Bay of Plenty District Health Board
Annual Report 2018

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 2018

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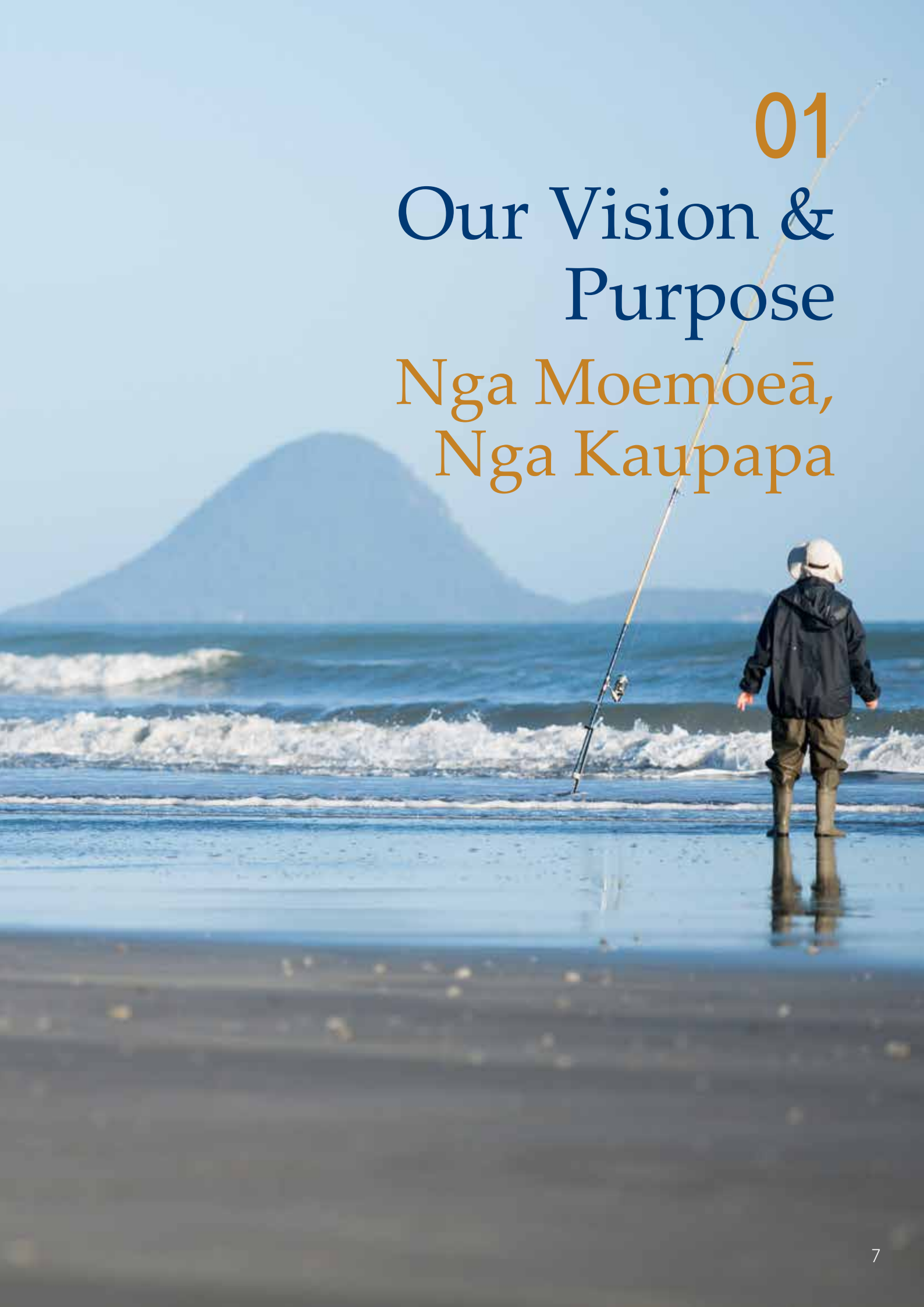
Contents



01
Our Vision & Purpose
Nga Moemoeā, Nga Kaupapa

He Pou Oranga Tangata Whenua Māori Determinants of Health Principles

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.

CARE means

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

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

CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

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.

Our District

The Bay of Plenty District Health Board (BOPDHB) is one of 20 District Health Boards (DHBs) in New Zealand, and has a purpose of funding and providing personal health services, public health services and disability support services for the Bay of Plenty. It was established under the New Zealand Health and Disability Act 2000. This Act sets out the roles and functions of DHBs[1].

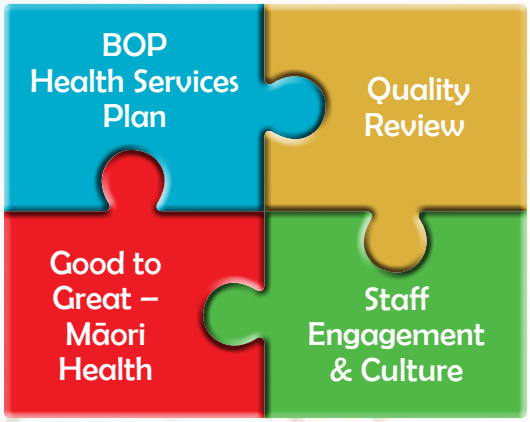
1. New Zealand Health and Disability Act 2000

02
Our Priorities & Performance
Mahi Whakariterite

Board Chair & Chief Executive's Report

Welcome to the Bay of Plenty District Health Board's (BOPDHB) Annual Report for 2018, where we report to our community and the Government, on our progress towards achieving our vision of Healthy, Thriving Communities - Kia Momoho Te Hāpori Oranga.

The BOPDHB aims to make a tangible improvement in the health of our community by being a high performing health system. This will be achieved through our four current Strategic Priorities: Strategic Health Services Plan (SHSP); Staff Engagement and Culture; Good to Great Māori Health; and Quality Review.



Looking back on 2017/18 we feel proud of the healthcare our BOPDHB teams and our contracted providers have delivered, in what has been a demanding year. It has also been one in which the excellence shown by our staff, providers and volunteers, has reflected our CARE values. As well as continuing to deliver the services our patients' and whānau need, our teams have improved performance, undertaken new initiatives, continued learning and researching. Both doing our jobs and improving our jobs. Some positive initiatives over the last year are as follows:

Strategic Health Services Plan

The development of the Strategic Health Services Plan for the Bay of Plenty has been a major piece of work for the BOPDHB. Our patients, families and whānau are at the heart of the Strategic Health Services Plan, and it sets the scene for what we need to focus on over the next ten years to support our communities to be healthy and thriving, and to live well, stay well and get well. In the 2018 year, we actioned a number of significant projects:

Case Coordination for Long-term Support of Chronic Conditions

Two case coordinator positions have been recruited to for long-term support of chronic conditions. Based at Support Net, these positions will be reviewing existing packages of care for long-term conditions clients in the community in order to support them in their own homes and avoid admission to hospital or aged residential care.

Community Care Coordination Service

The Community Care Coordination (CCC) demonstration site has been operational for five months and has managed more than 3600 referrals. A shift in more 'routine' care being delivered in general practice and clinic settings is becoming apparent. As work flow is better managed and capacity in District Nursing is freed up, critical home visits are made for those who need them most. Once the site has been evaluated, consideration will be given to expanding the current scope and opportunities to deliver more care in community settings.

Sleep Apnoea Service

Initiatives are underway to improve this service, including: a room for training patients and whānau, adjacent to the Cardiology/Respiratory laboratories; an increase in the use of pulse oximetry testing (a less invasive, easier test for initial assessment where appropriate); and work continues on reviewing the 'test, diagnose, treat' for improved access and greater monitoring of treatment adherence.

Early Identification of Aged Residential Care (ARC) Patients who are Susceptible to Admission to Hospital

This builds on the existing service with WBOPPHO and expands the programme to include recognition of the existing Nurse Practitioner role, 0.5 FTE clinical pharmacist, and 0.5 FTE project manager (RN). These positions expand the capacity across our ARC sector to focus on reducing acute presentations into the hospital system while improving the overall quality of care of ARC residents.

Shifting Routine Wound Care Services from District Nursing to General Practice

Shifting routine wound care services out into the community this year has been very well supported by Primary Care. The majority of practices in the Bay

have signed up to take referrals for patients discharged from hospital with post-operative wound care needs. Visits are funded by the District Health Board. This has had a flow-on effect, allowing district nursing to focus on more complex cases, and people still have the option of a district nurse visit when they cannot safely travel to their GP to be seen. Given the success of the routine wound care initiative, we plan to work with General Practice to identify more services that can be safely and conveniently delivered out of the patient's Health Care Home, their community General Practice.

Bay of Plenty Information Systems Group Workplan

This includes projects related to SHSP implementation and integration initiatives between Primary and Secondary Care. A key initiative is the development of a risk stratification tool. Analysts (from Primary and Secondary Care) together with a small group of GPs are starting to drill into what the data is telling us about our most high risk, high need patients.

Whole of System Education Project

The aim of this project is to support implementing the Strategic Health Services Plan and foster a whole of system approach by exploring options for the wider Primary and Community DHB funded providers to have access to education resources held by the Bay of Plenty District Health Board.

Māori Health Strategy Good-to-Great Implementation Project

This project has enabled the fixed term appointments of two health navigators to facilitate pre-school oral health enrolments.

Improving Māori Health Equity

The BOPDHB is committed to the principles of the Treaty of Waitangi, and improving Māori Health is one of our four strategic priorities.

In 2017 we welcomed Tricia Keelan, our new General Manager of Māori Health Gains and Development. This position was created to provide leadership and direction to the BOPDHB in all matters affecting the Māori population of Te Moana a Toi, Māori services, and Māori staff, as well as leading the Māori Health Strategy, Good to Great. Close to 1,000 of our team have attended "Engaging Effectively with Māori" education sessions. There has been a number of quality improvement initiatives which are beginning to show good improvements for our Māori population. We're pleased to see an increase in the number of our Māori workforce. Whilst there has been progress, there is still much mahi ahead.

Quality and Clinical Governance

The new Clinical Governance framework has been developed and is now in the process of being implemented, with quality being clinically led across our organisation.

We were pleased to be part of the Partners in Care co-design programme which saw patients and staff working together to use their experience for developing better health services.

The Health Quality and Safety Commission support the programme, which is modelled on the Experience Based Design approach, developed by the National Health Service in England, and uses patient and staff experiences in the co-design. Patients bring a unique viewpoint and can provide valuable input on how services can be improved, where priorities should be set, and where quality issues have arisen in the delivery of health services.

The BOPDHB Consumer Council has been established, and we look forward to working with the Council to further improve our services.

Good progress has been made on our Health and Safety systems, and enhanced risk reporting has been introduced.

Staff Engagement and Culture

Over the last 12 months we have continued the work we started in 2017 with the Creating Our Culture campaign. In November 2017 we completed the second Creating our Culture staff and patients' survey. The purpose of the second survey was to investigate the impact of the Creating our Culture activities and actions during the 12 month period, between the first survey in November 2016 and last Novembers one. Overall the employee survey shows that there was good progress within the year, as well as a clear link between staff and patient wellbeing. At the beginning of the year we launched our evolved CARE values, based on patient, family and staff feedback. We then introduced new staff name badges, in response to our patients and families feedback, saying they want to know who is caring for and supporting them. We continue to work closely with our unions. Our relationships with our unions are very important to us. In the year ahead we'll be progressing this work with our focus on "Speak up Safely".

Health Targets 2017/18

We are pleased to report that by the end of 2017/18 we achieved five out of the six health targets. Those achieved were Shorter Stays in Emergency Departments, Improved Access to Elective Surgery, Faster Cancer Treatment, Better Help for Smokers to Quit, and Raising Healthy Kids; with just Increased Immunisation not achieved. That's a wonderful result and we want to thank all of our staff for their hard work. The health impact for our population is significant.

Sustainability in Healthcare

It's clear from our daily lives that sustainability, and the sense of societal responsibility around it, is gaining traction. Some of our team have been going to great lengths to reduce waste, recycle and employ a range of other sustainability

activities for some time. We are now at a stage of seeking greater understanding about what sustainability means for our work practices and how we move forward with a Sustainability Plan.

Smokefree

Smoking is a leading cause of preventable death in New Zealand. This year we were pleased to learn that the Bay of Plenty's free Stop Smoking Support service, Hāpainga remains top of the country 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 is required to record the number of clients who are deemed to have successfully quit smoking meaning they are 'smokefree' four weeks after their set quit date.

eSpace Programme and Information Service

The eSpace Programme, which has a long term goal of regionalising (covering the five Midland DHBs) IT systems, clinical workflows, standards and processes, has continued to progress over the last 12 months. The regional clinical portal is known as the Midland Clinical Portal (MCP). In July 2017 the MCP foundation launched an initial read-only capability, and since then, an ever-increasing number of clinicians (c.3000 in June 2018) from all five DHBs have access to more than 3 million patient events, and 2.2 million patient documents across the region. This is a great step forward to achieving our vision of 'One Patient, One Record' for a region home to approximately one quarter of New Zealand's population.

Other progress on Information Services includes the BOPDHB being the first DHB nationally to establish Infrastructure as a service. In addition, BOPDHB was one of 4 DHBs nationally which went live with the National Oracle Solution. There has been a strong focus on cyber awareness.

BOPDHB receives Clinical Campus Status

Our DHB has recently received official Clinical Campus status from the University of Auckland's (UOA) Faculty of Medical and Health Sciences.

We are only the fifth such campus in New Zealand and only the second outside of Auckland to receive this level of recognition. It is an announcement which we can justifiably be proud of. It is a positive signal to our community and our patients and instils great confidence in the services they're receiving and in the skillsets of our clinicians.

National Mental Health and Addictions Services Review

BOPDHB was pleased to have so many community stakeholders present to the National panel. We look forward to the recommendations of the panel, which will inform how we enhance the delivery of Mental Health and Addiction Services in the year ahead.

Improving Inpatient Services

'Stop wasting our patients' time' is a mantra which has been adopted with award-winning commitment by staff at Tauranga Hospital.

It is well-known that elderly patients are at risk of deconditioning if they spend too long in hospital. The PARIS (Patients at Risk of Increased Stay) project was introduced to Tauranga Hospital last year to address this, focusing on patients over 75 and looking at ways their hospital journeys could be improved.

As a result, over the past 12 months, Allied Health staff and Medical Floor and Admissions Planning Unit nurses have significantly changed the way they work; promoting a collaborative, task-sharing model between the different professions. It has meant less duplication of routine tasks, fewer new faces at the bedside, and shorter waiting times for patients. In short, the same quality care delivered in less time, which is better for the patient. The initiative is now being implemented in Whakatāne Hospital.

Reflecting back on the last 12 months reminds us of all the positive change initiatives we have happening across our DHB. We are proud to lead an organisation where so many people are engaged in making positive change, improving the services we provide to our communities and we are proud of what our DHB has achieved over the last year. In our line of work, the sense of achievement is accompanied by the knowledge that we are positively impacting the health of our communities.

Sally Webb
Board Chair

Helen Mason
Chief Executive

Māori Health Rūnanga Year in Review

MĀORI HEALTH
RŪNANGA

Māori Health Rūnanga Chair's Report

Ko te Mana Atua ngā pou mana o Io
Ko te Mana Tupuna a Toi te Huatahi
Ko te Mana Whenua, ko te Mana Moana mai i ngā Kuri ā Whārei ki Tihirau
Ko te Mana Tangata o ngā tini o Toi
Toi ora e!

Ka rere ngā mihi ki ngā tōpito, ngā whārua, ngā kāinga maha o te rohe nei mai i ngā Kuri ā Whārei ki Tihirau. Tēnei te haumihi a te Rūnanga Hauora Māori o Te Moana a Toi ki te mana whenua, te mana moana, te mana tūpuna, te mana tangata o tēnei rohe o tātou.

Kua tae atu te wā ki te whakahoki mahara ki te tau kua pahure nei. Ahakoa ngā piki me ngā heke o te wā, kua tau mai te wairua o te kōmurihau kia eke āmai o ngaru, hei nanao atu tātou i te kakau o te hoe o tēnei waka oranga. Me mihi ka tika ki te rangatira a Pouroto, māna e tū hei ārahi atu i a tātou ki Te Toi Ahorangi, otirā, ki te Toi Ora mai i ngā pou mana o Io.

Ko te tumanako, mā te kaha o te kotahitanga me ngā whakaaro rangatira o tātou, ka taea e tātou ki te piki ake ki ngā Toi Ahorangi, kia whaiwhai haere i te Toi Ora hei oranga wairua, hei oranga hinengaro, hei oranga tinana, hei oranga whatumanawa.

Mauria atu te pono me te tika i roto i te aroha, i runga i te rangimarie,

Punohu McCausland
Outgoing Chair | Te Rūnanga Hauora Māori ō Te Moana a Toi

Rūnanga members and several senior Māori Health staff gather at Iramoko Marae to learn, share and grow the teachings of He Pou Oranga.

Our Iwi

Our unique composition as a collective of eighteen 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, Tūhoe, Waitahā and Whakatōhea to influence the decision-making processes of the BOPDHB Board.

Our Leadership | Te Tira Hou

Tēnei te tira hou, tēnei hara mai nei!

Incoming Chair's report | Pouroto Ngaropo

Before the rising of Matariki, the Māori Health Rūnanga convened a meeting in June to appoint a new Chairperson to lead us into the future. In doing so, we collectively decided to strengthen our executive team from two to four members. We are pleased to advise that as a result of these triennial elections, our new Executive reflects a change of the guard, with myself stepping into the role of Chair and Punohu McCausland accepting the invitation of the Rūnanga to be Deputy Chair. As two influencial members of the Māori Health Rūnanga, we welcome the vitality of Terehia Biddle and Rutu Maxwell-Swinton who will support our work to maintain a strong and influential partnership with the Board.

Chair
Pouroto Ngaropo
Ngāti Awa

Deputy Chair
Punohu McCausland
Waitaha

Member
Terehia Biddle
Tūhoe

Member
Rutu Maxwell-Swinton
Tapuika

We acknowledge the contribution of Punohu throughout her time as Chair of the Māori Health Rūnanga. We are grateful that she continues to represent her Iwi Waitaha and that she maintains the position of Deputy Chair to support the succession of our Rūnanga and new Executive members.

DHB partnership

Our Māori Health Rūnanga also welcomed Dr Anna Rolleston, who was appointed by the Board to be their representative at our Rūnanga meetings. Dr Anna Rolleston brings a wealth of experience in wellness orientated systems, providing a strong community grounded approach to Māori Health with the robustness of evidence-based practice and research. The Rūnanga continues to hold quarterly partnership meetings with the Board and several of our iwi members fulfil representative roles on statutory Board Committees.

Our Toi Ora Journey

Challenges received from our iwi members questioning the role, function, purpose and value of the Māori Health Rūnanga in effectively operating as agents of Māori Health leadership have been a catalyst for reflection. We recognise that as a Rūnanga we do not have genuine Tiriti partnership arrangements in place with the District Health Board. We are seeking to enhance the current arrangements so that we can more effectively participate and influence decision-making within the District Health Board. We acknowledge that we must begin to address the systemic barriers that prevent equitable decision-making for our iwi so that we are able to directly influence the prioritisation, investment and resourcing of Māori Health within the BOPDHB.

It is our aim that the Māori Health Rūnanga and individual iwi representatives have closer working relationships with the respective iwi. In an effort to reach out to our people, we have held wānanga at Tahuwhakatiki Marae in Welcome Bay. The wānanga proved valuable in enabling our Māori Health Rūnanga and the Board to connect with our people, to hear their views and to expand our thinking in regard to how we can collectively work together towards realising Toi Ora.

A strong message from the Rūnanga members and the wānanga was the need to reconnect with He Pou Oranga toward a greater understanding and appreciation of our tangata whenua model. As a result I have run a number of He Pou Oranga wānanga which have not only enhanced our knowledge as a Rūnanga but also grown our cohesiveness as a leadership group who are growing together (as we represent our respective iwi).

We have also been working on several key actions this year that aim to ensure we have a greater level of accountability to our whānau, hapū and iwi of Te Moana a Toi. We are instituting arrangements to better record and monitor the work of our iwi representatives in championing change and influencing decision-making. At the same time we are establishing iwi reporting templates so that we are able to effectively capture the unique aspirations of our eighteen iwi and that these are woven into the fabric of all BOPDHB strategic long-term and annual planning pathways. As part of assessing our arrangements and increasing effectiveness we are also looking at the resourcing implications for us as a Rūnanga going forward.

Ultimately, we look forward to resetting our foundation to be effective and appropriately resourced and positioned to operate for and on behalf of our iwi across our region. We wish to see our whānau move from a state of wairua kore to wairua ora, and that the mana and mauri of our whānau, hapū and iwi is protected and enhanced, allowing us all to realise our ultimate potential as descendants of the multitudes of Toi – Toi ora e!

Pouroto Ngaropo
Incoming Chair | Ngāti Awa

Māori Health Rūnanga Membership

Iwi	Member
Te Whānau a Apanui / Te Whānau ā Te Ēhutu	Astrid Tawhai
Ngai Tai	Linda Steel
Ngāti Awa/ Chair	Pouroto Ngaropo
Whakatōhea	Dickie Farrar
Tūhoe	Terehia Biddle
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/ Deputy Chair	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

Māori Health Gains and Development Report

BOPDHB is the first DHB in Aotearoa to establish an executive General Manager Māori Health Gains and Development leadership role that focuses on and leverages a whole of systems approach.

Tēnei te matatau kia eke, whakatū tārewa ki te rangi
Ūhi, wēro, tau mai arā ko te
Mana Atua, Mana Whenua, Mana Moana, Mana Tūpuna, Mana Tāngata
Ka puta rā ki te whei Ao, ki te Ao Mārama
Tūturu whakamaua kia tīna
Tīna, hui e
Toi Ora e!

New Leadership

Work has been underway for sometime within the Bay of Plenty District Health Board to redesign and unify Māori Health by adopting a whole of systems approach to achieve Toi Ora. In October 2017, BOPDHB advanced this change by recruiting for the newly created role of General Manager Māori Health Gains and Development (GMMHG&D). This position provides leadership and direction to the BOPDHB on all matters affecting the Māori population of Te Moana a Toi, Māori services, and Māori staff, including policy development, resource allocation, organisational goals, service delivery and decision-making. The role is charged with elevating and strengthening the executive leadership of Māori Health across the whole organisational structure of BOPDHB and district. This includes building a united and strong connection between the work and activity of Māori Health Planning, and Funding and Regional Māori Health Services to leverage a whole of system response towards achieving Toi Ora. A key difference to note here in the formation of this new role, is the expectation that the GMMHG&D will work across the entire BOPDHB system. Our DHB is the first to establish an executive Māori leadership role that focuses on a whole of system approach.

New Approach

With the onset of innovative and brave change discussions, Māori Health Gains and Development

BOPDHB is the first DHB in Aotearoa to establish an executive General Manager Māori Health Gains and Development leadership role that focuses on and leverages a whole of systems approach.

is now in a phase of adjusting our sails as we begin a voyage towards realising better outcomes for our people. In February 2018, we began this transition as we shifted towards a single executive leadership structure to unify and collectivise Regional Māori Health Services and Māori Planning and Funding. With any change comes both significant opportunity and challenge. However, our shared vision for Toi Ora provides a stronghold towards the pathways that we must navigate in order to strengthen our collective impact.

What this shift has revealed is the significant gap between the newly created role of the General Manager Māori Health Gains and Development and the next layer of Māori Health in the organisation. Ensuring that the organisation has a strong operational Māori Health leadership team in place is a key priority in the near future.

Overall, this year Tricia has focused on preparing the soil for the planting of new seeds of strategic direction and leadership. An important part of our collective preparations is ensuring that we have the vision, plan, energy, relationships, skills, knowledge, information, and resources to effect the change that we want to see in the Bay of Plenty. Laying the foundation for change takes time and careful planning, and we are looking to build on that platform with our new strategy.

New Strategy

Te toi ahorangi

In May 2018, our Rūnanga gifted the name Te Toi Ahorangi, to encapsulate in te reo Māori the strategic intent for Good to Great. This will now be the name for a new Toi Ora Strategy to be developed by December 2018. Conceptually, Te Toi Ahorangi provides a richness of meaning that honours and acknowledges our eponymous ancestor Toi te Huatahi and the multitudes of his descendants within Te Moana nui a Toi, whilst affirming our collective vision of Toi Ora. Key to this strategy is the holistic notion of our iwi aspirations positioned alongside Crown aspirations towards achieving Pae Ora at a national level, and Toi Ora at our district level. The new strategy will also provide an opportunity to refresh He Pou Oranga as a model of care and in doing so, ground it in the work that we all do within the BOPDHB. We look forward to sharing what we have been working on in preparing for the engagement and new launch of our strategy over the coming months.

