Annual Report
for the year ended
30 June 2016

Presented to the House of Representatives pursuant to section 150(3) of the CE Act

Contents

Message from the Board Chairman

The public has high expectations of its health system. I believe that we can be very proud of the range and quality of the health services people in the Lakes DHB community can enjoy.

The health sector faces significant challenges and Lakes DHB is no exception. New technologies, changes in models of care and clinical practice, an ageing population and increases in demand and community expectations require the health system to be adaptable and responsive. Underpinning change there must always be a commitment to quality and sustainability and a commitment to put the patient at the heart of everything we do.

The on-going pressure of the financial environment is one of the factors driving the need for the health system to seek efficiency gains and improvements in purchasing, productivity and the quality of our operation and service delivery. Improving performance across the sector is fundamental to the outcome of New Zealanders living longer, healthier and more independent lives and the health system being cost effective.

Our fiscal situation has been very challenging this year, driven by increasing acute volumes, that is, the growing number of people who attend the emergency departments or come to hospital due to an accident or acute illness and may have to have surgery. An ageing population and more people with long term conditions are also increasing demand across the system for both acute and non acute care. Acute demand pressures on hospital services can limit opportunities to better balance investment across the system and for the local health system to operate within available funding. Integrating primary care with other parts of the health service is vital for better management of long term conditions, mental health, an ageing population and patients in general.

Lakes DHB continues to focus on the same priorities, because the challenges we face are not issues that can be resolved in a short period of time. A driving priority for Lakes DHB is the health of Maori. We must improve health outcomes and reduce disparity by addressing priority needs first. Targeting of vulnerable populations is essential if we are to realise more equitable health outcomes.

Lakes DHB has done well delivering against the elective services and immunisation national health targets. This success has not been enjoyed against every target. Board members understand that every member of a clinical team comes to work every day to do their best for their patients and provide the best care possible. The Board remains focused on improving performance across the health targets and has pushed for clear plans and is committed to achieving all health targets in the coming year.

Research shows that the role of primary care is vital for better management of long term conditions and in managing acute demand. The demand for hospital services is growing at a rapid rate and as more hospital admissions occur due to preventable causes, we need to continue working closely with primary care to ensure ongoing integrated services to the Lakes community.

Lakes DHB continues to support cross agency work that delivers outcomes for children across a range of dimensions and works closely with other social sector organisations to achieve sector goals in relation to the Better Public Services initiatives, Whanau Ora, The Children's Action plan and youth mental health.

Potentially, there are significant gains to be made from DHBs working together in new and innovative ways both in terms of cost savings and improved patient well-being. It is vital this is a whole of system approach which means that primary care needs to be a key partner engaged in developments in this arena.

My thanks go to my fellow Board members for their commitment to the health of our community. To every person who works across the health sector to allow us to enjoy the health services we do, my sincere thanks for your dedication and hard work over the past year.

Deryck Shaw
Chair, Lakes District Health Board

Message from the Chief Executive

Focusing on the first 2000 days of a child's life remains a priority area for Lakes DHB. This is a focus on the first five years of life including the conception to birth period which encompasses eliminating maternal smoking and ensuring all mothers and children have access to universal services.

Lakes DHB has continued to make progress with its maternal and child health service integration which means better, sooner more convenient health services for this population. Our over-riding approach is to ensure a continuum of maternal and child health services across all health services. We want our population engaged in these services, and for the services to be easy to access, high quality and for the patient journey to be seamless.

To support this integration of services, Lakes DHB continues to work towards the development of the Children's Health Centre which will support child health in the Lakes community.

We have renewed our focus on reducing smoking in pregnancy. A renewed impetus is required in order to achieve the government's aspirational goal of a Smokefree New Zealand by 2025, which has also been a goal of the Midland DHBs. We have revitalised our Tobacco Control Plan focussing on who our smokers are, where they live, work and play and how we can provide support to help them quit. The smokefree health targets remain a priority and we continue to engage regularly with our primary care partners and share information about the targets as well as monitoring performance against them.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to the most prevalent long term conditions. These are avoidable risk factors preventable through a supportive environment, improved awareness and personal responsibility for health and well-being. Supporting people to make healthy choices will enable our population to attain a higher quality of life and avoid, delay or reduce the impact of long term conditions, such as diabetes and heart conditions.

We know that long term conditions contribute significantly to health disparity. There are two long term care models using an integrated care approach between primary/community care and secondary specialist services operating in the Lakes area. These are Long Term Conditions Management Planning (LTMCP) in the southern district and Lakes Integrated Network Care (LINC) in the northern as well as the community pharmacists' medications adherence management programmes.

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease through education, screening and early detection and provision of treatment. Primary and community services support people to stay well by providing earlier interventions, diagnostics and treatment and better managing their illness or long term condition.

A greater emphasis on care in the community also sees a greater emphasis on self-care support groups for those with long term conditions.

We are committed, learning and improving from our mistakes and working in partnership with the Health Quality and Safety Commission to deliver on the national initiatives. Lakes DHB reports regularly on progress with the Quality and Safety Markers, hand hygiene, falls, prevention of peri-operative harm, surgical site infection, medication safety, appropriate skin preparation and safe use of opioids programmes.

Thank you to the executive and clinical governance teams for their support and dedication. Thank you also to every staff member, clinical and non-clinical for coming to work every day to support the health outcomes of our people.

Ron Dunham
Chief Executive

Our Statement of Purpose

Vision
The Lakes District Health Board's Vision for the health and independence of its community is:

Healthy Communities – *Mauriora!*

Mission
- Improve health for all;
- Maximise independence for people with disabilities;
- With tangata whenua support a focus on health.

Values
Lakes District Health Board has three core values:

1. Manaakitanga
   Respect and acknowledgement of each other's intrinsic value and contribution

2. Integrity
   Truthfully and consistently acting collectively for the common good

3. Accountability
   Collective and individual ownership for clinical and financial outcomes and sustainability

Our Strategic Priority for 2015/16

To contribute to achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2015/16. Our strategic intent represents a continuation from previous years, as the challenges we face are not short term issues that can be easily resolved within a 12-month period.

While Lakes DHB's over-arching strategic outcome remains achieving health equity, our local strategic outcomes are:

1. To improve the health of the Lakes DHB population
2. To reduce or eliminate health inequalities

Priority Area	Description
The First 2,000 Days	This is a focus on the first five years of life including the conception to birth period, which encompasses eliminating maternal smoking, particularly in the third trimester and all mothers and children have access to universal services.
Establishment of the Child Health Centre	To support the above and all areas of child health in the Lakes community
Management of long term conditions (LTC)	This involves an Integrated Care approach between primary/community care and secondary specialist services; in particular the active management of the two PHO LTC models; `LTCMP` for the southern region and the `LINC `model for the northern region and the Community Pharmacist LTC (Medications) adherence management programme. We know that long term conditions contribute significantly to health disparity
Financials	Ensuring delivery on agreed financial forecasts and the ability to live within our means
Service Integration	Ensuring better integration across services, vertically (secondary/primary) and horizontally

Regional collaboration	Improving clinical services quality and viability across the Midland region and reducing duplication of effort and bureaucracy

The local priorities have been included in our overall performance story to ensure items important to us that are not explicitly covered in the regional strategic intent are included within the 2015/16 Annual Plan. An example of such a priority is the establishment of the Child Health Centre.

Key Risks and Opportunities

By its nature, the health sector is complex and challenging. We have identified the following risks and opportunities as being particularly relevant for 2015/16.

Health Inequalities

We are committed to reducing or eliminating the effects of health disparities through, firstly, identifying them and, secondly, through funding and providing universal programmes which include a focus on reducing disparities as well as specific programmes that target disparities and improve access to services. It should be noted that long term conditions, particularly those that are exacerbated by tobacco use, and maternal smoking (particularly in the third trimester) are significant contributors to health disparity.

The approach we take includes:

- implementing Te Maheretanga Hauora Maori (our Maori Health Plan)
- promoting screening services to hard to reach groups to increase early detection of disease
- implementing services that target communities with identified health inequalities
- setting targets by ethnicity or by high needs
- supporting kaupapa Maori services and 'for Pacific by Pacific' services where appropriate
- increasing the capability of the Maori and Pacific workforce across our district
- using an equity lens as part of decision-making processes (e.g. the Health Equity Assessment Tool)
- engaging with our Disability Support Advisory Committee to provide advice and inform decision making
- engaging with iwi governance bodies to provide advice and inform decision making
- engaging with community health forums and expert advisory groups to provide and receive advice - this will include alliance mechanisms and service level alliance teams representing community/primary/DHB perspectives

The challenge for DHBs in this region is to configure health service delivery in a way that takes account of the complex relationships between the key social determinants of health inequalities (e.g. housing quality and employment), while recognising that a number of public and private agencies influence health outcomes.

About Lakes District Health Board

Lakes DHB was established under the New Zealand Public Health and Disabilities Act 2000 and is responsible for planning, prioritising, funding and providing government-funded health and disability support services to the nearly 105,000 people living in the Rotorua, Taupo, Mangakino and Turangi districts.

Lakes DHB is responsible for funding personal health, Maori health, mental health, primary health, aged care services and some public health in the Lakes district and operates two general hospitals; Rotorua and Taupo supported by the community based services.

Our hospital services provide inpatient beds, outpatient clinics and day services across medical, surgical, child health and maternity services. Within these services there are a variety of specialties (cardiac rehabilitation and diabetes services, surgical specialties such as orthopaedics and ear, nose and throat) and special units (intensive care, coronary care and special care baby units). Surgical services provide operations through theatre complexes at Rotorua and Taupo hospitals. Emergency departments exist at both hospital sites.

Mental health, alcohol and other addictions services are provided through a full range of inpatient and community support services. These services are for child and youth, adult and older people, and incorporate Maori mental health services.

Community-based services provided include district nursing, social work and home support services and disability support. Population health services include public health nursing, school dental services, immunisation, universal newborn hearing screening, vision and hearing testing and B4 School checks.

Through contracts, Lakes DHB funds a range of providers in the wider health sector. Lakes DHB holds over 300 contracts with approximately 145 health service providers and also contracts dentists, pharmacists and primary care services.

Good Employer Initiatives and Equal Employment Opportunities (EEO)

Lakes DHB is a major employer in the Lakes district with approximately 1,500 staff working full time, part time and casual. In addition, there are over 100 contracted staff working at Lakes DHB for OCS, and Spotless Services.

Lakes DHB, as part of its good employer practices and in line with its objective of growing a positive organisational culture, ensured the fair and proper treatment of employees in all aspects of their employment by continuing to review and renew policies, procedures and programmes in accordance with a set review timeline.

In order to enhance transparency and fairness to all groups, the organisation has participated in a further EEO study through the University of Waikato.

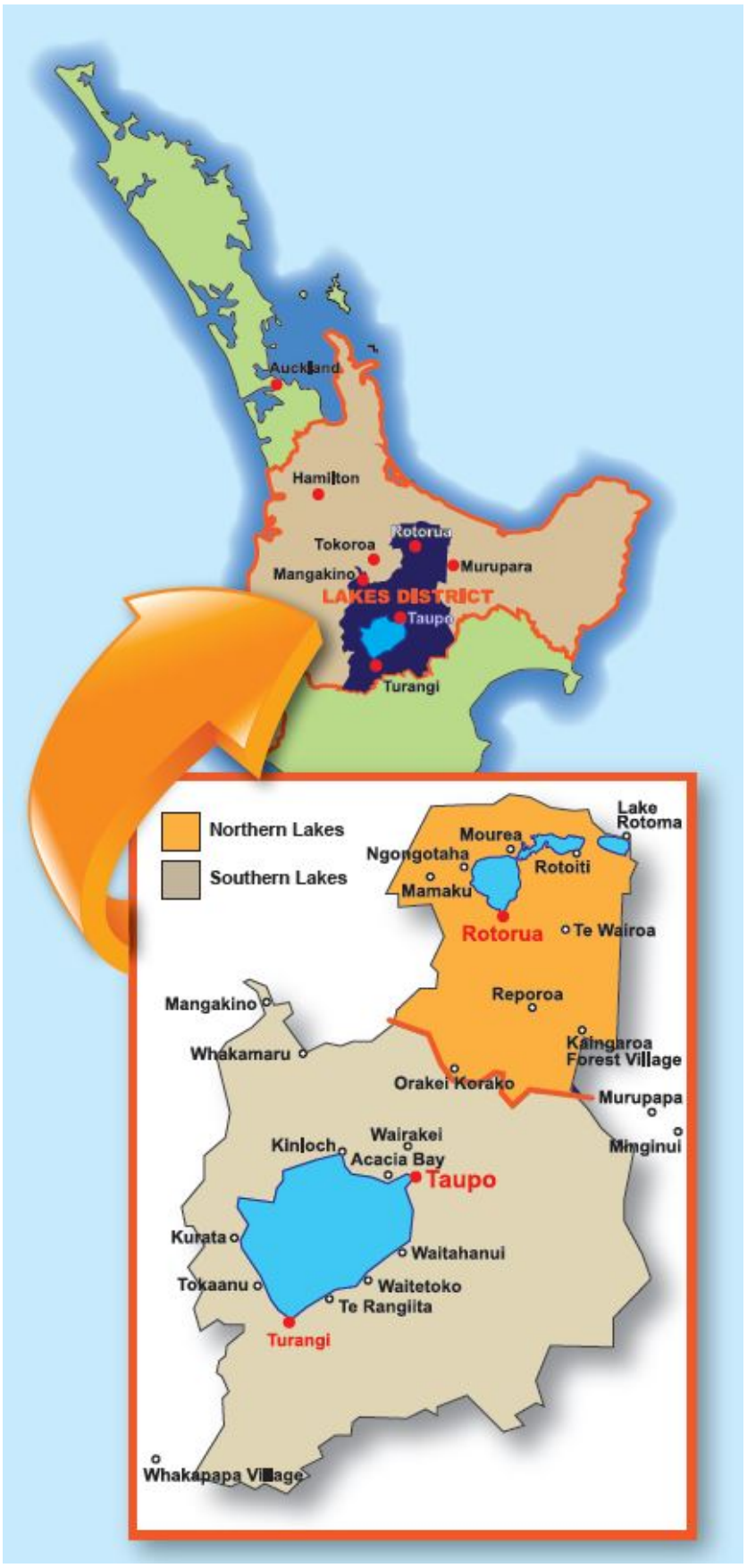
Good employer initiatives focused on bipartite meetings which were held with Council of Trade Union (CTU) union groups on a regular (quarterly / monthly) basis to discuss industrial matters, continue to build on healthy workplaces principles and developing effective partnerships.

The Board appoints the chief executive to manage all DHB operations.

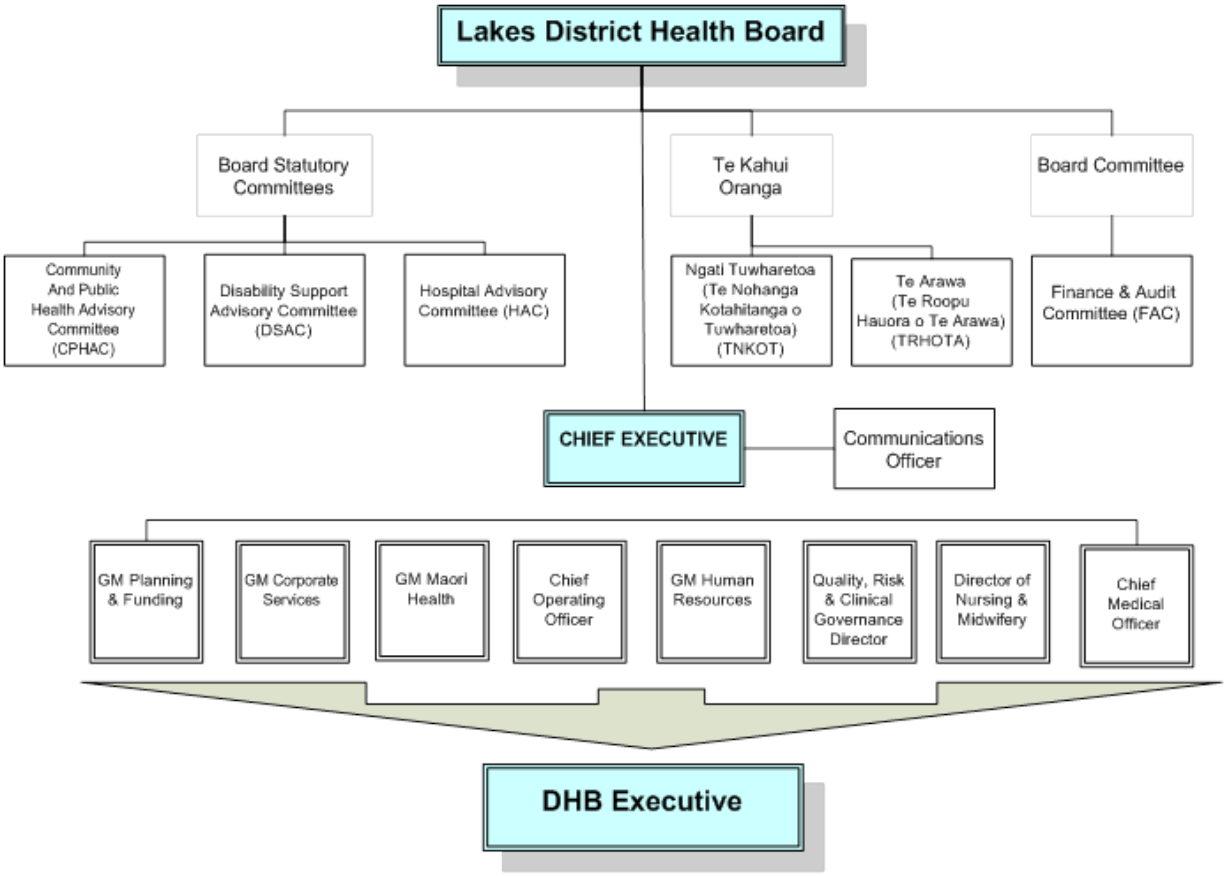
The continued upwards trend in the Staff Satisfaction Survey results for 2012 have shown the policies and practices of the DHB are enhancing a positive and healthy workplace for our employees.

Lakes DHB has become the first DHB or crown entity in New Zealand and first organisation in the Bay of Plenty region to achieve the Gold Standard in the WorkWell audit.

Lakes DHB Boundaries



Governance Structure for 2015/16



The Board

Accountability
The Board holds monthly meetings to monitor progress toward its strategic objectives and to ensure that the affairs of the DHB and its subsidiaries are being conducted in accordance with the DHB's policies. The Disability Support Advisory Committee (DSAC) and Community and Public Health Advisory Committee (CPHAC) meet two-monthly and the Hospital Advisory Committee (HAC) meets two-monthly. The Finance and Audit Committee (FAC) also meets monthly.

Lakes DHB Board members were appointed to the advisory committees at the 13 December 2013 Board meeting.

Conflicts of Interest
The Board maintains an Interests Register and ensures Board members are aware of their obligations to declare any potential conflicts of interest.

Risk Management
The Board acknowledges that it is ultimately responsible for the management of risks to the DHB. The Board has charged the chief executive through its risk management policy with establishing and operating a risk management programme in accordance with the Australian/New Zealand Standard Risk Management AS/NZ 4360:2004. Internal audit occurs as a part of the Board's risk management activity.

Lakes District Health Board 2014
L-R seated: Danny Loughlin, Ailsa Gathergood, Deryck Shaw (Chair), Mary Burdon, Ian McLean
L-R standing; Merepeka Raukawa-Tait, Rob Vigor-Brown, Lyall Thurston (Deputy Chair)' Maggie Bentley, Charles Sturt
Inset: Tamarapa Lloyd

Lakes DHB Board Members

Board Members	Meetings Attended
Deryck Shaw - Chair	11/12
Lyall Thurston – Deputy Chair	11/12
Rob Vigor-Brown	12/12
Mary Burdon	11/12
Ian McLean	11/12
Ailsa Gathergood	10/12
Danny Loughlin	10/12
Maggie Bentley	10/12
Merepeka Raukawa-Tait	9/12
Tamarapa Lloyd	9/12
Charles Sturt (resigned 10 June 2016)	4/10

Iwi Governance Bodies

Te Kahui Oranga is a combined leadership group of Lakes DHB and iwi governance representatives from Te Arawa and Ngati Tuwharetoa). Te Kahui Oranga aims to provide leadership, direction and advice to Lakes DHB, Board committees, the Chief Executive and management on all strategic matters affecting the health of Maori.

Te Kahui Oranga ensures participation at a governance level by agreeing the principles that underpin decision making processes that impact on the health and disability services for Maori within the Lakes DHB district. Te Kahui Oranga is also the vehicle for ensuring effective consultation, and participation of whanau, hapu and iwi (Te Arawa and Ngati Tuwharetoa).

Te Roopu Hauora o Te Arawa and Te Nohanga Kotahitanga o Tuwharetoa continue to participate in Lakes DHB governance activity in particular the Lakes DHB Board committees, and provide advice and direction on specific programmes/projects, as required. Maori Health and Planning and Funding divisions continue to ensure that information is provided to them and that they are given an opportunity to provide feedback.

Te Roopu Hauora o Te Arawa and Te Nohanga Kotahitanga o Tuwharetoa are further developing their capability, and considering relationships across sectors with other organisations and within their own iwi to advance their aim of better health outcomes for Maori.

Iwi governance representatives continue to participate in the Hospital Advisory Committee (HAC), Community, Public Health Advisory Committee (CPHAC) and Disability and Support Advisory Committee (DSAC). At these meetings they receive up to date Ministry of Health and Lakes DHB information, then feed this information back to their respective iwi boards or ask Maori Health to arrange a presentation to their Boards at their monthly hui.

The iwi governance chairs continue to participate in and attend the Midland Iwi Relationships Board forum that meets bi-monthly. This regional collaboration has been developed to participate in and contribute to the regional work across the Midland region. During the 2015/16 year, discussion continued as to how to operate the iwi governance structure in a way that is more efficient and also takes into account increased Midland iwi governance responsibilities.

Iwi Governance Body Membership

Te Roopu Hauora o Te Arawa Members	Te Nohanga Kotahitanga o Tuwharetoa Members
Peri Marks (Chair)	Kim Gosman (Acting Chair)
Aroha Morgan (Deputy Chair)	Anah Pedersen (Pouakani)
Beatrice Yates (Ngati Pikiao - Koeke)	Arana Taumata (Tutetawha Tapuwae)
Harata Patterson (Ngati Rangiwewehi)	Celia Lindsay
Jenny Kaka-Scott (Ngati Manawa)	Delani Brown (Ngati te Maunga)
Kathy Porter (Ngati Hurunga o te Rangi)	Joanna Katipa (Administrator)
Lillian Emery (Ngati Ngararanui)	Johnette Callaghan
Raelynn Marks (Interim Secretary)	Leann Loughlin (Ngati Ruingarangi)
Stephen Te Moni (Rangatahi – Tane)	Mere Maniapoto (Mokai)
Sue Westbrook (Ngati Tahu/Ngati Whaoa)	Olga Rameka (Ngati Hinerau)
Tahae Tait (Ngati Whakaue)	Peehi Wall (Kuia)
	Puti Ruhaina Isaacs
	Thia Priestly
	Tuatea Smallman (Ngati Turangitukua)
	Tuihana Rameka

Community and Public Health Advisory Committee

The Community and Public Health Advisory Committee advises the Board on the needs and health status of the Lakes district population and priorities for use of the health funding provided. The aim of the advice is to ensure that service interventions provided and funded by the Lakes DHB, and policies adopted by Lakes DHB, maximise health gain for the district's population.

The Committee's advice may not be inconsistent with the New Zealand Health Strategy. The Committee focuses on some key policy areas including:

- Primary care and the implementation of the Better, Sooner, More Convenient business cases and primary health organisations
- Whanau Ora and the development and implementation of nationally approved whanau ora initiatives
- Pharmacy including the national process for updating the pharmacy agreement and any locally led initiatives
- Chronic conditions including the ongoing progress towards the Health Targets and locally led initiatives
- Public health concerns including oral health and obesity

CPHAC Committee Membership

Committee Members	Meetings Attended
Lyall Thurston – Chair	5/6
Ailsa Gathergood – Deputy Chair	6/6
Deryck Shaw – Board Chair, Ex-officio	4/6
Mary Burdon	6/6
Maggie Bentley	5/6
Charles Sturt (resigned 10 June 2016)	4/5
Tania Hodges – Waikato DHB committee representative	
Ron Scott – Bay of Plenty DHB committee representative	
Lawrie Croxson – community representative : passed January 2016	
Catriona Watson – community representative	
Margie Robbie – community representative	
Peri Marks – TRHOTA primary representative	
Ana Pedersen – TNKOTH primary representative	
Sue Westbrook – TRHOTA alternate representative	
Delani Brown – TNKOTH alternate representative	
Dr Phil Shoemack/Dr Jim Miller – Ex-officio Medical Officers of Health	
Janet Hanvey – Ex-officio Toi Te Ora Public Health	
Kim Gosman – community representative : replaced Lawrie Croxson February 2016	
Helen Parker – Ex-officio Midlands Health Network : resigned February 2016	
Matthew Davies – Ex-officio Midlands Health Network : appointed April 2016	

Disability Support Advisory Committee

The Disability Support Advisory Committee advises the Board on the disability support needs of the Lakes district population and priorities for use of the health funding provided. The aim of the advice is to promote the inclusion and participation in society, and maximise the independence of the people with disabilities. The committee gives direction on the disability support services the Lakes DHB provides.

