investigations or further review."

Above: Geriatrician Dr Vicky Henstridge (left) and Pharmacist Adele Harrex (right) at the new outpatient clinic providing better support for people taking multiple medications for multiple health conditions.

The new clinic has been set up to support older people to stay well and improve their quality of life. Its progress will be monitored and, depending on its success, the BOPDHB may look to develop a similar clinic at Whakatāne Hospital.

Smart System

Latest technology frees up healthcare professionals' time for patients

Technology, in the form of an automated tablet-counting machine, is helping speed up a traditional task and free up more time for patients say healthcare professionals.

Manually counting tablets has historically been a big time consumer for pharmacists, pharmacy technicians and nurses. No longer, as the BOPDHB becomes one of New Zealand's first DHBs to install a repackaging machine in its Tauranga Hospital Pharmacy.

The EV-54 NANO vial filling machine ('Evie' for short) went fully operational on Wednesday (5 June) and the benefits it represents have been eagerly anticipated said Pharmacy Manager Cindy Mortimer.

"It's all about the patients at the end of the day," said Cindy. "It frees staff up from manual, non-value-add tasks and allows the pharmacists and technicians to spend more time with them. It's about adding value out on the wards with the people we're caring for.

"This is one of the first repackaging machines in a DHB in the country. Installing it has been about listening to staff and giving them the tools to do their job more efficiently."

Above (from left): Pharmacy Technician Tayla Lum and Pharmacy Manager Cindy Mortimer in front of the EV-54 NANO vial filling machine in Tauranga Hospital Pharmacy.

Pharmacy Technician Tayla Lum and her colleagues undertook timed tests manually counting tablets and then replicating those with 'Evie'. Early results showed the machine was around 4.5 times faster.

"Not only does it take less time to do the job than it would manually, but you can be doing other things whilst it's working, such as labelling." said Tayla.

Value and high performance

Taonga gifted recognising staff cultural care in ICU

Thomas Mitai is lucky to be alive and he's grateful.

In February the prominent and talented singer, kapa haka performer, film maker, member of Ringatū church and manager of Te Whare Wānanga o Awanuiārangi Tech Pā Studio was on his way to work when he had a head on car crash.

Thomas suffered multiple injuries including eight fractured ribs, punctured lungs, a lacerated spleen, hematoma on his liver, a broken leg and several cuts.

"I just came around the corner and the other car was on the wrong side of the road. ...I managed to stay conscious, but I was in a bad way. I couldn't breathe and I lost a lot of blood," says Thomas.

He was taken to Whakatāne Hospital and transferred to the Intensive Care Unit (ICU) at Tauranga Hospital.

"I have huge respect for those who treated and cared for me in hospital. They accepted and acknowledged my Māoritanga, Ringatū faith and whānaungatanga. Having my whānau and friends at my bedside gave me strength. For me, that was everything and a key part of my recovery."

Every evening Thomas was in hospital, his dad, Richard, a Tohunga of Ringatū would hold a karakia at his bedside. Staff and patients would gather around as well. There was waiata too.

"I'd crumble if I couldn't sing, it's who I am. Their presence and hearing them sing while I rested really lifted my spirit."

Recently Thomas returned to the hospital bringing morning tea for staff and gifting a carved waka hoe (paddle) to ICU as a symbol of his gratitude for the care he'd received.

Thomas says the message etched on the waka hoe is one for all.

"Kia mau ki tō hoe. E hoe tō waka. Hold on to your paddle. Continue your journey."

Pictured: Thomas Mitai (centre) with Tauranga Hospital ICU Clinical Nurse Manager Chris Southerwood (left) and Health Care Assistant Tracy Penwarden (right).

People powered

5210 – The Healthy Way to Go

Tamariki across the Bay of Plenty are being given a head start on healthy habits thanks to a brand new range of health resources given at their routine B4 School Check.

The BOPDHB and Toi Te Ora Public Health have developed a range of resources called "5210", which feature local scenes and local people teamed up with some simple messages to help make the healthy choice the easy choice. Not only are these resources being distributed at the B4 School Check, but also via general practices, early childhood centres, and dental clinics around the Bay.

Public Health Nurse, Debbie Trenberth, has been handing out the resources as part of the B4 School Check and says they help to generate healthy conversations with whānau and drive home the simple 5210 message.

"We have some great new resources that can be easily understood to help kids and their families remember to go 5210 everyday. These include the 5210 book bags and stickers." She adds, "The resources remind families that we need to eat five vegetables and fruit a day, cut down kids screen time to less than two hours, be active for an hour or more each day, and have zero sugary drinks but drink water or milk instead."

Following his B4 School Check with Public Health Nurse, Debbie Trenberth (left), Maverick Rawson (right) is all set to start school with his new 5210 bag.

Dr Alison James, a Tauranga GP, was part of the team that helped develop the resources.

"The resources can be used by anyone in the community, so families and whānau see these messages and are encouraged to live them," she said. "If kids can live 5210 every day they are learning healthy habits which will help prevent chronic illnesses, like diabetes, in adulthood."

Health practitioners can also access specific resources to support conversations with whānau about children's food, sleep and activity, as well helping families set goals towards creating healthy habits.

For 5210 resources and information visit www.toiteora.govt.nz/5210

One team

Faster treatment and shorter stays the goal for Emergency Department project

Tailoring patients to the most appropriate health professionals in the timeliest way is the thought-process behind a successful Whakatāne Hospital Emergency Department (ED) project.

A small group of health professionals known as the ALPHA team has been working closely with ED doctors and nurses over the last six months identifying incoming patients whose treatment aligns with their professions. These include: physiotherapists, occupational therapists, podiatrists, pharmacists and nurse specialists. For many patients the team's work has meant faster treatment and shorter hospital stays.

"It's a shift from the traditional way of doing things where those patients were only seen by those types of health professionals once they'd either been admitted to a ward or from an ED referral," said Whakatāne Hospital ED Clinical Lead Dr Tamsin Davies.

"For patients picked up by the ALPHA team what we're finding is that they are getting the healthcare they need much sooner. Particularly our older patients (75+), faster treatment means a better recovery and less time spent in hospital."

Dr Davies says some patients were also avoiding a hospital stay altogether by being connected with the right health support they need in the community.

The ALPHA team is part of a broader programme to improve the care treatment pathway, making better use of hospital resources and saving patients' time in the process.

"We're constantly looking at ways to improve the timeliness and quality of care provided at the hospital," said Service Improvement Programme Manager Fiona Burns. "We don't want patients waiting unnecessarily when there's no good medical reason to do so.

"We have been monitoring progress closely and since the programme began approximately 7 out of 10 patients are going home a day earlier."

From left: ED Clinical Lead Dr Tamsin Davies with part of the ALPHA team, Occupational Therapist Ellise Robinson, Nurse Practitioner Theresa Ngamoki and Podiatrist Amanda Johnstone.

Care closer to home

BOP quit smoking service one of the best in NZ

The Bay of Plenty's free Stop Smoking Support service, Hāpainga remains one of the top three services in New Zealand for its successful quit smoking rate.

New Zealand has 16 Stop Smoking Support services. As part of the Government's goal of Smokefree Aotearoa 2025, each service works hard to encourage as many of the community to become Smokefree.

Smoking cessation practitioners use a carbon monoxide detector, a bit like a breathalyser, at four weeks to verify whether or not a client is smokefree. Low to nil levels of carbon monoxide indicates the person is no longer smoking, at which point they receive a $50 supermarket voucher.

Hāpainga Team Leader Lizzie Spence says, "For the last couple of years, we've consistently had a minimum 75% successful quit smoking rate at four weeks – ranked in the top three across the country.

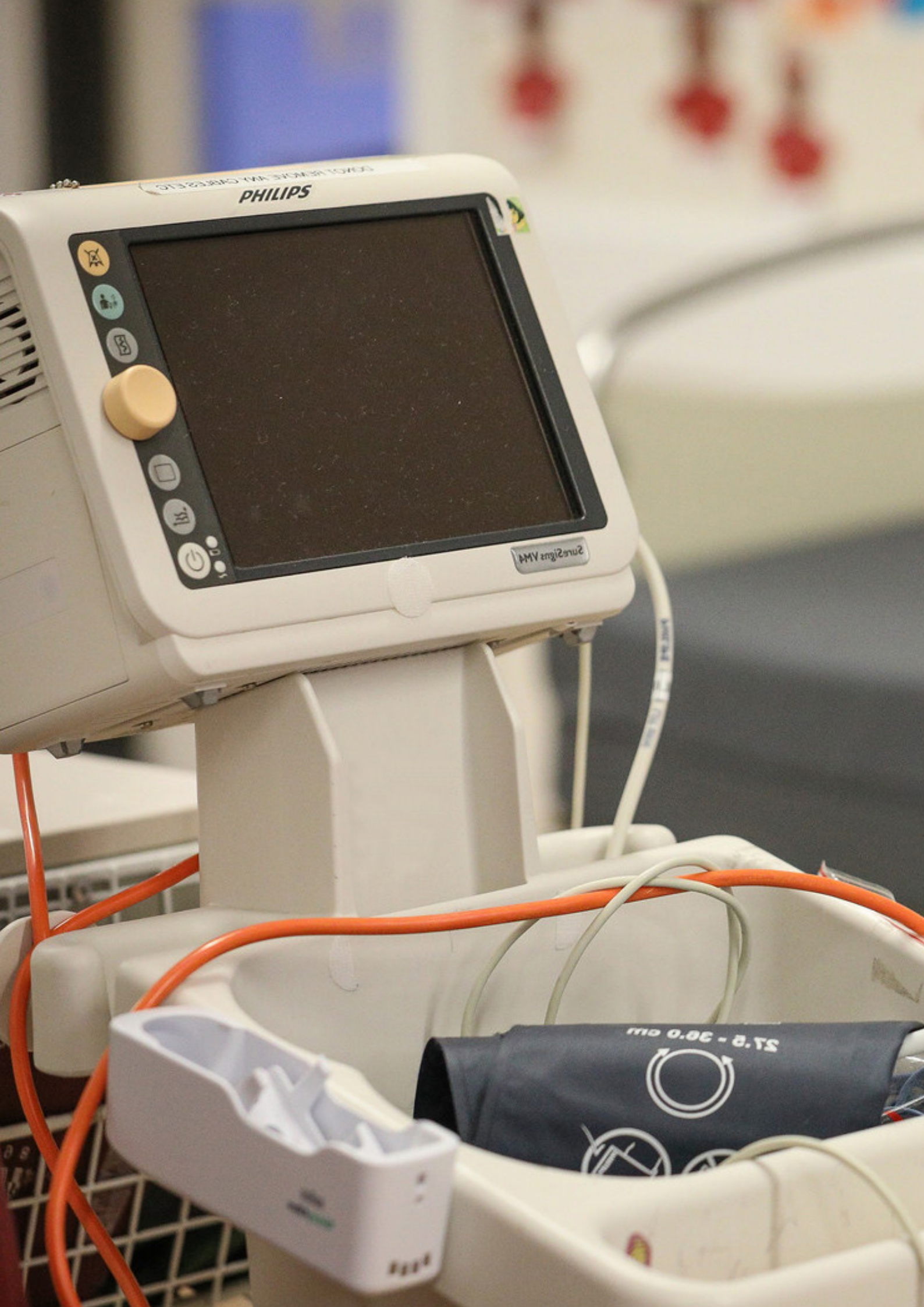
"It's a great achievement. We're a small team of five smoking cessation practitioners supporting people to quit across both the Eastern and Western Bay. We understand the struggles people go through trying to quit but also the struggles of buying the smokes. For the average couple smoking 10 tailor-made cigarettes a day, the yearly bill is over $10,000.

"Our team really focuses on treating each client as an individual. Quitting smoking is a real journey. Our team might meet with a client several times before they even set a quit date. Building a rapport and trust with them is crucial to the successful outcome," says Lizzie.

Hāpainga
Stop Smoking Service

Call 0800 HĀPAINGA (427246)

Below: The Hāpainga team pictured left to right: Walter Harawira Stevie-Lee Hiroki, Candy Blackwell, Monique Rio, Kate Warner and Lizzie Spence.


PHILIPS

04

Our Leadership
Mana Tangata

Introduction and Objectives of the Board

The Bay of Plenty District Health Board (BOPDHB) was established pursuant to section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD).

The BOPDHB is a Crown Entity and subject to the provisions of the Crown Entities Act 2004 (CEA). As an agent of the Crown, the BOPDHB is committed to fulfilling its role as a Treaty of Waitangi partner and is guided by two key strategic documents that provide the blueprint for how we will best respond to the health needs and aspirations of tangata whenua and our wider population. Te Toi Ahorangi and the Strategic Health Services Plan (SHSP) sit directly alongside each other. to guide how the BOPDHB plans, prioritises, funds and delivers services in Te Moana ā Toi (The Bay of Plenty DHB area) as an integrate system across Primary, community and secondary care.

The objectives of the Board are:

- To improve, promote, and protect the health of Bay of Plenty people and communities.
- To promote the integration of health services, especially primary and secondary health services.
- To promote effective care or support for those in need of personal health services or disability support services.
- To promote the inclusion and participation in society and independence of people with disabilities.
- To reduce health disparities by improving health outcomes and equity for Māori and other population groups.
- To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to improve health outcomes.
- To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services.
- To foster community participation in health improvement, planning for the provision of services and for significant changes to the provision of services.
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.
- To be a good employer.
- The Board will pursue and demonstrate its objectives in accordance with its Strategic Health Services Plan, Te Toi Ahorangi Strategy, Annual Plan and any directions or requirements given to the Board by the Minister of Health (the Minister) under sections 32 or 33 of the NZPHD Act.

Back row: *Anna Rolleston, Judy Turner, Marion Guy, Geoff Esterman, Mark Arundel, Yvonne Boyes.*
Front row: *Bev Edlin, Ron Scott, Sally Webb, Pouroto Ngaropo.*

Functions of the Board

For the purpose of pursuing and demonstrating its objectives, the Board has the following functions:

- To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement.
- To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities.
- To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people.
- To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement.
- Maintain the partnership relationship between the Board and the Māori Health Rūnanga.
- To continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori.
- To provide relevant information to Māori for the purposes of fostering Māori participation in Māori health improvement.
- To regularly investigate, assess, and monitor the health status of its resident population, any factors that the BOPDHB believes may adversely affect the health status of that population, and the needs of that population for services.
- To promote the reduction of adverse social and environmental effects on the health of people and communities.
- To monitor the delivery and performance of services by the BOPDHB and by persons engaged by the BOPDHB to provide or arrange for the provision of services.
- To participate, where appropriate, in the training of health professionals and other workers in the health and disability sector.
- To provide information to the Minister for the purposes of policy development, planning and monitoring in relation to the performance of the BOPDHB and to the health and disability support needs of New Zealanders.
- To provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Public Finance Act 1989.
- To collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes.
- To perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister of Health by written notice to the Board of the BOPDHB after consultation with it.

Board Governance

Structure

In accordance with the New Zealand Public Health and Disability Act (NZPHD) the Board may consist of seven elected members and up to four members appointed by the Minister of Health. Currently the BOPDHB consists of seven elected and four appointed members.

Under the NZPHD the Minister of Health appoints the Board Chair and Deputy Chair from among the elected or appointed members. Our current Board Chair is Sally Webb and our Deputy Chair is Ron Scott.

The NZPHD requires the formation of three statutory committees:

- Community & Public Health Advisory Committee (CPHAC).
- Disability Services Advisory Committee (DSAC).
- Hospital Advisory Committee - Bay of Plenty Hospital Advisory Committee (BOPHAC).

The Community & Public Health and the Disability Services Advisory Committees, function as a combined Committee within the BOPDHB.

In addition to the statutory committees required by the NZPHD Act, the Board maintains two Committees of the Board, an Audit, Finance and Risk Management Committee (AFRM) and a Strategic Health Committee and one standing committee, the CEO Performance and Remuneration Committee. These committees meet four times a year, unless their meeting is scheduled in the month of January, in which case they only meet two or three times that year, as there are no January meetings. This is rotated every year between the committees.

The Board also has a Memorandum of Understanding with the Māori Health Rūnanga, which establishes a partnership between the Board and the Rūnanga. The Rūnanga advises the Board on Māori health issues, reviews planning documents and delivery of services to ensure that they reflect an approach that is culturally acceptable to Māori. The Rūnanga also advises the Board on other issues affecting Māori that may arise from time to time.

The Board is responsible for the governance of the BOPDHB. The Board employs the Chief Executive who is responsible for the management and operation of the BOPDHB.

Accountability and communication

The Board acknowledges its responsibility to maintain consistent and open communication with its stakeholders. The Board values the input of the community and interested groups to assist the Board with its goal of building Healthy, Thriving Communities. Without the people of our region taking an interest in their individual and community health, and disability issues, the Board cannot succeed in its goals and responsibilities.

The Board is at all times accountable to its stakeholders, and to ensure accountability is maintained by the Board, it endeavours to be as transparent and open as possible in its decision-making. Transparency is maintained through the conducting of open Board and Statutory Committee meetings and the ready availability of Board papers, minutes and other publications.

Board elections

The Board is elected every three years. Ministerial Appointments occur to coincide with the BOPDHB election process, however if there is a Ministerial vacancy, the Minister may appoint to fill this vacancy at any time.

Board and committee fees

Effective from 1 July 2013 Board Members receive a fee of $22,440 per annum, the Board Chair receives $46,200 per annum and the Deputy Chair receives $28,050 per annum.

Committee Members of the two Statutory Committees (Combined Community & Public Health Advisory and Disability Services Advisory Committee and Bay of Plenty Hospital Advisory Committee) and the Committee of the Board (Audit, Finance & Risk Management Committee) and Strategic Health Committee are paid $250 per meeting. The Chair of the Committee receives $312.50 per meeting.

Both Board and Committee Members are reimbursed for reasonable expenses including mileage.

Further details on Board and Committee fees can be found in Cabinet Office circular CO (12)06 Fees Framework for Members Appointed to Bodies in which the Crown has an Interest.

Actual fees paid to Board and Committee Members are listed on the opposite page (dollars).

Name	Board	AFRM	CPHAC - DSAC	BOPHAC	SHC	Expenses	2019 Total
Mark Arundel**	22,440	2,750	250	-	938	572	26,950
Yvonne Boyes	22,440	-	-	500	500	1,629	25,069
Bev Edlin**	22,440	2,500	313	-	750	-	26,033
Geoff Esterman	22,440	2,750	-	1,250	750	99	27,289
Marion Guy	22,440	-	500	-	500	161	23,601
Peter Nicholl**	22,440	2,000	-	750	500	2,394	28,084
Matua Parkinson	22,440	-	-	750	-	-	23,190
Anna Rolleston**	22,440	1,250	250	-	750	395	25,085
Ron Scott**	28,050	3,438	500	1,000	750	923	34,661
Judy Turner	22,440	-	250	-	500	833	24,023
Sally Webb	46,200	2,250	500	750	500	5,327	55,527
Total Board Members	**276,210**	**16,938**	**2,563**	**5,000**	**6,438**	**12,333**	**319,512**
Punohu McCausland*	250	-	-	-	-	-	250
Lyall Thurston	-	-		1,000	-	501	1,501
Mary-Anne Gill	-	-	500	-	500	488	1,488
Janine Horton	-	-	250	-	-	54	304
Clyde Wade	-	-	-	750	-	518	1,268
Paul Curry	-	-	250	-	-	-	250
Pouroto Ngaropo*	1,000	-	-	-	250	102	1,352
Total All Members	**277,460**	**16,938**	**3,563**	**6,750**	**7,188**	**13,996**	**325,925**

* Pouroto Ngaropo became Chair of the BOP Runanga, succeeding Punohu McCausland, in August 2018
** Board Members who participate as reciprocal members for other Midland DHB Committees

Attendance

The Board meets on a monthly basis and holds extra meetings when required for planning or other specific issues. Examples of these additional meetings are regional workshops and joint planning sessions.

Board Member attendance at Board meetings during the year was as follows:

Meetings			
Name	Scheduled	Attended	Comments
Mark Arundel	11	11	
Yvonne Boyes	11	11	
Bev Edlin	11	11	
Geoff Esterman	11	9	
Marion Guy	11	11	
Punohu McCausland	11	1	Rūnanga Representative
Pouroto Ngaropo	11	4	Rūnanga Representative
Peter Nicholl	11	7	
Matua Parkinson	11	7	
Anna Rolleston	11	9	
Ron Scott	11	11	Deputy Chair
Judy Turner	11	10	
Sally Webb	11	10	Board Chair

Interests declared

No Board Member is a member of the Executive of the BOPDHB.

The Board maintains an interest register and ensures members are aware of their obligations to declare conflicts of interest. The register outlines areas where a Board or Committee Member has an interest that could lead to a potential conflict. In addition to the register members declare any specific conflicts at the commencement of each meeting.

The full Board and Committee Member Interests Register as at 30 June 2019 is available on the BOPDHB website.

Board members' loans

There were no loans to Board Members.

Combined Community and Public Health and Disability Services Advisory Committee

Functions

- Make recommendations and provide advice to the Board on the health care and disability support needs of the population of the district.
- Make recommendations and provide advice to the Board on any factors that the Committee believes may adversely affect the health status of the population.
- To advise and recommend to the Board, within funding levels, priorities for disability support services for the population aged over 65 or having like needs, and those whose disability is a result of a medical condition.
- Make recommendations to the Board on the priorities for the allocation of health funding.
- Provide advice to the Board on the implications for planning and funding of nationwide health strategies.
- Provide advice and make recommendations to the Board on strategies to reduce disparities in health status.
- Ensure mechanisms are in place to assess the performance of service providers against accountability documents, and industry and sector standards.
- Monitor the performance of service providers against accountability documents, and industry and sector standards.
- To liaise with community groups in relation to the provision of disability support services for the over 65 age group.
- To perform any other function as directed by the Board.

Membership and attendance

- Membership of the Committee shall be determined by the BOPDHB and shall include at least one Māori representative.
- The appointment of members must comply with the requirements set out in Schedule 4, Clause 6 of the NZPHD.
- The BOPDHB will appoint the Chair and Deputy Chair. The appointment of the Chair and Deputy Chair will comply with the requirements set out in Schedule 4, Clause 11 of the NZPHD.

The Committee meets on a quarterly basis and Committee membership and attendance during the year was as follows

Meetings			
Name	Scheduled	Attended	Comments
Ron Scott	2	2	
Sally Webb	2	2	
Judy Turner	2	1	
Mark Arundel	2	1	
Beverley Edlin	2	1	Chair
Anna Rolleston	2	1	
Marion Guy	2	2	
Janine Horton	2	1	Lakes DHB Representative
Paul Curry	2	1	Community Representative
Mary-Anne Gill	2	2	Waikato DHB Representative
Pouroto Ngaropo	2	0	Rūnanga Representative

Bay of Plenty Hospitals' Advisory Committee

Functions

- To monitor the financial and operational performance of the hospitals, Community Health and Disability Services, Public Health and related services of the BOPDHB and to advise the Board of any current or future implications of monitored performances.
- Assess and monitor strategic issues relating to the provision of hospital and other services provided by the BOPDHB and give advice and make recommendations to the Board based on the results of the monitoring and assessment.
- Monitor the development of systems to manage operational and clinical risk and advise the Board if a significant risk is not being mitigated.
- Assess the performance of the hospital and related services of the BOPDHB against the hospital and related services provisions of the Annual Plan, accountability documents, and accepted industry and sector standards. Report any variation from expected standards to the Board and advise the Board of possible corrective measures.
- Monitor campus redevelopment programmes.
- Approve variations and changes that are within delegated authorities and the scope of the projects.
- To perform any other function as directed by the Board.

Membership and attendance

- Membership of the Committee shall be determined by the BOPDHB and shall include at least one Māori representative.
- The appointment of members must comply with the requirements set out in Schedule 4, Clause 6[5] of the NZPHD.
- The BOPDHB will appoint the Chair and Deputy Chair. The appointment of the Chair and Deputy Chair will comply with the requirements set out in Schedule 4, Clause 11[6] of the NZPHD.

