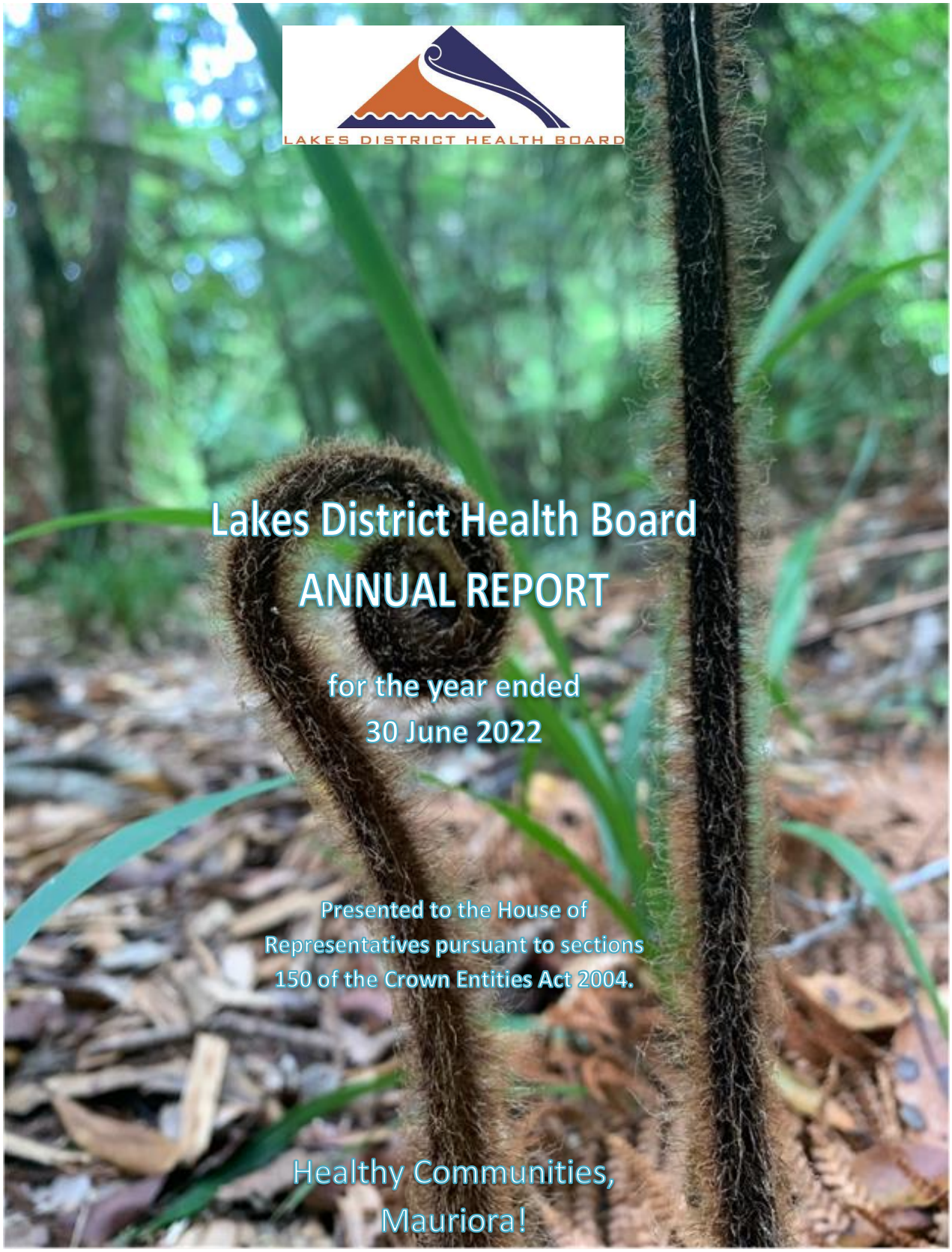

LAKES DISTRICT HEALTH BOARD
Lakes District Health Board
ANNUAL REPORT
for the year ended
30 June 2022
Presented to the House of
Representatives pursuant to sections
150 of the Crown Entities Act 2004.
Healthy Communities,
Mauriora!

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.
- The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand. Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the Lakes DHB is working in line with this national direction.
- The direction to support a whole-of-government approach to pay restraint issued on 28 April 2021 under s.95(c) of the Public Service Act 2020.
- The direction to implement the Carbon Neutral Government Programme (CNGP). The CNGP has been set up to accelerate emissions reductions across the public sector. The direction was issued in May 2022 under s.107 of the Crown Entities Act.

Contents

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:

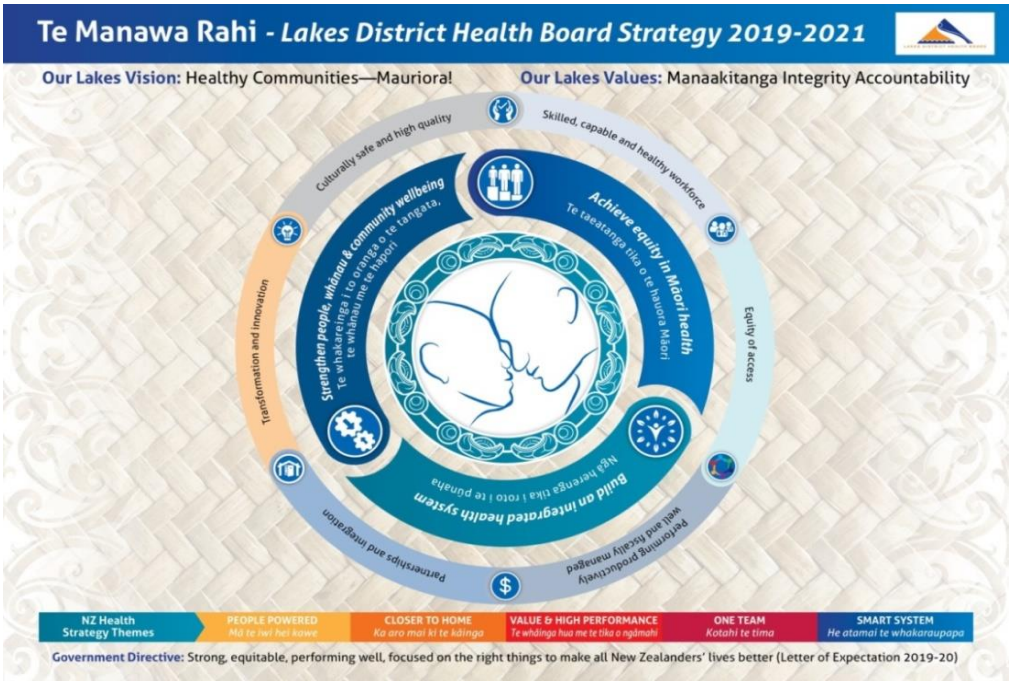
- **Manaakitanga**
  Respect and acknowledgement of each other's intrinsic value and contribution
- **Integrity**
  Truthfully and consistently acting collectively for the common good
- **Accountability**
  Collective and individual ownership for clinical and financial outcomes and sustainability

Our Strategic Intentions and Priorities for 2021/22

To contribute to achieving the outcomes at a national and regional level, Lakes DHB continued the local priorities identified in Te Manawa Rahi for 2021/22. 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

Lakes DHB continued to be guided by this strategy, extending it to 2022, as we faced an upcoming system transformation and new national strategies. Te Manawa Rahi continued to guide how we undertake our mahi, 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.

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 2021/22.

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.

Lakes DHB, working in partnership with Te Arawa Whanau Ora and Tūwharetoa Health
– Healthy Communities – Mauri Ora!
He Tangata He Tangata

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 too 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 belongs 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 118,690 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. And it 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.

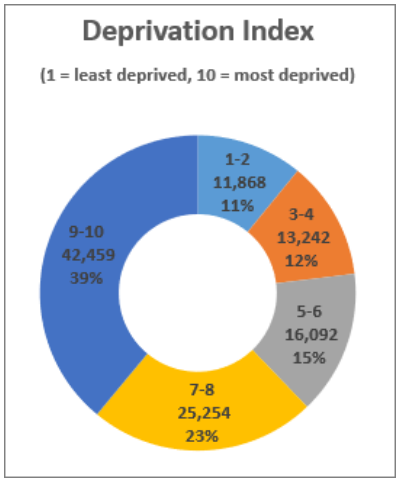
Community-based services provided include district nursing, social work and home support services and disability support. Population health services include public health nursing, school dental services, immunisation, universal new-born hearing screening, vision and hearing testing and B4 School checks.

Through contracts, Lakes district funds a range of providers in the wider health sector. We hold 337 contracts with approximately 161 health service providers and also contract dentists, pharmacists and primary care services.

Lakes district serves a population of just over 118,000 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 boundaries take in the two main iwi groups of Te Arawa and Ngāti Tūwharetoa and Ngāti Kahungunu in the west (Mangakino).

According to the 2021 Population Projection, 38% 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 38,520 under 25 (0-24) year olds, of whom 20,880 are Māori. 2018 Census shows there is a relatively high proportion of people in the most deprived section of the population.



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

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 District:

- Works with key stakeholders to plan the strategic direction for health and disability services
- 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 districts
- 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 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 1,733 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.

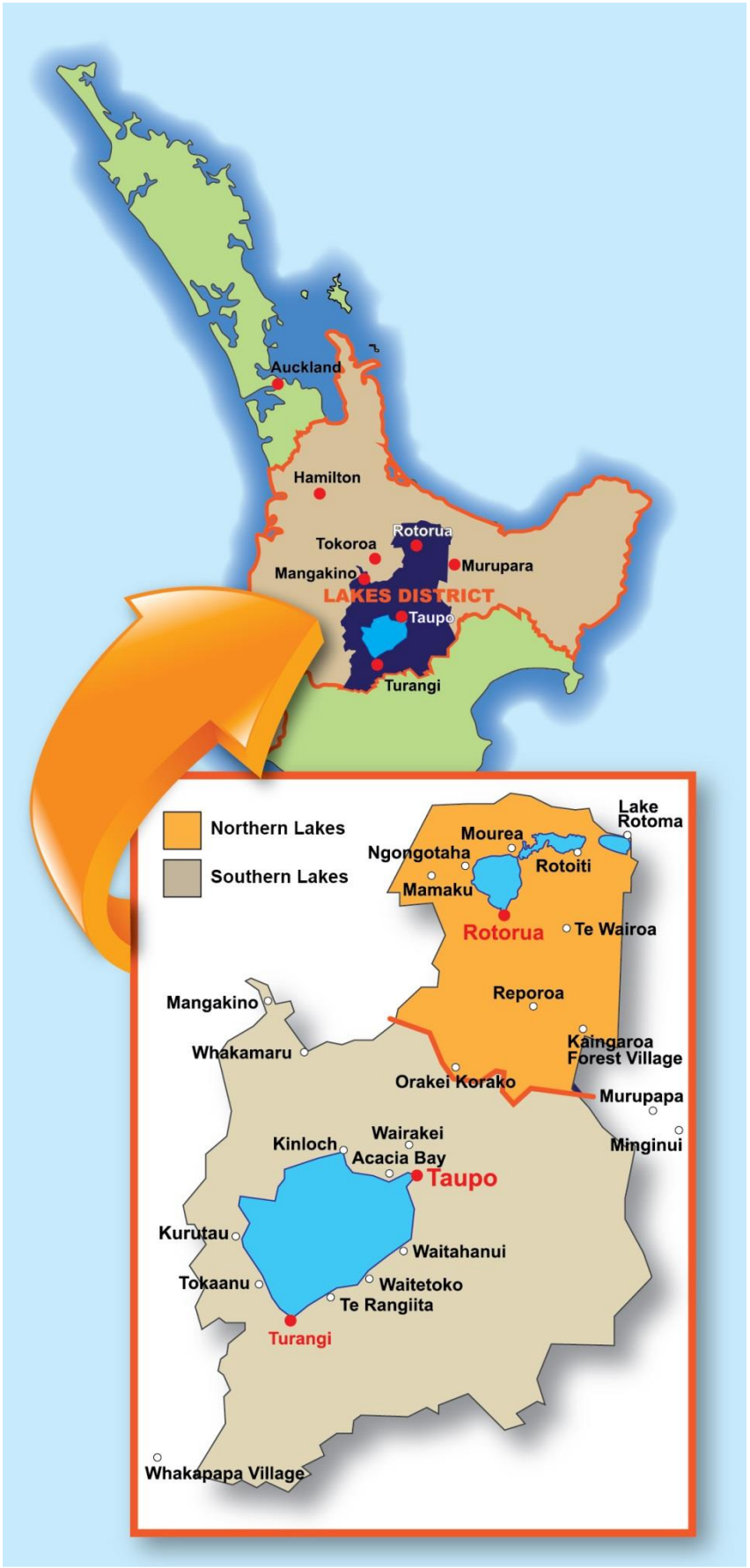
Good employer initiatives focused on bipartite meetings which were held with Council of Trade Union (CTU) union groups on a regular (quarterly/monthly) basis to discuss industrial matters, continue to build on healthy workplaces principles and developing effective partnerships.

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

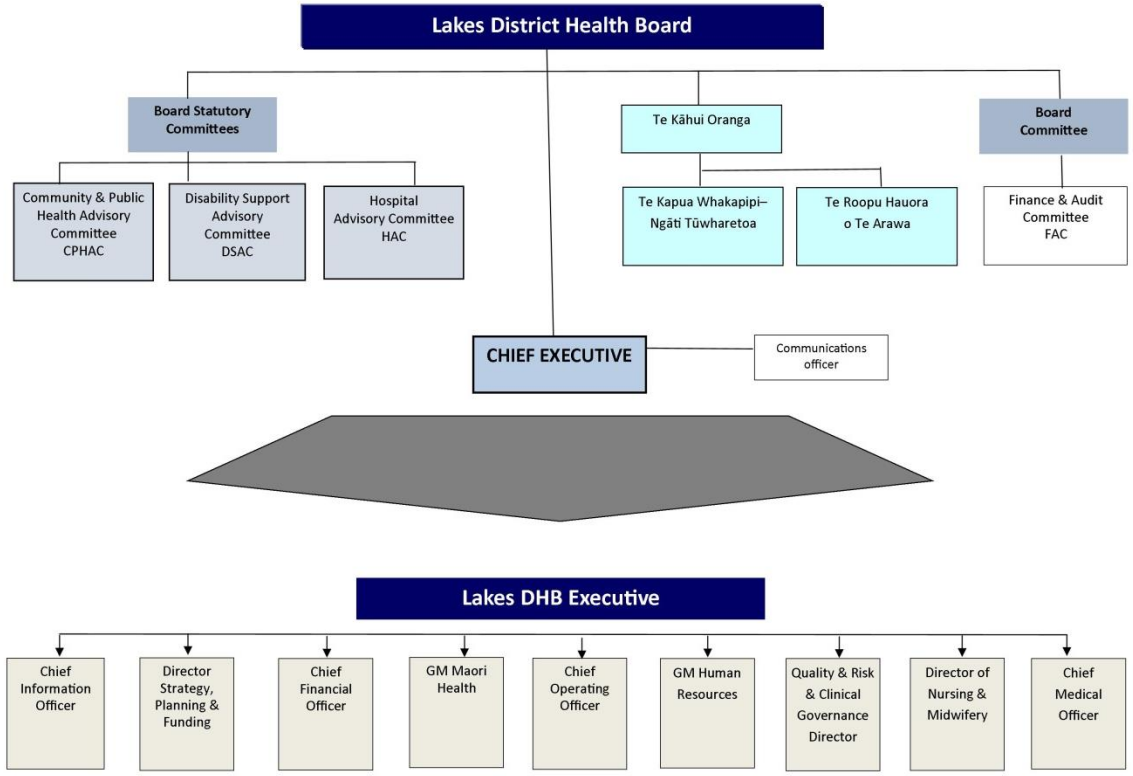
The policies and practices of the DHB work to enhance a positive and healthy workplace for our employees.

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 2021/22



The Board

Accountability

The Board held 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) met two-monthly and the Hospital Advisory Committee (HAC) met two-monthly. The Finance and Audit Committee (FAC) also met monthly.

Conflicts of Interest

The Board maintained an Interests Register and ensured 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	11/11
Dr Rees Tapsell	10/11
Lana Ngawhika	10/11
Patrick Ngahihi-O-Te-Ra Bidois	11/11
Christine Rankin	9/11
Janine Horton	10/11
Dr Johan Morreau	11/11
Merepeka Raukawa-Tait	8/11
Robert Vigor-Brown	6/8 (Passed away in March 2022)
Lyall Thurston	11/11
Iwi Representatives:	
Aroha Morgan	11/11
Trudy Ake	11/11

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 Tūwharetoa 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.

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

Strategy - TE ARA KI TIKITIKI O RANGI

'The pathway to optimum and divine health outcomes'

Te Ara ki Tikitiki o Rangi is the Te Arawa Health 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.

Recognising 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.

Membership -Te Arawa Māori Partnership Board.