The Committee's focus includes the following:

Health of Older People

- Developing and maintaining health and community support services to provide older people in the Lakes district with a continuum of care, including support for carers, regular review of aged residential care capacity and occupancy, quality of workforce skills and training.

Mental Health and Addiction Services

- Advancing continuum of care approach to health and support services to people with mental health issues.

Support for Disabled People

- Improving access to health and disability services.
- Increasing the awareness and education for people working in the health and disability sector.

Consumer Participation

- Arrangements have been put in place for two members of the DSAC committee to assist hospital management in reviewing the templates for letters that are sent to service users, including those that are used in the complaints process. This involvement will ensure that a consumer perspective is considered during the revision of these documents.

Responsive Services

- Encouraging the delivery of health and disability services in a way that is responsive and sensitive to the needs of people with disability and monitoring the implementation of policies, in particular, those relating to services of older people, people with long term disability and people who require palliative care services.

Meetings feature invited speakers who provide information on trends and initiatives that are occurring in this and other communities thus ensuring continual development of committee and staff members' knowledge.

DSAC Committee Membership

Committee Members	Meetings Attended
Lyall Thurston – Chair	4/5
Rob Vigor-Brown – Deputy Chair	4/5
Deryck Shaw – Board Chair, Ex-officio	4/5
Ailsa Gathergood	5/5
Charles Sturt (resigned 10 June 2016)	4/5
Merepeka Raukawa-Tait	3/5
Crystal Beavis – Waikato DHB committee member to 24.02.16	
Pippa Mahood – Waikato DHB committee member from 26.04.16	
Ron Scott – Bay of Plenty DHB committee member	
Colin Cockburn – community representative	
Cherie Reinders – community representative	
Mere Maniapoto – TNKOTH primary representative - resigned	
Leanne Loughlin – TNKOTH primary representative from 27.04.16	
Sue Westbrook – TRHOTA primary representative	
Renee Delamere – ex-officio Support Net representative - resigned	
Don Sorrenson – ex-officio Support Net representative from February 2016	
Matt Watson – RAPHS representative from April 2016	

Hospital Advisory Committee

The Hospital Advisory Committee monitors the financial and operational performance of the Hospital and Specialist Secondary Services (H&SSS), assesses strategic issues relating to the provision of hospital services by or through Lakes DHB and gives the Board advice and recommendations on the monitoring and assessment of performance.

The Hospital Advisory Committee's primary function is that of performance monitoring. The key monitoring work carried out in the 2015/16 year was:

Monitoring of regular H&SSS reports to the Ministry of Health. These include:

- Health Targets
- Hospital benchmarking indicators
- Contract performance including elective services
- Elective Services Patient Flow Indicators (ESPIs)
- Crown Funding Agreement performance relating to H&SSS

Monitoring oversight of the progress on major projects. This has included:

- Clinical governance systems
- Lakes Health Services Improvement Project site development – design brief and concept design
- Progressing lean thinking approach to work design and efficiency
- Credentialing process
- Annual Clinical Services Plan – progress against the targets set for each service
- Workforce development for H&SSS
- Human resource and industrial relations
- Quality and productivity improvement

HAC Committee Membership

Committee Members	Meetings Attended
Mary Burdon – Chair	6/7
Danny Loughlin – Deputy Chair	7/7
Deryck Shaw – Board Chair – Ex officio	5/7
Maggie Bentley	5/7
Ian McLean	5/7
Tamarapa Lloyd	1/7
Martin Gallagher – Waikato DHB community representative	
Mark Arundel – Bay of Plenty DHB community representative	
Julie Calnan – community representative	
David Honore – community representative	
Harata Paterson – TRHOTA primary representative	
Aroha Morgan – TRHOTA HAC representative (deputised)	
Peri Marks – TRHOTA alternate representative	
Ned Wikaira – TNKOTH primary representative – resigned 25.2.16	
Edna Isaacs - TNKOTH alternate representative – passed away 29.10.15	
Ruhaina Isaacs – TNKOTH primary representative – appointed 29.2.16	

Finance and Audit Committee

The Finance and Audit Committee assists the Board with reviewing the monthly financial accounts and related business planning issues. The committee also reviews information systems initiatives, financing issues and the viability of proposed business opportunities. The Finance and Audit Committee is not a statutory committee of the Board.

The purpose of the FAC committee is to ensure that the DHB Board complies with its financial accountabilities and responsibilities including, but not limited to, those set out in sections 39, 41 and 42 of the NZPHD Act and section 51 and part 4 of the Crown Entities Act 2004 and related regulations.

FAC's role includes but is not limited to:

- overseeing the development of the DHB's financial strategies, to monitor the effective management of the organisation's finances and to manage the associated risk issues;
- ensuring that the information presented to the Board is accurate, identifies the relevant issues and is useful for decision making;
- ensuring that appropriate quality, audit and risk management frameworks and systems are established, implemented, monitored and reviewed.

Major projects in 2015/16 included:

- Reviewing and approving all governance policies as they required updating
- Participating in the Insurance Renewal proposal for 2015/16 period with Marsh and NZ Health Partnerships Limited
- Evaluating the impact of the various shared services on Lakes DHB, such as HealthAlliance, NZ Health Partnerships, HealthShare Limited, etc
- Recommended the Board approving in principle the draft Lakes DHB Annual Plan for 2016/17 prior to submitting to Ministry of Health
- Reviewing and making recommendations to the Board on Information Systems strategic direction in terms of security, privacy, Disaster Recovery Plan, etc
- Reviewing the business cases and recommended the Board approve the:
    - Finance lease with Equigroup for the purchase of the CT Scanner and Anaesthetic equipment
    - The regional eSpace Foundation Programme business case
    - Midland shared instance of ProVation business case for $416,379
    - The extension of the food and linen services contract to align with a national contract for both services
    - A Crown loan facility to partially finance capital expenditure associated with the building of the new Children's Centre
    - Declares land surplus for a long term lease at Taupo Hospital and approves management to progress with the development of a business case for St John to lease hospital land for its new building
    - Reviewing and making recommendations on regional and national procurement business cases.

FAC Committee Membership

Committee Members	Meetings Attended
Danny Loughlin - Chair	10/10
Rob Vigor-Brown – Deputy Chair	10/10
Ian McLean	8/10
Deryck Shaw – Ex-Officio	7/10
Merepeka Raukawa-Tait	7/10
Tamarapa Lloyd	5/10

Research and Ethics Committee

The Lakes DHB Research and Ethics Committee was established in 2005 to promote and support high quality locally focused research carried out in accordance with appropriate ethical standards and to encourage the development of an energetic and relevant research culture within the DHB.

Of the committee members, three cover Maori and community interests and possess backgrounds that complement the range of ethical, research and clinical skills of other members who are all employees of the Lakes DHB.

The committee meets on the first Wednesday of each month and deals with research submissions from a range of researchers and research organisations from within and outside the Lakes DHB boundaries. Its activities also include assisting staff and consumers work through ethical issues that have arisen around clinical practice and other work situations. The committee continues to host well-attended and successful research seminars in November of each year - the first being held in 2007.

Research and Ethics Committee Membership

Committee Members
Barry Smith Population Health Analyst, Lakes DHB, chair
Annie Morley, Clinical Nurse Manager, ICU/CCU
Jenny Weston, Family Violence Intervention Co-ordinator
Kristina Maconaghie, Community Representative, Taupo
Marita Ranclaud, Portfolio Manager, Mental Health
Paul Malpass, Clinical Director Taupo Hospital
Tiannie Hillman-Lepper, Special Projects Administrator, Lakes DHB

Clinical Governance

This year has seen the continuing development of the systems encompassed within the pillars of Clinical Governance. The organisation has established an organisational Clinical Audit Committee to oversee and ensure a more robust process around the clinical audit activity occurring throughout the services. This committee has representation from most hospital departments and services and reviews and provides constructive feedback around proposed audit topics.

The Mortality and Morbidity Committee is growing in membership and strength and is lead by Dr Maha Naguib. This year is seeing more of an emphasis on reviewing Lakes DHB's Health Roundtable data on mortality and morbidity. The group is maturing to take greater ownership of departmental and service level performance and the next step is to standardise reporting up through the services, enabling greater transparency and identification of issues in patient care.

This year has seen the implementation of the regional Datix platform for managing incidents and complaints. The Datix platform offers the opportunity to more readily identify recurring themes pertaining to incidents and complaints within the organisation. This will support a more evidenced based approach to determine future quality improvement activities.

This year has also seen the inclusion of consumer and Board representatives sitting at the Clinical Governance table, along with a refocus of the service manager reports supporting alignment with the core components of Clinical Governance.

The Clinical Governance Group has also sanctioned and supported a number of other quality improvement activities. Significant work has been undertaken and is ongoing with identifying and managing the deteriorating patient. This work is led by Dr Maha Naguib who is also currently undergoing training as a Quality Improvement Advisor through Ko Awatea. The organisation has implemented the Quality Walk-arounds, work which is led by the Clinical Director for Quality, Dr Denise Aitken. This initiative has seen DHB executive members visit a number of departments within the organisation and have proved successful in increasing leadership visibility whilst enabling departments to showcase their quality improvement activities.

The year has also seen the implementation of a new Treatment Escalation Pathway supporting clinical staff to provide better and more appropriate care to patients. We have also seen the successful implementation of an Acute Admissions form based on a self populating clerking template. This form and process facilitates more detailed and appropriate care planning for acute admissions to the hospital.

A robust process around prioritisation of business cases has involved members of the Clinical Governance team. One of the many ratified cases included access to an Infectious Diseases Specialist. This is a key role for the organisation in terms of clinical governance moving forward and the individual will be responsible for many quality improvement activities including work around hand hygiene, hospital-acquired infections and antibiotic stewardship.

In addition to the work outlined above, the Clinical Governance Committee continues to oversee on-going patient safety projects including work on VTE prophylaxis and opiate safety led by Dr Ulrike Buehner.

Clinical Governance

Membership	
Sharon Kletchko	Quality, Risk and Clinical Governance Director (Chair)
Martin Thomas	Chief Medical Officer
Gary Lees	Director of Nursing and Midwifery
Nick Saville-Wood	Acting General Manager Clinical Services
Hannes Schoeman	General Manager, Human Resources
Sue Wilkie	Communications Officer
Stephen Bradley	Clinical Director Woman, Child and Family
Peter Freeman	Clinical Director Emergency Department
Paul Malpass	Clinical Director Taupo
Denise Aitken	Clinical Director Quality
Ulrike Buehner	Clinical Director Quality
Nic Crook	Clinical Director Medical Services
Jane Chittenden	Service Manager Medical
Greg Vandergoot	Service Manager Surgical Services
Roger Lysaght	Service Manager Ambulatory
Donna Mayes	Service Manager Woman, Child and Family
Jenny Martelli	Service Manager Medical Management Unit/Hospital Support
Michael Bland	Service Manager, Mental Health Services
Julie Eilers	Service Manager Taupo Hospital, Dental and District Nursing Service
Michael O'Connell	Clinical Nurse Director Mental Health
Jane James	Clinical Nurse Director Surgical Services/Medical Services
Christine Payne	Clinical Nurse Director - WCF, Ambulatory, Medical Management Unit
Ann McKellar	Allied Health Professional Advisors Group Representative
Alex Wheatley	Chief Information Officer
Alan Mountfort	Finance Manager / CFO
Wendy Bunker	Programme Manager
Joanne Hartigan	Laboratory Manager
Sue Finch	Clinical Midwife Manager
Courtenay Thrupp	Consumer Representative
Jo Scott	Personal Assistant CMO & DonM, Secretariat to Committee

Quality and Safety

This year Lakes District Health Board continued our journey towards achieving the New Zealand Triple Aim for our local communities. This is depicted below:

Quality and Safety are embedded within our organisation and the responsibility for supporting quality and safety in everything we do is through the Quality Risk and Clinical Governance Director. This function is central to ensuring patients are safe, our workplace facilitates the ability of our staff to collaborate, protect and promote safety and wellness, our workforce are engaged in action whose primary intent is to enhance health, and our culture delivers care as a core responsibility.

To enable us to continue our journey towards patient safety we have been working collectively at a national level, mainly through supporting the objectives of Health Quality and Safety Commission; regionally, with the Midland DHBs, and locally with providers across the care continuum.

We do this through:

- continuously learning – audit, complaints resolution, incident investigation, etc;
- continuously listening – what did we do? what should we do? how do we do it better?;
- continuously improving – how do we support clinicians and our staff to provide care that is safe, effective, timely, appropriate, acceptable and efficient.

By focusing on learning, listening and improving we are delivering better care and working to achieve the Triple Aim.

So what did we achieve in 2015/16? We:

- demonstrated continuous improvements in falls and fracture prevention within our hospitals
- achieved the national target for hand hygiene and raising awareness of the importance of hand hygiene throughout our organisation
- achieved the minimum expectation that 90% of operations use the three parts of the WHO surgical safety checklist (sign in, time out and sign out)
- worked across our services to support 'Early Warning Signs' monitoring to pick up deteriorating patients
- met the threshold for the clinical interventions specified by the Surgical Site Infection Improvement Programme (SSII)
- are improving medication safety through ensuring medicine reconciliation at admission, transfer and discharge through both paper-based and/or electronic solutions
- are engaging with consumers of our services to improve our informed consent processes and information, to provide feedback to us on what we can improve and to assist us in learning about how and what they experience as patients within our care
- worked to address 'preventable harm to patients' through the Midland Regional DHBs new DATIX system to investigate, improve our services and disseminate our learning
- celebrate our innovations and our results through our Annual Quality Account

Reducing Inequalities

Reducing health inequalities remains at the top of Lakes DHB's agenda. Poorer health and significant health disparities between population groups persist, providing the DHB with its greatest challenge for 2015/16 and beyond. Detailed results are to be found in the Statement of Performance section.

However, compared with the final quarter of 2014/15, progress shown at the same period in 2015/16 has included:

- The achievement of the B4 Schools programme targets which included seeing over 100% of the target group for the Lakes DHB programme.

- HPV immunisation coverage for year 8 girls in Lakes DHB schools continues to be very well focussed and targeted for young Maori women with the results highlighting the success of this approach with significantly higher coverage for Maori than non-Maori and achieved an outstanding report from the Ministry.

- All Lakes DHB school based health services and youth one stop shops are focussed on delivering services to high deprivation children and young people, including the delivery of increased services in Decile 1, 2 and 3 schools, Rotorua School for Young Parents and Alternate Education providers.

- A continued reduction in teenage pregnancies and terminations of pregnancy for women under 20 years of age, with a more marked drop for young Maori than young non-Maori women.

- Lakes DHB continues to have poor oral health compared to other DHB areas in New Zealand. The Lakes DHB caries-free rate at five years of age was one of the lowest, with fewer than half (46 percent) of all five-year-olds being caries free. Within this statistic however, the rate of caries free for Maori at five years of age in Lakes DHB was only 33 percent. Oral health is a significant focus for future work with a major project underway to implement recommendations from the Oral Health Service Report completed in December 2014.

- Smoking in pregnancy is an important measure of health status generally and it is pleasing to see 100% of women who identify themselves as smokers are being given advice to quit.

- Continued equitable Maori/non-Maori hospitalised smoker advice continues to be achieved whilst also meeting the 95% target although work in improving performance is still required with regard to the primary smoking target.

- The achieving of equitable results for eight month immunisation rates by one PHO while the other PHO is showing good improvement in this regard.

- Performance around CVD Risk Assessment (a National Health Target) has shown only very slight improvement during the 12 month period to June 2016 however, disparity is still evident between Maori and non-Maori. Closing this seven percent gap is an area of focus for the coming year.

- While not national targets, the persistent discrepancies seen between Maori and non-Maori for breast and cervical screening is a concern given the serious consequences associated with these conditions and the fact the Maori have higher mortality rates around both of these. Reducing the disparity in these areas was a key focus for the 2015/16 year where a halving of the gap between Maori and non-Maori was encouraging. However, while coverage has improved in breast screening, the differences between Maori and non-Maori persist.

- Did not Attends (DNA) or Was not Brought (WNB / as in children) to outpatient clinics remains a concern in spite of the focus on this area. Generally, in the most recent fiscal year little headway has been made in reducing the differences between Maori and non-Maori non-attendance.

- The Community Pharmacy Programme that focuses on medicines adherence for those with long term conditions is now underway in Lakes and it is expected this will drive benefits as long term

conditions account for significant health disparity. However it is too early to gauge effectiveness of this programme.

The disparity chart below indicates the key areas of disparity between Maori and non-Maori at the end of the 2015/16 year, and the equivalent measure for quarter 4 as at June 30, 2016 except where otherwise indicated.

Measure	Actual 2013/14	Actual 2014/15	Actual 2015/16	Goal 2015/16	5 year goal (eliminate disparity)
8 Month Immunisation Rate	6%	4%	2%	↓ to achieve equity	Nil
% Breastfed at Six Months	18%	3%	15%	↓ to achieve equity	Nil
% Children Enrolled in Dental Services	13%	38%	2%	↓ to achieve equity	Nil
CVD Risk Assessment	12%	8%	7%	↓to achieve equity	Nil
3 Year Cervical Cancer Screen	12%	10%	5%	↓to achieve equity	Nil
Breast Screen	13%	6%	10%	↓ to achieve equity	Nil
Was not brought / Failed to deliver services to children < 15 years - Outpatient Services (for Maori vs NZ European)	17.8% Rate ratio 3.6	13.2% Rate ratio 2.8	15.4% Rate ratio 3.5	↓ to achieve equity	Nil
Sudden Unexpected Death of Infant	The crude SUDI rate suggests that there is a difference between Maori and non-Maori, for 2008-2012 the Maori rate was 2.58, non Maori 0.87.				

The challenge for the Lakes DHBs is to configure health service delivery in a way that takes account of the complex relationships between the key social determinants of health (e.g. housing quality and employment), whilst recognising that a number of public and private agencies in health and other sectors through their policies and activities also play a major role in influencing health outcomes.

Lakes Health Services Improvement Project (LHSIP)

Seismic strengthening works to mechanical services at Rotorua hospital were completed December 2015. This marked the end of the official LHSIP project.

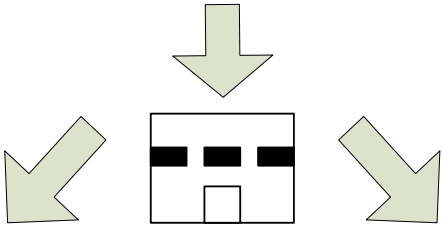
Taupo Hospital

Rotorua Hospital

How Lakes DHB Funding Flows[1]

Note: "Provider Arm" is an umbrella term and includes other DHB Provider Arms. Community Services include the community services of other DHBs e.g. Hauora Waikato

Ministry of Health
Vote Health
$321M

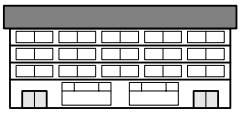


Lakes DHB

$5M
Governance and Administration (G&A)

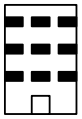
CE, Governance (Board and Statutory Committees), Corporate Services, Planning and Funding

$154M



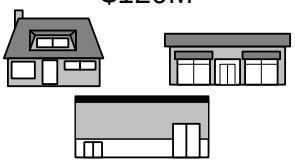
Provider Arm (HSSS/Population Health)
Clinical Services, ED, Specialist Assessments, Surgery, Fracture Clinic, Chemotherapy, Pain Clinics, District Nursing, Home Oxygen, Home Help, Meals on Wheels, NASC, IDFs, etc

$42M



Other DHBs
Secondary and Tertiary

$120M



Community Services
Labs, Pharmacy, Mental Health, Dentists, Aged Residential Care, PHOs, NGOs, Public Health, Home Based Support Services, Primary Care

[1] CE (Chief Executive), P&F (Planning & Funding), ED (Emergency Department), PHOs (Primary Health Organisations), NGOs (Non Government Organisations), NASC (Needs Assessment Service Co-ordination), IDFs (Inter District Flows)

Key Achievements for 2015/16

Lakes DHB continues to work at reducing health disparity in its region with this goal being the underlying factor that shapes much of the health service delivery in the Lakes district. This is a goal shared by the primary/community sector who has given pivotal support to the DHB in its significant achievements. The better working and patient environments resulting from the Rotorua and Taupo Hospital site redevelopment has contributed to the year's achievements.

Health Targets

Most Health Target results are based on performance in the last quarter of the 2015/16 year. The exceptions to this data span are for "improved access to elective surgery" where a 12-month data period is used. Good performance across all health targets is important to Lakes as a part of its overall goal to reduce health disparity in the Lakes region.

Nationally, one target was met for the final quarter of 2015/16:

- Improved access to elective surgery target

Other Lakes results were disappointing showing that more focus is required around work with the hospital and primary care to achieve better results across the board. A persistent challenge for the DHB remains the meeting of the "shorter stays in emergency departments" target where Lakes is last after returning a figure showing that 89% of presentations (as against a target of 95%) were admitted, discharged or transferred from ED within six hours. Lakes DHB is putting in considerable work into progressing this target with this effort being ongoing. However, results to date are still disappointing.

Childhood Immunisation

Lakes DHB has seen a significant improvement since 2010 when Lakes DHB had the lowest immunisation coverage in the country with only 65% of all two-year-olds having an up to date immunisation record. At the end of the fourth quarter 2015/16 Lakes had 91% against the target of 95% of all eight month olds up to date noting that in quarter two and three Lakes DHB reached 96% coverage and ranked among the top 20 DHBs. Of significant achievement was the ongoing high coverage for Maori children being as good or better than non-Maori across the quarters. The goal is to see consistently high results across all quarters.

Elective Services

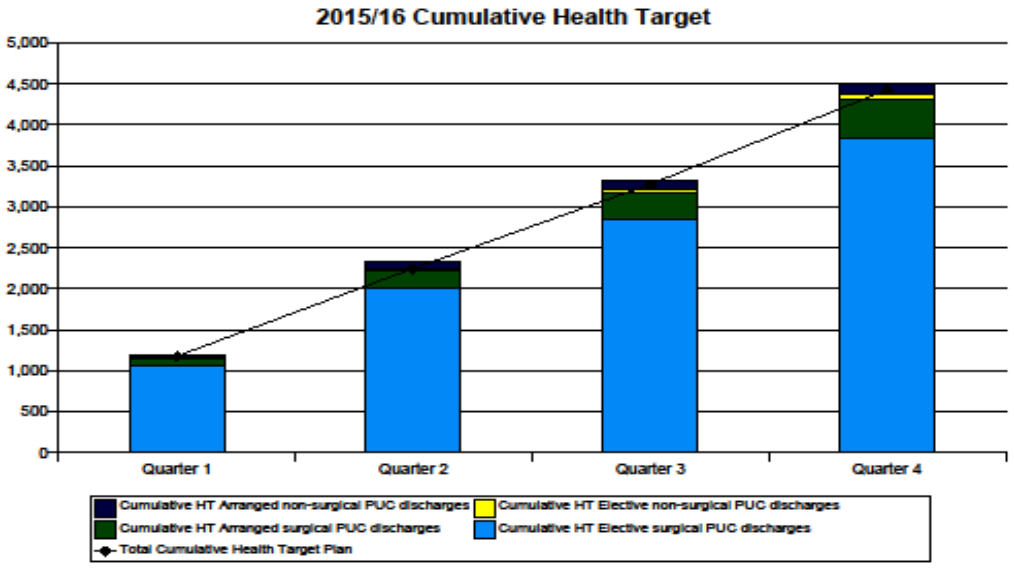
Lakes District Health Board
2015/16 Electives Health Target Report

2015/16 Health Target Delivery

	Year to Date HT Plan	Year to Date HT Delivery	Variance from plan	2015/16 Health Target
Elective surgical PUC	3,819	3,847	28	4,421
Elective non-surgical PUC	69	60	-9	
Arranged surgical PUC	388	467	79	
Arranged non-surgical PUC	145	141	-4	
YTD Health Target	4,421	4,515	94	102.1 %

Health Target includes elective and arranged inpatient surgical discharges, regardless of whether they are discharged from a surgical or non-surgical specialty (excluding maternity). Surgical discharges are defined as discharges from a surgical purchase unit (PUC) including intraocular injections and Skin Lesions reported to NMDS, or discharges with a surgical DRG.

