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Bay of Plenty District Health Board

Annual Report 2021

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

Ministerial Directions

BOPDHB complies with the following Ministerial Directions in accordance with the Crown Entities Act (section 151 (f)):

- 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.
- In addition DHBs were advised in March 2020 by the Minister of Health that he had issued a COVID-19 response direction.

The Bay of Plenty District Health Board Annual Report 2021

Produced in 2021
by the Bay of Plenty District Health Board
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Bay of Plenty District Health Board

Annual Report 2021

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

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01

Our Vision, Mission & Values
Nga Moemoeā, Nga Kaupapa

NGA MOEMOE, NGA KAUPAPA

Our **VISION**

Tā Mātou Moemoea

Healthy, Thriving Communities – Kia Momoho Te Hāpori Oranga

Our **MISSION**

Tā Mātou Matakite

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

Our **VALUES**

Ā Mātou Uara

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

He Pou Oranga Tangata Whenua Māori Determinants of Health Principles

Wairuatanga
Understanding and engaging in a spiritual existence.

Rangatiratanga
Positive leadership.

Manaakitanga
Show of respect or kindness and support.

Kotahitanga
Maintaining unity of purpose and direction.

Ukaipotanga
Place of belonging, purpose and importance.

Kaitiakitanga
Guardianship and stewardship over people, land and resource.

Whānaungatanga
Being part of and contributing collectively.

Pukengatanga
Teaching, preserving and creating knowledge.

CARE

Compassion All-one-team Responsive Excellence

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

CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

OUR DISTRICT

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

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

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

1. New Zealand Health and Disability Act 2000

BOPDHB'S POPULATION

The Bay of Plenty District Health Board (BOPDHB) is one of 20 DHBs in New Zealand, and one of five DHBs that make up the Midland region. We serve a population of approximately 255,110[2] residents (199,751 living in Western Bay of Plenty, and 55,359 in the Eastern Bay of Plenty), for the major population centres of Tauranga, Katikati, Te Puke, Whakatāne, Kawerau and Ōpōtiki. Of this, 31% are under 25 and 25.6% identify as having Māori ethnicity, and like the national population, our population is ageing (currently 20% aged 65 or over, and forecast to reach 23% in 2026). Eighteen Iwi are located within our district.

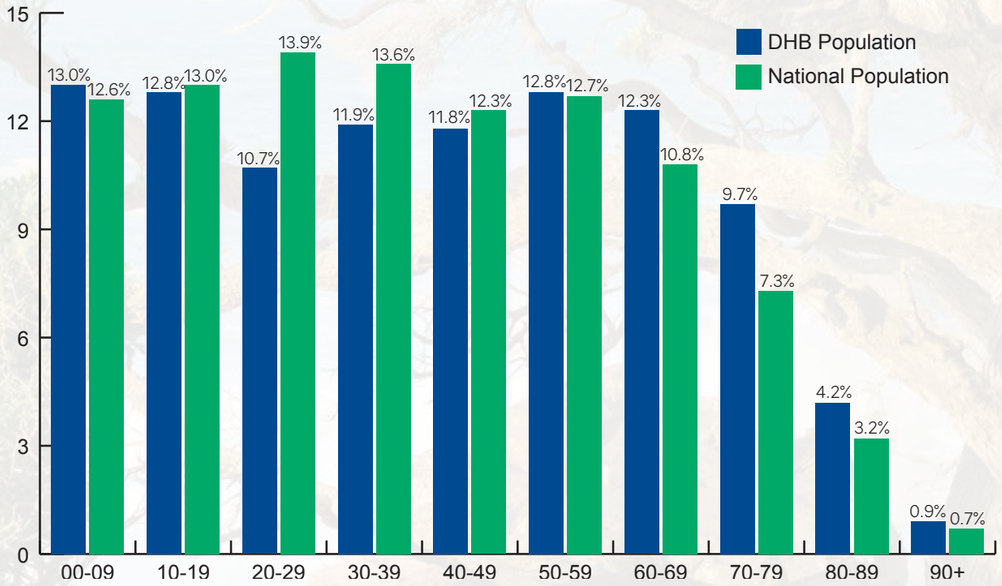
The Bay of Plenty is growing at a faster rate than the New Zealand population, as a whole. The forecast for population growth from 2016 to 2026 is 20.5% with the majority of the growth expected to be in the Western Bay of Plenty region (particularly Tauranga city) with the Eastern Bay of Plenty expected to experience a static or declining population. 78.3% of our population resides in the Western Bay of Plenty[3].

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

The BOPDHB acknowledges these challenges and are refocusing their approach to achieving health outcomes. This will become more collaborative with community and agencies outside the health sector, with emphasis on Health in all Policies. Over the next thirty years, progressing to determinants of health approach, through a collective effort will be required to improve health of all New Zealanders[4].

Population by Age 2020/21

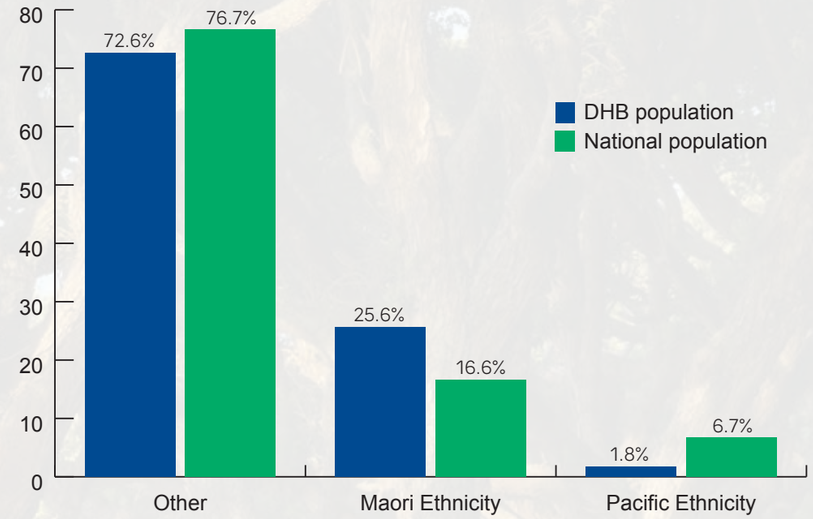
Bay of Plenty's population tends to be older than the national average[5].



2. MOH projected population for 2019/2020 based on 2018 census data.
3. http://www.bopdhb.govt.nz/your-dhb/about-your-dhb/
4. Mason Drury November 2015.
5. Ministry of Health NZ

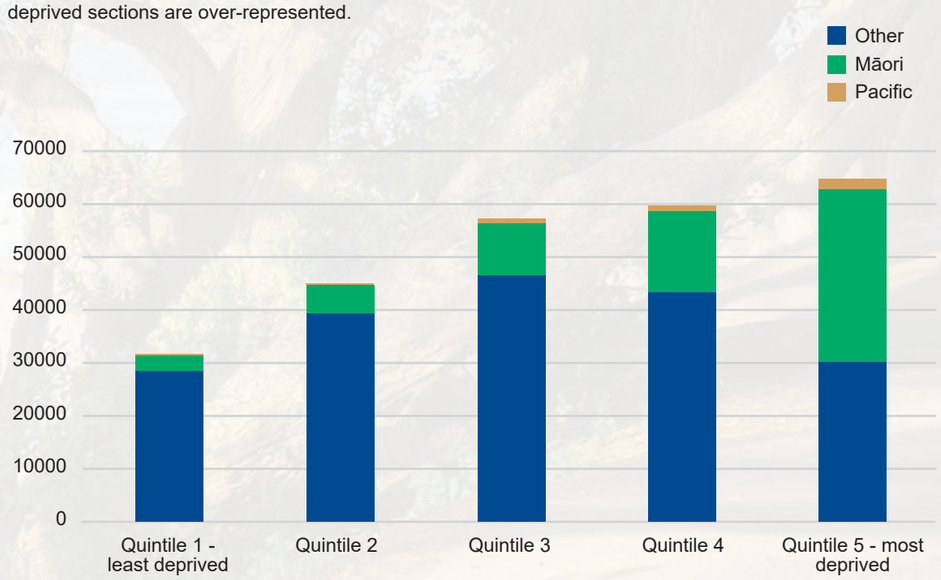
Ethnic mix 2020/21

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



Deprivation 2020/21

Bay of Plenty has a relatively low proportion of people in the least deprived section of the population while the most deprived sections are over-represented.



02

Our Priorities and Performance

Mahi Whakariterite

STRATEGIC INTENTIONS/PRIORITIES

The BOPDHB Annual Report is where we report on our organisational progress as well as performance related to the Annual Plan 2020-2021, towards achieving our vision – Kia Momoho te Hapūri Oranga, Healthy Thriving Communities. Te Tiriti o Waitangi is central to our identity and mission, and we acknowledge our partners in that journey, the DHB Māori Health Rūnanga.

Over the next ten years, the BOPDHB and the Māori Health Rūnanga (collectively known as Te Kohao o Te Waka o Toi) commit to working together, partnering for outcomes across sectors and ensuring that tangata whenua determinants of wellbeing are addressed and invested here in Te Moana ā Toi.

The Bay of Plenty Strategic Health Services Plan 2017-27 sets the scene for what we need to focus on to support our communities to be healthy and thriving. It guides us to provide health services which better support people to stay well and manage their own health.Te Toi Ahorangi 2030 provides a strategic framework that describes a unified vision, voice and intention to successfully influence health and wellbeing outcomes for tangata whenua and all people living in Te Moana ā Toi, from preconception throughout the life course. This vision directly aligns with He Korowai Oranga, the Government's national Māori Health Strategy and vision of Pae Ora - healthy, Māori futures.

Achieving Health Equity

Achieving equity in health and wellness is a focus for BOPDHB. Given our population make up and our obligations under Te Tiriti o Waitangi, the BOPDHB has further focused this priority to ensure that reducing Māori inequities are at the forefront of the work we do.

Equity in health for the BOPDHB and the wider Manawa Taki region is aligned with all Articles and Principles in Te Tiriti o Waitangi, in particular Article III (which has an Equity focus) and the Principle of Equity. It is also aligned with the United Nations Declaration on the Rights of Indigenous Peoples, which affirms the rights of Māori to determine, develop, maintain, access and administer programmes, medicines and practices that support optimal health and wellbeing. Finally, it incorporates and enhances the Ministry of Health's definition.

In the Bay of Plenty, this means prioritising service delivery to achieve equity of access, equity of quality, and equity of outcomes for Māori that reflects aspirations and needs in the context of advancing overall health outcomes.

"Equity is purposeful investment of resources that transforms pathways of disadvantage to advantage:

1. Supports rectifying differences that are avoidable, unfair and unjust:
   It recognises that avoidable, unfair, and unjust differences in health are unacceptable.
2. Proportionate investment of resources based on rights and needs:
   It requires that people with different levels of advantage, receive proportionate investment of resources and approaches based on rights and need.
3. Implements Te Tiriti o Waitangi in contemporary ways at system and service levels:
   It demands a health and disability system that is committed to implementing Te Tiriti o Waitangi in contemporary ways as a catalyst for success; that our system is culturally safe, competent and enabling of wellbeing.
4. Success is measured by equity of access, quality and/or outcomes:
   We will know we have achieved equity when we see equity of access, quality and outcomes in the region; particularly for Māori and then for all others who are affected unnecessarily by disadvantage."

Making measurable progress to achieve equity in health and wellness requires innovation and different approaches to how services are delivered, as evident in both Te Toi Ahorangi and the Strategic Health Services Plan.

BOARD CHAIR AND CHIEF EXECUTIVE OFFICER'S REPORT

E mihi kau ana ēnei ki a koutou, e ngā rau rangatira mā, mai i ngā kurī ā Whārei ki Tihirau, mai i Maketū ki Tongariro. He hokinga mahara ki a rātou i wehe ki te pō i te tau kua hipa, ā ka tangi tonu te ngākau ki a rātou i hinga i te parekura ki te Puia o Whakaari. E haere atu rā. Kua tau mai au ki raro i te korowai o ngā iwi o te rohe nei, ka nui te mihi atu, tēnā koutou katoa.

We are pleased to present Bay of Plenty District Health Board's Annual Report 2020/21 which describes and reflects on the activities, performance, and achievements according to our national, regional, and local priorities for the year.

In 2020/21, Bay of Plenty DHB remained focused on health equity, improving access to services and care, within both and hospital and community health settings, and continuing to build an integrated and sustainable healthcare system. Added to these service aspects, has been the need to focus on the wellbeing of our workforce given the pressures they face from COVID and population growth related impact on our services.

We experienced a number of challenges over the 2020/21 year, supporting our communities and staff with the continued recovery from Whakaari White Island disaster in 2019, building our health system's response to COVID-19, with the introduction of vaccination, screening, reconfiguration of physical environments to protect from COVID, recruitment and training of new staff, and advising, caring for and treating our people.

COVID has been the major focus during the year and navigating the impact of lockdowns and other restrictions on clinical services has required careful balancing of minimising the spread of COVID with the best possible levels of service provision. However, COVID has impacted this significantly and catching up on service backlogs and extended waiting times will be a key focus during 2022.

BOP population growth and demand on healthcare services surged in the last quarter of 2020/21, where both hospital and community clinical services were operating beyond their maximum capacity. BOPDHB continue to plan for more blended models of care across the whole system, to meet the urgent care needs of the community. Having a strong focus on equity across this mahi, has been critical as we look to improve the health and wellbeing of tangata whenua and reduce continuing health disparities.

The COVID-19 immunisation roll out began in the last quarter of the year, and we undertook 62,622 vaccinations before the end of the financial year. Alongside this, we continued to work hard on improving child immunisation in the BOPDHB region. The challenge around recruiting additional COVID-19 vaccinating staff has been significant within the Bay of Plenty, and in particular within the Eastern Bay , due to its smaller population to draw potential recruits from. This has meant our Public Health nurses who primarily focus on preschool, primary school, and adolescent health issues, are continuing to assist in the ongoing COVID-19 vaccination programme.

Other key pieces of work:

- Te Toi Ahorangi 2030, our health equity strategy for Māori, sets a clear direction for tangata whenua and our DHB to achieve Toi Ora, together. The strategy provides both room and support for self-determination in the provision of care by Māori, for Māori. This is important for our DHB as a party to the Treaty of Waitangi, and is essential to our 18 Iwi – our Te Tiriti o Waitangi partners, as collectively we work towards strengthening an authentic relationship that supports tangata whenua to define, decide and determine wellness pathways.
- Telemedicine and digital health were begun, which meant the DHB has been able to maintain some services, especially to rural or remote communities where transport may be challenging.
- A number of key, sector leading change initiatives have progressed well including our Community Orthopaedic Service model, moving towards and integrated children's care service and starting to provide specialist outpatient clinics in remote rural communities to address historic access issues.

During the year we discussed what matters the most to us and what we needed to Stop, Pause (for more information), or Push hard on progressing. We recognised the huge load on everyone and wanted to make sure we thought carefully about where we prioritise effort over the remaining 14 months of the current DHB model, and where we might be able to ease up and take some pressure off people. Going into the 2021/22 year the BOPDHB decided on the below top 5 priorities :

1. COVID-19 outbreak readiness and vaccination programme.
2. Actively taking the best care of our people that we can.
3. Work related to easing capacity, demand, and population growth pressures.
4. Work that will move the dial on specific avoidable inequities.
5. Achieving HNZ transition expectations: agreed financial position, project conclusions, orderly handover.

We wish to express our gratitude to the BOPDHB workforce and want to reiterate how sincerely we appreciate the vision, drive and sheer hard work throughout both our DHB and wider BOP health workforce.

Sharon Shea
Board Chair

Pete Chandler
Chief Executive Officer

2020 / 2021 HIGHLIGHTS

Planning and Funding

The Planning and Funding division of the DHB agrees funding allocations with providers on the basis of need and priority with a particular focus on equity. This year, under extraordinary circumstances, we supported Providers to manage the unpredictability of the pandemic, allay concerns about the unknown, and as much as possible ensure that providers were still able to care for their communities during the various level changes. Members of the team were also seconded into the pandemic effort which then transitioned into the largest vaccination effort in this country's history.

Generally the work of the Planning and Funding division is behind the scenes, as it should be. Funding should not be the start of the conversation in matters pertaining to health. It is an enabler, and during this past year in particular the partnering ethos that we aspire to as a division was no more apparent than in the midst of a crisis. Our aim going forward, as the times settle, is to retain the spirit of these challenging times in the best health interests of our community. Inherent in the new health reforms set for next year, is the potential to enhance a collective, community-minded approach to health care as we think about commissioning, rather than funding and procuring services. Ideally all parts of the system, including the end users of health services will feature in the decision-making process. In short there are profound and exciting times ahead if we are bold enough to embrace the challenge.

Improving Access to Contraception (Protected and Proud)

Protected&Proud is a contraception service designed by and for women/wāhine in the Bay of Plenty to provide access to the most effective contraception, including Implants and Intra Uterine Devices (IUDs), to reduce unplanned pregnancies. A set of co-designed service principles underpin the approach, including: choice of service providers and delivery by a range of healthcare professionals; services closer to home (<30mins); and access to confidential, accurate and unbiased contraception services.

The Protected&Proud model has evolved since inception in October 2019, through the expansion of more than 50+ trained practitioners delivered by a local training provider, specifically for Registered Nurses, School Nurses and Midwives, alongside General Practitioners (GPs). Free services (for eligible target group) are funded under a Ministry of Health contract and delivered across general practices, Lead Maternity Carers (LMCs), kaupapa Māori and iwi hauora providers, school nurses, and hospital services. Innovative service models have been developed, including a home-based fit and forget service for women/wāhine that are post-partum and a pharmacy based clinic (pilot). The BOP exceeded the annual targets set by the MoH for inserts and removals by 211% for this financial year.

Improve access to assessment and treatment of skin infections and infestations in the EBOP and Te Puke for children aged 2 – 19 years.

The Community Pharmacy Kiri Ora Pilot Project is a service offering free assessment and treatment of common preventable skin infestations and infections under a standing order. The service aimed to reduce inequality of health outcomes for targeted preventable skin conditions for children in the area. Currently these children experience significantly higher rates of serious skin infection hospitalisations than the national average with Māori children in particular bearing the highest burden of these conditions. Offering funded services through community pharmacies provided patients with another avenue to access care in an area where GP services can often be stretched beyond capacity.

Clinical support is provided to pharmacists by both paediatric and infectious disease specialists with patient's GPs promptly informed of any assessments and treatments provided. Patients are assessed and provided with appropriate treatment, resources, advice and structured follow ups to enable them to successfully and safely treat their conditions. There are now have 42 pharmacists trained to provide the service in the Bay of Plenty. Follow up calls post service have been overwhelmingly positive, with patients thanking the DHB for providing such as well needed service. Another aspect is that patient engaging with the service with no GP have been able to be connected to a practice and registered.

So far, the largest group of conditions treated has been headlice but it is easy to under-estimate the impact of such a problem. Headlice is a common reason for missing school whilst getting treated and frequently spreads through whole families. Treatment can be financially challenging for many of those served by this initiative. On the more significant end of the scale impetigo and cellulitis are common causes of morbidity in children. The monitoring of this programme has shown pharmacist-based assessment of children with these infections to be accurate and safe and frequently prevented the need for GP review. They communicate treatments provided for these problems to GP to keep them in the loop. Where more severe they appropriately refer on to the GP or emergency department this preventing unnecessary review or expediting emergency treatment.

Integrated Care

Intravenous Iron infusions

BOPDHB Primary Care Nurse Leader worked with surgical services on a proposal to fund the devolution of intravenous iron infusions from hospital day stay, to primary care. Consultation was also undertaken with primary care, and this confirmed primary cares' willingness and ability to undertake IV iron infusion in general practice. Consequently intravenous iron therapy is now funded by for eligible Māori, Pacifika, and community service hard holders to be completed in primary care. This has increased convenience of our most vulnerable population groups and released some capacity within the hospital. This initiative has been taken up by Western Bay of Plenty Primary Health Organisation (WBOPPHO), Ngā Mataapuna Oranga (NMO) and Eastern Bay Primary Health Association (EBPHA).

Just in Case plans

Just in case plans are a new initiative devised by Philippa Jones, DON and workforce, WBOPPHO and led by Ruth McChesney, nurse specialist WBOPPHO in collaboration with St John. Just in case documents support palliative patients to stay in their own home through the prescribing of anticipatory medicine to manage acute exacerbations of underlying health conditions. The prescribed medicines can be administered by St John and therefore are particularly useful in the evenings and weekends when the patient's GP may not be available. WBOPPHO is currently funding general practice to complete these plans. BOPDHB have been supportive of the Just in Case plans and there is agreement to ensure these are readily available for completion by Emergency department and other hospital specialists. The spread of this initiative has the potential to reduce hospital readmissions, and to ensure that patients can be safely managed in their home environment for longer.

Aged Residential Care transition of care plans

WBOPPHO employs two aged residential care nurse specialists under a DHB funded contract. These nurses work closely with staff and patients in aged residential care facilities providing expert advice, education and comprehensive assessments. A new project has recently been launched to improve the discharge experience of Aged Residential Care (ARC) residents who have been admitted to hospital. The two ARC nurses participate in Tauranga hospital rapid rounds and input to the discharge planning for ARC residents, with the intent of ensuring that patients have a good discharge experience and minimise the risk of readmission

The BOP primary care nurse leader (Philippa Jones), has been instrumental in the creation of a number of joined up initiatives across the BOP and within the midland region. Within the BOP, Continuing Medical Education (CME) accreditation was achieved for all providers under the auspices of the well-established CME program managed by WBOPPHO. This enabled other health providers to claim CME points for education provision provided to General Practitioners. Midland wide, BOP took a lead role in the establishment of the Midland Collaborative[6]. Designated Registered Nurse Prescribing in Community Health (RNPCH) programme that is designed to enable a prescribing scope to meet the learning needs of registered nurses who work with normally healthy people in community and other primary and ambulatory health settings. We have commenced our third intake to the course.

The COVID-19 response between the DHB and Primary Health has led to other initiatives, including:

- The training and development of competencies to enable the unregulated workforce to undertake nasopharyngeal swabbing. This has supported a number of Māori provider across the Bay to provide an essential service with surveillance swabbing. Ngati Ranginui lead the surveillance swabbing for the Port of Tauranga and utilise their unregulated workforce who are supervised by a registered nurse.
- The development of drive through influenza vaccination clinics. These were well received and have been replicated nationally. The collaborative work for these underpinned the drive through COID 19 vaccination guidance issued by the MoH.
- N95 fit testing. WBOPPHO have a small team working under the guidance of the nurse lead who are providing N95 mask fit testing. Both methods, qualitative and quantitative (using the Porta Count) are being utilised. This work is essential in helping to keep our front line workers safe.

6. The Midland Collaborative comprises five Midland based DHBs (Bay of Plenty (BOP) DHB, Lakes DHB, Tairawhiti DHB, Taranaki DHB, Waikato DHB), and eight PHOs (Eastern Bay of Plenty Health Alliance, Western Bay of Plenty PHO, Nga Mataapuna Oranga PHO, Rotorua Area Primary Health Services, Hauraki PHO, National Hauora Coalition, Pinnacle Midlands Health Network, Ngati Porou Hauora).

Allied Health

The core skills of the Allied Health, Scientific and Technical (AHST) workforce represent a major resource for our BOP health system and are clearly aligned with the objectives of both the Strategic Health Service Plan (SHSP) and Te Toi Ahorangi (TTA). In addition, the proposed reforms set out in the Health and Disability System Review with a focus towards prevention, early intervention, wellness, access, and equity provide the AHST workforce with an opportunity to contribute, in a pro-active way, and provide many of the solutions that will be required to deliver true person centred, equitable healthcare.

Over the past year significant work programmes have gained traction across the wider NZ health system such as the Community Orthopaedic Triage Service (COTS) which focuses on enabling adults with musculoskeletal conditions to access appropriate triage, assessment, and early interventions closer to home. While demand on orthopaedic services continues to increase the actual referrals from Primary Care to direct to orthopaedics is slowly reducing.

Based on current data >60% of all patients seen in the COTS service went on to have a wellbeing programme rather than onward referral into secondary care services. We are also seeing a higher uptake of Māori into the service as well as a better attendance rate.