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


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

Increasing and Improving Health Equity for Māori

Achieving equity in health for Māori is a focus for Lakes DHB. Addressing Te Tiriti within a Hauora context is a priority for the DHB and we continued to work towards reducing Māori inequities.

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 completed 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 2021/2022 Lakes DHB worked towards equitable access of health care for Māori in the Lakes DHB through the following activities:

- Maintained strong relationships with iwi Māori
- Supported and prepared for health system transformation that ensures that Iwi Māori is in key decision-making roles, including hospital, community and localities
- Iwi health governance groups set the direction for priority initiatives in their locality
- Support Māori leadership design and delivery of pro-equity initiatives and enhance wellbeing
- Continued 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
- 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
- Supported community and intersectoral primary 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
- 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).

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.

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	5/5
Merepeka Raukawa-Tait	3/5
Janine Horton	4/5
Lyall Thurston	5/5
Aroha Morgan - TRHOTA iwi alternate representative	
Tania Te Akau - TNKOT iwi primary 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 (Passed away in March 2022)	1/2
Janine Horton - Deputy Chair	2/3
Merepeka Raukawa -Tait	2/3
Dr Rees Tapsell	2/3
Lana Ngawhika	1/3
Sue Westbrook - TRHOTA primary representative	
Aroha Morgan - TRHOTA alternate representative	
Tania Te Akau - TNKOT primary representative	
Ian Finch, Bay of Plenty DHB representative	
Jordana Bealing, Community 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 2021/22 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)	5/5
Dr Johan Morreau (Deputy Chair)	5/5
Dr Jim Mather (Board Chair – ex-Officio)	2/5
Christine Rankin	3/5
Ngahi Bidois	2/5
Lana Ngawhika	2/5
Mary Burdon (Community Representative)	5/5
Margie Robbie (Community Representative)	4/5
Tangihaere Macfarlane (Community Representative)	5/5
Aroha Morgan (Te Roopu Hauora o Te Arawa Representative)	4/5
Ngaiterangi Smallman (Te Kapua Whakapipi Ngati Tuwharetoa Representative (alternative))	2/5
Tania Te Akau (Te Kapua Whakapipi Ngati Tuwharetoa Representative (Primary))	4/5
Dr Geoff Esterman (BOPDHB Community Representative)	3/5

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.

FAC Committee Membership

Committee Members	Meetings Attended
Stuart Burns (Chair)	10/10
Rob Vigor-Brown (passed away during the year)	5/10
Christine Rankin	7/10
Dr Rees Tapsell	7/10
Allison Lawton	10/10
Ex Officio	
Dr Jim Mather	6/10
Johan Morreau	1/10

Research and Ethics Committee

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

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
Neyssa Fielding, Administrative Support
Kristina Maconaghie, Chairperson
Annie Morley, Clinical Representative
Suzanne Gower, Community Representative, Turangi
Katalla Kramer, Clinical Representative

Quality Governance, Risk & Compliance

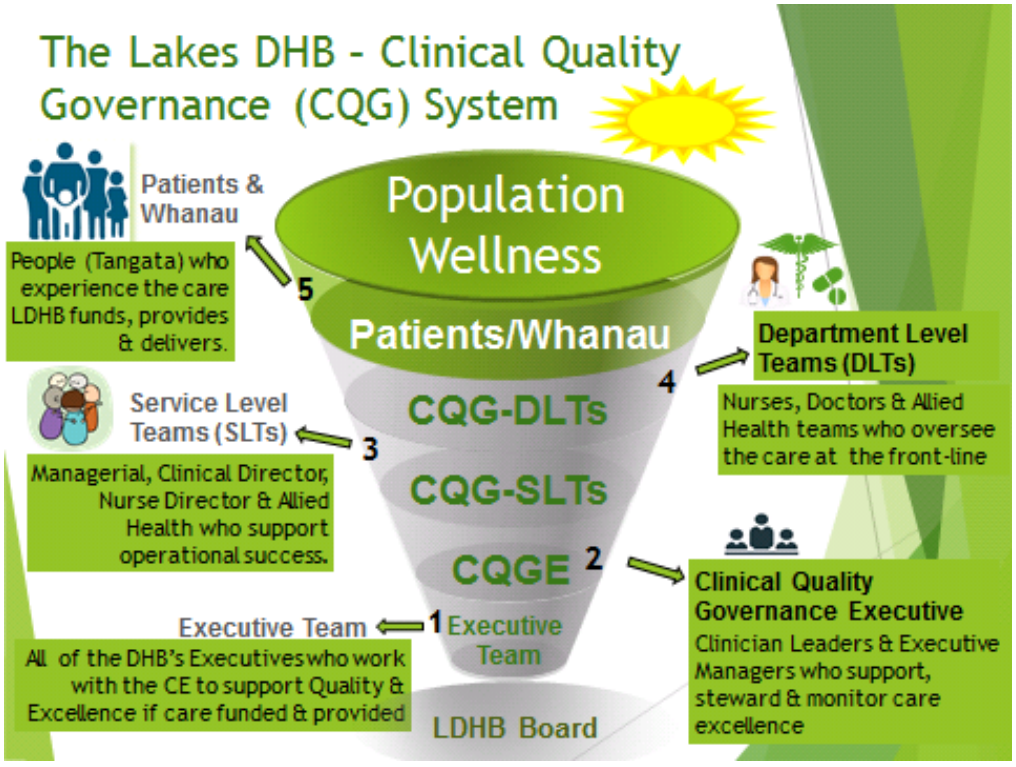
The year 2021/22 continued to see effort around managing the COVID-19 omicron surge at a time when a surge in winter illnesses were also expected. It also involved ensuring that patients who required elective services were prioritised in terms of Equity and our Te Tiriti obligations.

The Lakes Way|Our Place, Our Culture document produced in response to staff surveys, has been 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 Māori health
- Building an integrated health system
- Strengthening people, whanau and community wellbeing.

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 Gerrie Snyman	Chief Medical Officer
Dr Peter Freeman	Clinical Director, Clinical Effectiveness
Mr Alan Wilson	Chief Operations Officer
Ms Nina Hartley	Acting Director of Nursing & Midwifery
Dr Ulrike Buehner	Clinical Director Quality Improvement
Dr Chloe Corbett	Senior Registrar, Public Health
Ms Jillian Sutherland	Chief Pharmacist
Mr Joe Monkhouse	Clinical 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

How Lakes DHB Group Funding Flows

Ministry of Health
$499M

Other Revenue
$47M

Lakes DHB

$13M
Governance and Administration

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

$278M
Provider Arm (HSSS/Population Health)

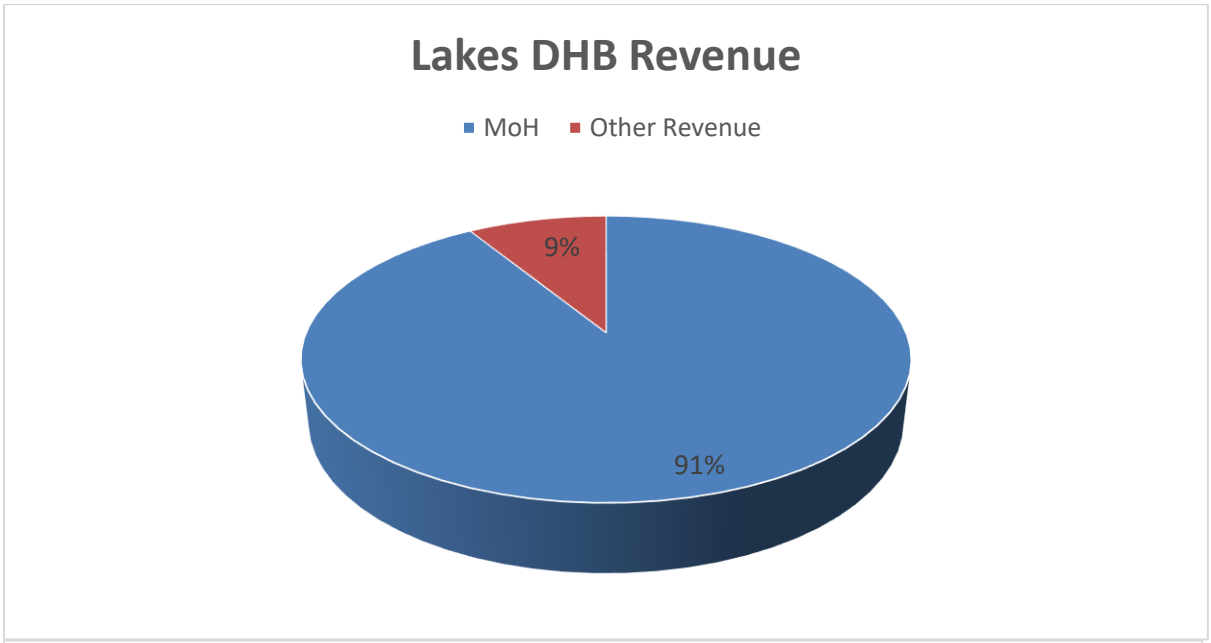
Clinical Services / Specialist Assessments / Surgery / Oncology / NASC / NTA / District and Community Nursing

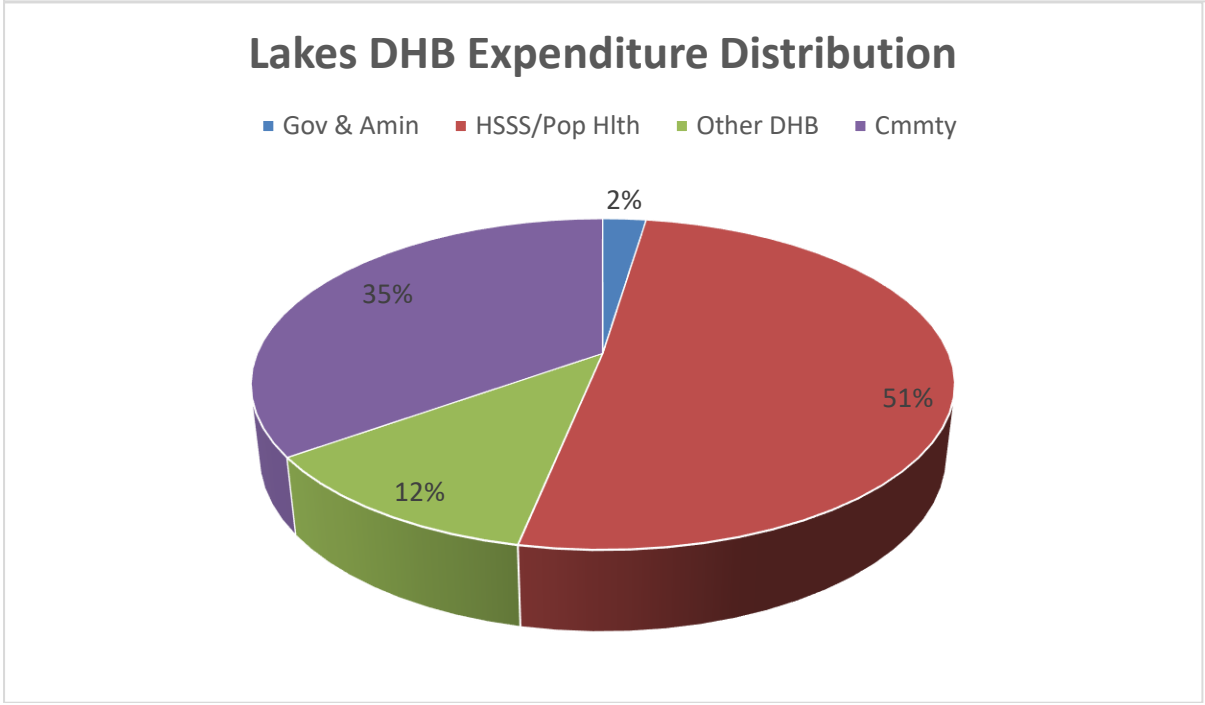
$64M
Other DHBs

Secondary and Tertiary

$188M
Community Services

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


Lakes DHB Revenue
MoH
Other Revenue
9%
91%


Lakes DHB Expenditure Distribution
Gov & Amin
HSSS/Pop Hlth
Other DHB
Cmmty
2%
35%
51%
12%

Other Statutory Disclosures

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:

Salary range	2022 Number of staff (clinical and other staff)	2021 Number of staff (clinical and other staff)
$100,001 - $110,000	113	91
$110,001 - $120,000	78	59
$120,001 - $130,000	65	27
$130,001 - $140,000	27	28
$140,001 - $150,000	18	9
$150,001 - $160,000	13	13
$160,001 - $170,000	12	5
$170,001 - $180,000	4	5
$180,001 - $190,000	4	10
$190,001 - $200,000	12	4
$200,001 - $210,000	4	7
$210,001 - $220,000	7	7
$220,001 - $230,000	5	2
$230,001 - $240,000	2	5
$240,001 - $250,000	4	0
$250,001 - $260,000	7	8
$260,001 - $270,000	8	6
$270,001 - $280,000	4	4
$280,001 - $290,000	7	8
$290,001 - $300,000	1	7
$300,001 - $310,000	9	2
$310,001 - $320,000	6	5
$320,001 - $330,000	4	2
$330,001 - $340,000	5	5
$340,001 - $350,000	2	8
$350,001 - $360,000	5	0
$360,001 - $370,000	4	5
$370,001 - $380,000	3	5
$380,001 - $390,000	3	3
$390,001 - $400,000	3	1
$400,001 - $410,000	0	2
$410,001 - $420,000	1	3
$420,001 - $430,000	1	0
$430,001 - $440,000	0	0
$440,001 - $450,000	0	0
$450,001 - $460,000	0	0
$460,001 - $470,000	0	1
$470,001 - $480,000	1	0
Total	442	347

Of the 442 employees shown above, 338 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 751 (2021: 624) compared with the actual total number of 442 (2021: 347).

The figures shown above exclude remuneration payable to employees as a result of the New Zealand Nurses Organisation (NZNO) pay equity claim interim order issued by the Employment Relations Authority on 14th of December 2022. In total, $3.8m was accrued in relation to 889 employees.

Board remuneration

The following people held office as Board members during the twelve months ending June 2022 and the amounts of remuneration were set by the Minister of Health.

	Board Fees 2022 $000	Board Fees 2021 $000
Jim Mather - Chair	49	50
Johan Morreau - Deputy Chair	34	32
Lyall Thurston	27	26
Merepeka Raukawa-Tait	26	22
Rob Vigor- Brown ***	20	27
Janine Horton	25	25
Christine Rankin	26	27
Trudy Ake	24	24
Ngahi Bidois	25	25
Aroha Morgan	27	30
Lana Ngawhika	25	25
Rees Tapsell	26	26
Allison Lawton *	26	0
Total board remuneration	**360**	**340**

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 (2021: Nil).

Non - board committee remuneration

The following people were non-board committee members who received remuneration during the twelve months ended 30 June 2022:

	Committee Fees 2022 $000	Committee Fees 2021 $000
Hospital Advisory Committee		
Margie Robbie	1.0	1.5
Mary Burdon *	1.3	0.0
Ngaiterangi Smallman *	0.5	0.0
Tangihaere Macfarlane	1.3	1.5
Tania Te Akau *	1.0	0.0
G Esterman	0.8	1.0
	5.9	4.0

	Committee Fees 2022 $000	Committee Fees 2021 $000
Community and Public Health Advisory Committee		
Leanne Karauna	1.0	1.0
Anahera Waru	1.0	1.3
T Te Akau	0.5	0.8
I Finch *	0.3	0.0
Mary-Louise Barnett	0.0	1.0
	2.8	4.0

	Committee Fees 2022 $000	Committee Fees 2021 $000
Disability Support Advisory Committee		
J Bealing *	1.0	0.0
Tania Te Akau	0.5	0.8
Sue Westbrook	0.8	1.3
I Finch *	0.3	0.0
Ngaterangi Smallman **	0.0	0.3
	2.6	2.4
Total non - board committee remuneration	**11.3**	**10.4**

* Commenced term during 21/22
** Completed term during 21/22
*** Deceased during 21/22

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 10 employees under this scheme (2021: 12).

Severance Payments

During the year three Lakes DHB employees (2021: 0) received compensation and other benefits in relation to cessation of their employment with the Board.

Number of employees	Amount $000
3	59

In addition to the figures shown above, one employee was made redundant as a result of the sector reforms, effective 1 July 2022. A redundancy of $93,000 will be due to the employee.

Directors' and Officer's Insurance

Insurance premiums were paid in respect of board members' and certain officer's liability insurance. Lakes DHB policies do not specify a premium for each individual.

The policies provide 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.

Key Achievements for 2021/22

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

At the beginning of the 2021-22 year, Lakes DHB was busy responding to the August 21 Delta outbreak. Once that eased off and we started planning for the Omicron variant, and the accompanying changes to the public health measures we reviewed and updated our plans. For the Delta response we avoided significant outbreaks within our facilities and staff teams. As Omicron progressed and the public health measures eased we saw an increase in staff COVID-19 infections and more significant outbreaks within aged residential care and hospital facilities. These were in the main handled well due to the work that had been carried out the previous year on planning for outbreaks.