	Q1 Result	Q2 Result	Q3 Result	Q4 Result
Final Published Health Target Result	101.5%	103.2%	101.7%	102.1%



Report to: June 2016

Date Last Refreshed: 01/08/2016

Improved Access to Elective Surgery

During the 2015/16 year, the target for elective procedures for Lakes DHB population was 4420 discharges. The actual number achieved was 4514 discharges of which 3357 (74%) elective operations and procedures were carried out in the Lakes DHB hospitals and 26% at our inter district flow (IDF) service providers.

A total of 13,496 first specialist assessments have been completed against the Health Target of 11,550. Of these outpatient appointments, 11,372 were attended at both hospital sites in Rotorua or Taupo, Lakes DHB, and at our specialist third party provider locations. Lakes DHB continues to demonstrate improved access to elective services.

Elective Services Performance Indicators (ESPIs)

The clinical teams put a lot of effort into achieving the four months target (no referrals waiting longer than four months for First Specialist Assessment or elective procedure) and are striving to maintain these targets. We note that some 71% of patients already received their elective procedure within three months of referral to the booking system during the 2015/16 year.

Development of the Colorectal Service

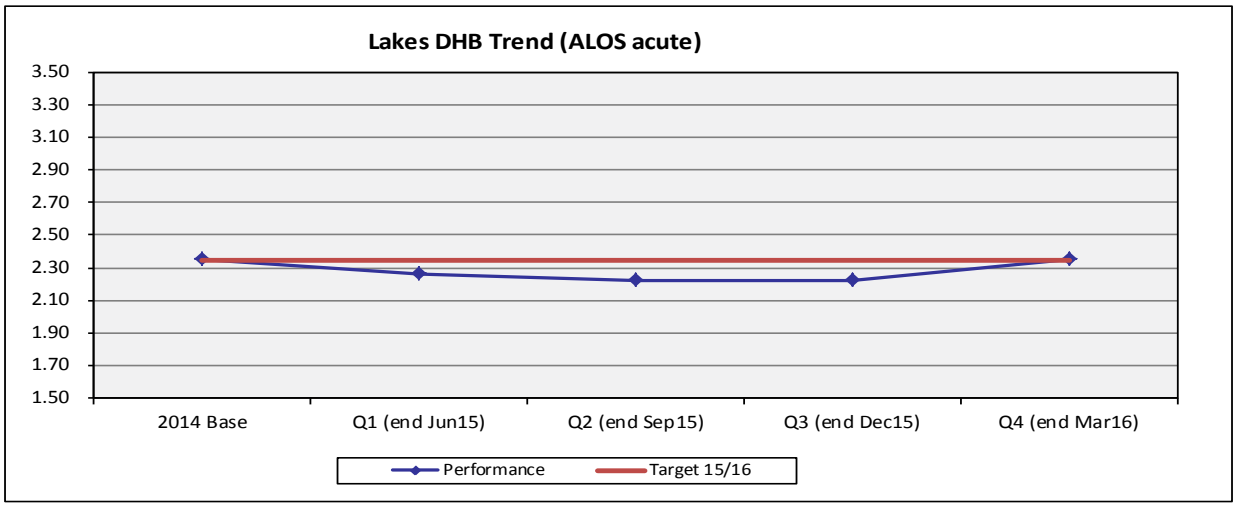
Lakes DHB Surgical Services has introduced a Colo Rectal Nurse specialist to the team to enhance the service we provide to the community. This appointment has lead to an improved co ordination of service across the patient continuum. It has also provided increased support to patients that are under emotional stress while providing one point of contact for patients and there support people.

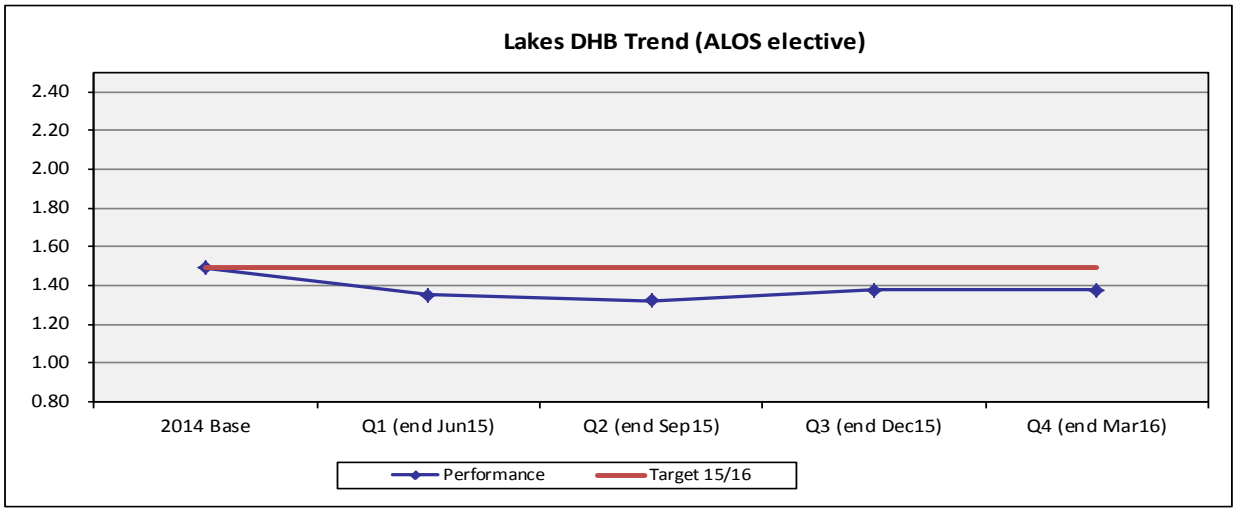
Additional Endoscopy Volumes

Lakes DHB Surgical Services was approached by the Ministry of Health (MoH) with an offer of additional funding support to improve our performance against the colposcopy indicators. A plan was developed using a team approach and with a lot of good will by all involved. The resource was put in place and over a six week period we treated an additional 169 patient above our normal contracted levels. This should bring us into alignment with the MoH colonoscopy indicators.

Length of Stay

Lakes DHB Clinical Services continue to achieve length of stay below the national average for both acute and elective admissions.





Acute Readmissions to Hospital

The new Ministry of Health acute readmissions report shows for the 12 months to 31st March 2016 Lakes DHB as a standardised readmission rate of 6.8% for all ages. The national average is 7.9%.

For the 75+ age group Lakes DHB standardised rate is 8.6% and the national average is 10.6%. This is an improvement on the twelve months to 30 June 2015 which was 9.3%.

ED Presentations

During the 2015/16 year there were 48091 presentations to Lakes DHB emergency departments.

- Rotorua – 34154
- Taupo – 13937

Admissions

During the 2015/16 there were 20609 acute admissions to Lakes DHB hospitals excluding Mental Health Services and 3065 admitted for elective procedures, plus 1782 endoscopy procedures.

Outpatient Attendances

During the year there were 41,372 specialist outpatient attendances at Rotorua and Taupo hospitals.

Value for Money

Clinical Equipment Pool

- The 2015/16 year has seen the continued improvements provided to the clinical services by the clinical equipment pool and centralising the purchasing and management of shared equipment including bariatric beds and mattresses.
- The change in the type of suction pumps loaned to children at home has resulted in these not only being cheaper but smaller and because they come in a carry bag, easier for the families to manage.
- A service improvement in the issuing and management of nursing staff uniforms has resulted in savings as well as better management.

Mortuary

- The Rotorua Mortuary passed the IANZ accreditation visit in 2015, which was a full visit after four years of surveillance visits.
- We purchased the Cover Cool 170 cooling system which keeps the deceased cool while whanau view over extended periods.
- The Mortuary Manager was invited to speak in Wellington and Christchurch with the Alcohol Impairment Education Programme (AIEP) run by the Police.

Junior Medical Staff

- Lakes DHB have introduced there new community allocations for first and second year junior medical staff with GP practices in Turangi, Murupara and Owhata.

Hospital Volunteers

- A service with volunteers based at the Help Desk in the atrium at Rotorua hospital has commenced to assist with visitors to the DHB finding their way around the hospital.

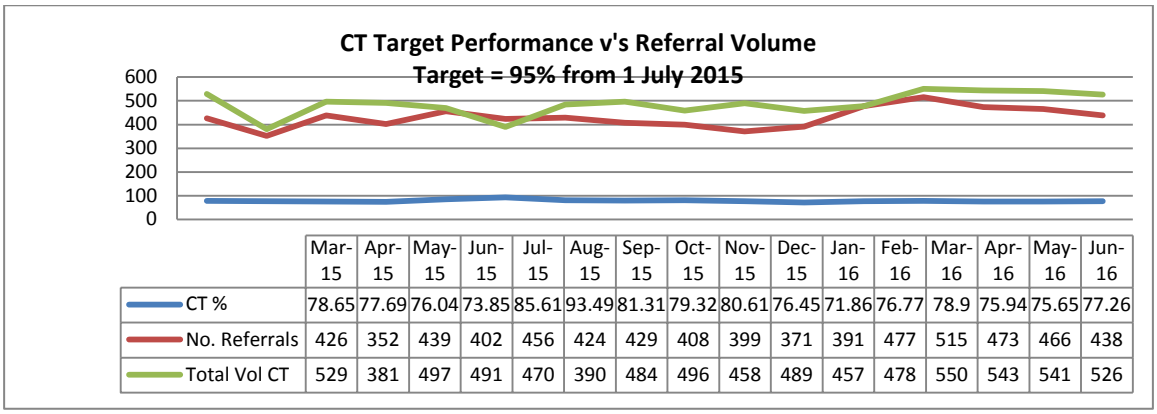
Woman Child and Family (WCF) Service Improvements

- During the 2015/16 year the service introduced a Maternity Day Assessment Unit (DAU) to provide rapid access to assessment for women experiencing problems during pregnancy, referred by lead maternity care midwives. The DAU also successfully supports the obstetric antenatal service where the DAU midwife works in partnership with the consultant obstetrician and so increases the capacity of each clinic.
- The gynaecology on-line Prioritisation Tool was successfully implemented by the O&G team by August 2015.
- The children's unit outdoor play area had a significant upgrade over the summer months and is now safer and used more often.
- The colposcopy service successfully completed an upgrade of its Gynae+ IT system to enable direct electronic reporting to the MoH.
- A successful internal integration project between iCAMHS and WCF child health has provided a psychologist service alongside the paediatric service this year, which has made a significant

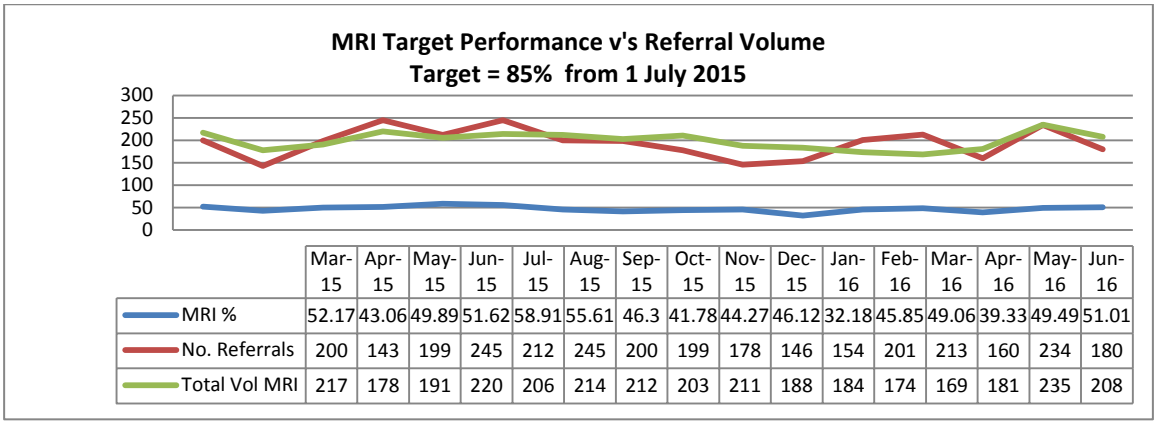
difference for several children and families who have had complex issues to deal with over the past year.

Radiology Department Service Improvements

- Radiology target performance has been variable throughout the year for both CT and MRI. CT is currently at 77.26% against the target of 95%, MRI is currently at 51.01% against the target of 85%.
- IANZ Accreditation – an annual surveillance assessment in November 2015 achieved an excellent result with no corrective actions.
- Referral demand has continued to increase, as are the overall examinations performed. Production has increased overall by 4.7% higher than the previous year's production. Modality of particular concern is CT which saw 10.5% growth in the past year.
- Successful procurement process and business case submitted to Board for the replacement of the current 11 year old MRI scanner. Expected implementation is in October 2016.
- Final paper provided to the MoH on the Radiology Service Improvement Initiative project with formal evaluation acknowledging that the Lakes DHB project had been successful in some areas most significantly the achievement of capacity optimisation, and the development of a lean booking template producing very low DNA rates.
- Participation in clinical pathway development for TIA/Stroke and the GP DVT diagnostic pathway.



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
CT %	78.65	77.69	76.04	73.85	85.61	93.49	81.31	79.32	80.61	76.45	71.86	76.77	78.9	75.94	75.65	77.26
No. Referrals	426	352	439	402	456	424	429	408	399	371	391	477	515	473	466	438
Total Vol CT	529	381	497	491	470	390	484	496	458	489	457	478	550	543	541	526



	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
MRI %	52.17	43.06	49.89	51.62	58.91	55.61	46.3	41.78	44.27	46.12	32.18	45.85	49.06	39.33	49.49	51.01
No. Referrals	200	143	199	245	212	245	200	199	178	146	154	201	213	160	234	180
Total Vol MRI	217	178	191	220	206	214	212	203	211	188	184	174	169	181	235	208

Outpatients Service Improvements

- The outpatient service has increased registered nursing support into speciality clinics to support patients and doctors, this includes multiple sclerosis monitoring, and nurse led talipes clinics as well as general support.
- All clinic staff have had a focus on reducing the number of children non attending clinics.
- The service has introduced a process to check the standard of letters to patients by having regular surveys in the waiting room.
- National Patient Flow programme has resulted in a number of system processes being improved as the implementation has highlighted issues.

Taupo Hospital

- The senior nursing structure at Taupo Hospital has been realigned to better support service delivery and patient flow.
- The Taupo Clinical Services Plan was endorsed by the Board and the implementation plan for the next two years agreed.
- There is an increase in the number of outpatient clinics being provided at Taupo Hospital and this will continue to grow.

Mental Health and Addiction Sector

- Consistent with national trends, the demand for service across the sector has continued to grow. This is particularly so for alcohol and drug services, child mental health services and primary mental health services.
- In 2015/16 the Mental Health Inpatient Unit underwent renovation to better meet patient needs.
- A number of small initiatives saw secondary and primary services working in partnership to deliver group programmes or service in more community based settings e.g. perinatal mental health based at Flourishing Families, an anxiety group for teens co-run by REAL and iCAMHS.

Smoking Health Target

Significant project work has gone into achieving the secondary care and maternity smoking Health Target and providing smoking cessation services. We have a particular focus on smoking in pregnancy. Lakes DHB's population has a higher rate of smokers than nationally, however the recent census results of smoking prevalence in the Lakes population indicated (proportionally) a more pronounced reduction than the national decline in the number of smokers.

Lakes has also provided support to primary care in Rotorua to assist GPs meet the smoking target for their enrolled populations. Results have slowly improved as a result and the 89% achieved in the final quarter of 2015/16 fell just short of the 90% target.

B4 Schools

Lakes DHB delivers a very successful B4 Schools programme which it co-ordinates.

Public Health Nursing and Screening Team: the nurse checks are delivered by the B4 Schools nurses, Tipu Ora, Plunket Rotorua and the Midland Health Network practice nurses. The Vision and Hearing component is delivered by the Vision Hearing Testers (VHTs).

The successful results seen in the 2015-16 year and the high coverage of children living in areas of high deprivation has been a highlight for this team of nurses and the DHB.

Cancer and Palliative Care

The Midland Cancer Network team continues to provide support to Lakes with the development of a range of cancer and palliative care services expected nationally to be delivered across the region.

The key areas of service development in Lakes have included:

- Development of Midland psychological and social support service with the recruitment of a cancer specialist psychologist into the Lakes Cancer Care team
- Multi-disciplinary cross DHB clinician video conferencing meetings to discuss diagnosis and treatment protocols for people diagnosed with cancer has expanded to cover more tumour streams and links with Auckland and Midland DHB clinicians
- Streamlining the tracking of patients diagnosed with cancer from referral to treatment and follow up and review of progress against national target timeframes
- Defining Midland Radiation Oncology Exceptional Circumstance guidelines that cover access criteria for people seeking treatment through the Bay of Plenty Kathryn Kilgour Centre
- Negotiating access to accommodation and support through Cancer Society Lions Lodge for people accessing Waikato DHB cancer treatment centre

- Reviewing transport options for people from Rotorua and Taupo needing to travel to Waikato
- Participating regionally in the development of services relating to tumour standards for sarcoma, lymphoma, gynaecology, prostate, bowel cancers
- Implementation of the national prostate cancer guidelines for active surveillance
- Preparation for Midland participation in the national bowel screening programme

Regionally, the Midland Cancer Network, with all hospices and specialist palliative care services, works closely to develop a full range of services in recognition of increasing future demand and limited expert staff and resources.

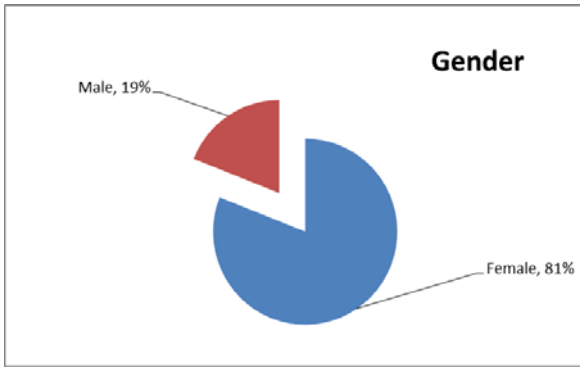
The key areas of development in Lakes have included:

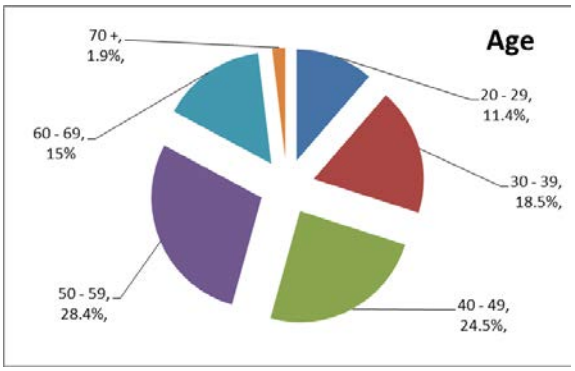
- Supporting hospice led business cases to access additional funding for innovative services to increase palliative care education in primary and residential care settings, as well as the development of volunteer support in Rotorua and cultural support in Taupo
- Aligning DHB reporting requirements to hospice PALCARE database to standardise Midland reporting criteria
- Regular education programmes for community and hospital based health professionals based on the Fundamentals of palliative care and specific care skills
- Providing input into the national service specification alignment to local community service model, national palliative care review report
- Support for the use of End of Life Care planning tools in both hospital and residential care settings
- Standardising referral and care planning processes used by specialist palliative care nursing services
- Continued development of clinical palliative care pathway for children with cancer

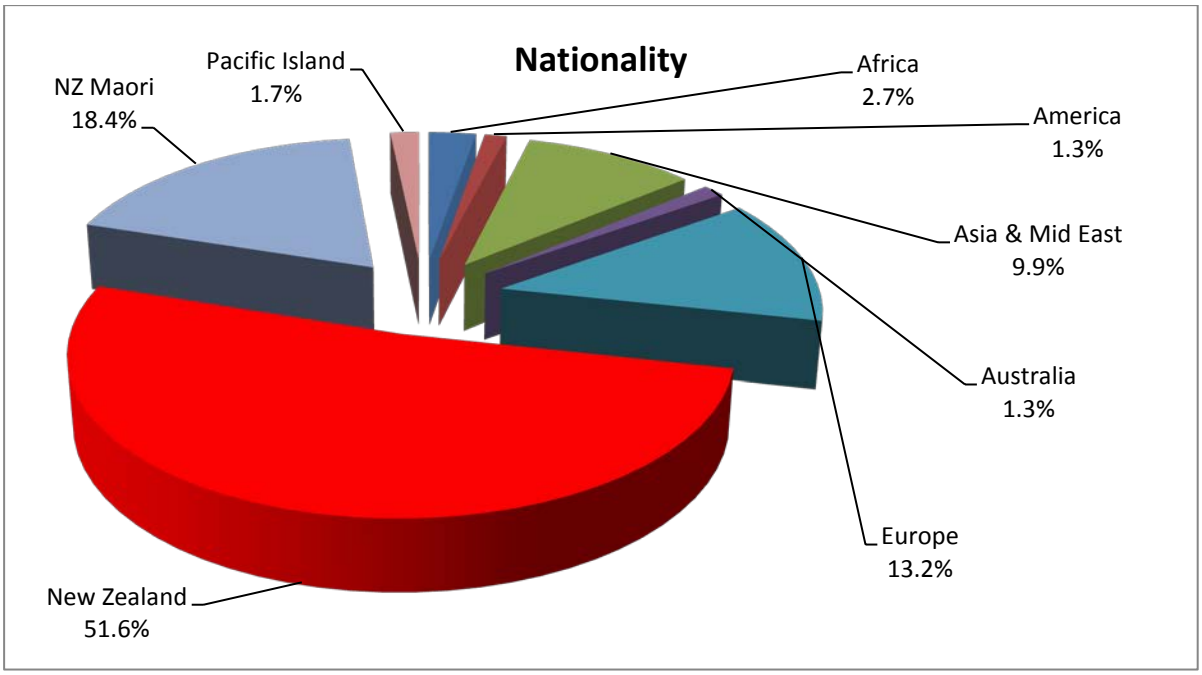
Human Resources

Introduction

Lakes DHB is one of the larger employers in the Lakes district, using contracting services (Spotless and OCS) as well as employing approximately 1500 staff. Lakes DHB offers flexible employment options, permanent, fulltime or part time and casual. The workforce profile at Lakes is depicted in the pie charts below and, as is typical in health, is made up of a high proportion of female staff 81%. The Lakes DHB workforce is diversely represented with 18.4% identifying themselves as New Zealand Maori, 1.7% as Pacific Island origin and 51.6% as being from New Zealand. With regards to age, Lakes DHB staffing has 11.4% between 20 and 29, 18.5% between 30 and 39 years. 24.5% of employees are aged between 40 and 49 years, 28.4% between 50-59 years, 15.3% between 60-69 years of age and 1.9% are 70 and over.







Lakes DHB utilises open and transparent recruitment processes and health and safety pre-employment screening to ensure staff with disabilities are supported into employment and appropriate equipment and support are provided as necessary. Assessments and support is provided where staff identify and report a disability. Lakes DHB has an underreported disabled workforce and as such, data has not been included in this report.

Lakes DHB, in conjunction with employees and unions, continue to work within a number of policies which ensure the wellbeing and fair treatment of employees is maintained. Unions and employee representatives are consulted when new policies affecting employees are developed or existing policies are reviewed.

Equal employment opportunities are maintained in all aspects of recruitment, training and other opportunities. Our policies guide leaders and employees within the organisation to have an understanding of and adhere to fair work practices. Lakes DHB is a member of the EEO group and utilises the information in the regular newsletters and updates when conducting reviews of policies and procedures. This allows the support and promotion to all employees to treat others, and be treated with, respect and freedom from discrimination. A key policy for this reason is the Lakes DHB's Freedom from Discrimination Policy.

Key Elements and Activities

Leadership, Accountability and Culture

Lakes DHB continues with the Lakes Way which is about focussing on being leaders in the health field, being sensitive to patient needs culturally and as human beings, and to be accountable for the actions taken in providing health care to the community. It is important to the organisation and the community that each patient is recognised as an individual and treated with courtesy and respect in all aspects of their treatment pathway.

A Leadership Domains Framework has been developed at a national level and Lakes DHB is currently working on a project to incorporate a Leadership Capabilities Matrix to focus all levels of the organisation on agreed leadership behaviours.

Activities included:

- On-going Managers in Action (MiA) training for all managerial activities, e.g. Recruitment and Selection (including equal employment), Bullying and Harassment (definition and management of), Performance Appraisals, (fairness and consistency), Worker Safety Checking, etc

- Midlands Leadership Development Programmes – The Leadership in Practice Programme for new leaders and the Advanced Leadership Programme for mid to senior leaders covering both clinical and non-clinical groups
- Regular Bullying and Harassment awareness training for employees (definition and conduct)
- Regular meetings with unions and employee representatives as part of our Bipartite and joint consultative arrangements with union groups.