The Committee meets on a quarterly basis and the Committee membership and attendance during the year was as follows:

Meetings			
Name	Scheduled	Attended	Comments
Yvonne Boyes	4	2	
Geoff Esterman	4	4	Chair
Matua Parkinson	4	3	
Peter Nicholl	4	3	
Ron Scott	4	4	
Sally Webb	4	3	
Clyde Wade	4	3	Waikato DHB Representative
Lyall Thurston	4	4	Lakes DHB Representative

5. New Zealand Public Health and Disability Act 2000.
6. New Zealand Public Health and Disability Act 2000.

Audit, Finance and Risk Management Committee

Functions

Audit

- Liaise with the internal auditor and review internal audit scope, planning and resourcing.
- Assist the external auditor to identify risks and issues relevant to the external audit planning process.
- The Chair of the Committee is to receive draft copies of all internal and external audit reports when these are circulated to management for comment.
- The Committee will receive the final reports of the internal and external auditors and review their findings
- Monitor the progress made by management in implementing recommendations arising from audit.

Financial planning and reporting

- Review and advise the Board on its approval of the BOPDHB's financial statements and disclosures.
- Review draft Annual Plans and other accountability documents for their financial impact.
- Review and advise the Board regarding finance-related policies and procedures requiring Board approval, including delegation policies.
- Review management accounting and internal financial reporting practices and issues and alert the Board to any areas which appear ineffective.
- Review capital expenditure and asset management planning and their relationship with service planning.
- Monitor the financial performance and position of the BOPDHB against budget and forecast.

Risk management oversight

- Ensure that the BOPDHB complies with its obligations under key legislation.
- Keep other legislative compliance arrangements under review (such as employment legislation).
- Monitor risk assessment and risk management mechanisms, including internal control.
- Receive and investigate disclosures under the BOPDHB's 'whistle-blowing' policy where it is not appropriate for these to be received and investigated by the Chief Executive.
- Monitor and review policies and procedures to minimise and manage conflicts of interest among BOPDHB Board members, management and staff.
- Monitor and review policies and procedures to minimise and manage risks in the contracting of health services.
- Other monitoring responsibilities as determined by the Board, for example in relation to major contracts or construction projects.

Membership and attendance

The Audit, Finance and Risk Management (AFRM) Committee comprises:

- The BOPDHB Chair.
- Chairs of the following committees:
  - Combined Community and Public Health and Disability Services Advisory Committee.
  - Bay of Plenty Hospitals Advisory Committee.
- Other Members as appointed by the Board.
- The Board will endeavour, where appropriate, to include Māori representation on the committee (clause 38(2), Schedule 3, NZPHD Act).

The Committee meets on a monthly basis and as required for particular issues.

Committee membership and attendance during the year was as follows:

Meetings			
Name	**Scheduled**	**Attended**	**Comments**
Mark Arundel	11	11	
Anna Rolleston	11	5	
Beverley Edlin	11	10	
Geoff Esterman	11	11	
Sally Webb	11	9	
Peter Nicholl	11	8	
Ron Scott	11	11	Chair

Internal control

To fulfil its responsibilities, management maintains adequate accounting records and has developed and continues to maintain a system of internal controls:

- The Board acknowledges that it is responsible for the systems of internal financial control.
- Internal financial controls implemented by management can provide only reasonable and not absolute assurance against material misstatement or loss.

The Audit, Finance & Risk Management Committee has established certain key procedures, which are designed to provide effective internal financial control. No major breakdowns were identified during the year in the system of internal control.

After reviewing internal financial reports and budgets the Committee Members believe that the BOPDHB will continue to be a going concern in the foreseeable future, subject to ongoing support from the Crown. For this reason they continue to adopt the going concern basis in preparing the financial statements.

Strategic Health Committee

Functions

The Strategic Health Committee (SHC) is a combined forum of the Community and Public Health Advisory Committee / Disability Services Advisory Committee (CPHAC/DSAC) and the Bay of Plenty Hospitals Advisory Committee (BOPHAC). The role of the SHC is to provide strategic advice to the Board in relation to strategic objectives one, two and three of the Bay of Plenty Strategic Health Services Plan, to explore disruptive initiatives, and to challenge the status quo.

Membership and attendance

The Committee meets on a quarterly basis.

Committee membership and attendance during the year was as follows:

Meetings			
Name	**Scheduled**	**Attended**	**Comments**
Mark Arundel	3	3	Chair
Sally Webb	3	2	
Ron Scott	3	3	
Anna Rolleston	3	3	
Beverley Edlin	3	3	
Geoff Esterman	3	3	
Judy Turner	3	2	
Marion Guy	3	2	
Yvonne Boyes	3	2	
Peter Nicholl	3	2	
Matua Parkinson	3	0	
Mary-Anne Gill	3	2	Waikato DHB Representative
Pouroto Ngaropo	3	1	Rūnanga Representative

CEO Performance and Remuneration Committee

Functions

The BOPDHB employs the Chief Executive in accordance with Schedule 3, clause 44 of the NZPHD.

The CEO Performance and Remuneration Committee performs the duties of the Board in relation to the employment of the Chief Executive.

Membership

The Committee meets on an as required basis for particular issues.

Committee Members during the year were:

- Peter Nicholl (Chair)
- Sally Webb (Board Chair)
- Bev Edlin
- Anna Rolleston
- Ron Scott

Delegations

The Board has an approved Delegation Policy in accordance with Schedule 39(3) of the NZPHD Act[7]. The NZPHD Act requires, under S26(3)[8] that the board of a DHB must delegate to the chief executive of the DHB, under clause 39 of Schedule 3, the power to make decisions on management matters relating to the DHB, but any such delegation may be made on such terms and conditions as the Board thinks fit.

7. Schedule 3, New Zealand Public Health and Disability Act, 2000.
8. Section 26, New Zealand Public Health and Disability Act, 2000.


VOLUNTEER

05

Our People Te Hunga Ora

Being a Good Employer

The BOPDHB recognises the seven key elements of being a good employer, as identified by the Human Rights Commission[9]. These elements are derived from fundamental good human resource practices:

- Leadership, Accountability and Culture.
- Recruitment, Selection and Induction.
- Employee development, Promotion and Exit.
- Flexibility and Work Design.
- Remuneration, Recognition and Conditions.
- Harassment and Bullying prevention.
- Safe and Healthy Environment.

BOPDHB has the stated intention of being a good employer consistent with Section 118 in the Crown Entities Act 2004[10] which cover:

- healthy and safe working conditions
- an equal employment opportunities programme
- the impartial selection of suitably qualified persons for appointment
- recognition within the workplace of the aims, aspirations and cultural differences of Māori, other ethnic or minority groups, women and persons with disabilities
- opportunities for the enhancement of the abilities of individual employees.

The BOPDHB's equal employment opportunities policy and is governed by Human Rights[11], Health and Safety in Employment[12], and Employment Relations[13] legislation.

People and Capability policies and procedures are reviewed biennially according to the BOPDHB's commitment to good employer practices and the BOPDHB's values. Current employment policies include:

- equal employment opportunity
- occupational health and safety
- recruitment and selection
- discipline and dismissal
- protected disclosures (whistle blowing)
- learning policies
- employee assistance programme
- performance development
- leave (annual, sick, tangihanga/bereavement, leave without pay, long service, jury service)
- orientation
- staff presentation
- position descriptions
- identity card standards
- volunteers and work experience
- shared expectations (Code of Conduct).

> It is BOPDHB policy to provide equal employment opportunities for all employees and applicants.

Employment equity

It is BOPDHB policy to provide equal employment opportunities for all employees and applicants. This ensures:

- employment decisions are made on the grounds of relevant merit, not on the basis of personal characteristics unrelated to ability
- BOPDHB avoids employment practices that may be inconsistent with or contrary to the provisions of the Human Rights Act 1993 and other relevant legislation
- there is no discrimination (as required by human rights legislation)
- all employees have the opportunity to develop to their potential
- recognition of the aims and aspirations of Māori in recognition of our commitment to the Treaty of Waitangi.

The Board has adopted a remuneration policy that reflects the need to set a target range for each individual employment agreement position, within the limitations of available funding. This gender neutral, fair remuneration policy is part of an overall employment relations strategy that includes defining the role of employees, performance development and appropriate reward mechanisms. Students are casual, therefore not staff. We pay above minimum wage. BOPDHB supports the Government putting into place pay and employment equity response plans, and recognises the obligations we have to make sure we continue to address and respond to any identified gender inequities as part of good management practice and being a good employer. BOPDHB are proud to report this measure, by key occupational groupings.

Gender pay equity

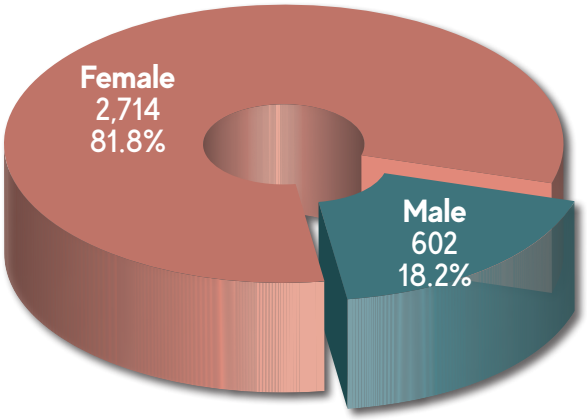
In New Zealand many female employees have occupations that are made up of more than 80% female staff, with Employment New Zealand reporting that these female dominated occupations tend to be lower paid, and that women are under-represented in higher level jobs[14]. The gender pay gap is a high level indicator of the difference between women and men's earnings, with a number of factors contributing to the gender pay gap.

9. Human Rights Commission NZ
10. Section 118 Crown Entities Act 2004
11. Human Rights Act 1993
12. Health and Safety at Work Act 2015
13. Employment Relations Act 2000
14. Employment NZ

Pay and employment equity cannot be achieved for women or men unless the ways gender is affecting employment are identified and addressed. Government policy and direction encourages employment and workplace relations that demonstrate good faith, natural justice, human rights, sound employer practice and legal compliance.

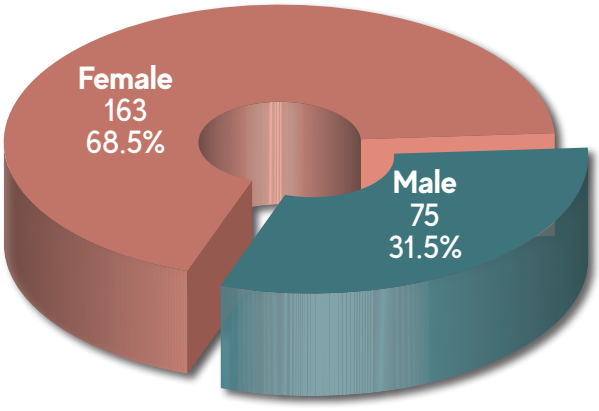
The majority of BOPDHB staff are covered by collective employment agreements (93%, 3,316 of our 3,554 staff). This ensures that all employees, regardless of gender or other areas of potential inequity, are remunerated at the same level for equivalent work.

2018/19 Employees with Collective Employment Agreements



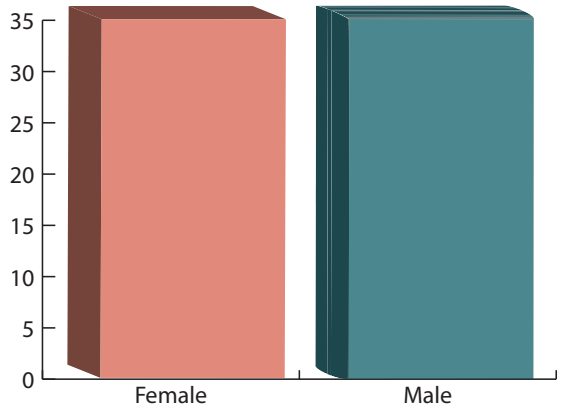
The remaining 238 staff are covered by individual employment agreements (IEA). To ensure that IEA roles are fairly remunerated, BOPDHB has adopted the Strategic Pay SP10 job evaluation methodology. This methodology has extensive following in the public and private sectors, and provides high quality and robust remuneration data. It suits a wide range of roles including executive and professional; technical; administrative or production and environments where points differentials, also known as role sizing, is considered important. This methodology also gives due weight to roles with a requirement for education, experience and strong problem-solving skills, and ensures that each position is objectively remunerated, regardless of gender or other areas of potential inequity.

2018/19 Employees with Individual Employment Agreements

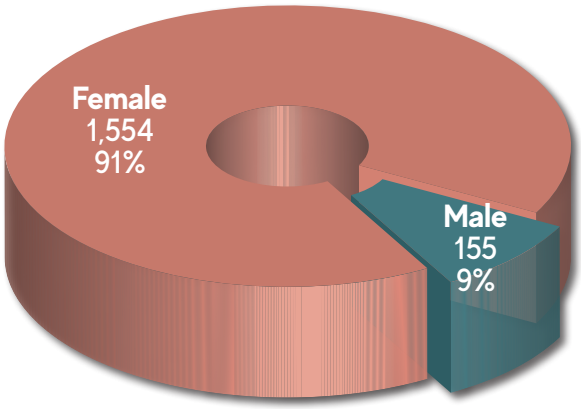


Nursing is our largest employment occupational group, representing 1,709 staff and 48% of our work force (2017/18: 1,643 48%). Ninety one percent of this group are female, and no difference is noted in median remuneration between male and female staff.

Median hourly rate - nursing

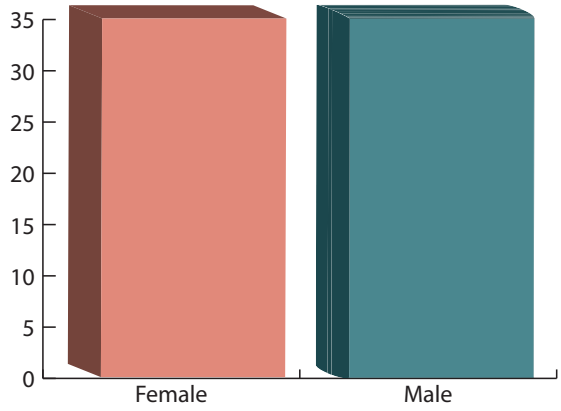


2018/19 Nursing staff

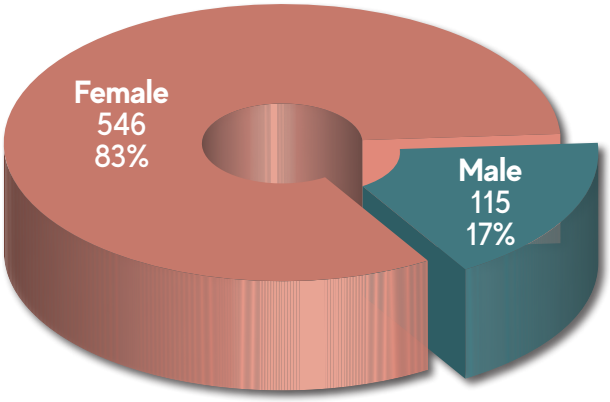


Allied Health is our next largest group, representing 661 staff (2017/18: 626). This group includes Occupational Therapists, Social Workers, Physiotherapists and a range of other clinical positions. 83% of this group are female, and no difference is noted in median remuneration between male and female staff.

Median hourly rate - Allied Health

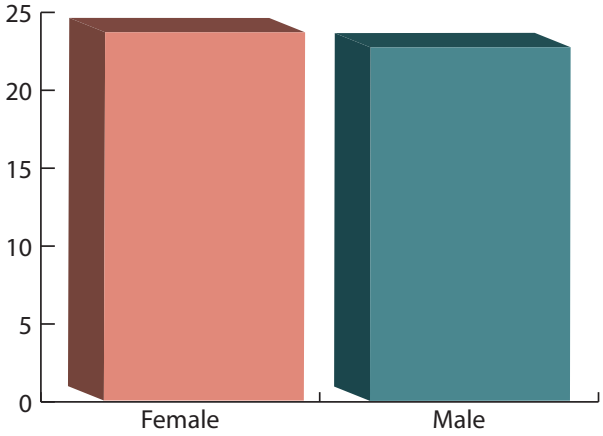


2018/19 Allied Health staff

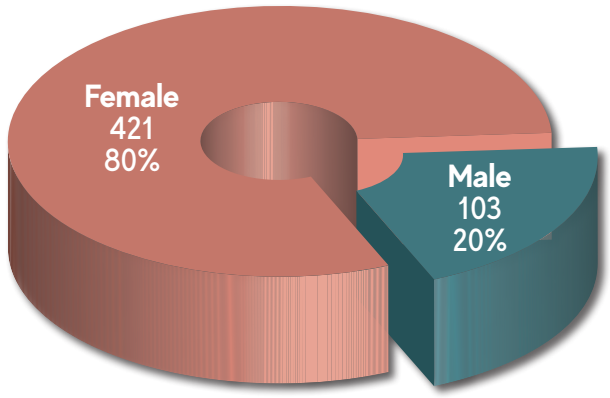


Non-clinical and clerical staff are another large group, representing 524 staff. This group includes Security, Stores, Orderlies and Clerical staff, amongst others. 80% of this group are female, and there is a small difference noted in median remuneration between male and female staff.

Median hourly rate - non-clinical support and clerical services



2018/19 Non-clinical and clerical staff



The three groups reported above represent over 80% of our work force. The remaining 20% of staff cannot be compared for equity. Remuneration is determined by different individual employment agreement factors, seniority of service or the nature of the hours worked and the associated allowances earned.

Board & senior management

Numbers stayed the same for 2018/19 with 58% of the Board Members being female and 17% Māori. 27% of Managers in the top two tiers of the BOPDHB are female (27% in 2017/18) and 18% are Māori (18% in 2017/18).

Employment

This year we welcomed 662 new staff (2017/18: 587), including 549 clinical staff (2017/18: 484). Of our employees, 93% are covered by collective employment agreements. The majority of these agreements have documented "management of change" provisions, which detail the information to be provided, the communication processes to be used and the level of consultation. The BOPDHB has comprehensive Management of Change resources to ensure good practice is followed.

Workforce development

The BOPDHB recognise the need to develop the capacity and capability of our workforce in response to the increased population, and evolving models of care.

The BOPDHB has endorsed Te Tumu Whakarae Position Statement about increasing Māori Participation in the Workforce, and has endorsed the targets to support the Position Statement being realised. Our Māori workforce has increased to 13% of our total workforce.

Workforce Development is a strategic priority and we continue to engage with the Ministry of Health according to the strategic health and disability workforce priorities 2019- 2024.

Unions

The New Zealand Nurses Organisation (NZNO) Joint Action Group (JAG) with nursing, Association of Senior Medical Staff (ASMS) Joint Consultative Committee with senior doctors, the Public Service Association (PSA) Enterprise Committee (Mental Health Nursing, Clerical and Allied Health) and the Local Resident Medical Officer (RMO) Engagement Group (LERG), form key partnerships with unions in delivering improved levels of staff engagement, as well as taking a joint action approach to support the delivery of improved health services through strengthening clinical governance and decision making processes.

The BOPDHB was the first DHB in New Zealand to appoint a union convener role. This role is dedicated to enhancing the partnership approach with PSA, the BOPDHB is proud to be part of this sector leading initiative.

A pan union forum known as the BOPDHB Bipartite Forum enables the gains from the activity of the various union groups to be shared and monitored and the translation of the national Bipartite Action Group initiatives to something beneficial and workable at a local level.

Valuing people

The Staff Service Recognition Programme was introduced in 2007 by the Board and Chief Executive, as a means of recognising and thanking staff for their loyalty and service to the BOPDHB (and its predecessor organisations).

The annual Staff Recognition Celebrations recognise staff with over ten years' service. The longest serving staff member recognised in the 2018/19 year has served 60 years in Whakatāne, with our longest serving Tauranga staff member recognised for 46 years. Across the Bay of Plenty, our recipients have provided 5,920 years of service to our community.

- 353 people recognised (276 Tga, 77 Whakatāne).
- 72 roles in Tauranga - 27 roles in Whakatāne.

The BOPDHB has had no substantiated complaints regarding discrimination with respect to recruitment, selection and employment.

The BOPDHB is open to applications for flexible work and considers them on a case-by-case basis. Feedback from both the Pulse Engagement Survey and Exit Survey indicate that staff believe the BOPDHB has flexible work practices in place and that these meet the requirements of employees.

Health and safety

BOPDHB has worn very proudly the status of being a model site in New Zealand for Safe Staffing Healthy Workplace. In particular, the BOPDHB has hosted visits from a number of DHBs across the country seeking to better understand our approach to resourcing our services based on patient acuity, and staff capability and competency. Both the areas of visually presenting the patient demand "hospital at a glance" and managing the throughput has been greatly enhanced by whole of hospital teamwork, supported by good systems.

The BOPDHB has continued to demonstrate its commitment to its employees by retaining Tertiary status within the ACC Partnership Programme at the annual audit conducted in July 2016. This is the highest level possible in this program.

The following Health and Safety initiatives have been undertaken by the BOPDHB's Health and Safety Governance Group over the past year:

- Online training provided to all employees on the new Health and Safety Acts 2015 requirements.
- Reviewing and updating of health and safety polices and protocols.
- A Health and Safety Legal compliance audit has been conducted to provide a road map for the BOPDHB to meet it legal requirements under the new Health and Safety at Work Act 2015.
- A Project based program is underway to ensure both the ACC Partnership and legal requirements are proactively met along with the creation of a positive health and safety culture.
- Health and Safety risks have been prioritized and action plans developed to reduce accidents.

The overall impact of the BOPDHB's Health and Safety management systems and effective claims management resulted in a significant reduction in the total cost paid for work related injury claims from $719,372 for 2017/2018 to $462,549 for this financial year. It is important to note that there was an increase in the number of employees during the last year and there was also an increase in the cost of medical care.

The vast majority of all injuries to employees are the result of soft tissue injuries from manual handling activities, their injuries.

A number of new initiatives are in progress to prevent work related injuries and to implement effective rehabilitation plans to assist injured employees to return to work quicker.

Performance of the BOPDHB

Year	Total cost of work related injury claims	Number of open claims
2016/2017	$523,489	214
2017/2018	$719,372	194
2018/2019	$464,549	21

Claims per $1 million of liable earnings	
BOPDHB	Levy risk group (Average of other DHB's)
0.61	0.81
0.82	0.87
0.80	0.84

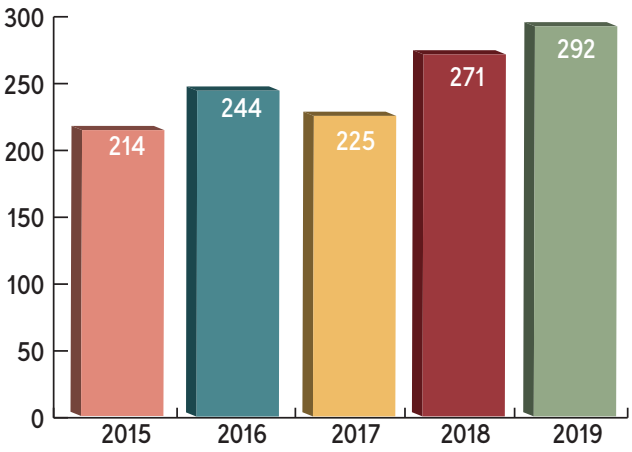
The BOPDHB is consistently performing better than the average performance of the other District Health Boards in NZ, when comparing claims per $1 million of liable earnings.

A lot of work was completed on reducing the number of open claims, as can be seen in the table above, where the total number reduced from 194 to 21 at end June 2019.

EAP Services

In the graph below it is evident that there is a steady increase in the number of employees using EAP services. In 2018/2019 a total of 292 employees accessed EAP compared with 271 the year before. 38.2% (40.2% in previous year) of all EAP sessions were work related with 61.8% (59.8% in previous year) were related to personal issues. Workload at 23.8% was identified as the biggest issue for employees accessing EAP services.

Number of BOPDHB clients per year



A Staff Health clinic is available for all employees and volunteers onsite to check cholesterol, blood sugars, blood pressure, body mass index and body fat percentage and visual acuity. Also offered is a discussion on healthy living, diet and lifestyle. Cervical screening for female staff can be arranged, as can the recommended hospital funded vaccinations for some employees. The BOPDHB offers a staff influenza vaccination programme that runs during April 1st – 31st August. For 2018/19, 73.1% of staff (2,556 staff members) received vaccination (2017/18: 67%, 2,316 staff members).

The BOPDHB provides two on-site staff funded gym facilities (Staff Wellness Exercise and Training - SWEAT), based on the Tauranga and Whakatāne campus'. SWEAT started as a voluntary staff movement with the simple objective of providing an affordable health and wellness service, at a convenient location, for all BOPDHB staff and associated organisations staff to enjoy.

Over a decade later, now managed by Wellness Systems Group Limited, the SWEAT membership of more than 800 people has access to equipment, weekly timetabled group fitness classes (virtual and live instruction), and a variety of annual wellness programmes and services.

