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Bay of Plenty District Health Board

Annual Report 2022

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

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Ministerial Directions

BOPDHB complies with the following Ministerial Directions 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 2022

Produced in 2022
by the Bay of Plenty District Health Board
PO Box 12024, Tauranga 3143
www.bopdhb.govt.nz

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Bay of Plenty District Health Board

Annual Report 2022

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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.

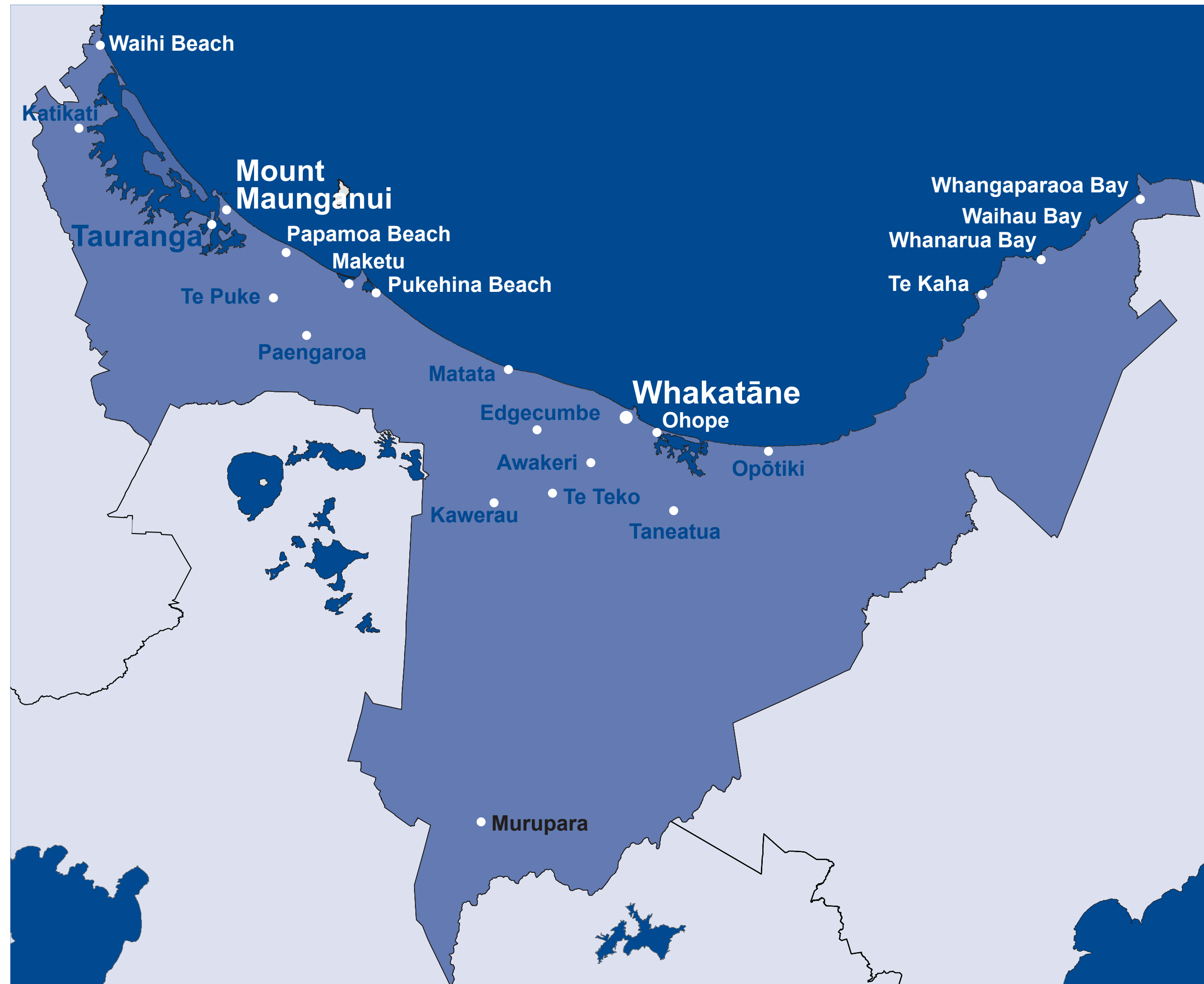
CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

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 Te Manawa Taki, the Midland region.

During the 2021/2022 year, the BOPDHB served a population of approximately 269,670[2] residents (213,300 living in Western Bay of Plenty, and 56,370 in the Eastern Bay of Plenty), for the major population centres of Tauranga, Katikati, Te Puke, Whakatāne, Kawerau and Ōpōtiki. Of this, 51% of people were over 40 years and 9.5% were under 14 years, and like the national population, the population continued to age (currently 21% aged 65 or over, and forecast to reach 23% in 2026). Eighteen Iwi are located within the district.

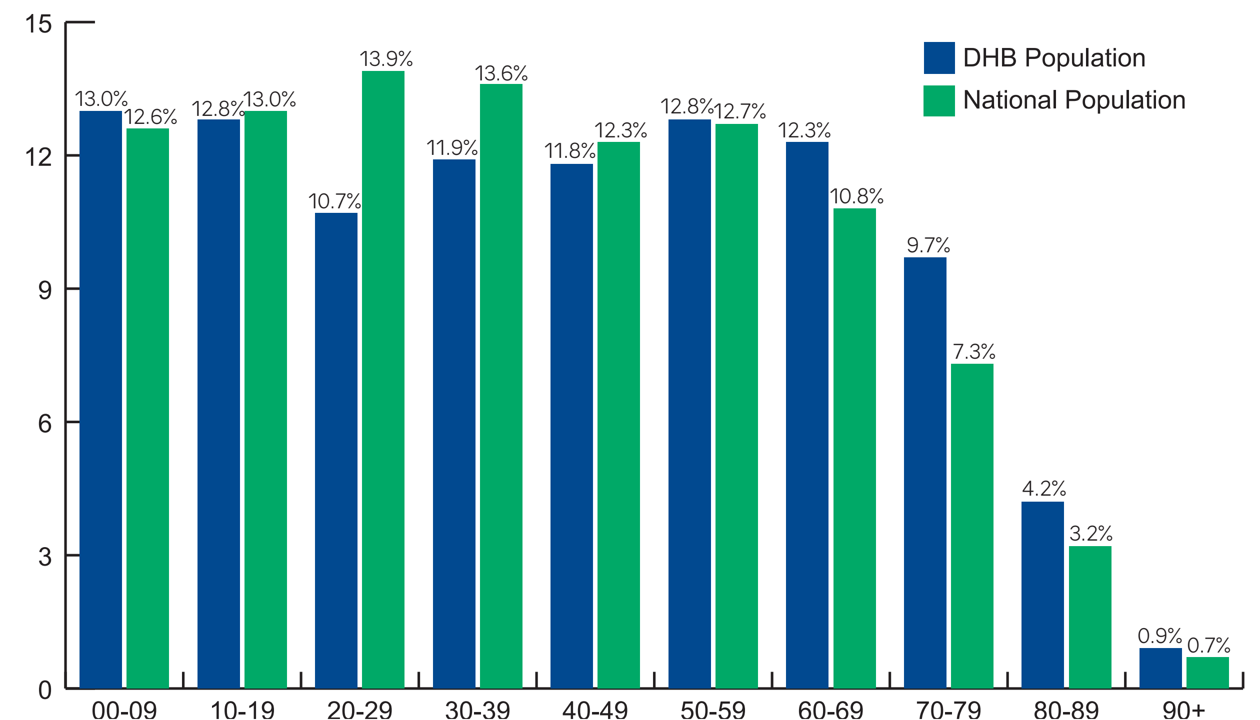
The Bay of Plenty (BOP) continues to grow at a faster rate than the New Zealand population, as a whole. The forecast for population growth from 2018 to 2028 is 12.7%, with the majority of the growth expected to be in the Western Bay of Plenty region (particularly Tauranga city) with the Eastern Bay of Plenty expected to experience a steady trend, Under 65 year population is declining in the Eastern Bay of Plenty. 79.1% of the population resides in the Western Bay of Plenty[3].

- The BOP is strongly bicultural with 26% of residents Māori[4], where it is 17% nationally.
- 21% of our residents are 65 or older. This is expected to grow to 22% by 2026. The over 90 age group in particular will grow from 6,690 to 7,890 people.
- According to the latest performance data on Better Help for Smokers to Quit Health Target,11.7% of the Bay of Plenty population are current smokers, out of which 75.5% have been given brief advice. This is higher than the national average of 67.3%
- 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 the strategic approach to achieving health outcomes. This will become more integrated and 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 2021/2022

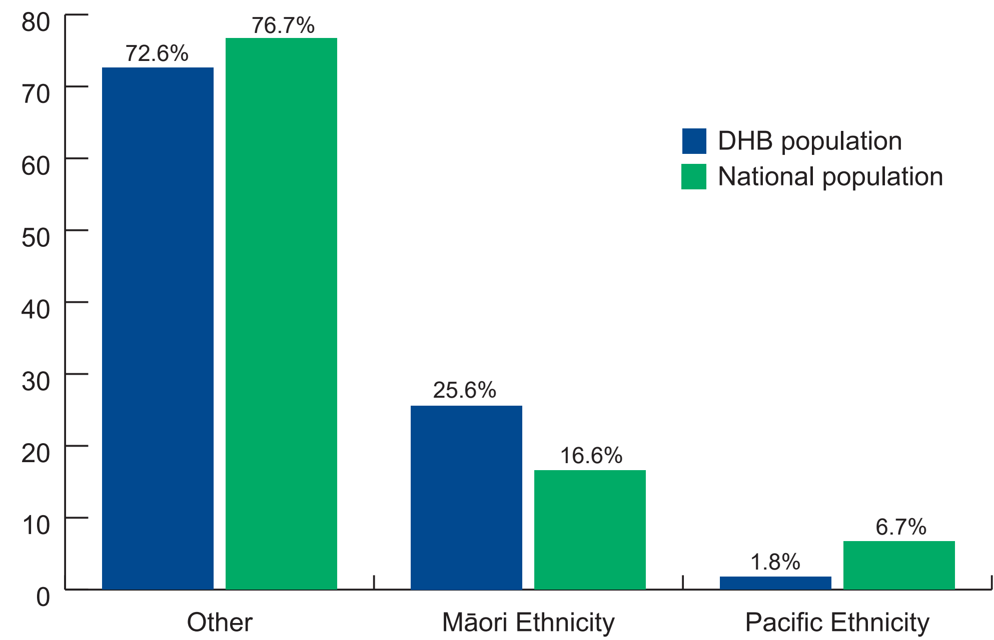
Bay of Plenty's population tends to be older than the national average[5].



2. MOH projected population for 2021/2022 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

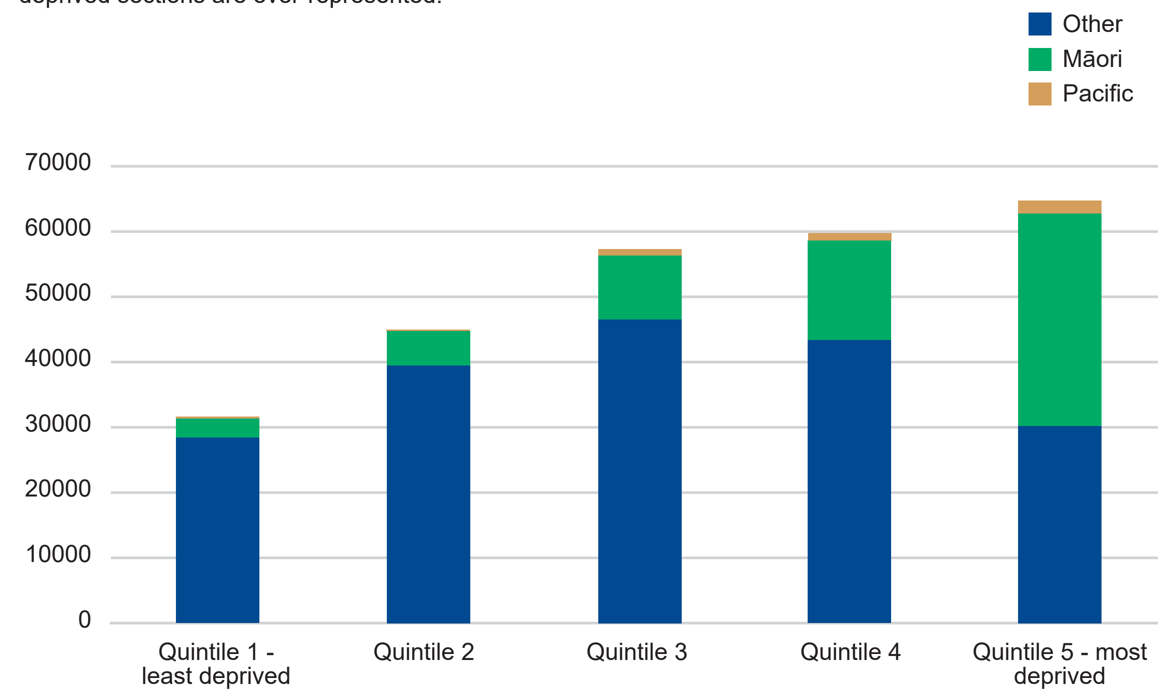
Ethnic mix 2021/2022

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



Deprivation 2021/2022

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 2021/2022, 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.

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 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.

2021/2022 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. Generally, our work goes unnoticed, as it should. Funding should not be the start of the conversation in matters pertaining to health. The role of Planning and Funding as an enabler is set to become more pronounced under the Health Reforms. Locality planning will soon give communities the opportunity to identify key priorities and work with Health NZ as to the best ways to address need.

As we move into a new era of Health Reforms it is important to acknowledge and build on the achievements of the past year, some of which are highlighted below.

Eastern Bay Locality Prototype

Planning and Funding worked with 3 Iwi leads in the Eastern Bay and other key stakeholders to develop a proposal that was one of nine selected nationally as a prototype for how Locality Planning could be progressed as a concept.

Whakatohea, Te Runanga o te Whanau and A Ngai Tai have collectively defined a concept of locality underpinned by a tribal ecosystem framework based on Māori knowledge, values and perspectives that distinguishes 'cultural values' from 'cultural services' and extends the definition of cultural values across the whole ecosystem services framework.

The proposed phased approach will commence at the sub-locality level and over a three-year period develop into a framework that will be available for use across the wider Eastern Bay region. The role of Planning and Funding was to support Iwi to lead out this piece of work.

Methamphetamine Harm Reduction Service Te Ahi Mauri

Based on a Northland model Te Ara Oranga, Te Ahi Mauri is a methamphetamine harm reduction programme that was successfully launched in the Murupara area during the past year.

The service involves non-clinical connector roles with lived experience of the harm caused by methamphetamine who can support those impacted by the drug to seek help. Health and NZ Police have partnered in this space and longer-term the current model of care will evolve through a mahi-tahi process of community engagement and co-design that is community led.

Future developments will see service options expand across the Eastern Bay of Plenty in way that complements the development of a residential rehab facility being progressed under via Proceeds of Crime funding.

Transitional Care Beds Project

Driven initially by the need to outfit inpatient wards to manage COVID-19 presentations, this initiative saw patients transitioned out into community-based beds as part of their journey home. Supported by both Medical and Allied Health teams, patients experienced Hospital level care in the community as appropriate, via a re-enablement model intent of early supported discharge home.

The potential to discharge patients and alleviate pressure on the Hospital wards was further enhanced with the advent of short-term respite agreements issued to aged residential care providers during the year. As with the transitional care project, the intent is short-term, focused interventions that enable patients to recover in a community-setting, closer to home.

Integrated Primary Mental Health and Addictions Roll-out Transitional Care Beds Project

This initiative involves the development of Mental Health support services within Primary Care via "Health Coaches" and "Health Improvement Practitioners" based in General Practice. The roll-out of these services has been embraced by GPs, particularly as the impact of the Pandemic on Mental Health and well-being has become more pronounced. The initiative has seen closer ties develop between Primary and Secondary Mental Health services and represents a forerunner to current thinking about the development of enhanced Primary Care teams as part of the Health Reforms. By the end of June next year, the service rollout will be completed and already data on the uptake of services by the community is demonstrating that this strategy of early intervention is making a real difference in the lives of those affected by Mental illness.

Gender Dynamix

This mahi focused on meeting the specific mental health service needs of the Transgender and Nonbinary community of the Bay of Plenty. The goal is to work with individuals and whānau to best meet their needs in a clinical manner reflective of national and international standards of care and LGBTQI+/Takatāpui cultural needs. Over the 2021/2022 funding year the service expanded for children and youth, with services now available in the Eastern Bay community . Work that the

service undertakes includes with psychology 1:1, gender counselling 1:1, and community pathways to transition. Of note is the expansion of services to include online support groups and face to face parallel groups for children, youth and for their families. A further new development has been in offering training and support to other organisations which aim to build capability in their work. The challenge of a fire and loss of a building has been responded to with strong support from the community for this excellent service which is making a difference.

Protected&Proud

In 2021/2022 we have 190% achievement against the Long-acting Reversable Contraception (LARC) target. 48% of our service users are wahine Maori and 1 in 3 women are aged under 25 years old.

Through Protected&Proud we have built a strong provider network (midwives, school nurses, iwi Hauora, pacific island provider, community nurses, general practices, hospital and tertiary education) which means we can help regions when they have staffing shortages. For example, in Murupara they no longer have a LARC practitioner in their GP so once per month another LARC provider travels to the region to support women to have their LARC there.

Since 2019 we have seen an increase in LARC provision in primary care, and a decrease in secondary care, which helps demonstrate a KPI set through our co-design process or providing LARCs closer to where women live.

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 of 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. This 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 2021-2022 including:

- E3 Acute Flow Programme (Eastern, Everyone, Excellence)
- First 2000 days/ Toi Oranga Mokopuna Programme
- Keeping Me Well Phase 2 Model of Care
- Community Care Coordination
- Shared Goals of Care
- Digital Enablement Programme
- Planned Care Initiatives
- Palliative Care Services Review
- Advanced Care Planning
- Safe Trache Management Pathway (Tracheostomy Pathway)
- DHB Suicide Prevention/Postvention Action Plan 2022/2023
- ED Suicide Prevention Referral Pathway
- Integrated Care Programme
- Child Health Integrated Response Pathway (CHIRP)
- Te Tauihi o te Waka – Optimising Leadership & Management of Acute Demand Programme.

Supporting and implementing sustainable changes, and improvements across the organisation is an aim of the Innovation and Improvement team. Examples of where the team have supported change and improvement include the below:

Orthopaedic Transformation Programme

A community-based orthopaedic triage service (COTS) model has been developed, piloted, and implemented for adults with non-urgent orthopaedic/MSKconditions across the BOP.

A paediatric orthopaedic triage service (POTS) model has been developed and is currently being piloted for tamariki (children) with non-urgent orthopaedic/MSK conditions across the BOP

An emergency department MSK physiotherapy service has been developed and is now fully operational in both Tauranga and Whakatāne During the past two and a half years, Innovation & Improvement has supported the Orthopaedic Transformation Programme in enabling people with musculoskeletal conditions to live well in the BOP. The programme focuses on utilising Allied Health

professionals in supporting those with MSK conditions through the promotion of early intervention, and ensuring only those who are appropriate for surgery are referred onto a surgical pathway. During the tenure of the programme:

- COTS clinicians have carried out 2465 assessments and 927 of those have resulted in on-referral for physiotherapy (a rehabilitative non-surgical management pathway).
- A further 789 of COTS assessments were deemed appropriate for surgical input and were therefore on-referred to Orthopaedics.