Other initiatives include:

- Paediatric Orthopaedic Triage Service POTS) which is similar to COTS but focusing on children and young adults.
- Community in-reach focusing on reducing the length of stay for patients and providing a course of rehabilitation and enablement in the person's home.
- The launch of Lifecurve with a free app for people across Aotearoa

These are just a few of the demonstrable initiatives where the AHST workforce in the BOPDHB are delivering value-based healthcare which will be essential in the new health system.

Innovation and Improvement

The Innovation and Improvement team leads, enables and supports innovation and improvement in health services across the BOPDHB. The team supports the operationalising BOPDHB strategic priorities, programme management of large scale change and builds organisational capability for innovation and quality improvement. The team works alongside health staff across the Bay of Plenty Health system in primary, community and hospital services. Our approach focusses on design for equity and sustainability, cross-sector collaboration to support and strengthen equitable outcomes for Māori, Institute for Healthcare model for improvement to accelerate improvement, project and programme management methodology to implement strategy, connecting an growing a network of change agents, support clinical leaders to improve services, patient and whānua experience and equitable outcomes, foster community engagement to improve population health outcomes and staying agile and being responsive. Our work is guided by Te Toi Ahorangi 2030 Toi Ora Strategy & the Strategic Health Services Plan 2017-2027.

The dynamic nature of the year that was, saw the Innovation & Improvement team pivot and reorientate to support the organisation to respond to COVID-19. In addition to the COVID-19 response, the team continued to be involved in a number of programmes, projects and quality improvement initiatives during 2020/21 including:

- E3 Acute Flow Programme (Eastern, Everyone, Excellence)
- First 2000 days/ Toi Oranga Mokopuna Programme
- Keeping Me Well Model of Care
- Community In-reach and Reablement
- Community Care Coordination
- Shared Goals of Care
- Digital Enablement Programme
- Orthopaedic Transformation Programme
- Planned Care Initiatives
- Healthpoint Directory
- Advanced Care Planning
- Safe Trache Management Pathway
- Pressure Injury Prevention and Management Initiative
- Infection prevention and control review
- ED Suicide Prevention Referral Pathway
- Palliative Care Services Review
- Te Tauihi o te Waka – Optimising Leadership & Management of Acute Demand Programme

Supporting and implementing sustainable changes, and improvements across the organisation is an ultimate aim of the Innovation and Improvement team. Examples of where the team have supported change and improvement include, the cellulitis pathway within the Eastern Bay of Plenty, the start-up of the community orthopaedic triage service and the foundations to support the pressure injury prevention and management initiative.

Within the E3 Acute programme Cellulitis admissions to Whakatāne Hospital were identified in 2020 as an area of focus, to reduce demand on acute inpatient beds. This led to the development of a business case for an Eastern Bay specific funded pathway for treatment of cellulitis. The pathway includes two free visits, initial and follow up, and a one stop shop medication pack given at the first visit. The pilot is a collaborative across Whakatāne Hospital and Eastern Bay Primary Health Alliance (EBPHA). Early outcomes over the first nine months are: a reduction in Length of Stay (LOS) from 3.9 in 2020 to 2.9 in 2021, admission numbers reduced 8% overall and 17% for Māori, LOS reduction 32% for all and 34% for Māori, 283 bed days saved, 311 patients referred to EBPHA Integrated Case Management team from ED and 1558 treatment claims by Primary care.

Within the Orthopaedic Transformation programme, a new community-based, physiotherapist-led orthopaedic triage and assessment model (COTS) was introduced and expanded across the Bay of Plenty to support orthopaedic services. The model enables adults with musculoskeletal problems to access appropriate triage, assessment and early intervention closer to home, provides self-management information to patients/whānau to optimise health and wellbeing and ensures only those that require specialist orthopaedic assessments in a secondary care setting are referred to orthopaedic specialists. COTS is currently available to 92% of General Practices. 809 COTS assessments were completed during 2020/21. A total of 504 (62%) COTS assessments resulted in proactive rehabilitation (non-surgical) recovery pathways (45%) or provision of self-management information (17%) to better manage their condition at home instead of referral for Orthopaedic FSA by an orthopaedic surgeon.

The Pressure Injury Prevention and Management initiative resulted in sustainable changes within the organisation by making improvements to staff education, information for staff, patient information, policy, procedures, and reporting. These sustainable changes will support the initiative to continue to work towards and monitor progress against the established success factors and the desired impact of the initiative being realised.

Nursing

While 2020/21 was dominated by industrial action and the impacts of Covid-19 nursing managed to progress some key pieces of work.

Bay of Plenty DHB continued to champion Care Capacity Demand Management (CCDM) by completing the annual FTE calculations for nursing and midwifery which were budgeted and progressed to recruitment. The project to develop of the CCDM electronic Core Data Set was completed and implemented with refinements ongoing.

From the ACCORD BOPDHB received funding for a registered nurse coach to provide additional support for new graduate nurses. Recruitment has been successful and the person is based at Whakatane to provide additional support.

Recruitment has also been successful to the Pandemic Surge Training position.

The workforce stocktake was delivered and the nursing data shared across the sector as a foundation for the nursing workforce priority.

Under the nursing Foundation of Excellence priority the Pressure Injury reduction Initiative, funded by ACC progressed in conjunction with selected Aged Residential Care facilities. This produced excellent resources for staff and families/whanau to use, staff education modules and a pressure injury database tracking performance towards the agreed key performance indicators.

Facilities and Business Operations

The main strategic focus during the last 12 months has been the development of the design and completion of the business case for a new Mental Health & Addiction facility for the Whakatane campus. The design of the building has focused on achieving a green building using sustainable materials and low energy operational cost. We have also commenced of development of the site masterplan for the Tauranga Hospital which will meet the services demand to 2040 and beyond. The site masterplan is an input into an Indicative Business Case which is being prepared and documents how we will meet the demand for increased services It is planned to be submitting the business case to the Ministry before March 2022.

Sustainability

The Government is taking climate change seriously by introducing the Climate Change Response (Zero Carbon) Amendment Act 2019 and announcing the Carbon Neutral Government Programme (CNGP), both of which have an impact on Bay of Plenty District Health Board. Overall, BOPDHB has seen a 17% carbon reduction since its baseline year. Within this, BOPDHB has seen a 5% reduction in carbon emissions from energy use. This is BOPDHB's third year of being engaged with Toitū Envirocare's carbonreduce programme and this, alongside the implementation of the BOPDHB's Kaitiakitanga Environmental Sustainability Framework, is starting to have some impact on practice.

Māori Health Rūnanga Chair's Report

Tēnā koutou katoa. Anei te mihi a te Rūnanga Hauora Māori o te Moana a Toi. Ko te tumanako kei te noho ora mai koutou ngā whanau katoa

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!

As the new Chair of te Rūnanga Hauora Māori o te Moana a Toi I would like to express thanks and appreciation to Pouroto Ngaropo for his leadership, not only as the previous Chair of the Rūnanga but as the representative for many years for Ngati Awa. His leadership and wisdom alongside Whaea Punoho McCausland for Waitaha held our waka together through the highs and lows as we navigated our way towards meaningful change.

"He waka kōtuia kāhore e tukutukua ngā mimira".

Pouroto's narrative at the launch of Te Toi Ahorangi in 2019 is still as powerful as it was then - We must work together to ensure we leave flourishing legacies for our future generations" "Te tini o Toi, Te waka o Toi, kia puawai ai te toi ora o ngā iwi katoa"

Te Rūnanga Hauora Māori o te Moana a Toi

Our unique composition as a collective of Iwi across the Bay of Plenty 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 rangatira, mana moana motuhake and mana tangata of our respective tribal regions. The Māori Health Rūnanga provides a platform to influence the decision-making processes of the BOPDHB Board and ensure meaningful engagement that brings to life the spirit and the essence of our Treaty relationship in all the decisions that we make for and on behalf of our people. Ngāi Tūhoe are in a direct relationship with the board and CEO of the BOPDHB.

"Ko koe tēnā, ko ahau tenei, kiwai te kete Toi Ora,
Ka mahitahi tatou"

Māori Health Rūnanga Membership 2020/21

Ngāi Tai (Chair)
Ngāi Te Rangi (Deputy Chair)
Ngāti Awa
Ngāti Makino
Ngāti Manawa
Ngāti Pukenga
Ngāti Ranginui
Ngāti Rangitihi
Ngāti Tūwharetoa ki Kawerau
Ngāti Whakahemo
Ngāti Whakaue ki Maketu
Ngāti Whare
Tapuika
Te Whānau-ā-Apanui / Te Whānau a Te Ehutu
Waitaha
Whakatōhea

Linda Steel
Kipouaka Pukekura-Marsden
Enid Ratahi-Pryor
Grant Ngatai
John Porima
Titihuia Pakeho
Tamar Courtney
Robin Cheung
Dot Mareroa
Margaret Hinepo Williams
Manu Pene
Jane Nicholas
Rutu Maxwell-Swinton
Astrid Tawhai
Punohu McCausland
Dickie Farrar

Te Toi Ahorangi

Te Toi Ahorangi as the way finder on the essential change in direction and approach for both kaupapa Māori and kaupapa Pākehā is reflected strongly in the recent release of the combined BOPDHB Board and Rūnanga Position Statement on Te Tiriti, Equity and Racism which was developed over a nine-month period and launched in May 2021. Te Rūnanga and the Board are active in the progression of our relationship as authentic Te Tiriti partners. It is envisaged the relationship is one of mutual benefit between those who were here (tangata whenua) and all those who have come (tangata Tiriti). The focus for both boards is ensuring tangata whenua rights to equitable access, quality and experience of care within the environs of the Bay of Plenty health system.

The vision and strategies within Te Toi Ahorangi on their own are not enough to achieve flourishing whānau, hapu, iwi and communities. From now on every decision that is made must work towards our pursuit of oranga ake, oranga mokopuna, oranga whānau, oranga ngākau and oranga tikanga.

Ngā Hua

The main achievements that the Rūnanga are proud of for the year are the continued collaboration with Te Manawa Taki consolidating the approach of the 2020 – 2023 Regional Equity Plan which also aligns with Whakamaua: Māori Health Action Plan 2020 – 2025 (Ministry of Health, July 2020).

Embedding our te Tiriti partnership as Te Kohao o te Waka o Toi with a focus on co-commissioning which necessitated a refresh of the Memorandum of Understanding between the BOPDHB and the Rūnanga and the Rūnanga's Terms of Reference and aligning to the impending national health reform changes in July 2022.

Te Pare o Toi continue to work tirelessly operationalising Te Toi Ahorangi and supporting the Rūnanga in a multitude of ways – ngā mihi nui ki a koutou ngā kaimahi katoa.

Mai i te rangi ki te whenua, te whenua ki te rangi.

Ngā mihi mahana
Linda Steel (Ngai Tai), Chairperson
Te Rūnanga Hauora Māori o te Moana a Toi

MĀORI HEALTH GAINS AND DEVELOPMENT YEAR IN REVIEW

Building and reinforcing our relationships through whakawhanaungatanga, transparency of information and manaakitanga in 2021 has provided multiple opportunities for Te Pare ō Toi to innovate and enable our partners. This philosophy affirming our commitment through action to the Bay of Plenty DHB Board and Te Rūnanga Hauora Māori o Te Moana a Toi Position statement on Te Tiriti, Equity and Racism.

Progress continues on the strategic implementation of Te Toi Ahorangi, the 12-month action plan endorsed in July this year will see pivotal and transformative pieces of work come to fruition in July 2022 namely the; Toi Ora Outcomes Framework, Toi Ora Zones and the long-awaited priority for the Rūnanga – the reinvigoration and realisation of He Pou Oranga Tangata Whenua Determinates of health via the Toi Ora System of Care.

The internal transformation of Te Pare ō Toi continues, we are holding ourselves to account, moving beyond rhetoric and continuing to push towards our 21/22 service priorities:

Toi Ora Wellbeing

This is number one priority for 2021, we want anyone in our service to feel stable through the health reform, through the multiple changes, demands that are occurring internally and external to the service. We want our people to achieve Toi Ora, to feel acknowledged, valued and empowered to maintain their mauri with support from our service. Our wellbeing project feeds into the organisation wellbeing program.

Māori Immunisation

Childhood, flu, MMR, COVID-19, we are extremely proud of the volume and quality of work our Kaupapa Nursing, Te Pou Kokiri, Administrators Teams are involved with, the team have entered collaborative partnerships alongside our providers by invitation, a great privilege for us to support them in this way.

Toi Ora Excellence

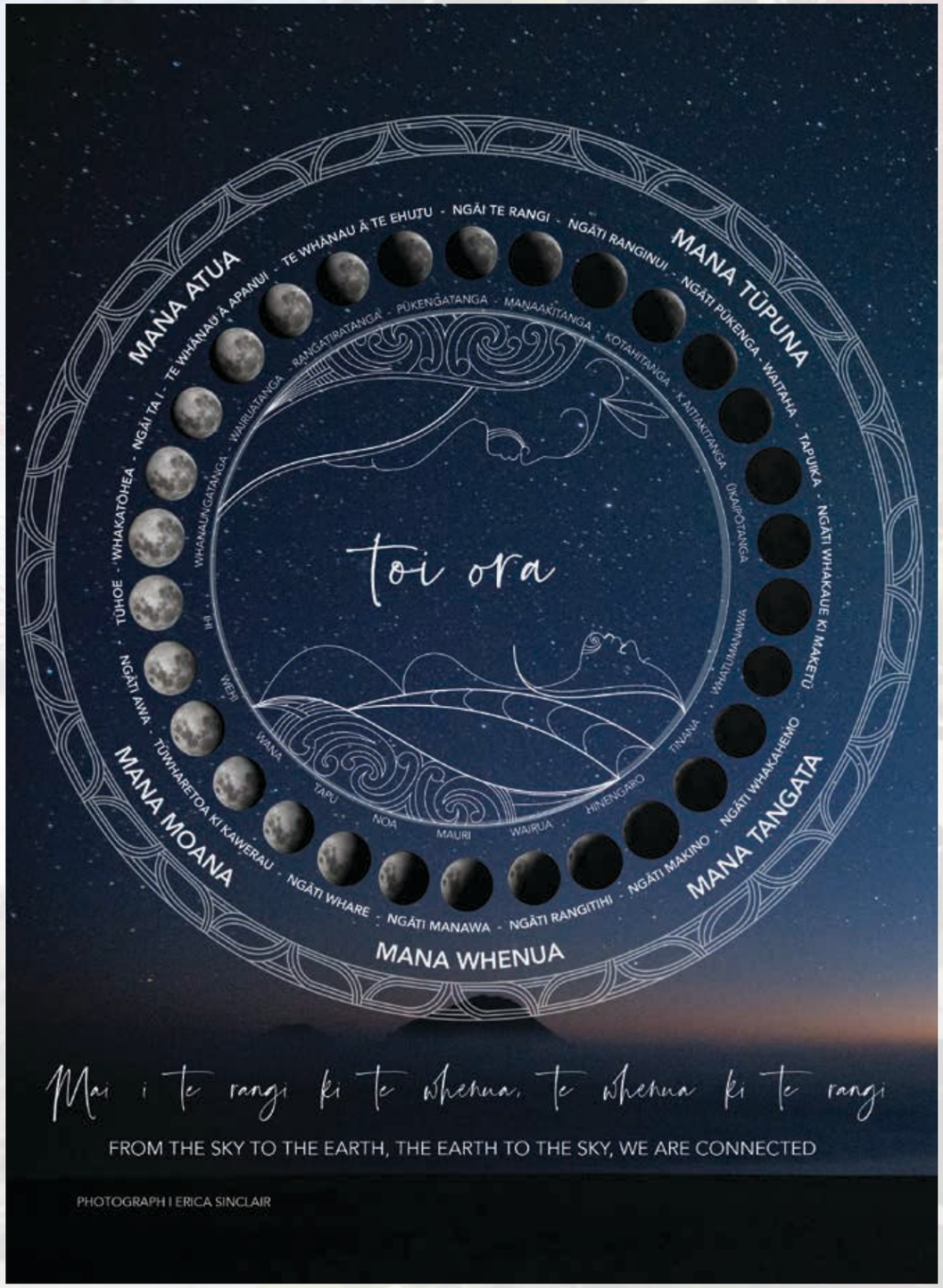
We are redesigning systems and process, setting standards and expectation, innovating to improve quality and efficacy of all facets of our service delivery model (Clinical, Business, Operations, Tikanga), this work supports the wider organisations transition plan and Te Toi Ahorangi's transformation plan in alignment with health reform timelines.

Māori Pandemic Response | Delta 2021

We have relationships from COVID-19, 2020 that are built on **Toi Te Kupu** - uphold the word, **Toi te Mana** - uphold the power and **Toi Tu Te Ora** - to uphold the vision of flourishing whānau. These are the guiding principles which have informed the way our service continues to enables Iwi, Kaupapa Māori Providers to respond to the challenges that Delta has brought to the surface during this year. We are committed to ensuring a holistic, whanau ora approach is applied to our DHB response so that equity of access, quality outcomes, sustainable Kauapapa Māori solutions and wider social determinants are prioritised for whanau, Hapu, Iwi.

Lastly, transformation does not happen through initiatives; it happens through people being prepared to change behaviours and to put the work in towards the common goal. The majority of transformational change happens out of the limelight, below the waterline if we are using the iceberg analogy, it can be a difficult and tiring journey. Kotahitanga and reaching Toi Ora goals are only achieved when a team transcends ego to chase collective vision. Te Pare ō Toi has pulled together in 2021, our service has grown in size, stars have emerged, our next generation of Māori leaders have made themselves known, it has certainly been an honour and a privilege to be part of it.

Marama Tauranga
Manukura - Executive Director
Toi Ora



2020 / 2021 Highlights

Te Toi Ahorangi Strategic Implementation

The Whare Waka (Te Pare o Toi, Programme Management Office) continued to progress the Au Rangi (programmes) to deliver on the aspirations within Te Toi Ahorangi. The 12-month Action plan contained the following programmes for 2021/22 which are all active.

- Authentic Partnership through Governance (Uphold Te Tiriti O Waitangi and Our indigenous Rights)
- Toi Ora System of Care (Be a Toi Ora Change Leader)
- Toi Ora Zones (Elevate Wai Ora and Reduce Acute Demand)
- Mental Health and Addiction Transformation (Whakamana Whanau with Solutions Embedded in Aroha)
- Toi Ora Outcomes Framework (Whakamana Whanau with Solutions Embedded in Aroha)
- Mahi Tahi Approach for engagement (Support Iwi Led Development)
- Investment Review for Equity (Invest in Toi Ora Innovation)
- Equity Action Plan and Dashboard (Uphold Te Tiriti O Waitangi and Our indigenous Rights)
- Health Quality and Safety Service (Be a Toi Ora Change Leader)

All programmes are presented monthly to the Te Toi Ahorangi Programme Executive group, its membership has representatives from Te Pare o Toi, Rūnanga and a BOPDHB Board member.

Communication over the past 12 months has increased to engagement and understanding of the transformational impact of Te Toi Ahorangi on equity across the whole of system.

Toi Oranga Mokopuna (Flourishing Mokopuna)

SUDI

The establishment of our Bay of Plenty (BOP) SUDI Coordinator (0.6 FTE) within Te Pare o Toi has been implemented in partnership with Ngāti Ranginui Health and Social Services and Te Tohu o te ora ō Ngāti Awa who hold one Safe Sleep Coordinator role (0.6 FTE) each. All roles have been established and working closely together as designed – DHB and Community Iwi Hauora partnership.

Bay of Plenty DHB SUDI Prevention Strategy is in draft, and its development is led by Te Pare ō Toi and supported by BOP wide stakeholders, including CYMRC whom have also supported this journey.

A system-wide review of Health and Social services accessed by people at risk of SUDI has been completed through an independent consultant, Kāhui Tautoko Consulting Limited. A communication and distribution strategy is currently being designed, led by Te Pare o Toi. This review will further inform the development and implementation of the BOPDHB SUDI Prevention Strategy.

Well Child Tamariki Ora

Te Pou Mataaho -Mokopuna contracts were integrated using Te Pou Mataaho which is an outcomes-based framework with Te Tohu o te Ora o Ngāti Awa. The outcomes, learnings and process will be shared openly across our Well Child Tamariki Ora (WCTO) providers to guide future processes of integration and Iwi lead framework development.

Toi Mahi Design - Involves all six WCTO providers and will be led by Law Creative to support marketing and promotion development of our local Kaupapa Māori WCTO services. Although based on WCTO (The Service) this opportunity opens our local providers to work collectively and design what Mokopuna Ora looks like for our whānau across the BOP.

Quality Improvement – Early engagement project - Internal DHB contractor (First 2000 Days) is engaged to work with all six WCTO providers and whānau to review engagement process. Idea is that if engagement was earlier for māmā and pāpā then greater rapport and support could be offered before birth. Enhancement would be implemented and trialled.

Toi Oranga Ngākau (Flourishing Hearts)

Tūhoe Hauora, supported and worked with Te Pare ō Toi, to redesign, rethink and redevelop a suite of services to enable greater responsiveness to their communities they serve. The lead worked with iwi and other government agencies to develop a new way of servicing addiction and other drug services, and bolstering linkages and support through justice.

Integration of Mental Health and Addiction Contracts

An extensive review of mental health contracts in a hauora was completed with their manager, their clinical leads and the Toi Oranga Ngākau Change Leader to ensure the needs of the community were being met through these contract deliverables as a means of transforming and re-designing mental health and addiction service outputs. The changes to the contracts were seen as being a solution to trends and issues highlighted during the contract review. These were across the lifespan and included but were not limited to: homelessness, over-crowding, rural isolation, whānau relocating out of area away from whānau supports, high-risk rangatahi life-style choices, aggression, gang affiliation, disconnection with whānau, sole parenting, entrenched poverty, intergenerational cycles of abuse, family violence, and addictions (alcohol, drug and gambling).

There was a greater need for advocacy, brokerage and support of whanau and to provide greater access to identified external service provision. In addition, gaps in service to support AOD wrap around support with rural communities would help to prevent cycling secondary crisis service presentation. A whānau ora solutions to these current trends and issues was sought through innovative contracting.

Working in partnership with the Hauora to integrate these contracts provided a space where the hauora could be more flexible and agile in their responses to tangata whaiora. Their preferred kaupapa Māori model of care was embedded within their contract specifications to promote the uniqueness of their rohe. Benefits also included a reduction in quarterly reporting pressures thus providing more time for kaimahi to work with whānau. This has supported a more responsive approach with their funding and an ability to be better positioned to be driven by community need. Integrating Mental Health Contracts, whilst labour intensive to develop has multiple benefits for communities, this will be a component included in subsequent conversations with other hauora.

Positioning hauora for co-design processes to develop more responsive AOD positions

Co-design development with hauora to establish service specification with an embedded whānau ora response for AOD roles. This position specification supports mental health and addiction assessment, early intervention, screening, support for both individuals and whānau. It provides a phased approach to set up a platform to support whānau who are addicts to care for whānau with wrap around support. This process was able to identify a shift in target age range from rangatahi only to 13-60 years old which allows for greater whānau access to service. This provision bolsters a service for whole whānau engagement and responsiveness to presenting needs at a grass-roots level.

Talking therapies counselling services

Planning and Funding have been working alongside hauora to develop counselling services within rural communities to support mild to moderate consumers that cannot access these services. Presenting issues include grief and loss, the impact of suicide on whanau, health impacting mental health and situational depression. This will provide better access and choice, as well as lessening travel for tangata whaiora.

Toi Oranga Ake (Accelerating Flourishing)

This year we appointed the Pou Oranga Ake - Māori Public Health leader that works as part of the Te Pare ō Toi Cluster Leadership structure. The appointment of this role has led to enhanced collaboration with Toi Te Ora Public health leadership to work collaboratively towards Māori population outcomes.

Te Iti Kahurangi Strategy guides operational improvements and the goals within this strategy aim to deliver on Te Tiriti o Waitangi by raising the capability of Toi Te Ora to respond to Māori communities has been a focus with activities held to increase staff cultural awareness and safety. Toi Te Ora has achieved 75% achievement of Te Kakenga suite. As a result of Te Iti Kahurangi new roles; Whanake Hauora have been introduced, these roles are orientated to support Iwi and community aspirations for hauora.