Recruitment, Selection and Induction
Lakes DHB has been able to accurately report on recruitment statistics via the Taleo system and, where necessary, look at policies required to assist with the attraction of a diverse workforce.

In the period 1 July 2015 to 30 June 2016, 3968 job applications were received by Lakes DHB. Of these applicants, 4% were employed. Of the 623 Maori candidates for jobs, 5% were employed making up almost 20% of the total number employed. Of the 997 New Zealand European applicants, 8% were employed equating 49% of the total number employed.

Kia Ora Hauora is a Midlands DHBs' programme, promoting health careers to Maori with the aim of increasing numbers of Maori participating in health training. Lakes DHB homes the Kia Ora Hauora coordinator and administrator and provides staff management and overall coordination of the programme. In addition to Kia Ora Hauora, there has been continued successful involvement with secondary schools to place students on experiential work placements – Gateway - where health has been identified as a preferred career option as well as attendance at local career expos to promote health as a career.

Through pre-employment health screening, we are able to support staff (where required) who start work with disabilities.

Activities included:
- Continued commitment to EEO principles in recruitment practices
- Development and review of recruitment and selection practices on a regular basis
- Review of and continued monthly orientation of new employees to the organisation's expectations and requisite knowledge
- Continued robust selection practices including Maori health representation on interview panels
- Development of a training programme to assist recruiters and interviewers with cultural assessments within the recruitment and selection process
- Monthly reporting on recruitment statistics
- Post-entry survey for new employees at three months to assess Realistic Job Previewing, Induction practices and working environment
- Kia Ora Hauora programme participation
- Attendance at local careers expos
- Secondary school Gateway placements
- Pre-employment health screening
- Individual work station assessments

Employee Development, Promotion and Exit
Continuing professional development is important to all professional groups at Lakes DHB. The learning and development team and professional development unit utilise training needs analysis from the annual performance management process to identify and schedule training. Training is available for all staff in all areas, including leadership development and capability. All employees have access to dedicated learning and development funds and training days.

The Managers in Action training provided by Lakes DHB and the Leadership Programmes are open for application to all employees. These programmes allow employees opportunities for development and allowing for succession options when more senior roles become available. Lakes DHB supports employees 'acting up' into leadership and management positions for leave cover which provides further opportunity for growth.

To enhance training within a flexible workforce, Lakes DHB has e-learning modules available to staff with further courses under development for the upcoming year.

Lakes DHB continues to utilise data from exit interviews to improve work areas where necessary.

Activities Included:

- Continuing Professional Development Funds (psychologists, sonographers and MRTs)
- Continuing Medical Education for doctors
- Learning and Development Training Funds
- Nurses' Training fund
- Support of extramural tertiary training
- Provision of Mentoring and Professional Advisors
- Monthly reporting on access by service and professional group including acceptance statistics
- Utilisation of Exit Interviews
- Ongoing e-learning programme development
- Retirement seminars

Flexibility and Work Design

Lakes DHB operates 24 hours a day, seven days a week, providing full-time, part-time and casual employment opportunities. Lakes DHB has flexible working arrangement policies allowing for employees' diversity with consideration of a flexible approach to rostering for employees requesting alternative working hours for personal reasons. A separate breastfeeding policy allows for mothers returning to the workforce to do so with confidence. The Lakes DHB rostering practices recognise that not all families are the same and the needs and responsibilities can be very different, this does not have to have a negative impact on the work environment or operational requirements, but can enhance the roster situation.

Activities included:

- Continued provision of breastfeeding facilities to mothers returning to work.
- Flexible working arrangements where possible for employees changing circumstances.
- Flexible rostering practices with some departments allowing for "self-rostering"

Remuneration, Recognition and Conditions

Lakes DHB continues to utilise the Strategic Pay job evaluation and remuneration system for staff on Individual Employment agreements and administrative roles.

Lakes DHB has a Remuneration Procedure specifying equal pay for all groups. The procedure provides for a logical and consistent remuneration system that is known and transparent. Nursing and midwifery roles are scoped using the JERC (Job Evaluation Review Committee) process as per the national multi employer collective agreement.

Recognition activities included:

- Celebratory Long Service Awards
- Nursing and Midwifery Awards
- Administration Awards
- Staff Christmas BBQ

Harassment and Bullying Prevention

Lakes DHB has a zero tolerance to bullying and harassment. The human resources team continues to provide training programmes in bullying and harassment to managers and team leaders and a separate programme to staff. A clear Harassment Policy is in place at Lakes DHB with a clear definition and easy to follow flow chart for employees should they have bullying or harassment from a colleague.

Activities included:

- Continued Bullying and Harassment training for managers
- Continued Bullying and Harassment training for employees
- Investigations into allegations of workplace bullying and harassment
- Counselling and facilitated meetings for employees experiencing workplace relationship issues.

Safe and Healthy Environment

Lakes DHB has done a tremendous amount of work over the past 12 months readying the workplace and managers for new Health and Safety legislation.

The Health and Safety Service works with Accident Compensation Corporation (ACC) to return staff to work following work and non-work injury claims. Our aim remains to bring employees back to work early, but safely, and employees are encouraged to be engaged in their return to work planning. Socialisation back into the workplace is important at an early stage, and with the support of their manager and colleagues, a shorter recovery time can be achieved.

Employees participate in an annual ACC Workplace Safety Management Practices and biennial WorkWell Focus Group audit which has resulted in a consistently high level of achievement in both audits.

Electronic reporting has been introduced to the DHB this year which allows for earlier notification and follow-up of any workplace safety concerns or incidents.

Activities included:

- Achievement of a Tertiary Level pass (the highest Level achievable) in the ACC Workplace Safety Management Practices audit
- Work and non-work illness rehabilitation and return to work programme
- Implementation of an online incident and risk notification system
- A range of injury prevention programmes
- Online manual handling modules with area based on the job trainers
- Employee consultation and support forums
- Maintenance of a Gold Level pass in the WorkWell re-accreditation audit
- Improved Healthy Actions programme
- Policy of 'no added sugar' in drinks sold in the cafeteria and vending machines on Lakes DHB premise
- Employee involvement in return to work programmes
- Provision of a free Employee Assistance Services programme
- Provision of a range of immunisations for employees
- Provision of smoking cessation support options for staff
- Pre-employment health screening and ongoing monitoring of those deemed to be 'at risk' due to the work they are undertaking
- On-site Pilates and massage sessions
- On-site introduction to meditation

Conclusion

Lakes DHB is committed to continuing it's good employer status and has continued over the past 12 months with initiatives that support this.

Lakes DHB Community Children's Centre

The DHB has a number of teams dealing with children that are currently in accommodation that needs replacing (Infant, Child and Adolescent Mental Health Service [iCAMHS] and Child Development Team). Lakes DHB is working with Rotorua Lakes Council to co-locate the teams in a central location within the existing library building. With the addition of some other child related services such as dental and paediatric out-patients we are intending to create a more comprehensive child and young person focussed community service. The co-location with the library will add additional value as we are planning with them, ways to improve access to health information to the wider community. This facility will also serve as a hub for services across the district as we are talking to many agencies and NGOs about becoming involved in a wider collaborative to improve services for children. During the 2015/16 year architects were commissioned to develop designs. Lakes DHB will also continue work on developing a collaborative model of care for the centre alongside a wide range of stakeholders, and there will be wider consultation with the public and with iwi.

Linkages across government agencies have been a key part of the early discussions and planning. The Ministry of Education, New Zealand Police, Ministry of Social Development have all indicated support for the project as government agencies work hard on developing an intersectorial model for providing care for children and their families.

The architects have progressed to the detailed design stage of the project. A project manager is in place. The project is being led by Rotorua Lakes Council as they are the building owners, but Lakes DHB is well represented on the project steering committee. The model of care document for the health provision in the building is completed. Alongside the design user group we have now set up a changing practice user group to determine the detailed processes around how clinical teams will operate in the new environment. Inter-sectoral work is continuing to build the relationships and connections between agency leadership teams.

Maori Health

The nationally driven Whanau Ora innovations in our district continue to be strongly supported by our DHB. The Te Arawa Whanau Ora collective has grown from strength to strength, and in the 2015/16 year had to consider changes with the introduction of Te Pou Matakana (Commissioning authority). Te Arawa Whanau Ora has risen to the occasion and met all of the milestones. A specific focus on rangatahi/taiohi is their aspiration for the next few years, however work is continuing with whanau/families. In recent months Te Arawa Whanau Ora has developed a vulnerable whanau hub at a local marae. Using a collective impact framework and working across agencies, the hub supports homeless whanau to find a home and have the necessary supports. The national IT platform for the Northland Commissioning Agency, Whanau Tahi, is being implemented currently and will provide a consistent view of Whanau Ora outcome achievements. Te Arawa Whanau Ora continues to be involved in the Lakes DHB Alliance network.

Tuwharetoa Whanau Ora is currently undergoing significant change, and by September 2016 a new plan guiding the work ahead will be developed. Lakes DHB's Maori Health team continues to support our Whanau Ora collectives. Whanau Ora is one of the most important initiatives from a Maori health and Maori/ whanau development perspective and is incorporated into "He Maheretanga Hauora Maori" – the Maori Health Plan. Whanau Ora is about ensuring a holistic model of service provision which is kaupapa Maori strengths based and puts whanau first and measures change through outcomes determined by whanau. This aligns to the revised He Korowai Oranga overarching aim of Pae Ora – healthy futures.

The Lakes region has two Whanau Ora Collectives, Te Arawa Whanau Ora (TAWO) Collective in the northern end of our district comprising Korowai Aroha Health Trust, Ngati Pikiao Health Services, Aroha Mai Maori Cancer Support, Te Kahui Hauora Trust, Te Waiariki Purea Trust, Maketu Health and Social Services and Te Roopu a Iwi o Te Arawa. Whanau Ora ki Tuwharetoa (WOKT) is in the southern end of our district (Tuwharetoa Charitable Trust, Te Korowai Roopu Tautoko Inc, Te Kupenga Charitable Trust and Tongariro Whanau Support Trust Inc). Furthermore Manaaki Ora (combined organisations Tipu Ora and Te Utuhina Manaakitanga Trust), whilst outside of the Te Arawa Whanau Ora collective, has Whanau Ora central to their organisation's goal.

The programme outcomes for our Whanau Ora Collectives continue to be:

- Whanau are more self-managing and empowered e.g. new skills
- Whanau wellbeing is enhanced e.g. health improvement
- Whanau are more cohesive and connected e.g. keep whanau safe from violence
- Whanau have acquired knowledge that will better enable them to enhance their lives e.g. education
- Whanau are able to embrace Te Ao Maori e.g. tikanga knowledge
- Whanau are more economically secure e.g. improved financial literacy

Iwi Governance

Lakes DHB established Te Kahui Oranga (strategic joined board of Lakes DHB and iwi governance members) from the two iwi governance bodies, Te Roopu Hauora o Te Arawa for the northern part of the district, and Te Nohanga Kotahitanga o Tuwharetoa, for the southern part. Te Kahui Oranga aims to work collaboratively and provide a strategic focus on board activities. Te Kahui Oranga has a terms of reference and membership including the Chairs and Deputy Chairs of the Lakes DHB Board, and both iwi governance boards. Te Roopu Hauora o Te Arawa and Te Nohanga Kotahitanga o Tuwharetoa are currently working on a Memorandum of Understanding that will define and confirm their objectives and the relationship they want with the DHB. The landscape has changed and it is expected

that we will be only one of the partners with an established relationship with iwi governance in health. Te Arawa Whanau Ora was seconded onto this group at Te Roopu's last meeting.

Needs Assessment Service Co-ordination (NASC)

The Lakes DHB Needs Assessment Service Co-ordination service focus continues to be on using health professionals specifically trained in comprehensive health needs assessment and service planning who can work with people and their family to develop a range of support that responds to their identified needs and maximises their ability to remain at home longer or, where appropriate, transfer into long term residential care. The client group includes people who have a need for support that is related to age, long term chronic health conditions, or short term requirements during recovery.

In 2015/16 the referral volumes for assessment and access to support services through NASC have continued to rise with the increase in older vulnerable population and the demand for out of home care in residential respite service after hospital admission. The additional staffing appointments in 2014/15 have improved response wait times for assessment and services and this is continuing to be monitored within Lakes DHB and the Ministry of Health.

As at June 2016, 100% of the NASC client base of approximately 3000, were assessed using a standardised geriatric assessment interRAI tool which identifies the clinical risks for individual older people - information which is shared with their general practitioner and service provider. The national development of interRAI service has resulted in regular reporting of interRAI assessment findings for both people living in the community or in residential care. In addition, the development of a national training programme has seen the Lakes DHB lead practitioner role shifting to national service.

The use of interRAI assessment outcomes at a client level has been promoted within hospital and primary care settings as way of improving the information available to health professionals when considering treatment and support options.

The cost of support services available through NASC has increased over 2014/15 and further work is planned to ensure older people are supported to age well and continue to live in the community for longer with access to DHB funded services being prioritised to those with highest need.

The NASC team continues to successfully provide people able to be discharged early with required community support.

National Health Sector Entities

During 2015/16 we aligned our planning with the planning intentions of key national agencies. These agencies include:

- National Health Information Technology Board
- Health Quality and Safety Commission
- Health Workforce NZ
- National Health Committee (NHC)
- PHARMAC

Nursing Initiatives and Programmes

The career force training started last year has resulted in the first graduating class and we are currently recruiting for a second intake. The second uptake is up and running.

School nurses are now meeting regularly with the Associate Director of Nursing (Primary and Community), allowing them to share ideas and learning across the group and giving them access to professional support from the DHB.

An essentials of care audit has been introduced to check service user opinion of the quality of nursing care delivered in the hospital setting. The first report from this work was presented to the Board with a second planned for August-September. Results so far are mostly positive, with some issues arising from noise at night and food quality. Results have also been presented to unit managers.

A pilot ICU outreach service has been implemented which operates at the weekends. This is designed to improve detection of deteriorating patients at a time of week when Health Roundtable data showed we had higher numbers of failure to rescue. This project is moving to business as usual following successful evaluation.

An improved process and record for managing fluid balance has been introduced in response to audit data showing that performance on the old forms was below expected.

A 'green bag' has been introduced as a visible place to put the patient's own medication which is helping us improve medication reconciliation accuracy within the hospital.

New restraint documentation and training has been developed with a focus on the consent aspect of restraint use. This is aimed at promoting conversation with service users and their family/whanau to ensure we use the least restrictive options when caring for patients.

A review of the Nurse Entry to Practice programme (NETP) is being initiated to build on some work initiated in the mental health service that encourages patients to provide feedback to clinical staff on their perceptions of therapy. Our idea is to develop a process that gets the new graduates to seek feedback from their patients and bring that back to their training sessions. The aim is to have a clearer patient centred focus to the year long programme.

The professional development unit is increasing its use of and development of e-learning materials. So far we have developed a podcast of a training session as well as some video content for training. Our plan is to continue to expand this activity to create more engaging e-learning content.

Older People's Health

Improved Services for Older People:

From 2014, the population of older people in Lakes started to rise with an increased number of people who turn 65 and those in the most vulnerable and very old categories. This has already seen an increase in demand for support and medical services that is expected to continue over next 15 to 20 years. It also coincides with a reduction in the health professional / carer workforce who will have retired. This will challenge the need for the DHB to ensure older people remain as fit and able for longer so as to reduce this demand for funded services / support.

A number of national and regional priorities continue to influence DHB service development and locally the focus continues to be on:

- Supporting primary care to identify people with dementia earlier, consider treatment and ensure referral to range of support services for the person and their carer
- Reducing the risk of falls and injury from falls in hospital and the community
- Increasing access to allied health / community rehabilitation programmes to support older person to retain their mobility, strength and balance
- Earlier diagnosis and improved management of delirium in acute settings
- Preventing osteoporosis and the risk of second fractures for people over 50 through development of fracture liaison service
- Redesigning home and community support services to be more flexible and sustainable through the:
    - Development of individualised funding service for people with long term support – chronic health conditions
    - Regional policy for Paid Family Carers living in the same home as the client
    - Midland approach to future HBSS service development
- Support of the development of specialist services for older people living in the community or in residential care
- Reduction in harm from medication
- Working with PHO alliance groups to define how to better meet the clinical and support needs of older people
- Support of national work reviewing improvements in home and community home based support services that includes payment to support workers for travel in between clients, and improving

development of less casualised, untrained workforce and more flexible responsive services that have national standardised links

- Improving the quality of Home and Community Support Services and Aged Related Residential Care providers services through regular auditing processes and the introduction of national complaints reporting process for home based support providers
- Support national work relating to older people services, such as revised Health of Older People Strategy, development of Secure Dementia Unit Design Guidelines, revised service specifications
- Regular review of Aged Related Residential care provider occupancy and capacity needs
- Reduction in the risk of social isolation for older people via the continuing development of:
    - Accredited Visitors service through Rotorua Age Concern
    - Stroke Foundation aphasia therapy group
    - Elder Abuse and Neglect Prevention service through Family Focus / Age Concern
    - Living Well with Dementia education programme for carers – through Alzheimers and Day Break
- Increase use of interRAI geriatric assessment data to influence local service needs and development within community, primary and secondary care.

Primary Care

The key achievements for a `whole of system` approach have been built on the relationships and shared approaches between primary care and hospital based (secondary services) in the Lakes DHB region. The two Alliance Leadership Teams (ALT) now have plans in place for future focus and priority of service design. The alliance contracting approach has provided a consistent and planned approach for new service design in the region. The Midlands Alliance has released a three year plan that sets out a comprehensive approach for successful implementation of primary care programmes, including Lakes Primary Options and Map of Medicine.

In the northern region the Team Rotorua Alliance with Rotorua Area Primary Health Service (RAPHS) Public Health Organisation (PHO) and the Te Arawa Whanau Ora Collective have commenced the implementation of the recommendations for new service design developed by three `Service Level Alliance Teams` (SLATs) in the prioritised areas: long term conditions (LTC), older person's health and child health. The Youth Slat will report to the ALT in the 2016/17 financial year.

Primary care has maintained a focus on key health deliverables to drive health gains for our population within health targets and capacity and consolidation of new service programmes that address chronic disease prevention and management of long term conditions (LTC). PHO performance with primary health targets has shown variable results when compared to the national average performance. Pinnacle Midlands Health Network (MHN) has generally achieved the targets while RAPHS has not met the 'More Heart and Diabetes Checks' or the 'Better Help for Smokers to Quit' target. It has been pleasing to note however that in quarter 4 RAPHS has showed significant improvement especially in the Better Help for Smokers to Quit target where a rise in excess of 20% has been achieved.

Integrated LTC management programmes are maturing their approach through information systems which provide links for disease register/ patient data transfer, management of care planning, multi disciplinary teams (MDT) interventions and development of clinical measures that improve case management at the practice level. Both PHOs have established extended care support teams that are multi-disciplinary and support practices to deliver care to the most at risk patients using risk stratification processes.

Primary Options for Acute Care (POAC) services are established in both PHOs to assist addressing the increasing acute demand. Extended GP management of patients in the community who have presented with acute illness has improved through implementation of `Primary Options for Acute Care` (POAC) primary options. The programme provides timely diagnostic and clinical management support to the practices to prevent avoidable referral to ED at no extra cost for the patient.

In the southern Lakes region GP practices have transitioned to a new model of care known as Health Care Home for sustainable development of the GP service. LTC management programmes employed multi disciplinary roles in dietetics and social work to strengthen the team approach and have continued to provide activity and nutrition programme support for self management. Nurse practitioner roles have

worked closely with DHB secondary specialists to provide a seamless service for clients in the community.

In the northern Lakes region the Lakes Integrated Network Care (LINC) programme has consolidated the LTC approach through nurse led care co-ordination such as the `Diabetes Care Improvement Programme` (DCIP) for management of a critical long term condition. The LINC programme provides a suite of tools, including dynamic disease registers and risk stratification, to assist providers in allocating patients to care programmes based on their level of need.

The clinical pathways tool `Map of Medicine` has rolled out to both primary and secondary clinicians as part of a regional Midland approach. Clinicians have completed the localisation of pathways for deep vein thrombosis (DVT), cellulitis, dementia, contraception, gout, child asthma, lung cancer, colo-rectal cancer and several gynaecology pathways.

Community pharmacies in the Lakes region have adopted the national approach for improved medicine management and have actively registered clients with adherence to medication issues within their LTC programme for monthly clinical management. All pharmacies have adopted the approach and client numbers are expected to grow consistently as the programme tools become an accepted part of the pharmacy service. Lakes Community Pharmacy group has merged with the Midland Community Pharmacy Group (MidCPG) and a new pharmacy delivered gout service supported by MidCPG has been established in the region.

Continued development of electronic processes accessible across the whole system remains a priority for primary care providers including e-referral between primary and secondary care. Patient Portal, National Child Health Information Programme (NCHIP), access to clinical pathways for consistent client journeys and shared care planning that utilises the continuum of service provider input for a whole of system and right for person outcome are the key goals.

Rheumatic Fever

Lakes DHB was identified by the government as a DHB with a high and growing rate of rheumatic fever and rheumatic heart disease. We are required to address this and to co-ordinate services and prioritise initiatives to achieve the government's Better Public Services target to reduce the incidence of rheumatic fever by two thirds to 1.3 cases per 100,000 people by 2017. In 2015 the Minister of Health agreed to our approach and signed off the refreshed Lakes DHB Rheumatic Fever Plan for another three year period 2015-2018. While numbers are small, the impact of rheumatic fever on children is life-long and a considerable cost to families and communities. Additionally, this is a disease of developing countries. Progress to date has seen a reduction in acute cases and a primary care approach to treating strep throats which can progress to acute rheumatic fever. A register of all rheumatic fever patients enables the DHB to continue providing follow up care and prevent recurrences.

Services have been implemented that target children and families at risk of rheumatic fever. These programmes include rapid response nursing services for children in high prevalence areas to sore throat assessment and treatment. In the same area we have implemented a healthy homes programme where children at risk or admitted to secondary care with related illnesses are referred for housing assessments and support to improve their housing. This may include heating, insulation, bedding and clothing.

National Health Targets[2]

Health Targets are a set of national performance measures specifically designed to improve the performance of DHBs by focussing on rapid progress against key national priorities. They provide a focus for action.

Public reporting of DHB health target results is made every quarter comparing DHB's performance and progress against the targets.

Below are listed the 2015/16 Lakes DHB Quarter Four results.

Key **A** Achieved - **NA** Not Achieved

Table: Lakes DHB Health Targets 2015/16

Health Target	Long Term Target	Lakes 2015/16 target	Result	Status
	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95 percent	89%	NA
	The volume of elective surgery will be increased by an average of 4,000 discharges per year.[3]	100 percent	102 percent	A
	85 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.	85 percent	56 percent	NA
	95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	95 percent	91 percent	NA
	• 95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking. • 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking: • Progress towards 90 percent of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered brief advice and support to quit smoking.	95 percent 90 percent	97 percent 89 percent 100 percent	A NA A
	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.	90 percent	89 percent	NA

[2] Note the commentary from page 27 on these targets.

[3] The specific target for Lakes DHB during the 2015/16 year was for 4420.

Lakes DHB Statement of Performance 2015/16

The outputs noted in the Statement of Performance reflect the performance of the four main functions carried out by District Health Boards. These output classes are:

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

Prevention

Preventative services are publicly funded services that protect and promote health of the whole population or identifiable sub-populations and comprises services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services address individual behaviours by targeting population-wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. High need and at risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services represent our best opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings, including general practice, community and Maori health services, pharmacist services, community pharmaceuticals (the Schedule), child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative with treatment services focused on individuals in smaller groups of individuals.

Intensive Assessment and Treatment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a ‘hospital’. These services are generally complex, more costly and provided by health care professionals that work closely together.

They include:

- Ambulatory services (including outpatient, district nursing and day services across the range of secondary preventive, diagnostic , therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

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

Rehabilitation and Support

Rehabilitation and support services are delivered following a ‘needs assessment’ process and coordination input by Needs Assessment and Service Coordination (NASC) services for a range of services including palliative care services, home-based support services and residential care services.

On a continuum of care these services provide support for individuals following a health-related event.

The financial performance associated with these four functions is detailed in Note 33 in the financial section.

The target results are taken from the final quarter of the 2015/16 fiscal year. Where other data periods are used, these will be clearly noted.

