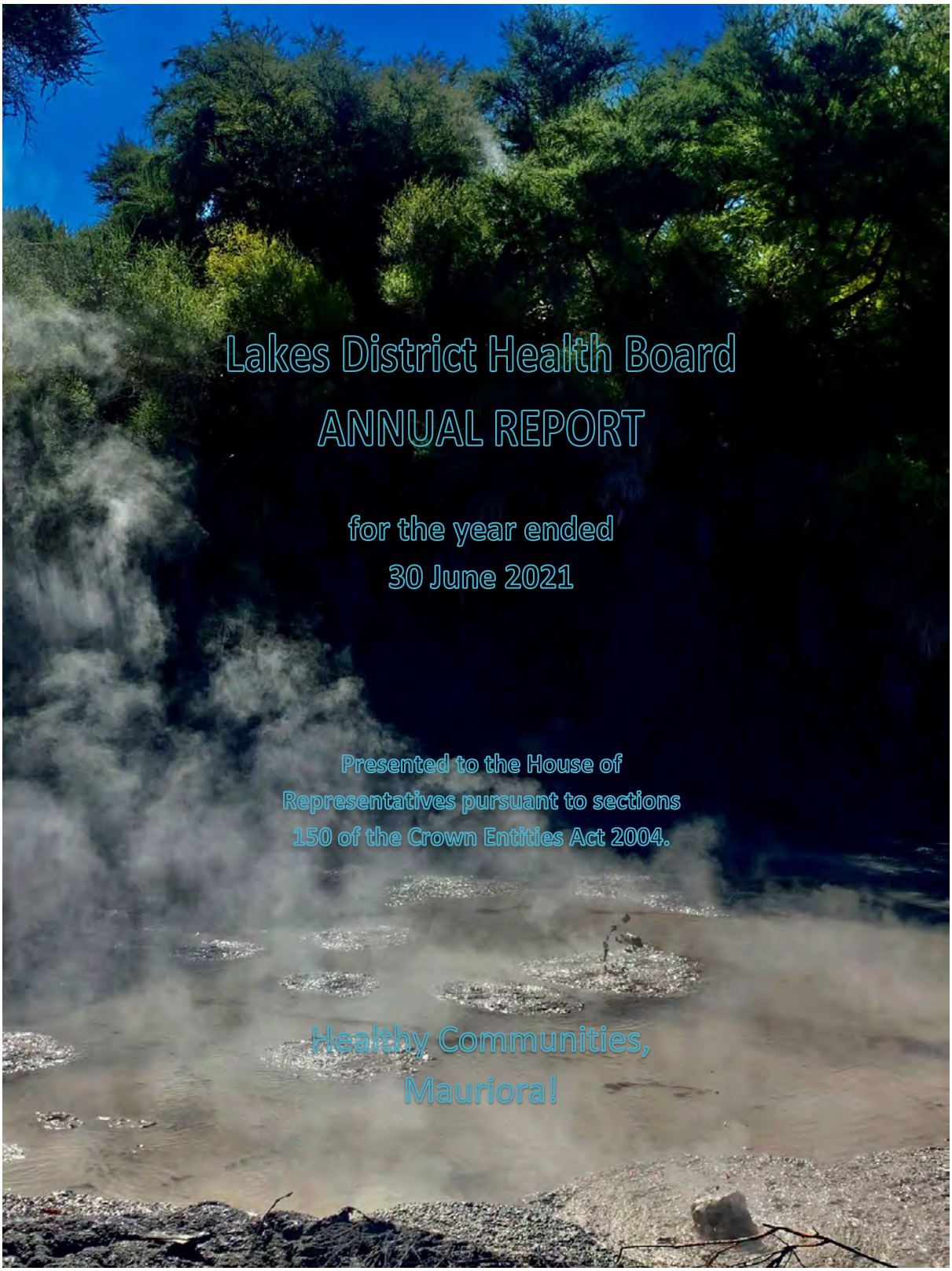
LAKES DISTRICT HEALTH BOARD



Ministerial Directions

Lakes DHB complies with the following Ministerial Directions:

- The 2011 Eligibility Direction issues under s.32 of the NZ Public Health and Disability Act 2000
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of Government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. Procurement and ICT apply to Hutt Valley DHB.
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizable ICT business transactions and investment specifically listed within the 2014 direction.

Contents

Message from the Board Chairman

Every year we receive the Minister of Health's Letter of Expectation which expresses the government's expectations for district health boards. Our annual plan articulates our commitment to meeting the expectations, and our continued commitment to achieving the Lakes DHB vision of Healthy Communities - Mauri Ora!

It is with pride we present this annual report for 2020/2021 outlining our achievements against the plan.

The Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance. The focus on strengthening financial management and performance is supported by collaboration with other DHB Chairs and iwi partners in Te Manawa Taki region.

We have continuously held the Chief Executive to account on the delivery of equitable health outcomes. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. Te Manawa Taki Regional Equity Plan sees the five Midland DHBs join forces on this commitment to equity. There is a strong focus in Te Manawa Taki, working with joint iwi and chairs to increase impact and decrease inequity for Māori.

Lakes DHB has had formal relationships with Te Arawa and Ngāti Tūwharetoa since 2002. Iwi governance representatives now participate in the Board and the Finance and Audit Committee (FAC) and continue to participate in the Hospital Advisory Committee (HAC), Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC).

The DHB's equity dashboard called Te Kaoreore is focused on Māori equity outcomes in key areas of disparity immunisation, oral health, and respiratory care and is a clear way of measuring change and challenging outcomes.

Lakes DHB has begun the process of redesigning the Māori health service model in partnership with Ngāti Tūwharetoa and Te Arawa iwi. Part of this redesign centres on the acknowledgement that tikanga, kawa and Māori values are the key to improved Māori health outcomes. The model is a partnership model based on shared values that sees us working closely with Te Arawa Whānau Ora and Tūwharetoa Health.

It was an important step to welcome the new position of Director of Equity and Outcomes to the DHB in May 2021.

Te Arawa and Ngāti Tūwharetoa have been developing their iwi strategies and Action Plans and Te Arawa's health strategy Te Ara Tikitiki o Rangi was published this year. These key lead documents will provide the platform and direction for Lakes DHB ensuring that we work together to achieve the aspirations and visions of the iwi.

The Reorua strategy Tuheao; Tuhepo provides a planned approach to embed te reo and kaupapa Māori into all services and practices and it was excellent to see the number and range of staff who took advantage of classes this year.

Tuterangiharuru the Māori Workforce plan will be carried forward with the appointment of a Māori workforce role which is soon to join the newly designed Māori Health team. The Māori workforce

programme Kia Ora Hauora continues to work with secondary school students to encourage them into health roles, particularly in hard to recruit areas like midwifery.

Lakes DHB's Health Equity based commissioning plan has an equity focus to ensure resources are directed to services and projects that will improve the health of Māori and vulnerable population groups. Lakes and Bay of Plenty DHBs are also jointly working on an equity focussed Disability Action Plan for the Bay of Plenty and Southern Lakes region.

To fully optimise integration and equity aspirations and ensure health outcomes are realised, it is essential that the DHBs work in collaboration, not only with each other, but with the wider state sectors. Lakes DHB continues to explore opportunities to strengthen our work with other sectors to integrate services and decrease the impacts of adverse social determinants.

In closing, I recognise that the last year has been very challenging and it is important that, on behalf of the Board, I acknowledge the commitment of our Chief Executive, Nick Saville-Wood, alongside our senior leadership team. To that end, I am also very appreciative of the support provided by every single member of the Board and our various sub-committees. As we look forward to the introduction of the reforms to the health system, I would like to thank everyone across the Lakes DHB district who works tirelessly every day to ensure our people have the best health system possible.

Nāku iti nei, nā

Dr Jim Matner
Chair, Lakes District Health Board

Message from the Chief Executive

I am pleased to present to our Rotorua and Taupō communities, and stakeholders, this Annual Report for financial year 2020/2021 which summarises our achievements in this year.

In 2020/2021 New Zealand and the world have been dominated by the on-going effects of the COVID-19 virus, and more recently the Delta variant. Health resources across the sector have been focused on planning for, and managing the virus, to ensure the health and wellbeing of our community. As well as this, Lakes DHB have been working hard to catch up on the provision of services which were stalled during the 2020 level four response.

In July 2020, we set up under urgency three COVID-19 managed isolation facilities (MIFs) in Rotorua and continued to provide the health staff to these facilities for New Zealanders returning home. Over 10,000 people have come through these three facilities in this financial year.

Lakes DHB staff also set up and manned COVID-19 swabbing centres in Rotorua and Taupō, and been committed and flexible to ensure the service could meet demand as COVID cases have surged over the year.

The COVID-19 vaccination programme which began in February 2021 was the most ambitious vaccination programme undertaken in Aotearoa when considering the timeframes required. By February 2022 Lakes DHB managed to achieve the target of over 90% for its total population however fell short on our target for Maori, where we succeeded at delivering over 90% of the Maori population with first doses but fell short on second doses, at 87%.

Hospital and community health services have continued to plan to be ready for any surge in positive cases in our rohe and many people have stepped up to be trained to be contact tracers, and upskill as ICU nurses, vaccinators and administrators.

On behalf of our communities, I express my sincere thanks to every person who has made this huge effort and commitment to keep our communities as safe as possible.

One of the exceptional results of our community response to fight COVID-19 has been the collaboration across sectors, agencies, iwi and hapu, health service providers and councils to ensure the wellbeing of our most vulnerable people.

This huge effort has affected our business as usual health services and meant some of our plans have not come to fruition. However, I am exceptionally proud of our commitment to the health and wellbeing of our communities.

Improving child wellbeing is a key priority of the Minister of Health, and Lakes DHB. In December 2020 the Prime Minster launched the Tiaki Whānau programme to support young parents in need of extra help at Tunuhopu marae in Ohinemutu. Well Child Tamariki Ora provider Manaaki Ora delivers the culturally appropriate and whānau based care for young parents who need extra support.

Our commitment to improving mental health and wellbeing has continued with our model of care Te Ara Tauwhirotanga Pathways that lead us to act with kindness, being rolled out across the sector. Our Whare Whakaue Inpatient Unit is taking the opportunity to transform some ways of working and

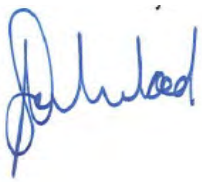
successful outcomes are being represented in some of the statistics. The Unit staff are having monthly wananga, which are challenging staff to reflect on how practice is aligned to Māori whaiora. Feedback Informed Treatment methodology which measures outcomes, shows a high percentage of Māori are satisfied with their wellbeing outcomes.

The Alliance Leadership Teams (ALTs) have provided a consistent and planned approach to new service design in the region. The joint DHB and Primary Health Organisations' development of the System Level Measures Improvement Plan has provided direction and focus to activity in the primary health setting.

System Level Measures are developed as part of the alliance work with PHOs and Whānau Ora to provide a framework for continuous quality improvement and integration across the health system. The purpose of the SLM leadership group is to develop, lead, deliver, and monitor an equity focussed SLM plan for Lakes DHB district. There is a particular focus on children, youth and people with high needs.

COVID-19 showed us the importance of enabling digital options for whānau to connect to health services. A telemedicine project called Pokapu o Te Taiwhenua is a collaboration of health providers, primary care and specialists supporting the use of video telehealth for appointments with GPs and specialists. Pokapu facilitators work alongside whanau in the community to help make this happen and we have increased the number of digitally enabled outpatient rooms at Rotorua Hospital from one to 18 out of 28.

My thanks go to every person across the health sector for their commitment to the health and wellbeing of our communities and their on-going hard work to provide an excellent health service.



Nick Saville-Wood
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:

- **Manaakitanga**
  Respect and acknowledgement of each other's intrinsic value and contribution
- **Integrity**
  Truthfully and consistently acting collectively for the common good
- **Accountability**
  Collective and individual ownership for clinical and financial outcomes and sustainability

Our Strategic Priority for 2020/21

To contribute to achieving the outcomes at a national and regional level, Lakes DHB identified the local strategic intent for 2020/21. Lakes DHB strategic intent represents a continuation from previous years, as the challenges faced are not short term issues that can be easily resolved within a 12-month period.

Te Manawa Rahi Lakes DHB Strategy 2019 - 2021

This strategy sets out how we are going to do things differently to improve outcomes and enable our whanau and community to Live Well, Stay Well and Get Well.

While Lakes DHB's over-arching strategic outcome remains achieving health equity, our local strategic outcomes are to address local population challenges for the following life course groupings:

- Pregnancy
- Early years and childhood
- Adolescence and young adulthood
- Adulthood
- Older people.

The table below identifies the action or priority area that covers the group.

Life course group	One significant action that is to be delivered in 2020/2021
Pregnancy	Access to free dental care for eligible pregnant women
Early years and childhood	The Lakes Baby service will be fully implemented providing easy and appropriate engagement and access for pregnant women to all relevant health services to optimise pregnancy outcomes and provide a good start to life
Adolescence and young adulthood	Co-designing of a future focussed, comprehensive and integrated school base health service will support physical and mental wellbeing of young people
Adulthood	Delivery of specialist mental health care to stable mental health patients in primary care with the aim of providing community based care provision for patients with a long-term illness, integrated with social support services and specialist care
Older people	Continued development of ACC/DHB led Falls and Fracture Prevention programme with emphasis on strength and balance and reduction of fragility fractures

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 2020/21.

Improving Equity for Māori

The World Health Organization defines equity as "The absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."

"In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."

Lakes DHB has begun the process of redesigning the Māori health service model in partnership with Ngāti Tūwharetoa and Te Arawa iwi. Part of this redesign centres on the acknowledgement that tikanga, kawa and Māori values are the key to improved Māori health outcomes. The model is a partnership model based on shared values that will see us working closely with Te Arawa Whānau Ora and Tūwharetoa Health.

The Board has developed and ratified the new Strategic Plan Te Manawa Rahi (2019-2021). This plan was developed with both Te Arawa and Ngāti Tūwharetoa iwi and has a strategic goal to achieve equity in Māori Health.

The Approach we take Continues to Include:

- updating Te Maheretanga Hauora Māori (our Māori 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 Māori services
- increasing the capability of the Māori 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 Advisory Committees 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.

Lakes DHB belong to the Waiariki Leadership group and have a strong relationship with other interagency organisations where together we are working on these cross sector challenges.

Health Inequalities

We are committed to reducing or eliminating the effects of health outcomes disparities through, firstly, identifying them and, secondly, through commissioning, funding and providing universal programmes which include a focus on reducing health outcomes disparities as well as specific programmes that target the causes of inequity and improve access to needed 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 outcomes inequity. The WAI2575 report on Stage One of the health services and outcomes Kaupapa Inquiry further emphasises the challenges Lake DHB must address to improve health outcomes for Māori.

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 116,370 people living in the Rotorua, Tāupo, Mangakino and Turangi districts.

Lakes DHB is responsible for funding personal health, Māori health, mental health, primary health, aged care services and some public health in the Lakes district and operates two general hospitals; Rotorua and Tāupo 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 Tāupo 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 Māori mental health services.

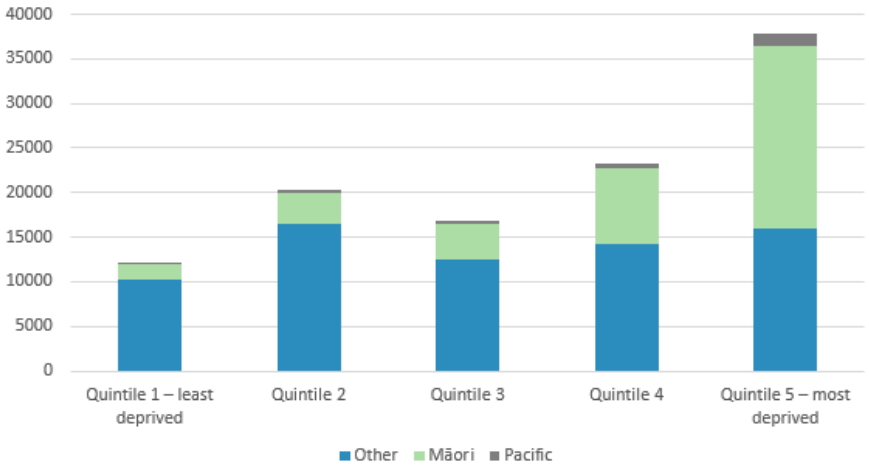
Community-based services provided include district nursing, social work and home support services and disability support. Population health services include public health nursing, school dental services, immunisation, universal new-born hearing screening, vision and hearing testing and B4 School checks.

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.

Lakes DHB serves a population of just over 110,000 and covers 9,570 square kilometres. It stretches from Mourea in the north to Mangakino in the west down to Tūrangi in the south and across to Kaingaroa village in the east. The major centres of population are Rotorua and Taupō and the main smaller communities are Mangakino and Tūrangi. The DHB boundaries take in the two main iwi groups of Te Arawa and Ngāti Tūwharetoa and Ngāti Kahungunu in the west (Mangakino).

As at the 2018 census, 37% of the Lakes population identify as having Māori ethnicity, a higher proportion of Māori than the national average of 17%. In the Lakes district, there are 38,650 under 25 (0-24) year olds, of whom 20,360 are Māori DHB area has a relatively high proportion of people in the most deprived section of the population[1].

[1] MOH NZ



Lakes DHB is responsible for the provision (or funding the provision) of the majority of health services in the Lakes district.

These Services in our district Include:

- Māori health providers
- Mental health providers
- Doctors and primary health organisations
- Dentists
- Maternity services
- Rest homes
- Hospitals
- Other health services, such as pharmacies and physiotherapy.

Lakes DHB:

- Works with key stakeholders to plan the strategic direction for health and disability services
- Plans regional and national work in collaboration with the MoH and other DHBs
- Funds the provision of the majority of the public health and disability services in the Lakes district, through the agreements with providers
- Provides hospital and specialist services primarily for our population and also for people referred from other DHBs
- Promotes, protects and improves our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives

Health Challenges for Lakes:

We know that some of our population are not doing quite so well, particularly Māori who:

- Are twice as likely to develop diabetes
- Have higher rates of hospitalisation for chronic obstructive pulmonary disease (or 'smoker's lung')
- Have higher cancer rates (especially for lung cancer)
- Are more likely to need mental health and addiction services.

There are also other big health issues in Lakes that need addressing including:

- The number of women who smoke in pregnancy
- The high number of obese, and morbidly obese adults and children
- Poor oral health of our children
- Declining Immunisation rates.

Good Employer Initiatives and Equal Employment Opportunities (EEO)

Lakes DHB is a major employer in the Lakes district with approximately 1,855 staff working full time, part time and casual. In addition, there are over 100 contracted staff working at Lakes DHB for 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.

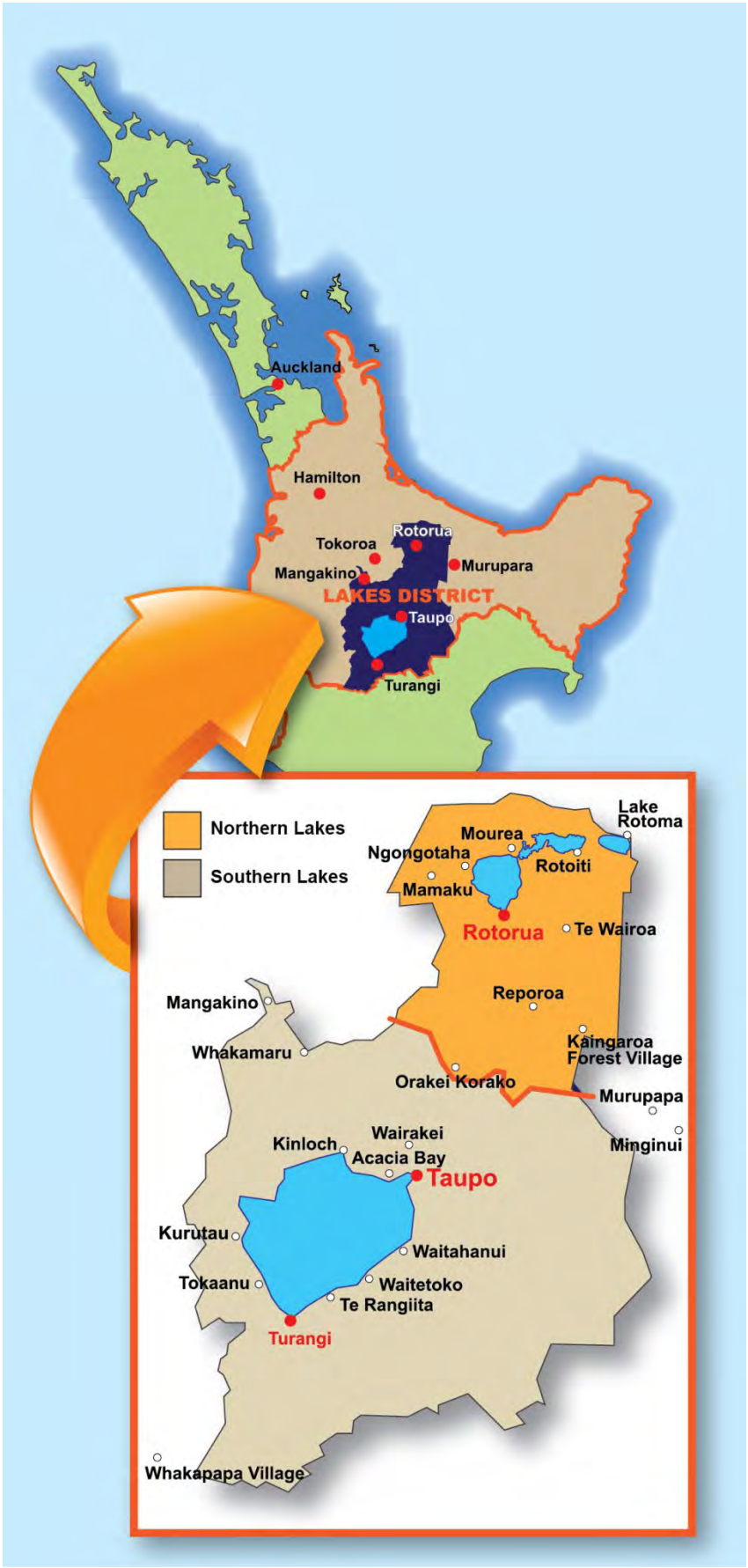
Good employer initiatives focused on bipartite meetings which were held with Council of Trade Union (CTU) union groups on a regular (quarterly/monthly) basis to discuss industrial matters, continue to build on healthy workplaces principles and developing effective partnerships.

The Board appoints the Chief Executive to manage all Lakes DHB operations.