Our Year's Highlights

Spotlight on oral health (māori health indicator target improvements)

Our current Good to Great strategy focuses on the improvement of key Māori Health indicators that aim to have high impact on the health and wellbeing of our Māori whānau[2]. We are pleased to have seen a record performance improvement in the number of oral health service enrolments

2. BOPDHB. (2016). Good to Great - Māori Health Strategy. Bay of Plenty District Health Board.

Tricia Keelan

General Manager
Māori Health Gains and Development

Tricia has iwi affiliations to Ngāti Porou, Te Aupouri, Ngāti Rongomaiwahine and Ngāti Kahungunu, and brings with her strong executive leadership experience and a proven ability to achieve Māori health gains. In her most recent role, Tricia was the General Manager Māori and Population Health of Tū Ora Compass Health, a PHO servicing 330,000 people across Wellington. Tricia has a Degree in Public Policy, an Executive MBA, and an advanced Diploma in Te Pīnakitanga ki te Reo Kairangi. As a leader, Tricia brings a love for te reo me ōna tikanga and a passion for achieving the aspirations of tangata whenua by creating pathways for Toi Ora amongst whānau, hapū and iwi. Her strategic focus is to utilise He Pou Oranga as a model of care and framework for change, and to work alongside the Rūnanga, Māori Health Providers and the entire BOPDHB to achieve Toi Ora.

Tricia is focused on affirming the aspirations of iwi in the future strategy, Te Toi Ahorangi. Her priorities for the new strategy include: Genuine Tiriti partnerships; Reigniting He Pou Oranga; Addressing Institutional racism; Valuing tangata whenua; Investment in Kaupapa Māori; Toi Ora and whānau driven co-designing of services; Toi Ora outcomes commissioning; Driving performance for Toi Ora; Strengthening our Toi Ora providers and workforce; Growing a Toi Ora Excellence Centre; Sharing indigenous intelligence; and Inspiring Toi Ora zones (Blue Zones).

for pre-schoolers as a result of close collaboration with the Provider Arm, the Ministry of Health and our wider community. This has seen the team lift preschool oral health service enrolments from 59% to 84%, and in turn contribute to the BOPDHB reaching the national target (95%) for the total population.

Mental health and addiction inquiry

Tricia led the Tumu Whakarae submission to the Government's Inquiry into Mental Health and Addiction. This submission provided rigorous input to the panel from the perspective of tangata whenua leaders within DHBs across the country.

strong progress towards increasing enrolments and improving outcomes in a systematic way.

First 1000 days project

Led by an advisory group, a programme was developed to facilitate service improvement opportunities to see future generations of Toi flourishing. A key focus was implementing actions to improve maternal and child nutrition. We acknowledge the importance of supports within the first 1000 days and beyond in order to grow flourishing whānau and communities. We are committed to investing in our babies and their futures.

At a local level, we provided slam poetry workshops for rangatahi[1] to actively participate in the process; as well as the facilitation of a Māori Health Provider workshop and provision of a submission writer as resource to capture the Māori Health provider collective aspirations, issues and solutions. Two hearings were held in our region, one in Tauranga and a second at Mataatua Marae which allowed the Māori community to share their whānau experiences of the Mental Health system.

Well Child Tamariki Ora

The Well Child/Tamariki Ora (WCTO) Quality Improvement Programme aims to promote and support the development and sustainability of a high performing Well Child sector. The Universal New-Born Multi Enrolment Form and follow up service was a focus for 2017/18. As a result, we reviewed the Universal New Born Multi Enrolment form within the Maternity unit in Tauranga Hospital, with the intention to maximise whānau engagement with and access to Toi Ora services supports. We are making

Primary care transformation

Māori Health Gains and Development are driving a Tiriti o Waitangi, rangatiratanga based approach to Toi Ora in Primary Care. This includes development of a unique model of general practice that learns from tangata whenua, indigenous, and western best practice in order to support and grow Toi Ora alongside our Kaupapa Māori Hauora providers, iwi and communities. In addition, we are growing our own intelligence by considering the Health Care Home initiatives and Nuka Care model as developed by the Southwestern Foundation and Alaska Native community. Our response to long term conditions included improved risk assessments and the realignment of diabetes services to focus primarily on Māori and high needs.

Tricia Keelan
General Manager
Māori Health Gains and Development

General Manager Corporate Services Report

This financial year we achieved a deficit result of $9.85m, on total revenue of $796.1m. Our result was $7.1m off our targeted deficit of $2.74m. This result represents deterioration from last year's surplus result of $0.374m.

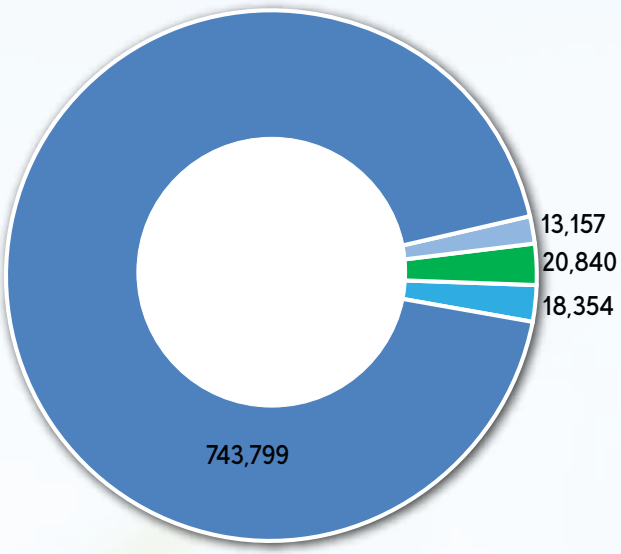
As with other DHBs, we continue to face increasing demand for health and disability services across our district. The Bay of Plenty has experienced sustained growth in our population, and our demography continues to age.

This growth includes the servicing of record numbers of elective surgeries (12,112 – prior year: 11,315), acute discharges and Emergency Department attendances (80,693 – prior year: 78,688), whilst ensuring that 94.4% (Target: 95%) of our Emergency Department patients were admitted, discharged or transferred within six hours.

Our DHB has mitigated some of the financial impact of this unplanned service growth through proactive cash-flow management. This has resulted in our financial position strengthening, with $22.0m held in cash and investments available at year end, a significant improvement on the $14.7m from last year.

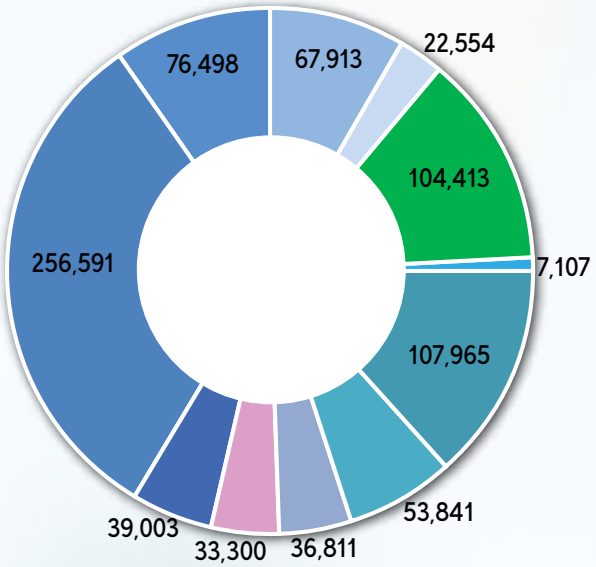
The 2018/19 financial year will continue to provide financial challenges as we service the health needs and demands of our growing population.

Revenue ($000s)



- Crown Funding
- Other MOH revenue
- Other Revenue
- Services to other DHBS

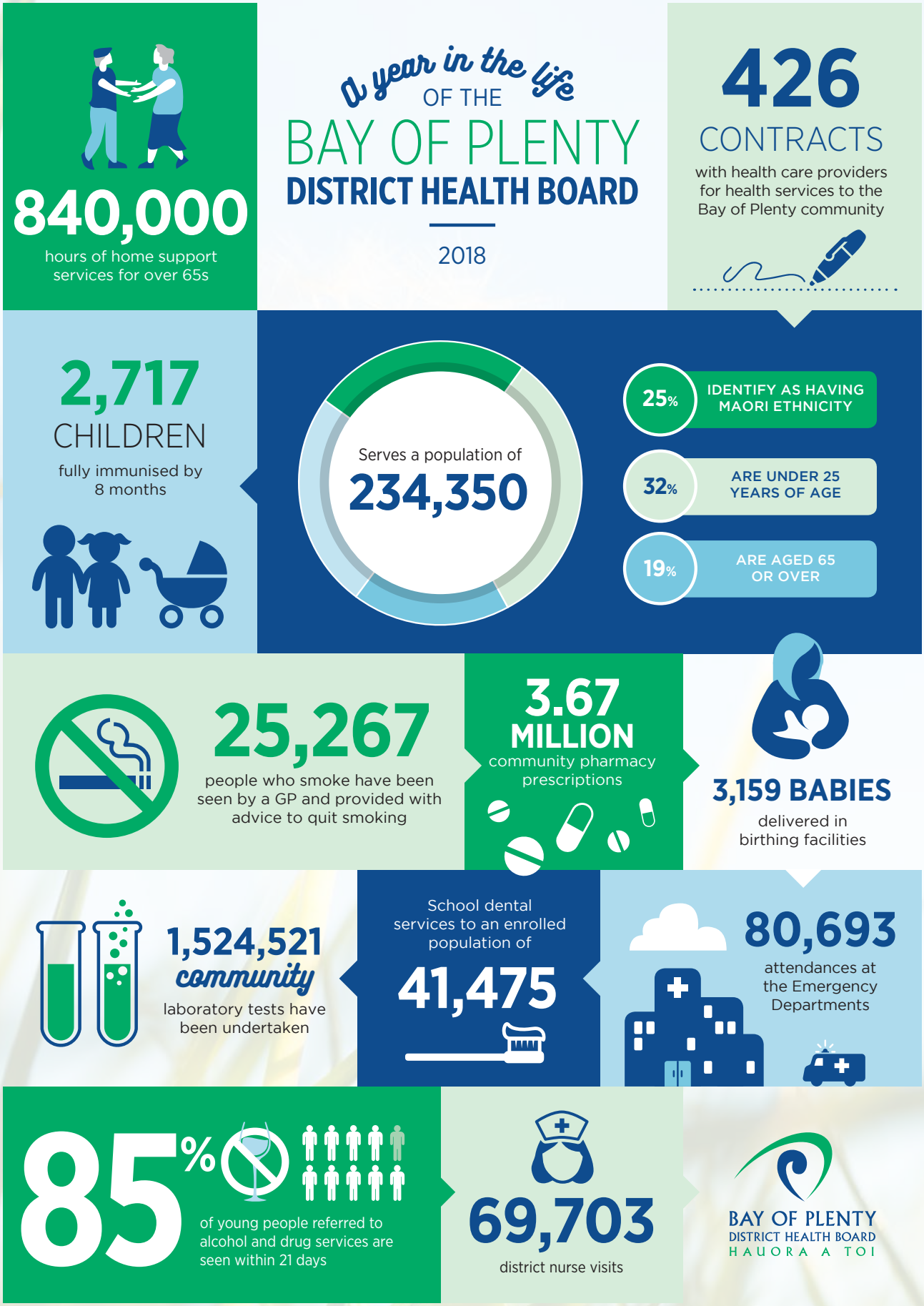
Expenditure ($000s)



- Clinical expenses
- Community Mental Health
- Community Older Persons
- Community Other Providers
- Community Personal health
- Community Pharmaceuticals
- Depreciation, Interest & Capital Charge
- Infrastructure & Non-Clinical Supplies
- Outsourced
- Personnel
- Services from Other DHBS

Owen Wallace
General Manager Corporate Services

Service Performance Overview – What We Provided in 2017/18



Our Overarching Strategies and Priority Populations

The BOPDHB is guided by a number of 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". The BOPDHB welcomes opportunities to collaborate locally, regionally and nationally to achieve this goal.

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

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.

Healthy families
Whānau Ora

1. Family/whānau live well with long-term conditions.
2. People are safe, well and healthy in their own homes and communities.

Healthy environments
Wai Ora

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	**Developing our workforce**	**Using information to improve value**
Building effective partnerships	**Developing our facilities**	**Making of the most of new technologies**

Redesigning funding and contracting models to better match care with need

Integrated Healthcare Strategy 2020 (IHS)

Our response to the challenges facing us requires us to work together in partnership with people and our community, as one system. In particular, to work together with our primary care partners, through our Bay of Plenty Alliance Leadership Team, to make changes to the health system, for the benefit of our population.

Midland Regional Strategy

Improve the health of the Midland populations

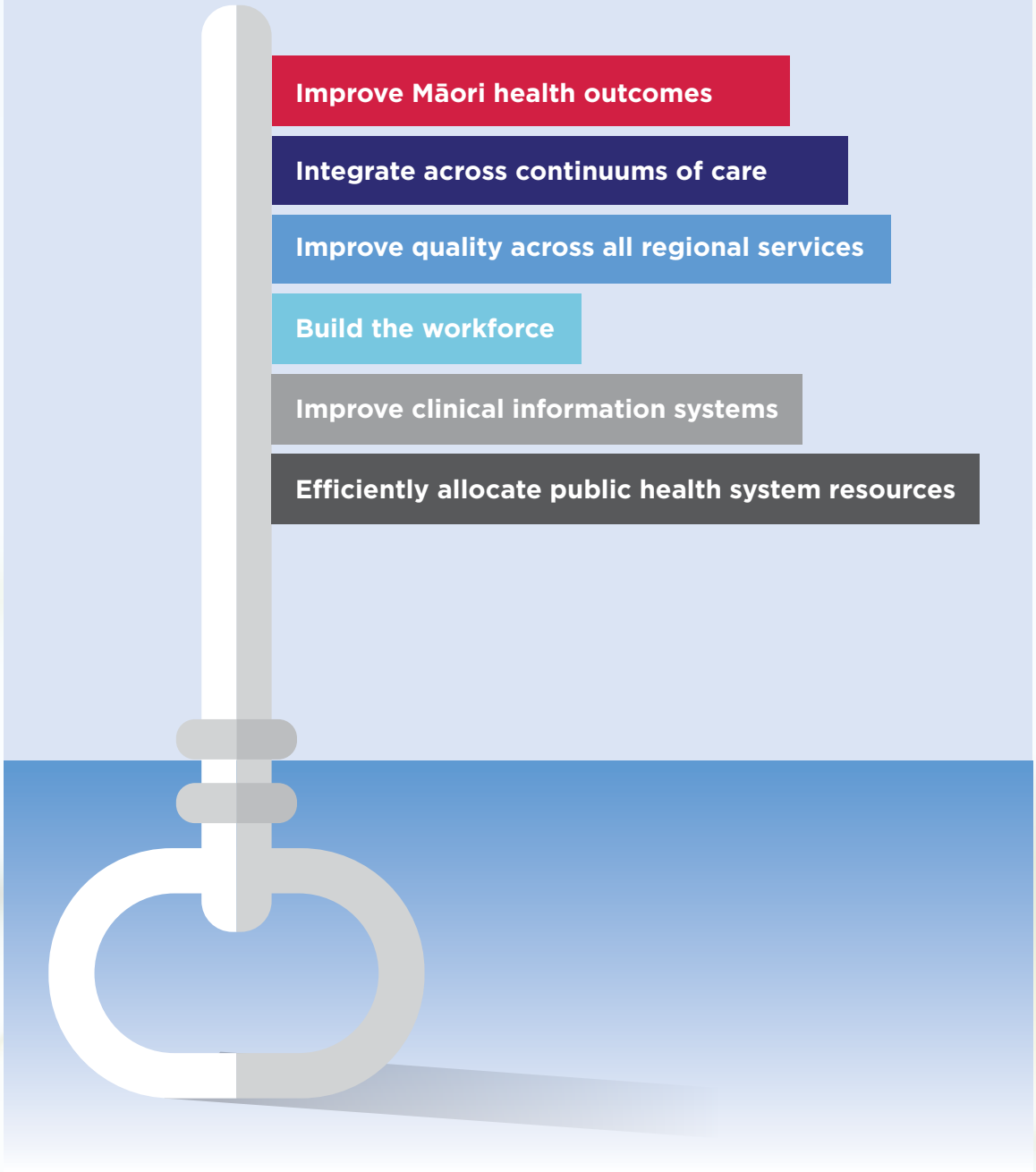
Health and wellbeing is everyone's responsibility. Individuals and family and whānau are to actively manage their health and wellbeing; employers and local and central body regulators and policy makers are expected to provide a safe and healthy environment that communities can live within.

Eliminate health inequalities

Success in reducing inequalities in health brings positive results for the individual, the economy and society. It enables New Zealanders to live healthier, longer lives. Our ongoing challenge is to reduce inequalities in health outcomes for populations, particularly Māori and Pacific people.

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. Eliminating health inequalities is the goal.

Our six regional objectives



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 234,350 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.

Key Points[3]

- BOP has steady population growth projected for Tauranga and Western 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% pa, similar to the New Zealand average.
- 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.
- While heart disease and suicide are the largest causes of premature death, diabetes in Eastern BOP and motor vehicle injury in Western 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.
- Children (0-14 years) and youth (10-24 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.
- 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.
- BOP has a higher rate of hazardous drinking than the national average.
- 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.
- 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 Whakatāne Hospital (8). 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 re-mains 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 over-used compared with community-based support.
- Suicide and self harm rates are higher than the NZ average.

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, we aim to improve the health of our community.[4]

3. BOPDHB Health and Service Profile, 2016.
4. Mason Drury November 2015.

Our fresh approach for the Bay of Plenty Health System

CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

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

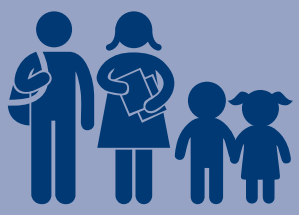
EAST BOP

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

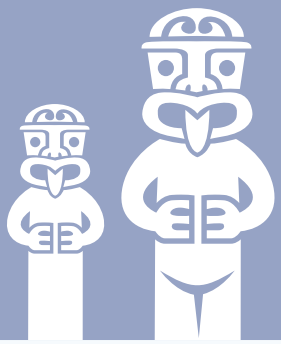
16% of adults have chronic pain, with many assessed for home care noting severe persistent pain. Rates of long term opioid use are high despite lack of effectiveness

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



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

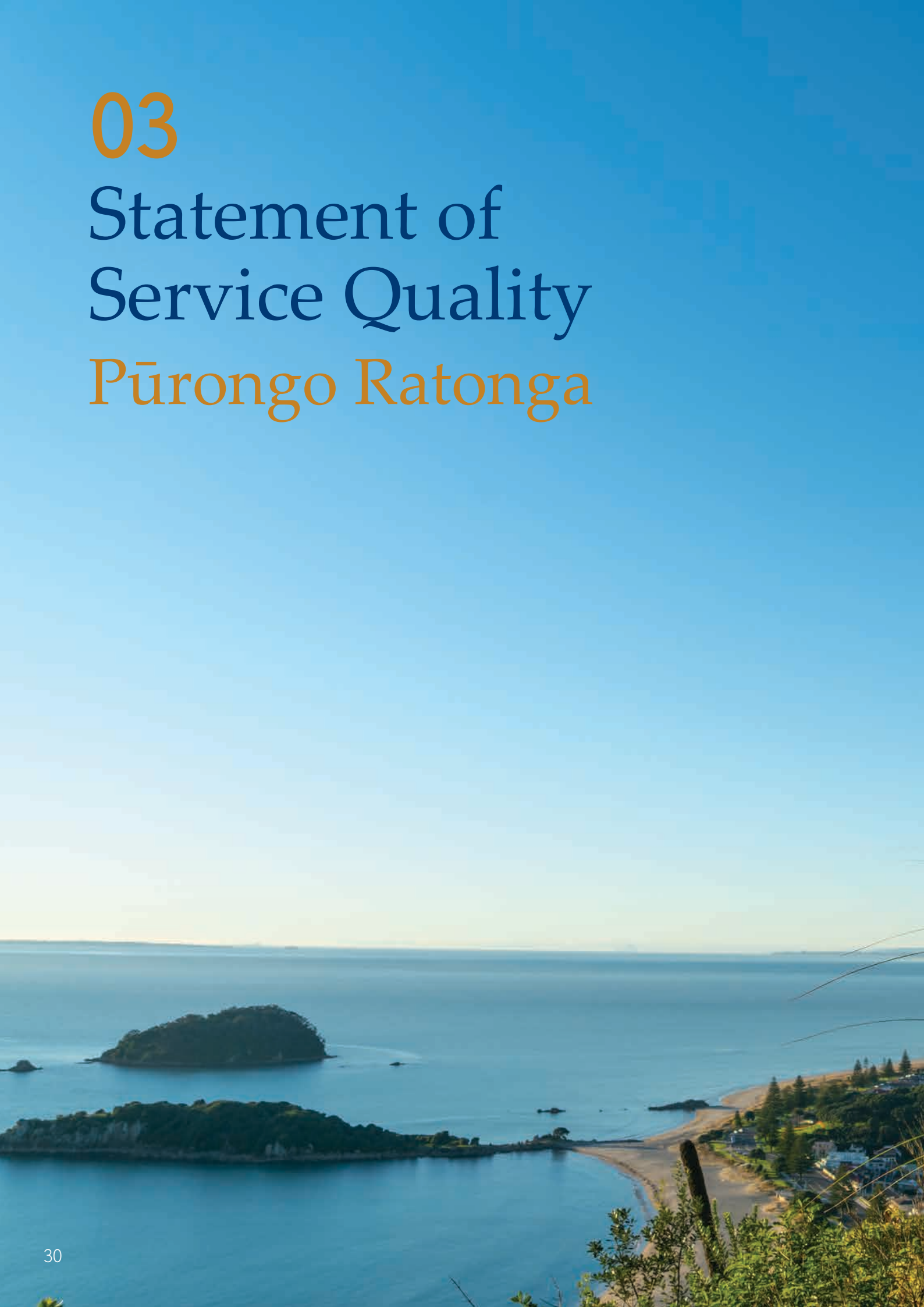
The birth rate is declining, but fertility remains higher than the NZ average. Obesity rates during pregnancy are similar to New Zealand rates. Caesarean section rates are relatively low

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

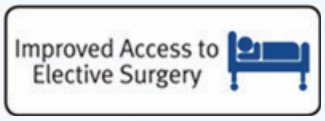
03
Statement of Service Quality
Pūrongo Ratonga



Health Targets

There are six 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	2017/18 Q4 Results	Achievement
The target is: 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours. 	95%	95%	√
The target is: The volume of elective surgery will be increased by an average of 4000 discharges per year nationally. 	100%	111% (2017/18 target surgery discharges was 10,937. Actual total was 12,112. This exceeded the target by 1175.)	√
The target is: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months. 	90%	91%	√
The target is: 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 weeks. 	90%	96%	√
The target is: 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 by December 2017. 	95%	99%	√
The target is: 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time. 	95%	85%	X

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 2018.

Marker Definition	New Zealand Goal	Q3 July to September 2017	Q4 October to December 2017	Q1 January to March 2018	Q2 April to June 2018
Falls: Percentage of patients aged 75 and over (Māori and Pacific Islanders 55 and over) that are given a falls risk assessment.	90%	88%	87%	89%	87%
Falls: Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk.	90%	94%	97%	96%	95%
Hand Hygiene: Percentage of opportunities for hand hygiene for health professionals.	80%	85%	85%	83%	83%
Surgical Site Infections: Percentage of hip and knee arthroplasty* primary procedures were given an antibiotic in the right time.	100%	97%	100%	98%	Data not available
Surgical Site Infections: Percentage of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose.	95%	97%	98%	97%	Data not available

Compared to other DHBs

Upper group Middle group Lower group

Fortnightly adult inpatient experience survey scores

Domain	Q1 2018	Q2 2018	NZ (to May 2018)
Communication	8.5	9.0 ↑	8.5
Partnership	8.6	8.8 ↑	8.6
Coordination	8.1	8.9 ↑	8.6
Physical and emotional needs	8.5	9.1 ↑	8.8

Achieving our Vision of Healthy Thriving Communities

Patient centred

My medication - What's it called, what's it for, what changes have been made and how do I take it?

These are questions healthcare professionals frequently assume a patient has answers to before discharge, but often they don't.