Te Pare o Toi is currently collaborating with Information Services as part of the BOPDHB Digital strategy group to ensure the development of digital equity tools and approaches that reflect our communities and providers digital realities.

Toi Oranga Whānau (Flourishing Whānau)

Whānau are critical to the wellbeing and protection of each individual. Over the past year, the team have delivered:

- National Bowel Screening Programme (NBSP) Equity, Communications and Engagement Plan that focuses on equitable participation and quality for Māori, Pacific Peoples and high deprivation communities in the NBSP.
- NBSP Outreach Plan and pre-reach activities to promote and raise awareness of the NBSP amongst Māori and Pacific communities; and involve Māori and Pacific organisations in supporting participation of their communities in the NBSP.

- Māori Community Cancer hui partner with Te Aho o te Kahu to hear the voice and aspirations of whānau Māori.
- Individualised Funding test of change for over 65-year-olds, to determine the viability of whānau Māori controlling and contracting care that best meets their needs.
- Agreed scope for a Māori provider integrated outcomes contract to be progressed in 2021/22, to increase efficiencies and effectiveness in the delivery of multiple service lines to whānau.
- Māori equity adjusters implemented in the Home and Community Support Services Responsive Model of Care.

Toi Oranga Tikanga (Flourishing Tikanga)

In May, the Bay of Plenty DHB Board and te Rūnanga Hauora Māori o Te Moana a Toi (the Rūnanga) endorsed their Position Statement on Te Tiriti, Equity and Racism. This is a significant step towards being an authentic Tiriti partner and a foundation for establishing a Toi Ora for urihaumate and whānau within the DHB.

The statement has supported a policy refresh within the DHB including formalising the endorsement role of the Rūnanga and Te Amorangi Kāhui Kaumātua. The Cultural Safety - Māori policy and Mandatory Training policy have both now been refreshed reflecting the statement and Te Kawa o Te Pare ō Toi is being progressed through the Controlled Documents process to establish a formalised tikanga and kawa policy for the DHB.

Significant effort has gone into education to improve the capability and capacity of BOPDHB staff and our health sector partners. The suite of training is known as Te Kakenga includes Te Tiriti o Waitangi, Unconscious Bias and Institutional Racism, both online and in person (started in November 2020) and Cultural Intelligence (started in February 2021). 1,149 DHB staff have attended these education courses over 2020/21.

In recognition of the benefit of whakawhanaungatanga and manaakitanga in improving patient and whānau safety and care and in response to the demand from DHB services, the tikanga workforce of Pou Kōkiri has expanded on both Whakatāne and Tauranga campuses.

Workforce, Whanau Services, Quality and Research

Our People

Te Pare ō Toi Kaupapa Māori nursing services have grown from strength to strength in the last year. In particular this nursing team have consolidated their community services reaching vulnerable Māori across the district and have also grown their immunization capacity to serve MMR/ Influenza and COVID-19 care.

Te Pou Kōkiri team at te Pare o Toi has grown and has expanded Māori cultural services into project-based work such as radiology, and immunisation.

Quality

Progress on introduction of a Kaupapa Māori Quality Coordinator has been made this year and will go to market in late September. This position will create a strong partnership between the HQ&SS and Te Pare ō Toi teams.

Pūrāukau (reflection on services and experience) are a notable component of the Te Pare ō Toi quality work and are conducted by the Health Navigator. Consistent themes from this kanohi ki te kanohi engagement include miscommunication between clinical or administrative staff with whānau or urihaumate, poor continuity or care and culturally unsafe practice. Further development of the role of Health Navigator and system is planned.

Te Pare ō Toi cluster leaders have this year progressed discussion on the establishment of a real time and evidence-based dashboard to inform the quality and performance of its services. All of Te Pare ō Toi Cluster leaders influence quality and performance in services other than their own and it is through this influence and input to programmes and services that the wider tide of quality services for Māori is realised. Active quality improvement influence and direction of Te Pare ō Toi leaders includes the Acute Demand Programme, Mortality Review, Clinical Governance, Maternity Review, Orthopaedic Transformation Programme, Renal Service Strategy, Te Manawa Taki Cardiac Clinical Network.

Research

Te Pare ō Toi has received and reviewed 37 applications for Māori review of research this year. Thirty of these applications were approved, one was declined, one application was withdrawn and six are currently in process.

Several of these studies are national or international trials and collaborations. Several of the studies are of great relevant to Māori health including the Incidence of Chemotherapy Induced Cardiotoxicity in Māori and non-Māori, Bay of Plenty Myringoplasty Practice, Addressing Inequities in Health Outcomes – Liver Disease and the Mega-Rox Trial (comparing conservative and liberal oxygenation therapy in the ICU).

However, there are also a number of applications where the attention to Māori health and equity is poor in terms of study purpose, design and research capability. This matter has been raised in the clinical governance committee.

Work is now underway in Te Pare ō Toi to modernize the Māori review of research system and to create a process for Mori review of clinical audits.

Te Pare Ō Toi KŌWHEORI-19 Pandemic Response

Te Pare Ō Toi continues to operate a parallel structure to the Bay of Plenty DHB Coordinated Incident Management System (CIMS) Emergency Operations Centre (EOC). The focus of this TPOT EOC structure is to drive a focus on equity for Māori. The workstreams operate in a similar manner to CIMS positions but with them being termed and operated based te ao Māori wellbeing factors:

- **Tinana** Toitiaki/Operations/Logistics/Provider Arm/Staff Welfare/Planning;
- **Oranga** Welfare/Planning/Intel/Recovery/Financial Oversight;
- **Tikanga** Tikanga and Kawa advice to support DHB EOC/Iwi intel; and
- **Whanaungatanga** Logistics/Community Liaison.

The team is under the guidance of a collaboratively developed pandemic plan.

Our Wayfinding Compass

GENERAL MANAGER CORPORATE SERVICES REPORT

Our annual report provides us with an opportunity to tell our community and our stakeholders what we have achieved over the last 12 months, and provides more context about the environment in which we have operated.

2020/21 has been a particularly challenging year financially as the cost impacts of COVID-19 and increasing demand levels – particularly in acute areas – have placed significant pressure on the DHB's financial resources.

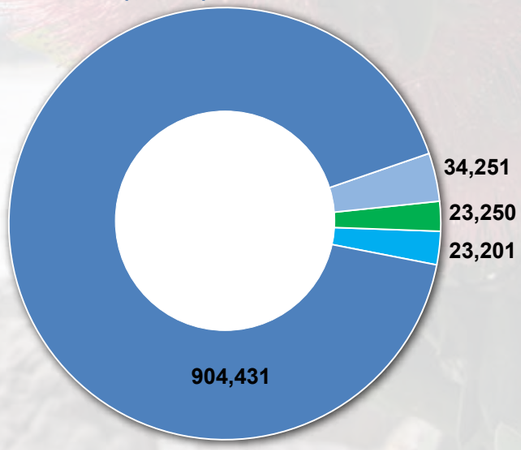
This year we report a deficit of $25.5m on a total revenue of $985.1m. This is a $20.1m unfavourable variance to our annual plan deficit of $5.4m. Included in this variance are the costs of unprecedented acute growth, the COVID-19 pandemic response and vaccination programme costs and recognition of the potential remediation costs to comply with the Holiday's Act 2003.

As a consequence of this year's deficit, our financial position has deteriorated with a significant reduction in our cash closing balance of $15.5m overdrawn, compared with a positive balance of $2.4m for 2019/20. Despite this drop in cash reserves, the DHB has achieved the Government's goal for Crown entities to pay 95% of domestic invoices within 10 working days.

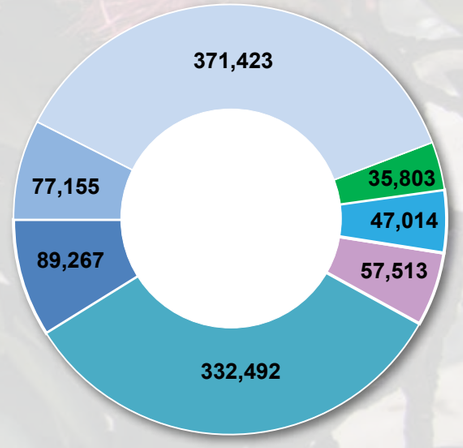
Employee liabilities have increased over the year as lower than planned levels of staff leave has been taken due to the impact of COVID-19 – lockdown impacts and reduced international travel opportunities. This remains a focus of the DHB as it balances the workforce requirements of increasing service demands with the need to ensure the wellbeing of its workforce.

The 2021/22 financial year poses an ongoing challenge for the DHB as a result of COVID-19 impacts, a forecast of continued high levels of service demand and the transition activities required under the Health sector reform programme that will see DHBs cease to exist from 30 June 2022. Despite these challenges, the DHB will seek to maintain a focus on planning, funding and delivering high quality services to its communities.

Revenue ($000s)



Expenditure ($000s)



Owen Wallace
General Manager Corporate Services

TOI TE ORA PUBLIC HEALTH YEAR IN REVIEW

Toi Te Ora Public Health (Toi Te Ora) is the public health unit for the Bay of Plenty and Lakes districts and has role to protect and promote the health of the population, with a focus on the achievement of equity, particularly for Māori. The public health response to COVID-19 remained a major focus for Toi Te Ora for the 2020-2021 year. This work included strengthening the planning and readiness of our local response in preparation for potential community outbreaks, and providing technical and communications support to the COVID-19 immunisation programme. There was emphasis on strengthening approaches to ensure equity in our response and protecting vulnerable settings such as Aged Residential Care.

To support the community resilience and recovery from COVID-19, Toi Te Ora completed a rapid Community Needs Assessment to develop an understanding of the impacts of COVID-19 locally following the first lock down. This report covered the impacts on primary and secondary health care, community mental wellbeing, and the determinants of health, such as housing and food security. The findings from this report were used to refocus the work of Toi Te Ora to support the needs of the population, and also provided valuable insight for other organisations, such as local government, for recovery planning.

Despite the focus on COVID-19, Toi Te Ora was able to progress many significant projects. In the 2020-21 year, Toi Te Ora launched a new website and intranet, which features significant improvements to the functionality and design, to create a more user-friendly experience. Then new website has been a key communication channel for COVID-19 information for our communities, as well as internally to assist in the public health response to COVID-19. The Issues of Health and Wellbeing – Population Survey 2020 was also completed and published. This is the fourth population survey produced by Toi Te Ora which enables an understanding of the views of people in the Bay of Plenty and Lakes districts across a range of issues relevant to public health.

Youth of Kopeopeo continued as a multi-agency and multi-project initiative based in Whakatāne that aims to empower rangatahi to make decisions about Kopeopeo for the health and wellbeing of all people. Projects completed included place-making through the Innovating Streets fund, supporting rangatahi training in partnership with Whakatāne High School, and the Eat + Be:Long event to create positive experiences.

Toi Te Ora held a Healthy Pregnancy Education Day providing workforce development to a range of maternal and infant health professionals in the Bay of Plenty and Lakes region. Positive evaluation was received, and presentations focused on mental health and substance use in pregnancy.

OUR PLANNING PRIORITIES

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

This Annual Report reflects the commitment of Bay of Plenty District Health Board (BOPDHB) to meeting the Aotearoa, New Zealand Minister of Health's expectations, and our continued commitment to achieving the BOPDHB vision of Healthy, Thriving Communities - Kia momoho te hapori oranga!, not just in the BOPDHB region, but across the whole Waiariki, Bay of Plenty.

Achieving the objectives required by sections 22 and 38 of the New Zealand Public Health and Disability Act 2000, requires full commitment from the DHBs to Te Tiriti o Waitangi, the New Zealand Health Strategy, Whakamaua: Māori Health Action Plan 2020-2025[7], The UN Convention on the Rights of Persons with Disabilities, the New Zealand Disability Strategy, the Healthy Ageing Strategy and Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan[8].

NZ Health Strategy

Annual Plan 2020/21

There were six key areas of focus for the BOPDHB for 2020/21, as directed by the Minister of Health Letter of Expectations:

The guidance and subsequent plan was structured to reflect these priorities, which were:

1. Improving child wellbeing
2. Improving mental wellbeing
3. Improving wellbeing through prevention
4. Better population health outcomes supported by a strong and equitable public health and disability system
5. Better population health outcomes supported by primary health care
6. Strong fiscal management

Some of the actions BOPDHB planned for 2020/21 were delayed due to COVID-19 activities. This had some effect of the BOPDHB's performance.

7. https://www.health.govt.nz/our-work/populations/Māori -health/whakamaua-Māori -health-action-plan-2020-2025.
8. https://www.health.govt.nz/publication/ola-manuia-pacific-health-and-wellbeing-action-plan-2020-2025.

Te Manawa Taki Regional Equity Plan

Te Manawa Taki, Regional Equity Plan 2020-2023, is the plan for the five Midland Region District Health Boards, working within a Te Tiriti o Waitangi partnership. This new plan reflects the way we will work together in order to implement true Te Tiriti o Waitangi based relationships to effect sustainable and positive partnered change over time.

Sustainability at Bay of Plenty District Health Board

At Bay of Plenty District Health Board (BOPDHB) we understand that while our work has positive outcomes for our people, it consumes resources and impacts the environment, and therefore goals must be set to reduce these impacts as much as possible, and to regenerate the environment where we can.

BOPDHB views its sustainability principles and organisational purpose and vision holistically. By understanding and applying the concepts of the Kaitiakitanga Framework for Environmental Sustainability, we aim to work with stakeholders to protect our environment, culture, society, and economic stability, to enable our communities to get well, live well, and stay well.

Kaitiakitanga is one of the eight Pou Oranga in He Pou Oranga Tāngata Whenua. This pou is our acknowledgement that we are all custodians of knowledge and practices that enhance our relationships with each other and our environment.

BOPDHB recognises that Climate Change is an international public health emergency, and we are not immune in Aotearoa New Zealand. The Government is taking climate change seriously by introducing the Climate Change Response (Zero Carbon) Amendment Act 2019 and announcing the Carbon Neutral Government Programme (CNGP), both of which have an impact on Bay of Plenty District Health Board.

Financial Year 1 July 2020 – 30 June 2021 Carbon Footprint Information

During the 2020/2021 financial year, BOPDHB saw an overall carbon footprint reduction of ~17% from the baseline year (FY18/19) (see Table). Like FY19/20, this reduction is likely attributed to the COVID-19 impacts, rather than planned and considered changes to business practice, specifically reduction in ability to travel by air. We have, however seen a 10% decrease in emissions from natural gas, offset by a 6.4% increase in electricity use, due in part to better data quality and HVAC installation.

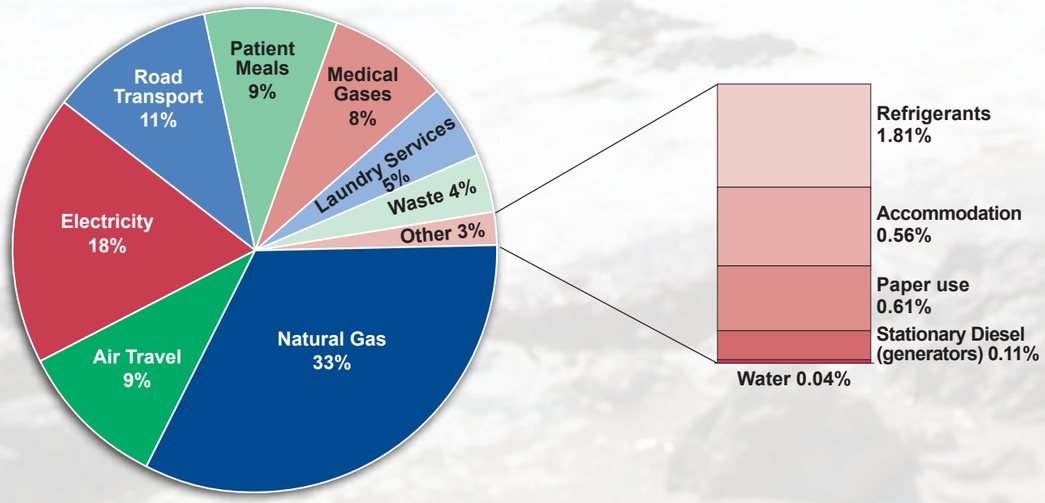
We hope to see a reduction in GHG emissions attributed to business activities (and not COVID-19 response/recovery alone) over the coming months and years as we work to embed the Kaitiakitanga Framework into our practice and reach the goals of our Environmental Sustainability Action Plan. These documents are available to view on our website: bopdhb.health.nz/about-us/environmental-sustainability-kaitiakitanga/

The graph figures illustrate BOPDHB's audited carbon footprint and emissions source information for the 2020/2021 Financial Year.

Changes in emissions activity FY20/21 compared with baseline year

Activity – Emission Source	Global Warming Potential (t CO2e) FY20/21	Global Warming Potential (t CO2e) FY18/19 (Baseline)	Increase (+) / Reduction (-)
Natural Gas	2,372.79	2,636.87	- 10.0%
Electricity	1,268.72	1,191.94	+ 6.4%
Patient Meals	656.22	645.88	+ 1.6%
Fuels (Vehicles and Machinery)	630.27	646.87	- 2.6%
Medical Gases	609.41	570.64	+ 6.8%
Laundry Services	396.04	379.52	+ 4.4%
Air Travel – Long Haul	336.34	1,173.90	- 71.3%
Waste	275.64	218.07	+ 26.4%
Patient Transfers by Air	159.10	126.87	+ 25.4%
Natural Gas T&D Losses	142.30	436.88	- 67.4%
Electricity T&D Losses	140.85	309.12	- 54.4%
Refrigerants	138.24	248.86	- 44.5%
Private Car Use	108.74	90.28	+ 20.5%
Air Travel – Domestic	94.30	165.34	- 43.0%
Patient Transfers by Road	87.30	104.91	- 16.8%
Air Travel – Short Haul	71.06	52.52	+ 35.3%
Paper Use	46.73	51.79	- 9.8%
Accommodation	43.07	74.39	- 42.1%
Rental Vehicles	26.28	33.37	- 21.3%
Taxis	9.04	11.90	- 24.0%
Stationary Diesel (Generators)	8.13	8.67	- 6.2%
Water	3.01	3.02	- 0.4%
TOTAL	**7,623.58**	**9,181.61**	**- 17.0%**

GHG Emissions Source % of Total Carbon Footprint FY20/21 (~7623 tCO_2e)



BOPDHB Carbon Footprint Year on Year Comparison (~7623 tCO_2e FY20/21)

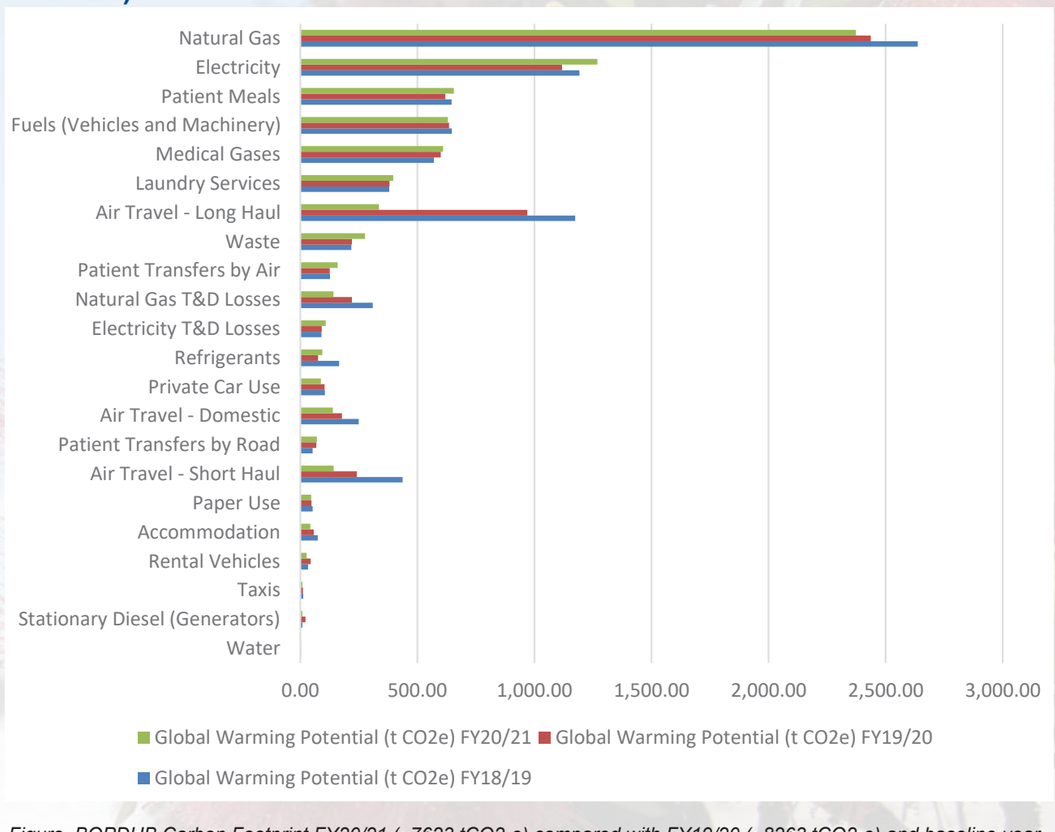


Figure. BOPDHB Carbon Footprint FY20/21 (~7623 tCO2-e) compared with FY19/20 (~8263 tCO2-e) and baseline year FY18/19 (~9181 tCO2-e)[9]

Sustainability Goals Financial Year 1 July 2020 – 30 June 2021

Below are five goals relating to environmental sustainability we set out to achieve over the 2020 – 2021 financial year.

Goal 1. Paper use and printing activities are reduced by 25% from baseline year (FY18/19). *In Progress.*

New printers have been rolled out across Tauranga and Whakatāne Hospital's which include technologies that will work towards paper reduction. When this rollout is complete training and education programmes will occur relating to our paper footprint and mechanisms for reduction that do not impact on service delivery.

Goal 2. A 10% reduction in waste to landfill footprint from baseline year (FY18/19) is achieved. *Not achieved.*

The onset of COVID-19 has seen the increase of use of single-use PPE (e.g., masks, gloves, etc.). However, despite this Tauranga and Whakatāne Hospitals have managed to achieve an overall landfill footprint reduction of around 9% and have introduced two new circular economy waste programmes. The first of these is working with MedSalv to reprocess some of our non-evasive medical equipment, and the second is working with Expol to repurpose our waste polystyrene in to building products. Over the coming year BOPDHB hopes to be trialling an organic waste solution which, if successful, could mean as much as 30% of the landfill footprint is reduced.

9. There have been changes to the previously reported footprints as better data was made available and the addition of transmission and distribution losses for energy emissions.

GOAL 3: BOPDHB understands the vehicle fleet utilisation baseline. *Achieved.*

BOPDHB has completed a task that understands how its vehicle fleet is utilised. This is currently informing fleet reduction and transition programmes.

GOAL 4: A Fleet Transition Plan outlining activity to reduce the carbon footprint of the BOPDHB fleet is in place, informed by vehicle utilisation information. *In progress.*

BOPDHB is working with EECA to plan a transition of up to 90% of the fleet being replaced with battery electric vehicles (BEVs). This will occur over a number of years, however the first BEVs should be entering the fleet before the end of 2021. BOPDHB is also working on ensuring only the required number of vehicles are in the fleet and will be launching vehicle sharing and utilisation programmes over the coming months.

GOAL 5: Energy consumption is reduced by 2% from baseline year (FY18/19). *Achieved.*

In 2020, BOPDHB conducted an Energy Transition Accelerator (ETA) in collaboration with EECA, which works to understand how energy is currently used in the organisation and maps a pathway for carbon reduction; namely decoupling from natural gas infrastructure which is currently used for steam and hot water heating in our hospitals. This information informs our asset management planning and will be taken into consideration when infrastructure comes to the end of its useful life, and/or when new builds and renovations are occuring. As BOPDHB moves away from fossil fuel powered energy sources, a significant reduction in carbon emissions from energy use will be achieved.