Key **A** Achieved **PA** Partially Achieved **NA** Not Achieved

1 Outcome: People are supported to take greater responsibility for their health

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
Fewer people smoke	Percentage of hospitalised smokers offered advice to quit (Health Target)	Maori	100%	95%	98%	A
		Non-Maori	99%	95%	95%	A
		Total	99%	95%	97%	A
	Percentage of PHO enrolled smokers offered advice to quit (Health Target)	High Needs	79%	90%	Not available[4]	-
		Total	78%	90%	89%	NA
	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 (Health Target and Maori Health Plan)	Maori	68%	90%	100%	A
		Non-Maori	90%	90%	100%	A
		Total	77%	90%	100%	A

Significance of the Measure

It is estimated that some 5,000 New Zealanders die prematurely each year as a direct result of smoking with an estimated reduction in life expectancy being around 15 years. Moreover, the negative consequences of smoking impacts unevenly across the population with Maori, and those experiencing higher levels of social deprivation, suffering most. In terms of the Lakes DHB's aim to reduce health disparity across its population it is critical that work on helping smokers quit is given prominence.

Lakes DHB Performance

Lakes DHB has achieved well against the Minister's 'secondary' smoking target since 2011, often returning a figure of 100%. While Lakes did not reach the primary smoking target significant improvement was made over quarter four with a 15.7% improvement and Midland Health Network meeting the target at 90.5% and RAPHS at 88.3%. The achievement of the maternity target is significant for Lakes DHB with high numbers of Maori women smoking in pregnancy this is a priority area for the DHB to improve outcomes. To this end, the DHB smokefree team has worked tirelessly to achieve this target. Of particular significance in this goal of reducing Maori smoking rates is that a Health Research Council funded research project focusing on the use of cytisine in Maori populations is to be based in Lakes DHB with the research team involving University of Auckland and Lakes DHB staff.

[4] The high needs smoking data is not available as it is no longer collected or reported in this format.

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
Reduction in Vaccine Preventable Diseases	Percentage of eight-month-olds fully immunised (Health Target & Maori Health Plan)	Maori	87%	95%	90%	NA
		Non-Maori	93%	95%	92%	NA
		Total	89%	95%	91%	NA
	Percentage of the population >65 years who have received the seasonal influenza immunisation (PPP & Maori Health Plan)	High Needs	63%	70%	59%	NA
		Total	67%	70%	61%	NA

Significance of the Measure

Immunisation is one of the most important medical interventions to prevent serious disease and also one of the safest. Timing of immunisation is organised to make sure children are protected as early as the immunisation can be effective. All children should be immunised on time for best protection. Childhood diseases like whooping cough and many forms of meningitis can cause death or brain damage to a baby and are preventable. To be really effective, and recognising the concept of herd immunity, 90-95 per cent of the childhood population needs to be immunised.

The current schedule for children to be immunised through their family doctor is at:

- six weeks
- three months
- five months
- 15 months
- four years
- 11 years
- 12 years (available at school)

Older people and people with long term chronic health conditions are recognised as vulnerable populations to influenza flu epidemics which occur during the winter months and are related to an increase number of hospital admissions, general practice visits and risk of further long term effects or death.

Influenza vaccinations are offered to all over the age of 65 and more particularly encouraged for the older frailer population to be provided through primary care. The uptake depends on national and local public awareness marketing and primary care initiatives to contact eligible people with the greatest effect being when immunisation is undertaken in autumn, rather than winter.

Lakes DHB Performance

While Lakes DHB did not reach the 8 months target in quarter 4 the target was successfully reached in quarters 2 and 3. Of significance was the improvement and coverage for Maori across the 2015/16 fiscal year.

Influenza vaccination during 2015/16 which covers the winter of 2015 and the autumn of 2016 indicates the annual target of 70% was not achieved. However, data covering this indicator is being treated with caution as it does not align with information provided for earlier periods.

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
Improving Health Behaviours	Percentage of infants who are fully or exclusively breastfed at 6 months (Maori Health Plan)[5]	Maori	54%	60%	52%	NA
		Non-Maori	72%	60%	67%	A
		Total	66%	60%	59%	NA
	The number of people participating in the GRx (Green Prescription) programmes[6]	Total	231	817	1,006	A
	Reduce the prevalence of gonorrhoea (local measure) Number of cases	Number of cases	165	140	128	A
	Rate per 100,000[7]	Rate per 100,000	141	140	Not available for 2015 calendar year	-

Significance of the Measure

The Green Prescriptions service is intended to introduce people identified at risk of long-term health conditions, through education and personal skills development, to improved physical activity levels and healthy nutrition to reduce the need for health service intervention. The programmes focus on self-management, as individuals and the family/whanau environment forms a proactive part of the systematic approach to management of Long Term Conditions (LTC) within the health service environment. Critically, the programme is focused on children 4 – 18 years and their family/whanau and has specific reference to obesity (weight control), high blood pressure, and depression/anxiety and pre diabetic prevalence present for the person. The value of breastfeeding for the health of children is well established.

Lakes DHB Performance

Green Prescriptions is a national programme and includes the following range of programmes in the Lakes region; `Active Living`, `Family Lifestyle Coach` and `Play in the Bay`. The performance is measured on volume targets and reported outcomes from participants by survey. Referral volumes to the service record a high success rate for intervention with 39% Maori referrals into the programmes across the Rotorua, Taupo and Turangi regions. Programme outcomes rated from client feedback and monitoring fall into three main areas; increased activity; changes in nutritional habits and the person adopting a greater awareness of self-improvement for key personal challenges with only a few reporting no benefit. GRx services are provided within Lakes DHB by Sport BOP for the Rotorua/northern Lakes district and Sport Waikato for Taupo/Turangi and southern Lakes.

Lakes DHB has developed and implemented in the 2015/16 year a breastfeeding service across the whole DHB. We have four fully qualified lactation consultants offering hospital community and home visiting clinics. The percentage of infants who are fully or exclusively breastfed at six months results suggest that more work is needed to encourage and support women to breastfeed to this point in their child's development.

[5] Data covers period July – December, 2015

[6] A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management

[7] The latest data available covers the 2014 calendar year.

2 Outcome: People stay well in their homes and communities

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
An improvement in childhood oral health	Percentage of children (0-4) enrolled in DHB funded dental services (PP13)	Maori	49%	90%	68%	NA
		Non-Maori	62%	90%	70%	NA
		Total	60%	90%	69%	NA
	Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (PP13b)[8]		12%	8%	5%	A
	Percentage of adolescent utilisation of DHB funded dental services (PP12)[9]		69%	85%	73%	NA

Significance of the Measure

Good oral health demonstrates early contact with a health promotion health prevention service and reduced risk factors, such as poor diet, which has lasting health benefits in terms of improved nutrition and healthier body weight and general wellbeing. Oral health is also an integral part of lifelong health and impacts on nutrition, health seeking behaviour, self esteem and quality of life.

Maori children are three times more likely to have decayed, missing and filled teeth and improved oral health is a proxy measure of equity of access and effectiveness of mainstream targeting to high needs.

While water fluoridation can significantly reduce tooth decay across all population groups, only about one fifth of children up to 18 years of age in the Lakes DHB district have access to fluoridated water.

Lakes DHB Performance

Lakes DHB did not meet the oral health targets in the past fiscal year which is disappointing given our high need population. Moreover, it is preventable through, among other interventions, early access to community oral health services and oral health education and promotion. It is evident from the range of oral health data (not all presented here) that this is an area of inequality. However, the establishment of the electronic oral health record (Titanium) over the past two years for every child has generated efficiency gains which should enable the DHB to make gains in this critical area of child health and this is reflected in the gains observed in the above data even though the oral health targets were not achieved.

[8] Data covers the 2015 Calendar Year.
[9] Data covers the 2015 Calendar Year.

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
Long-Term Conditions are Detected Early and Managed Well	Per cent of the eligible population will have had their cardiovascular risk assessed in the last five years (Health Target & MHP)	Maori	80%	90%	85%	NA
		Non-Maori	92%	90%	92%	A
		Total	88%	90%	89%	NA
	Percentage of eligible women (25-69) have a cervical cancer screen every 3 years (Maori Health Plan)[10]	Maori	71%	80%	74%	NA
		Non-Maori	83%	80%	79%	NA
		Total	79%	80%	77%	NA
	Percentage of eligible women (50-69) have a breast screen in the last 2 years (Maori Health Plan)[11] Data used Q3 IPIF results	Maori	63%	70%	72%	A
		Non-Maori	70%	70%	82%	A
		Total	68%	70%	79%	A

Significance of the Measure

Key outcome sought: `New Zealanders living longer, healthier and more independent lives`. Diabetes is a good indicator of the responsiveness of a health service to people in most need, as it is a major and increasing cause of disability and premature death. Long term conditions comprise the major health burden for New Zealand now and into the foreseeable future. Levels of deprivation are a significant predictor for high needs however Maori and Pacific peoples are disproportionately affected.

Cardiovascular Diabetes Risk Assessment is targeted as a key early detection measure for long-term conditions within primary care; that will assist transfer clients into a care management approach so that self-management and regular checks prevent avoidable hospital admissions, promote improved health outcomes through regular advice and create timely access to integrated primary and secondary service options as and when required.

National Screening Unit/Ministry of Health programmes for breast and cervical screening are intended to capture all women and those identified as high priority, to reduce incidence and mortality through routine screens at regular intervals (at minimum within a three to five year period).

Disparity in results between Maori and non-Maori have led to a priority approach for access to screening and reduce the inequality of health outcome for Maori, Pacific and other non-European ethnic groups. Lakes DHB will continue to focus on achieving equitable outcomes along these measures.

Lakes DHB Performance

Primary care enrolment with PHO for primary medical care is maximised, currently 35% of the enrolled population for Lakes is Maori, slightly below the percentage of Maori for total population of the region as a whole.

Cardio vascular disease (CVD) risk assessment has improved but plateaued in the last two quarters with the PHO/GP practice performance reaching only 89% which sits just below the national average of 90%. The result is marginally below the national target of 90% and the PHO performance target set within the Integrated Performance and Incentive Framework (IPIF) programme. Maintenance of current systematic activities within the Long Term Conditions (LTC) programmes in place in both the northern and southern Lakes areas are expected to eventually meet the national target, this is also expected as the number of people who remain unscreened are known and out-reach service approaches seek to contact people at work and other venues outside the GP practice.

[10] Data coverage is the three years to 30 June 2016

[11] In the 2015/16 Annual Plan data for breast screening, was given as covering a three year period. This was incorrect. The data properly covers a two year period.

Diabetes is a condition of focus within LTC programmes with annual follow-up PHO LTC programmes include `Diabetes Care Improvement Packages`, this approach has a strong involvement of multi-disciplinary team members and allied health services, for managed care from within the clients medical home (GP) practice, for support to treatment services and self- management.

The Lakes Diabetes Team (LDT) provides an integrated vehicle for the range of services including consumers active with diabetes to achieve a co-ordinated LTC approach. This is matched to national guidelines, MoH work planning and local implementation, which includes clinical leadership, shared resources, CME availability and a network of staff contacts.

Cervical screening performance at the Lakes DHB level is marginally below the national target of 80% at 77.2%. The performance of the PHO `support to screening` services have maintained consistent improvement to meet PHO targets, including improvement in coverage for priority woman that has reduced the disparity between non-Maori and Maori. However the overall trend for reduction of disparity although improved indicates a plateauing of results which will need a planned approach to avoid any loss of performance for improved access by priority women.

Breast screening coverage for women aged 50-69 over two years reached 79% which marginally below the national target of 70% but still reflects the need to improve access to screening for Maori women.

Lakes DHB s working in partnership with contracted primary care PHO services and selected Kaupapa Maori providers to deliver an Integrated Care approach for Long Term Conditions; LTC programmes have built service capacity with clinical staff and implemented clinical tools (Risk Assessment, Care Planning and Care Co-ordination); engaged multi-disciplinary team (MDT) skills and experience and developed additional services such as nutrition and exercise programmes which support people with self-management, resulting in a co-ordinated care approach for people managing their long term conditions.

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
Fewer People are Admitted to Hospital for Avoidable Conditions	Percentage of Rest Home residents receiving vitamin D supplement from their GP		78%	80%	85%	A
	Percentage of all Emergency Department presentations that are categorised as triage level 4&5		55%	50%	52%	NA
	Percentage of eligible population who have had their B4 school checks completed	High Needs	90%	90%	112%	A
		Total	91%	90%	101%	A
	Incidence rates per 100,000 for rheumatic fever		5.8	3.5	5.7	NA
	Hospitalisation rates per 100,000 for acute rheumatic fever		6.6	3.5	4.8	NA
	Increased coverage numbers of Year 9 students receiving Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety (HEEADSSS) assessment in decile 1-3 schools	Maori	NA	400	Not Available	-
		Non-Maori	NA	400	Not Available	-
		Total	330[12]	800	Not Available[13]	-

Significance of the Measure

The Well Child Tamariki Ora (WCTO) and B4 School check service is a screening, surveillance, education and support service offered to all New Zealand children and their family/whanau from birth to five years. It assists families/whanau to improve and protect their children's health.

Vitamin D supplements for vulnerable older people living in age related residential care facilities is a key ACC led intervention. Research has confirmed the majority of older adults have insufficient levels of Vitamin D and are at risk of increased falls and injury from falls. Adequate levels of Vitamin D improve muscle strength and balance as well as bone density and cognitive function. The ACC injury prevention focus is to minimise the risk of injury, especially fracture of neck of femur as a result of a fall, by encouraging general practice and residential care providers to use Vitamin D supplements.

Lakes DHB Performance

Lakes DHB has three WCTO providers, Tuwharetoa Health Charitable Trust (Turangi/Taupo), Plunket and Tipu Ora (Rotorua). The providers have a set number of new babies allocated to them annually in relation to the number of births in the population. All babies are enrolled at birth with the services then looking after them for their core checks through their pre school years. If families shift, the babies are transitioned between providers and DHBs. In the coming year we will be focussing on ensuring all babies are enrolled with a WCTO provider and 100% of babies receive their core checks in the first 12 months.

The Lakes DHB Public Health Nursing and Screening Service coordinate the B4 School programme and work with Tipu Ora, Plunket Rotorua and the Midland Health Network to provide the service to Lakes DHB four year olds. Lakes DHB achieved well above the 90% B4 School target for 2015/16 year. This is a significant achievement in a high deprivation population due to the difficulty in finding children who are not engaged with early childhood education, are transient and are not engaged with other child health services. The target was achieved through a mixture of home visiting and community clinics.

The national target of 80% of residential care residents receiving vitamin D supplement continues to be met in Lakes with results being an average of 85% for 2015 – 16 year. Efforts continue to expand

[12] Data for terms 3 and 4 2012 and terms 1 and 2 2013. Data not available by ethnicity.
[13] These data are not easily obtainable

implementation to include vulnerable and frail older people living in the community will be part of the ACC / Lakes DHB Falls and Fracture Prevention Programme.

Impact	Baseline measure		Targets		
	Output Description	Base	2015/16	Result	Achieved / Not Achieved
More People Maintain their Functional Indepen-dence	Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	99%	100%	100%	A
	Standardised acute re-admission rate[14]	6.63%	6.60%	6.80%	NA
	Standardised inpatient average length of stay (elective) in days [15]	1.49	1.49	1.41	A
	Percentage of patients who require radiation or chemotherapy are treated with 4 weeks	100%	100%	100%	A
	Faster Cancer Treatment –proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis[16]	100%	100%	56%	NA

Significance of the Measure

With knowledge and support vulnerable groups of people can build their resilience and become less dependent on funded services.

The increase in the proportion of the population in older age categories over the next 10 to 15 years enhances the need to support people to age positively and remain mobile, active, socially engaged with their community and living at home for longer in an aim to minimise the need for high cost treatment or institutional care. The incidence of chronic medical conditions and age related conditions such as dementia will also increase the demand for community and residential support services.

The national, regional and local emphasis is on knowing the people who need support, using standardised comprehensive assessment of the need processes, collaboration and sharing information with other health professionals and service providers, providing seamless services that are outcome focussed and flexible and responsive to the person's (and carer's) family/whanau.

Lakes DHB Performance

Responsive home and community support services focus on identified need and providing information, education and support that will meet a need which, in Lakes, includes access to community based allied health teams, as well as a range of home-based support services and respite and day programmes.

The number of older people being referred to physiotherapy and occupational therapists as part of attending community rehabilitation programmes continues to rise with the expected outcomes of improved mobility, strength and balance and increased access to aids and equipment to support living at home for longer. These teams utilise information from standardised comprehensive clinical geriatric assessment tool - interRAI and are linked with the home-based support providers staff to ensure continuity to their intervention.

Lakes DHB continues to contract for services to provide non facility based meaningful activity programmes for people who have dementia, education programmes for carers or people with dementia through Living Well with Dementia programme facilitated through Mental Health Services for Older People and Alzheimer's NZ local teams. Accredited visitors service with Age Concern, Falls and

[14] Data covers 12 month period to March 2016

[15] Data covers 12 month period to March 2016

[16] Data covers the period January-June 2016

Fracture Prevention programme initiative, information and advisory services for conditions such as Stroke, Arthritis, Dementia, Cancer Support and Rongoa Maori Traditional Healing services.

Lakes DHB through Needs Assessment Service Co-ordination (NASC) services has used the interRAI assessment tools for the past eight to nine years for all older people requiring community or residential care support. Quarterly reviews of the number of assessments that have been completed using interRAI assessment tools indicates that 100% of older people are receiving services based on an interRAI assessment. InterRAI assessments are also used for all people being discharged from hospital and needing short term support in the recovery period.

In addition, interRAI clinical assessment tool for long term care has been fully implemented into Lakes DHB Age Related Residential care with all facilities have the required competent registered nurse expertise and be able to undertake a standardised assessment and follow up reassessments. The assessments are used to determine residents needs and develop appropriate care plans.

InterRAI assessments are stored on national data bases and with the development of national InterRAI data centre DHBs have access to range of clinical risk data that can influence areas where service development is required to reduce health and care risks for total population of older people.

The national interRAI centre is developing a training and support unit that will facilitate the training of assessors across the country. This will result in changes to the DHB Lead Practitioner and System Clinician roles in 2016/17.

Nationally across the three funders of home based support services, DHBs, MoH DSS and ACC there are work streams that are looking at how to improve the quality of home based support services for the client and the support workers. This has resulted in new MoH funding for DHB and MoH DSS providers to cover the cost of travel for support workers travelling between clients and reduce the inequity between DHBs.

Further work streams established nationally are considering what is needed to develop a less casualised, well trained workforce and less contractual variances between funders for similar services.

ACC and Health Quality Safety Commission have developed focus on Falls and Fracture Prevention with expectations that DHBs will develop a range of initiatives with a multi agency approach to reduce the incidence of falls and fractures in the older population. A stocktake of current providers working in this field has been completed as well as one training session with health professionals on the national work. In 2016/17 Lakes DHB and ACC will work together to develop a more structured Falls and Fracture Prevention programme.

For people who develop cancer, the emphasis has been to ensure people are seen and diagnosed quickly and access treatment quickly. This work is overseen by MoH and Midland Cancer Network and locally with working groups that focus on Faster Cancer Treatment targets.

The proportion of people who receive radiotherapy and/or chemotherapy treatment within 4 weeks of days of diagnosis continues to be within required standard of 100% and reflects the ability of the Waikato DHB and Kathryn Kilgour Centre in BOP DHB area to support Lakes patients.

The national requirement for faster access to cancer treatment from the date of diagnosis changed in October 2014 to cover all forms of treatment. Lakes DHB is working to improve the percentage of people receiving cancer treatment within 31 days of diagnosis with a result of 56% being recorded in the last six months of the year.

The new faster cancer treatment health target in 2015/16 expects people being referred with a high suspicion of cancer to be seen by a specialist within two weeks and to receive their first cancer treatment within 62 days. A number of changes to current clinical practice has seen standardising the referral and triaging process, develop electronic process to monitor patient progress through the referral, specialist appointment, diagnosis and treatment pathway and co-ordinated monitoring by cancer care co-ordinators to reduce the risk of delays for the patient.

As at June 2016, the percentage of patients meeting this criteria is lower than expected, but with improved systems and focussed staff practices is expected to improve significantly in 2016/17.

Regionally and locally, it is recognised that some people with cancer present as an acute admission rather than through GP referral to specialist, some cancers require numerous diagnostic tests before treatment can be confirmed, and some patients need to travel to other DHBs for diagnosis and treatment thus having an impact on the timeframe from referral to treatment. A multi-disciplinary team continues to monitor progress and develop changes in current practice to meet this requirement.

3 Outcome: People receive timely and appropriate specialist care

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
People Have Appropriate Access to Elective Services	Percentage of patients waiting longer than four months (from Jan 2015) for their first specialist assessment (Elective Service Performance Indicator 2)		0.1%	Nil	Nil	A
	Number of surgical discharges under the elective initiative (Health Target)		4166	4420	4514	A
	Did-not-attend percentage for outpatient clinics (Maori Health Plan)	Maori	20.0%	12.0%	20.4%	NA
		Non-Maori	6.6%	12.0%	6.7%	A
		Total	11.0%	12.0%	11.4%	A

Significance of the Measure

Access to elective services for the Lakes' population as early as possible aid our communities' overall wellbeing. Our aim is to operate theatre space as efficiently as possible, while reducing idle time where practical. To enable more elective procedures, higher volumes of first and follow up assessment were also required. The commitment of quality staff to deliver these targets was put in place for 2015/16. Where specialist treatment lay outside of the secondary skill set of our DHB, appropriate referrals to tertiary hospitals were made.

The extent to which service users attend outpatient services is an important measure of the degree to which service provision to individual patients is complete.

Lakes DHB Performance

Lakes DHB populations have had access to and been served in excess of the target around elective services. The waiting list continues to reduce in line with the Ministry of Health's expectations and guidelines. No patient has had a wait of more than four months from January 2015. Standard intervention rates have been met in a number of specialist areas with orthopaedics being a standout for 2015/16. Theatre utilisation continued to meet the target enabling a satisfactory workflow and throughput during 2015/16 for Lakes DHB and peer DHB workload.

Lakes has been working to reduce the disparity noted in its 'did not attend' data. This has included regular monitoring and investigating where the key issues lie in order to better target effort.

Impact	Baseline measure				Targets		
	Output Description			Base	2015/16	Result	Achieved / Not Achieved
Improved Health Status for those with Severe Mental Illness and/or addictions	**Short Term Clients**[17] Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (Policy Priority 8)	Mental Health	0-19 yr olds	51%	80%	60%	NA
			20-64 yr olds	52%	80%	64%	NA
			65+ yr olds	83%	80%	80%	A
		Addictions	0-19 yr olds	84%	80%	82%	A
			20-64 yr olds	79%	80%	77%	NA
			65+ yr olds	78%	80%	80%	A
	Long Term Clients 1. The number of adults and older people (20 years plus) with enduring serious mental illness or addictions who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) 2. Provide employment status for the adult client group according in line with the table below 3. Describe the methodology used to ensure adult measure long-term clients employment status.	In Paid employ-ment >30 hrs a week	Maori	New measure	Not available	Employment information is not being currently collected. However this will be gathered through Project for the Integration of Mental Health Data in NZ (PRIMHD) as a compulsory supplementary indicator from July 2016	
			Pacific	New measure	Not available		
			Total	New measure	Not available		
		In Paid employ-ment 1 - 30 hrs a week	Maori	New measure	Not available		
			Pacific	New measure	Not available		
			Total	New measure	Not available		
		Unem-ployed - less than 1 hour per week	Maori	New measure	Not available		
			Pacific	New measure	Not available		
			Total	New measure	Not available		
	Average length of acute inpatient stays as a proportion of total bed days(KPI 8)[18]			17.3%	Not available	Not available	-
	Rates of post-discharge community care (KPI 18) [19]			59%	90%	Not available	-

Significance of the Measure

This measure is concerned with the capacity of services to see people in a timely manner while planning for effective discharge and follow up as a means to reducing symptom exacerbation or relapse of mental illness.

[17] Data covers the year to March 2016

[18] Data covers the year to June 2014. The target indicator in the 2015/16 Annual Plan was incorrectly defined and entered and has been corrected for this 2015/16 Annual Report.

[19] Data covers the year to June 2014. The target indicator in the 2015/16 Annual Plan was incorrectly defined and entered and has been corrected for this 2015/16 Annual Report.

Systems that improve service access and make for a more seamless 'flow' through the service continuum (including primary care) provide service users with better opportunity for earlier intervention and reduced long term impact from illness.

Lakes DHB Performance

Considerable work continued to occur to enable Lakes DHB to meet its targets for mental health and addiction services.

Reporting against the measures has been affected in part by the relatively small numbers of under 20 year olds (relapse prevention plans), limitation of wait time data to 10 months of information for the year, and significant issues with data quality.

In terms of acute patient length of stay, long stay inpatients impact on the average length of stay which, as an indicator, is a broader reflection of the increasing complexity and/or risk that people are presenting with. However, the DHB has returned good performance here which indicates a commendable degree of efficiency around the patient discharge process.