As a staff initiative, there is a measured and positive difference in absenteeism, ACC claims (workplace and out of work injuries) and productivity between the staff who are active members of SWEAT and those who are not members.

WorkWell is a free, workplace wellbeing initiative developed by our Public Health Service, Toi Te Ora. Workwell supports workplaces to work better through setting wellbeing goals with businesses and staff.

Workwell has now been rolled out at a national level and is able to be adapted to suit any work place.

For the year end June 2019, Toi Te Ora have 54 workplaces signed up regionally, and nationally, 110 are signed up with Workwell. Five of those being other DHBs, and seven other DHB's in New Zealand are delivering WorkWell to their communities.

There are eight priority and wellbeing areas:

- Alcohol and other drugs.
- Breastfeeding.
- Healthy eating.
- Infection control and immunisation.
- Mental health and wellbeing.
- Physical activity.
- Smokefree.
- Sun safety.

The BOPDHB is accredited at the highest level, gold.

Gold Standard Accreditation was awarded to the BOPDHB in July 2016 when we demonstrated having all the successful components of a health and wellbeing programme, and these have become embedded in the BOPDHB work-place.

Leave

In 2018/19, 78 staff went on paid parental leave (compared to 76 staff in 2017/18). In addition to the government paid parental leave, the BOPDHB provides between six weeks and 14 weeks paid parental leave to most employees. Staff sick leave utilisation has remained materially stable at 3.5% (2017/18: 3.4%).

Turnover has increased to 10.3% in 2018/19, compared to 8.82% in 2017/18.

Staff Engagement and Partnership

Creating our culture

Staff Engagement and Culture is one of the four key strategic priorities of the Bay of Plenty District Health Board.
The initial work began in 2016 and identified four priorities:

1. To implement the CARE values.
2. Improve inter-personal and team communications.
3. Performance appraisals.
4. Address inappropriate and bullying behaviours.

A programme addressing these priorities, "Creating our Culture" was launched in November 2016.

Since then individual pieces of work have been completed as part of the Creating our Culture initiative. These include:

- The refreshed CARE values.
- The BUILD model used to call out inappropriate behaviour.
- The ABC of appreciation model used to promote positive behaviour.
- The V-BR model, which is a values based recruitment model used for recruiting new staff who live by our CARE values.
- Speak up Safely initiative, developed to embed a safe environment in which to speak out about unprofessional or unsafe practice or behaviours.

Scholarships and study funding

The BOPDHB is committed to supporting staff financially with study undertaken through a tertiary institution such as a university or polytechnic.

Study funding totalling $42,800 was awarded to BOPDHB employees during the 2018/19 financial year (2017/18: $57,645).

- Advanced Study Fund: **$20,560**
- Whakatane Staff Study Fund: **$650**
- BOP Learning Scholarships: **$21,500**

BOP Learning Scholarships are available to staff through the generous support of businesses sponsoring the funding of the scholarships. In 2018/19 scholarships totalling $22,000 were sponsored by: Bay of Plenty Medical Research Trust, Holland Beckett Lawyers, Pure Print, Farmers Auto Village, and Guild & Spence Electrical.

Learning scholarships were awarded to 10 staff members (compared with 12 awarded in 2017/18). Recipients were from a range of roles and services including Allied Health, Radiography, Sterilising Unit and Clinical Physiology. One Whakatāne staff member from Radiology received awards from the Whakatāne Staff Study Fund[15].

In 2018/19, 14 BOPDHB employees were reimbursed a portion of their course fees for tertiary study through the Advanced Study Fund (compared to 26 employees in 2017/18). Applicants received 60% reimbursement towards their fees[16].

Innovation awards

The BOPDHB Innovation Awards are held every two The BOPDHB Innovation Awards are held every two years and give BOPDHB employees and contractors an opportunity to showcase innovative initiatives completed in their service within the past two years. There is a focus on initiatives which all connected to one of the DHB or Ministry of health priorities: closer to home; good to great; smart systems. Our next awards will be held in October 2019.

Learning environment

The Education Team works to embed learning, innovation and information into organisational culture; within the framework of BOPDHB CARE values and honouring Te Tiriti o Waitangi.

An education strategy is being developed to support the vision "To enhance patient care by enabling staff through information, education and development".

Te Tiriti o Waitangi

The BOPDHB is committed to the principles of the Treaty of Waitangi. Employees receive training on bicultural practice in accordance to Te Tiriti o Waitangi commitments. In 2018/19, a total of 822 staff attended these training courses (1155: 2017/18).

This year, we started delivering Treaty of Waitangi courses internally, with Graham Bidois Cameron delivering both the full day event and a half day refresher, which meant we could offer them more regularly than in the past. These were also opened up to our community and primary providers.
Attendances are as follows:

- Treaty of Waitangi Half day Refresher: **95**
- Treaty of Waitangi full day Course: **120**
- Engaging Effectively with Māori: **607**

In addition, training is provided for managers and staff on the Human Rights Act 1993, health and disability rights, Shared Expectations (State Services Code of Conduct), and the BOPDHB's employment policies.

Professional development

In 2018/19, 1774 internal training events were offered with 27,930 participants completing training. (2017/18: 1,820 events and 23,432 participants). This figure includes Orientation, clinical, non-clinical, leadership, fire, health and safety, IT training and mental health.

43% of learning was completed online (compared with 38% in 2017/18) with 67 on-line learning courses offered through Te Whāriki ā Toi (previously Midland Learning). Te Whāriki ā Toi also includes the Mahara e-Portfolio platform which enables staff to demonstrate professional competency.

Study funding totalling $42,800 was awarded to BOPDHB employees during the 2018/19 financial year (2017/18: $57,645).

15. We had another Radiology staff member withdraw her application, and we also funded somebody in Pharmacy who left, so didn't use funding which makes it appear that we didn't pay much. We had spent the whole fund, but the situation changed.
16. It was a bit different this year, we gave up to $2000, so for some people they got the whole thing, for others it was a portion. Also less staff applied, so we were able to provide more funding.


EXIT
VOLUNTEER
VOLUNTEER

Staff Status

Staff number	3,554 permanent and temporary staff (2017/18: 3,434)
Average age	Average age is 47.0 years (2017/18: 47.1 years)
Disability profile	Our proportion of employees who report a disability is 0.1% (2017/18: 0.1%)
Gender profile	Women make up the majority of our workforce with 81.0% female compared with 20.0% male (2017/18: Female 80.6%, Male 19.4%)

The BOPDHB recognises and accommodates the workplace needs of staff with stated disabilities. The BOPDHB currently employs four people who identify with a disability, covering a range of different impairments.

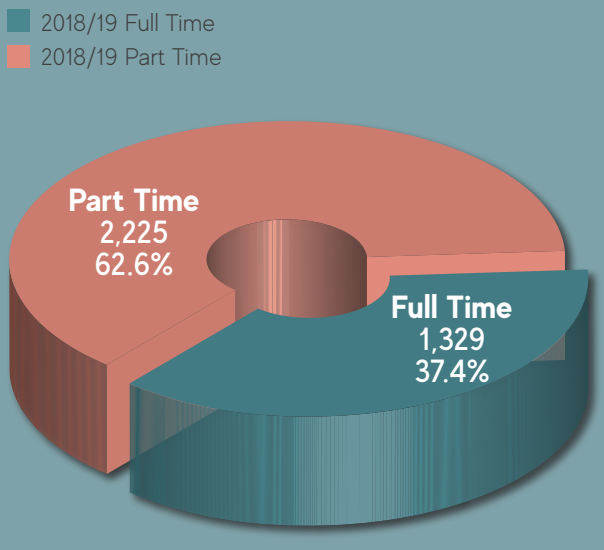
Staff who require suitable parking are provided with the option to access this on campus in close proximity to their work area. Staff are also encouraged to use the in-house occupational health service as and when they require assistance.

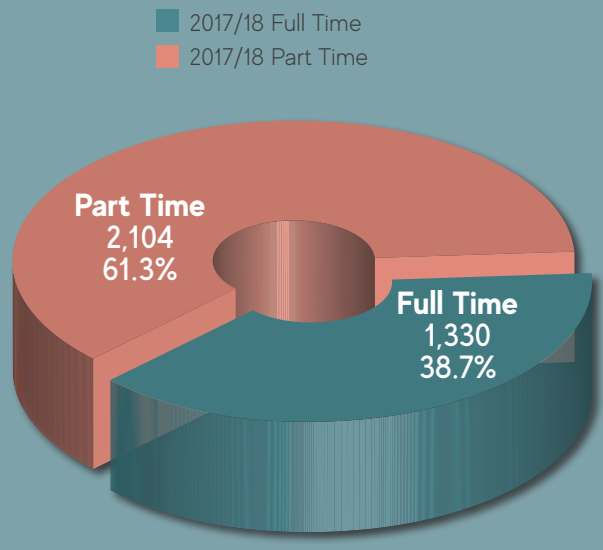
Staff with disabilities that impact on their mobility are identified, and a buddy system is set up to assist them in event of emergency evacuation of buildings.

Staff with disabilities provide a valuable insight into the challenges faced by those with disabilities within our communities.

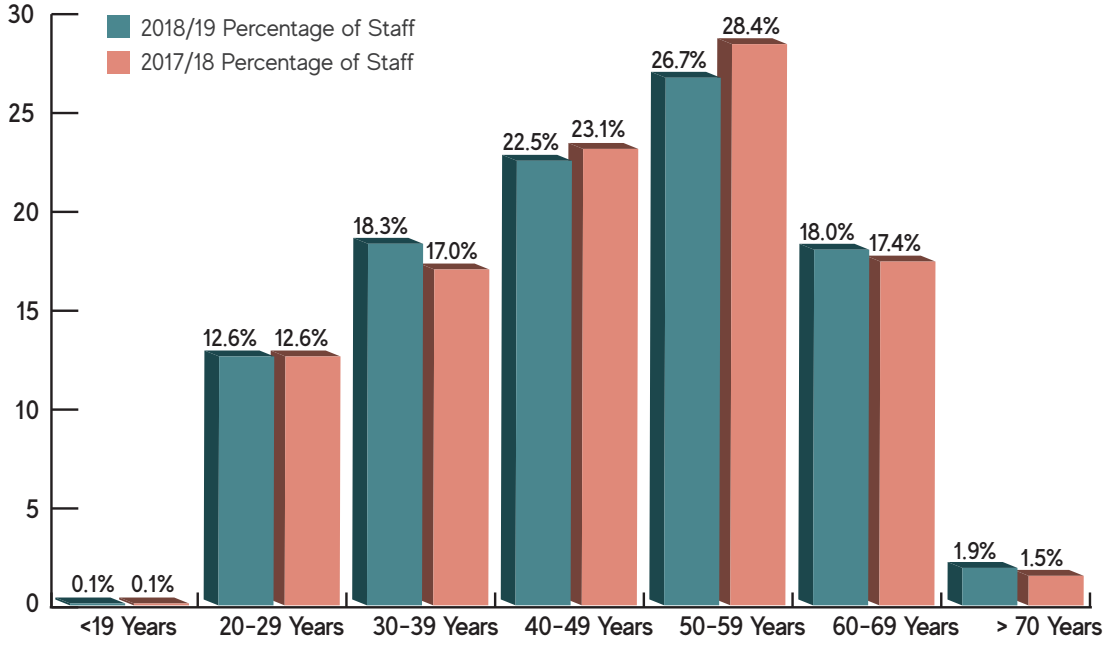
Occupational Group	2018/19 Full Time	2018/19 Part Time	2018/19 Total	2017/18 Full Time	2017/18 Part Time	2017/18 Total
Admin/Management	368	266	634	361	252	613
Allied Health	352	309	661	340	286	626
Medical	289	134	423	295	123	418
Non-clinical Support	63	64	127	70	63	133
Nursing	257	1,452	1,709	264	1,380	1,644
Total	**1,329**	**2,225**	**3,554**	**1,330**	**2,104**	**3,434**

BOPDHB staff status

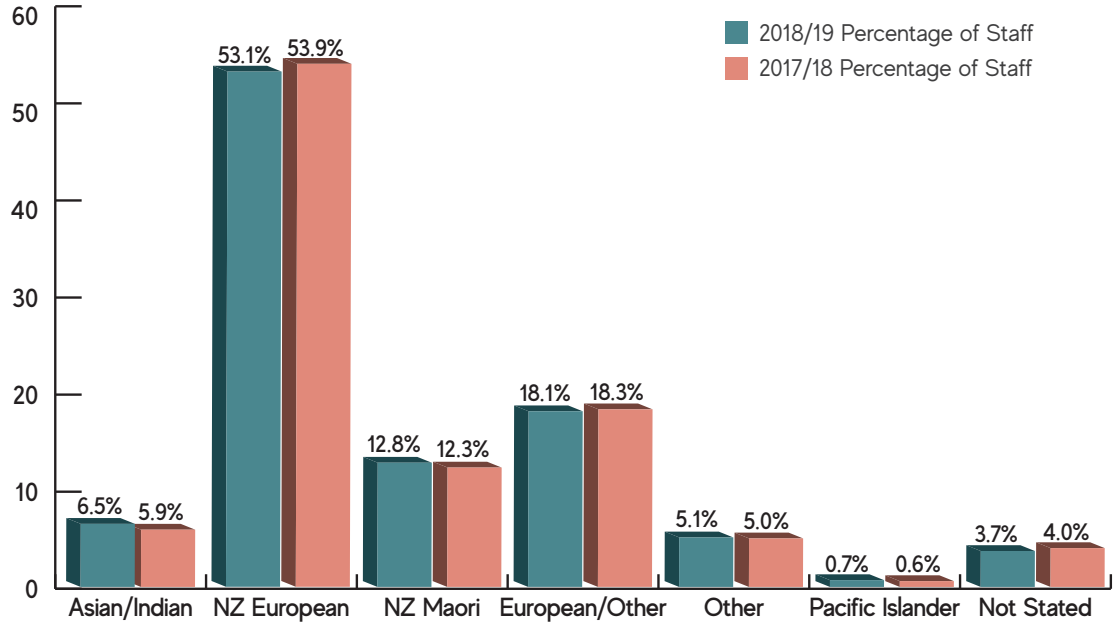




BOPDHB staff by age band



BOPDHB staff by ethnicity



Termination payments 2018/19

Reason	Number	Redundancy	Gratuity	Gratuity Totals
Redundancy	1	$26,029.00		
Redundancy	1	$6,340.82		
Retire	1		$11,206.78	$11,206.78
Retire	1		$7,129.02	$7,129.02
Retire	1		$3,798.01	$3,798.01
Retire	9		$2,500.00	$22,500.00
Retire	2		$2,000.00	$4,000.00
Total	**16**	**$32,369.82**		**$48,633.81**

Salaries over $100,000

Year ended 30 June 2019				30 June 2018
Salary Bands	Medical & Dental Staff	Other	Total	Total
100,000-110,000	33	77	110	95
110,001-120,000	25	44	69	53
120,001-130,000	11	27	38	29
130,001-140,000	6	10	16	23
140,001-150,000	16	8	24	15
150,001-160,000	16	8	24	17
160,001-170,000	13	1	14	12
170,001-180,000	10	0	10	11
180,001-190,000	6	0	6	8
190,001-200,000	5	2	7	11
200,001-210,000	9	3	12	9
210,001-220,000	5	0	5	5
220,001-230,000	8	0	8	16
230,001-240,000	10	1	11	11
240,001-250,000	16	1	17	12
250,001-260,000	10	0	10	8
260,001-270,000	7	0	7	5
270,001-280,000	8	0	8	10
280,001-290,000	11	0	11	7
290,001-300,000	8	0	8	5
300,001-310,000	6	0	6	5
310,001-320,000	6	0	6	5
320,001-330,000	4	0	4	6
330,001-340,000	7	1	8	5
340,001-350,000	3	0	3	1
350,001-360,000	4	1	5	2
360,001-370,000	1	0	1	1
370,001-380,000	2	0	2	3
380,001-390,000	0	0	0	2
390,001-400,000	0	0	0	0
400,001-410,000	1	0	1	0
410,001-420,000	3	0	3	0
420,001-430,000	1	0	1	0
430,001-440,000	1	0	1	0
440,001-450,000	0	0	0	2
450,001-460,000	0	0	0	1
460,001-470,000	0	0	0	0
470,001-480,000	0	1	1	0
480,001-490,000	0	0	0	0
490,001-500,000	0	0	0	0
500,001-510,000	1	0	1	0
510,001-520,000	1	0	1	0
520,001-530,000	0	0	0	0
530,001-540,000	1	0	1	1
580,001-590,000	1	0	1	0
Total over $100,000	275	185	460	397

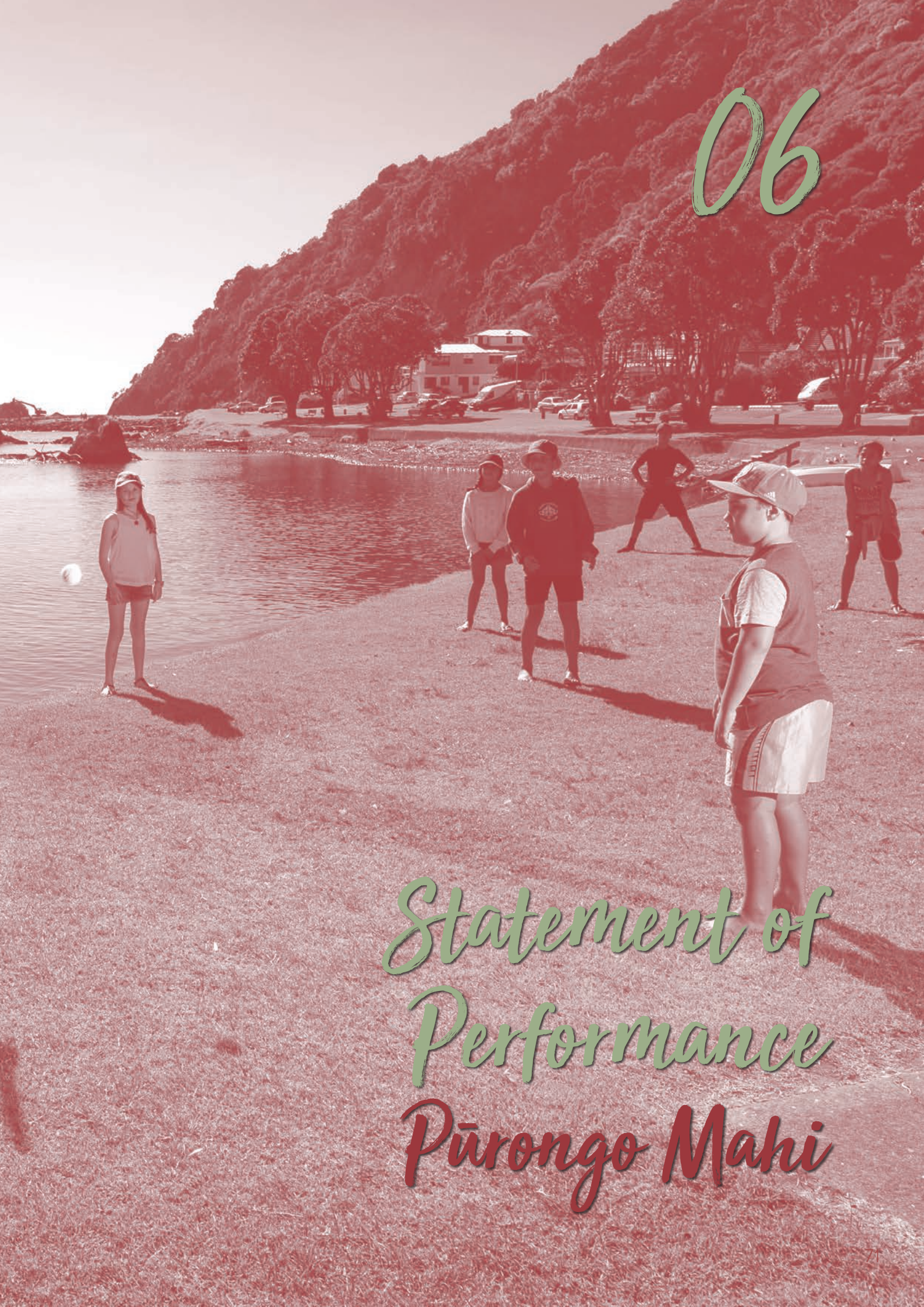
Directors' and officers' insurance

Insurance premiums were paid in respect of Board Members' and certain Officers' Liability Insurance. The policies do not specify a premium for each individual.

The policy provides cover against costs and expenses involved in defending legal actions and any resulting payments arising from a liability to people or organisations (other than the BOPDHB) incurred in their position as Board Members or Officers.

Donations

The BOPDHB made no donations during the year 2018/19 (2017/18: Nil).



06

Statement of Performance

Pūrongo Mahi

Achievement in Health for the Bay of Plenty

This section documents our outputs for 2018/19 against the measures which were set in our Statement of Performance Expectations in the BOPDHB Annual Plan[17].

The Bay of Plenty District Health Board (BOPDHB) provides health and disability services in the Bay of Plenty in order to improve the health outcomes of our 238,380 residents, a quarter of whom identify as being Māori. Our vision of Kia Momoho Te Hāpori Oranga, 'healthy, thriving communities,' compels us to understand the level of need within our population, how effective our services are in reaching the intended recipients while considering the current and future drivers of service demand.

Increasingly we are called to collaborate with other government agencies and local body organisations to best deliver services that will achieve the greatest outcomes for our community. Recognition of the impact of social determinants such as healthy housing solutions, employment, establishing whānau goals and public health initiatives on the health and wellbeing of whānau and individuals requires the DHB to embrace innovative working.

This section provides an overview of the key elements of our outcomes framework, which is designed to align with the strategic direction and statement of intent of the Ministry of Health, and the Midland region, of which we are one of the five member DHBs.

Our strategic direction identifies health outcomes for three population groups. These are:

1. Healthy Individuals - Mauri Ora:

All people deserve to live healthily and expect a good quality of life. All children deserve the best start in life. People should be given the opportunity to die in their place of choice.

2. Healthy Families – Whānau Ora:

Family and whānau should be empowered to live well with long-term conditions. People are entitled to be safe, well and healthy in their own homes and community-based settings.

3. Healthy Environments – Wai Ora:

All people should live, learn, work and play in an environment that supports and sustains healthy life. Our population should be enabled to self-manage their personal health. People should expect to receive timely, seamless and appropriate care on their health journey.

These long-term outcomes will be achieved through the combined efforts of all those people working across the Bay of Plenty health system, central and local government, other DHBs within and outside of our region, and the wider health and social services sector. Progress towards these long-term outcome measures is monitored through the annual metrics reported in this Statement of Performance.

In monitoring our progress towards these measures the DHB compares annual performance against results of previous years as well as targets within our annual plan. While we have not met all targets for our performance measures in many cases a positive trend is evident when compared with baseline indicators from prior years.

The Statement of Performance summarises performance against metrics used by BOPDHB to evaluate and assess the services and products required to deliver the outcomes of the 2018/19 Annual Plan. The performance measures chosen are not a comprehensive list and do not cover all BOPDHB activity. However, BOPDHB believes the outputs and measures presented do provide a good representation of the full range of services we provide, and highlight our performance in major areas of service activity against local, regional and national priorities. Where possible, past performance information (baseline data) has been supplied to clearly articulate the performance story over time. Any historical data differences will be due to the BOPDHB updating past data with the most current and available information. Prior year comparatives that do not match current actual results, are due to that data not being available at last year's time of reporting.

This year's Statement of Performance provides the reader with a detailed account of performance against five key priority groups outlined in BOPDHB's Strategic Health Services Plan. Again, these metrics do not tell the full performance story, but provide an overview of the work BOPDHB has underway to address the health needs of our priority populations.

17. BOPDHB Annual Plan 2018/19.

Output classifications

Section 149E of the Crown Entities Amendment Act 2013 requires District Health Boards (DHBs) to identify reportable classes of output delivery each year in a Statement of Performance Expectations. Output classes allow DHBs to group services and demonstrate the application of Board and Government service priorities, population health 'impacts' of Population Based Funding (PBF) allocations, and monitoring of investment across the entire health spectrum. For each output class there are agreed national output performance measures and targets. Supplementing nationally agreed measures are a number of regional and local measures that report our achievement against strategic or operational goals targeted in our Strategic Health Services Plan and Annual Plan.

DHBs are required to provide performance measures and a statement of performance each year under one of four output classes. For 2018/19 these were:

1. Prevention.
2. Early Detection and Management.
3. Rehabilitation and Support.
4. Intensive Assessment and Treatment Services.