The newly developed services are now business as usual within Allied Health, so the involvement of Innovation & Improvement has concluded. This is an exciting new chapter where Allied Health services will continue to improve service model design and delivery to further support people with MSK conditions in the Bay of Plenty.

Digital Enablement Programme

The Innovation and Improvement Digital Enablement Programme, lead by Leanne Elder Programme Manager, aims to provide staff with technical tools, systems and knowledge to digitally enable and support BOPDHB staff to work with digital systems. The Programme will ensure consumer and whānau-focused choice and a smarter way of scheduling in-person and virtual appointments and improving the patient experience and sharing of knowledge across the sector in shared care planning.

The Programme Manager has recently recruited a Clinical Director of Telehealth, and a Telehealth Coordinator, to implement the Telehealth workstream. Their first task has been to test improvements in scheduling Zoom outpatient appointments with schedulers and clinicians. Following this, an 8-week project will take place to test these improvements. If successful, a service-by-service rollout will take place early next year. The Digital Enablement Project is leading the Scheduling and Shared Care projects applying a patient-focused system approach. Our Cross Sector Digital Architect, ensures efforts are connected across the secondary, primary and community services. There is also a focus on making sure our data and digital health systems are designed to enable a more seamless patient experience.

A community co-design hui on Matakana Island in December 2021 marked a new milestone in the journey to better connect island residents with health services using technology.

The hui, led by staff from the Western Bay of Plenty Primary Health Organisation with support from the Bay of Plenty District Health Board and Ministry of Health, was organised for Māori whānau and Te Awanui Hauora Trust to share their healthcare experiences on the island, specifically relating to accessing services.

The journey to improve access to health services on Matakana Island started in February 2020 during a community hui when residents first shared their healthcare experiences with the PHO. Since then, the PHO, DHB and Western Bay of Plenty District Council joined forces to provide the 8m high radio mast which was installed next to the Hauroa clinic in April, as well as 4Gnetwork technology, diagnostic equipment, and technical expertise.

Acute Demand Programme

The focus of the Acute Demand Programme has been on improving patient flow and strengthening relationships between allied services. Work in the 2021/2022 year has included refining the referral process between the hospital and the team at the Community Care Co-ordination (CCC) for short-term services and district nursing referral process, the 5 Patient Questions', the Well Organised Ward, patient observation units, blocked catheter Emergency Department presentations, staff engagement boards and the Transfer of Care Pathways being piloted on the Orthopaedic Ward.

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 2021/2022 year, significant work programmes continued, including 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 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 where the AHST workforce in the BOPDHB are delivering value- based healthcare:

- 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 LifeCurve™ app

  This app is based on international research, it is a free and simple-to-use phone and mobile device app which gives older adults the ability to live better by learning easy ways to stay active and independent. The LifeCurve™ app and website successfully launched in Aotearoa / New Zealand in April 2021. For the last 12 months the focus has been on partnership with Te Pare ō Toi, community engagement and incorporating the use of LifeCurve™ within Community Allied Health as an episodic and life course measure. A new version of LifeCurve™ is being co-designed in partnership with Māori and due for release in Aotearoa /New Zealand in late July/early August 2022. Adaptations to the new version of LifeCurve™ will include input from Kaupapa Māori research led by the team at Manawaora and a Te Ao Māori focus group from Hauora a Toi Bay of Plenty. The new LifeCurve™ digital service (app and citizen facing website) will be more user friendly, have a whānau focus and include Te Reo Māori as well as decision support for Māori aspirations for healthy ageing.
- Keeping Me Well

  In the last 12 months BOPDHB operationalised Allied Health led rehabilitation programmes in the community from hospital and the community as part of the Keeping Me Well concept. In addition, we have provided a transitional care pathway for those that cannot return home immediately but do not require acute hospital support – this has just reached its 1000th bed day since the trial was set up in October. Patients are now able to access strengths bases, restorative rehabilitation programmes delivered in the home that are based on 'what matters to them' with community services acting as an integrated team coordinated by community care coordination centre. This includes providing alternative access points in areas of high Māori population to ensure equitable access to rehabilitation services.
- Clinical settings

  The high occupancy of both hospitals and the acuity of patients has challenged Allied Health to try and work differently. To help meet the need of patients a weekend service is now provided with a physio in ED (Emergency Departments) at both sites and a Social Worker and Saturday Occupational Therapist in Tauranga. Our teams have all increased in FTE (Full Time Equivalent) in varying amounts which just reflects the growth in workload and the complexity of the patients. On the wards Allied Health staff and nurse navigators work closely to align treatment plans and discharge planning, this is work in progress. Outpatients have expanded across all disciplines and to align with our SHSP (Strategic Health Service Plan), clinics are held closer to home in a variety of community sites across the Bay.

Director of Nursing

2021/2022 has been dominated by workforce challenges in response to the COVID pandemic. National competition for new FTE via FTE calculations, combined with boarder closures and significant workforce shifts from acute hospitals to COVID community vaccination workforce contributed to unprecedent vacancy rates. Despite this Nursing, alongside the multidisciplinary team marshalled a powerful response to COVID in patient care and rapidly changing processes of care. Nursing across the district is to be commended and acknowledge for professional agility and responsiveness to the pandemic. Despite this challenging context there are distinct bright spots to convey. That is, in response to RN graduate feedback and attrition, additional Nurse Educator and RN Coach roles were implemented to support the graduates in their first year of practice having an immediate positive impact. Responsiveness of RN's in the community to re-enter the workforce to provide patient care support. An assessment conducted by Safe Staffing Healthy Workplaces Unit of BOPDHB's CCDM implementation against national standards resulted in the outcome of "fully implemented". A review of Infection Prevention and Control services across the district, whilst deferred for late 2021, is scheduled to occur in August 2022. The model of executive nursing leadership across the district was progressed with Chief Nursing Officer role appointed.

Chief Operations Officer

This year presented a substantial increase in complexity in providing health services to Bay of Plenty communities and central to navigating this has been the ongoing evolution of the Integrated Operating Centre.

During the 2021/2022 year, increasing vacancies across all areas, in parallel with; high unplanned leave and the outcome of staff vaccine mandates, resulted in significant impacts to the workforce and ability to deliver care. The management of this rapidly changing environment required prioritising acute flow of patients, a team care way of working as well as overtime and numerous short notice 12-hour shifts. Alternative approaches were put in place including an amazing response from many staff volunteering to being redeployed (clinical and non-clinical staff), employment of paramedics in emergency departments, Maori Wardens to support Tauranga hospital front door COVID-19 screening of visitors and patients and increased use of Allied Health in a range of roles. Additionally, some nursing staff were deployed to Auckland hospitals ICU to assist in their Delta outbreak and the flexible working policy enabled a range of staff to work from home.

Delta and Omicron COVID-19

The impact of the Delta and Omicron COVID-19 outbreaks (including community, inpatient, and staff exposure events), greater than forecast; volume and acuity of hospital presentations, acute surgery, admissions, and increasing vacancies across all areas provided significant pressure on the health system, hospital services, resources, and facilities capacity.

Undertaking Tauranga Hospital structural works to create negative pressure areas within the intensive care unit and an inpatient ward to provide for the pandemic response was a significant achievement in the context of high occupancy and staffing shortages. The use of the conference centre as transit lounge, and the transit lounge area converted to temporary ward, alongside the introduction of transitional care beds enabled this to occur. During the peak of COVID-19 surges these negative pressure inpatient areas were at capacity. The use of Perioperative and Medical Daystay areas for overflow has been crucial in times of very high occupancy.

Planned Care

High levels of planned care were disrupted due to consistent levels of high occupancy across both hospitals, high volumes of surgical acute presentations and the impact of COVID-19 on both inpatients and staffing. The process for enabling as much planned care as possible to be delivered required a daily review of theatre lists to match hospital resource availability (theatre, ward and ICU capacity and staffing) with a focus on priority-one cases (urgent and cancers). Outsourcing to private providers utilised whatever available capacity the region offered.

Many ambulatory services moved to telehealth, particularly through the COVID-19 surges and there has been a specific focus on maintaining telehealth as a key mode of service delivery. The Bowel Screening Programme was a very welcome launch in May for the Bay of Plenty.

Tauranga Hospital Masterplan

Following completion of the Hauora o Toi Bay of Plenty Clinical Services Plan we have commence planning for a new clinical services building. The new clinical services building drivers are both clinical demand and the fact we have seven clinical buildings that been classified as earthquake prone buildings and now have a limited occupation 12.5 years life.

Tauranga Hospital has been included on the Health NZ Regional Hospital Redevelopment Programme. There is a documented framework defining the steps to be followed for the completion of the indicative business case.

Sustainability at the BOPDHB 2021/2022

BOPDHB 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 (available on our website), 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.

The 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 mandating the Carbon Neutral Government Programme (CNGP), both of which have an impact on Te Whatu Ora.

Financial Year 1 July 2021 – 30 June 2022 Carbon Footprint Information

During the 2021/2022 financial year, BOPDHB saw an overall carbon footprint reduction of ~13% from the baseline year (FY 2018/2019) (see Table), a slight increase on last year, primarily due to air travel resuming. However, like FY 2020/2021, 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 12.7% decrease in emissions from natural gas, offset by a 12.7% increase in electricity use, due in part to HVAC installation.

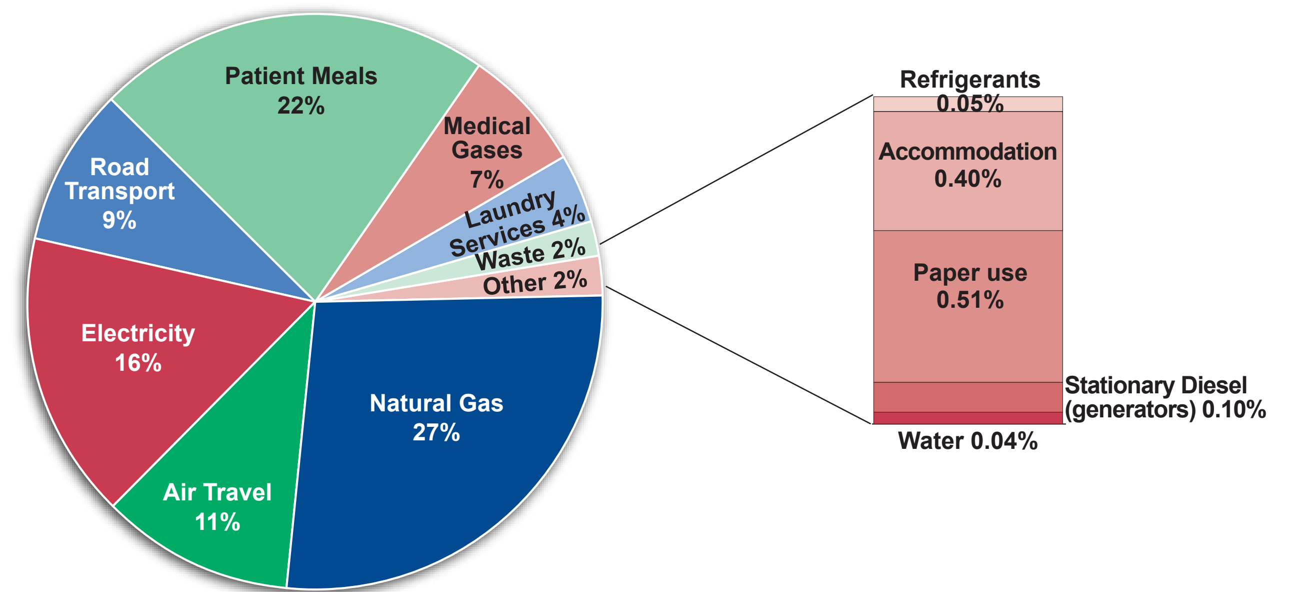
This year has seen a significant increase to the emissions factor used to determine the carbon footprint of patient meals. This has been retrospectively applied to previous years meaning an increase to the baseline year by over 1,100 tCO2-e. It has also meant changes to the significance of patient meals as an emissions source, putting total patient meals as the second largest source of emissions behind natural gas.

Moving forward, Te Whatu Ora will set targets on a national level and a new baseline will be created. Te Whatu Ora will also report nationally on progress towards these targets through its annual report as directed under the CNGP.

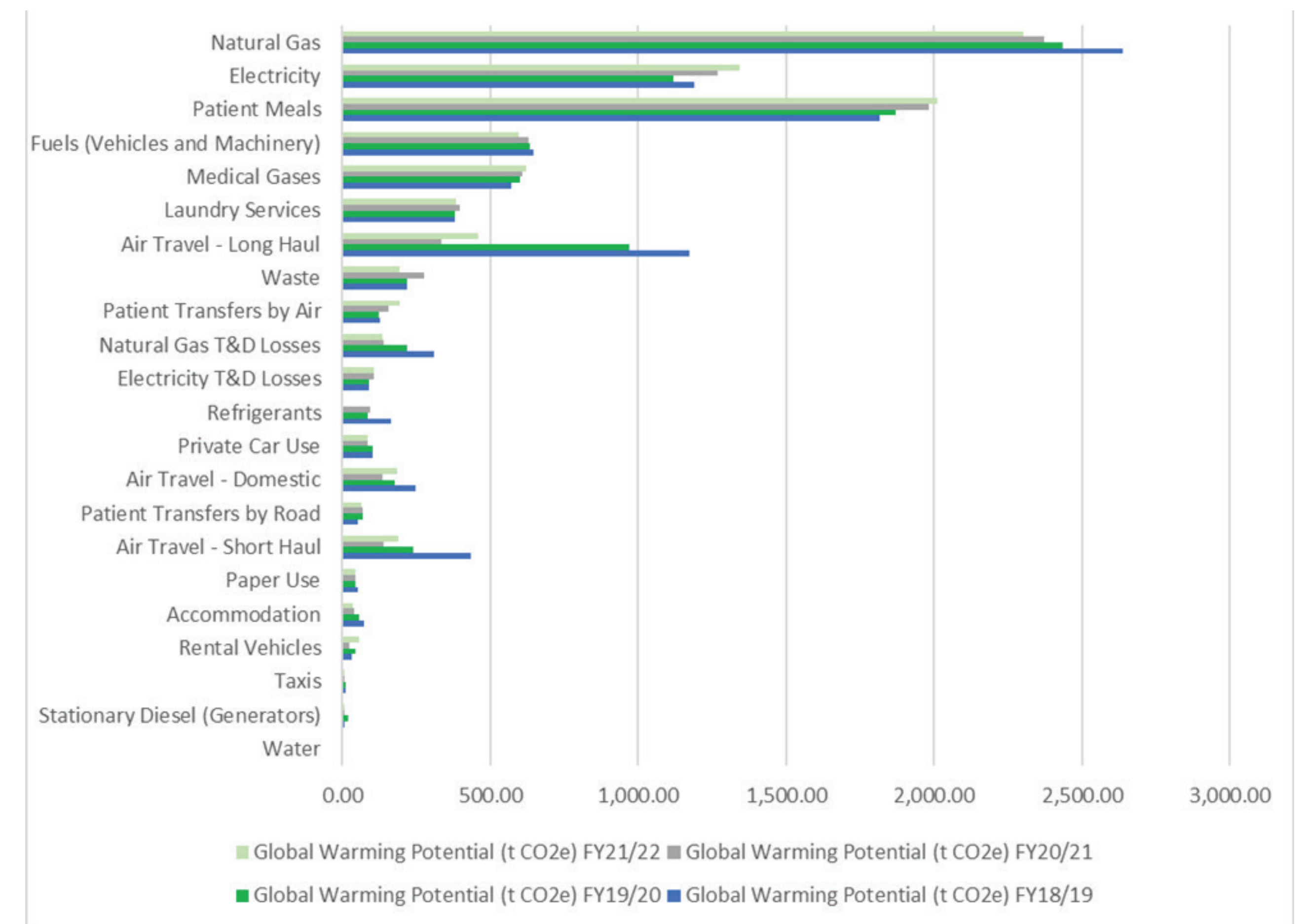
The graphs and table below illustrate the BOPDHB audited and verified carbon footprint, and emissions source information for the 2021/2022 Financial Year.

Changes in emissions activity FY 2021/2022 compared with baseline year			
Activity – Emission Source	**Global Warming Potential (t CO2e) FY 2020/2021**	**Global Warming Potential (t CO2e) FY 2018/2019 (Baseline)**	**Increase (+) / Reduction (-)**
Natural Gas	2636.87	2302.67	- 12.67%
Patient Meals	1817.43	2012.78	+ 10.75%
Electricity	1191.94	1343.32	+ 12.70%
Medical Gases	570.64	620.71	+ 8.77%
Fuels (Vehicles and Machinery)	646.87	596.94	- 7.72%
Air Travel - Long Haul	1173.90	459.61	- 60.85%
Laundry Services	379.52	384.64	+ 1.35%
Patient Transfers by Air	126.87	195.44	+ 54.04%
Waste	218.07	193.92	- 11.08%
Air Travel - Short Haul	436.88	188.98	- 56.74%
Air Travel - Domestic	248.86	186.49	- 25.06%
Natural Gas T&D Losses	309.12	136.74	- 55.77%
Electricity T&D Losses	90.28	109.10	+ 20.85%
Private Car Use	104.91	87.60	- 16.50%
Patient Transfers by Road	52.52	63.86	+ 21.59%
Rental Vehicles	33.37	56.29	+ 68.70%
Paper Use	51.79	46.47	- 10.28%
Accommodation	74.39	36.42	- 51.04%
Taxis	11.90	9.72	- 18.32%
Stationary Diesel (Generators)	8.67	9.63	+ 11.12%
Refrigerants	165.34	4.29	- 97.41%
Water	3.02	3.50	+ 15.90%
TOTAL	**9049.14**	**10,353.16**	**- 12.60 %**

GHG Emissions Source % of Total Carbon Footprint FY 2021/2022 (~7623 tCO_2e)



BOPDHB Carbon Footprint Year on Year Comparison (~7623 tCO_2e FY 2021/2022)[6]



BOPDHB Carbon Footprint FY 2021/2022 (~9049 tCO2-e) compared with FY 2020/2021 (~8949tCO2-e), FY 2019/2020 (~9526 tCO2-e) and baseline year FY 2018/2019 (~10353 tCO2-e)[6]

6. There have been changes to the previously reported footprints as better data was made available specifically relating to the emissions factors of patient meals.

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

The following goals were set for achievement over the past 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. COMPLETE. To be replaced by national approach.

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. To be embedded into national approach.

GOAL 4: Complete a climate related risk assessment enabling equitable health provision to be part of any climate change adaptation planning. COMPLETE. Risk assessment complete. Regional adaptation plan to be created.

Toi Te Ora Public Health

Toi Te Ora Public Health is the Public Health Unit for the Bay of Plenty and Lakes regions. Our role is to promote and protect the health of the population, with a focus on the achievement of equity, in particular for Māori.

COVID-19 Response

The local public health response to COVID-19 continued to be a key focus for Toi Te Ora during 2021/2022. The whole-service response to COVID-19 rapidly transformed over time, as we responded to new variants and changes in the national strategies, progressing from an elimination to a management strategy. The COVID-19 response provided opportunities to develop new ways of working, cultivate relationships, in particular with Iwi and Māori organisations, and increase diversity in our workforce, which we are now carrying through into our other work areas.

COVID-19 Recovery

Toi Te Ora formally stood down the COVID-19 Incident Management Team in March 2022. This signified a shift from COVID-19 as an emergency response to a core public health work area. Toi Te Ora has since been able to refocus on COVID-19 recovery for both the service and the community. The development of an internal Recovery Plan, has provided guidance for this, and identifies three key phases:

- Rest & Reflect – This includes supporting staff wellbeing and reflecting on public health priorities. To assist, a Community Health Needs Assessment is currently underway.
- Reconnect & Re-group – This focuses on re-building or developing relationships and identifying areas for collaboration, particularly to support recovery and achieve Māori health equity.
- Refocus & Rebuild – This involves recommencing public health work in a planned way to respond to shifts in priorities due to COVID-19 and to ensure our focus is on achieving Māori health equity.