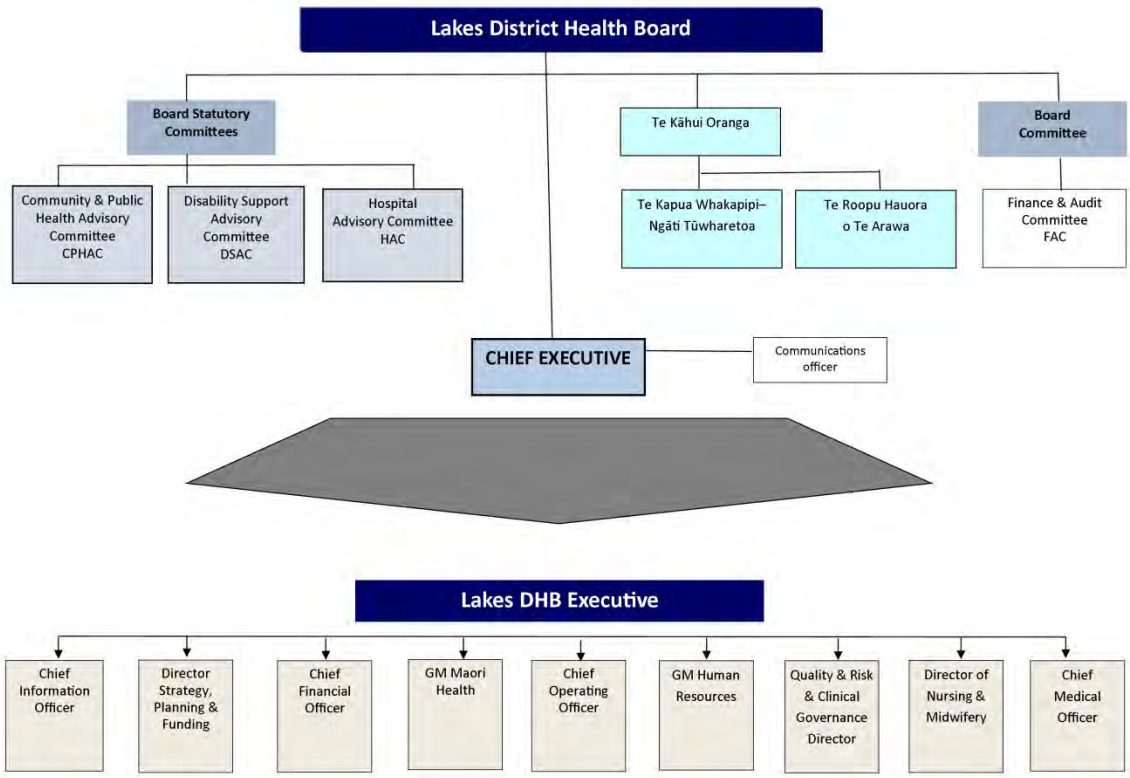
The policies and practices of the DHB work to enhance a positive and healthy workplace for our employees.

Lakes DHB became 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 Work Well audit.

Lakes District Health Board Boundaries



Governance Structure for 2020/21



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.

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 DHB Board Members

Board Members	Meetings Attended
Dr James Mather	11/11
Allison Lawton	2/2
Dr Rees Tapsell	9/11
Lana Ngawhika	9/11
Patrick Ngahihi-O-Te-Ra Bidois	10/11
Christine Rankin	10/11
Janine Horton	9/11
Dr Johan Morreau	11/11
Merepeka Raukawa-Tait	7/11
Robert Vigor-Brown	9/11
Lyall Thurston	10/11
Iwi Representatives:	
Aroha Morgan	11/11
Trudy Ake	10/11

Lakes District Health Board 2020
L-R: Lana Ngawhika, Rob Vigor-Brown, Lyall Thurston, Merepeka Raukawa-Tait, Janine Horton, Dr Rees Tapsell, Dr Jim Mather, Dr Johan Morreau, Ngahihi o-te-ra Bidois, Aroha Morgan, Trudy Ake **Inset:** Christine Rankin

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, leadership and direction on specific programmes/projects, as required. Lakes DHB and Te Roopu Hauora o Te Arawa have a formal relationship through a Memorandum of Understanding which was signed in 2018. Ngati Tuwharetoa also, continues to participate in Lakes DHB governance activity, the "door" to Ngāti Tūwharetoa is through Ta Tumu Te Heuheu office - Te Kapua Whakapipi. Lakes DHB has worked with representatives from Te Kapua Whakapipi over the past year and ensured their participation at a Governance level.

Lakes DHB is required under the Community Public Health and Disability Act 2000 to establish formal relationships with iwi. Lakes DHB has had formal relationships with Te Arawa and Ngāti Tūwharetoa since 2002.

The basis for the relationships is:

- Provide leadership, direction, and advice to the Lakes DHB, Board committees, chief executive and management on all strategic matters affecting the health of Māori.
- 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 Māori within the Lakes DHB district.
- To be the vehicle for ensuring effective consultation, and participation of whānau, hapu and iwi (Te Arawa and Ngāti Tūwharetoa). To participate in strategic development and planning to support the wellbeing of Te Arawa and Tūwharetoa 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). Additionally, governance groups such as COVID Vaccination Rollout, Mental health building development, Lakes Cancer Service Improvement Group Te Arawa COVID Hub and MIQ Iwi Partnership forum.

We are in a new era. We are collectively witnessing how iwi/Māori have the ability, capacity and sophisticated infrastructure to partner with the health and disability system (and many others outside the health system), to optimise peoples' health and wellbeing. The ability to leverage off iwi/Māori and wider system resources to achieve future equity and wellbeing is critical. Pre and post COVID-19, our commitment to partnering to find new and innovative solutions for Māori and other population wellbeing, continues.

Strategy - Te Ara ki Tikitiki o Rangi

Te Ara ki Tikitiki o Rangi is a five - year strategy and introduces the recognition and acceptance of Māori health practices and envelopes methods and ideologies that are beneficial for Māori holding Māori health practices such as Tohunga and mirimiri in the same stead as western practices.

This strategy also acknowledges the importance of holistic wellbeing and nurtures healthy whānau at each of the Whare Tapa Whā aspects striving to protect the future generations of Māori health. We believe that transformational change is necessary to achieving optimal health for Māori.

Recognizing that Lakes DHB Health Board serves a diverse population, a large proportion attribute to Māori. Within the context of Tukua mai ki a piri, Tukua mai ki a tata, the principle of ensuring that Māori are a vital and visible element throughout the organization, will be recognized when applying a

Te Ao Māori perspective to Māori health. The obligation will impact upon all key participants to actively seek opportunities, guidance and advice on matters of Tikanga Māori.

It is our vision that Māori receive quality healthcare whilst actively protecting Māori cultural concepts. It is important that we strengthen the role of our Māori Health Providers and to recognize the unique contribution to the wellbeing and success of Māori health and wellness. Te Ara ki Tikitiki o Rangi and Tukua mai kia piri, Tukua mai kia tata encapsulates the coming together of important relationships, in order to foster and develop inclusive and meaningful strategies, that will ultimately result in enhancing Māori health and care services with a Māori world view.


TE ARA KI TIKITIKI O RANGI • TE ARAWA HEALTH STRATEGY 2020-2025
TUKUA MAI KI PIRI, TUKUA MAI KIA TATA
WHĀINGA - OBJECTIVES
1. Action rangatiratanga (authority) and mana motuhake (autonomy)
2. Live and thrive as Te Arawa: implementing Pae Ora
3. Achieve Māori health equity and wellbeing
TE RAUTAKI - STRATEGIC DIRECTIONS
Strategy 1 - Te Tiriti enabled partnerships
Strategy 2 - Commissioning and co-commissioning
Strategy 3 - Performance and accountability for results
Strategy 4 - Data, digital and intelligence
Strategy 5 - Māori provider development
Strategy 6 - Māori workforce development
WHĀNAU ORA
Healthy families
IWI ORA
HAPŪ ORA
PAE ORA
HEALTHY FUTURES FOR MĀORI
WAI ORA
Healthy environments
MAURI ORA
Healthy individuals
MARAE ORA
TE HEKENGA-A-RANGI - NGĀ IWI O TE ARAWA WAKA
TE IHU O TE WAKA
Ngāti Mākino
Ngāti Whakaue ki Maketu
Ngāti Whakahemo
Tapuika
Waitaha
Ngāti Rangitihi
TE KEI O TE WAKA
Ngāti Tūwharetoa
Ngāti Hotu
Ngāti Tūrangitukua
TE TĀKERE O TE WAKA
Ngāti Tahu Ngāti Whaoa
Ngāti Kearoa Ngāti Tuarā
Ngāti Rongomai
Ngāti Rangiwewehi
Ngāti Pikiao
Ngāti Rangiteaorere
Ngāti Tarāwhai
Tūhourangi-Ngāti Wāhiao
Uenuku-Kōpako
Ngāti Whakaue
Ngāti Ngararanui
Te Pou o Taungatapu
POU
NGĀ MĀTAPONO
VALUES
Te Pou o PUHAORANGI
The Creator
TINO RANGATIRATANGA
Self determination
Indigenous Rights: Te Tiriti Enabled Partnerships
Te Pou o OHOMAIRANGI
The Designer
MANA MOTUHAKE
Options
Commissioning and Co-commissioning
Te Pou o RUAMUTURANGI
The Navigator
WHAKAUTE
Respect
Performance and Accountability for Results
Te Pou o TAUNGATAPU
The Historian
KAITIAKITANGA
Active Protection
Data, digital and intelligence
Te Pou o MAWAKETAPU
The Provider
MANAAKITANGA
Equity/Balancing
Provider Development
Te Pou o URUIKA TUATAHI
The Architect
WHAKAWHANAUNGATANGA
Partnerships & Relationships
Workforce Development
WHĀINGA
Whainga 1
Action Rangatiratanga and Mana Motuhake: Authority and Autonomy
Whainga 2
Live and thrive as Te Arawa: Implementing Pae Ora
Whainga 3
Achieve Māori health equity and wellbeing

Te Manawa Taki

Te Manawa Taki Governance Group is the overarching governance group for the region, overseeing and holding accountability for regional direction, strategy and key programmes of change. Membership is the five Chairs of Te Manawa Taki DHBs and five Chairs of Te Manawa Taki Iwi Relationship Board. This 50:50 composition reflects a Te Tiriti of Waitangi-based partnership.

Each DHB Chair is accountable to their DHB Board and is responsible for informing their DHB of matters of significance, including risk and mitigation strategies, for matters arising from the group's deliberations.

TMT Māori comprises the five Chairs of each mandated DHB iwi group collective: Bay of Plenty - Māori Health Runanga; Lakes - Te Rōopu Hauora o Te Arawa Hauora; Tairāwhiti - Te Waiora o Nukutaimemeha; Taranaki - Te Whare Pūnanga Kōrero Trust; Waikato - Iwi Māori Council. The TMT Regional Equity Plan.

Within the Te Manawa Taki region, as across the nation, there are persistent inequities within different populations, especially for Māori. Key to our regional strategy is achieving Māori health equity, as well as identifying and addressing equity gaps in other populations.

Many complex factors lead to poor health status. However, as a population group, Māori have on average the poorest health status of any group in New Zealand. This is unacceptable to us. Based upon evidence of inequities, we are prioritising our effort in three key areas: Cancer, Child Health and Mental Health.

Iwi Governance Body Membership

Te Roopu Hauora o Te Arawa Members	Te Nohanga Kotahitanga o Tūwharetoa Representative
Aroha Morgan (Chair) Tuhourangi Ngāti Wahiao Harata Patterson (Ngāti Rangiwewehi) Jenny Kaka-Scott (Ngāti Kea/Ngati Tuara) Dr Grace Malcolm (Ngati Tarawhai) Sue Westbrook (Ngāti Tahu/Ngāti Whaoa) Mihaere Kirby (Ngati Whakanue) Rolland Kingi (Ngāti Pikiao) Harina Rupapere (Ngati Uenukukopako) Julie Beach (Ngati Ngaranui) Te Kumeroa Vercoe (Ngati Rangiteaorere) Te Taepounamu Ruha (Rangatahi) Lydia Rickard (Matawaka) Dr John Armstrong Vacancy (Ngati Hurunga Te Rngi)	**Representatives from Ta Tumu Office:** Ngaiterangi Smallman Tania Te Akau Teresa Chapman **Representative from Mangakino:** Anah Pederson

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
- Whānau Ora and the development and implementation of nationally approved Whānau 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
Dr Johan Morreau - Chair	5/5
Patrick Ngahihi-O-Te-Ra Bidois	4/5
Merepeka Raukawa-Tait	1/5
Dr Jim Mather	3/5
Janine Horton	4/5
Lyall Thurston	3/5
Aroha Morgan - TRHOTA iwi alternate representative	
Tania Te Akau - TNKOT iwi primary representative	
Theresa Chapman - TNKOT iwi alternative representative	
Leanne Karauna	
Trudy Ake	
Te Mauri Kingi	
Anahera Waru	
Ian Finch, Bay of Plenty DHB representative	
Ex-officio members:	
Dr Phil Shoemack/Dr Jim Miller - Toi Te Ora Medical Officers of Health	
Janet Hanvey - Toi Te Ora Public Health	
Bevan Bayne/Pen Blackmore - Pinnacle Midlands Health Network	
Kirsten Stone - RAPHS	
Lorraine Hetaraka - Te Arawa Whanau Ora	

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:

Health of Older People

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

Mental Health and Addiction Services

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

Support for Disabled People

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

Consumer Participation

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

Responsive Services

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

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

DSAC Committee Membership

Committee Members	Meetings Attended
Rob Vigor-Brown - Chair	2/2
Janine Horton - Deputy Chair	2/2
Merepeka Raukawa -Tait	1/2
Dr Rees Tapsell	2/2
Lana Ngawhika	0/2
Dr Jim Mather - ex Officio	2/2
Tere Lawson - community representative	
Mary Barnett - community representative	
Sue Westbrook - TRHOTA primary representative	
Aroha Morgan - TRHOTA alternate representative	
Tania Te Akau - TNKOT primary representative	
Teresa Chapman - TNKOT alternate representative	
Ian Finch, Bay of Plenty DHB representative	
Ex-officio members:	
Don Sorrenson - Support Net representative	
Kirsten Stone - 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 2020/21 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
Lyall Thurston (Chair)	6/6
Dr Johan Morreau (Deputy Chair)	6/6
Dr Jim Mather (Board Chair - ex-Officio)	3/6
Christine Rankin	6/6
Ngahi Bidois - Member from July 2020	3/6
Lana Ngawhika	4/6
Mary Burdon (Community Representative) - Member from July 2020	6/6
Margie Robbie (Community Representative) - Member from July 2020	6/6
Tangihaere Macfarlane (Community Representative) - Member from July 2020	5/6
Aroha Morgan (Te Roopu Hauora o Te Arawa Representative)	4/6
Ngaiterangi Smallman (Te Kapua Whakapipi Ngati Tuwharetoa Representative (alternative) Member from July 2020	3/6
Tania Te Akau (Te Kapua Whakapipi Ngati Tuwharetoa Representative (Primary) Member from July 2020	2/6
Dr Geoff Esterman (BOPDHB Community Representative) - Member from September 2020	4/5

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 2020/2021 Included:

- Reviewing and approving all governance policies as they require updating
- Insurance Renewal proposal for 2021/2022 period with Marsh and NZ Health Partnerships Limited
- Draft Lakes DHB Annual Plan for 2021/2022
- Reviewing and making recommendations on Information Systems strategic direction in terms of security, privacy, Disaster Recovery Plan
- Holidays Act Remediation Project
- Review financial implications of COVID 19 pandemic
- Managed isolation facilities and community testing (funding)
- Approve 21st Omnibus Variation 2021/2022 Funding agreement
- Approve Finance and management information system (FMIS) Cloud migration
- Receive Payroll/Human Resources system updates.

Reviewed the Business Cases and Recommended the Board Approve:

- National procurement catalogue project $1,101,000
- Voice of internet (VOIP) Phone system - Phase four $492,647
- Fleet car replacements $876,188
- Oral Health infrastructure project $800,000
- Bedside patient monitoring and patient telemetry $2,369,934
- Digital x-ray equipment for Emergency Department $342,550
- Commissioning of additional beds in Medicine $265,000.

FAC Committee Membership

Committee Members	Meetings Attended
Stuart Burns (Chair)	9/9
Rob Vigor-Brown	8/9
Christine Rankin	6/9
Dr Rees Tapsell	8/9
Ex Officio	
Dr Jim Mather - ex Officio	8/9
Johan Morreau	9/9

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.

Alongside monitoring and evaluation, research has a key role to play in improving health and disability services, reducing disparities, and achieving equity. Acknowledging Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and the special character of the Lakes rohe, the committee promotes early engagement through local Māori consultation networks and the inclusion of Māori researchers whenever possible.

As the Pūtaiora writing group including Dr Barry Smith put it in Te Ara Tika: Guidelines for Māori research ethics, "All research in New Zealand is of interest to Māori, and research which includes Māori is of paramount importance to Māori."

Committee membership includes clinical and community representatives, who can speak to Māori and community interests, some have backgrounds in ethics or research and we have a broad representation of health disciplines.

The committee meets on the last Friday of each month and deals with research submissions and locality assessments from a range of researchers and research organisations from within and outside the Lakes DHB boundaries.

The Research and Ethics Committee Terms of Reference include assisting staff and consumers work through ethical issues that have arisen around clinical practice and other work situations.

Research and Ethics Committee Membership

Committee Members
Louise Armstrong, Clinical Representative
Ulrike Buehner, Clinical Representative
Mary Burdon, Community Representative, Rotorua
Candy Cookson-Cox, Māori Research Representative
Koshy Yohannan, Administrative Support
Kristina Maconaghie, Chairperson
Annie Morley, Clinical Representative
Suzanne Gower, Community Representative, Turangi
Katalla Kramer, Clinical Representative

Quality Governance, Risk & Compliance

The year 2020/21 saw considerable effort around managing the COVID-19 Lockdown and resurgence planning. It also involved ensuring that patients who required elective services were prioritised in terms of Equity.

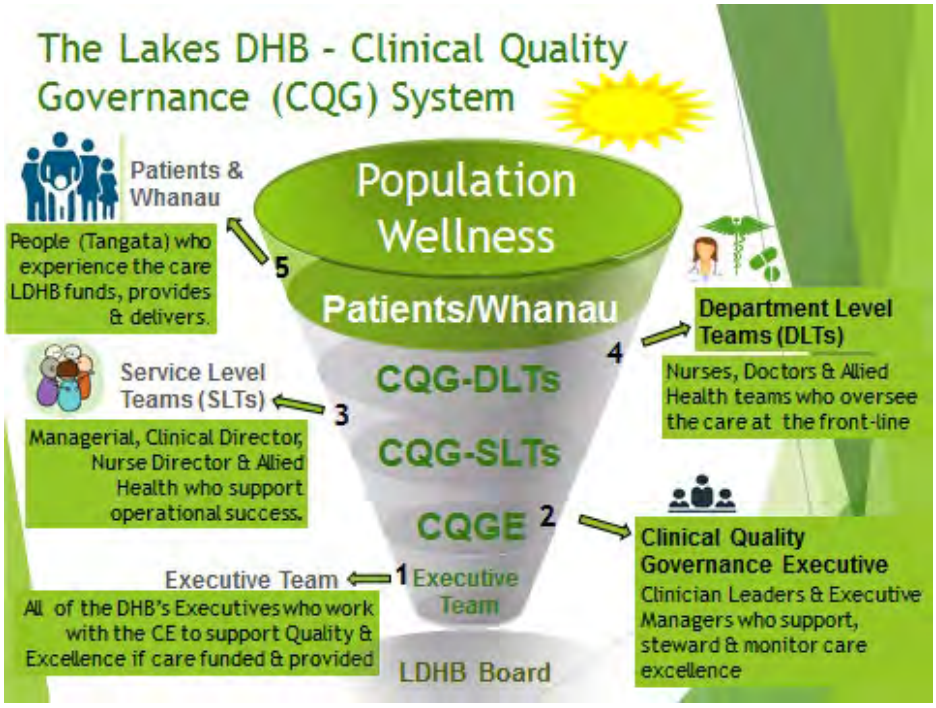
In July 2020 TE ITI KAHURANGI was published - The Lakes Way|Our Place, Our Culture. This document was produced in response to staff surveys and the outcomes from the speaking up for staff and patients' workshops held in early February 2020. The document is intended to be used to guide staff behaviours, actions and interactions noting that inappropriate behaviour can impact on the wellbeing and health of our colleagues and that this can have negative impacts on patient safety. Te Iti Kahurangi reflects who we are and what's important to us. It frames our efforts to deliver on the Board's priorities:

- Achieving equity in Maori health
- Building an integrated health system
- Strengthening people, whanau and community wellbeing.

In August through September the Director Quality Governance Risk and Compliance worked with a team of committed individuals, the Ministry of Health and supported by Standards New Zealand to revise the Health and Disability Services (safety) Standards. The final version came into effect on 28 February 2021 - Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. This was a major achievement that Lakes DHB took a major role in progressing.

The Lakes DHB Clinical Quality Governance Executive Group met mostly monthly to oversee a number of improvements in care. The Group made up of Clinical Leaders and Managers reports monthly to the Lakes DHB Board and the Hospital Advisory Committee and endorses and mandates reports, learning reviews, quality safety markers assessments, new ways of providing care and approaches to delivering care that makes a substantive difference to patient outcomes.

The Group receives reports from a number of Technical Sub-committees and feeds back information to these committees and to Clinical Quality Governance Service Level Teams. This networked model of working ensures that the patient/whanau and patient/clinician interface are empowered to deliver the best care possible.



Our Clinical Quality Governance model focuses on empowered clinical delivery teams with the authority to act effectively, efficiently, safely wisely and in partnership with their patients/whānau. These teams are decentralised, well-co-ordinated and have widespread information exchange that gives them 'shared consciousness' to do the right thing with and for patients and whānau. Information is able to be shared using feedback loops between and within the clinical-managerial networks.

This Māori concept of mahi tahi, *'If we work together we can succeed: Mehemea ka **mahi tahi** taua tera ano e taea'* enables us to be resilient, and, to support parts of the 'system of care' to reconfigure or adapt in response to change. The focus is on purpose and adaptability, rather than procedure and efficiency. Hierarchy exists as a part of the network with leadership creating the climate for mahi tahi learning, and creativity that can only come from working collectively to generate new ways of working that no one individual can produce.

The Clinical Quality Governance Operating Principles include:

- Managing through alignment and coaching at all levels
- Strengthening cooperation through 'connected' networks
- Clarity of roles, responsibilities and accountabilities
- Clarity and consistency of standards
- Culture of safety, openness and transparency
- Good performance management of individuals and teams
- Stewarding energetic and enthusiastic willingness to work within and across the system of care
- Support for autonomy of decision-making at the patient-clinician interface
- Support for 'quality', 'innovation' and change
- Clear 'line-of-sight' patient/whānau safety from bedside to board-room.

Clinical Quality Governance Executive Group

Membership	
Dr Sharon Kletchko	Chair - Quality Governance Risk Compliance Director
Mr Nick Saville-Wood	Lakes DHB Chief Executive
Dr Martin Thomas	Chief Medical Officer
Mr Alan Wilson	Chief Operations Officer
Ms Nina Hartley	Acting Director of Nursing & Midwifery
Mr Gary Lees	Director of Nursing & Midwifery (Emergency Op Incident Controller - EOCR-IC))
Dr Ulrike Buehner	Clinical Director Quality Improvement
Ms Karen Evison	Director Strategy Planning & Funding (Alternate EOCR-IC)
Ms Jillian Sutherland	Chief Pharmacist
Mr Roger Lysaght	Director Allied Health
Ms Jo Scott	Secretary

Joint Clinical Council

The Joint Clinical Council (JCC) is made up of community, primary and secondary clinicians and was formed improve clinical leadership and clinically driven change.