Our measures and financial performance against these output classes for the year ended 30 June 2019 are set out in the following section of our annual report.

Output class 1: Prevention

Preventative Services are services that protect and promote health for the whole population or identifiable sub-populations. They comprise services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability impairment. Services such as health promotion ensure that illness is prevented and unequal outcomes are reduced. Obligatory health protection services that are delivered by our Toi Te Ora Public Health team protect the public from communicable diseases and population health protection services such as immunisation and screening services provided by staff in our General Practice clinics reduce the risks of poor health in the future.

These services influence whānau and individual behaviours by targeting population wide physical and social environments to enhance health and wellbeing.

Preventative Services have the following strategic goals:

1. People are healthier, able to self-manage and live longer.
2. People are able to participate more in society and retain their independence for longer.
3. Health inequalities between population groups in our community will reduce by identifying and addressing preventable conditions across the population early.

Preventative Services are represented in our reporting as an outcome target of 'people take greater responsibility for their health' with three impact goals:

1. Fewer people smoke.
2. Reduction in vaccine preventable diseases.
3. People have healthier diets.

Output class 2: Early detection and management

Early Detection and Management Services are delivered by a range of health and allied health professionals in both the community and hospital settings. These services are delivered by private clinicians, not-for-profit agencies and governmental organisations including general practice, community and whānau-centred groups, pharmacists, laboratories, radiography services and community dentists.

These services are by their nature more general in design, usually accessible from multiple health providers and from a number of different locations within BOPDHB.

On a continuum of care these services are preventative and treatment services focus on individuals and smaller family/whānau groups. More recently, health professionals have sought to empower individuals to better understand their specific health needs and continue self-management of life-long conditions.

By detecting health needs and implementing management strategies across the population before acute or chronic disease occurs, these services will assist in achieving the following strategic goals:

1. People receive timely and appropriate complex care.
2. Early detection programs with focus in health inequities.

Early Detection and Management services are represented in our reporting by an outcome target of 'people stay well in their homes and communities' with the following impact goals:

1. Children and Adolescents have better oral health.
2. Treatable conditions are detected early and people are better at managing their long term conditions.
3. Fewer people are admitted to hospital for avoidable conditions.

Output class 3: Rehabilitation and support

Rehabilitation and Support Services are aimed at supporting people to maximise their independence and increase their ability to live in the community. Access to a range of short or long-term community based services is arranged by Needs Assessment Service Coordination (NASC) services following a 'needs assessment' and service co-ordination process. The range of services includes palliative care services, home-based support services, day programmes, respite and residential care services.

Ideally these services will provide support for individuals and their carers while being provided predominantly within a community setting or in the patient's home.

Rehabilitation and support services assist in achieving the following strategic goals:

1. People are able to participate more in society and retain their independence for longer.
2. Restore some or all the patient's capabilities.
3. Support people to live independently after an illness or accident.

By ensuring the provision of timely and appropriate rehabilitation and support services, individuals can return to the best possible level of participation in society as quickly as possible.

Output class 4: Intensive assessment and treatment services

Intensive Assessment and Treatment Services are delivered by a range of secondary and tertiary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.

They include:

1. Ambulatory services (including outpatient, district nursing and day services across the range of secondary preventive, diagnostic , therapeutic, and rehabilitative services).
2. Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.
3. 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 are focused on individuals.

Intensive Assessment and Treatment services will assist in achieving the following strategic objectives:

1. People receive timely and appropriate complex care.
2. People experience an informative and seamless hospital journey.
3. Preventing deterioration/complications.

These objectives will be reached by ensuring access to timely acute and elective services to the Bay of Plenty population before the burden of disease significantly impacts on individuals and their ability to participate in society.

Intensive Assessment and Treatment services are represented in our reporting as an outcome target of 'people receive timely and appropriate care' with four impact goals:

1. People are seen promptly for acute and arranged care.
2. People have appropriate access to elective services.
3. Improved health status for people with a severe mental illness or addictions.
4. People with end-stage conditions are supported.

System level measures

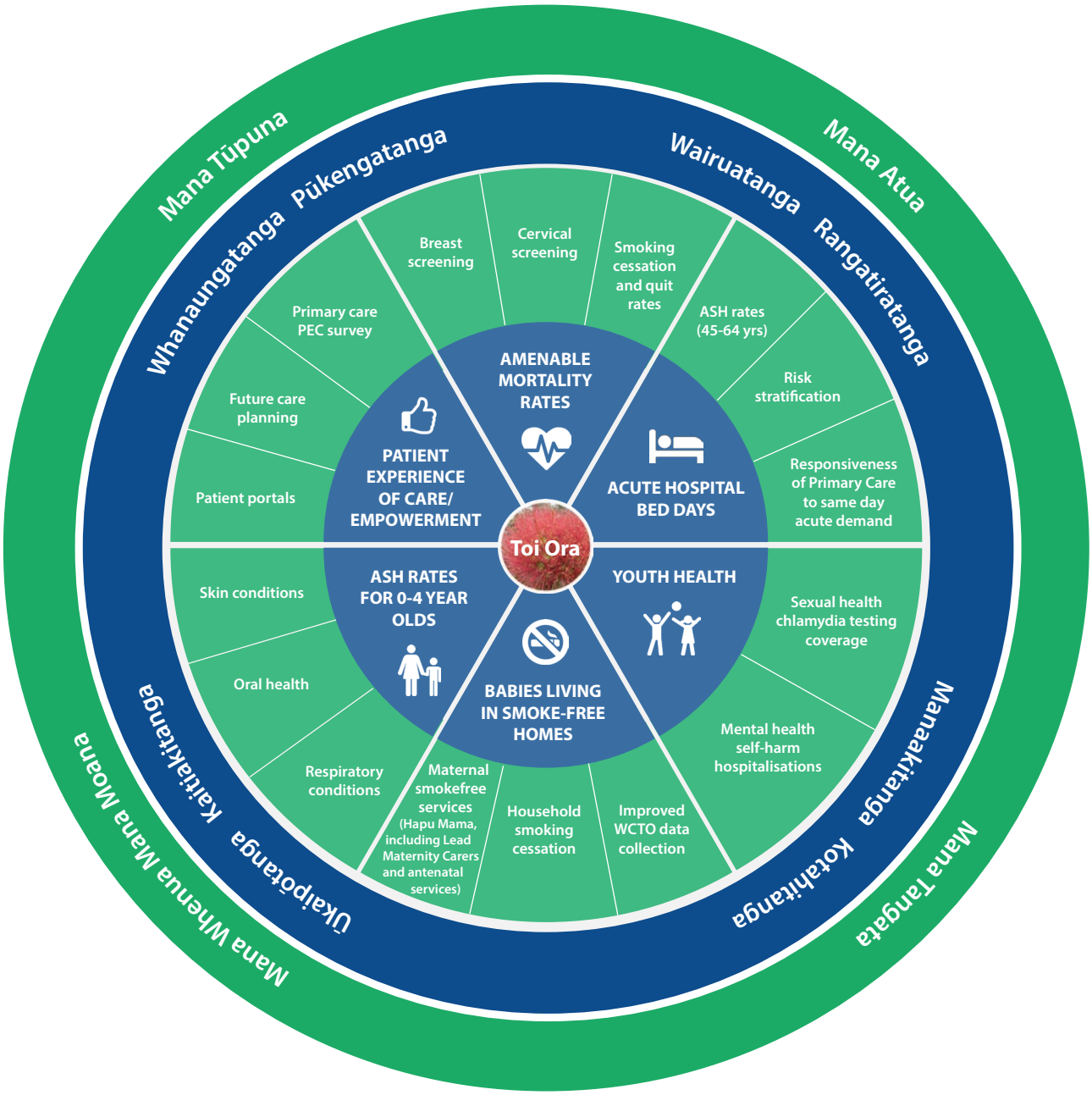
The five themes of the New Zealand Health Strategy place an emphasis on measuring the performance of the whole system as well as component parts.

The BOPDHB developed a System Level Measurement (SLM) Improvement Plan for 2018/19, in partnership with the Bay of Plenty Alliance Leadership Team (BOPALT), through an established SLM structure.

The planning process aligned national SLM actions and measures to strategic health objectives and utilised a health equity assessment tool to target actions to reduce inequities.

The table below shows an overview of the key focus areas for each of the system level measures.

- Acute Hospital Bed Stays: Using Health Resources Effectively.
- Amenable Mortality: Prevention and Early Detection.
- Ambulatory Sensitive Hospitalisations (ASH) 0-4 years: Keeping Children Out of Hospital.
- Youth Sexual Health: Youth are Health, Safe and Supported.
- Youth Mental Health: Youth are Healthy, Safe and Supported .
- Patient Experience of Care: Person, Family/Whānau Centred Care.
- Babies Living in Smokefree Homes: A Healthy Start.



Statement of Financial Performance by Output Class

The following table discloses the actual financial performance by output class against our Annual Plan for the year ended 30 June 2019.

Summary of revenues and expenses by output class	2018/19 $000s Actual	2018/19 $000 Plan	2017/18 $000s Actual	2017/18 $000s Plan
Early detection				
Total revenue	215,769	204,800	193,444	202,600
Total expenditure	220,227	207,300	195,839	203,300
Net surplus / (deficit)	**(4,458)**	**(2,500)**	**(2,395)**	**(700)**
Rehabilitation and support				
Total revenue	149,012	125,600	142,518	131,800
Total expenditure	152,091	127,200	144,283	132,200
Net surplus / (deficit)	**(3,079)**	**(1,600)**	**(1,764)**	**(400)**
Prevention				
Total revenue	36,931	16,000	10,537	16,000
Total expenditure	37,694	16,200	10,667	16,100
Net surplus / (deficit)	**(763)**	**(200)**	**(130)**	**(100)**
Intensive assessment and treatment				
Total revenue	439,019	487,025	449,652	445,900
Total expenditure	448,084	493,201	455,219	447,400
Net surplus / (deficit)	**(9,065)**	**(6,176)**	**(5,566)**	**(1,500)**
Totals				
Total revenue all output classes	840,731	833,425	796,151	796,300
Total expenditure all output classes	858,096	843,901	806,007	799,000
Net surplus / (deficit)	**(17,365)**	**(10,476)**	**(9,856)**	**(2,700)**

Output Class Achievement Summary

Prevention

- We provided 96% of smokers in secondary services with smoking cessation advice and support.
- We fully immunised 2,478 (82%: target 95%) eight month olds against vaccine preventable diseases.
- We promoted seasonal influenza immunisation to ensure 58% of our over 65 aged population received immunisation (target 75%).
- We co-ordinated 2,932 participants in the Green Prescription (GRx) programme.
- Seven out of every ten infants were still receiving some breast milk at six months - this reduces to six out of ten for Maori infants.

Early Detection and Management

- We dispensed just under 3.61m pharmaceutical items.
- The percentage of pre-school aged children enrolled in dental services is at 101% (target 95%), 96% for Maori and one in two 5-year olds have no dental caries.
- PHO enrolment rates remain over 5% higher in the BOPDHB region than observed nationally for both the total population (99% v 94%) and for Maori (96% v 90%). When Te Kaha is included (DHB facility), over 97% of Maori are enrolled with a primary health provider.
- We completed 72,770 community referred radiology events (measured as relative value units).
- We undertook 1,565,573 community laboratory tests and completed these within 48 hours 99% of the time (target 90%).

Rehabilitation and Support

- Total ED volumes (across Tauranga and Whakatane) were significantly higher for the period December 2018 to January 2019.
- We treated and discharged 12,101 elective patients against a target of 11,269. This represented a 2018/19 result of 107% against this target.
- Of our patients referred for radiotherapy or chemotherapy treatment, 92% were seen within 62 days of referral (target 90%).
- We achieved four of six Elective Services Patient Flow Indicator (ESPI) targets in 2018/19. ESPIs measure performance against patient referral, wait time and clinical assessment criteria in a hospital setting.

Intensive Assessment and Treatment Services

- Our hospices supported 1,157 patients and their families in the community.
- We lowered our percentage of residents who are over 65 years and accessing DHB funded Aged Residential Care services to 3.7%.

Over the next three years, we will fund services and partner with health providers who will make a positive impact on the health and wellbeing of our population. Our key outcomes are as follows:

Healthy, Thriving Communities - Kia Momoho Te Hāpori Oranga

Healthy Futures - Pae Ora

Healthy, Thriving Communities - Kia Momoho Te Hāpori Oranga

Healthy Futures - Pae Ora

Population Priorities: People with long term severe mental health and addiction; Māori; First 1000 Days issues; Vulnerable Children and Young People; Vulnerable Older People

Healthy Individuals - Mauri Ora	Healthy Families - Whānau Ora	Healthy Environments - Wai Ora	
Bay of Plenty Local Outcomes: 1. All people have healthy lifestyles with a good quality of life. 2. All children have the best start in life. 3. People die in comfort in their place of choice.	**Bay of Plenty Local Outcomes:** 1. Family/whānau live well with long term conditions. 2. People are safe, well and healthy in their own homes and communities.	**Bay of Plenty Local Outcomes:** 1. All people live, learn, work and play in an environment[18] that supports and sustains a healthy life. 2. Our population is enabled to self-manage. 3. All people receive timely, seamless and appropriate care.	Strategic Direction
Population Indicators: Fewer people smoke. Reduction in vaccine preventable diseases. Improving healthy behaviours. People can access their health information. Fewer children and adolescents have decayed missing filled teeth. People with a terminal illness or life limiting chronic disease die in their place of choice.	**Population Indicators:** Fewer people are admitted to hospital for avoidable conditions. Long-term conditions are detected early and managed well. People maintain functional independence. Families and whānau are at the centre of their healthcare.	**Population Indicators:** Providing healthier homes. Connecting with agencies to meet community needs. Appropriate access to services. People receive prompt and appropriate acute and arranged care. Services provided or funded by the BOPDHB contribute to the transfer of knowledge and skills to family/whānau to enable self-management.	Delivering on Priorities
Population Measures: **How much did we do?** # referrals of adults to the Green Prescription programme. # general practices offering patient portals. % enrolled patients[19] registered to use general practice portals.	**Population Measures:** **How much did we do?** # of whānau ora promotional activities undertaken. % eligible Maori men in the PHO aged 35-44 who have their cardiovascular disease risk assessed in the last 5 years.	**Population Measures:** **How much did we do?** A BOP Healthy Housing Improvement Plan in place. # homes that are insulated through the community-based insulation and healthy housing programmes. # people supported by specialist palliative care. # registered users of CHIP client health information portal.	Statement of Performance
How well did we do? % people received smoking cessation advice – hospital and primary care. % pregnant women who identify as smokers offered advice. % children fully immunised at eight months. % population over 65 years who have had the influenza immunisation. % infants fully and exclusively breastfed at three months. % children caries free at 5 years of age.	**How well did we do?** Reduced ASH rates 45 – 64 years. % population enrolled with a Primary Health Organisation. % women enrolled in a PHO aged 50-69 years who are enrolled in the Breast Screening Programme with Breastscreen Midland. % women enrolled in a PHO aged 25-69 years who have had a cervical sample taken in the past three years. % of triage level 4 and 5s presenting to the Emergency Department.	**How well did we do?** Number of inpatient surgical discharges under elective initiative. Percentage of patients admitted, discharged or transferred from an ED within six hours. Standardised Intervention Rates meet national expectations. % improvement in access to mental health services. Improved management for long term conditions (CVD, Acute heart health, Diabetes and Stroke). % patients to receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	
Is anyone better off? % obese children identified in the B4SC programme will be offered a referral to a health professional. % patients receiving specialist palliative care die in their chosen place of death.	**Is anyone better off?** Maintain current percentage of population over 65 years who have accessed aged residential care. Incidence number of acute rheumatic fever cases.	**Is anyone better off?** Hospitalisation rates per 100,000 for acute rheumatic fever. % of long-term condition clients reporting an improved quality of life.	

Infrastructure Workforce, facilities, information, partnerships, contracting, technology

18. Environment includes social, economic, natural and cultural attributes.
19. Enrolled in a Primary Health Organisation.

Healthy Individuals – Mauri Ora

Our performance against our long-term framework is reported over the following pages. Overall, these outcome measures show the health of our population is improving.

Outcome goal	Outcome measure
All people have healthy lifestyles with a good quality of life.	■ Fewer people smoke. ■ Reduction in vaccine preventable diseases.
All children have the best start in life.	■ Improving healthy behaviours. ■ People can access their health information. ■ Fewer children and adolescents have decayed, missing or filled teeth.
People die in comfort in their place of choice.	■ People with terminal illness or life limiting chronic disease die in their place of choice.

Fewer people smoke

The Ministry of Health reports that if no one in New Zealand smoked, the lives of almost 5,000 New Zealanders would be saved every year.

The health effects of smoking are devastating:

1. Smoking harms nearly every organ and system in the body.
2. It's the cause of 80% of lung cancer cases, and is linked to many other cancers.
3. It's a major cause of heart attacks, heart disease, stroke, and respiratory diseases such as emphysema and chronic bronchitis.
4. Smoking can also cause blindness, impotence and infertility.
5. Smoking also hurts your children, through the damage done by smoking when pregnant or the effects of second-hand smoke.

In March 2011 the New Zealand Government committed to a goal of New Zealand becoming smokefree by 2025. The BOPDHB is committed to achieving this target, and is proud of our performance in this area. Following three years of consistent improvement, our secondary services team have now successfully embedded smoking cessation 'ABCs' (Ask and document if smoker, Brief advice on quitting, Cessation support) into standard operating procedures.

The Ministry of Health reports that if no one in New Zealand smoked, the lives of almost 5,000 New Zealanders would be saved every year.

The ongoing focus of our Primary Health Organisations (PHOs) on ABCs in a primary care setting has enabled steady performance against this Health Target in 2018/19. The primary care smoking cessation Health Target stipulates that brief advice is offered and support to quit smoking given to 90% of eligible patients who smoke and were seen by a health practitioner in general practices within the last 15 months. This target has not been met during 2018/19 by a 0.6%, due to a PHO restructure and changes in data collection, although the high percentage reflect the maturity of cessation programmes delivered and the conversations facilitated by all health professionals in general practice. There remains inequity of performance against this metric for Maori, though the gap is now less than 3% based on average 2018/19 data – the total population result was 89.4%, while the result for Maori was 86.7%. There is also a clear inequity of smoking prevalence based on the primary care smoking data. While Maori comprise roughly 25% of the population in the BOPDHB region, they make up over 45% of smokers, based on 2018/19 primary care smoking data.

Expectant mothers who register with Lead Maternity Carers are also offered support to quit if they are smokers. The health target is 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer (LMC) are offered advice and support to quit. There have been mixed results against this metric during 2018/19, which is, in large part, due to small numbers in the denominator for this metric. The 90% target was achieved in all four quarters for the total population, and all four quarters for Maori. The

principal concern with the maternity smoking measure, is again the disparity in smoking prevalence between expectant Maori and non-Maori mothers. In 2018/19, based on the maternity smoking data set, approximately two of every five Maori mothers was a smoker, which represents a rate of smoking prevalence between three and four times greater than for non-Maori mothers. There remain ongoing concerns with the quality of the maternity smoking data set, as the denominator is only a fraction of what it should be based on annual births within the BOPDHB region.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2018 Actual	2019 National Average	Achieved	
Output class: 1 Providing Smokers who access primary and secondary services with smoking cessation advice and support. **Hospitalised Smokers:**							Secondary smoking cessation advice targets were met for both total and Maori populations in 2018/19. There is still a significant concern in regard to the disparity in smoking prevalence, with Maori in secondary settings, on average, 2-3 times more likely to smoke than non-Maori. Reducing smoking prevalence for Maori is a focus area of the 2018/19 system level measures plan.
■ Total	96%	97%	95%	**96%**	NA	✓	
■ Māori	96%	96%	95%	**96%**	NA	✓	
Output class: 1 **Primary Care:**							Smoking cessation advice in primary care did not met the 90% target for the total population and Maori, while being just below the target. Both results are higher than the National average.
■ Total	90%	91%	90%	**89%**	87%	✗	
■ Māori[17]	87%	89%	90%	**87%**	85%	✗	
Output class: 1 Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.							Maternity smoking targets were achieved for both total and Māori populations in 2018/19. Smoking prevalence for Māori mothers is a significant concern and is one of the key focus areas in the DHB. Face to face education sessions continue to be held across the region that support midwives to have smoke cessation conversations with pregnant women and their whānau who smoke.
■ Total	91%	92%	90%	**93%**	NA	✓	Ongoing recommendation of referral to Hapainga stop smoking service to all women and whānau members who smoke.
■ Māori[18]	90%	95%	90%	**93%**	NA	✓	
							Ultrasound provider Medex offering stop smoking information to pregnant women during pregnancy scans.
Output class: 1 Maori babies who live in smokefree households at six weeks post-natal.[20]	NA	NA	60%	**35%**	30%	✗	A series of 4 day Wananga – called 'Ukaipo' for hapu mama who smoke have been held around the region. Mothers register for the upcoming Ukaipo during their pregnancy and whānau members are also invited to attend. Ukaipo are held on Marae and attract 5-12 pregnant mothers per wananga. Mothers and whānau reduce or quit smoking after attending Ukaipo and are also referred to Hapainga (regional stop smoking service) to continue their smokefree journey. In addition, BOPDHB fund wahakura wananga (safe sleep) where smoking is identified as a key risk factor for SUDI. Women and whānau who attend these marae based wananga are also supported towards a smokefree life.

20. Data for the last quarter on 2018/19 was not available at the time of the Statement of Performance Expectations was published.