The Lakes DHB is working on approaches to collecting employment status information noted in the indicator above.

Impact	Baseline measure		Targets		
	Output Description	Base	2015/16	Result	Achieved / Not Achieved
More People With End Stage Conditions are Supported Appropriately	Number of Aged Residential Facilities utilising advanced directives	New measure	100%	100%	A

Significance of the Measure

Advanced directives gives health professionals and care providers direction on what treatment and care the resident considers is important at a time when they may not be able to express their views because of an acute change in their wellbeing.

All Lakes DHB Age Related Residential care providers are required to complete advanced directive documentation that is confirmed by the resident's general practitioner and in consultation with the resident and / or family members. Providers are regularly audited to ensure this information is in place.

The promotion of Advanced Care Plans that can provide additional information to clinicians on the person's wishes and beliefs that can be used to direct medical intervention, treatment and future care continues. In Lakes there is the option for people and GPs to have an Advance Care Plan stored on the Patient Management information hospital records to ensure clinicians have access to this if the person presents to the hospital.

Provision of palliative care is a part of most health services with specialist palliative care services being available through hospices and Waikato DHB. Recent national documents and reports outline the current and future demands for palliative care including a resource and capability framework that focuses on the need for further up-skilling of all providers of palliative care, standardising clinical pathways and establishing a regional pool of specialist expertise.

Lakes DHB Performance

Both Rotorua Community Hospice and Lakes Taupo Hospice services report that referral volumes continue to rise along with the complexity of client need has increased in recent years with both people who have long term chronic health conditions but also people who have cancer. Changes in cancer treatment and management has seen people living longer but with more complex needs at the end of life with are more people undergoing palliative radiotherapy and chemotherapy for symptom control (mostly pain management) than ever before with both Waikato DHB oncologists and palliative care medical specialists being involved. The need for care co-ordination between services has increased. Visiting specialist palliative care physician clinics in both Rotorua and Taupo and a 24 / 7 telephone advice link to Waikato continue.

MoH provided both hospices additional funding ($500K for Lakes services) to meet operational shortfall and the development of new innovative services to improve the quality of palliative care in primary, community and residential care services. A joint approach from both hospices resulted in successful business proposals that are aimed at improving training for non specialist health professionals and family carers, the development of volunteer services in Rotorua and cultural support services in Taupo.

Both specialist palliative care services will be moving to new premises in 2016/17.

The specialist palliative care providers, along with other providers of palliative care are continuing to meet regularly to implement the actions outlined in the Lakes Adult Palliative Care Work Plan and are also linked with the Midland Cancer Network – cancer executive and palliative care team, regional specialist palliative care provider networks and the Lakes Palliative and Cancer services forums. Collaborative work continues to develop a Lakes paediatric palliative care clinical pathway for children and families that will involve Lakes paediatric team taking clinical lead and working closely with the specialist paediatric palliative care team of Starship and the local specialist palliative care teams through hospice.

Impact	Baseline measure			Targets		
	Output Description		Base	2015/16	Result	Achieved / Not Achieved
Support Services	Radiology – Improved wait times for diagnostic services – accepted referrals for CT and MRI receive their scan within 6 weeks	CT	91.8%	95%	79%	NA
		MRI	59.4%	85%	45%	NA
	Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Category 1: Within 24 hours	100%	95%	96%	A
		Category 2: Within 96 hours	100%	100%	100%	A
		Category 3: Within 72 hours	100%	100%	100%	A
	Number of community pharmacy prescriptions items		1,361,320	Decrease[20]	1,479,293	NA

Significance of the Measure

Access to community referred diagnostics including radiology, is a clinical pathway strategy that is designed to enhance an `Integrated` model of health care, that will also assist management of acute demand on secondary services, avoid inappropriate hospital admissions and ED presentation and support people to receive health services closer to their home in the community.

Primary referred radiology facilitates improved integration between primary and secondary referral for primary care management and first specialist intervention.

The Community Pharmacy Services Agreement (CPSA) is now at stage four in its development towards increased `patient centric` community pharmacy services within the community service model. This new service approach will see pharmacist assisted medication management for improved adherence to treatments and avoidance of multiple medications due to better reconciliation and clinical control. This approach will integrate pharmacy dispensing within the persons medical care team (GP) practice and linked to key health programmes. One of these programmes is management of Long Term Conditions (LTC) where patients are registered into a pharmacy programme for pro-active management in the community.

The key impact gained to date has been a reduction in repeat dispensing although it is acknowledged there has also been growth in initial dispensing to better manage medicines reconciliation.

Lakes DHB Performance

Community Pharmacy Services has worked to consolidated a planned reduction in repeat prescriptions. The increase of only 8% over the previous year shows that this strategy is beginning to gain traction but has some way to go to achieve its full impact.

Community pharmacies in the Lakes region have adopted the national approach for improved medicine management and have actively registered clients with adherence to medication issues within their Long Term Conditions (LTC) programme for regular clinical management.

Lakes DHB has trialled a Clinical Pharmacy role working within a GP practice and feedback to date has been positive from the medical team for the roles contribution to treatment plans and patient education achieved.

The clinical pharmacy role outcomes include; improved co-ordination of medication regime with other service providers attending the patient; improved self-education for patients' adherence and reduction of client poly pharmacy.

[20] The target in the annual plan was "TBC" and this has been changed to "Decrease" based on a decision that Lakes DHB would like to see fewer, not more, prescriptions being provided to its community as an indicator of improving health status.

Statement of Responsibility for the Year Ended 30 June 2016

1 The Board and management of Lakes District Health Board accept responsibility for the preparation of the financial statements and the judgments used in them.

2 The Board and management of Lakes District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting and non financial reporting.

3 The Board and management of Lakes District Health Board accept responsibility for any end of year performance information provided by Lakes District Health Board under section 19A of the Public Finance Act 1989.

4 In the opinion of the Board and management of Lakes District Health Board the financial statements for the year ended 30 June 2016 fairly reflect the financial position and statement of service performance of Lakes District Health Board.

Board Member

14 October 2016

Board Member

14 October 2016

Report of the Audit Office

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Lakes District Health Board group's financial statements and performance information for the year ended 30 June 2016

The Auditor-General is the auditor of Lakes District Health Board Group (the Group). The Auditor-General has appointed me, Clarence Susan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Group consisting of Lakes District Health Board and its subsidiaries and other controlled entities, on her behalf.

We have audited:

- the financial statements of the Group on pages 63 to 106, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, 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 Group on pages 42 to 57.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Group on pages 63 to 106:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2016; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers

Some significant performance measures of the Group, (including some of the national health targets), rely on information from third-party health providers, such as primary health organisations. The Group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Group for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Group on pages 42 to 57:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of 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 appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 14 October 2016. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Group's financial statements and performance information 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 Group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and the performance information. Also, we did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand;
- present fairly the Group's financial position, financial performance and cash flows; and
- present fairly the Group's performance.

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

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

In addition to the audit we have carried out assignments in the areas of a Post-implementation Review of the Lakes Health Services Improvement Project (LHSIP), which is compatible with those independence requirements. Other than the audit and these assignments, we have no relationship with or interests in the Group.

Clarence Susan
Audit New Zealand
On behalf of the Auditor-General
Tauranga, New Zealand

Financial Statements

Statement of Comprehensive Revenue and Expense for the year ended 30 June 2016

	Notes	Lakes DHB Group Budget 2016 $000	Lakes DHB Group Actual 2016 $000	2015 $000
Revenue				
Revenue	1	327,989	332,344	325,128
Other operating revenue	2	3,964	4,281	4,616
Gains	3	0	17	21
Finance revenue	4	460	532	801
Total revenue		332,413	337,174	330,566
Expenditure				
Personnel costs	5	108,595	108,705	103,692
Depreciation and amortisation expense	11, 12	10,218	10,284	10,627
Other operating expenses	6	203,386	214,257	211,357
Finance costs	4	3,020	2,455	2,442
Capital charge		6,705	6,999	6,668
Total operating expenditure		331,924	342,700	334,786
SURPLUS/(DEFICIT) BEFORE TAX		489	(5,526)	(4,220)
Share of associate/joint venture surplus/(deficit)	13	130	264	175
SURPLUS/(DEFICIT) BEFORE TAX		619	(5,262)	(4,045)
Income tax expense		0	0	0
SURPLUS/(DEFICIT) AFTER TAX		**619**	**(5,262)**	**(4,045)**
OTHER COMPREHENSIVE REVENUE AND EXPENSE				
Gains on property revaluations	19	0	0	9,046
Cash flow hedges	19	0	(53)	(504)
Total other comprehensive revenue and expense		**0**	**(53)**	**8,542**
TOTAL COMPREHENISVE REVENUE AND EXPENSE		**619**	**(5,315)**	**4,497**

Explanations of significant variances against budget are detailed in note 34

The accompanying accounting policies and notes form part of these financial statements

Statement of Changes in Equity for the year ended 30 June 2016

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2016

	Notes	Lakes DHB Group Budget 2016 $000	Lakes DHB Group Actual 2016 $000	Lakes DHB Group Actual 2015 $000
BALANCE AT 1 JULY		85,148	90,225	86,029
Prior year adjustments		0	9	0
Capital contribution from the Crown		0	0	0
Repayment of capital to the Crown		(301)	(301)	(301)
Total comprehensive revenue and expense		619	(5,315)	4,497
BALANCE AT 30 JUNE	**19**	**85,466**	**84,618**	**90,225**

Explanations of significant variances against budget are detailed in note 34

The accompanying accounting policies and notes form part of these financial statements

Statement of Financial Position as at 30 June 2016

	Notes	Lakes DHB Group Budget 2016 $000	Lakes DHB Group Actual 2016 $000	2015 $000
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	7	2,699	2,036	4,197
Receivables	8	10,031	11,640	11,271
Inventories	9	2,159	2,135	2,131
Other financial assets	14	0	700	700
TOTAL CURRENT ASSETS		14,889	16,511	18,299
NON - CURRENT ASSETS				
Receivables	8	0	516	623
Property, plant and equipment	11	143,599	148,901	152,588
Intangible assets	12	13,748	4,580	3,526
Investments in associates		1,404	0	0
Investments in joint ventures	13	0	1,165	1,182
Other financial assets	14	0	750	750
TOTAL NON - CURRENT ASSETS		158,750	155,912	158,669
TOTAL ASSETS		**173,639**	**172,423**	**176,968**
LIABILITIES				
CURRENT LIABILITIES				
Payables	15	12,430	16,729	16,050
Employee entitlements	16	14,130	13,175	14,073
Borrowings	17	6,720	5,014	4,674
Provisions	18	0	31	31
Derivative financial instruments	10	72	0	0
TOTAL CURRENT LIABILITIES		33,352	34,949	34,828

The accompanying accounting policies and notes form part of these financial statements

	Notes	Lakes DHB Group Budget 2016 $000	Lakes DHB Group Actual 2016 $000	2015 $000
NON CURRENT LIABILITIES				
Employee entitlements	**16**	2,407	2,650	2,488
Borrowings	**17**	51,615	48,027	47,301
Other financial liabilities	**14**	0	750	750
Derivative financial instruments	**10**	800	1,429	1,376
TOTAL NON CURRENT LIABILITIES		54,822	52,856	51,915
TOTAL LIABILITIES		**88,173**	**87,805**	**86,743**
NET ASSETS		**85,466**	**84,618**	**90,225**
EQUITY				
Crown equity	**19**	20,387	20,386	20,693
Other reserves	**19**	46,033	54,523	54,576
Retained earnings/(losses)	**19**	18,083	8,910	14,166
Trust funds	**19**	963	799	790
TOTAL EQUITY		**85,466**	**84,618**	**90,225**

For and behalf of the Board

Board Member

14 October 2016

Board Member

14 October 2016

Explanations of significant variances against budget are detailed in note 34

The accompanying accounting policies and notes form part of these financial statements

Statement of Cash Flows for the year ended 30 June 2016

	Notes	Lakes DHB Group Budget 2016 $000	Lakes DHB Group Actual 2016 $000	Lakes DHB Group Actual 2015 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and patients		332,703	336,363	326,688
Dividend received		0	0	0
Interest received		460	532	801
		333,163	336,895	327,489
Cash was applied to:				
Payments to suppliers		203,923	213,301	209,890
Payments to employees		109,296	109,441	102,624
Interest paid		2,337	2,455	2,442
ACC Partnership Programme Payments		0	0	218
Distribution to owners: capital charge		6,699	6,999	6,668
GST (net)		(178)	(144)	16
		322,077	332,052	321,858
Net cash flows from operating activities	**20**	11,086	4,843	5,631
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of property		1,500	17	0
		1,500	17	0
Cash was applied to:				
Purchase of other financial assets		0	0	700
Purchase of property, plant and equipment		7,875	5,823	7,584
Purchase of Prepaid Licence		0	0	730
Purchase of intangible assets		5,302	1,963	1,364
		13,177	7,786	10,378
Net cash flows from investing activities		(11,677)	(7,769)	(10,378)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds from finance lease liabilities		1,723	1,913	0
Proceeds from CHFA loans		2,000	0	0
Proceeds from shareholder capital injection		0	0	0
Cash was applied to:				
Repayments of shareholder capital		(301)	(301)	(301)
Repayments of finance lease liabilities		0	(847)	(414)
Net cash flows from financing activities		3,422	765	(715)
Net increase/(decrease) in cash, and cash equivalents		**2,831**	**(2,161)**	**(5,462)**
Cash and cash equivalents at beginning of year		(133)	4,197	9,659
Cash and cash equivalents at end of year	**7**	**2,698**	**2,036**	**4,197**

During the period Lakes DHB acquired property, plant and equipment totaling $2,104k (2015: $1,011k) by means of finance leases.

Explanations of significant variances against budget are detailed in note 34

The accompanying accounting policies and notes form part of these financial statements

STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDED 30 JUNE 2016

Summary of Accounting Policies

Reporting Entity

The Lakes District Health Board (Lakes DHB or the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown.

The consolidated financial statements of the Lakes DHB Group comprise of Lakes DHB and its subsidiaries (together referred to as 'The Group') and Lakes DHB Group's interest in associates and jointly controlled entities.

The group consists of Lakes DHB, its subsidiary, Spectrum Health Limited (100% owned), in substance subsidiary, The Lakes District Health Board Charitable Trust, and jointly controlled entities HealthShare Limited (20% owned) and Laboratory Services Rotorua (50% owned) and NZ Health Partnerships Limited (2.15% owned).

The DHB's primary objective is to deliver health, disability and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity (PBE) for accounting purposes applying the International Public Sector Accounting Standards (IPSAS).

Statement of compliance

These financial statement are prepared in accordance with the Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with New Zealand GAAP.

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

For the purposes of these financial statements, the Lakes District health Board reporting entity has been designated as a public benefit entity. PBEs are reporting entities whose primary objective is to provide goods and services for community or social benefit and where any equity has been provided with a view to supporting the primary objective rather than for as financial return to equity holders.

Basis of Preparation

The financial statements have been prepared on the basis of historic cost modified by the revaluation of certain assets and liabilities, and prepared on an accrual basis, unless otherwise specified (for example in the statement of cash flows).

The financial statements are presented in New Zealand dollars rounded to the nearest thousand, ($000) unless separately identified.

Judgements and estimations

The preparation of these financial statements requires judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. For example, the present value of cash flows that are predicted to occur a long time into the future, as with the settlement of some staff provision, depends on judgements regarding future cash flows, including inflation assumptions and the risk free discount rate used to calculate present values.

The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an on going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that

period, or in the period of the revision and future periods if the revision affects both current and future periods.

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:

Lease classification
Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Land and buildings revaluations
Note 11 provides information about the estimates and assumptions applied in the measurement of re-valued land and buildings.

Estimating useful lives and residual values of property, plant and equipment
The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Accessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual life will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programmes;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Where other judgements significantly affect the amounts recognised in the financial statements they are described below and in the following notes.

Early adoption of standards and interpretations
In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Lakes DHB has applied these standards in preparing its 30 June 2016 financial statements.

Reporting period
The reporting period for these financial statements is the financial year ended 30 June 2016.

Changes in accounting policies
There have been no accounting policy changes in the 2016 financial statements when compared to 2015.

Significant Accounting Policies

Basis of consolidation

Subsidiaries

Lakes DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the group for each financial year. Subsidiaries are entities controlled by Lakes DHB. Control exists when Lakes DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Joint ventures

Joint ventures are those entities over whose activities Lakes DHB Group has joint control, established by contractual agreement. The consolidated financial statements include Lakes DHB's interest in joint ventures using the equity method from the date that joint control commences until the date that joint control ceases.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or Revenue and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of Lakes DHB Group's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance date sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of comprehensive revenue and expenses.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-Monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are those approved by the board in its Annual Plan, included within the Statement of Intent, tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP.

Financial instruments

Non-derivative financial assets

Non-derivative financial assets comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial assets are recognised initially at fair value plus, for instruments not at fair value through the surplus or deficit, any directly attributable transactions costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

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

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of Lakes DHB Group's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Available-for-sale financial assets
Lakes DHB Group's investments in equity securities are classified as available-for-sale financial assets. Subject to initial recognition, they are measured at fair value and changes therein, other than impairment losses, and foreign exchange gains and losses on available-for-sale monetary items are recognised directly in equity. When an investment is derecognised, the cumulative gain or loss in equity is transferred to profit or loss.

Instruments at fair value through the surplus or deficit
An instrument is classified as at fair value through the surplus or deficit if it is held for trading or is designated as such upon initial recognition. Financial instruments are designated at fair value through the surplus or deficit if Lakes DHB Group manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in the surplus or deficit when incurred.

Subsequent to initial recognition, financial instruments at fair value through the surplus or deficit are measured at fair value, and changes therein are recognised in the surplus or deficit.

Other
Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment costs.

Investments in equity securities
Investments in equity securities held by Lakes DHB Group are classified as available-for-sale, except for investments in equity securities of subsidiaries, associates and joint ventures which are measured at cost.

The fair value of equity investments as available-for-sale is their quoted bid price at the balance sheet date.

Property, plant and equipment
Classes of property, plant and equipment
The major classes of property, plant and equipment are as follows:

- Freehold land
- Leasehold
- Freehold buildings
- Plant, equipment and motor vehicles
- Work in progress

Owned assets
Except for land and buildings and the assets vested from the Hospital and Health Service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are re-valued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every three years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expenses. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive revenue and expenses.

Additions to property, plant and equipment between revaluations are recorded at cost.

Property that is being constructed or developed for future use as investment property is classified as property, plant and equipment and stated at cost until construction or development is complete, at which time it is reclassified as investment property.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, plant and equipment vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Lakeland Health Limited (a Hospital and Health Service) vested in Lakes DHB on 1 January 2001. Accordingly, assets were transferred to Lakes DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the health board has recognised the cost (or in the case of some land and buildings the valuation) and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment
Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive revenue and expenses is calculated as the difference between the net sales price and the carrying amount of the asset.

Subsequent costs
Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Lakes DHB Group. All other costs are recognised in the statement of comprehensive revenue and expenses as an expense as incurred.

Depreciation
Depreciation is charged to the statement of comprehensive revenue and expenses using the straight line method. Land is not depreciated.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
Buildings		
Structure	25 to 150 years	1% - 4%
Services	15 to 30 years	3% - 7%
Fit-out	5 to 20 years	5% - 20%
Site specific	20 to 50 years	2% - 5%
Plant and equipment	5 to 20 years	5% - 20%
Motor vehicles	5 to 15.5 years	6.5% - 20%
Computer hardware	3 to 7 years	14.3% - 33%

The residual value of assets is reassessed annually.

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

Intangible Assets

Acquisition
Intangible assets that are acquired by Lakes DHB Group are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure
Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation
Amortisation is charged to the statement of comprehensive revenue and expenses on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible

assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of Asset	*Estimated life*	*Amortisation rate*
• Software purchased/in-house	3 - 10 years	10% - 33%
• Rights to access shared services	indefinite	Nil

Debtors and other receivables

Debtors and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired.

The amount of the impairment is the difference between the assets carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are classified as current (that is, not past due).

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost, adjusted when applicable, for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Inventories held for use in the production of good and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the statement of comprehensive revenue and expenses in the period of the write-down.

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits, and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of Lakes DHB Group's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Impairment

The carrying amounts of Lakes DHB Group's assets other than investment property, inventories, and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance date and was estimated at the date of transition.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive revenue and expenses.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that has been

recognised directly in equity is recognised in the statement of comprehensive revenue and expenses even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive revenue and expenses is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive revenue and expenses.

The recoverable amount of Lakes DHB group's receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at the original effective interest rate (i.e. the effective interest rate computed at initial recognition of these financial assets). Receivables with a short duration are not discounted.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

Calculation of recoverable amount
The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains or losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of comprehensive revenue and expenses. An impairment loss is reversed only to the extent that the assets carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest-bearing loans and borrowings
Interest-bearing borrowings are classified as other non-derivative financial assets.

All borrowing costs are recognised as an expense in the period in which they are incurred. Borrowings are classified as current liabilities unless Lakes DHB and Group have an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Employee entitlements
Defined contribution plans
Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive revenue and expenses as incurred.

Defined benefit schemes plans
Lakes DHB belongs to the defined benefit plan contributors scheme (the scheme) which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave, retirement gratuities, and medical education leave
Lakes DHB Group's net obligation in respect of long service leave, sabbatical leave, retirement gratuities and medical education leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market rate on relevant New Zealand government bonds at the balance date.

Annual leave and sick leave
Annual leave and sick leave are short-term obligations and are calculated on an actual basis at the amount Lakes DHB Group expects to pay. Lakes DHB Group accrues the obligation for paid absences when the obligation both 'relates to employees' past services and it accumulates.

The liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

Presentation of employee entitlements
Sick leave, medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical 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.

Provisions
A provision is recognised when Lakes DHB Group has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring
A provision for restructuring is recognised when Lakes DHB Group has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Onerous contracts
A provision for onerous contracts is recognised when the expected benefits to be derived by Lakes DHB Group from a contract are lower than the unavoidable cost of meeting its obligations under the contract.

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 surpluses;
- revaluation reserves; and
- trust funds.

Revaluation reserves
These reserves are related to the revaluation of land and buildings to fair value.

Cash flow hedge reserves
These reserves are related to the revaluation of derivatives.

Trust funds
This reserve records the unspent amount of donations and bequests provided to the DHB.

Creditors and other payables
Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Derivative financial instruments and hedge accounting
Lakes DHB Group uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investing activities.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are stated at fair value. The gain or loss on re-measurement to fair value is recognised immediately in the statement of comprehensive revenue and expenses. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount that Lakes DHB Group would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current credit worthiness of the swap counterparts. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Lakes DHB Group designates certain derivatives as either:
- hedges of the fair value of recognised assets or liabilities or a firm commitment (fair value hedge); or
- hedges of highly probable forecast transactions (cash flow hedge).

Lakes DHB Group documents at the inception of the transaction the relationship between hedging instruments and hedged items, as well as its risk management objective and strategy for undertaking various hedge transactions. Lakes DHB Group also documents its assessment, both at hedge inception and on an on-going basis, of whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in fair values or cash flows of hedged items.

The full fair value of a hedge accounting derivative is classified as non-current if the remaining maturity of the hedged item is more than 12 months, and as current if the remaining maturity of the hedged item is less than 12 months.

The full fair value of a non-hedge accounted foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date; otherwise, foreign exchange derivatives are classified as non-current. The portion of the fair value of a non-hedge accounted interest rate derivative that is expected to be realised within 12 months of the balance date is classified as current, with the remaining portion of the derivative classified as non-current.

Fair value hedge
The gain or loss from re-measuring the hedging instrument at fair value, along with the changes in fair value on the hedged item attributable to the hedged risk, is recognised in the surplus or deficit. Fair value hedge accounting is only applied for hedging fixed interest risk on borrowings.

If the hedge relationship no longer meets the criteria for hedge accounting, the adjustment to the carrying amount of a hedged item for which the effective interest rate method is used is amortised to the surplus or deficit over the period to maturity.

Cash flow hedge
The portion of the gain or loss on a hedging instrument that is determined to be an effective hedge is recognised in other comprehensive revenue and expenses, and the ineffective portion of the gain or loss on the hedging instrument is recognised in the surplus or deficit as part of finance costs.

If a hedge of a forecast transaction subsequently results in the recognition of a financial asset or a financial liability, the associated gains or losses that were recognised in other comprehensive revenue

and expenses are reclassified into the surplus or deficit in the same period or periods during which the asset acquired or liability assumed affects the surplus or deficit. However, if it is expected that all or a portion of a loss recognised in other comprehensive revenue and expenses will not be recovered in one or more future periods, the amount that is not expected to be recovered is reclassified to the surplus or deficit.