Public Health Priorities

A key priority for Toi Te Ora is re-aligning the service to be Te Tiriti led. This is being guided by the implementation of Te Iti Kahurangi, an internal action plan, which addresses leadership, workforce, culture, community engagement, relationships and programme development and improvement. As part of this, Toi Te Ora have been running 'Pae Ora', a series of internal trainings, which cover a range of topics such as Te Reo, Tikanga, history of Iwi in the region, equity and Te Tiriti.

Toi Te Ora is beginning to re-initiate settings-based wellbeing programmes with schools, early years services, workplaces, and the community, which have been on hold during the COVID-19 response. The focus of this work has been to re-establish relationships and support COVID-19 recovery, including a focus on mental wellbeing and food security. Toi Te Ora has also re-launched Building Blocks for Hauora, a wellbeing programme for early learning services. This has been redeveloped through co-design with Te Arawa to develop a pūrākau that provides a backbone to the programme, and weaves together principles from Te Te Whāriki, Te Whare Tapa Whā, and He Pou Oranga Tangata Whenua.

As essential public health activities, most environmental, border health and communicable disease work continued throughout the COVID-19 response to protect the community from harm. Toi Te Ora is now re-initiating tobacco and alcohol enforcement and policy advocacy work. Retailer education about the recently updated legislation on vaping is an initial priority.

Public health communications and analysis has been an essential function for Toi Te Ora throughout the COVID-19 response and has supported the development of strong relationships and collaborations. Toi Te Ora will be maintaining these relationships through supporting the establishment of Tu Wharetoa locality and collaborating with Te Pare o Toi to develop an outcomes and performance framework.

Future Directions

Toi Te Ora is enthusiastic about the future of public health locally. We are relentlessly optimistic about achieving health equity for Māori, and the realignment of our service to be Te Tiriti led will continue to be a focus. Toi Te Ora is actively engaging in the establishment of the National Public Health Service and the opportunities this will bring to strengthen the public health voice. Finally, following the completion of the Community Health Needs Assessment, as part of COVID-19 recovery, we will develop a greater understanding of the status and the needs of the community which will help re-prioritise public health action locally.

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 lo 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!

Te Rūnanga Hauora Māori o Te Moana a Toi continued to work with and have the support of the Bay of Plenty District Health Board as they identified some key focus areas which became the main priorities as the health system navigated the many challenges brought about by the Covid19 pandemic/variants and the health reform transition.

Te Toi Ahorangi continues to permeate throughout the organisation workstreams, and this is a credit to Te Pare o Toi. Toi Oranga Mokopuna is the first co-commissioned project between the Rūnanga and the BOPDHB.

Te Poari Hauora a Te Moana a Toi

The Rūnanga had the added responsibility of supporting the process to establish Te Poari Hauora o Te Moana a Toi - Iwi Māori Partnership Board (IMPB) as well as ensuring the waka continued to navigate in partnership for the benefit of the communities we serve.

With the restructure of Aotearoa's health system and the launch next month of the Māori Health Authority (MHA), the IMPB will serve a pivotal role in transforming the health outcomes of whānau and upholding both the MHA and Health NZ to account.

The IMPB is the successor to the Rūnanga which has operated for 22 years. While the structures and staff will undergo changes during this time of transition, the kaupapa remains the same as that started by a group of kaumatua and kuia decades ago, better health outcomes for whānau can only be driven by equal partnership as described in the principles of Te Tiriti.

Māori don't want to just experience the system, they need to play a crucial role in the decision-making. Fifteen iwi representatives have been appointed to the Iwi-Māori Partnership Board (IMPB), with an opportunity for other iwi representatives and mātāwaka to be appointed in the near future. The IMPB will supply the MHA with valuable insights into the lived experiences of whānau in Te Moana a Toi.

As direct representatives of their iwi, the appointees of the IMPB have a clear line of communication to the needs of their whānau. Collating data and vital information from these 'flax roots' and disseminating it to central agencies such as the MHA and Health New Zealand offers an opportunity for responsive decision-making based on real-life outcomes.

The contribution that the IMPB will make acknowledges the long-held relationship between the Rūnanga and the Bay of Plenty District Health Board (now Te Whatu Ora Hauora a Toi); a special relationship which is unique to our region.

Dr Bev Edlin, past Chairperson of the BOPDHB agrees that the partnerships forged by previous Rūnanga and DHB representatives provide strong support to the IMPB.

"Our direction has been clear for a number of years now, we want to proactively meet our responsibilities to Māori, to work alongside them as equal Treaty partners and develop responsive initiatives which address health outcomes for whānau in Te Moana a Toi," she says.

The selection process for the IMPB appointees was managed by an external consultant with awhi from Te Rūnanga Hauora Māori o Te Moana a Toi.

The selection process for the IMPB appointees was managed by an external consultant with awhi from Te Rūnanga Hauora Māori o Te Moana a Toi.

The successful appointees were as follows:

Ngāi Tai	Lucy Steel
Ngāi Te Rangi	Roimata Ah Sam
Ngāti Awa	Jackie Copeland-Davis
Ngāti Makino	Te Ata Ngatai
Ngāti Manawa	John Porima
Ngāti Pukenga	Kipouaka Pukekura-Marsden
Ngāti Ranginui	Melanie Tata
Ngāti Whakahemo	Margaret Hinepo Williams
Ngāti Whakaue ki Maketu	Susan Elliot
Ngāti Whare	Jane Nicholas
Tapuika	Rutu Maxwell-Swinton
Te Whānau-ā-Apanui	Dayle Takitimu
Te Whānau a Te Ehutu	Theresa Ngamoki
Waitaha	Carliza Patuawa (Appointed)
Whakatōhea	Mariana Hudson

Māori Health Rūnanga Membership 2021/2022

Ngāi Tai (Chair)	Linda Steel
Ngāi Te Rangi (Deputy Chair)	Kipouaka Pukekura-Marsden
Ngāti Awa	Enid Ratahi-Pryor
Ngāti Makino	Grant Ngatai
Ngāti Manawa	John Porima
Ngāti Pukenga	Titihuia Pakeho
Ngāti Ranginui	Tamar Courtney
Ngāti Rangitihi	Robin Cheung
Ngāti Whakahemo	Margaret Hinepo Williams
Ngāti Whakaue ki Maketu	Manu Pene
Ngāti Whare	Jane Nicholas
Tapuika	Rutu Maxwell-Swinton
Te Whānau-ā-Apanui / Te Whānau a Te Ehutu	Astrid Tawhai
Waitaha	Punohu McCausland (Resigned)
	Carliza Patuawa (Appointed)
Whakatōhea	Dickie Farrar

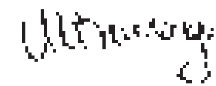
Ngā mihi mahana
Linda Steel (Ngai Tai), Chairperson
Te Rūnanga Hauora Māori o te Moana a Toi

MĀORI HEALTH GAINS AND DEVELOPMENT YEAR IN REVIEW

During the 2021/2022 year Te Pare ō Toi was focused on supporting vaccination against COVID, addressing the backlogs in service delivery caused by COVID, on top of delivering on our strategy described in Te Toi Ahorangi. The Delta and Omicron waves made it challenging to achieve our strategic goals during this 12-month period but we have collaborated with providers to reach whanau and support Pae Ora.

In parallel, the transformation of the New Zealand health system gained momentum, with official implementation from 1 July 2022. The transformation introduced changes in the way that services are delivered and the way that our organisation is structured, but also presented opportunities for greater collaboration within Hauora a Toi – Bay of Plenty, and across the motu.

Amidst the significant events of the past year, we have worked to support providers, foster innovation, and to collaborate with our Iwi Māori Partnership Board. We will continue our efforts to support whānau in the 2022-2023 year under the leadership of Te Aka Whai Ora, the Māori Health Authority.



Marama Tauranga
Manukura - Executive Director
Toi Ora

Toi Ora Wellbeing

Toi Ora Wellbeing has been a priority for our service during the transition from a local District Health Board based approach to planning, funding, and service delivery, to a nationally-led locally-influenced approach within Health New Zealand. The transformation of the health system holds many opportunities for our organisation, team members and whanau, but has also added challenges as we re-orient to the new health system model. For this reason, we have prioritised working with team members to ensure that they are informed at all stages of the health system transformation journey so that they are empowered to maintain their mauri and wellbeing, and support providers with their ongoing efforts to serve whanau.

Māori Immunisation

Successive waves of COVID-19 introduced many challenges with immunisation over the 2021/2022 year. Nationally, childhood immunisation declined, and the influenza peak occurred earlier, and was more rapid than in past years. To help reduce the impact of influenza we promoted vaccination among PHOs and providers and formed a close collaboration with Ngā Kakano Foundation. This saw Ngā Kakano Foundation achieve the 75% national target for immunisation among its Māori population aged 65 and over for the first time ever; in parallel the organisation vaccinated double the proportion of Māori in the 55-64 years age group compared with the DHB overall. We are extending the lessons we learned with influenza vaccination to childhood immunisation in 2022/2023. In secondary care, our nursing team members completed vaccinator training in order to provide opportunistic vaccinations to whānau visiting our hospital sites.

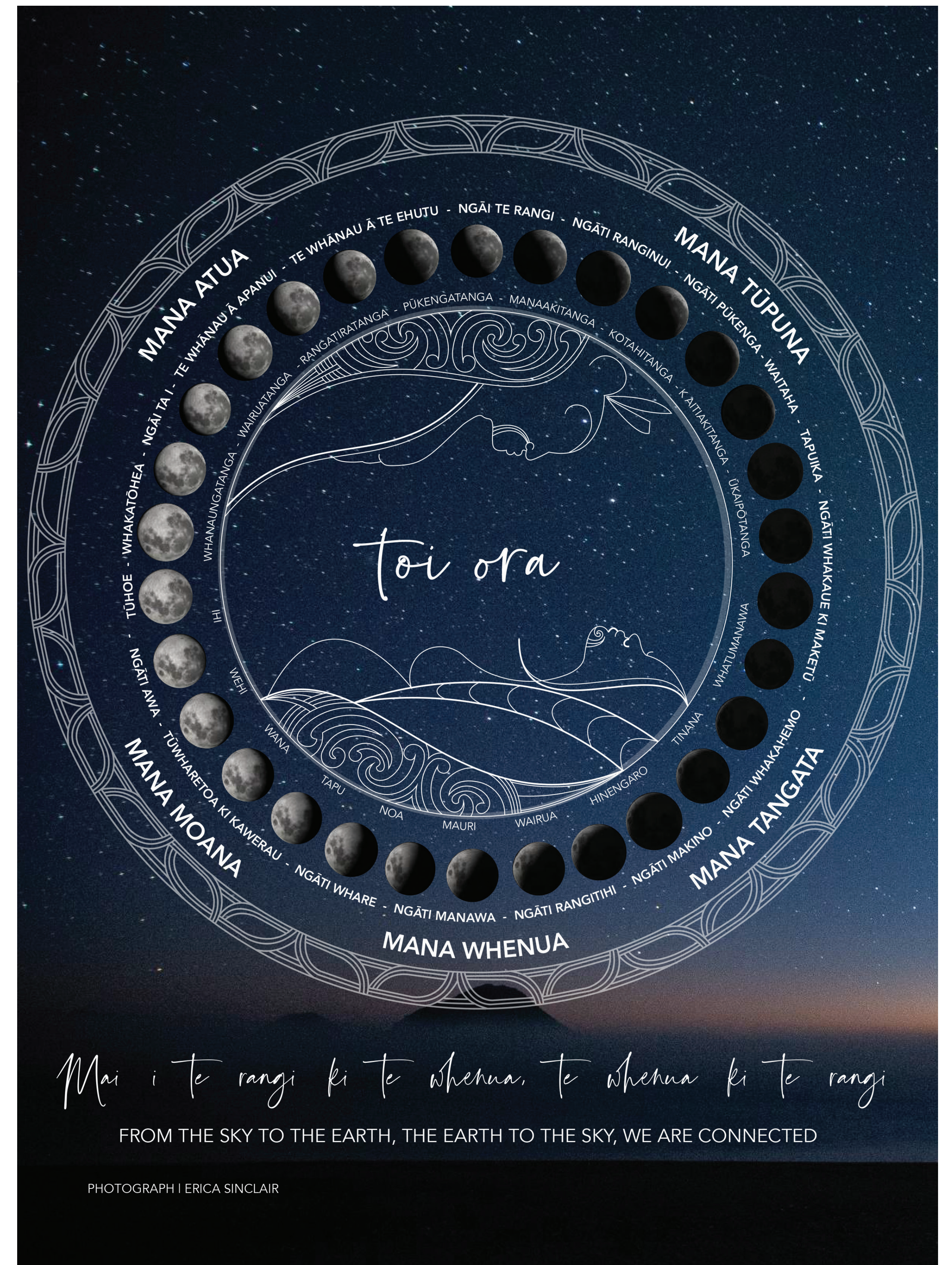
Toi Ora Excellence

Over the past year Te Pare o Toi team members balanced the challenges of COVID with the delivery of our usual services, and the nationally-led transformation of the health system. During this time, we developed and completed the Toi Ora Outcomes tool which will help the system monitor outcomes for Māori whanau both within the health sector, and across other areas that impact health such as education, employment, and housing. The Toi Ora investment tool is now complete providing the mechanism to commission and invest for Toi Ora. To assist with innovation, we reviewed and contributed to a range of research proposals that will impact Māori

whanau. Our Pou Haumanu developed a quality performance monitoring dashboard to ensure that risks for Māori whanau are monitored and addressed. In late 2021, Te Pare o Toi helped facilitate the recruitment of 21 new Māori graduate nurses; with graduates commencing in January and February 2022. Of these, four new graduates joined Māori primary care providers and one joined the Kaupapa Māori nursing service of Te Pare o Toi. In the future we will continue to support research and innovation that supports whanau, monitor service delivery quality, and support workforce development.

Māori Pandemic Response

COVID has had a significant impact on whānau over the past two years; both through the direct effects of COVID, and the indirect effects on access to primary care and elective services delivered by our hospitals. Over the past year our nurse vaccinators have collaborated with providers to immunise whānau. In parallel our team has supported vaccination events and facilitated education on infection prevention. In addition, our Pou Oranga Ake has worked with Toi te Ora Regional Public Health and Iwi to develop processes that see welfare needs supported in addition to clinical needs among those that experienced COVID infection. In secondary care, we have worked with DHB teams to ensure that backlogs in service delivery and waiting lists created by COVID focus on the needs of Māori that have a higher burden of illness.



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. Both the continual growth in demand and the disruption caused by COVID-19 has resulted in 2021/2022 being another challenging year for the DHB, with these impacts being also felt financially. This year we report a deficit of $54.0m on a total revenue of $1.162m.

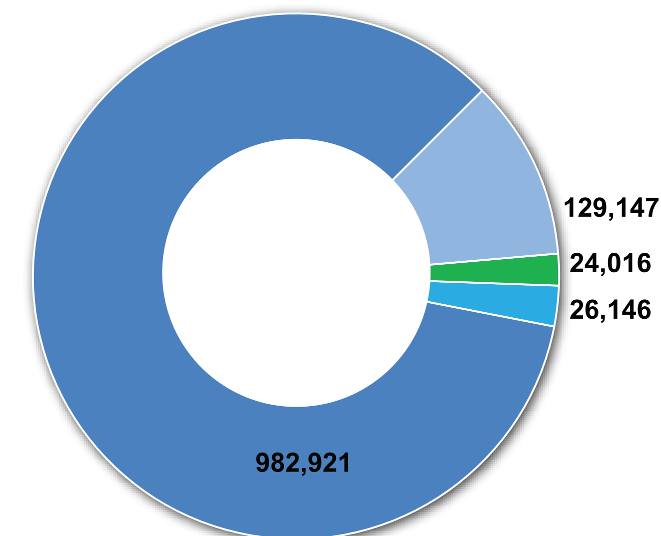
This is a $23.3m unfavourable variance to our annual plan deficit of $30.8m. The variance primarily relates torecognition of the expected remediation costs to comply with the Holiday's Act of $13m, but also include the cost of continued acute growth and the uplift of employee remuneration.

The deficit's impact on our financial position has been offset by the equity injection received midyear. Our closing cash balance of $4.4m overdrawn (FY21: $15.5m overdrawn) is offset by increased MOH debtors and our net working capital is stronger than the prior period, despite significant increases in employee entitlements.

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.

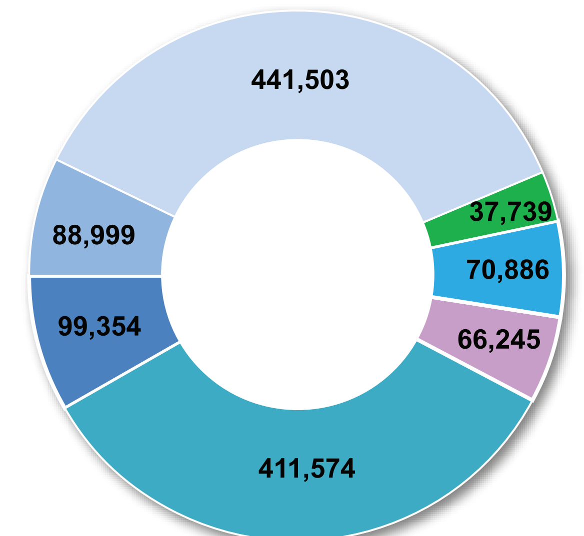
Although the DHB will not be reporting in 2022/2023 we expect it to be another challenging year for the District, as part of Te Whatu Ora. Continued population growth, addressing planned care challenges as well as the impact of the Health sector reform transition will have both an operational and financial impact. Despite these challenges, staff and services will maintain focus on delivering high quality care to our communities.

Revenue ($000s)



- Crown Appropriation Revenue
- Other MOH revenue
- Other Revenue
- Services to other DHBs

Expenditure ($000s)



- Clinical expenses
- Community Providers
- Depreciation, Interest & Capital Charge
- Infrastructure & Non-Clinical Supplies
- Outsourced
- Personnel
- Services from Other DHBS

Owen Wallace
General Manager Corporate Services

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].

Annual Plan 2021/2022

There were six key areas of focus for the BOPDHB for 2021/2022, 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

As with the previous year, some of the actions BOPDHB planned for 2021/2022 were delayed due to COVID-19 activities. This had some effect of the BOPDHB’s performance which is further reported in the Statement of Performance.

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.

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.

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. The BOPDHB consisted 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	Combined Committee Te Rapa Hou	Expenses	2021/2022 Total
Hori Ahomiro	23,171	-	750	-	23,921
Mark Arundel	23,171	2,750	1,250	-	27,171
Bev Edlin *	34,787	2,750	1,250	273	39,060
Geoff Esterman **	28,963	2,750	1,250	-	32,963
Ian Finch	23,171	2,250	1,250	507	27,178
Marion Guy	23,171	2,750	1,250	-	27,171
Ron Scott	23,171	3,438	1,250	-	27,859
Sharon Shea *	23,201	1,250	500	596	25,547
Leonie Simpson	23,171	-	750	-	23,921
Arihia Tuoro	23,171	2,750	1,563	-	27,484
Wayne Williams *	23,171	2,750	-	695	26,616
Total Board Members	**272,320**	**23,438**	**11,063**	**2,071**	**308,891**
Linda Steel ***	2,500	-	250	778	3,528
Lyall Thurston	-	-	1,000	133	1,133
Paul Curry	-	-	500	-	500
Kipouaka Marsden	-	-	750	-	750
Mariana Hudson +	2,500	1,750	250	229	4,729
Natu Vaeluaga +	2,750	1,250	1,000	-	5,000
Total All Members	**280,070**	**26,438**	**14,813**	**3,211**	**324,531**

* Board Chair until departure - December 2021
** Board Chair from December 2021
*** Rūnanga (Chair) representative to the Board, commenced 24/2/21
+ 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: During 2021/2022 as part of a Ministry initiative "seat at the table" the BOPDHB had two observers Natu Vaeluaga and Mariana Hudson.