It reports through to the Clinical Quality Governance Executive Group.

The purpose of this group is to provide a clinical forum with the capability, experience and knowledge to provide clinical advice and guidance for the Lakes Health system.

The JCC has a strategic (Transformational Change) and an operational service improvement agenda. It takes a population health and whole of system approach to clinical decision making informed by local or localised evidence base.

The JCC meets on a 2-monthly basis, and more frequently as required.

Joint Clinical Council

Membership	
Hayden McRobbie	Lakes DHB, Consultant in Lifestyle Medicine - Chair
Natalie Clarke	GP, Pinnacle PHO
Suzanna Aitken	Extended Care Team Lead, Pinnacle PHO
David Honore	Pharmacist, Central Pharmacy
Jo Scott-Jones	Medical Director, Pinnacle PHO
Gary Lees	Director of Nursing, Lakes DHB
Stuart Williams	GP, RAPHS
Phil Shoemack	Medical Officer of Health, Toi Te Ora Public Health
Jo Marino	Korowai Aroha
Pen Blackmore	Pinnacle PHO
Janet Bland	Nurse, RAPHS
Anna Brightmore	Pharmacist, RAPHS
Lisa Hughes	GP, RAPHS
Neil Poskitt	GP, RAPHS
Mike Williams	GP, RAPHS
John Lufkin	GP, Pinnacle
Roger Lysaght	Service Manager, Lakes DHB
Mariska Lambert	ED consultant, Lakes DHB
Gerrie Synman	CMO, Lakes DJB

Increasing and Improving Health Equity for Māori

Achieving equity in health for Māori is a focus for Lakes DHB. Given our population make up and our obligations under the Treaty of Waitangi, the DHB has further focused this priority to ensure that reducing Māori inequities are prioritised.

The strategic plan Te Manawa Rahi, identifies this as one of three imperatives and has identified the approaches that Lakes DHB and iwi believe will make a difference. Ensuring measurable progress is being made is a Board expectation, and monitoring is underway through the development of a Māori Equity Dashboard, Te Kaoreore. The DHB currently focuses on (and will continue to) Māori equity outcomes in key areas of disparity e.g. immunisation, oral health, respiratory care.

During 2020/21 Lakes DHB worked towards equitable access of health care for Māori in the Lakes DHB through the following activities:

- Continue to advocate for a lowering of the age for bowel screening for Māori, and monitor Lakes participation rates to ensure equity is maintained at all stages
- Continue to focus on equity in Māori health in the planning and delivery of our System Level Measures work with our alliance partners
- Reset the Lakes DHB and Māori/iwi relationship to develop a shared vision and strong, active working partnership, to co-design and implement services where the impact will be significant for Māori health outcomes
- Significantly increase our immunisation coverage for Māori
- Maximise the impact of all screening programmes to achieve equity for Māori; bowel, breast, cervical and Cardiovascular Disease Risk Assessment (CVDRA) and management, by use of evidence-based innovations
- Workforce development strategy, and Te Manawa Taki Kia ora Hauora Programme to increase the number of Māori staff members across the disciplines and the health sector
- Support community and intersectoral primaral initiatives that meet the health needs, physical environment, health behaviours, socioeconomic factors and aspirations of Māori. Note: housing improvements are key to improving health outcomes
- Use recommended clinical guidelines and decision making tools that focus on achieving health equity for Māori maternal and child health services that focus on and are designed to improve outcomes for Māori babies and children
- Continue to work with social agency partners (via BOPCIGG) and TLAs to integrate services, and decrease impacts of adverse social determinants of health (in particular housing, truancy from school, and employment).

Membership

Committee Members	
Dr Jim Mather Dr Johan Morreau Ngahihi Bidois Lana Ngawhika Aroha Morgan Trudy Ake	

How Lakes DHB Group Funding Flows

Ministry of Health
$421M

Other Revenue
$51M

Lakes DHB

$11M
Governance and Administration

CE / Governance Board and Statutory Committees / Strategy Planning and Funding / GM Māori

$241M
Provider Arm (HSSS/Population Health)

Clinical Services / Specialist Assessments / Surgery / Oncology / NASC / NTA / District and Community Nursing

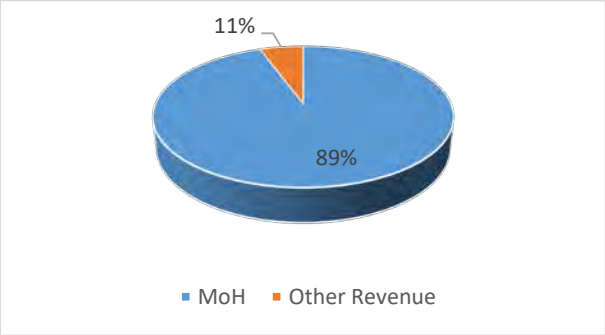
$56M
Other DHBs

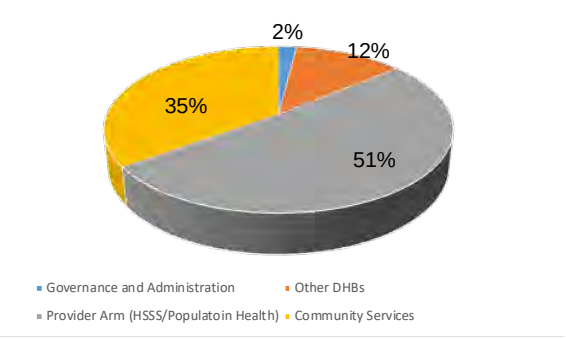
Secondary and Tertiary

$164M
Community Services

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

Lakes DHB Revenue





Key Achievements for 2020/21

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.

COVID-19

During the 2020-21 year, Lakes DHB response continued through catching up on backlog that occurred as a result of the March-April response levels. This was due the impact COVID-19 had on all departments within Lakes DHB. Service delivery for all providers, for example, in planned care (electives) surgical volumes were reduced. Planning the roll-out of the COVID-19 immunisation programme began in quarter 3 2020/21.

Emergency Operations Centre (EOC)

Most of the year has been covered with a virtual incident management team supported by an incident controller seconded into the role. The amount of activity has varied according to circumstances. Since the beginning of 2021 the focus has been largely on the vaccination programme, though community testing, managed isolation and planning for future outbreaks has also been part of the work.

At alert levels above 2 the incident management team reconvened as a full EOC.

Staff Utilisation

Managing the staffing impact of COVID-19 on our system has been challenging. In addition to all the work a DHB would normally be doing we have added community testing, managed isolation and a large vaccination programme. During outbreaks with raised alert levels it has been possible to re-deploy staff from services that reduce or stop operations at that time, but at level 1 those staff are back at their usual work. We have been successful in recruiting additional staff into the COVID-19 related work streams, but on many occasions providing adequate staffing has been a challenge and we have relied on the good will of our staff to cover gaps.

Testing

We have continued to provide community testing centres in Rotorua and Tāupo which have supplemented the testing carried out in primary care. Like all of our COVID-19 response the testing centres have flexed their opening hours and days according to the situation. During usual level 1 operations they are open 3 days per week. During higher alert levels or when there have been outbreaks in other parts of the country the provision is scaled up.

As an example, in August 2020 we added in additional testing centres and pop-up testing to enable us to process around 1200 tests per day for a few days. In preparation for surges in demand we keep enough IT equipment on hand to add two additional centres at short notice.

Contact Tracing/Toi Te Ora

We try and support demand from our public health unit for additional staff to provide contact tracing. This will frequently be for contacts anywhere in New Zealand, not just locally, so any outbreak in the country results in increased workload for the PHU. To do this we have all of our public health nurses trained to contact trace and we have a range of other staff who have volunteered to be trained. The nurse educator that supports the managed isolation facilities is a trainer for contact tracing and during surges of activity can be released from the managed isolation work to support the PHU in training new tracers.

Managed Isolation Facilities (MIF)

Since inception the Managed Isolation facility in Rotorua has accommodated a total of 11,698 guests. This was made up of 300 cohort arrivals. Guests were swabbed on day 0, day 3 and then on day 12. All cases that returned a positive COVID-19 test isolated in their room and arrangements then made to move them to Jet Park in Auckland which is the isolation facility. Currently the facility employs approximately 55 staff made up of Registered Nurses, Health Care Assistances, Admin and Welfare navigators. There is wonderful support from the community with a number of local businesses donating items for the children that enter these facilities. We have also had great support from the Education Department who supply packs for different age children.

In the last two months a regional command centre has been set up in Rotorua to take overall responsibility for the facilities in Hamilton, Wellington and Rotorua.

Care Capacity Demand Management (CCDM)

During the 2020-21 year, Lakes worked hard to implement Care Capacity Demand Management for nursing and midwifery services, in alignment to the Safe Staffing, Healthy Workplaces (SSHW) Unit. The Government's accord, signed with the Nurses Union and DHBs in August 2018, puts safe staffing levels at a top priority for nurses, midwives and DHBs.

The Care Capacity Demand Management (CCDM) programme is a set of tools and processes that help DHBs better match the capacity to care with patient demand. In 2020-21, Lakes completed the following mahi:

- Established permanent FTE for CCDM Co-ordinator and Trendcare Care Co-ordinator. The roles are now both line managed under the Chief Nursing Advisor who is responsible to CEO. This allows a cohesive approach to the CCDM programme and sharing of knowledge as required. The work of these roles significantly contributes to the shared governance model of CCDM.
- Union involvement at CCDM council and working groups has continued to be embedded over 20-21, underpinned by a partnership workshop and co-created partnership charter
- A main work stream involved setting up and embedding all the pre-requisites for a hospital at a glance (HaaG) screen and then the full development of a bespoke HaaG for Lakes DHB
- New training and educational programmes have been set up to cover all sectors of the hospital from board to the floor and working with individual areas to improve data capture and accuracy
- The overall milestone achievement for the CCDM programme is now 88% with plans in place to achieve full implementation as assessed by the SSHW Unit.

Clinical Services

2020/21 Planned Care Interventions Delivery

	Year to Date Plan	Year to Date Delivery	Variance from plan	2020/21 Health Target
Inpatient surgical discharges	4,726	4,926	200	**7,103**
Minor procedures	2,300	2,847	547	
Non-surgical interventions	77	2	-75	
YTD **Planned Care**	**7,103**	**7,775**	**672**	**109.5%**

2020/21 Year to Date Caseweight Delivery (CWD) Summary

Figures are DHB of Domicile and include publicly funded, Elective and Arranged Surgical Discharges reported to NMDS, and selected Minor Procedures.

Procedure Purchase Units reported to NMDS and NNPAC

	Base YTD Planned	Additional YTD Planned	Total YTD Planned	Actual Delivery	YTD Delivery
Inpatient Caseweight delivery	5,018.4	1,763.5	6,781.9	**7,290.9**	**107.5%**
Inpatient surgical discharges	3,468	1,258	4,726	**4,926**	**104.2%**
Minor procedures	1,433	867	2,300	**2,847**	**123.8%**

During the 2020/21 year, the target for elective procedures for Lakes DHB population was 4726 planned discharges. The actual number achieved was 4926 discharges. The planned CWD volume for the year was 6,781.9 CWDs, but the actual delivery was 7,290.9 CWDs. *(1 CWD = $5545.26 NZD).* Clinical Services delivered $2.82m of additional planned care caseweights above target.

A total of 52,328 Outpatient clinics for first specialist assessments (FSA) and follow-up (FU) have been completed, with 32.7% being FSA and 67.3% being FU. Of these outpatient appointments, 82.5% were attended at Rotorua Hospital and 17.5% in the Southern Lakes rohe. These assessments included Medicine 17,321; Surgery services 23,729; Woman Child Family services 9,654, and others 1,624. Lakes DHB continues to demonstrate improved access to all planned care and elective services.

Elective Services Performance Indicators (ESPIs)

The Provider Arm has focused on achieving required performance targets of no referrals waiting longer than four months for First Specialist Assessment (FSA) or elective procedure.

ESPI 2 measures patients waiting longer than 4 months for their first specialist assessment (FSA). ESPI 5 measures patients given a commitment to treatment but not treated within 4 months. For ESPI 2, in 2020/21 99.2% patients have received the assessment within the required timeframe of 4 months. For ESPI 5, 90% patients have received the treatment within the required timeframe of 4 months.

ESPI 2 compliance (First Specialist Appointment FSAs) is exemplary with compliance in all services as at June 2021 – no patient in any service having waited for more than four months.

For ESPI 5, despite major increases in outputs, we have been unable to achieve compliance in General Surgery, Specialist Dental and Orthopaedics due to recovery following the 2020 COVID-19 lockdown,

increased demand and complexity, and other major events. Lakes DHB performance toward ESPI 5 compliance is one of the best performances amongst DHBs (Ministry of Health reports).

Radiology production was particularly impressive with the service achieving compliance for CT (90% receiving CT scans in 6 weeks or less) and MRI (95% receiving MRI scans in 6 weeks or less) as of June 2021.

Day of surgery admission rate continued to be above 99% and elective theatre utilisation rate was 98.1% for the year.

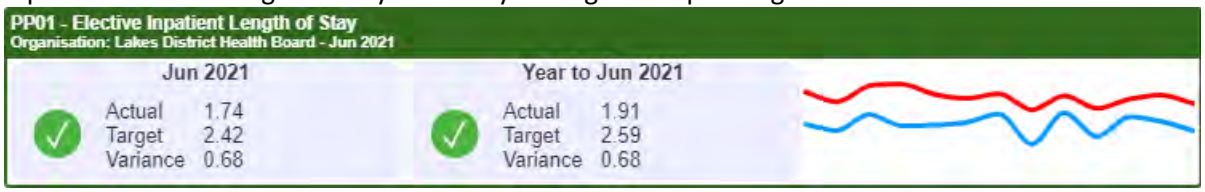
Care Capacity Demand Management (CCDM)

Lakes DHB continues to work proactively with the Safe Staffing Unit and has made excellent progress on CCDM during the year. CCDM identified a number of additional positions to meet staffing needs on the floor, and additional positions are being recruited to increase leave and backfill provisions. The number of vacancies is being stabilised well by an active Nursing Recruitment Programme.
Rotorua Hospital and Tāupo Hospital now have the "Hospital at a Glance" screen for CCDM that shows easily and graphically the hospital bed for nurses and allied health. It is updated in real time from both iPM (i.Patient Manager, the DHB's main patient management system), and Trendcare (the patient acuity and workload management software used to manage staff workloads on the wards, inpatient acuity and care plans) and is proving very useful for bed and staffing management.

Length of Stay

Long stay share of bed days in the latest period was 8.0% (compared to national ranges around 10-15%). Adjusted long stay patient meetings are facilitated each week with all Clinical Nurse Managers with any patient on the Long stay list and options for patients identified. For patients who are medically fit but challenged by social issues or Aged Care availability, a significant amount of work is being done by our staff to plan for these complex discharge requirements.

Inpatient elective Length of Stay is actively managed and pleasing results achieved.

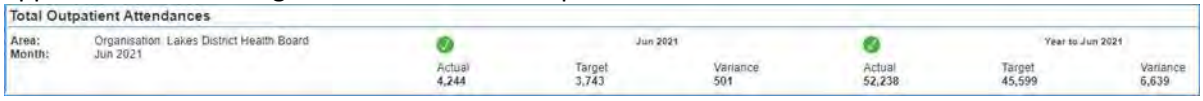


Admissions

During the 2020/21 there were 19,983 acute inpatient admissions and 4,862 admitted for elective procedures to Lakes DHB hospitals.

Outpatient Attendances

During the year there were 52,238 specialists and other professional outpatient attendances and their subsequent appointments at Rotorua and Tāupo hospitals, including telehealth. Telehealth was highlighted from the need to provide healthcare differently to support patients during the COVID lockdowns. The need for telehealth was highlighted to improve equity and give patients the opportunity to have healthcare provided to them in their homes or at community hubs via video or telephone where appropriate. Lakes DHB are exploring initiatives to address barriers to attendance at appointments including time and costs for the patient.

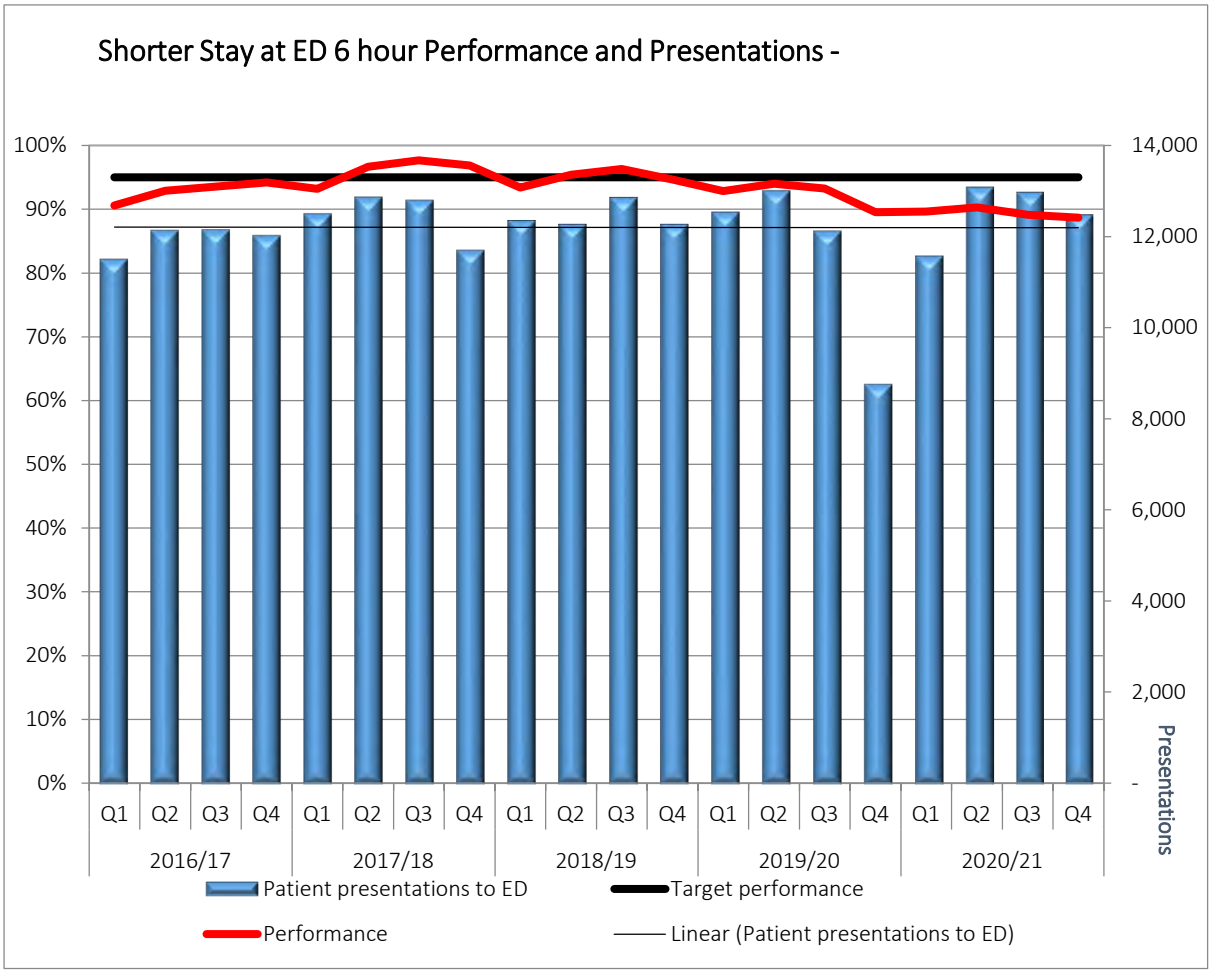


ED Presentations

During the 2020/21 year there were 50,095 presentations to Lakes DHB emergency departments distributed as follows:

- Rotorua - 34,340
- Tāupo - 15,755

The increase in the number of presentation shows the increase in community access to emergency department at Rotorua and Tāupo Hospitals. The following Ministry of Health graph shows the quarterly presentations and six-hour target:



	Year to June 2021	
Performance Measure	**Target Performance**	**Actual Performance**
Shorter Stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours	90%

COVID-19 Immunisation Programme

The COVID-19 Immunisation Programme was established within the Provider Arm on 27 February in Rotorua and May in Tāupo. Ministry of Health is responsible for managing COVID-19 in New Zealand and immunisation issues, with each DHB responsible for their population.

The COVID-19 vaccination programme has been rolled out by the Ministry of Health with prioritisation determined by the Ministry of Health. Lakes DHB made special arrangements for isolated, rural, Maori and high needs populations to promote equity across the population.

The Pfizer vaccine requires two vaccination events per person, now at six week interval between doses between doses. The programme required a very robust Cold Chain process, including obtaining cold chain accreditation, at times, scarcity of the vaccine necessitated no wastage of the vaccine.

Fixed short term premises were leased in both Rotorua and Tāupo. A focus of the programme has been marae-based clinics and outreach to Aged Residential Care, large enterprises, disability and rural communities.

Recruitment of a strong team of high–performing staff with several seconded public health services has been the driving force involved in this programme.

Managed Isolation Facilities

Lakes DHB continues to operate three very successful Managed Isolation Facilities in Rotorua. This has required a much higher contribution from the local health workforce than any other DHB, and that this has been accommodated alongside local staff providing a large COVID-19 testing system, and effective and efficient immunisation programme.

Radiology Procedures

Radiology Examination Volumes 2020 - 21

Modality	
Plain Film	37,820
RCT	7865
Image Intensifer	896
Mobiles	1138
MRI	4068
Ultrasound	6404
Fluoroscopy	910
Grand Total	**59,101**

The total Radiology production increased markedly over the year with the service achieving compliance in March for CT (95% receiving CT scans in 6 weeks or less) and MRI (90% receiving MRI scans in 6 weeks or less). Full recovery following the mid-2020 COVID-19 outbreak was achieved in 2020/21, with the majority of referrals were seen within the intended wait time for all population at Lakes DHB.

Clinical Services Equity Action Plan

Changing a culture is a large-scale undertaking, and strong and consistent leadership to improve equity is required to change behaviours and outcomes within Lakes DHB. All services are focused on improving equity. In 2020/21 the Chief Operating Officer undertook five sessions on equity and customer services at Rotorua and Tāupo hospitals. These sessions were attended by schedulers, booking clerks and receptionists, with a clear vision of how Lakes DHB can improve front-line cultural safety for patients and promulgating that vision rapidly with leadership storytelling. Positive feedback was received after the sessions and a number of noticeable changes observed.

The Provider Arm has developed actions and measureable outcomes that will deliver better Equity of Outcomes within Provider Arm responsibilities and focus. These actions were developed with and

endorsed by the Māori Health Team, Te Aka Matua, Clinical Directors, Heads of Department and Service Managers.

A two-monthly report, containing narrative and data, has been provided in relation to the Provider Arm performance in each of these outcome areas, with an on-going development of measures and reports. Each Provider Arm Equity report demonstrated positive improvements for Māori. In some measures this was shown through reduction in the gap between Māori and non-Māori. In other measures significant improvement for Māori was more reflective of parallel improvement in outcomes for non-Māori, all of which benefit our Maori population.