Sustainability Goals for Financial Year 1 July 2021 – 30 June 2022

The following goals have been set for achievement over the coming financial year:

GOAL 1: Revisit 2019 BOPDHB Travel Plan to enable significant reductions in global warming potential from travel for and to work. *In progress.*

GOAL 2: Realign framework and action plans to ensure alignment with CNGP and other central government direction. *In progress.*

GOAL 3: Ensure a Te Ao Māori lens, ensuring an equitable focus and responsibilities within Te Tiriti O Waitangi are upheld in work in this space. *Ongoing.*

GOAL 4: Complete a climate related risk assessment enabling equitable health provision to be part of any climate change adaptation planning. *In progress.*

Science Based Targets

As part of the CNGP requirements, BOPDHB will be required to report on its science-based target achievement in the three scopes of greenhouse gas emissions as outlined in ISO14604-1:2006. The figure below identifies the baseline (FY18/19 indicated by the dotted line on the outside), the 2025 target (the green line), the 2030 target (the blue line), and the financial year's achievement (the green content). You can see that generally BOPDHB is tracking well towards these targets, with the exception of Scope 2 (purchased electricity). It is expected the Energy Transition Accelerator project described earlier, and the Energy Management Plan that is currently being created, will provide the guidance to meet these targets.

FY20/21 Actual vs Science Based Targets - 1.5C (against baseline)

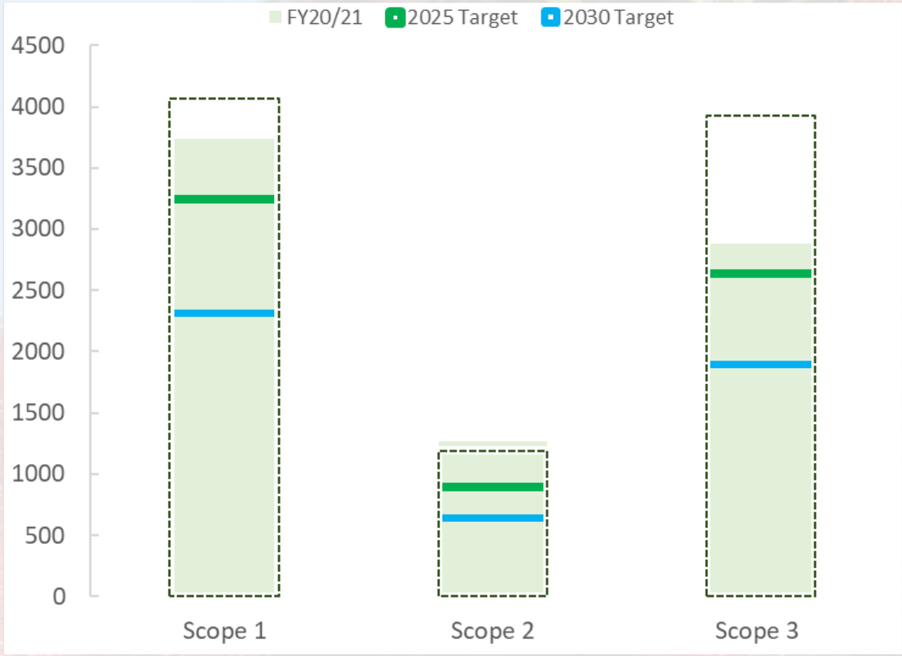


Figure. FY20/21 Actual carbon emissions vs science-based targets within 1.5C scenario

03

Our Leadership
Mana Tangata

INTRODUCTION AND OBJECTIVES OF THE BOARD

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

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

The objectives of the Board are:

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

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 GOVERANCE

Structure

In accordance with the 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. Sir Michael Cullen was appointed as Board Chair in November 2019 however due to health reasons he stepped down in March 2020 and Sharon Shea became Interim Board Chair, Ron Scott became Interim Deputy Chair. In April 2021 Sharon Shea was appointed as Board Chair and Geoff Esterman as deputy. 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, functioned as a combined Committee within the BOPDHB until late 2020 when a decision was made to include the Hospital Advisory Committee in the Combined Committee and Te Rapa Hou Combined Committee (TRHCC) was formed.

In addition to the statutory committees required by the NZPHD Act, the Board maintains a Finance, Audit and Risk Management Committee (FARM) as a Committee of the Board and one standing committee, the CEO Performance and Remuneration Committee. The FARM Committee meets on a monthly basis. The CEO Performance and Remuneration Committee meets as required, however is scheduled to meet twice yearly for review.

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. In quarter four the options to move to a co governing relationship with co commissioning have been explored and are being progressed.

An important milestone in the journey towards health equity for Māori and the fight against racism saw the launch of a joint Bay of Plenty District Health Board (BOPDHB) Board and BOP Māori Health Rūnanga Position Statement on Tiriti o Waitangi, Equity and Racism.

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

Board Members receive a fee of $23,171 per annum, the Board Chair receives $46,403 per annum and the Deputy Chair receives $28,963 per annum.

Committee Members of the Statutory Committees (Te Rapa Hou Combined Community & Public Health Advisory, Disability Services Advisory Committee and Bay of Plenty Hospital Advisory Committee) and the Committee of the Board (Finance, Audit & Risk Management 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 (19) 1 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	FARM	CPHAC - DSAC	BOPHAC	Combined Committee Te Rapa Hou	Expenses	2020/21 Total
Hori Ahomiro	23,171	-	500	750	1,000	-	25,421
Mark Arundel	23,171	3,000	750	-	1,250	292	28,463
Bev Edlin ***	23,171	3,000	750	-	1,250	150	28,321
Geoff Esterman ***	24,619	3,000	-	938	1,250	-	29,807
Ian Finch	23,171	2,250	750	-	1,250	1,511	28,932
Marion Guy	23,171	2,750	-	750	1,250	458	28,379
Ron Scott	27,515	3,750	-	750	1,250	142	33,407
Sharon Shea	45,630	2,750	-	250	1,000	4,534	54,164
Leonie Simpson	23,171	-	-	500	750	569	24,990
Arihia Tuoro	23,171	2,500	938	-	1,563	1,617	29,788
Wayne Williams *	5,793	750	-	-	-	423	6,965
Total Board Members	**265,754**	**23,750**	**3,688**	**3,938**	**11,813**	**9,697**	**318,638**
Linda Steel **	1,250	-	-	-	-	984	2,234
Lyall Thurston	-	-	-	750	750	806	2,306
Paul Curry	-	-	500	-	1,250	-	1,750
Rob Vigor-Brown	-	-	250	-	-	-	250
Pouroto Ngaropo	250	-	-	-	-	-	250
Punohu McCausland	-	-	250	-	-	-	250
Kipouaka Marsden	-	-	-	-	1,000	-	1,000
Mariana Hudson +	1,500	-	-	-	-	590	2,090
Natu Vaeluaga +	1,500	-	250	250	750	294	3,044
Total All Members	**270,254**	**23,750**	**4,938**	**4,938**	**15,563**	**12,372**	**331,813**

CPHAC-DSAC and BOPHAC Committees joined to become the Combined Te Rapa Hou Committee in January 2021

* New Board Member as at 28/4/21
** Rūnanga (Chair) representative to the Board, commenced 24/2/21
*** Board Members who participate as reciprocal members for other Midland DHB Committees
+ Seat at the Table Board Observers – fees are recompensed by MOH

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**
Hori Ahomiro	12	10	
Mark Arundel	12	12	
Bev Edlin	12	12	
Geoff Esterman	12	12	Deputy Chair from April 2021
Ian Finch	12	12	
Marion Guy	12	11	
Ron Scott	12	12	Interim Deputy Chair to April 2021
Sharon Shea	12	12	Board Chair
Leonie Simpson	12	8	
Arihia Tuoro	12	11	
Wayne Williams	12	3	Appointed Board Member 28/4/21
Linda Steel	12	5	Rūnanga (Chair) rep from 24/2/21
Pouroto Ngaropo	12	1	Rūnanga (Chair) rep to Oct 2020
Mariana Hudson	12	6	Commenced Sept '20
Natu Vaeluaga	12	6	Commenced Sept '20

Interest 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 are declared in each meeting agenda which is publicly available on the BOPDHB website.

Board Members' Loans

There were no loans to Board Members.

COMBINED COMMUNITY AND PUBLIC HEALTH AND DISABILITY SERVICE ADVISORY COMMITEE

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**
Mark Arundel	3	3	
Hori Ahomiro	3	2	
Bev Edlin	3	3	
Ian Finch	3	3	
Arihia Tuoro	3	3	Chair
Paul Curry	3	2	Community Representative
Punohu McCausland	3	1	Rūnanga Representative

Committee was moved to Combined Te Rapa Hou Committee in January 2021.

BAY OF PLENTY HOSPITALS' ADVISORY COMMITEE

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[10] 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[11] 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**
Hori Ahomiro	3	3	
Geoff Esterman	3	3	Chair
Marion Guy	3	3	
Ron Scott	3	2	
Leonie Simpson	3	2	
Sharon Shea	3	1	
Lyall Thurston	3	3	Lakes DHB Rep

10. New Zealand Public Health and Disability Act 2000.
11. New Zealand Public Health and Disability Act 2000.

FINANCE, AUDIT AND RISK MANAGEMENT COMMITTEE

Functions

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.

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.

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 Finance, Audit and Risk Management (FARM) Committee comprises:

- The BOPDHB Chair
- Chairs of the following committees:
  - Combined Community and Public Health, Disability Services Advisory Committee and 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	12	12	
Bev Edlin	12	12	
Geoff Esterman	12	12	
Ian Finch	12	9	
Marion Guy	12	11	
Ron Scott	12	12	Chair
Sharon Shea	12	11	
Arihia Tuoro	12	10	
Wayne Williams	12	3	Appointed 28/4/21

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 Finance, Audit & 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.

TE RAPA HOU COMBINED COMMITTEE

Functions

The Te Rapa Hou combined committee (TRHCC) 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 TRHCC is to fulfil the functions of the Boards statutory committees.

Membership and Attendance

The Committee meets on a monthly basis.

Committee membership and attendance during the year were as follows:

Meetings			
Name	**Scheduled**	**Attended**	**Comments**
Mark Arundel	5	5	
Hori Ahomiro	5	4	
Bev Edlin	5	5	
Geoff Esterman	5	5	
Ian Finch	5	5	
Marion Guy	5	5	
Ron Scott	5	5	
Sharon Shea	5	4	Ex officio
Leonie Simpson	5	3	
Arihia Tuoro	5	5	Chair
Kipouaka Marsden	5	4	Rūnanga Representative
Lyall Thurston	5	3	Lakes DHB Representative
Paul Curry	5	5	Community Representative

The Committee was formed in January 2021.

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:

- Mark Arundel (Chair)
- Sharon Shea (Board Chair)
- Bev Edlin
- Ron Scott
- Leonie Simpson
- Arihia Tuoro

DELEGATIONS

The Board has an approved Delegation Policy in accordance with Schedule 39(3) of the NZPHD Act[12]. The NZPHD Act requires, under S26(3)[13] 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.

12. Schedule 3, New Zealand Public Health and Disability Act, 2000.
13. Section 26, New Zealand Public Health and Disability Act, 2000.

04

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[14]. These elements are derived from fundamental good human resource practices:

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

BOPDHB has the stated intention of being a good employer consistent with Section 118 in the Crown Entities Act 2004[15] 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 is governed by Human Rights[16], Health and Safety in Employment[17], and Employment Relations[18] 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
- recruitment and selection
- protected disclosures (whistle blowing)
- employee assistance programme
- leave (annual, sick, tangihanga/bereavement, leave without pay, long service, jury service)
- orientation
- position descriptions
- volunteers and work experience
- occupational health and safety
- discipline and dismissal
- learning policies
- performance development
- staff presentation
- identity card standards
- shared expectations (Code of Conduct).

Workforce Development

BOPDHB has endorsed the Te Tumu Whakarae Position Statement on Increasing Māori Participation in the Workforce, and has endorsed the targets to support the Position Statement being realised. Our Māori workforce has increased to 12.31% of our total workforce.

Workforce development is a key strategic objective in both Te Toi Ahorangi and the Strategic Health Services plan (Strategic Objective 2: Develop a smart, fully integrated system to provide care close to where people live, learn, work and play and 3: Evolve models of excellence across all of our hospital services).

In 2019/20 year BOPDHB prepared a stocktake of its workforce, and started to explore how to enable the workforce to provide care closer to our communities. The BOPDHB continues to focus on lifting Māori participation in our workforce with a particular focus on Māori leadership. We continued the Creating our Culture strategic programme to further embed our CARE values to guide how we work together.

Whakaari impacted the BOPDHB staff in many ways, and we continues psychosocial support and offering wellbeing programmes to support recovery.

Towards the end of the financial year, the demands of COVID-19 also impacted our people and we continue to offer additional support. It also bought a time of more flexible working arrangements for many staff with technology supporting staff to work remotely. Many found that this offered benefits for both staff and the organisation and continue to work in this way.

Work has recently been initiated to develop a programme of work to build the people direction statement to grow the information, knowledge, and capacity of delivering a full people strategy that delivers on the business outcome. There is significant work that needs to be competed in this space and resources to enable our capability and capacity.

14. Human Rights Commission NZ
15. Section 118 Crown Entities Act 2004
16. Human Rights Act 1993
17. Health and Safety at Work Act 2015
18. Employment Relations Act 2000

Employment Equity

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

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

The Board has adopted a remuneration policy that reflects the need to set a target range for each individual employment agreement position, within the limitations of available funding. This gender neutral, fair remuneration policy is part of an overall employment relations strategy that includes defining the role of employees, performance development and appropriate reward mechanisms. Students are casual, therefore not staff. We pay above minimum wage.

BOPDHB supports the Government putting into place pay and employment equity response plans, and recognises the obligations we have to make sure we continue to address and respond to any identified gender inequities as part of good management practice and being a good employer. BOPDHB are proud to report this measure, by key occupational groupings.

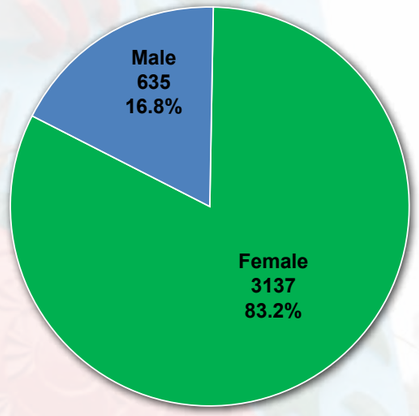
Gender Pay Equity

Many female employees in New Zealand work in occupations that are more than 80% female, and these female-dominated occupations tend to be lower paid. Women are under-represented in higher-level jobs[19]. 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.

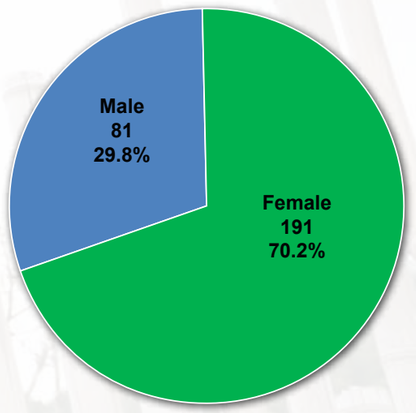
Pay and employment equity cannot be achieved for women or men unless the ways gender is affecting employment are identified and addressed. Government policy and direction encourages employment and workplace relations that demonstrate good faith, natural justice, human rights, sound employer practice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

The majority of our staff are covered by collective employment agreements (93%, 3,772 of our 4,044 staff). This ensures that all employees, regardless of gender or other areas of potential inequity, are remunerated at the same level for equivalent work.

2020/21 Employees with Collective Employment Agreements



2020/21 Employees with Individual Employment Agreements



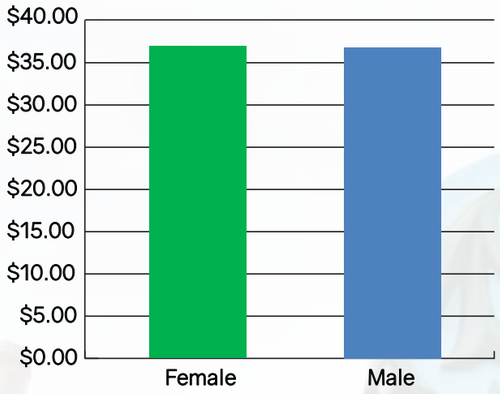
19. Employment NZ

The remaining 272 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.

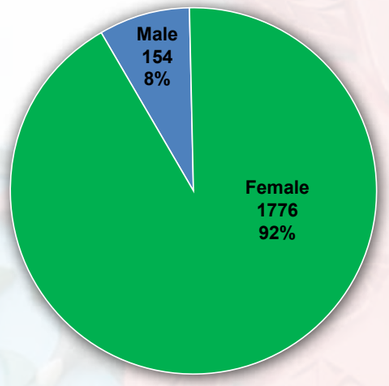
This methodology also gives due weight to roles with a requirement for education, experience and strong problem-solving skills, and ensures that each position is objectively remunerated, regardless of gender or other areas of potential inequity.

Nursing is our largest employment occupational group, representing 1,930 staff (48%) of our work force (2019/20: 1,834, 48%). 92% of this group are female, and no difference is noted in median remuneration between male and female staff.

Median Hourly Rate - Nursing

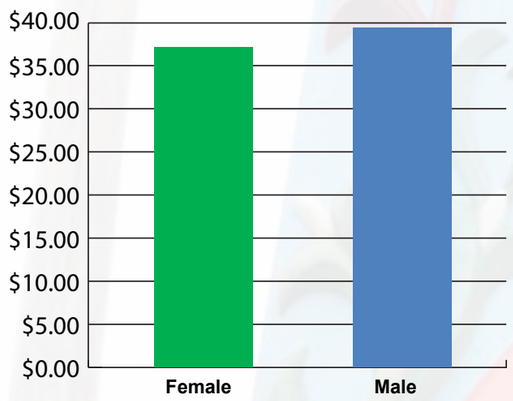


2020/21 Nursing Staff

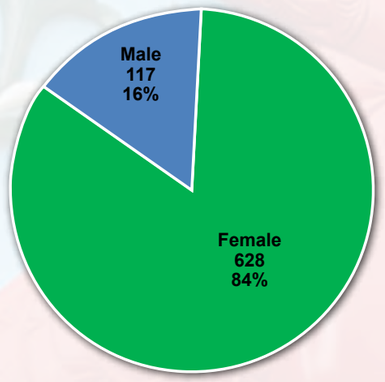


Allied Health is our next largest group, representing 745 staff (2019/20: 706). This group includes occupational therapists, social workers, physiotherapists, therapy assistants and a range of other clinical positions. 84% of this group are female, and there is a difference noted in average remuneration between male and female staff with males earning 6% more on average. This is due to the nature of the roles filled by male vs female. Females occupy a higher portion of lower paid groups such as therapy assistants. All allied health staff are paid agreed MECA rates based on qualifications and experience.

Median Hourly Rate - Allied Health

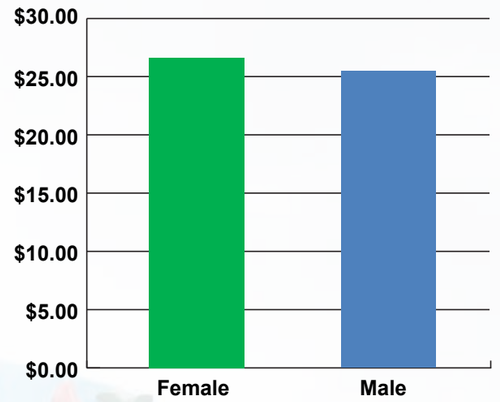


2020/21 Allied Health Staff

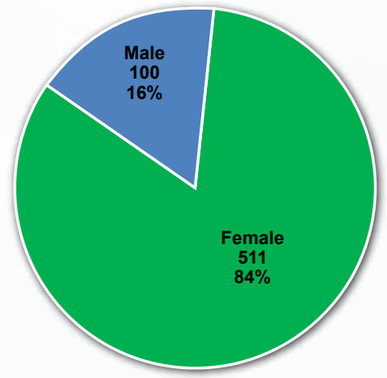


Non-clinical and clerical staff are another large group, representing 611 staff. This group includes Security, Stores, Orderlies and Clerical staff, amongst others. 84% of this group are female, and there is a difference noted in average remuneration between male and female staff with females being paid 6% more on average. This is due to more female staff occupying clerical roles which are higher paid than support roles.

Median Hourly Rate - Non-Clinical Support and Clerical Services



2020/21 Non-Clinical and Clerical Staff



The three groups reported above represent 81% of our work force. The remaining 19% of staff cannot be compared for equity. 12% of the remaining 19% are medical staff on Collectives. Remuneration for this group is determined by seniority of service, the needs of the service in relation to on-call and availability and the associated allowances earned. 7% of the remaining staff are on individual employment agreements.

Board and Senior Management

Numbers stayed the same for 2020/21 with 58% of the Board Members being female and 42% Māori. 45% of Managers in the top two tiers of the BOPDHB are female (27% in 2019/20) and 18% are Māori (18% in 2019/20).

Employment

This year we welcomed 783 new staff (2019/20: 795 new staff), including 607 clinical staff (2019/20: 639 new clinical staff).

The majority of our staff are covered by collective employment agreements (93%, 3,772 of our 4,044 staff). This ensures that all employees, regardless of gender or other areas of potential inequity, are remunerated at the same level for equivalent work.

Leave

In 2020/21, 120 staff went on paid parental leave (compared to 95 staff in 2019/20). Staff sick leave utilisation has remained materially stable at 3.5% (2019/20: 3.3%)

Resignations/Turnover has increased to 11.0% in 2020/21 (up from 9.2% in 2019/20).

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 was dedicated to enhancing the partnership approach with PSA, the BOPDHB was 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.

Additionally, the P&C team have initiated joint collaborative workshop with the PSA and the HR Business Partnering team to pilot a new way of working with each other in a constructive and restorative framework. This will be also offered to other union partners as we gain some insights has to the benefits of this.

Valuing People

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

The annual Staff Recognition Celebrations recognise staff with over ten years' service. There have been 2 longest serving staff members recognised in the 2020/21 year. Each has served 45 years, one in Taurang and one in Whakatāne.

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

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

Health and Safety

Safe and Healthy Environment

Effective workplace health and safety contributes to organisational success and to a safe working environment for all staff, visitors and contractors. It can also influence business risk, higher productivity and lower preventable costs. Poor workplace health and safety conversely can have detrimental impacts on the lives of individuals and their families. There are a number of contributory factors including an awareness of organisational culture and embedding the safety culture into the organisation to ensure the safety culture is shared and integrated across all areas.

The changing work environment is also challenging with a need to address any catastrophic events and the changing nature of harm. Some of the key impacts for the future include the changing population dynamic, growth in the sector, technological advancement and innovation, the changing nature of work and increasing prevalence of psychological harm. Everything that contributes to safe, healthy workplaces – people, organisations and environment are part of the wider health and safety at work framework.

The Health and Safety Team for the Bay of Plenty District Health Board consists of the Health and Safety Manager, two Health and Safety Advisors and nearly 100 Health and Safety Representatives from all the Services. The Health and Safety Representatives consist of staff voted into the role by the relevant service and are given allocated time at work to complete tasks to support the safety of the designated areas assigned

Bay of Plenty District Health Board has systems and processes to identify workplace hazards, minimize the risk and reduce the risk of harm or injury to patients, visitors and workers. There is a 24/7 on-line system for incidents and risk to be documented and reported (Datix) and this is available and accessible to all staff with log in rights. Datix is utilized to assist with identifying deficits, trends and ensuring the business can be proactive in risk management.

We ensure that our people, prospective new employees, other clinical personnel, including locums and health care students are assessed, screened and vaccinated against infectious diseases prior to commencing employment or clinical placement. All staff are required to complete on-line health and safety training specific to the business before they start employment. There are regular updates on health and safety for staff and a requirement for staff to ensure they are updated on new developments and specific programmes each month. These updates are online, and they are sent to each staff member individually.

We continue to demonstrate our commitment to safety within the workplace for the patients, visitors and employees by retaining Tertiary status within the ACC Partnership Programme at the annual audit which was last undertaken in July 2019

Health and Safety activities include:

- Work and non-work accident rehabilitation of employees in conjunction with Work AON, our third-party provider
- A range of injury prevention programmes including moving and handling refreshers, fire evacuation practice and workstation assessments
- On-line Health and Safety, Moving and Handling, Electrical and Fire Safety, Infection control and Hand Hygiene training modules are available for employees to update their knowledge
- Health and Safety representatives actively monitor workplaces for hazards and liaise with the Health and Safety Advisors to address any concerns
- Encouragement to employees and stakeholder participation in health and safety ensuring there is representation from all parties; this includes the Health and Safety Operations group, Health and Safety Advisory Group and Bi- Partite meetings with Unions
- Employee Assistance Programmes are provided to staff at no cost and there are two providers of this service
- Both Tauranga and Whakatāne Hospitals have a gym and membership is available to all staff at a reduced rate
- There is a yearly influenza vaccination programme provided for all staff at no cost
- Ongoing training for Health and Safety Representatives
- Health and Safety Community site on the intranet for information on all health and safety, occupational health and emergency management programmes.