Emergency Operations Centre (EOC)

Throughout the year we have had an 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 2022 we prepared for and responded to the Omicron wave. A significant feature of this work was the rapid roll out of Rapid Antigen Testing distribution centres as the laboratory capacity to process PCR tests became overwhelmed. In addition, we have continued with COVID-19 vaccination, managed isolation and in the lead up to winter 2022 there has been a significant focus of resurgence planning and winter planning. Much of this at a regional as well as local level.

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 it has been possible to re-deploy staff from services that reduce or stop operations at that time, through most of the period 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 Taupo 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. In addition, as the system transitioned to use of RATs the community testing centres have become RAT distribution centres. This capacity was initially supplemented by Rotorua and Taupo council staff and later by community pharmacies and iwi providers. The CTCs continue to provide PCR testing as required though currently the demand is low.

Managed Isolation Facilities (MIF)

In March this year the three managed isolation hotels in Rotorua were closed. The health staff from the facilities who wished to carry on working with the DHB were re-deployed into new roles and much equipment added to the DHB inventory. Of particular value have been a significant number of air filtration units which are being regularly used as part of infection control precautions within the hospitals.

Aged Residential Care

Creation of a community infection control role and a principle advisor supporting the sector within the Strategy Planning and Funding team has resulted in improved collaboration and support for the rest homes. This sector has dealt with numerous COVID-19 outbreaks this year and by and large the facilities have done an excellent job of managing the impact.

Vaccination

In January 21 we set up our COVID-19 vaccination service and began delivering the vaccine initially for staff working in our managed isolation facilities. This was then extended to other groups in the population according to the sequencing framework. Vaccination has been delivered from fixed, pop-up and drive through settings and involved collaboration with Iwi providers, GPs and pharmacies.

Responding to COVID in the community:
Care in the Community (CitC) Response Centre

During the 2021/22 year, through an immense effort, and integration across the Lakes district, the CitC and framework was further developed, making up a Northern Lakes hub, and a Southern Lakes hub. This was stood up to better coordinate care and in response to the rules around COVID-19 isolation requirements.

The role of the Care in the Community (CitC) Response Centre is to assist people to isolate safely at home, or to organise and coordinate the assessments needed to facilitate alternative accommodation and clinical oversight for those who cannot safely isolate at home, due to a varying number of factors.

Working alongside welfare agencies, Primary Health Organisations (Te Arawa Whanau Ora, Whakarongorau, Tu Whare Ora, Raphs and Pinnacle Health), Toi Te Ora Public Health, General Practitioner's (GPs), Medical Centres and Pharmacies who are involved in assisting vulnerable and at risk cases to ensure appropriate care/welfare is provided.

Care Capacity Demand Management (CCDM)

Lakes CCDM programme has been classed as fully implemented following an external assessment in June 2022. This achievement has required significant effort at a time when it has been challenging to introduce change. Supported by the CE, the CCDM and Trendcare team have worked alongside the Director of Nursing and Midwifery, unions and our wider workforce to meet the five standards of CCDM. The team provide a monthly governance report to the CCDM council, indicating progress and any issues that need to be addressed.

There is a culture of continuous improvement and engagement with staff providing onsite support and opportunities for feedback. FTE calculations are standard practice, allowing all parties to contribute throughout the process, from assumption setting to the final matrix decisions. The Core Data Set has been transferred into a new electronic dashboard that multiple users can access to review the data metrics in current and historical formats to support decision making. The set-up allows easy comparisons within wards and as part of broader services.

Rotorua hospital and Tāupo hospital now have a "Hospital at a Glance" screen that shows easily and graphically the hospital bed status and the current workload for nurses, midwives and allied health. It is updated in real-time from both iPM - the primary patient management system, and Trendcare, the patient acuity and workload management software. It is proving very useful for bed and staffing management. Additionally, a specific function allows in-time commentary to be added in any clinical area to indicate concerns and how these are being addressed. This commentary is recorded and can be available to support or review variance response management.

Healthy Ageing Model of Care Redesign

We have continued to focus strong support across Aged Residential Care (ARC) providers and Home Care Support Services (HCSS) with respect to maintaining operations within a pandemic. Focus to maintain operations has made a clear shift over the 2021/22 year from infection control and procedure to maintaining workforce capability. Strengthened collaborative relationships both between providers, and between providers and Lakes have enabled continuation of services and maintenance of client safety under at times very challenging circumstances.

The key areas of development in Lakes have included:
Development and utilisation of a non-registered workforce has been a key highlight in the Healthy Ageing space. Cross sector collaboration with Ministry of Social Development has successfully piloted a new pathway with a Te Ao Māori focus for long term beneficiaries to return to work within the aged care space. Further collaborative initiatives with iwi, kaupapa Māori providers and Auckland University has seen the stand up of a dedicated kaiāwhina workforce for older Māori within the primary health space. Further work is underway in collaboration with TAS to pilot an interRAI self-assessment tool with the aim of enhancing early interventional engagement.

A collaborative approach by HOP managers across the Te Manawa Taki region was successful in enabling national sign off on a new initiative of virtual nursing teams to facilitate the coverage of night shifts within ARC. The aim of this being to help address burnout and other issues related to significant staffing shortages prevalent in many facilities.

Work Streams including:

- Established permanent full FTE physiotherapy role across ED and MAPU to mitigate low acuity admissions.
- Collaborative project with TAS around Kaupapa Māori InterRAI assessment framework.
- Collaborative project with MSD regarding recruitment and training of kaiāwhina workforce.
- Strengthening of District Dementia Strategy with imbedding of Dementia CNS role across acute wards and community.
- Linkage of Pokapu digital enablement and telehealth initiatives with NASC services to increase accessibility and reach.
- Instigated project with ARC facilities to improve capability of nursing staff to manage low acuity issues and avoid hospital admission.
- Mixed model of CARE ARC moved from pilot to permanent model of care.
- Pilot of kaupapa Māori specific community based strength and balance classes initiated.

Disability Action Plan

This was successfully completed in the 2021-22 year. The Ministry of Health directed DHBs to develop a Disability Action Plan (DAP) to improve access to quality health services and improve the health outcomes of disabled people.

This co-designed development was sponsored by Lakes and Bay of Plenty DHBs, in partnership with Momenta. The action plan was written as a direct result of feedback from people in the local disability community, including service users, whānau and providers. The plan is designed to ensure the Waiariki district is a place where disabled people have an equal opportunity to achieve their goals and aspirations.

The Waiariki Disability Action plan is a living document which will continue to be adapted to meet the needs of disabled people and the changes occurring in the health system. In April 2022 the Bay of Plenty and Lakes District Health Boards endorsed and approved the inaugural Waiariki Disability Action Plan for their sub-region.

The outcome of the DAP acknowledges 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 was developed 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.

Wellbeing in Schools

A codesign with tamariki, whanau, primary and intermediate schools and their associated communities across Waiariki was undertaken to determine how a collaborative service framework between health and education could look that would enable an early interventional approach to addressing wellbeing needs of tamariki. A strong theme through the process was the need for a holistic approach that addresses not only the needs of the child to enable their learning potential, but also address the underlying social determinants that impact the child and their whānau's wellbeing. The service framework also needed to be community lead with the agility to be adapted to accommodate the variances that exist in different localities across the Waiariki rohe. A proposed framework was presented to the Ministry of Health at the end of March 2022 that encompassed multiple initiatives including a registered and non-registered workforce amalgamated in a top of scope working model across school communities. The framework has been accepted and funded for progressive implementation over the 2023-2027 period.

Mental Health Services

Te Ara Tauwhirotanga: Pathways that lead us to act with kindness

Te Ara Tauwhirotanga is the model of care for Mental Health Services in the Lakes District. It is the product of a five-month co-development process with tangata whaiora, people with lived experience of mental illness, whanau/family members, communities and a range of local service providers (DHB clinical staff, NGOs and primary care).

The model of care is named Te Ara Tauwhirotanga to echo the aspirations of the community that services and systems are designed to "act with kindness."

During the 2021- 22 year, the following projects were completed:

- Maternal Wellbeing Community Support Initiative
- Alcohol and Drug continuum of services
- Suicide Postvention Framework
- Workforce capacity and capability assessment Project
- High and Complex needs service (Residential Facilities stood up)
- Te Pokapū Clinical Nurse Specialist: The health response to homelessness under Te Ara Tauwhirotanga resulted in a full time CNS working with Te Pokapū
- Two successful Sector wide forums held and the first Primary MH forum
- Te Ara Tauwhirotanga Implementation Dashboard introduced and implemented
- Wellbeing in schools has a stronger profile under Te Ara Tauwhirotanga and continues to grow utilisation of whāraurau and capability growth around trauma informed approaches in primary and intermediate schools
- Peer Support Workforce
- Consumer Participation Framework

In the 2021-22 year Lakes DHB continued with our Planned Care funded programme as per the Ministry of Health (MoH) directive. The MoH invested a significant amount of funding into the improvement and redesign of Planned Care[1]. With this boost in funding, Lakes DHB was able to continue with a second year of Planned Care improvement projects, completing them all, or moving them into "business as usual" and as part of the locality model development.

[1] MoH: Planned Care Services

Planned Care Interventions Delivery:

	Year to date plan	Year to date delivery	Variance from plan	2021/22 Health Target
Inpatient Surgical Discharges	4,726	4,408	-318	7,350
Minor Operation	2,547	2,528	-19	
Non-Surgical Interventions	77	73	-4	
YTD Planned care	7,350	7,009	-341	95.4%

Tier One and Locality Planning

Turangi Wellbeing Network: Southern Lakes Locality

During the 2021/22 year, Lakes DHB worked alongside key stakeholders to develop a proposal for the southern lakes locality prototype. This was accepted by the Ministry of Health for further development. The interim collective is comprised of representatives from the following organisations:

- Ngāti Tūwharetoa Iwi
- Lakes District Health Board
- Taupo Hospital
- Pinnacle Midlands Health Network
- Taupo District Council

Nursing and Midwifery Initiatives and Programmes

Although 2021-2022 remained a time of uncertainty and challenge, Lakes DHB nursing and midwifery workforce have continued to provide excellent care to our community. The demands of the COVID-19 response at the same time as we are experiencing a nationwide shortage of nurses and midwives has at times stretched our workforce significantly; however, there have been opportunities to adapt and evolve to meet the changing needs and the positive attitude of staff within this space has been demonstrated in the outcomes achieved.

Rotorua supported several MIQ spaces, recruiting nurses and care assistants to work within this unique environment. The team adopted a continuous improvement approach, working collegially with multiple intergovernmental agencies to provide safety and care for this population. The work completed on the process and assessment for pregnant returnees became the nationally accepted tool within the Border Clinical Management System (BCSM). The team were also able to provide virtual RN support to Auckland MIQ and locally support nurses to convert from annual practicing certificates (APC) with restrictions to full certificates.

Our COVID-19 response was far-reaching with multiple components. The overall achievements were significant vaccination rates, home or virtual support and the development of many pathways and processes to provide patient care at the level required to keep patients as safe as possible within the hospital, the community and for the transitions between them.

Lakes DHB maintained strong relationships with our academic providers at undergraduate and postgraduate levels. In turn, this minimised the impact of COVID-19 for our trainees whilst also supporting the growth and development of our existing workforce to gain the knowledge and skills required to progress as RN/RM or specialists within the community or hospital. Lakes is also represented on several professional programme advisory boards with tertiary education institutes, providing the opportunity to influence the content and delivery of programs. Several staff also

contribute to delivering these programmes, ensuring the links between practice and academia are maintained.

Quality improvements in both service models and clinical delivery have continued. One example is establishing a dedicated mental health nurse educator within our emergency departments. This role has already led to some environmental changes enabling assessments to take place in a low stimulus area, thereby reducing patient distress. There is also increased support available for individual clinicians around approaches and skills required to support this vulnerable group of patients.

The midwifery team have explored a new role of a maternity care assistant, individuals who are provided with specific training to support new mothers and their babies. Early feedback indicates the positive impact for the midwifery team and the care they can deliver.

Adult inpatient nursing documentation has also been completely revised, with a new Patient Journey Planner launched throughout both hospitals in recent weeks. The new documents aim to encourage patient and whanau participation throughout their episode of care. They also provide one content source for vital assessments and activation of appropriate care interventions to reduce risk in areas such as falls, pressure injuries and cognitive decline.

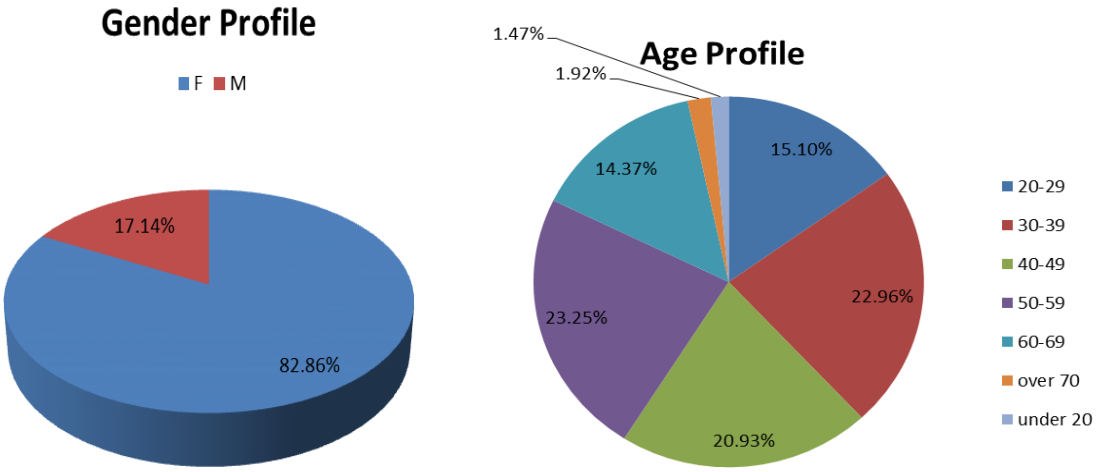
This year has also seen further development of the Pou Arataki ADON Māori position. This role is vital to continue supporting Māori nurses in their own development whilst also providing leadership to develop nursing and midwifery practice that ensures we are upholding Te Tiriti o Waitangi and achieving health gain for Māori.

Lakes DHB Good Employer Report 2021/2022

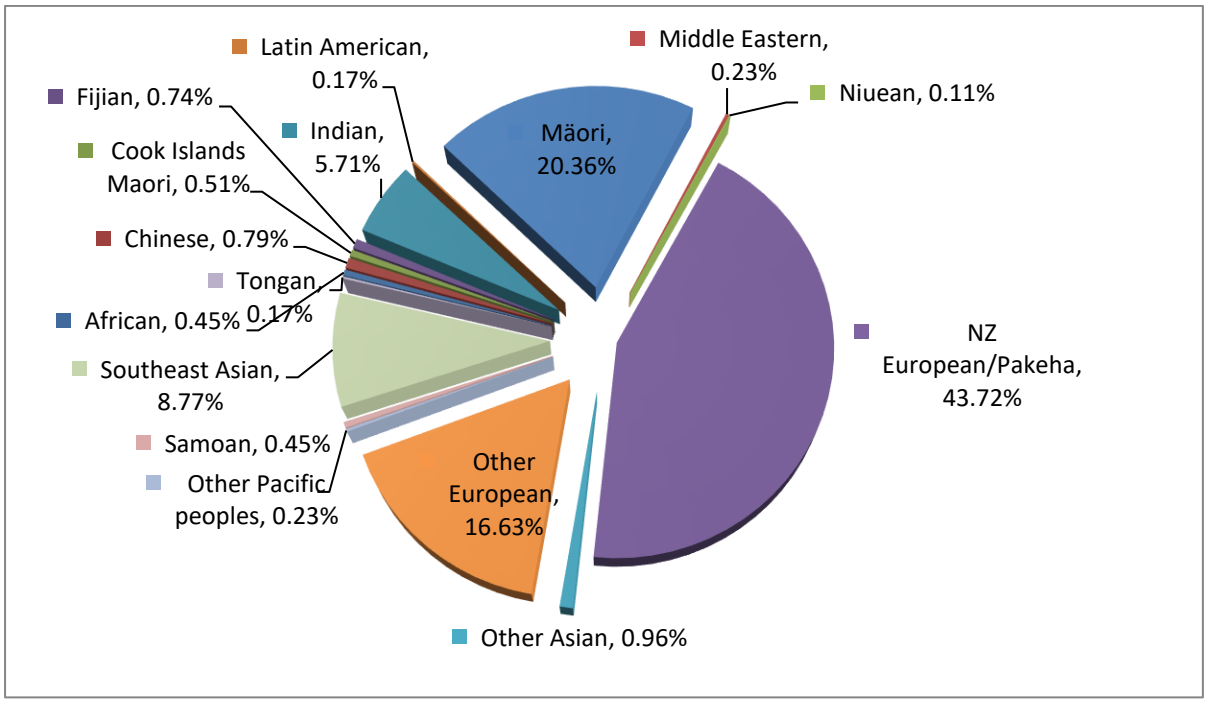
Introduction

Diversity & Inclusion/ Workforce Profile

Lakes workforce has returned to pre COVID-19 staffing levels due to the disestablishment of Managed Isolation Facilities, Swabbing Clinics and Immunisation Hubs. Lakes is one of the larger employers in the Lakes district, using contracting services (Spotless) as well as employing approximately 1768* staff down from 1855 staff in June 2021. Lakes offers flexible employment options, permanent, fulltime or part-time and casual. The workforce profile at Lakes is depicted in the pie charts below and, as is typical in health, is made up of a high proportion of female staff 82.86% (this is a small increase from last year which was 81%). The Lakes workforce is diversely represented with almost 20.36% identifying themselves as New Zealand Māori (a slight increase on last year), 2.21% as Pacific Island origin and 43.72% as being New Zealand European (a decrease of almost 5% on last year). The age profile has remained reasonably static with 1.47% under 20, 15.1% between 20 and 29, 22.96% between 30 and 39 years, 20.93% of employees are aged between 40 and 49 years, 23.25% between 50-59 years, 14.37% between 60-69 years of age and 1.92% 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.