Meetings			
Name	Scheduled	Attended	Comments
Hori Ahomiro	12	7	
Mark Arundel	12	12	
Bev Edlin	12	12	Board Chair from December 2021
Geoff Esterman	12	12	Deputy Chair
Ian Finch	12	10	
Marion Guy	12	12	
Ron Scott	12	12	
Sharon Shea	12	6	Departed December 2021
Leonie Simpson	12	9	
Arihia Tuoro	12	12	
Wayne Williams	12	12	
Linda Steel	12	10	Rūnanga Chair
Mariana Hudson	12	10	Board Observer
Natu Vaeluaga	12	11	Board Observer

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.

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	11	11	
Bev Edlin	11	11	
Geoff Esterman	11	11	
Ian Finch	11	9	
Marion Guy	11	11	
Ron Scott	11	11	Chair
Sharon Shea	11	5	Departed December 2021
Arihia Tuoro	11	11	
Wayne Williams	11	11	

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.

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:

Name	Meetings		Comments
	Scheduled	Attended	
Mark Arundel	5	5	
Hori Ahomiro	5	3	
Bev Edlin	5	5	
Geoff Esterman	5	5	
Ian Finch	5	5	
Marion Guy	5	5	
Ron Scott	5	5	
Sharon Shea	5	2	Ex officio - Departed December 2021
Leonie Simpson	5	3	
Arihia Tuoro	5	5	Chair
Kipouaka Marsden	5	3	Rūnanga Representative
Lyall Thurston	5	4	Lakes DHB Representative
Paul Curry	5	2	Community Representative

CEO PERFORMANCE AND REMUNERATION COMMITTEE

Functions

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

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

Membership

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

Committee Members during the year were:

- Mark Arundel (Chair)
- Sharon Shea (Board Chair) - Departed December 2021
- Bev Edlin - (Board Chair) - from December 2021
- Ron Scott
- Leonie Simpson
- Arihia Tuoro
- Linda Steel

DELEGATIONS

The Board has an approved Delegation Policy in accordance with Schedule 39(3) of the NZPHD Act[9]. The NZPHD Act requires, under S26(3)[10] 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.

9. Schedule 3, New Zealand Public Health and Disability Act, 2000.
10. Section 26, New Zealand Public Health and Disability Act, 2000.

04

Our People
Te Hunga Ora

BEING A GOOD EMPLOYER

Our Manaakitanga CARE values at the BOPDHB

Our objective is to make the BOPDHB organisation an even better place to work. By building on existing good practice, higher staff engagement drives higher quality patient care. There is a clear relationship between the wellbeing of staff and patient wellbeing.

The BOPDHB recognises the seven key elements of being a good employer, as identified by the Human Rights Commission[11]. 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[12] 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[13], Health and Safety in Employment[14], and Employment Relations[15] legislation.

People and Capability (HR) policies and procedures are reviewed biennially in-line with the BOPDHB's commitment to good employer practices and theBOPDHB'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

Toi Oranga Tikanga (Workforce Development) is refreshing how we worked as a DHB in a changing world, with a focus on empowering and supporting our workforce to flourish. This strategic priority links our developing People Strategy, digital transformation, workforce wellbeing initiatives, policy, and internal processes with the aim of supporting people to be able to give their best and enjoy their work in an agile, positive and supportive culture. This strategic development area has enabled the support of our whole of system integration Initiatives. Where workforce teams are moving across Tier 1 and Tier 2 services, the BOPDHB supported the training, education, development and career progression needs of the wider Bay of Plenty healthcare workforce.

Psychosocial Wellbeing

The pandemic response and demands impacted the BOPDHB staff in many ways, and we continued psychosocial support and offering programmes to ensure the wellbeing of our workforce.

It continued to be 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.

- Strategic investment in leadership and people committed to enhancing experiences of wellbeing and delivery of operational wellbeing initiatives. Commitment to visibility and engagement with staff around the topic of wellbeing/experience at work and making space for these to be reflected and listened to in strategic and operational leadership spaces such as executive committee, IOC, Health and Safety Operations Group. Review and refresh of Mahi Ora (workwell) group, enhancement of staff break areas - Café in Whakatāne, staff breakout area in Tauranga, staff wellness room in Whakatāne ED, parenting room.
- Development of whakawhanaungatanga focused wellbeing initiatives such as leadership support circles, care spaces, manaakitanga movement, regular one to

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

one conversations with frontline managers, Kaimahi mauri ora staff check in (Whakatāne), recognition and appreciation campaign Te Whetu Koe "You are a STAR!" clinical psychologists on-site support for ED/ICU, on-site counsellors during late 2021, emerged from the assisted dying workstream. Review of suitability and effectiveness of EAP services, (ongoing), delivery of educational support via Psychological First Aid Training, bespoke team support sessions, kanuka wellbeing virtual learning, leading and navigating uncertainty.

- Advocating for wellbeing at the heart of decision making example – assisted dying implementation - trauma informed peer support programme which
- Facilitating the delivery of community support initiative – Rise Up – baking for DHB staff.

Employment Diversity, Equity and Inclusion

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.

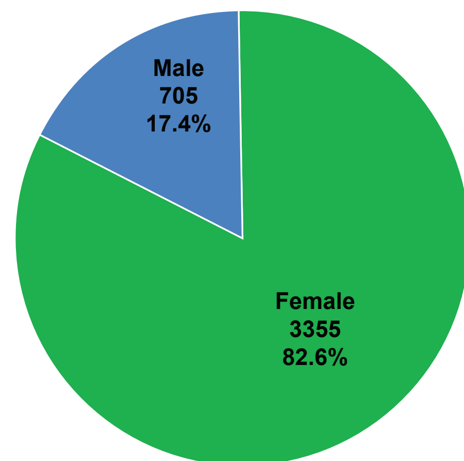
BOPDHB supports the Government putting into place pay and employment equity response plans, such as Kia Toipoto, and recognises the obligations we have to make sure we continue to address and respond to any identified gender inequities as part of good management practice and being a good employer. BOPDHB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

Gender Pay Equity

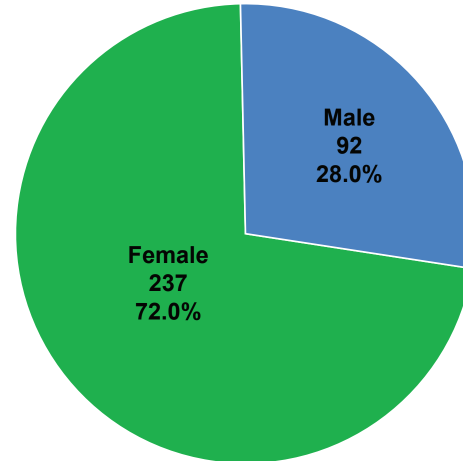
The gender pay gap helps provide an understanding of high-level indicators on the difference between women and men's earnings, as well as the benefits of pay and employment equity. In 2022, research has shown men earn on average 10% more than women in New Zealand[16].

The majority of our staff are covered by collective employment agreements (93%, 4,060 of our 4,389 staff). This ensures that all employees, regardless of gender or other areas of potential inequity, are remunerated at the same level for equivalent work.

2021/2022 Employees with Collective Employment Agreements



2021/2022 Employees with Individual Employment Agreements



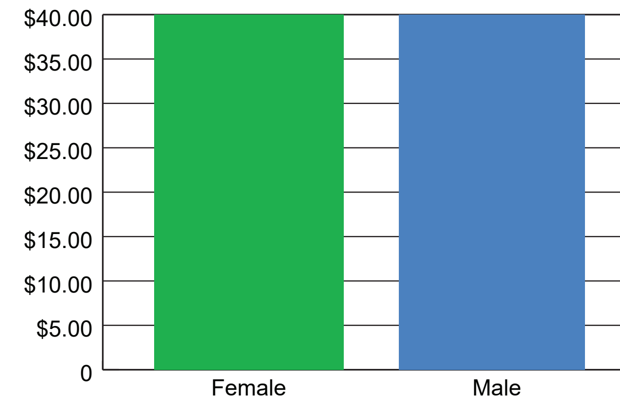
19. Employment NZ

The remaining 329 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.

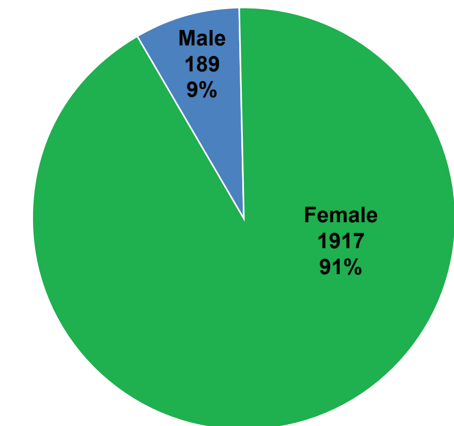
This methodology also gives due weight to roles with a requirement for education, experience and strong problem-solving skills, and ensures that each position is objectively remunerated, regardless of gender or other areas of potential inequity.

Nursing is our largest employment occupational group, representing 2,106 staff (48%) of our work force (2020/2021: 1,930, 48%). 91% of this group are female, and no difference is noted in median remuneration between male and female staff.

Median Hourly Rate - Nursing

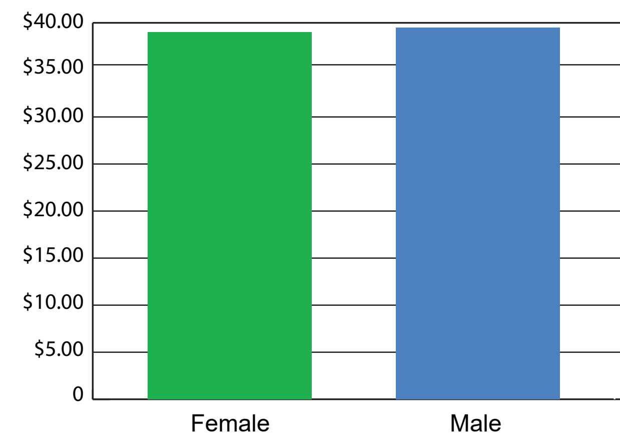


2021/2022 Nursing Staff

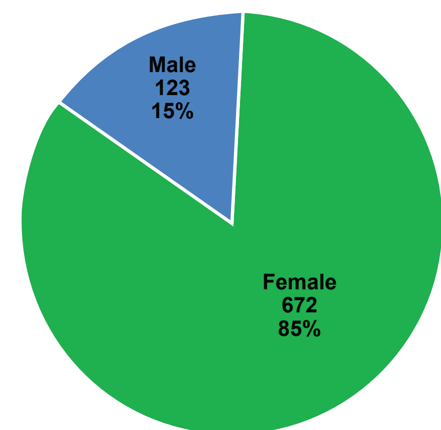


Allied Health is our next largest group, representing 795 staff (2020/2021: 745). This group includes occupational therapists, social workers, physiotherapists, therapy assistants and a range of other clinical positions. 85% of this group are female, and there is a difference noted in average remuneration between male and female staff with males earning 2.5% 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

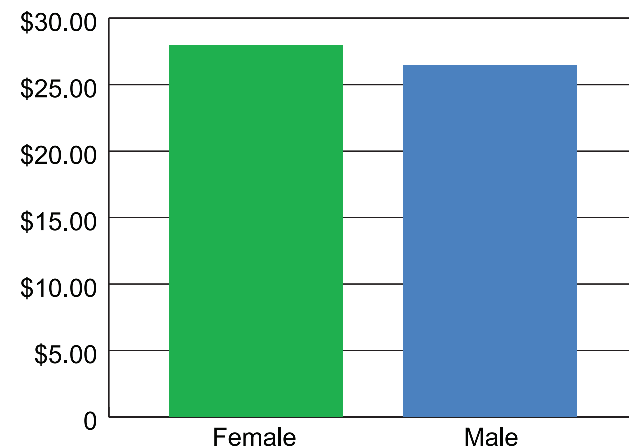


2021/2022 Allied Health Staff

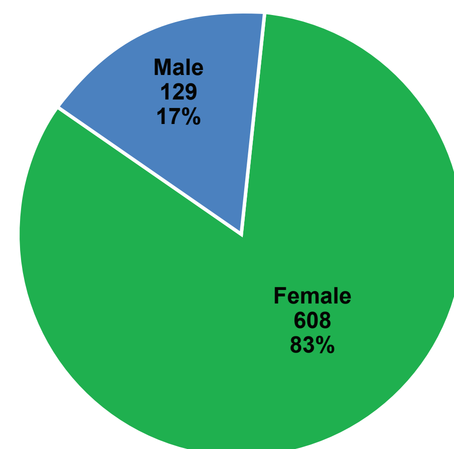


Non-clinical and clerical staff are another large group, representing 737 staff. This group includes Security, Stores, Orderlies and Clerical staff, amongst others. 82% of this group are female, and there is a difference noted in average remuneration between male and female staff with females being paid 3.6% 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



2021/2022 Non-Clinical and Clerical Staff



The three groups reported above represent 83% of our workforce. The remaining 17% of staff cannot be compared for equity. 12% of the remaining 17% 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. 5% of the remaining staff are on individual employment agreements.

Board and Senior Management

Numbers stayed the same for 2021/2022 with 58% of the Board Members being female and 42% Māori. 50% of Managers in the top two tiers of the BOPDHB are female (45% in 2020/21) and 17% are Māori (18% in 2020/2021).

Employment

This year we welcomed 1,245 new staff (2020/2021: 783 new staff), including 937 clinical staff (2020/2021: 607 new clinical staff).

The majority of our staff are covered by collective employment agreements (93%, 4,060 of our 4,389 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 2021/2022, 120 staff went on paid parental leave (the same as 120 staff in 2020/2021). Staff sick leave utilisation has remained stable at 3.3% (2020/2021: 3.5%)[17]

Resignations/Turnover has increased to 13.1% in 2021/2022 (up from 11.0% in 2020/2021).

17. Sick leave stats exclude COVID sick leave as per our national sick leave reporting guidelines. The true level of 'staff sickness' is therefore understated.

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 Staff Recognition Celebrations recognise staff with over ten years' service. The BOPDHB did not hold the Staff Recognition ceremony since 2020/2021 due to Covid related restrictions on gatherings.

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

Work place injuries happen every day and can profoundly affect workers, their families and communities in which they live. Effective workplace health and safety contributes to organisational success and to a safe working environment for all staff, visitors, and contractors. Hauora a Toi Bay of Plenty succeeds through participation and engagement with all workers. Effective Health and Safety can influence business risk, higher productivity and lower costs associated with Lost Time Injuries. Our culture strategy is focused on developing a strong health and safety culture within the organisation and this is being achieved through demonstrated leadership in health and safety. Only with leadership does our organisation achieve a strong safety culture, encourage engagement across the organisation, provide the environment where everyone feels responsible for their safety and the safety of others, and talk openly about the safety challenges on the job. In doing this we build capability in people at all levels, so they are able to carry out their roles safely and productively.

Some of the key impacts for the future include Priority Restoration, Worker Engagement, Participation and Representation.

Everything that contributes to safe, healthy workplaces – people, organisation and current environment are part of the wider health and safety at work framework.

The Health and Safety Team for Hauora a Toi Bay of Plenty consists of the Health and Safety Manager, three Health and Safety Advisors a Wellness Coordinator, Workplace Violence Prevention Coordinator and over 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. The Representatives are supported by resources, facilities, training and the Health and Safety Advisors.

Hauora a Toi Bay of Plenty has a dedicated Occupational Health and Safety Wellness Lead as well as a Mahi Ora Page for all staff to access health and wellbeing resources.

Hauora a Toi Bay of Plenty has systems and processes to identify workplace hazards, minimize the risk and reduce the risk of harm or injury to patients, visitors, and workers. The organisation actively engages with workers who are involved in the activities associated with top critical risks when reviewing these risks regularly. 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 organisation 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 organisation 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 participating in the ACC Partnership Programme at the annual audit which was last undertaken in July 2022.

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, workstation assessments and the Pain and Early Discomfort Pathway.
- On-line Health and Safety, Moving and Handling, Health and Safety for Managers and Team leaders, Fire Warden, Handling Harder Conversations, Personal Wellbeing, Responding to People in Distress and Safe Working in the Community.
- Face to Face Health and Safety, De-escalation Training, Moving and handling, SPEC Training and Managing Representatives.
- 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. Health and Safety Advisors carry out regular 'Safety Walks' with the Health and Safety Reps.
- Ongoing Training for Health and Safety Representatives
- 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 and Bi Monthly Health and Safety Rep meetings.
- Employee Assistance Programmes are provided to staff at no cost and there are two providers of this service EAP and Benestar.
- There is a yearly influenza vaccination programme provided for all staff at no cost
- Health and Safety Community site on the intranet for information on all Health and Safety, Occupational Health and Emergency Management programmes.

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 staff and associated organisations 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 group fitness classes (virtual and live instruction), and a variety of annual wellness programmes and services.

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.

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)
2017/2018	$719,372.00	194	0.82	0.87
2018/2019	$464,549.00	21	0.80	0.84
2019/2020	$704,015.07	45	Not available	Not available
2020/2021	$586,093.10	13	Not available	Not available
2021/2022	**$575,353.00**	**212**	**0.68**	**0.67**

Employer Assisted Programme

BOPDHB continued to provide individual psychosocial support to staff, which is able to be accessed 24 hours a day our contracted EAP service providers. All staff members are entitled to 3 free confidential sessions of EAP to assist with work or personal issues. Extra providers have been mobilise in order to provide bespoke services to acute services under a three month trial in Tauranga and a preventative initiative has been trialed for the Whakatane provider arm . BOPDHB spent $142,412.61 on EAP services for 2021/2022.

WorkWell is a workplace wellbeing accreditation 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 workplace. For the year end June 2022, Toi Te Ora have 42 workplaces signed up regionally, and nationally, 117 are signed up with WorkWell and 3 of those being other DHBs.

There are 8 DHBs in total (including BOPDHB) that are offering WorkWell to workplaces in their regions. Three of these DHBs are doing WorkWell themselves (internally). Due to the impacts of COVID-19, there has been a reduction in the number of workplaces registered with WorkWell and the number of other DHBs offering WorkWell in their regions.

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. The BOPDHB Healthy Living Team are currently reviewing and gathering the required evidence, to submit for the WorkWell Gold Maintenance Standard of Accreditation.

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 $56,558 was awarded to BOPDHB employees during the 2021/2022 financial year ($46,625 in 2020/2021).

- Advanced Study Fund: $23,208
- Whakatāne Staff Study Fund: $3,300
- BOP Learning Scholarships: $21,000
- Hauora a Toi Karahipi: $9,050

BOP Learning Scholarships are available to staff through the generous support of businesses sponsoring the funding of the scholarships. In 2021/2022 scholarships totaling $29,500 were sponsored by: Bay of Plenty Medical Research Trust, Holland Beckett Law; Guild & Spence, Pure Print, and Jigsaw Architecture. Learning scholarships were awarded to 10 staff members (compared with 12 awarded in 2020/2021). Recipients were from a range of roles and services including Allied Health, Oral Health, Community Health and Mental Health. Three Whakatāne staff members received awards from the Whakatāne Staff Study Fund. 5 staff members received funding through Hauora a Toi Karahipi.