When a hedge of a forecast transaction subsequently results in the recognition of a non-financial asset or a non-financial liability, or a forecast transaction for a non-financial asset or non-financial liability becomes a firm commitment for which fair value hedge accounting is applied, the associated gains and losses that were recognised in other comprehensive revenue and expenses will be included in the initial cost or carrying amount of the asset or liability.

If a hedging instrument expires or is sold, terminated, exercised, or revoked, or no longer meets the criteria for hedge accounting, the cumulative gain or loss on the hedging instrument that has been recognised in other comprehensive revenue and expenses from the period when the hedge was effective will remain separately recognised in equity until the forecast transaction occurs. When a forecast transaction is no longer expected to occur, any related cumulative gain or loss on the hedging instrument that has been recognised in other comprehensive revenue and expenses from the period when the hedge was effective is reclassified from equity to the surplus or deficit.

Income tax

Lakes DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

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.

ACC contracted revenue

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

Revenue from other DHBs

Inter district patient inflow revenue occurs when a patient treated within the Lakes DHB region is domiciled outside the Lakes district. The MoH credits to Lakes DHB with a monthly amount based on estimated patient treatment for non Lakes district residents within Lakes DHB. An annual wash up occurs at year end to reflect the actual non Lakes district patients treated at Lakes DHB.

Goods sold and services rendered

Revenue from goods sold is recognised when Lakes DHB Group has transferred to the buyer the significant risks and rewards of ownership of the goods and Lakes DHB Group 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 Lakes DHB Group and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Lakes DHB Group.

Rental revenue

Rental revenue from investment property is recognised in the statement of comprehensive revenue and expenses on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

Dividend revenue
Dividend income is recognised in the statement of comprehensive revenue and expenses when the shareholder's right to receive payment is established.

Interest revenue
Interest revenue is accrued using the effective interest rate method. The effective interest rate method exactly discounts estimated future cash receipts through the expected life of the financial asset to that asset's net carrying amount. The method applies this rate to the principal outstanding to determine revenue each period.

Capital charge
The capital charge is recognised as an expense in the financial year to which the charge relates.

Trust and bequest funds
Donations and bequests to Lakes DHB are recognised as revenue when control over assets is obtained. A charitable trust fund has been established and Lakes DHB administers its funds. Donations and bequests received are treated as revenue on receipt in the statement of comprehensive revenue and expenses. Those with restrictive conditions are subsequently appropriated to trust funds forming part of equity.

Leases
Operating lease payments
Leases where the lessor retains substantially all the risks and benefits of ownership of the asset are classified as operating leases. Initial direct costs incurred in negotiating an operating lease are added to the carrying amount of the leased asset and recognised over the lease term on the same basis as the lease revenue.

Operating lease payments are recognised as an expense in the statement of comprehensive revenue and expenses on a straight-line basis over the lease term.

Finance lease payments
Leases where Lakes DHB Group assumes substantially all the risks and rewards of ownership are classified as finance leases.

Lease payments are apportioned between finance charges and reduction of the lease liability so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are included in the statement of comprehensive revenue and expenses as finance costs.

Capitalised leased assets are depreciated over the shorter of the estimated useful life of the asset and the lease term.

The interest expense component of finance lease payments is recognised in the statement of comprehensive revenue and expenses the effective interest rate method.

Statement of cash flows
Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the health board invests as part of its day-to-day cash management.

Operating activities include cash received from all revenue sources of the health board and records the cash payments made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of non-current assets. *Financing activities* comprise the change in equity and debt capital structure of the health board.

Cost of service (Statement of Service Performance)
The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of Lakes DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

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

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs

"Direct costs" are those costs directly attributable to an output class.

"Indirect costs" are those costs which cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs

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.

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions 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 of future events that are believed to be reasonable under the circumstances.

1 Revenue

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
MOH Crown appropriation revenue (1)	284,778	278,253
Other MOH contracted revenue	21,674	22,519
Other Government revenue	3,186	2,627
Inter-DHB revenue	19,001	18,648
ACC revenue	3,705	3,081
Total revenue	**332,344**	**325,128**

(1) Performance against this appropriation is reported in the Statement of Performance on pages 42 to 57. The appropriation revenue received by Lakes DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act. The budgeted appropriation amount from the Ministry of Health was $284,778,000.

Revenue for health services includes all revenue received from the Crown (via the Ministry of Health), Accident Rehabilitation and Compensation Insurance Corporation (ACC) and other sources.

2 Other Operating Revenue

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Sale of goods	799	528
Rendering of services	3,049	3,560
Dividend revenue	0	0
Donations and bequests received	36	320
Other	397	208
Total other operating revenue	**4,281**	**4,616**

3 Gains

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Non-financial instruments		
Property, plant, and equipment gains on disposal	17	21
Total gains	**17**	**21**

4 Finance Income and Finance Costs

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Finance revenue		
Interest revenue:		
Term and call deposits	532	801
Total finance revenue	**532**	**801**
Finance costs		
Interest expense:		
Interest on finance leases	181	86
Interest on borrowings	2,274	2,356
Total finance costs	**2,455**	**2,442**

5 Personnel Costs

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Salaries and wages	107,341	100,736
Defined contribution plan employer contributions	2,100	1,888
Increase/(decrease) in employee entitlements/liabilities	(736)	1,068
Total personnel costs	**108,705**	**103,692**

6 Other Operating Expenses

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Fees to auditor:		
fees to Audit New Zealand for audit of financial statement	125	122
fees to Audit New Zealand for other services	25	0
ACC Partnership Programme	70	184
Board of director fees (note 24)	259	273
Inventory consumption	(23)	(20)
Impairment of receivables (note 8)	0	9
Loss on disposal of property, plant, and equipment	63	60
Minimum lease payments under operating leases	532	561
(Increase)/decrease in provisions (note 18)	0	(34)
Other operating expenses	213,206	210,202
Total other expenses	**214,257**	**211,357**

7 Cash and Cash Equivalents

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Cash at bank and in hand	836	848
Term deposits with maturities less than three months	0	0
Loan to NZHPL	1,200	3,349
Cash and cash equivalents in the statement of cash flows	**2,036**	**4,197**

The carrying value of short-term deposits with maturity dates less than three months approximates their fair value.

The Lakes District Health Board Trust's total value of cash and cash equivalents that can only be used for specified purpose as outlined in the trust deed is $798,612 (2015: $789,098).

8 Receivables

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Current		
Receivables (gross)	11,770	11,341
Less provision for impairment	(130)	(70)
Total Current	11,640	11,271
Non-Current		
Receivables (gross)	516	623
Total Non Current	516	623
Total receivables	**12,156**	**11,894**
Total receivables comprises:		
Receivables from the sale of goods and services (exchange transactions)	12,156	11,894
Receivables from grants (non-exchange transactions)	0	0

Impairment

As of 30 June 2016 and 2015, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual 2016 Gross $000	Actual 2015 Gross $000
Lakes DHB Group		
Not past due	11,785	11,093
Past due 1 - 60 days	119	497
Past due 61 - 90 days	140	199
Past due > 90 days	242	175
Total	**12,286**	**11,964**

	Actual 2016 Impairment $000	Actual 2015 Impairment $000
Lakes DHB Group		
Not past due	0	0
Past due 1 - 60 days	0	(2)
Past due 61 - 90 days	0	0
Past due > 90 days	(130)	(68)
Total	**(130)**	(70)

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

The impairment provision has been calculated based on expected losses for Lakes DHB's pool of debtors. Expected losses have been determined based on an analysis of Lakes DHB's losses in previous periods, and review of specific debtors as detailed below:

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Individual impairment	130	70
Collective impairment	0	0
Total provision for impairment	**130**	**70**

Individually impaired receivables have been determined to be impaired because of the significant financial difficulties being experienced by the debtor. An analysis of these individually impaired debtors is as follows:

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Past due 1 - 60 days	0	2
Past due 61 - 90 days	0	0
Past due > 90 days	130	68
Total individual impairment	**130**	**70**

Movements in the provision for impairment of receivables are as follows:

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
At 1 July	70	61
Additional provisions made during the year	92	32
Provisions reversed during the year	(32)	(14)
Receivables written off during period	0	(9)
At 30 June	**130**	**70**

9 Inventories

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Pharmaceuticals	349	381
Surgical and medical supplies	865	894
Other supplies	921	856
Total inventories	**2,135**	**2,131**

The carrying amount of inventories pledged as security for liabilities is $Nil (2015: $Nil). No inventories are subject to retention of title clauses.

The write down of inventories held for distribution because of a loss in service potential amounted to $Nil (2015: Nil). There have been no reversals of write downs (2015: Nil).

10 Derivative Financial Instruments

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Current liability portion		
Interest rate swaps - cash flow hedges	0	0
Total current liability portion	0	0
Non - current liability portion		
Interest rate swaps - cash flow hedges	1,429	1,376
Total non - current liability portion	1,429	1,376
Total derivative financial instrument liabilities	**1,429**	**1,376**

Fair Value

Interest rate swaps

The fair values of interest rate swaps have been determined by calculating the expected cash flows under the terms of the swaps and discounting these values to present value. The inputs into the valuation model are from independently sourced market parameters such as interest rate yield curves. Most market parameters are implied from instrument prices.

Interest rate swaps
The notional principal amounts of the outstanding interest rate swap contracts for Lakes DHB Group were $18 million (2015: $18 million).

At 30 June 2016, the fixed interest rate of cash flow hedge interest rate swaps varied from 5.45% to 5.65% (2015: 5.45% to 5.65%).

Gains and losses recognised in the hedging reserve in equity (note 19) on interest rate swap contracts as at 30 June 2016 will be released to the surplus or deficit as interest is paid on the underlying debt.

11 Property, Plant and Equipment (PPE)

Movements for each class of property, plant and equipment (including work in progress) are as follows:

Lakes DHB and Group	Freehold land (at valuation)	Freehold buildings (at valuation/ cost)	Medical Plant and equipment	Non-Medical Plant and equipment	Computer Equipment	Motor Vehicles	Leased assets	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Cost								
Balance at 1 July 2014	5,280	131,587	27,065	3,509	9,472	2,620	5,420	184,953
Additions	0	4,456	1,518	290	800	40	549	7,653
Disposals	0	(43)	(857)	(122)	(461)	(89)	(240)	(1,812)
PPE Class Transfers	0	0	0	0	0	0	0	0
Work in Progress	0	(859)	193	(37)	243	0	(10)	(470)
Revaluations	1,690	(7,628)	0	0	0	0	0	(5,938)
Balance at 30 June 2015	**6,970**	**127,513**	**27,919**	**3,640**	**10,054**	**2,571**	**5,719**	**184,386**
Balance at 1 July 2015	6,970	127,513	27,919	3,640	10,054	2,571	5,719	184,386
Additions	0	2,513	1,724	187	2,157	0	1,969	8,550
Disposals	0	0	(3,207)	(180)	(806)	(107)	(775)	(5,075)
PPE Class Transfers	0	0	2	(2)	0	0	0	0
Work in Progress	0	(450)	(193)	0	(1,869)	0	(149)	(2,661)
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2016	**6,970**	**129,576**	**26,245**	**3,645**	**9,536**	**2,464**	**6,764**	**185,200**

11 Property, Plant and Equipment (PPE) (Continued)

Lakes DHB and Group	Freehold land (at valuation)	Freehold buildings (at valuation/ cost)	Medical Plant and equipment	Non-Medical Plant and equipment	Computer Equipment	Motor Vehicles	Leased assets	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Depreciation and Impairment charges								
Balance at 1 July 2014	0	(9,552)	(18,157)	(1,875)	(5,956)	(1,280)	(1,802)	(38,622)
Depreciation charge for the year	0	(5,477)	(2,346)	(295)	(769)	(161)	(895)	(9,943)
Disposals	0	10	835	114	461	89	239	1,748
PPE Class Transfers	0	0	0	0	0	0	0	0
Work in Progress	0	0	0	0	0	0	0	0
Revaluations	0	15,019	0	0	0	0	0	15,019
Balance at 30 June 2015	**0**	**(0)**	**(19,668)**	**(2,056)**	**(6,264)**	**(1,352)**	**(2,458)**	**(31,798)**
Depreciation and Impairment charges								
Balance at 1 July 2015	0	(0)	(19,668)	(2,056)	(6,264)	(1,352)	(2,458)	(31,798)
Depreciation charge for the year	0	(4,923)	(2,027)	(299)	(1,078)	(144)	(904)	(9,375)
Disposals	0	0	3,061	161	797	107	748	4,874
PPE Class Transfers	0	0	0	0	0	0	0	0
Work in Progress	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2016	**0**	**(4,923)**	**(18,634)**	**(2,194)**	**(6,545)**	**(1,389)**	**(2,614)**	**(36,299)**
Carrying amounts								
At 1 July 2014	5,280	122,035	8,908	1,634	3,516	1,340	3,618	146,331
At 30 June 2015	**6,970**	**127,513**	**8,251**	**1,584**	**3,790**	**1,219**	**3,261**	**152,588**
At 1 July 2015	6,970	127,513	8,251	1,584	3,790	1,219	3,261	152,588
At 30 June 2016	**6,970**	**124,653**	**7,611**	**1,451**	**2,991**	**1,075**	**4,150**	**148,901**

Valuation

Land

Land is valued at fair value using market-based evidence on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the land where an owner is unable to use the land more intensely.

Restrictions on the DHB's ability to sell the land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

The most recent valuation of land was performed by a registered independent valuer Peter Todd of Darroch Ltd, and the valuation is effective 30 June 2015.

Buildings

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement is derived from recent construction contracts of similar assets and Property Institute of New Zealand information.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

The most recent valuation of buildings was performed by a registered independent valuer Peter Todd of Darroch Limited, and the valuation is effective 30 June 2015.

Restrictions

Some freehold and leasehold land, including the Rotorua Hospital site, is restricted for the provision of health care only. The value of the restricted land is $6,970,000 (2015: $6,970,000).

The disposal of certain other land may be subject to legislation such as the Reserves Act 1977 and the "offer back" provisions of sections 40 - 42 of the Public Works Act 1981, as modified by clause 3 of the First Schedule to the Health Reforms Act (Transitional Provisions) 1993.

Subject to such legislation, if the board has declared land surplus and wishes to sell it, the Crown may require the board to sell that surplus land to it for use in the redress of Treaty of Waitangi claims. The board may also be required to assist the Crown to meet its obligations over Maori sites of significance.

Leased Assets

Lakes DHB Group leases vehicles under a number of finance lease agreements. At 30 June 2016, the net carrying amount of leased vehicles was $501,733 (2015: $605,495). The leased vehicles secures Lakes DHB Group's lease obligations.

Lakes DHB Group leases three buildings under operating lease agreements. Various leasehold improvements have been made by the DHB during the lease terms. At 30 June 2016, the net carrying amount of building leasehold improvements was $824,604 (2015: $903,226).

Lakes DHB Group leases IT equipment under a finance lease agreement. At 30 June 2016, the net carrying amount of leased IT equipment was $661,563 (2015: $744,976). The leased computer hardware secures Lakes DHB Group's lease obligations.

Lakes DHB Group leases medical and non-medical plant and equipment under a finance lease agreement. At 30 June 2016, the net carrying amount of the medical and non-medical plant and equipment was $2,116,789 (2015: $813,460). The leased plant and equipment secures Lakes DHB Group's lease obligations.

Impairment

Lakes DHB's buildings have been assessed for indicators of impairment using a range of standard indicators in PBE IPSAS 21. No evidence of impairment has been identified at 30 June 2016 (2015: Nil).

Work in progress

The closing balances of work in progress by asset class is:

Buildings	223,002
Computer Equipment	178,644
Leased Assets	45,623

12 Intangible Assets

Movements for each class of intangible assets are as follows:

Lakes DHB and Group

	Acquired Computer Software $000	Developed Computer Software $000	Total Computer Software $000
Cost			
Balance at 1 July 2014	6,931	0	6,931
Additions	1,387	0	1,387
Disposals	0	0	0
Work in progress	0	0	0
Transfer to other classes	0	0	0
Balance at 30 June 2015	**8,318**	**0**	**8,318**
Balance at 1 July 2015	8,318	0	8,318
Additions	951	0	951
Disposals	(25)	0	(25)
Work in progress	1,012	0	1,012
Transfer to other classes	0	0	0
Balance at 30 June 2016	**10,256**	**0**	**10,256**
Accumulated amortisation and impairment losses			
Balance at 1 July 2014	(4,108)	0	(4,108)
Amortisation expense	(684)	0	(684)
Impairment losses	0	0	0
Disposals	0	0	0
Transfer from other classes	0	0	0
Balance as at 30 June 2015	**(4,792)**	**0**	**(4,792)**
Balance at 1 July 2015	(4,792)	0	(4,792)
Amortisation expense	(909)	0	(909)
Impairment losses	0	0	0
Disposals	25	0	25
Transfer from other classes	0	0	0
Balance as at 30 June 2016	**(5,676)**	**0**	**(5,676)**
Carrying amounts			
At 1 July 2014	2,823	0	2,823
At 30 June 2015	**3,526**	**0**	**3,526**
At 1 July 2015	3,526	0	3,526
At 30 June 2016	**4,580**	**0**	**4,580**

Lakes DHB Group leases Computer Hardware under a finance lease agreement which includes a component of computer software. At 30 June 2016, the net carrying amount of leased computer software was $2,604 (2015: $6,071). The leased computer hardware (including software) is security for Lakes DHB Group's lease obligations.

There are no restrictions over the title of the non leased portion of Lakes DHB Group's intangible assets, nor are any intangible assets pledged as security for liabilities.

13 Investment in Joint Ventures

i) HealthShare Ltd

Lakes DHB Group's participatory interest in HealthShare Ltd is accounted for as a jointly controlled entity.

The principal activity of HealthShare Ltd is to provide the DHB service planning, purchasing and contracting functions as agreed by the parties. HealthShare Ltd has a balance sheet date of 30 June and was incorporated in New Zealand. HealthShare Ltd is operated on a break even basis.

a) Carrying amount of investments in joint venture	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
	255	286

b) Lakes DHB Group's interests in the jointly controlled operation is as follows:

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Current assets	3,355	3,330
Non - current assets	11,607	11,186
Current liabilities	7,489	6,063
Non - current liabilities	6,199	7,020
Revenue	11,979	10,996
Expenses	12,140	10,568
Group's interest	20%	20%

ii) Laboratory Services Rotorua

In June 2008 the parent of Spectrum Health Limited (Lakes District Health Board) received Ministerial approval to proceed with a joint venture laboratory with community laboratory provider Diagnostic Rotorua Limited.

The joint venture commenced 1 September 2008, initially for a period of 5 years with the option of the parties to negotiate a further five year period.

The joint venture is trading under the name Laboratory Services Rotorua (LSR). The joint venture partnership agreement incorporates ownership on a 50-50 basis between Spectrum Health Limited (as a 100% owned subsidiary of Lakes District Health Board) and Diagnostic Rotorua Limited.

Lakes DHB Group's participatory interest in Laboratory Services Rotorua is accounted for as a jointly controlled entity.

The principal activity of Laboratory Services Rotorua is to provide public laboratory services to the population served by Lakes DHB (excluding Taupo and Turangi).

Laboratory Services Rotorua has a balance sheet date of 30 June.

a) Carrying amount of investments in joint venture

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
	910	896

b) Lakes DHB Group's interests in the jointly controlled operation is as follows:

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Current assets	1,716	1,595
Non - current assets	1,442	1,633
Current liabilities	1,332	1,431
Non - current liabilities	0	0
Revenue	8,939	8,610
Expenses	8,411	8,255
Group's interest	50%	50%

Joint venture commitments and contingencies
Details of any commitments and contingent liabilities arising from the group's involvement in these joint ventures are disclosed separately in notes 21 and 22.

14 Other Financial Assets and Liabilities

In the 2014/15 Lakes DHB received a pledge from Rotorua Energy Charitable Trust for a donation of $750,000 toward the new proposed children's centre in Rotorua. This will be available for uplift after 1 April 2017 and is likely to be uplifted in the 2017/18 year.

The financial asset recognises the future benefit Lakes DHB will receive from the pledged funds.

The financial liability recognises Lakes DHB's future obligation to fulfil the pledge by completing the children's centre.

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Finance asset - current		
Term deposits with maturities three to twelve months	700	700
Finance asset - non-current		
RECT Donation	750	750
Total finance asset	**1,450**	**1,450**
Finance liability - non-current		
RECT Donation	750	750
Total finance liability - non-currrent	**750**	**750**

15 Payables

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Payables under exchange transactions		
Trade payables and expenses	13,149	12,953
Revenue in advance	11	18
ACC Levy payable	574	454
Total payables under exchange transactions	13,734	13,425
Payables under non-exchange transactions		
GST, PAYE, and FBT payable	2,995	2,625
Total payables under non-exchange transactions	2,995	2,625
Total payables	**16,729**	**16,050**

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

16 Employee Entitlements

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Current liabilities		
Retirement gratuities	192	144
Long service leave	147	151
Sabbatical leave	83	75
Annual leave	8,046	7,988
Sick leave	0	17
Continuing medical education (CME) leave	674	624
Continuing medical education (CME) expenses	1,620	1,558
Accrued salary and wages	2,413	3,516
Total current portion	13,175	14,073
Non - current liabilities		
Retirement gratuities	239	362
Long service leave	1,736	1,532
Sabbatical leave	675	594
Total non - current portion	2,650	2,488
Total employee entitlements	**15,825**	**16,561**

17 Borrowings

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Current		
Finance leases	1014	674
Ministry of Health Loans	4,000	4,000
Total current portion	5,014	4,674
Non current		
Finance leases	2,462	1,736
Ministry of Health Loans	45,565	45,565
Total non - current portion	48,027	47,301
Total borrowings	**53,041**	**51,975**

Security and terms

Crown Sector

Lakes DHB has unsecured loans with the Ministry of Health (MoH).

	Actual 2016 $000	Actual 2015 $000
Loan facility limits		
Ministry of Health	49,565	49,565

The MoH liabilities are secured by a negative pledge.

Without the MoH's prior written consent, Lakes DHB cannot perform the following actions:

- Create any security interest over its assets except in certain defined circumstances;
- Lend money to another person (except in the ordinary course of business and then only on commercial terms), or give a guarantee;
- Make a substantial change in the nature or scope of its business as presently conducted;
- Dispose of any of its assets except disposals made in the ordinary course of its ordinary business or disposals for full value; or
- Provide services to or accept services from a person other than for proper value and on reasonable commercial terms.

The fair value of MoH borrowings is $52.760m (2015: $51.26m). Fair value has been determined using contractual cash flows discounted using a rate based on Government bond rates at balance date ranging from 2.17% to 5.66% (2015: 3.21% to 4.75%).

The MoH loans have maturity dates ranging from 2016 - 2023. The loans will be rolled over on the maturity dates unless there is an event of review. There are no circumstances that Lakes DHB or the MoH are aware of that would trigger an event of review.

The MoH took over the loan management and lending functions previously provided by the Crown Health Financing Agency (CHFA) from 1 July 2012. Lakes DHB's current lending documents, terms and conditions, facility agreements and loans transitioned to the MoH at this date. The MoH is currently investigating converting all loans into equity.

Working capital facility

Lakes DHB is a party to the DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (HPL) and the participating DHBs. This agreement enables HPL to sweep DHB bank accounts and invest surplus funds on their behalf. These services used to be provided by Health Benefits Limited (HBL). On 30 June 2015, HBL ceased to operate and all contracts where transferred to HPL.

The DHB Treasury Services Agreement provides for individual DHB's to have a credit facility with HPL, which will incur interest at on-call interest rates received by HPL plus an administrative margin.

The maximum credit facility that is available to any DHB is the value of one month's Provider Arm funding, less Inter-District In-Flows, plus GST. For Lakes DHB this equates to $14.525 million.

Analysis of finance leases

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Total minimum lease payments are payable		
Not later than one year	1,197	803
Later than one year and not later than five years	2,213	2,103
Later than five years	690	360
Total minimum lease payments	4,100	3,266
Future finance charges	(623)	(442)
Present value of minimum lease payments	3,477	2,824
Present value of minimum lease payments payable		
Not later than one year	1,014	674
Later than one year and not later than five years	1,827	1,444
Later than five years	636	291
Total present value of minimum lease payments	3,477	2,409
Represented by:		
Current	1,014	674
Non-current	2,463	1,735
Total finance leases	**3,477**	**2,409**

Description of material leasing arrangements

Lakes DHB Group has entered into finance leases for various items of plant and equipment. The net carrying amount of the leased items is shown in notes 11 and 12.

Motor Vehicle Finance leases at 30 June 2016 are with Toyota Financial Services. IT Finance Leases at 30 June 2016 are with CBA Asset Finance (NZ) Ltd. Medical Equipment Finance Leases at 30 June 2016 are with Allleasing New Zealand Ltd.

Finance lease liabilities are effectively secured as rights to the leased asset revert to the lessor in the event of default.