COVID-19 impacted a significant number of staff and services pre and post lockdown.

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. From July 2020 to June 2021, 802 staff were vaccinated. Note: most of the flu vaccinations for 2021 were done after July.

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.

Year	Total cost of work related injury claims	Number of open claims	Claims per $1 million of liable earnings	
			BOPDHB	Levy risk group (average of other DHB's)
2016/17	$ 523 489.00	214	0.61	0.81
2017/18	$ 719 372.00	194	0.82	0.87
2018/19	$ 464 549.00	21	0.80	0.84
2019/2020	$704,015.07	45	Not available	Not available
2020/21	**$586,093.10**	**13**	**Not available**	**Not available**

Employer Assisted Programme

BOPDHB continuted to provide individual psychosocial support to staff, which is able to be accessed 24 hours a day. All staff members are entitled to 3 free confidential sessions of EAP to assist with work or personal issues. Extra providers remained to assist with EAP for Whakaari related experiences for the 2020/21 year. BOPDHB spent $88,388.72 on EAP services for 2020/21.

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

Workwell has now been rolled out at a national level and is able to be adapted to suit any work place. For the year end June 2021, Toi Te Ora have 58 workplaces signed up regionally, and nationally, 123 are signed up with Workwell and 6 of those being other DHBs.

There are 9 DHBs in total (including BOPDHB) that are offering WorkWell to workplaces in their regions. Six of these DHBs are doing WorkWell themselves (internally).

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.

STAFF ENGAGEMENT AND PARTNERSHIP

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 $46,625 was awarded to BOPDHB employees during the 2020/21 financial year (2019/20: $49,123).

- Advanced Study Fund: $23,149
- Whakatāne Staff Study Fund: $3,476
- BOP Learning Scholarships: $20,000
- Hauora a Toi Karahipi: $3,500

BOP Learning Scholarships are available to staff through the generous support of businesses sponsoring the funding of the scholarships. In 2020/21 scholarships totalling $20,000 were sponsored by: Bay of Plenty Medical Research Trust, Guild & Spence, Pure Print, and Jigsaw Architecture. Learning scholarships were awarded to 11 staff members (compared with 12 awarded in 2019/20). Recipients were from a range of roles and services including Allied Health, Radiography, Community Health and Medical Records. 11 Whakatāne staff members received awards from the Whakatāne Staff Study Fund. 2 staff members received funding through Hauora a Toi Karahipi.

In 2020/21, 18 BOPDHB employees were reimbursed a portion of their course fees for tertiary study through the Advanced Study Fund (the same as 18 employees in 2019/20). Applicants received 60% reimbursement towards their fees[20].

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. More education is being opened up to our primary and community care colleagues, with closer working relationships being fostered.

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 2020/21, a total of 1149 staff attended these training courses (2019/20: 652).

In mid-2021, Te Kakenga was launched, a suite of education opportunities that support staff to be Toi Ora Change Leaders and bring Te Toi Ahorangi to fruition.

Attendances are as follows:

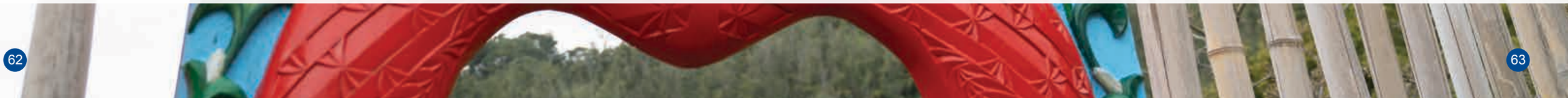
- Treaty of Waitangi half day refresher: 51 (this ceased in October 2020)
- Treaty of Waitangi full day course: 256
- Unconscious Bias online course: 515
- Unconscious Bias and Institutional racism half day course: 146 (started in November 2020)
- Cultural Intelligence full day course: 181 (started in February 2021)

In addition, non-DHB staff members who work for DHB-funded health providers in the Bay of Plenty, including PHOs, Aged Residential Care, General Practice and other partners in health have attended a number of training sessions, mainly by attending pre-scheduled DHB courses, but in some cases, arranging tailored sessions with the Pou Tikanga.

- Treaty of Waitangi full day course: 60
- Unconscious Bias and Institutional Racism: 30
- Unconscious Bias online course: 5
- Half day cultural intelligence workshops: 208

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), conflicts of interest, confidentiality and the BOPDHB's employment policies.

20. It was a bit different this year, we gave up to $2000, so for some people they got the whole thing, for others it was a portion. Also less staff applied, so we were able to provide more funding.



Professional Development

In 2020/21, 1,446 internal training events were offered with 32,740 participants completing training, both face-to-face and online. (2019/20: 1,654 events and 29,921 participants). This figure includes orientation, clinical, non- clinical, leadership, health and safety, IT training and mental health.

57% of learning was completed online (compared with 55% in 2019/20) with108 on-line learning courses offered through Te Whāriki ā Toi.

There are 108 courses available online for BOPDHB staff and 29 of these are also available for DHB funded providers. There are currently 1043 ‘external’ users

Te Whāriki ā Toi also includes the Mahara e-Portfolio platform which enables staff to demonstrate professional competency.

Completion of online learning courses increased by 14% with 18,722 courses completed in 2020/21 compared to 16,451 in 2020/21.

STAFF STATUS 2020/21

Workforce Profile

Staff Number	4,044 permanent and temporary staff (2019/20: 3,789)
Average Age	Average age is 47.2 years (2019/20: 47.3 Years)
Disability Profile	Our proportion of employees who report a disability is 2.0% (2019/20: 0.1%)
Gender Profile	Women make up the majority of our workforce with 82.3% female compared with 17.7% male (2019/20: Female 81.7%, Male 18.3%)

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

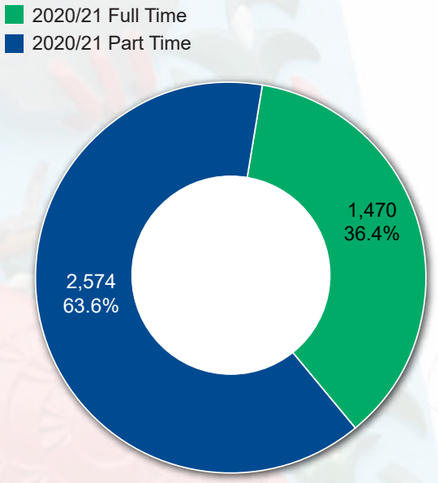
Staff who require suitable parking are provided with the option to access this on campus in close proximity to their work area. Staff are also encouraged to use the in-house occupational health service as and when they require assistance.

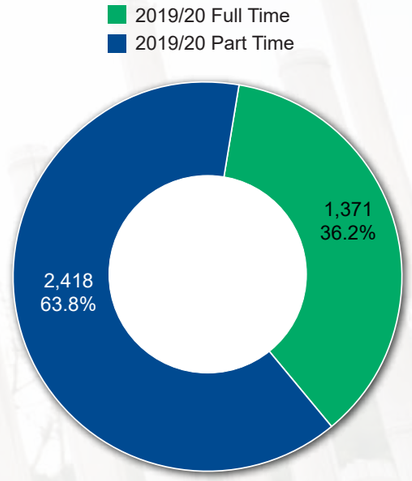
Staff with disabilities that impact on their mobility are identified, and a buddy system is set up to assist them in event of emergency evacuation of buildings. Staff with disabilities provide a valuable insight into the challenges faced

by those with disabilities within our communities and are valuable in the development of Disability Planning in the BOPDHB.

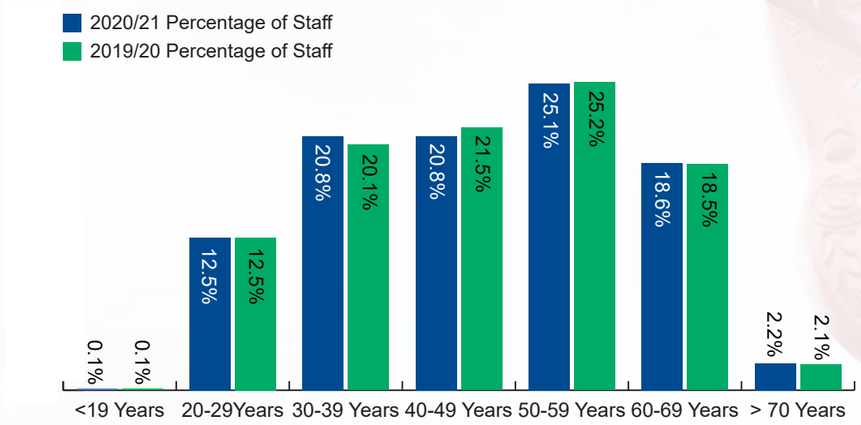
Occupational Group	2020/21 Full Time	2020/21 Part Time	2020/21 Total	2019/20 Full Time	2019/20 Part Time	2019/20 Total
Admin/Management	406	336	742	364	300	664
Allied Health	392	353	745	360	346	706
Medical	338	144	482	317	126	443
Non-clinical Support	68	77	145	69	73	142
Nursing	266	1,664	1,930	261	1,573	1,834
Grand Total	**1,470**	**2,574**	**4,044**	**1,371**	**2,418**	**3,789**

BOPDHB Staff Status

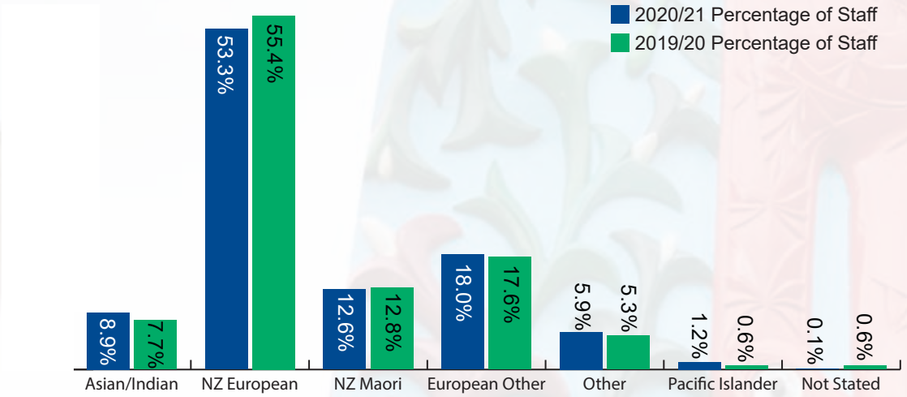




BOPDHB Staff by Age Band



BOPDHB Staff by Ethnicity



Termination Payments 2020/21

Reason	Number	Redundancy	Gratuity	Exgratia
Redundancy	1	$10,280.00		
Redundancy	1	$7,923.00		
Gratuity	1		$122,723.00	
Gratuity	1		$76,156.00	
Gratuity	1		$62,649.00	
Gratuity	1		$60,154.00	
Gratuity	1		$54,840.00	
Gratuity	1		$44,671.00	
Gratuity	1		$43,120.00	
Gratuity	1		$40,629.00	
Gratuity	1		$38,794.00	
Gratuity	1		$32,511.00	
Gratuity	1		$30,450.00	
Gratuity	1		$29,902.00	
Gratuity	1		$28,024.00	
Gratuity	1		$27,942.00	
Gratuity	1		$24,510.00	
Gratuity	1		$20,479.00	
Gratuity	1		$20,292.00	
Gratuity	1		$20,230.00	
Gratuity	1		$19,970.00	
Gratuity	1		$11,833.00	
Gratuity	1		$11,345.00	
Gratuity	1		$10,000.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,500.00	
Gratuity	1		$2,000.00	
Gratuity	1		$2,000.00	
Gratuity	1		$2,000.00	
Gratuity	1		$2,000.00	
Gratuity	1		$1,311.00	
Exgratia	1			$2,500.00
Total	**37**	**$18,203.00**	**$858,035.00**	**$2,500.00**

Salaries over $100,000

Year ended 30 June 2021				30 June 2020
Salary Bands	Medical & Dental Staff	Other	Total	Total
100,000-110,000	41	126	167	145
110,000-120,000	37	55	92	88
120,000-130,000	30	40	70	63
130,000-140,000	27	17	44	36
140,000-150,000	14	14	28	22
150,000-160,000	7	5	12	20
160,000-170,000	15	3	18	14
170,000-180,000	10	2	12	16
180,000-190,000	13	0	13	12
190,000-200,000	13	3	16	12
200,000-210,000	14	4	18	16
210,000-220,000	11	1	12	9
220,000-230,000	12	1	13	10
230,000-240,000	13	0	13	10
240,000-250,000	9	2	11	11
250,000-260,000	11	0	11	11
260,000-270,000	13	2	15	8
270,000-280,000	16	0	16	11
280,000-290,000	7	0	7	8
290,000-300,000	8	0	8	14
300,000-310,000	7	0	7	4
310,000-320,000	7	0	7	3
320,000-330,000	4	0	4	2
330,000-340,000	5	1	6	8
340,000-350,000	0	0	0	4
350,000-360,000	4	0	4	1
360,000-370,000	5	0	5	4
370,000-380,000	1	0	1	1
380,000-390,000	3	0	3	2
390,000-400,000	2	0	2	0
400,000-410,000	1	0	1	3
420,000-430,000	1	0	1	0
430,000-440,000	1	0	1	1
440,000-450,000	0	0	0	1
450,000-460,000	1	1	2	1
460,000-470,000	1	0	1	0
470,000-480,000	1	0	1	0
500,000-510,000	0	0	0	2
580,000-590,000	0	0	0	1
600,000-610,000	1	0	1	0
860,000-870,000	1	0	1	0
Total over $100,000	367	277	644	574

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 2020/21 (2019/20: Nil).

05

Statement of Performance
Pūrongo Mahi

Statement of Performance for year ended 30 June 2021

Module Three: Statement of Performance

3.1 Statement of Performance (SP)

3.1.1 Output Classes

Output Class Funding Allocation

Output Class Achievement Summary

Key Outcomes

3.2 Healthy Individuals – Mauri Ora

3.2.1 Fewer People Smoke

3.2.2 Reduction in vaccine preventable diseases

3.2.3 Improving Healthy Behaviours

3.2.4 Fewer Children and Adolescents have Decayed Missing Filled Teeth

3.3 Healthy Families – Whānau Ora

3.3.1 Fewer people are admitted to hospital for avoidable conditions

3.3.2 Long-term conditions are detected early and managed well

3.3.3 People Maintain Functional Independence

3.3.4 Families and whānau are at the centre of their healthcare

3.4 Healthy Environments – Wai Ora

3.4.1 Appropriate Access to Services

3.4.2 People receive prompt and appropriate acute and arranged care

ACHIEVEMENT IN HEALTH FOR THE BAY OF PLENTY

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 259,090 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.

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 2020/21 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 priority groups outlined in BOPDHB's Strategic Health Services Plan. Again, these metrics do not tell the full performance story, but provide an overview of the work BOPDHB has underway to address the health needs of our priority populations.

To assist you in reading and interpreting this report, we have colour coded our 2020/21 achievements. A ✓ symbol indicates that our performance has achieved, or exceeded the target. A ✕ symbol indicates that we have not achieved the target.

Output Classifications

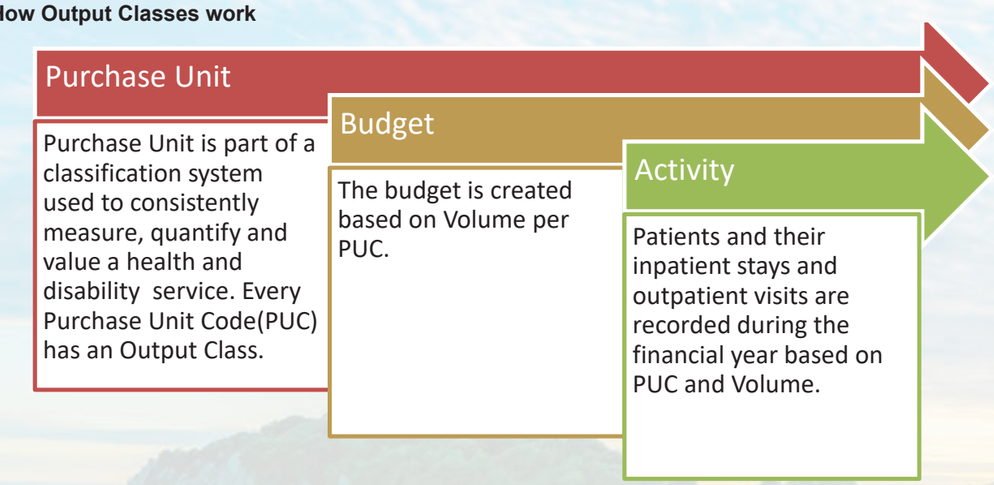
Section 149E of the Crown Entities Amendment Act 2013 requires District Health Boards (DHBs) to identify reportable classes of output delivery each year in a Statement of Performance Expectations. Output classes allow DHBs to group services and demonstrate the application of Board and Government service 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 2021 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 2021 are set out in the following section of our annual report.

How Output Classes work



Output Class 1: Prevention

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

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

Preventative Services have the following strategic goals:

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

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

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

Output Class 2: Early Detection and Management

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

These services are by their nature more general in design, usually accessible from multiple health providers and from a number of different locations within 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 receive timely and appropriate complex care.
2. Early detection programs with focus in health inequities.

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

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

Output Class 3: Rehabilitation and Support

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

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

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

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

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

Output Class 4: Intensive Assessment and Treatment Services

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

They include:

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

3. Emergency Department services including triage, diagnostic, therapeutic and disposition services.

On a continuum of care these services are at the complex end of treatment services and are focused on individuals.

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

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

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

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

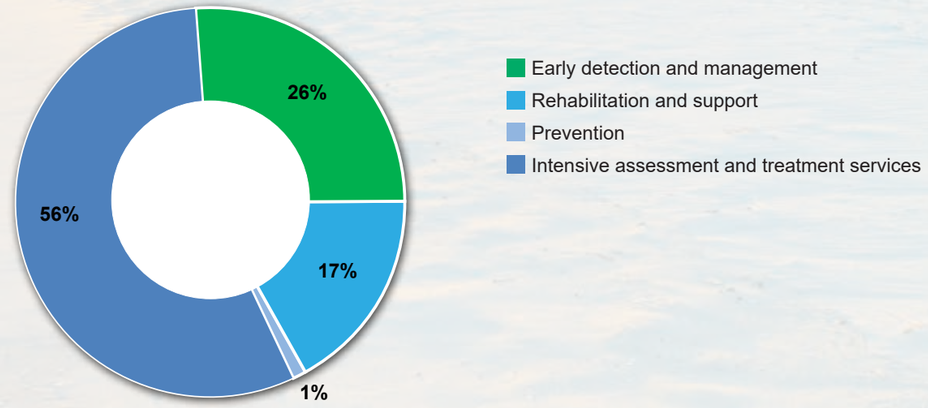
1. People are seen promptly for acute and arranged care.
2. People have appropriate access to elective services.
3. Improved health status for people with a severe mental illness or addictions.
4. People with end-stage conditions are supported.

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 2021.

Summary of Revenues and Expenses by Output Class	2020/21 $000s Actual	2020/21 $000 Plan	2019/20 $000s Actual	2019/20 $000s Plan
Early Detection				
Total Revenue	259,873	234,254	244,022	204,700
Total Expenditure	266,609	235,486	253,192	207,200
Net Surplus / (Deficit)	**(6,736)**	**(1,232)**	**(9,170)**	**(2,500)**
Rehabilitation & Support				
Total Revenue	165,670	143,664	157,151	140,700
Total Expenditure	169,965	144,495	163,056	142,300
Net Surplus / (Deficit)	**(4,295)**	**(831)**	**(5,905)**	**(1,600)**
Prevention				
Total Revenue	12,080	18,301	11,985	16,500
Total Expenditure	12,393	18,403	12,436	16,700
Net Surplus / (Deficit)	**(313)**	**(102)**	**(451)**	**(200)**
Intensive Assessment & Treatment				
Total Revenue	547,509	557,040	483,045	513,300
Total Expenditure	561,700	560,258	501,196	519,500
Net Surplus / (Deficit)	**(14,191)**	**(3,218)**	**(18,151)**	**(6,200)**
Totals				
Total Revenue All output classes	985,132	953,259	896,203	875,200
Total Expenditure All output classes	1,010,667	958,641	929,880	885,700
Net Surplus / (Deficit)	**(25,535)**	**(5,382)**	**(33,677)**	**(10,500)**

Summary of expenses by output class



OUTPUT CLASS ACHIEVEMENT SUMMARY

Prevention

- We provided 87% of smokers in primary care services with smoking cessation advice and support.
- We fully immunised 84.3% eight month olds against vaccine preventable diseases.
- We provided seasonal influenza immunisation to 70.3% of our over 65 aged population during this year.
- Six out of every ten infants were still receiving some breast milk at three months - this reduces to five out of ten for Māori infants.
- As at 30 June 21, 62,622 dose of COVID-19 vaccination were adminstered to residents.

Early Detection and Management

- We dispensed over 4.5m pharmaceutical items.
- The percentage of pre-school aged children enrolled in dental services is at 105.8% (target 95%), 97.8% for Māori.
- PHO enrolment rates remains high in the BOPDHB region than observed for both the total population (97%) and for Māori (92%). A further 1660 (1445 Māori) BOPDHB residents are enrolled with Te Kaha practice.
- We undertook 1,799,302 community laboratory tests and completed these within 48 hours 100% of the time (target 90%).

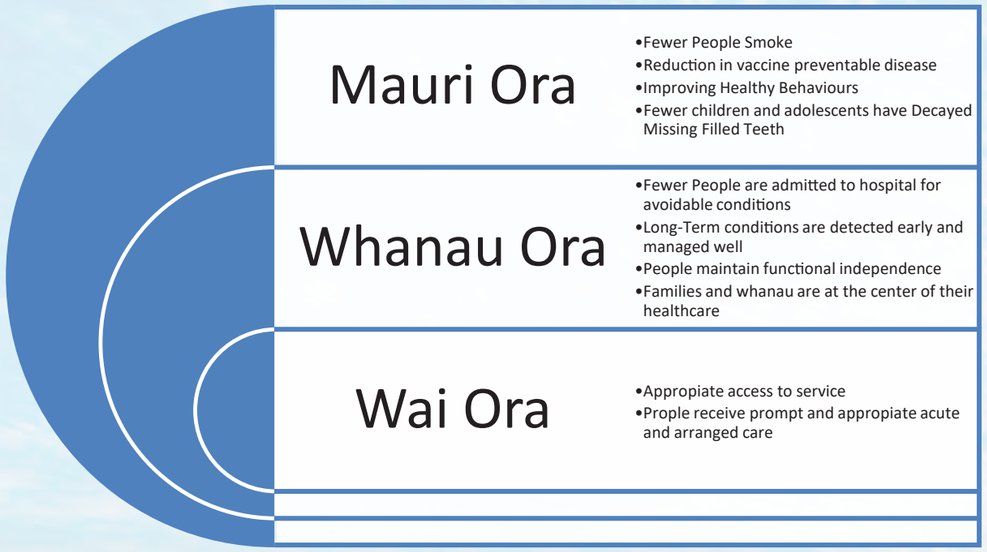
Rehabilitation and Support

- We treated and discharged 19,809 elective patients against a target of 18,249.
- Of our patients referred for radiotherapy or chemotherapy treatment, 88% were seen within 62 days of referral (target 90%).
- We completed 82,019 community referred radiology events (measured as relative value units).

Intensive Assessment and Treatment Services

- Our hospices supported 1,037 patients and their families in the community.
- 86% of patients were admitted, discharged or transferred from an ED within 6 hours.

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 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. ■ Fewer children and adolescents have Decayed Missing Filled Teeth.