An ongoing project is being undertaken at Tauranga Hospital to ensure they do.

It is looking at the potential benefits of providing increased levels of pharmacy support at the point of discharge; improving the quality of information patients receive about their medication; and improving communication between healthcare professionals and patients to increase patient understanding of their medication before going home.

The information gathered from hospital staff, community pharmacy staff and patients has identified some key themes, opportunities and possible improvements.

Small tests of change trialled to date have included: introducing pharmacist-led medicine reconciliation on discharge; reviewing discharge medication lists to reduce errors; pharmacists preparing medication for prioritised high-risk patients; the provision of medication education for selected patients and preparation of a medication card if necessary; and an increased liaison with the patient's community pharmacy.

This project is continuing, collecting more patient stories and patient feedback/ideas for improvement by using a paper questionnaire or follow-up phone calls. The team are also recording the number of pharmacist interventions on discharge paperwork.

Project team: Kelly Hiha (left), Tamsin Willis (right), Ashleigh Eaden and Consumer Rep Nada Byrne (not pictured)

Partners in Care Co-design Programme

Six BOPDHB project teams, working together with consumers took part in the 8 month long 'Co-design Partners in Care' programme facilitated by the Health Quality & Safety Commission.

The "pharmacy service on discharge" team found working together with patients towards a shared outcome is positively changing practice, that 'seeing aspects of health care from a patient's viewpoint' is invaluable, and the benefits in taking a little extra time with a patient is helping to improve patient involvement and health outcomes.

Smart System

Dr Marshall Hollister-Jones, of Tauranga's Chadwick Healthcare.

Patients in control of own healthcare the future, says GP

Patients managing their own healthcare online is the future says a Bay of Plenty GP, and the future is here.

Dr Marshall Hollister-Jones, of Tauranga's Chadwick Healthcare, says his practice has been offering the ManageMyHealth website (by which patients can access their personal health records) for five years.

"I've been a vocal supporter of this technology locally for some time," said Dr Hollister-Jones. "We have over 2000 people registered and that number is increasing all the time.

"It's turning patients from being passive recipients to being partners in, and driving, their own care. That means they are much more active and engaged. It's a significant shift and leads to better results for the patients. It's what the future will look like," said Dr Hollister-Jones.

Through the secure website patients can access information on things like: medications; diagnoses; immunisations history; test results; reminders - e.g. for your flu jab; booking appointments; lodging queries; changes in treatment. Enrolled patients simply have to sign up for the service.

And if you've ever closed your GP's door and immediately thought "Now what did he say again?" then ManageMyHealth can help. As of 1 February 2018, Chadwick Healthcare became the first practice regionally to upload records of all doctor's visits onto the website.

ManageMyHealth patient experience

Chadwick Healthcare patients Kate and Jim Cater are ManageMyHealth advoctaes.

"Jim was given instructions by his skin specialist for treating a skin cancer," said Kate. "He either did not hear them or had so much to take in that he didn't follow the instructions. When he read the specialist's letter to the GP online later he immediately realised what he should be doing.

"Often at the doctor there is a lot of information to take in and it's easy to miss something," added Kate.

Value and high performance

Ground-breaking procedure sees stroke sufferer walk out of hospital three days later

A stroke sufferer has become the first Bay of Plenty man to undergo a ground-breaking procedure and was able to walk out of hospital three days later as a result. Omokoroa resident George Stirling was in Tauranga Hospital for tests following an abnormal ECG when he suffered the stroke.

"George had acute ischaemic stroke due to blockage (clot) in one of the major blood vessels in the brain," said Consultant Stroke Physician and Geriatrician Dr Mohana Maddula. "The clot was stopping blood flow to the brain and there was a risk of permanent brain injury and/or death. After urgent brain scans and discussion with specialists in Auckland he was transferred by helicopter to Auckland City Hospital for Endovascular Clot Retrieval.

"This procedure involves a device being inserted through the femoral artery in the groin up into the brain, to extract the clot and restore blood flow."

The procedure is currently only performed in Auckland, Christchurch and Wellington, is not suitable for all stroke sufferers, and needs to be performed soon after the onset of stroke symptoms.

"The procedure is very time-critical," said Dr Maddula. "George had this emergency procedure soon after arrival in Auckland.

"He returned to Tauranga Hospital the next day and was discharged home a couple of days later. He walked home, almost completely recovered from his stroke," said Dr Maddula.

What's next?

The Bay of Plenty District Health Board is working with colleagues in Auckland to develop and streamline the Endovascular Clot Retrieval treatment pathway.

"A lot more work needs to be done to make this treatment available for the whole BOP region," said Dr Maddula. "We were lucky with George because when he had the stroke, the helicopter and flight team were available and the weather was good. To provide this treatment 24/7 we need to develop transfer systems that are readily available and can operate in all weather conditions."

George Stirling (right) with wife Alison (left).

People powered

Patient viewpoints to the fore in new health consumer council

Ensuring patient perspectives are at the heart of how our health services are developed is the task of a newly formed consumer council.

Eleven people have been selected for the Bay of Plenty Health Consumer Council, which will work in partnership with the BOPDHB as an advisory body. It will promote the patient and community voice as a core service ingredient.

"You need people outside of the system who have an objective eye," said Council member Florence Trout. "Consumers can fill that role and have a powerful impact on how health systems operate. Consumers tend to cut through bureaucracy more and bring a pragmatic view of the world with them.

"They will be able to say 'yes this works' or 'no it doesn't' and suggest alternatives," added Florence. She said the BOPDHB was reaching out for more community involvement and that should be applauded.

The Council aims to enhance consumer experience and service integration across the sector, promote equity and ensure that services are organised around the needs of the people in our communities.

The council will meet monthly and John Powell has been chosen as its Chair. It will have input and advise on issues including development of health service priorities, enhancing patient safety and clinical quality, and reducing inequities.

BOP Consumer Council member Florence Trout.

Who is on the Consumer Council?

Members of the new BOP Consumer Council include:

Adrienne von Tunzelmann
Florence Trout
John Powell
Julia Genet
Lisa Murphy
Maz McKevitt
Rosalie Liddle Crawford
Sue Horne
Sue Matthews
Tessa Mackenzie
Wol Hansen

One team

War on tooth decay in the Bay

Free dental care was provided in the Eastern Bay township of Taneatua in March during a New Zealand Defence Force (NZDF) exercise with the Bay of Plenty District Health Board (BOPDHB) and Tuhoe iwi.

Exercise Wisdom Tooth saw the 25-member NZDF team providing dental treatment at a temporary clinic set up in the town over two weeks.

The NZDF contingent had a mix of Regular Force personnel and reservists, including up to six dentists, four dental hygienists, eight dental assistants and a physical training Instructor.

Amongst the contingent of Army reserves were BOPDHB Community Dental Oral Health Therapist Timmy Reiber and Dental Assistant Elle Lloyd. Lieutenant Reiber and Private Lloyd are Army reserves outside of their day jobs.

"The NZDF engages regularly in community outreach activities in New Zealand and the southwest Pacific region," says Warrant Officer Class 2 Ross Heald, who led the team.

"An important part of our training is practising delivery of treatment in a field environment. This is what we do on operations such as when we deploy to the Pacific as part of a humanitarian aid response."

Caring for your child's teeth

Your child's teeth are at risk of tooth decay (holes) as soon as their teeth appear. Tooth decay is easy to prevent by:

- brushing your child's teeth twice a day with regular-strength fluoride toothpaste
- ensuring your child has a healthy diet low in sugar
- ensuring your child has regular dental check-ups.

Your child is entitled to free oral health care until they turn 18. To enrol them with your local Community Oral Health Service, call 0800 TALK TEETH (0800 825 583).

Lieutenant Timmy Reiber (BOPDHB Dental Oral Health Therapist) talks to schoolchildren about the importance of maintaining good oral health, a healthy diet and exercise.

Care closer to home

Respite house giving youth hope of a brighter future

18-year-old Claudia* is one of the Bay's young people benefiting from a new respite house for those experiencing mental distress.

Claudia has been struggling with an eating disorder in recent years and having been referred to Real youth services, which runs the respite house in Tauranga, has stayed twice in the last few months.

"It's like a home and there are always people around who understand and care," says Claudia. "Plus, it's so much better than having to go to hospital when you're having a tough time, and not too far for my mum to visit me."

The house is designed as a homely and welcoming environment and, on the day we visited, Claudia was engrossed in designing and painting inspirational rocks for the garden and had spent the morning with her youth worker at the Historic Village.

Claudia said spending time the youth workers was "a good distraction from my eating disorder".

The service, which has been operating since September 2017, offers a positive and relaxed environment where 12 to 18-year olds can go to focus on their wellness, with 24/7 support from clinical staff and youth workers.

"Early invention is key for young people in our community" said Real team coach and registered nurse, Danica Thompson.

The respite service is available both in crisis situations and for planned stays. How long people stay is based on their individual needs.

*Name has been changed for privacy.

Young people are supported in a homely environment.

Respite house referral and mental health support

Young people must be clients of MICAMHS (Maternal Infant Child and Adolescent Mental Health Services) and Voyagers (Child and Adolescent Mental Health Service) to be placed at the Tauranga respite house.

For mental health support call:

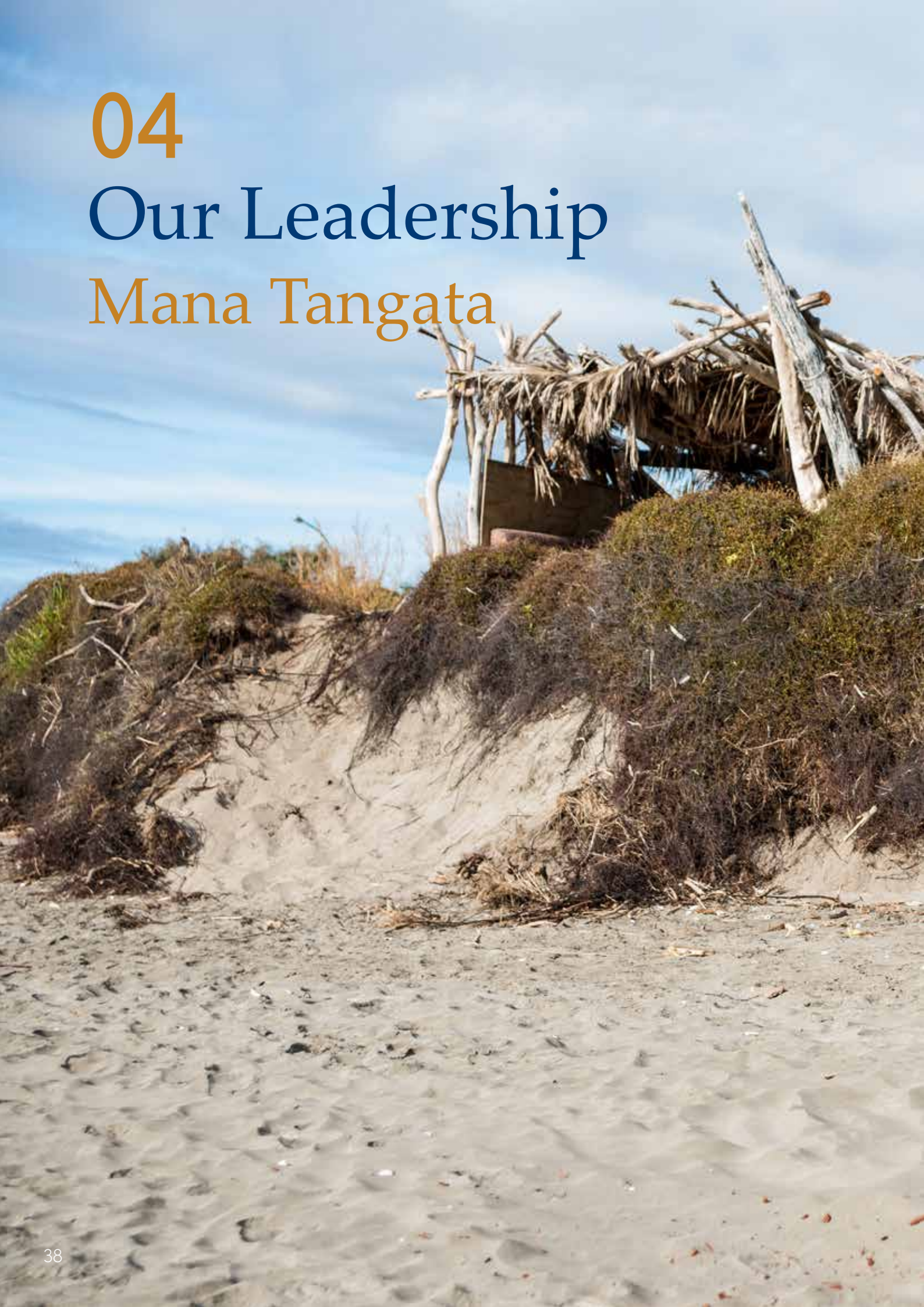
The Mental Health Crisis line on 0800 774 545.

For Eastern Bay youth (0-18 years) call Voyagers on 0800 486 947.

For Tauranga and Western Bay youth (0-18 years) call 0800 333 061.

For Youth Alcohol & Drug issues call Sorted on 0800 BAYSORT (0800 229 7678).

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).

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 and 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.

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.

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 below (dollars):

Name	Board	AFRM	CPHAC - DSAC	BOPHAC	SHC	Expenses	2018 Total
Mark Arundel	22,440	2,500	750	-	1,250	438	27,378
Yvonne Boyes	22,440	-	-	750	500	1,401	25,091
Bev Edlin	22,440	2,750	938	-	1,000	31	27,159
Geoff Esterman	22,440	2,750	-	1,250	1,000	248	27,688
Marion Guy	22,440	-	750	-	750	465	24,405
Peter Nicholl	22,440	2,250	-	1,000	750	1,217	27,657
Matua Parkinson	22,440	-	-	250	250	220	23,160
Anna Rolleston	22,440	750	750	-	1,000	375	25,315
Ron Scott	28,050	3,000	750	1,000	1,000	431	34,231
Judy Turner	22,440	-	500	-	1,000	813	24,753
Sally Webb	46,200	2,813	750	750	750	5,096	56,359
Total Board Members	276,210	16,813	5,188	5,000	9,250	10,734	323,196
Punohu McCausland	1,500	-	500	-	-	485	2,485
Lyall Thurston	-	-		750	-	368	1,118
Mary-Anne Gill	-	-	750	-	750	584	2,084
Janine Horton	-	-	500	-	-	-	500
Clyde Wade	-	-	-	750	-	168	918
Paul Curry	-	-	750	-	-	-	750
Total All Members	277,710	16,813	7,688	6,500	10,000	12,339	331,050

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	8	
Yvonne Boyes	11	9	
Bev Edlin	11	10	
Geoff Esterman	11	10	
Marion Guy	11	10	
Punohu McCausland	11	6	Rūnanga Representative
Peter Nicholl	11	7	
Matua Parkinson	11	8	
Anna Rolleston	11	9	
Ron Scott	11	11	Deputy Chair
Judy Turner	11	9	
Sally Webb	11	9	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 2018 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	3	3	
Sally Webb	3	3	
Judy Turner	3	2	
Mark Arundel	3	3	
Beverley Edlin	3	3	Chair
Anna Rolleston	3	3	
Marion Guy	3	3	
Janine Horton	3	2	Lakes DHB Representative
Paul Curry	3	3	Community Representative
Mary-Anne Gill	3	3	Waikato DHB Representative
Punohu McCausland	3	2	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	3	
Geoff Esterman	4	4	Chair
Matua Parkinson	4	1	
Peter Nicholl	4	4	
Ron Scott	4	4	
Sally Webb	4	3	
Clyde Wade	4	3	Waikato DHB Representative
Lyall Thurston	3	2	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	10	
Anna Rolleston	3	3	Anna joined AFRM later than everyone else
Beverley Edlin	11	11	(from April 2018)
Geoff Esterman	11	11	
Sally Webb	11	10	Chair (to April 2018)
Peter Nicholl	11	9	
Ron Scott	11	11	Chair (from April 2018)

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	4	4	Chair
Sally Webb	4	3	
Ron Scott	4	4	
Anna Rolleston	4	4	
Beverley Edlin	4	4	
Geoff Esterman	4	4	
Judy Turner	4	4	
Marion Guy	4	3	
Yvonne Boyes	4	2	
Peter Nicholl	4	3	
Matua Parkinson	4	1	
Mary-Anne Gill	4	3	Waikato DHB 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:

- Sally Webb (Board Chair)
- Mark Arundel
- Yvonne Boyes
- Matua Parkinson
- 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.

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 (HR) policies and procedures are reviewed biennially in-line with 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).

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.

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

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.

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

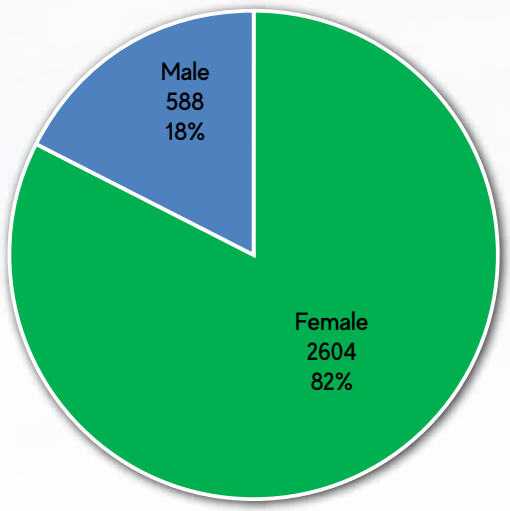
Gender Pay Equity

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.

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.

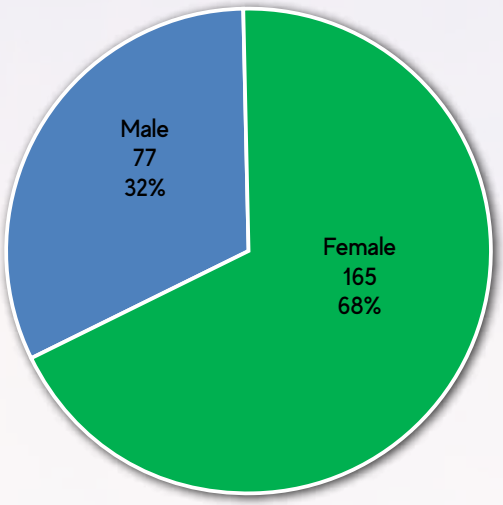
The majority of BOPDHB staff are covered by collective employment agreements (93%, 3,192 of our 3,434 staff). This ensures that all employees, regardless of gender or other areas of potential inequity, are remunerated at the same level for equivalent work.

2017/18 Employees with Collective Employment Agreements



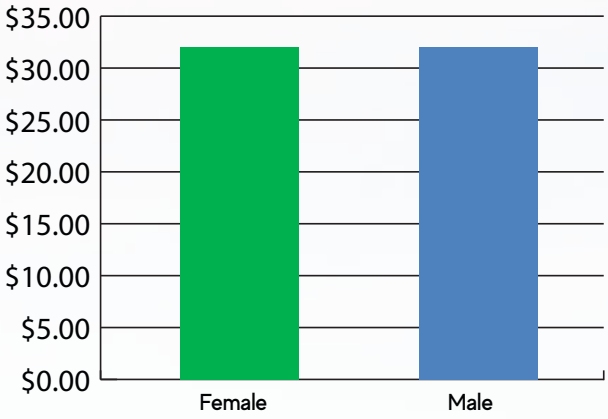
The remaining 242 staff are covered by individual employment agreements (IEA). To ensure that IEA roles are fairly remunerated, BOPDHB has adopted the Strategic Pay SP10 job evaluation methodology. This methodology has extensive following in the public and private sectors, and provides high quality and 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.

2017/18 Employees with Individual Employment Agreements

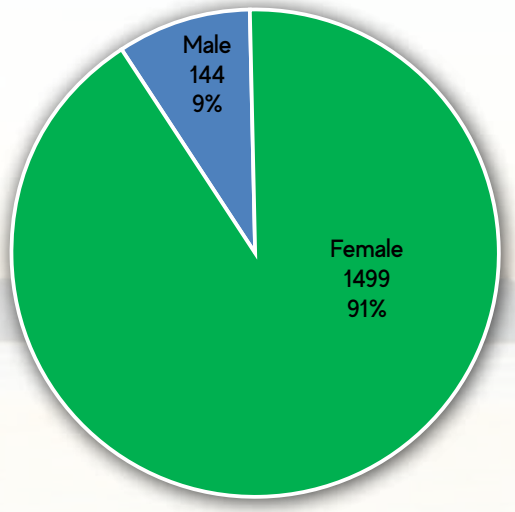


Nursing is our largest employment occupational group, representing 1643 staff and 48% of our work force (2017/18: 1,587, 48%). 91% of this group are female, and no difference is noted in average remuneration between male and female staff.

2017/18 Median Hourly Rate Nursing

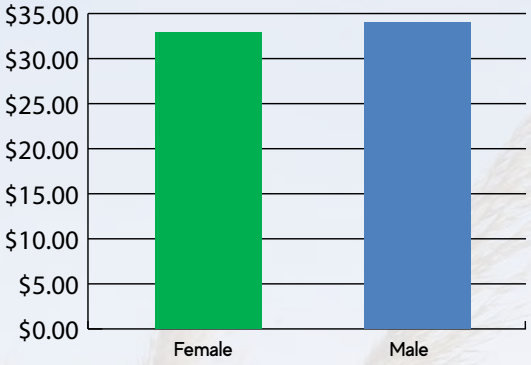


Nursing

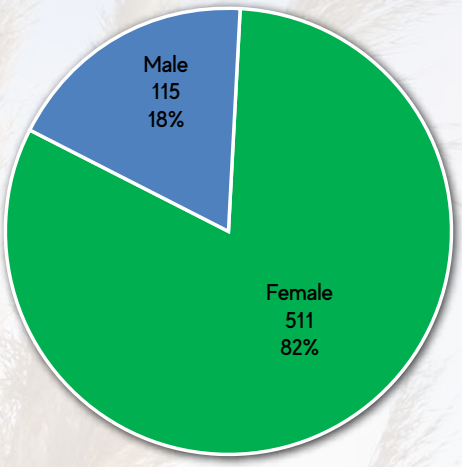


Allied Health is our next largest group, representing 626 staff (2016/17: 611). This group includes Occupational Therapists, Social Workers, Physiotherapists and a range of other clinical positions. 82% of this group are female, and there is minimal difference noted in average remuneration between male and female staff.

Median Hourly Rate - Allied Health

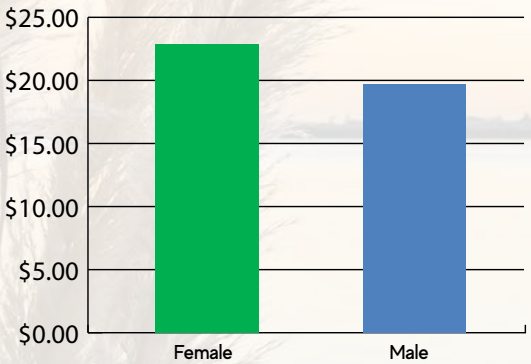


Allied Health 2017/18

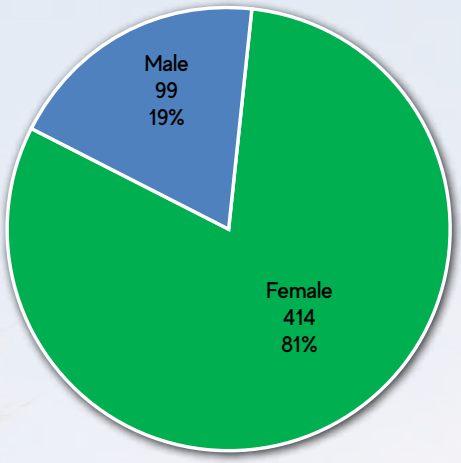


Non-clinical and clerical staff are another large group, representing 500 staff. This group includes Security, Stores, Orderlies and Clerical staff, amongst others. 81% of this group are female, and a difference is noted in average remuneration between male and female staff. Women are represented more in senior management positions with this specialty leading to higher female wages.

Median Hourly Rate - Non-Clinical Support and Clerical Services



Non-Clinical Support and Clerical Services



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 2017/18 with 58% of the Board Members being female and 17% Māori. 27% of Managers in the top two tiers of the BOPDHB are female (compared to 30% in 2016/17) and 18% are Māori (compared to 8% in 2016/17).

Employment

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.

Māori make up 25% of the Bay of Plenty working age population however only 11.5% of the BOPDHB employees. There are a number of strategies in place to grow this segment of the BOPDHB employee population. Workforce Development has been identified as one of the Health Service Plan priorities.