Other Key Achievements

- Successfully recruitment of long-term hard to fill vacancies including an orthopaedic surgeon and general surgeon
- Successful integration of Woman Child Family services and Population Health services providing a more seamless experience for patients and whanau
- Successfully addressing the Child Development Team waiting list and increasing service capacity and capability
- Implementation of Fluoride Varnish programme across all schools in Lakes DHB region which will reduce cavities by 35% by two years
- Implemented a successful programme to reduce First Specialist Assessment Did Not Attend programme for Maori in medical services.

Disability Action Plan

The Ministry of Health directed DHBs to develop a regional Disability Action Plan to improve access to quality health services and improve the health outcomes of disabled people.

Lakes DHB and Bay of Plenty DHB agreed to develop a joint Waiariki Disability Action Plan and began the engagement process with a provider to develop key messages, engage with stakeholders and the community and to deliver a cohesive Disability Action Plan. The outcome of the DAP is to acknowledge current established community disability resources and set the standard/expectations for health sectors response to health equity and general population needs in the disability sector. It will align with key messages and actions of Whāia Te Ao Mārama 2018 to 2022, the Māori Disability Action Plan and the NZ Disability Strategy 2016-2023 and will be cognisant of social sector and local government role in supporting the aspirations of the disability sector.

Healthy Ageing Model of Care Redesign

The COVID-19 pandemic impacted on service development for older people from February 2020 with a change in emphasis to ensure that DHB aged care providers were prepared for continuing to provide services for vulnerable people whether at home or in aged care.

The highlights from this have seen providers with updated, clear pandemic plans especially in infection control measures, use of protective equipment, screening staff and clients to minimise risk of transmission.

Residential care services in conjunction with DHB/Toi Te Ora incident management teams have developed plans in preparation for any outbreak in a facility.

Community support services who longer were able to have close contact with clients, implemented range of alternative ways to keep in contact with clients that included phone, social media, zoom, newsletters, activity packs options as well as providing support with shopping, accessing medication and providing and delivering meals.

The Key Areas of Development in Lakes have included:

Progress on development of Lakes Healthy Ageing Strategic Plan and Healthy Ageing Commissioning Plan. Key work streams have been identified and commenced that align to the national healthy ageing priorities and equity for Maori.

Work Streams including:

- Shift in allied health resource to establish an early supported response targeting readmission avoidance and improved Allied resource within ED and community with targeted admission prevention
- Collaborative project with TAS around Kaupapa Maori InterRAI assessment framework
- Collaborative project with MSD regarding development of kaiāwhina workforce
- Collaborative project with Auckland University research team to integrate Meta wareware framework and MANA cognitive assessment tool in dementia strategy
- Continued implementation of Lakes Palliative care strategy
- Linkage of Healthy Ageing Strategy to Digital Enablement project to facilitate equity for hard to reach populations
- On boarding of InterRAI acute assessment tool to streamline data capture in older population and prepare for implementation ACC NARP services
- Planning and preparation groundwork to facilitate shift to new HCSS Framework July 2022.

The third year of the Live Stronger for Longer - ACC Falls & Fracture Prevention programme has resulted in:

- More than 90 exercise/activity programmes in Lakes meeting ACC requirements for promoting strength and balance exercises
- Increasing number of people over the age of 50 have been assessed and treated by Fracture Liaison Service for osteoporosis following a fall from standing height that resulted in a fragility fracture. In this client group 50% of people could avoid another fracture if received medication to treat osteoporosis early.
- Community rehabilitation programmes expanded to support more than 600 older people who no longer able to leave home now participating in Otago Exercise programme at home led by physiotherapists and occupational therapists
- ACC claims data now available to assist with reviewing impact of initiatives and areas for future development
- Older People seeking elective surgery seen by geriatrician as part of pre-admission process - with a third option of choosing not to proceed with surgery once they had considered the risk of treatment on their quality of life and being able to make an informed decision on whether to have or not have surgery
- Implementation of multidisciplinary outpatient's service focused on chronic spinal, knee and hip pain. Service aims to use education and supervised conservative intervention strategies to facilitate outcomes of behavioural change and self-management strategies and avoid further medical interventional management
- New hospital led initiatives to reduce the risk of complications from falls, pressure injuries, delirium with aged care providers
- Continued implementation of training programmes for health professionals on need for early diagnosis, access to treatment and support services for people who have dementia and their family and cohesion of meta wareware Kaupapa Maori framework for understanding dementia intertwined with this
- The third year of the MoH/DHB pilot with age related residential care facility - The CARE Village in Ngongotaha new model of care based on 13 houses within a secure area continues to demonstrating residents experience a more normal way of living, appearing to engage with daily activities in a more settled environment

- Within the age related residential care services the current psycho-geriatric and dementia secure units expanded by 12 rooms, increasing total capacity to 850 beds
- Early stages of discussion with iwi groups to gain vision around Kaupapa Maori specific ARC facilities.

Interagency Response to Homelessness

Lakes DHB and MSD jointly engaged with Atlantis Healthcare for a proposal related to understanding the homelessness journey from a client and whānau perspective. The purpose of the social research was to capitalise on the learnings from this study to strengthen support and improve consumers' experience interacting with support services.

Healthy Homes Initiative Extension Programme - Tāupo District Area

During 20-21, Lakes DHB, Te Kapua Whakapīpī and Sustainability Options Ltd worked in partnership to progress the delivery of the Tāupo district area Healthy Homes Initiative Extension Programme, with a priority focus on Tūrangi and other high deprivation areas.

As a stakeholder collective there is a vision of using the Healthy Homes Initiative extension programme as a platform to generate outputs that will lead to better health and social outcomes for whānau and community. In essence, transformational change through a programme of health related projects.

To progress the vision, the collective drafted a programme brief including implementation of the healthy homes initiative programme supported by Te Kapua Whakapīpī, with establishment of appropriate referral pathways for reaching whānau/family members at risk of experiencing serious health conditions such as asthma, respiratory infections, and rheumatic fever as a result of cold and damp housing, housing affordability, substandard housing and crowding.

Housing Hub

The development of the Housing Hub (which will process all requests for housing and emergency housing) was undertaken during the 2020-21 year. While the Hub is not in operation at the moment, four service providers are in the final stages of negotiating their agreements with MHUD. This is expected to be completed in within the next week.

Twelve sites (re-purposed motels) began to be prepared to accept four groups of homeless individuals and/or whanau into them. These groups will transfer from existing emergency accommodation that is not deemed suitable. Each of these will be supported by the four service providers. The more vulnerable and health compromised individuals / whanau will be managed by a provider with clinical staffing.

Maori Health

Lakes DHB continued the process of redesigning the Māori health service model in partnership with Ngāti Tūwharetoa and Te Arawa iwi. Part of this redesign centres on the acknowledgement that tikanga, kawa and Māori values are the key to improved Māori health outcomes. The model must be based on shared values that will see us working closely with Te Arawa and Ngati Tūwharetoa.

We have also had initial discussions with the Transition agency in regard the Health Reforms, so certainly aim to work with Iwi and ensure they have what they need to prepare for this development.

There is a strong focus in Te Manawa Taki, working with joint Iwi and chairs to increase impact and decrease inequity for Māori. Each DHB has a senior executive member in the equity leadership team with a focus on delivering the following aims:

- Prioritise a Te Ao Māori world view and whānau voice
- Measure achievement (or not) of Māori Health equity using clear and evident data
- Develop and apply a Hauora Commissioning Framework to commission health services using the optimal mix of cultural and clinical specificity
- Agree, implement and monitor equitable funding strategies
- Collaborate on the development and implementation of wellbeing plans for priority Māori health equity areas of mental health, child health, cancer and cardiology
- Ensure the workforce reflects the needs and aspirations of Māori communities
- Build Māori capacity to meet whānau Māori health needs and the regional Māori population
- Build Māori provider capacity and capability to meet whānau Māori health needs.

Nursing and Midwifery Initiatives and Programmes

2020-2021 has continued to be a year of challenges and opportunities. The global pandemic strengthened the need for a flexible, responsive workforce to manage outbreaks and on-going managed isolation needs. This presents a new normal which the nursing and midwifery teams have adapted to in the midst of ongoing healthcare demands and a continued drive to provide the best outcomes for patients, whanau and clients.

Lakes DHB provides nursing staff to the isolation facilities within the rohe. The roles and skills for this unique setting evolve as new evidence or technologies emerge. Whilst being able to maintain the safety of guests in Rotorua, the team expanded their scope to support other isolation facilities remotely. Transferring to a fully electronic national clinical record means all assessments and health checks are recorded directly into a management system. The system links to the swab results database and contact tracing system - important information can be flagged, follow up arranged and email referrals completed as required. The remote capability comes in when a RN in Rotorua can now routinely complete appropriate phone checks as per policy for a guest in other facilities outside Rotorua and enter the data into the central system.

A number of individual nurse led initiatives within the acute sector also demonstrate how the local workforce continues to look at care delivery differently. There are new outpatient pathways to promote timely and appropriate interventions, including a skin lesion pathway which enables standardized nurse led triaging and a nurse led follow up service for orthopaedic patients in the year post a knee or hip replacement, both receiving positive patient feedback.

An additional example reflects a scenario where a new palliative care room in Rotorua Hospital's Emergency Department was created to enable palliative care patients some comfort when they need treatment. The idea was to make it a quiet restful place to provide privacy and peace for patients and their whanau. The nursing team recognised that palliative patients can sometimes have no alternative but to attend ED for care and for many patients and whanau, the ED can be a place that triggers painful

memories. To be able to offer them a room that looks very different from our usual clinical areas is really special.

Tāupo and Rotorua nurses continue to strengthen the falls prevention strategy, this includes assessment for risk, modifying environments and using trigger tools such as post fall care stickers to enable meaningful investigations when falls do occur, with the ultimate aim of reducing harm. This also led to more in depth development work to identify and support the patient with delirium. A revision of the Te iti o Kahu delirium pathway has incorporated current evidence and embraces a multi professional responsibility to provide support and appropriate management of patients with this diagnosis. Early audit results indicate better recognition, documentation and a growing implementation of non- pharmacological interventions driven by a care companion concept. By reducing the rate and extent of delirium or preventing falls, patient length of stay and ongoing complications can be reduced. The hospital advisory committee are maintaining a watchful eye over this work.

Fall audits form one of several submissions to the HQSC Quality Safety Markers Programme – through this the DHB ensures these areas remain as focus points. It also provides a graduated learning pathway for staff to become involved in patient improvement activities with many of the audits carried out at the clinical floor level by staff who understands the impacts to the patients. It also ensures that any learning can be targeted as required.
The maternity service has implemented the maternity early warning scoring (MEWS) system both into the main maternity suites but also other areas where women who are pregnant could be admitted. The early audit data indicates improved capture of observations and appropriate escalation process. A further improvement in midwifery service delivery is the presence of a midwife at births that occur within the theatre complex both planned and emergency caesarean sections. In January 2020 it was very rare that a midwife could attend this and has now risen to 73% of events and includes both DHB and LMC midwives or a SCBU RN that have been orientated and socialised to the area.

Nurses have been an important contributor to the new mental health and addictions strategy for Lakes DHB - this involved a co-designed collaborative approach with nurses within MH&A provider arm, senior nursing leads, Māori health, consumer health, and speciality experts. The strategy aims to ensure Lakes DHB Mental Health and Addiction Service nurses are committed to continuous quality improvement and advancing nursing practice and strive to deliver and serve the community in an equitable, compassionate and professional way. This strategy provides guidance to reduce inequities and improve outcomes for people that access the service. There is a deliberate focus on improving outcomes for Māori. An important part of the strategy is a section setting out tangible metrics on which as nurses we will be held accountable to and provides a report quarterly. This reporting metric framework is against the three Pou that sit within Te Ara Tauwhirotanga.

The development of a new nurse practitioner (NP) position within this model of care provides an alternative to work with tāngata whai ora and their whānau within their own home as opposed to a ward admission. This ‘closer to home’ work aligns with He Ara Oranga and Lakes own model of care Te Ara Tauwhirotanga and makes excellent use of the NP scope of practice.

Planned Care

In the 2020-21 year the Ministry of Health invested a significant amount of funding into the improvement and redesign of Planned Care[2]. With this boost in funding, Lakes DHB was able to undertake a number of Planned Care improvement projects:

- Fit for Surgery for Māori - Accessing Planned Care
- Māori Oral Health

[2] MoH: Planned Care Services

- Māori Opening Up Pathways
- Equity in Planned Care- Project Lead Role
- Develop RN Anaesthetic Assistants.

The above projects were established with a focus on improving health equity, and designing a more integrated and sustainable health system. A number of these projects have shown successful outcomes since implementation in October 2020, including clearing back long on elective surgery waiting lists, and preventing a number of admissions to the hospitals.

A Planned Care Advisory Group was established in the 2020-21 year at Lakes DHB to oversee the DHBs direct responsibility with regards to implementation and evolution as per policy direction, of Planned Care Services, and providers needed to deliver equitable and positive outcomes for the Lakes population in accordance with Te Manawa Rahi.

This gives assurance to the Lakes DHB Board, via Health Advisory Committee (HAC), delivery of Planned Care Services reflect Planned Care principles (Equity, Access, Quality, Timeliness, Experience) which to improve outcomes for service users and improve efficiency in terms of resource utilisation.

Te Kuku o te Manawa (an equity project for heart health)

Te Kuku o Te Manawa is a Māori leadership group that has been established to give direction on improving the prevention and management of cardiovascular disease (CVD) and diabetes for Māori residing in the Te Arawa region of Lakes DHB. The DHB realised that a different approach was needed to tackling the inequity that exists in CVD.

This equity project is being led by Māori, both in governance and in key decision making roles. The DHB project team is working under the direction leadership group and is responsible for day-to-day project management, data collection and analysis, and support of implementation activities.

The leadership group identified a number of structural barriers to the provision of services that contribute to the prevention and management of CVD and diabetes. A recurring theme that emerged throughout the initial working phase of Te Kuku o te Manawa is the short-term contract tenure of Māori providers.

This is destabilising (e.g. Māori workforce recruitment and retention), discouraging (e.g. Māori Provider confidence, inability to long term plan, financial uncertainty) and inefficient, and highlights inequitable Māori Health Provider contracting funding and arrangement. Solutions for improving the prevention and management of CVD and diabetes for Māori need time to be developed, tested and refined.

The DHB has since changed the way that it contracts with Māori providers and is now taking the next steps to consider a range of interventions to start to address some of the key risk factors including: opportunistic CV screening (e.g. blood pressure, blood glucose); community-based smoking cessation interventions; and enhanced workplace interventions that would target young Māori men.

Telehealth and Digital Enablement: Pokapū o Te Taiwhenua Network

During 2020-21, Lakes DHB developed Pokapū o Te Taiwhenua Network, an inclusive network of health and wellbeing community providers, community members, primary care, and specialist care actively closing the technology gap in virtual care to support health equity, whānau wellness, and integration of health and wellbeing services.

The two Major Developments for this Network are that:

> "Clients who are offered and desire a video consultation appointment into a health or wellbeing service but do not have the access to the equipment or the self-efficacy, can be supported with video consultation facilitation matched to the appropriate workforce which supports equity of access to virtual care and will optimize the value of video consultation appointment for both the client and the provider."
>
> "Collecting and applying digital health equity strategies."

Pokapū o te Taiwhenua is a project focused on providing equal access to video telehealth through facilitation using a non-clinical workforce in the community and using that interaction as a proxy for understanding what barriers are keeping that client/whanau digitally excluded, provide options to overcome digital exclusion, and then socialise digital health and wellbeing options to the client and their whanau.

Tier One and Locality Planning

Turangi Wellbeing Network

The DHB and Ngāti Tūwharetoa Iwi (with regional interagency funders) agreed to the joint development of Turangi as a Locality. This will continue to progress during 2021-22 in partnership with Iwi, state sector services linked through the Waiariki Leadership group and local council.

The stakeholders will progress the development of multi-agency placed based wellbeing partnerships. Two initial areas have been identified following work undertaken over the last year, and planning began for Ōpōtiki and Turangi locality work. Ōpōtiki sits under the Bay of Plenty DHB area currently, and therefore BOPDHB and Lakes DHB will work together with the Waiariki Leadership Group in these developments.

Enhancing equity and turning traditional models of top-down service provision into an approach that best meets the aspirations and needs of local communities. In linking the collective resource and community wellbeing focus of Health, MSD, Education, Oranga Tamariki and Local Councils we have an opportunity to address historic challenges of inequity and disadvantage.

Tobacco

Hauora Hemi

Lakes DHB, in collaboration with key stakeholders, developed a series of seven novel health promotion videos that prompt health behaviour change in the areas of physical activity, immunisation, smoking cessation, alcohol, drug use, health kai, and good oral health. The videos were designed to appeal to a Māori audience and involve local actors and filmed in Rotorua.

The hero of the stories is Hauora Hemi, our caped crusader who will share top tips on how to keep our whānau healthy. The tag line is Ka taea e koe! (You can do it!), which encourages whānau to give healthy lifestyle changes a go. The videos were predominantly used on social media, but have also been shared with a range of providers to use in waiting rooms, post-COVID vaccination waiting etc.

Local Stop Smoking Service Projects

Working with our local stop smoking service we have commenced two innovative service pilot projects. One involves supporting people who have struggled to stop smoking using conventional treatments to access a vaping product to help them quit smoking.

Early indications are that this is proving successful. The other is testing an enhanced financial incentive project for hapū māmā. This project is a collaboration between lead maternity carers (LMCs) and the stop smoking service. Here LMCs provide an invitation to māmā who smoke to have an initial kōrero with the Tipu Ora, which is exchanged for a grocery voucher on having the kōrero.

The rationale is that the financial incentive encourages first attendance, and then service engagement encourages the uptake of ongoing support.

The Waiariki Leadership Group (WBOPRLG)

To fully optimise integration and equity aspirations and ensure health outcomes are realised, it is essential that the DHBs work in collaboration, not only with each other, but with the wider state sectors.

Changes to the State Sector Act 1988, prompted the Waiariki regional leaders of public agencies to join together to help deliver better outcomes and services for the population as a whole region. Since 2018, the region has been growing this approach to support regional and local government, and community leaders, to work together with central government agencies on agreed priorities for the wellbeing of local communities.

The regional leadership group is comprised of CEOs, Governance and Iwi representatives from the following agencies:

- Health
- Ministry of Education
- Police
- Ministry of Social Development
- Oranga Tamariki
- Tuhoe
- Ngāti Rangitihi
- Te Arawa
- Ngāti Tūwharetoa Ki Kawerau (Putauaki)
- Bay of Plenty Regional Council.

The regional vision closely aligns with both Lakes and BoP DHB priorities:
Bay of Plenty to be the best place in Aotearoa for whānau to raise a child - wellbeing is supported, brought up in a safe, loving, nurturing and healthy environment.

There are five Aspirations:

- Building Capability to engage and partner with Māori - address our unconscious bias and build our responsiveness, capability and capacity to better engage with our Iwi partners
- Acting Early for Child Wellbeing - identifying vulnerable whānau with focussed support especially in the first 2000 days
- Engaging Rangatahi and Strengthening Pathways - improve school attendance and engagement in education especially young people in care and strengthen the pathway to future employment and or training
- Safe and Thriving Whānau - keeping whānau safe from harm with a focus on addictions, as a way of improving the safety and social cohesion of our communities

- Building Communities - supporting whānau and communities most in need with appropriate and safe housing options so that whānau are warm, safe and healthy.

Responding to Covid Resurgence

During the 2020/21 year the group responded to issues raised by the covid-19 outbreak and resurgence, and in particular, during the lockdown levels of 4 and 3. During this period the Group met frequently, two days a week, which was much more than its normal six weekly meetings.

The meetings were focused on key issues including:

- Proposed border/boundary controls for the BoP region - check points and Iwi concerns
- Food security - the provision and delivery of food to vulnerable groups, where current providers were under pressure or where there was no service
- The health response - vaccination, mask distribution and supporting testing.

These issues were addressed by the WBOPRLG, through various ways including, the sharing of information, advocating for change and drawing on the resources of each other.

Examples include, mask distribution drawing on Police, Iwi and health resources to source and distribute 60,000 masks to communities. In the food security area, information was shared about current funded food providers, and opportunities for Iwi to receive support to address whanau needs they had identified were not being met by food providers, ultimately leading to additional funding being available to the region and Iwi.

Identifying Longer Term Priorities

As New Zealand, and the BoP region moved out of the resurgence response, the WBOPRLG also moved its focus away from covid-19 and looked at how it could address some longer term priorities, some of which were highlighted by the resurgence of covid-19 (rather than created by covid-19).

The six priorities were:

- Health workforce - strengthening the health workforce in the region to be able to respond to community needs (in times of crisis and when not in crisis) - e.g. increasing the recruitment of Maori and the development of the unregulated workforce
- Workforce development long term employment - providing employment opportunities for to those people and communities most vulnerable to long-term unemployment - e.g. Maori and rural communities
- Mental/Health and addictions - addressing the high unmet needs in the community for mental health and addiction services that are effective - reducing the impact of meth and other addictions on family harm, community safety and wellbeing
- Data and insights - a need to develop a way to collect, share and use data to inform better decisions - e.g. shared evaluation and research processes across Iwi, TLAs, Health and Government
- Addressing long term welfare dependency - how to break the cycle of dependency, innovative ways of building resilient communities
- One funding funnel - a way for the group to have better oversight and influence on funding and resourcing decisions that impact on the BOP region - discretionary regional fund, connecting funding opportunities across government and advocating for change in funding.

Many of these priorities continue to be developed in terms of work plans, and will form the basis of the WBOPRLG's ongoing work.

Lakes DHB Good Employer Report 2020/2021

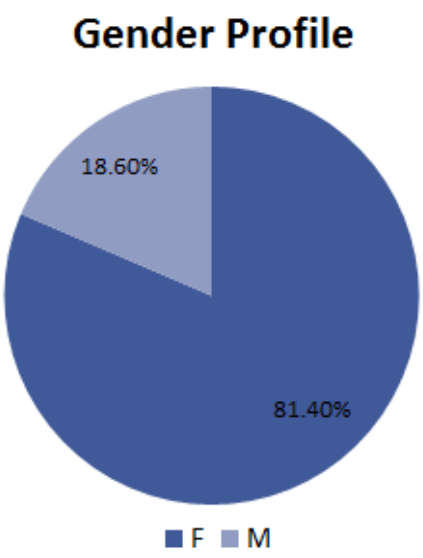
Diversity & Inclusion/Workforce Profile

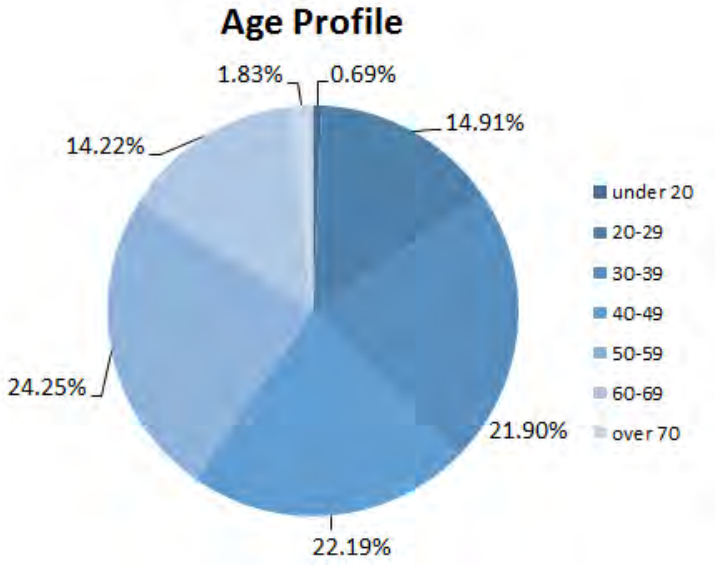
Lakes DHB's workforce has had unprecedented growth in the 2020/2021 year with the institution of managed isolation facilities, swabbing clinics and immunisation hubs due to the COVID-19 pandemic.