In 2021/2022, 14 BOPDHB employees were reimbursed a portion of their course fees for tertiary study through the Advanced Study Fund (slighly down from 18 in 2020/2021). Applicants received 60% reimbursement towards their fees[18].

Learning Environment

The Education Team works to embed learning, innovation and information into organisational culture; within the framework of BOPDHB CARE values and honoring Te Tiriti o Waitangi. More education is being offered 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 2021/2022, a total of 1,871 staff completed these training courses (2020/2021: 1149).

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.

In October 2021, Te Tiriti o Waitangi shifted to be an online course.

Attendances are as follows:

- Treaty of Waitangi full day course: 135 (stopped running in February 2022)
- Te Tiriti o Waitangi online course: 226
- Unconscious Bias online course: 990
- Unconscious Bias and Institutional racism half day course: 258
- Cultural Intelligence full day course: 262

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.

Professional Development

In 2021/2022, 1,731 internal training events were offered with 33,938 participants completing training, both face-to-face and online. (2020/2021: 1,446 events and 32,704 participants). This figure includes orientation, clinical, non- clinical, leadership, health and safety, IT training and mental health.

63% of learning was completed online (compared with 57% in 2020/2021) with153 on-line learning courses offered through Te Whāriki ā Toi.

There are 153 courses available online for BOPDHB staff and 39 of these are also available for DHB funded providers. There are currently 1209 '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 19% with 21,470 courses completed in 2021/2022 compared to 18,722 in 2020/2021.

STAFF STATUS 2021/2022

Workforce Profile

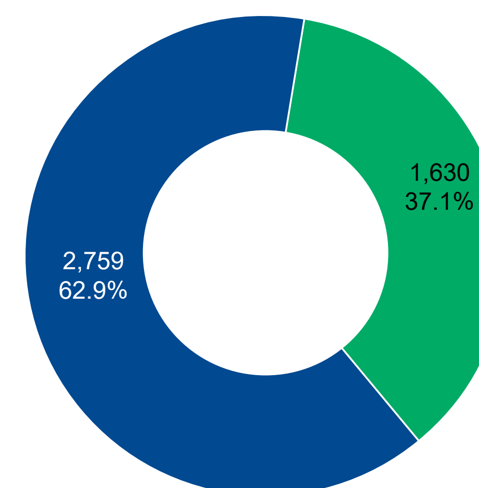
4,389 permanent and temporary staff (2021/2022: 4,044)	4,389 permanent and temporary staff (2021/2022: 4,044)
Average Age	Average age is 46.3 years (2021/2022: 47.2 Years)
Disability Profile	Our proportion of employees who report a disability is 2.0% (2021/2022: 2.0%)
Gender Profile	Women make up the majority of our workforce with 81.8% female compared with 18.2% male (2021/2022: Female 82.3%, Male 17.7%)

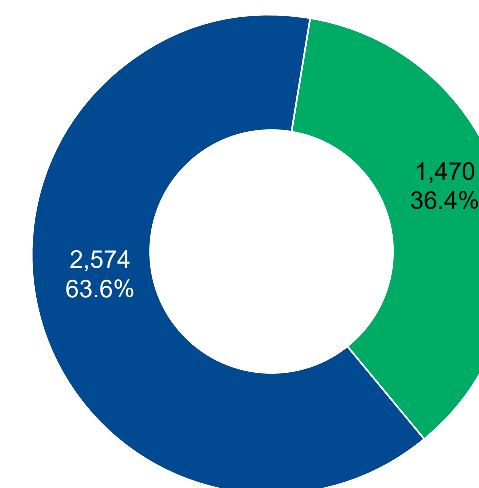
The BOPDHB recognises and accommodates the workplace needs of staff with stated disabilities. The BOPDHB currently employs four people who identify with a disability, covering a range of different impairments.

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.

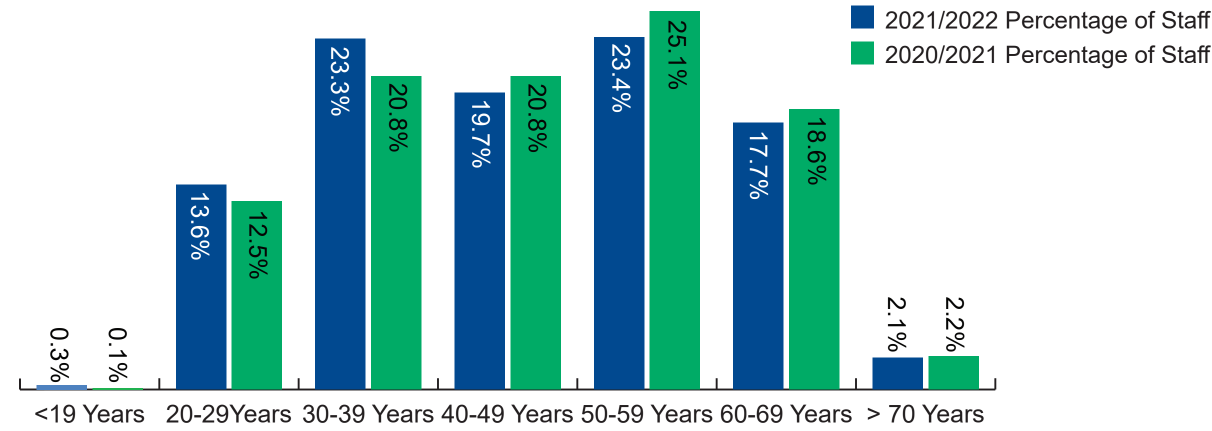
Occupational Group	2021/2022 Full Time	2021/2022 Part Time	2021/2022 Total	2020/2021 Full Time	2020/2021 Part Time	2020/2021 Total
Admin/Management	473	337	810	406	336	742
Allied Health	395	400	795	392	353	745
Medical	345	165	510	338	144	482
Non-clinical Support	78	90	168	68	77	145
Nursing	339	1,767	2,106	266	1,664	1,930
Grand Total	**1,630**	**2,759**	**4,389**	**1,470**	**2,574**	**4,044**

BOPDHB Staff Status

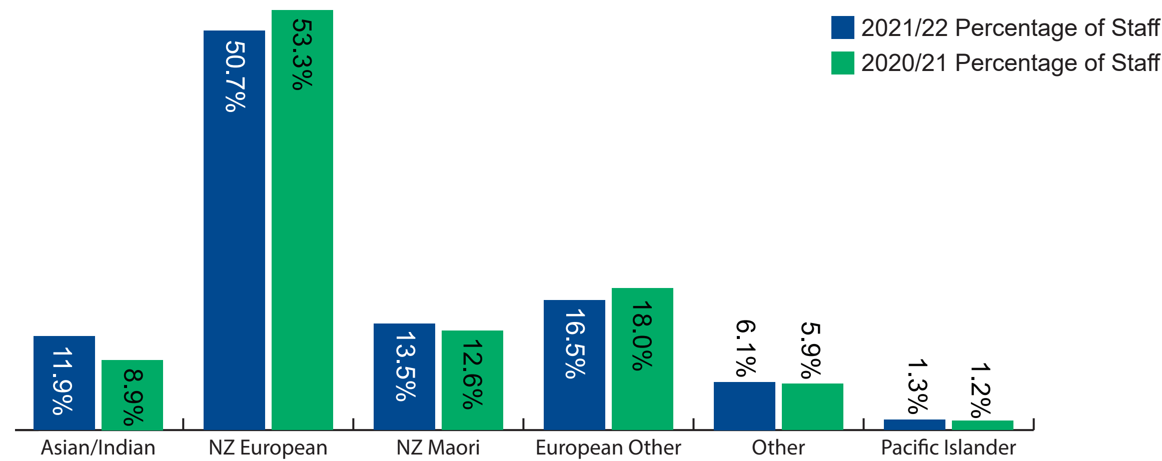




BOPDHB Staff by Age Band



BOPDHB Staff by Ethnicity



Termination Payments 2021/2022

Reason	Number	Redundancy	Gratuity	Exgratia
Redundancy	1	$54,576.00		
Retire	1		$45,380.00	
Retire	1		$35,233.00	
Retire	1		$30,150.00	
Retire	1		$29,166.00	
Retire	1		$27,418.00	
Retire	1		$13,121.00	
Retire	1		$2,500.00	
Retire	1		$2,500.00	
Retire	1		$2,100.00	
Retire	1		$2,000.00	
Exgratia	1			$11,507.00
Exgratia	1			$2,500.00
Exgratia	1			$2,500.00
Exgratia	1			$2,500.00
Exgratia	1			$2,000.00
Exgratia	1			$2,000.00
Total	17	$54,576.00	$189,568.00	$23,007.00

Salaries over $100,000

Year ended 30 June 2022				30 June 2021
Salary Bands	Medical & Dental Staff	Other	Total	Total
100,000-110,000	35	199	234	167
110,000-120,000	32	128	160	92
120,000-130,000	31	64	95	70
130,000-140,000	29	37	66	44
140,000-150,000	21	28	49	28
150,000-160,000	13	14	27	12
160,000-170,000	11	7	18	18
170,000-180,000	19	3	22	12
180,000-190,000	16	3	19	13
190,000-200,000	12	2	14	16
200,000-210,000	18	4	22	18
210,000-220,000	14	1	15	12
220,000-230,000	10	2	12	13
230,000-240,000	17	0	17	13
240,000-250,000	19	1	20	11
250,000-260,000	10	2	12	11
260,000-270,000	10	0	10	15
270,000-280,000	8	1	9	16
280,000-290,000	12	0	12	7
290,000-300,000	8	0	8	8
300,000-310,000	10	0	10	7
310,000-320,000	6	0	6	7
320,000-330,000	3	0	3	4
330,000-340,000	7	0	7	6
340,000-350,000	2	1	3	0
350,000-360,000	6	1	7	4
360,000-370,000	4	0	4	5
370,000-380,000	4	0	4	1
380,000-390,000	0	0	0	3
390,000-400,000	2	0	2	2
400,000-410,000	0	0	0	1
410,000-420,000	1	0	1	0
420,000-430,000	1	0	1	1
430,000-440,000	0	0	0	1
440,000-450,000	1	0	1	0
450,000-460,000	1	0	1	2
460,000-470,000	0	0	0	1
470,000-480,000	1	1	2	1
600,000-610,000	0	0	0	1
610,000-620,000	1	0	1	0
740,000-750,000	1	0	1	0
860,000-870,000	0	0	0	1
Total over $100,000	396	499	895	644

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 2021/2022 (2020/2021: Nil).

05

Statement of Performance

Pūrongo Mahi

Statement of Performance for year ended 30 June 2022

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 2021/2022 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 2021/2022 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

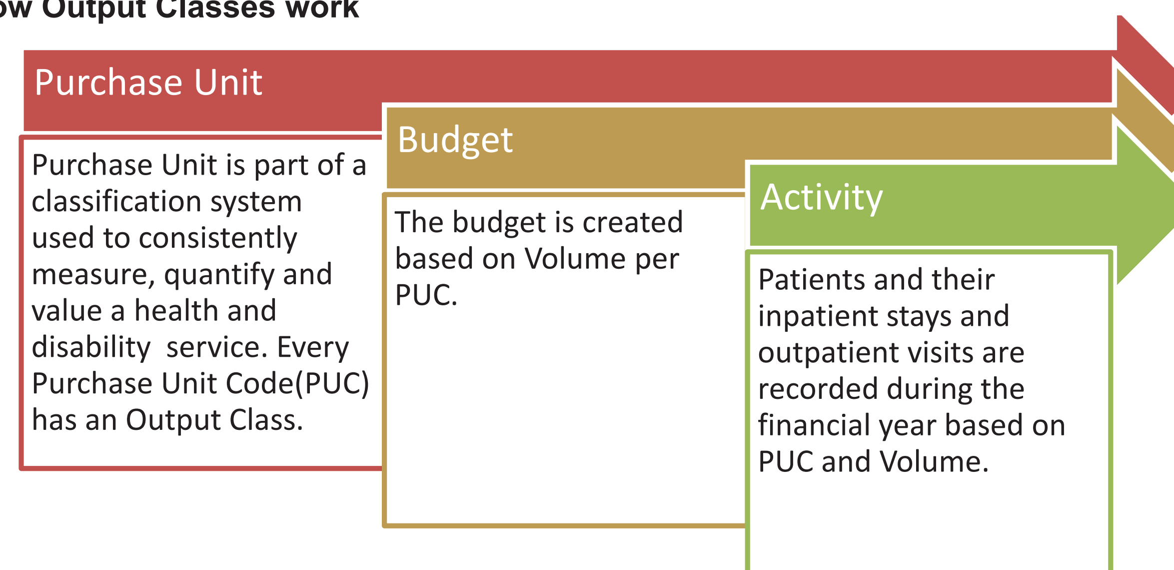
Section 149E of the Crown Entities Amendment Act 2013 requires District Health Boards (DHBs) to identify reportable classes of output delivery each year in a Statement of Performance Expectations. Output classes allow DHBs to group services and demonstrate the application of Board and Government service 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 2022 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 2022 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:

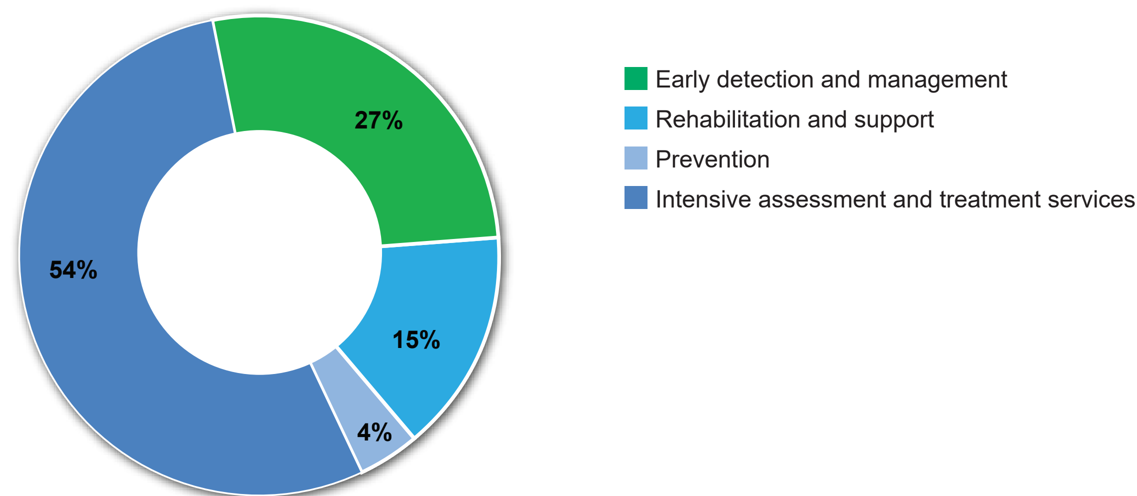
1. People are seen promptly for acute and arranged care.
2. People have appropriate access to elective services.
3. Improved health status for people with a severe mental illness or addictions.
4. People with end-stage conditions are supported.

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 2022.

Summary of Revenues and Expenses by Output Class	2021/2022 Actual	2021/2022 Plan	2020/2021 Actual	2020/2021 Plan
Early Detection				
Total Revenue	311,763	275,737	259,873	234,254
Total Expenditure	326,267	283,850	266,609	235,486
Net Surplus/ (Deficit)	**(14,504)**	**(8,113)**	**(6,736)**	**(1,232)**
Rehabilitation & Support				
Total Revenue	179,278	175,784	165,670	143,664
Total Expenditure	187,618	180,956	169,965	144,495
Net Surplus / (Deficit)	**(8,340)**	**(5,172)**	**(4,295)**	**(831)**
Prevention				
Total Revenue	48,930	12,817	12,080	18,301
Total Expenditure	51,206	13,194	12,393	18,403
Net Surplus / (Deficit)	**(2,276)**	**(377)**	**(313)**	**(102)**
Intensive Assessment & Treatment				
Total Revenue	622,259	580,931	547,509	557,040
Total Expenditure	651,209	598,024	561,700	560,258
Net Surplus / (Deficit)	**(28,949)**	**(17,093)**	**(14,191)**	**(3,218)**
Totals				
Total Revenue	1,162,230	1,045,269	985,132	953,259
Total Expenditure	1,216,300	1,076,024	1,010,667	958,641
Net Surplus / (Deficit)	**(54,070)**	**(30,755)**	**(25,535)**	**(5,382)**

Summary of expenses by output class



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.

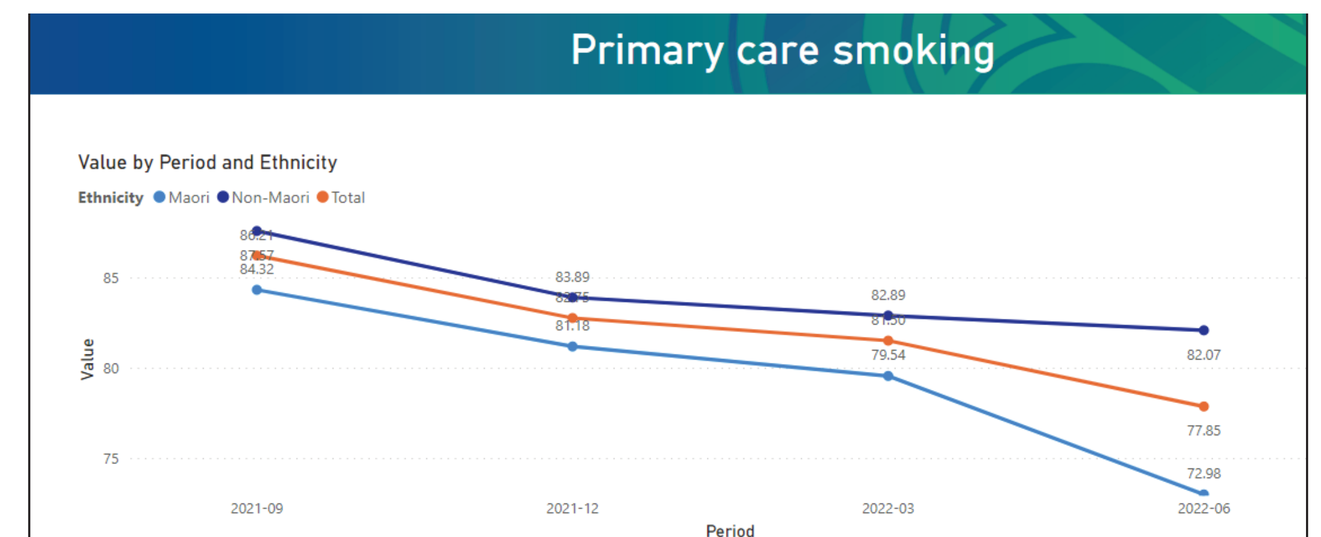
3.2.1 Fewer People Smoke

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

In the context of the COVID-19 pandemic the WHO has advised: Tobacco smoking is a known risk factor for many respiratory infections and increases the severity of respiratory diseases. A review of studies by public health experts convened by WHO on 29 April 2020 found that smokers are more likely to develop severe disease with COVID-19, compared to non-smokers.