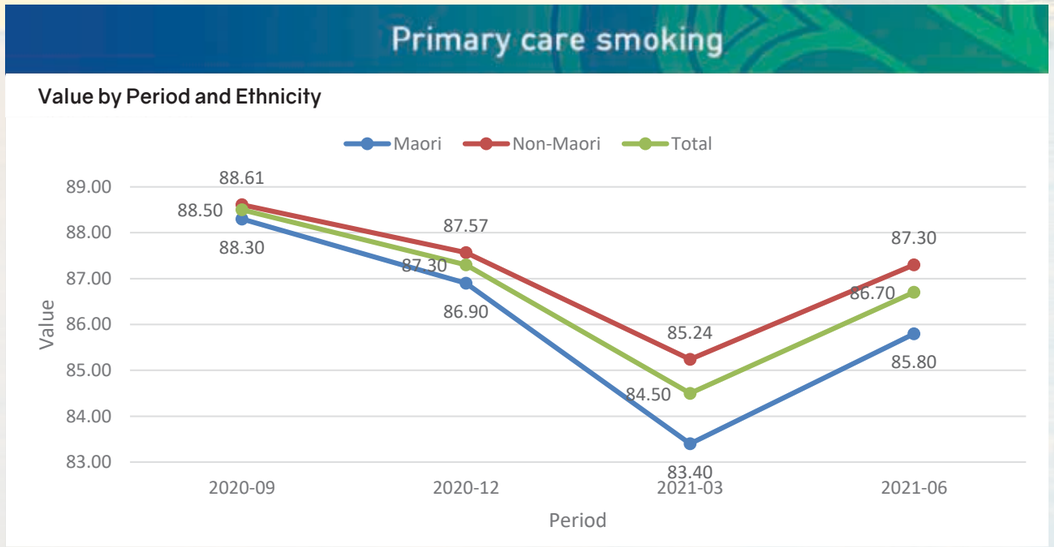
3.2.1 Fewer People Smoke

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

The health effects of smoking are devastating:

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

The ongoing focus of our Primary Health Organisations (PHOs) on ABCs in a primary care setting has enabled steady performance. The primary care smoking cessation stipulates that brief advice is offered and support to quit smoking given to over 86% of eligible patients who smoke and were seen by a health practitioner in general practices within the last 15 months. This target has not been met during 2020/21 by a 3% for total population, it has not improved from last year. The high percentage reflects 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 less than 1% based on 2020/21 data – the total population result was 86.7%, while the result for Māori was 85.8%. There is also a clear inequity of smoking prevalence based on the primary care smoking data. While Māori comprise roughly 25.6% of the population in the BOPDHB region, they make up over 44% of smokers, based on 2020/21 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 2020/21, which is, in large part, due to small numbers in the denominator for this metric. The 90% target was not achieved. The principal concern with the maternity smoking measure, is again the disparity in smoking prevalence between expectant Māori and non-Māori mothers. The smoking prevalence is higher for non-Māori mothers, similar to previous years. There remain ongoing concerns with the quality of the maternity smoking data set, as the denominator is only a fraction of what it should be based on annual births within the BOPDHB region.

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 1 Providing smokers who access primary care services with smoking cessation advice and support **– PH04.**							Smoking cessation advice in primary care did not meet the 90% target for the total population and Māori, while being just below the target by 3% for Total population and 4% for Māori. To increase stop smoking capability along the East coast, National Stop Smoking Training service is collaborating with Te Rūnanga o Te Whanau a Apanui to professionally develop Whanau Ora kaimahi to become Stop Smoking practitioners.
■ Total	89%	89%	90%	87%	76%	✗	
■ Māori	87%	88%	90%	86%	73%	✗	
Output class: 1 Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit. **CW09**							Maternity smoking targets were not achieved for both total and Māori populations in 2020/21. Smoking prevalence for Māori mothers is a significant concern and is one of the key focus areas in the DHB. Planning meetings have begun with both Maternity services CNMs , Hapainga (Stop smoking service) supported by Waikato DHB and Midcentral DHB to explore taking on the ' Opt Out' approach. The aim is to routinely offer all women the opportunity to be supported to quit smoking whilst pregnant.
■ Total	93%	86%	90%	84%	NA	✗	
■ Māori	93%	87%	90%	76%	NA	✗	
Output class: 1 Māori babies who live in smokefree households at six weeks post-natal.	35%	33%	60%	32%	35%	✗	Six (4 day) Marae based Wananga – called 'Ukaipo' for hapu mama who smoke have been held around the region. Mothers register for the upcoming Ukaipo during their pregnancy and whānau members are also invited to attend. Ukaipo are held on Marae and attract 5-12 pregnant mothers per wananga. 2 wananga had to be postponed due to COVID-19. Mothers and whānau reduce or quit smoking after attending Ukaipo and are also referred to Hapainga (regional stop smoking service) to continue their smokefree journey. In addition, BOPDHB fund wahakura wananga (safe sleep) where smoking is identified as a key risk factor for SUDI. Women and whānau who attend these marae based wananga are also supported towards a smokefree life. The BOPDHB funds a Hapū Māmā Programme with the Hāpainga Stop Smoking service. This enables a pregnant mother to receive up to $250 in vouchers over a 12 week period. A Quit Buddy can also be identified (preferably the partner) who can receive up to $150 vouchers when successfully quit. This has now been extended to cover the First 2000 Days Initiative and is available to the main carer of the child that may not be the mother.

3.2.2 Reduction in vaccine preventable diseases

Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. The immunisation coverage measures have been adjusted to reflect a shift in focus to ensuring children have received all the immunisations scheduled for them up to and including the age measured. In addition the measures include a stronger focus on achieving equitable coverage.

During 2020/21 there are several complex, systemic/ process and service user challenges that have effected immunisation rates, these include:

- Increased Primary Care demand compounded by a reduced GP staffing.
- Loss of engagement with general practice as parents seek alternative wellness settings
- Non-enrolled or delayed enrolment of new-borns increasing for Māori
- Multiple and inconsistent data sources resulting in reduced co-ordination of service for timeliness
- The impact of social and economic determinants causing multi-factorial challenges for Whanau and barriers to access health services
- The COVID-19 effect on staffing, vaccination anxieties in the community and the need for public and community education to build trust and confidence for those parents who may be hesitant and delay.

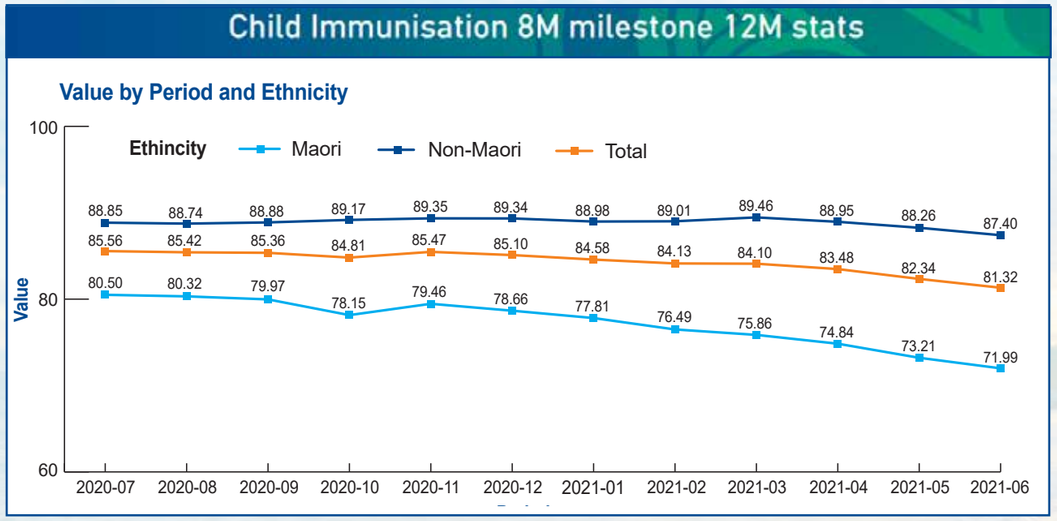
Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 1 Children are fully immunised at two years of age and five years of age – **CW05**.							Our service delivery model continues to have a strong improvement focus on timely vaccination and missed babies, however acknowledging missed babies can be due to either parental choice to delay, immunisations given at GP practice but after the milestone age. Transfers in to BOPDHB already overdue are included in the missed target data, these children are on catch-up programmes including outreach so unable to complete by milestone age despite strong system priority for timely vaccination to the schedule.
■ Two years of age Māori	NA	81%	95%	**81%**	NA	✗	
■ Two years of age Total	83%	76%	95%	**85%**	NA	✗	
■ Five years of age Māori	NA	78%	95%	**82%**	NA	✗	
■ Five years of age Total	NA	82%	95%	**85%**	NA	✗	
Output class: 1 Children are fully immunised at eight months.[21]							The issues of timeliness are apparent across the age cohorts within the Immunisation schedule but consistently below expected rates for 6 and 8 months. The new Action Plan being implemented will focus support to GP practices and explore alternative delivery options for Māori. Outreach services are trialling more flexible approaches such as walk in Wellness clinics with flexible hours.
■ Total	82%	83%	95%	**84%**	NA	✗	
■ Māori	76%	77%	95%	**77%**	NA	✗	

21. Data is from the influenza coverage data which reports influenza vaccination administered during a given calendar year

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 1 Percentage of the population (>65 years) who have had the seasonal influenza immunisation[22]							Despite prioritised actions for Māori and a strong collaborative approach with a variety of providers results were below target but showed some improvements at provider level and actions tested for future use.
■ Total	58%	74%	75%	**70%**	63	✗	
■ Māori	51%	68%	75%	**62%**	53	✗	

Eight month immunisation coverage performance explained

Eight month immunisation coverage was one of the targets monitored by the Ministry of Health in 2020/2021. This target stipulates that 95% of children at eight months of age would have received the requisite immunisations as outlined within the schedule. Eight month immunisation coverage has been a challenging area for BOPDHB, due to historically high rates of declines and opt-off children over 10%.



The graph above illustrates rolling twelve months DHB immunisation rates for Māori, non-Māori and the total population for the twelve month period from June 2020 to June 2021. Rolling twelve-monthly immunisation shows a steady decline in the latest half year for Māori, non-Māori and the total population.

22. 2020/21 actual results usually reflects influenza coverage in the 2020 calendar year. The 2020-21 influenza immunisation season ends in September 2021, with data not available until October 2021, which is outside of annual reporting timeframes, therefore we normally report previous year data.

3.2.3 Improving Healthy Behaviours

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

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class: 1 Percentage of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family bases nutrition, activity and lifestyle interventions – **CW10**	NA	94%	95%	**85%**	✗	Although below target due in part to COVID-19 effect on the B4SC service we have seen improvement due to new staff engagement and improved referral processes with GP and active family/ Whanau intervention programmes. We have two main programmes; Active Families and Te Hihiko healthy lifestyles programme; alternative efforts were made through Facebook/website information and phone contacts with family to maintain contacts during COVID-19 affected periods.
Output class: 2 Percentage of infants receiving breast milk at three months[23] **CW06**.						In order to change breastfeeding at 3 months, we need to address the earlier inequities. Our 2 community kaupapa Māori breastfeeding support services have seen a steady increase in volumes over the past year, which will hopefully impact future breastfeeding prevalence. In the past 6 months (Jan-June 2021) the combined two services have supported 693 mama and pepi and their whānau. to continue breastfeeding. 356 in the Eastern Bay and 337 in the Western Bay. Last year the service supported 556 mama and their pepi. 80% of non-Māori and 79% of Māori infants are exclusively breastfed at 2 weeks of age (inequity of 1%) This result has seen a 5% improvement in the equity gap from last year. 74% of non-Māori and 67% Māori infants and are still exclusively breastfed at discharge from LMC at 4-6 weeks post-natal (inequity of 7%) This result has seen a 4% improvement in the equity gap from last year. 66% of non-Māori and 52% of Māori infants continue to be exclusively breastfed at 3 months old (inequity of 14%). This result has seen a 5% improvement in the equity gap from last year.
■ Total	72%	64%	70%	**64%**	✗	
■ Māori	62%	51%	70%	**52%**	✗	

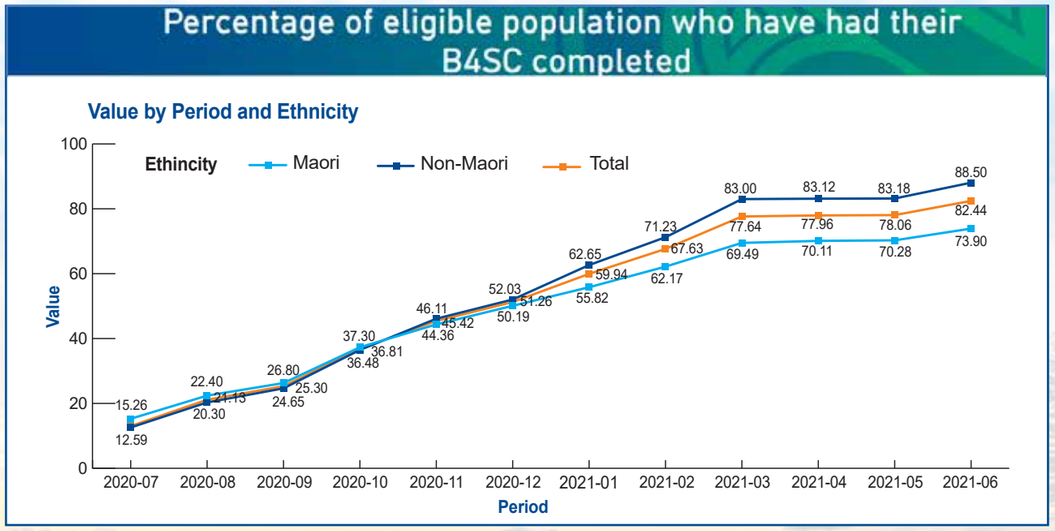
23. This measure is reported on as part of Well Child Tamariki Ora reporting, and monitor in the IDP reporting, only data available from MOH was for March 2021, this was the only data available for period 2020/21.

3.2.4 Fewer Children and Adolescents have Decayed Missing Filled Teeth

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 2 Percentage of children who are caries free at age five - **CW01**[24]							Significant disparities remain of concern and an active evaluation project is underway to improve the rate of unseen/over-due children to improve intervention potential for treatments and follow ups. The Oral health promotion team and the 5 2 1 0 Nutrition and activity programme adopted within the BOPDHB region will be a key promotion programmes for improvement in population rates
■ Total	51%	52%	54%	**41%**	NA	✗	
■ Māori	34%	34%	54%	**30%**	NA	✗	
Output class: 2 Percentage of adolescent utilisation of DHB funded dental services – **CW04**[25]							COVID-19 has significantly affected the numbers of youth seen, due to the need to protect against an airborne virus in the dental environment where aerosol treatment predominates. The Oral health Promotion Team are actively evaluating the transfer of year 9 adolescents to private dentists to ensure access to service providers is explained and informed for good access.
■ Total	73%	70%	>85%	**61%**	71%	✗	
Output class: 2 Percentage of Children (0-4 years - % year 1) enrolled in DHB funded dental service – **CW03**							Improvements has been driven by a preschool enrolment initiative, where parents of non-enrolled Māori children were identified and called. This is ongoing and with internal titanium reporting we expect better monitoring will flow through to children being seen
■ Total	101%	102%	<=95%	**106%**	NA	✓	
■ Māori[26]	96%	96%	<=95%	**98%**	NA	✓	
■ Non-Māori	104%	106%	<=95%	**112%**	NA	✓	
Output class: 2 Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination – **CW04**[27]							As an unintended consequence the substantive improvements in enrolments has placed additional demand on an already constrained service. Addressing these capacity challenges should enable improvements in this area. Intervention scheduling and system capacity is currently under investigation through an analytics project to determine future improvements required (system and resource) to ensure maximum potential to see enrolled children
■ Total	17%	17%	<=10%	**12%**	NA	✗	
■ Māori	17%	16%	<=10%	**17%**	NA	✗	

24. Oral health reporting is by calendar year to align with school clinics. Published results are for the 12 month period ending 31 December 2020. 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.
25. This measure was extracted from MoH report on adolescent utilisation for calendar year 2019.
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.
27. This measures is calculated for 2020 calendar year.

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 2 Percentage of eligible population who have had their Before School Checks (B4SC) completed.							COVID-19 secondment of staff has had a dramatic effect on production for B4SC service. Weekly performance monitoring continued and allowed remedial planning for flexibility and catch up responses with the cohorts of children due. Community partners also assisted completion of B4SC checks to mitigate the COVID-19 effect.
■ Total	90%	82%	90%	**81%**	NA	✗	
■ High Needs	92%	84%	90%	**78%**	NA	✗	



HEALTHY FAMILIES – WHĀNAU ORA

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

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

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

3.3.1 Fewer people are admitted to hospital for avoidable conditions

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

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
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 2, 3 Reduced ASH rates 45 – 64 years.[28]							Overall, for total and other BOPDHB are in an improved position from 2020. We have seen a sustained reduction in the total population ASH rates year on year but acknowledge that a sustained reduction has not been achieved for Māori. In recent months there has been significant resource investment in acute demand and ASH, with the intent to realise significant improvements in acute demand and in particular Māori ASH rates .
■ Māori	7899	7362	7309	**7564**	7074	✓	
■ Total	3859	3859	3691	**3665**	3713	✗	
■ Other	NA	2796	2879	**2697**	2938	✗	

28. Period reported is the 12 months ending 31 June 2021(Non-Standardised ASH Rate).

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class: 3 Percentage of triage level 4 and 5 presenting to the Emergency Department (ED).	48%	44%	≤65%	**43%**	✓	Continued decrease in lower acuity presentations to the ED has been offset by an increase in ATS triage 2-3 presentations so there has been no reduction in patient presentation numbers for acute care; patients presenting to ED are likely to be higher acuity.
Output class: 3 Number of presentations to ED – Triage Level 4 and 5 as a percentage of the total population.	16%	13%	15%	**13%**	✓	Achieved a less than 15% of total population presenting as lower triage levels to the ED.(as above).

3.3.2 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
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 2 Percentage of population enrolled with a Primary Health Organisation (PHO)[29].							BOPDHB achieved overall PHO enrolment targets in 2020/21, with 97% of our population of 259090 enrolled with a PHO. Māori enrolment was over 91% (66260).
■ Total	99%	96%	90%	**97%**	94%	✓	
■ Māori	97%	91%	95%	**92%**	84%	✗	
Output class: 1 Woman enrolled in a PHO age 25-69 years who have had a cervical cancer screen sample taken in the past three.							Cervical screening coverage did not reach the target for Total and Māori but all the measures are over the National Average. COVID-19 lockdowns and the cessation of screening services have impacted on screening achievement. General Practice are indicating that they are stretched to capacity and cervical screening recalls and booking of appointments have lapsed as an outcome. Community clinics have been established by Support to Screening Services and when women are referred to them (eg. by GPs) they have a good rapport with wāhine Māori and screening achievement.
■ Total	81%	79%	80%	**74%**	71%	✗	
■ Māori	74%	73%	80%	**66%**	62%	✗	
■ Non-Māori	84%	80%	80%	**77%**	73%	✗	

29. 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 1,660(1445 Māori) 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 by2 % to over93.7 % enrolment.

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class: 1 Woman enrolled in a PHO age 50-69 years who are enrolled in a breast screen program with breast screen midland.							National breast screening programme is 2 yearly for women aged 45-69. 68% of BOPDHB women were screened in the 2 years prior to July 2021. BOPDHB did not achieve the 70% breast screening targets for any ethnic group. There is an equity gap between Māori and non-Māori/non-Pacific of ~10%. 59% of Māori women were screened in the 2 years ending July 2021. This year has been impacted by COVID-19 lockdowns and no screening provision during that time. The Mobile screening visits in Kawerau and Opotiki were successful in reaching rural Māori women.
■ Total	73%	74%	70%	**68%**	67%	✗	
■ Māori	66%	67%	70%	**59%**	60%	✗	
■ Non Māori	75%	75%	70%	**70%**	68%	✓	
Output class 2 **Focus Area 2 - Diabetes Services (HbA1c):** Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator) **SS13-FA2.**	69%	69%	80%	**68%**	NA	✗	During 2020/21, three equity issues have been identified and addressed by increased FTE (3.2) in the diabetes team, including a Māori internship and increase in 1 FTE for NMO PHO to address demand among Māori with diabetes. Western Bay of Plenty PHO (funded by DHB) continues to run diabetes self-management classes on Marae for Māori.
Output class 3 **Focus Area 5 - Stroke Services:** Percentage of potentially eligible stroke patients thrombolysed. **SS13-Ind2**	9%	11%	12%	**11%**	NA	✗	Population growth is resulting in increased stroke presentations. Whilst thrombolysis is standard first line management for ischaemic stroke we are now also fully participating in the identification and transfer of people for thrombectomy to Auckland Hospital. This is not included in re-perfusion data. Target of admission to stroke unit achieved by increasing allocated acute stroke beds from 6 to 8 within HIA clinical unit to meet increased demand. This allows timely transfer of patients from ASU to inpatient rehabilitation service as required.
Output class 3 **Focus Area 5 - Stroke Services:** Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. **SS13-Ind1**	73%	82%	80%	**80%**	NA	✓	

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 3 Percentage of the population 65+ years that access Home and Community Support Services (HCSS)	9%	8%	12%	**8%**	✗	Whilst the percentage of the over 65 year old population accessing HCSS is increasing, this is being offset by population growth. As a result, the percentage of the eligible population accessing HCSS remains low.
Output class 3 Maintain current percentage of population over 65 years who have accessed aged residential care (ARC)	4%	3%	5%	**4%**	✓	The population of over 75 age group who are the group requiring aged care is increasing however the percentage requiring ARC care remains well below target figure. This reflects the effectiveness of other initiatives to support people to remain living at home.

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class 3 **Focus Area 5 - Stroke Services:** Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission. **SS13-Ind3**	71%	70%	80%	**83%**	NA	✓	

3.3.3 People Maintain Functional Independence

3.3.4 Families and whānau are at the centre of their healthcare

The Annual Plan 2020/21 identified families and whānau as key stakeholders in a patient's health and wellbeing. The Whanau Ora target was introduced to reflect this importance. A Whānau Ora pathway is in place with our kaupapa PHO as a clinical care tool that is accessible by all health professionals involved in the care of Māori patients.

Main measures of performance		Volumes				Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 2 % of BOPDHB contracted Whānau Ora providers that are using the Whānau Ora and/ or Tūāpapa assessment tool.	NA	11%	TBD	**NA%**	NA	Progressing with the development of a new indicator to align with the responsiveness of Whānau Ora.

HEALTHY ENVIRONMENTS – WAI ORA

Whānau that are connected within their communities will have support networks to assist them in managing adverse health events.

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

Outcome goal	Outcome measure
Our population is enabled to self-manage.	■ Appropriate access to services. ■ People receive prompt and appropriate acute and arranged care.

3.4.1 Appropriate Access to Services

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

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 3 Number of inpatient surgical discharges under elective initiative (includes all discharges regardless of whether they are discharged from surgical or medical specialty) Total	12,101	9,488	18,249	**19,809**	✓	
Output class 3 ESPIs (Elective Services Performance Indicators) **ESPI 1** - timely processing of referrals in 15 calendar days or less	100%	100%	100%	**100%**	✓	
ESPI 2 – percentage of patients waiting longer than four months for their first specialist assessment	5%	13%	0%	**7%**	✗	Multiple pressures are affecting all services and thresholds are adjusted accordingly. COVID-19 significantly impacted elective delivery.
ESPI 3 - patients waiting without a commitment to treatment	0%	0%	0%	**0%**	✓	Achieved
ESPI 5 - patients given a commitment to treatment but not treated within four months	6%	14%	0%	**18%**	✗	As noted above, COVID-19 has significantly impacted this target, alongside other multiple pressures including: • Theatre capacity • Bed capacity • Acute demand • ICU/HDU bed availability Increased outsourcing has assisted.
ESPI 8 - proportion of patients treated who were prioritised using recognised tools and processes.	100%	99%	100%	**95%**	✗	BOPDHB is working towards all services using the electronic national prioritisation tool for all patients. The not achieved result was due to delays with this roll out, due to rolling strike action, the COVID-19 response, and an increased focus on outsourcing planned care for patients with significant delays to treatment (competing demands for the same resource allocated for the eNFA rollout). BOPDHB will continue to roll out an electronic notice for admission (eNFA), across all planned care services (currently orthopaedics use) which has the prioritisation tool embedded, and a mandatory field.
Output class 3 Did Not Attend (DNA) rate for outpatient services.						Māori outpatient DNA rates are similar than previous year. However, Māori DNA remains significantly higher than the 5% target and the DNA rate achieved for non-Māori.
■ Total	5%	6%	NA	**6%**	✗	
■ Māori	14%	14%	NA	**13%**	✗	
■ Non Māori	4%	4%	NA	**4%**	✓	
Output class 3 Number of clients supported by specialist palliative care.	1,157	1,102	769	**1,037**	✓	This is a hospice service delivery measure as inpatients with palliative care needs are supported via a consult liaison service – numbers are not reported.
Output class 3 Percentage of people supported by specialist palliative care, other than cancer or end stage renal failure.	29%	22.7%	23%	**21%**	✗	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
Output class 2 Number of community pharmacy prescriptions[30]	3,606,864	4,238,026	3,676,982	**4,531,877**	✓	Community pharmacy prescriptions have increased significantly in 2020-21. Given population growth is around 3% per annum, this means that prescription levels per head of population have increased more than population growth in 2020-21. However, we acknowledge that part of the increase will be the result in monthly dispensing for several months during COVID-19, as opposed to three monthly dispensing.