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 programme recognises 10, 15, 20, 25, 30, 35 and 35+ years of continuous service and receives positive feedback from participants. For 2017/18, the longest serving staff members recognised this year had served 59 years (Whakatāne) and two staff had each served 45 years in Tauranga.

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.

This year we welcomed 587 new staff (2016/17: 484), including 484 clinical staff.

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.

This year we welcomed 587 new staff (2016/17: 484), including 484 clinical staff.

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 its 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, has been a continuing drop in the cost of compensation claims, estimated to be $376,000 (194 open claims), reduced from the last financial year (2016/17 - $395,000: 214 open claims).

As well as Health & Safety training, the BOPDHB provides staff with Healthy Living, Working with Aggression and Restraint Minimisation and Manual Handling training. The latter course has seen a marked decrease in the number of back injuries.

employee healthyliving

In 2017/18, 271 staff accessed EAP (compared with 248 in 2016/17), 59.8% of sessions related to personal issues, and 40.2% related to workplace issues.

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. For 2017/18, 67% of staff (2,316 staff members) received vaccination (2016/17: 64.3%, 2,137 staff members).

sweat

staff wellness exercise and training

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 which supports workplaces to work better through wellbeing.

Developed by Toi Te Ora, the BOPDHB Public Health Service, WorkWell can be adapted to any workplace. 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.

WORKWELL™

Leave

In 2017/18, 76 staff went on paid parental leave (compared to 70 staff in 2016/17). 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 for 2017/18 was 3.36%, compared to 3.15% in 2016/17.

Turnover has increased to 8.82% in 2017/18 compared to 8.31 % in 2016/17.

Staff Engagement and Partnership

Creating our Culture

Evidence shows when healthcare staff are more engaged in their work, teamwork improves, patients have a better experience and care is safer, of higher quality and more productive.

Staff Engagement and Culture is one of the four key strategic priorities of the Bay of Plenty District Health Board, and the CARE values have evolved as the result of the collective thoughts of the 2800 staff and patients who participated in the Creating our Culture workshops and surveys.

The initial work 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/December 2016.

Every staff member and leader was encouraged to take part in a series of workshops, feedback sessions and masterclasses (patients also participated through surveys and session attendance) and the buy-in was remarkable. By the end of the first week of Creating our Culture 1,010 staff and 289 patients, families and their whānau, attended 17 sessions across both Whakatāne and Tauranga sites and 1,826 surveys were completed (1,537 by staff and 289 by patients).

The work continues and at its foundation remains the BOPDHB's evolved CARE values, encompassed within Manaakitanga;

In November 2017 we completed the second Creating our Culture staff and patients' survey. The purpose of the second survey was to investigate the impact of the Creating our Culture activities and actions during the 12-month period between the first survey in November 2016 and last Novembers one.

Overall the employee survey shows there has been good progress within the year. Although we had less staff and patients complete the surveys, the participation rates were still credible with 1,147 staff (1,537 in 2016) and 241 (289 in 2016) patients taking part in this latest survey.

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 $57,645 was awarded to BOPDHB employees during the 2017/18 financial year (2016/17: $55,110).

- Advanced Study Fund: $34,978.33
- Whakatāne Staff Study Fund: $1,667
- BOP Learning Scholarships: $21,000

BOP Learning Scholarships are available to staff through the generous support of businesses sponsoring the funding of the scholarships. In 2017/18 scholarships totalling $21,000 were sponsored by: Bay of Plenty Medical Research Trust, Pure Print, Holland Beckett Lawyers, Venturo Ltd, NZ Institute of Safety Management, Interlink, Farmers Auto Village, and Guild & Spence Electrical.

Learning scholarships were awarded to 12 staff members (compared with 20 awarded in 2016/17). Recipients were from a range of roles and services including Community Allied Health, Information Management, Community Health 4Kids, People & Capability Team, Service Improvement Unit, Pharmacy, and Regional Māori Health Services.

Two Whakatāne staff from Radiology and the Service Improvement Unit received awards from the Whakatāne Staff Study Fund.

In 2017/18, 26 BOPDHB employees were reimbursed a portion of their course fees for tertiary study through the Advanced Study Fund (compared to 21 employees in 2016/17). Applicants received 60% reimbursement towards their fees.

Innovation Awards

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.

Twenty nine entries were received for the 2017 Innovation Awards, held in October, with six finalists chosen.

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 2017/18, a total of 1,155 staff attended these training courses (337: 2016/17).

Attendances are as follows:

- Treaty of Waitangi Refresher: 18
- Treaty of Waitangi 2 Day Course: 58
- Cultural Awareness Tauranga Moana: 14
- Engaging Effectively with Māori: 1,065

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.

Staff Recognition

Held in December 2017, the awards recognised staff with over ten years' service. The longest serving staff members recognised had served 59 years (Whakatāne) and two staff had each served 45 years in Tauranga.

Professional Development

In 2017/18, 1,820 internal training events were offered with 23,432 participants completing training. (2016/17: 1,578 events and 25,330 participants). This figure includes Orientation, clinical, non-clinical, leadership, fire, health and safety, IT training and mental health.

38% of learning was completed online (compared with 41% in 2016/17) with 55 on-line learning courses offered through Midland Learning. Midland Learning also includes the Mahara e-Portfolio platform which enables staff to demonstrate professional competency.

Research Awards

The Bay of Plenty Clinical School Research Awards was held in October 2017. Twenty nine applications were received from a variety of services across the BOPDHB. The six finalists were from Patient Information Centre, Adult Community Mental, Health & Addiction Service, Toi Te Ora, WBOP PHO and ENT & Speech Language Therapy teams and Admissions Planning Unit.

First Place Winner was "Reduce waiting time for acute medical patients New Model of Care" from Admissions Planning Unit.

Second Place Winner (and People's Choice Award) was "The Patient Information Centre – Journey from Fledgling to Flourishing".

Staff Status

Staff Number	3,434 permanent and temporary staff (2016/17: 3,315)
Average Age	Average age is 47.1 years (2016/17: 47.1 years)
Disability Profile	Our proportion of employees who report a disability is 0.1% (2016/17: 0.1%)
Gender Profile	Women make up the majority of our workforce with 80.6% female compared with 19.4% male (2016/17: Female 80.2%, Male 19.2%)

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.

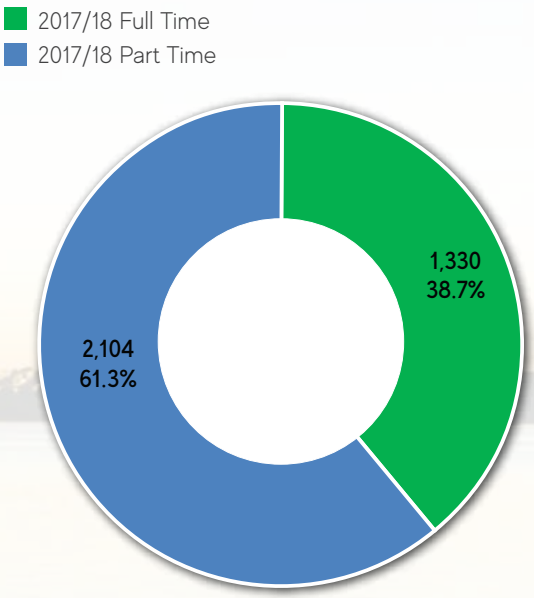
Staff who are require suitable parking are provided with the option to access this on campus in close proximity to their work area. Staffs are also encouraged to use the in-house occupational health service as and when they require assistance.

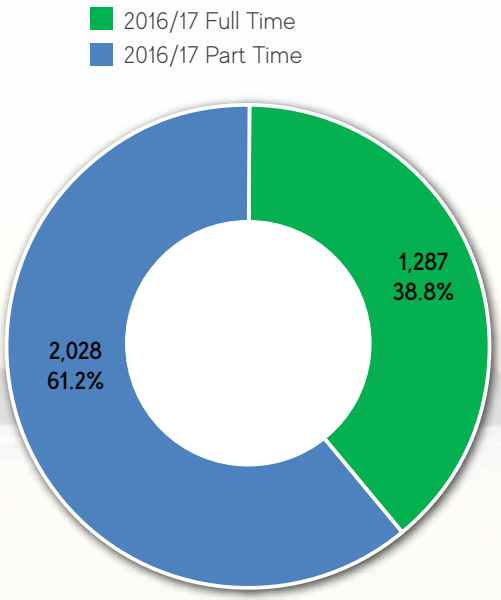
Staff with disabilities that impact on their mobility are identified and a buddy system is set up to assist them in event of emergency evacuation of buildings.

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

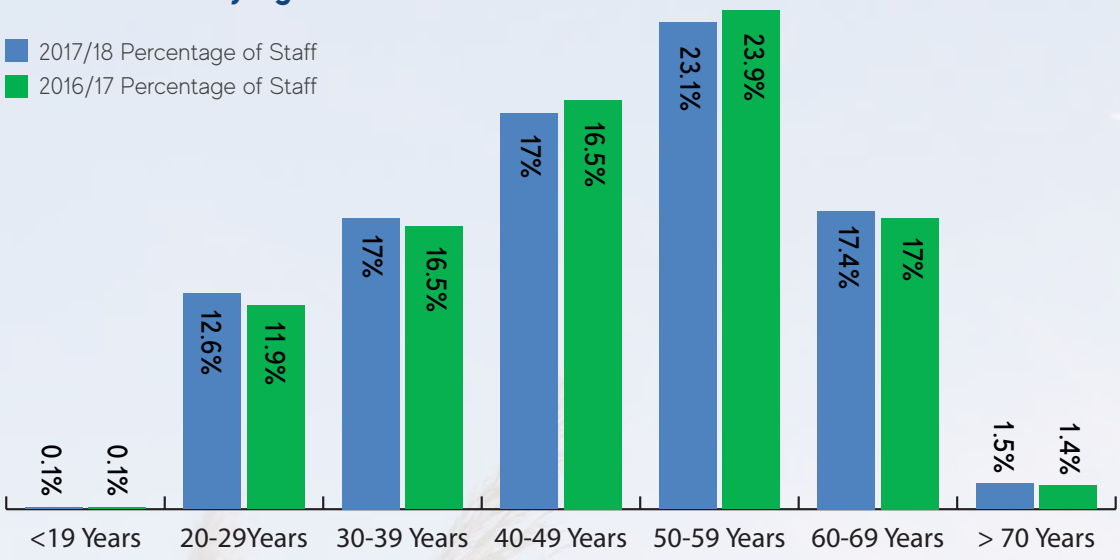
Occupational Group	2017/18 Full Time	2017/18 Part Time	2017/18 Total	2016/17 Full Time	2016/17 Part Time	2016/17 Total
Admin/Management	361	252	613	355	244	599
Allied	340	286	626	326	285	611
Medical	295	123	418	268	119	387
Nursing	264	1,380	1,644	270	1,317	1,587
Support	70	63	133	68	63	131
Total	1,330	2,104	3,434	1,287	2,028	3,315

BOPDHB Staff Status

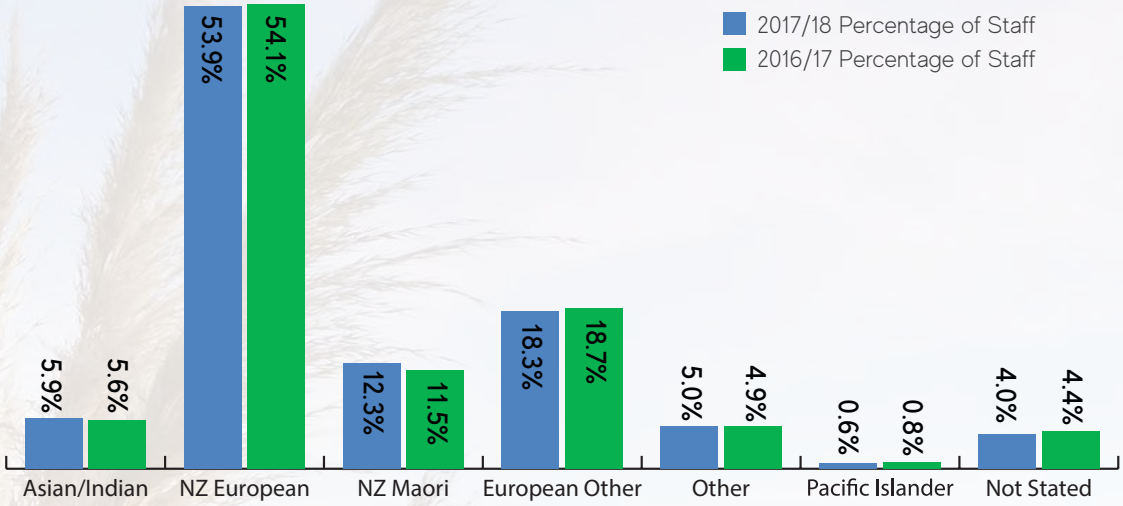




BOPDHB Staff by Age Band



BOPDHB Staff by Ethnicity



Termination Payments 2017/18

Reason	Number	Gratuity	Redundancy
Redundancy	1		$33,033.67
Redundancy	1		$38,792.50
Redundancy	1		$19,275.90
Redundancy	1		$19,875.00
Redundancy	1		$9,500.10
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,500.00	
Retire	1	$2,000.00	
Retire	1	$2,500.00	
Retire	1	$6,708.37	
Retire	1	$2,000.00	
Total	18	$35,708.37	$120,477.17

Salaries over $100,000

Year ended 30 June 2018				30 June 2017
Salary Bands	Medical & Dental Staff	Other	Total	Total
100,000-110,000	41	54	95	74
110,000-120,000	28	25	53	57
120,000-130,000	14	15	29	18
130,000-140,000	15	8	23	19
140,000-150,000	13	2	15	17
150,000-160,000	13	4	17	11
160,000-170,000	10	2	12	11
170,000-180,000	10	1	11	10
180,000-190,000	5	3	8	7
190,000-200,000	8	3	11	9
200,000-210,000	8	1	9	11
210,000-220,000	5	0	5	8
220,000-230,000	15	1	16	15
230,000-240,000	11	0	11	12
240,000-250,000	11	1	12	10
250,000-260,000	8	0	8	11
260,000-270,000	5	0	5	11
270,000-280,000	10	0	10	6
280,000-290,000	7	0	7	9
290,000-300,000	5	0	5	5
300,000-310,000	5	0	5	4
310,000-320,000	5	0	5	5
320,000-330,000	6	0	6	3
330,000-340,000	4	1	5	1
340,000-350,000	1	0	1	0
350,000-360,000	1	1	2	2
360,000-370,000	1	0	1	3
370,000-380,000	3	0	3	0
380,000-390,000	2	0	2	1
430,000-440,000	0	0	0	1
440,000-450,000	1	1	2	0
450,000-460,000	1	0	1	1
470,000-480,000	0	0	0	2
490,000-500,000	0	0	0	0
510,000-520,000	1	0	1	1
530,000-540,000	1	0	1	0
Total over $100,000	**274**	**123**	**397**	**355**

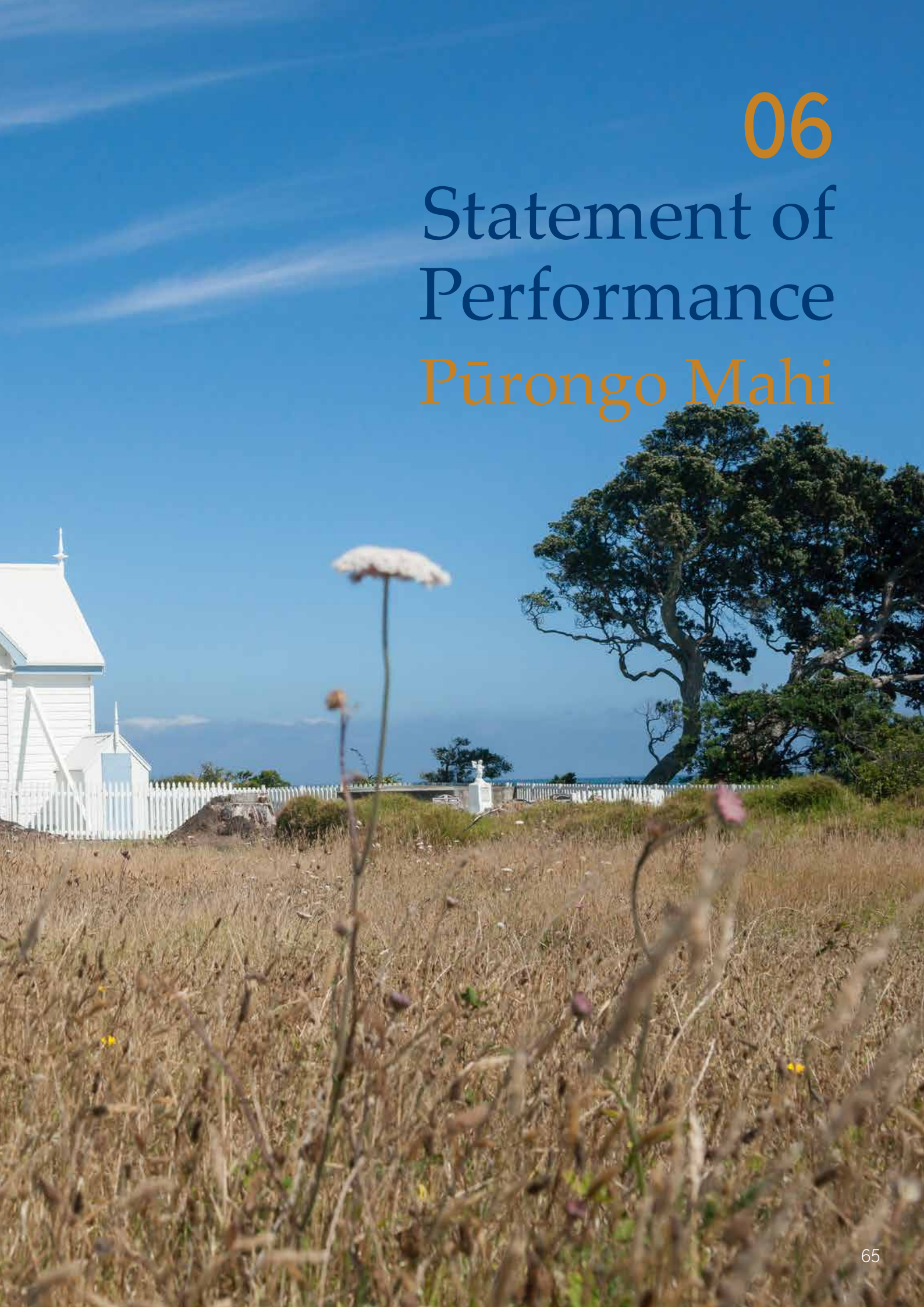
Directors' and Officers' Insurance

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 2017/18 (2016/17: Nil).



06
Statement of Performance
Pūrongo Mahi

What We Are Trying To Achieve

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 234,350 residents, a quarter of whom identify as being Māori. Our vision of '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 improve our engagement with other government agencies and local body organisations to best deliver services that will achieve the best outcomes for our residents. 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 new ways of 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.

To assist you in reading and interpreting this report, we have colour coded our 2017/18 achievements. A ✓ symbol indicates that our performance has achieved, or exceeded the target. A ✗ symbol indicates that we have not achieved the target.

The function of the Statement of Performance Expectations is to summarise performance against metrics used by BOPDHB to evaluate and assess the services and products required to deliver the outcomes of the 2017/18 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.

This year's Statement of Performance Expectations provides the reader with a detailed account of performance against five key metrics that map to the five key priority populations 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.

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 or 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 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 2018 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. People receive timely and appropriate complex care
4. 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 Bay of Plenty DHB.

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 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. People receive timely and appropriate complex care.
4. Health inequalities between population groups in our community will reduce.

Early Detection and Management services are represented in our reporting by an outcome target of 'people stay well in their homes and communities' with four 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.
4. More people maintain their functional independence.

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 healthier, able to self-manage and live longer.
2. People are able to participate more in society and retain their independence for longer.

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:

4. People are healthier, able to self-manage and live longer.
5. People are able to participate more in society and retain their independence for longer.
6. People receive timely and appropriate complex care.
7. Health inequalities between population groups in our community will reduce.

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:

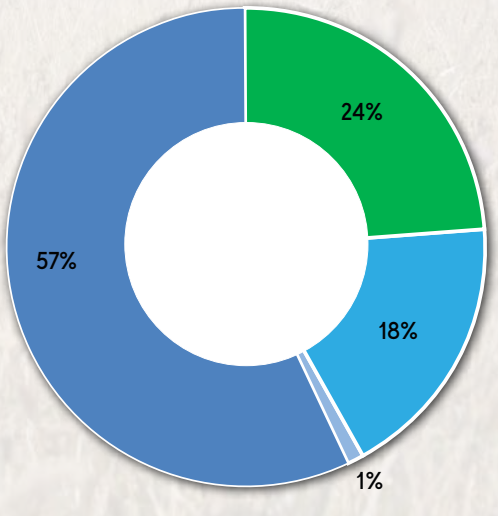
8. People are seen promptly for acute and arranged care.
9. People have appropriate access to elective services.
10. Improved health status for people with a severe mental illness or addictions.
11. People with end-stage conditions are supported.

Statement of Financial Performance by Output Class

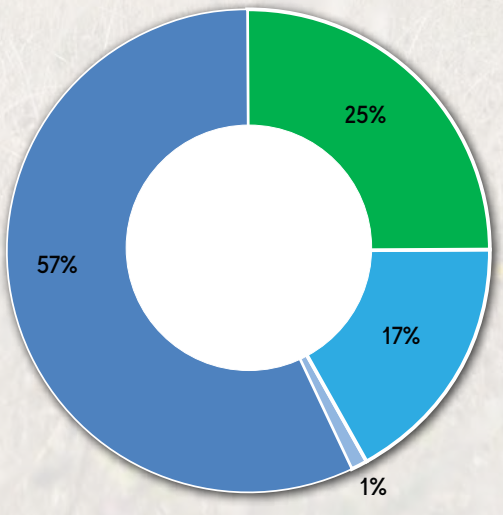
The following table discloses the actual financial performance by output class against our Annual Plan for the year ended 30 June 2018.

Summary of Revenues and Expenses by Output Class	2017/18 $000s Actual	2017/18 $000 Plan	2016/17 $000s Actual	2016/17 $000s Plan
Early Detection				
Total Revenue	193,444	202,600	188,181	190,900
Total Expenditure	195,839	203,300	188,088	190,100
Net Surplus / (Deficit)	**(2,395)**	**(700)**	**93**	**800**
Rehabilitation & Support				
Total Revenue	142,518	131,800	126,080	114,100
Total Expenditure	144,283	132,200	126,018	113,700
Net Surplus / (Deficit)	**(1,764)**	**(400)**	**62**	**400**
Prevention				
Total Revenue	10,537	16,000	10,748	15,000
Total Expenditure	10,667	16,100	10,743	14,900
Net Surplus / (Deficit)	**(130)**	**(100)**	**5**	**100**
Intensive Assessment & Treatment				
Total Revenue	449,652	445,900	429,907	426,200
Total Expenditure	455,219	447,400	429,694	424,400
Net Surplus / (Deficit)	**(5,566)**	**(1,500)**	**213**	**1,800**
Totals				
Total Revenue All output classes	796,151	796,300	754,916	746,200
Total Expenditure All output classes	806,007	799,000	754,542	743,100
Net Surplus / (Deficit)	**(9,856)**	**(2,700)**	**374**	**3,100**

Summary of expenses by output class 2017/18



Summary of expenses by output class 2016/17



Early detection | Rehabilitation | Prevention | Intensive assessment and treatment

Output Class Achievement Summary

Prevention

Health Target: We provided 91% of smokers accessing primary care (target 90%) and 96% in secondary services with smoking cessation advice and support.

Health Target: We fully immunised 2,717 (86%: 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 coordinated 2,584 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 & Management

Health Target: We referred 99% of our clinically obese children to a health professional for nutrition advice (target 95%) in the latest reporting period.

The percentage of pre-school aged children enrolled in dental services remained steady at 92% (target 90%), though there was an increase for Maori to 71%. 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 93%) and for Maori (96% v 91%). When Te Kaha is included (DHB facility), over 98% of Maori are enrolled with a primary health provider.

Breast and cervical screening targets were again met for the total population in the BOPDHB region. However, Maori coverage was significantly (around 10%) lower for both screening programmes.

The percentage of residents who are 65 plus and accessing DHB funded Aged Residential Care services increased to 5.73%, noting the data source for this information has changed.