The ongoing focus of our Primary Health Organisations (PHOs) on ABCs (Ask about smoking, Briefly advise to quit and offer Cessation support) in a primary care setting has been challenged by the pressures mounted on the health system due to the COVID-19 pandemic. The primary care smoking cessation stipulates that brief advice is offered and support to quit smoking given to over 90% of eligible patients who smoke and were seen by a health practitioner in general practices within the last 15 months. This target has not been met during 2021/22 by 12% for total population, this is a reduction from last year. The drop in performance reflects the strain in primary care through the pandemic. There remains inequity of performance against this metric for Māori, with a gap of 9% based on final Quarter 4 data – the gap last reporting year was only 1%. The total population result as at Quarter 4 2021/22 was 78%, while the result for Māori was 73% and for non- Māori was 82%.



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 2021/2022, 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
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 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 below the target by 12% for Total population and 17% for Māori. To increase cessation advice and support to smokers who access primary care we have been working closely with the PHOs to improve reaching their targets. There have been a few improvement activities which have been identified by the PHOs. In the Western Bay they have appointed a specialist smoking cessation support practitioner to oversee the primary care practices. In the Eastern Bay they have been actively working as the health promotion team to increase ABC as priority tasks. There is no current contract with the kaupapa Māori PHO organisation. We have been actively engaging with Dr John McMenamin as a smokefree team and he has engaged with the three PHOs, as well as nurse leads. During the COVID-19 surge, the community COVID-19 team engaged in ABCs, and continued to engage in these after the surge. Moving forward the two contracted PHOs are writing up an improvement plan to reach these targets.
▪ Total	89%	87%	90%	**78%**	71%	×	
▪ Māori	88%	86%	90%	**73%**	68%	×	
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**							From the 1 July 2022 reporting is no longer required on Maternity Targets. Smoking prevalence for Māori mothers is a significant concern and is one of the key focus areas in the Hauora a Toi. The Hapū Māmā 'First 2000 days' Incentive programme is available across the whole of the Bay. Promotional resources have been developed to highlight these new initiatives and continue to be distributed across the region to all appropriate stakeholders, e.g., General Practice, LMCs, hospitals. Facebook, and other social media outlets are also being utilised to good effect to increase the profile of the programme as well as radio advertisements. There is slow progress engaging the opt out process in the Maternity wards; meanwhile we are encouraging non-clinical staff in both Emergency and Maternity wards to become ABC trained and confident – this has been well received. Community midwives (LMC'S) have access to NRT (Nicotine replacement therapy) from both Tauranga Maternity and Ko Matariki (Whakatane). 'Hapainga' Bay wide stop smoking service has scheduled regular visits (every Friday) to Ko Matariki (Whakatane).
▪ Total	86%	84%	90%	**NA**	NA	NA	
▪ Māori	87%	76%	90%	**NA**	NA	NA	

Main measures of performance	Volumes						Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
Output class: 1 Māori babies who live in smokefree households at six weeks post-natal.[18]	33%	32%	60%	**31%**	35%	×	Heru and Hapū Māmā a kaupapa Māori smoking cessation program was piloted in the Eastern Bay. There were 23 enrolments; of these 12 have successfully quit smoking and 6 are still on the programme, 2 are still smoking and 3 withdrew after enrolment. Kairua ran a successful training day with Hauora and other service providers who are now in the early stages of rollout for this service to be accesssible across the bay. This is being achieved in collaboration with the SUDI service and a number of wrap around services e.g. breastfeeding, antenatal etc.

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 2021/22 there are several complex, systemic/ process and service user challenges that have affected 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 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
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 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 & 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 into 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	81%	81%	95%	**70%**	NA	×	
▪ Two years of age Total	76%	85%	95%	**80%**	NA	×	
▪ Five years of age Māori	78%	82%	95%	**71%**	NA	×	
▪ Five years of age Total	82%	85%	95%	**79%**	NA	×	

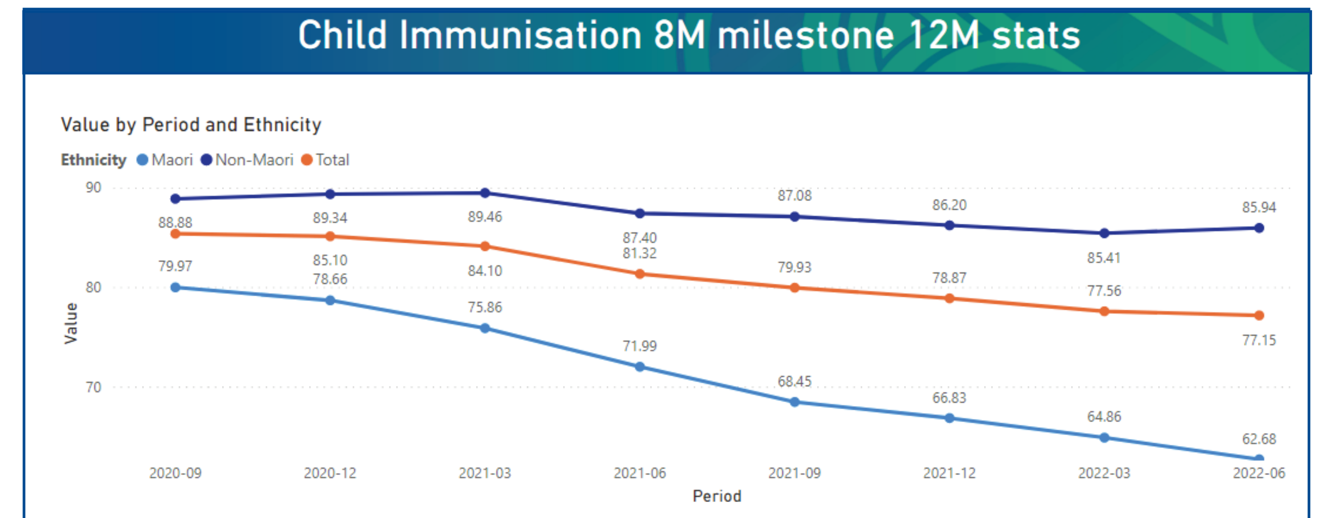
18.Data for this indicator is available only from Jul to Dec 21

Main measures of performance	Volumes						Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
Output class: 1 Eight month olds will have their primary course of immunisation (six week, three months and five months immunisation events) on time. ■ Total ■ Māori	 83% 77%	 84% 77%	 95% 95%	 **78%** **66%**	 NA NA	 × ×	Vaccination rates are declining now due to a variety of known factors within Bay of Plenty. While the trend is experienced nationally our local challenges which impact our rates include the following: • Vaccine hesitancy and misinformation. • GP services lacking resources to cover their calling/reminders in a timely manner – leading to referral to outreach/OIS and subsequent lack of time to vaccinate before target. • GP's reporting multiple appointment cancellations due to client illness • Reports from Outreach services that clients are not wanting to engage with clinics due to debt at their enrolled practice. • Closed enrolment for new clients with GP practices, delaying engagement. • Lack of alternatives to GP delivery.
Output class: 1 Percentage of the population (>65 years) who have had the seasonal influenza immunisation[19] ■ Total ■ Māori	 74% 68%	 70% 62%	 75% 75%	 **70%** **61%**	 63 53	 × ×	Despite prioritised actions for Māori and a strong collaborative approach with a range of providers results were below target.
Output class: 1 Percentage of the population (15-30) immunised for MMR.[20] ■ Total ■ Māori	 N/A N/A	 N/A N/A	 90% 90%	 **N/A** **N/A**	 N/A N/A	 N/A N/A	Data has been unable to source nationally.

19. 2021/2022 actual results usually reflects influenza coverage in the 2021 calendar year. The 2021/2022 influenza immunisation season ends in September 2022, with data not available until October 2022, which is outside of annual reporting timeframes, therefore we normally report previous year data.
20. This is a new measure that was included to track the MMR campaign.

Eight month immunisation coverage performance explained

Eight month immunisation coverage was one of the targets monitored by the Ministry of Health in 2021/2022. 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 July 2020 to June 2022. Rolling twelve-monthly immunisation shows a steady decline in the latest half year for Māori, non-Māori and the total population.

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
	2020 Actual	2021 Actual	2022 Target	2022 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**	94%	85%	95%	**76%**	×	Although below target due in part to the COVID-19 effect on our 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.

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class: 2 Percentage of infants fully and exclusively breast fed at three months **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.
■ Total	64%	64%	70%	**61%**	✗	
■ Māori	51%	52%	70%	**52%**	✗	

3.2.4 Fewer Children and Adolescents have Decayed Missing Filled Teeth

Main measures of performance	Volumes						Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
Output class: 2 Percentage of children who are caries free at age five - **CW01**[22]							Our 2021 calendar year continued to be affected by the coronavirus pandemic and reduced overall service delivery for the year, but notably, year 8 tamariki were prioritised and the number of Year 8 tamariki examined in 2021 increased slightly from 2020; unfortunately, mean DMFT increased slightly to 1.10 (1.06 in 2020) but this is lower than the current target of 1.21; mean DMFT Māori increased to 1.69 (1.54 in 2020); the 2021 year also meant continued compliance with DCNZ/MoH practice guidelines/ restrictions, a slowed-down approach to patient care and widespread staff vacancies, however, our Year 8 tamariki remained a key priority group for us and we managed to see a high number of this cohort of tamariki in 2021.
■ Total	52%	41%	54%	**44%**	NA	✗	
■ Māori	34%	30%	54%	**29%**	NA	✗	
Output class: 2 Percentage of adolescent utilisation of DHB funded dental services – **CW04**[23]							It is acknowledged that the rate of access to annual dental checks for adolescents is below that needed for healthy preventive oral health. This is also recognised as a national issue with similar rates around the country, including an equity gap for Māori. Increasingly it is realised that improved community engagement with family/Whanau is required to improve access and acceptance of dental care through local practices.
■ Total	70%	61%	>85%	**59%**	71%	✗	

22. Oral health reporting is by financial year. Published results are for the 12 month period ending 30 June 2022. 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.
23. This measure was extracted from MoH report on adolescent utilisation for financial year 2021/2022.

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
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
Output class: 2, 3 Reduced ASH rates 45 – 64 years.[24]							BOPDHB achieved and exceed all agreed targets for ASH 45-64. Māori ASH rates have improved by 8.4% exceeding the 5% target set in the Annual Plan. This is largely the result of improvements in rates within one PHO (NMO) due to the introduction of the Tūāpapa model. The biggest reductions came from heart failure presentations down 40% and angina and chest pain presentations, down 22% for NMO (Nga Mataapuna Oranga) PHO.
■ Māori	7362	7564	7309	**7196**	7074	✓	
■ Total	3859	3665	3691	**3622**	3713	✓	
■ Other	2796	2697	2879	**2694**	2938	✓	

24. Period reported is the 12 months ending 31 June 2022 (Non-Standardised ASH Rate).

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class: 2 Percentage of eligible population who have had their Before School Checks[25] (B4SC) completed. Total High needs	 82% 84%	 81% 78%	 90% 90%	 **82%** **86%**	 ✗ ✗	This important WCTO (Well Child Tamariki Ora) check before school has been affected by COVID-19 requirements and the effects on community from the disruption. Maintaining full staff coverage for delivery of the service was compromised but is now back on track. To the extent that key improvements have been identified for the system recording of checks and the training of staff to ensure children are known for follow up and completion of the check process.
Output class: 3 Percentage of triage level 4 and 5 presenting to the Emergency Department (ED)[26]	44%	43%	≤65%	**41%**	✓	In 21-22 we saw a decrease in less acute presentations to ED but there was an increase in triage 2-3 presentations. Therefore we haven't seen a reduction in patient presentation numbers for acute care; patients presenting to ED are likely to be higher acuity.

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
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
Output class: 2 Percentage of population enrolled with a Primary Health Organisation (PHO)[27]. ■ Total ■ Māori	 96% 91%	 97% 92%	 90% 95%	 **94%** **88%**	 94% 84%	 ✓ ✗	BOPDHB achieved overall PHO enrolment targets in 2021/2022, with 94% of our population of 271200 enrolled with a PHO. Out of which 1289 are enrolled with Te kaha practice. Māori enrolment was over 88% (70860)

25. A nationwide programme offering free health and development checks for four year olds. It aims to identify and address any health, behavioural, social or developmental concerns which could affect a child's ability to get the most benefit from school. Health checks include vision, hearing and oral. This service is provided by CCYHS (Community Child and Youth Health Service and Nga Mataapuna Oranga PHO.
26. ED services in New Zealand utilise a scale of 1-5 triage, with 1 being the most urgent. These principally determine who should be seen first. This is a quality measure because triage categories 4 and 5 may be more appropriately seen in the primary sector and poor performance in this area impacts on our capacity to provide quality services for triage 1-3.
27. Access to primary care has been shown to have positive benefits in maintaining good health, including early detection, and managing long term conditions. It also reduces the economic cost of ill health and is key in reducing disparities in health. 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 1,289 (1,086 Maori) Te Kaha residents enrolled at Te Kaha practice, which is a BOPDHB run primary health care facility.

Main measures of performance	Volumes						Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
Output class: 1 Woman enrolled in a PHO age 25-69 years who have had a cervical cancer screen sample taken in the past three - PV02. ■ Total ■ Māori ■ Non-Māori	 79% 73% 80%	 74% 66% 77%	 80% 80% 80%	 **72%** **61%** **75%**	 71% 62% 73%	 ✗ ✗ ✗	Cervical screening coverage did not reach the target for Total and Māori. Reasons cited are many women opting to wait for the HPV self-swabbing, lack of resources in General Practice due to other focuses, no advertising, limited options for screening to take place. Cervical Screening is simply not a priority for women or general practice at this time. The messaging around the change to primary HPV testing has not been clear. There is a misconception amongst many GPs/nurses that the change is to a self-testing programme and as such they have not been training any new nurses in cervical sample-taking. It has been clarified to the PHO leads that this is not the case, it is the laboratory test that is changing, and to pass on to their GPs. There is also frustration that very little information or training around the transition has been forthcoming given that this is less than a year away. Screening, colposcopy and HPV immunisation all need to occur at times and places convenient to wāhine. Women (and people in general) increasingly want options of where to access healthcare. Many, especially younger people, are not enrolled with a GP which leaves them without options for screening and vaccination.
Output class: 1 Woman enrolled in a PHO age 50-69 years who are enrolled in a breast screen program with breast screen midland. - PV01 ■ Total ■ Māori ■ Non Māori	 74% 67% 75%	 68% 59% 70%	 70% 70% 70%	 **66%** **60%** **68%**	 67% 60% 68%	 ✗ ✗ ✗	National breast screening programme is 2 yearly for women aged 45-69. 66% of all women were screened in the 2 years prior to July 2022. 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 ~8%. This is a decrease from last year. 60% of Māori women were screened in the 2 years ending July 2022. 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.

Main measures of performance	Volumes						Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	2022 National Average	Achieved	
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%	68%	80%	**69%**	NA	×	Based on FY 2021/2022 data, this is at 69% which is an improvement from last year. Progress has not been as fast as we would have liked given the impact of COVID 19. In line with Diabetes standards we have established, with the support of Diabetes NZ, a Local Diabetes Team (LDT) across primary, secondary, consumer and NGO sectors to meet and establish some priority actions for the district in line with the new Diabetes Action Plan (still in Draft at MOH level).

3.3.3 People Maintain Functional Independence

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 3 Percentage of the population 65+ years that access Home and Community Support Services (HCSS)	8%	8%	12%	**8%**	×	The percentage of people accessing HCSS during 2021/2022 COVID-19 pandemic were impacted by reduced workforce with the need to reprioritise staff to support those with greatest needs. The population of >65 increases to rise and proportionally increase in percentage needing HCSS support. The target of 12.15% requires review as considered too high.
Output class 3 Maintain current percentage of population over 65 years who have accessed aged residential care (ARC)	3%	4%	5%	**4%**	×	3.57% of over 65 population requiring ARC services is less than national average of 4.4% and considered reflects range of services in place to support people to remain at home. Target of 5% needs reviewing. COVID-19 outbreaks, workforce shortages in ARC in 2022 has seen decrease in some facilities able to maintain full occupancy.

3.3.4 Families and whānau are at the centre of their healthcare

The Annual Plan 2021/22 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
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 2 % of contracted Whānau Ora providers that are using the Whānau Ora and/or Tūāpapa model.	N/A	N/A	N/A	**N/A**	N/A	This is a new measure and we are unable to source data. In future we will be 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 Improving wellbeing though prevention

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 1 LARC insertions/removals for priority groups Total	N/A	N/A	900	**1,709**	✓	Through Protected&Proud we have built a strong provider network (midwives, school nurses, iwi Hauora, pacific island provider, community nurses, general practices, hospital and tertiary education) which means we can help regions when they have staffing shortages. For example in Murupara they no longer have a LARC practitioner in their GP so once per month another LARC provider travels to the region to support women to have their LARC there. Since 2019 we have seen an increase in LARC provision in primary care and a decrease in secondary care, which helps demonstrate a KPI set through our co-design process or providing LARCs closer to where women live. 48% of our service users are wahine Māori and 1 in 3 women are aged under 25 years old. This is a new measure. In 2021/2022 we have 190% achievement against the LARC target.

3.4.2 Appropriate Access to Services

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 3 Number of inpatient surgical discharges under elective initiative SS07 Measure1 Total	9,488	19,809	18,896	**18,053**	×	Sustained high acute demand, high hospital occupancy and associated limited access to inpatient and HDU beds, COVID-19 Alert Level changes, community surge and winter illnesses and workforce vacancies across both sites have negatively impacted planned care delivery in the 2022 year. High volumes of outsourcing across multiple providers.
Output class 3 ESPIs (Elective Services Patient Flow Indicators):[28] -SS07 Measure 2 ESPI 2 – Patients waiting longer than four months for their first specialist assessment (FSA)	13%	7%	0%	**31%**	✓	Patients with cancer presentations or other urgent presentations continue to be prioritised to be seen and treated. A focus on telehealth has had variable results across services.
Output class 3 Did-not Attend (DNA) rate for outpatient services[29] Measure 7.						As an organisation Did Not Attend rates are reported monthly using Power BI as the visualisation tool. Services have the ability to drill down on the data. Phase one of the MoH supported Outpatient Scheduling project will offer patients an Online Booking option. The first two services selected for roll out are Paediatrics and Dental. Both services have high Māori DNA rates. Also of note is the preliminary planning to commission a bus/van to travel around the communities we serve to extend the outreach Outpatient Services we provide. Did Not Attend rates remain a high priority across services, however there is no, one dedicated resource currently allocated to this. There are workstreams currently underway that will impact on this KPI (eg: PC018 Increased Radiology Engagement with Māori, telehealth, Community Orthopaedic Triage, and Equity Reviews by Te Pare ō Toi). Did Not Attend rates are being monitored as balancing measures under these workstreams and for PC018 reducing Māori who did not attend appointments is the focus. There was no target set for 2021/2022.
■ Total	6%	6%	N/A	**6%**	N/A	
■ Māori	14%	13%	N/A	**14%**	N/A	
■ Non Māori	4%	4%	N/A	**4%**	N/A	
Output class 2 Number of clients supported by specialist palliative care Total	1,102	1,037	769	**787**	✓	This is a hospice service delivery measure as inpatients with palliative care needs are supported via a Consult Liaison Service. The volume number does not include 2022-Q2 data from Waipuna hospice, and 2022-Q3/Q4 from Eastern BOP Hospice. The DHB has not received the missing quarterly performance numbers from the MoH Sector Services team.

28. ESPIs are seen as quality measures for elective services because underperformance against any of these indicators has the potential to impact negatively on patient outcomes.
29. This is a quality measure because by reducing our DNA rate, we free up a lot of capacity for people who require treatment. The targets are lower than the baseline, because fewer DNAs means less resources are wasted.