At Lakes, 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 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 Freedom from Discrimination Policy, alongside other policies that encourage a diverse and inclusive approach, and retaining the principles of equal employment opportunities.

Lakes DHB continued 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 reports a disability. Disability awareness training (e-learning and classroom

style) is provided throughout the year to employees. Lakes has an under reported disabled workforce and as such, data has not been included in this report.

The 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.

Māori Health Workforce Participation/ Papa Pounamu

It is recognised that achieving health equities for our Māori population (a strategic and aspirational goal of Lakes DHB) will include a higher representation of Māori across the professional groups within health. Lakes DHB is working towards six key targets agreed nationally with strategies being developed within the Māori 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 Māori workforce to reflect Māori 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 Māori 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	Grand Total
Admin	3.73%	14.54%
Allied	2.94%	13.91%
Coordinator	0.40%	1.47%
Executive	0.11%	0.45%
Manager	0.17%	0.23%
Medical	1.30%	11.14%
Non Clinical	2.04%	4.02%
Nursing	9.67%	54.24%
Grand Total	20.36%	100.00%

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

- Reintroduction of the Associate Director of Nursing of Māori Health
- Newly established position of Te Aka Whai Ora - Principal Advisor, successfully recruited to at the beginning of 2022
- 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 and 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

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 Taupo hospital.

Gender Pay Gap and Pay Equity

As at 30 June 2022, Lakes DHB Gender Pay Gap is 2% and Ethnic Pay Gaps are Māori 23% (up from 20%), Asian 0% (down from 1% last year) and Pacific 23% (down from 31%). Lakes continues to see some positive shifts in the pay gaps, 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 expected to lessen with the introduction of an entirely new national pay and job banding structure for the Administration and Clerical roles, along with an increase in experience levels in the health professions, many will move up the various Multi Employer Collective Agreement (MECA) salary scales into more senior positions and more diversity is introduced at entry level.

MECAs 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.

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 actively promotes Te Iti Kahurangi which fosters professional behaviour and accountability; plus, supports 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.

The Speaking Up for Patient Safety Programme is now a mandatory part of employee orientation, along with Promoting Professional Accountability.

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. This Staff Survey was further delayed due to another wave of COVID-19 but a Pulse Survey is expected to take place in November 2022.

Activities include:

- 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
- 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
- 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 2021 to 30 June 2022, more than 3395 job applications were received by Lakes DHB. 1164 appointments were made; 128 of those appointments were candidates who identified as Māori (11%; 25.1% last year) and 13 candidates appointed identified as Pacific origin (1.1%; 3.2% 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 Te Manawa Taki district's 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, provide staff management and overall coordination of the programme.

Lakes will participate with promotion and events linked to the Kia Ora Hauora programme. Kia Hauora promotes health as a career focussing on the recruitment of Māori in to the health workforce. The Kia Ora Hauora programme aim is:

- To increase access to Māori health information regionally and locally
- Increase uptake and achievement by Māori students in secondary schools science
- Increase retention rates for Māori tertiary students studying a health related qualification

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

Activities included:

- Continued commitment to EEO principles in recruitment practices
- Development, review and update of recruitment resource materials to ensure cultural sensitivity
- Review of and continued monthly orientation of new employees to the organisation's expectations and requisite knowledge
- Work collaboratively with Māori health teams in terms of Māori health representation (as available) on interview panels
- Develop and deliver training opportunities to assist recruiters and interviewers with cultural assessments within the recruitment and selection process
- Monthly reporting on recruitment statistics (including ethnicity)
- 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

Employee Development, Promotion and Exit

Both the learning and development team and professional development unit utilise the training needs analysis from the annual performance management process to identify and schedule training. Continuing professional development is essential to all professional groups at Lakes, so there is a focus in ensuring that 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.

Due to the COVID-19 pandemic face to face onsite training had to cease. For staff to continue with their training needs, and 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).

The Managers in Action training programmes provided by Lakes 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.

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. Due to the COVID-19 pandemic Lakes DHB introduced a Flexible Working Arrangement procedure specifically for this and future emergency situations, to ensure that all employees that were unable to physically attend work during the pandemic had the ability to consider short term variations to their working arrangements and continue to be in paid employment as much as possible.

Lakes DHB also has a separate breastfeeding policy which 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. In the early part of 2022, an entirely new national pay and job banding structure was carried out to deliver the pay equity settlement to all administration and clerical roles. This unfortunately is not reflected in this year's report, as the new structure was effective July 2022. Lakes DHB is confident that this will have a positive impact on the gender pay gap.

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:

- Nursing and Midwifery Awards
- Celebrating Long Service Awards
- Staff Christmas BBQ

Harassment and Bullying Prevention

Lakes DHB has a zero tolerance for bullying and harassment. A Harassment, Workplace Bullying and Related Inappropriate Behaviours Policy is in place that provides clear definitions and an easy to follow flow chart of the process for employees should they experience untoward behaviour from a colleague.

The human resources team continues to provide training programmes in bullying and harassment to managers and team leaders, along with separate programme for staff.

Activities included:

- Provision of counselling services (EAP) and facilitated meetings for employees experiencing workplace relationship issues
- Continued Bullying and Harassment training for managers along with continued Bullying and Harassment training for employees
- Investigations into allegations of workplace bullying and harassment

Safe and Healthy Environment

Lakes DHB 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 assist employees back to work in a timely manner, but safely, with 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 healthy workplace programme which encourages and engages employees to actively participate in improving 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 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. Due to the unprecedented work demands caused by the COVID -19 pandemic combined with the transition to Te Whatu Ora – Health New Zealand there has been no capacity by either party to facilitate an audit to review the accreditation status in the 2021-22 year.

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/injury and illness rehabilitation which include 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, workplace assessments and comprehensive occupational vaccination programme
- Online training modules include (but not limited to) Health and Safety, Moving and Handling, Electrical & Fire Safety, Infection control & Hand Hygiene and Calm are available for 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 assist with the facilitation of these programmes within their chosen speciality.
- Fully implemented Healthy Drink and Food Policy
- Breastfeeding accreditation with lactation consultant and a breastfeeding facility available for employees on site

- Mental Health awareness promotion including webinars and e-learning packages regarding fatigue, shift work, burn out, anxiety and resilience
- Workshops on career planning and readiness for retirement
- Provision of a free Employee Assistance Services programme
- Provision of a range of vaccinations for employees, including seasonal Influenza
- Provision of smoking cessation support options for staff
- Pre-employment health screening and ongoing health monitoring of employees
- Onsite mirimiri, annual cervical screening
- Discounted gym memberships
- Eligibility for in-store purchase/service 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 2021/22

The outputs noted in the Statement of Performance reflect the performance of the four 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.
4. People are provided with appropriate rehabilitation and support services.

Results for 2021/22 are presented according to these four dimensions recognising that these dimensions are based around the following strategic ideas[2].

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 Lakes district. 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

[2] 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 26 in the financial section.

Health Promotion

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.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of hospitalised smokers offered advice to quit (SS06)	Māori	78.7%	80.5%	73.8%	95%	✗	Lakes has fallen short of the all smoking targets at the end of full 2021/22 fiscal year. Within the hospital setting performance was higher for Māori than non-Māori.
	Non-Māori	75.4%	75.7%	69.9%		✗	
	Total	77.3%	78.6%	72.3%		✗	
Percentage of PHO enrolled smokers offered advice to quit (PH04)[3]	Māori	77.6%	63.1%	64.4%	90%	✗	We are continuing to partner with PHO's to provide these discussions with whanau when appointments are available with GP Practices. 2021/22 Target was disrupted by re-focussing services to the wash-up of COVID services.
	Non Māori	84.5%	75.7%	72.4%		✗	
	Total	80.6%	68.4%	67.7%		✗	
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 to quit (CW09)	Māori	89.1%	83.0%	83.2%	90%	✗	The LMC workforce has been significantly reduced over the past 24months due to enforcement of the COVID mandate. Sadly, this precious resource has not returned, leaving secondary care (maternity Ward) to absorb increasing overflow. LMC's are prioritising their time with Hapū Māma and utilising referrals to
	Non Māori	80.0%	85.5%	79.6%		✗	
	Total	87.2%	83.6%	82.4%		✗	

[3] The data covers 15 months ending 30 June 2022 for patients aged 15 to 74 years old.

							Hapū Māma Wananga to reinforce "quit smoking", which shows in the minimal percentage decrease.
Percentage of babies living in smokefree homes at six weeks postnatal[4]	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	27.4%	58%	✗	More development is required in the collection and measurement of data. Postnatal follow-up process needs more endorsement and continued encouragement from clinician/Kiatiaki/whanau. Currently investigating a change to the model of care and service delivery.
	Non Māori			61.1%		✓	
	Total			42.6%		✗	
Percentage of infants who are exclusively or fully breastfed at 3 months (CW06)[5]	Māori	N/A-New Measure for 2021/2022	43%	42%	70%	✗	More development is required in the collection and measurement of data. Postnatal follow-up process needs more endorsement and continued encouragement from clinician/Kiatiaki/whanau. Currently investigating a change to the model of care and service delivery.
	Non Māori		60%	60%		✗	
	Total		53%	52%		✗	
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (CW10)[6]	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	92.6%	95%	✗	All children who are classified as having weight concerns are given advice by B4Sc nurse and referred onto their GP to be monitor.
	Non Māori			97.9%		✓	
	Total			94.5%		✗	

[4] The latest available data covers 12 months ending 31 December 2021.

[5] The latest available data covers 12 months ending 31 December 2021.

[6] The data covers 12 months ending 31 May 2022.

Immunisation

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 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.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of two year olds fully immunised (CW05)	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	62.0%	95%	×	The need to refocus efforts towards the First 2000 days which makes all childhood immunisation is a top priority for Lakes DHB. Community uptake is an all-time low following COVID messaging fatigue. Lakes Outreach Immunisation Service are absorbing a large number of "hard to reach" whanau, caused from an overflow from GP clinics predominately facing winter illnesses and COVID fatigue/general un-wellness. Service workups are being developed within the Localities Pilot Project to increase immunisation across the full life cycle.
	Non-Māori			84.1%		×	
	Total			73.0%		×	
Rate of HPV immunisation coverage (CW05)	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	59.6%	75%	×	WCFC are responsible for HPV School based immunisation programme carried out by Public Health Nursing team. The programme is currently running to deliver the 2nd dose of HPV programme will be

							complete in November. Catch programmes are to be done.
Percentage of the population >65 years who have received the seasonal influenza immunisation (CW05)[7]	High Needs	45%	47.5%	31.3%	75%	✗	These figures are due to the period of measurement and layover of COVID for this period. The 2022/23 figures are tracking significantly higher.
	Māori	N/A	N/A	39.0%		✗	
	Non-Māori	N/A	N/A	38.9%		✗	
	Total	69%	60.1%	39.0%		✗	

Screening

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.

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.

School Based Health Services (SBHS) ensures that all rangatahi entering secondary schools / kaupapa Māori kura meet the school nurse in person to develop a personal connection and have a private and confidential psychosocial Health Check assessment in Year 9 – HEEADSSS assessment: Home, Education/Employment, Eating, Activities, Drug, Sexuality, Suicide and Depression, and Safety (from injury and violence). This helps the school nurse/health professional formulate a plan in partnership with rangatahi. SBHS are available in lower decile (one to five) secondary schools, Teen Parent Units (TPUs) and Alternative Education sites (AE) nationally.

7 The data relates to the year of 2022 as Influenza vaccine runs from March to September every year.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of eligible women (25-69 years of age) who have had a cervical cancer screen completed in the last three years (PV02)	Māori	73%	61.7%	55.0%	80%	×	Despite our joint efforts with PHO and alliance partners to improve screening rate, the performance has dropped further this year, for both Māori and non-Māori. Whilst this is likely to be partly related to the COVID-19 pandemic, we will continue to work towards improving equitable access to diagnostic and treatment for priority groups. The example of this includes "Smear your Mea" campaign to support initiatives to improve screening rate by raising awareness through early detection for whānau and their communities.
	Non-Māori	76%	74.0%	72.8%		×	
	Total	75%	69.8%	66.4%		×	
Percentage of women (50-69 years of age) who have had a breast screen in the last two years (PV01)	Māori	67%	59.4%	55.2%	70%	×	Again we are seeing a decrease in the rate for both Māori and non-Māori, despite our joint efforts to increase the rate of screening for eligible women. This will be likely due to COVID-19 pandemic and extra pressure we had during the Health Reform which affected many providers and ourselves. However, we will continue to work with Breast Screening Midland, Te Arawa and Ngāti Tūwharetoa Iwi on design of interventions which will bring significant impact on Māori health outcomes.
	Non-Māori	72%	71.4%	68.6%		×	
	Total	71%	67.9%	64.5%		×	
Percentage of eligible population who have had their B4 School Checks completed	High Needs	68%	100.9%[8]	71.4%	90%	×	Lakes DHB performance in the completion of B4 School Checks had dropped in 2021/22, largely due to the COVID-19 pandemic. Within Lakes we have
	Māori	N/A	N/A	73.5%		×	

[8] 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 2021 and 7 July 2022 whereas Eligible Population is based on financial Year.

	Non-Māori	N/A	N/A	85.4%		✗	increased clinics. Due to the resignation of our Vision Hearing team this has somewhat impacted on completion of B4SC as hearing and vision is an integral part of checks. We are now on course to remedy this
	Total	74%	95.8%	79.3%		✗	
A routine health assessment (including HEEADSSS assessment) coverage in DHB funded school health services[9]	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	22.4%	95%	✗	Kura Kaupapa Māori in this rohe decline SBHS. Four secondary schools, one kura Auraki, one AE and one TPU provide HEEADSSS assessments for rangatahi in the northern and southern Lakes rohe for Jan-Jun 2022. Data received for SBHS Lakes July-Dec 2021 could not be validated as correct.
	Non-Māori			31.9%		✗	
	Total			26.5%		✗	

[9] The data covers 6 months ending 30 June 2022.

Output Class 2 – Early Detection and Management

Primary Health Care

Access to professional health care provided in the community is important in improving health care for many people. Diabetes is a condition of focus within both PHOs' LTC programmes with annual follow-up. PHO LTC programmes include `Diabetes Care Improvement Packages`. This approach has a strong involvement of multi-disciplinary Extended Care Support Teams members and allied health services for managed care from within the clients' medical home (GP) practice and for support to treatment services and self- management.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of population enrolled with a Primary Health Organisation (PHO)	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	84.7%	90%	✗	The GP unknown project is continuing with our partners at RAPHS and the focus continues to be on improving these rates for our Māori population. The Frequent Attendees MDT group continues to identify patients regularly presenting to ED and have dedicated staff to work alongside those who aren't enrolled to engage with a GP.
	Non-Māori			96.9%		✓	
	Total			92.2%		✓	
Proportion of people with diabetes (aged 15-74) and enrolled with Lakes DHB practices who have had an annual review	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	83.7%	85%	✗	There have been multiple community outreach events that have offered patients the opportunity to get their DAR completed and we have had positive feedback and uptake. We expect the target to be met by next year. The Lakes Local Diabetes group have also been working in this space to encourage patients and practices to improve this rate.
	Māori			39.0%	65%	✓[10]	

[10] HbA1C of more than 64mmol/mol is considered to be diabetic, thus results are achieved against the target.