Rehabilitation & Support

We dispensed just under 3.67m pharmaceutical items.

We completed 76,942 community referred radiology events (measured as relative value units).

We undertook 1,524,521 community laboratory tests and completed these within 48 hours 99% of the time (target 90%).

Our hospices supported 1,490 patients and their families in the community.

Intensive Assessment & Treatment Services

Health Target: Total ED volumes (across Tauranga and Whakatane) were significantly higher for the period December 2017 to March 2018, challenging achievement of this target. However, the target was achieved in three of the four quarters, which means the target was met for 2017/18.

Health Target: We treated and discharged 12,112 elective patients against a target of 10,937. This represented a 2017/18 result of 110.7% against this target.

Health Target: Of our patients referred for radiotherapy or chemotherapy treatment, 94% were seen within 62 days of referral (target 90%).

We achieved three of six Elective Services Patient Flow Indicator (ESPI) targets in 2017/18. ESPIs measure performance against patient referral, wait time and clinical assessment criteria in a hospital setting.

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

Population Priorities

	Healthy Individuals - Mauri Ora	Healthy Families - Whānau Ora	Healthy Environments - Wai Ora	
Long-term Conditions	**Bay of Plenty Population Accountabilities (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 Population Accountabilities (Local Outcomes):** 1. Family/whānau live well with longterm conditions. 2. People are safe, well and healthy in their own homes and communities.	**Bay of Plenty Population Accountabilities (Local Outcomes):** 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.	Strategic Direction Module 1
	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.	**Population Indicators:** Providing healthier homes. Connecting with agencies to meet community needs. Appropriate access to services. People receive prompt and appropriate acute and arranger care. Services provided or funded by the BOPDHB contribute to the transfer of knowledge and skills to family/whānau to enable self-management.	Modules 1, 2 and 3
Child and Youth	**Population Measures:** **How much did we do?** ■ referrals of adults to the Green Prescription programme ■ general practices offering patient portals ■ enrolled patients2 with a patient portal ■ of future care plans that are shared with health professionals	**Population Measures:** **How much did we do?** ■ of whānau ora referrals/ promotional activities undertaken % eligible population who have their cardiovascular disease (CVD) risk assessed completed in the last 5 years	**Population Measures:** **How much did we do?** A BOP Healthy Housing Improvement Plan in place ■ governance group meetings held for co-designed multi-agency initiatives ■ governance group meetings attended for Healthy Families initiatives ■ people supported by specialist palliative care ■ registered users of	Statement of Performance Expectations Module 3
Health of Older People	**How well did we do?** % of people received smoking cessation advice. % pregnant women who identify as smokers. % children fully immunised at eight months. % population over 65 years who have had influenza immunisation. % infants receiving any breastfeeding at six months. % children age 5 caries-free.	**How well did we do?** Reduced ASH rates % of population enrolled with a Primary Health Organisation. % eligible women (45-69) have breast screen examination every three years. % eligible women (20-69) have a cervical cancer screen every three years. ■ presentations to Emergency Department - Triage Level 4 and 5 as a percentage of the total population	**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 wait times for diagnostic services. % 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. % patients reporting better understanding of their health journey.	
Maloti Health – Achieving Equity	**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 place of choice.	**Is anyone better off?** Average age of entry into aged residential care. Hospitalisation rates per 100,000 for acute rheumatic fever.	**Is anyone better off?** Hospitalisation rates per 100,000 foracute rheumatic fever. % of long-term condition clients reporting an improved quality of life.	

Resources: Workforce, performance management, risk management, quality improvement, information communications technology, capital investment partnerships, collaboration, innovation.

Health Target – Summary of Performance

Health Targets are a set of national performance measures designed to improve the performance of health services. Further information is published by the Ministry of Health at www.health.govt.nz/healthtargets.

Health Target	Measure	2018 Target	BOPDHB Sep-17 Qtr.	BOPDHB Dec-17 Qtr.	BOPDHB Mar-18 Qtr.	BOPDHB Jun-18 Qtr.	Achieved
Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours	95%	94.9%	95.0%	93.3%	94.6%	✓
Improved access to Elective Surgery	The volume of elective surgery will be increased by at least 4,000 discharges nationally per year[15]	100%	112.0%	110.3%	111.2%	110.7%	✓
Faster Cancer Treatment	90% of patients receive their first cancer treatment within 62 days of referral with high suspicion of cancer and a maximum two week wait to be seen	90%	90.6%	95.7%	96.7%	95.0%	✓
Increased Immunisation	95% of eight month olds will have their primary course of immunisation (six weeks, three months, and five months immunisation events) on time	95%	86.2%	85.8%	88.5%	84.5%	✗
Better help for Smokers to Quit	90% of enrolled patients who smoke and are seen by a health practitioner in general practices are offered brief advice and support to quit smoking.	90%	89.9%	89.5%	90.2%	90.6%	✓
	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.	90%	94.3%	89.7%	88.2%	100%	✓
Raising Healthy Kids	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 by December 2017[16].	95%	82.4%	98.1%	97.9%	98.7%	✓

15. Our elective surgery discharge target was 10,937 discharges.
16. The Ministry of Health added this measure from 1 July 2016, replacing the previous More Heart & Diabetes Checks measure that is now routinely reported quarterly with other health targets.

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 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

Output Class 1: Prevention

Outcome: People take greater responsibility for their health

Impact: 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 from 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 Bay of Plenty DHB 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 ongoing focus of our Primary Health Organisations (PHOs) on ABCs in a primary care setting has enabled steady performance against this Health Target in 2017/18. 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 been met consistently during 2017/18, reflecting 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 Māori, though the gap is now less than 2% based on Q4 2017/18 data – the total population result in Q4 was 90.6%, while the result for Māori was 88.9%. There is also a clear inequity of smoking prevalence based on the primary care smoking data. While Māori comprise roughly 25% of the population in the BOPDHB region, they make up over 45% of smokers, based on Q4 2017/18 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 2017/18, which is, in large part, due to small numbers in the denominator for this metric. The 90% target was achieved in three of four quarters for the total population, and all four quarters for Māori. The principal concern with the maternity smoking

measure, is again the disparity in smoking prevalence between expectant Māori and non-Māori mothers. In 2017/18, based on the maternity smoking data set, approximately two of every five Māori mothers was a smoker, which represents a rate of smoking prevalence between three and four times greater than for non-Māori 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. These smoking rates signal a significant challenge in achieving the national goal of a smokefree New Zealand by 2025.

Main measures of performance	Volumes						Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	2018 National Average	Achieved	
Providing Smokers who access primary and secondary services with smoking cessation advice and support.							Secondary smoking cessation advice targets were met for both total and Māori populations in 2017/18. There is still a significant concern in regard to the disparity in smoking prevalence, with Māori in secondary settings, on average, 2-3 times more likely to smoke than non-Māori. Reducing smoking prevalence for Māori is a focus area of the 2018/19 system level measures plan, and the Bay of Plenty Strategic Health Services Plan. A gamification approach was introduced early in 2017/18 to incentivise referrals to specialist smoking cessation services. This approach saw gold, silver or bronze awards given to wards based on referral volumes. This approach has been highly successful, with referral volumes more than doubling since its introduction.
Hospitalised Smokers:							
■ Total	95%	96%	95%	**97%**	NA	✓	
■ Māori	96%	96%	95%	**96%**	NA	✓	
Primary Care:							Smoking cessation advice in primary care met the 90% target for the total population, while being just below the target for Māori. Both results represented a 1% improvement from the previous year. While BOPDHB performs reasonably well for this indicator, our rates of cessation support in primary care are amongst the lowest in the country and, at 19.7%, are significantly below the national average of 34.1%.
■ Total	76%	90%	90%	**91%**	90%	✓	
■ High needs/Māori[17]	76%	87%	90%	**89%**	87%	✗	
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 2017/18. Smoking prevalence for Māori mothers is a significant concern and is one of the key focus areas in the 2018/19 system level measures plan. There is an action within the plan to focus smoking cessation services on Hapu Mama.
■ Total	95%	91%	90%	**92%**		✓	Data quality issues remain a concern with this data set. For example, the Q4 2017/18 maternity smoking report, provided by the Ministry of Health, included only 54 mothers – this is despite 700-800 births in Bay of Plenty in any given quarter.
■ Māori[18]	94%	90%	90%	**95%**		✓	

17. Previous Primary Care reporting focussed on all decile 9/10 smokers, who were classified as High Needs. A significant proportion of these were Māori. System Level Monitoring now enables reporting for Māori smokers in 2017.
18. Our Māori Health Plan target for 2016/17 monitored in Trendly was 95%; the target noted here is our 2016/17 Annual Plan target.

Reduction in vaccine preventable diseases

Output Class 1: Prevention

Outcome: People take greater responsibility for their health

Impact: Reduction in vaccine preventable diseases

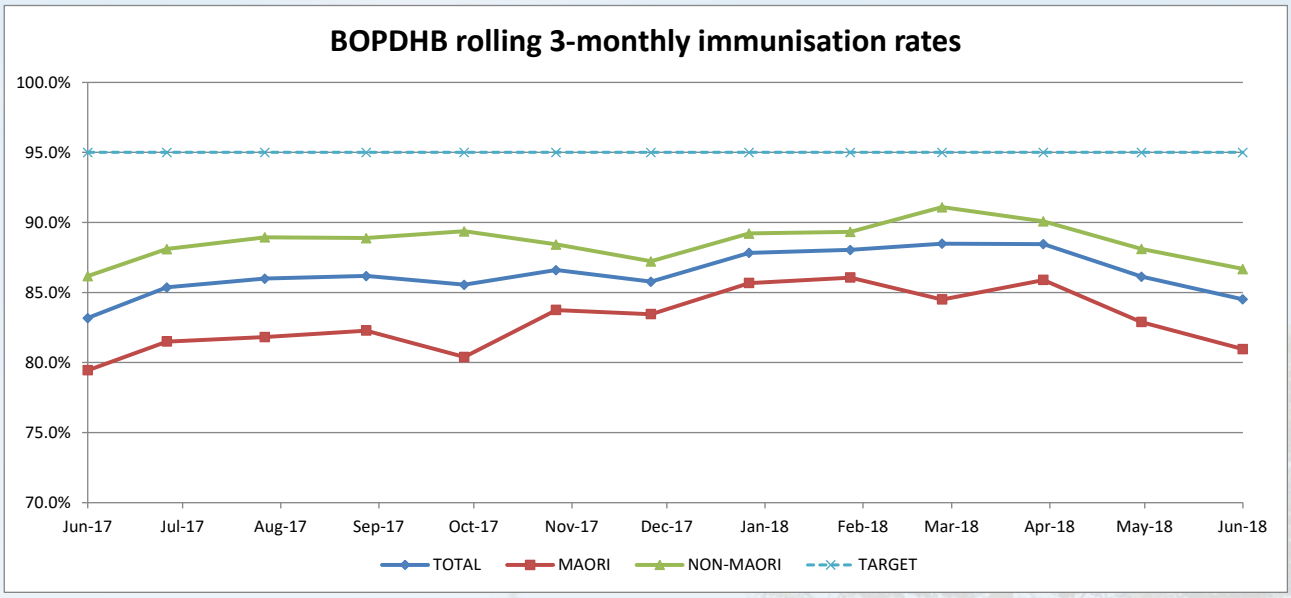
Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. The national 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 Base	2018 Target	2018 Actual	2018 National Average[19]	Achieved	
Children are fully immunised at eight months[20]						A new model of service introduced in 2017/18 has led to reductions in the cohort of missed children – rolling 3-monthly rates of missed children have reduced from 6% to 4.5%. However, in the last quarter there has been a substantive increase in declines, with the latest result (April-June) showing a decline rate in excess of 10%. The increase in declines has reduced the impacts in the missed children space, such that immunisation rates are largely unchanged from 2016/17. The Immunisation Advisory Group is presently exploring evidence-based options for reducing declines, with the intent to achieve sustained coverage above 90% for both total and Māori populations.
■ Total	86%	95%	**86.3%**	91.3%	✗	
■ Māori	82%	95%	**82.5%**	86.9%	✗	
Percentage of the population (>65 years) who have had the seasonal influenza immunisation[21]						Total population 65+ influenza immunisation coverage fell by 2% in the BOPDHB region during the 2017 season. This was despite a 3% improvement in coverage for Māori, which was driven, in part, by a test of change implemented within Nga Mataapuna Oranga PHO. The direction of these changes resulted in a 5% reduction in disparities in influenza coverage between 65+ total and Māori populations. Coverage for both total and Māori 65+ populations remained well below the 75% target in 2017, though performance in the BOPDHB region was better than performance nationally (on average), particularly for Māori.
■ Total Population	60%	75%	**58%**	54%	✗	
■ Māori	51%	75%	**54%**	46%	✗	

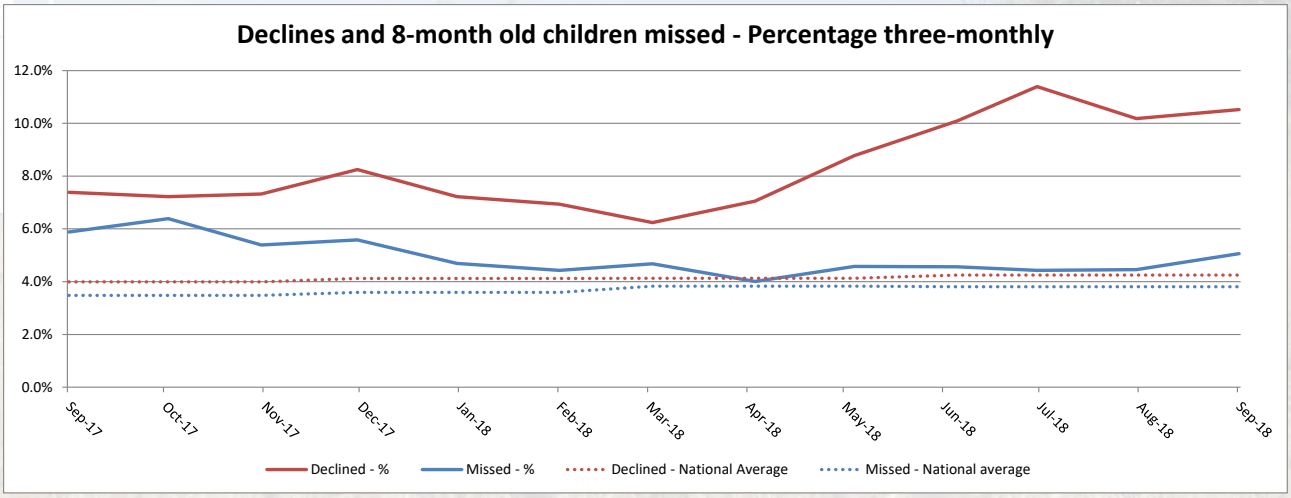
19. National Average source is the 12 month activity for 2017/18 from National Immunisations Register 8-month milestone results.
20. Immunisation result reported is the annual coverage for 12 months ended 30 June 2018, which differs from quarter 4 health target reported results as this is reported over a three month period only.
21. 2018 actual results reflect influenza coverage in the 2017 calendar year. The 2018 influenza immunisation season ends in September 2018, with data not available until October 2018, which is outside of annual reporting timeframes.

Eight month immunisation coverage performance explained

Eight month immunisation coverage was one of the six health targets monitored by the Ministry of Health in 2017/18. This health 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 missed children. A new model of care was introduced during 2017/18, taking effect around September 2017, with a focus on the reduction of missed children and subsequent improvements in coverage for all population groups.



The graph above illustrates rolling three-monthly DHB immunisation rates for Māori, non-Māori and the total population for the thirteen month period from June 2017 to June 2018. Rolling three-monthly immunisation coverage improved for all populations – Māori, non-Māori and total – between June 17 and June 18, though gains in coverage observed between June 17 and March/April were followed by consecutive periods of declining coverage.



The graph above shows that BOPDHB has had higher decline and missed rates than national averages in the last 13 months. Rolling three-monthly decline rates have increased substantially over the last three months, from just over 6% in March 2018 to over 10% in June 2018, which is the principal factor in the reductions in coverage seen in May and June.

Over the last twelve months, decline rates have, on average, been more than twice national average levels (8.4% versus 4.0%), with the last two months impacting heavily on this result. Rates of missed children in BOPDHB have also been above the national average, though this gap has been closing as the rates of missed children in the BOPDHB region have reduced from over 6% to around 4.5% on a rolling three-monthly basis.

While good progress has been made 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 missed children within the cohort who are not enrolled with one of the three local PHOs, particularly at Murupara practice, plays an integral role here.

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 rolling three-monthly result for June saw 61.9% of this cohort immunised (26 of 42)[22]. It is worth noting that opt offs are included in this cohort, which can have a material impact on coverage – the June result was impacted by 7 opt-offs. Rates of missed children are also much higher for this cohort, with high rates of missed children at Murupara Practice a key factor in this.

Improving Healthy Behaviours

Output Class 1: Prevention

Outcome: People take greater responsibility for their health

Impact: People have healthier diets

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.

Bay of Plenty DHB again exceeded the 60% six month breastfeeding target for the total population (2017/18 result was 71%), with a 5% improvement made from 2016/17. However, the target was missed for Māori, which resulted in the disparity for this metric, between total and Māori populations, increase from 3% in 2016/17 to 14% in 2017/18. Breast feeding coverage for Māori, particularly rates of exclusive at three months of age, are a key area of focus for BOPDHB in 2018/19.

Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Number of schools engaged in the Health Promoting Schools programme	44	59	83	73	✗	An additional 14 schools engaged with the Health Promoting schools programme in 2017/18, though this was ten schools short of target. The intent is that all schools in the region are engaged in this programme.
The number of referrals to adult GRx (Green Prescription) programmes	2,376	2,461	2,233	2,584	✓	Green Prescription volumes continued to improve in 2017/18, with an approximate 5% improvement on the previous year. The improvement was driven in almost equal measure by improvements in volumes for Māori (4.3%) and non-Māori (5.5%). BOPDHB again achieved this target, though there still remains an inequity between Māori and non-Māori participation.
■ Māori	1,068	1,040		1,085		
■ Non-Māori	1,308	1,421		1,499		
Percentage of infants receiving breast milk at six months[23]						Well Child Tamariki Ora (WCTO) reporting by the Ministry of Health recommenced in March 2018, though the six month breastfeeding indicator is no longer reported. However, the reporting system recently implemented by Plunket enables BOPDHB to monitor performance of this metric for women who are enrolled with Plunket (around 70% of women in the BOPDHB region). 2017/18 data indicates a drop off in the percentage of Māori infants receiving breastmilk at six months, while there was an improvement overall (indicating a significant improvement for non-Māori infants). There result of these changes is a clear disparity for this indicator in 2017/18. There is presently a project underway that is focussed on exclusive breastfeeding for Māori at three months, which should flow into the six monthly results for Māori too.
■ Total	67%	66%	60%	71%	✓	
■ Māori	61%	63%	60%	57%	✗	

22. The cohort of children not enrolled with one of the three local PHOs includes children enrolled at Murupara Practice, Waihi Beach Practice and Te Kaha Health clinic, children who have been opted off the national immunisation register, and children where the GP is unknown.
23. This measure is no longer reported on as part of Well Child Tamariki Ora reporting, as indicators were revised prior to this reporting recommencing in March 2018 (backdate reporting was also provided). 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 Māori.

People Can Access their Health Information

A key objective within the Integrated Healthcare Strategy is to empower patients to achieve better health by promoting health literacy and improving information systems. 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 Base	2018 Target	2018 Actual	Achieved	
The number of general practices offering patient portals	17	20	20	✓	20 of the 40 general practices in the BOPDHB region are presently offering patient portals (data to December 2017). This includes 13 (of 26) practices with Western Bay of Plenty Primary Health organisation, five (of 12) with Eastern Bay Primary Health Alliance and two (of 2) with Nga Mataapuna Oranga.
The percentage of enrolled patients with a patient portal[24]	8%	50%	9%	✗	There has been a small increase in uptake of patient portals by enrolled patients in the BOPDHB region. Note the 50% target was set without baseline data and was overly ambitious. This will remain an area of focus in 2018/19.

24. The 2017/18 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.

Fewer Children and Adolescents have Decayed Missing Filled Teeth

Output Class 2: Early Detection and Management

Outcome: People stay well in their homes and communities

Impact: Children and Adolescents have better oral health

Main measures of performance	Volumes						Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	2018 National Average[25]	Achieved	
Percentage of children who are caries free at age five - PP11							In 2017/18 there has been a programme of work to increase preschool oral health enrolment, which has been very successful (see measure below). However, improved enrolment has led to additional capacity issues within an already constrained service. This has been a key factor in reductions in caries free aged 5. Reductions were seen for both populations, while significant disparities remain. The 5 2 1 0 programme adopted within the BOPDHB region will be a key enabler of improvement.
■ Total	51%	51%	58%	**50%**	NA	✗	
■ Māori	27%	30%	58%	**29%**	NA	✗	
Percentage of adolescent utilisation of DHB funded dental services - PP12							Ministry of Health CDA data indicates that 9,222 adolescents were seen by community dental providers in 2017. This is essentially unchanged from 2016, when 9,214 adolescents were seen in the community. In addition, a further 429 high need adolescents were seen by community dental services, or Te Manu Toroa. In total 68% of adolescents (9,651) received dental services in 2017, which is in line with the national average. The development of dashboard reporting enables identification of high performing schools and dentists, while showing that adolescent dental utilisation increases with age, with a peak for 17 year olds as expected.
■ Total	70%	67%	85%	**68%**	68%	✗	
Percentage of Children (0-4 years - % year 1) enrolled in DHB funded dental service – PP13 (measure 1)							A significant data quality exercise was carried out in early 2017, which resulted in around 7,000 incorrectly enrolled children being removed from titanium. This exercise saw a dramatic reduction in preschool dental enrolment (from 67% to 58% for Māori), which provides context around the improvements made for Māori in 2017. Improvements were driven by a preschool enrolment initiative, where parents of non-enrolled Māori children were identified and called. The improvements made during 2017 have continued during 2018, with internal titanium reporting indicating Māori preschool dental enrolment is now above 84%.
■ Total	89%	93%	95%	**92%**	NA	✗	
■ Māori[26]	65%	67%	95%	**71%**	NA	✗	
■ Non-Māori	95%	114%	95%	**108%**	NA	✓	
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination – PP13 (measure 2)							Arrears (children overdue for their scheduled performance) percentages increased for both total and Māori populations during 2017. As mentioned above, there have been substantive improvements made in the number of children enrolled in dental services during 2017, which has placed additional capacity on an already constrained service. Addressing these capacity challenges should enable improvements in this area during 2018 and beyond.
■ Total	12%	12%	10%	**15%**	NA	✗	
■ Māori	-	12%	10%	**13%**	NA	✗	

25 Oral health reporting is by calendar year to align with school clinics. Published results are for the 12 month period ending 31 December 2017. 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.

26 Enrolment of Māori children (0-4) in Oral health services is a priority in the Māori Health Plan with a target of 95% engagement.

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. Measures of effective palliative care have been extended this year to include patient choice outcomes and the appropriateness of services for families/whānau.

Main measures of performance	Volumes				Comments
	2017 Base	2018 Target	2018 Actual	Achieved	
Percentage of patients receiving specialist palliative care who die in their chosen place of death.	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. Data completeness and quality around chosen place of death has improved substantively during 2017/18 and it is anticipated the data will be useable for 2018/19.

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 in remaining in their homes for longer by delivering functional services such as personal care and household management services.

These multiple contacts with the health system provided 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

Output Class 2: Early Detection and Management

Outcome: People stay well in their homes and communities

Impact: Children and Adolescents have better oral health

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 six 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
	2016 Base	2017 Base	2018 Target	2018 Actual	2018 National Average	Achieved	
Reduced ASH rates 45 – 64 years[27]							Standardised 45-64 ASH rates in the BOPDHB region are below national averages for both total and Māori populations. This is despite ASH rates increasing for both populations over the last 12 months. More realistic 45-64 ASH targets for Māori have been set for 2018/19.
■ Total	3783	3859	3592	**3731**	3925	✗	
■ Māori	6732	6894	6060	**7590**	7824	✗	
Percentage of eligible population who have had their Before School Checks (B4SC) completed							Collaboration between multiple agencies enabled achievement of both total and high needs B4SC targets in 2017/18. 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	90%	92%	90%	**90%**	NA	✓	
■ High needs	90%	91%	90%	**90%**	NA	✓	
Incidence number of acute rheumatic fever cases[28]	6	9	3	**5**	NA	✗	Data is unconfirmed at this stage, but indicates a reduction in rheumatic fever cases compared to the previous two years.
Hospitalisation rates per 100,000 for acute rheumatic fever – PP28	2.8	4.0	1.3	**2.1**	NA	✗	The number of cases and hence the incidence rate of rheumatic fever were both above targets in 2017/18 based on unconfirmed results.
Percentage of Rest Home residents receiving vitamin D supplement from their GP[29]	73%	67%	70%	**NA**	NA	NA	This metric was not reported during 2017/18 and will be removed from future Statement of Performance Expectations.