Reduction in vaccine preventable diseases

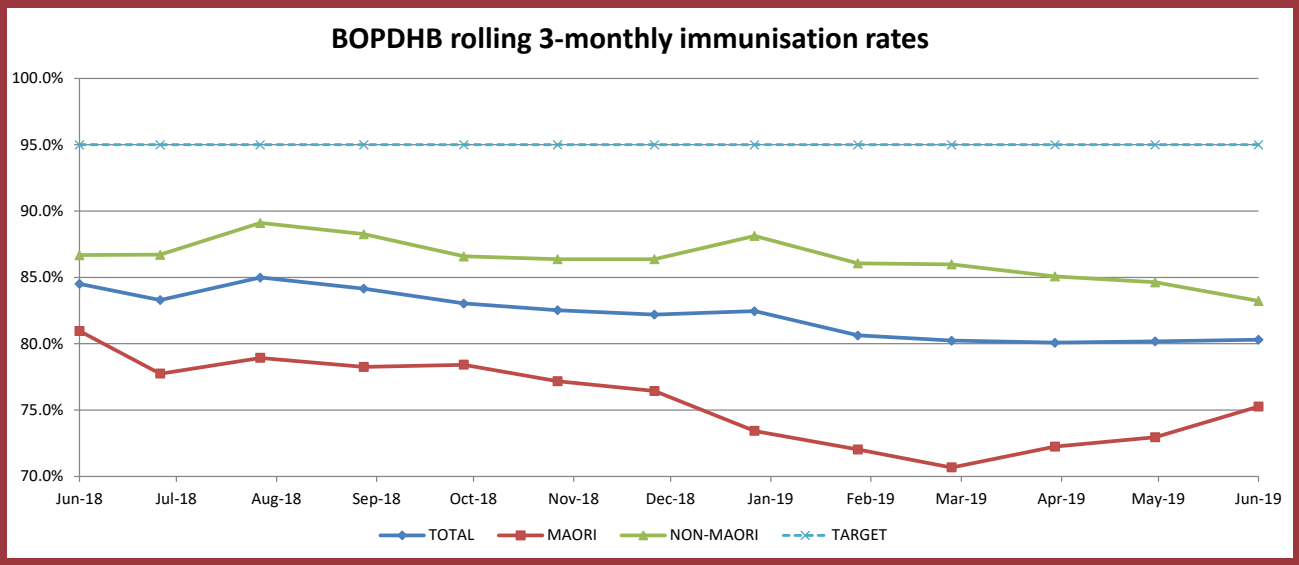
Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. The immunisation goal is that 95% of infants aged eight months will have completed their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Targetl	2019 Actual	2019 National Average[21]	Achieved	
Output class: 1 Children are fully immunised at eight months.[22]							In the last 3 quarters there has been a substantive increase in declines & missed vaccinations, with the latest result (April-June) showing a missed rate in excess of 8%. Current combined opt-off and decline rates at 10% are a limit to achieving the target. The disparity in coverage between Maori and total populations remains high as is an area of focus for the IAG. The DHB has implemented a Quality Improvement Project & temp Leader role to work through a quality and performance improvement plan, based on the recommendation of the recent service review. The outcome will be improved Primary Care vaccination delivery process, improved monitoring report information for targeted action leading to improved coverage from reduced hesitation and decline rates.
■ Total	86%	86%	95%	**82%**	90%	✗	
■ Māori	82%	83%	95%	**76%**	84%	✗	
Output class: 1 Percentage of the population (>65 years) who have had the seasonal influenza immunisation.[23]							Total population 65+ influenza immunisation coverage in the BOPDHB region is stable on 2018 season. Although there is a reduction in coverage of 3% for Maori. Coverage for both total and Maori 65+ populations remained well below the 75% target in 2018, though performance in the BOPDHB region is over the national performance (on average), particularly for Maori.
■ Total Population	60%	58%	75%	**58%**	55%	✗	
■ Māori	51%	54%	75%	**51%**	44%	✗	

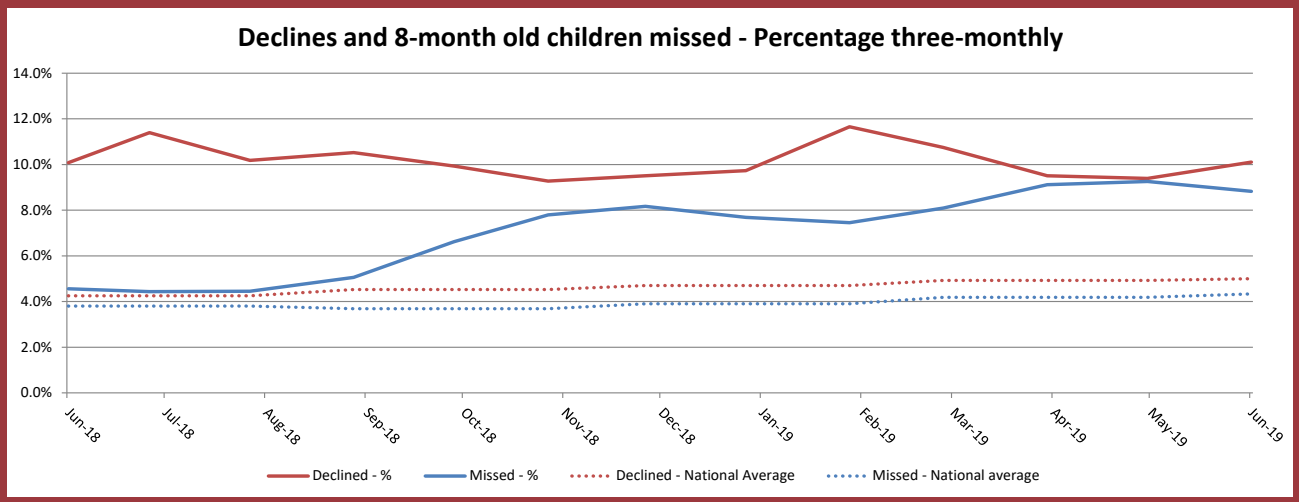
22. Immunisation result reported is the annual coverage for 12 months ended 30 June 2019.
23 2019 actual results reflect influenza coverage in the 2018 calendar year. The 2019 influenza immunisation season ends in September 2019, with data not available until October 2019, which is outside of annual reporting timeframes.

Eight month immunisation coverage performance explained

Eight month immunisation coverage was one of the targets monitored by the Ministry of Health in 2018/19. This target stipulates that 95% of children at eight months of age would have received the requisite immunisations as outlined within the schedule. Eight month immunisation coverage has been a challenging area for BOPDHB, due to historically high rates of declines and opt-off children over 10%. A process improvement project work underway is expected to reduce missed kids and declines for 2018/19, with a focus in operational and communication collaborative improvements, is hopeful of a sustained rise in rates of coverage and subsequent improvements in coverage for all population groups.



The graph above illustrates rolling three-monthly DHB immunisation rates for Maori, non-Maori and the total population for the thirteen month period from June 2018 to June 2019. Rolling three-monthly immunisation shows in the latest quarter an improvement for Maori due to PHO/NMO with practices with predominantly Maori enrolled where an internal remedial improvement plan and new recruitment is evident in results.



The graph above shows that BOPDHB has had higher decline and missed rates than national averages in the last 12 months. Rolling three-monthly missed rates have increased substantially over the last nine months, from just over 4% in June 2018 to over 8% in June 2019, which is a focus point in the quality and performance improvement plan.

Over the last twelve months, decline rates have, on average, been more than twice national average levels (10% versus near 4%). Rates of missed children in BOPDHB have also been above the national average.

While the quality and performance improvement plan has identified key focus with missed children, BOPDHB will continue to struggle to achieve consistent immunisation coverage above 90% without a concerted effort being made to reduce declines. In addition, BOPDHB should seek continued improvements in the missed children cohort, with an aim to reduce this cohort to as close to 0% as possible – acknowledging high levels of delayed children within the cohort.

A key strategy for improvement from the Analytic Project will be delivery system/process improvement with particular focus on the six month age to ensure vaccination rates are tracking well for the 8 month target.

Immunisation coverage of children not enrolled with one of the three local PHOs was well below the levels of coverage for enrolled children – for example, the 24-month data result saw over 70% of this cohort are overdue[24]. System improvements have been identified for improved NIR enrolment to reverse this rate. It is worth noting that opt offs are included in this cohort, which can have a material impact on coverage – the result shows 19%.

Improving healthy behaviours

Breastfeeding helps lay the foundations of a healthy life for a baby and also makes a positive contribution to the health and wider wellbeing of mothers and whānau/families. Exclusive breastfeeding is recommended by the Ministry of Health until babies are around six months as it provides numerous health benefits for mother and baby. These benefits include helping baby develop physically and emotionally, providing protection from infections, reducing the risk of sudden unexpected death in infancy.

BOPDHB again exceeded the 70% six month breastfeeding target for the total population (2017/18 result was 71%), with a 6% improvement made from 2016/17. However, the target was missed for Maori, which resulted in the disparity for this metric, between total and Maori populations, decrease from 14% in 2017/18 to 10% in 2018/19. Breast feeding coverage for Maori, particularly rates of exclusive at three months of age, are a key area of focus for BOPDHB in 2019/20.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class: 1 Number of schools engaged in the Health Promoting Schools programme.	59	73	83	**49**	✗	The intent is that all schools in the region are engaged in this programme. But there have been ongoing changes with the programme so while we might appear to be working with less schools, the number of interactions with schools are a lot higher.
Output class: 1 The number of referrals to adult GRx (Green Prescription) programmes.	2,461	2,584	2,233	**2,932**	✓	Green Prescription volumes continued to improve in 2018/19, with an approximate 13% improvement on the previous year. The improvement was driven in almost equal measure by improvements in volumes for Māori (21%) and non-Māori (8%). BOPDHB again exceeded the target number of referrals received. In 2019, 45% of referrals are Māori, compared to 42% of referrals were Māori in 18/19.
■ Māori	1,040	1,085	NA	**1,313**		
■ Non-Māori	1,421	1,499	NA	**1,619**		
Output class: 1 Percentage of infants receiving breast milk at six months.[25]						BOPDHB recognised the gap of a community based integrated breastfeeding support service and underwent a procurement of a service provider to fulfil this gap. We now have 2 new services operating and should see an impact on breastfeeding rates in the 2019/20 year. The new service is founded on Kaupapa Māori principles and is orientated towards Māori service usage. Although the prevalence of breastfeeding at 6 months for Māori infants is less than the target (62%), there was a 5% increase from the previous year. This could be attributed to the trial community lactation consultant that was based in Plunket who supported Māori mothers to continue breastfeeding.
■ Total	66%	71%	70%	**72%**	✓	
■ Māori	63%	57%	70%	**62%**	✗	

24. The cohort of children not enrolled with one of the three local PHOs includes children who have been opted off the national immunisation register and children where the PHO and GP is unknown.
25. This measure is no longer reported on as part of Well Child Tamariki Ora reporting, however, six-monthly breastfeeding was one of the fourteen metrics looked at as part the Good to Great programme, which is focussed on achieving equal health outcomes for Maori.

People can access their health information

The use of patient portals within general practice provides a mechanism for greater involvement of patients in their personal health management. Portals such as 'Manage my Health' enable patients to self-manage by monitoring test results, reviewing BMI updates and booking on-line appointments with their GP.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class: 2 The percentage of enrolled registered to use general practice portals.[26]	8%	9%	15%	**15%**	✓	There has been an increase in uptake of patient portals by enrolled patients in the BOPDHB region.

Fewer children and adolescents have decayed missing filled teeth

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	2019 National Average[27]	Achieved	
Output class: 2 Percentage of children who are caries free at age five - PP11.							Reductions to target were seen for both populations; while significant disparities remain of concern an active evaluation project is underway to improve the rate of unseen/over-due children to improve intervention potential for treatments.
■ Total	51%	50%	53%	**51%**	NA	✗	The Oral health promotion team and the 5 2 1 0 Nutrition and activity programme adopted within the BOPDHB region will be a key promotion programmes for improvement in population rates.
■ Māori	30%	29%	53%	**34%**	NA	✗	
Output class: 2 Percentage of adolescent utilisation of DHB funded dental services - PP12.							Although below target the utilisation is marginally improved in total and in line with national average results. The number of dentists available for the CDA service remains the similar to last year and does not appear to limit service availability for access. Mobile sites are available at dedicated schools in the Mount and Papamoa.
■ Total	67%	68%	85%	**73%**	69%	✗	
Output class: 2 Percentage of Children (0-4 years - % year 1) enrolled in DHB funded dental service – PP13 (measure 1).							Improvements were driven by a preschool enrolment initiative, where parents of non-enrolled Maori children were identified and called. The improvements made during 2018 have continued during 2019, with internal titanium reporting indicating Maori preschool dental enrolment is now above 95%. System improvement is ongoing and duplicate or expired enrolments will be reduced for accuracy.
■ Total	93%	92%	95%	**101%**	NA	✓	
■ Māori[28]	67%	71%	95%	**96%**	NA	✓	
■ Non-Māori	114%	108%	95%	**104%**	NA	✓	

26. The 2018/19 Annual Plan patient portal measure is one of the contributory measures for the Patient Experience System Level Measure. On reflection, the target set was extremely ambitious due to the lack of baseline data. Results are for Q3 2018/19.
27. Oral health reporting is by calendar year to align with school clinics. Published results are for the 12 month period ending 31 December 2018. Key metrics are caries-free, which measures the number of children who require no dental interventions; and decayed, missing, filled teeth (DMFT) that measures the converse number of teeth that are in a poor state due to decay, extraction or previous dental work.
28. Enrolment of Māori children (0-4) in Oral health services is a priority in the Māori Health Plan with a target of 95% engagement.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	2019 National Average[25]	Achieved	
Output class: 2 Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination – PP13 (measure 2).							As an unintended consequence the substantive improvements in enrolments has placed additional capacity on an already constrained service. Addressing these capacity challenges should enable improvements in this area during 2019 and beyond. Intervention scheduling and system capacity is currently under investigation through an analytics project to determine future improvements required (system & resource) to ensure maximum potential to see enrolled children. Additional resource has been implemented in the short-term to maintain capacity before further results can be implemented.
■ Total	12%	15%	10%	**17%**	NA	✗	
■ Māori	12%	13%	10%	**17%**	NA	✗	

People with a terminal illness or life limiting chronic disease die in their place of choice

Palliative care focuses on providing patients with the most appropriate care in end of life stages or advanced state of terminal illness. Historically palliative medicine has considered patients who access services in our community hospices and we have monitored activity accordingly. Palliative medicine utilises a multidisciplinary approach to patient care, relying on input from physicians, pharmacists, nurses, chaplains, social workers, psychologists, and other allied health professionals within secondary services. This multidisciplinary approach allows the palliative care team to address physical, emotional, spiritual, and social concerns that arise with advanced illness.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class: 4 Percentage of patients receiving specialist palliative care who die in their chosen place of death.	New	New	NA	**TBD**	NA	This measure is presently still in development as we work with specialist providers on the accurate capture of information in this space. Although data completeness and quality around chosen place of death has improved substantively, data is not reliable yet.

Healthy Families – Whānau Ora

Families that are informed of the best ways to maintain their health and well-being will get the most out of life. They are best placed to manage their own health needs with guidance from the appropriate health professionals along their journey through life. Lead Maternity Carers, Plunket nurses and Public Health nurses can provide advice until children reach school. Kaimanaaki, Whanau Ora navigators and General Practitioners can support families in managing respiratory illnesses, skin infections, pneumonia and other avoidable admissions. Nurse specialists can provide support for diabetes patients and individuals with chronic obstructive pulmonary disease (lung disease). Home and community support providers assist older people to remain in their homes for longer by delivering functional services such as personal care and household management services.

These multiple contacts with the health system provide opportunities for whānau to be empowered in managing their health needs. Our objective is to enable people to live well with long term conditions and be safe and healthy in their communities.

Outcome goal	Outcome measure
Family/whānau live well with long term conditions.	■ Fewer people are admitted to hospital for avoidable conditions. ■ Long-term conditions are detected early and managed well.
People are safe, well and healthy in their own homes and communities.	■ People maintain functional independence. ■ Families and whānau are at the centre of their healthcare.

Fewer people are admitted to hospital for avoidable conditions

The Ministry of Health defines a group of conditions, such as cellulitis, asthma, angina and chest pain, as avoidable, based on the premise that early diagnosis and proactive treatment by a health professional in general practice or the community could prevent an admission to hospital. These conditions are referred to as Ambulatory Sensitive Hospitalisation (ASH) conditions and are regularly monitored for the 0-4 and 45-64 age groups. Rates of childhood (0-4) ASH are one of seven System Level Measures and hence are not reported within the Statement of Performance Expectations.

Rheumatic fever is a condition that affects patients for their entire life and can lead to heart issues if not properly treated. However, rheumatic fever can be prevented by throat swabbing programmes within schools. With the introduction of this school based programme, BOPDHB aims to reduce the incidence of first-reported cases of rheumatic fever over time.

Health professionals acknowledge that Māori often develop chronic conditions at an earlier age than other sub-populations, and that disparities and inequalities exist when Māori access support and health services. Programmes such as Whanau Ora, Koroua and Kuia, and Kaupapa Māori nursing services exhibit strong cultural values and are delivered by Māori service providers in the community. Culturally responsive services are also necessary within mainstream hospital and primary care settings to ensure Māori can access appropriate health services and receive equitable health outcomes.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	2019 National Average	Achieved	
Output class: 2, 3 Reduced ASH rates 45 – 64 years.[29]							Standardised 45-64 ASH rates in the BOPDHB region are below national averages for both total and Maori populations. This is despite ASH rates increasing for both populations over the last 12 months.
■ Total	3859	3731	No target	**3859**	3905	✓	
■ Māori	6894	7590	7050	**7899**	8121	✗	
Output class: 1 Percentage of eligible population who have had their Before School Checks (B4SC) completed.							Collaboration between multiple agencies has maintained targeted achievement of both total and high needs B4SC targets in 2018/19. Weekly updates of performance to the team allowed for check volumes to be allocated smartly across the year, and enabled the team to front foot the volumes challenges encountered over the summer holiday months.
■ Total Population	92%	90%	90%	**90%**	NA	✓	
■ High needs	91%	90%	90%	**92%**	NA	✓	
Output class: 2, 3 Incidence number of acute rheumatic fever cases.[30]	4.0	2.1	<1.3 p100,000	**2.5**	NA	✗	Data indicates a small increase in rheumatic fever cases compared to the previous year. We continue to provide targeted primary and secondary prevention of Rheumatic Fever including; school and pharmacy based throat swabbing services, Healthy Housing Initiative and secondary prophylaxis register and district nursing delivery model. We have recognised that some of the cases this year may have been attributed to un treated skin infections and adult diagnosed ARF (including during pregnancy). The conclusion of the National 'sore throats matter' campaign, may also have impacted the increased rate.

29. Period reported is the 12 months ending 31 March 2019
30. Bay of Plenty DHB Rheumatic fever rates are for the financial year ending 30 June 2019. Please note that annual trending is not particularly reliable for this metric as the number of cases are small.

Our Emergency Departments received 83,238 presentations during the 2018/19 financial year from people seeking medical assistance. This represented a growth in presentation volumes of 3.1%, and was primarily driven by high ED demand over the autumn-winter months – from May to June 2019. Despite the increased demand pressures, the ED (triage 4-5) target was achieved in all four quarters, which represents achievement across the 2018/19 year.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class: 3 Percentage of triage level[31] 4 and 5 presenting to the Emergency Department (ED).	53%	51%	≤65%	**48%**	✓	Our Emergency Departments received 83,238 during the 2018/19 financial year from people seeking medical assistance. This represented a growth in presentation volumes of 3.1%, and was primarily driven by high ED demand over the autumn-winter months – from May to June 2018, where presentations were between 7% and 14% higher than the equivalent month in 2017/18. Despite the increased demand pressures, the ED (triage 4-5) target was achieved in all four quarters, which represents achievement across the 2018/19 year. Compared with the previous financial year, the number of triage 4 and 5 ED presentations has been steady, while total presentations have increased. The significant majority of level 4 and 5 presentations are the result of self-referrals (88%) – this proportion has slowly, but steadily, increased from 87.2% to 88.7% from 2017/18 to 2018/19.
Output class: 3 Number of presentations to ED – Triage Level 4 and 5 as a percentage of the total population.	18%	18%	12%	**15.9%**	✗	While BOPDHB has experienced steady population growth in 2018/19 (over 2%), and triage 4 and 5 ED presentations have also been steady, there has been no change to this metric (when reported as a whole number). Therefore, we again missed our target of 12%. Identifying further opportunities to encourage people to attend primary care in the first instance, will assist with meeting this target.

31 For Triage Levels go to the Ministry of Health NZ

Long-term conditions are detected early and managed well

The percentage of population enrolled with a Primary Health Organisation (PHO) is an important measure as it indicates the proportion of our residents who have access to primary care and have visited a general practitioner within a three year period. Access to primary care has been shown to have positive benefits in maintaining good health, including early detection of long term conditions and assistance in managing these often life-long conditions.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target[32]	2019 Actual	2019 National Average	Achieved	
Output class: 2 Percentage of population enrolled with a Primary Health Organisation (PHO).							BOPDHB achieved both PHO enrolment targets in 2018/19, with over 99% of our population of 238,380 enrolled with a PHO. Maori enrolment was over 96% (of 59,440). A further 1,662 (1,386 Maori) BOPDHB residents are enrolled with Te Kaha practice, which is a BOPDHB primary care facility.
■ Total	98%	99%	90%	**99%**	94%	✓	
■ Māori	94%	96%	90%	**97%**	90%	✓	
Output class: 2 Percentage of eligible population who have their cardiovascular disease (CVD) check completed within the last 5 years.[33]							BOPDHB achieved CVDRA targets for both total and non-Maori populations for the five year period ending 30 June 2019. While the target was missed for Maori, BOPDHB is ranked 1st equal for performance against this metric nationally for Maori. BOPDHB performs well against this metric for all populations reported on in the Statement of Performance Expectations.
■ Total	92%	93%	90%	**92%**	87%	✓	
■ Māori	89%	89%	90%	**87%**	85%	✗	
■ Non Māori	92%	94%	90%	**93%**	87%	✓	
Output class: 2 Percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the last five years.[34]	72%	75%	90%	**73%**	69%	✗	The principal focus for CVDRA has shifted to the high risk cohort of Maori males aged 35-44. As with the general CVDRA metric, BOPDHB performs well for this metric national, though there is still significant room for improvement to achieve the 90% target.

32. In addition to BOPDHB residents who are enrolled with one of the three local PHOs – Western Bay of Plenty Primary health Organisation, Eastern Bay Primary Health Alliance and Nga Mataapuna Oranga – there are a further 1,662 Te Kaha residents enrolled at Te Kaha practice, which is a BOPDHB run primary health care facility. If these residents are included, then Maori enrolment in primary care increases by 2% to over 97% enrolment.
33. Data for the last quarter on 2018/19 was not available on the time of the Statement of Performance Expectations was published.
34. Data for the last quarter on 2018/19 was not available on the time of the Statement of Performance Expectations was published.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	2019 National Average	Achieved	
Output class: 1 Woman enrolled in a PHO age 25-69 years who have had a cervical cancer screen sample taken in the past three.							Cervical screening coverage improved for both Māori and total populations in the past year – with Māori improvement (3%) higher than non-Māori (1%). The support to screening services have provided innovative approaches to helping more Māori women get screened this year, including receiving 'iwi points' for having a smear at Kapa Haka regional competitions.
■ Total	80%	81%	80%	**81%**	73%	✓	
■ Māori	69%	71%	80%	**74%**	68%	✗	
■ Non-Māori	83%	83%	80%	**84%**	74%	✓	
Output class: 1 Woman enrolled in a PHO age 50-69 years who are enrolled in a breast screen program with breast screen midland.							BOPDHB achieved breast screening targets for total and non-Māori populations. This year has seen continued improvements for Māori women screened (increase of 5%) compared to 1% for non-Māori.
■ Total	69%	71%	70%	**73%**	72%	✓	
■ Māori	58%	61%	70%	**66%**	66%	✗	
■ Non Māori	71%	74%	70%	**75%**	73%	✓	
Output class 2 **Focus Area 2 - Diabetes Management (HbA1c):** Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator)- PP20.	76%	66%	80%	**69%**	NA	✗	There has been an increase in the proportion of patients with a good HbA1c score (≤64mmol). There is a substantive discrepancy in this metric by ethnicity. Less than 60% of Maori and Pasifika patients had good HbA1c scores, while 73% for non-Maori, non-Pasifika.
Output class 3 **Focus Area 5 - Stroke Services:** Percentage of potentially eligible stroke patients thrombolysed.	5%	8%	10%	**9%**	NA	✗	BOPDHB continue to work towards the targets specifically for thrombolysis through increased education. In addition, we have worked with Auckland to successfully implement the transferral of patients to Auckland for clot retrieval.
Output class 3 **Focus Area 5 - Stroke Services:** Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	76%	74%	80%	**73%**	NA	✗	
Output class 3 **Focus Area 5 - Stroke Services:** Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	NA	NA	80%	**71%**	NA	✗	

Breast and cervical screening coverage for Maori explained

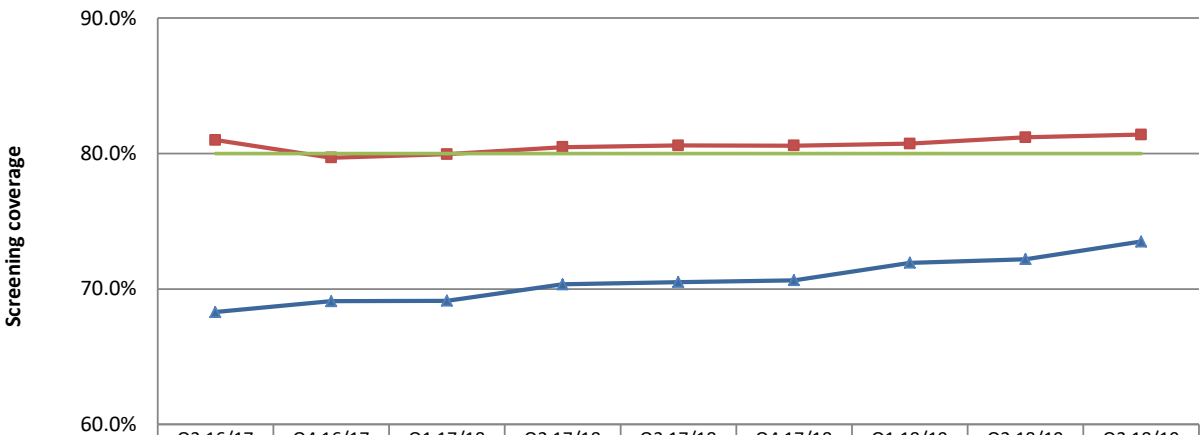
BOPDHB continued to achieve improved breast and cervical screening coverage for Māori during the 2018/19 financial year – compared to non-Māori. This demonstrates our commitment to improving health equity for Māori in the Bay of Plenty. However, a disparity still remains, with 10% disparity for cervical screening (reduced by 2% from 2018) and 9% disparity for breast screening (4% reduction from 2018) in coverage between Māori and non-Māori women. This disparity highlights the need for cervical screening coverage for Māori to remain a priority in 2019/20, which is why this remains an area of focus as part of Bay of Plenty's approved 2019/20 System Level Measure plan and a focussed effort to achieve the aspirations of Te Toi Ahorangi- the BOPDHB Māori health strategic plan.