Proportion of people with diabetes (aged 15-74) and enrolled with Lakes DHB practices who have a HbA1C > 64 mmol/mol	Non-Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	28.9%		✓	The Lakes Local Diabetes Team works in collaboration with stakeholders including consumers, Lakes DHB teams, local PHOs, non-government organisations (NGO), community providers, and pharmacists. Pre-diabetes Community workshops in conjunction with RAPHS and Diabetes NZ Rotorua, Sports BOP have developed and implemented a three-part workshop designed to support pre-diabetics. Sports BOP is a member of the steering group and also presents a workshop on the benefits of physical activity and how to start an exercise programme.
	Total			33.5%		✓	
Proportion of people with CVD or diabetes and enrolled with Lakes DHB practices that have a weight recorded in the last year	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	64.5%	85%	×	
	Non-Māori			62.5%		×	
	Total			63.0%		×	
Proportion of people who have had an acute cardiovascular event in the last 10 years who are prescribed triple therapy[11]	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	39.9%	55%	×	Triple Therapy is a combination of a lipid-lowering, blood pressure lowering and anti-platelet medication for CVD patients. RAPHS Clinical Pharmacists support prescribers with medicines information and reviewing target patient lists to support improved outcomes.
	Non-Māori			48.8%		×	
	Total			46.9%		×	

[11] Triple therapy consists of a lipid-lowering, blood pressure lowering, and anti-platelet medication

Oral Health

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. Good oral health is a combination of an environment that promotes good oral health especially early in life and an environment that ensures oral health services are accessible and responsive to the population.

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. 38% of the Lakes population identify as being of Māori descent, a much higher proportion of Māori than the national average of 17%. Lakes has a relatively high proportion of people in the most deprived section of the population.

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. Rotorua will have in the near future fluoridated water following the government mandate, which we hope will help to decrease the incidence of tooth decay in our population.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of children (0-4) enrolled in DHB funded dental services (CW03)	Māori	92%	87%	91%	95%	✗	Overall, Lakes DHB met the 2021/22 target of 95%, with an actual result of 99%, but fell short for Māori (91% actual; 95% target).
	Non-Māori	107%	104%[12]	100%		✓	
	Total	99%	95%	99%		✓	
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years (CW04)[13]	Māori	N/A	N/A	31.4%	85%	✗	We have new person recruited for the oral health educator / adolescent coordinator role. This person has been working in the transfer process of the adolescents from

[12] 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.

[13] The data comes from annual Ministry of Health report on adolescent utilisation for 2021 which covers from 1 January to 31 December 2021.

	Non-Māori	N/A	N/A	55.5%		✗	our service to the dentists that they are enrolled with. The proportion of adolescents enrolled with us of the total of population is very low. The majority of them are enrolled with dentist, therefore the COHS don't have visibility of them after been transferred. Our adolescent coordinator will be working in future with the dentists to be sure that most of adolescents will be followed up. This should produce a positive effect in the level of utilization in future.
	Total	63%	51.4%	42.7%		✗	
Mean DMFT (Decayed Missing or Filled Teeth) Score for Year 8 Children (12/13 years)	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	1.5	< 1.65	✓	Overall, Lakes DHB met the 2021/22 target of a DMFT < 1.65, with an actual average of 1.1
	Non-Māori			0.8		✓	
	Total			1.1		✓	
Percentage of enrolled children caries free at age 5 years	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	33.1%	47%	✗	We are not meeting this target but we are working whit our fluoridation program and oral health education to change this result in future.
	Non-Māori			61.5%		✓	
	Total			45.4%		✗	

Testing and Diagnostics

Access to community referred diagnostics, 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.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Category 1: Within 24 hours	100%	100%	99%	100%	✗	Category 2 was not met over this period of time due to unprecedented number of COVID swabs that were tested on the same machines as the tests with 96 hours TAT (Turn Around Time). This is an anomaly that will not be repeated next year as the COVID numbers have significantly reduced, we have extra machines with higher capacity and worldwide demand for reagents has decreased. Unfortunately, last year was a perfect storm of unprecedented demand, difficulty getting reagents (due to worldwide demand) and the occasional machine breakdown. We worked 24 hours shifts but were limited to the capacity of numbers on the machines for testing.
	Category 2: Within 96 hours	98%	93%	78.5%		✗	
	Category 3: Within 72 hours	100%	100%	100%		✓	

Pharmacy

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

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Number of community pharmacy prescriptions[14]	Total	1.65 million	1.85 million	1.78 million	-	-	There has been an approximate 4% decrease in the number of Community Pharmacy Prescriptions. During this timeframe we have dealt with higher measures and protocols for COVID, limiting interactions. As well as various different medicines coming off of close control due to supply issues. All of which can give an explanation to this decrease seen.

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

Output Class 3 – Intensive Assessment and Treatment

Acute Services

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.

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.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of all Emergency Department presentations who are triaged at levels 4 and 5[15]	Māori	N/A	N/A	41.4%	Under development	-	Lakes 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.
	Total	45.8%	44.1%	40.7%		-	
Percentage of patients events admitted, discharged or transferred from ED within six hours	Māori	N/A	N/A	84.7%	95%	✗	Lakes has not achieved the target for patients discharged or transferred from ED within six hours. Lakes has experienced significant challenges with staffing and inpatient bed capacity over the winter.
	Non-Māori	N/A	N/A	85.3%		✗	
	Total	N/A	90%	85.1%		✗	
Average inpatient length of stay (acute)	Māori	N/A	N/A	2.1 days	2.3 days	✓	Average length of stay (acute) has improved in 2021/2022. For acute surgical patients, we have focused on

[15] This reports on all ED presentations at both hospitals, Rotorua and Lakes, regardless of patient domicile.

	Non-Māori	N/A	N/A	2.6 days		✗	reducing pre-surgery length of stay, increasing number of acute arrange admissions, increasing Average WIES per theatre session per specialty, optimise early finishes and late starts, improve turnover and turnaround times. Although the target was not reached, overall, length of stay is effectively and proactively managed despite challenges around staffing and higher thresholds for admission.
	Total	N/A	3.0 days	2.4 days		✗	
Average inpatient length of stay (elective)	Māori	N/A	N/A	1.0 days	1.3 days	✓	Lakes has met the elective length of stay target for 2021/22 except for Non-Māori and has continued to see a downward trend. This is, in part, reflective of the weekly operational group that review all patients that are in hospital >10days. The primary successor, early involvement of our allied workforce working through the EPOA/PPPR and ARC facility procedure.
	Non-Māori	N/A	N/A	1.4 days		✗	
	Total	N/A	1.9 days	1.3 days		✓	
Acute re-admission rate	Māori	N/A	N/A	12.3%	< 12%	✗	There was a 0.3% improvement in the acute readmission rate since 2020/21. Reducing acute re- admissions can be an indication of quality care. Lakes are committed to reviewing patients re admitted for opportunities to improve. There is a readily available report that provides this information.
	Non-Māori	N/A	N/A	12.3%		✗	
	Total	12.4%	12.6%	12.3%		✗	

Cancer Services

Intensive assessment and treatment services are delivered by a range of specialist 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.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Faster Cancer Treatment –proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 62 days of diagnosis (SS01)	Total	100%	N/A	94.7%	90%	✓	Lakes has met the FCT target for 2021/22. We continue to work with the National Cancer Control Agency, Te Aho o Te Kahu on various Cancer Improvement activities with a focus on improving equity in the cancer services.

Elective Services

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 appointments the rates of non-attendance have been higher for Māori.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Proportion of patients waiting longer than 4 months for their first specialist assessment (FSA)	Total	4.6%	0.5%	2.3%	0%	✗	Lakes has made significant progress, despite workforce challenges, in reducing the proportion of patients waiting more than four months for their first specialist appointment. This expected to improve with the appointment of an onsite neurologist. Services non-compliant with the target are gynaecology (resourcing being addressed now) and neurology (resourcing addressed).
Proportion of patients who do not attend outpatient clinics (all patients)	Māori	16.0%	15.1%	14.0%	< 10%	✗	Lakes has fallen short of reaching non-attendance targets for Māori despite ongoing improvement. Lakes have introduced patient focused bookings and appointed a Pou Awhina (community based support role) to engage and support Māori patients to attend appointments. Total DNA targets are being achieved.
	Non-Māori	5.0%	4.4%	4.4%		✓	
	Total	9.0%	7.9%	7.6%		✓	

Diagnostics

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.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Proportion of patients with accepted referrals for CT and MRI receive their scan within 6 weeks (SS07)	CT	74%	83.4%%	80.6%	95%	✗	Lakes has not achieved CT and MRI wait times. CT is expected to improve due to the installation of a second CT Scanner in Taupo. Lakes has experienced significant challenges with staffing over the winter.
	MRI	61%	86.3%%	57.6%	90%	✗	
Proportion of patients receiving elective diagnostic colonoscopy within the prescribed waiting time (SS15)	Urgent colonoscopy (within 2 weeks)	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	83.6%	95%	✗	Lakes has not achieved colonoscopy wait times. Lakes has experienced significant challenges with staffing over the winter. Lakes are exploring the feasibility of two additional theatres which will increase capacity
	Non urgent colonoscopy (within 6 weeks)			44.4%		✗	
	Surveillance colonoscopy (within 12 weeks)			58.6%		✗	

Mental Health

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.

Output Description			2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (MH03)[16]	Mental Health	Age 0-19	52%	57.3%	53.6%	80%	✗	Lakes DHB has sustained improvement in performance of these mental health indicators for most areas. Targets were surpassed for addiction services, but not achieved for the mental health services for those under the age of 65 years. Significant pressure due to vacancies and staff illness has negatively impacted on the ability of some services to meet the targets.
		Age 20-64	51%	66.1%	62.5%		✗	
		Age 65+	75%	81.8%	84.9%		✓	
	Addictions	Age 0-19	99%	97.9%	99.3%	80%	✓	
		Age 20-64	88%	92.0%	96.4%		✓	
		Age 65+	94%	100.0%	100.0%		✓	
Rates of 7 day follow-up in the community post discharge (MH07)		Total	58.6%	64.3%	59.6%	75%	✗	Achievement of the 75% target was hindered by key staffing shortage along with marked increases in referral from the inpatient unit to the community team which has resulted in a drop of fulfilling the 7 day follow up requirements. This is being addressed with recent staff appointment and the implementation of a Registrar Clinic in the community where clients are followed up within 7 days.

[16] The latest available data covers 12 months from April 2021 to March 2022.

Quality and Safety

Quality and Safety Markers (QSMs) are used by the Health Quality & Safety Commission to evaluate the success of its quality improvement programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred. The QSMs are sets of related indicators concentrating on specific areas of harm. The first two outputs below reflect Lakes performance against two of these QSMs. The third output describes the patient reported experience of care specifically around their perceived involvement in their own care measured through the Adult Inpatient Hospital Surveys.

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Rate of in-hospital falls resulting in fractured neck of femur (FNOF) per 100,000 admissions	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	4.2	Under Development	-	Lakes achieved an internal 4.2 rate per 100,000 admissions, in comparison to the national average of 11.4.
Surgical site infections per 100 hip and knee operations[17]	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	4.2	Under Development Under	-	Lakes has not achieved its internal target at 1.9 rate per 100 hip and knee surgery site infections. Lakes identified 4 cases with pseudomonas aeruginosa caused by plumbing related biofilms, and undertook eradication successfully
	Non-Māori			1.4		-	
	Total			1.9		-	
Percentage of respondents who reported the highest level of involvement in their own care	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	84.9%	Under Development	-	Lakes is gradually improving. COVID-19 impacted on achieving the better results.

[17] The data covers 12 months ending December 2021.

Output Class 4 – Rehabilitation and support services

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.

Home Based Support

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of the population over 65 years that access Home Based Support Services (HBSS)	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	11.9%	Under Development	-	Home and community support providers (HCCS) have had considerable depletion in workforce capacity since the onset of the COVID pandemic, and demographics indicate a substantial increase in persons aged 65+ in the Lakes region. Lakes undertook a Home Based Support Service review involving providers to understand workforce capacity and look at solutions for improving access to this, as part of the Healthy Ageing Model of Care redesign. This is aligned with the new National Framework for Home and Community Support Services, and provides a consistent approach across the country to supporting older people to live independently in their homes for as long as possible.

Residential Care

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Percentage of population over 65 years who have accessed aged residential care (ARC)	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	3.0%	Under development	-	Staffing levels have impacted movement of persons into beds, but no closures of beds or facilities to date. Secure / Psychogeriatric beds in short supply within Lakes district. Regularly seeking placement outside Lakes District.

Palliative Care

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Number of initial and follow-up primary care delivered palliative care visits	Māori	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	293	Under development	-	Currently developing business case to implement an Advanced Care Planning community co-ordinator role (in the community setting rather than in hospital setting).
	Non-Māori			777			
	Total			1070			

Assessment, treatment and rehabilitation

Output Description		2019/20 Actual	2020/21 Actual	2021/22 Actual	2021/22 Target	Achieved	Comments
Number of people aged 65+ that have been seen by the Fracture Liaison Service (FLS)	Total	N/A-New Measure for 2021/2022	N/A-New Measure for 2021/2022	78	Under development	-	QE Health completes FLS assessment and education to clients. 78 individuals over the age of 65 received this service. A nurse will be taking on this component of the service. Currently in discussion with ACC (Accident Compensation Corporation) regarding an equity focused model of care and matched funding support to enable this.

Implementing the COVID-19 vaccine strategy

Additional performance information: COVID-19 vaccinations and mortality

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

COVID-19 vaccinations

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

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

HSU 2021

People are included if they were:

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

HSU 2020

People are included if they were:

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

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

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

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

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

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

To determine the coverage of the COVID-19 vaccine across the population of Lakes DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population
vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[18]

[18] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

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

Year [20]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	13.41%	14.05%
2021/2022	73.43%	76.97%
Total	**86.84%**	**91.02%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 86.84%, compared with 91.02% using HSU 2020 as at 30 June 2022.

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

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Lakes DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

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

Year[21]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[22]
2020/2021	19,934	13,343	0	0	33,277
2021/2022	72,337	74,342	52,576	591	199,846
Total	**92,271**	**87,685**	**52,576**	**591**	**233,123**

[19] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.

[20] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

[21] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.

[22] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

By 30 June 2022, a total of 233,123 COVID-19 vaccinations had been administered, of which 86% were administered in 2021/22.

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

COVID-19 vaccine doses administered by age group

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

COVID-19 vaccine doses administered by age group[23]

Age group	Primary course				
(years)[24]	Dose 1	Dose 2	Booster 1	Booster 2	Total[25]
0 to 11	4947	1968	0	0	6915
12 to 15	6282	5926	3	0	12211
16 to 19	4759	4729	1022	1	10511
20 to 24	5242	5137	1973	0	12352
25 to 29	5737	5667	2543	1	13948
30 to 34	6172	6147	3232	6	15557
35 to 39	5406	5495	3453	4	14358
40 to 44	5102	5206	3665	6	13979
45 to 49	5436	5575	4187	7	15205
50 to 54	5542	5852	4913	17	16324
55 to 59	5313	5745	5335	31	16424
60 to 64	4884	5505	5576	38	16003
65 to 69	2889	3996	5010	86	11981
70 to 74	2037	3180	4610	134	9961
75 to 79	1159	1990	3160	140	6449
80 to 84	798	1266	2188	86	4338
85 to 89	441	666	1091	28	2226
90+	191	292	615	6	1104
Total	72337	74342	52576	591	199846

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

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

[23] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[24] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[23] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 people vaccinated by age group during 2021/22[24]

Age group[25] (years)	Partial [26]		Primary course [27]		Booster course			
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	4140	21%	1707	9%	0	0%	0	0%
12 to 15	5303	76%	4593	66%	0	0%	0	0%
16 to 19	5258	88%	5139	86%	597	33%	0	0%
20 to 24	5220	76%	5126	75%	1908	35%	0	0%
25 to 29	5617	73%	5557	72%	2428	40%	0	0%
30 to 34	6211	74%	6204	74%	3119	46%	0	0%
35 to 39	5626	77%	5694	78%	3433	54%	0	0%
40 to 44	5145	76%	5265	78%	3614	62%	0	0%
45 to 49	5250	73%	5407	75%	4077	67%	0	0%
50 to 54	5649	75%	5905	79%	4825	72%	13	2%
55 to 59	5240	70%	5619	75%	5211	79%	32	5%
60 to 64	5124	71%	5700	79%	5565	83%	37	5%
65 to 69	3383	56%	4293	71%	5036	88%	81	8%
70 to 74	2172	40%	3346	62%	4667	92%	135	11%
75 to 79	1338	37%	2247	62%	3484	94%	137	13%
80 to 84	883	36%	1463	59%	2347	96%	97	13%
85 to 89	480	39%	730	59%	1177	99%	29	7%
90+	242	35%	387	56%	711	106%	8	3%
Total	**72,281**	**61%**	**74,382**	**63%**	**52,199**	**68%**	**569**	**8%**

[24] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[25] Age groupings in this table reflect age of the persons at end of financial year.
[26] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[27] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

COVID-19 vaccine doses administered by ethnicity

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

COVID-19 vaccine doses[28] administered by ethnicity[29] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	6010	5984	4489	12	16495
European/other	38524	41343	34306	516	114689
Māori	25326	24519	12150	54	62049
Pacific peoples	1967	1964	1195	3	5129
Unknown	510	532	436	6	1484
Total	**72,337**	**74,342**	**52,576**	**591**	**199,846**

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

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

[28] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.