30. 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.

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 3 Improved wait times for diagnostic services[31] – accepted referrals receive their scan: Coronary Angiography in 90n days or less	99%	68%	95%	**89%**	✗	MOH targets for access to acute angiography within 3 days of acute coronary syndrome presentation take precedence over planned angiography. Access has been impacted by acute demand (i.e., delays to transfer from Whakatāne to Tauranga for ACS due to no available acute beds in CCU) and the impact of COVID-19 lockdown on planned care. The current facility is required to deliver acute and planned care including pacemaker and ICD implantation. A business case for commissioning of the second cath lab has been approved with a time frame of 12 months (August – September 22)to being fully operational. We will endeavor to improve performance however until the additonal facility is commissioned we will continue to be impacted by acute demand and other procedures which require cath lab access.
Diagnostic Colonoscopy Urgent (within 14 days) Non-urgent (within 42 days)	90% 43%	94% 33%	90% 70%	**96%** **43%**	✓ ✗	We have consistently met the target of 14 days from referral to colonoscopy for urgent patients in 2020- 21; however due to ongoing demand and facility limitations we have been unable to meet timeframe for non-urgent colonoscopy. Additional capacity (outsourced) has been in place since November 2020 and we have seen a slow reduction in waiting list numbers and improving performance against wait time targets due to this however the net impact of COVID-19 lock down on planned care continues to provide challenges to meeting this target. The goal for compliance with non-urgents is to be on track to achieve this by May 2022.
Surveillance Colonoscopy	56%	32%	70%	**23%**	✗	Despite what appears to be a decrease in performance over the year, we are on track to have all surveillance colonoscopies delivered within MOH time frame by December 2021. This is largely due to outsourcing and additional sessions across the BOP facilities.
Computing Tomography (CT) scans in 42 days (6 weeks) or less	97%	92%	95%	**97%**	✓	Achieved.
Magnetic Resonance Imaging (MRI) scans in 42 days (6 weeks) or less	91%	90%	90%	**92%**	✓	Achieved
Output class 3 Total number of community referred radiology Relative Value Units (*RVUs)	72,770	72,845	72,090	**82,019**	✓	Delivery of community radiology services exceeded target in 2020/21. The volume delivered was comprised of referrals from both Primary and Secondary service providers.
Output class 2 Total number of community laboratory tests	1,565,573	1,535,544	1,450,000	**1,799,302**	✓	Community laboratory test volumes increased in 2020/21. Test volumes are increasing at a rate comparable to population growth.

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 2 Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes: Category 1: Within 24 hours Category 2: Within 96 hours Category 3: Within 72 hours	 97% 100% 100%	 100% 100% 100%	 95% 100% 100%	 **100%** **99%** **100%**	 ✓ ✗ ✓	Category 1 and Category 3 non-urgent community lab test targets were met during 2020/21. Category 2 non-urgent community lab tests fell 1% short of target. No adverse outcomes reported in this category.
Output class 2 Percentage of community laboratory tests completed within designated timeframe from receipt of the specimen at the laboratory Within 48 hours (routine test) Within 3 hours (urgent test)	 99% 97%	 99% 97%	 90% 80%	 **100%** **100%**	 ✓ ✓	Targets in both categories were met.
Output class 3 Improving mental health services using transition (discharge) planning for child and youth – **MH02** ■ Total ■ Māori	 80% 75%	 74% 79%	 95% 95%	 **75%** **83%**	 ✗ ✗	Work in the Child and Youth service focus has been on integration with paediatric and child development teams to improve and develop on a Child at the centre model. The focus is on reducing waiting times and improving co-ordination of service to reduce duplication. Work specific to transition plans has continued in Adult services and will inform Child and Youth services transitions as the service development progresses. It is pleasing to see the progress made for Māori.
Output class 3 Average length of acute adult (18+ years) inpatient stay (days)	16 days	19 days	14-21 days	**16 days**	✓	This metric is met.
Output class 3 Rates of 7 day follow-up in the community post discharge	67%	64%	90%	**60%**	✗	It has been disappointing that initiatives tested are not showing the results anticipated in this area. Recruitment, referral volume and COVID-19 restrictions have all provided challenges to meeting this target. The continued focus in the up coming year will be around improvement of follow up linked to integrated MDT processes with community, inpatient and NGO provider teams. The development of an Intensive home based treatment team is also planned for 21/22.

31. Activity is for all patients who received a diagnostic service in the 12 months ended 30 June 2021. The percentage reflects the proportion of patients who received their service in the specified timeframe.

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 middle of the target range. There are a number of factors that impact the length of stay for an acute adult inpatient, which is why a target range is identified. 28-day readmission rates are also closely tied to average length of stay.

Some of the factors that impact length of stay include:

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

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class 3 A referral of a young person (0-19 years) is seen by Alcohol and other drug health professional within 3 weeks of referral being received.	79%	**71%**	**80%**	**70%**	74%[29]	✗	Vacancy and recruitment challenges have impacted on delivery of care to 0-19 yr olds referred for addictions in the 20-21 financial year. Child and youth services are currently undergoing a change process to improve integration and support client flow.
Output class 2 Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks. Mental Health (Provider Arm) % people seen <3 weeks.							Waiting times in child and youth services have remained challenging with on going vacancies and increased referral rates for MH and Addition services. Adult services have continued to meet Mental Health wait time targets in this current year. Work in Child and Youth services is on integration with paediatrics and child development services. Referral rates in child and youth services have significantly risen creating additional pressures. Access rates have continued to be higher than the national average in all areas(except one) which has further challenged our system
0-19 yrs	77%	71%	80%	**69%**	65%[30]	✗	
20-64 yrs	85%	86%	80%	**86%**	81%	✓	
Addictions (Provider Arm and NGO) % people seen <3 weeks							
0-19 yrs	79%	75%	80%	**76%**	81%	✗	
20-64 yrs	77%	75%	80%	**66%**	75%	✗	

Main measures of performance	Volumes						Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	2021 National Average	Achieved	
Output class 2 Percentage of people referred for non-urgent mental health or addiction services are seen within 8 weeks. Mental Health (Provider Arm) % people seen <8 weeks.							Performance against eight-week wait time targets has largely been maintained for mental health and addiction service provision. Child and Youth services have been utilising groups where appropriate to enable provision of support while waiting for individual case management. Recruitment is also underway for all vacant positions.
0-19 yrs	96%	93%	95%	**90%**	87%	✗	
20-64 yrs	95%	95%	95%	**94%**	93%	✗	
Addictions (Provider Arm and NGO) % people seen <8 weeks							
0-19 yrs	90%	88%	95%	**89%**	96%	✗	
20-64 yrs	96%	94%	95%	**91%**	93%	✗	

3.4.2 People receive prompt and appropriate acute and arranged care

Bay of Plenty DHB achieved over 88% of patients with a confirmed diagnosis of cancer received their first treatment within 62 days – which is down from the 2020 result.

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 3 Percentage of patients admitted, discharged or transferred from an ED within six hours – Health Target.	93%	91%	95%	**86%**	✗	Performance against this target has been challenged by growth in acuity of presentations to the ED alongside an increase in actual numbers presenting. This is in line with population growth and ageing. Of particular concern is the deterioration in performance in terms of people requiring inpatient admission which is a measure of the total systems ability to respond and provide timely access to inpatient facilities. This is Board KPI for the next 6 months and significant work is underway across the acute flow system to improve performance.
Output class 3 Focus area 4 – Acute Heart service 70% of high risk patients receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0' – **SS13**	93%	91%	70%	**84%**	✓	Achieved - although some impact noted in delays to acute transfers due to high inpatient occupancy.

Main measures of performance	Volumes					Comments
	2019 Actual	2020 Actual	2021 Target	2021 Actual	Achieved	
Output class 3 Focus area 4 – Acute heart service. Over 90% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/ PCI registry data collection within 30 days – **SS13**	99%	100%	95%	**99%**	✓	Completed – on target.
Output class 3 Part A Faster Cancer Treatment – 62-day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 62 days of decision-to-treat– see Health Target.	92%	95%	90%	**88%**	✗	BOPDHB achieved the FCT target in Q1 & Q4 in 2020/2021, the 88.2% result representing a weighted average of these quarterly results.
Output class 3 Part B Faster Cancer Treatment – 31 day indicator. Patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-trea	88%	91%	85%	**88%**	✓	BOPDHB achieved the FCT target in three quarters(not Q3) in 2020/2021, the 88.3% result representing a weighted average of these quarterly results.

IMPLEMENTING THE COVID-19 VACCINE STRATEGY

Vaccine doses administered by Bay of Plenty District Health Board as at 30 June 2021.

	Dose 1	Dose 2	Total
Vaccine doses administered	37,805	**24,817**	62,622

Vaccine doses administered by age group (note 4)

Age range (years)	Dose 1	Dose 2	Total
12 to 15	0	0	0
16 to 19	231	131	362
20 to 24	721	577	1,298
25 to 29	1,144	903	2,047
30 to 34	1,251	1,025	2,276
35 to 39	1,170	940	2,110
40 to 44	1,273	981	2,254
45 to 49	1,531	1,166	2,697
50 to 54	1,865	1,435	3,300
55 to 59	2,167	1,591	3,758
60 to 64	2,671	1,800	4,471
65 to 69	5,866	3,490	9,356
70 to 74	6,553	3,859	10,412
75 to 79	4,980	2,977	7,957
80 to 84	3,501	2,093	5,594
85 to 89	1,750	1,059	2,809
90+	1,131	790	1,921
TOTAL	**37,805**	**24,817**	**62,622**

Eligible population fully vaccinated by age group (note 5)

Age range (years)	**Proportion vaccinated** (note 1)
12 to 15	-
16 to 19	1.45%
20 to 24	5.02%
25 to 29	6.30%
30 to 34	6.62%
35 to 39	6.51%
40 to 44	6.81%
45 to 49	7.42%
50 to 54	9.30%
55 to 59	10.08%
60 to 64	11.78%
65 to 69	23.77%
70 to 74	28.46%
75 to 79	29.65%
80 to 84	31.39%
85 to 89	28.34%
90+	37.30%
TOTAL	**12.55%**

Vaccine doses administered by ethnicity (note 4)

Ethnicity	Dose 1	Dose 2	Total
Asian	1,805	1,438	3,243
European or other	30,501	19,954	50,455
Māori	5,041	3,094	8,135
Pacific peoples	381	283	664
Unknown	77	48	125
TOTAL	**37,805**	**24,817**	**62,622**

Eligible population fully vaccinated by ethnicity (note 5)

Ethnicity	Proportion vaccinated (note 1)
Asian	11.92%
European or other	14.14%
Māori	7.61%
Pacific peoples	8.54%
Unknown	19.78%
TOTAL	**12.55%**

Vaccine doses administered by sequencing group (note 4)

Sequencing group (note 3)	Dose 1	Dose 2	Total
Group 1	1,499	1,383	2,882
Group 2	14,381	11,674	26,055
Group 3	20,999	11,336	32,335
Group 4	926	424	1,350
TOTAL	**37,805**	**24,817**	**62,622**

Note 1:

Fully vaccinated means two doses have been administered to an individual.

Note 2:

The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.,.

The Total population estimate based on HSU as at 30 June 2020 is 259,154. This is 4,846 below the Stats NZ total projected population of 264,000 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Māori	63,895	67,900	(4,005)
Pacific	4,809	4,850	(41)
Asian	16,702	18,350	(1,648)
Other	173,748	172,900	848
TOTAL	**259,154**	**264,000**	**(4,846)**

Note 3:

Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4:

The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5:

The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

STATEMENT OF RESPONSIBILITY FOR THE YEAR ENDED 30 JUNE 2021

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

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

In the opinion of the Board and Management of the BOPDHB, the financial statements for the year ended 30 June 2021 fairly reflect the financial position and operations of the BOPDHB.

Sharon Shea
Interim Board Chair

Pete Chandler
Chief Executive Officer

Owen Wallace
General Manager
Corporate Services

06

Financial Statements
Pūrongo Pūtea

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE
For the year ended 30 June 2021

	Note	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
Income				
Crown revenue	4	**976,165**	**944,588**	886,587
Finance income	9	**237**	**317**	654
Other revenue	5	**8,594**	**8,354**	8,890
Total income		**984,996**	**953,259**	896,131
Less expenditure				
Employee expenses	7	**332,492**	**322,110**	312,347
Depreciation and amortisation expense	14,15	**23,552**	**23,649**	21,225
Outsourced services		**57,513**	**43,157**	37,897
Clinical supplies		**77,155**	**75,830**	70,368
Other district health boards		**89,267**	**84,506**	82,462
Non-health board provider payments		**371,423**	**354,800**	344,716
Non-clinical expenses	8	**47,014**	**39,673**	45,515
Finance costs	9	**12,251**	**14,916**	15,263
Total operating expenditure		**1,010,667**	**958,641**	929,793
Share of joint ventures surplus/(deficit)	17	**136**	**-**	(15)
Surplus/(deficit)		**(25,535)**	**(5,382)**	(33,677)
Other comprehensive revenue and expense				
Items that will not be reclassified to surplus/(deficit)				
Gains/(losses) on property revaluations		**107,861**	**-**	26,184
Total other comprehensive income		**107,861**	**-**	26,184
Total comprehensive income		**82,326**	**(5,382)**	(7,493)

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 2021

	Note	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
ASSETS				
Current assets				
Cash and cash equivalents	10	**8**	**6**	2,429
Trade and other receivables	12	**47,413**	**33,960**	36,059
Inventories	13	**3,716**	**2,947**	3,133
Total current assets		**51,137**	**36,913**	41,621
Non-current assets				
Investments in joint ventures	17	**564**	**443**	428
Other investments		**304**	**304**	305
Property, plant and equipment	14	**409,209**	**302,685**	304,380
Intangible assets	15	**18,700**	**14,029**	16,672
Total non-current assets		**428,777**	**317,461**	321,785
Total assets		**479,914**	**354,374**	363,406
LIABILITIES				
Current liabilities				
Trade and other payables	19	**64,189**	**45,751**	53,169
Borrowings	20	**15,552**	**(281)**	57
Employee benefits liabilities	18	**48,427**	**41,631**	43,894
Provisions	21	**14,952**	**-**	12,480
Total current liabilities		**143,120**	**87,101**	109,600
Non-current liabilities				
Borrowings	20	**246**	**-**	302
Employee benefits liabilities	18	**1,614**	**1,676**	1,682
Total non-current liabilities		**1,860**	**1,676**	1,984
Total liabilities		**144,980**	**88,777**	111,584
Net assets		**334,934**	**265,597**	251,822
EQUITY				
Crown equity		**224,057**	**223,270**	223,271
Accumulated funds		**(84,199)**	**(54,888)**	(58,664)
Property revaluation reserve		**195,076**	**97,215**	87,215
Total equity		**334,934**	**265,597**	251,822
Total equity		**334,934**	**265,597**	251,822

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

Sharon Shea

Ron Scott

STATEMENT OF CHANGES IN NET ASSETS/ EQUITY
For the year ended 30 June 2021

	Crown equity $'000	Property revaluation reserve $'000	Retained earnings $'000	Total $'000
Balance as at 1 July 2020	223,271	87,215	(58,664)	251,822
Comprehensive revenue and expense				
Surplus or deficit for the year	-	-	(25,535)	(25,535)
Gain on the revaluation of land and buildings	-	107,861	-	107,861
Total comprehensive revenue and expense	-	107,861	(25,535)	82,326
Transactions with owners				
Contribution from the Crown	786	-	-	786
Total transactions with owners	786	-	-	786
Balance as at 30 June 2021	224,057	195,076	(84,199)	334,934

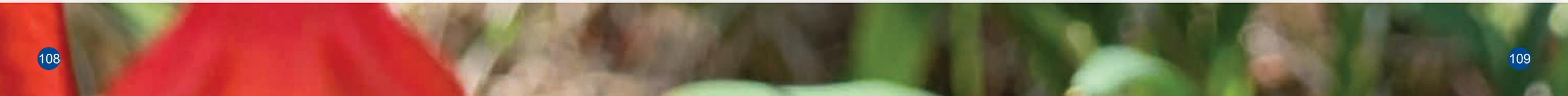
	Crown equity $'000	Property revaluation reserve $'000	Retained earnings $'000	Total $'000
Balance as at 1 July 2019	223,271	61,031	(24,987)	259,315
Comprehensive revenue and expense				
Surplus or deficit for the year	-	-	(33,677)	(33,677)
Gain on the revaluation of land and buildings	-	26,184	-	26,184
Total comprehensive revenue and expense	-	26,184	(33,677)	(7,493)
Balance as at 30 June 2020	223,271	87,215	(58,664)	251,822

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 2021

	Note	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
Cash flows from operating activities				
Receipts from Crown and patients		**975,544**	**946,423**	893,737
Interest received		**221**	**317**	774
GST (net)		**(180)**	**643**	659
Payments to suppliers		**(634,805)**	**(593,609)**	(585,995)
Payments to employees		**(324,808)**	**(318,102)**	(293,533)
Capital charge paid		**(12,207)**	**(14,891)**	(15,249)
Net cash flow from operating activities	11	**3,765**	**20,781**	393
Receipts from sale of property, plant, and equipment		**128**	**(50)**	88
Purchase of property, plant and equipment		**(18,226)**	**(20,613)**	(14,251)
Purchase of intangible assets		**(3,846)**	**(2,909)**	(5,040)
Net cash flow from investing activities		**(21,944)**	**(23,572)**	(19,203)
Cash flows from financing activities				
Capital contributions from the Crown		**320**	**-**	-
Payments of principal for finance leases		**(57)**	**-**	(38)
Net cash flow from financing activities		**263**	**-**	(38)
Net increase/(decrease) in cash and cash equivalents		**(17,916)**	**(2,791)**	(18,848)
Cash and cash equivalents at the beginning of the year	10	**2,429**	**3,078**	21,277
Cash and cash equivalents at the end of the year	10	**(15,487)**	**287**	**2,429**

Cash at bank and in hand	10	8	-6	7
Call deposits	10	-	-281	2,422
Bank overdrafts	20	(15,495)	--	-
		(15,487)	**-287**	**2,429**



NOTES TO THE FINANCIAL STATEMENTS

1. Statement of accounting policies for the year ended 30 June 2021

1.1 Reporting entity

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

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

The financial statements of Bay of Plenty DHB incorporate Bay of Plenty DHB and Bay of Plenty DHB's interest in 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 _____.

2. Summary of significant accounting policies

2.1 Basis of preparation

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

Health sector reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Maori Health Authority will monitor the state of Maori health and commission services directly. Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022. Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and Cash flow forecast

The Board has considered the current year's deficit of $25.5m and the forecasted deficit of $30m for the 2021/22 financial year together with forecast information relating to operational viability and investing cash flow requirements of the DHB. The cash flow forecast for the 2021/22 year prepared by the DHB reflects that equity funding, potential lease funding, together with the working capital facilities may be required to meet cash requirements. The cash flow forecast is updated regularly and reviewed by both the Board and Ministry of Health. The Board is confident that cash requirements can be met without breaching covenants or borrowing restrictions through careful management of the cash flow. Further, the Board has taken assurance from the letter of comfort that the Ministry of Health would provide short-term cash assistance or, if appropriate, equity funding if required. However, if the DHB was required to settle the holiday pay liability disclosed in note 21 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with the DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

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.

Critical accounting estimates

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

2.2 Reclassification of comparative figures

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

2.3 Non-derivative financial instruments

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

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

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

2.3.1 Financial assets

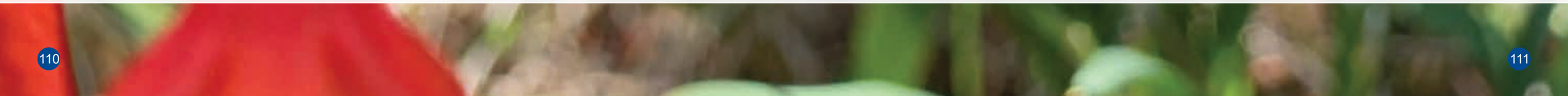
Cash and cash equivalents, receivables and investments in joint ventures under 2.5,2.9 and 2.4 respectively.

2.3.2 Financial liabilities

Payables and accruals are described under 2.10

2.4 Cash and cash equivalents

Cash and cash equivalents include cash on hand and deposits held at call with banks with original maturities of three months or less.
Bank overdrafts are shown within interest bearing liabilities in current liabilities in the statement of financial position.
Bank overdrafts that are repayable on demand and form an integral part of the Bay of Plenty DHB's cash management are included as a component of cash and



cash equivalents for the purpose of the statement of cash flows.

2.5 Trade and other receivables

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

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

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

Previous accounting policy for impairment of trade and other receivables

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

The expected credit loss rates for receivables at 30 June 2021 and 1 July 2020 are based on the payment profile of revenue on credit over the prior 2 years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

2.6 Inventory

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

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

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

2.7 Property, plant and equipment

Property, plant, and equipment consist of:

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

Revaluation

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

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

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

Additions

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

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

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

Depreciation

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

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

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

Freehold land and work in progress are not depreciated.

Subsequent costs

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

Disposals

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

COVID-19

The DHB is required to revalue its land and buildings at least every 3 years. The DHB engaged an independent valuer to perform the required 2021 revaluation. Their assessment considered market evidence which includes but is not limited to the impacts of Covid 19, resulting in an increase in the carrying values of both land and buildings. This was an increase of $107.8m from the high level valuation review that was recognised in the 2020 financial statements.

2.8 Intangible assets

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

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

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

Realised gains and losses arising from the disposal of intangible assets are recognised in statement of comprehensive revenue and expense in the year in which the disposal occurs.

Intangible assets comprise:

Computer software

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

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

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

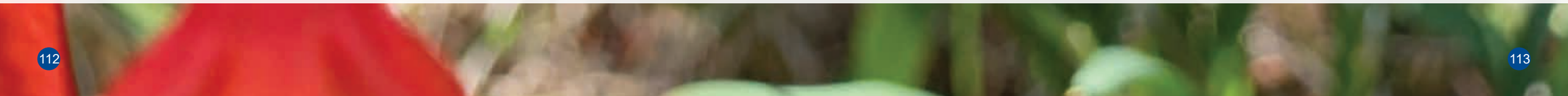
Staff training costs are recognised as an expense when incurred.

Finance Procurement Supply Chain, including Finance Procurement and Information Management (FPIM)

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

Amortisation

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



the surplus or deficit.

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

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

2.9 Joint ventures

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

2.10 Trade and other payables

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

2.11 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.

Long term employee entitlements

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

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

Presentation of employee entitlements

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

(i) Defined contribution schemes

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

(ii) Wages and salaries, annual leave, sick leave and medical education leave

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

(iii) Long service leave

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

2.12 Provisions

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

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

2.13 Equity

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

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

Property revaluation reserves

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

2.14 Income tax

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

2.15 Goods and services tax

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

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

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

2.16 Revenue

Revenue is measured at fair value.