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 2 Number of community pharmacy prescriptions	4,238,026	4,531,877	3,676,982[30]	**4,465,450**	✓	The pharmacy role in primary health care services has grown dramatically during COVID-19 / pandemic response, through provision of improved access (7 Day) to first response clinical care and treatment. The community trust and confidence in the pharmacy service could account for the increased dispensing of prescription medications. Population increases in general for the BOP region will also account for this growth in prescriptions.
Output class 3 Improved wait times for diagnostic services[31] – accepted referrals receive their scan: SS07 Measure 3						High acute demand for angiography (70% of total work) Limitations with Cardiologist resource for planned activity impacts this result. A second Cath Lab will be opening in March 2023 which will support an improvement in this measure. Increased demand for services, MRI shutdown (6 weeks), COVID-19 Alert Level changes, community surge and winter illnesses and high workforce vacancies across both sites have negatively impacted achievement. Outsourcing contracts have been increased to support delivery.
Coronary Angiography in 90 days or less	68%	89%	95%	**84%**	×	
Computing Tomography (CT) (within six weeks)	92%	97%	95%	**94%**	×	
Magnetic Resonance Imaging (MRI) (within six weeks)	90%	92%	90%	**88%**	×	
Output class 3 Improving waiting time for Colonoscopy – SS15						Overall wait times have improved considerably for patients awaiting colonoscopy. In the previous 12 months there has been considerable time, effort and focus on improving the CWTI to ensure BOP were meeting the MOH recommended timeframes before the National Bowel Screening Programme commenced. As a result, BOP has been compliant since May 2022. As at June 2022: Urgent 90.9, (target 90%), Non urgent 79.3, (target 70%), Surveillance 77.4, (target 70%). This is all while there has been a consistent net gain of 815 during April-August, onto the wait list. Service improvement actions have included a review and modification of scheduling processes, as well as weekly capacity and demand meetings with service management, scheduling, and clinical staff. Also, additional waiting lists where possible for outsourcing care has continued to grow, alongside reviewing and modifying our preassessment process. These improvement activities have been ongoing while BOP commenced the National Bowel Screening Programme, (which displaces symptomatic lists), and the service has faced its own staff recruitment and retention challenges.
Urgent (within 14 days)	94%	96%	90%	**94%**	✓	
Non-urgent (within 6 weeks)	33%	43%	70%	**61%**	×	
Surveillance Colonoscopy (within 84 days)	32%	23%	70%	**46%**	×	
Output class 3 Total number of community referred radiology Relative Value Units (*RVUs)[32]	72,845	82,019	72,090	**77,873**	✓	Delivery of community radiology services exceeded target in 2021/2022. The volume delivered was comprised of referrals from both Primary and Secondary service providers.

30. This calculation is based on the current intent of the new community pharmacy service model with zero growth in total dispensing items. It is expected to have initial items growth between 2.5% and 5% with a significant reduction in repeats dispensing. As the service model is expected to change, the actual volume will vary from the target. Note this is also a quality measure, as by managing demand / volume to this level, it demonstrates effectiveness in implementation of the new pharmacy service model. 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.
31 Activity is for all patients who received a diagnostic service in the 12 months ended 30 June 2022. The percentage reflects the proportion of patients who received their service in the specified timeframe.
32 An individual operative / diagnostic / assessment according to the Royal Australian and New Zealand College of Radiologists.

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 2 Total number of community laboratory tests[33]	1,535,544	1,799,302	1,450,000	**1,701,586**	✓	Community laboratory test volumes increased in 2021/2022. Test volumes are increasing at a rate comparable to population growth.
Output class 2 Access rates to mental health and addiction services across DHB and NGO services.						This is a new measure, and the target was not set for 2021/2022.
■ Total	N/A	N/A	N/A	**5%**	N/A	
■ Māori	N/A	N/A	N/A	**7%**	N/A	
Output class 2 Chlamydia testing coverage for 15-24 year olds.[34]	N/A	N/A	N/A	N/A	N/A	This is a new measure, and the target was not set for 2021/2022. We are unable to source data.

3.4.2 People receive prompt and appropriate acute and arranged care

Bay of Plenty DHB achieved over 86% of patients with a confirmed diagnosis of cancer received their first treatment within 62 days – which is higher than the 2021 result.

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 3 Percentage of patients admitted, discharged or transferred from an Emergency Department within six hours – SS10 Health Target.	91%	86%	95%	**79%**	×	Performance against this target has been challenged by growth in acuity of presentations to the ED alongside a 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 was a Board KPI and remains a focus for the next 6 months within the BOP, with significant work underway across the acute flow system to improve patient access and experience.
Output class 3 Part A Faster Cancer Treatment (FCT) – 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– SS11 see Health Target	95%	88%	90%	**86%**	×	Breach reasons have been closely reviewed and themed. Some good improvement work occurring across tumour streams. The FCT Coordinator role has been vacant, and BOP has been supported by Te Manawa Taki Te Aho o Te Kahu hub.

33. Baseline is calculated on actual delivery in the community
34. This is a milestone within the youth domain of the System Level Measure Improvement 2020/2021.

Main measures of performance	Volumes					Comments
	2020 Actual	2021 Actual	2022 Target	2022 Actual	Achieved	
Output class 3 Part B Faster Cancer Treatment – 31 day indicator. Patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	91%	88%	85%	**84%**	×	Patients with cancer presentations continue to be prioritised to be seen and treated. Only slightly under the target. The teams are providing high quality cancer care amidst challenging circumstances.

ADDITIONAL PERFORMANCE INFORMATION: COVID-19 VACCINATIONS AND MORTALITY

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of BOPDHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by).

The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022[35].

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[36] (HSU 2021 vs HSU 2020)

Year[37]	HSU 2021	HSU 2020
2020/2021	11.14%	11.88%
2021/2022	76.92%	82.06%
TOTAL	**88.05%**	**93.94%**

35. https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology
36. Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/2021 annual report.
37. Data as at 30 June 2021 for 2020/2021 and 30 June 2022 for 2021/2022.

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 91.02%, compared with 88.05% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in BOPDHB during 2021/2022 and the prior financial year (2020/2021). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[38]	Dose 1	Dose 2	Booster 1	Booster 2	Total[39]
2020/2021	39,230	25,665	0	0	64,895
2021/2022	177,424	180,727	125,385	1,681	485,217
TOTAL	**216,654**	**206,392**	**125,385**	**1,681**	**550,112**

By 30 June 2022, a total of 550,112 COVID-19 vaccinations had been administered, of which 88.2% were administered in 2021/2022.

There are two similar, but distinct metrics used within the following tables: Doses administered, and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore, deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[40]

Age range (years)[41]	Dose 1	Dose 2	Booster 1	Booster 2	Total[42]
0 to 11	10,715	3,911	0	0	14,626
12 to 15	13,146	12,344	1	0	25,491
16 to 19	10,565	10,439	2,107	0	23,111
20 to 24	11,942	11,736	4,458	0	28,136
25 to 29	13,681	13,582	5,803	3	33,069
30 to 34	14,551	14,486	7,613	12	36,662
35 to 39	13,306	13,251	7,633	8	34,198
40 to 44	12,252	12,336	7,811	12	32,411
45 to 49	13,025	13,224	9,335	18	35,602
50 to 54	13,156	13,463	10,661	39	37,319
55 to 59	12,995	13,506	11,666	61	38,228
60 to 64	12,389	13,226	12,568	109	38,292
65 to 69	8,269	10,648	12,490	251	31,658
70 to 74	6,630	9,332	11,976	315	28,253
75 to 79	4,669	6,658	9,196	344	20,867
80 to 84	3,355	4,799	6,707	282	15,143
85 to 89	1,814	2,508	3,388	132	7,842
90+	964	1,278	1,972	95	4,309
TOTAL	**177,424**	**180,727**	**125,385**	**1,681**	**485,217**

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/2021).

38. Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
39. Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.
40. Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
41. Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
42. Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/2022. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/2022[43]

	Partial[44]		Primary Course[45]		Booster course			
Age group (years)[46]	**Partially vaccinated**	**Partially vaccinated** (% eligible)	**Completed primary course**	**Completed primary course** (% eligible)	**Received first booster** (18+)	**First booster** (% eligible) (18+)	**Received second booster** (50+)	**Received second booster** (% eligible) (50+)
0 to 11	8,987	21%	3,383	8%	0	0%	0	0%
12 to 15	11,188	76%	9,565	65%	0	0%	0	0%
16 to 19	11,498	88%	11,219	86%	1,211	30%	0	0%
20 to 24	11,782	80%	11,606	79%	4,294	35%	0	0%
25 to 29	13,280	76%	13,238	76%	5,477	38%	0	0%
30 to 34	14,931	79%	14,912	79%	7,405	46%	0	0%
35 to 39	13,670	81%	13,698	81%	7,664	52%	0	0%
40 to 44	12,563	81%	12,647	81%	7,779	57%	0	0%
45 to 49	12,678	77%	12,868	79%	8,905	63%	0	0%
50 to 54	13,526	80%	13,807	82%	10,637	70%	32	3%
55 to 59	12,610	75%	13,079	77%	11,199	76%	60	5%
60 to 64	12,774	77%	13,522	81%	12,621	82%	106	7%
65 to 69	9,439	61%	11,285	73%	12,471	88%	239	11%
70 to 74	6,734	48%	9,383	67%	11,881	92%	302	12%
75 to 79	5,233	50%	7,432	71%	9,932	94%	351	15%
80 to 84	3,667	49%	5,291	70%	7,131	96%	281	16%
85 to 89	2,078	55%	2,863	75%	3,732	98%	153	18%
90+	1,174	52%	1,602	71%	2,227	106%	106	18%
TOTAL	**177,812**	**65%**	**181,400**	**66%**	**124,566**	**67%**	**1,630**	**12%**

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[47] administered by ethnicity[48] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	**Dose 1**	**Dose 2**	**Booster 1**	**Booster 2**	**Total**[39]
Asian	15,622	15,187	8,937	30	39,776
European/other	117,160	122,586	95,809	1,528	337 083
Māori	39,611	38,049	18,068	116	95 844
Pacific peoples	4,564	4,443	2,271	6	11 284
Unknown	467	462	300	1	1 230
TOTAL	**177,424**	**180,727**	**125,385**	**1,681**	**485,217**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/2021).

43. Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
44. Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
45. Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).
46. Age groupings in this table reflect age of the persons at end of financial year.
47. This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
48. Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/2022[49]

Ethnicity (Note 1)	**Partially vaccinated** (12+)	**Partially vaccinated** (12+) (% eligible)	**Completed primary course** (12+)	**Completed primary course** (12+) (% eligible)	**Received first booster** (18+)	**Received first booster** (18+) (% eligible)	**Received second booster** (50+)	**Received second booster** (50+) (% eligible)
Asian	14,759	85%	14,987	86%	8,928	58%	20	9%
Māori	37,363	74%	37,377	74%	17,957	52%	110	7%
European/ other	111,553	71%	120,403	76%	95,109	73%	1,494	12%
Pacific peoples	4,627	89%	4,694	91%	2,265	50%	5	5%
Unknown	168,825	73%	178,017	77%	124,566	67%	1,630	12%
TOTAL	**523**	**97%**	**556**	**103%**	**307**	**49%**	**1**	**5%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	**Partially vaccinated** (12+)	**Partially vaccinated** (12+) (% of HSU2021)	**Completed primary course** (12+)	**Completed primary course** (12+) (% of HSU2021)	**Received first booster** (18+)	**Received first booster** (18+) (% eligible)	**Received second booster** (50+)	**Received second booster** (50+) (% eligible)
Asian	16,863	97%	16,597	96%	8929	58%	20	9%
Māori	42,680	84%	40,631	80%	17957	52%	110	7%
European/ other	143,130	91%	140,909	89%	95110	73%	1,494	12%
Pacific peoples	5,129	99%	5,005	97%	2265	50%	5	5%
Unknown	208,470	90%	203,789	88%	124568	67%	1,630	12%
TOTAL	**668**	**124%**	**647**	**120%**	**307**	**49%**	**1**	**5%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022) . Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022). Received First Booster counted for 18+ years old (age as at 30-Jun-2022). Received Second Booster counted for 18+ years old (age as at 30-Jun-2022). 50+ age determined as at 30-Jun-2022. Basis of population is HSU2021 for 12+ years old. All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our 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 ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ[50]:

49. Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
   a. National population estimates (produced quarterly)
   b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
   a. Official national and subnational projections
   b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- 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 response.

Stats NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'[51]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

As at 31 December 2021, there is an estimated 273,751 health service users in the HSU 2021. This is an increase of 14,597 people from the HSU 2020 (an approximate 6% increase), and 3,951 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.[52]

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	66,918	70,100	3,182
Pacific peoples	6,337	5,050	-1,287
Asian	21,154	18,100	-3,054
European/other	178,782	176,500	-2,282
Unknown	560	0	-560
TOTAL (Note 1)	**273,751**	**269,800**	**-3,951**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) 273751. This is 3951 above the Stats NZ total projected population of 269,800 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

50. https://www.stats.govt.nz/methods/population-statistics-user-guide.
51. More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/
52. HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021.

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison.

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[53]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	63,895	68,400	4,505
Pacific peoples	4,809	4,930	121
Asian	16,702	17,900	1,198
European/other	173,451	173,800	349
Unknown	297	0	-297
TOTAL (Note 1)	**259,154**	**265,000**	**5,846**

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 259,154. This is 5,846 below the Stats NZ total projected population of 265000 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[54] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Bay of Plenty DHB by age group at the time of death (as at 30 June 2022).

Age group (years)	Deaths
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	1
50 to 59	1
60 to 69	2
70 to 79	11
80 to 89	21
90+	17
Total	**53**

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Bay of Plenty DHB by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	Deaths
Asian	0
European/other	42
Māori	11
Pacific peoples	0
Unknown[55]	0
Total	**53**

53. HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.
54. EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health.
55. 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

STATEMENT OF RESPONSIBILITY FOR THE YEAR ENDED 30 JUNE 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Bay of Plenty DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Bay of Plenty District Health Board financial statements and statement of performance, and for the judgements made in them.

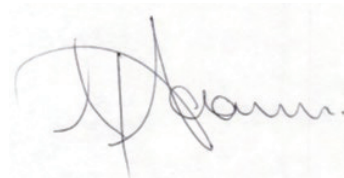
We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Bay of Plenty District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson
Acting Chair

Dated: 6 March 2023



Hon Amy Adams
Board member

Dated: 6 March 2023

06

Financial Statements

Pūrongo Pūtea

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2022

	Note	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
Income				
Crown revenue	4	**1,154,141**	**1,038,981**	976,165
Finance income	9	**451**	**64**	237
Other revenue	5	**7,889**	**6,204**	8,594
Total income		**1,162,481**	**1,045,249**	984,996
Less expenditure				
Employee expenses	7	**411,574**	**354,396**	332,492
Depreciation and amortisation expense	14,15	**21,349**	**28,531**	23,552
Outsourced services		**66,245**	**52,835**	57,513
Clinical supplies		**88,999**	**82,113**	77,155
Other district health boards		**99,354**	**93,190**	89,267
Non-health board provider payments		**441,503**	**395,531**	371,423
Non-clinical expenses	8	**70,886**	**52,363**	47,014
Finance costs	9	**16,390**	**17,045**	12,251
Total operating expenditure		**1,216,300**	**1,076,004**	1,010,667
Share of joint ventures surplus/(deficit)	16	**(251)**	**-**	136
Surplus/(deficit)		**(54,070)**	**(30,755)**	(25,535)
Other comprehensive revenue and expense				
Items that will not be reclassified to surplus/(deficit)				
Gains/(losses) on property revaluations		**60,192**	**-**	107,861
Total other comprehensive income		**6,122**	**-**	107,861
Total comprehensive income		**6,122**	**(30,755)**	82,326

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 2022

	Note	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
ASSETS				
Current assets				
Cash and cash equivalents	10	**4**	**10**	8
Trade and other receivables	12	**89,428**	**34,169**	47,413
Inventories	13	**9,299**	**3,249**	3,716
Total current assets		**98,731**	**37,428**	51,137
Non-current assets				
Investments in joint ventures	16	**313**	**429**	564
Other investments		**299**	**304**	304
Property, plant and equipment	14	**458,744**	**397,150**	409,209
Intangible assets	15	**4,419**	**31,699**	18,700
Total non-current assets		**463,775**	**429,582**	428,777
Total assets		**562,506**	**467,010**	479,914
LIABILITIES				
Current liabilities				
Trade and other payables	18	**71,080**	**47,592**	64,189
Borrowings	19	**4,495**	**53,644**	15,552
Employee benefits liabilities	17	**70,346**	**45,436**	48,427
Provisions	20	**28,106**	**14,749**	14,952
Total current liabilities		**174,027**	**161,421**	143,120
Non-current liabilities				
Borrowings	19	**189**	**194**	246
Employee benefits liabilities	17	**2,094**	**1,657**	1,614
Total non-current liabilities		**2,283**	**1,851**	1,860
Total liabilities		**176,310**	**163,272**	144,980
Net assets		**386,196**	**303,738**	334,934
EQUITY				
Crown equity		**269,197**	**224,059**	224,057
Accumulated funds		**(138,269)**	**(115,397)**	(84,199)
Property revaluation reserve		**255,268**	**195,076**	195,076
Total equity		**404,196**	**303,738**	334,934
Total equity		**386,196**	**303,738**	334,934

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

STATEMENT OF CHANGES IN NET ASSETS/ EQUITY

For the year ended 30 June 2022

	Crown equity $'000	Property revaluation reserve $'000	Retained earnings $'000	Total $'000
Balance as at 1 July 2021	224,057	195,076	(84,199)	334,934
Comprehensive revenue and expense				
Surplus or deficit for the year	-	-	(54,070)	(54,070)
Gain on the revaluation of land and buildings	-	60,192	-	60,192
Total comprehensive revenue and expense	-	60,192	(54,070)	6,122
Transactions with owners				
Contribution from the Crown	45,140	-	-	45,140
Total transactions with owners	45,140	-	-	45,140
Balance as at 30 June 2022	**269,197**	**255,268**	**(138,269)**	**386,196**

	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**

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 2022

	Note	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
Cash flows from operating activities				
Receipts from Crown and patients		**1,119,928**	**1,052,811**	975,544
Interest received		**356**	**64**	221
GST (net)		**2,644**	**153**	(180)
Payments to suppliers		**(747,708)**	**(691,497)**	(634,805)
Payments to employees		**(375,910)**	**(353,331)**	(324,808)
Capital charge paid		**(16,328)**	**(16,754)**	(12,207)
Net cash flow from operating activities	11	**(17,018)**	**(8,554)**	3,765
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		**42**	**20**	128
Receipts from investment		**6**	**-**	-
Purchase of property, plant and equipment		**(13,739)**	**(29,500)**	(18,226)
Purchase of intangible assets		**(3,321)**	**-**	(3,846)
Net cash flow from investing activities		**(17,012)**	**(29,480)**	(21,944)
Cash flows from financing activities				
Capital contributions from the Crown		**45,140**	**-**	320
Payments of principal for finance leases		**(57)**	**(57)-**	(57)
Net cash flow from financing activities		**45,083**	**(57)-**	263
Net increase/(decrease) in cash and cash equivalents		**11,053**	**(38,091)**	(17,916)
Cash and cash equivalents at the beginning of the year	10	**(15,487)**	**(15,486)**	2,429
Cash and cash equivalents at the end of the year	10	**(4,434)**	**(53,577)**	(15,487)
Cash at bank and in hand	10	**4**	**10**	8
Call deposits	10	**-**	**-**	-
Bank overdrafts	19	**(4,438)**	**(53,587)**	(15,495)
		(4,434)	**(53,577)**	(15,487)

NOTES TO THE FINANCIAL STATEMENTS

1. Statement of accounting policies for the year ended 30 June 2022

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 6th March 2023.