The improvements in equity for Māori women in breast screening is the product of an integrated service improvement project between the support to screening services, PHOs, Breast Screen Midland, Bay Radiology and BOPDHB-Planning and Funding.

A summary of the key changes were; making improvements to the invite process, increasing the volume of Māori women invited, improving access to radiology appointments over the Christmas closure period, and increasing Māori women enrolment with Breast Screen Midland.

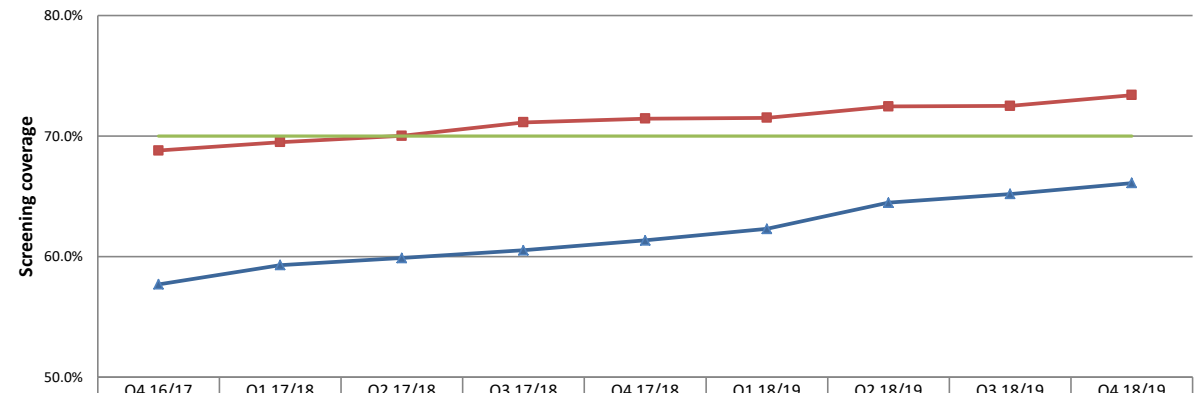
The Western BOP support to screening service has been an exemplar performer against their indicators. Due to recruitment and administrative issues, in addition to the social complexities experienced by women living in rural, high deprivation areas, the Eastern Bay model has not been as successful. There will be a regionalisation of the support to screening services in 19/20 and we are optimistic our breast and cervical rates will continue to improve for Māori as a result.

Quarterly cervical screening coverage results against target



	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
Total	81.0%	79.7%	79.9%	80.5%	80.6%	80.6%	80.7%	81.2%	81.4%
Maori	68.3%	69.1%	69.1%	70.3%	70.5%	70.6%	71.9%	72.2%	73.5%
Target	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8

Quarterly breast screening coverage results against target



	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Total	68.8%	69.5%	70.0%	71.1%	71.4%	71.5%	72.5%	72.5%	73.4%
Maori	57.7%	59.3%	59.9%	60.5%	61.4%	62.3%	64.5%	65.2%	66.1%
Target	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7

People maintain functional independence

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 4 Percentage of the population 65+ years that access Home and Community Support Services (HCSS).	12.03%	11.86%	12.15%	**9.13%**	✗	The proportion of the 65+ population receiving home community support services has been steady but since population is growing in this cohort the percentage is low.
Output class 4 Maintain current percentage of population over 65 years who have accessed aged residential care (ARC).	5.2%	5.7%	5.0%	**3.7%**	✓	There are a number of initiatives that target this cohort to stay home for longer, therefore the result of a 2% decrease is positive, particularly as the population of this cohort is increasing.
Output class 4 Increase in occupancy rate for Residential Respite Bed Days.	36%	47%	82%	**90%**	✗	While there was an increase in occupancy in 2017/18, rates were still significantly below target. This was primarily because one of three contracted beds was used extremely infrequently – this need for this third bed will be reviewed.

Families and whānau are at the centre of their healthcare

The Annual Plan 2018/19 identified families and whānau as key stakeholders in a patient's health and wellbeing. The Whanau Ora target was introduced to reflect this importance.

A Whānau Ora pathway is in place with our kaupapa PHO as a clinical care tool that is accessible by all health professionals involved in the care of Māori patients.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 4 # of Whānau Ora promotional activities undertaken.	128	539	112	**468**	✓	Each of the nine Whanau Ora providers within the BOPDHB region has a target of delivering two promotional activities per quarter – this equates to 112 promotional activities per annum across all providers (as one of the contracted providers has subcontracts with six other providers). In 2018/19, providers delivered significantly more promotional activities than required by the target – one provider alone managed to deliver 278 promotional activities during the year.

Healthy Environments – Wai Ora

People who live in dry, warm homes are most likely to have the best chance of a healthy life. Families that are able to provide appropriate food and clothing for children will be less likely to need intervention from health professionals for preventable illnesses. Whānau that are connected within their communities will have support networks to assist them in managing adverse health events.

Our goal is for families and whanau to have as much information as they need to make good decisions about their environments and personal well-being. When they are required to contact a health professional they have easy access to the expertise required and receive the right health services as soon as possible.

Outcome goal	Outcome measure
All people live, learn, work and play in an environment that supports and sustains a healthy life.	■ Providing healthier homes. ■ Connecting with agencies to meet community needs.
Our population is enabled to self-manage.	■ Appropriate access to services. ■ People receive prompt and appropriate acute and arranged care.
All people receive timely, seamless and appropriate care.	■ Services provided or funded by the BOPDHB contribute to the transfer of knowledge and skills to family / whānau to enable self-management.

Providing healthier homes

Main measures of performance	Volumes				Comments
	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 1 Number of homes that are insulated through the community-based insulation and healthy housing program.	NA	60	137	✓	There has been a significant increase of homes in 2019 that have been insulated due to BOPDHB financially assisting with the 40% co-payment required to match the 60% ECCA funding. The increase is due to active monitoring, advocacy and accountability of the BOPDHB Healthy Housing initiative homes with the insulation provider.
Output class 1 Percentage of eligible referrals to healthy home initiatives program have an intervention plan.	NA	85%	78%	✗	2019 has seen the highest number of referrals to the HHI since the initiative began in 2015. The increase in referrals is due to active engagement with NGO's, health and social service providers, community hui, improving paediatric referral pathway at the hospital sites.

Connecting with agencies to meet community needs

Main measures of performance	Volumes				Comments
	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 1 Number of governance group meetings held for co-designed multi-agency initiatives.	5	NA	7	NA	Putting health to the fore when planning new urban developments is a significant outcome of the Tauranga and Western Bay of Plenty Collaborative Planning and Implementation MOU. The MOU has been signed between Tauranga City Council, Western Bay of Plenty District Council, Bay of Plenty Regional Council, Bay of Plenty District Health Board (BOPDHB), New Zealand Transport Agency and Ministry of Education. Multi-agency collaboration aims to ensure new and existing communities are planned, designed and developed to help people live well and stay well. While the councils have collaborated before, BOPDHB was not been part of this work previously. The signing of the MOU enables BOPDHB to get involved at an early stage in the planning of new communities; for example, those being established in Papamoa East, Tauriko West and Omokoroa. The MOU provides BOPDHB with the platform to raise health opportunities and issues at an early stage, and to provide input on the recommended health service infrastructure for these new communities. Specific areas of focus for this collaborative work are: transport; health; education; land use and infrastructure planning.

Appropriate access to services

The intent is to deliver a public health system that delivers better, sooner, more convenient healthcare for all New Zealanders. This includes access to services when needed, prompt referrals between different facets of the health system and a simplified process for receiving healthcare that members of the public understand and comprehend.

Outcomes of such a health system are a greater number of residents receiving elective surgeries (for example, joint replacements, cardiology services and eye procedures), efficient services within Emergency Departments and timely referrals for suspicion of cancer. BOPDHB, in delivering 12,101 elective surgery discharges this year (target: 11,269), has exceeded our target by 7%.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 3 Number of inpatient surgical discharges under elective initiative (includes all discharges regardless of whether they are discharged from surgical or medical specialty) - Total.	11,315	12,112	11,269	**12,101**	✓	BOPDHB exceeded the 2018/19 electives target by 832 discharges. This is a great result considering the impact of both the nursing strike that occurred during July 2018, and the subsequent ongoing RMO strike activity.
Standardised Intervention Rates as per 10,000 of population- SI4.						Standardised intervention rates for coronary angiography, cardiac and angioplasty procedures were below targets and national averages. However the figures for angiography do not include the CT Angiography figures performed. Cardiac surgery has faced some considerable constraints in 2018/2019. This was despite improved performance over the past year. Targets were achieved for both joint and cataract procedures.
Coronary Angiography	28.03	31.66	34.7	**30.3**	✗	
Cardiac	5.05	5.20	6.50	**5.14**	✗	
Angioplasty	10.82	11.27	12.5	**11.20**	✗	
Joint	27.37	26.33	21.0	**28.02**	✓	
Cataract	25.35	24.80	27.0	**29.20**	✓	

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 3 **ESPIs (Elective Services Performance Indicators)** **ESPI 1** – timely processing of referrals in 15 calendar days or less.	100%	100%	100%	**100%**	✓	Achieved
ESPI 2 – percentage of patients waiting longer than four months for their first specialist assessment.	0%	0.1%	0%	**5.3%**	✗	Multiple pressures are affecting all services and thresholds have been adjusted accordingly. Strike action has significantly impacted elective delivery. Vacant SMO FTE and unplanned SMO sick leave has also negatively impacted elective delivery.
ESPI 3 – patients waiting without a commitment to treatment.	0%	0%	0%	**0%**	✓	Achieved
ESPI 5 – patients given a commitment to treatment but not treated within four months.	0.7%	0.7%	0	**6.3%**	✗	As noted above, there are multiple pressures impacting on this target. Increased orthopaedic outsourcing has assisted.
ESPI 6 – patients in active review who have not received assessment within 6 months.	0%	0%	0%	**0.0%**	✓	Achieved
ESPI 8 – proportion of patients treated who were prioritised using recognised tools and processes.	100%	99.8%	100%	**100%**	✓	Achieved
Output class 3 Did Not Attend (DNA) rate for outpatient services.						There were further improvements in Maori outpatient DNA rates during 2018/19, with a reduction to 13.8%. However, Maori DNA remains significantly higher than the 5% target and the DNA rate achieved for non-Maori. A Maori liaison nurse is now based in outpatients. Their role is to contact Maori patients prior to scheduled appointments, and offer support with health literacy, overcoming barriers for attendance. As part of the Ambulatory Programme, there is a sub project to reduce follow up attendances by offering alternative modalities eg: telemedicine, SOS visits.
■ Total	6.4	6.3	5.0	**5.4**	✗	
■ Māori	15.3	14.6	5.0	**13.9**	✗	
■ Non Māori	3.9	3.9	5.0	**3.7**	✓	

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 4 Number of clients supported by specialist palliative care.[35]	1,156	1,490	769	**1,157**	✓	These figures only include hospice palliative care services as this data has not been collected to date by the palliative care team in Tauranga Hospital. Changes are being made to enable this data to be collected.
Output class 4 Percentage of people supported by specialist palliative care, other than cancer or end stage renal failure.	30%	18%	23%	**29%**	✗	As in 2018/19, there was a significant increase in demand for palliative care services, which is a potential reflection of the ageing population in the BOPDHB region. The majority of clients supported in specialist palliative care, where a primary diagnosis was recorded, had cancer or end stage renal failure as their primary diagnosis. 75 clients supported in 2018/19 did not have a primary diagnosis recorded and were excluded from the denominator of this indicator, i.e. the denominator was 1,157 – 75 = 1,082.

35. Our main hospice provider installed a new patient management system (PalCare) that provides greater transparency over patient support and types of activity within palliative care services. The service review will provide a greater understanding of the demand pressures within palliative care.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 2 Number of community pharmacy prescriptions.[36]	3,641,556	3,666,354	3,676,982	**3,606,864**	✓	Community pharmacy prescriptions remained relatively steady in 2018/19, with 1.6% decrease – compared to 0.6% growth in 2017/18. Given population growth is around 2%, this means that prescription levels per head of population have reduced in 2018/19. The intent is to maintain prescription numbers as much as possible, acknowledging there may be changes in line with population growth.
Output class 2 Improved wait times for diagnostic services[37] – accepted referrals receive their scan: - PP29.						The coronary angiography target was achieved in 2018/19. This is a significant improvement on previous years.
Coronary Angiography	97%	92%	95%	**98.6%**	✓	
Diagnostic Colonoscopy						The urgent target has been achieved for 2018/2019 through significant focus particularly on administrative processes. The non-urgent target was not achieved. This, on the whole, is a capacity issue with the service receiving significantly more referrals than capacity allows. The service does where possible contract out non-urgents but the market has a limited capacity. In addition, the service continues to utilise locums where available for leave cover and extra lists are provided utilising existing staffing, particularly at weekends.
Urgent (within 14 days)	NA	82%	90%	**90%**	✓	
Non-urgent (within 42 days)	43%	44%	70%	**43%**	✗	
Surveillance Colonoscopy	11%	39%	70%	**56%**	✗	A slight improvement on 2017/18 however the surveillance result is also affected by capacity as per non-urgent noted above.
Computing Tomography (CT)	97%	98%	95%	**97%**	✓	The CT target was exceeded by BOPDHB in 2018/19, with BOPDHB being one of seven DHBs to meet this target. The target was achieved in all months of the 2018/19 financial year. The Increase in attended CT scan referrals in 2018/2019 when compared with 2017/2018 was 13%.
Magnetic Resonance Imaging (MRI)	95%	91%	90%	**91%**	✓	BOPDHB achieved the MRI target again during 2018/19. The target was achieved in November 2018 to June 2019 from when an additional MRI scanner became operational by our Contracted Provider. The Increase in attended MRI scan referrals in 2018/2019 when compared with 2017/2018 was 13.26%.
Output class 2 Total number of community referred radiology Relative Value Units (RVUs).	73,762	76,942	72,090	**72,770**	✓	Delivery of community radiology services exceeded target in 2018/19. The volume of delivery was comprised of 68,054 volumes delivered in secondary settings and 4,716 volumes delivered in primary care (933 by EBPHA and 3,783 by WBOPPHO).
Output class 2 Total number of community laboratory tests.	1,460,701	1,524,521	1,450,000	**1,565,573**	✓	Community laboratory test volumes continued to increase steadily in 2018/19, with the number of community tests increasing by 3% in the last year, following an 4% increase the year before. As test volumes are increasing at a rate exceeding population growth, the implication is that there is also an increase in the number of community lab tests completed per person in the BOPDHB region.

36. This output is measured by the total number of pharmaceutical items dispensed in the community for Bay of Plenty residents. Data is sourced from Central TAS.

37. Activity is for all patients who received a diagnostic service in the 12 months ended 31 May 2019. The percentage reflects the proportion of patients who received their service in the specified timeframe.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 2 Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes:						All non-urgent community lab test category targets were met during 2018/19. Category results were broadly similar to those obtained in the previous financial year.
Category 1: Within 24 hours	100%	98%	95%	**97%**	✓	
Category 2: Within 96 hours	95%	100%	100%	**100%**	✓	
Category 3: Within 72 hours	100%	100%	100%	**100%**	✓	
Output class 2 Percentage of community laboratory tests completed within designated timeframe from receipt of the specimen at the laboratory.						While there were small reductions in performance against both routine and urgent targets, 2018/19 results were both well in excess of annual plan targets.
Within 48 hours (routine test)	100%	99%	90%	**99%**	✓	
Within 3 hours (urgent test)	99.9%	98%	80%	**97%**	✓	
Output class all Improvement in the participation domain for Māori and non-Māori within the primary care survey.						The health care homes initiative has commenced, promoting practices to improve participation in the survey and awareness of key measures that improve performance.
■ Maori	7.1	7.5	8	**7.3**	✗	To achieve ongoing impact in this area, the system level measures working group identified the need for initiatives to be consumer led with sound co-design principles. We are in the process of transferring leadership to the consumer council and determining the support they will require to lead initiatives.
■ Non-Maori	8.1	7.6	8	**7.6**	✗	
Output class all Maori patients completing will provide over 15% of responses in the primary care survey.	NA	NA	15%	**13%**	✗	Commentary on this metric is provided below.
Output class 3 Improving mental health services using transition (discharge) planning for child and youth – PP7.[38]						There has been a high turnover of staff, which means further allocation on the processes required.
■ Total	95%	87%	95%	**80%**	✗	
■ Maori	Not reported	82%	95%	**75%**	✗	
Output class 3 Average length of acute adult (18+ years) inpatient stay (days) KPI 8.	13 days	14 days	14-21 days	**16**	✓	Average length of stay reflects difficult to place people with high and complex needs. There have been several patients who have been ready for discharge, however suitable accommodation options have not been available. Others have periods of unwellness that have taken longer than expected to treat.
Output class 3 Rates of 7 day follow-up in the community post discharge KPI 19.	69%	77%	90%	**67%**	✗	The intent of this KPI indicator is to encourage staff to meet with their clients within 3 days of discharge.

38. Mental Health reports are for 12 months rolling periods and are not currently reported by ethnicity..

Average length of acute adult inpatient stay explained

Average length of stay for acute adult mental health inpatients has remained steady over the last three financial years, towards the target range. There are a number of factors impact the length of stay for an acute adult inpatient, which is why a target range is identified. 28-day readmission rates are also closely tied to average length of stay.

Some of the factors that impact length of stay include:

- ongoing limitations in funded housing/ respite options in the community, which means clients stay longer than required for treatment.
- clients with borderline intellectual disability (not picked up by Support Net) who, due to limitations in independent living, reside for long periods in the inpatient unit as there are no accommodation options available to discharge them.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	2019 National Average	Achieved	
Output class 3 A referral of a young person (0-19 years) is seen by Alcohol and Other Drug health professional within 3 weeks of referral being received – PP8.	91%	85%	80%	**79%**	83%	✗	Three-week youth (0-19) AOD wait times have not been met for the 12 month period from April 18 – March 19. There has been a reduction over the past twelve months. Further detail around what's driving this reduction is outlined in the three week youth AOD wait times explained section below.
Output class 2 Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks.[39]							Meeting 3 week waiting times in mental health and AOD has been challenging in the last 12 months due to the number of vacancies in the service and turnover rates. All vacancies in the Youth AOD team (SORTED) has now been filled and we expect to see improvements in waiting times accordingly.
Mental Health (Provider Arm) % people seen <3 weeks.							
0-19 yrs	77%	80%	80%	**77%**	67%	✗	Access rates have also been higher than the national average in all areas which has further challenged our system.
20-64 yrs	82%	80%	80%	**85%**	81%	✓	
Addictions (Provider Arm and NGO) % people seen <3 weeks.							
0-19 yrs	91%	85%	80%	**79%**	83%	✗	
20-64 yrs	85%	77%	80%	**77%**	81%	✗	
Output class 2 Percentage of people referred for non-urgent mental health or addiction services are seen within 8 weeks.							Performance against eight-week wait time targets has largely been maintained for mental health and addiction service provision in 2017/18. The only area of any significant change is a reduction in the eight-week wait time metric for adult AOD service provision. This reduction is driven by reductions in performance for both DHB and NGO provided services, though DHB provided AOD services did meet the target in the latest reporting period. Performance against eight-week wait time metrics is equivalent or better than national averages for all metrics.
Mental Health (Provider Arm) % people seen <8 weeks.							
0-19 yrs	96%	96%	95%	**96%**	91%	✓	
20-64 yrs	96%	96%	95%	**95%**	94%	✓	
Addictions (Provider Arm and NGO) % people seen <8 weeks.							
0-19 yrs	98%	97%	95%	**90%**	96%	✗	
20-64 yrs	97%	94%	95%	**96%**	94%	✓	

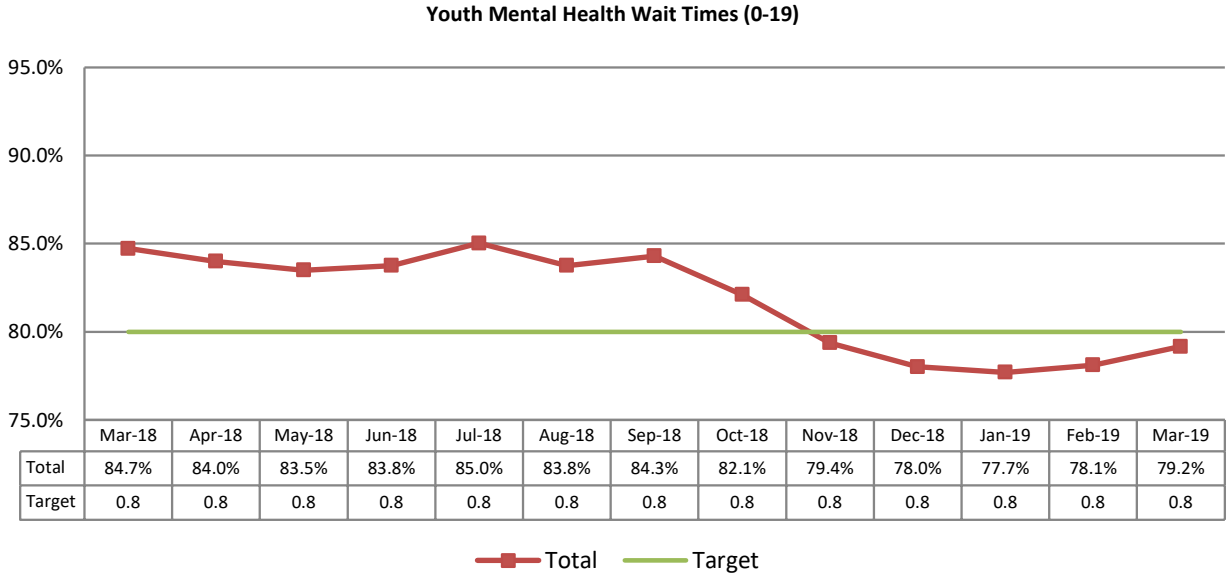
39. See comments. This needs to be redefined in the 19/20 financial year.

Main measures of performance	Volumes						Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	2019 National Average	Achieved	
Output class 3 Maori youth (10-24) ED hospitalisations per 10,000 population resulting from deliberate self harm.	NA	NA	43.6	TBD	NA	NA	Over the 18/19 period, the MH101 youth workforce training initiative commenced with a view to improving early identification and referral of those at risk of self-harm. This will be evaluated in the new year with a view to determining whether this approach has been successful.
Output class 1 An increase in the number of Maori youth seen within Primary Mental Health.	NA	NA	10% increase	TBD	NA	NA	As above – this initiative focuses on early identification in areas that most commonly interact with youth. This is a multiagency focus.
Output class 1 An increase in chlamydia testing coverage for 15-24 years olds.	NA	NA	5% increase	TBD	NA	NA	As a part of the SLM for young people we are investigating the development of self-testing chlamydia kits to improve coverage. A prototype has been developed specifically targetted in remote or rural areas. Work of 19/20 will focus on the kits being accessible for youth.

Three week alcohol and other drug wait times for youth explained.

The three-week and eight-week wait times measures provide key insight into service provider efficiency and the demand on services. Youth alcohol and other drug (AOD) services have been selected as the area of focus for this explained session as it aligns with the Governments Policy Priorities (PP8) and with one of the key demographics of focus within BOPDHB's Strategic Health Services Plan (SHSP) – vulnerable youth.

BOPDHB has achieved three-week AOD wait times for youth over a long period of time – over 80% of new youth AOD clients have been seen within three weeks in 2017-18 and 2018-19 firsts 8 months reporting periods. However, as can be observed in the graph below, performance against the three-week wait time metric for youth AOD services has been steadily trending downwards over the last six reporting periods. While BOPDHB has meeting targets during the first eight months, there has been an increase in three-week wait time target results for youth AOD services in the BOPDHB region over the last twelve months, based on the reporting period ending 31 March 2019.



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total	84.7%	84.0%	83.5%	83.8%	85.0%	83.8%	84.3%	82.1%	79.4%	78.0%	77.7%	78.1%	79.2%
Target	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8

The reduction in three-week wait time performance has primarily been driven by an increase in three-week wait time performance for DHB provided AOD services. There have been significant challenges within provider arm mental health services over the last few months with a number of personnel changes; these changes inhibited performance against AOD wait time targets. Hence, the latest three-week youth AOD wait time result for DHB services has dropped to less than the target during the latest reporting period. NGO provided services achieved 83% against the three-week wait time target in the latest reporting period.