The finance leases can be renewed at Lakes DHB Group's option with rents set by reference to current market rates for items of equivalent age and condition. Lakes DHB Group does have the option to purchase the asset at the end of the lease term.

There are no restrictions placed by Lakes DHB Group on any of the finance leasing arrangements.

18 Provisions

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Current provisions are represented by:		
ACC Partnership Programme	31	31
Total provisions	**31**	**31**

19 Equity

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Crown equity		
Balance at 1 July	20,693	20,994
Prior year adjustment	(6)	
Contributions from the Crown	0	0
Repayments to the Crown	(301)	(301)
Balance at 30 June	20,386	20,693
Other reserves		
Asset revaluation reserves		
Balance at 1 July	55,952	46,906
Revaluation gains/(losses)		
- Land	0	1,690
- Buildings	0	7,392
Transfer of asset revaluation reserve to retained earnings on disposal of property		
- Land	0	0
- Buildings	0	(36)
Balance at 30 June	55,952	55,952
Represented by:		
Total Land	5,414	5,414
Total Buildings	50,538	50,538
	55,952	55,952
Cash flow hedge reserve		
Balance at 1 July	(1,376)	(872)
Fair value gains/(losses) in the year	(53)	(504)
Reclassification to the surplus or deficit	0	0
Balance at 30 June	(1,429)	(1,376)
Total other reserves	54,523	54,576

The asset revaluation reserve relates to land and buildings. Where buildings are reclassified as investment property, the cumulative increase in the fair value of the buildings at the date of reclassification in excess of any previous impairment losses is included in the revaluation reserve.

The cash flow hedge reserve comprises the effective portion of the cumulative net change in the fair value of derivatives designated as cash flow hedges.

Retained earnings

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Balance at 1 July	14,166	18,009
Prior year adjustment	15	
Surplus(deficit) for year	(5,271)	(3,843)
Transfer to retained earnings of revaluation reserve on disposal of property	0	0
Balance at 30 June	8,910	14,166

Trust Funds

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Balance at 1 July	790	992
Transfer to retained earnings in respect of:		
Interest received	26	38
Donations and funds received	17	5
Transfer to retained earnings in respect of:		
Funds spent	(34)	(245)
Balance at 30 June	799	790
Total equity at 30 June	**84,618**	**90,225**

The Lakes District Health Board Charitable Trust is a separate legal entity. Lakes DHB, however, exercises majority control over the trust, thereby rendering it an 'in substance subsidiary'. The balance date of the Trust is 30 June. The results of the Trust for the 12 months to 30 June 2016 have been consolidated into the results of Lakes DHB.

The Trust assets and funds are made up of assets donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the statement of comprehensive revenue and expense. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds.

All trust funds are held in bank accounts that are separate from Lakes DHB Group's normal banking facilities. Refer Note 7 for Trust cash and cash equivalents on hand 30 June 2016.

20 Reconciliation of Net Surplus/(Deficit) After Tax with Net Cash Flow from Operating Activities

	Lakes DHB Group Actual 2016 $000	Actual 2015 $000
Surplus/(deficit) after tax	(5,262)	(4,045)
Add/(less) non-cash items:		
Depreciation and amortisation expense	10,284	10,627
Share of associate and joint venturer (surplus)/deficit	18	(41)
(Gains)/losses in fair value of investment property	0	0
	5,040	6,541
Add/(less) items classified as investing or financing activity:		
Net loss(gain) on disposal of property, plant and equipment	46	17
	46	17
Add/(Less) movements in working capital items:		
(Increase)/Decrease in debtors and other receivables	(326)	(3,077)
(Increase)/Decrease in inventories	(2)	(126)
Increase/(Decrease) in creditors and other payables	821	1,242
Increase/(Decrease) in employee entitlements	(736)	1,068
Increase/(Decrease) in provisions	0	(34)
	(243)	(927)
Net cash inflow/(outflow) from operating activities	**4,843**	**5,631**

21 Capital Commitments and Operating Leases

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Capital commitments		
Buildings	571	135
Computer Plant & Equipment	0	0
Medical Plant & Equipment	1,253	1,473
Non Medical Plant & Equipment	0	0
Intangible assets	615	0
Total capital commitments	**2,439**	**1,608**

There are no capital commitments in relation to Lakes DHB Group's interest in HealthShare Ltd or Laboratory Services Rotorua joint ventures.

Operating leases as lessee

Lakes DHB Group leases buildings, vehicles, and office equipment in the normal course of its business. These non-cancellable leases typically range from 1 to 5 years (for buildings) and 1 to 5 years (for vehicles, and office equipment). The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Not later than one year	240	338
Later than one year and not later than five years	183	420
Later than five years	0	0
Total non-cancellable operating leases	**423**	**758**

The total minimum future sublease payments expected to be received under non-cancellable subleases at balance date is $Nil (2015: $Nil).

Leases can be renewed at Lakes DHB Group's option, with rents set by reference to current market rates for items of equivalent age and condition. In the case of leased buildings, lease payments are increased annually to reflect market rentals. None of the leases includes contingent rentals.

There are no restrictions placed on Lakes DHB Group by any of the leasing arrangements.

During the year ended 30 June 2016, $531,969 was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2015: $560,630).

Operating leases as lessor

Lakes DHB Group licences the use of its Rotorua and Taupo Laboratories to third parties. The substance of these licences take the form of operating leases arrangements. These leases have non-cancellable terms of between four and five years.

The Rotorua Laboratory is licensed to Laboratory Services Rotorua as part of the joint venture arrangement between Spectrum Health Ltd and Diagnostic Rotorua Ltd (note 13). Laboratory Services Rotorua pays a monthly licence fee to Lakes DHB to operate the Rotorua Laboratory situated at Lakes DHB. The licence is due to expire 30 June 2017.

The Taupo Laboratory is licensed to Southern Community Laboratories Ltd. Southern Community Laboratories Ltd pays a monthly licence fee to Lakes DHB to operate the Taupo laboratory situated at Lakes DHB. The licence is due to expire 30 June 2017.

The future minimum lease payments to be collected under non-cancellable leases are as follows:

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Not later than one year	416	420
Later than one year and not later than five years	0	416
Later than five years	0	0
Total non-cancellable operating leases as lessor	**416**	**836**

No contingent rents have been recognised in the statement of comprehensive revenue and expense during this period.

22 Contingencies

Contingent liabilities

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
Contract Disputes - non employment	0	0
Legal proceedings - employment	0	100
Total contingent liabilities	**0**	**100**

Contract Disputes - non employment
There were no contract disputes - non employment as at 30 June 2016 (2015: Nil).

Legal proceedings - employment
Lakes DHB Group has been notified of no potential employment claims as at 30 June 2016 (2015: 1). The claimants are seeking $0 in damages (2015:$100,000).

Other unquantified claims
Lakes DHB is a participating employer in the National Provident DBP Contributors scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, Lakes DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Lakes DHB could be responsible for an increased share of the deficit.

As at 31 March 2016, the Scheme had a past service surplus of $11.7 million (7.4% of the liabilities). (2015: surplus of $20.943 million (11% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

The actuarial valuation for the scheme as at 31 March 2016 had not been made available at 30 June 2016.

The Actuary to the Scheme has recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended employer contributions remain suspended.

Joint venture contingent liabilities
There are no contingent liabilities associated with HealthShare Ltd, or Laboratory Services Rotorua, or other activities of the Group (2015: $Nil).

Contingent assets
Lakes DHB Group has no contingent assets (2015: $Nil).

23 Related Party Transactions

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 it is reasonable to expect Lakes DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transaction 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

Board members

During the financial year the DHB funded or made payments to entities in which Board members had governance, shareholder or other interests. Board members do not participate in decisions directly related to funding of their related entities.

There are close family members of executive team members employed by Lakes DHB. The terms and conditions of these arrangements are no more favourable than Lakes DHB would have adopted if there were no relationship to executive team members.

Key management personnel compensation

	Actual 2016 $000	Actual 2015 $000
Board Members		
Remuneration	258	273
Full-time equivalent members	1	1
Leadership Team		
Remuneration	2091	2,048
Full-time equivalent members	9	9
Total key management personnel remuneration	2349	**2,321**
Total full-time equivalent personnel	10	**10**

Key management personnel include board members, chief executive, and executive team members.

24 Remuneration

Board remuneration

The following people held office as Board members during the twelve months ending June 2016 and the amounts of remuneration were set by the Minister of Health.

	Board Fees 2016 $000	Board Fees 2015 $000
Deryck Shaw - Chair	42	46
Lyall Thurston - Deputy Chair	25	28
Mary Burdon	22	24
Ailsa Gathergood	21	21
Danny Loughlin	24	23
Ian McLean	22	23
Merepeka Raukawa-Tait	21	21
Rob Vigor- Brown	22	23
Charles Sturt **	19	21
Tamarapa Lloyd *	20	21
Margaret Bentley *	21	22
Total board remuneration	**259**	**273**

* Commenced term during 13/14
** Commenced term during 13/14 and completed term in May 2016

No remuneration was paid to the directors of the subsidiary company, Spectrum Health Ltd. No Board members received compensation or other benefits in relation to cessation (2015: Nil).

Non - board committee remuneration

The following people were non-board committee members during the twelve months ending 30 June 2016.

	Committee Fees 2016 $000	Committee Fees 2015 $000
Hospital Advisory Committee		
Te Rau Morgan	2.0	2.5
Julie Calnan	0.8	2.0
David Honore	1.5	2.0
Ned Wikaira **	1.3	2.0
Mark Arundel	1.8	1.5
Edna Isaacs	0.0	0.3
Gwendolyn Puti-Ruhaina Isaacs *	0.3	0.0
Ewan Wilson (Waikato DHB rep)	0.0	1.3
Martin Gallager (Waikato DHB Rep)	1.8	0.5
	9.5	12.1
Community and Public Health Advisory Committee		
Lawrence Croxson	0.5	1.0
Sue Westbrook	0.0	0.3
Margaret Robbie	1.0	1.7
Catriona Watson	0.8	1.0
Peri Marks	0.0	1.3
Anahera Pedersen	1.0	1.3
Te Rau Morgan (TRHOTA Rep) *	0.3	0.0
Harata Rangimarie Paterson *	0.8	0.0
Kamiria Iwa Grace Gosman *	0.3	0.0
Ronald Scott (BOP DHB rep)	1.3	1.5
Tania Hodges (Waikato DHB rep)	0.5	1.7
	6.5	9.8
Disability Support Advisory Committee		
Colin Cockburn	1.3	1.8
Mere Maniapoto	0.3	1.0
Sue Westbrook	1.3	1.5
Leeann Loughlin	0.8	0.7
Cherie Reinders	0.3	1.0
Crystal Beavis	0.3	1.5
Ronald Scott (BOP DHB rep)	1.3	1.5
Te Rau Morgan	0.0	0.3
	5.6	9.3
Total non - board committee remuneration	**21.6**	**31.1**

* Commenced term during 15/16
** Completed term during 15/16

Further details on board and committee fees can be found in the cabinet office circular CO (12) 6. Fees framework for members of statutory and other bodies appointed by the Crown.

Employee remuneration

Salary range	2016 Number of staff clinical and other staff	2015 Number of staff clinical and other staff
$100,001 - $110.000	30	27
$110,001 - $120,000	22	24
$120.001 - $130.000	11	12
$130,001 - $140,000	8	10
$140,001 - $150,000	10	7
$150.001 - $160,000	6	5
$160,001 - $170,000	4	8
$170,001 - $180,000	3	4
$180,001 - $190,000	5	4
$190,001 - $200,000	2	4
$200,001 - $210,000	4	3
$210,001 - $220,000	5	4
$220,001 - $230,000	5	0
$230,001 - $240,000	3	4
$240,001 - $250,000	9	8
$250,001 - $260,000	3	10
$260,001 - $270,000	5	4
$270,001 - $280,000	4	7
$280,001 - $290,000	5	1
$290,001 - $300,000	4	1
$300,001 - $310,000	2	3
$310,001 - $320,000	3	3
$320,001 - $330,000	4	3
$330,001 - $340,000	5	2
$340,001 - $350,000	3	2
$350,001 - $360,000	0	2
$360,001 - $370,000	0	1
$370,001 - $380,000	1	1
$380,001 - $390,000	0	3
$390,001 - $400,000	4	1
$400,001 - $410,000	1	0

Of the 171 employees shown above, 140 are medical or dental employees

If the remuneration of part time employees was grossed up to an FTE (full time equivalent) basis, the total number of employees with FTE salaries of $100,000 or more would be 214 compared with the actual total number of 171.

25 Severance Payments

During the year, Lakes DHB made no severance payments to former employees in respect to employment with the Board.

Number of employees	Amount $
0	0

26 Directors' and Officer's Insurance

Insurance premiums were paid in respect of board members' and certain officer's 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 DHB) in their position as board members or officers.

27 Ministry of Education Early Childhood Education Funding

Lakes DHB runs an Early Childhood Education Centre which it receives funding from the Ministry of Education. As a condition of funding, Lakes DHB is required to disclose the specific funding received from the Ministry of Education in the annual financial statements.

	Actual 2016 $000	Actual 2015 $000
ECE Funding Subsidy	**116**	153
20 Hrs ECE	0	0
Equity Funding	22	27
ATIS (Annual Top-Up for Isolated Services)	0	0
	138	**180**

28 Events After the Balance Date

No significant events have occurred since balance date.

29 Financial Instrument Categories

The carrying amounts of financial assets and liabilities in each of the NZ PBE IPSAS 29 categories are as follows:

Note		Lakes DHB Group Actual 2016 $000	Actual 2015 $000
	FINANCIAL ASSETS		
	Loans and receivables		
7	Cash and cash equivalents	2,036	4,197
8	Debtors and other receivables	12,156	11,894
14	Other financial asset	1,450	1,450
	Total loans and receivables	**15,642**	**17,541**
	Held to maturity	**0**	**0**
	Fair value through other comprehensive revenue	**0**	**0**
	FINANCIAL LIABILITIES		
	Financial liabilities at amortised costs		
14	Other financial liability	750	750
15	Creditors and other payables	16,729	16,050
	Borrowings:		
7	Bank overdraft	0	0
17	Finance lease liabilities	3,476	2,410
17	MOH Loans	49,565	49,565
	Total financial liabilities at amortised costs	**70,520**	**68,775**

30 Fair Value Hierarchy Disclosures

For those instruments recognised at fair value in the statement of financial position, fair values are determined according to the following hierarchy:

- Quoted market price (level 1) - Financial instruments with quoted prices for identical instruments in active markets.
- Valuation technique using observable inputs (level 2) - Financial instruments with quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in inactive markets and financial instruments valued using models where all significant inputs are observable.
- Valuation techniques with significant non-observable inputs (level 3) - Financial instruments valued using models where one or more significant inputs are not observable.

The following table analyses the basis of the valuation of classes of financial instruments measured at fair value in the statement of financial position:

Lakes DHB and Group

	Quoted market Price $000	Observable inputs $000	Significant non-observable inputs $000	Total $000
2016				
Financial Assets	0	0	0	0
Financial Liabilities				
Derivatives	0	1,429	0	1,429
2015				
Financial Assets	0	0	0	0
Financial Liabilities				
Derivatives	0	1,376	0	1,376

There were no transfers between the different levels of the fair value hierarchy.

31 Financial Instrument Risks

Lakes DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk Lakes DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions which are speculative in nature to be entered into.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. The DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Borrowing issued at fixed rates exposes Lakes DHB to fair value interest rate risk. Lakes DHB's treasury policy is to maintain approximately 60% of its borrowings in fixed rate instruments.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable interest rates expose Lakes DHB to cash flow interest rate risk.

Lakes DHB's investment policy requires a spread of investment maturity dates to limit exposure to short-term interest rate movements.

Lakes DHB's borrowing policy requires a spread of interest rate repricing dates on borrowings to limit the exposure to short term interest rate movements.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

Lakes DHB is exposed to foreign currency risk on minor purchases for goods and services which require it to enter into transactions in foreign currencies. Transactions in foreign currencies are translated at the foreign exchange rate at the date of the transaction. As a result of these activities, limited exposure to currency risk arises.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Lakes DHB, causing the DHB to incur a loss.

Due to the timing of its cash inflows and outflows, Lakes DHB invests surplus cash into term deposits with high - quality financial institutions and has a treasury policy that limits the amount of credit exposure to any one financial institution. The DHB only invests funds with registered banks with specified Standard and Poor's credit ratings.

Lakes DHB's maximum credit exposure for each class of financial instrument is represented by the total carrying amount of cash and cash equivalents (note 7), and net debtors (note 8). There is no collateral held as security against these financial instruments, including those instruments that are overdue or impaired.

Concentrations of credit risk from debtors are high due to the reliance on the Ministry of Health for 96% of Lakes DHB's revenue. It is assessed to be a low risk and high - quality entity due to its nature as the government funded purchaser of health and disability support services.

At 30 June there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

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

	Lakes DHB Group	
	Actual 2016 $000	Actual 2015 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and term deposits		
AA-	2,034	4,195
Other financial assets		
AA-	700	700
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Cash at bank and term deposits	2	2
Other financial assets	750	750
Receivables	12,156	11,894

Liquidity risk

Management of liquidity risk
Liquidity risk is the risk that Lakes DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions. Lakes DHB aims to maintain flexibility in funding by keeping committed credit lines available.

In meeting its liquidity requirements, Lakes DHB maintains a target level of investments that must mature in the next 12 months.

Lakes DHB manages its borrowings in accordance with its funding and treasury policies. These policies have been adopted as part of the Lakes DHB Annual Plan.

Lakes DHB has a credit facility with New Zealand Health Partnership Limited (HPL) which allows the DHB to draw down the value of one month's Provider Arm funding, less Inter-District In-Flows, plus GST. For Lakes DHB this equates a maximum of $14.525 million. There are no restrictions on the use of this facility.

Contractual maturity analysis of financial liabilities, excluding derivatives
The table below summarises Lakes DHB Group's financial liabilities into the relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future

interest payments on floating rate debt are based on the floating rate at the balance sheet date. The amounts disclosed are the contractual undiscounted cash flows.

	Less than 1 year $000	1 - 2 years $000	2 - 5 years $000	5 + years $000
2016				
Creditors and other payables (note 15)	16,729	0	0	0
Bank overdraft (note 7)	0	0	0	0
Finance lease liabilities (note 17)	1,014	634	1,193	636
Other financial liabilties (note 14)	0	750	0	0
MOH loans (note 17)	4,000	6,000	27,565	12,000
2015				
Creditors and other payables (note 15)	16,050	0	0	0
Bank overdraft (note 7)	0	0	0	0
Finance lease liabilities (note 17)	674	726	718	291
Other financial liabilties (note 14)	0	750	0	0
MOH loans (note 17)	4,000	-	23,000	22,565

Contractual maturity analysis of derivative financial liabilities

The table below analyses Lakes DHB Group's derivative financial instrument liabilities into those that will be settled on a net basis and those that will be settled on a gross basis in relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows.

	Liability carrying amount $000	Asset carrying amount $000	Contractual Cash flows NZ$ $000	Less then 1 year NZ$ $000	2 -5 years NZ$ $000	5+ years NZ$ $000
2016						
Gross settled derivatives	0	0	0	0	0	0
Net settled derivatives	1,429	0	1,429	239	1,190	
2015						
Gross settled derivatives	0	0	0	0	0	0
Net settled derivatives	1,376	0	1,376	0	1,376	

Contractual maturity analysis of financial assets

The table below analyses Lakes DHB Group's financial assets into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date.

	Less than 1 year $000	1 - 2 years $000	2 - 5 years $000	5 + years $000
2016				
Cash and cash equivalents (note 7)	2,036	0	0	0
Debtors and other receivables (note 8)	12,156	0	0	0
Other financial assets (note 14)	700	750	0	0
2015				
Cash and cash equivalents (note 7)	4,197	0	0	0
Debtors and other receivables (note 8)	11,894	0	0	0
Other financial assets (note 14)	700	750	0	0

Sensitivity analysis

Interest rate risk

In managing interest rate risks Lakes DHB Group aims to reduce the impact of short term fluctuations on Lakes DHB Group's earnings. Over the longer term, however, permanent changes in interest rates would have an impact on consolidated earnings.

Cash and cash equivalents include deposits at call totalling $2,036,000 (2015: $4,197,000) which are at floating rates. A movement in interest rates of plus or minus 1.0% has an effect on interest revenue of $20,360 (2015: $41,970).

Derivatives financial liabilities hedge accounted includes interest rate swap fair value hedges with a fair value totalling $1,438,952 (2015: $1,376,220). A movement in interest rates of plus or minus 1.0% has an impact of $1,825,696 / ($1,045,828) (2015: $(1,934,525 / ($840,417) on equity through the cash flow hedge reserve. The sensitivity for interest rates has been calculated using a derivative valuation model using hypothetical forward rates.

32 Capital Management

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

Lakes DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

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

Trust and bequest reserves are set up where Lakes DHB Group has been donated funds that are restricted for particular purposes. Interest is added to trust and bequest reserves where applicable and deductions are made where funds have been used for the purpose they were donated.

There have been no material changes in Lakes DHB Group's management of capital during the period.

33 Summary of Revenues and Expenses by Output Class

	Lakes DHB Group Budget 2016 $000	Lakes DHB Group Actual 2016 $000
Output Class Revenue		
Prevention	4,750	6,764
Early Detection and Management	74,702	75,960
Intensive Assessment and Treatment	212,701	215,889
Rehabilitation and Support	40,258	38,825
Total Revenue	**332,411**	**337,438**
Output class Expenses		
Prevention	2,770	1,043
Early Detection and Management	70,966	79,816
Intensive Assessment and Treatment	222,723	224,870
Rehabilitation and Support	35,333	36,971
Total Expenses	**331,792**	**342,700**
Surplus/(deficit) by Output class		
Prevention	1,980	5,721
Early Detection and Management	3,736	(3,856)
Intensive Assessment and Treatment	(10,022)	(8,981)
Rehabilitation and Support	4,925	1,854
Net Surplus/(Deficit)	**619**	**(5,262)**

Definitions of the four output classes:
Intensive Assessment and Treatment comprise services that are delivered by hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include: outpatient, district nursing, day services, diagnostic, therapeutic, and rehabilitative services, Inpatient services, Emergency Department services.

Early Detection and Management comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Maori health services, pharmacist services, community pharmaceuticals (the schedule) and child and adolescent oral health and dental services.

Prevention include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic and environmental risk and communicable diseases; and, individual health protections services such as immunisation and screening services.

Rehabilitation and Support comprise services that are delivered following a 'needs assessment' process and coordination input by NASC services for a range of services including palliative care services, home-based support services and residential care services.

34 Explanation of Major Variations from Statement of Intent

Statement of comprehensive revenue and expense
The Lakes DHB Group recorded a deficit of $5.2 million compared with a budgeted profit of $619k. The major reasons for the variances between actual and budgeted result of $5.8 million was due to:

	Variance $000
- additional Government sourced revenue including new MoH side contracts of $3.617 million	3,617
- lower actual costs for Medical personnel due to unfilled vacances of $746k.	746
- higher actual costs for nursing employees due to increased volumes of 1.011 million.	(1,011)
- higher actual costs for outsourced medical personnel due to vacancies, sick leave and cover of $4.144 million.	(4,144)
- higher outsourced clinical services expenses due to increased volumes of $2.325 million.	(2,325)
- higher actual costs for clinical supply costs due to increased volumes of $670k.	(670)
- higher actual costs for community pharmaceuticals, primary practice services and primary 'health care strategy's of $1,640	(1,640)
- higher net actual costs related to home support and aged residential care $636k.	(636)
- numerous other small favourable and unfavourable variances	182
Total variance	(5,881)

Statement of financial position

- Equity - The variance relates to a worse than planned comprehensive revenue and expense of ($5.3) million vs. budget $619k, variance between planned property revaluation figures and actual, a reduction in Trust funds, and an unbudgeted increase in the value of interest rate swaps, resulting in a net movement in equity of $857k.

- Current assets - Overall cash on hands was in line with expectations, however higher than planned accounts receivables and accrued debtors relating to MoH, Pharmac and IDF flows saw a net increase in planned current assets of $1.622m.

- Non-current assets - Due to a delay in a number of capital projects being commenced, overall non current assets expenditure was ($2.838m) lower than planned.

- Current liabilities - Higher than planned payables due to an increase in operational costs of ($4.299m), a delay in crown borrowing lead to lower than planned term loans $1.778m and timing of S&W payments and an increase in the annual leave provision meant an increase in planned employment related provisions of ($955k), resulting in a overall net unfavourable increase in current liabilities of ($1.597m).

- Non current liabilities - Due to a delay in capital projects, finance lease borrowings was lower than planned $2.209m, this was partially offset by an increase in employment related costs of ($243k), resulting in a net reduction of $1.966m.

Directory

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