Lakes is one of the larger employers in the Lakes district, using contracting services (Spotless) as well as employing approximately 1855* staff up from 1745 staff in June 2020. Lakes DHB offers flexible employment options, permanent, fulltime or part-time and casual. The workforce profile at Lakes is depicted in the pie charts below and, as is typical in health, is made up of a high proportion of female staff 81% (unchanged from last year).

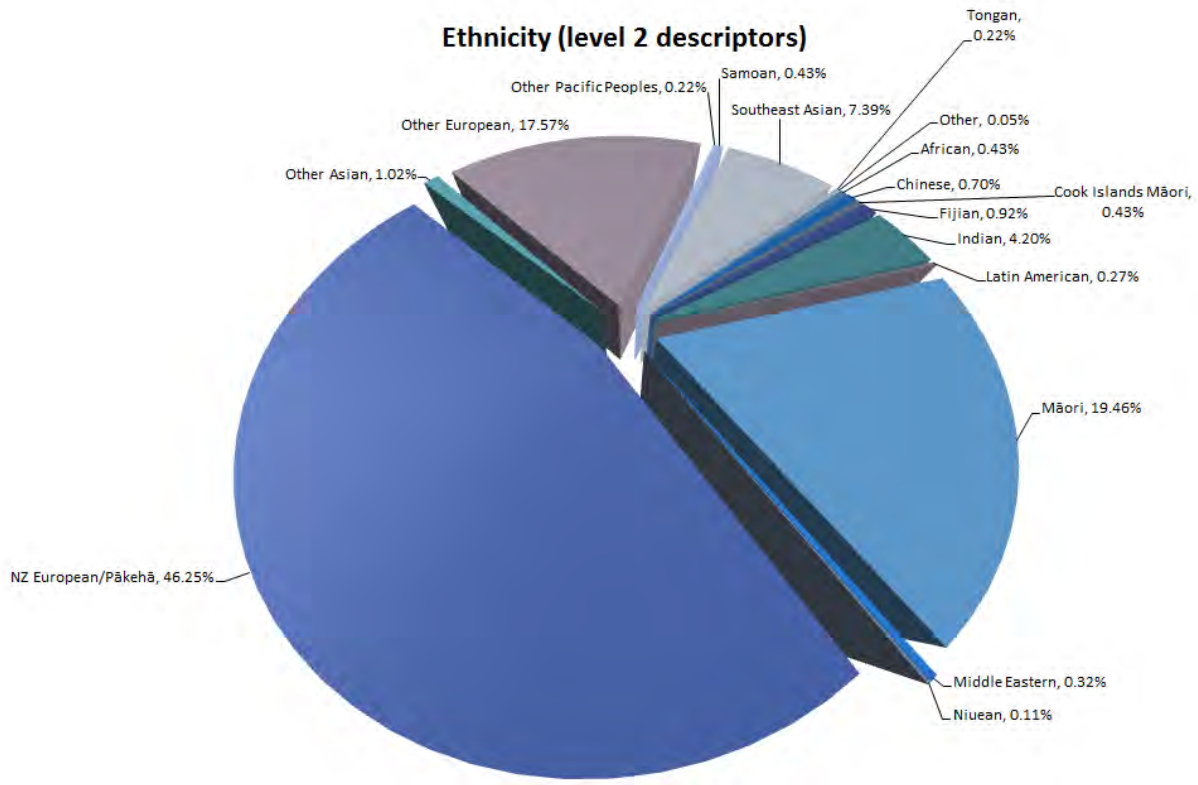
The Lakes DHB workforce is diversely represented with almost 19.5% identifying themselves as New Zealand Māori (a slight increase on last year), 2.32% as Pacific Island origin and 46.25% as being New Zealand European (a decrease of almost 2% on last year).

The age profile has remained reasonably static with less than 1% under 20, 14.9% between 20 and 29, 21.9% between 30 and 39 years. 22.2% of employees are aged between 40 and 49 years, 24.25% between 50-59 years, 14.2% between 60-69 years of age and 1.8% are 70 and over.





*Nb. all figures and graphs are based on DHB headcount of all employees including permanent full-time and part-time, fixed term, casual, employees on leave.



Lakes DHB continues to utilise 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. Disability awareness training (e-learning and classroom style) is provided throughout the year to employees. Lakes DHB has an under reported disabled workforce and as such, data has not been included in this report.

Lakes DHB, in conjunction with employees and unions, works 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 Diversity Works 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. The DHB has policies that encourage a diversity and inclusion approach, and retaining the principles of equal employment opportunities.

Māori Health Workforce Participation/Papa Pounamu

It is recognised that achieving health equities for our Maori population (a strategic and aspirational goal of the Lakes DHB) will include a higher representation of Maori across the professional groups within health. Lakes DHB is working towards six key targets agreed nationally with strategies being developed within the Maori Health team and Te Manawa Taki Regional Equity Plan to achieve these within the timeframes specified.

The six targets are split into three areas: growing the Maori workforce to reflect Maori population proportionality; cultural competence realised for clinical staff, the Board and staff that have direct patient contact; measurement and reporting of recruitment and retention of Maori staff.

The immediate targets to be met, such as recording, recruitment initiatives and retention reporting have all been implemented, and the longer term targets to be met by 2030 and 2040 (being related to workforce proportionality) are gradually improving.

Occupational Group	Māori Workforce
Management & Admin	23.87%
Allied & Technical	19.53%
Medical	6.22%
Support	48.15%
Nursing & Midwifery	18.13%
Total	19.46%

In respect to increasing Māori workforce participation, strengthening cultural competency and processes to Māori health equity:

- All Māori applicants who meet the minimum criteria of a position are shortlisted and interviewed
- Inclusion of cultural safety questions as standard practice within the organisational interview questionnaires
- Māori representation on interview panels
- Access to Māori health prospective tool kit if Māori representatives are not available to attend interviews
- Scope for inclusion of local hapu & iwi to be involved in interview panels
- Scope for candidates to bring support people and whakatau process followed if required
- Priority given to candidates who meet role criteria that can whakapapa to our region or who are fluent in Te Reo or exemplify great cultural competency/willingness
- Māori health presentation at organisational orientation providing an overview of their service and their role within the organisation
- Access/links to Māori health team provided as part of the recruitment training module
- Māori Health are consulted when the recruitment procedure is up for review
- Institutional racism awareness training
- Te Reo lessons
- Te Reo pronunciation lessons
- Promotion and activities for Māori language week.

The Lakes DHB Te Aka Matua team lead morning karakia and song in the Rotorua hospital atrium which is open to any staff, visitors and patients to attend, further strengthening cultural awareness and promotion within the hospital community. There is a further session in our mental health inpatient unit and a weekly waiata is held in Tāupo hospital.

Gender Pay Gap and Pay Equity

As at 30 June 2021, Lakes DHB's Gender Pay Gap remains at 4% and Ethnic Pay Gaps are Māori 18% (down from 20%), Asian 1% (up from 0% last year) and Pacific 31% (up from 18%). Lakes DHB continues to see some positive shifts in the pay gaps, unfortunately there was an increase for Pacific overall. This negative change appears to be the result of more Pacific peoples entering the regulated workforce as junior staff following completion of studies. As more minorities enter regulated health professions it is positive to see ethnicity and gender mixes in some traditionally gender, age and ethnicity biased

professions. The current gap is due to experience levels in those professions now, in years to come this should lessen as the minority workforces move up the various Multi Employer Collective Agreement (MECA) salary scales into more senior positions and more diversity is introduced at entry level.

MECA's cover most professions across the DHB and within the MECAs the salary scale and steps provide for equity within professions with experience levels determining any pay gap rather than gender or ethnicity.

Aside from pay gap, Lakes DHB is continuing to work through claims from unions regarding pay equity of a number of professions as part of a national process as well as an individual claim.

With the Kia Ora Hauora programme offered within the Midlands, it should be expected to see higher Māori participation in our regulated workforces at an entry level. As such, some spikes of the Māori pay gap are expected as these new employees come in on lower salaries appropriate to their experience level and gradually, as they gain experience, the pay gap will reduce.

Key Elements and Activities

Leadership, Accountability and Culture

Lakes DHB introduced Te Iti Kahurangi in 2020/2021 which reinforces and overarches the Lakes Way. The Lakes Way is about focussing on being leaders in the health field, being sensitive to patient needs culturally and emotionally, 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.

Te Iti Kahurangi promotes professional behaviour and accountability in order to achieve the Lakes Way. The Speaking Up for Patient Safety programme is now a mandatory part of employee orientation, and the second module of this programme Promoting Professional Accountability was rolled out during the latter part of 2020.

Lakes DHB also has a Leadership Capabilities Matrix, to focus all levels of the organisation on agreed leadership behaviours. This matrix incorporates leadership behaviours in daily practice and is supported by definitions and indicators in job descriptions, recruiting for leadership behaviours and reviewing performance on those leadership capabilities. Leadership is not only focussed in formal leadership positions but on the roles staff play in informally leading their colleagues and patients in day to day behaviours.

A staff survey was last conducted with all staff in November 2019 and substantial work was done in the various services on the focus areas. A repeat survey was expected to be completed in 2021 (delayed due to Covid-19 and the Health and Disability Sector Review) to see any gains realised from changes instigated as a result of the 2019 survey and to inform any new areas for focus.

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, employment relations etc.
- Regional 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
- Speak Up for Patient Safety training programme
- Promoting Professional Accountability
- Te Iti Kahurangi
- Addressing bias and discrimination training
- Strengthening cultural competency training.

Recruitment, Selection and Induction

In the period 1 July 2020 to 30 June 2021, more than 4700 job applications were received by Lakes DHB. 431 appointments were made; 108 of those appointments were candidates who identified as Māori (25.1%; 18.6% last year) and 14 candidates appointed identified as Pacific origin (3.2%; 1.7% last year).

Lakes DHB attended the Rotorua Career Expo in May this year. We had a good response with a number of students seeking out information regarding health careers. Due to COVID 19 pandemic lockdowns and hospital staffing shortages the Health Career Seminars were not offered to secondary school students.

Kia Ora Hauora is a Midland DHBs programme, promoting health careers to Māori with the aim of increasing numbers of Māori participating in health training. The Kia Ora Hauora coordinator and administrator roles, based at Lakes DHB, provide staff management and overall coordination of the programme.

Kia Ora Hauora is also supporting new graduates transitioning into employment. "Transition to Mahi" workshops will continue.

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

Work continues with the implementation of the online 'on-boarding' process. This will allow faster access to information and systems required as a successful applicant and new staff member.

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 (as available) on interview panels
- Continuing training opportunities 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 career seminars
- 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 programmes 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 and experience for growth.

To enhance training within a flexible workforce, Lakes DHB has a wide range of e-learning modules available to staff with courses continually under development (clinical and non-clinical). Lakes DHB has recently moved to a new e-learning platform along with several other DHBs.

Lakes DHB has an electronic exit interview system and the feedback and information provided are used to improve work areas.

Activities included:

- Continuing professional development funds (psychologists, sonographers and MRTs)
- Continuing medical education for senior medical officers
- Learning and development training funds
- Nursing and midwifery 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
- Manager's 'orientation' training.

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 consideration of employees' diverse personal circumstances when considering requests for alternative working hours. 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 negatively impact on the work environment or operational requirements.

Lakes DHB has a transition to retirement policy allowing employees to work with their line manager on a retirement plan and potential to work flexibly leading into their retirement.

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"
- Transition to retirement.

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. Please see information on Pay Gaps and Pay Equity above.

Recognition activities included:

- Celebratory Long Service Awards
- Nursing and Midwifery 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 experience untoward behaviour 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 (EAP) and facilitated meetings for employees experiencing workplace relationship issues.

Safe and Healthy Environment

Lakes District Health Board has developed systems and processes to effectively reduce risk of harm or injury from known workplace hazards.

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. Lakes DHB works with the understanding that 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.

BeneFITus is Lakes DHB's healthy workplace programme which encourages and engages employees to actively improve their overall wellbeing. Regular activities and events are facilitated by BeneFITus. To ensure continuous improvement of workplace health Lakes DHB belongs to Toi Te Ora, Public Health WorkWell programme. The WorkWell programme includes a framework with eight focal areas which form the basis of a biennial accreditation process. Lakes DHB has achieved and maintained Gold status (the highest level of achievement) in this accreditation. A Healthy workplace co-ordinator is employed one day per week to ensure the ongoing success of the BeneFITus programme.

Electronic reporting is continuing and has enabled earlier notification and follow-up of any workplace safety concerns or incidents.

Activities included:

- 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 and infection prevention programmes for example, FIT-testing, moving and handling training and workplace assessments
- Online health and safety, moving and handling, electrical and fire safety, infection control and hand hygiene and calm training modules are available to all employees to regularly update their knowledge and understanding
- Employee consultation and support forums in the form of health and safety representation, BeneFITus working group and moving and handling core-trainers. All these employees help facilitate programmes within their specialities
- Fully implemented Healthy Drink and Food Policy
- Breastfeeding accreditation with lactation consultant and a breastfeeding facility available for employees on site
- Provision of a free Employee Assistance Services programme
- Provision of a range of vaccinations for employees, including Covid-19
- Provision of smoking cessation support options for staff
- Pre-employment health screening and ongoing health monitoring of employees
- Onsite mirimiri
- Discounted gym memberships
- Eligibility for in-store purchase discounts within a variety of business within Rotorua.

Conclusion

Lakes DHB is committed to maintaining its good employer status with regular reviews and updating of practice against information available.

Lakes DHB Statement of Performance 2020/21

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 2020/21 are presented according to these three dimensions recognising that these dimensions are based around the following strategic ideas[3].

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 Māori 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

[3] Health targets were a set of national performance measures in place from July 2007 to 30 June 2020, designed to improve the performance of health services.

The health targets have now been replaced by the Health System Indicators, which will be reported on for the 21/22 year due to a delay in implementation.

- 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 28 in the financial section.

Outcome: People are Supported to take Greater Responsibility for their Health

Long Term Impact	**People are supported to take greater responsibility for their health**		
Intermediate Impacts	**Fewer people smoke**	**Reduction in vaccine preventable diseases**	**Improving health behaviours**

Fewer People Smoke

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 1 Percentage of hospitalised smokers offered advice to quit (SS06)	Māori	79.4%	78.7%	95%	80.5%	×
	Non-Māori	78.1%	75.4%	95%	75.7%	×
	Total	78.9%	77.3%	95%	78.6%	×
Output class 1 Percentage of PHO enrolled smokers offered advice to quit (PH04)[4]	Māori	84%	77.6%	90%	63.1%	×
	Non Māori	86%	84.5%	90%	75.7%	×
	Total	80.6%	80.6%	90%	68.4%	×
Output class 1 Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit (CW09)	Māori	88%	89.1%	Progress towards 100%	83.0%	×
	Non-Māori	82%	80.0%	Progress towards 100%	85.5%	✓
	Total	86%	87.2%	Progress towards 100%	83.6%	×

[4] The data covers 12 months ending 30 June 2021 for patients aged 15 to 74 years old.

Significance of the Measure

Reducing smoking uptake and supporting people who smoke to quit are key objectives for improving the health and wellbeing of the population. 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 Māori, 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 motivating people who smoke to quit is given prominence.

Lakes DHB Performance

Lakes DHB has fallen short of the all smoking targets at the end full 2020/21 fiscal year. Within the hospital setting performance was higher for Māori than non-Māori and showed improvement from previous years. However the reverse was true for primary care and pregnant women. Additional effort has been invested to look at ways in which the DHB can improve performance in this area, including mechanisms that allow nurses and other allied health care staff to provide nicotine replacement therapy to people who smoke, additional educational sessions for primary care teams and community-based initiatives to promote quit attempts.

Reduction in Vaccine Preventable Diseases

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 1 Percentage of eight month olds fully immunised (CW05)	Māori	82%	79%	95%	68.9%	×
	Non-Māori	90%	92%	95%	90.2%	×
	Total	86%	86%	95%	79.4%	×
Output class 1 Percentage of the population >65 years who have received the seasonal influenza immunisation (CW05)[5]	High Needs	32%	45%	75%	47.5%	×
	Total	38%	69%	75%	60.1%	×
Output class 1 Percentage of girls (CW05)[6]	Fully immunised	66%	53%	75%	78.2%	✓
	HPV Vaccine	66%	53%	75%	59.3%	×

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.

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

[5] Influenza vaccine runs from March to September every year.

[6] Due to ambiguity of the wording of this measure, we have aligned this with one of 2021-22 Statement of Performance Expectation measures-Rate of HPV immunisation coverage. This year, it has been agreed to report on 5 year old girls that are fully immunised and girls that received full doses of HPV vaccine.

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, as well as through community outreach initiatives.

Lakes DHB Performance

The results for 8-month old immunisation indicate that ongoing effort is required in the community and primary care to reach the childhood immunisation targets. An equity gap is also evident and Lakes DHB continues to focus on reducing this difference. Our drop in performance is due to a number of factors, including difficulty in contacting whānau due to change in address and other contact details; the current health system is difficult for some whānau to access, for a whole range of reasons, and the impact of COVID-19 pandemic. The underlying disparity between Māori and Non- Māori continues to be a key priority for Lakes DHB.

In 2020/21, influenza vaccination was made available for older people in mid-March in an aim to achieve a higher uptake to reduce the risk of COVID 19 respiratory illnesses occurring at the same time as winter influenza outbreak and resulting in an increase in hospital admissions or premature deaths. Whilst Lakes DHB did not meet the target for influenza vaccination the equity gap has narrowed in 2020/21, where vaccination rates for Māori were 59.1%, compared to 61.0% for non-Māori. An evaluation7 of the 2020 campaign found three main strategies made a difference to vaccination rates for Māori: (1) Providers mobilised their services, going into communities to vaccinate whānau. This involved going to where whānau gather or live and bringing whānau to services; (2) Taking a whānau-centric approach. Part of this approach was extending eligibility to all whānau, as opposed to only those over 65 years of age; and (3) focus on building Māori workforce capability and capacity. Lakes DHB is building on these findings in our current immunisation campaigns.

In respect of HPV vaccine, some work is still required to reach the 75% coverage target. Moving forward into 21-22 Lakes DHB have developed a Childhood Immunisation Outreach Action Plan to improve the uptake of childhood immunisations. The goal with this plan is to deliver an immunisation programme, over and above the current primary care system, that increases access to vaccination opportunities for tamariki Māori (6 months - 5 years old) with the aim of increasing vaccination rates to above the national average within 12 months.

[7] Wehipeihana, N., Sebire, K. W., Spee, K. & Oakden, J. (2020). *More than just a jab: Evaluation of the Māori influenza vaccination programme as part of the COVID-19 Māori health response.* Ministry of Health

Improving Health Behaviours

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 1 Percentage of infants who are exclusively or fully breastfed at 3 months (CW06)[8]	Māori			65%	43%	×
	Non-Māori		New measure	65%	60%	×
	Total			65%	53%	×
Output class 1 The number of people participating in the GRx (Green Prescription) programmes[9]	Total	480	382	800	480	×
Output class 1 Reduce the prevalence of gonorrhoea (local measure)[10]	Number of cases	114	107	Decrease	131	×
	Rate per 100,000	104	98	Decrease	119	×

Significance of the Measure

Breastfeeding confers a range of benefits for infant growth and development, and is a key intervention focus for Lakes DHB. Significant resource has been invested in breastfeeding services across Lakes DHB population. The 2020/21 target is 65% of 3 month olds fully or exclusively breastfed. The priority group for breastfeeding services is Māori babies.

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/whānau environment forms a proactive part of the systematic approach to management of Long Term Conditions (LTC) within the health service environment.

Gonorrhoea is a sexually transmitted infection that is common in young people. It is easily treated, but left untreated can result in significant long term health problems including infertility, increased risk of ectopic pregnancy and pelvic inflammatory disease. Safe sexual practices and regular sexual health checks are key steps for the preventing the spread of this infection. Over the past 5 years there has been a steady increase in the prevalence of gonorrhoea across the country.

Lakes DHB Performance

Breastfeeding

The Lakes DHB performance for 3 month old breast feeding fell short of the target for both Māori and non-Māori. However our results for Māori are an improvement in performance from Jul-Dec 2019

[8] The latest available data covers 12 months ending 31 December 2020.
[9] 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.
[10] The latest available data covers 12 months ending 30 June 2020. The data is updated with approximately 6 months lag but this has been extended further due to COVID.

(42%). Support mothers to breastfeed is a priority across a range of service areas, including midwifery care, lactation services, and our newly commissioned kaupapa Māori Hapū Wānanga service. This will remain a priority area for Lakes DHB.

Green Prescription

Lakes DHB fell short of its aspirational target of having 800 people access Green Prescription. However, the majority of clients who engaged with the programme show positive changes in self-reported measures of wellbeing and physical activity.

Gonorrhoea

Lakes DHB, like other areas, have seen a rise in the rates of gonorrhoea this year. Whilst this cannot be completely attributed to deficiencies in service delivery there are some specific challenges for Lakes DHB in the Sexual health space. These include challenges related to equitable access to free sexual health care and limitations to service delivery (staffing and clinic space).

Outcome: People Stay Well in their Homes and Communities

Long Term Impact	**People stay well in their homes and communities**			
Intermediate Impacts	**An improvement in childhood oral health**	**Long-term conditions are detected early and managed well**	**Fewer people are admitted to hospital for avoidable conditions**	**More people maintain their functional independence**

An Improvement in Childhood Oral Health

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 2 Percentage of children (0-4) enrolled in DHB funded dental services (CW03)	Māori	89%	92%	95%	87%	✗
	Non-Māori	111%	107%	95%	104%[11]	✓
	Total	99%	99%	95%	95%	✓
Output class 2 Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (CW03)		21%	31%	5%	18.5%	✗
Output class 2 Percentage of adolescent utilisation of DHB funded dental services (CW04)[12]		47%	63%	85%	51.4%	✗

[11] Results greater than 100% may be due to variation between ethnicity recorded for children on enrolment with oral health service and ethnicity captured for the same population cohort by Statistics NZ and/or divergence between actual local population changes and the Statistics NZ population projections.

[12] The data comes from MoH report on adolescent utilisation for 2020 which covers from 1 January to 31 December 2020.

Significance of the Measure

Good oral health is dependent on many factors including: early contact with community oral health services, reduced risk factors (e.g. poor diet) which has lasting health benefits in terms of improved nutrition and healthier body weight and general wellbeing and access to fluoridated water. Oral health is an integral part of child wellbeing and impacts on nutrition, health seeking behaviour, learning, self-esteem and quality of life.