2. Summary of significant accounting policies

2.1 Basis of preparation

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 replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health. The Act disestablished all DHBs and the Health Promotion Agency and transferred the Bay of Plenty District Health Boards assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis. However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

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).

Breach of statutory reporting deadline

The 2021/22 annual report of Bay of Plenty District Health was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

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.

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

Amendment to PBE IPSAS 2 Cash Flow Statement
An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. The group does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has assessed that there will be little change as a result of adopting the new standard, as the requirements are similar to those contained in PBE IFRS 9.

PBE FRS 48 Service Performance Reporting PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

Changes in accounting policies

There have been no changes in accounting policies during the financial year apart from the application of IFRIC interpretation on software-as-a-service (SaaS).

IFRIC released an agenda decision in April 2021 in relation to accounting for configuration and customisation costs incurred in implementing SaaS arrangements. SaaS arrangements are service contracts providing the DHB with the right to access the cloud provider's application software over the contract period. The agenda decision clarifies how current accounting standards should be applied to these types of arrangements.

The DHB's accounting policy has historically been to capitalise costs directly attributable to the configuration and customisation of SaaS arrangements as intangible assets in the Statement of Financial Position. Following the adoption of the above IFRIC agenda decision, current SaaS arrangements were identified and assessed to determine if the DHB has control of the software. For those arrangements where the DHB does not have control of the developed software, the configuration and customisation costs previously capitalised have been derecognised and prospectively these costs are now recognised as operating expenses when the services are received. Amounts paid to the supplier in advance of the commencement of the service period, including for configuration or customisation that are not distinct from the underlying SaaS, are treated as a prepayment.

The impact on prior year has been considered to be not material and restatement of 2021 financial statement has not been made.

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 are described 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.

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.

Covid inventory cost is allocated using the first in, first out (FIFO) method, which assumes that the items for inventory that were purchased first are distributed or used first.

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

2.7 Property, plant and equipment

Property, plant, and equipment consist of:
(i) Land
(ii) Buildings
(iii) Plant, equipment and vehicles
(iv) Leasehold improvements
(v) Work in progress

Revaluation

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

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

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

Additions

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

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

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

Depreciation

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

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

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

Freehold land and work in progress are not depreciated.

Subsequent costs

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

Disposals

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

2.8 Intangible assets

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

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

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

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

Intangible assets comprise:

Computer software

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

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

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

Staff training costs are recognised as an expense when incurred.

Finance Procurement Supply Chain, including 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 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 17.

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 all interpretations are agreed, these would be used by each DHB to systematically assess their liability. The BOPDHB has included an estimated liability in note 20.

Other Provision

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

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

4. Crown revenue

	Actual 2022 $'000	Actual 2021 $'000
Crown appropriation revenue	**982,921**	904,431
Inter-district patient inflows	**26,146**	23,201
Crown non appropriation revenue	**145,074**	48,533
Total Crown revenue	**1,154,141**	976,165

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 2022 $'000	Actual 2021 $'000
Donations and bequests received	**120**	136
Other revenue	**7,169**	7,843
Rental income from investment properties	**600**	615
	7,889	8,594

6. Exchange versus non exchange revenue

	Actual 2022 $'000	Actual 2021 $'000
Exchange revenue	**177,222**	78,330
Non-exchange revenue	**985,259**	906,666
	1,162,481	984,996

7. Employee benefit costs

	Actual 2022 $'000	Actual 2021 $'000
Salaries and wages	**364,432**	315,356
Defined contribution plan employer contributions	**11,590**	10,199
Increase/(decrease) in employee entitlements/liabilities	**35,552**	6,937
Total personnel costs	**411,574**	332,492

8. Non clinical expenses

	Actual 2022 $'000	Actual 2021 $'000
Fees to Deloitte for financial statements audit	**241**	186
Impairment of receivables	**222**	190
Operating lease expenses	**5,575**	6,766
Infrastructure servicing costs and other sundry expenses	**64,311**	39,662
Directors' fees	**322**	290
Koha	**117**	27
Loss/(gain) on sale of assets	**98**	(107)
Total other expenses	**70,886**	47,014

9. Finance income and finance costs

	Actual 2022 $'000	Actual 2021 $'000
Finance income		
Interest income	**451**	237
Total finance income	**451**	237
Finance costs		
Interest expense	**51**	31
Bank charges	**11**	13
Capital charge	**16,328**	12,207
Total finance costs	**16,390**	12,251
Net finance costs	**15,939**	12,014

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 2022 was 5% (2021: 5%).

10. Cash and cash equivalents

	Actual 2022 $'000	Actual 2021 $'000
Cash at bank and in hand	**4**	8
Call deposits	**-**	-
Total cash and cash equivalents	**4**	8

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 2022 $'000	Actual 2021 $'000
Surplus/(deficit)	**(54,070)**	(25,535)
Add/(less) non-cash items		
Share of joint ventures (surplus)/deficit	**251**	(136)
Share of other investment surplus	**-**	-
Depreciation and amortisation expense	**21,349**	23,552
Rapid Antigen Testing stock provided by MOH	**5,217**	-
Total non-cash items	**26,817**	23,416
Add/(less) items classified as investing or financing activities		
(Gains)/losses on disposal of property, plant, and equipment	**(42)**	(128)
Total items classified as investing or financing activities	**(42)**	(128)
Add/(less) movements in working capital items		
(Increase)/Decrease in receivables	**(30,287)**	(9,060)
(Increase)/Decrease in inventory	**(366)**	(583)
Increase/(Decrease) in payables and employee benefit liabilities	**40,930**	15,655
Net movement in working capital items	**1,277**	6,012
Net cash inflow/(outflow) from operating activities	**(17,018)**	3,765

12. Trade and other receivables

	Actual 2022 $'000	Actual 2021 $'000
Trade receivables from non-related parties	**1,147**	1,354
Expected credit loss	**(309)**	(194)
Amounts due from related parties	**242**	263
Crown and Ministry of Health receivables	**64,286**	30,797
Accrued income	**10,404**	13,106
Prepayments	**13,658**	2,087
Total debtors and other receivables	**89,428**	47,413
Receivables from exchange transactions	**62,457**	14,824
Receivables from non-exchange transactions	**26,971**	32,589
	89,428	47,413

Included in prepayment is $10,437,463 being transferred from intangible assets in accordance with the retrospective application of IFRIC SaaS interpretation.

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 2022 $'000	Actual 2021 $'000
At 1 July	**(194)**	(264)
Movement in expected credit losses on recognised receivables	**(115)**	70
At 30 June	**(309)**	(194)

13. Inventories

	Actual 2022 $'000	Actual 2021 $'000
Central stores	**2,839**	2,548
Covid 19 Testing Distribution Centre	**5,217**	-
Pharmaceuticals	**1,243**	1,168
	9,299	3,716

Inventories are recognised at their historical cost. Inventories recognised in the profit or loss amounted to $52,196,474 (2021: $42,052,617)

No inventories are pledged as security for liabilities (2021: 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 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**

	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 2021	**48,935**	**323,573**	**5,202**	**82,609**	**12,471**	**472,790**
Revaluation Surplus	5,345	36,708	-	-	-	42,053
Additions	-	527	1,460	7,648	13,852	23,487
Disposals	-	(9)	-	(3,746)	-	(3,755)
Capitalised	-	-	-		(9,635)	(9,635)
Transfers	-	-	-	-	-	-
Balance as at 30 June 2022	**54,280**	**360,799**	**6,662**	**86,511**	**16,688**	**524,940**

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 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)**

	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 2021	**-**	**(9)**	**(2,066)**	**(61,506)**	**-**	**(63,581)**
Depreciation charge	-	(18,149)	(315)	(5,902)	-	(24,366)
Elimination on revaluation	-	18,149	-	-	-	18,149
Disposals	-	9	-	3,593	-	3,602
Transfers	-	-	-	-	-	-
Balance as at 30 June 2022	**-**	**-**	**(2,381)**	**(63,815)**	**-**	**(66,196)**
Net book value						
As at 30 June 2021	**48,935**	**323,564**	**3,136**	**21,103**	**12,471**	**409,209**
As at 30 June 2022	**54,280**	**360,799**	**4,281**	**22,695**	**16,689**	**458,744**

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 2022.

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 2022 in relation to property, plant and equipment (2021: nil).

15. Intangible assets

Gross carrying amount	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)
	-	-	-	-
Balance as at 30 June 2021	**25,541**	**1,722**	**3,829**	**31,092**

	Computer software $'000	Others $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2021	**25,541**	**1,722**	**3,829**	**31,092**
Additions	1,722	-	3,932	5,654
Transfers (note 12)	(7,296)	-	(3,141)	(10,437)
Capitalised	-	-	(1,722)	(1,722)
Disposals	(10,399)	-	(394)	(10,793)
Balance as at 30 June 2022	**9,568**	**1,722**	**2,504**	**13,794**

Accumulated amortisation and impairment	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)
Transfer	-	-	-	-
Balance as at 30 June 2021	**(12,148)**	**(244)**	**-**	**(12,392)**

	Computer software $'000	Others $'000	Work in Progress $'000	Total $'000
Balance as at 1 July 2021	**(12,148)**	**(244)**	**-**	**(12,392)**
Amortisation charge for the year	(2,561)	(124)	-	(2,685)
Disposals	5,702	-	-	5,702
Transfers	-	-	-	-
Balance as at 30 June 2022	**(9,007)**	**(368)**	**-**	**(9,375)**

	Computer software $'000	Others $'000	Work in Progress $'000	Total $'000
Net book value				
As at 30 June 2021	**13,393**	**1,478**	**3,829**	**18,700**
As at 30 June 2022	**561**	**1,354**	**2,504**	**4,419**

16. Investments joint venture

(a) General information

Name of entity	Principal activities	Interest held at 2022 %	Interest held at 2021 %	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
2022					
HealthShare Limited	**34,561**	**32,994**	**1,567**	**20,451**	**(1,800)**
2021					
HealthShare Limited	37,274	33,908	3,365	24,424	1,221

(c) Share of profit of joint ventures

	Actual 2022 $'000	Actual 2021 $'000
Share of profit/(loss) before tax	**(251)**	136
Tax expense	**-**	-
Share of profit/(loss) after tax	**(251)**	136

(d) Investment in joint ventures

	Actual 2022 $'000	Actual 2021 $'000
Carrying amount at the beginning of the year	**564**	428
Share of total recognised revenue and expenses	**(251)**	136
Carrying amount at the end of the year	**313**	564

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

There are no contingent liabilities and commitments at year end (2021: nil).

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

17. Employee entitlements

	Actual 2022 $'000	Actual 2021 $'000
Current portion		
Annual leave	**44,036**	35,673
Long service leave	**1,558**	1,625
Salary and wages accrual	**24,752**	11,129
Total current portion	**70,346**	48,427
Non-current portion		
Long service leave	**2,094**	1,614
Total non-current portion	**2,094**	1,614
Total employee entitlements	**72,440**	50,041

18. Trade and other payables

	Actual 2022 $'000	Actual 2021 $'000
Trade payables	**7,721**	2,444
ACC levy payable	**542**	500
Accrued expenses	**46,787**	47,535
Amounts due to related parties	**276**	299
PAYE payable	**3,517**	3,976
Income received in advance	**5,803**	5,645
GST payable	**6,434**	3,790
Total creditors and other payables	**71,080**	64,189
Payables from exchange transactions	**60,587**	55,923
Payables from non-exchange transactions	**10,493**	8,266
	71,080	64,189

19. Borrowings

All borrowings are measured at amortised cost.

	Actual 2022 $'000	Actual 2021 $'000
Current portion		
Secured		
Bank overdrafts	**4,438**	15,495
Finance lease liabilities	**57**	57
Total current portion	**4,495**	15,552
Non-current portion		
Finance lease liabilities	**189**	246
Total non-current portion	**189**	246
Total borrowings	**4,684**	15,798

19. Borrowings (continued)

Analysis of finance leases

	Actual 2022 $'000	Actual 2021 $'000
Total minimum lease payments payable		
Not later than one year	**57**	57
Later than one year and not later than five years	**189**	226
Later than five years	**-**	19
Total minimum lease payments	**246**	302
Present value of minimum lease payments	**246**	302
Present value of minimum lease payments payable		
Not later than one year	**57**	57
Later than one year and not later than five years	**189**	226
Later than five years	**-**	19
Total present value of minimum lease payments	**246**	302

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 $142,621 (2021: $ $138,556).

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.

20. Provisions

Movements in provisions are as follows

	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

	Holiday Act provisions $'000	Other provisions $'000	Total $'000
2022			
Balance as at 1 July 2021	14,952	-	14,952
Use of provisions	-	-	-
Additional provisions and increases to existing provisions	13,154	-	13,154
Balance as at 30 June 2022	28,106	-	28,106

20. Provisions continued

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 Holidays Act).

Work has been ongoing since 2016 on behalf of all DHBs and the New Zealand Blood Service, with the Council of Trade Unions, health sector unions, and the Ministry of Business, Innovation and Employment Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act noncompliance 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 has proven to be a significant undertaking and work to assess all non-compliance will continue post the 2021/22 financial year.

As at 30 June 2022, in preparing these financial statements, Bay of Plenty DHB has determined a potential liability based on its own review of payroll processes and systems which identified instances of non-compliance with the Act and the requirements of the MOU.

This indicative liability is based on a detailed calculation at individual staff member level, as opposed to an estimate based on extrapolated sample testing. The inputs for this calculation are the latest interpretations agreed at national level for all major level elements. The DHB considers it's methodology to be sound, and the estimated liability to be materially correct based on these current interpretations. However, there remain outstanding issues that, when finalised, may change the parameters used to calculate the liability and so the estimates and assumptions may differ to the final outcome as further work is completed. Any further adjustment to the carrying amount of the provision liabilities will occur within the next financial year.

21. 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 2022 $'000	Actual 2021 $'000
Not later than one year	**3,691**	3,892
Later than one year and not later than five years	**7,418**	7,406
Later than five years	**5,282**	6,225
Total non-cancellable operating leases	**16,391**	17,523

Capital commitments

	Actual 2022 $'000	Actual 2021 $'000
Not later than one year	**2,553**	-
Later than one year and not later than five years	**-**	-
Later than five years	**-**	-
Total non-cancellable operating leases	**2,553**	-

During the year ended 30 June 2022 $5,474,113 of operating leases were recognised as an expense in the profit or loss, split between clinical expenses and non-clinical expenses (2021: $4,553,527).

22. Financial instruments

Credit risk

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

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

Concentrations of credit risk for receivables are limited due to the large number and variety of customers. The MoH is the largest debtor (approximately 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.

	2022 Gross Receivable $'000	2021 Gross Receivable $'000	**2022 Impairment $'000**	2021 Impairment $'000
Not past due	**22,735**	3,772	**-**	-
Past due 0-30 days	**1,001**	118	**-**	-
Past due 31-120 days	**14,538**	619	**-**	-
Past due 121-360 days	**1,340**	738	(309)	(194)
Total	**39,614**	5,247	(309)	(194)

	Actual 2022 $'000	Actual 2021 $'000
Trade receivables		
Gross trade receivables	**39,614**	5,247
Individual impairment	**(309)**	(194)
Net total trade receivables	**39,305**	5,053

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.

22. Financial instruments continued

	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
2022							
Payables and accruals	71,080	-	-	-	-	71,080	71,080
Finance leases	29	28	57	132	-	246	246
Total financial liabilities	71,109	28	57	132	-	71,326	71,326
2021							
Payables and accruals	64,189	-	-	-	-	64,189	64,189
Finance leases	28	28	57	170	19	302	302
Total financial liabilities	64,217	28	57	170	19	64,491	64,491

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
2022				
Cash and cash equivalents	4	(4,438)	(4,434)	(4,434)
Trade and other receivables	75,770	-	75,770	75,770
Trade and other payables	-	(65,277)	(65,277)	(65,277)
	75,774	**(69,715)**	**6,059**	**6,059**
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	-	(58,544)	(58,544)	(58,544)
	45,333	**(74,039)**	**(28,706)**	**(28,706)**

Capital management

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

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

23. Related party transactions

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.

Transactions with key management personnel

Key management personnel compensation

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

	Actual 2022 $'000	Actual 2021 $'000
Board members		
Full-time equivalent members	10	10
Remuneration	272	279
Executive Management Team, including the Chief Executive		
Full-time equivalent members	10	9
Remuneration	2,728	2,475
Total full-time equivalent personnel	20	19
Total key management personnel compensation	3,000	2,754

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 (2021: nil).

24. Segment information

Description of segments

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

25. Impact of Covid-19 on the DHB

During the financial year, Bay of Plenty DHB's operations have been significantly impacted by COVID-19.

In August 2021, the Bay of Plenty moved into Alert Level 4. In September the Bay of Plenty moved to Alert Level 3, and then Alert Level 2. In December 2021 all of New Zealand moved to the COVID-19 Protection Framework and Bay of Plenty operated at the Orange setting for the remainder of the year.

While the DHB has received funding for cost directly related to the COVID-19 response, COVID-19 has caused inevitable disruption to the operational services of the DHB. It is difficult to determine the indirect operational and financial impact of COVID-19 during the financial year, or the longer-term impact which may have a material impact on the DHB.

Government funding

The MOH provided funding of $84.6m to assist with the direct costs associated 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 as permanent and casual staff were recruited to assist with the COVID-19 response. Further, we redeployed parts of the existing workforce into the planning and resourcing of a response to the outbreaks, including vaccinations, testing, awareness and patient care. Parts of the workforce not specifically redeployed to the COVID-19 response were still impacted, with additional duties, administration, reporting and responsibility incorporated into their 'business-as-usual' roles as a result of COVID-19. All areas of the workforce were impacted by staff becoming infected with COVID-19 and unable to work, preventative measures and restrictions due to lockdowns, quarantine and travel restrictions.

Other expenses

Supply chain issues resulting from global lockdowns have affected both the cost and availability of goods directly related to the COVID-19 response (e.g. PPE) but has also had a wider impact on other clinical supplies, building costs and consumables. The capacity of outsourced clinical services and the ability to recruit locums was also restricted due to capacity constraints and travel restrictions, having an immediate impact but also a future one as procedures were inevitably delayed. The COVID-19 response also resulted in an increase in administration expenses, including leasing additional premises, hygienic and sanitation supplies, pharmaceutical, security management, advertising, and communications.

26. Events after Balance Date

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

07

Audit Report

Pūrongo Aotake Pūtea

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INDEPENDENT AUDITOR'S REPORT

**TO THE READERS OF
BAY OF PLENTY DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2022**

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 86 to 112, that comprise the statement of financial position as at 30 June 2022, 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 56 to 83.

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 86 to 112:

- present fairly, in all material respects:
  - its financial position as at 30 June 2022; 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 56 to 83:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, 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

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- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 6 March 2023. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to other matters. In addition, we outline the responsibilities of the Board of Te Whatu Ora – Health New Zealand 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 20 on page 107, 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 $28.11 million for the estimated amounts owed to current and past employees. Work on the provision is ongoing, due to the complex nature of health sector employment arrangements, and there is a high level of uncertainty over the amount of the provision. We have therefore 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 $14.95 million provision as at 30 June 2021. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2021.

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 91 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora - Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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Impact of Covid-19

Note 25 on page 112 to the financial statements, which outline(s) the ongoing impact of Covid-19 on the Health Board.

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

Page 78 to 83 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board 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 on page 81 to 83. The notes outlines 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 Health Board 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 of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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.

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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 of Te Whatu Ora.

- 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 disestablishment basis by the Board of Te Whatu Ora.

- 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 of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 6 to 55 and page 84, 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.

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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

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI