LAKES DISTRICT HEALTH BOARD

Annual Report
for the year ended
30 June 2017

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

Contents

Message from the Board Chairman

The health sector is complex and challenging, so understanding our health profile plays an important part in our decision making processes. This information helps us focus on where we can make the greatest gains in terms of our health outcomes as well as for planning and prioritisation of programmes at an operational level.

Lakes DHB remains committed to improving the health outcomes of our most vulnerable population in particular Maori, our children and youth, and people with mental health conditions. The long term outcomes we are seeking are that people take greater responsibility for their health, stay well in their own homes and communities and receive timely and appropriate specialist care when necessary.

As providers of hospital and specialist services, DHBs face increasing demand and workforce pressure. When coupled with the current fiscal situation this means we need to develop innovative ways of treating more people and reducing waiting times with limited resources. There is growing concern that the current configuration of health services and health workforce is unable to keep pace with the demands and we need to seek more integrated models of healthcare.

DHBs are expected to budget and operate within allocated funding. This has been another challenging year, where Lakes DHB's financial performance has been unfavourable to our agreed budget. The Board continues to monitor detailed plans to improve our financial performance, with a clear expectation that the DHB make efficiency gains. Our focus is on maintaining and improving quality whilst reducing cost by increasing productivity and redesigning services wherever possible.

One of the ways we can make savings is to work together with other DHBs at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. In 2016/17 all five Midland DHBs continued to progress activities towards greater regional cooperation and Lakes DHB is committed to the collaboration needed to ensure successful implementation of current programmes, as well as identify and develop future opportunities.

The Lakes Board is committed to working in partnership across the health and social service provider sector. We work in collaboration with Whanau Ora, the Children's Action Plan, Healthy Families NZ, healthy housing, primary health organisations and the Prime Minister's Youth Mental Health project. The government's Better Public Services initiatives are focussed on improving the lives of vulnerable families and Lakes DHB strongly supports the range of cross agency work that delivers outcomes for children and young people.

The health targets are important for driving health sector performance and the Board pays close attention to how well we do in the targets. Meeting these targets makes a practical difference to individuals and families by improving access to services and reducing wait times or preventing harmful conditions. While it has been a challenging year financially, Lakes has continued to fund and deliver quality services in a timely and accessible manner. My thanks to our board, Chief Executive, all of our staff and to the many people that deliver and support health services in our communities.

Deryck Shaw
Chair, Lakes District Health Board

Message from the Chief Executive

Many people in our Lakes DHB communities are not as healthy as we would like them to be and a major contributor to this is the high levels of deprivation. Many of the standard health indicators show the Lakes population to have a very high level of health inequality.

Our focus must be on health not hospitals. If people are well they do not need as many hospital level or long stay interventions. Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better management of their illness or long term condition.

Primary care can deliver services sooner and closer to home and prevent disease through education, screening, early detection and timely provision of treatment. Supporting primary care are a range of other health professionals including midwives, community nurses, social workers, aged residential care providers, personal health providers and pharmacists.

The Children's Health Centre will create single, integrated, multi disciplinary teams that focus on children from pregnancy to adolescence. This new approach to the way we look after our children will see the Ministry of Education, Ministry of Social Development, Rotorua Lakes Council, Rotorua Children's Team and the Police being part of the teams that deliver services to children and families. This community-based service will include relocating some of our children's health services to the new Library and Child health hub, Te Aka Mauri.

The high incidence of long term conditions particularly among Maori is exacerbated by tobacco use and little or late engagement with primary care. Lakes DHB remains steadfast in its commitment to the 2025 Smokefree goal. Supporting smokers to quit needs to be integrated into all primary, secondary and maternity health services and DHBs have a leading role. We have required our providers to prioritise smoking and ensure all staff, patients and their families are provided with help to quit smoking. Lakes DHB continues to focus on reducing smoking in pregnancy.

Quality and patient safety are a top priority for Lakes DHB. Quality of care, listening to consumers and the community and preventing harm are at the centre of Lakes DHB's quality improvement plan. The on-going involvement of clinical leadership and a robust clinical governance framework that provides motivation and oversight is critical to patient safety.

We continue to keep our patients safe by having a just culture and encouraging the reporting of adverse events and the robust analysis of patient safety data to ensure we maintain standards and critically assess delivery of care.

Our deficit financial result for the 2016-17 years was disappointing. It means that we have to carry forward the amount into the next year which makes it more difficult for us.

However, I want to thank all our staff for their productivity, their support and their commitment to our organisation, to our patients and to everyone in our Lakes DHB communities.

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 2016/17

To contribute to achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2016/17. 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 2016/17.

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 continues to include:

- 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 about 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.

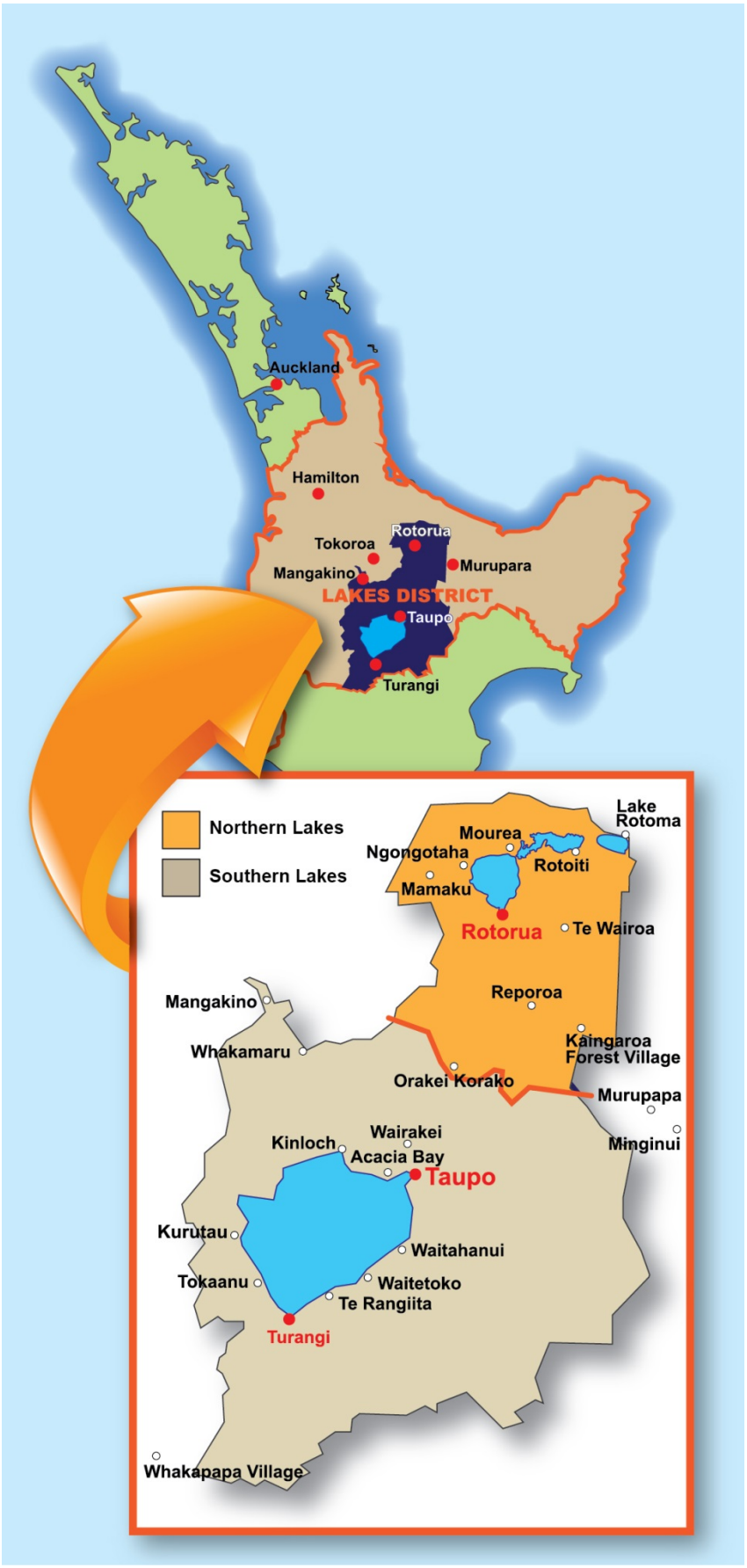
Good employer initiatives focused on bipartite meetings which were held with Council of Trade Union (CTU) union groups on a regular (quarterly / monthly) basis to discuss industrial matters, continue to build on healthy workplaces principles and developing effective partnerships.

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

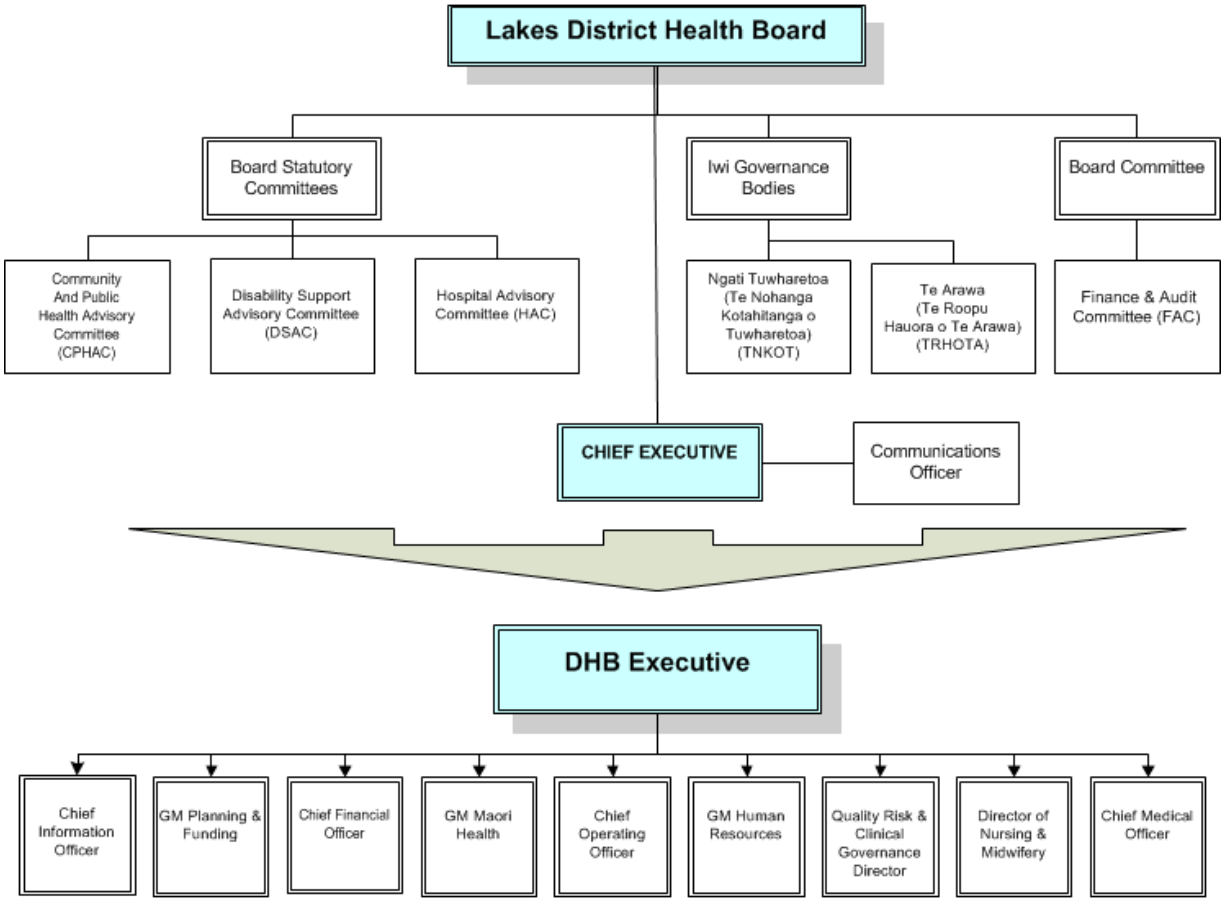
The policies and practices of the DHB work to enhance a positive and healthy workplace for our employees.

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 2016/17



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.

The announcement of Lakes DHB Board members to the advisory committees was made in early January 2017.

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 District Health Board 2016-2019
Back L-R: Merepeka Raukawa-Tait (inset), Stuart Burns, Christine Rankin, Johan Morreau, Janine Horton, Rob Vigor-Brown, Warren Webber
Front L-R: Des Epp, Lyall Thurston (Deputy Chair), Deryck Shaw (Chair), Ana Morrison

Lakes DHB Board Members

Board Members	Meetings Attended
July – November 2016	
Deryck Shaw - Chair	5/5
Lyall Thurston – Deputy Chair	5/5
Mary Burdon	5/5
Ailsa Gathergood	5/5
Danny Loughlin	5/5
Ian McLean	5/5
Rob Vigor-Brown	5/5
Maggie Bentley	4/5
Merepeka Raukawa-Tait	4/5
Tamarapa Lloyd	3/5
Charles Sturt (resigned 10 June 2016)	N.A.
December 2016 – June 2017	
Deryck Shaw - Chair	5/6
Lyall Thurston - Deputy Chair	5/6
Stuart Burns	6/6
Des Epp	6/6
Janine Horton	6/6
Johan Morreau	6/6
Merepeka Raukawa-Tait	5/6
Rob Vigor-Brown	6/6
Ana Morrison	5/6
Christine Rankin	5/6
Warren Webber	5/6

Iwi Governance Bodies

Te Roopu Hauora o Te Arawa (iwi governance board that represents the interests of Te Arawa iwi) continues 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. The following is derived from the Iwi Governance terms of Reference:

- Provide leadership, direction, and advice to the Lakes DHB, Board committee's, Chief Executive and management on all strategic matters affecting the health of Maori.
- To participate at a governance level (Board and Board committees) in agreeing the principles that underpin decision making processes that impact on the health and disability services for Maori within the Lakes DHB district.
- To be the vehicle for ensuring effective consultation, and participation of whanau, hapu and iwi (Te Arawa and Ngati Tuwharetoa). To participate in strategic development and planning to support the well being of Te Arawa and Tuwharetoa and providing information and advice with the ability to influence and direct health service delivery.

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

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. Lakes DHB currently do not have a formal relationship with a Ngati Tuwharetoa entity (Te Nohanga Kotahitanga o Tuwharetoa), the DHB is awaiting guidance from Ta Tumu Te Heuheu to guide us.

Executive Governance – Te Kahui Oranga

The authority Te Kahui Oranga was derived from the Chairs (Lakes DHB, Te Nohanga Kotahitanga o Tuwharetoa (TNKOTH) and Te Roopu Hauora o Te Arawa (TRHOTA) and selected board members.

Te Kahui Oranga is a combined leadership/executive group of Lakes DHB Board 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).

Membership consists of three or four chosen representatives from each of the Iwi governance boards/Iwi, and from the Lakes DHB including Lakes DHB Chair, Deputy Chair and two Board members. It is an expectation that members will be current members of their respective Governance group. .

- Chairperson of both Iwi Governance
- Lakes DHB Chair

- Additional members of iwi governance (2)
- Lakes DHB CE
- GM Maori Health
- GM Planning and Funding
- GM Corporate Services (as and when required)

Midlands Iwi Relationship Boards (MIRB)
Taranaki, Tairawhiti, Bay of Plenty, Waikato and Lakes iwi relationship board chairs (and in some cases deputy chairs complete the composition of MIRB and contribute to the regional work across the Midland region. During the 2016/17 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.

- To advise and support GMs Maori and endorse regional and national strategies and policies that protect the investment in Maori health
- Maintain high level relationships with DHB Chairs and other strategic groups as appropriate to ensure a coordinated approach to Maori Health development
- Effective implementation of agreed Midland Maori Health plan (now Midlands Regional Services Plan)
- A coordinated inclusive approach to development of the Maori health strategies.
- Provide strong leadership on regional Maori health issues

The resignations of GM Maori BoP DHB and GM Maori Waikato DHB have had a significant impact however the appointment of Lorraine Elliot to Waikato adds impetus. The reallocation of responsibilities in improving Maori Health Outcomes had to be reconsidered, however, the current Acting GMs, with the support of other GMs, are ensuring implementation of the objectives remains a priority. GM Maori Lakes DHB is acting Chair of Nga Toka Hauora.

Given the changes of the requirements of Maori Health Plans by the Ministry of Health , Nga Toka Hauora remain committed to maintain achieving health equity and improving Maori Health Outcomes for the development and implementation of Regional Service Plans and Annual Plans.

In general the initiatives developed to promote improving Maori health outcomes are gaining momentum, and implementation over the entire Midland region is a priority. Some of the resources developed within these projects are of a very high standard and have been accepted and endorsed by MIRB and Nga Toka Hauora.

Trendly has been adopted by DHBs as a Maori Health Plan monitoring tool and is presented as a standard agenda item at Advisory Board level. Feedback reflects the simplicity and clarity of the tool has merit and accordingly will be promoted nationally.

Midland Iwi Relationship Boards recommended and endorsed the following from the Midlands RSP:
The Midland region's approach in 2017/18 is to focus efforts on supporting the Midland region DHBs, including its agencies, to build a culture of equity which is enabling of attaining health equity for Maori. To achieve this there is a commitment to:

1. Health equity assessment using the Health Equity Assessment Tool, or an appropriate tool, being scheduled and/or carried out to assess the effectiveness for Maori, of existing

regional services and/or new regional service models, programmes, policies and projects identified in the Regional Services Plan;

2. Applying whanau-centred health information management to regional services that supports whānau to better self-manage their own health and wellbeing;
3. Setting, monitoring and reporting 'no differential' targets for Maori and non-Maori for all monitored regional activity;
4. Increasing the Maori health and disability workforce across Midland DHBs, including its agencies; and providing support to increase the responsiveness of the health workforce to Maori.

Nga Toka Hauora, the Midland DHB GMs Maori Health, will work with HealthShare, with regional and local networks to guide the application of commitments 1 to 4 above across 2017/18 regional network activity in accordance with a Health Equity Template.

Iwi Governance Body Membership

Te Roopu Hauora o Te Arawa Members	Te Nohanga Kotahitanga o Tuwharetoa Representative (interim)
Peri Marks (Chair) Beatrice Yates (Ngati Pikiao - Koeke) Harata Patterson (Ngati Rangiwewehi) Jenny Kaka-Scott (Ngati Manawa) Kathy Porter (Ngati Hurunga o te Rangi) Lillian Emery (Ngati Ngararanui) Raelynn Marks (Interim Secretary) Stephen Te Moni (Rangatahi – Tane) Sue Westbrook (Ngati Tahu/Ngati Whaoa) Tahae Tait (Ngati Whakaue) Te Mauri Kingi (Rangatahi – Tane) Kiriwaitingi Rei (Rangatahi – Wahine)	Kim Gosman (Acting Chair)

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
	July-October 2016
Lyall Thurston – Chair	2/2
Ailsa Gathergood – Deputy Chair	2/2
Deryck Shaw – Board Chair, Ex-officio	2/2
Mary Burdon	2/2
Maggie Bentley	1/2
Tania Hodges – Waikato DHB committee representative	
Ron Scott – Bay of Plenty DHB committee representative	
Kim Gosman – community representative	
Catriona Watson – community representative	
Margie Robbie – community representative	
Peri Marks – TRHOTA primary representative	
Ana Pedersen – TNKOTH primary 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	
Matthew Davies - RAPHS	
Bevan Bayne – Pinnacle Midlands Health Network	

Committee Members – CPHAC continued	Meetings Attended
	February-June 2017
Lyall Thurston – Chair	3/3
Warren Webber – Deputy Chair	3/3
Deryck Shaw – Board Chair, Ex-officio	2/3
Merepeka Raukawa-Tait	3/3
Des Epp	2/3
Johan Morreau	3/3
Peri Marks – TRHOTA primary representative	
TRHOTA alternate representative – to be advised	
Ana Pedersen – TNKOTH primary 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	
Matthew Davies - RAPHS	
Bevan Bayne – Pinnacle Midlands Health Network	

Disability Support Advisory Committee

The Disability Support Advisory Committee advises the Board on the disability support needs of the Lakes DHB's 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 people with disabilities. The committee gives direction on the disability support services the Lakes DHB provides.

The Committee's focus includes the following:

1. 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.

2. Mental Health and Addiction Services
   - Advancing continuum of care approach to health and support services to people with mental health issues.

3. 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.

4. 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.

5. 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
July to October 2016	
Lyall Thurston – Chair	2/2
Rob Vigor-Brown – Deputy Chair	2/2
Deryck Shaw – Board Chair, Ex-officio	2/2
Ailsa Gathergood	2/2
Merepeka Raukawa-Tait	1/2
Pippa Mahood – Waikato DHB representative	
Ron Scott – Bay of Plenty DHB representative	
Colin Cockburn – community representative	
Cherie Reinders – community representative	
Sue Westbrook – TRHOTA primary representative	
Peri Marks – TRHOTA alternate representative	
Leeann Loughlin – TNKOTH primary representative	
Kim Kaukau – TNKOTH primary representative	
Don Sorrenson – ex-officio Support Net representative	
Matt Watson – ex officio RAPHS representative	

Committee Members		Meetings Attended
February – June 2017	**Note: May meeting cancelled**	
Rob Vigor-Brown –Chair		1/1
Merepeka Raukawa-Tait – Deputy Chair		1/1
Deryck Shaw – Board Chair, Ex-officio		1/1
Janine Horton		1/1
Des Epp		1/1
Stuart Burns		1/1
Sue Westbrook – TRHOTA primary representative		
Peri Marks – TRHOTA alternate representative		
Leeann Loughlin – TNKOTH primary representative		
Hineata Rameka – TNKOTH alternate representative		
Don Sorrenson – ex-officio Support Net representative		
Matt Watson – ex officio RAPHS representative		

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 2016/17 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
- 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
July – October 2016	
Mary Burdon – Chair	1/1
Danny Loughlin – Deputy Chair	1/1
Deryck Shaw – Board Chair – Ex officio	1/1
Ian McLean	1/1
Tamarapa Lloyd	Nil
Maggie Bentley	Nil
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 primary representative	
Peri Marks – TRHOTA alternate representative	
Ruhaina Isaacs - TNKOTH primary representative	
TNKOTH alternate representative – to be advised	

HAC Committee Membership

Committee Members – HAC continued	Meetings Attended
February – June 2017	
Lyall Thurston – Chair	3/3
Ana Morrison – Deputy Chair	2/3
Deryck Shaw – Board Chair – Ex officio	2/3
Johan Morreau	3/3
Janine Horton	2/3
Christine Rankin	3/3
Martin Gallagher – Waikato DHB representative – appointed June/July 2017	
Peri Marks – TRHOTA primary representative	
TRHOTA alternate representative – to be advised	
Ruhaina Isaacs - TNKOTH primary representative	
TNKOTH alternate representative – to be advised	

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 2016/17 included:

- Reviewing and approving all governance policies as they required updating
- Participating in the Insurance Renewal proposal for 2017/18 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 2017/18 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
- Oversaw the tender procurement for Laboratory services for Lakes DHB
- Reviewing the business cases and recommended the Board approve the:
    - Replacement MRI Scanner $1.6m
    - Implementation of Imprivata IS one sign system $435,000
    - Implementation of Cisco based Regional Video Conferencing
    - Awarded Cleaning Services Contract to Spotless Services Limited
    - Awarded the supply of multifunctional devices and associated print management services to Fuji Xerox for 60 months
    - Replacement vehicle fleet leasing
    - Agreed participation in the eSpace Midland Clinical Portal
    - Agreed the implementation of TrendCare Patient Acuity system

FAC Committee Membership

Committee Members	Meetings Attended
Danny Loughlin – Chair from July - November 2016	5/5
Rob Vigor-Brown – Deputy Chair from July - November 2016	5/5
Ian McLean – from July - November 2016	5/5
Deryck Shaw – Ex-Officio – from July - November 2016	5/5
Merepeka Raukawa-Tait – from July - November 2016	2/5
Tamarapa Lloyd – from July - November 2016	0/5
Deryck Shaw – Chair from February until 27 March 2017, then Ex-Officio	3/5
Stuart Burns – Deputy from February until 27 March 2017, then appointed as Chair from 1 May 2017	5/5
Rob Vigor-Brown – Appointed Deputy from 1 May 2017	5/5
Ana Morrison – from February - June 2017	4/5
Warren Webber - from February - June 2017	3/5
Christine Rankin – from February - June 2017	4/5

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, two 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

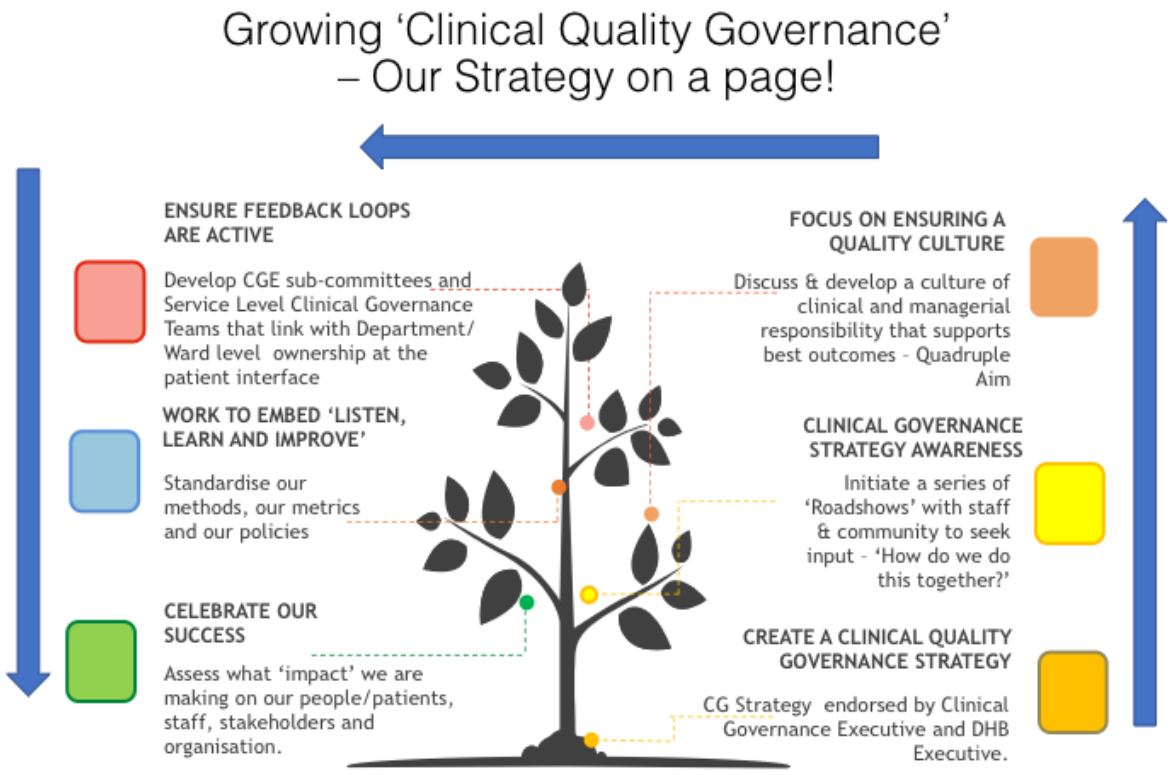
Committee Members
Mary Burdon, Community Representative, Rotorua
David Laidlow, Clinical Representative
Kristina Maconaghie, Community Representative, Taupo
Annie Morley, Clinical Nurse Manager, ICU/CCU, Lakes DHB, Nursing Representative
Marita Ranclaud, Portfolio Manager, Lakes DHB, Mental Health Representative
Barry Smith, Population Health Analyst, Lakes DHB, Chair
Tiannie Hillman-Lepper, Administrator, Lakes DHB

A separate Clinical Ethics Committee has also been established that contains a number of clinical representatives and some members from the Research and Ethics Committee. It is led by the chair of the Research and Ethics Committee. This committee assists clinical staff work through ethical challenges met during the delivery of care. It meets on an as is required basis.

Clinical Quality Governance

The 2016/17 year established the new Clinical Quality Governance (CQG) Strategy along with the Implementation Pathway. The strategy is gradually being socialised and enhanced through iterative internal discussions with staff and providers throughout the Lakes health system.

The diagram below sets out the strategy on a page. We anticipate embedding a 'team of teams'[1] 'way of working' that is reflected throughout the organisation with requisite capability for oversight and major decision-making by the Clinical Governance Executive Committee. It is about 'building consensus', 'a shared sense of purpose and, 'shared consciousness'. It involves transparency, listening, learning engaging, leading and improving.



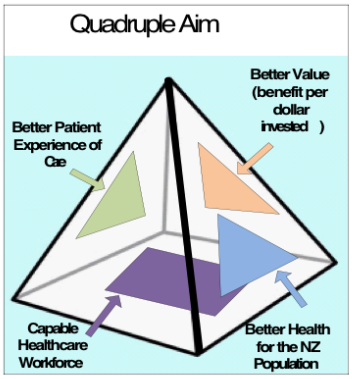
[1] General Stanley McChrystal: Team of Teams: New Rules of Engagement for a Complex World

The Clinical Governance Executive has also agreed the approach to be taken towards implementing the 'process cycle' illustrated in the following slide.

CQG incorporates all of the programmes, activities and approaches that are required to deliver the key goals of Lakes DHB in terms of the 'quadruple aim' set out below.

What we intend to measure!

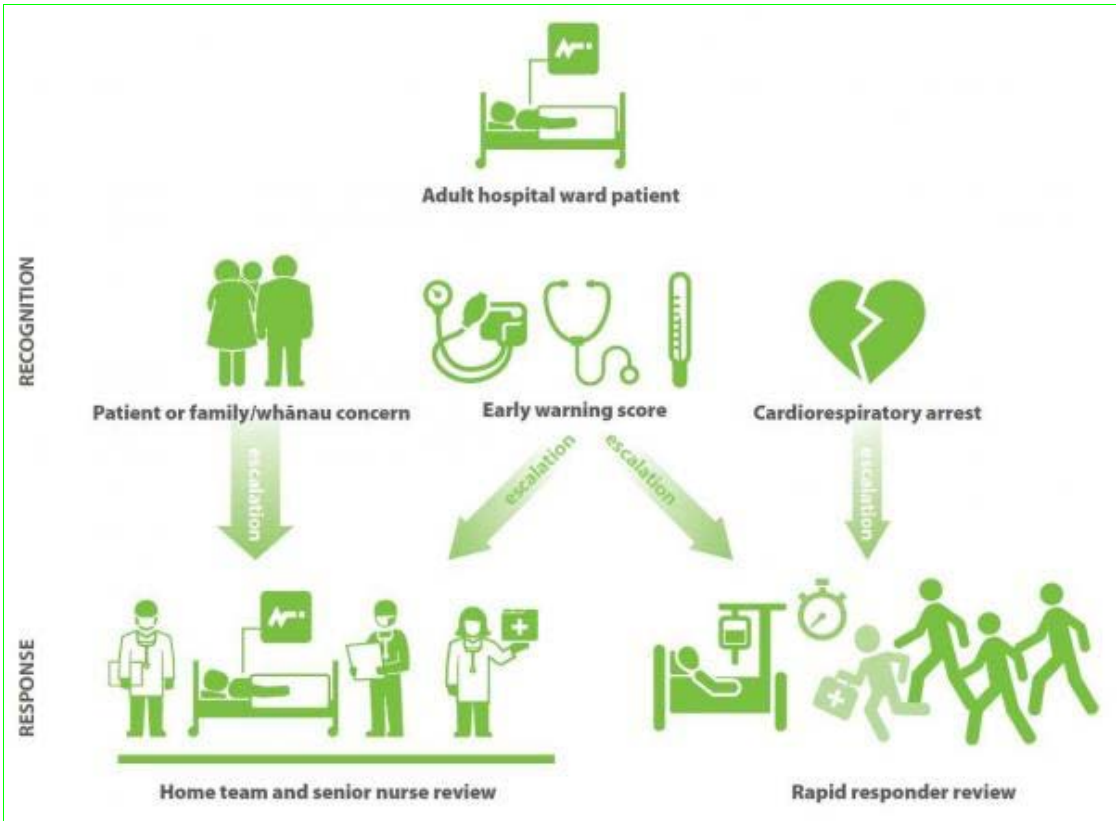
- ✓ Better patient experience of care
- ✓ Better health for the Lakes' population
- ✓ Better value
- ✓ A capable, engaged & flexible LHS healthcare workforce



Our progress in terms of programmes and activities includes:

1. Initiation of our Clinical Quality Improvement Half day: this programme involves all clinical staff (not on acute duty) within Lakes DHB hospitals having half-a-day every two months to come together to work on one of two initiatives that involve multi-disciplinary, across services development. Currently the teams are working on the 'Deteriorating Patient Escalation Pathway' and 'Obstetric Patients with Mental Health issues Pathway'. To date staff have demonstrated a keen work ethic and both of these pathway developments have progressed at pace. This programme includes work within the Health Quality and Safety Commission's national patient deterioration programme particularly:

- Recognition and response (early warning) systems for adult patients
- Recognition and response to family/whanau concerns
- Rapid responder review of the patient.



2. Orthopaedic Spinal Surgery Staph Bundle: the introduction of a proactive approach to reduce post-operative staphylococcal aureus infections has been successfully implemented. This approach builds on the HQSC's Surgical Site Infection (SSI) Improvement Programme which promotes and encourages culture change and provides guidance on practice improvement that reduce SSIs. This programme is being enhanced by inclusion of antibiotic prophylaxis, skin preparation and 'clipping' not 'shaving' interventions. The focus over the 2016/17 year has been on orthopaedic surgery in total.

3. We have now substantively embedded our regional reporting system for incidents, complaints and other related events using the DATIX software programme. Lakes DHB has added Health and Disability Commissioner (HDC) complaints, complaints in general, hospital acquired infections and coroner's reports on top of the SAC 1& 2 incidents required to be reported to the HQSC.

4. Infection Prevention and Control is now supported by an Infectious Disease Specialist and Microbiologist working within the IPC Subcommittee reporting to CGE. The IPC nurse has initiated work beyond the hospital walls to support IPC in aged-care facilities, non-Government healthcare providers and primary care. IPC has developed a robust infection control representative training and support group who are at the clinical coalface and ready to assist with emergent issues as well as monitor our hand hygiene compliance. We now also have an Antibiotic Stewardship Group and process along with a restricted antibiotic process and list.

5. Medication Safety continues to be a continuous quality improvement initiative within Lakes DHB through our clinical pharmacists' support for medication management processes and documentation and medicines related adverse events including reducing prescription of opioid medicines and a recent focus on anticoagulation for Venous Thrombo-embolism (VTE) prophylaxis.

6. Business as usual (BAU) includes VTE prophylaxis with a significant focus on application of the agreed Lakes DHB policy and procedures; falls recognition, assessment, documentation and prevention processes; hand hygiene promotion and monitoring; surgical check-lists and, prevention of central line infections.

The longer term aim is to progress our regional quality management initiatives both to reduce variation in care delivery across all of Midland DHBs but also to learn from our expert Quality Managers to build our local Quality Improvement capability. Quality Improvement is a major lever towards achieving our Clinical Quality Governance goals.

Clinical Governance

Membership	
Dr Sharon Kletchko	Chair – Quality, Risk & Clinical Governance Manager
Ron Dunham	Lakes DHB Chief Executive
Dr Martin Thomas	Chief Medical Officer
Gary Lees	Director of Nursing & Midwifery
Dr Ulrike Buehner	Clinical Director, Quality
Dr Denise Aitken	Clinical Director, Innovation
Dr Mike Williams	GP representative
Mary Smith	General Manager, Planning and Funding
Jo Scott	Secretariat

Reducing Inequalities

Reducing health inequalities remains at the top of Lakes DHB's agenda noting that this aim is in keeping with the new Health Strategy. Poorer health and significant health disparities between population groups persist, providing the DHB with its greatest challenge for 2016/17 and beyond. Detailed results are to be found in the Statement of Performance section.

However, compared with the final quarter of 2015/16, change shown at the same period in 2016/17 has included:

- Statistics NZ birth registration data the 2016 calendar year for Lakes DHB show a continuing reduction in live births 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 in the 2015 calendar year, with around half (51 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 34 percent but 68% for 'other'. Oral health is a significant focus within Lakes with efforts aimed at reducing ethnic discrepancy

- 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 comfortably meeting the 95% target while steady performance has also enabled the 90% primary smoking target to be achieved in the final two quarters of 2016/17.

- The achieving of equitable results for eight month immunisation rates by PHOs has eluded Lakes DHB with the latest quarter 4 results for 2016/17 showing a disparity between 'other' and Maori of 94% and 89% respectively.

- Performance around CVD Risk Assessment has shown only very slight improvement during the 12 month period to June 2017 in terms of disparity between Maori and non-Maori.

- Whilst 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 focus for the 2016/17 year. Unfortunately, the gap between Maori and non-Maori has remains at 8% and 7% respectively.

- 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 operational.

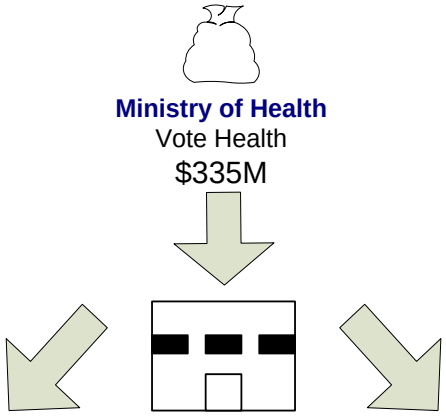
The disparity chart below indicates the key areas of disparity between Maori and non-Maori at the end of the 2016/17 year, and the equivalent measure for quarter 4 as at June 30, 2016 except where otherwise indicated.

Measure	Actual 2014/15	Actual 2015/16	Actual 2016/17	Goal	5 year goal (eliminate disparity)
8 Month Immunisation Rate	4%	2%	6%	↓ to achieve equity	Nil
% Breastfed at Six Months	3%	15%	5%	↓ to achieve equity	Nil
% Children Enrolled in Dental Services	38%	2%	9%	↓ to achieve equity	Nil
CVD Risk Assessment	8%	5%	6%	↓to achieve equity	Nil
3 Year Cervical Cancer Screen	10%	5%	7%	↓to achieve equity	Nil
Breast Screen	6%	10%	8%	↓ to achieve equity	Nil
Was not brought / Failed to deliver services to children < 15 years - Outpatient Services (for Maori vs NZ European)	13.2% Rate ratio 2.8	15.4% Rate ratio 3.5	17% Rate ratio 3.2	↓ 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 2011-2015 the Maori rate was 2.09, non-Maori 1.25				

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.

How Lakes DHB Funding Flows[2]

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



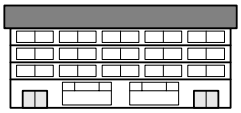
Ministry of Health
Vote Health
$335M

Lakes DHB

$5M
Governance and Administration (G&A)

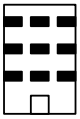
CE, Governance (Board and Statutory Committees), Corporate Services, Planning and Funding

$158M



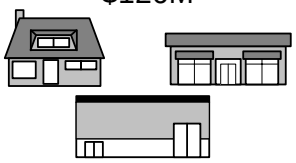
Provider Arm (HSSS/Population Health)
Clinical Services, ED, Specialist Assessments, Surgery, Fracture Clinic, Chemotherapy, Pain Clinics, District Nursing, Home Oxygen, Home Help, Meals on Wheels, NASC, IDFs, etc

$46M



Other DHBs
Secondary and Tertiary

$126M



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

[2] 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 2016/17

Lakes DHB continues to work at reducing health disparity in its region with this goal being the underlying factor that shapes the configuration of much of the health service delivery in the Lakes district. This is a goal shared by the primary/community sector whose support is critical to the DHB in its significant achievements.

Health Targets

Most of the health target results noted in this Annual Report are based on performance in the last quarter of the 2016/17 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, two targets were met for the final quarter of 2016/17:

- Improved access to elective surgery target
- Better Help for Smokers to Quit

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 94% of presentations (as against a target of 95%) were admitted, discharged or transferred from ED within six hours. Lakes DHB has put in a considerable amount of work progressing this target up from 15/16's 89%. Continued effort is required to attain and then maintain this target from 2016/2017 onwards.

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 will maximise 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 2016/17 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. Additional staffing appointments in 2015/16 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 2017, 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 2015/16 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.

Elective Services

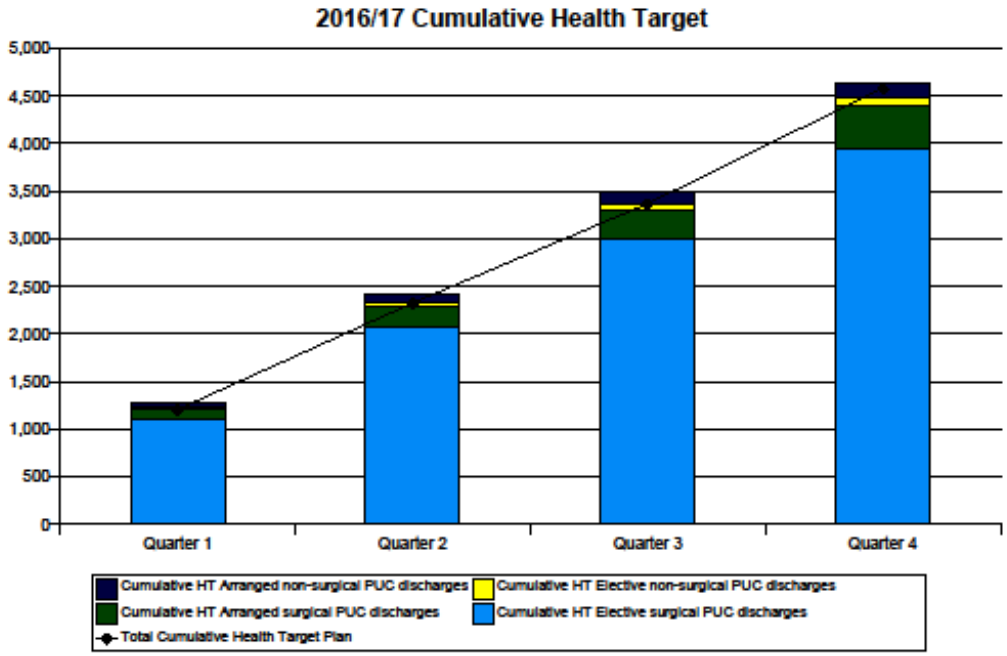
Lakes District Health Board
2016/17 Electives Health Target Report

2016/17 Health Target Delivery

	Year to Date HT Plan	Year to Date HT Delivery	Variance from plan	2016/17 Health Target
Elective surgical PUC	3,976	3,934	-42	4,578
Elective non-surgical PUC	69	77	8	
Arranged surgical PUC	388	467	79	
Arranged non-surgical PUC	145	165	20	
YTD Health Target	4,578	4,643	65	101.4 %

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	106.0%	103.6%	103.8%	101.4%



Report to: June 2017

Date Last Refreshed: 07/08/2017

During the 2016/17 year, the target for elective procedures for Lakes DHB population was 4578 discharges. The actual number achieved was 4643 discharges of which 3467 (75%) elective operations and procedures were carried out in the Lakes DHB hospitals and 25% at our inter district flow (IDF) service providers.

A total of 14,145 first specialist assessments have been completed against the Health Target of 11,527. Of these outpatient appointments, 11,951 were attended at both hospital sites in Rotorua or Taupo and at our specialist third party provider locations. These assessments included General Medicine 1735; General Surgery 1630; Orthopaedic 2126; Paediatric Medicine 765; ENT 1827; and gynaecology 906. Lakes DHB continues to demonstrate improved access to elective services.

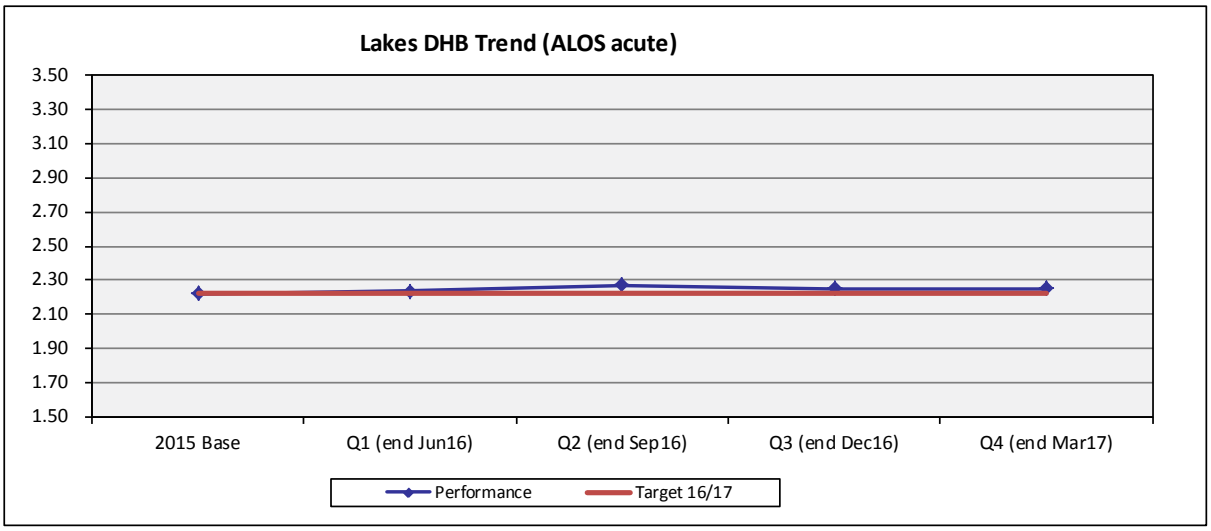
Elective Services Performance Indicators (ESPIs)

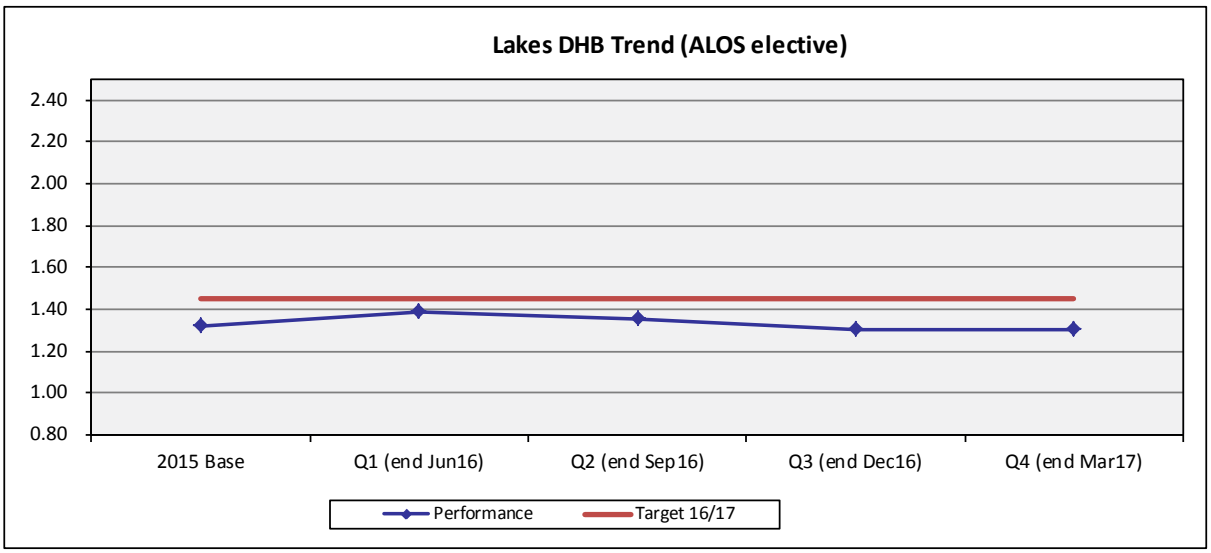
The clinical teams put a lot of effort into achieving the four months target (no referrals waiting longer than four months for First Specialist Assessment (FSA) or elective procedure) and are striving to maintain these targets. We note that some 78% of patients already received their elective procedure within three months of referral to the booking system during the 2016/17 year.

At the end of June 2017 there were three (3) referrals waiting longer than four months for an FSA and nine (9) waiting longer than four months for a procedure.

Length of Stay

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





Acute Readmissions to Hospital

The Ministry of Health acute readmissions report shows for the 12 months to December 2016 Lakes DHB has a standardised readmission rate of 6.7% across all ages. The national average is 7.9% meaning that Lakes DHB has one of the lowest readmission rate in the country.

For the 75+ age group Lakes DHB standardised rate is 9% against a national average of 10.7%.

ED Presentations

During the 2016/17 year there were 36,133 presentations to Lakes DHB emergency departments distributed as follows:

- Rotorua – 22,086
- Taupo – 1,4047

Admissions

During the 2016/17 there were 21,043 acute admissions to Lakes DHB hospitals excluding Mental Health Services and 3,189 admitted for elective procedures. This was a 4% increase on the previous year and included 1814 endoscopy procedures.

Outpatient Attendances

During the year there were 39,853 specialist outpatient attendances (FSA and subsequent appointments) at Rotorua and Taupo hospitals.

There were 1,681 attendances at the various Specialist Nurse clinics in the 16/17 year. These attendances are expected to increase with the introduction of new Nurse Specialist roles.

Surgical Services

- **Achieving the National Targets for Endoscopy**
  The service has achieved the national targets for Endoscopy at the end of the financial year 30 June 2017 as per the following figures: urgent colonoscopy 85%; non-urgent colonoscopy 88% and surveillance colonoscopy 81%.

- **Web Based Scoring tools**
  The Service achieved the introduction and implementation of the web based scoring tools in all services as per the MoH requirements.

- **Development of the Breast Nurse Service**
  Lakes DHB Surgical Services has introduced a Breast 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 their support people.

Taupo Hospital

- Respiratory CNS co-facilitates a nine week *Programme for Pulmonary Rehabilitation* with Exercise Consultant Pinnacle MHN and a GP. The programme aims to: improve people's exercise capacity, activities of daily living, quality of life and to improve lung function. Early indications demonstrate a beneficial effect to most participants in the programme. This is a good example of primary/secondary interface.
- Occupational Therapy is continuing to use the FIM (Functional Independence Measure) - a tool which measures the patients level of independence in 18 areas. This is a 'burden of care' score measured on admission and discharge. With the rehabilitation happening on the ward we are seeing a decrease in these scores which is a favourable outcome for patients and subsequent care needed in the community.
- The Team Leader Physiotherapy is conducting hip and knee replacement rehabilitation classes weekly. This includes outpatient based manual therapy and gym based rehab therapy and LFT spirometry.
- A new videoconference (VC) unit has been set up in Outpatient Clinics which will increase the clinics capacity. Clinicians based at Rotorua are using the VC for patients attending at Taupo which saves on both time and travel.

Medical Management Unit and Hospital Support Services

Junior Medical Staff

- We were the first DHB in the country to action the requirements of Schedule 10 of the new MECA which saw three of our RMO rosters altered to comply with the new '10 shift in a row maximum'. This required additional resources and considerable consultation with the affected RMOs.
- Lakes DHB was ranked No 1 in the country as the employer of choice by PGY1s (Postgraduate Year One) applying for their first house officer position. This was due to the outstanding support and guidance they get from the senior medical staff at Rotorua hospital and the lifestyle opportunities available to them in the region.

Hospital Volunteers

- The volunteer service has been extended to the wards to provide support for patients and staff.
- We have implemented a 'Take Home and Settle" service run by St John to take mostly elderly or vulnerable patients home post discharge that have no other way to get home. These volunteers take the patient to collect their prescriptions, ensure they have sufficient food in the house to get by and ensure the house is warm and welcoming for them.

Hospital Support

- The Clinical Flow Manager role introduced this year has proven successful with a reduction in ED 6 hour target breaches during the dayshift resulting in a more coordinated approach to patient flow.
- The Medical Acute Assessment Unit with five beds was introduced in August 2016. This assisted in improving the ED 6 hour target (but see above) and supports the assessment and treatment of acute medical patients in a timelier manner.

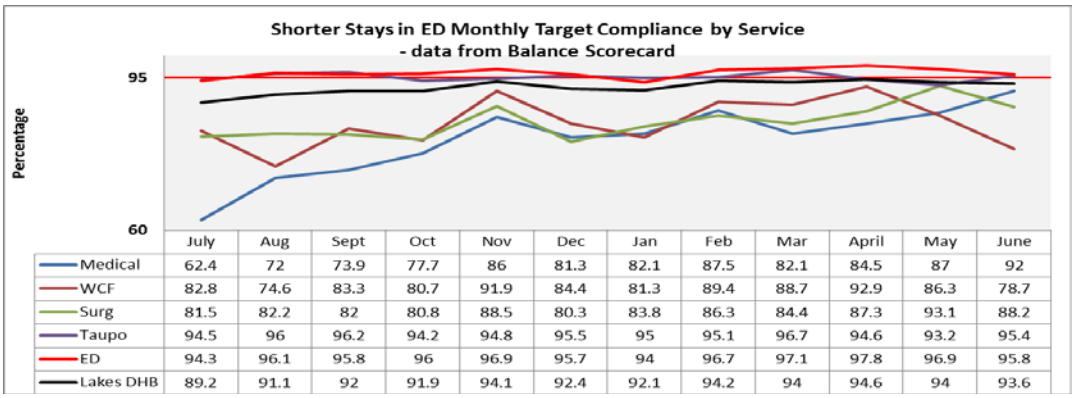
Woman Child and Family (WCF) Service Improvements

- A review of primary maternity services in Taupo was completed during the year and has resulted in a staffing model plan to improve sustainability of the service in the future.
- The midwifery staffing model for Rotorua birthing unit was reviewed and staffing increased to reflect the significant increase in women requiring *secondary* maternity care during labour and delivery.
- The service has been involved in the planning and development of the off-site Children's Health Hub due to open in November 2017.

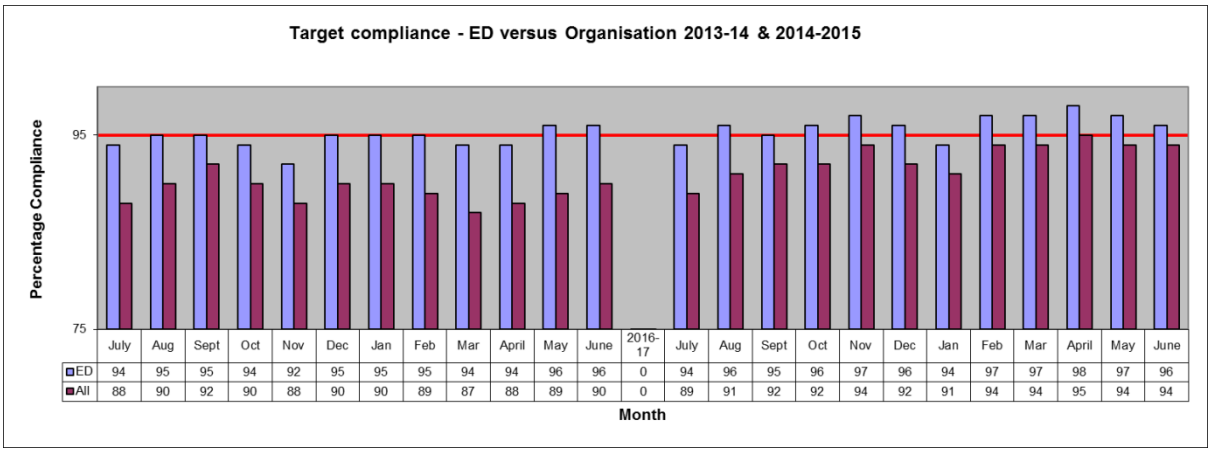
Ambulatory Service Achievements

Emergency Department Service Improvements

- Shorter Stays in ED Health Target progress
  Q1 - 91%
  Q2 - 93%
  Q3 - 94%
  Q4 - 94%



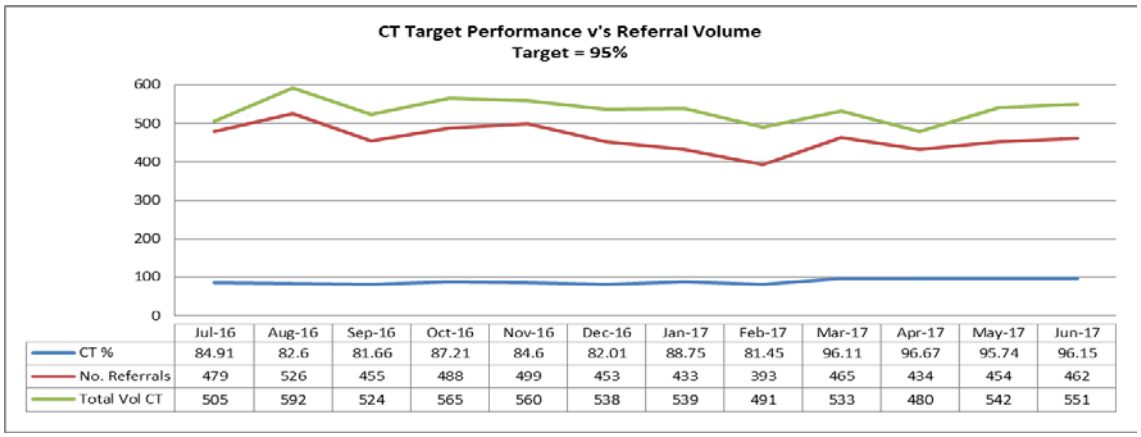
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Medical	62.4	72	73.9	77.7	86	81.3	82.1	87.5	82.1	84.5	87	92
WCF	82.8	74.6	83.3	80.7	91.9	84.4	81.3	89.4	88.7	92.9	86.3	78.7
Surg	81.5	82.2	82	80.8	88.5	80.3	83.8	86.3	84.4	87.3	93.1	88.2
Taupo	94.5	96	96.2	94.2	94.8	95.5	95	95.1	96.7	94.6	93.2	95.4
ED	94.3	96.1	95.8	96	96.9	95.7	94	96.7	97.1	97.8	96.9	95.8
Lakes DHB	89.2	91.1	92	91.9	94.1	92.4	92.1	94.2	94	94.6	94	93.6



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	2016-17	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
ED	94	95	95	94	92	95	95	95	94	94	96	96	0	94	96	95	96	97	96	94	97	97	98	97	96
All	88	90	92	90	88	90	90	89	87	88	89	90	0	89	91	92	92	94	92	91	94	94	95	94	94

ED has averaged >95% compliance across the full 2016–17 year

- ED presentation volumes were slightly lower this year compared with 2015–16 and this resulted in slight under delivery in ED attendances but significant over delivery persisted in ED case weights
- The new ED Clinical Nurse Manager was appointed late in 2016
- Audits are regularly undertaken and documented through the monthly department CQI (continuous quality improvement)
- A stroke thrombolysis after hours pathway has been implemented

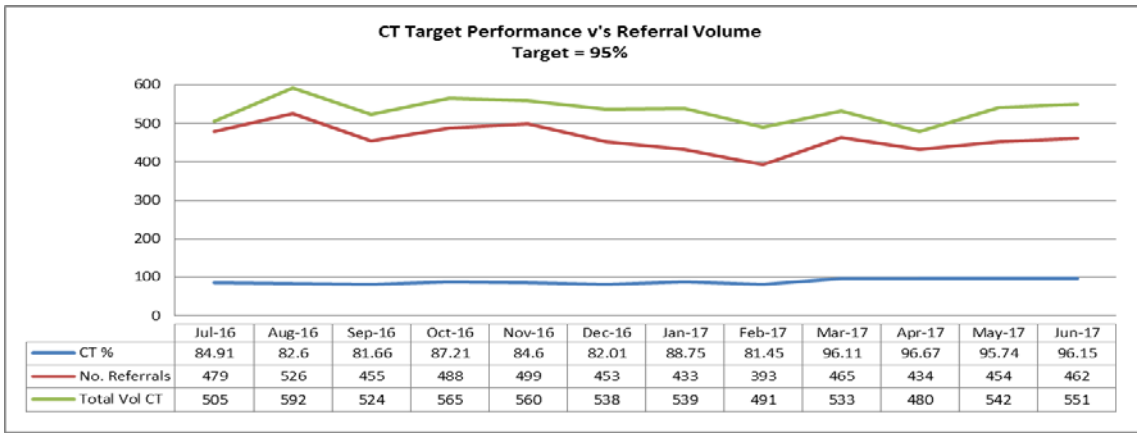


	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
CT %	84.91	82.6	81.66	87.21	84.6	82.01	88.75	81.45	96.11	96.67	95.74	96.15
No. Referrals	479	526	455	488	499	453	433	393	465	434	454	462
Total Vol CT	505	592	524	565	560	538	539	491	533	480	542	551

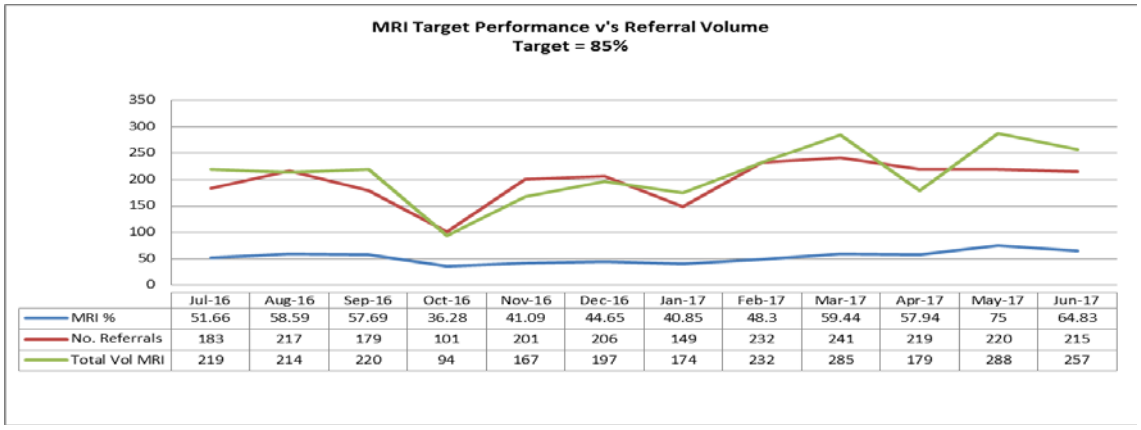
Radiology Department: Key Service Improvements

These include:

- Successful implementation of a new MRI scanner October 2016
- MRI MoH Target demonstrating steady progression toward target achieving above 50% since March 2017, first time since installation of new scanner
- Renovations within Radiology designed to better support MRI workflow and new portacath service completed January 2017
- Meeting and maintaining CT MoH Target March 2017
- Introduction of new methodology for administering intravenous contrast for CT studies with the result being improved scan quality, decreased contrast / consumables usage and therefore reduced costs and decreased plastic waste
- Introduction of the Radiology led PICC (peripherally inserted central catheter) Line Insertion Service



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
CT %	84.91	82.6	81.66	87.21	84.6	82.01	88.75	81.45	96.11	96.67	95.74	96.15
No. Referrals	479	526	455	488	499	453	433	393	465	434	454	462
Total Vol CT	505	592	524	565	560	538	539	491	533	480	542	551



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
MRI %	51.66	58.59	57.69	36.28	41.09	44.65	40.85	48.3	59.44	57.94	75	64.83
No. Referrals	183	217	179	101	201	206	149	232	241	219	220	215
Total Vol MRI	219	214	220	94	167	197	174	232	285	179	288	257

Outpatients Service Improvements

These include

- First video conference gastroenterology clinic which ensures the Taupo and Turangi patients do not need to travel to Rotorua
- Taupo Minor Operation clinic held to avoid elderly travel
- Improvements are observed in orthopaedic child attendance re moving the under 15years of age clinics to the paediatric administration role to minimise risk of booking delays and to book paediatric and orthopaedic appointments on same day. The future outlook is to have a child outpatient administration role for all specialties to improve attendance
- Introduction of venous blood gas in respiratory clinics that reduce painful arterial testing but provides the result required while giving consultants more time to see patients
- Patients that are seen in the emergency department and require fracture clinic follow up in one to two weeks time now leave ED with a scheduled outpatient appointment
- Participation in the Telehealth project. Video conference clinics were initiated in March. Oncology held their first videoconference clinic. Link from Waikato to Lakes

- Outpatient nurses now work closely with breast care nurses to improve the delivery of care and information for patients attending the breast clinic

Facility Service Improvements

- Replacement of two new main chillers meaning the hospital now has a compliment of five new chillers supplying chilled water for air conditioning with future proofing for site air conditioning for the next 5 to 10 years at current capacity plus able to supply any new MH building.
- Tendered cleaning services at RPH with new supplier, increased cleaning specification and a financial saving of $560k year one. Commenced December 2016.
- February 2016 – commissioned the $250k reconfiguration and refurbishment of Mental Health inpatient area.
- Building work for the MRI upgrade.
- Taupo Theatre upgrade.

Cancer and Palliative Care

The Midland Cancer Network team continues to provide support to Lakes DHB 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:

- Multi-disciplinary cross DHB clinician video conferencing meetings to discuss diagnosis and treatment protocols for people diagnosed with cancer which have 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 reviewing of progress against national target timeframes
- Realigning access for people with urological cancers to access both urology specialists (Venturo) and oncology services (Kathryn Kilgour Centre) based at Tauranga to reduce the need for patients to travel to both Tauranga and Waikato DHB services. Midland Radiation Oncology Exceptional Circumstance guidelines that cover access criteria for people seeking treatment now apply for access to Waikato DHB oncology services
- 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 Tauranga and 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.

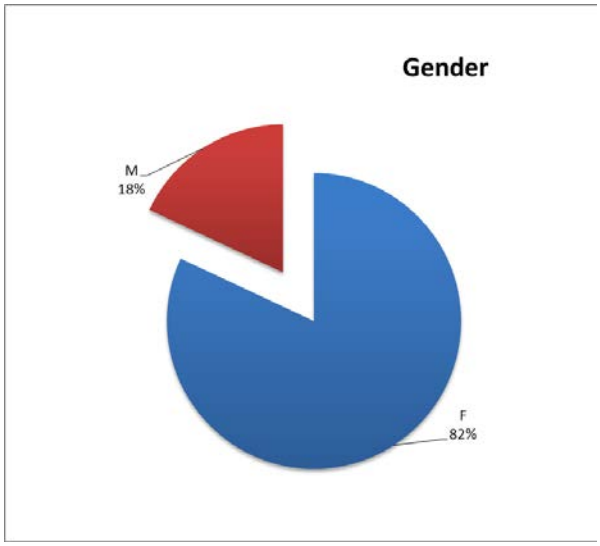
The key areas of development in Lakes have included:

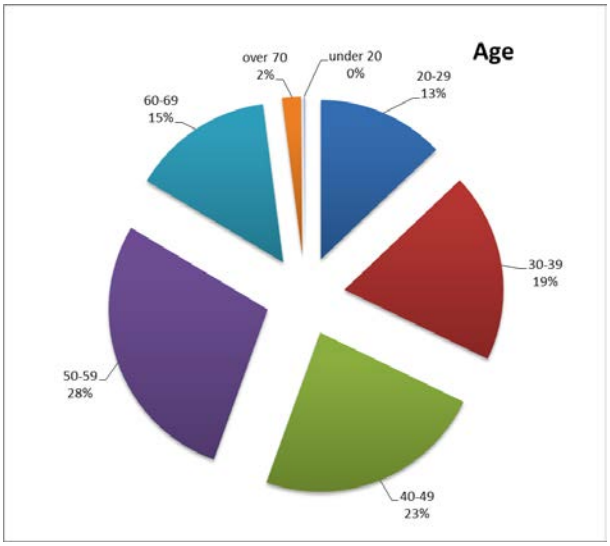
- Supporting hospice led business cases to access additional funding for innovative services to increase palliative care education in primary and residential care settings, as well as the development of volunteer support in Rotorua and cultural support in Taupo
- Aligning DHB reporting requirements to 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
- Support for the use of Last Days 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

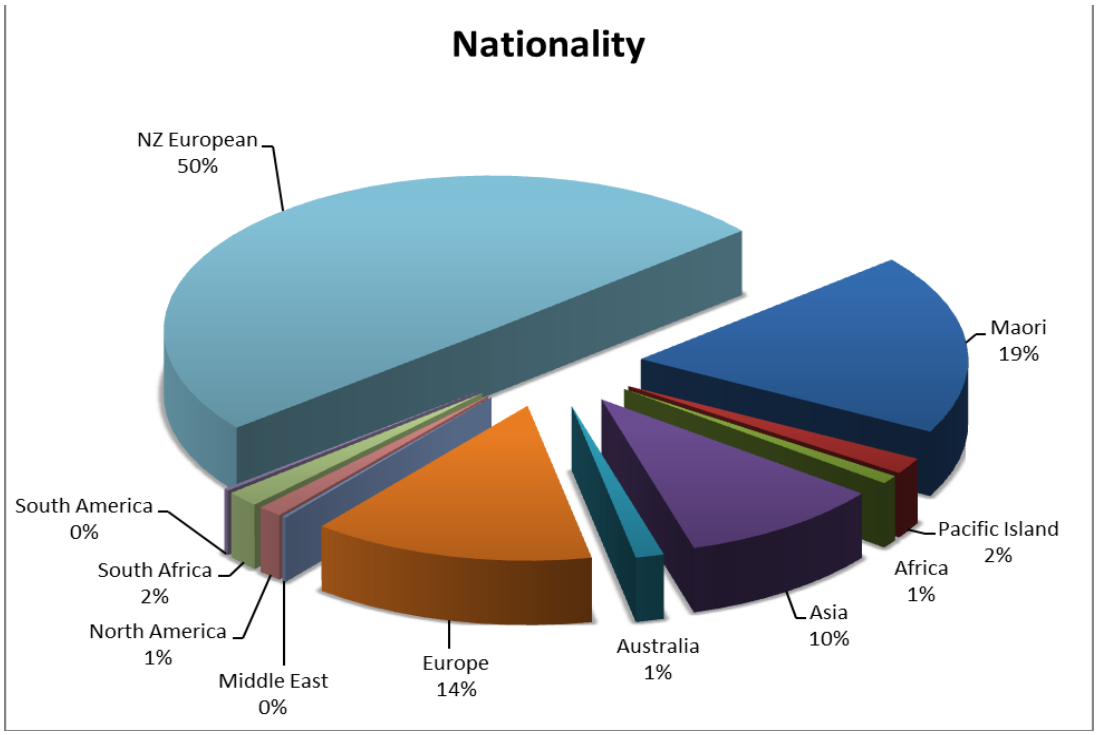
Human Resources

Introduction

Lakes DHB is one of the larger employers in the Lakes district, using contracting services (OCS) as well as employing approximately 1562 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 82%. The Lakes DHB workforce is diversely represented with 18.9% identifying themselves as New Zealand Maori, 1.7% as Pacific Island origin and 49.7% as being New Zealand European. With regards to age, Lakes DHB staffing has 12.9% between 20 and 29, 19.2% between 30 and 39 years. 23.37% of employees are aged between 40 and 49 years, 28% between 50-59 years, 14.4% 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 if required. 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, continues 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 with, and be treated with, respect and freedom from discrimination. A key policy in this regard is the Lakes DHB's Freedom from Discrimination Policy.

Key Elements and Activities

Leadership, Accountability and Culture
Lakes DHB maintains 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 being 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 has now started implementation of a Leadership Capabilities Matrix to focus all levels of the organisation on agreed leadership behaviours. This matrix is to be incorporated into daily practice and is supported by definitions and indicators in job descriptions, recruiting for leadership behaviours and reviewing performance on those leadership capabilities.

Activities include:

- 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.
- Lakes DHB Leadership Capability Matrix Project.

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 2016 to 30 June 2017, 4603 job applications were received by Lakes DHB. Of these applicants, 8.3% were employed. 21.3% of the total employed were candidates who identified as Maori.

Kia Ora Hauora is a Midlands DHB programme, promoting health careers to Māori with the aim of increasing numbers of Māori participating in health training. Lakes DHB houses 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 Māori 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 for 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 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 been part of a pilot programme with WorkSafe for the health sector. This has included participation in audits and working closely with WorkSafe inspectors to ensure that we meet legislative requirements.

The Health and Safety Service works with the 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 WorkWell Focus Group audit biennially and the Organisation has maintained Gold Standard in the re-accreditation Audit.

Electronic reporting is continuing and has enabled 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 (WSMP) audit
- Work and non-work illness rehabilitation and involvement of employees in return to work programmes
- Management of an online incident and risk notification system
- A range of injury prevention programmes for example, moving and handling training and workplace assessments
- Online Health and Safety, Moving and Handling, Electrical & Fire Safety, Infection control and Hand Hygiene and Calm training modules are available to all employees to regularly update
- Employee consultation and support forums in the form of Health and Safety Representation and Workwell Group and Moving and Handling Core-Trainers. All these employees help facilitate programmes within their specialities

- Policy of 'no added sugar' in drinks sold in the cafeteria and vending machines on Lakes DHB premise
- Breastfeeding accreditation with lactation consultant and room available for employees on site
- Provision of a free Employee Assistance Services programme
- Provision of a range of vaccinations for employees
- Provision of smoking cessation support options for staff by Smokefree Co-ordinators
- Pre-employment health screening and ongoing health monitoring of employees
- On-site Yoga and massage sessions
- On-site introduction to Tai Chi

Conclusion

Lakes DHB is committed to being a good employer and has a number of ongoing initiatives and policies to enable the maintenance of good employer status.

National Health Sector Entities

During 2016/17 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
- PHARMAC

Nursing Initiatives and Programmes

The professional development unit has continued to progress the development of e-learning alongside the HR department. We now have 46 courses available and have trained staff available to support course development. We have also increased the quantity of simulation based learning with the nurse educator group being trained to develop simulation scenarios. Whilst we continue to use a dedicated simulation training centre we are also increasing the amount of in-situ simulation happening across the hospital.

A 'teaching on the run' trainer's course has been provided to a group of nurse and doctor educators which has increased the capacity to deliver practical education in the workplace.

An 'essentials of care' audit has been introduced to check service user opinion of the quality of nursing care delivered in the hospital setting. 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. The audits are now being completed by a consumer representative rather than hospital staff.

A new falls reduction process which includes a new assessment and care planning document as well as coloured wristbands that make risk level visible to staff and visitors is being piloted in 4 clinical areas.

A review of the Nurse Entry to Practice programme (NETP) was carried out last year 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. The idea to develop a process that gets the new graduates to seek feedback from their patients and bring that back to their training sessions has now been implemented in the February 2017 intake and will be evaluated at the end of the programme.

Work has begun on implementing the national Early Warning document that will provide us with a standardised way of detecting patient deterioration and escalating to an appropriate response.

The last year has seen the development of a medical admissions and planning unit. Essentially this is a short stay area designed to facilitate rapid assessment of patient need, provide an area for close monitoring and when required institute supportive care in either the community or using outpatient services. The nurses are skilled in assessments and are able to facilitate nurse led discharges based on agreed criteria which aids the flow of patients for either discharge or full admission to the medical ward.

The concept of a dedicated education unit was trialled in OPRS for two cohorts of second year nursing students – this is a move away from preceptor based supervision to that based around identified learning needs. This whole team approach to student support includes the full interdisciplinary team and the establishment of academic liaison nurses from the nursing school and clinical liaison nurses taken from existing nurses in the clinical area. The initial evaluations from focus groups and questionnaires have been very positive and are expected to be presented as a research paper compiled by Toi Ohomai, Lakes DHB and BoP DHB. Further work is now been considered for future developments and expansion of the DEU (Dedicated Education Unit) concept.

The professional development unit is making full use of the new e-learning platform working with both existing and new online learning packages. The development of four new wound modules now complement a workshop giving both theory and an opportunity for practice. The CVAD (Central Venous Access Device) training has also taken on this approach using pre existing modules and a practice workshop, overall this means more time can be dedicated to hands on simulation training during the workshops rather than covering content that is essentially the theory behind the practice.

The midwifery team have also been developing new workshops with increasing levels of simulation, examining the newborn, a suturing workshop and an emergency refresher programme. All have skill stations and scenarios to practice not only skill but communication and teamwork both vital to increasing competence and confidence in all clinical areas.

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 the demand for funded services and 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 and to consider treatment and referral to a range of support services for the person and their carer
- Development of Lakes Falls & Fracture Prevention Programme approach in conjunction with ACC with the aim of reducing the risk of falls and fractures both in hospital and the community
- Increasing access to allied health and 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 a fracture liaison service
- Supporting the development of specialist services for older people living in the community or in residential care
- Reduction in harm from medication
- Support of the national work focus on improvements in home and community home based support services that includes payment to support workers for:
    - travel in between clients,
    - changes to guaranteed hours when client is not at home
    - pay equity with increase in hourly pay rate that is linked to training qualifications
- Ongoing improvement in the quality of Home and Community Support Services and Aged Related Residential Care providers services through regular auditing processes and use of the Development of Healthy Ageing Strategy which will direct DHB focus on the shape of service development over next 5 to 10 years
- 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 and Age Concern

    - Living Well with Dementia education programme focusing on the Cognitive Stimulation Training for people with early dementia
    - Rotorua Dementia Friendly Community council led initiative
- Increase use of interRAI geriatric assessment data to influence local service needs and development within community, primary and secondary care.

Primary Care

The refreshed New Health Strategy has guided the approaches for primary care services in the Lakes region during 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 against the primary health targets has shown variable results when compared to the national average performance.

Over this financial year both Alliance Leadership Teams (ALT) have reviewed their plans for future focus and priority of service design. The alliance contracting approach provides a consistent and planned approach for new service design in the region.

Integrated LTC management programmes are using a continuous quality improvement cycle to guide future developments. Both PHOs have 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 due to the implementation of `Primary Options for Acute Care` (POAC) programmes. The programmes provide 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 including 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.

Lakes DHB and Pinnacle Midland Health Network have implemented an integrated contract which will continue in 17/18. Good relationships and regular contract reviews combined with the flexibility of this contract has enabled new initiatives to be piloted.

As part of this integrated contract a new Kaiawhina role has been implemented. In Quarter Four, 45 referrals for people disengaged from primary care where received of which 55% reengaged with general practice. Of the people who have re-engaged 90% are Maori.

The Kaiawhina has worked to re-engage 22 clients whose HbA1c ranged from 55-136 mmols and has seen 38% become re-engaged. A further development is shared medical appointment/group consults. These shared appointments have focused on high need Maori with COPD or obesity. This whanau centric model of group consults between general practice and extended care team was featured in NZ doctor.

In the northern Lakes region, Rotorua Area Primary Health Services (RAPHS) 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 long term conditions. There has been further development of the LINC programme which provides a suite of tools, including dynamic disease registers, reporting, bench marking and risk stratification, to assist providers in allocating patients to care programmes based on their level of need.

RAPHS have designed and developed a patient register and benchmarking dash board reports for key health targets. These reports have three key components.

1. Individual performance and benchmarking against all other practices
2. Gap to target numbers
3. Links to patient lists which drill down to individual patients.

During 2016/17 year has seen RAPHS develop an integrated Agreement that will commence 1 July 2017.

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. Several community pharmacies have provided funded Influenza vaccinations to patients over 65 years.

Rheumatic Fever

Rheumatic fever is a serious illness in our communities. It mainly affects Maori and Pacific children (aged four to 19 years) especially if someone in the family has had rheumatic fever before. Rheumatic fever starts with a sore throat that is known as "strep throat" - a throat infection caused by a bacterial infection or bug called Group A Streptococcus. If the "strep throat" is not treated with antibiotics it can cause rheumatic fever. Lakes DHB has shown its commitment to reducing the incidence of Rheumatic Fever by two thirds by 2017. The 2016/17 Annual Plan described the initiative used to achieve this goal.

National Health Targets[3]

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 2016/17 Lakes DHB Quarter Four results.

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

Table: Lakes DHB Health Targets 2016/17

Health Target	Long Term Target	Lakes 2016/17 target	Result	Status
	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95 percent	94%	NA
	The volume of elective surgery will be increased by an average of 4,000 discharges per year.[4]	100 percent	101%	A
	Progress against target to achieve 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.	85 percent	77%	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	92%	NA
	• 90 percent of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. • 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	90 percent 90 percent	90% 100%	A A
	By December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	95 percent	88%	NA

[3] Note the commentary from page 29 on these targets.

[4] The specific target for Lakes DHB during the 2016/17 year was for 4578.

Lakes DHB Statement of Performance 2016/17

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

1. People are supported to take greater responsibility for their health
2. People stay well in their homes and communities
3. People receive timely and appropriate specialist care

Results for 2016/17 are presented according to these three dimensions recognising that these dimensions are based around the following strategic ideas.

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 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 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 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 the four functions of Intensive Assessment and Treatment, Early Detection and Management, Prevention and Rehabilitation and Support is detailed in Note 33 in the financial section.

The target results are taken from the final quarter of the 2016/17 fiscal year. Where other data periods are used, these will be clearly noted.

The baseline in the following tables are from the Annual Plan and are based on 2014/15 results.

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

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

Impact	Baseline measure			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
Fewer people smoke	Percentage of hospitalised smokers offered advice to quit	Maori	100%	98%	95%	99%	A
		Non-Maori	95%	95%	95%	91%	NA
		Total	98%	97%	95%	95%	A
	Percentage of PHO enrolled smokers offered advice to quit (Health Target)	Maori	83%	-	90%	Not Available	-
		Non Maori	100%	-	90%	Not Available	-
		Total	92%	89%	90%	90%	A
	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	88%	100%	90%	100%	A
		Non-Maori	100%	100%	90%	100%	A
		Total	91%	100%	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 met all smoking targets at the end of quarter four. This includes the secondary, primary and maternity targets for people who smoke. 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.

Impact	Baseline measure			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
Reduction in Vaccine Preventable Diseases	Percentage of eight-month-olds fully immunised (Health Target & Maori Health Plan)	Maori	90%	90%	95%	89%	NA
		Non-Maori	94%	92%	95%	95%	A
		Total	92%	91%	95%	92%	NA
	Percentage of the population >65 years who have received the seasonal influenza immunisation (PPP & Maori Health Plan)[5]	Maori	59%	59%	70%	32%	NA
		Total	62%	61%	70%	38%	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. Changes in the influenza strains used in 2017 vaccine have resulted in an increase in the number of cases in Lakes.

Lakes DHB Performance

The results for 8 month old immunisation show that there was a disparity between non-Maori (at 95%) and Maori (89%). Lakes DHB continues to focus on reducing this difference.

Influenza vaccination during 2016/17 which covers the winter of 2016 and the autumn of 2017 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.

Regarding the immunisation target for 8 month olds, Lakes DHB has delivered results that fall just short of the target. This is due to a very small number of cases. The ability to track these cases is the focus of recent work.

[5] Data covers the period March – August 2017

Impact	Baseline measure			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
Improving Health Behaviours	Percentage of infants who are fully, exclusively or partially breastfed at 6 months (Maori Health Plan)[6]	Maori	54%	52%	60%	58%	NA
		Non-Maori	68%	67%	60%	63%	A
		Total	62%	59%	60%	60%	A
	The number of people participating in the GRx (Green Prescription) programmes[7]	Total	501	1,006	817	574	NA
	Reduce the prevalence of gonorrhoea (local measure) Number of cases	Number of cases	141	128	140	136	A
	Rate per 100,000[8]	Rate per 100,000	136	Not available for 2015 calendar year	135	127	A

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.

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. 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. Green Prescription services are provided within Lakes DHB by Sport BOP for the Rotorua/northern Lakes district and Sport Waikato for Taupo/Turangi and southern Lakes.

Increase in community physical options in Rotorua: the Green Prescription team during 16/17 financial year have focused on increasing the number of Green Prescription client suitable physical activity options. The following have been added to the Green Prescription calendar; Ace of Hearts, Heart of Gold, All about me wellness, Beginner circuit class.

Walking Group at the Redwoods – held every Monday, excluding public holiday. A 45min- 1hour moderate intensity walk. 12-15 attending each week

Walking Group at the Lakefront (Green Prescription advisor led) – held every Thursday. 45 min beginners, moderate intensity walk. Up to 15 attending each week.

Aqua Classes- held Mondays and Wednesdays at the Rotorua Aquatic Centre. Up to 24 attending each session.

[6] Data covers period January to June, 2016
[7] 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
[8] The latest data available covers the year to March 2017

Low Impact Lifefit class, Ngongotaha- held every Tuesday, at Cross Fit Ruark gym. 3-5 attending this low intensity, beginners class. Clients learn basic Cross Fit technique and have the opportunity to move up to a more advanced class.

Begin to Spin Class, Owhata - held every Thursday, at Kaha Fitness. 5-8 attending (demand has seen a second class introduced. We now have a beginner 10am class and intermediate class at 11am.

Supermarket Tours – offered monthly, at Countdown Fenton St Rotorua. During this quarter one tour was held with a total of two participants.

Lakes DHB has a vibrant and successful 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.

2 Outcome: People stay well in their homes and communities

Impact	Baseline measure			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
An improvement in childhood oral health	Percentage of children (0-4) enrolled in DHB funded dental services (PP13)[9]	Maori	56%	68%	95%	91%	NA
		Non-Maori	84%	70%	95%	125%	A
		Total	70%	69%	95%	107%[10]	A
	Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (PP13b)[11]		11%	5%	8%	15%	NA
	Percentage of adolescent utilisation of DHB funded dental services (PP12)[12]		68%	73%	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.

In the 2017-18 year a remodelling of the community oral health service is planned to drive preventative oral health care.

[9] Data covers the year ending June 2017

[10] The percentage enrolled is derived from population projections for the 2016 calendar year based on Census 2013 information (Statistics New Zealand). The percentage over 100% indicates growth in the Lakes DHB area has been ahead of projected population numbers

[11] Data covers the 2016 Calendar Year

[12] Data covers the 2016 Calendar Year

Impact	Baseline measure			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
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 (Maori Health Plan)	Maori	82%	85%	90%	67%	NA
		Non-Maori	90%	92%	90%	Not Available	-
		Total	87%	89%	90%	91%	A
	Percentage of eligible women (25-69) have a cervical cancer screen every 3 years (Maori Health Plan)[13]	Maori	71%	74%	80%	71%	NA
		Non-Maori	82%	79%	80%	78%	NA
		Total	78%	77%	80%	75%	NA
	Percentage of eligible women (50-69) have a breast screen in the last 2 years (Maori Health Plan)[14] Data used Q3 IPIF results	Maori	65%	72%	70%	64%	NA
		Non-Maori	71%	82%	70%	72%	A
		Total	70%	79%	70%	70%	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 case 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.

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

Cardio vascular disease (CVD) risk assessment has improved with both PHOs performance reaching the target of 90%. Maintenance of current systematic activities within the Long Term Conditions (LTC) programmes in place in both the northern and southern Lakes areas are expected maintain this level of achievement. Both PHOs are focusing on improving coverage of Māori Males aged 35 to 44 years and this measure has been included in the System Level Measures programme.

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

[13] Data coverage is the three years to 30 June 2017
[14] Data coverage is for the two years to June 2017

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 75%. Te Arawa Whanau Ora was the successful `support to screening` services provider and will be focusing on improvement in coverage for priority women and a reduction in disparity between non-Maori and Maori.

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

Lakes DHB is 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			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
Fewer People are Admitted to Hospital for Avoidable Conditions	Percentage of Rest Home residents receiving vitamin D supplement from their GP		82%	85%	80%	80%	A
	Percentage of all Emergency Department presentations that are categorised as triage level 4&5		54%	52%	50%	40%	A
	Percentage of eligible population who have had their B4 school checks completed	High Needs	100%	112%	90%	100%	A
		Total	100%	101%	90%	100%	A
	Incidence rates per 100,000 for rheumatic fever		5.2	5.7	3.5	6.3	NA
	Hospitalisation rates per 100,000 for acute rheumatic fever		7.8	4.8	2.6	3.8	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	Not available	400	Not available	-
		Non-Maori	NA	Not Available	400	Not Available	-
		Total	480[15]	Not Available	800	Not Available	-

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 has been a key ACC led initiative for a number of years. 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.

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 2016/17 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.

[15] Data for terms 3 and 4 2012 and terms 1 and 2 2013. Data not available by ethnicity.

The national target of 80% of residential care residents receiving vitamin D supplement has consistently been met in Lakes. In 2016/17 ACC / MoH report to DHBs on Vitamin D supplement use in residential care ceased with only one report received. Efforts continue to expand implementation to include vulnerable and frail older people living in the community to be part of the ACC / Lakes DHB Falls and Fracture Prevention Programme.

Impact	Baseline measure		2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description	Base				
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	100%	100%	100%	100%	A
	Standardised acute re-admission rate[16]	6.8%	6.80%	6.6%	6.7%	NA
	Standardised inpatient average length of stay (elective) in days [17]	1.35	1.41	1.45	1.28	A
	Percentage of patients who require radiation or chemotherapy are treated within 4 weeks	100%	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[18]	92%	56%	100%	94%	NA[19]
	Faster Cancer Treatment –proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 62 days of diagnosis[20]	52%	56%	85%	77%	NA[21]

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.

In 2017 a revision of the health of older people strategy was released as Health Ageing Strategy which will cover the next 10 years of service development.

[16] Data covers 12 month period to March 2017
[17] Data covers 12 month period to March 2017
[18] Data covers the period January-June 2017
[19] Refers to treatment within 31 days of confirmed diagnosis
[20] Data covers the period January-June 2017
[21] Refers to treatment within 62 days of referral for high suspicion of cancer

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 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 training and data centre facilitates the training of assessors across the country and provides DHB and residential care providers range of reports that outline the key risks to older population in an area and informs the development of new services.

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. In 2015/16 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.

In 2016, additional MoH / DHB funding has required home based support providers to guarantee hours of work for support workers and covered period of time when clients may not receive a service, such as in hospital. As a result of a pay equity settlement claim, MoH / DHB and ACC are working with community and home based support providers and residential care providers to increase the pay of support workers significantly from 1 July 2017. New pay rates are linked to qualifications.

In 2016/17 Lakes DHB and ACC worked together to develop a more structured Lakes Falls and Fracture Prevention programme that will focus on reducing risk of fractures due to osteoporosis, increase the number of older people who participate in strength and balance exercise programmes, encourage health professionals to follow clinical best practice models of assessment and treatment.

For people who develop cancer, the emphasis continues 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 four 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 100% of people accessing all forms of cancer treatment from the date of diagnosis was achieved with 360 out of 388 (93%) receiving treatment within 31 days of confirmed diagnosis. Diagnosis and treatment planning for majority of cancers is now supported by multi disciplinary meeting (MDM) where specialists from across region discuss and agree plan for patient care.

For people being referred with a high suspicion of cancer and needing to be seen by a specialist within two weeks and to receive their first cancer treatment within 62 days there is a structured monitoring process and inter disciplinary working group in place to ensure there are no delays through the diagnosis and access to treatment pathway. This has resulted in 77% (target is 85%) of patients receiving treatment within 62 days of referral. There has been significant improvements made with 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. It is recognised that some of the delays have resulted from limited resources at tertiary services and the diagnostic process for some tumours requires a wide range of interventions at both Lakes and Waikato services before decision to treat can be made.

Regionally and locally, it is recognised that many people with cancer first present as an acute presentation to ED rather than through GP referral to specialist and therefore are not covered by the 62 day faster cancer target. A multi-disciplinary team continues to consider changes in current practice required to ensure a greater percentage of patients are referred earlier and access treatment within 62 days.

3 Outcome: People receive timely and appropriate specialist care

Impact	Baseline measure			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
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)		Nil	Nil	Nil	0%	A
	Number of surgical discharges under the elective initiative (Health Target)		4035	4514	4578	4643	A
	Did-not-attend percentage for outpatient clinics (Maori Health Plan)	Maori	20.4%	20.4%	10.0%	16.1%	NA
		Non-Maori	7.2%	6.7%	10.0%	4.4%	A
		Total	11.4%	11.4%	10.0%	6.6%	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 2016/17. 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 during 2016/17.

Standard intervention rates have been met in a number of specialist areas with General Surgery being a standout during 2016/17. Theatre utilisation continued to meet the target enabling a satisfactory workflow and throughput during 2016/17 for Lakes DHB and peer DHB workload.

Lakes DHB has been working to reduce the disparity as duly 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				2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description			Base				
Improved Health Status for those with Severe Mental Illness and/or addictions	**Short Term Clients**[22] 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	40%	60%	80%	60%	NA
			20-64 yr olds	54%	64%	80%	67%	NA
			65+ yr olds	64%	80%	80%	85%	A
		Addictions	0-19 yr olds	55%	82%	80%	89%	A
			20-64 yr olds	81%	77%	80%	93%	A
			65+ yr olds	90%	80%	80%	100%	A
	Average length of acute inpatient stays as a proportion of total bed days(KPI 8)			10.0	Not available	9.5	12	NA
	Rates of post-discharge community care (KPI 18)			79%	Not available	90%	51%	NA

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.

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.

In terms of post discharge community care (KPI 18) Lakes DHB has fallen short of achieving the target of 90% with a result of only 51%.

[22] Data covers the year to March 2017

Impact	Baseline measure		2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description	Base				
More People With End Stage Conditions are Supported Appropriately	Number of Aged Residential Facilities utilising advanced directives	100%	100%	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. 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 more people undergoing palliative radiotherapy and chemotherapy for symptom control (mostly pain management) than ever before. Both Waikato DHB oncologists and palliative care medical specialists have been involved in this. 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 moved into to new premises in 2016/17 which have allowed for the expansion of psycho-social services, further development of day programmes and volunteer services that are aimed to meet the need of clients and their families.

The specialist palliative care providers, along with other providers of palliative care are continuing to meet 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			2015/16 Result	2016/17 Target	2016/17 Result Against Base	Achieved / Not Achieved
	Output Description		Base				
Support Services	Radiology – Improved wait times for diagnostic services – accepted referrals for CT and MRI receive their scan within 6 weeks (Policy Priority 29)	CT	80.5%	79%	95%	87%	NA
		MRI	51.2%	45%	85%	52%	NA
	Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Category 1: Within 24 hours	98%	96%	95%	99%	A
		Category 2: Within 96 hours	100%	100%	100%	100%	A
		Category 3: Within 72 hours	100%	100%	100%	87%	NA
	Number of community pharmacy prescriptions items		1,024,376	1,479,293	Decrease [23]	1,049,525	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 presentations 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) has been extended till 30 June 2018 and supports `patient centric` community pharmacy services within the community service model. This service approach sees 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.

Lakes DHB Performance

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 three FTE Clinical Pharmacy roles working within a PHOs or 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.

[23] 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.

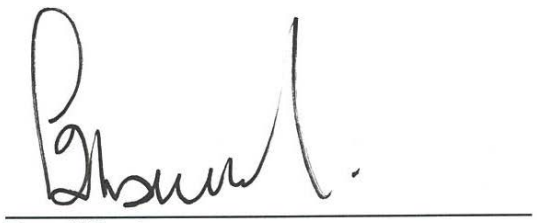
Statement of Responsibility for the Year Ended 30 June 2017

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 and statement of performance for the year ended 30 June 2017 fairly reflect the financial position and operations of Lakes District Health Board.



Board Member

30 October 2017

Board Member

30 October 2017

Report of the Audit Office

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Lakes District Health Board's group financial statements and performance information for the year ended 30 June 2017

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 on his behalf.

We have audited:

- the financial statements of the Group on pages 70 to 112 and page 114, that comprise the statement of financial position as at 30 June 2017, 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 47 to 62 and page 113.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Group on pages 70 to 112 and page 114:

- present fairly, in all material respects:
  - its financial position as at 30 June 2017; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

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

In respect of the 30 June 2016 comparative information only, some significant performance measures of the Group (including some of the national health targets, relied on information from third-party health providers, such as primary health organisations. The Group's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the Group's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the Group on pages 47 to 62 and page 113:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - 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; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2017. 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, we comment on other information, and we explain our independence.

Basis for our opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- We obtain sufficient appropriate evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The board is responsible for the other information. The other information comprises the information included on pages 3 to 46 and 115 to 116, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than the audit, we have no relationship with, or interests in, the 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 2017

	Notes	Lakes DHB Group Budget 2017 $000	Lakes DHB Group Actual 2017 $000	2016 $000
Revenue				
Revenue	1	345,874	347,780	332,344
Other operating revenue	2	4,961	4,834	4,281
Gains	3	0	11	17
Finance revenue	4	363	465	532
Total revenue		351,198	353,090	337,174
Expenditure				
Personnel costs	5	115,454	111,919	108,705
Depreciation and amortisation expense	11, 12	11,174	10,720	10,284
Other operating expenses	6	213,646	227,296	214,257
Finance costs	4	2,917	2,703	2,455
Capital charge		6,539	5,258	6,999
Total operating expenditure		349,730	357,896	342,700
SURPLUS/(DEFICIT) BEFORE TAX		1,468	(4,806)	(5,526)
Share of associate/joint venture surplus/(deficit)	13	186	494	264
SURPLUS/(DEFICIT) BEFORE TAX		1,654	(4,312)	(5,262)
Income tax expense		0	0	0
SURPLUS/(DEFICIT) AFTER TAX		**1,654**	**(4,312)**	**(5,262)**
OTHER COMPREHENSIVE REVENUE AND EXPENSE				
Gains on property revaluations	19	0	16,976	0
Cash flow hedges	19	0	1,429	(53)
Total other comprehensive revenue and expense		**0**	**18,405**	**(53)**
TOTAL COMPREHENISVE REVENUE AND EXPENSE		**1,654**	**14,093**	**(5,315)**

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 2017

	Notes	Lakes DHB Group Budget 2017 $000	Lakes DHB Group Actual 2017 $000	Lakes DHB Group Actual 2016 $000
BALANCE AT 1 JULY		88,856	84,618	90,225
Prior year adjustments		0	0	9
Capital contribution from the Crown		0	49,565	0
Repayment of capital to the Crown		(301)	(301)	(301)
Total comprehensive revenue and expense		1,654	14,093	(5,315)
BALANCE AT 30 JUNE	19	**90,209**	**147,975**	**84,618**

Explanations of significant variances against budget are detailed in note 34

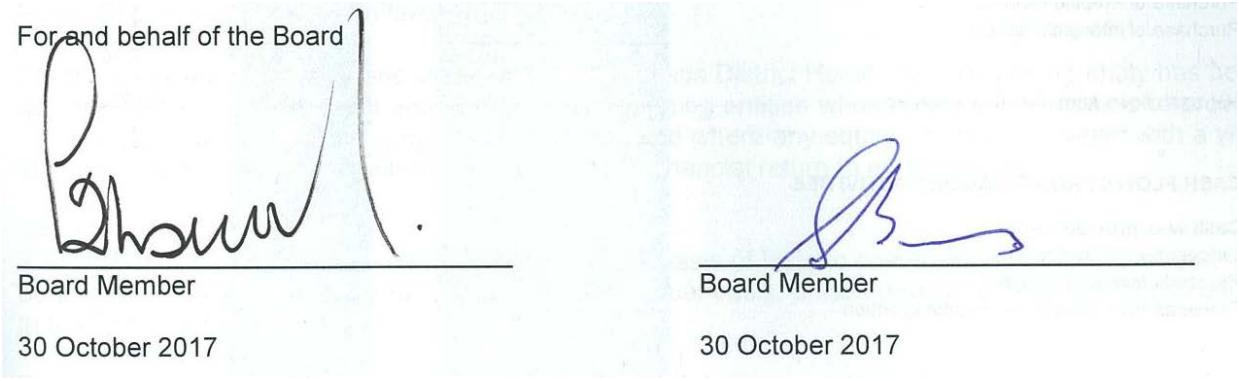
The accompanying accounting policies and notes form part of these financial statements