27. Period reported is the 12 months ending 31 March 2018
28. Bay of Plenty DHB Rheumatic fever rates are for the financial year ending 30 June 2018 – data is unconfirmed at this stage. Please note that annual trending is not particularly reliable for this metric as the number of cases are small.
29. Source data for Vitamin D injections was received quarterly from ACC; however, reporting for this metric ceased approximately 18 months ago.

Our Emergency Departments received over 80,000 presentations (81,049) during the 2017/18 financial year from people seeking medical assistance. This represented a growth in presentation volumes of 2.5%, and was primarily driven by high ED demand over the summer months – from December 2017 to March 2018, where presentations were between 3.6% and 9.4% higher than during the equivalent month in 2016/17. Despite the increased demand pressures, the ED target was achieved in three of four quarters, which represents achievement across the 2017/18 year.

Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Percentage of triage level 4 and 5 presenting to the Emergency Department (ED)	50%	53%	≤65%	**51%**	✓	There was a small, but significant, reduction in the proportion of triage 4 and 5 presentations to ED during 2017/18. Over the last three financial years the number of triage 4 and 5 ED presentations has declined, while total presentations have increased. Fewer presentations of lower acuity enable us to attend to the more serious conditions in a timely fashion. The significant majority of level 4 and 5 presentations are the result of self-referrals (high 80%'s) – this proportion has slowly, but steadily, increased from 86.3% to 88.5% from 2015/16 to 2017/18.
Number of presentations to ED – Triage Level 4 and 5 as a percentage of the total population	19%	18%	12%	**18%**	✗	While BOPDHB has experienced steady population growth in 2017/18 (over 2%), and triage 4 and 5 ED presentations have reduced, there has been no change to this metric (when reported as a whole number). Therefore, we again missed our target of 12%. To achieve this target would require a substantive reduction in low acuity presentations, which would need to be driven by a reduction in self-referrals, i.e. identifying further opportunities to encourage people to attend primary care in the first instance. There are initiatives currently in place, such as referring patients from ED back to primary care for specified conditions, that are targeted at this area.
Increased numbers of Year 9 students receiving HEEADSSS assessment in decile 1-3 schools[30]	198	198	250	**433**	✓	433 year 9 students received a HEEADSSS assessment in the 2017 calendar year, an improvement of over 100% on the previous year and over 70% above target. With 512 eligible students over the period, this represents a rate of coverage of 84.6%. There was disparity in coverage for Māori, with 245 of 316 eligible students receiving an assessment (77.5%), compared to 188 of 196 non-Māori (95.9%).

30 These are assessments on factors relating to Home, Education, Employment, Activities, Drugs and Alcohol, Sexuality, Suicide and Spirituality (HEEADSSS), with a focus on year 9 students in decile 1-3 schools. Data for this metric is for the calendar year ending December 2017 and is sourced from Q2 (October-December 2017) IDP reporting for PP25.

Long-term conditions are detected early and managed well

Output Class 2: Early Detection and Management

Outcome: People are safe, well and healthy in their own homes and communities

Indicator: 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
	2016 Base	2017 Base	2018 Target[31]	2018 Actual	2018 National Average	Achieved	
Percentage of population enrolled with a Primary Health Organisation (PHO)							BOPDHB achieved both PHO enrolment targets in 2017/18, with over 99% of our population of 234,450 enrolled with a PHO. Māori enrolment was over 96% (of 58,380). A further 1592 (1357 Māori) BOPDHB residents are enrolled with Te Kaha practice, which is a BOPDHB primary care facility.
■ Total	99%	98%	90%	**99.1%**	93.4%	✓	
■ Māori	97%	94%	90%	**96.1%**	90.8%	✓	
Percentage of eligible population who have their cardiovascular disease (CVD) check completed within the last 5 years.							BOPDHB achieved CVDRA targets for both total and non-Māori populations for the five year period ending 30 June 2018. While the target was missed for Māori, BOPDHB is ranked 2nd equal for performance against this metric nationally for Māori. BOPDHB performs well against this metric for all populations reported on in the Statement of Performance Expectations.
■ Total	90%	92%	90%	**93%**	88%	✓	
■ Māori	86%	89%	90%	**89%**	86%	✗	
■ Non Māori	92%	92%	90%	**94%**	89%	✓	
Percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the last five years	New	72%	90%	**75%**	69%	✗	The principal focus for CVDRA has shifted to the high risk cohort of Māori males aged 35-44. Performance against this metric has improved over the past 12 months, though there is still significant room for improvement to achieve the 90% target. As with the general CVDRA metric, BOPDHB performs well against this metric nationally (1st), with two of the three PHOs in the BOPDHB region in the top five performers nationally.

31. The PHO enrolment target was reduced to 90% in 2017/18 to align with PP33. 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 1,600 Te Kaha residents enrolled at Te Kaha practice, which is a BOPDHB run primary health care facility. If these residents are included then Māori enrolment in primary care increases by 2% to over 98% enrolment.

Main measures of performance	Volumes						Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	2018 National Average	Achieved	
Eligible women (25-69) have a cervical cancer screen every three years. (See MHP)							Cervical screening coverage improved for both Maori and total populations in the past year – with total population improvement driven by the improvement for Maori. Contracting for equity, where screening for Maori women was prioritised, has had an impact, but there still remains a significant disparity between Maori and non-Maori screening coverage. BOPDHB has performed well for all populations when compared nationally, and is consistently ranked in the top 3 DHBs for cervical screening coverage.
■ Total	79%	80%	80%	**81%**	74%	✓	
■ Māori	70%	69%	80%	**71%**	67%	✗	
■ Non-Māori	82%	83%	80%	**83%**	75%	✓	
Eligible women (50-69) have a breast screen examination every two years[32] (See MHP)							BOPDHB achieved breast screening targets for total and non-Maori populations. However, there is significant disparity in coverage for Maori, despite an improvement in coverage in the past financial year. A project group has been formed to improve this metric for Maori, with breast screening remaining a priority area in the 2018/19 System Level Measures plan.
■ Total	71%	69%	70%	**71%**	72%	✓	
■ Māori	60%	58%	70%	**61%**	65%	✗	
■ Non Māori	73%	71%	70%	**74%**	72%	✓	
Focus Area 2 - Diabetes Management (HbA1c): Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control – PP20.	75%	76%	80%	**66%**	NA	✗	There has been a reduction in the proportion of patients with a good HbA1c score (≤64mmol). There is a substantive discrepancy in this metric by ethnicity. Less than 50% of Maori and Pasifika patients had good HbA1c scores, while this increased to 76% for non-Maori, non-Pasifika.
Focus Area 5 - Stroke Services:[33] Percentage of potentially eligible stroke patients thrombolysed.	9%	5%	8%	**7%**	NA	✗	All three stroke services metrics were missed during 2017/18. Work is presently underway to improve access to thrombolysis outside of standard clinic hours. A proposed telehealth service via Waikato has currently stalled due to resourcing issues. The stroke pathway target was missed by 6% during 2017/18, which challenges being presented at times of high occupancy within the Acute Stoke Unit. There is some concern in regard to the denominator definition for the rehabilitation metric. The way this metric is presently defined significantly inhibits achievement of the target, though a significant improvement was made during 2017/18 – from 26% to 36%.

32 The coverage period reported is the two years ending 30 June 2018.

33. Reported results are aggregated confirmed results for quarters 1,2 and 3 of the 2017-18 financial year, i.e. the results cover the period from July 2017 to March 2018. April to June 2018 results are not presently available.

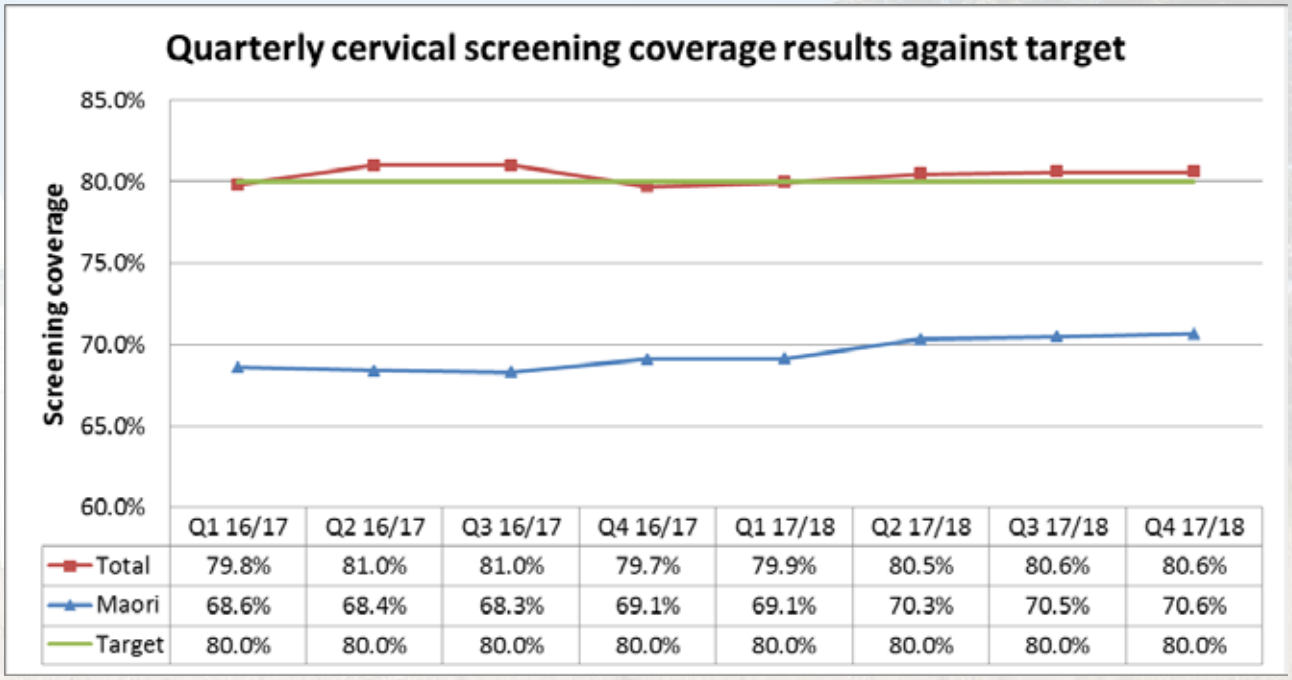
Breast and cervical screening coverage for Māori explained

BOPDHB continued to achieve improved cervical screening coverage for Māori during the 2017/18 financial year – with coverage for Māori increasing from 69.1% in Q1 2017/18, to 70.6% in Q4 17/18. However, while coverage has improved, and while BOPDHB is one of the better performing DHBs (in the top 3) nationally for Māori cervical screening coverage, there is still a significant disparity (12%) in coverage between Māori and non-Māori women. This disparity highlights the need for cervical screening coverage for Māori to remain a priority in 2018/19, which is why this remains an area of focus as part of Bay of Plenty's approved 2018/19 System Level Measure plan.

Cervical screening has been an area of focus in 2017/18, with the NCSP Regional Co-ordinator continuing to work alongside PHOs and Support to Screening Service providers, spending at least one day per week based in offices across the BOPDHB catchment. A closer relationship has been forged with a PHO that was previously resistant to working with the NCSP Regional Co-ordinator and Support to Screening Service Providers. Data integrity issues continue to be identified and remedied, a referral pathway established, and the PHO has committed to utilising the recommended screening outcome codes. An education session is planned for Q1 of 2018/19 to ensure all clinical staff are using the correct codes and processes.

HPV vaccination in tertiary and alternative education facilities is presently on hold due to the vaccine shortage. Clinics have been pencilled in for September 2018 pending vaccine being available. Smear-takers are reminded to offer HPV vaccine to all eligible women at time of screening.

Cervical Screening clinics held alongside mobile Breast Screening Clinics in areas with high priority-group women have been successful and will continue. In the Eastern Bay of Plenty there is the ability to hold cervical screening clinics at the same location as the breast screening clinic.



	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total	79.8%	81.0%	81.0%	79.7%	79.9%	80.5%	80.6%	80.6%
Maori	68.6%	68.4%	68.3%	69.1%	69.1%	70.3%	70.5%	70.6%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

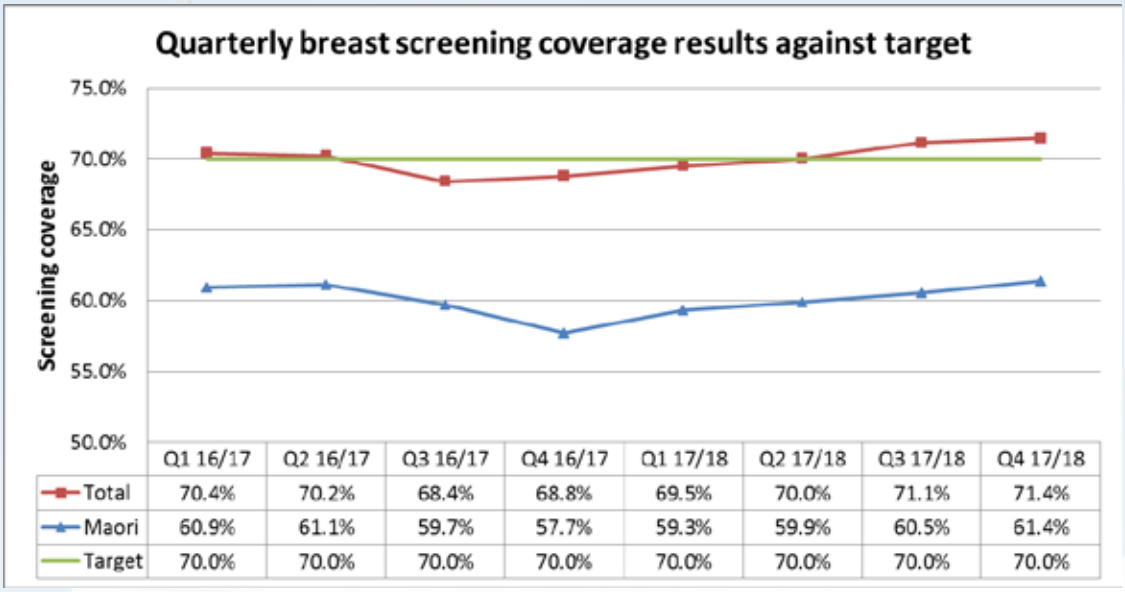
BOPDHB has also achieved a 3.7% improvement in breast screening coverage for wahine Māori, to 61.4%, over the past 12 months (achieved 57.7% coverage for Māori for the period ending 30 June 2017). However, despite the improvement, significant disparities (13%) in breast screening coverage between Māori and non-Māori remain, and BOPDHB screening coverage for Māori remains around 4% lower than the national average. This suggests there is further work to be done in this area, particularly in regard to equity of coverage.

During the 2017/18 financial year, there have been a number of initiatives focussed on improving breast screening coverage for wāhine Māori. These initiatives include:

- introducing annual mobile visits in Te Puke (previously 2-yearly)
- Katikati mobile service visit
- prioritising Māori DNRs within Support to Screening Services
- ongoing reviews of appointment schedules in radiology, and making adjustments to provide additional after-hours appointments
- special projects targeting Opotiki and Kawerau wāhine (where mobile unit previously visited); and
- developing a Breast Screening Midland (BSM) Engagement Plan

Following a review of the previous action plan and approach, BOPDHB, the National Screening Unit (NSU) and BSM have agreed a new approach that focuses on improving breast screening rates for Māori. BOPDHB will utilise the Institute

for Healthcare Improvement quality improvement methodology to identify and implement small tests of change to improve breast screening coverage for wāhine Māori. BSM will provide key operational and data capacity, with BOPDHB currently seeking agreement with a general practice to form the collaborative group and identify an appropriate test of change. Updates will be provided to the NSU on a monthly basis.



	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total	70.4%	70.2%	68.4%	68.8%	69.5%	70.0%	71.1%	71.4%
Maori	60.9%	61.1%	59.7%	57.7%	59.3%	59.9%	60.5%	61.4%
Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%

People Maintain Functional Independence

Output Class 2: Early Detection and Management

Outcome: People are safe, well and healthy in their homes and communities

Indicator: People maintain functional independence

In 2017 the Board of the BOPDHB endorsed older people in the Strategic Health Services Plan 2017-2027 (SHSP) as a population priority group for the next ten years.

Our objectives within the SHSP are to:

1. Empower our population to live healthy lives. This means we want to encourage people to stop smoking, encourage people to eat well and be active, and increase the number of healthy warm homes.
2. Develop a smart, fully integrated system to provide care close to where people live, learn, work and play. This means we want to invest more in community services so that we don't need to grow our hospital capacity.
3. Evolve models of excellence across all of our hospital services. This means we want to make the patient's journey through the hospital as quick and easy as possible.

Bay of Plenty DHB aims to proactively manage community support services for residents over the age of 65 years and those receiving disability support services. Bay of Plenty's population is ageing, with the number of people aged 75 years or older predicted to grow at an average annual growth rate of 3.5% by 2020. To achieve these objectives Bay of Plenty DHB this year entered into an Alliancing arrangement with three consortia of Home and Community Support Service providers with a primary purpose of advancing a Restorative model of patient care. The objective of this model was to give clients greater functional independence and move them towards a higher level of functional independence while maintaining patient care and safety in their own homes.

We monitor our progress in providing greater functional independence with two key performance indicators:

- Managing the growth in demand from our over 65 population for Home Based Support Services, whether household management or personal care.
- Maintaining the percentage of our over 65 population who access DHB funded Aged Residential Care facilities.

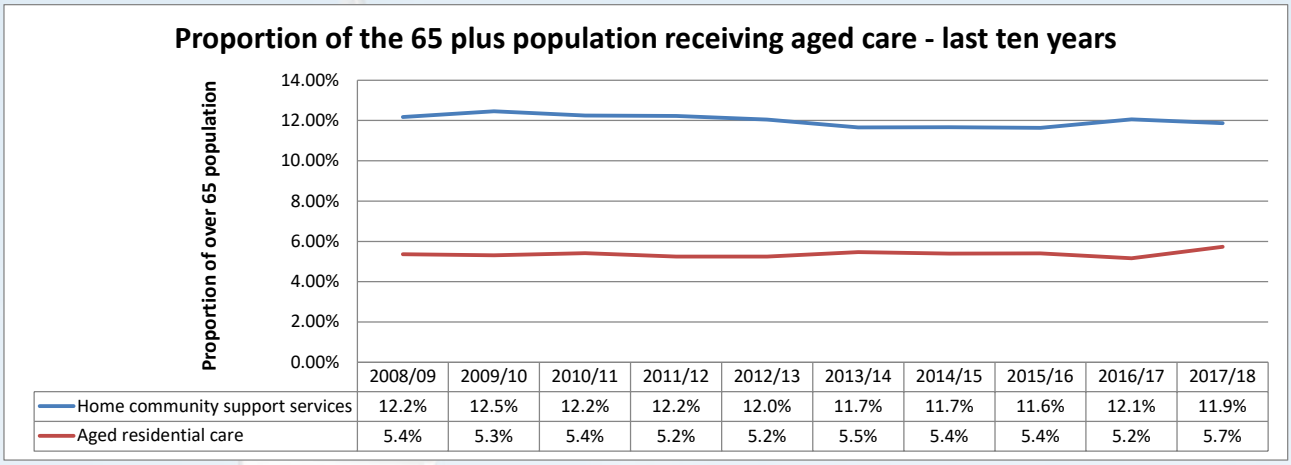
Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Percentage of the population 65+ years that access Home and Community Support Services (HCSS)	11.3%	12.0%	12.2%	**11.9%**	✓	The proportion of the 65 plus population receiving home community support services has reduced from 2016/17. This is explained in more detail below.
Maintain current percentage of population over 65 years who have accessed aged residential care (ARC)	5.4%	5.2%	5.0%	**5.7%**	✗	There has been a substantive increase in the proportion of the 65 plus BOPDHB population who accessed aged residential care in 2017/18. However, the source of this data has changed from 2016/17, which means the 2017/18 result essentially sets a new baseline. A more detailed explanation is provided below.
Increase in occupancy rate for Residential Respite Bed Days[34]	75%	36%	82%	**47%**	✗	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.
Increased number of dementia specific day programme attendances for clients with dementia[35].	847	1,118	990	**1,620**	✓	Dementia day programme attendances continued to increase in 2017/18. Attendance were up 45% on the previous year, and were over 60% above target. New models of service are presently being introduced for dementia care.
Percentage of older people receiving long term home support who have had a comprehensive clinical assessment and a completed care plan in the last twelve months - PP18	100%	100%	100%	**NA**	NA	This is no longer included within the Government's Policy Priorities, and is not reported on.

34. This measure represents respite nights where carers are afforded rest opportunities, which enables the person being cared for to remain in their own homes for longer. Result is for the 12 months ended 30 June 2018 based on the last complete performance monitoring return submitted by the service provider. BOPDHB presently contracts for three beds.

35. Attendances are derived from provider monitoring returns received during the year, and only include clients with a confirmed dementia diagnosis.

Home and community support services and age-related residential care explained

The graph below shows ten year trending of access by the 65 plus age group to home community support services and aged residential care. Access is reported as a proportion of the 65 plus population at the time based on the latest statistics New Zealand population estimates as commission by the Ministry of Health. Simple linear trend lines have also been applied to the graph, though it is worth noting the 2017/18 results have been taken from a different source to previous years – this essentially is setting a new baseline.



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Home community support services	12.2%	12.5%	12.2%	12.2%	12.0%	11.7%	11.7%	11.6%	12.1%	11.9%
Aged residential care	5.4%	5.3%	5.4%	5.2%	5.2%	5.5%	5.4%	5.4%	5.2%	5.7%

The graph above indicates there was a substantive increase in the proportion of the 65 plus population who accessed aged residential care in 2017/18, despite a 3.4% increase in the 65 plus population from the previous year. As noted previously, it is difficult to read too much into this result given the change in data source, though it does represent a result well in excess of the 5.03% target. There is presently some development work around monitoring the proportion of the population transitioning from home community support services into aged residential care. This will provide BOPDHB with an important outcome focussed metric regarding the effectiveness of the new cluster based home community support services model.

The change in home community support services model has had minimal impact on the proportion of the 65 plus population accessing home community support services – this proportion has remained around the 12% mark over the last ten years with annual variation above and below this marker. As well as the transition metric described above, we are also looking at opportunities for developing more outcomes based reporting on the new service model, which was introduced in September 2016. Initial thinking is around monitoring cluster usage and comparing this to what was modelled, looking at transitions between clusters, and identifying how providers are allocating their hours of care across the different clusters. The new model does appear to be having an impact in regard to the total hours of care provided, due to the ability to tailor services based on the level of need.

Families and whānau are at the centre of their healthcare

The Annual Plan 2017/18 identified families and whānau as key stakeholders in the health and wellbeing of a patient. A new measure was added to consider our performance in effectively engaging with those close to the patients who would be contributing to their ongoing care.

A Whānau Ora pathway is being trialled within 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 Base	2018 Target	2018 Actual	Achieved	
The number of Whānau Ora promotional activities undertaken	128	112	539	✓	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 2017/18, providers delivered significantly more promotional activities than required by the target – two providers alone managed to deliver 408 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 whānau to have as much information as they need to make good decisions about their environments and personal wellbeing. 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
	2017 Base	2018 Target	2018 Actual	Achieved	
Number of governance group meetings attended for Healthy Families initiatives	3	NA	3	NA	Three Healthy Families governance meetings were held during the reporting period – in March, April and May. The Ministry have since gone back to market, though the hope is that meetings will resume again shortly. There was no target specified for 2017/18, so NA has been recorded in the achieved column.

Connecting with Agencies to Meet Community Needs

Main measures of performance	Volumes				Comments
	2017 Base	2018 Target	2018 Actual	Achieved	
Number of governance group meetings held for co-designed multi-agency initiatives.	5	NA	5	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 has not been part of this work. 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 of the New Zealand Health Strategy 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.