People receive prompt and appropriate acute and arranged care

Bay of Plenty DHB achieved over 90% of patients with a confirmed diagnosis of cancer received their first treatment within 62 days – which reflects the improvements made under some of the recent initiatives introduced within the cancer space at BOPDHB and the change in methodology for calculating this result.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 3 Percentage of patients admitted, discharged or transferred from an ED within six hours – Health Target.	95%	94%	95%	**93%**	✗	Performance against this target has dropped slightly, particularly in the last quarter of the year. The last 4 months saw an 8% growth in volume at Tauranga in comparison to previous year, and that combined with a high level of staff sick leave during that period, has impacted significantly on performance.
Output class 3 Focus area 4 – Acute Heart service 70% of high risk patients receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') – PP20.	89%	91%	70%	**93%**	✓	BOPDHB have achieved both acute coronary syndrome services targets in 2018/19. Reported results are based on the mean of the four quarterly results reported to the Ministry of Health as part of the IDP reporting process.
Output class 3 Focus area 4 – Acute heart service Over 90% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days – PP20.	99%	97%	90%	**99%**	✓	Performance against both acute coronary syndrome services metrics is similar to what has been achieved in the previous two years.

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 3 Standardised Elective Inpatient length of stay (LOS) reduced (days) – OS3(i).	1.55	1.53	1.47	**1.52**	✗	ALOS for both admission types has seen further reductions, however, both remain slightly above target. The Acute Flow Programme continues across Tauranga and Whakatāne facilities and opportunities to improve both patient flow and patient models of care are continuing to be a focus. In spite of significant population growth and ED presentations, we are maintaining our hospital bed occupancy levels at/or below the levels we used 8 years ago.
Output class 3 Standardised Acute Inpatient length of stay (LOS) reduced (days) – OS3(ii).	2.64	2.55	2.30	**2.53**	✗	
Output class 3 Part A Faster Cancer Treatment – 62-day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 62 days of decision-to-treat- see Health Target.	79%	94%	90%	**92%**	✓	BOPDHB achieved the FCT target in all four quarters in 2018/2019, the 92% result representing a weighted average of these quarterly results. BOPDHB has regularly been in the top five DHBs in the country for this metric in 2018/2019, with the Q4 2018/2019 result (91.5%) dropping to 6th nationally
Output class 3 Part B Faster Cancer Treatment – 31 day indicator. Patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat – PP30.	93%	90%	85%	**88%**	✓	The figure reported is from the latest (Q4 2018/2019) policy priority data – this covers records submitted between January and June 2019. BOPDHB achieved the target, with 447 records (of 519 total) being addressed within the 31 day timeframe. BOPDHB's result was just under 1% better than the national average during Q4, which saw BOPDHB ranked 12th nationally for this metric. The data supplied is not broken down by ethnicity.
Output class 1-4 Percentage of survey responses for Maori patients completing the Primary Care patient experience survey.	NA	13.5	>15%	**13%**	✗	To achieve ongoing impact in this area, the system level measures working group identified the need for initiatives to be consumer led with sound co-design principles. We are in the process of transferring leadership to the consumer council and determining the support they will require to lead initiatives.

Services provided or funded by the BOPDHB contribute to the transfer of knowledge and skills to family/whānau to enable self-management

Main measures of performance	Volumes					Comments
	2017 Actual	2018 Actual	2019 Target	2019 Actual	Achieved	
Output class 2 Number of registered users of the client health information portal (CHIP).[40]	5,695	6,440	6,500	**3,231**	NA	There are two instances of CHIP in use within the BOPDHB region: The secondary care view of CHIP and for primary care use. The secondary care instance of CHIP has 3,183 users currently accessing the portal. The primary instance has 48 practices currently accessing the portal.
Output class 4 Percentage of long-term conditions clients reporting an improved quality of life.	In developent	In development	TBC	-	NA	This metric is not feasible. The means to monitor performance against this metric, such as a patient survey, is still in development.

40. During the current financial year, data has been cleaning for the transition to regional systems, therefore all users without access in 90 days were deactivated/unregistered. Current measure is based on users in the last 90 days as at 6th Aug 2019.

Statement of Responsibility for the Year Ended 30 June 2019

The Board and Management of the BOPDHB accept responsibility for the preparation of the financial statements and the judgements used in them.

The Board and Management of the BOPDHB accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of the financial reporting and non-financial reporting.

In the opinion of the Board and Management of the BOPDHB, the financial statements for the year ended 30 June 2019 fairly reflect the financial position and operations of the BOPDHB.

Sally Webb

Board Chair

Helen Mason

Chief Executive

Owen Wallace

General Manager
Corporate Services

07

Financial Statements
Pūrongo Pūtea

Statement of Comprehensive Revenue and Expense for the Year Ended 30 June 2019

	Note	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
Income				
Crown revenue	4	**831,908**	**824,490**	783,259
Finance income	9	**1,229**	**810**	1,249
Other revenue	5	**7,594**	**8,125**	11,605
Total income		**840,731**	**833,425**	796,113
Less expenditure				
Employee expenses	7	**279,019**	**269,610**	256,592
Depreciation and amortisation expense	14,15	**21,028**	**22,108**	20,819
Outsourced services		**43,732**	**38,261**	40,425
Clinical supplies		**66,653**	**61,840**	63,240
Provider payments		**389,771**	**396,862**	372,382
Non-clinical expenses	8	**41,701**	**38,962**	36,509
Finance costs	9	**16,322**	**16,258**	16,040
Total operating expenditure		**858,226**	**843,901**	806,007
Share of associates/joint ventures surplus/(deficit)	16,17	**130**	**-**	38
Surplus/(deficit)		**(17,365)**	**(10,476)**	(9,856)
Other comprehensive revenue and expense				
Items that will not be reclassified to surplus/(deficit)				
Gains/(Losses) on property revaluations		**-**	**-**	16,103
Total other comprehensive income		**-**	**-**	16,103
Total comprehensive income		**(17,365)**	**(10,476)**	6,247

The above statement of comprehensive revenue and expenses should be read in conjunction with the accompanying notes.

Statement of Financial Position as at 30 June 2019

	Note	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
ASSETS				
Current assets				
Cash and cash equivalents	10	**21,277**	**11,076**	21,970
Trade and other receivables	12	**31,400**	**29,408**	28,059
Inventories	13	**3,086**	**3,175**	2,904
Total current assets		**55,763**	**43,659**	52,933
Non-current assets				
Investments in associates and joint ventures	16,17	**503**	**680**	375
Other investments		**304**	**-**	305
Property, plant and equipment	14	**284,582**	**291,324**	293,754
Intangible assets	15	**12,034**	**13,097**	10,632
Total non-current assets		**297,423**	**305,101**	305,066
Total assets		**353,186**	**348,760**	357,999
LIABILITIES				
Current liabilities				
Trade and other payables	19	**52,335**	**46,674**	44,053
Employee benefits liabilities	18	**35,594**	**35,278**	36,665
Provisions	20	**4,832**	**-**	-
Total current liabilities		**92,761**	**81,952**	80,718
Non-current liabilities				
Employee benefits liabilities	18	**1,110**	**601**	601
Total non-current liabilities		**1,110**	**601**	601
Total liabilities		**93,871**	**82,553**	81,319
Net assets		**259,315**	**266,207**	276,680
EQUITY				
Crown equity		**223,271**	**223,269**	223,271
Accumulated funds		**(24,987)**	**(18,093)**	(7,622)
Property revaluation reserve		**61,031**	**61,031**	61,031
Total equity		**259,315**	**266,207**	276,680
Total equity		**259,315**	**266,207**	276,680

The above statement of financial position should be read in conjunction with the accompanying notes.

Sally Webb

Board Chair
31 October 2019

Ron Scott

Deputy Chair
31 October 2019

Statement of Changes in Net Assets/Equity for the Year Ended 30 June 2019

	Crown equity $'000	Property revaluation reserve $'000	Retained earnings $'000	Total $'000
Balance as at 1 July 2018	223,271	61,031	(7,622)	276,680
Comprehensive revenue and expense				
Surplus or deficit for the year	-	-	(17,365)	(17,365)
Gain on the revaluation of land and buildings	-	-	-	-
Total comprehensive revenue and expense	-	-	(17,365)	(17,365)
Transactions with owners				
Contribution from the Crown	-	-	-	-
Total transactions with owners	-	-	-	-
Balance as at 30 June 2019	223,271	61,031	(24,987)	259,315

	Crown equity $'000	Property revaluation reserve $'000	Retained earnings $'000	Total $'000
Balance as at 1 July 2017	223,271	43,368	3,794	270,433
Comprehensive revenue and expense				
Surplus or deficit for the year	-	-	(9,856)	(9,856)
Gain on the revaluation of land and buildings	-	16,103	-	16,103
Transfer on disposal of land and buildings	-	1,560	(1,560)	-
Total other comprehensive income, net of tax	-	17,663	(1,560)	16,103
Total comprehensive revenue and expense	-	17,663	(11,416)	6,247
Transactions with owners				
Contribution from the Crown	-	-	-	-
Total transactions with owners	-	-	-	-
Balance as at 30 June 2018	223,271	61,031	(7,622)	276,680

The above statement of changes in net assets/equity should be read in conjunction with the accompanying notes.

Statement of Cash Flows for the Year Ended 30 June 2019

	Note	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
Cash flows from operating activities				
Receipts from Crown and patients		**836,789**	**831,766**	802,289
Interest received		**1,380**	**811**	1,197
GST (net)		**(852)**	**(100)**	999
Payments to suppliers		**(531,557)**	**(534,090)**	(514,640)
Payments to employees		**(275,156)**	**(270,924)**	(250,940)
Capital charge paid		**(16,294)**	**(16,211)**	(15,994)
Net cash flow from operating activities	11	**14,310**	**11,252**	22,911
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		**9**	**-**	-
Purchase of property, plant and equipment		**(10,383)**	**(22,149)**	(8,634)
Purchase of intangible assets		**(4,138)**	**-**	(7,016)
Acquisition of investments		**(491)**	**-**	-
Net cash flow from investing activities		**(15,003)**	**(22,149)**	(15,650)
Cash flows from financing activities				
Net cash flow from financing activities		**-**	**-**	-
Net increase/(decrease) in cash and cash equivalents		**(693)**	**(10,897)**	7,261
Cash and cash equivalents at the beginning of the year	10	**21,970**	**21,970**	14,709
Cash, cash equivalents, and bank overdrafts at the end of the year	10	**21,277**	**11,073**	21,970

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

1. Statement of accounting policies for the year ended 30 June 2019

1.1 Reporting entity

Bay of Plenty District Health Board (DHB) is a District Health Board established by the New Zealand Public Health and Disability Act 2000. Bay of Plenty DHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown, and is domiciled and operates in New Zealand. Bay of Plenty DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 (NZ PHD), the Financial Reporting Act 2013, the Public Finance Act 1989 and the Crown Entities Act 2004 (CEA).

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

The financial statements of Bay of Plenty DHB incorporate Bay of Plenty DHB and Bay of Plenty DHB's interest in associates and joint ventures. Bay of Plenty DHB is required under the CEA to prepare consolidated financial statements in relation to the economic entity for each financial year.

Consolidated financial statements for the economic entity have not been prepared due to the small size of the controlled entities which means that the controlling entity and economic entity amounts are not materially different. The following are the Bay of Plenty DHB controlled entities which have not been consolidated in the financial statements:

Tauranga Community Health Trust (Inc.) and Whakatāne Community Health Trust (Inc.) are charitable trusts which administer donations received which are tagged for specific use within the Bay of Plenty DHB. The Bay of Plenty DHB has no financial interest in either of these trusts. The trusts are controlled by the Bay of Plenty DHB in accordance with PS PBE IPSAS 6 as the Bay of Plenty DHB is able to appoint the majority of the Trustees of the Charitable Trusts. The objective for which the Charitable Trusts are established is entirely charitable.

Bay of Plenty DHB's activities involve funding and delivering health and disability services and mental health services in a variety of ways to the community.

The financial statements were authorised for issue by Bay of Plenty DHB on 31/10/2019.

Going Concern Assumption

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

(i) Operating and Cash flow forecast

The Board has considered the current year's deficit of $17.4m and the forecasted deficit of $10.5m for next year together with forecast information relating to operational viability and cash flow requirements as well as the significant proposed capital spend in the future period. The Board expects that it will be able to use its working capital facility and access to additional funding, together with making adjustments to its capital spend to address the operational viability and cash flow for the coming year whilst still meeting expected patient demand and funding the required resources to deliver the relevant clinical services to meet such demand.

(ii) Borrowing covenants and forecast borrowing requirements

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

(iii) Letter of comfort

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

2. Summary of significant accounting policies

2.1 Basis of preparation

The financial statements have been prepared on the going concern basis, and the accounting policies have been applied consistently throughout the year.

Statement of compliance

These financial statements, including the comparatives, have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with Public Sector Tier 1 PBE Accounting Standards (PS PBE IPSAS). These standards are based on International Public Sector Accounting Standards (IPSAS).

Measurement base

The financial statements have been prepared on a historical cost basis, except that land and buildings are stated at their fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($'000) unless otherwise stated. The functional currency of the Bay of Plenty DHB is New Zealand dollars.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

PBE IFRS 9 Financial Instruments

(Effective 1 January 2022, early adoption permitted).

The Bay of Plenty DHB has early adopted the standard for its financial statements for the year ended 30 June 2019. The DHB has applied PBE IFRS 9 retrospectively, but has elected not to restate comparative information. As a result, the comparative information provided continues to be accounted for in accordance with the DHB's previous accounting policy. On 1 July 2018, certain assets have been reclassified from 'Loans and receivables' to 'Financial assets at amortised cost'. (refer to note 22).

The standard also introduced a new expected credit losses model that replaced the incurred loss impairment model used in PBE IPSAS 29 for calculating the provision for doubtful debts. The DHB has applied this expected credit losses model to the loans advanced however the impact of this is not material to the DHB.

Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

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

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

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the Bay of Plenty DHB, are:

- **PBE IPSAS 34: Separate financial statements** (Effective date: periods beginning on or after 1 January 2019).

  Locates in one standard the accounting and disclosure requirements for investments in controlled entities, joint ventures and associates when an entity prepares separate financial statements with no significant changes to the underlying requirements.

- **PBE IPSAS 35: Consolidated financial statements** (Effective date: periods beginning on or after 1 January 2019).

  Introduces a new definition of control requiring both power and exposure to variable benefits and includes more guidance on assessing control (including additional guidance on substantive and protective rights). Provides an exception from consolidation for investment entities. This exception also applies to the parent of an investment entity that is not itself an investment entity (which is different from the equivalent exception in the for profit standards). Includes guidance on principal/agent relationships and factors to consider when determining whether an investor has control or is acting as an agent. Adds guidance on network and partner agreements. Incorporates guidance from PBE IPSAS 6 on the application of consistent accounting policies when consolidating for profit entities into a PBE group.

- **PBE IPSAS 36: Investments in associates and joint ventures** (Effective date: periods beginning on or after 1 January 2019).

  Requires the use of the equity method in accounting for all interests in associates and joint ventures (eliminating the option of using proportionate consolidation for jointly controlled entities).

- **PBE IPSAS 37: Joint arrangements** (Effective date: periods beginning on or after 1 January 2019).
  Establishes two 'types' of joint arrangement: (i) joint operations; and (ii) joint ventures based on whether the investor has rights to the assets and obligations for the liabilities of the joint arrangement or rights to the net assets of the joint arrangement.

- **PBE IPSAS 38: Disclosure of interests in other entities** (Effective date: periods beginning on or after 1 January 2019).
  Establishes two 'types' of joint arrangement: (i) joint

operations; and (ii) joint ventures based on whether the investor has rights to the assets and obligations for the liabilities of the joint arrangement or rights to the net assets of the joint arrangement.

- **PBE IPSAS 39: Employee benefits** (Effective date: periods beginning on or after 1 January 2019).
  PBE IPSAS 39 replaces PBE IPSAS 25, which is substantially converged with NZ IAS 19. The main changes relate to the removal of options for the recognition and presentation of actuarial gains and losses arising from defined benefit plans and replacing interest cost and expected return on plan assets with a single net interest component.
- **PBE IPSAS 48: Service Performance Reporting** (Effective date: periods beginning on or after 1 January 2021).
  The objective of this Standard is to establish principles and requirements for an entity to present service performance information that is useful for accountability and decision-making purposes in a general purpose financial report.

The Bay of Plenty DHB has not yet assessed the effects of these new standards.

Critical accounting estimates

The preparation of financial statements requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Bay of Plenty DHB's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in note 3.

2.2 Reclassification of comparative figures

Certain comparative figures have been reclassified to be on a consistent basis as the current year figures.

2.3 Non-derivative financial instruments

Non derivative financial instruments include cash and cash equivalents, receivables (excluding prepayments), investment in associates, investment in joint ventures, payables, accruals and borrowings. These are recognised initially at fair value plus or minus any directly attributable transaction costs.

A financial instrument is recognised if the Bay of Plenty DHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the Bay of Plenty DHB's contractual rights to the cash flows from the financial assets expire or if the Bay of Plenty DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, i.e., the date the Bay of Plenty DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the Bay of Plenty DHB's obligations specified in the contract expire or are discharged or cancelled.

Subsequent to initial recognition, non derivative financial instruments are recognised as described below :

2.3.1 Financial assets

Cash and cash equivalents, receivables and investments in JV & associates under 2.4, 2.5, 2.9 and 2.10 respectively.

2.3.2 Financial liabilities

Payables and accruals are described under 2.11.

2.4 Cash and cash equivalents

Cash and cash equivalents include cash on hand and deposits held at call with banks with original maturities of three months or less.

Bank overdrafts are shown within interest bearing liabilities in current liabilities in the statement of financial position.

Bank overdrafts that are repayable on demand and form an integral part of the Bay of Plenty DHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

2.5 Trade and other receivables

Short term debtors and other receivables are recorded at the amount due, less an allowance for expected credit losses. The DHB applies the simplified expected credit loss model of recognising the lifetime expected credit losses for receivables.

In measuring expected credit losses, short term debtors and other receivables have been assessed on a collective basis as they possess shared credit risk characteristics.

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

Previous accounting policy for impairment of trade and other receivables.

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

The expected credit loss rates for receivables at 30 June 2019 and 1 July 2018 are based on the payment profile of revenue on credit over the prior 2 years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

2.6 Inventory

Inventories acquired through non exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the weighted average cost method) and net realisable value.

The amount of any write down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write down.

2.7 Property, plant and equipment

Property, plant, and equipment consist of:

(i) Land
(ii) Buildings
(iii) Plant, equipment and vehicles
(iv) Leasehold improvements
(v) Work in progress

Revaluation

Land and buildings are revalued by an independent valuer with sufficient regularity to ensure that their carrying amount does not differ materially from fair value and at least every three years.

Revaluations of land and buildings are accounted for on a class of asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset if, and only if, it is probable that future economic benefits or service potential associated with the item will flow to the Bay of Plenty DHB and the cost of the item can be measured reliably.

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

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non exchange transaction, it is recognised at its fair value as at the date of acquisition.

Depreciation

Depreciation is provided on a straight line basis on all property, plant, and equipment other than land, at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Class of property, plant and equipment	Estimated useful life
Buildings	2 to 92 years
Leasehold improvements	2 to 50 years
Plant, equipment and vehicles	1 to 25 years

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year end.

Freehold land and work in progress are not depreciated.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Bay of Plenty DHB and the cost of the item can be measured reliably.

Disposals

Realised gains and losses on disposal of property, plant and equipment are recognised in the statement of comprehensive revenue and expense. Any amounts included in property, plant and equipment revaluation reserve in respect of the disposed property, plant and equipment are transferred from the property revaluation reserve to accumulated funds.

2.8 Intangible assets

Intangible assets are initially recorded at cost. Where acquired in a business combination, the cost is the fair value at the date of acquisition. The cost of an internally generated intangible asset represents expenditure incurred in the development phase.

Subsequent to initial recognition, intangible assets with finite useful lives are recorded at cost, less any amortisation and impairment losses and are reviewed annually for impairment losses. Amortisation of intangible assets is provided on a straight line basis that will write off the cost of the intangible asset to estimated residual value over their useful lives. Assets with indefinite useful lives are not amortised but are tested, at least annually, for impairment and are carried at cost less accumulated impairment losses.

Where an intangible asset's recoverable amount is less than its carrying amount, it will be reported at its recoverable amount and an impairment loss will be recognised. Impairment losses resulting from impairment are reported in statement of comprehensive revenue and expense.

Realised gains and losses arising from the disposal of intangible assets are recognised in statement of

comprehensive revenue and expense in the year in which the disposal occurs.

Intangible assets comprise:

Computer software

Acquired computer software licences are capitalised based on the costs incurred to acquire and bring to use the software. Costs are amortised using the straight line method over their estimated useful lives.

Costs associated with maintaining computer software programmes are recognised as an expense when incurred.

Costs directly associated with the development of identifiable and unique software products are recognised as an asset.

Staff training costs are recognised as an expense when incurred.

Finance Procurement Supply Chain, including National Oracle Solution (NOS)

The Finance Procurement Supply Chain (FPSC), which includes the Finance Procurement and Information Management (FPIM), is a national initiative funded by DHB's and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Bay of Plenty DHB holds an asset at the cost of capital invested by Bay of Plenty DHB in the FPSC programme. This investment represents the right to access the FPSC assets and is considered to have an indefinite life. DHB's have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on charging of depreciation and amortisation on the assets to the DHB's will be used to, and is sufficient to, main the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each period is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Class of intangible asset	Estimated useful life
Software	2 to 15 years

2.9 Investments in associates

The Bay of Plenty DHB's associate investments are accounted for using the equity method.

An associate is an entity over which the Bay of Plenty DHB has significant influence, and that is neither a controlled entity nor an interest in a joint venture.

Under the equity method, the investment in an associate is initially recognised at cost, and the carrying amount is increased or decreased to recognise the Bay of Plenty DHB's share of surplus or deficit of the investee after the date of acquisition. The Bay of Plenty DHB's share of the surplus or deficit of the associate is recognised in the Bay of Plenty DHB's statement of comprehensive revenue and expenses. Distributions received from an associate reduce the carrying amount of the investment in the Bay of Plenty DHB's statement of financial position.

If the Bay of Plenty DHB's share of deficits of an associate equals or exceeds its interest in the associate, the Bay of Plenty DHB discontinues recognising its share of further deficits, unless it has incurred legal or constructive obligations or made payments on behalf of the associate.

If the associate subsequently reports surpluses, the Bay of Plenty DHB resumes recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

The surplus or deficits resulting from transactions between the Bay of Plenty DHB and the associate are eliminated to the extent of the Bay of Plenty's interest in the associate or joint venture.

2.10 Joint ventures

The interest in a joint venture is accounted for in the financial statements using the equity method and is carried at cost. Under the equity method, the share of the profits or losses of the joint venture is recognised in the statement of comprehensive revenue and expense, and the share of movements in reserves is recognised in reserves in the statement of financial position.

2.11 Trade and other payables

Short term creditors and other payables are recorded at amortised cost.

2.12 Employee entitlements

Short term employee entitlements

Employee benefits expected to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to, but not yet taken at balance date, and sick leave.

Long term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the year in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis.

The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, vested long service leave, non vested long service leave and retirement gratuities expected to be settled within 12 months of balance date, are classified as a current liability. All other employee entitlements are classified as a non current liability.

(i) Defined contribution schemes
Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit when incurred.

(ii) Wages and salaries, annual leave, sick leave and medical education leave
Liabilities for wages and salaries, including non monetary benefits, annual leave and accumulating sick leave expected to be settled within 12 months of the reporting date are recognised in other payables in respect of employees' services up to the reporting date and are measured at the amounts expected to be paid when the liabilities are settled. Liabilities for non accumulating sick leave are recognised when the leave is taken and measured at the rates paid or payable.

(iii) Long service leave, sabbatical leave and retirement gratuities
The liability for long service leave, sabbatical leave and retirement gratuities are recognised in the provision for employee benefits and measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date using the projected unit credit method. Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

2.13 Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

2.14 Equity

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

- Crown equity.
- Accumulated funds.
- Property revaluation reserves.

Property revaluation reserves

This reserve relates to the revaluation of land and buildings to fair value after initial recognition.

2.15 Income tax

Bay of Plenty DHB is a crown entity under the NZ PHD and is exempt from income tax under section CW38 of the Income Tax Act 2007.