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

(i) Crown funding

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

(ii) ACC contracted revenue

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

(iii) Goods sold and services rendered

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

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

(iv) Revenue relating to service contracts

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

(v) Financing revenue

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

(vi) Inter District Flow Revenue

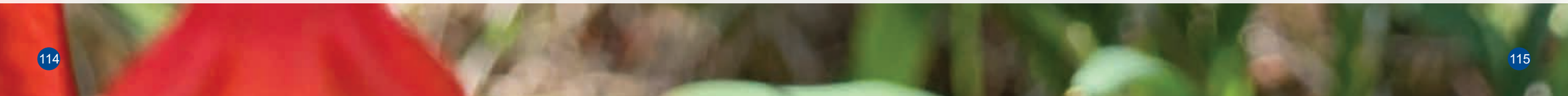
Inter District Flow revenue is received for activity undertaken by Bay of Plenty DHB for patients domiciled in other DHB regions. Receipts are based on an agreed level of production and are subject to wash up rules if actual volumes are different to agreed volumes.

2.17 Leases

(i) Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the start of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.



The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the Entity will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

(ii) Operating leases

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

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

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

2.18 Financing costs

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

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

2.19 Budget figures

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

2.20 Cost allocation

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

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

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

3. Critical Accounting Estimates and Judgements

Critical accounting estimates and assumptions

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

Fair value of land and buildings

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

Useful lives of property, plant and equipment

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

Impairment of intangible assets

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

Estimation of Employee Entitlement Accruals

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

Compliance with Holidays Act 2003

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

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability. The BOPDHB has included an estimated liability in note 21.

Other Provision

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

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

4. Crown revenue

	Actual 2021 $'000	Actual 2020 $'000
Crown appropriation revenue	**904,431**	819,146
Inter-district patient inflows	**23,201**	20,411
Crown non appropriation revenue	**48,533**	47,030
Total Crown revenue	**976,165**	886,587

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 2021 $'000	Actual 2020 $'000
Donations and bequests received	**136**	68
Other revenue	**7,843**	8,096
Rental income from investment properties	**615**	726
	8,594	8,890

6. Exchange versus non exchange revenue

	Actual 2021 $'000	Actual 2020 $'000
Exchange revenue	**78,330**	55,836
Non-exchange revenue	**906,666**	840,295
	984,996	896,131

7. Employee benefit costs

	Actual 2021 $'000	Actual 2020 $'000
Salaries and wages	**315,356**	284,251
Defined contribution plan employer contributions	**10,199**	9,224
Increase/(decrease) in employee entitlements/liabilities	**6,937**	18,872
Total personnel costs	**332,492**	312,347

8. Non clinical expenses

	Actual 2021 $'000	Actual 2020 $'000
Fees to Deloitte for financial statements audit	**186**	181
Impairment of receivables	**190**	243
Operating lease expenses	**6,766**	6,614
Infrastructure servicing costs and other sundry expenses	**39,662**	38,178
Directors' fees	**290**	273
Koha	**27**	39
Loss/(gain) on sale of assets	**(107)**	(13)
Total other expenses	**47,014**	45,515

9. Finance income and finance costs

	Actual 2021 $'000	Actual 2020 $'000
Finance income		
Interest income	**237**	654
Total finance income	**237**	654
Finance costs		
Interest expense	**31**	-
Bank charges	**13**	14
Capital charge	**12,207**	15,249
Total finance costs	**12,251**	15,263
Net finance costs	**12,014**	14,609

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 2021 was 5% (2020: 6%).

10. Cash and cash equivalents

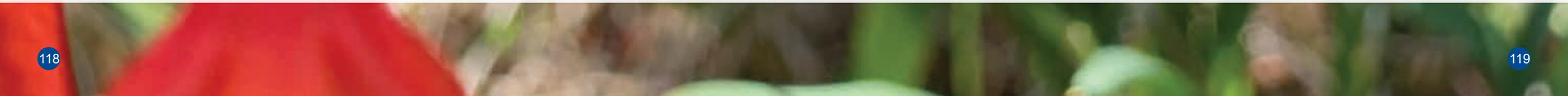
	Actual 2021 $'000	Actual 2020 $'000
Cash at bank and in hand	**8**	7
Call deposits	**-**	2,422
Total cash and cash equivalents	**8**	2,429

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 2021 $'000	Actual 2020 $'000
Surplus/(deficit)	**(25,535)**	(33,677)
Add/(less) non-cash items		
Share of joint ventures (surplus)/deficit	**(136)**	15
Share of other investment surplus	**-**	59
Depreciation and amortisation expense	**23,552**	21,225
Impairment on intangibles	**-**	-
Total non-cash items	**23,416**	21,299
Add/(less) items classified as investing or financing activities		
(Gains)/losses on disposal of property, plant, and equipment	**(128)**	(88)
Total items classified as investing or financing activities	**(128)**	(88)
Add/(less) movements in working capital items		
(Increase)/Decrease in receivables	**(9,060)**	(4,659)
(Increase)/Decrease in inventory	**(583)**	(47)
Increase/(Decrease) in payables and employee benefit liabilities	**15,655**	17,565
Net movement in working capital items	**6,012**	12,859
Net cash inflow/(outflow) from operating activities	**3,765**	393



12. Trade and other receivables

	Actual 2021 $'000	Actual 2020 $'000
Trade receivables from non-related parties	**1,354**	1,344
Expected credit loss	**(194)**	(264)
Amounts due from related parties	**263**	435
Crown and Ministry of Health receivables	**30,797**	23,956
Accrued income	**13,106**	9,164
Prepayments	**2,087**	1,424
Total debtors and other receivables	**47,413**	36,059
Receivables from exchange transactions	**14,824**	14,386
Receivables from non-exchange transactions	**32,589**	21,673
	47,413	36,059

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

Due to the large number of other receivables, the assessment for 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 2021 $'000	Actual 2020 $'000
At 1 July	**(264)**	(296)
Movement in expected credit losses on recognised receivables	**70**	32
At 30 June	**(194)**	(264)

13. Inventories

	Actual 2021 $'000	Actual 2020 $'000
Central stores	**2,548**	2,006
Pharmaceuticals	**1,168**	975
Other supplies	**-**	152
	3,716	3,133

Inventories are recognised at their historical cost. Inventories recognised in the profit or loss amounted to $42,052,617 (2020: $37,894,766)

No inventories are pledged as security for liabilities (2020: nil). However, some inventories are subject to retention of title clauses.

14. Property, plant and equipment

Cost/valuation	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2019	**14,605**	**257,684**	**4,968**	**79,165**	**3,501**	**359,923**
Revaluation surplus	-	(958)	-	-	-	(958)
Additions	-	6,095	29	5,549	13,501	25,174
Disposals	-	-	(59)	(5,568)	-	(5,627)
Capitalised	-	-	-	-	(11,673)	(11,673)
Balance as at 30 June 2020	**14,605**	**262,821**	**4,938**	**79,146**	**5,329**	**366,839**

	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2020	**14,605**	**262,821**	**4,938**	**79,146**	**5,329**	**366,839**
Revaluation Surplus	34,330	57,957	-	-	-	92,287
Additions	-	2,986	74	8,406	18,607	30,073
Disposals	-	-	-	(4,943)	-	(4,943)
Capitalised	-	-	-	-	(11,465)	(11,465)
Transfers	-	(191)	190	-	-	(1)
Balance as at 30 June 2021	**48,935**	**323,573**	**5,202**	**82,609**	**12,471**	**472,790**

Accumulated depreciation	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2019	**-**	**(13,252)**	**(1,696)**	**(60,393)**	**-**	**(75,341)**
Depreciation charge	-	(13,890)	(199)	(5,756)	(28)	(19,873)
Elimination on revaluation	-	27,142	-	-	-	27,142
Disposals	-	-	59	5,554	-	5,613
Transfers	-	-	-	-	-	-
Balance as at 30 June 2020	**-**	**-**	**(1,836)**	**(60,595)**	**(28)**	**(62,459)**

	Land at valuation $'000	Buildings at valuation $'000	Leasehold improvements $'000	Plant, equipment and vehicles $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2020	**-**	**-**	**(1,836)**	**(60,595)**	**(28)**	**(62,459)**
Depreciation charge	-	(15,595)	(218)	(5,816)	-	(21,629)
Elimination on revaluation	-	15,574	-	-	-	15,574
Disposals	-	-	-	4,905	-	4,905
Transfers	-	12	(12)	-	28	28
Balance as at 30 June 2021	**-**	**(9)**	**(2,066)**	**(61,506)**	**-**	**(63,581)**
Net book value						
As at 30 June 2020	**14,605**	**262,821**	**3,102**	**18,551**	**5,301**	**304,380**
As at 30 June 2021	**48,935**	**323,564**	**3,136**	**21,103**	**12,471**	**409,209**

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 RS Valuation Limited and a member of the New Zealand Institute of Valuers. The valuation is effective as at 30 June 2021.

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.

Impairment

No impairment losses have been recognised by Bay of Plenty DHB during 2021 in relation to property, plant and equipment (2020: nil).

15. Intangible assets

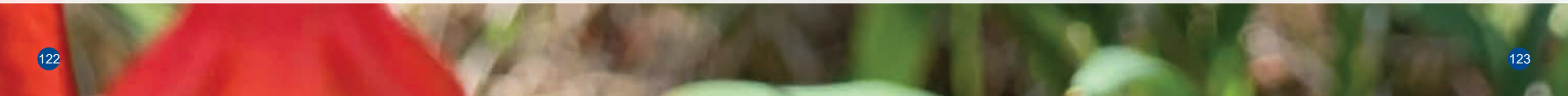
Gross carrying amount	**Computer software $'000**	**Others $'000**	**Work in Progress $'000**	**Total $'000**
Balance as at 1 July 2019	**15,145**	**1,722**	**5,380**	**22,247**
Additions	847	-	5,989	6,836
Disposals	(1,123)	-	-	(1,123)
Capitalised	-	-	(847)	(847)
	-	-	-	-
Balance as at 30 June 2020	**14,869**	**1,722**	**10,522**	**27,113**

	Computer software $'000	**Others $'000**	**Work in Progress $'000**	**Total $'000**
Balance as at 1 July 2020	**14,869**	**1,722**	**10,522**	**27,113**
Additions	10,672	-	3,979	14,651
Impairment charge	-	-	-	-
Capitalised	-	-	(10,672)	(10,672)
Transfers	-	-	-	-
Balance as at 30 June 2021	**25,541**	**1,722**	**3,829**	**31,092**

Accumulated amortisation and impairment	**Computer software $'000**	**Others $'000**	**Work in Progress $'000**	**Total $'000**
Balance as at 1 July 2019	**(10,213)**	**-**	**-**	**(10,213)**
Amortisation charge for the year	(1,230)	(122)	-	(1,352)
Disposals	1,124	-	-	1,124
Balance as at 30 June 2020	**(10,319)**	**(122)**	**-**	**(10,441)**

	Computer software $'000	**Others $'000**	**Work in Progress $'000**	**Total $'000**
Balance as at 1 July 2020	**(10,319)**	**(122)**	**-**	**(10,441)**
Amortisation charge for the year	(1,829)	(122)	-	(1,951)
Transfers	-	-	-	-
Balance as at 30 June 2021	**(12,148)**	**(244)**	**-**	**(12,392)**

	Computer software $'000	**Others $'000**	**Work in Progress $'000**	**Total $'000**
Net book value				
As at 30 June 2020	**4,550**	**1,600**	**10,522**	**16,672**
As at 30 June 2021	**13,393**	**1,478**	**3,829**	**18,700**



16. Investments in associates

(a) Investment in associate entities

The investment with Venturo Limited was exited in July 2019. There was no interest held as at 30 June 2021 and 30 June 2020. The table below shows the movement in the investment from 1 July 2019 to 30 June 2021.

	Actual 2021 $'000	Actual 2020 $'000
Carrying amount at the beginning of the year	**-**	60
Other impairment losses	**-**	(60)
Carrying amount at the end of the year	**-**	-

17. Investments in joint ventures

(a) General information

Name of entity	**Principal activities**	**Interest held at 2021 %**	**2020 %**	**Balance date**
HealthShare Limited		**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**
2021					
HealthShare Limited	**37,274**	**33,908**	**3,365**	**21,352**	**1,205**
2020					
HealthShare Limited	37,604	35,459	2,145	18,630	(72)

(c) Share of profit of joint ventures

	Actual 2021 $'000	Actual 2020 $'000
Share of profit/(loss) before tax	**136**	(15)
Tax expense	**-**	-
Share of profit/(loss) after tax	**136**	(15)

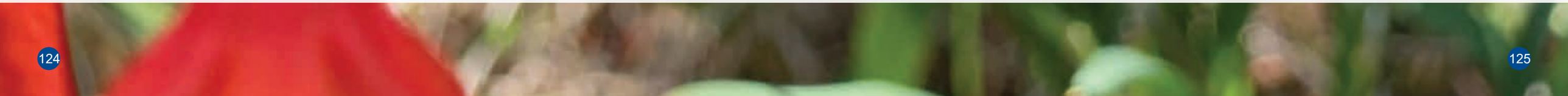
(d) Investment in joint ventures

	Actual 2021 $'000	Actual 2020 $'000
Carrying amount at the beginning of the year	**428**	443
Share of total recognised revenue and expenses	**136**	(15)
Carrying amount at the end of the year	**564**	428

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

There are no contingent liabilities and commitments at year end (2020: nil).

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



18. Employee entitlements

	Actual 2021 $'000	Actual 2020 $'000
Current portion		
Annual leave	**35,673**	32,362
Long service leave	**1,625**	1,694
Salary and wages accrual	**11,129**	9,838
Total current portion	**48,427**	43,894
Non-current portion		
Long service leave	**1,614**	1,682
Total non-current portion	**1,614**	1,682
Total employee entitlements	**50,041**	45,576

19. Trade and other payables

	Actual 2021 $'000	Actual 2020 $'000
Trade payables	**2,444**	4,129
ACC levy payable	**500**	378
Accrued expenses	**47,535**	37,028
Amounts due to related parties	**299**	112
PAYE payable	**3,976**	3,557
Income received in advance	**5,645**	3,995
GST payable	**3,790**	3,970
Total creditors and other payables	**64,189**	53,169
Payables from exchange transactions	**55,923**	45,264
Payables from non-exchange transactions	**8,266**	7,905
	64,189	53,169

20. Borrowings

All borrowings are measured at amortised cost.

	Actual 2021 $'000	Actual 2020 $'000
Current portion		
Secured		
Bank overdrafts	**15,495**	-
Finance lease liabilities	**57**	57
Total current portion	**15,552**	57
Non-current portion		
Finance lease liabilities	**246**	302
Total non-current portion	**246**	302
Total borrowings	**15,798**	359

Analysis of finance leases

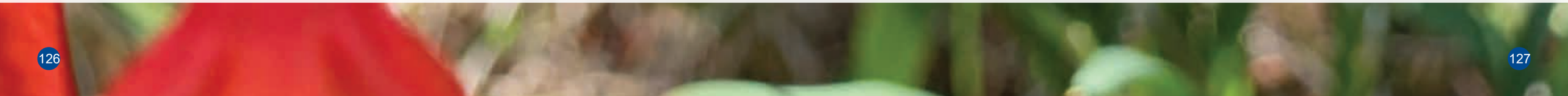
	Actual 2021 $'000	Actual 2020 $'000
Total minimum lease payments payable		
Not later than one year	**57**	57
Later than one year and not later than five years	**226**	227
Later than five years	**19**	75
Total minimum lease payments	**302**	359
Present value of minimum lease payments	**302**	359
Present value of minimum lease payments payable		
Not later than one year	**57**	57
Later than one year and not later than five years	**226**	227
Later than five years	**19**	75
Total present value of minimum lease payments	**302**	359

Finance leases as lessee

Finance leases are for various items of plant and equipment. The net carrying amount of the plant and equipment held under finance leases is $138,556 (2020: $182,121).

Finance leases can be renewed at the Bay of Plenty DHB's option, with rents set by reference to current market rates for items of equivalent age and condition. The Bay of Plenty DHB does have the option to purchase the assets at the end of the lease terms.

There are no restrictions placed on the Bay of Plenty DHB by any of the finance leasing arrangements.



21. Provisions

Movements in provisions are as follows

	Holiday Act provisions $'000	Other provisions $'000	Total $'000
2020			
Current			
Balance as at 1 July 2019	2,239	2,593	4,832
Use of provisions	-	(2,352)	(2,352)
Additional provisions and increases to existing provisions	10,000	-	10,000
Balance as at 30 June 2020	12,239	241	12,480

	Holiday Act provisions $'000	Other provisions $'000	Total $'000
2021			
Balance as at 1 July 2020	12,239	241	12,480
Use of provisions	-	(241)	(241)
Additional provisions and increases to existing provisions	2,713	-	2,713
Balance as at 30 June 2021	14,952	-	14,952

Compliance with the Holidays Act 2003

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2021, in preparing these financial statements, Bay of Plenty DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties. The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

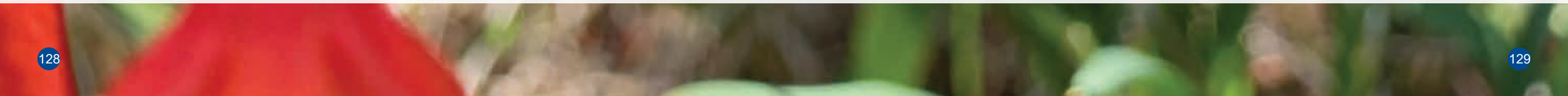
22. Operating and capital commitments

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 2021 $'000	Actual 2020 $'000
Not later than one year	**3,892**	2,662
Later than one year and not later than five years	**7,406**	4,963
Later than five years	**6,225**	1,435
Total non-cancellable operating leases	**17,523**	9,060

During the year ended 30 June 2021 $4,553,527 of operating leases were recognised as an expense in the profit or loss, split between clinical expenses and non-clinical expenses (2020: $3,876,243).



23. Financial instruments

Credit risk

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

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

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The MoH is the largest debtor (approximately 69%). It is assessed as a low risk and high quality entity due to being a government funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets

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

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

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

	2021 Gross Receivable $'000	2020 Gross Receivable $'000	**2021 Impairment $'000**	2020 Impairment $'000
Not past due	**3,772**	4,965	**-**	-
Past due 0-30 days	**118**	273	**-**	-
Past due 31-120 days	**619**	907	**-**	-
Past due 121-360 days	**738**	1,423	**(194)**	(264)
Total	**5,247**	7,568	**(194)**	(264)

	Actual 2021 $'000	Actual 2020 $'000
Trade receivables		
Gross trade receivables	**5,247**	7,568
Individual impairment	**(194)**	(264)
Net total trade receivables	**5,053**	7,304

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**
2021							
Payables and accruals	59,913	-	-	-	-	59,913	59,913
Finance leases	28	28	57	170	19	302	302
Total financial liabilities	59,941	28	57	170	19	60,215	60,215
2020							
Payables and accruals	49,500	-	-	-	-	49,500	49,500
Finance leases	28	29	57	170	75	359	359
Total financial liabilities	49,528	29	57	170	75	49,859	49,859

Classification and fair values

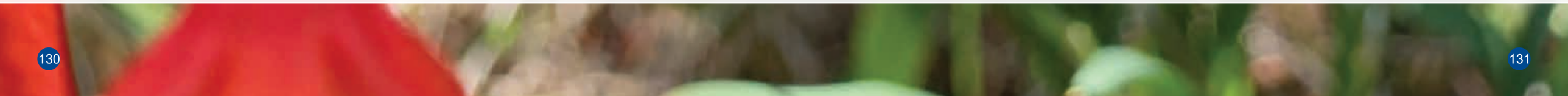
The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows:

	Financial assets at amortised cost $'000	**Financial liabilities at amortised cost $'000**	**Carrying amount $'000**	**Fair value $'000**
2021				
Cash and cash equivalents	8	(15,495)	(15,487)	(15,487)
Trade and other receivables	45,325	-	45,325	45,325
Trade and other payables	-	(59,913)	(59,913)	(59,913)
	45,333	**(75,408)**	**(30,075)**	**(30,075)**
2020				
Cash and cash equivalents	2,429	-	2,429	2,429
Trade and other receivables	34,635	-	34,635	34,635
Trade and other payables	-	(49,500)	(49,500)	(49,500)
	37,064	**(49,500)**	**(12,436)**	**(12,436)**

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.



24. 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 joint ventures

Other than disclosed elsewhere in the financial statements, 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 (2020: nil).

Transactions with key management personnel

Key management personnel compensation

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

	Actual 2021 $'000	Actual 2020 $'000
Board members		
Full-time equivalent members	**10**	11
Remuneration	**279**	273
Executive Management Team, including the Chief Executive		
Full-time equivalent members	**9**	6
Remuneration	**2,475**	1,749
Total full-time equivalent personnel	**19**	17
Total key management personnel compensation	**2,754**	2,022

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 (2020: 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 (2020: nil).

The Bay of Plenty DHB did not provide any loans to key management personnel or their close family members (2020: nil).

25. 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).

26. Impact of Covid-19 on the DHB

During August and September 2020 and February and March 2021, the Auckland Region moved into Alert Levels 3 and 2 and other parts of the country, which includes the DHB's service area, moved into Alert level 2. At Alert Level 2, the operating capacity of the DHB was reduced. At Alert Level 1, the DHB resumed to normal business activity and in some instances at a higher level than pre Covid 19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels. While the DHB has received funding for costs directly related to the COVID 19 response, COVID 19 has caused inevitable disruption to acute services and constraints on staffing resources available. This has both operational and financial implications, impacting on the services the DHB is able to provide to the local community and will continue to have longer term consequences.

Government funding

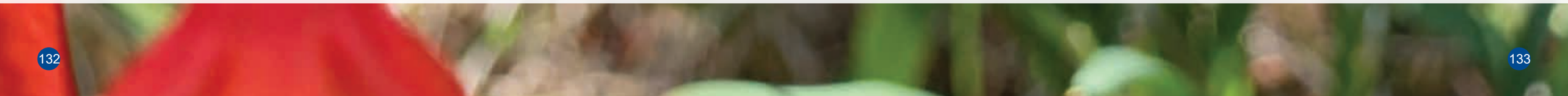
The DHB received funding of $18.5m to assist with the Covid 19 response. This included funding distributed through the DHB to Primary Health Organisations, pharmacies, and aged care providers.

Personnel expenses

Personnel expenses have increased due to an increase in permanent and casual staff, to support both COVID testing and the vaccination role out. Also, staff have taken less leave since the pandemic declaration, increasing the liability owing to staff for leave entitlements.

Other expenses

There was an increase in clinical and infrastructure and non clinical supply costs, mainly driven by the administration of the Covid 19 vaccine roll out such as leasing additional premises, hygienic and sanitation supplies, pharmaceutical, patient transport, security management, advertising, and communications.



08

Audit Report

Pūrongo Aotake Pūtea

Deloitte.

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF BAY OF PLENTY DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2021

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

We have audited:

- the financial statements of the Health Board on pages 106 to 133, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive income, statement of changes in 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 72 to 101 .

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the financial statements of the Health Board on pages 106 to 133:

- present fairly, in all material respects:
    - its financial position as at 30 June 2021; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and

Unmodified opinion on the performance information

In our opinion, the performance information of the Health Board on pages 72 to 101:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2021, 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.

Deloitte.

Our audit of the financial statements and the performance information was completed on 21 December 2021. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

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

As outlined in note 3 on page 117 and note 21 on page 128, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes a provision of $14.95 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the Health Board's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain adequate evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain adequate evidence of the $12.24 million provision as at 30 June 2020. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2020.

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

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

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

Emphasis of matters

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

The financial statements have been appropriately prepared on a disestablishment basis

Note 2.1 on page 110 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Health board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

The Health Board is reliant on financial support from the Crown

Note 2.1 on page 110 outlines that Crown support would be required if the Health Board was required to settle the estimated historical Holidays Act 2003 liability within the period of one year from approving these financial statements. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with financial support, where necessary.

Impact of Covid-19

Note 26 on page 133 to the financial statements outlines the ongoing impact of Covid-19 on the Health Board.

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

Pages 99 to 101 outlines the information used by the DHB to report on its Covid-19 vaccine coverage. The DHB uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in Pages 100 to 101. The notes outline that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The DHB has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 8 to 69, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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