[29] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

COVID-19 people vaccinated by ethnicity

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

COVID-19 people vaccinated by ethnicity during 2021/22[30]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	5,511	71%	5,777	74%	4,484	69%	6	3%
Māori	23,888	75%	24,041	75%	12,064	53%	48	5%
European /other	36413	65%	40,393	72%	34,022	75%	506	9%
Pacific peoples	1,818	74%	1,911	78%	1,192	61%	3	4%
Unknown	511	64%	553	69%	437	66%	6	16%
Total	**68,141**	**69%**	**72,675**	**73%**	**52,199**	**68%**	**569**	**8%**

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

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

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

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	7,062	91%	6,992	90%	4,484	69%	6	3%
Māori	27,588	86%	26,386	82%	12,064	53%	48	5%
European /other	50,457	90%	49,721	89%	34,022	75%	506	9%
Pacific peoples	2,240	91%	2,163	88%	1,192	61%	3	4%
Unknown	701	87%	682	85%	437	66%	6	16%
Total	**88,048**	**89%**	**85,944**	**87%**	**52,199**	**68%**	**569**	**8%**

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

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

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

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

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

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[31]

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

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

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

[31] https://www.stats.govt.nz/methods/population-statistics-user-guide.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [32]

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

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

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

- age
- ethnicity
- DHB
- gender

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

Comparison of HSU 2021 to the Stats NZ projected resident population

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

[32] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

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

As at 31 December 2021, there is an estimated 118,780 health service users in the HSU 2021. This is an increase of 4,349 people from the HSU 2020 (an approximate 3.8% increase), and 380 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[33]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	42,024	44,900	2,876
Pacific peoples	3,098	3,000	-98
Asian	9,468	10,100	632
European/other	63,339	60,400	-2,939
Unknown	851	0	-851
Total (Note 1)	**118,780**	**118,400**	**-380**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[34]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	39982	43900	3918
Pacific peoples	2935	2970	35
Asian	7995	9970	1975
European/other	62847	60800	-2047
Unknown	672	0	-672
Total (Note 1)	114431	117600	3169

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

[33] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

[34] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[35] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

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

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

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

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

COVID-19 Deaths by age group

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

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	1
50 to 59	1
60 to 69	3
70 to 79	3
80 to 89	10
90+	7
Total	**25**

[35] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

COVID-19 deaths by ethnicity

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

Ethnicity	
Asian	0
European/other	18
Māori	6
Pacific peoples	1
Unknown[36]	0
Total	**25**

[36] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

Statement of Responsibility for the Year Ended 30 June 2022

For the 12 months ended 30 June 2022

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

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

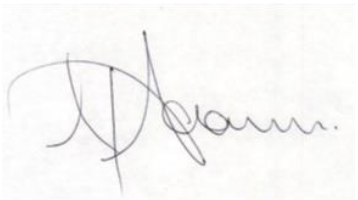
The Board and Management of Te Whatu Ora take responsibility for the preparation of the Lakes District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Lakes DHB group under section 19A of the Public Finance Act."

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

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

Signed on behalf of the Te Whatu Ora Board:



Naomi Ferguson
Acting Chair

Dated: 7 March 2023

Hon Amy Adams
Board member

Dated: 7 March 2023

Report of the Audit Office

Financial Statements

Statement of Comprehensive Revenue and Expense for the Year Ended 30 June 2022

	Notes	Lakes DHB Group Budget 2022 $000	Lakes DHB Group Actual 2022 $000	2021 $000
Revenue				
Patient care revenue	2(i)	500,271	534,930	458,548
Other revenue	2(ii)	7,428	10,947	13,631
Finance revenue	3	205	458	193
Total revenue		507,904	546,335	472,372
Expenditure				
Personnel costs	4	170,179	175,439	153,394
Depreciation and amortisation expense	10, 11	16,098	14,842	12,224
Outsourced services		16,818	22,356	21,812
Clinical supplies		37,406	39,009	36,421
Infrastructure and non-clinical expenses	19	23,914	26,831	23,295
Other district health boards		62,154	64,264	55,881
Non-health board provider expenses		174,343	180,971	163,947
Capital charge	5	7,515	9,851	7,005
Finance costs	3	172	80	115
Other operating expenses	6	1,555	9,032	1,514
Total operating expenditure		510,154	542,675	475,608
Share of associate/joint venture surplus/(deficit)	12	0	(360)	244
SURPLUS/(DEFICIT) BEFORE TAX		(2,250)	3,300	(2,992)
Income tax expense		0	0	0
SURPLUS/(DEFICIT) AFTER TAX		**(2,250)**	**3,300**	**(2,992)**
OTHER COMPREHENSIVE REVENUE AND EXPENSE				
Gains on property revaluations	18	0	55,484	57,816
Total other comprehensive revenue and expense		**0**	**55,484**	**57,816**
TOTAL COMPREHENSIVE REVENUE AND EXPENSE		**(2,250)**	**58,784**	**54,824**

Explanations of significant variances against budget are detailed in note 28

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

Statement of Changes in Equity for the Year Ended 30 June 2022

	Notes	Lakes DHB Group Budget 2022 $000	Lakes DHB Group Actual 2022 $000	Lakes DHB Group Actual 2021 $000
BALANCE AT 1 JULY		204,595	198,887	144,314
Prior year adjustments				
Capital contribution from the Crown		14,808	720	0
- Other contributions		0	0	60
Repayment of capital to the Crown		(301)	(301)	(301)
Total comprehensive revenue and expense		(2,250)	58,784	54,824
Adjustment to Trust funds		0	(863)	0
Prior year adjustment		(17)	(25)	(10)
BALANCE AT 30 JUNE	18	216,835	257,202	198,887

Statement of Financial Position as at 30 June 2022

	Notes	Lakes DHB Group Budget 2022 $000	Lakes DHB Group Actual 2022 $000	Lakes DHB Group Actual 2021 $000
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	7	0	23,892	12,328
Receivables	8	15,599	28,358	17,549
Prepayments		1,330	1,495	1,550
Inventories	9	2,444	2,601	2,700
Other financial assets	13	500	0	500
TOTAL CURRENT ASSETS		19,873	56,346	34,627
NON - CURRENT ASSETS				
Prepayments		2,190	1,462	1,518
Property, plant and equipment	10	259,636	280,816	231,171
Intangible assets	11	12,994	4,748	3,720
Investments in associate / joint venture	12	429	313	673
TOTAL NON - CURRENT ASSETS		275,249	287,339	237,082
TOTAL ASSETS		**295,122**	**343,685**	**271,709**

Explanations of significant variances against budget are detailed in note 28

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

	Notes	Lakes DHB Group Budget 2022 $000	Lakes DHB Group Actual 2022 $000	2021 $000
LIABILITIES				
CURRENT LIABILITIES				
Bank overdraft	7	15,247	0	0
Payables	14	27,555	33,677	32,012
Employee entitlements	15	30,936	33,729	23,732
Provisions	16	0	14,878	12,571
Borrowings	17	341	346	529
TOTAL CURRENT LIABILITIES		74,079	82,630	68,844
NON CURRENT LIABILITIES				
Employee entitlements	15	3,557	2,795	2,982
Provisions	16	-	407	-
Borrowings	17	651	651	996
TOTAL NON CURRENT LIABILITIES		4,208	3,853	3,978
TOTAL LIABILITIES		78,287	86,483	72,822
NET ASSETS		**216,835**	**257,202**	**198,887**
EQUITY				
Crown equity	18	86,230	72,170	71,751
Other reserves	18	164,527	215,410	159,926
Retained earnings/(losses)	18	(34,745)	(30,378)	(33,653)
Trust funds	18	823	0	863
TOTAL EQUITY		**216,835**	**257,202**	**198,887**

Explanations of significant variances against budget are detailed in note 28

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

For and on behalf of the Health New Zealand Board

_____
Health New Zealand Board Member

Date: 10 March 2023

_____
Health New Zealand Board Member

Date: 10 March 2023

Statement of Cash Flows for the Year Ended 30 June 2022

	Notes	Lakes DHB Group Budget 2022 $000	Lakes DHB Group Actual 2022 $000	2021 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and patients		507,700	527,730	469,548
Interest received		205	381	133
		507,905	528,111	469,681
Cash was applied to:				
Payments to suppliers		316,126	330,844	302,379
Payments to employees		169,672	163,229	150,108
Interest paid		486	80	115
Distribution to owners: capital charge		7,207	9,851	7,005
GST (net)		(389)	2,353	(229)
		493,102	506,357	459,378
Net cash flows from operating activities		14,803	21,754	10,303
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from sale of property		0	45	74
Receipts from investments		0	1,000	0
		0	1,045	74
Cash was applied to:				
Purchase of property, plant and equipment		26,152	9,360	7,814
Purchase of intangible assets		5,356	400	-71
Adjustment to Trust cash holdings		0	866	0
Acquisition of investments		17	500	0
		31,525	11,126	7,743
Net cash flows from investing activities		(31,525)	(10,081)	(7,669)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds from finance lease liabilities		0	0	0
Proceeds from shareholder capital injection		14,808	720	0
Cash was applied to:				
Repayments of shareholder capital		301	301	241
Repayments of finance lease liabilities		532	528	630
Net cash flows from financing activities		13,975	(109)	(871)
Net increase/(decrease) in cash, and cash equivalents		**(2,747)**	**11,564**	**1,763**
Cash and cash equivalents at beginning of year		(12,500)	12,328	10,565
Cash and cash equivalents at end of year	**7**	**(15,247)**	**23,892**	**12,328**

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 28.

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 2022 $000	Actual 2021 $000
Surplus/(deficit) after tax	3,300	(2,992)
Add/(less) non-cash items:		
Depreciation and amortisation expense	14,842	12,224
Share of associate and joint venture (surplus)/deficit	360	(244)
Property, plant and equipment impairment	0	(659)
Provisions	2,714	0
	17,916	11,321
Add/(less) items classified as investing or financing activity:		
Net loss(gain) on disposal of property, plant and equipment	(6)	(8)
	(6)	(8)
Add/(Less) movements in working capital items:		
(Increase)/Decrease in debtors, prepayments and other receivables	(11,031)	(5,791)
(Increase)/Decrease in inventories	99	(27)
Increase/(Decrease) in creditors and other payables	1,665	4,514
Increase/(Decrease) in employee entitlements	9,811	1,463
Increase/(Decrease) in provisions	0	1,823
	544	1,982
Net cash inflow/(outflow) from operating activities	**21,754**	**10,303**

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 and Lakes DHB's interest in associates and jointly controlled entities (together referred to as "The Group" or the "Lakes DHB Group").

The group consists of Lakes DHB, its subsidiary, Spectrum Health Limited (100% owned), in substance subsidiary, The Lakes District Hospitals Charitable Trust (previously known as 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).

The financial statements for the group were approved for issue by the Health New Zealand Board on 27 January 2023.

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.

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 ongoing 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 2022.

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:

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 IPSAS 29 Financial Instruments: Recognition and Measurement

PBE IPSAS 29 Financial Instruments was issued by the XRB in September 2014 and incorporates amendments to 31 January 2021. This standard was superseded, in part, by PBE IFRS 9 Financial Instruments which was issued in January 2017. This standard is applicable to annual periods beginning on or after 1 January 2022, with early adoption permitted. Although Lakes DHB has not assessed the effect of the new standard, it does not expect any significant changes to result from application of the standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements. It is effective for reporting periods beginning on or after 1 January 2022, with earlier adoption permitted. Lakes DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

New Group Accounting Standard

PBE IPSAS 34 Separate Financial Statements was issued concurrently with PBE IPSAS 35 Consolidated Financial Statements. When applied, the two Standards supersede PBE IPSAS 6 (PS) Consolidated and Separate Financial Statements and PBE IPSAS 6 (NFP) Consolidated and Separate Financial Statements. PBE IPSAS 36 Investments in Associates and Joint Ventures supersedes PBE IPSAS 7 Investments in Associates. PBE IPSAS 37 Joint Arrangements supersedes PBE IPSAS 8 Interests in Joint Ventures. All of these four standards were issued by the XRB and all are effective for reporting periods beginning on or after 1 January 2022, with earlier adoption permitted. Although Lakes DHB has not assessed the effect of the new standards, it does not expect any significant changes to result from application of the standards.

New amendment applied

An amendment to PBE IPSAS 2 Cash Flow Statements requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. The new information required by this amendment has been disclosed in Note 17.

Changes in accounting policies

There have been no accounting policy changes in the 2022 financial statements when compared to 2021.

Change in presentation

Section 152 of the Crown Entities Act 2004 (CEA) requires the Lakes DHB to disclose information in the annual report about payments in respect of members, committee members, and employees.

The CEA does not require this information to be disclosed within the audited financial statements. These disclosures were included in the notes to the 2021 Group financial statements. The 2022 equivalent information is disclosed in a new section "Other Statutory Disclosures" within the 2022 Lakes DHB Annual Report.

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 District Health Board is required (as a Crown Entity) to adopt the update its accounting policy regarding Software as a Service (SaaS). Lakes DHB has performed a SaaS assessment as at 30 June 2022, as prescribed by the IFRC agenda decision. The assessment has resulted in no material changes (as defined in PBE IPSAS 1) in implementing the accounting policy. No retrospective or comparative information has been restated. Therefore, no change to accounting treatment or to financial performance or position reported in prior years has been recorded.

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 Health New Zealand Board the financial statements of Spectrum Health Limited and the Lakes District Hospitals Charitable Trust were unaudited. The unaudited results of Spectrum Health and the Lakes District Hospitals 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.

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.

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 26, 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.

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.

MOH contract revenue

The revenue recognition approach for MOH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

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 2022 $000	Actual 2021 $000
MOH Crown appropriation revenue **(1)**	413,421	380,184
Other MOH contracted revenue	79,219	40,370
Other Government revenue	7,339	7,583
Inter-DHB revenue	28,600	25,025
ACC revenue	6,351	5,386
Total revenue	**534,930**	**458,548**

(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 $411,799,200 (2021: $381,002,089).

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 2022 $000	Actual 2021 $000
Sale of goods	1,279	2,037
Rendering of services	2,043	10,759
Donations and bequests received *	7,005	96
Property, plant, and equipment gains on disposal	6	61
Other	614	678
Total other operating revenue	**10,947**	**13,631**

* During the 2022 financial year the Lakes DHB received Covid-19 personal protective equipment and supplies valued at $6,981,807 donated to it by the Ministry of Health.

3. Finance Income and Finance Costs

	Lakes DHB Group Actual 2022 $000	Actual 2021 $000
Finance revenue		
Interest revenue:		
Term and call deposits	458	193
Total finance revenue	**458**	**193**
Finance costs		
Interest expense:		
Interest on finance leases	80	115
Total finance costs	**80**	**115**

4. Personnel Costs

Accounting Policy

Salaries and Wages

Salaries and wages are recognised as an expense as employees provide 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 2022 $000	Actual 2021 $000
Salaries and wages	158,464	145,544
Defined contribution plan employer contributions	4,950	4,564
Increase/(decrease) in employee entitlements/liabilities	9,811	1,463
Increase/(decrease) in provision for holiday pay remediation	2,214	1,823
Total personnel costs	**175,439**	**153,394**

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 2022 was 5% (2021: 5%).

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 2022 $000	Actual 2021 $000
Fees for financial statement audits:		
- Fees for the audit of the 2021 financial statements	145	151
- Fees for the audit of the 2022 financial statements	213	0
- Fees for the audit of the 2022 financial statements of Spectrum Health Limited	15	0
Fees for the audit of the 2022 - Specialist Audit and Assurance Service review	31	0
ACC	(12)	53
Board of director fees (note 22)	360	208
Inventory consumption *	6,992	71
Impairment of receivables (note 8)	73	5
Loss on disposal of property, plant, and equipment	18	69
Minimum lease payments under operating leases	1,197	830
Restructuring expenses (note 16)	0	127
Total other expenses	**9,032**	**1,514**

* During the 2022 financial year the Lakes DHB received Covid-19 personal protective equipment and supplies valued at $6,981,807 donated to it by the Ministry of Health (refer to Note 2ii). These items were consumed during the 2022 financial year.

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 2022 $000	Actual 2021 $000
Cash at bank and in hand	399	466
Term deposits with maturities less than three months	0	700
Loan to NZHPL	23,493	11,162
Cash and cash equivalents in the statement of cash flows	**23,892**	**12,328**

While cash and cash equivalents at 30 June 2022 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 2022, this limit was $22.517 million (2021: $19.996 million).

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

The Lakes District Hospitals Charitable Trust's total value of cash and cash equivalents that can only be used for specified purpose as outlined in the trust deed is nil (2021: $166,086). Further information can be found in Note 18.