2.16 Goods and services tax

All items in the financial statements are stated exclusive of goods and services tax (GST), except for receivables and payables, which are presented on a GST inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

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

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

2.17 Revenue

Revenue is measured at fair value.

The specific accounting policies for significant revenue items are explained below:

(i) Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

(ii) ACC contracted revenue

ACC contract revenue is recognised when eligible services are provided and any contract conditions have been fulfilled.

(iii) Goods sold and services rendered

Revenue from goods sold is recognised when Bay of Plenty DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Bay of Plenty DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Bay of Plenty DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Bay of Plenty DHB.

(iv) Revenue relating to service contracts

Bay of Plenty DHB receives revenue for service contracts on an invoice or payment schedule basis. Bay of Plenty DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Bay of Plenty DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

(v) Financing revenue

Interest received and receivable on funds invested are calculated using the effective interest rate method and are recognised in the surplus or deficit.

(vi) Inter District Flow Revenue

Inter District Flow revenue is received for activity undertaken by Bay of Plenty DHB for patients domiciled in other DHB regions. Receipts are based on an agreed level of production and are subject to wash up rules if actual volumes are different to agreed volumes.

2.18 Leases

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

2.19 Financing costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, are recognised in the surplus or deficit.

The interest expense component of finance lease payments is recognised in the surplus or deficit using the effective interest rate method.

2.20 Budget figures

The budget figures are made up of Bay of Plenty DHB's Annual Plan which was tabled in Parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Bay of Plenty DHB in preparing these financial statements.

2.21 Cost allocation

Bay of Plenty DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Direct costs are charged directly to output classes. Direct costs are those costs directly attributable to an output class. Indirect costs are charged to output classes based on cost drivers and related activity and usage information. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

3. Critical accounting estimates and judgements

Critical accounting estimates and assumptions

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

Fair value of land and buildings

Land and buildings are carried at fair value as determined by an independent valuer, which is based on market based evidence. The fair value of buildings is determined based on optimised depreciated replacement cost where a number of assumptions are applied in determining the fair value of land and buildings. Where a revaluation is not undertaken in a financial year, Bay of Plenty DHB undertake an assessment at each financial reporting date to ensure the fair value of property, plant and equipment does not materially differ to the carrying values of those assets.

Useful lives of property, plant and equipment

The Bay of Plenty DHB reviews the estimated useful lives of property, plant and equipment at the end of each annual reporting period. In addition to this, every three years the land, buildings and infrastructure are re valued by an independent valuer, estimating the remaining life of these assets thus setting the appropriate annual depreciation to reflect this.

Impairment of intangible assets

The Bay of Plenty DHB assesses intangible assets that are not yet available for use and indefinite life intangible assets (FPSC/FPIM) at the end of each annual reporting period. These assets have been tested for impairment by comparing the carrying amount of the intangible assets to its depreciated replacement cost (DRC). The carrying value intangible assets, including any accumulated impairment losses, are disclosed in note 15.

Estimation of Employee Entitlement Accruals

The liability relating to back pay and long term employee benefits (long service leave, gratuities and sabbatical leave) is based on a number of assumptions in relation to the estimated length of service, the timing of release of the obligation and the rate at which the obligation will be paid to be applied in determining the present value. If any of these factors changed significantly, the actual outcome could be materially different to the estimate provided in the financial statements. The carrying value of the accruals has been disclosed in note 18.

Compliance with Holidays Act 2003

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

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability. The BOPDHB has included an estimated liability in note 20.

Other Provision

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in “finance costs”.

4. Crown revenue

	Actual 2019 $'000	Actual 2018 $'000
Crown appropriation revenue	**770,381**	723,263
Inter-district patient inflows	**19,575**	18,353
Crown non appropriation revenue	**41,952**	41,643
Total Crown Revenue	**831,908**	783,259

The appropriation revenue received by the DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act. Performance against this appropriation is reported in the Statement of Performance.

5. Other revenue

	Actual 2019 $'000	Actual 2018 $'000
Donations and bequests received	**200**	116
Other revenue	**6,774**	10,655
Rental income from investment properties	**620**	834
	7,594	11,605

6. Exchange versus non exchange revenue

	Actual 2019 $'000	Actual 2018 $'000
Exchange revenue	**51,904**	45,084
Non-exchange revenue	**788,827**	751,029
	840,731	796,113

7. Employee benefit costs

	Actual 2019 $'000	Actual 2018 $'000
Salaries and wages	**270,987**	243,220
Defined contribution plan employer contributions	**8,594**	7,666
Increase/(decrease) in employee entitlements/liabilities	**(562)**	5,706
Total personnel costs	**279,019**	256,592

8. Non clinical expenses

	Actual 2019 $'000	Actual 2018 $'000
Fees to Deloitte for financial statements audit	**175**	171
ACC partnership programme	**481**	380
Impairment of receivables	**250**	111
Operating lease expenses	**2,286**	2,214
Infrastructure servicing costs and other sundry expenses	**36,650**	33,011
Directors' fees	**289**	292
Intangible asset impairment	**1,542**	255
Koha	**37**	27
Loss/(gain) on sale of assets	**(9)**	48
Total other expenses	**41,701**	36,509

9. Finance income and finance costs

	Actual 2019 $'000	Actual 2018 $'000
Finance income		
Interest income	**1,229**	1,249
Total finance income	**1,229**	1,249
Finance costs		
Interest expense	**11**	-
Bank charges	**17**	46
Capital charge	**16,294**	15,994
Total finance costs	**16,322**	16,040
Net finance costs	**15,093**	14,791

The Bay of Plenty DHB pays a six monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance. The capital charge rate for the period ended 30 June 2019 was 6% (2018: 6%).

10. Cash and cash equivalents

	Actual 2019 $'000	Actual 2018 $'000
Cash at bank and in hand	**6**	6
Call deposits	**21,271**	21,964
Total cash and cash equivalents	**21,277**	21,970

Working capital facility

Bay of Plenty DHB is a party to the DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZ HPL) and the participating DHBs. This agreement enables NZ HPL to sweep DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a credit facility with NZ HPL, which will incur interest at on-call interest rates received by NZ HPL plus an administrative margin. The maximum credit facility that is available to any DHB is the value of one month's planned Provider Arm Crown funding, inclusive of GST.

11. Reconciliation of net surplus/(deficit) to net cash flow from operating activities

	Actual 2019 $'000	Actual 2018 $'000
Surplus/(deficit)	**(17,365)**	(9,856)
Add/(less) non-cash items		
Share of associates/joint ventures surplus	**(130)**	(38)
Share of other investment surplus	**(4)**	(68)
Depreciation and amortisation expense	**21,028**	20,819
Impairment on intangibles	**1,542**	255
Total non-cash items	**22,436**	20,968
Add/(less) items classified as investing or financing activities		
(Gains)/losses on disposal of property, plant, and equipment	**(9)**	(48)
Total items classified as investing or financing activities	**(9)**	(48)
Add/(less) movements in working capital items		
(Increase)/Decrease in receivables	**(3,341)**	7,516
(Increase)/Decrease in inventory	**(182)**	(89)
Increase/(Decrease) in payables and provisions	**12,771**	4,420
Net movement in working capital items	**9,248**	11,847
Net cash inflow/(outflow) from operating activities	**14,310**	22,911

12. Trade and other receivables

	Actual 2019 $'000	Actual 2018 $'000
Trade receivables from non-related parties	**691**	1,140
Expected credit loss	**(296)**	(394)
Amounts due from related parties	**921**	623
Crown and Ministry of Health receivables	**27,505**	21,602
Accrued income	**1,412**	3,656
Prepayments	**1,167**	1,432
Total debtors and other receivables	**31,400**	28,059
Receivables from exchange transactions	**10,161**	13,451
Receivables from non-exchange transactions	**21,239**	14,608
	31,400	28,059

All receivables greater than 30 days in age are considered to be past due.

Due to the large number of other receivables, the assessment for expected credit losses is performed on a collective basis. These debtors were grouped into commercial, patients and Crown entities. The credit losses were based on an analysis of past collection history and write-offs.

Movements in the allowance for credit losses are as follows:

	Actual 2019 $'000	Actual 2018 $'000
At 1 July	**(394)**	(256)
Movement in expected credit losses on recognised receivables	**98**	(138)
At 30 June	**(296)**	(394)

13. Inventories

	Actual 2019 $'000	Actual 2018 $'000
Central stores	**1,791**	1,723
Pharmaceuticals	**965**	898
Other supplies	**330**	283
	3,086	2,904

Inventories are recognised at their historical cost. Inventories recognised in the profit or loss amounted to $33,684,220 (2018: $29,319,870).

No inventories are pledged as security for liabilities (2018: nil). However, some inventories are subject to retention of title clauses.

14. Property, plant and equipment

Cost/valuation	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2017	**13,338**	**262,415**	**9,865**	**84,531**	**3,778**	**373,927**
Revaluation surplus	1,260	(19,437)	-	-	-	(18,177)
Additions	7	4,975	-	3,628	1,777	10,387
Disposals	-	-	-	(15,534)	-	(15,534)
Transfers	-	5,934	(5,934)	836	(1,759)	(923)
Balance as at 30 June 2018	**14,605**	**253,887**	**3,931**	**73,461**	**3,796**	**349,680**

	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2018	**14,605**	**253,887**	**3,931**	**73,461**	**3,796**	**349,680**
Elimination on revaluation	-	-	-	-	-	-
Additions	-	3,793	1,037	5,838	9,563	20,231
Disposals	-	-	-	(129)	-	(129)
Capitalised	-	-	-	-	(9,635)	(9,635)
Transfers	-	4	-	(5)	(223)	(224)
Balance as at 30 June 2019	**14,605**	**257,684**	**4,968**	**79,165**	**3,501**	**359,923**

14. Property, plant and equipment (continued)

Accumulated depreciaton

	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2017	**-**	**(22,401)**	**(1,897)**	**(59,200)**	**-**	**(83,498)**
Depreciation charge	-	(11,521)	-	(7,870)	-	(19,391)
Eliminaton on revaluation	-	34,280	-	-	-	34,280
Disposals	-	-	-	15,397	-	15,397
Transfers	-	(358)	358	(2,714)	-	(2,714)
Balance as at 30 June 2018	**-**	**-**	**(1,539)**	**(54,387)**	**-**	**(55,926)**

	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2018	**-**	**-**	**(1,539)**	**(54,387)**	**-**	**(55,926)**
Depreciation charge	-	(13,271)	(137)	(6,146)	-	(19,554)
Elimination on revaluation	-	-	-	-	-	-
Disposals	-	-	-	130	-	130
Transfers	-	19	(20)	10	-	9
Balance as at 30 June 2019	**-**	**(13,252)**	**(1,696)**	**(60,393)**	**-**	**(75,341)**
Net book value						
As at 30 June 2018	**14,605**	**253,887**	**2,392**	**19,074**	**3,796**	**293,754**
As at 30 June 2019	**14,605**	**244,432**	**3,272**	**18,772**	**3,501**	**284,582**

Restrictions

Bay of Plenty DHB does not have full title to crown land it occupies but transfer is arranged if and when land is sold.

Some of the land is subject to Waitangi Tribunal claims. Titles to land transferred from the Crown to Bay of Plenty DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

The disposal of certain properties may also be subject to the provision of section 40 of the Public Works Act 1981.

Revaluation

The most recent valuation of land and buildings was performed by an independent registered valuer, Peter Todd of Darroch Limited and a member of the New Zealand Institute of Valuers. The valuation is effective as at 30 June 2018. The board determines that the revaluation still reflects the best estimate value for land and building as at 30 June 2019.

Land is valued at fair value using market based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made for specific market factors such as nature, location and condition of the land.

Non specialised buildings (such as houses and medical clinics) are valued at fair value using market based evidence with reference to standard lease terms or comparable property.

Specialised buildings are valued at fair value using optimised depreciated replacement cost because no reliable market data is available for such buildings. Optimised depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

Significant estimates

Depreciated replacement cost is determined using a number of significant assumptions and estimates. Significant assumptions and estimates include:

- The optimised replacement cost of the asset is based on the modern equivalent asset cost ('MEA') with adjustments where appropriate due to technical obsolescence and over design or surplus capacity.

- The remaining useful life of assets has been estimated based on estimates by the DHB, discussions with maintenance staff, and manufacturer's recommended life. This has been complemented by physical inspections. These numbers are then adjusted based on a number of factors such as quality, utilisation of asset, obsolescence, legislative and environmental factors.
- Straight line depreciation has been applied to reflect the consumption of the asset.

The next valuation is expected to be completed as at 30 June 2021.

Impairment

No impairment losses have been recognised by Bay of Plenty DHB during 2019 in relation to property, plant and equipment.

15. Intangible assets

Gross carrying amount

	Computer software $'000	NZHPL (FPSC/NOS) $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2017	**10,425**	**3,021**	**-**	**13,446**
Additions	820	-	5,186	6,006
Impairment charge	-	(255)	-	(255)
Capitalised	-	-	(435)	(435)
Transfers	(836)	-	1,759	923
Balance as at 30 June 2018	**10,409**	**2,766**	**6,510**	**19,685**

	Computer software $'000	NZHPL (FPSC/NOS) $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2018	**10,409**	**2,766**	**6,510**	**19,685**
Additions	4,736	498	3,271	8,505
Impairment charge	-	(1,542)	-	(1,542)
Capitalised	-	-	(4,625)	(4,625)
Transfers	-	-	224	224
Balance as at 30 June 2019	**15,145**	**1,722**	**5,380**	**22,247**

Accumulated amortisation and impairment

	Computer software $'000	NZHPL (FPSC/NOS) $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2017	**(10,348)**	**-**	**-**	**(10,348)**
Amortisation charge for the year	(1,419)	-	-	(1,419)
Transfers	2,714	-	-	2,714
Balance as at 30 June 2018	**(9,053)**	**-**	**-**	**(9,053)**

	Computer software $'000	NZHPL (FPSC/NOS) $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2018	**(9,053)**	**-**	**-**	**(9,053)**
Amortisation charge for the year	(1,474)	-	-	(1,474)
Transfers	314	-	-	314
Balance as at 30 June 2019	**(10,213)**	**-**	**-**	**(10,213)**
Net book value				
As at 30 June 2018	**1,356**	**2,766**	**6,510**	**10,632**
As at 30 June 2019	**4,932**	**1,722**	**5,380**	**12,034**

16. Investments in associates

(a) General information

Name of entity	Principal activities	Interest held at 2019 %	Interest held at 2018 %	Balance date
Venturo Limited	**Provision of urology services**	**50**	50	30 June

(b) Summary of financial information on associate entities (100 per cent)

	Assets $'000	Liabilities $'000	Equity $'000	Revenue $'000	Profit/(loss) $'000
2019					
Venturo Limited	**1,053**	**934**	**119**	**6,490**	**350**
2018					
Venturo Limited	1,041	1,061	(20)	6,252	(15)

(c) Share of profit of associate entities

	Actual 2019 $'000	Actual 2018 $'000
Share of profit/(loss) before tax	**62**	(7)
Share of profit/(loss) after tax	62	(7)

(Note this includes final prior year wash-up amount)

(d) Investment in associate entities

	Actual 2019 $'000	Actual 2018 $'000
Carrying amount at the beginning of the year	**-**	46
Share of total recognised revenue and expenses	**62**	(7)
Other impairment losses	**(2)**	(39)
Carrying amount at the end of the year	**60**	-

(e) Share of associates' contingent liabilities and commitments

There are no contingent liabilities and commitments at year end (2018: nil).

The Bay of Plenty DHB is not jointly or severally liable for the contingent liabilities owing at balance date by the associates.

17. Investments in joint ventures

(a) General information

Name of entity	Principal activities	Interest held at 2019 %	Interest held at 2018 %	Balance date
HealthShare Limited	**Provision of health contracting services**	**20**	20	30 June

(b) Summary of financial information on joint ventures (100 per cent)

	Assets $'000	Liabilities $'000	Equity $'000	Revenue $'000	Profit/(loss) $'000
2019					
HealthShare Limited	**26,525**	**24,309**	**2,216**	**17,390**	**340**
2018					
HealthShare Limited	21,043	19,168	1,875	15,384	420

(c) Share of profit of joint ventures

	Actual 2019 $'000	Actual 2018 $'000
Share of profit/(loss) before tax	**68**	84
Tax expense	**-**	-
Share of profit/(loss) after tax	**68**	84

(d) Investment in joint ventures

	Actual 2019 $'000	Actual 2018 $'000
Carrying amount at the beginning of the year	**375**	291
Share of total recognised revenue and expenses	**68**	84
Carrying amount at the end of the year	**443**	375

(e) Share of joint ventures' contingent liabilities and commitments

There are no contingent liabilities and commitments at year end (2018: nil).

The Bay of Plenty DHB is not jointly or severally liable for the contingent liabilities owing at balance date by the joint venture.

18. Employee entitlements

	Actual 2019 $'000	Actual 2018 $'000
Current portion		
Annual leave	**27,686**	25,310
Long service leave	**1,492**	1,254
Salary and wages accrual	**6,416**	10,101
Total current portion	**35,594**	36,665
Non-current portion		
Long service leave	**1,110**	601
Total non-current portion	**1,110**	601
Total employee entitlements	**36,704**	37,266

19. Trade and other payables

	Actual 2019 $'000	Actual 2018 $'000
Trade payables	**6,197**	2,947
ACC levy payable	**350**	402
Accrued expenses	**37,236**	33,734
Amounts due to related parties	**1,016**	430
PAYE payable	**3,258**	2,189
Income received in advance	**970**	186
GST payable	**3,308**	4,165
Total creditors and other payables	**52,335**	44,053
Payables from exchange transactions	**45,419**	37,297
Payables from non-exchange transactions	**6,916**	6,756
	52,335	44,053

20. Provisions

Movements in provisions are as follows

	Other provisions $'000	Total $'000
Balance as at 1 July 2017	-	-
Additional provisions and increases to existing provisions	-	-
Balance as at 30 June 2018	-	-
Balance as at 1 July 2018	-	-
Additional provisions and increases to existing provisions	4,832	4,832
Balance as at 30 June 2019	4,832	4,832

21. Operating and capital commitments

Capital commitments

	Actual 2019 $'000	Actual 2018 $'000
Not later than one year	**1,031**	-
Later than one year and not later than five years	**-**	-
Later than five years	**-**	-
	1,031	-

Operating leases as lessee

The Bay of Plenty DHB leases property, plant, and equipment in the normal course of its business. The future aggregate minimum lease payments payable under non-cancellable operating leases are as follows:

	Actual 2019 $'000	Actual 2018 $'000
Not later than one year	**2,706**	2,574
Later than one year and not later than five years	**6,509**	5,785
Later than five years	**2,015**	770
Total non-cancellable operating leases	**11,230**	9,129

During the year ended 30 June 2019 $3,465,022 of operating leases were recognised as an expense in the profit or loss, split between clinical expenses and non-clinical expenses (2018: $3,404,592).

22. Financial instruments

Credit risk

In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, receivables, and forward foreign exchange contracts in an asset position. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

The Board places its cash and term investments with high quality financial institutions via a national DHB shared banking arrangement, facilitated by NZ Health Partnerships Limited.

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The MoH is the largest debtor (approximately 88%). It is assessed as a low risk and high quality entity due to being a government funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

The status of trade receivables at the reporting date is as follows:

The trade receivables balance is made up of trade receivables from non related parties and trade receivables from related parties.

Not past due	**1,808**	3,910	**(51)**	-
Past due 0-30 days	**460**	148	**(28)**	-
Past due 31-120 days	**288**	699	**(21)**	(40)
Past due 121-360 days	**2,022**	1,581	**(196)**	(354)
Total	**4,578**	6,338	**(296)**	(394)

	Actual	Actual
	2019	2018
	$'000	$'000
Trade receivables		
Gross trade receivables	**4,578**	6,338
Individual impairment	**(296)**	(394)
Net total trade receivables	**4,282**	5,944

Liquidity risk

Liquidity risk is the risk that the Bay of Plenty DHB will encounter difficulty raising funds to meet commitments as they fall due.

Liquidity risk represents the Bay of Plenty DHB's ability to meet its contractual obligations. The Bay of Plenty DHB evaluates its liquidity requirements on an ongoing basis. In general, the Bay of Plenty DHB generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and has credit lines in place to cover potential shortfalls.

In the previous year, cash and cash equivalents were classed as cash and cash equivalents, and Trade and other receivables classed as loans and receivables.

Contractual maturity analysis of financial liabilities

The table below analyses the Entity's financial liabilities into relevant maturity groupings based on the period remaining at balance date until the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate on the instrument at the balance date. The amounts disclosed are the contractual undiscounted cash flows.

	Less than 6 months	Between 6 months and 1 year	Between 1 and 2 years	Between 2 and 5 years	Over 5 years	Total contractual cash flows	Carrying Amount (assets)/ liabilities
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
2019							
Payables and accruals	48,057	-	-	-	-	48,057	48,057
Total financial liabilities	48,057	-	-	-	-	48,057	48,057
2018							
Payables and accruals	44,053	-	-	-	-	44,053	44,053

Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows:

	Financial assets at amortised cost $'000	Financial liabilities at amortised cost $'000	Carrying amount $'000	Fair value $'000
2019				
Cash and cash equivalents	21,277	-	21,277	21,277
Trade and other receivables	30,233	-	30,233	30,233
Trade and other payables	-	(48,057)	(48,057)	(48,057)
	51,510	**(48,057)**	**3,453**	**3,453**
2018				
Cash and cash equivalents	21,970	-	21,970	21,970
Trade and other receivables	28,059	-	28,059	28,059
Trade and other payables	-	(44,053)	(44,053)	(44,053)
	50,029	**(44,053)**	**5,976**	**5,976**

Capital management

The Bay of Plenty DHB's capital is its equity, which comprises Crown equity, reserves and retained earnings. Equity is represented by net assets. The Bay of Plenty DHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes.

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

23 Related party transactions

Ownership

The Bay of Plenty DHB is a Crown Entity in terms of the Crown Entities Act 2004, and is owned by the Crown.

Related party disclosures have not been made for transactions with related parties that are:

- within a normal supplier or client/recipient relationship,
- on terms and conditions no more or less favourable than those that are reasonable to expect that the Entity would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Related party transactions with subsidiaries, associates, or joint ventures.

Bay of Plenty DHB entered into no transactions with related parties on non commercial terms, and as a result there are no amounts outstanding or due at balance date (2018: nil).

Transactions with key management personnel.

Key management personnel compensation.

Total remuneration is included in employee benefit costs (note 7).

	Actual 2019 $'000	Actual 2018 $'000
Board members		
Full-time equivalent members	**11**	11
Remuneration	**301**	280
Executive Management Team, including the Chief Executive		
Full-time equivalent members	**6**	7
Remuneration	**1,849**	2,023
Total full-time equivalent personnel	**17**	18
Total key management personnel compensation	**2,150**	2,303

All remuneration paid to key management personnel is short term benefits and they did not receive any remuneration or compensation other than in their capacity as key management personnel (2018: nil).

The Bay of Plenty DHB did not provide any compensation at non arm's length terms to close family members of key management personnel during the year (2018: nil).

The Bay of Plenty DHB did not provide any loans to key management personnel or their close family members (2018: nil).

24 Segment information

Description of segments

The Bay of Plenty DHB operates in only one business segment, the funding and provision of health and disability services, throughout one geographical region (Bay of Plenty).

25 Contingencies

Compliance with the Holidays Act 2003

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

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

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

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

Notwithstanding, as at 30 June 2019, in preparing these financial statements, Bay of Plenty DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. BOPDHB has included an estimated liability in note 20 of $2,239,000.

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

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

26 Events occurring after the balance date

Description of segments

The investment with Venturo Limited was exited by Bay of Plenty DHB in July 2019.


TAURANGA

08

Audit Report

Pūrongo Aotake Pūtea

Deloitte.

INDEPENDENT AUDITOR'S REPORT

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

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

We have audited:

- the financial statements of the Health Board on pages 108 to 133, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 70 to 104.

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

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

- the financial statements of the Health Board on pages 108 to 133:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 70 to 104:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriations; and
        - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
    - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2019. This is the date at which our qualified opinion is expressed.

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The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we draw outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 25 on page 133, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $2.2 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

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

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

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1 on page 112 that outline the financial difficulties being experienced by the Health Board in relation to operating and cash flow forecasts. The Health Board has determined that it is a going concern, because it has obtained a letter of support from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

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

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

The Board is responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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

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

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

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

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

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

Our responsibilities arise from the Public Audit Act 2001.

Deloitte.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 6 to 67, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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

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