Māori 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

Overall, Lakes DHB met the 2020/21 Output class 2 target of 95%, with an actual result of 95%, but fell short for Māori (87% actual; 95% target). The DHB has managed to reduce the proportion of children aged 0-12 who are overdue their scheduled dental examination, but not to a 5% threshold. There is also ongoing work needed to increase the proportion of adolescents utilising DHB funded dental services. Lakes DHB is investing in an oral health strategy in 2021/22 to provide clear direction in how to increase performance in this area.

Long-Term Conditions are Detected Early and Managed Well

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 1 Percentage of eligible women (20-69) have a cervical cancer screen every 3 years (PV02)[13]	Māori	76%	73%	80%	61.7%	×
	Non-Māori	78%	76%	80%	74.0%	×
	Total	78%	75%	80%	69.8%	×
Output class 1 Percentage of eligible women (50-69) have a breast screen in the last 2 years (PV01)	Māori	65%	67%	70%	59.4%	×
	Non-Māori	72%	72%	70%	71.4%	✓
	Total	70%	71%	70%	67.9%	×

Significance of the Measure

Screening plays a critical role in ensuring that long term conditions are detected early. In general, earlier detection is associated with better health outcomes. 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 Māori and non-Māori have led to a priority approach for access to screening and reduce the inequality of health outcome for Māori, Pacific and other non-European ethnic groups.

Lakes DHB Performance

Unfortunately performance has dropped this year, for both Māori and non-Māori. However the drop in performance is greater for Māori. Whilst this is likely to be partly related to the COVID-19

[13] Correction: The reporting age range is 25-69 years for the 3 years ending 30 June 2021. National Cervical Screening Programme (NCSP) changed the recommended starting age from 20 to 25 years in November 2019. https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/age-range-change-cervical-screening-1
It has been agreed to report on 25-69 years this year and also this aligns with one of 2021-22 Statement of Performance Expectation measures- Percentage of women (25-69 years of age) who have had a cervical cancer screen completed in the last three years (PV02).

pandemic, we acknowledge that the current system is not performing well for Māori and increased effort is being invested in reversing this trend.

Fewer People are Admitted to Hospital for Avoidable Conditions

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 2/3 Percentage of all Emergency Department presentations who are triaged at levels 4 and 5[14]		47.3%	45.75%	50%	44.1%	✓
Output class 1 Percentage of eligible population who have had their B4 School checks completed	High Needs	100%	68%	95%	100.9%[15]	✓
	Total	100%	74%	95%	95.8%	✓
Output class 2/3 Hospitalisation rates per 100,000 for acute rheumatic fever (CW13)[16]		4.3	4.1	Reduce by two thirds	5.1	✗

Significance of the Measure

Emergency departments are set up to address health issues that require urgent specialist care. Triage categories 4 and 5 are not critical and in many cases, but not all, may have been better addressed in Primary Care.

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/whānau from birth to five years. It assists families/whānau to improve and protect their children's health. The Lakes DHB Public Health Nursing and Screening Service co-ordinates the B4 School programme and works with Tipu Ora, Plunket Rotorua and the Pinnacle Midlands Health Network to provide the service to Lakes DHB four-year-olds.

Lakes DHB Performance

Lakes DHB has met the ED target for 2020/21 and has continued to see a downward trend in the proportion of patients presenting to ED who are triaged at levels 4 and 5. This is, in part, reflective of the work that the DHB and PHOs have undertaken to reduce acute demand.

Lakes DHB performance in the completion of B4 School Checks had dropped in 2019/20, largely due to the COVID-19 pandemic. However results have improved this year, especially for our high needs population.

The hospitalisation rate for Rheumatic fever has increased this year. However small changes in case numbers can see the rate fluctuate widely. Lakes DHB continues to strengthen and primary and secondary prevention programmes aimed at reducing the adverse effects of rheumatic fever.

[14] This reports on all ED presentations at both hospitals, Rotorua and Lakes, regardless of patient domicile.
[15] Results greater than 100% may be due to a slight different period covered by numerator and denominator. Checks Completed to Date covers report period between 8 July 2020 and 7 July 2021 whereas Eligible Population is based on financial Year.
[16] This output is now reporting on the first episode rheumatic fever hospitalisation rate. The data is sourced from Ministry of Health. The change in methodology is to report results from central data source that is more reliable especially it being a small figure. The result for 2019/20 is not available as the number of first episode rheumatic fever hospitalisation events was less than 4 , in which case the number is too small to produce a reliable estimate of rate. For reference, the result for 2018/19 was 6.1.

More People Maintain their Functional Independence

Output Description	2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 4 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%	✓

Significance of the Measure

With knowledge and support vulnerable groups of people can build their resilience and become less dependent on funded services. The incidence of chronic medical conditions and age related conditions such as dementia, increase the demand for hospital, community and residential support services particularly in the last 3 – 4 years of life. The increase in the proportion of the population in the over 75 age group over the next 10 to 15 years highlights 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 and reduce risk of increasing loss of independent function.

Using standardised international comprehensive needs assessment tools (interRAI), increasing the range of home and community support services, along with access to health professionals following an acute event are initiatives all aim to minimise avoidable hospital admissions / readmissions, long length of hospital stays and life changing deconditioning.

Lakes DHB Performance

Comprehensive Assessment

Access to long term support services continues to be based on the comprehensive clinical assessment tool (interRAI) used by Lakes Needs Assessment Service Co-ordination service and Age Related Residential Care providers. This assessment tool identifies the key clinical risk factors for an older person and supports the development of care plans, including referrals to other older people related health professionals. The national requirement that all older people who seek to access home based support will have had an interRAI geriatric needs assessment before services are planned and provided is achieved in Lakes. All residents in Age related Residential care services are reassessed within 6 months also continues to be close to 100%.

Lakes Specific Approach to Improving InterRAI Assessment Rates in Māori

Nationally it is a recognised equity issue that Māori is underrepresented in the interRAI data base. We are currently working with TAS to run a project of using trained Kaiāwhina to assist in delivery of an InterRAI self-assessment tool to older Māori. The tool is part of the international suite of interRAI tools, and designed to assess early stage support needs. The project team is working to convert the tool for delivery as korero between Kaiāwhina and client that uses language structured in Te Ao Māori view. Information captured is then entered into the interRAI dataset and used to inform needs and establish care plans. The entirety of the data set captured over the project period will inform better understanding of needs and care planning for older Māori populations.

Outcome: People Receive Timely and Appropriate Specialist Care

Long Term Impact	**People receive timely and appropriate care**			
Intermediate Impacts	People receive prompt and appropriate acute and arranged care	People have appropriate access to elective services	Improved health status for people with a severe mental health illness and/or addiction	More people with end-stage conditions are appropriately supported

People Receive Prompt and Appropriate Acute and Arranged Care

Output Description	2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 3 Faster Cancer Treatment – proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of diagnosis (SS01)	95%	85%	85%	91.6%	✓
Output class 3 Acute inpatient length of stay	2.3 days	Measure removed by MoH	Maintain	3.0 days	×
Output class 3 Inpatient average length of stay (elective)	1.4 days	Measure removed by MoH	Maintain	1.9 days	×
Output class 3 Acute re-admission rate	12.3%	12.4%	Reduce	12.6%	×

Significance of the Measure

Intensive assessment and treatment services are delivered by a range of specialists providers in a range of health care settings. The metrics in this measure show our performance of how quickly people diagnosed with cancer receive their first cancer treatment. Shortening hospital stay (measured by length of acute and arranged inpatient stay), whilst ensuring people receive sufficient care to avoid hospital readmission, provides and indicator of hospital productivity. Improving hospital productivity can be achieved through freeing up beds and other resources so that the DHB can provide more elective procedures and reduce the length of stay in ED.

Lakes DHB Performance

Fast Cancer Treatment SS01 - 31 day indicator

Lakes DHB continued to work with the National Cancer Control Agency, Te Aho o Te Kahu on various Cancer Improvement activities with an focus on improving equity in the cancer services. A review of Lakes chemotherapy services was undertaken and recommendations were added to the annual plan for 2021/22.

Acute Inpatient Length of Stay

Given the increased pressures around acute demand and Emergency Department (ED) presentations, the hospital occupancy was high in 2020/21, with the increased pressures around acute demand and ED presentations.

The Ministry National Collections (NNPAC and NMDS) remain the key source of official reporting for understanding performance and trends, but Lakes DHB has been working with MoH in the process of programme of work around acute demand across the health system flow and hospital discharges.

Lakes DHB Provider Arm has been managing the daily operation effectively and efficiently via advance winter and summer bed planning, regular operation meeting to make changes to address more nebulous challenges or issues, minimising planned cancellations of theatre lists when there is large amount of sickness in theatre, etc.

While these were in place for Lakes district, increase in complexity and patient presentations were consistent around the country including at our hospitals. We plan to use CCDM more efficiently through Hospital At A Glance (HaaG) which had increased transparency of daily staffing and needs using real-time data.

For acute surgical patients, we will focus on reduction in pre-surgery length of stays for acutes, increasing number of acute arrange admissions, increase in Average WIES per theatre session per specialty, optimise early finishes and late starts, improve turnover and turnaround times.

Also, Lakes DHB is a small-medium sized DHB but we operate three large MIFs which takes many nurses out of the system. We have an uncharacteristically large number of vacancies but have a nursing recruitment project to work on this. RSV and RSV-like patients have added strain to the hospital capacity as well as other respiratory illness. Overall, acute length of stay was effectively and proactively managed despite the increased pressures.

Inpatient Average Length of Stay

While each hospital may have different standards to identify long-stay patients, it should typically be based on determining the number of days beyond the patient's expected length of stay as defined by their diagnosis related group (the presumptive diagnosis), and the physician's plan of care. Weekly length of stay patient lists are generated for meetings with the Service Manager and Clinical Nurse Managers.

Patients with complex discharge requirements such as those who are medically fit but challenged by social issue(s) or Aged Care availability, have discharge plans developed through regular meetings with the Funder Arm, Service Manager representatives, and Aged Care facility managers to maintain communication and improve patient outcomes.

Acute Readmission Rate

There was a 0.2% increase in the acute readmission rate since 2019/20 due to points explained above. For the upcoming year, we will focus on documented process for all acute flows including increased usage of Arranged Acutes; extension of operating hours for acute anaesthetics (evening anaesthetist will be on shift in evening and not covering ICU), documented process for all elective flows, for example preventing cancellations; list selection and optimisation to avoid early finishes.

These will be implemented through regular Theatre Performance Group meetings, reviewing data and actions. Lakes DHB has joined Health Round Table Surgical Journey programme, to enhance the visibility of data and performance.

Health Round Table data has highlighted the common hospital acquired infection data, and we will discuss nursing lead initiatives to improve these in 2021/22. Clinical Pharmacists are actively reviewing patients in medical wards to utilise Medical Reconciliation for all patients, and the shift from Lakes Clinical Work Station, to the Midland Clinical Portal will enhance electronic Transfer of Care (eTOC) upon discharge, and improve the handover communication from secondary care to primary care.

People Have Appropriate Access to Elective Services

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 3 Percentage of patients waiting longer than four months for their first specialist assessment		8.2%	4.6%	Nil	0.5%	✗
Output class 3 Number of Planned Care initiatives[17]		4519	Not Available	4726[18]	7,775	✓
Output class 3 Did-not-attend percentage for outpatient clinics	Māori	15.3%	16.0%	10%	15.1%	✗
	Non-Māori	5.2%	5.0%	10%	4.4%	✓
	Total	8.7%	9.0%	10%	7.9%	✓

Significance of the Measure

Access to Planned Care (elective services) for the Lakes population as early as possible improves our communities' overall wellbeing. To enable more elective procedures, Lakes has had to deliver higher volumes of first specialist assessments and follow up clinics as well as having the qualified quality staff in order to deliver these targets. This has been a challenge for Lakes DHB over several years with a number of specialist positions not being recruited to. Where specialist treatment lay outside of the secondary skill set of our DHB, appropriate referrals were made to tertiary hospitals.

Planned Care relates to provide services that are based on clinical need, as well as people's preferences, to achieve better health and wellbeing outcomes within the resources available. Planned care includes medical and surgical activity that is not limited to just hospital settings (such as early intervention musculoskeletal programmes and minor surgical procedures).

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. Whilst the majority of both Māori and non-Māori attend their outpatient appoints the rates of non-attendance have been higher for Māori.

Lakes DHB Performance

Lakes DHB has made significant progress, despite workforce challenges, in reducing the proportion of patients waiting more than four months for their first specialist appointment (from 8.2% in 2019/20 to just 0.5% in 2020/21). However as noted in the table above, the target was not achieved.

Lakes DHB also fell short of reaching its target for non-attendance in outpatient clinics (10%) for Māori. There has been little change over the past three years for Māori non-attendance rates, but this issue remains a priority for the DHB. Projects are underway to address the inequity.

[17] 2020/21 result reflects Inpatient Surgical Discharges, Minor procedures and Non-surgical interventions for the year.
[18] This target was set for Inpatient Surgical Discharges only. The target for total planned care is 7,103.

Targets were met for the number of planned care initiatives delivered and overall outpatient non-attendance rates were below the 10% acceptable threshold.

Improved Health Status for those with Severe Mental Illness and/or Addictions

Output Description			2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 3 Short Term Clients Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (MH03)[19]	Mental Health	0-19 yrs	52%	52%	80%	57.3%	✗
		20-64 yrs	51%	51%	80%	66.1%	✗
		65+ yrs	78%	75%	80%	81.8%	✓
	Addictions	0-19 yrs	100%	99%	80%	97.9%	✓
		20-64 yrs	91%	88%	80%	92.0%	✓
		65+ yrs	80%	94%	80%	100.0%	✓
Output class 3 Average length of acute inpatient stays			15.3 days	14 days	Decrease	12 days	✓
Output class 3 Rates of post-discharge community care			47.2%	58.6%	Increase	64.3%	✓

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

Lakes DHB has demonstrated improvement in performance of these mental health indicators. Targets were surpassed for addiction services, but not achieved for the mental health services for those under the age of 65 years.

Lakes DHB's average length of stay for acute inpatient stays reflects the increasing acuity and challenges with finding suitable post discharge accommodation. However Lakes DHB has met the targets of reducing the length of inpatient stay and increase the rates of post-discharge community care. The DHB continues to proactively work on further improvement in these measures.

[19] The latest available data covers 12 months from April 2020 to March 2021.

Support Services

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 2 Radiology - Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks (SS07)	CT	89%	74%	95%	83.4%	✗
	MRI	67.5%	61%	85%	86.3%	✓
Output class 2 Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes:	Category 1: Within 24 hours	100%	100%	100%	100%	✓
	Category 2: Within 96 hours	100%	98%	100%	93%	✗
	Category 3: Within 72 hours	98%	100%	100%	100%	✓
Output class 2 Number of community pharmacy prescriptions[20]		1.58 million	1.65 million	-	1.85 million	-

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.

Laboratory services play an important role diagnosis and management of disease. Timely completion and communication of results to practitioners is critical for patient care and outcomes.

Pharmacy services play a key role in the prevention and management of long-term conditions.

Lakes DHB Performance

The total Radiology production had increased with the service achieving compliance in March for CT (95% receiving CT scans in 6 weeks or less) and MRI (90% receiving MRI scans in 6 weeks or less). Full recovery was achieved in 2020/21 and majority of the referrals were seen within the intended wait time for all population at Lakes DHB.

There has been an approximate 12% increase in the number of community pharmacy prescriptions, which, in part, reflects the population increase.

[20] This is the total number of pharmaceutical items dispensed in the community for Lakes residents.

Percentage of population aged 12 and over who have received COVID vaccination[21]

Output Description		2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual	Achieved
Output class 1 [22] Percentage of population aged 12 and over who have received COVID vaccination	Māori	N/A	N/A	90%	7%	✗
	Non-Māori			90%	17%	✗
	Total			90%	14%	✗

[21] Additional Data as requested by Audit NZ

[22] This measure looks at eligible population who have received double doses. The low % intake as at 30 June 2021 is due to the fact that NZ's COVID-19 vaccination rollout began in 20 February 2021

Implementing the COVID-19 vaccine strategy

Vaccine doses administered by DHB DHB of service	Dose 1	Dose 2	Total
Lakes	20,559	13,789	34,348

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 4) DHB of residence	Proportion fully vaccinated (note 1)
Lakes	**15.34%**

Vaccine doses administered by age group (note 4) Age range (years)	Dose 1	Dose 2	Total
12 to 15	1	0	1
16 to 19	231	146	377
20 to 24	571	404	975
25 to 29	788	596	1,384
30 to 34	851	671	1,522
35 to 39	826	621	1,447
40 to 44	828	647	1,475
45 to 49	1,000	767	1,767
50 to 54	1,253	903	2,156
55 to 59	1,546	1,091	2,637
60 to 64	1,724	1,084	2,808
65 to 69	2,892	1,749	4,641
70 to 74	3,185	1,950	5,135
75 to 79	2,207	1,339	3,546
80 to 84	1,460	971	2,431
85 to 89	742	503	1,245
90+	454	347	801
Total	**20,559**	**13,789**	**34,348**

Eligible population fully vaccinated by age group (note 4) Age range (years)	Proportion fully vaccinated (note 1)
12 to 15	–
16 to 19	2.64%
20 to 24	6.29%
25 to 29	7.53%
30 to 34	8.74%

35 to 39	9.31%
40 to 44	9.64%
45 to 49	10.30%
50 to 54	12.34%
55 to 59	14.06%
60 to 64	15.68%
65 to 69	28.83%
70 to 74	36.67%
75 to 79	37.77%
80 to 84	44.12%
85 to 89	39.69%
90+	52.04%
Total	**15.34%**

Vaccine doses administered by ethnicity (note 4)			
Ethnicity	Dose 1	Dose 2	Total
Asian	1,598	1,264	2,862
European or other	14,687	9,804	24,491
Māori	3,619	2,316	5,935
Pacific peoples	427	248	675
Unknown	228	157	385
Total	**20,559**	**13,789**	**34,348**

Eligible population fully vaccinated by ethnicity (note 4)	
Ethnicity	Proportion fully vaccinated (note 1)
Asian	20.58%
European or other	18.37%
Māori	8.43%
Pacific peoples	12.22%
Unknown	20.50%
Total	**15.34%**

Vaccine doses administered by sequencing group (note 4)			
Sequencing group (note 3)	Dose 1	Dose 2	Total
Group 1	1,947	1,637	3,584
Group 2	7,869	6,915	14,784
Group 3	9,396	4,786	14,182
Group 4	1,347	451	1,798
Total	**20,559**	**13,789**	**34,348**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: Pages 68 to 70 outline the information used by the Lakes DHB to report on its Covid-19 vaccine coverage. Lakes DHB uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out below. There would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The table on the following page highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2021. People are included if they were alive as at 30 June 2021, were 12 years of age as of 30 June 2021, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2021 calendar year. There are other data sets that estimate the total number of people in New Zealand.

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

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

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

The total population estimate based on HSU as at 30 June 2021 is 114,431. This is 3,059 below the Stats NZ total projected population of 117,490 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

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

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

Total population	HSU	Stats NZ	Difference
Māori	39,982	43,700	(3,718)
Pacific	2,935	2,940	(5)
Asian	7,995	10,150	(2,155)
Other	63,519	60,700	2,819
Total	114,431	117,490	(3,059)

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

Note 4: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

Statement of Responsibility for the Year Ended 30 June 2021

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 2021 fairly reflect the financial position and operations of Lakes District Health Board.

Board Member

Date: 27 June 2022

Board Member

Date: 27 June 2022

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 2021

The Auditor-General is the auditor of Lakes District Health Board Group (the Group). The Auditor-General has appointed me, J R Smaill, 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 appropriations, of the Group on his behalf.

We have audited:

- the financial statements of the Group on pages 80 to 128, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expenses, 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 31 to 37 and 54 to 72.

Opinion

In our opinion:

- the financial statements of the Group on pages 80 to 128, which have been prepared on a disestablishment basis:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2021; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Group on pages 31 to 37 and 54 to 72:
  - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2021, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriations; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed late

Our audit was completed on 27 June 2022. This is the date at which our opinion is expressed. We acknowledge that our audit was completed later than required by the Crown Entities Act 2004, section 156(3)(a). This was due to the consequential effects of Covid-19, including lockdowns on the Group and an auditor shortage in New Zealand.

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

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 85 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, comes into effect on 1 July 2022. The Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 16 on pages 111 and 112 outlines that the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Group has estimated a provision of $12.57 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

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

Pages 69 to 72 outlines the information used by the Group to report on its Covid-19 vaccine coverage. The Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 71 and 72. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 32 on pages 126 to 128 of the financial statements outlines the impact of Covid-19 on the Group. We draw specific attention to note 10 on page 102 which outlines that there is a significant valuation uncertainty in estimating the fair value of the Group's land and buildings due to Covid.