Health targets set by the Government reflect a national mandate to deliver this outcome throughout the country. BOPDHB, in delivering 12,112 elective surgery discharges this year (2017: 11,315), has exceeded our plan and recorded a health target result of 110%. Despite periods of significant demand through ED, BOPDHB achieved the 95% target in three of four quarters in 2017/18, which is sufficient for achievement of the target across the 2017/18 year. Over 90% of patients with a confirmed diagnosis of cancer received their first treatment within 62 days – this is a significant improvement on previous years' results, 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
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Number of inpatient surgical discharges under elective initiative (includes all discharges regardless of whether they are discharged from surgical or medical specialty) – Total	11,113	11,315	10,937	**12,112**	✓	BOPDHB exceeded the 2017/18 electives target by over 1,000 discharges in 2017/18, which represents a 7% increase in discharges from the previous year. It is anticipated the nursing strike that occurred during July 2018, will have an impact on this area in 2018/19.
Standardised Intervention Rates as per 10,000 of population[36] – SI4						Standardised intervention rates for coronary angiography, cardia and angioplasty procedures were below targets and national averages. This was despite improved performance over the past year. However, targets were achieved for both joint and cataract procedures, though interestingly performance in these two areas dipped from the previous year. Despite the dip in performance, rates of major joint procedures in BOPDHB were above the national average, though intervention rates for cataracts were well below the national average.
Coronary Angiography	28.33	28.03	34.7	**31.66**	✗	
Cardiac	6.41	5.05	6.5	**5.20**	✗	
Angioplasty	10.48	10.82	12.5	**11.27**	✗	
Joint	29.05	27.37	21.0	**26.33**	✓	
Cataract	21.20	25.35	24.0	**24.80**	✓	

36. SIRs are a ratio of discharges per population for elective procedures; a standardised measure is a comparison against a national benchmark. The data is reported for the 12 month period ended 31 March 2018 for coronary angiography, cardiac and angioplasty intervention rates. Joint and cataract intervention rates are for the 2016/17 financial year – these are only reported on annually in October of each year, so the 2017/18 result will not be reported until after the annual report deadline.

Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
ESPIs (Elective Services Performance Indicators) **ESPI 1** – timely processing of referrals in 15 calendar days or less	100%	100%	100%	**100%**	✓	BOPDHB has been working towards a single grader across most specialties. This approach is providing consistent and timely triaging of referrals.
ESPI 2 – percentage of patients waiting longer than four months for their first specialist assessment	0%	0%	0%	**0.1%**	✗	High demand for specialist review continues across all specialities, which challenges the achievement of this target.
ESPI 3 – patients waiting without a commitment to treatment	0%	0%	0%	**0%**	✓	All patients that have been given a commitment to treatment are managed.
ESPI 5 – patients given a commitment to treatment but not treated within four months	0.8%	0.7%	0.8%	**0.7%**	✗	BOPDHB has experienced significant pressure across all surgical specialties, with General Surgery and Orthopaedics of most concern. Wait Lists are being closely monitored. Tauranga patients are offered treatment at Whakatane as appropriate. These steps have meant the target was achieved in 2017/18.
ESPI 6 – patients in active review who have not received assessment within 6 months	0%	0%	0%	**0.0%**	✓	Active Review is not used at BOPDHB.
ESPI 8 – proportion of patients treated who were prioritised using recognised tools and processes	100%	100%	100%	**99.8%**	✗	All specialties that have a national online prioritisation tool available are using it, in the significant majority of cases.
Did Not Attend (DNA) rate for outpatient services						There were further improvements in Maori outpatient DNA rates during 2017/18, with a reduction to 14.6%. However, Maori DNA remains almost three times the 5% target and almost four times higher than the DNA rate for non-Maori. There have been various projects and small tests of change over the years that have looked at DNA rates, which are reasonable on a national level. However, none of these initiatives have focussed specifically on Maori DNA. A project has recently commenced with a focus on reducing Maori paediatric DNA using Health Improvement Agency methodology. Paediatric DNA has been chosen as it one of the top three areas of outpatient DNA for Maori for both first specialist appointments and follow ups.
■ Total	6.6%	6.4%	5%	**6.3%**	✗	
■ Māori	15.6%	15.3%	5%	**14.6%**	✗	
■ Non Māori	4.0%	3.9%	5%	**3.9%**	✓	

Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Number of clients supported by specialist palliative care[37]	823	1156	769	1490	✓	There was a further substantive increase in clients supported by specialist palliative care in 2017/18. Volumes were up 29% on the previous year, exceeding the target by over 100%. The palliative care review undertaken in 2017/18 sought to identify opportunities for enhancing delivery of palliative care in hospital and primary care settings. The findings of this review, and the associated recommendations, are still under consideration.
Percentage of people supported by specialist palliative care, other than cancer or end stage renal failure	22%	30%	25%	18%	✗	As in 2016/17, 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. 132 clients supported in 2017/18 did not have a primary diagnosis recorded and were excluded from the denominator of this indicator, i.e. the denominator was 1490 – 132 = 1358. 18% of clients supported had an alternate primary diagnosis, e.g. Alzheimers, stroke, sepsis.

37. 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
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Number of community pharmacy prescriptions[38]	3,557,403	3,641,556	3,676,982	**3,666,354**	✓	Community pharmacy prescriptions remained relatively steady in 2017/18, with 0.7% growth – compared to 2.4% growth in 2016/17. Given population growth is around 2%, this means that prescription levels per head of population have reduced in 2017/18. The intent is to maintain prescription numbers as much as possible, acknowledging there may be changes in line with population growth.
Improved wait times for diagnostic services[39] – accepted referrals receive their scan: - PP29 Coronary Angiography	99%	97%	95%	**92%**	✗	The coronary angiography target was missed in 2017/18, despite achievement of 100% from March to June 2018. The 92% result was due to monthly performance ranging from 76.8% to 83.1% during the four month period from October 2017 to January 2018.
Diagnostic Colonoscopy Urgent (within 14 days)	NA	NA	90%	**82%**	✗	Both urgent and non-urgent diagnostic colonoscopy targets were missed during 2017/18. In January 2018 issues with booking procedures were identified for urgent patients. Since then, urgent targets have been met.
Non-urgent (within 42 days)	39%	43%	70%	**44%**	✗	Despite running additional lists, utilising private capacity, locum leave cover and reviewing administrative processes, the volume of non-urgent colonoscopy referrals continue to outstrip capacity.
Surveillance Colonoscopy	12%	11%	70%	**39%**	✗	Significant improvements were made in the surveillance colonoscopy area, though BOPDHB remained significantly below target across 2017/18. However, the identification and correction of a significant reporting anomaly meant the target was achieved across Q4 (April to June 2018).
Computing Tomography (CT)	96%	97%	95%	**98%**	✓	The CT target was again achieved in 2017/18, with BOPDHB one of the few DHBs to meet this target. The target was achieved in all months of the 2017/18 financial year with high availability of CT scanners.
Magnetic Resonance Imaging (MRI)	92%	95%	90%	**91%**	✓	BOPDHB achieved the MRI target again during 2017/18, though there was a 4% reduction in performance from the prior year. This reduction in performance has been driven by a 31% increase in referral volumes in 2017/18, with particularly high demand in May and June. This increase in demand has meant the contacted provider has not been able to meet target in the last two months. While the provider has been able to deliver 20% more volume in 2017/18, the decision has been made to install a fourth MRI scanner in October 2018, to help meet the increased demand.
Total number of community referred radiology Relative Value Units (RVUs)	69,990	73,762	72,090	**76,942**	✓	Delivery of community radiology services exceeded target in 2017/18. The volume of delivery was comprised of 61,548 volumes delivered in secondary settings and 15,393.5 volumes delivered in primary care (3,363.8 by EBPHA and 12,029.7 by WBOPPHO).
Total number of community laboratory tests[40]	1,351,553	1,460,701	1,450,000	**1,524,521**	✓	Community laboratory test volumes continued to increase steadily in 2017/18, with the number of community tests increasing by 4% in the last year, following an 8% 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. The target for community lab tests completed was exceeded in 2017/18.

38 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.

39. Activity is for all patients who received a diagnostic service in the 12 months ended 31 May 2018. The percentage reflects the proportion of patients who received their service in the specified timeframe.

40. The 2016/17 laboratory test result was underreported, with the revised figure included in this 2017/18 Statement of Performance Expectations.

Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
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 2017/18. Category results were broadly similar to those obtained in the previous financial year.
Category 1: Within 24 hours	-	100%	95%	**98%**	✓	
Category 2: Within 96 hours	-	95%	100%	**100%**	✓	
Category 3: Within 72 hours	-	100%	100%	**100%**	✓	
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, 2017/18 results were both well in excess of annual plan targets.
Within 48 hours (routine test)	100%	100%	90%	**99%**	✓	
Within 3 hours (urgent test)	99.5%	99.9%	80%	**98%**	✓	
Patient Experience Survey – Eligible patients are offered the chance to participate in the survey[41]	NA	NA	90%	**47%**	✗	This is a new measure within the Annual Plan and is one of BOPDHB's six System Level Measure milestones. As with patient portals, there was no baseline data available prior to setting this target, resulting in an overly ambitious target. While the target was missed there have been steady improvements for this metric from 27% in Q1 to 47% currently.
Improving mental health services using transition (discharge) planning for child and youth – PP7[42]						This is the first full year of collecting this data in the SCR format for this team. In addition, there has been a high turnover of staff, which means further education on the process is required. It is anticipated there will be improvements in this area in 2018/19.
■ Total	100%	95%	95%	**87%**	✗	
■ Māori	Not reported	-	95%	**82%**	✗	
Average length of acute adult (18+ years) inpatient stay (days) KPI 8	14 days	13 days	14-21 days	**14 days**	✓	Commentary on this metric is provided below.
Rates of 7 day follow-up in the community post discharge KPI 19	64%	69%	90%	**77%**	✗	A discharge support team was introduced during 2017/18, which has resulted in some improvement in this KPI. In addition, we have implemented a 3 days post discharge KPI internally. The intent of this KPI indicator is to encourage staff to meet with their clients within 3 days of discharge. The introduction of these two changes should ensure this target will be achieved in the near future.

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 lower end (14 days) of 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

41. Data is provided by Cemplicity (who runs the survey) individually for each PHO before being amalgamated.
42. Relapse/prevention plan measure was a new measure for 2014/15. Mental Health reports are for 12 months rolling periods and are not currently reported by ethnicity.

- 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.

The introduction of the initiatives outlined in the commentary for KPI 19 also have relevance to this metric. The introduction of additional resource for follow-up post discharge provides a more comprehensive discharge process, which means clients can potentially be discharged earlier than if these supports were not in place.

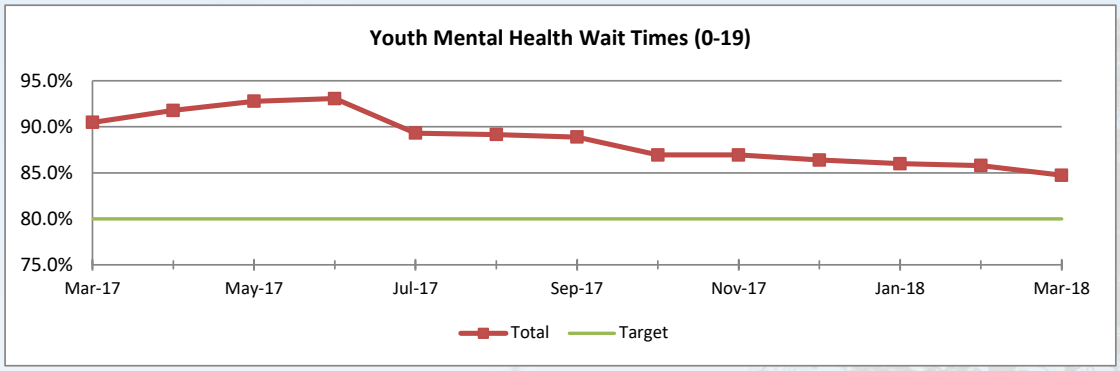
Main measures of performance	Volumes						Comments
	2016 Base	2017 Base	2018 Target	2018 Actual[43]	2018 National Average	Achieved	
A referral of a young person (0-19 years) is seen by Alcohol and Other Drug health professional within 3 weeks of referral being received – PP8	80%	91%	80%	**85%**	84%	✓	Three-week youth (0-19) AOD wait times have been met for the 12 month period from April 17 – March 18. This is the 21st consecutive reporting period where three-week AOD wait times have been achieved, though there has been a reduction of 6% 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.
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks							BOPDHB has generally performed well against three-week wait time targets, achieving three of four metrics in this area. Youth mental health results are particularly strong given performance nationally. Adult three-week AOD wait times have also reduced over the last twelve months. This is again driven primarily by declining results in the provider arm due to the challenges above. However, unlike with AOD wait times, three week mental health wait times have generally been maintained over 2017/18, with an increase for youth balanced by a decrease for adults.
Mental Health (Provider Arm) % people seen <3 weeks							
0-19 yrs	81%	77%	80%	**80%**	69%	✓	
20-64 yrs	82%	82%	80%	**80%**	83%	✓	
Addictions (Provider Arm and NGO) % people seen <3 weeks							
0-19 yrs	79.6%	91%	80%	**85%**	84%	✓	
20-64 yrs	81%	85%	80%	**77%**	81%	✗	
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	98%	96%	95%	**96%**	91%	✓	
20-64 yrs	96%	96%	95%	**96%**	94%	✓	
Addictions (Provider Arm and NGO) % people seen <8 weeks							
0-19 yrs	89%	98%	95%	**97%**	96%	✓	
20-64 yrs	90%	97%	95%	**94%**	94%	✗	

43 Reporting period is 12 months ended 31 March 2018.

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 consistently 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 each of the last 21 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 nine reporting periods. While BOPDHB has continued to meet targets during this time, there has been a 6% reduction 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 2018.



The reduction in three-week wait time performance has primarily been driven by a decrease 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 76% during the latest reporting period – this was around 90% earlier in the year. NGO provided services achieved 89% against the three-week wait time target in the latest reporting period, and have been consistently around (or just above) the 90% mark over the past twelve months.

People receive prompt and appropriate acute and arranged care

Bay of Plenty DHB achieved the ED health target of 95% of patients admitted, discharged or transferred from an emergency department within six hours for the 2017/18 year, despite the full year result indicating that 94.4% of patients were transitioned through the ED in the six hour window. Achievement across the financial year is based on achieving the 95% target in three of the four quarters during 2017/18. The target was missed during Q3 – January to March 2018, as this was a period of significant demand through the Emergency Department. Monthly ED presentations during this period were between 6.6% and 9.4% higher than for the equivalent month in 2016/17. Total ED volumes were up by 2.5% during 2017/18, which challenged the achievement of this target.

Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Percentage of patients admitted, discharged or transferred from an ED within six hours – Health Target	94%	95%	95%	**94.4%**	✓*	Commentary on this measure is provided in the paragraph above. * Despite achievement of 94.4% against this metric across 2017/18, the target was still achieved. This is because the quarterly target was achieved in three of the four quarters during the year.
Focus area 4 – Acute coronary syndrome services: >70% of high risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') – PP20	87%	89%	70%	**91%**	✓	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.
Focus area 4 – Acute coronary syndrome services: >95% 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	98%	99%	>95%	**97%**	✓	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
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Standardised Elective Inpatient length of stay (LOS) reduced (days) – OS3(i)[44]	3.19	1.55	1.47	**1.53**	✗	2015/16 base results are no longer reliable baselines, as the methodology used to calculate average length of stay (ALOS) was amended. 2017/18 results for both elective and acute ALOS were improvements on the previous year, though both remain above target.
Standardised Acute Inpatient length of stay (LOS) reduced (days) – OS3(ii)	3.91	2.64	2.30	**2.55**	✗	The acute flow programme, which has been in place for 2017/18 within Tauranga hospital has been the primary reason for the improvement in acute ALOS. This programme in now being introduced at Whakatane hospital. BOPDHB ALOS results were above national averages for both acute and elective inpatients, though not substantively – elective ALOS was 2.0% higher for BOPDHB (1.53 v 1.50), while acute ALOS was 2.8% higher (2.55 v 2.48)
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	73%	79%	90%	**94%**	✓	There was a change to the FCT target and methodology at the commencement of the 2017/18 financial year. The target was increased to 90%, while the new methodology resets baseline achievement. BOPDHB achieved the FCT target in all four quarters in 2017/18, the 94% 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 2017/18, with the Q4 2017/18 result (95%) seeing BOPDHB ranked 3rd nationally. There has been a marked improvement against this metric in 2017/18 when compared against previous years, though in part (not quantified) this is due to the methodology change.
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	81%	93%	85%	**90%**	✓	The figure reported is from the latest (Q4 2017/18) policy priority data – this covers records submitted between January and June 2018. BOPDHB achieved the target, with 449 records (of 500 total) being addressed within the 31 day timeframe. BOPDHB's result was just over 1% better than the national average during Q4, which saw BOPDHB ranked 8th nationally for this metric. The data supplied is not broken down by ethnicity.
Percentage of patients reporting better understanding of their health journey		New	TBC	**In development**	NA	This measure is still in development. Consideration is still being given to the most appropriate methodology for accurately assessing this metric.

44.These results are for the year ending 31 March 2018.

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

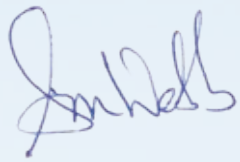
Main measures of performance	Volumes					Comments
	2016 Base	2017 Base	2018 Target	2018 Actual	Achieved	
Number of registered users of the client health information portal (CHIP)	-	5,695	TBC	6,440	NA	There are two instances of CHIP in use within the BOPDHB region. The first is the secondary care view of CHIP, which is the metric reported on here. This secondary care instance of CHIP has 6,440 registered users, of which 1,043 are presently considered inactive (no activity within the last 90 days). This is a 13% increase in registered users from last year. The second instance if CHIP for primary care use, which has 1,157 registered users (324 inactive).
Percentage of long-term conditions clients reporting an improved quality of life	-	In development	TBC	In development	NA	The means to monitor performance against this metric, such as a patient survey, is still in development.

Statement of Responsibility for the Year Ended 30 June 2018

The Board and Management of the BOPDHB (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.

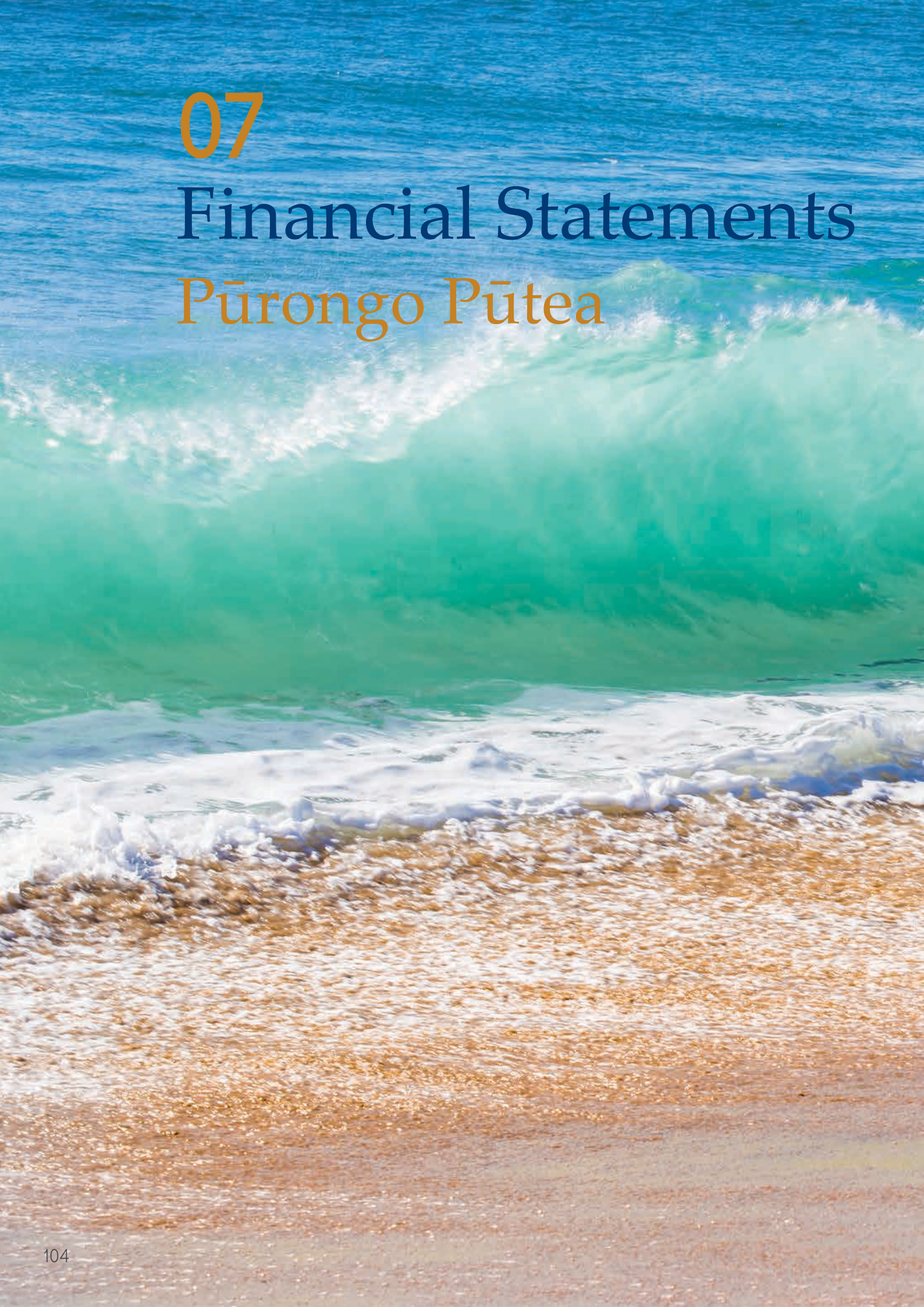
In the opinion of the Board and Management of the BOPDHB, the financial statements for the year ended 30 June 2018 fairly reflect the financial position and operations of the BOPDHB.



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 2018

	Note	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
Income				
Crown revenue	4	**783,259**	**786,961**	744,672
Finance income	9	**1,249**	**1,030**	1,057
Other revenue	5	**11,605**	**8,369**	8,029
Total income		**796,113**	**796,360**	753,758
less Expenditure				
Employee expenses	7	**256,592**	**250,904**	241,328
Depreciation and amortisation expense	14,15	**20,819**	**21,501**	19,325
Outsourced services		**39,006**	**29,903**	31,963
Clinical supplies		**62,257**	**58,220**	57,449
Provider payments		**372,382**	**383,395**	353,459
Non-clinical expenses	8	**38,911**	**38,843**	38,539
Finance costs	9	**16,040**	**16,333**	11,365
Total operating expenditure		**806,007**	**799,099**	753,428
Share of associates/joint ventures surplus/(deficit)	16,17	**38**	**-**	44
Surplus/(deficit)		**(9,856)**	**(2,739)**	374
Other comprehensive revenue and expense				
Items that will not be reclassified to surplus/(deficit)				
Gains/(Losses) on property revaluations		**16,103**	**-**	-
		16,103	**-**	-
Total comprehensive revenue and expense		**6,247**	**(2,739)**	374

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 2018

	Note	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
ASSETS				
Current assets				
Cash and cash equivalents	10	**21,970**	**14,119**	14,709
Trade and other receivables	12	**28,059**	**22,158**	35,500
Inventories	13	**2,904**	**3,000**	2,815
Total current assets		**52,933**	**39,277**	53,024
Non-current assets				
Investments in associates and joint ventures	16,17	**375**	**-**	337
Other investments		**305**	**160**	243
Property, plant and equipment	14	**293,754**	**287,707**	290,429
Intangible assets	15	**10,632**	**3,021**	3,098
Total non-current assets		**305,066**	**290,888**	294,107
Total assets		**357,999**	**330,165**	347,131
LIABILITIES				
Current liabilities				
Trade and other payables	19	**44,053**	**34,881**	45,138
Employee benefits liabilities	18	**36,665**	**27,421**	31,000
Total current liabilities		**80,718**	**62,302**	76,138
Non-current liabilities				
Employee benefits liabilities	18	**601**	**547**	560
Total non-current liabilities		**601**	**547**	560
Total liabilities		**81,319**	**62,849**	76,698
Net assets		**276,680**	**267,316**	270,433
EQUITY				
Crown equity		**223,271**	**223,270**	223,271
Accumulated funds		**(7,622)**	**44,046**	3,794
Property revaluation reserve		**61,031**	**-**	43,368
Total equity		**276,680**	**267,316**	270,433
Total equity		**276,680**	**267,316**	270,433

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

For and on behalf of the BOPDHB:

Sally Webb
Board Chair
31 October 2018

Ron Scott
Deputy Chair
31 October 2018

Statement of Changes in Net Assets/ Equity for the Year Ended 30 June 2018

	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

	Crown equity $'000	Property revaluation reserve $'000	Retained earnings $'000	Total $'000
Balance as at 1 July 2016	71,071	43,368	3,420	117,859
Comprehensive revenue and expense				
Surplus or deficit for the year	-	-	374	374
Total comprehensive revenue and expense	-	-	374	374
Transactions with owners				
Contribution from the Crown	152,200	-	-	152,200
Total transactions with owners	152,200	-	-	152,200
Balance as at 30 June 2017	223,271	43,368	3,794	270,433

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 2018

	Note	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
Cash flows from operating activities				
Receipts from Crown and patients		**802,289**	**794,995**	750,198
Interest received		**1,197**	**1,030**	1,151
GST (net)		**999**	**90**	166
Receipts from Crown and patients		**(514,640)**	**(510,403)**	(446,892)
Payments to employees		**(250,940)**	**(250,256)**	(270,901)
Interest paid		**-**	**-**	(5,037)
Capital charge paid		**(15,994)**	**(16,280)**	(7,483)
Net cash flow from operating activities	11	**22,911**	**19,176**	21,202
Cash flows from investing activities				
Purchase of property, plant and equipment		**(8,634)**	**(18,001)**	(13,744)
Purchase of intangible assets		**(7,016)**	**-**	-
		(15,650)	**(18,001)**	(13,744)
Net cash flow from investing activities		**(15,650)**	**(18,001)**	(13,744)
Cash flows from financing activities				
Net cash flow from financing activities		**-**	**-**	-
Net increase/(decrease) in cash and cash equivalents		**7,261**	**1,175**	7,458
Cash and cash equivalents at the beginning of the year		**14,709**	**12,944**	7,251
Cash and cash equivalents at the end of the year	10	**21,970**	**14,119**	14,709

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 2018

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 Whakatane 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 October the 17th 2018.