Statement of Financial Position as at 30 June 2017

	Notes	Lakes DHB Group Budget 2017 $000	Lakes DHB Group Actual 2017 $000	Lakes DHB Group Actual 2016 $000
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	7	4,906	5,003	2,036
Receivables	8	12,543	12,683	11,640
Inventories	9	2,224	2,212	2,135
Other financial assets	14	0	700	700
TOTAL CURRENT ASSETS		19,673	20,598	16,511
NON - CURRENT ASSETS				
Receivables	8	623	378	516
Property, plant and equipment	11	153,561	161,211	148,901
Intangible assets	12	6,131	5,088	4,580
Investments in associates		0	0	0
Investments in joint ventures	13	1,556	1,430	1,165
Other financial assets	14	0	0	750
TOTAL NON - CURRENT ASSETS		161,871	168,107	155,912
TOTAL ASSETS		**181,544**	**188,705**	**172,423**
LIABILITIES				
CURRENT LIABILITIES				
Payables	15	17,523	18,449	16,729
Employee entitlements	16	11,617	14,542	13,175
Borrowings	17	5,511	889	5,014
Provisions	18	31	0	31
Derivative financial instruments	10	0	53	0
TOTAL CURRENT LIABILITIES		34,682	33,933	34,949

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

	Notes	Lakes DHB Group Budget 2017 $000	Lakes DHB Group Actual 2017 $000	2016 $000
NON CURRENT LIABILITIES				
Employee entitlements	**16**	2,488	2,681	2,650
Borrowings	**17**	52,788	3,328	48,027
Other financial liabilities	**14**	0	0	750
Derivative financial instruments	**10**	1,376	788	1,429
TOTAL NON CURRENT LIABILITIES		56,652	6,797	52,856
TOTAL LIABILITIES		**91,334**	**40,730**	**87,805**
NET ASSETS		**90,210**	**147,975**	**84,618**
EQUITY				
Crown equity	**19**	20,086	69,650	20,386
Other reserves	**19**	54,575	72,928	54,523
Retained earnings/(losses)	**19**	14,750	4,574	8,910
Trust funds	**19**	799	823	799
TOTAL EQUITY		**90,210**	**147,975**	**84,618**



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 2017

	Notes	Lakes DHB Group Budget 2017 $000	Lakes DHB Group Actual 2017 $000	Lakes DHB Group Actual 2016 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and patients		349,872	353,855	336,363
Interest received		363	465	532
		350,235	354,320	336,895
Cash was applied to:				
Payments to suppliers		212,854	226,620	213,301
Payments to employees		115,442	110,521	109,441
Interest paid		2,357	2,703	2,455
ACC Partnership Programme Payments		0	31	0
Distribution to owners: capital charge		6,945	5,258	6,999
GST (net)		(245)	(28)	(144)
		337,353	345,105	332,052
Net cash flows from operating activities	**20**	12,882	9,215	4,843
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of property		0	21	17
		0	21	17
Cash was applied to:				
Purchase of other financial assets		0		0
Purchase of property, plant and equipment		8,498	5,210	5,823
Purchase of Prepaid Licence		0		0
Purchase of intangible assets		2,170	1,499	1,963
		10,668	6,709	7,786
Net cash flows from investing activities		(10,668)	(6,688)	(7,769)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds from finance lease liabilities		175	968	1,913
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	(227)	(847)
Net cash flows from financing activities		1,874	440	765
Net increase/(decrease) in cash, and cash equivalents		**4,088**	**2,967**	**(2,161)**
Cash and cash equivalents at beginning of year		816	2,036	4,197
Cash and cash equivalents at end of year	**7**	**4,904**	**5,003**	**2,036**

During the period Lakes DHB acquired property, plant and equipment totalling $567k (2016: $2,104k) by means of finance leases.

In February 2017, all existing Crown loans were converted into Crown Equity and was completed by a non-cash transaction. The value of the loans was $49,565,000.

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 2017

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), 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.

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

Financial Instruments
In January 2017, the External Reporting Board issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with earlier application permitted. The main changes under the standard are:
- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

The timing of the DHB adopting PBE IFRS 9 will be guided by the Treasury's decision on when the Financial Statements of Government will adopt PBE IFRS 9. The DHB has not yet assessed the effects of the new standard.

Impairment of Revalued Assets
In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes in revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards. Under the amendment, a revalued asset can be impaired without having to revalue the entire class of-asset to which the asset belongs. The timing of the DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of Government will adopt the amendment.

Reporting period
The reporting period for these financial statements is the financial year ended 30 June 2017.

Changes in accounting policies
There have been no accounting policy changes in the 2017 financial statements when compared to 2016.

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	40 to 70 years	1% - 3%
Services	30 to 32 years	3.1% - 3.3%
Fit-out	27 to 30 years	3.3% - 3.7%
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 asset's 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 asset's 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

Annual leave is a short-term obligation and is 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 this obligation accumulates.

Presentation of employee entitlements

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 2017 $000	Actual 2016 $000
MOH Crown appropriation revenue (1)	300,118	284,778
Other MOH contracted revenue	20,956	21,674
Other Government revenue	3,142	3,186
Inter-DHB revenue	19,917	19,001
ACC revenue	3,647	3,705
Total revenue	**347,780**	**332,344**

(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 $300,118,000.

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

	Actual 2017 $000	Actual 2016 $000
Sale of goods	960	799
Rendering of services	2,657	3,049
Donations and bequests received	806	36
Other	411	397
Total other operating revenue	**4,834**	**4,281**

3 Gains

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Non-financial instruments		
Property, plant, and equipment gains on disposal	11	17
Total gains	**11**	**17**

4 Finance Income and Finance Costs

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Finance revenue		
Interest revenue:		
Term and call deposits	465	532
Total finance revenue	**465**	**532**
Finance costs		
Interest expense:		
Interest on finance leases	226	181
Interest on borrowings	2,477	2,274
Total finance costs	**2,703**	**2,455**

5 Personnel Costs

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Salaries and wages	108,349	107,341
Defined contribution plan employer contributions	2,172	2,100
Increase/(decrease) in employee entitlements/liabilities	1,398	(736)
Total personnel costs	**111,919**	**108,705**

6 Other Operating Expenses

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Fees to auditor:		
fees to Audit New Zealand for audit of financial statement	128	125
fees to Audit New Zealand for other services	0	25
ACC Partnership Programme	25	70
Board of director fees (note 24)	244	259
Inventory consumption	(43)	(23)
Impairment of receivables (note 8)	37	0
Loss on disposal of property, plant, and equipment	32	63
Minimum lease payments under operating leases	585	532
Restructuring expenses	99	0
Clinical services	23,931	23,317
Infrastructure & non-clinical expenses	16,098	15,779
Outsourced services	13,310	10,949
Other District Health Boards	46,014	42,309
Non-health-board provider expenses	126,836	120,852
Total other expenses	**227,296**	**214,257**

7 Cash and Cash Equivalents

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Cash at bank and in hand	1,166	836
Term deposits with maturities less than three months	0	0
Loan to NZHPL	3,837	1,200
Cash and cash equivalents in the statement of cash flows	**5,003**	**2,036**

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 $123,852 (2016: $798,612).

8 Receivables

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Current		
Receivables (gross)	12,820	11,770
Less provision for impairment	(137)	(130)
Total Current	12,683	11,640
Non-Current		
Receivables (gross)	378	516
Total Non Current	378	516
Total receivables	**13,061**	**12,156**
Total receivables comprises:		
Receivables from the sale of goods and services (exchange transactions)	13,061	12,156
Receivables from grants (non-exchange transactions)	0	0

Fair Value

Receivables are generally short-term and non-interest bearing. Therefore, the carrying value of receivables approximates their fair value.

Impairment

As of 30 June 2017 and 2016, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	Actual 2017 Gross $000	Actual 2016 Gross $000
Lakes DHB Group		
Not past due	12,511	11,785
Past due 1 - 60 days	96	119
Past due 61 - 90 days	401	140
Past due > 90 days	190	242
Total	**13,198**	**12,286**

	Actual 2017 Impairment $000	Actual 2016 Impairment $000
Lakes DHB Group		
Not past due	0	0
Past due 1 - 60 days	(21)	0
Past due 61 - 90 days	(2)	0
Past due > 90 days	(114)	(130)
Total	**(137)**	(130)

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 2017 $000	Actual 2016 $000
Individual impairment	137	130
Collective impairment	0	0
Total provision for impairment	**137**	**130**

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 2017 $000	Actual 2016 $000
Past due 1 - 60 days	21	0
Past due 61 - 90 days	2	0
Past due > 90 days	114	130
Total individual impairment	**137**	**130**

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

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
At 1 July	130	70
Additional provisions made during the year	90	92
Provisions reversed during the year	(57)	(32)
Receivables written off during period	(26)	0
At 30 June	**137**	**130**

9 Inventories

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Pharmaceuticals	353	349
Surgical and medical supplies	913	865
Other supplies	946	921
Total inventories	**2,212**	**2,135**

The carrying amount of inventories pledged as security for liabilities is $Nil (2016: $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 (2016: Nil). There have been no reversals of write downs (2016: Nil).

10 Derivative Financial Instruments

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Current liability portion		
Interest rate swaps - cash flow hedges	53	0
Total current liability portion	53	0
Non - current liability portion		
Interest rate swaps - cash flow hedges	788	1,429
Total non - current liability portion	788	1,429
Total derivative financial instrument liabilities	**841**	**1,429**

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 (2016: $18 million).

At 30 June 2017, the fixed interest rate of cash flow hedge interest rate swaps varied from 5.45% to 5.65% (2016: 5.45% to 5.65%).

As there is no longer any hedging, gains and losses valuation of the interest rate swaps have been released to the surplus or deficit.

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 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**
Balance at 1 July 2016	6,970	129,576	26,245	3,645	9,536	2,464	6,764	185,200
Additions	0	872	1,669	197	645	119	1,809	5,311
Disposals	0	0	(3,067)	(243)	(1,397)	(16)	(835)	(5,558)
PPE Class Transfers	0	102	(12)	(90)	0	0	0	0
Work in Progress	0	8	0	1	(158)	0	167	18
Revaluations	2,555	4,487	0	0	0	0	0	7,042
Balance at 30 June 2017	**9,525**	**135,045**	**24,835**	**3,510**	**8,626**	**2,567**	**7,905**	**192,013**

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 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)**
Depreciation and Impairment charges								
Balance at 1 July 2016	0	(4,923)	(18,634)	(2,194)	(6,545)	(1,389)	(2,614)	(36,299)
Depreciation charge for the year	0	(5,011)	(1,991)	(301)	(1,272)	(144)	(1,008)	(9,727)
Disposals	0	0	2,994	229	1,395	0	631	5,249
PPE Class Transfers	0	(41)	10	31	0	0	0	0
Work in Progress	0	0	0	0	0	0	0	0
Revaluations	0	9,975	0	0	0	0	0	9,975
Balance at 30 June 2017	**0**	**(0)**	**(17,621)**	**(2,235)**	**(6,422)**	**(1,533)**	**(2,991)**	**(30,802)**
Carrying amounts								
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**
At 1 July 2016	6,970	124,653	7,611	1,451	2,991	1,075	4,150	148,901
At 30 June 2017	**9,525**	**135,045**	**7,214**	**1,275**	**2,204**	**1,034**	**4,914**	**161,211**

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 2017.

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 2017.

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 $9,525,000 (2016: $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 2017, the net carrying amount of leased vehicles was $598,131 (2016: $501,733). 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 2017, the net carrying amount of building leasehold improvements was $708,511 (2016: $824,604).

Lakes DHB Group leases IT equipment under a finance lease agreement. At 30 June 2017, the net carrying amount of leased IT equipment was $401,168 (2016: $661,563). 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 2017, the net carrying amount of the medical and non-medical plant and equipment was $2,991,725 (2016: $2,116,789). 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 2017 (2016: Nil).

Work in progress

		Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Work in progress			
The closing balances of work in progress by asset class is :	Buildings	231,015	223,002
	Computer Equipment	21,209	178,644
	Leased Assets	212,400	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 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**
Balance at 1 July 2016	10,256	0	10,256
Additions	675	0	675
Disposals	(308)	0	(308)
Work in progress	824	0	824
Transfer to other classes	0	0	0
Balance at 30 June 2017	**11,447**	**0**	**11,447**
Accumulated amortisation and impairment losses			
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)**
Balance at 1 July 2016	(5,676)	0	(5,676)
Amortisation expense	(991)	0	(991)
Impairment losses	308	0	308
Disposals		0	0
Transfer from other classes	0	0	0
Balance as at 30 June 2017	**(6,359)**	**0**	**(6,359)**
Carrying amounts			
At 1 July 2015	3,526	0	3,526
At 30 June 2016	**4,580**	**0**	**4,580**
At 1 July 2016	4,580	0	4,580
At 30 June 2017	**5,088**	**0**	**5,088**

Lakes DHB Group leases Computer Hardware under a finance lease agreement which includes a component of computer software. At 30 June 2017, the net carrying amount of leased computer software was $Nil (2016: $2,604). 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.

Lakes DHB has incorporated its share of contributions to HealthShare Ltd in the statement of comprehensive revenue and expense.

a) Carrying amount of investments in joint venture

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
	303	255

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

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Current assets	3,154	3,355
Non - current assets	11,755	11,607
Current liabilities	4,115	7,489
Non - current liabilities	923	6,199
Revenue	13,682	11,979
Expenses	13,460	12,140
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.

Laboratory Services Rotorua is a non-going concern as at 30 June 2017. The Directors have agreed to dissolve the Partnership as per the terms stated in the Partnership Agreement. The assets and liabilities have been stated at their net realisable value.

a) Carrying amount of investments in joint venture

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
	1,127	910

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

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Current assets	2,226	1,716
Non - current assets	1,283	1,442
Current liabilities	1,257	1,332
Non - current liabilities	0	0
Revenue	9,281	8,939
Expenses	8,120	8,411
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 was available for uplift from 1 April 2017, $250,000 has been received and the rest will be uplifted in the 17/18 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 2017 $000	Actual 2016 $000
Finance asset - current		
Term deposits with maturities three to twelve months	700	700
Finance asset - non-current		
RECT Donation	0	750
Total finance asset	**700**	**1,450**
Finance liability - non-current		
RECT Donation	0	750
Total finance liability - non-currrent	**0**	**750**

15 Payables

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Payables under exchange transactions		
Trade payables and expenses	13,907	13,149
Revenue in advance	1,221	11
ACC Levy payable	183	574
Total payables under exchange transactions	15,311	13,734
Payables under non-exchange transactions		
GST, PAYE, and FBT payable	3,138	2,995
Total payables under non-exchange transactions	3,138	2,995
Total payables	**18,449**	**16,729**

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 2017 $000	Actual 2016 $000
Current liabilities		
Retirement gratuities	189	192
Long service leave	158	147
Sabbatical leave	88	83
Annual leave	8,677	8,046
Continuing medical education (CME) leave	931	674
Continuing medical education (CME) expenses	1,682	1,620
Accrued salary and wages	2,817	2,413
Total current portion	14,542	13,175
Non - current liabilities		
Retirement gratuities	177	239
Long service leave	1,707	1,736
Sabbatical leave	797	675
Total non - current portion	2,681	2,650
Total employee entitlements	**17,223**	**15,825**

Estimating retirement and long service leave obligations

The present value of retirement and long service leave obligations depend on a number of factors that are determined on a actuarial basis. Three key assumptions used in calculating this liability include the discount rate, the salary inflation factor and the resignation rate. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using Treasury's published forward Risk-Free Discount Rates and these were chosen in accordance with PBE IPSAS 25. The discount rates used have maturities that match, as closely as possible, to the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns. The discount rates range from 1.87% to 3.61% in a 10 year range (2016: 2.03% to 3.30%) and a salary inflation factor of 2.5% (2016: 3.0%) was used.

17 Borrowings

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Current		
Finance leases	889	1,014
Ministry of Health Loans	0	4,000
Total current portion	889	5,014
Non current		
Finance leases	3,328	2,462
Ministry of Health Loans	0	45,565
Total non - current portion	3,328	48,027
Total borrowings	**4,217**	**53,041**

Security and terms

Crown Sector

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

	Actual 2017 $000	Actual 2016 $000
Loan facility limits		
Ministry of Health	0	49,565

The MoH liabilities were secured by a negative pledge.

Without the MoH's prior written consent, Lakes DHB could not 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 $Nil (2016: $52.760m). Fair value had 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% (2016: 2.17% to 5.66%).

The MoH loans had maturity dates ranging from 2016 - 2023.

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 lending documents, terms and conditions, facility agreements and loans transitioned to the MoH at this date.

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

The impact on the statements of account for the DHB is as follows:

	Note	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Opening Balance - Crown Loans		49,565	49,565
Conversion of loans to equity		-49,565	0
Closing Balance - Crown Loans	**17**	**0**	**49,565**
Opening Balance - Contributed Capital		20,386	20,693
Captial Contributions from/(repayment to) the Crown		(301)	(301)
Prior year adjustment		0	(6)
Conversion of Crown loans to equity		49,565	0
Closing Balance - Contributed Capital	**19**	**69,650**	20,386

Working capital facility

Lakes DHB is a party to the DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (HPL) and the participating DHB's. 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 $13.138 million.

Analysis of finance leases

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Total minimum lease payments are payable		
Not later than one year	1,037	1,197
Later than one year and not later than five years	2,938	2,213
Later than five years	1,096	690
Total minimum lease payments	5,071	4,100
Future finance charges	(854)	(623)
Present value of minimum lease payments	4,217	3,477
Present value of minimum lease payments payable		
Not later than one year	889	1,014
Later than one year and not later than five years	2,345	1,827
Later than five years	983	636
Total present value of minimum lease payments	4,217	3,477
Represented by:		
Current	889	1,014
Non-current	3,328	2,463
Total finance leases	**4,217**	**3,477**

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 2017 are with Toyota Financial Services and Orix New Zealand Ltd. IT Finance Leases at 30 June 2017 are with CBA Asset Finance (NZ) Ltd and MCL

Capital Ltd. Medical Equipment Finance Leases at 30 June 2017 are with Allleasing New Zealand Ltd and MCL Capital 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 2017 $000	Actual 2016 $000
Current provisions are represented by:		
ACC Partnership Programme	0	31
Total provisions	**0**	**31**

19 Equity

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Crown equity		
Balance at 1 July	20,386	20,693
Prior year adjustment	0	(6)
Contributions from the Crown	49,565	0
Repayments to the Crown	(301)	(301)
Balance at 30 June	69,650	20,386
Other reserves		
Asset revaluation reserves		
Balance at 1 July	55,952	55,952
Revaluation gains/(losses)		
- Land	2,555	0
- Buildings	14,493	0
Transfer of asset revaluation reserve to retained earnings on disposal of property		
- Land	0	0
- Buildings	(72)	0
Balance at 30 June	72,928	55,952
Represented by:		
Total Land	7,969	5,414
Total Buildings	64,959	50,538
	72,928	55,952
Cash flow hedge reserve		
Balance at 1 July	(1,429)	(1,376)
Fair value gains/(losses) in the year	0	(53)
Reclassification to the surplus or deficit	1,429	0
Balance at 30 June	0	(1,429)
Total other reserves	72,928	54,523

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. As the loans have been removed, the cashflow hedge no longer exists. The interest rate swaps have remained and therefore the hedge reserve deficit was recognised in the comprehensive revenue and expense statement. Any changes in swap valuation are now recognised directly in the comprehensive revenue and expense statement as a surplus or deficit.

Retained earnings

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Balance at 1 July	8,910	14,166
Prior year adjustment	0	15
Surplus(deficit) for year	(4,408)	(5,271)
Transfer to retained earnings of revaluation reserve on disposal of property	72	0
Balance at 30 June	4,574	8,910

Trust Funds

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Balance at 1 July	799	790
Transfer to retained earnings in respect of:		
Interest received	22	26
Donations and funds received	55	17
Transfer to retained earnings in respect of:		
Funds spent	(53)	(34)
Balance at 30 June	823	799
Total equity at 30 June	**147,975**	**84,618**

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 2017 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 2017.

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

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Surplus/(deficit) after tax	(4,312)	(5,262)
Add/(less) non-cash items:		
Depreciation and amortisation expense	10,720	10,284
Share of associate and joint venturer (surplus)/deficit	(265)	18
(Gains)/losses on derivative financial instruments	841	0
	6,984	5,040
Add/(less) items classified as investing or financing activity:		
Net loss(gain) on disposal of property, plant and equipment	21	46
Net loss(gain) on disposal of investments classified as fair value	0	0
	21	46
Add/(Less) movements in working capital items:		
(Increase)/Decrease in debtors and other receivables	(905)	(326)
(Increase)/Decrease in inventories	(77)	(2)
Increase/(Decrease) in creditors and other payables	1,794	821
Increase/(Decrease) in employee entitlements	1,398	(736)
	2,210	(243)
Net cash inflow/(outflow) from operating activities	**9,215**	**4,843**

21 Capital Commitments and Operating Leases

	Lakes DHB Group Actual 2017 $000	Actual 2016 $000
Capital commitments		
Buildings	3,845	571
Computer Plant & Equipment	0	0
Medical Plant & Equipment	0	1,253
Non Medical Plant & Equipment	0	0
Intangible assets	448	615
Total capital commitments	**4,293**	**2,439**

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 2017 $000	Actual 2016 $000
Not later than one year	280	240
Later than one year and not later than five years	11	183
Later than five years	0	0
Total non-cancellable operating leases	**291**	**423**

The total minimum future sublease payments expected to be received under non-cancellable subleases at balance date is $Nil (2016: $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 2017, $585,389 was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2016: $531,696).

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 new licence has been issued to the new company Pathlab Lakes Ltd.

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 new licence has been issued to the new company Pathlab Lakes Ltd.

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

	Lakes DHB Group	
	Actual 2017 $000	Actual 2016 $000
Not later than one year	492	416
Later than one year and not later than five years	0	0
Later than five years	0	0
Total non-cancellable operating leases as lessor	**492**	**416**

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 2017 $000	Actual 2016 $000
Contract Disputes - non employment	0	0
Legal proceedings - employment	0	0
Total contingent liabilities	**0**	**0**

Contract Disputes - non employment
There were no contract disputes - non employment as at 30 June 2017 (2016: Nil).

Legal proceedings - employment
There were no legal proceedings - employment as at 30 June 2017 (2016: Nil).

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 2017, the Scheme had a past service surplus of $8 million (6.12% of the liabilities). (2016: surplus of $11.7 million (7.4% 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 2017 had not been made available at 30 June 2017.

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 (2016: $Nil).

Contingent assets
Lakes DHB Group has no contingent assets (2016: $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 2017 $000	Actual 2016 $000
Board Members		
Remuneration	244	258
Full-time equivalent members	1	1
Leadership Team		
Remuneration	2,243	2,091
Full-time equivalent members	10	9
Total key management personnel remuneration	2,487	**2,349**
Total full-time equivalent personnel	11	**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 2017 $000	Board Fees 2016 $000
Deryck Shaw - Chair	43	42
Lyall Thurston - Deputy Chair	26	25
Mary Burdon *	11	22
Ailsa Gathergood *	10	21
Danny Loughlin *	11	24
Ian McLean *	10	22
Merepeka Raukawa-Tait	20	21
Rob Vigor- Brown	22	22
Charles Sturt **	0	19
Tamarapa Lloyd *	6	20
Margaret Bentley *	10	21
Desmond Epp ***	10	0
Janine Horton ***	10	0
Johan Morreau ***	11	0
Christine Rankin ***	11	0
Stuart Burns ***	11	0
Ana Morrison ***	11	0
Warren Webber ***	11	0
Total board remuneration	**244**	**259**

* Commenced term during 13/14 and completed term in December 2016
** Commenced term during 13/14 and completed term in May 2016
*** Commenced term during 16/17

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 (2016: Nil).

Non - board committee remuneration

The following people were non-board committee members during the twelve months ending 30 June 2017.

	Committee Fees 2017 $000	Committee Fees 2016 $000
Hospital Advisory Committee		
Te Rau Morgan	0.8	2.0
Julie Calnan	0.0	0.8
David Honore**	0.3	1.5
Ned Wikaira	0.0	1.3
Mark Arundel	0.0	1.8
Gwendolyn Puti-Ruhaina Isaacs	0.8	0.3
Peri Marks*	0.3	0.0
Stephen Te Moni*	0.3	0.0
Martin Gallager (Waikato DHB Rep)	0.8	1.8
	3.3	9.5
Community and Public Health Advisory Committee		
Lawrence Croxson	0.0	0.5
Sue Westbrook	0.3	0.0
Margaret Robbie**	0.3	1.0
Catriona Watson**	0.5	0.8
Peri Marks*	0.3	0.0
Anahera Pedersen	1.0	1.0
Te Rau Morgan (TRHOTA Rep)	1.5	0.3
Harata Rangimarie Paterson	0.0	0.8
Kamiria Iwa Grace Gosman **	0.8	0.3
Ronald Scott (BOP DHB rep) **	0.8	1.3
Stephen Te Moni*	0.3	0.0
Tania Hodges (Waikato DHB rep)	0.8	0.5
	6.6	6.5

Disability Support Advisory Committee		
Colin Cockburn **	0.5	1.3
Mere Maniapoto	0.0	0.3
Sue Westbrook	0.5	1.3
Leeann Loughlin	0.3	0.8
Cherie Reinders	0.5	0.3
Crystal Beavis	0.0	0.3
Peri Marks	0.3	0.0
Phillippa Mahood*	0.3	0.0
Ronald Scott (BOP DHB rep)**	0.5	1.3
	2.9	5.6
Total non - board committee remuneration	**12.8**	**21.6**

* Commenced term during 16/17
** Completed term during 16/17

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	2017 Number of staff clinical and other staff	2016 Number of staff clinical and other staff
$100,001 - $110.000	33	30
$110,001 - $120,000	21	22
$120.001 - $130.000	7	11
$130,001 - $140,000	7	8
$140,001 - $150,000	8	10
$150.001 - $160,000	7	6
$160,001 - $170,000	3	4
$170,001 - $180,000	2	3
$180,001 - $190,000	5	5
$190,001 - $200,000	5	2
$200,001 - $210,000	5	4
$210,001 - $220,000	7	5
$220,001 - $230,000	3	5
$230,001 - $240,000	6	3
$240,001 - $250,000	2	9
$250,001 - $260,000	5	3
$260,001 - $270,000	6	5
$270,001 - $280,000	6	4
$280,001 - $290,000	2	5
$290,001 - $300,000	4	4
$300,001 - $310,000	4	2
$310,001 - $320,000	3	3
$320,001 - $330,000	4	4
$330,001 - $340,000	3	5
$340,001 - $350,000	1	3
$350,001 - $360,000	2	0
$360,001 - $370,000	1	0
$370,001 - $380,000	1	1
$380,001 - $390,000	1	0
$390,001 - $400,000	2	4
$400,001 - $410,000	2	1

Of the 168 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 242 compared with the actual total number of 168.

25 Severance Payments

During the year, Lakes DHB made 2 (2016: 0) severance payments to former employees in respect to employment with the Board.

Number of employees	Amount $
2	99,259

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 2017 $000	Actual 2016 $000
ECE Funding Subsidy	**152**	116
20 Hrs ECE	0	0
Equity Funding	27	22
ATIS (Annual Top-Up for Isolated Services)	0	0
	179	**138**

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 2017 $000	Actual 2016 $000
	FINANCIAL ASSETS		
	Loans and receivables		
7	Cash and cash equivalents	5,003	2,036
8	Debtors and other receivables	13,061	12,156
14	Other financial asset	700	1,450
	Total loans and receivables	**18,764**	**15,642**
	Held to maturity	**0**	**0**
	Fair value through other comprehensive revenue	**0**	**0**
	FINANCIAL LIABILITIES		
	Financial liabilities at amortised costs		
14	Other financial liability	0	750
15	Creditors and other payables	18,449	16,729
	Borrowings:		
7	Bank overdraft	0	0
17	Finance lease liabilities	4,217	3,476
17	MOH Loans	0	49,565
	Total financial liabilities at amortised costs	**22,666**	**70,520**

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
2017				
Financial Assets	0	0	0	0
Financial Liabilities				
Derivatives	0	841	0	841
2016				
Financial Assets	0	0	0	0
Financial Liabilities				
Derivatives	0	1,429	0	1,429

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 2017 $000	Actual 2016 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and term deposits		
AA-	5,001	2,034
Other financial assets		
AA-	700	700
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Cash at bank and term deposits	2	2
Other financial assets	0	750
Receivables	13,061	12,156

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 $13.138 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
2017				
Creditors and other payables (note 15)	18,449	0	0	0
Bank overdraft (note 7)	0	0	0	0
Finance lease liabilities (note 17)	889	724	1,621	983
Other financial liabilties (note 14)	0	0	0	0
MOH loans (note 17)	0	0	0	0
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	1193	636
Other financial liabilties (note 14)	0	750	0	0
MOH loans (note 17)	4,000	6,000	27,565	12,000

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
2017						
Gross settled derivatives	0	0	0	0	0	0
Net settled derivatives	841	0	841	53	788	
2016						
Gross settled derivatives	0	0	0	0	0	0
Net settled derivatives	1,429	0	1,429	239	1,190	

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
2017				
Cash and cash equivalents (note 7)	5,003	0	0	0
Debtors and other receivables (note 8)	13,061	0	0	0
Other financial assets (note 14)	700	0	0	0
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

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 $5,003,000 (2016: $2,036,000) which are at floating rates. A movement in interest rates of plus or minus 1.0% has an effect on interest revenue of $50,030 (2016: $20,360).

Derivatives financial liabilities includes interest rate swaps with a fair value totalling $840,880 (2016: $1,438,952). A movement in interest rates of plus or minus 1.0% has an impact of $849,289 / ($832,471) (2016: $(1,825,696 / ($1,045,828) on the surplus/deficit through the statement of comprehensive revenue and income. 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 2017 $000	Lakes DHB Group Actual 2017 $000
Output Class Revenue		
Prevention	6,298	5,962
Early Detection and Management	79,163	79,191
Intensive Assessment and Treatment	223,581	227,212
Rehabilitation and Support	41,190	40,742
Total Revenue	**350,232**	**353,107**
Output class Expenses		
Prevention	4,580	1,993
Early Detection and Management	76,010	87,710
Intensive Assessment and Treatment	227,171	228,163
Rehabilitation and Support	40,817	39,553
Total Expenses	**348,578**	**357,419**
Surplus/(deficit) by Output class		
Prevention	1,718	3,969
Early Detection and Management	3,153	(8,519)
Intensive Assessment and Treatment	(3,590)	(951)
Rehabilitation and Support	373	1,189
Net Surplus/(Deficit)	**1,654**	**(4,312)**

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 $4.3 million compared with a budgeted profit of $1.7 million. The major reasons for the variances between actual and budgeted result of $5.9 million was due to:

	Variance $000
- additional Government sourced revenue including new MoH side contracts of $2.089 million	2,089
- higher actual revenue Inter-district inflows (IDFs) of $667K	667
- lower actual costs for Medical personnel due to unfilled vacances of $2,325k.	2,325
- higher actual costs for nursing employees due to increased volumes of 0.814 million.	(814)
- Cost savings in other staff categories of $1.097 million	1,097
- higher actual costs for outsourced medical personnel due to vacancies, sick leave and cover of $6.146 million.	(6,146)
- higher actual costs for hospital pharmaceuticals due to increased cancer treatmentsof $1.505 million.	(1,505)
- higher actual spend on professional fees and expenses $0.996 million	(996)
- higher actual costs for community pharmaceuticals of $1.555 million	(1,555)
- higher actual costs for personal health Inter-district flows (IDFs) of $1.458 million	(1,458)
- numerous other small favourable and unfavourable variances	330
Total variance	(5,966)

Statement of financial position

- Equity - The variance relates to a worse than planned comprehensive revenue and expense of ($4.3) million vs. budget $1.7 million, unbudgeted land and building revaluation of $16,796k , unbudgeted reclassification of loans into capital contributions of $49,565k, and the removal of the hedge accounting for the interest rate swaps ($1,429k).

- Current assets - Overall current assets was in line with expectations, however lower than planned capital expenditure and the deficit lead to the net impact of a higher cash position than budget of $0.099m

- Non-current assets - Due to an unbudgeted land and buildings revaluation and a delay in a number of capital projects being commenced, overall non current assets was $6.235m higher than planned.

- Current liabilities - Higher than planned payables due to an increase in operational costs, the removal of crown borrowing lead to lower than planned term loans $4m and an increase in the annual leave and CME leave provision meant an increase in planned employment related provisions of ($2,925k), resulting in a overall net favourable decrease in current liabilities of $0.749m.

- Non current liabilities - Due to a delay in capital projects, finance lease borrowings was lower than planned $1.895m, this was partially offset by an increase in employment related costs of ($193k), and the unplanned removal of the crown loans to equity of $47.565m resulted in a net reduction of $49.855m.

35 Ministerial Directions

As per section 151(1)(f) of the Crown Entities Act 2004 ("the Act"), all DHBs must report any new directions and current directions given to the DHB's by a Minister in writing during the financial year.

"Direction" is defined as "a direction given by a Minister under this Act or the entity's Act to an entity or to a member or employee or office holder of an entity (for example, a direction on government policy, a direction to perform an additional function [issued under section 112 of the Act], or a direction relating to the entity's statement of intent)".

Current Ministerial Directions

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.

- The requirement to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018, issued in May 2016 under s.107 of the Crown Entities Act.

- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property and the former two apply to DHBs.

- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Directory

Spectrum Health Limited Directors (wholly owned subsidiary company)
Deryck Shaw
Ron Dunham

Lakes District Health Board
Chief Executive
Ron Dunham

Chief Financial Officer
Alan Mountfort

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Bankers
Westpac New Zealand Ltd

Solicitors
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