Basis for our opinion

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

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

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

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

The Board 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 it determines 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. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the 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 disestablishment basis of accounting by the Board.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

- We obtain sufficient appropriate audit 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 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 governing body is responsible for the other information. The other information comprises the information included on pages 1 to 31, 38 to 53, 73 and 129, 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: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

J R Smaill
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand


Northern Lakes
Southern Lakes
Lake Rotoma
Mourea
Ngongotaha
Rotoiti
Mamaku
Rotorua
Te Wairoa
Reporoa
Mangakino
Whakamaru
Kaingaroa Forest Village
Orakei Korako
Murupapa
Minginui
Wairakei
Kinloch
Acacia Bay
Taupo
Kurutau
Waitahanui
Tokaanu
Waitetoko
Te Rangiita
Turangi
Whakapapa Village

Financial Statements

Statement of Comprehensive Revenue and Expense for the Year Ended 30 June 2021

	Notes	Lakes DHB Group Budget 2021 $000	Lakes DHB Group Actual 2021 $000	Lakes DHB Group Actual 2020 $000
Revenue				
Patient care revenue	2(i)	441,549	458,548	420,218
Other revenue	2(ii)	13,452	13,631	4,828
Finance revenue	3	210	193	288
Total revenue		455,211	472,372	425,334
Expenditure				
Personnel costs	4	149,152	153,394	145,611
Depreciation and amortisation expense	10, 11	13,297	12,224	12,035
Outsourced services		17,989	21,812	18,088
Clinical supplies		33,516	36,421	31,849
Infrastructure and non-clinical expenses		19,719	23,295	18,861
Other district health boards		55,894	55,881	53,677
Non-health board provider expenses		156,470	163,947	149,859
Capital charge	5	8,671	7,005	9,189
Finance costs	3	21	115	225
Other operating expenses	6	2,363	1,514	969
Total operating expenditure		457,092	475,608	440,363
Share of associate/joint venture surplus/(deficit)	12	0	244	(14)
SURPLUS/(DEFICIT) BEFORE TAX		(1,881)	(2,992)	(15,043)
Income tax expense		0	0	0
SURPLUS/(DEFICIT) AFTER TAX		**(1,881)**	**(2,992)**	**(15,043)**
OTHER COMPREHENSIVE REVENUE AND EXPENSE				
Gains on property revaluations	18	13,499	57,816	0
Total other comprehensive revenue and expense		**13,499**	**57,816**	**0**
TOTAL COMPREHENSIVE REVENUE AND EXPENSE		**11,618**	**54,824**	**(15,043)**

Explanations of significant variances against budget are detailed in note 29

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

Statement of Changes in Equity for the Year Ended 30 June 2021

	Notes	Lakes DHB Group Budget 2021 $000	Lakes DHB Group Actual 2021 $000	Lakes DHB Group Actual 2020 $000
BALANCE AT 1 JULY		144,323	144,314	159,667
Prior year adjustments		525		
Capital contribution from the Crown		12,803		
- Other contributions			60	0
Repayment of capital to the Crown		(301)	(301)	(301)
Total comprehensive revenue and expense		11,618	54,824	(15,043)
Prior year adjustment			(10)	(9)
BALANCE AT 30 JUNE	18	**168,968**	**198,887**	**144,314**

Explanations of significant variances against budget are detailed in note 29

Statement of Financial Position as at 30 June 2021

	Notes	Lakes DHB Group Budget 2021 $000	Lakes DHB Group Actual 2021 $000	Lakes DHB Group Actual 2020 $000
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	7	0	12,328	10,565
Receivables	8	13,428	17,549	12,487
Prepayments		2,117	1,550	1,280
Inventories	9	2,810	2,700	2,673
Other financial assets	13	500	500	500
TOTAL CURRENT ASSETS		18,855	34,627	27,505
NON - CURRENT ASSETS				
Prepayments		609	1,518	346
Property, plant and equipment	10	197,146	231,171	176,809
Intangible assets	11	11,685	3,720	4,812
Investments in joint ventures	12	443	673	429
TOTAL NON - CURRENT ASSETS		209,883	237,082	182,396
TOTAL ASSETS		**228,738**	**271,709**	**209,901**
LIABILITIES				
CURRENT LIABILITIES				
Bank overdraft	7	14,090	0	0
Payables	14	19,194	32,012	27,432
Employee entitlements	15	8,742	23,732	21,694
Provisions	16	12,697	12,571	10,748
Borrowings	17	528	529	657
			-	
TOTAL CURRENT LIABILITIES		55,251	68,844	60,531

	Notes	Lakes DHB Group Budget 2021 $000	Lakes DHB Group Actual 2021 $000	2020 $000
NON CURRENT LIABILITIES				
Employee entitlements	15	3,523	2,982	3,557
Borrowings	17	996	996	1,499
TOTAL NON CURRENT LIABILITIES		4,519	3,978	5,056
TOTAL LIABILITIES		**59,770**	**72,822**	**65,587**
NET ASSETS		**168,968**	**198,887**	**144,314**
EQUITY				
Crown equity	18	84,494	71,751	71,984
Other reserves	18	115,610	159,926	102,110
Retained earnings/(losses)	18	(31,959)	(33,653)	(30,619)
Trust funds	18	823	863	839
TOTAL EQUITY		**168,968**	**198,887**	**144,314**

For and behalf of the Board

Board Member

Date: 27 June 2022

Board Member

Date: 27 June 2022

Explanations of significant variances against budget are detailed in note 29

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

Statement of Cash Flows for the Year Ended 30 June 2021

	Notes	Lakes DHB Group Budget 2021 $000	Lakes DHB Group Actual 2021 $000	2020 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and patients		455,025	469,548	430,341
Interest received		120	133	338
		455,145	469,681	430,679
Cash was applied to:				
Payments to suppliers		288,458	302,379	271,722
Payments to employees		157,469	150,108	138,201
Interest paid		71	115	343
Distribution to owners: capital charge		8,818	7,005	9,189
GST (net)		(322)	(229)	(222)
		454,494	459,378	419,233
Net cash flows from operating activities		651	10,303	11,446
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of property		0	74	514
		0	74	514
Cash was applied to:				
Purchase of property, plant and equipment		17,099	7,814	3,641
Purchase of (proceeds from) intangible assets		6,838	(71)	2,731
		23,937	7,743	6,372
Net cash flows from investing activities		(23,937)	(7,669)	(5,858)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds from finance lease liabilities		0	0	0
Proceeds from shareholder capital injection		12,800	0	0
Cash was applied to:				
Repayments of shareholder capital		301	241	301
Repayments of finance lease liabilities		631	630	732
Net cash flows from financing activities		11,868	(871)	(1,033)
Net increase/(decrease) in cash, and cash equivalents		**(11,418)**	**1,763**	**4,555**
Cash and cash equivalents at beginning of year		(2,672)	10,565	6,010
Cash and cash equivalents at end of year	**7**	**(14,090)**	**12,328**	**10,565**

The budget cash and cash equivalents closing balance includes an overdraft which is included in the above figures. Explanations of significant variances against budget are detailed in note 29.

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

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

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Surplus/(deficit) after tax	(2,992)	(15,043)
Add/(less) non-cash items:		
Depreciation and amortisation expense	12,224	12,035
Share of associate and joint venture (surplus)/deficit	(244)	14
Impairment of prepayments	(659)	86
(Gains)/losses in fair value of investment property	0	0
(Gains)/losses on derivative financial instruments	0	(118)
Net foreign exchange (gains)/losses	0	0
	11,321	12,017
Add/(less) items classified as investing or financing activity:		
Net loss(gain) on disposal of property, plant and equipment	(8)	(30)
	(8)	(30)
Add/(Less) movements in working capital items:		
(Increase)/Decrease in debtors and other receivables	(5,791)	1,888
(Increase)/Decrease in inventories	(27)	37
Increase/(Decrease) in creditors and other payables	4,514	5,159
Increase/(Decrease) in employee entitlements	1,463	7,418
Increase/(Decrease) in provisions	1,823	0
	1,982	14,502
Net cash inflow/(outflow) from operating activities	**10,303**	**11,446**

1. Statement of Accounting Policies

Reporting Entity

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

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

The group consists of Lakes DHB, its subsidiary, Spectrum Health Limited (100% owned), in substance subsidiary, The Lakes District Health Board Charitable Trust, and jointly controlled entities HealthShare Limited (20% owned), and 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 generally accepted accounting practice (NZ 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 a disestablishment basis. The accounting policies have been applied consistently throughout the year. The financial statements have also 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.

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 15 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

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

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.

Where judgements or estimations could significantly affect the amounts recognised in the financial statements the details of this are highlighted in red in the notes they relate to.

Reporting Period

The reporting period for these financial statements is the financial year ended 30 June 2021.

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:

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash exchanges. This amendment is effective for annual periods beginning on or after 1 January 2021, with early adoption permitted. The Lakes DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Lakes DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2022. Lakes DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. Assessment will be completed for 2021/22 reporting.

Changes in Accounting Policies

There have been no accounting policy changes in the 2021 financial statements when compared to 2020.

Software-as-a-Service (SaaS) arrangements

In April 2021, the International Financial Reporting Interpretations Committee (IFRIC) published an agenda decision on accounting for configuration and customisation costs incurred in implementing SaaS. The IFRIC concluded that SaaS arrangements are service contracts providing the customer with the right to access the SaaS provider's application software over the contract period. Costs incurred to configure or customise software in a cloud computing arrangement, can be recognised as intangible assets only if the activities create an intangible asset that the entity controls and the intangible asset meets the recognition criteria.

Some of these costs incurred are for the development of software code that enhances or modifies, or creates additional capability to, existing on-premises systems and meets the definition of and recognition criteria for an intangible asset. These costs are recognised as intangible software assets and amortised over the useful life of the software on a straight-line basis. The useful lives are reviewed at least at the end of each financial year, and any change accounted for prospectively as a change in accounting estimate. Costs that do not result in intangible assets are expensed as incurred unless they represent payment for future services to be received. In which case a prepayment is initially recognised and then expensed as those subsequent services are received. The New Zealand Accounting Standards Board has not issued similar guidance, however, in the absence of a public benefit entity (PBE) standard specifically dealing with such costs, Lakes DHB considers the IFRIC decision relevant to the accounting for similar types of arrangements in accordance with PBE IPSAS 31 Intangible assets.

Lakes DHB has not performed a SaaS assessment as at 30 June 2021, as prescribed by the IFRC agenda decision. Lakes DHB will perform a robust assessment as at 30 June 2022.

Significant Accounting Policies

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

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.

At the date that these financial statements were approved by the Board the financial statements of the Lakes District Health Board Charitable Trust were unaudited. The unaudited results of the Lakes District Health Board Charitable Trust are included in the consolidated financial statements of the Lakes DHB.

Foreign Currency

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, using accounting policies that are consistent with those adopted by the board in preparing these financial statements.

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.

Impairment

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.

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.

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.

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.

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 Note 28, 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.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are in respect of:

- Estimating the fair value of land and buildings – refer to note 10.

2. Revenue

Accounting Policy
The specific accounting policies for significant revenue items are explained below.

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 costs for non-Lakes district residents treated within Lakes DHB. An annual wash up occurs at year end to reflect the actual non Lakes district patients treated at Lakes DHB. Inter-district revenue is recognised when eligible services are provided.

Goods Sold and Services Rendered
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 operating leases 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.

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue, unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met, e.g. as the funds are spent for the nominated purpose.

i Patient Care Revenue

	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
MOH Crown appropriation revenue **(1)**	380,184	344,424
Other MOH contract revenue	40,370	40,387
Other Government revenue	7,583	7,481
Inter-DHB revenue	25,025	23,073
ACC revenue	5,386	4,853
Total revenue	**458,548**	**420,218**

(1) Performance against this appropriation is reported in the Statement of Performance. 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 $381,002,089 (2020: $340,400,000).

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.

ii Other Revenue

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Sale of goods	2,037	1,401
Rendering of services	10,759	2,295
Gains Interest Rate Swap	0	118
Donations and bequests received	96	331
Property, plant, and equipment gains on disposal	61	11
Other	678	672
Total other operating revenue	**13,631**	**4,828**

3. Finance Income and Finance Costs

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Finance revenue		
Interest revenue:		
Term and call deposits	193	288
Total finance revenue	**193**	**288**
Finance costs		
Interest expense:		
Interest on finance leases	115	225
Interest on borrowings	0	0
Total finance costs	**115**	**225**

4. Personnel Costs

Accounting Policy

Salaries and Wages

Salaries and wages are recognised as an expense as employees provider services.

Superannuation Schemes

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.

Breakdown of personnel costs and further information	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Salaries and wages	145,544	134,055
Defined contribution plan employer contributions	4,564	4,138
Increase/(decrease) in employee entitlements/liabilities	3,286	7,418
Total personnel costs	**153,394**	**145,611**

Employee Remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

Of the 347 employees shown above, 264 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 654 (2020: 534) compared with the actual total number of 347 (2020: 308).

Salary range	2021 Number of staff clinical and other staff	2020 Number of staff clinical and other staff
$100,001 - $110,000	91	76
$110,001 - $120,000	59	59
$120,001 - $130,000	27	24
$130,001 - $140,000	28	15
$140,001 - $150,000	9	9
$150,001 - $160,000	13	9
$160,001 - $170,000	5	4
$170,001 - $180,000	5	7
$180,001 - $190,000	10	12
$190,001 - $200,000	4	4
$200,001 - $210,000	7	2
$210,001 - $220,000	7	5
$220,001 - $230,000	2	3
$230,001 - $240,000	5	3
$240,001 - $250,000	0	2
$250,001 - $260,000	8	7
$260,001 - $270,000	6	4
$270,001 - $280,000	4	6
$280,001 - $290,000	8	10
$290,001 - $300,000	7	5
$300,001 - $310,000	2	6
$310,001 - $320,000	5	5
$320,001 - $330,000	2	4
$330,001 - $340,000	5	3
$340,001 - $350,000	8	7
$350,001 - $360,000	0	4
$360,001 - $370,000	5	2
$370,001 - $380,000	5	3
$380,001 - $390,000	3	4
$390,001 - $400,000	1	1
$400,001 - $410,000	2	0
$410,001 - $420,000	3	0
$420,001 - $430,000	0	1
$430,001 - $440,000	0	0
$440,001 - $450,000	0	1
$450,001 - $460,000	0	1
$460,001 - $470,000	1	0
Total	347	308

Of the 347 employees shown above, 264 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 624 (2020: 534) compared with the actual total number of 347 (2020: 308).

Board Remuneration

The following people held office as Board members during the twelve months ending June 2021 and the amounts of remuneration were set by the Minister of Health.

	Board Fees 2021 $000	Board Fees 2020 $000
Deryck Shaw - Chair **	0	22
Jim Mather - Chair	50	27
Lyall Thurston - Deputy Chair	26	27
Johan Morreau - Deputy Chair	32	28
Merepeka Raukawa-Tait	22	24
Rob Vigor- Brown	27	25
Desmond Epp **	0	10
Janine Horton	25	25
Christine Rankin	27	26
Stuart Burns **	0	13
Ana Morrison **	0	10
Warren Webber **	0	11
Trudy Ake	24	7
Ngahi Bidois	25	14
Michael Cullen **	0	6
Aroha Morgan	30	6
Lana Ngawhika	25	14
Rees Tapsell	26	14
Total board remuneration	**340**	**309**

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 (2020: Nil).

Non-Board Committee Remuneration

The following people were non-board committee members who received remuneration during the twelve months ended 30 June 2021:

	Committee Fees 2021 $000	Committee Fees 2020 $000
Hospital Advisory Committee		
Te Rau Morgan **	0.0	0.3
Peter Nicholl **	0.0	0.3
Lydia Rickard **	0.0	0.5
Margie Robbie*	1.5	0.0
G Esterman*	1.0	0.0
T Macfarlane	1.5	0.0

	Committee Fees 2021 $000	Committee Fees 2020 $000
Community and Public Health Advisory Committee		
Anahera Pedersen **	0.0	0.5
Anahere Waru **	0.0	0.3
Bev Edlin **	0.0	0.5
Leeanne Karauna **	0.0	0.3
Lorraine Hetaraka **	0.0	0.3
Tania Te Akau	0.8	0.3
Te Rau Morgan **	0.0	0.8
Theresa Chapman **	0.0	0.3
Mary-Louise Barnett *	1.0	0.0
Leanne Karauna*	1.0	0.0
Angela Waru	1.3	0.0
	4.0	3.0

	Committee Fees 2021 $000	Committee Fees 2020 $000
Disability Support Advisory Committee		
Bev Edlin **	0.0	0.3
Mary-Lou Barnett **	0.0	0.5
Sue Westbrook	1.3	0.8
Tania Te Akau	0.8	0.3
Tere Lawson **	0.0	0.3
Theresa Chapman **	0.0	0.3
Ngaterangi Smallman*	0.3	0.0
	2.3	2.3
Total non - board committee remuneration	**10.3**	**6.3**

* Commenced term during 20/21
** Completed term during 20/21

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.

Other 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.

Lakes DHB is a participating employer in the National Provident DBP Contributors scheme ("the Scheme"), which is a multi-employer defined benefit scheme. There are 12-employees under this scheme.

5. Capital Charge

Accounting Policy

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

Further Information

The group pays a capital charge every six months to the Crown. The charge is based on the previous six month actual closing equity balance at 31 December and 30 June. The capital charge rate for the year ended 30 June 2021 was 5% (2020: 6%).

6. Other Operating Expenses

Accounting Policy

Operating Leases/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.

Breakdown of other expenses and further information	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Fees to auditor:		
- fees to Audit New Zealand for audit of the financial statements	151	167
ACC	53	8
Board of director fees (note 4)	208	284
Inventory consumption	71	(213)
Impairment of receivables (note 8)	5	29
Loss on disposal of property, plant, and equipment	69	45
Minimum lease payments under operating leases	830	503
Restructuring expenses	127	146
Total other expenses	**1,514**	**969**

7. Cash and Cash Equivalents

Accounting Policy

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.

Breakdown of other cash and cash equivalents and further information	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Cash at bank and in hand	466	375
Term deposits with maturities less than three months	700	700
Loan to NZHPL	11,162	9,490
Cash and cash equivalents in the statement of cash flows	**12,328**	**10,565**

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

The DHB is party to a DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHPL) and participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2021, this limit was $19.996 million (2020: $18.143 million).

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 $166,086 (2020: $118,415). Further information can be found in Note 17.

8. Receivables

Accounting Policy

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

In measuring expected credit losses, short term receivables have been assessed on an individual basis.

Short term receivables have been written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include bankruptcy, liquidation, receivership and default in payments.

Breakdown of receivables and further information	**Lakes DHB Group**	
	Actual 2021 $000	**Actual 2020 $000**
Current		
Receivables (gross)	17,731	12,706
Less: Allowance for credit losses	(182)	(219)
Total Current	17,549	12,487
Total receivables	**17,549**	**12,487**
Total receivables comprises:		
Receivables from MoH	4,993	5,507
Other receivables	12,556	6,980

Expected Credit Losses

As of 30 June 2021 and 2020, all overdue receivables have been assessed for expected credit losses and appropriate provisions applied, as detailed below:

	Actual 2021 Gross $000	**Actual 2020 Gross $000**
Lakes DHB Group		
Not past due	15,528	12,073
Past due 31 - 60 days	847	347
Past due 61 - 90 days	442	26
Past due > 90 days	914	260
Total	**17,731**	**12,706**

	Actual 2021 Allowance for credit losses $000	**Actual 2020 Allowance for credit losses $000**
Lakes DHB Group		
Not past due	(2)	(7)
Past due 31 - 60 days	0	0
Past due 61 - 90 days	0	(1)
Past due > 90 days	(180)	(211)
Total	**(182)**	**(219)**

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

The expected credit loss 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 2021 $000	Actual 2020 $000
Individual basis	182	219
Collective basis	0	0
Total provision for impairment	**182**	**219**

Expected credit losses have been determined because of the significant financial difficulties being experienced by the debtor. An analysis of these individual credit losses of debtors is as follows:

	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
Past due 1 - 60 days	2	7
Past due 61 - 90 days	0	1
Past due > 90 days	180	211
Total individual credit losses	**182**	**219**

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

	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
At 1 July	219	189
Increase in loss allowance made during the year	164	169
Credit losses reversed during the year	(161)	(134)
Receivables written off during period	(40)	(5)
At 30 June	**182**	**219**

9. Inventories

Accounting Policy

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.

Breakdown of inventories and further information	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
Pharmaceuticals	395	378
Surgical and medical supplies	1,456	1,456
Other supplies	849	839
Total inventories	**2,700**	**2,673**

The amount of inventories recognised as an expense during the year was $36.42 million (2020: $31.85 million) which is included under clinical supplies in the operating expense line of the statement of comprehensive revenue and expenses.

The carrying amount of inventories pledged as security for liabilities is Nil (2020: 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 (2020: Nil). There have been no reversals of write downs (2020: Nil).

10. Property, Plant and Equipment (PPE)

Accounting Policy

Classes of Property, Plant and Equipment

Property, plant and equipment consist of the following asset classes: freehold land, freehold buildings, medical plant and equipment, non-medical plant and equipment, computer equipment, motor vehicles, and leased assets.

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. Where revalued assets are sold, the amounts included in revaluation reserves in respect of these assets are transferred to retained earnings in equity.

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 and the cost can be measured reliably. 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:

- 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 15 to 150 years (0.7% - 6.7%)
- 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.

Leasehold assets are included in the asset classes above so any leased assets are depreciated using the relevant rates above.

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.

Impairment of Property, Plant and Equipment

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.

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.

Critical Accounting Estimates and Assumptions

Valuation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with PBE IPSAS 17, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the treasury for the valuation of hospitals and tertiary institutions.

The most recent valuation of land and buildings was performed by an independent registered valuer, Peter Todd BPA MRICS SPINZ of RS Valuation Limited. The valuation conforms to International Valuation Standards and was based on an optimised depreciation replacement cost methodology. The valuation is effective 30 June 2021.

At the date of the land and buildings revaluation conditions existed to elevate the level of valuation uncertainty. Peter Todd has noted that as a result of the COVID 19 pandemic, market uncertainty has increased. Market risk has also increased due to future uncertainties. The uncertainty due to COVID is significant and therefore the values provided are subject to a wider range of variation than in the past.

Market uncertainty arises when a market is disrupted at the valuation date by current or very recent events such as sudden economic, natural disaster or political crises. The disruption can manifest itself in a number of ways for example either through panic buying or selling or by a loss of liquidity due to a disinclination by market participants to trade. Market uncertainty existed at the time of the land and buildings revaluation due to the Covid-19 pandemic and the related government fiscal and monetary responses.

Market risk is the risk that an asset may lose value over time due to changes in market conditions that occur after the valuation date. The possibility of market conditions changing in the future and the potential for the price of an asset to be affected by those changes is something that is considered by market participants when negotiating a transaction and will be reflected in market prices. Market risk at the date of the revaluation was also elevated due to the uncertainties caused by the Covid-19 pandemic.

Both market uncertainty and market risk affect the estimated fair value of the Lakes DHB's freehold land. They also affect the estimated fair value of the Lakes DHB's building, based on depreciated replacement cost, as these uncertainties and risks impact the costs of building inputs such as materials, labour and financing and therefore building construction costs. While the property valuation estimates have been formed by Peter Todd after careful consideration of these factors, it must be recognised that Covid-19 is a unique situation and critical events that could help determine the duration and depth of its impact were unknown at the date of valuation. The valuation estimates were therefore subject to a wider range of variation than would otherwise have been the case.

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 RS Valuations Limited, and the valuation is effective 30 June 2021.

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 RS Valuations Limited, and the valuation is effective 30 June 2021.

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.

Breakdown of property, plant and equipment and further information

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

	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 2019	11,665	151,513	26,145	3,828	12,241	2,452	10,801	218,645
Additions	0	267	1,717	63	764	215	1	3,027
Disposals	0	0	(1,031)	(25)	(208)	(119)	(537)	(1,920)
PPE Class Transfers	0	48	6	(2)	(97)	(116)	0	(161)
Work in Progress	0	411	0	1	181	0	0	593
Revaluations	0	0	0	0	0	0	0	0
Balance at 30 June 2020	**11,665**	**152,239**	**26,837**	**3,865**	**12,881**	**2,432**	**10,265**	**220,184**
Balance at 1 July 2020	11,665	152,239	26,837	3,865	12,881	2,432	10,265	220,184
Additions		731	3,159	320	1,518	205		5,933
Disposals			(1,818)	(38)	(224)	(397)	(284)	(2,761)
PPE Class Transfers		(40)	(43)	51	(1,627)	5		(1,654)
Work in Progress		326	3,332	31	206	15		3,910
Revaluations	6,885	37,974						44,859
Balance at 30 June 2021	**18,550**	**191,230**	**31,467**	**4,229**	**12,754**	**2,260**	**9,981**	**270,471**

10. Property, Plant and Equipment (PPE) (Continued)

	Freehold land (at valuation)	Freehold buildings (at valuation/	Medical Plant and equipment	Non-Medical Plant and equipment	Computer Equipment	Motor Vehicles	Leased assets	Total
	$000	$000	$000	$000	$000	$000	$000	
Depreciation and Impairment charges								
Balance at 1 July 2019	0	0	(18,187)	(2,588)	(7,944)	(1,580)	(4,117)	(34,416)
Depreciation charge for the year	0	(6,267)	(2,111)	(275)	(1,081)	(155)	(939)	(10,828)
Disposals	0	0	992	24	206	113	534	1,869
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 2020	**0**	**(6,267)**	**(19,306)**	**(2,839)**	**(8,819)**	**(1,622)**	**(4,522)**	**(43,375)**
Depreciation and Impairment charges								
Balance at 1 July 2020	0	(6,267)	(19,306)	(2,839)	(8,819)	(1,622)	(4,522)	(43,375)
Depreciation charge for the year	0	(6,315)	(2,226)	(276)	(1,365)	(191)	(829)	(11,202)
Disposals	0	0	1,776	33	218	384	284	2,695
PPE Class Transfers	0	0	0	0	0	0	0	0
Work in Progress	0	0	0	0	0	0	0	0
Revaluations	0	12,582	0	0	0	0	0	12,582
Balance at 30 June 2021	**0**	**0**	**(19,756)**	**(3,082)**	**(9,966)**	**(1,429)**	**(5,067)**	**(39,300)**
Carrying amounts								
At 1 July 2019	11,665	151,513	7,958	1,240	4,297	872	6,684	184,229
At 30 June 2020	**11,665**	**145,972**	**7,531**	**1,026**	**4,062**	**810**	**5,743**	**176,809**
At 1 July 2020	11,665	145,972	7,531	1,026	4,062	810	5,743	176,809
At 30 June 2021	**18,550**	**191,230**	**11,711**	**1,147**	**2,788**	**831**	**4,914**	**231,171**

Land and buildings valuation basis

Buildings	Actual 2021 $000	Actual 2020 $000
Depreciated replacement cost	190,904	151,513
Historical cost	326	726
Total carrying value of buildings	**191,230**	**152,239**

All freehold land is valued at fair value, based on market-based evidence.

		Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Work in progress			
The closing balances of work in progress by asset class is:	Buildings	0	0
	Computer	427	2,078
	Motor Vehicle	0	0

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 $18,550,000 (2020: $11,665,000).

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 2021, the net carrying amount of leased vehicles was $56,004 (2020: $214,557). 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 2021, the net carrying amount of building leasehold improvements was $3,622,115 (2020: $3,845,552).

Lakes DHB Group leases IT equipment under a finance lease agreement. At 30 June 2021, the net carrying amount of leased IT equipment was Nil (2020: $13,618). 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 2021, the net carrying amount of the medical and non-medical plant and equipment was $1,233,292 (2020: $1,668,043). 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 2021 (2020: Nil).

Capital Commitments

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred. Details of the Lakes DHB commitments are as follows:

	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
Buildings	2,801	618
Computer Plant & Equipment	1,372	897
Medical Plant & Equipment	5,255	1,842
Non Medical Plant & Equipment	219	119
Intangible assets	3,499	3,042
Vehicles	652	209
Investment property		0
Total capital commitments	**13,798**	**6,727**

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

11. Intangible Assets

Accounting Policy

Acquisition

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

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the costs of materials and services, employee costs, and any directly attributable overheads.

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.

Information Technology Share Service Rights

The DHB has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the group's capital investment.

Impairment

Intangibles assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

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%)
Right to access shared services	Indefinite	Nil

Impairment

Refer to the policy for impairment of property, plant, and equipment in Note 10. The same approach applies to the impairment of intangible assets, except for the intangible assets that are still under development.

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

Breakdown of intangible assets and further information

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 2019	13,683	0	13,683
Additions	236	0	236
Disposals	(335)	0	(335)
Work in progress	2,496	0	2,496
Transfer to other classes	(7)	0	(7)
Balance at 30 June 2020	**16,073**	**0**	**16,073**
Cost Balance at 1 July 2020	16,073	0	16,073
WIP Balance at 1 July 2020	0	0	0
Additions	1,021	0	1,021
Disposals	(1,692)	0	(1,692)
Work in progress	537	0	537
Transfer to other classes	(1,629)	0	(1,629)
Balance at 30 June 2021	**14,310**	**0**	**14,310**
Accumulated amortisation and impairment losses			
Balance at 1 July 2019	(10,052)	0	(10,052)
Amortisation expense	(1,208)	0	(1,208)
Impairment losses	0	0	0
Disposals	0	0	0
Transfer from other classes	0	0	0
Balance as at 30 June 2020	**(11,260)**	**0**	**(11,260)**
Balance at 1 July 2020	(11,260)	0	(11,260)
Amortisation expense	(1,022)	0	(1,022)
Impairment losses	1,692	0	1,692
Disposals	0	0	0
Transfer from other classes	0	0	0
Balance as at 30 June 2021	**(10,590)**	**0**	**(10,590)**
Carrying amounts			
At 1 July 2019	3,631	0	3,631
At 30 June 2020	**4,812**	**0**	**4,812**
At 1 July 2020	4,812	0	4,812
At 30 June 2021	**3,720**	**0**	**3,720**

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.

12. Investment in Joint Ventures

Accounting Policy

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.

i) HealthShare Ltd

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

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

a) Carrying amount of investments in joint venture	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
	673	429

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

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Current assets	9,599	7,722
Non - current assets	27,674	29,881
Current liabilities	4,141	5,782
Non - current liabilities	29,768	29,677
Revenue	21,352	18,630
Expenses	20,146	18,702
Group's interest	20%	20%

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 19 and 20.

13. Other Financial Assets and Liabilities

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Finance asset - current		
Term deposits with maturities three to twelve months	500	500
Total finance asset	**500**	**500**

Term deposits are initially measured at the amount invested. Interest is subsequently accrued and added as a receivable. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

14. Payables

Accounting Policy

Creditors and other short term payables are recorded at their face value.

Breakdown of payables and further information	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Payables under exchange transactions		
Trade payables and expenses	22,199	20,109
Revenue in advance	5,170	3,073
Amounts owing to subsidiary companies	56	126
ACC Levy payable	374	142
Total payables under exchange transactions	27,799	23,450
Payables under non-exchange transactions		
GST, PAYE, and FBT payable	4,213	3,982
Total payables under non-exchange transactions	4,213	3,982
Total payables	**32,012**	**27,432**

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.

15. Employee Entitlements

Accounting Policy

Long Service Leave, Sabbatical Leave, Retirement Gratuities, and Medical Education Leave

Joint 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.

Critical Accounting Estimates and Assumptions

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 an 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 0.38% to 2.98% in a 10 year range (2020: 0.22% to 1.63%) and a salary inflation factor of 2.00% (2020: 2.72%) was used.

Breakdown of employee entitlements and further information	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
Current liabilities		
Retirement gratuities	97	8
Long service leave	182	60
Sabbatical leave	104	121
Annual leave	14,930	13,477
Continuing medical education (CME) leave	1,354	1,270
Continuing medical education (CME) expenses	3,276	2,472
Accrued salary and wages	3,789	4,286
Total current portion	23,732	21,694
Non - current liabilities		
Retirement gratuities.	137	288
Long service leave.	1,816	2,027
Sabbatical leave.	1,029	1,242
Total non - current portion	2,982	3,557
Total employee entitlements	**26,714**	**25,251**

16. Borrowings

Critical accounting estimates and assumptions

Compliance with Holidays Act 2003

"A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act"). Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated. The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2021/22 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 12 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2021, in preparing these financial statements, Lakes DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year. Lakes DHB has made progress in its review and it now believes it can determine a reliable estimate of its obligation to address historic non-compliance under the MoU.

	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
Holidays Act Remediation Provision	12,571	10,748

17. Borrowings

Accounting Policy

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.

Critical Accounting Estimates and Assumptions

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.

Breakdown of borrowings and further information	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Current		
Finance leases	529	657
Total current portion	529	657
Non current		
Finance leases	996	1,499
Total non - current portion	996	1,499
Total borrowings	**1,525**	**2,156**

Security and Terms

Working Capital Facility

Lakes DHB is a party to the DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and the participating DHB's. This agreement enables NZHPL to sweep DHB bank accounts and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHB's to have a credit facility with NZHPL, which will incur interest at on-call interest rates received by NZHPL 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 $19.996 million (2020: $18.143 million).

Analysis of Finance Leases

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Total minimum lease payments are payable		
Not later than one year	607	746
Later than one year and not later than five years	1,026	1,632
Later than five years	86	86
Total minimum lease payments	1,719	2,464
Future finance charges	(194)	(308)
Present value of minimum lease payments	1,525	2,156
Present value of minimum lease payments payable		
Not later than one year	527	657
Later than one year and not later than five years	913	1,414
Later than five years	85	85
Total present value of minimum lease payments	1,525	2,156
Represented by:		
Current	529	657
Non-current	996	1,499
Total finance leases	**1,525**	**2,156**

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 2021 are with Toyota Financial Services and Orix New Zealand Ltd. IT Finance Leases at 30 June 2021 are with CBA Asset Finance (NZ) Ltd and MCL Capital Ltd.

Medical Equipment Finance Leases at 30 June 2021 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. Equity

Accounting Policy

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

- Crown equity;
- Retained earnings;
- Other reserves; and
- Trust funds

Revaluation Reserves

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

Trust Funds

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

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.

Breakdown of equity and further information	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Crown equity		
Balance at 1 July	71,984	72,285
Contributions from the Crown		
- Conversion of Crown loan to equity		
- Other contributions	68	0
Repayments to the Crown	(301)	(301)
Balance at 30 June	71,751	71,984
Other reserves		
Asset revaluation reserves		
Balance at 1 July	102,110	102,110
Revaluation gains/(losses)		
- Land	6,885	0
- Buildings	50,931	0
Transfer of asset revaluation reserve to retained earnings on disposal of property		
- Land	0	0
- Buildings	0	
Balance at 30 June	159,926	102,110
Represented by:		
Total Land	16,994	10,109
Total Buildings	142,932	92,001
	159,926	102,110
Total other reserves	159,926	102,110

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.

Retained Earnings

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Balance at 1 July	(30,619)	(15,594)
Prior year adjustment	(42)	19
Surplus(deficit) for year	(2,992)	(15,044)
Transfer to retained earnings of revaluation reserve on disposal of property		
Balance at 30 June	(33,653)	(30,619)

Trust Funds

	Actual 2021 $000	Actual 2020 $000
Balance at 1 July	839	830
Transfer to retained earnings in respect of:		
Interest received	20	39
Donations and funds received	11	2
Transfer to retained earnings in respect of:		
Funds spent	(29)	(32)
Prior year adjustment	22	
Balance at 30 June	863	839
Total equity at 30 June	**198,887**	**144,314**

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 2021 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 2021.

19. Operating Leases

Accounting Policy

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.

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 25 years (for buildings) and 1 to 5 years (for vehicles, and office equipment). In February 2018 the DHB entered into a new 25 year building lease. The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

	Lakes DHB Group	
	Actual 2021 $000	Actual 2020 $000
Not later than one year	635	219
Later than one year and not later than five years	618	96
Later than five years	1,210	1,283
Total non-cancellable operating leases	**2,463**	**1,598**

The total minimum future sublease payments expected to be received under non-cancellable subleases at balance date is $Nil (2020: $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 2021, $580,677 was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2020: $503,986).

20. Contingencies

Contingent Liabilities

Contingent liabilities

	Lakes DHB Group Actual 2021 $000	Actual 2020 $000
Contract Disputes - non employment	0	0
Legal proceedings - employment	0	140
Total contingent liabilities	**0**	**140**

Contract Disputes - non employment

There were no contract disputes - non employment as at 30 June 2021 (2020: NIL).

Legal proceedings – employment

There were no employment related legal proceedings as at 30 June 2021 (2020: $140).

Joint Venture Contingent Liabilities

There are no contingent liabilities associated with HealthShare Ltd or other activities of the Group (2020: $Nil).

Contingent Assets

Lakes DHB Group has no contingent assets (2020: $Nil).

21. 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 2021 $000	Actual 2020 $000
Board Members		
Remuneration	343	309
Full-time equivalent members	1	1
Leadership Team		
Remuneration	2,732	2,612
Full-time equivalent members	11	11
Total key management personnel remuneration	**3,075**	**2,921**
Total full-time equivalent personnel	12	12

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

22. Severance Payments

During the year, no Lakes DHB employees (2020: 0) received compensation and other benefits in relation to cessation of their employment with the Board.

Number of employees	Amount $
0	0

23. 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.

24. 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 2021 $000	Actual 2020 $000
ECE Funding Subsidy	84	122
20 Hrs ECE	0	0
Equity Funding	22	26
ATIS (Annual Top-Up for Isolated Services)	106	0
	212	**148**

25. Events after the Balance Date

No significant events have occurred since balance date.

Covid-19 continued to affect the Lakes DHB operations after the end of the reporting period. See Note 32 for more details on the Impact of Covid-19 on the Lakes DHB. These are judged to be non-adjusting events - events that are indicative of conditions that arose after 30 June 2021 - and the amounts recognised in the financial statements have not been adjusted to reflect these events.

The Pae Ora (Healthy Futures) Act 2022 received royal assent on 14 June 2022. In accordance with the requirements of Sch1 cl 9 and 10 the passing of the legislation disestablishes the DHB on 1 July 2022.

26. Financial Instrument

Accounting Policy

Derivative Financial Instruments

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.

Non-derivative Financial Instruments

Non-derivative financial instruments 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.

Interest-Bearing Loans and Borrowings

Interest-bearing borrowings are classified as other non-derivative financial instruments.

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.

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.

26A. 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 2021 $000	Actual 2020 $000
	FINANCIAL ASSETS		
	Financial assets measured at amortised cost (2021: Loans and receivables)		
7	Cash and cash equivalents	12,328	10,565
8	Debtors and other receivables	17,549	12,487
13	Other financial asset	500	500
	Total financial assets measured at amortised cost	**30,377**	**23,552**
	Fair value through other comprehensive revenue	**0**	**0**
	FINANCIAL LIABILITIES		
	Fair Value through comprehensive revenue and expense		
	Derivative financial instruments liabilities - not hedge accounted	0	0
	Financial liabilities at amortised costs		
13	Other financial liability	0	0
14	Creditors and other payables	26,842	24,359
	Borrowings:		
7	Bank overdraft	0	0
16	Finance lease liabilities	1,525	2,156
	Total financial liabilities at amortised costs	**28,367**	**26,515**

26B. Financial Instrument - 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.

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

26C. 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 90% 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 2021, 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 2021 $000	Actual 2020 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and term deposits		
AA-	12,328	10,565
Other financial assets		
AA-	500	500
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Cash at bank and term deposits	0	0
Other financial assets	0	0
Receivables	17,549	12,487

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 (NZHPL) 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 $19.998 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
2021				
Creditors and other payables (note 14)	26,842	0	0	0
Finance lease liabilities (note 16)	527	0	913	85
2020				
Creditors and other payables (note 14)	24,359	0	0	0
Finance lease liabilities (note 16)	657	394	1,020	85

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.

	Less than 1 year $000	1 - 2 years $000	2 - 5 years $000	5 + years $000
2021				
Cash and cash equivalents (note 7)	12,328	0	0	0
Debtors and other receivables (note 8)	17,549	0	0	0
Other financial assets (note 13)	500	0	0	0
2020				
Cash and cash equivalents (note 7)	10,565	0	0	0
Debtors and other receivables (note 8)	12,487	0	0	0
Other financial assets (note 13)	500	0	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 $11,628,000 (2020: $9,865,000) which are at floating rates. A movement in interest rates of plus or minus 1.0% has an effect on Surplus/Deficit before tax of $116,280 / ($116,280) (2020: $98,865 / ($98,865).

27. 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.

28. Summary of Revenues and Expenses by Output Class

	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Output Class Revenue			
Prevention	9,127	12,561	13,370
Early Detection and Management	93,767	92,422	88,130
Intensive Assessment and Treatment	300,941	316,397	272,982
Rehabilitation and Support	51,376	50,992	50,852
Total Revenue	**455,211**	**472,372**	**425,334**
Output class Expenses			
Prevention	8,429	13,047	15,253
Early Detection and Management	110,040	105,991	103,864
Intensive Assessment and Treatment	287,662	306,606	272,048
Rehabilitation and Support	50,961	49,720	49,212
Total Expenses	**457,092**	**475,364**	**440,377**
Surplus/(deficit) by Output class			
Prevention	698	(486)	(1,883)
Early Detection and Management	(16,273)	(13,569)	(15,734)
Intensive Assessment and Treatment	13,279	9,791	934
Rehabilitation and Support	415	1,272	1,640
Net Surplus/(Deficit)	**(1,881)**	**(2,992)**	**(15,043)**

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 Māori 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.

29. Explanation of Major Variations from Statement of Intent

Statement of Comprehensive Revenue and Expense

The Lakes DHB Group recorded a deficit of $2,992 million compared with a budgeted deficit of $1,881 million. The major reasons for the variance between actual and budgeted result of $1,111 million were:

	Variance $000
· higher IDF Inflows, due to higher acute and elective volumes from other DHBs	896
· higher Health of older persons NGO costs -residential rest homes and hospitals	(443)
· higher ACC revenue due to a higher volume/demand especially rehabilitation services	528
· additional funding costs directly related to the COVID-19 response	664
· higher Medical staff costs including medical locums due higher than planned vacancies	(1,047)
· higher Nursing personnel costs due to higher than planned acute care	(1,278)
· increased provision for Holidays Act remediation costs over budget	(1,023)
· higher outsourced services Clinical and IT over budget	(527)
· increased Treatment disposables (net of recoveries) due to higher acute volumes	(1,140)
· higher clinical Instruments and equipment costs due to higher surgical volumes	(731)
· higher than budget Planned Care revenue	811
· higher revenue than budget revenue, with offsets in costs	1,641
· the net favourable impact of the range of other variances	539
Total variance	(1,110)

Statement of Financial Position

Equity - The variance relates to budgeted capital contributions of $12.803 million from the Crown not required, higher than planned comprehensive revenue and expense for the year of $54.824 million vs. budget $11.618 million. The asset revaluation reserve also increased by $57.816 million as a result of a revaluation during the year of land and buildings.

Current Assets - Current assets are $15.772 million higher due to cash still being in a positive position of $12.328 million due to capital expenditure projects being delayed and receivables being higher than plan by $4.121 million.

Non-Current Assets - Higher than plan by $27.199 million due a revaluation of land and buildings of $57.441 million, offset by a delay in a number of capital projects being commenced

Current Liabilities - Higher than planned payables due to an increase in operational costs due to Covid, and an increase in value of the provisions to $12,571 million due to the holidays act remediation.

Non-Current Liabilities - Lower than plan by $0.541 million due to lower term portion of employee entitlements.

30. Ministerial Directions

As per section 151(1)(f) of the Crown Entities Act 2004 ("the Act"), all DHB's 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.

31. Statement of Performance Expectation

Under section 149C of the Crown Entities Act 2004, Crown Entities are required to produce a statement of performance expectations before the start of each financial year. The Lakes DHB 2020-21 statement of performance expectations was in draft format at 30 June 2021. It has been approved by the Board on 14th August 2020.

32. The Effects of COVID-19 on Lakes DHB

For the period covered by these Financial Statements, the country was, for the most part, at Covid 19 Alert Level 1 and hospital services were able to operate on a business as usual footing, whilst ensuring infection control was prioritized for the safety of its patients and staff.

There were brief periods in Alert Level 2 for the Lakes District during the year: From 12 August to 21 September 2020, 14 February 2021 to 17 February 2021 and 28 February to 7 March 2021. During those times, services operated under restrictions in line with Alert Level guidelines for planned care, elective surgery and outpatient appointments.

The effect on our operations is reflected in these financial statements, based on the information available to the date these financial statements are signed. At this time, it is difficult to determine the full on going effect of Covid 19 and therefore some material uncertainties remain.

Since the balance date, Lakes District has been in Alert Level 4 lockdown from 17 August 2021 to 31 August 2021, Alert Level 3 from 31 August 2021 to 7 September 2021 and Alert Level 2 from 7 September to date. These changes to Alert Level have severely impacted the delivery of services.

As there is no such thing as 'business as usual' for Covid 19 Work streams, it is hard to predict how the DHB will be impacted. As the country moves from an elimination to a suppression approach, and adopts a traffic light system for Covid 19 restrictions, the nature and focus of Covid 19 related services will pivot more towards dealing with Covid 19 cases in the Community.

There could also be other matters that affect the DHB in the future, of which we are not yet aware.

We have also disclosed in the financial statements our significant assumptions and judgements regarding the future potential impacts that may have a material impact on the DHB. These uncertainties might have a material impact on the DHB in future.

The main impacts on the DHB's financial statements due to Covid -19 are explained below:

Government Funding

This provided Lakes District Health Board with certainty that it can continue to deliver to patients, despite disruption caused by Covid – 19. A total of $662,281.00 was received to cover hospital related Covid-19 costs.

Specific funding was also provided to deal with Covid- 19 related services:

Community Testing – based on a fee per test carried out
Vaccinations – reimbursement of costs incurred
Managed Isolation Facilities – fee per guest per night

Due to the differing bases used for calculating funding, the DHB found itself with a Covid 19 funding shortfall of $939,544.72. MOH recognized this issue and requested a wash-up calculation. The shortfall amount was received in September 2021.

For the 2021/2022 year all Covid 19 funding is received monthly on the basis of costs incurred, ensuring revenue matches costs and no wash up is required.

Operating Expenses

As a result of Covid 19, the DHB has incurred additional expenditure during the year of $7,888,897.00 on:

- Personnel costs: $4,995,971.00
- Outsourced Services: $1,323,521.00
- Clinical Supplies including PPE: $136,947.00
- Infrastructure and Non-clinical supplies: $1,432,458

Valuation of Land and Buildings

The level of property transactions had significantly reduced during the Level 4 lockdown resulting in a material valuation uncertainty over land values at 30 June 2020.

The DHB obtained a full valuation on land & buildings at 30 June 2021 which resulted in significant revaluations.

An impairment assessment has been completed for tangible and intangible assets. The result of this assessment was that no impairment is required at 30 June 2020 when the full impact of the Covid-19

is still being assessed. Further details regarding intangible assets are included in Note 12 – Intangible Assets.

33. Ministerial Extensions for Statements of Performance Expectations

"In late April 2020, Parliament passed an Act (the COVID-19 Response (Taxation and Other Regulatory Urgent Measures) Act 2020) that amended the Crown Entities Act 2004 by allowing responsible Ministers to grant an extension of time for the obligation to prepare statements of performance expectations (section 149CA) and statements of intent (section 139C) due to COVID-19. The extension was for up to 3 months, and to grant the extension the Minister was required to be satisfied that, as a consequence of the effects of COVID-19:

- The Crown entity is unable to, or will experience significant difficulties if required to, provide the information on or before 1 July 2020; or
- The Crown entity is unable to adequately assess how its future operations will be affected and the extension will enable it to provide a better statement of intent than it would be able to if the extension were not granted.

The amendments also require Crown entities that are granted an extension to:

- As soon as practicable after receiving notice from the Minister granting the extension, publish notice of the extension, and the Minister's reasons for granting it, on an Internet site maintained by or on behalf of the Crown entity; and
- Include, in the next annual report that it provides to its responsible Minister for presentation to the House of Representatives under section 150, a statement of the extension and the Minister's reasons for granting it.

34. Completion of Financial Statements

The Crown Entities Act 2004 Section 156 requires a Crown Entity to forward to the Auditor-General the entity's annual financial statements and other information within 3 months after balance date. The Auditor-General is required to audit the statements and information within 4 months after balance date. These time limits for the completion of the audit were extended because of Covid-19, to 31 December 2021. Lakes DHB did not provide the statements and information to the Auditor-General by the specified date. The Auditor-General did not provide an audit report by the specified date.

Directory

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Nick Saville-Wood

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