2. Summary of Significant Accounting Policies

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.

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 1: Approved Budget (amendments)** (Effective date: periods beginning on or after 1 January 2018)
  The amendments replace the reference to an 'approved budget' in PBE IPSAS 1 with a reference to the existing requirements regarding comparisons of 'general purpose prospective financial statements' and historical financial statements. When an entity is required to present a comparison of prospective and actual financial statements, the amendments also clarify how this shall be disclosed. Equivalent amendments have also been made to PBE IAS 34.
- **PBE IPSAS 21 and 26: Impairment of revalued assets** (Effective date: periods beginning on or after 1 January 2019)
  The amendments bring revalued property, plant and equipment and intangible assets within the scope of PBE IPSAS 21 and PBE IPSAS 26. The amendments clarify that an impairment of an individual asset outside of the revaluation cycle will not necessitate the revaluation of the entire class of assets to which the impaired asset belongs.
- **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 IFRS 9: Financial instruments** (Effective date: periods beginning on or after 1 January 2019)
  The NZASB has issued this standard in advance of the IPSASB issuing a new financial instruments standard based on IFRS 9. This standard gives PBEs in a mixed group the opportunity to early adopt a PBE Standard that is based on the for-profit standard NZ IFRS 9 on the same date that NZ IFRS 9 becomes mandatory in the for profit sector.

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.

Reclassification of comparative figures

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

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:

Financial assets

Cash and cash equivalents, receivables, investments in associates and joint ventures are described under 2.5,2.6,2.10 and 2.11 respectively.

Financial liabilities

Payables and accruals are described under 2.12

Impairment of financial assets

(i) Loans and other receivables, and held to maturity investments

Impairment of a loan or a receivable is established when there is objective evidence that the Entity will not be able to collect amounts due according to the original terms of the loan or receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, insolvency, receivership, or liquidation, and default in payments are considered to be indicators that the asset is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

(ii) Financial assets at fair value through other comprehensive revenue and expense

For debt investments, significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered objective indicators that the asset is impaired.

If impairment evidence exists for investments at fair value through other comprehensive revenue and expense, the cumulative loss (measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in the surplus or deficit) recognised in other comprehensive income is reclassified from equity to the surplus or deficit.

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.

Trade and other receivables

Short term debtors and other receivables are recorded at their face value, less any provision for impairment.

Impairment of a receivable is established when there is objective evidence that the Bay of Plenty DHB will not be able to collect the amount due.

The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate.

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.

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	15 to 50 years
Leasehold improvements	15 to 50 years
Plant, equipment and vehicles	3 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.

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 National Oracle Solution

(NOS), 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 3 years

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.

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.

Trade and other payables

Short term creditors and other payables are recorded at their face value.

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.

(i) 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.

(ii) 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.

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".

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.

Fair value through other comprehensive revenue and expense reserves

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.

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.

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.

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.

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.

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.

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/NOS) 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.

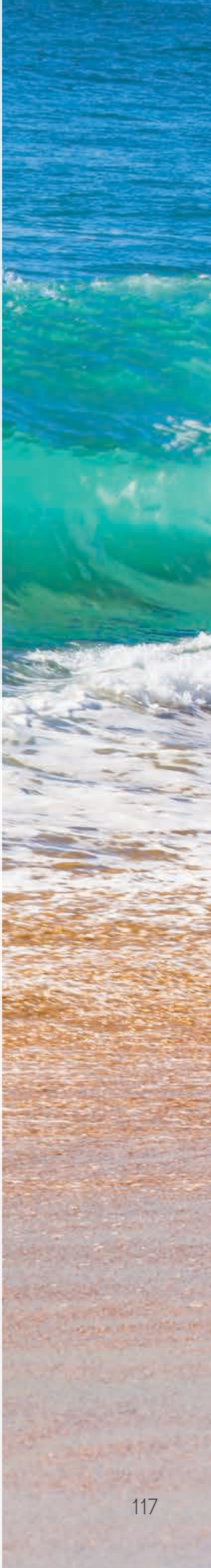
Compliance with Holidays Act 2003

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 as disclosed in note 18.



4. Crown revenue

	Actual 2018 $'000	Actual 2017 $'000
Crown appropriation revenue	**723,263**	679,755
Inter-district patient inflows	**18,353**	17,985
Crown non appropriation revenue	**41,643**	46,932
Total Crown Revenue	**783,259**	744,672

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 2018 $'000	Actual 2017 $'000
Donations and bequests received	**116**	134
Other revenue	**10,655**	7,704
Rental income from investment properties	**834**	191
	11,605	8,029

6. Exchange versus non exchange revenue

	Actual 2018 $'000	Actual 2017 $'000
Exchange revenue	**45,084**	39,442
Non-exchange revenue	**751,029**	714,316
	796,113	753,758

7. Employee benefit costs

	Actual 2018 $'000	Actual 2017 $'000
Salaries and wages	**243,220**	231,955
Defined contribution plan employer contributions	**7,666**	6,968
Increase/(decrease) in employee entitlements/liabilities	**5,706**	2,405
Total personnel costs	**256,592**	241,328

8. Non clinical expenses

	Actual 2018 $'000	Actual 2017 $'000
Fees to Deloitte for financial statements audit	**171**	183
ACC partnership programme	**380**	198
Impairment of receivables	**111**	325
Operating lease expenses	**2,214**	2,113
Infrastructure servicing costs and other sundry expenses	**35,413**	35,399
Directors' fees	**292**	280
Intangible asset impairment	**255**	-
Koha	**27**	10
Loss/(gain) on sale of assets	**48**	31
Total other expenses	**38,911**	38,539

9. Finance income and finance costs

	Actual 2018 $'000	Actual 2017 $'000
Finance income		
Interest income	**1,249**	1,057
Total finance income	**1,249**	1,057
Finance costs		
Interest expense	**-**	3,838
Bank charges	**46**	44
Capital charge	**15,994**	7,483
Total finance costs	**16,040**	11,365
Net finance costs	**14,791**	10,308

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 2018 was 6% (2017: 6%).

10. Cash and cash equivalents

	Actual 2018 $'000	Actual 2017 $'000
Cash at bank and in hand	**6**	19
Call deposits	**21,964**	14,690
Total cash and cash equivalents	**21,970**	14,709

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 2018 $'000	Actual 2017 $'000
Surplus/(deficit)	**(9,856)**	374
Add/(less) non-cash items		
Share of associates/joint ventures surplus	**(38)**	-
Share of other investment surplus	**(68)**	-
Depreciation and amortisation expense	**20,819**	19,325
Impairment on intangibles	**255**	-
Non-perpetual inventory write-down	**-**	193
Bad debt write-off	**-**	325
Donated assets	**-**	150
Total non-cash items	**20,968**	19,993
Add/(less) items classified as investing or financing activities		
(Gains)/losses on disposal of property, plant, and equipment	**(48)**	31
Total items classified as investing or financing activities	**(48)**	31
Add/(less) movements in working capital items		
(Increase)/Decrease in receivables	**7,516**	(6,675)
(Increase)/Decrease in inventory	**(89)**	31
Increase/(Decrease) in payables	**4,420**	7,448
Net movement in working capital items	**11,847**	804
Net cash inflow/(outflow) from operating activities	**22,911**	21,202

12. Trade and other receivables

	Actual 2018 $'000	Actual 2017 $'000
Trade receivables from non-related parties	**5,715**	5,365
Provision for doubtful receivables	**(394)**	(256)
Trade receivables from related parties (note 22)	**623**	1,417
Crown and Ministry of Health receivables	**17,027**	20,887
Accrued income	**3,656**	3,535
Prepayments	**1,432**	4,552
Total debtors and other receivables	**28,059**	35,500
Receivables from exchange transactions	**13,451**	20,678
Receivables from non-exchange transactions	**14,608**	14,822
	28,059	35,500

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 uncollectability is performed on a collective basis, based on an analysis of past collection history and write-offs.

Movements in the provision for uncollectability are as follows:

	Actual 2018 $'000	Actual 2017 $'000
At 1 July	**(256)**	(263)
Impairment losses on recognised receivables	**(138)**	7
At 30 June	**(394)**	(256)

13. Inventories

	Actual 2018 $'000	Actual 2017 $'000
Central stores	**2,112**	2,037
Pharmaceuticals	**509**	494
Other supplies	**283**	284
	2,904	2,815

Inventories are recognised at their historical cost. Inventories recognised in the profit or loss amounted to $29,319,870 (2017: $24,528,846).

No inventories are pledged as security for liabilities (2017: nil). However, some inventories are subject to retention of title clauses.

14. Property, plant and equipment

Cost/valuation	Land at valuation	Buildings at valuation	Leasehold improvements	Plant, equipment and vehicles	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Balance as at 1 July 2016	**13,338**	**255,190**	**9,865**	**93,726**	**1,719**	**373,838**
Revaluation surplus	-	-	-	-	-	-
Additions	-	7,225	-	4,390	4,860	16,475
Disposals	-	-	-	(13,585)	-	(13,585)
Transfers	-	-	-	-	(2,801)	(2,801)
Balance as at 30 June 2017	**13,338**	**262,415**	**9,865**	**84,531**	**3,778**	**373,927**

	Land at valuation	Buildings at valuation	Leasehold improvements	Plant, equipment and vehicles	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'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**

Accumulated depreciation	Land at valuation	Buildings at valuation	Leasehold improvements	Plant, equipment and vehicles	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Balance as at 1 July 2016	**-**	**(11,265)**	**(1,614)**	**(65,821)**	**-**	**(78,700)**
Depreciation charge	-	(11,136)	(283)	(6,949)	-	(18,368)
Revaluation increase/(decrease)	-	-	-	-	-	-
Disposals	-	-	-	13,570	-	13,570
Transfers	-	-	-	-	-	-
Balance as at 30 June 2017	**-**	**(22,401)**	**(1,897)**	**(59,200)**	**-**	**(83,498)**

	Land at valuation	Buildings at valuation	Leasehold improvements	Plant, equipment and vehicles	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Balance as at 1 July 2017	**-**	**(22,401)**	**(1,897)**	**(59,200)**	**-**	**(83,498)**
Depreciation charge	-	(11,521)	-	(7,870)	-	(19,391)
Elimination 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)**
Net book value						
As at 30 June 2017	**13,338**	**240,014**	**7,968**	**25,331**	**3,778**	**290,429**
As at 30 June 2018	**14,605**	**253,887**	**2,392**	**19,074**	**3,796**	**293,754**

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.

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 against any Property, Plant and Equipment by Bay of Plenty DHB during 2018.

15. Intangible assets

Gross carrying amount	Computer software $'000	NZHPL (FPSC/NOS) $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2016	**10,411**	**3,021**	**-**	**13,432**
Additions	14	-	-	14
Balance as at 30 June 2017	**10,425**	**3,021**	**-**	**13,446**

	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**

Accumulated amortisation and impairment	Computer software $'000	NZHPL (FPSC/NOS) $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2016	**(9,391)**	**-**	**-**	**(9,391)**
Amortisation charge for the year	(957)	-	-	(957)
Balance as at 30 June 2017	**(10,348)**	**-**	**-**	**(10,348)**

	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
Net book value				
As at 30 June 2017	**77**	**3,021**	**-**	**3,098**
As at 30 June 2018	**1,356**	**2,766**	**6,510**	**10,632**

16. Investments in associates

(a) General information

Name of entity	Principal activities	Interest held at 2018 %	2017 %	Balance date
Venturo Limited	**Provision of urology services**	**50**	50	30 June
Bay Imaging Group Limited	**Provision of CT scanning services**	**-**	50	30 June

Bay Imaging Group Limited was wound up during the year. There was no interest held as at 30 June 2018.

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

	Assets $'000	Liabilities $'000	Equity $'000	Revenue $'000	Profit/(loss) $'000
2018					
Venturo Limited	**1,041**	**1,061**	**(20)**	**6,252**	**(15)**
Bay Imaging Group	**-**	**-**	**-**	**-**	**-**
2017					
Venturo Limited	1,136	1,110	26	6,113	(10)
Bay Imaging Group	16	20	(4)	-	-

(c) Share of profit of associate entities

	Actual 2018 $'000	Actual 2017 $'000
Share of profit/(loss) before tax	**(7)**	(5)
Share of profit/(loss) after tax	**(7)**	(5)

(d) Investment in associate entities

	Actual 2018 $'000	Actual 2017 $'000
Carrying amount at the beginning of the year	**46**	51
Share of total recognised revenue and expenses	**(7)**	(5)
Other impairment losses	**(39)**	-
Carrying amount at the end of the year	**-**	46

(e) Share of associates' contingent liabilities and commitments

There are no contingent liabilities and commitments at year end.

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 2018 %	Interest held at 2017 %	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
2018					
HealthShare Limited	**21,043**	**19,168**	**1,875**	**15,384**	**420**
2017					
HealthShare Limited	14,908	13,419	1,489	13,682	222

	Actual 2018 $'000	Actual 2017 $'000
Share of profit/(loss) before tax	**84**	44
Tax expense	**-**	-
Share of profit/(loss) after tax	**84**	44

(d) Investment in joint ventures

	Actual 2018 $'000	Actual 2017 $'000
Carrying amount at the beginning of the year	**291**	247
Share of total recognised revenue and expenses	**84**	44
Carrying amount at the end of the year	**375**	291

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

There are no contingent liabilities and commitments at year end.

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 2018 $'000	Actual 2017 $'000
Current portion		
Annual leave	**25,310**	23,948
Long service leave	**1,254**	1,371
Salary and wages accrual	**10,101**	5,681
Total current portion	**36,665**	31,000
Non-current portion		
Long service leave	**601**	560
Total non-current portion	**601**	560
Total employee entitlements	**37,266**	31,560

Compliance with the Holidays Act 2003: Included in the Annual Leave provision above is an estimate of the Holidays Act compliance. BOPDHB has estimated its liability as at 30 June 2018 to be $284,000 ($200,000 in 2017). The BOPDHB updated and tested the payroll systems to ensure compliance with the Act in 2014/15. The estimate of liability above relates to those staff employed from 2011 to 2014.

This estimate is based on the best information available to the DHB at balance date but, due to the uncertainties involved, the actual liability could be different.

19. Trade and other payables

	Actual 2018 $'000	Actual 2017 $'000
Trade payables	**2,947**	8,683
ACC levy payable	**402**	623
Accrued expenses	**34,164**	26,085
PAYE payable	**2,189**	2,063
Income received in advance	**186**	4,519
GST payable	**4,165**	3,165
Total creditors and other payables	**44,053**	45,138
Payables from exchange transactions	**37,297**	39,286
Payables from non-exchange transactions	**6,756**	5,852
	44,053	45,138

20. Operating and capital commitments

Capital commitments

	Actual 2018 $'000	Actual 2017 $'000
Not later than one year	-	1,267
Later than one year and not later than five years	-	-
Later than five years	-	-
	-	1,267

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 2018 $'000	Actual 2017 $'000
Not later than one year	**2,574**	841
Later than one year and not later than five years	**5,785**	870
Later than five years	**770**	-
Total non-cancellable operating leases	**9,129**	1,711

During the year ended 30 June 2018 $3,404,592 of operating leases were recognised as an expense in the profit or loss, split between clinical expenses and non-clinical expenses (2017: 3,449,454).

21. Financial instruments

(a) Credit risk

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.

	2018 Gross Receivable $'000	2017 Gross Receivable $'000	2018 Impairment $'000	2017 Impairment $'000
Not past due	**3,910**	-	**-**	-
Past due 0-30 days	**148**	4,732	**-**	-
Past due 31-120 days	**699**	603	**(40)**	-
Past due 121-360 days	**1,581**	1,447	**(354)**	(256)
Total	**6,338**	6,782	**(394)**	(256)

	Actual 2018 $'000	Actual 2017 $'000
Trade receivables		
Gross trade receivables	**6,338**	6,782
Individual impairment	**(394)**	(256)
Net total trade receivables	**5,944**	6,526

(b) 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.

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 $'000	Between 6 months and 1 year $'000	Between 1 and 2 years $'000	Between 2 and 5 years $'000	Over 5 years $'000	Total contractual cash flows $'000	Carrying Amount (assets)/ liabilities $'000
2018							
Payables and accruals	44,053	-	-	-	-	44,053	44,053
Total financial liabilities	44,053	-	-	-	-	44,053	44,053
2017							
Payables and accruals	45,138	-	-	-	-	45,138	45,138

Classification and fair values

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

	Cash and cash equivalents $'000	Loans and receivables $'000	Financial liabilities at amortised cost $'000	Carrying amount $'000	Fair value $'000
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)
	21,970	**28,059**	**(44,053)**	**5,976**	5,976
2017					
Cash and cash equivalents	14,709	-	-	14,709	14,709
Trade and other receivables	-	35,501	-	35,501	35,501
Trade and other payables	-	-	(45,138)	(45,138)	(45,138)
	14,709	**35,501**	**(45,138)**	**5,072**	5,072

(c) 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.

22. 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 (2017: nil).

Transactions with key management personnel

Key management personnel compensation

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

	Actual 2018 $'000	Actual 2017 $'000
Board members		
Full-time equivalent members	**11**	13
Remuneration	**280**	317
Executive Management Team, including the Chief Executive		
Full-time equivalent members	**7**	8
Remuneration	**2,023**	2,313
Total full-time equivalent personnel	**18**	21
Total key management personnel compensation	**2,303**	2,630

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 (2017: 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 (2017: nil).

The Bay of Plenty DHB did not provide any loans to key management personnel or their close family members (2017: nil).

23. 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).

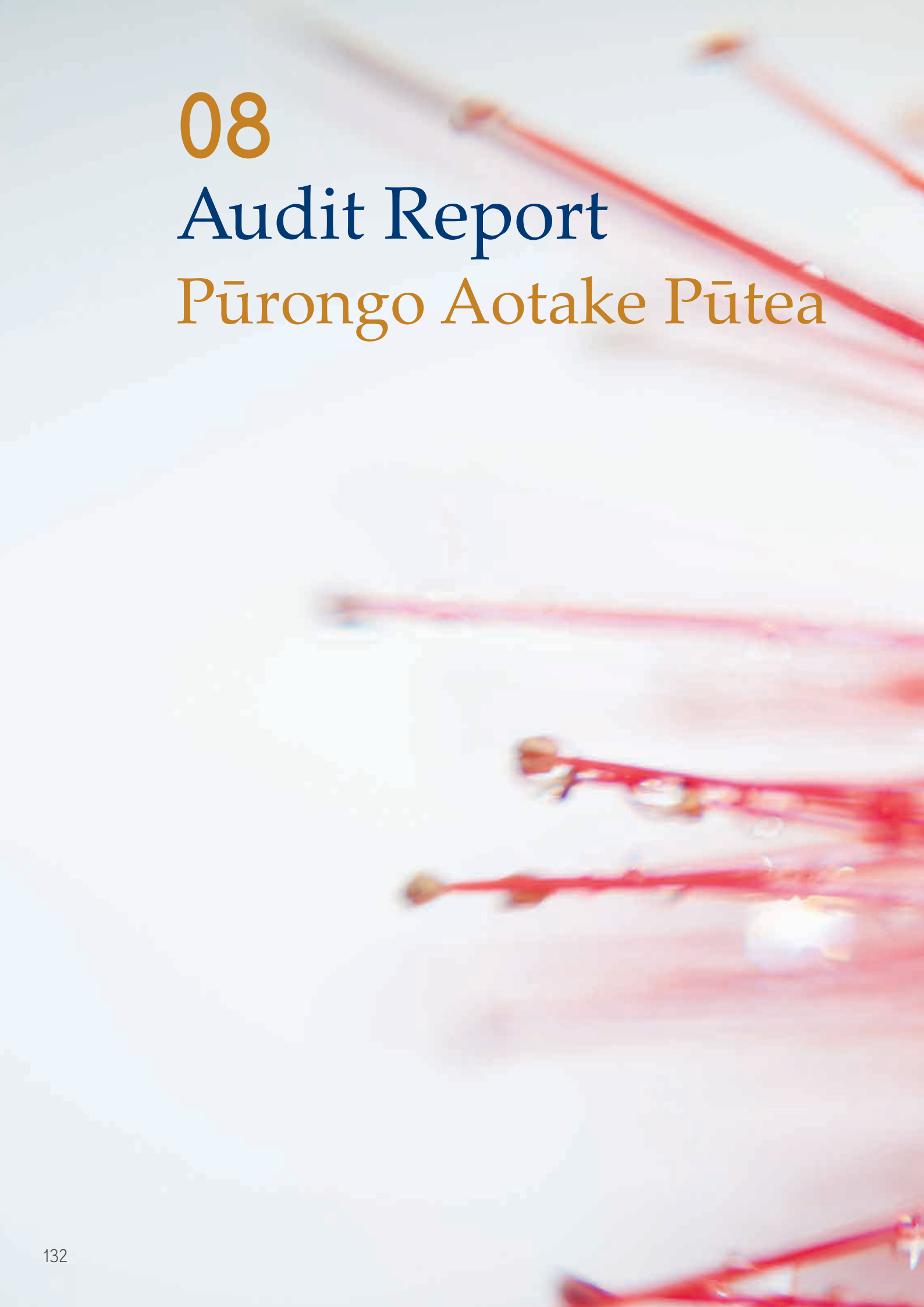
24. Contingencies

As at 30 June 2018 the Bay of Plenty DHB had no contingent liabilities or assets (2017: nil).

25. Events occurring after balance sheet

There were no events occurring subsequent to balance date which require adjustment to or disclosure in the financial statements.

08
Audit Report
Pūrongo Aotake Pūtea



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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 2018

The Auditor-General is the auditor of Bay of Plenty District Health Board (the Health Board). The Auditor-General has appointed me, Melissa Youngson, 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.

Opinion

We have audited:

- the financial statements of the Health Board on pages 106 to 130, that comprise the Statement of Financial Position as at 30 June 2018, 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 66 to 102.

In our opinion:

- the financial statements of the Health Board on pages 106 to 130:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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 66 to 102:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2018, 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 17 October 2018. This is the date at which our opinion is expressed.

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The basis for our opinion is explained below and we draw attention to a matter in relation to compliance with the Holiday Act 2003. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, and we explain our independence.

Compliance with Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in Note 18 on page 127. Our opinion is not modified in respect of this matter.

Basis for our opinion

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

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

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

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

The Board are 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 are 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 are responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board are 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.

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.

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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.

Other Information

The Board are responsible for the other information. The other information comprises the information included on pages 8 to 63, 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,

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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.

Melissa Youngson, Partner
for Deloitte Limited
On behalf of the Auditor-General
Hamilton, New Zealand