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 2022 $000	**Actual 2021 $000**
Current		
Receivables (gross)	28,613	17,731
Less: Allowance for credit losses	(255)	(182)
Total Current	28,358	17,549
Total receivables	**28,358**	**17,549**
Total receivables comprises:		
Receivables from MoH	9,879	4,993
Other receivables	18,479	12,556

Expected Credit Losses

As of 30 June 2022 and 2021, all overdue receivables have been assessed for expected credit losses and appropriate provisions applied, as detailed below:

	Actual 2022 Gross $000	**Actual 2021 Gross $000**
Lakes DHB Group		
Not past due	20,942	15,528
Past due 31 - 60 days	4,216	847
Past due 61 - 90 days	1,486	442
Past due > 90 days	1,969	914
Total	**28,613**	**17,731**

	Actual 2022 Allowance for credit losses $000	Actual 2021 Allowance for credit losses $000
Lakes DHB Group		
Not past due	(3)	(2)
Past due 31 - 60 days	0	0
Past due 61 - 90 days	0	0
Past due > 90 days	(252)	(180)
Total	**(255)**	**(182)**

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 2022 $000	Actual 2021 $000
Individual basis	255	182
Collective basis	0	0
Total provision for impairment	**255**	**182**

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 2022 $000	Actual 2021 $000
Past due 1 - 60 days	3	2
Past due 61 - 90 days	0	0
Past due > 90 days	252	180
Total individual credit losses	**255**	**182**

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

	Lakes DHB Group	
	Actual 2022 $000	Actual 2021 $000
At 1 July	182	219
Increase in loss allowance made during the year	92	164
Credit losses reversed during the year	(16)	(161)
Receivables written off during period	(3)	(40)
At 30 June	**255**	**182**

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 2022 $000	Actual 2021 $000
Pharmaceuticals	485	395
Surgical and medical supplies	1,293	1,456
Other supplies	823	849
Total inventories	**2,601**	**2,700**

The amount of inventories recognised as an expense during the year was $32.38 million (2021: $36.42 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 (2021: 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 (2021: Nil). There have been no reversals of write downs (2021: 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, leasehold 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 25 to 32 years (3.1% - 4.0%)
- Fit-out 25 to 30 years (3.3% - 4.0%)
- 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 useful lives, depreciation rates, 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.

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements.

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 2022.

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.

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.

Estimating Useful Lives and Residual Values of Property, Plant and Equipment

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 are as follows:

	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 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**
Balance at 1 July 2021	18,550	191,230	31,467	4,229	12,754	2,260	9,981	270,471
Additions	-	1,981	4,774	441	1,709	398	-	9,303
Disposals	-	-	(737)	(22)	(46)	(43)	(343)	(1,191)
Transfer to Intangibles	-	-	(1,128)	-	16	-	-	(1,112)
Revaluations	4,480	41,840	-	-	-	-	-	46,320
Balance at 30 June 2022	**23,030**	**235,051**	**34,376**	**4,648**	**14,433**	**2,615**	**9,638**	**323,791**

	Land (at valuation)	Freehold buildings (at valuation/	Medical Plant and equipment	Non-Medical Plant and	Computer Equipment	Motor Vehicles	Leased assets	Total
	$000	$000	$000	$000	$000	$000	$000	$000
Depreciation and Impairment charges								
Balance at 1 July 2020	-	(6,267)	(19,306)	(2,839)	(8,819)	(1,622)	(4,522)	(43,375)
Depreciation charge for the year	-	(6,315)	(2,226)	(276)	(1,365)	(191)	(829)	(11,202)
Disposals	-	-	1,776	33	218	384	284	2,695
Revaluations	-	12,582	-	-	-	-	-	12,582
Balance at 30 June 2021	**-**	**-**	**(19,756)**	**(3,082)**	**(9,966)**	**(1,429)**	**(5,067)**	**(39,300)**
Depreciation and Impairment charges								
Balance at 1 July 2021	-	-	(19,756)	(3,082)	(9,966)	(1,429)	(5,067)	(39,300)
Depreciation charge for the year	-	(9,164)	(2,492)	(254)	(1,200)	(198)	(682)	(13,990)
Disposals	-	-	701	21	45	43	341	1,151
PPE Class Transfers	-	-	(1)	-	-	-	1	-
Revaluations		9,164	-	-	-	-	-	9,164
Balance at 30 June 2022	**-**	**-**	**(21,548)**	**(3,315)**	**(11,121)**	**(1,584)**	**(5,407)**	**(42,975)**
Carrying amounts								
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**
At 1 July 2021	18,550	191,230	11,711	1,147	2,788	831	4,914	231,171
At 30 June 2022	**23,030**	**235,051**	**12,828**	**1,333**	**3,312**	**1,031**	**4,231**	**280,816**

Land and buildings valuation basis

Buildings	**Actual 2022 $000**	**Actual 2021 $000**
Depreciated replacement cost	232,746	190,904
Historical cost	2,305	326
Total carrying value of buildings	**235,051**	**191,230**

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

		Lakes DHB Group Actual 2022 $000	Actual 2021 $000
Work in progress			
The closing balances of work in progress by asset class is:	Buildings	2,305	0
	Plant & Equip - Medical	738	0
	Plant & Equip - Non Medical	188	0
	Computer	1,557	427
	Motor Vehicle	383	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 $23,030,000 (2021: $18,550,000).

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 Māori sites of significance.

Leased Assets

Lakes DHB Group leases vehicles under a number of finance lease agreements. At 30 June 2022, the net carrying amount of leased vehicles was $9,802 (2021: $56,004). 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 2022, the net carrying amount of building leasehold improvements was $3,402,290 (2021: $3,622,115).

Lakes DHB Group leases medical and non-medical plant and equipment under a finance lease agreement. At 30 June 2022, the net carrying amount of the medical and non-medical plant and equipment was $819,209 (2021: $1,233,292). 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 2022 (2021: 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 2022 $000	Actual 2021 $000
Buildings	326	2801
Computer Plant & Equipment	2,775	1372
Medical Plant & Equipment	621	5,255
Non Medical Plant & Equipment	205	219
Intangible assets	228	3,499
Vehicles	0	652
Total capital commitments	**4,155**	**13,798**

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
Acquired Computer Software	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:

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
Cost	
Balance at 1 July 2020	16,073
Additions	1,021
Disposals	(1,692)
Work in progress	537
Transfer to other classes	(1,629)
Balance at 30 June 2021	**14,310**
Cost Balance at 1 July 2021	14,310
Additions	768
Transfer from property plant and equipment	1,112
Balance at 30 June 2022	**16,190**
Accumulated amortisation and impairment losses	
Balance at 1 July 2020	(11,260)
Amortisation expense	(1,022)
Disposals	1,692
Balance as at 30 June 2021	**(10,590)**
Balance at 1 July 2021	(10,590)
Amortisation expense	(852)
Balance as at 30 June 2022	**(11,442)**
Carrying amounts	
At 1 July 2020	4,813
At 30 June 2021	**3,720**
At 1 July 2021	3,720
At 30 June 2022	**4,748**

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 Associate / 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 associate / joint venture	Lakes DHB Group Actual 2022 $000	Actual 2021 $000
	313	673

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

	Lakes DHB Group Actual 2022 $000	Actual 2021 $000
Current assets	6,938	9,599
Non - current assets	27,751	27,674
Current liabilities	3,755	4,141
Non - current liabilities	29,367	29,768
Revenue	18,650	21,352
Expenses	20,449	20,146
Share of associate/joint venture surplus/(deficit)	(1,800)	1,206
Group's interest	20%	20%
Share of associate/joint venture surplus/(deficit)	(360)	244

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 20.

13. Other Financial Assets and Liabilities

	Lakes DHB Group Actual 2022 $000	Actual 2021 $000
Finance asset - current		
Term deposits with maturities three to twelve months	0	500
Total finance asset	**0**	**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 2022 $000	Actual 2021 $000
Payables under exchange transactions		
Trade payables and expenses	26,669	22,199
Revenue in advance	4,743	5,170
Amounts owing to subsidiary companies	0	56
ACC Levy payable	405	374
Total payables under exchange transactions	31,817	27,799
Payables under non-exchange transactions		
GST, PAYE, and FBT payable	1,860	4,213
Total payables under non-exchange transactions	1,860	4,213
Total payables	**33,677**	**32,012**

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 3.34% to 4.31% in a 10-year range (2021: 0.38% to 2.98%) and a salary inflation factor of 2.00% (2021: 2.00%) was used.

Breakdown of employee entitlements and further information	Lakes DHB Group	
	Actual 2022 $000	Actual 2021 $000
Current liabilities		
Retirement gratuities	103	97
Long service leave	208	182
Sabbatical leave	78	104
Annual leave	17,594	14,930
Continuing medical education (CME) leave	1,048	1,354
Continuing medical education (CME) expenses	4,016	3,276
Accrued salary and wages	10,682	3,789
Total current portion	33,729	23,732
Non - current liabilities		
Retirement gratuities	130	137
Long service leave	1,872	1,816
Sabbatical leave	793	1,029
Total non - current portion	2,795	2,982
Total employee entitlements	**36,524**	**26,714**

16. Provisions

Accounting Policy

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.

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.

In preparing these financial statements, Lakes DHB recognises it has an obligation as at 30 June 2022 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 involved creating a copy of the payroll system, modifying the system configuration and running scripts to recalculate the value of the liability on an individual employee basis.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance continues. Lakes DHB has made significant progress with its review however, uncertainties remain. This is because the sector received legal advice in December 2022 on how to decide whether a day is an 'otherwise working day' when calculating the estimated holiday pay entitlements. Lakes DHB has not amended its provision for this advice and work in this regard was ongoing at the date of signing these financial statements.

Further adjustment to the carrying amount of the provision may therefore be required by Te Whatu Ora, Health New Zealand. The final outcome of the remediation project and timeline for addressing any non-compliance will not be determined until this work is completed.

Restructuring

The Pae Ora (Healthy Futures) Act 2022 received royal assent on 14 June 2022. Section 10 of the act states that every employee of a District Health Board (DHB) becomes an employee of Health New Zealand District Health with the exception of the DHB's Chief Executive Officer. As a result, the Lakes DHB has an obligation, arising from the employment agreement with the Chief Executive Officer, at 30 June 2022 to pay him compensation for redundancy. It is assumed that the redundancy payment will be due for payment shortly after 30 June 2022.

Onerous Contracts

The Lakes DHB operates an enterprise resource planning (ERP) software called Technology One. The DHB is contractual obliged to pay for Technology One software fees until September 2025 (fees are paid annual in advance). The DHB has been directed, on the 31st of May 2022 by the Health New Zealand Chief Executive Officer, to begin using an Oracle-based ERP instead of Technology One by June 2024. Health New Zealand aims to have all former DHB's using one ERP system for reporting and operational efficiency. The Lakes DHB therefore has an unavoidable contractual obligation to pay the Technology One fees for the period June 2024 to September 2025 during which time it will not receive substantial benefits, as it will be using the new Oracle-based ERP.

It has been assumed the DHB will meet all its current minimum contractual obligations but will not excise any rights to extend the contract term or purchase additional, post-term, services. It is also assumed that Lakes DHB will transition to the Oracle-based ERP system at or slight earlier than June 2024. Technology One fees increase with inflation and the rate of inflation, based on New Zealand Treasury forecasts, is assumed to be 3.9% and 2.6% in the next two financial years. A discount rate, to reflect the time value of money, has been used, based on New Zealand Treasury advice, in each subsequent year. The rates vary 3.34% and 3.85% per annum.

	Lakes DHB Group	
	Actual 2022 $000	Actual 2021 $000
Current provisions are represented by:		
Carrying amount at the beginning of the year	12,571	10,748
Additional provision	2,214	1,823
Holidays Act Remediation Provision	14,785	12,571
Restructuring provision	93	-
Total current portion	14,878	12,571
Non-current provisions are represented by:		
Onerous contracts	407	-
Total non - current portion	407	-
Total Provisions	**15,285**	**12,571**

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 2022 $000	Actual 2021 $000
Current		
Finance leases	346	529
Total current portion	346	529
Non current		
Finance leases	651	996
Total non - current portion	651	996
Total borrowings	**997**	**1,525**

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 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 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 $22.517 million (2021: $19.996 million).

Analysis of Finance Leases

	Lakes DHB Group Actual 2022 $000	Actual 2021 $000
Total minimum lease payments are payable		
Not later than one year	397	607
Later than one year and not later than five years	713	1,026
Later than five years	0	86
Total minimum lease payments	1,110	1,719
Future finance charges	(113)	(194)
Present value of minimum lease payments	997	1,525
Present value of minimum lease payments payable		
Not later than one year	346	527
Later than one year and not later than five years	651	913
Later than five years	0	85
Total present value of minimum lease payments	997	1,525
Represented by:		
Current	346	529
Non-current	651	996
Total finance leases	**997**	**1,525**

Reconciliation of movements in liabilities arising from financing activities

The table below provides a reconciliation between the opening and closing balance of finance lease liabilities.

	Actual 2022 $000
Balance at 1 July 2021	1,525
Cash outflows	(528)
New leases	0
Balance at 30 June 2022	**997**

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 10 and 11.

Motor Vehicle Finance leases at 30 June 2022 are with Toyota Financial Services and Orix New Zealand Ltd. IT Finance Leases at 30 June 2022 are with CBA Asset Finance (NZ) Ltd and MCL Capital Ltd. Medical Equipment Finance Leases at 30 June 2022 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.

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.

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 2022 $000	Actual 2021 $000
Crown equity		
Balance at 1 July	71,751	71,984
Contributions from the Crown		
- Conversion of Crown loan to equity		
- Other contributions	720	68
Repayments to the Crown	(301)	(301)
Balance at 30 June	72,170	71,751
Other reserves		
Asset revaluation reserves		
Balance at 1 July	159,926	102,110
Revaluation gains/(losses)		
- Land	4,480	6,885
- Buildings	51,004	50,931
Transfer of asset revaluation reserve to retained earnings on disposal of property		
- Land		0
- Buildings		0
Balance at 30 June	215,410	159,926
Represented by:		
Total Land	21,474	16,994
Total Buildings	193,936	142,932
	215,410	159,926
Total other reserves	215,410	159,926

The asset revaluation reserve relates to land and buildings.

Retained Earnings

	Lakes DHB Group Actual 2022 $000	Actual 2021 $000
Balance at 1 July	(33,653)	(30,619)
Prior year adjustment	(25)	(42)
Surplus(deficit) for year	3,300	(2,992)
Balance at 30 June	(30,378)	(33,653)

Trust Funds

	Lakes DHB Group	
	Actual 2022 $000	Actual 2021 $000
Balance at 1 July	863	839
Transfer to retained earnings in respect of:		
Interest received		20
Donations and funds received		11
Transfer to retained earnings in respect of:		
Funds spent		(29)
Prior year adjustment		22
Adjustment to Trust funds	(863)	
Balance at 30 June	0	863
Total equity at 30 June	**257,202**	**198,887**

The Lakes District Hospitals 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 2022 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 details of the Trust cash and cash equivalents.

During the year Spectrum Health Limited paid in cash an unimputed dividend to its parent, Lakes District Health Board, of $500,000 (2021: nil). The dividend has no impact on the consolidated group's cash or equity balances.

19. Impairment of Non-Cash generating assets

Accounting Policy

Non-cash-generating assets are those assets that are not held with the primary objective of generating a commercial return. The DHB does not hold any cash-generating assets. For non-financial non-cash-generating assets the DHB assesses at each reporting date whether there is an indication that a non-cash-generating asset may be impaired. If any indication exists, or when annual impairment testing for an asset is required, the DHB estimates the asset's recoverable service amount. An asset's recoverable service amount is the higher of the non-cash-generating asset's fair value less costs to sell and its value in use. Where the carrying amount of an asset exceeds its recoverable service amount, the asset is considered impaired and is written down to its recoverable service amount.

In assessing value in use, the Group has adopted the service units approach. Under this approach, the present value of the remaining service potential of the asset is determined by reducing the current cost of the remaining service potential of the asset before impairment to conform to the reduced number of service units expected from the asset in its impaired state.

In determining fair value less costs to sell, the price of the asset in a binding agreement in an arm's length transaction, adjusted for incremental costs that would be directly attributed to the disposal of the asset, is used. If there is no binding agreement, but the asset is traded on an active market, then the fair value less cost to sell is the asset's market price less cost of disposal. If there is no binding sale agreement or active market for an asset, then the DHB determines fair value less cost to sell based on the best available information.

Impairment losses are recognised immediately in surplus or deficit, except for assets previously revalued with the revaluation taken to other comprehensive revenue and expense. For such assets, the impairment is recognised in other comprehensive revenue and expense up to the amount of any previous revaluation in the same manner as a revaluation decrease.

For each asset, an assessment is made at each reporting date as to whether there is any indication that previously recognised impairment losses may no longer exist or may have decreased. If such indication exists, the DHB estimates the asset's recoverable service amount. A previously recognised impairment loss is reversed only if there has been a change in the estimates used to determine the asset's recoverable service amount since the last impairment loss was recognised. The reversal is limited so that the carrying amount of the asset does not exceed its recoverable service amount, nor exceed the carrying amount that would have been determined, net of depreciation, had no impairment loss been recognised for the asset in prior years. Such reversal is recognised in surplus or deficit unless the asset is carried at a revalued amount, in which case, the reversal is treated in the same manner as a revaluation increase.

Impairment of prepaid licences

Lakes DHB, along with other Midland Region District Health Boards, pay HealthShare Limited for the use of software HealthShare controls. The funding is used by HealthShare to design, build, commission and operate intangible software assets. The DHB is entitled to receive the use of the software and recognises a prepayment asset to the extent its payments are made in advance of receiving the software services. The prepayment asset is released and recognised as an expense in the statement of financial performance as the DHB receives the service under its arrangement with HealthShare Limited.

In 2021 HealthShare impaired its Te Manawa Taki Clinical Portal Work in Progress Intangible Asset and its corresponding Income in Advance liability, being the liability it owes to the DHBs to provide future software services. In 2022 HealthShare impaired its Medicines Management Pre Pilot and Mental Health and Addiction Services Intangible Assets and the corresponding Income in Advance liabilities owed to the DHBs.

Lakes DHB therefore assesses that its prepayment asset is impaired to the extent it will not receive the services related to the assets HealthShare has identified as impaired. The DHB has entirely written off the value of these specific assets, presented in Statement of Financial Position within Prepayments assets.

	Lakes DHB Group	
	Actual 2022 $000	Actual 2021 $000
Impairment Expense is recognised in the Statement of Comprehensive Revenue and Expenses:		
Infrastructure and non-clinical expenses	132	659

The Midland Region District Health Boards each have an ownership interest in HealthShare Limited (see Note 12).

20. 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 2022 $000	Actual 2021 $000
Not later than one year	974	635
Later than one year and not later than five years	1,420	618
Later than five years	1,368	1,210
Total non-cancellable operating leases	**3,762**	**2,463**

The total minimum future sublease payments expected to be received under non-cancellable subleases at balance date is $Nil (2021: $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 2022, $907,302 was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2021: $580,677).

21. Contingencies

Contingent Liabilities

Contract Disputes - non employment

There were no contract disputes - non employment as at 30 June 2022 (2021: NIL).

Legal proceedings – employment

The Lakes DHB group has been notified of three legal claims against it but, based on external legal advice received, it assesses that it is not likely to be found liable under these claims. The claims are employee-related. The group is vigorously contesting the claims and there is uncertainty as to what the legal outcomes might be. Therefore, it is not possible to estimate the financial effect on the group.

There are also ongoing industrial actions from a group of employees, Anaesthetic Technicians, the outcome and associated cost of which cannot be determined or estimated at this time.

There were no employment related legal proceedings as at 30 June 2021.

Joint Venture Contingent Liabilities

There are no contingent liabilities associated with HealthShare Ltd or other activities of the Group (2021: $Nil).

Contingent Assets

Lakes DHB Group has no contingent assets (2021: $Nil).

22. 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 2022 $000	Actual 2021 $000
Board Members		
Remuneration	360	343
Full-time equivalent members	1	1
Leadership Team		
Remuneration	2,982	2,732
Full-time equivalent members	12	11
Total key management personnel remuneration	**3,342**	**3,075**
Total full-time equivalent personnel	13	12

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

23. 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 2022 $000	Actual 2021 $000
ECE Funding Subsidy	109	84
Equity Funding	17	22
ATIS (Annual Top-Up for Isolated Services)	0	106
	126	**212**

24. Events after the Balance Date

Covid-19 continued to affect the Lakes DHB operations after the end of the reporting period. See Note 30 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 2022 - 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. See Note 1 for more details on the health sector reforms.

On 14 December 2022 the Employment Relation Authority issued an interim order in relation to a matter brought by the New Zealand Nurses Organistion Incorporated and the Public Service Association Te Pukenga Here Tikanag Mahi against Te Whatu Ora Health New Zealand. The order relates to an employment matter, and the interim order was issued with the consent of all parties in the matter. The interim order fixes employee pay rates and directs the remuneration for prior work of a group of employees. Lakes DHB has reflected the associated personnel expense and liabilities, estimated to be $3.8m, in these financial statements.

No other significant events have occurred since balance date.

25. Financial Instrument

Accounting Policy

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.

25A. Financial Instrument Categories

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

		Lakes DHB Group	
		Actual 2022	Actual 2021
Note		$000	$000
	FINANCIAL ASSETS		
	Financial assets measured at amortised cost (2021: Loans and receivables)		
7	Cash and cash equivalents	23,892	12,328
8	Debtors and other receivables	28,358	17,549
13	Other financial asset	0	500
	Total financial assets measured at amortised cost	**52,250**	**30,377**
	Fair value through other comprehensive revenue	**0**	**0**
	FINANCIAL LIABILITIES		
	Financial liabilities at amortised costs		
14	Creditors and other payables	28,935	26,842
17	Finance lease liabilities	997	1,525
	Total financial liabilities at amortised costs	**29,932**	**28,367**

25B. 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.

25C. 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 2022, 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 2022 $000	Actual 2021 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and term deposits		
AA-	23,892	12,328
Other financial assets		
AA-	0	500
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Receivables	28,358	17,549

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 $22.517 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
2022				
Creditors and other payables (note 14)	28,935	0	0	0
Finance lease liabilities (note 17)	346	105	545	0
2021				
Creditors and other payables (note 14)	26,842	0	0	0
Finance lease liabilities (note 17)	527	0	913	85

Contractual Maturity Analysis of Derivative Financial Liabilities

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

	Less than 1 year $000	1 - 2 years $000	2 - 5 years $000	5 + years $000
2022				
Cash and cash equivalents (note 7)	23,892	0	0	0
Debtors and other receivables (note 8)	28,358	0	0	0
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

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 $23,891,000 (2021: $11,628,000) 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 $238,910/ ($238,910) (2021: $116,280 / ($116,280)).

26. 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.

27. Summary of Revenues and Expenses by Output Class

	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Output Class Revenue			
Prevention	15,899	29,864	12,561
Early Detection and Management	104,801	132,099	92,422
Intensive Assessment and Treatment	326,734	320,497	316,397
Rehabilitation and Support	60,471	63,875	50,992
Total Revenue	**507,905**	**546,335**	**472,372**
Output class Expenses			
Prevention	17,599	19,641	13,047
Early Detection and Management	119,836	141,758	105,991
Intensive Assessment and Treatment	315,940	321,117	306,606
Rehabilitation and Support	56,780	60,519	49,720
Total Expenses	**510,155**	**543,035**	**475,364**
Surplus/(deficit) by Output class			
Prevention	(1,700)	10,223	(486)
Early Detection and Management	(15,035)	(9,659)	(13,569)
Intensive Assessment and Treatment	10,794	(620)	9,791
Rehabilitation and Support	3,691	3,356	1,272
Net Surplus/(Deficit)	**(2,250)**	**3,300**	**(2,992)**

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.

28. Explanation of Major Variations from Statement of Intent

Statement of Comprehensive Revenue and Expense

The Lakes DHB Group recorded a surplus of $3.300 million compared with a budgeted deficit of $2.250 million. The major reasons for the variance between actual and budgeted result of $5.550 million were:

	Variance $000
· higher ACC revenue due to a higher volume/demand especially rehabilitation services	1,142
· lower expenditure on information technology and information systems	2,470
· Additional net funding associated with the Planned Care initiative	544
· lower net impact of direct Covid additional revenue and costs (Funder & Provider Arms)	725
· net higher inter-district cost for treating other DHB's residents and for other DHBs to treat Lakes residents	(424)
· lower costs of Mental Health services	2,069
· higher pharmaceutical and implant costs	(2,450)
· Higher doctor costs (incl. locums)	(430)
· lower nursing costs (excluding the impact of the Holiday's Act remediation, but including interim order considering the NZNO equity pay)	913
· lower other staff costs (including management and allied staff)	512
· higher provision for the Holiday's Act remediation	(2,214)
· less income from Non-New Zealand residents	(424)
· lower Implants and protheses due to some surgeries being carried out at private hospitals	987
· lower treatment disposables costs	521
· higher outsourced servies costs	2,706
· lower costs of disability support services	(268)
· the net impact of the range of other variances	(829)
Total variance	5,550

Statement of Financial Position

Equity - Total equity is $40.367 million higher than planned. The largest reason for this change is the movement in the asset revaluation reserve, an increase of $55.484 million, as a result of a revaluation during the year of land and buildings. Other contributors to the variance include a budgeted capital contribution of $14.808 million from the Crown not required, higher than planned net surplus for the year, and an adjustment to Trust funds.

Current Assets - Current assets are $36.47 million higher due to cash still being in a positive position largely due to capital expenditure projects of $34.204 million being delayed not yet paying the Holidays Act remediation provision, and receivables being higher than plan by $12.768 million.

Non-Current Assets - Higher than plan by $12.09 million due a revaluation of land and buildings of $55.484 million, offset by a delay in a number of capital projects being commenced.

Current Liabilities - Higher than planned by $8.551 million payables due to an increase in operational costs, and holding a balance for provisions associated with restructuring and the Holidays Act remediation. A further $3.8 million was accrued for the New Zealand Nurses Organisation (NZNO) pay equity claim interim order issued by the Employment Relations Authority on 14th of December 2022.

Non-Current Liabilities - lower than plan by $0.355 million due to lower term portion of employee entitlements and increased provision for onerous contracts.

29. 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.
- The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand. Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the Lakes DHB is working in line with this national direction.

- The direction to support a whole-of-government approach to pay restraint issued on 28 April 2021 under s.95(c) of the Public Service Act 2020.
- The direction to implement the Carbon Neutral Government Programme (CNGP). The CNGP has been set up to accelerate emissions reductions across the public sector. The direction was issued in May 2022 under s.107 of the Crown Entities Act.

30. 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 2021-22 statement of performance expectations was in draft format at 30 June 2021. It was approved by the Board on 9th July 2021.

31. The Effects of COVID-19 on Lakes DHB

For the period covered by these Financial Statements, Lakes DHB's operations were affected by the effects of Covid-19. During the year there were outbreaks of Delta and Omicron variants of Covid-19.

Between July and December 2021 the Lakes district was operating at Covid 19 Alert Levels 1 and 2. In December 2021 the government implemented COVID-19 Protection Framework, also known as the traffic light system, to replace the COVID-19 Alert System. From December the Lakes district operated in the red traffic light setting until April 2022 when it moved to the less-restrictive orange setting. It has operated under the orange setting for the remainder of the financial year. The traffic light system mandates measures such as vaccinations, limits on the size of gatherings, mask wearing, record keeping (including the use of QR codes), isolation, quarantine, travel restrictions, and lockdown requirements. The government has stated that's its Covid-19 strategy moved from ""elimination"" to one of ""suppression"".

The Lakes DHB has been tasked with the provision of Covid-19 services. Community testing centres were run in Rotorua and Taupo and later Rapid Antigen Test (RAT) distribution centres. Health services were provided in managed isolation facilities (MIF) in Rotorua. Vaccination services have been delivered to staff and to the general public, at MIF, fixed, pop-up and drive through settings. In October a ""Super Saturday"" vaccination event was held. A Care in the Community (CitC) Response Centre was created.

The provision of services has been impacted by the Covid government frameworks and systems. Hospital and community services have largely been able to operate on a business as usual footing, whilst ensuring infection control was prioritized for the safety of its patients and staff. The Rotorua and Taupo hospitals have treated many patients with Covid-19. Infection control advice has also been provided to the residential care home sector.

There have been impacts of the Lakes workforce and work arrangements. For example, workforce availability has been impacted by staff becoming infected with Covid-19 and unable to work. Workforce mobility has been impacted by lockdowns, quarantine and travel restrictions. Work safeguards and procedures have been implemented to prevent infection. Where appropriate, staff have been working from home and on-site in 'bubbles'.

At this time, it is difficult to determine the full on going effect of Covid 19 and therefore some material uncertainties remain. We have also disclosed in these financial statements our significant assumptions and judgements regarding the future potential impacts that may have a material impact on the DHB.

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 $17,942,163 (2021: $662,281) was received to cover hospital related Covid-19 costs. This included $670,000 one off funding to cover the cost of treatment of Covid-positive patients in hospital. Specific funding was also provided to deal with Covid- 19 related services:

- Community Testing – based on a fee per test carried out relating to Primary Care, and reimbursement of costs to run the Community Testing Centres. The primary mode of Covid Testing changed from PCR to RAT test in February 2022 and RAT Distribution Costs are included in the annual costs.
- Vaccinations – reimbursement of costs incurred plus Price Per Dose for GPs and Pharmacies.
- Managed Isolation Facilities – Reimbursement of costs incurred. The three facilities in the District closed in March 2022, so costs have now ceased.
- Covid Care in the Community – From July 2021, since the Covid 19 Delta outbreak in NZ, the DHB was funded to provide health support for patients isolating at home and to provide alternative accommodation for those unable to isolate at home.

Due to the differing bases used for calculating funding, the DHB Provider Arm had a Covid-19 funding surplus of $293,773.

Operating Expenses

As a result of Covid 19, the DHB Provider Arm has incurred additional expenditure during the year of $17,648,390 (2021: $7,888,897) on:

- Personnel costs: $9,609,509
- Outsourced Services: $749,284
- Clinical Supplies including PPE: $298,871
- Infrastructure and Non-clinical supplies: $3,911,024
- Community Isolation and Quarantine Accommodation Costs: $3,079,702

Land and building were revalued, effective 30 June 2022. The ongoing consequences of Covid-19 caused increased market uncertainty, and therefore the valuation provided was subject to a wider range of variation. For more details, refer to note 10.

32. Completion of Financial Statements

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

Directory

Spectrum Health Limited Directors (wholly owned subsidiary company)
Alan Mountfort
Alan Wilson
Gary Lees

Lakes District Health Board
Chief Executive
Nick Saville-Wood

Chief Financial Officer
Alan Mountfort

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Rotorua Hospital
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NEW ZEALAND

Telephone: 07-348-1199
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Auditor
The group financial statements audited by Audit New Zealand on behalf of the Office of the Auditor-General.

Spectrum Health Limited's financial statements audited by UHY Haines Norton on behalf of the Office of the Auditor-General.

Bankers
BNZ Bank Limited

Solicitors
Claro Law

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Lakes District Health Board Group's financial statements and performance information for the year ended 30 June 2022

The Auditor-General is the auditor of the Lakes District Health Board Group (the Group). The Auditor-General has appointed me, JR 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 an appropriation, of the Group on his behalf.

We have audited:

- the financial statements of the Group on pages 86 to 134, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 34, 44 to 79 and 130.

Opinion

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our opinion section of our report, the financial statements of the Group on pages 86 to 134, which have been prepared on a disestablishment basis:

- present fairly, in all material respects:
    - its financial position as at 30 June 2022; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Unmodified opinion on the performance information

In our opinion, the performance information of the Group on pages 34, 44 to 79 and 130:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:

- its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

  - what has been achieved with the appropriation; and

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

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed late

Our audit on the financial statements and the performance information was completed on 8 March 2023. This is the date at which our opinion is expressed.

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

Basis for our opinion

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

As outlined in note 16 on pages 115 and 116, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The provision for employee entitlements includes a provision of
$14.8 million for the estimated amounts owed to current and past employees as at 30 June 2022.

During December 2022, the sector received legal advice on how to decide whether a day is an "otherwise working day" when calculating the estimated holiday pay entitlements. The calculation has not been amended to include an estimate of this factor and work in this regard was ongoing at the date of signing this report. We have therefore been unable to obtain adequate evidence to determine if the amount of the provision is reasonable. We did not calculate the effect of this advice on the total provision as it was impracticable for us to do so.

Our opinion on the financial statements for the year ended 30 June 2021 was not modified in respect of this matter.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following matters:

The financial statements have been prepared on a disestablishment basis

Note 1 on pages 91 and 92 outlines that the Group has prepared its financial statements on a disestablishment basis because the Group was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Group's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

The Covid-19 response on pages 67 to 69 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 in The Covid-19 response. 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 31 on pages 133 and 134 to the financial statements and pages 67 to 69 of the performance information, outline the ongoing impacts of Covid-19 on the Group.

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

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

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

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

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the 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 of Te Whatu Ora – Health New Zealand.

- 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 by the Board of Te Whatu Ora – Health New Zealand.

- 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 group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board of Te Whatu Ora – Health New Zealand is responsible for the other information. The other information comprises the information included on pages 2 to 33 and 35 to 43 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 completed a review of the Mauri Ora project management and procurement reviews. Other than our audit and this review we have no relationship with, or interests in, the Lakes District Health Board or any of its subsidiaries.

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