Annual Report 2019

COUNTIES MANUKAU HEALTH

Counties Manukau District Health Board

Cover photo

Tiaho Mai the light that comes from the moon and stars shine here.

The name Tiaho Mai was given by 'Sophie' Sophie Muru, a representative of the late Maaori Queen, Dame Te Atairangikaahu who passed away in August 2011.

It was Counties Manukau Health's longest serving Kaumatua Cultural Advisor Whitiora Cooper who blessed the name Tiaho Mai and carried out the rituals to open the building in 1999. Whitiora was much loved, not only by our CM Health community, but across the entire Auckland district. He was well respected as the steward for all things cultural and we are blessed to have had him as part of our lives. Whitiora passed away in November 2017.

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

Contents

Foreword from the Chair and Chief Executive

2018/19 has been a challenging year for Counties Manukau Health (CM Health). The challenges to strike a balance between achieving financial sustainability in a context of high population growth, the high cost of the burden of long term conditions and many of our residents living in low socioeconomic households is very real.

We welcomed the 2018/19 health sector focus on achieving health equity with 2018/19 being the fourth of our five year Healthy Together 2020 strategy which is working towards our strategic goal of achieving equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020.

Since Healthy Together was published in 2015, our growing and changing population has contributed to an ongoing marked increase in demand for health services and this has contributed to a substantial financial challenge for CM Health. To continue to progress Healthy Together within this context, we have had to make choices that achieve our goals but at a lower cost base and with prioritisation of resources. In 2018/19 we responded to this challenge through a focus on two key portfolios of work, both of which are targeted at extracting maximum value from all of our activities – 'Every Hour Counts' is not only about improving patient flow but also that our staff and partner health professionals are able to spend their time on activities that add value to the patient experience. In addition, the 'Every $ Counts' portfolio supports CM Health's financial objective to return to a sustainable financial position. In 2018/19 a number of projects were consolidated under Every $ Counts with a total savings of $8.15million.

We continued our focus on social wellbeing and system integration by working differently with social services through the South Auckland Social Wellbeing Board - a multi-sector endeavour involving 13 agencies which is trialling new ways of working to promote child wellbeing and better meet the needs of tamariki and whaanau in South Auckland. CM Health continues work to improve the health of our communities, alongside our primary and community care partners, through focusing on increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity. In 2018/19 CM Health implemented the Alcohol ABC Approach (Assessment, Brief advice, and referral for Counselling) in both the hospital and the community and our Living Smokefree service received over 5,500 referrals and achieved both the primary care and maternity national Smokefree targets in Quarter 4.

The pressures of our current operating environment are however reflected in some of the performance results reported in this 2018/19 Annual Report (Statement of Service Performance). We are concerned that the national policy settings that fund our system do not reflect the 'triple challenge' we face of growth, poverty and obesity. Our stewardship role is to be transparent about how we apply the resources we have, including what trade-offs we make as a Board.

In 2018/19 we identified and progressed regionally prioritised major capital investments that will add critical service capacity to the region, such as the expansion of radiology services and development of additional outpatient capacity at our Manukau site. We also advanced approved remediation investments, such as recladding of the Middlemore Hospital Scott building, and are proud of the new acute mental health building development, Tiaho Mai, that was opened in November 2018.

We are pleased to report that District Health Boards (DHBs) have agreed a way forward with respect to historical non-compliance with the Holidays Act 2003. CM Health has signed a Memorandum of Understanding between all DHBs, NZ Blood Service, the health Unions and the Ministry of Business, Innovation and Employment (MBIE) which sets out the process to be followed to enact this work. This process is a significant undertaking and will occur over the coming 24 months. CM Health has completed sample testing to determine a reasonable estimate of its liability and a further $105.92m provision has been made in the 2018/19 financial accounts. An additional one off adjustment of $2.94m has been made to write down (impair) the national Financial Procurement and Information Management System asset (FPIM). Following adjustment for these two extraordinary items the underlying result was a deficit of $43.949m, representing a $9.5m improvement on Budget.

We are grateful for the ongoing commitment and hard work of health staff across primary care, community, home and hospital settings to deliver high quality support and services every day for our diverse and vibrant communities.

Vui Mark Gosche
Chair

Fepulea'i Margie Apa
Chief Executive

Board Members

Board members for the period 1 July 2018 to 30 June 2019
Vui Mark Gosche (Chair)
Mr Pat Snedden MNZM (Deputy Chair)[1]
Mrs Colleen Brown MNZM
Dr Lyn Murphy
Mrs Catherine Abel-Pattinson RN Comp NZ, CATT, MBA, ICU Certificate, EHLP (Insead), BHS
Mrs Dianne Glenn ONZM, JP
Dr Ashraf Choudhary QSO, JP
Apulu Reece Autagavaia
Mr George Ngatai
Mrs Katrina Bungard
Ms Kylie Clegg[2]

[1] Appointed effective 14 August 2018
[2] Appointed effective 14 August 2018

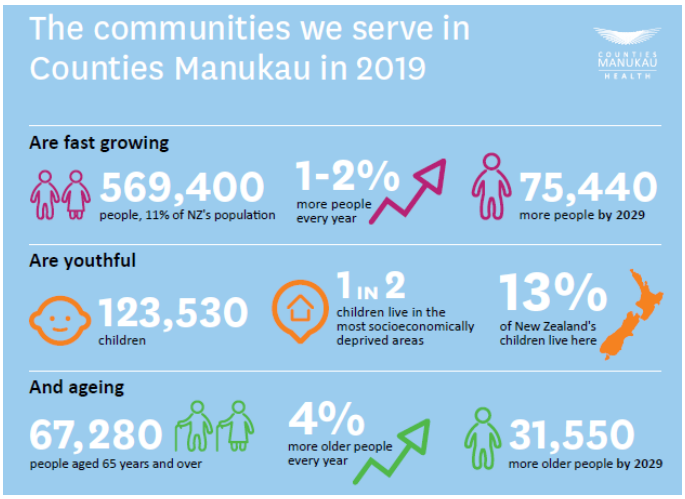
Executive Leadership Team

Executive Leadership Team	As at 30 June 2019
Margie Apa	Chief Executive Officer
Gloria Johnson	Chief Medical Officer
Margaret White	Chief Financial Officer
Aroha Haggie	Director Funding & Health Equity
Jenny Parr	Chief Nurse & Director of Patient & Whaanau Experience
Elizabeth Jeffs	Director of Human Resources
Parekawhia McLean	Director of Strategy & Infrastructure
Campbell Brebner	Chief Medical Advisor Primary Care
Mary Seddon	Director of Ko Awatea
Stuart Bloomfield	Chief Information Officer
Sanjoy Nand	Chief of Allied Health, Scientific & Technical Professions
Gary Jackson	Director of Population Health

Snapshot of Counties Manukau Health in 2018/19

Counties Manukau District Health Board is one of twenty district health boards established under the New Zealand Health and Disability Act 2000 (NZPHD Act 2000) to plan and fund the provision of personal health, public health and disability support services for the improvement of the health of the population.

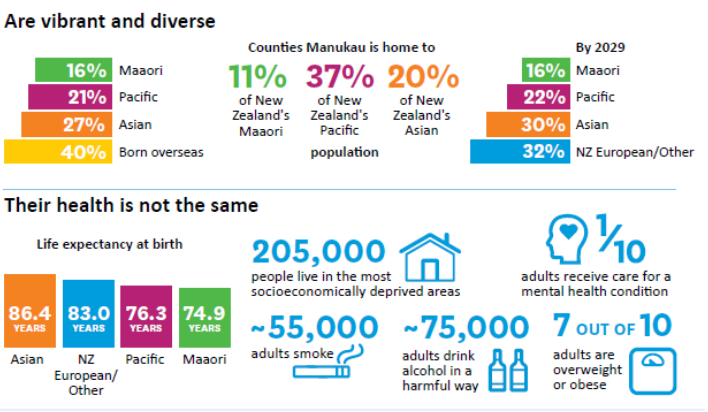
The Counties Manukau District Health Board provides and funds health and disability services to an estimated 569,400 people in 2019 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.[3]



Our population is diverse and vibrant with strong cultural values. Counties Manukau is home to New Zealand's second largest Maaori population, largest population of Pacific peoples, as well as fast growing Asian communities.

Across our district, the health and circumstances of our communities are not the same. Over 123,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation (NZDep2013 9&10).[4]

By 2029, our district is forecast to be 16 percent Maaori, 22 Percent Pacific, 30 percent Asian and 32 percent NZ European/Other ethnicity. There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[5] On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.



Long-term mental[6] and physical conditions do not affect all groups in our community equally. Our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity[7] and hazardous alcohol use) that contribute to a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. The rate of hospitalisation for circulatory diseases for our Maaori communities is estimated to be 88 percent higher than for non-Maaori.[8] Diabetes prevalence is higher amongst our Pacific (13.9 percent), Asian (6.9 percent) and Maaori (6.5 percent) communities compared to European/Other.[9] Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity is key to improving the health of our population.

[3] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – 2017 update.

[4] New Zealand Index of Deprivation (NZDep) is an area-based measure of socioeconomic deprivation. It measures the level of deprivation for people in each small area. It is based on nine Census variables. NZDep can be displayed as deciles or quintiles. Quintile 5, or deciles 9 and 10, represents people living in the most deprived 20 percent of these areas.

[5] Chan WC, Winnard D, Papa D (2016). Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 update. Auckland: Counties Manukau Health.

[6] Winnard D, Papa D, Lee M, Boladuadua S et al (2013) populations who have received care for mental health disorders. CM Health, Auckland

[7] Based on unadjusted prevalence of overweight (BMI 25-25.9) and obese (BMI 30 or more) for CM Health adults aged over 15 years. Unadjusted prevalence for 2014-2017, New Zealand Health Survey. May 2018

[8] Source: Counties Manukau DHB Maaori Health Profile 2015. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare. Based on hospitalisation data 2011-2013. http://www.countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/2015-counties-manukau-DHB-maori-health-profile.pdf

[9] Source: Health Quality and Safety Commission Atlas of Health Care Variation, Diabetes management (2016 data for CMDHB)

Key Achievements in 2018/19

Key achievements are outlined below under our three Healthy Together strategic objectives (see *Our Strategic Intentions* on page 13) that are closely aligned to the April 2016 New Zealand Health Strategy (NZHS) themes. Each of these achievements has contributed to the national strategy, as highlighted by the NZHS themes: **People-Powered**, **Closer to Home**, **Value and High Performance, One Team, Smart System.**

Healthy People, Whaanau and Families

- **Emergency Q:** The Emergency Q pilot began in September 2018. Emergency Q is a digital information system designed to help patients make informed choices about the most appropriate care for their condition. Emergency Q aims to alleviate demand pressure on the ED through encouraging eligible patients to attend alternative urgent care providers. Between September 2018 and March 2019, 1,689 (20%) eligible patients chose to use Emergency Q and attend a local A&M clinic for free.

Closer to home

- **Co-design approach to new model of care for long term conditions:** In August 2018 CM Health launched a co-design process to inform the development of a new model of care to support people and whaanau/families living with long term conditions. From this process we learnt about our community members' and providers' experiences of delivering and receiving care and ideas they have to inform future models. This process involved approximately 47 hui with over 500 participants.

People Powered

- **Feedback Central and complaints acknowledgment:** Feedback Central has achieved 100% of complaints being acknowledged within 5 working days (our KPI). This represents a significant improvement and is a result of standardising the logging and acknowledging process for all complaints by the Feedback Central team since being established in June 2018. Timely acknowledgment of complaints is an important part of communicating to the patient and their whaanau that their feedback is important.

- **Inaugural Maaori and Pacific Allied Health Awards:** In April 2019 the Allied Health, Scientific and Technical Professions Awards were celebrated and the inaugural Pacific and Maaori Health Awards were awarded to the Fanau Ola Social Work team and to Renee Taylor, speech language therapist. The Fanau Ola Social Work Team were acknowledged for the life changing work that they have been doing with all ethnicities across South Auckland and raising awareness of the Non-Governmental Organisations (NGOs) out in the community. Renee Taylor was acknowledged for her work to enhance professional practice and contribute to the betterment of Maaori health outcomes in Counties Manukau.

- **Models of Care:** A number of additional wards and clinics were opened over the 2018/19 year in order to increase capacity and introduce/trial new models of care. These included the new Respiratory Close Observation Unity (RCOU) which is to provide a higher level of acute care to patients with complex acute Respiratory problems, 30 beds which were opened for four months in medicine to help accommodate the acute winter workload and allowed a pilot of the home based ward concept, additional maternity beds to increase bed capacity for women's health, and the Maternity Assessment Clinic which relieved some workload on the Birthing and Assessment Unit.

Value and High Performance

- **Early Pregnancy Assessment Tool (EPAT):** The Northern Region EPAT is a web-form for use in the primary care setting at the first antenatal assessment with the aim of reducing inequities and improving maternal and child health outcomes. Our vision is that this is the first of a series of web-forms interacting with cloud-based health

One Team

information. This project has secured Health Promotions Agency funding and is a collaboration between the northern Primary Healthcare Organisations (PHOs) and CM Health Primary and Integrated Care.

Healthy Communities

- **Living Smokefree:** Of those referred to the Living Smokefree service who have set a quit date in 2018/19, the team have achieved a 70% Quit rate at 4 weeks (Carbon Monoxide validated - smokerlyser test for 4 weeks smokefree) compared to a national average of 47% with the UK average being 36% using the same 4 week measure.

  Value and High Performance

- **Development and implementation of the CM Health Alcohol Harm Minimisation Programme:** This programme focusses on alcohol as a key determinant of population health and wellbeing outcomes and prioritises prevention and early intervention actions. Key achievements in 2018/19 include the following:
  - Implementing the Alcohol ABC Approach (Assessment, Brief advice, and referral for Counselling) in general practices, Middlemore Hospital Emergency Department, the CM Health Living Smokefree Service, the Plastics inpatient ward, and with social workers in Manurewa. This has involved development of supporting systems and customised training and support for front-line staff to help them have skilled and empathetic conversations with people and whaanau about alcohol use.
  - Developing a regional data standard for general practice that defines Alcohol ABC indicators, data to be collected, and standard terms and codes for data recording and extract.
  - Working with communities, health agencies, and other intersectoral partners such as working with the Health Promotion Agency to localise the national communications campaign focussed on alcohol-free pregnancies and collaborating on the development of alcohol harm reduction approaches for high risk youth.
- **Increased transparency in the allocation of the Flexible Funding Pool (FFP):** The FFP is a pool of funding distributed under the national Primary Health Organisation Services Agreement for the purposes of health promotion, services to improve access, care plus for people with long term conditions and management services. Over 2018/19 we have worked to increase transparency in the way this funding is allocated across the district, and have begun development of a regional framework which aims to increase alignment of priorities and actions to improve equity.
- **Living Smokefree:** In 2018/19, Living Smokefree service has received over 5500 referrals. Of these, 70% are Maaori and Pacific which reflects the equity commitments the service adheres to. The service works across the health system in collaboration with primary care, secondary care, maternity care, mental health, community health and community settings, to engage with whaanau to support them to stop smoking.

  People Powered

- **Workforce reflecting our population:** An improved recruitment process for increasing Maaori and Pacific representation in the nursing workforce has been progressed during the 2018/19 year. The process for recruitment of the last intake of graduate nurses for 2018/19 (the September 2019 intake) identified that: 100% of all Maaori and Pacific nursing candidates were shortlisted to interview; a mihi whakatau and a creative interview assessment centre provided; and there was

cultural representation across all of the interview panels. Overall, Maaori and Pacific collectively represented 41% of this total graduate intake.

- **South Auckland Social Wellbeing Board (SASWB):** CM Health is a member (and host) of the SASWB is a multi-sector endeavour involving 13 agencies which is trialling new ways of working to promote child wellbeing and better meet the needs of tamariki and whaanau in South Auckland. SASWB spotlights the social determinants of health and is seeking to reduce siloed ways of working and commissioning across agencies. Over 2018/19 SASWB's activity included innovative ways to reduce the exposure of children to family violence and the impact this can have on lifecourse outcomes; the 'Start Well' initiative which is testing a new way of supporting young mothers, their babies and wider whaanau from pregnancy through to when the child is age five; and innovative support for teachers/kaiako and children in Early Childhood Education settings.

One Team

Healthy Services

- **MRI Waitlist Reduction:** The MRI team has reduced the MRI waiting list from 1,734 in April 2019 to 730 by June 2019. Opening the new Radiology unit in November 2018 allowed CM Health to co-locate two scanners and work a 2+1 Medical Radiation Technologists (MRTs) model, using three MRTs between two scanners. As we now have a shared control room and patient preparation area, we have been able to optimise our staffing, with one MRT on each scanner and one 'floating' between the two helping to prepare patients. This freed up two MRTs to keep the third MRI unit that is situated away from the main hospital open – and this has been our biggest efficiency gain.

Smart System

- **Urology Service Cx Bladder Project:** Cx bladder triage testing was introduced to Urology in October 2018 to investigate people with blood in their urine (haematuria), to assist in the diagnosis of potential cases of bladder cancer. The testing involves suitable patients visiting a local laboratory to provide a urine sample which is then forwarded to an external laboratory for analysis. Of the 371 reported tests to 30 June, 207 patients have been able to be discharged to GP care or other clinics with no further investigation required, where they would normally have required a cystoscopy.

Value and High Performance

- **Every Hour Counts:** Over 2018/19 the Every Hour Counts portfolio was established with the vision to improve patient flow to optimise the quality of care, the experience of care, and the experience of caring whilst improving the efficiency of the system. This covers both acute and ambulatory patient flow, with a number of work programmes in each area. This portfolio of work will support CM Health to deliver a more effective, timely, end to end, patient-focused system of care and also aims to optimise and value the time of staff, by reducing the steps in patient care to get the best out of the highly skilled workforce we have.
- **Safe Surgery Patient Safety Markers:** CM Health leads the country in auditing the

Safe Surgery Patient Safety markers of briefings, checking, timeout, sign out and debriefing at the end of the theatre lists and achieved 14,151 audited moments with a 97% average of good team engagement within the 2018/2019 financial year.

- **Every $ Counts:** The Every $ Counts portfolio supports CM Health's financial objective to return to a sustainable financial position. In 2018/19 a number of projects were consolidated under Every $ Counts with a total savings of $8.15million.
- **Hand hygiene:** In the latest national hand hygiene report to June 2019, CM Health has the second highest levels of 'moments' (the key moments when health-care workers should perform hand hygiene) recorded nationally and one of the best compliance rates for large DHBs with a compliance rate result of 87.7% against a national rate of 85.1%. All major groupings of health care workers met the 80% compliance rate in the latest audit results.
- **Falls in hospital:** CM Health has consistently met the target for the percentage of older patients assessed for risk of falling and having an individualised care plan that addresses this risk. Risk assessment and care planning has led to a consistently low number of in-hospital falls leading to hip fractures at CM Health sustained since October 2015.
- **Fundamentals of Care:** The Fundamentals of Care (FoC)[10] programme was introduced by CM Health in October 2017 to measure standards of care against nine fundamental elements of care at Middlemore Hospital and the Manukau Elective Surgery Centre. The programme aims to ensure the consistent, safe, and high quality delivery of the 'fundamental' aspects of care for all patients by all health professionals. FoC has steadily built in significance for our nursing teams and in March 2019 CM Health completed our third cycle of FoC review. The overall organisational result was 82.2%; the lowest achieved standard was 'Clinical Monitoring and Management' with 75.3% and the highest 'Respect, Privacy and Dignity', which scored 87.0%.

People Powered

- **Opening of our new acute mental health building – Tiaho Mai:** In November 2018 Stage One of the Tiaho Mai building development was completed, blessed and officially opened. The new 38-bed adult mental health facility is a New Zealand first; the design incorporates natural light and space, with large rooms and corridors adding to the sense of spaciousness. Co-design was at the heart of the design process; families, staff and cultural groups were all consulted throughout the design and build of the Unit. Stage Two is well underway and is planned for opening in late 2020.
- **Retinal Screening Combined Clinic:** A new 'walk-in' retinal screening clinic alongside High Risk Diabetes in Pregnancy clinic has been established. This clinic has captured several women who have significant retinal disease, some requiring urgent laser treatment to save their sight.
- **Closing the gender pay gap:** Gender pay equity is a fundamental issue of fairness at work. It is also one of the Government's priorities to close gender pay gaps in the public service. In 2018/19 CM Health undertook analysis to understand our gender pay gap for our employees. This analysis identified that in some cases women were paid less than men for performing jobs in the same job band. CM Health is committed to correcting this and during 2018/19 a gender pay gap correction was applied to eligible IEA women within bands 5-8 (approximately 150 employees). CM Health will work with the sector to address gender pay gaps for other groups over 2019/20 and 2020/21.

[10] Parr, J. M., Bell, J., & Koziol-McLain, J. (2018). Evaluating fundamentals of care: The development of a unit-level quality measurement and improvement programme. Journal of Clinical Nursing (Fundamental Care), 1-13. doi:10.1111/jocn.14250

- **Spend Five to Save Lives – Surgical Safety Checklist:** In 2018/19 CM Health successfully embedded the 'start of list briefings' (called huddles) throughout all theatres as part of the safe surgery campaign. For each of these huddles, the full surgical team meet for a few minutes before the start of the surgical list to introduce themselves and discuss each patient on the list and any other relevant issues for the day. The huddles are improving teamwork, camaraderie, patient safety and efficiency. *One Team*
- **Newly registered CM Health Nurse Practitioners:** Four nurses have gained Nurse Practitioner registration over 2018/19 reflecting the culmination of many years of hard work and focus bringing our total Nurse Practitioners working at CM Health to 18. The four newly registered Nurse Practitioners are now providing their expertise in our neonatal unit and mental health, ophthalmology and diabetes services.
- **Regional approach to using data for primary care quality improvement:** Under the Regional Data Sharing Framework, a number of key health outcome indicators has been agreed across DHBs and Primary Health Organisations (PHOs) in Auckland. Using Health Safe, quarterly uploads of this data are occurring and the information can be used for service quality improvement and planning. *Smart System*
- **The Medinz Primary Care Communications Platform:** The Medinz platform has now been implemented across the district. Medinz provides a single place for all primary care staff, including GPs, pharmacists and staff in urgent care clinics to receive communications from DHBs, community laboratory organisations, regional public health units and PHOs. This supports consistent and timely communication across the whole primary care sector.

Our Strategic Intentions

Healthy Together

2018/19 was year three of our five year Healthy Together strategy. Our Healthy Together strategy is a long term ambition with a transformational focus on integrated care in the community, supported by excellent hospital services. Achieving health equity in key indicators is critical to medium term population outcomes and longer term health system sustainability. Relying on treating people when they become unwell is not enough and will not achieve the health gains needed to achieve healthier longer lives in the community.

"Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020."

We aspire to live and breathe our values every day as the foundation of our strategic actions:

Valuing everyone – we make everyone feel welcome and valued

Kind - we care for other people's wellbeing

Together – we include everyone as part of a team

Excellent - we are safe, professional and always improving

To achieve our Healthy Together strategic goal, we will balance our resource investment and interventions across our three strategic objectives supported by our values as the foundation of our strategic actions.

Our Strategic Objectives

CM Health's Healthy Together strategy comprises three key objectives: **Healthy Communities, Healthy Services** and **Healthy People, Whaanau and Families.**

Progressing **Healthy Communities** through primary (ill-health) prevention across the life course is important. There is great potential to reduce the prevalence of long term health conditions by reducing risks early in life from conception to the young adult years, e.g. smoking (direct and indirect smoke exposure), unhealthy weight and nutrition, inadequate physical activity, and harmful alcohol consumption.

Healthy Services support improved health outcomes through more collaborative ways of working to make services easier to access and more responsive/personalised to people's needs. This can enable earlier identification of diseases, earlier intervention and better management of health conditions to achieve **Healthy People, Whaanau and Families.** We aim to enable people to take a more active role in their own health and support them to self-manage for longer at home and in the community.

We are committed to working with others to meet our performance expectations

CM Health operates as part of the New Zealand health system by contributing to national goals and performance expectations alongside local strategic priorities. The 2016 New Zealand Health Strategy provides the health sector with a collective vision for the future, that "All New Zealanders live well, stay well, get well". Translating this vision into improved outcomes for the Counties Manukau population requires alignment and integration of the many health system expectations – local, regional and national. Our strategic priorities and performance expectations closely link,

and are guided by, the current and future needs of the people living in Counties Manukau. CM Health cannot succeed in meeting these challenges without aligning key initiatives with strategic partners, including the other Metro Auckland and Northern Region DHBs, Counties Manukau-based PHO Alliance and related service providers, and intersectoral organisations.

Our context is also shaped by the priorities set by other national agencies. These include Health Workforce New Zealand, National Health IT Board, National Capital Investment Committee, National Health Committee and the Health Quality and Safety Commission. CM Health aims to integrate and align these national priorities with agreed budget commitments and ensure they are relevant and can be adapted to our local context.

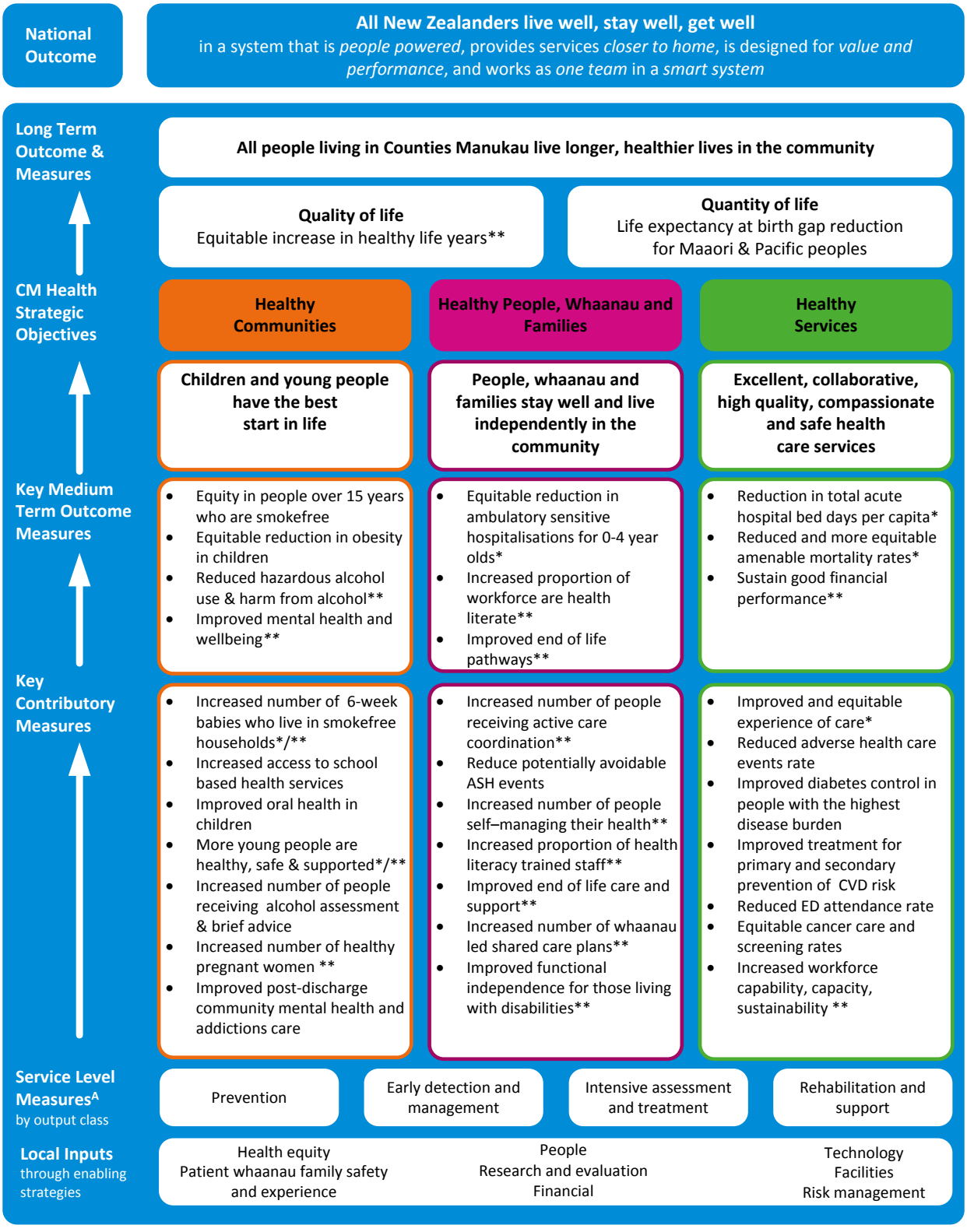
How we will measure our performance

We have developed our performance story to align with CM Health's strategic objectives and their contribution to our health equity strategic goal. Workforces and services need to be challenged and supported to work out what a health equity approach means in their services, their role and to implement change. To support this, we use the outcomes framework presented in Figure 1 to frame our performance story and highlight our performance and strategic goal for CM Health staff and providers across Counties Manukau, our Executive Leadership Team, Board and related committees.

Our outcomes framework (Figure 1) reflects our three Triple Aim long-term outcomes and contributory impacts. It integrates national, regional and local performance priorities through long term outcomes, supported by (proxy) "impact" measures that best reflect the health priorities and challenges faced by the diverse communities living in Counties Manukau. Our performance against these impact measures will not only affect our long-term outcomes but measuring these also enables us to gauge our progress in the shorter term. Also included in this framework are our "output" or service measures. These outputs are grouped to reflect the nature of the services they fund and provide as outlined by the Ministry of Health and allow us to report exactly how CM Health is performing year on year, against our national and local performance expectations.

CM Health's performance as at 2018/19 against the long-term outcomes and some of the related impacts in our outcomes framework is provided in the *Improving Outcomes* section of this Annual Report. CM Health's 2018/19 performance for the outputs identified in our outcomes framework is provided in the *Statement of Service Performance* on page 29. Together these two sections provide a current picture of the progress CM Health made towards achieving our long-term outcomes and strategic goal in 2018/19.

Figure 1: Healthy Together Outcomes Measurement Framework



Note denotes a National System Level Measure; each with regionally agreed Improvement Plans*

*Note** denotes measures in development over the 2017/18 year*

Note A: The planned and actual performance of CM Health's services by output class is monitored and reported annually in our Statement of Performance

Improving Outcomes

We know that no single programme, initiative or service change will achieve the health gains our communities deserve. There is not a simple relationship of action and impact measures to outcomes, but rather an 'overlay' of contribution over time; for example, 'improved population health and equity' requires a healthy start in life for children in addition to other long term ill health prevention approaches. To support healthier children, we invest in health promotion and community engagement to prevent disease, e.g. healthy weight, smokefree pregnant mums, alongside health service delivery, e.g. immunisation in children, reducing potentially avoidable hospital admissions.

In Counties Manukau, health equity is critical to achieving long term outcomes.

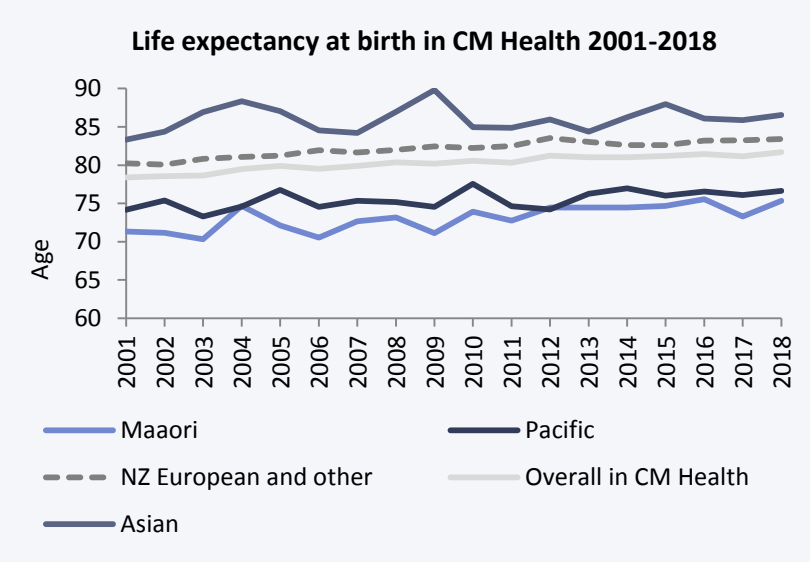
For the Counties Manukau community, we need to target outcome improvements to achieve health equity.[11] To better understand which people do not experience the same health outcomes, we report and compare results over time by ethnic group. Results are not always available for all ethnic groups and work is ongoing to improve the accuracy and scope of results by ethnic group.

To make more visible the health equity gaps, we have chosen the 'New Zealand European/Other' ethnic group as our 'local healthy equity comparator' target. We also contrast this with national targets to reflect the health sector performance expectations of District Health Boards and their related providers.

Overall long-term outcomes

Reduce life expectancy at birth gap for Maaori and Pacific peoples[12]

We know that not everyone in our diverse community experiences the same health outcomes. Our ambition is that everyone living in Counties Manukau lives longer, healthier lives. **Life expectancy at birth** is a key long-term measure of health and social development. Long standing health inequities for Maaori and Pacific peoples persist. We remain committed to reducing equity gaps in life expectancy and work with our communities and intersectoral partners to address the broader social determinants of health gaps.



The overall life expectancy at birth in Counties Manukau has steadily increased over the last ten years to 81.7 years in 2018, closely reflecting national trends. A gap of 8 years and 7 years persist between Maaori and Pacific peoples respectively and New Zealand European/Other. Our local and regional planning for 2019/20 is strongly focused on improving health equity for Maaori targeting those conditions and health outcomes that impact the most on amenable mortality and life expectancy, including cardiovascular disease, diabetes, long-term condition management and smoking cessation. The gap between Pacific and the New Zealand European/Other group is worryingly static and is also a significant concern. The most likely explanation for this is the very high obesity rates in Pacific people, and subsequent diabetes and other related conditions.

Life expectancy of Asian people is consistently greater than both the overall life expectancy and the average life expectancy of NZ European/Other ethnic groups. When we look deeper into the drivers of life expectancy, we see diversity of health status within the many Asian ethnicity subgroups. As the 'healthy migrant effect' typically reduces

[11] Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need.
[12] Data source: Ministry of Health (MoH) mortality collection and estimated population from Stats NZ (2018 edition)

over 5-7 years of New Zealand residency, to sustain this relatively high life expectancy, we are focused on early ill-health prevention and effective management of long term conditions in our Indian and Chinese communities.

Reducing the number of deaths at a young age from potentially preventable long term health conditions like cardiovascular disease, diabetes, respiratory diseases and cancer is important for improved life expectancy. Reducing risk factors like smoking, alcohol use, obesity, poor nutrition and physical inactivity and early disease identification are important for this long term outcome.

In 2018/19, CM Health Living Smokefree Service continued its strong equity focus and prioritised reducing smoking prevalence for Maaori and Pacific communities. In 2018/19 CM Health offered healthy lifestyle support to approximately 5,869 adults through the Green Prescription initiative. Additionally, 342 children aged 3-18 were referred to the Active Futures and Active Families healthy lifestyles programmes. CM Health also led development of a programme of collaborative alcohol harm minimisation actions, including implementing alcohol assessment, brief advice and referral pathways in general practice, our Emergency Department (ED), our inpatient plastics ward, the Living Smokefree Service, and with a community-based social work provider. The programme is being expanded to other settings in 2019/20 including maternity and outpatient services.

Equitable increase in healthy life years

The quality of additional years lived impacts the individual, their whaanau, family and demand for health services.

As in other countries, the improvement in estimated healthy life expectancy for New Zealand has grown more slowly than the improvement in life expectancy.[13] This means both men and women are living longer with some degree of impairment of their health than previously. This has important implications for the individual, their whaanau and family, with impacts for health and disability service demand due to increased duration of unhealthy life years.

CM Health is enhancing approaches that will reduce risk factors and improve management of long term health conditions. Approaches include preventing potentially avoidable ill-health (e.g. smoking cessation, immunisation), delaying onset of disease through early identification of disease (e.g. cardiovascular risk assessment, cancer screening, timely diagnostic services) and effective treatment (e.g. timely elective care, effective cardiovascular and diabetes treatment) and self-management. Actions to improve healthy life expectancy also need to address areas of ill health such as mental health and musculoskeletal conditions, which impact morbidity and quality of life to a greater extent than length of life per se, and the importance of investment early in the life course to provide equitable opportunities for positive life outcomes. These are important complementary considerations taken into account in CM Health planning and prioritisation.

Healthy Communities – Improved population health and equity

"Together we will help make healthy options easy options for everyone"

Many of the determinants of ill health are outside the control of the healthcare system. We can, however, exert our leadership role to support our communities in those issues that matter most to them, including through using our particular expertise in population health. By locating more healthcare services that are connected and integrated in community settings, we aim to make it easier for communities to access care and support. Regional and local approaches focus on reducing tobacco use, minimising hazardous use and harm from alcohol, increasing the likelihood of being physically active and improving nutrition environments and advice. To achieve healthy communities, we focus on reducing the prevalence of risk factors for ill-health and support the **best start in life for our children and young people that will have benefits for their whaanau, families and community**.

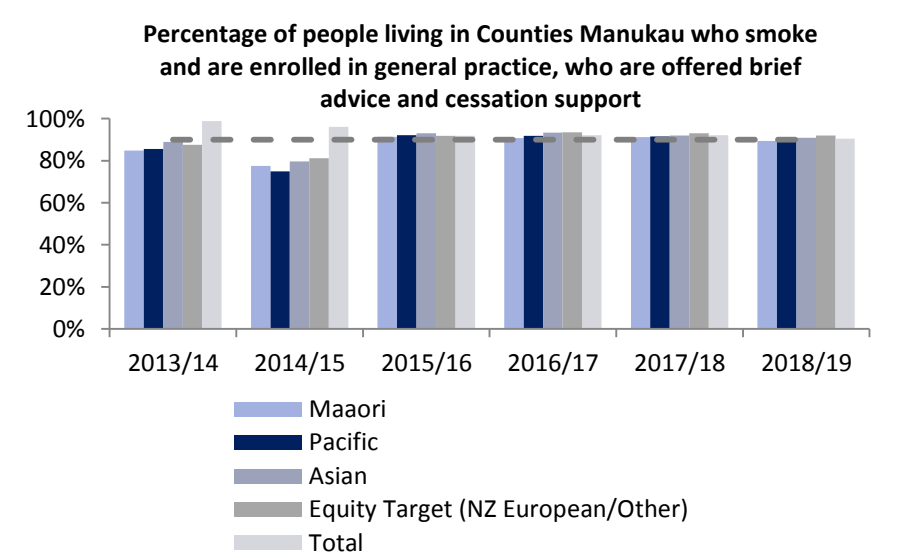
[13] Chan WC, Papa D, Winnard D (2019) Life Expectancy in Counties Manukau. 2018 Update. Auckland: Counties Manukau Health.

Medium term outcome: Equitable smokefree rates across Counties Manukau

Smoking, a leading risk to health in Counties Manukau, disproportionately burdens Maaori and Pacific peoples.
Inequities in smoking prevalence contribute to differences in life expectancy and wellbeing between Maaori and Pacific and non-Maaori/non-Pacific peoples. At the time of Census 2013 Maaori (36 percent) and Pacific peoples (22 percent) in Counties Manukau were three and nearly two times more likely to smoke respectively than people identifying as NZ European/Other ethnicities (12 percent).[14] Brief advice and cessation support can be effective at prompting quit attempts and long-term quit success.

Better help for smokers to quit (Primary)- 90% of Primary Healthcare Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking in the last 15 months[15]

In 2018/19, CM Health achieved the 90% target for Pacific (91%), Asian (91%) and for the total population (91%). CM Health almost achieved the target for Maaori at 89.4%. Performance increased between Quarter 3 and Quarter 4, reflecting PHOs' focus on supporting their low performing practices to improve performance. This has included strategies such as appointment scanning, improved coding systems and ensuring opportunities are not missed if the patient attends the practice with a family member.

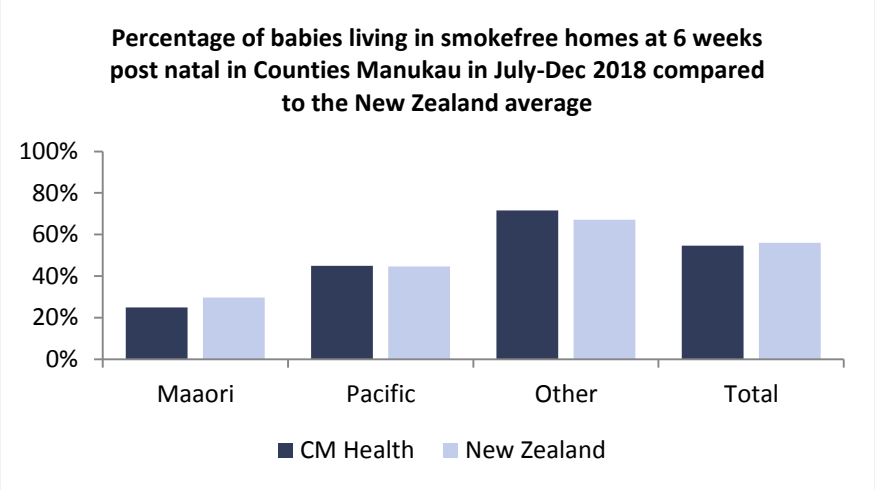


In 2018/19, the CM Health Living Smokefree Service took 5,496 referrals of which 41% were for Maaori patients and 28% for Pacific, reflecting the strong equity focus of this service.

Data source: Ministry of Health Performance Reporting

Key contributory measure: increased percentage of babies living in smokefree homes at 6 weeks post natal[16]

Increasing the number of babies living in smokefree homes will reduce potentially avoidable ill-health and hospitalisation (e.g. respiratory infections, asthma). Infant exposure to tobacco smoke contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. The System Level Measure "Babies living in Smokefree homes at 6 weeks post natal" includes other household members and so focuses the attention beyond maternal smoking to the home and whaanau environment that an infant will be raised in. In 2018, there were marked inequities for Maaori and Pacific infants who were less likely to live in a completely smokefree home compared to New Zealand/Other households. The ethnic inequities in CM Health are similar to the national averages across New Zealand.



In 2018 in Counties Manukau, an estimated 40% of Maaori women were identifed as currently smoking at the time

[14] Data on smoking prevalence from the 2018 Census is not yet available. Figures presented are from the 2013 Census.
[15] The data is for quarter four of each financial year
[16] In 2018/2019 a SLM has been introduced focused on the proportion of babies in smokefree households at six weeks of age. This measure has been included in CMDHB's 2018/19 Statement of Performance Expectations. It is now being used instead of the percentage of women who are smokefree at 2 weeks postnatal. The new data standards came into effect on 1 Jan 2019 which will improve data quality and accuracy.

of admission for birth, compared to 14% of Pacific women, 6% of NZ European/Other women and 2% of Asian women. In 18/19 smoking cessation support was targeted for women during and after birth. The Smokefree Maternity Incentives programme has demonstrated a highly effective approach to supporting pregnant women to stop smoking during pregnancy. In 2019/20 efforts will focus on increasing reach and engagement in the existing whaanau incentives programme to support more babies to live in smokefree homes. This will have an equity focus to support Maaori and Pacific women and their whaanau.

Data source: Ministry of Health Performance Reporting

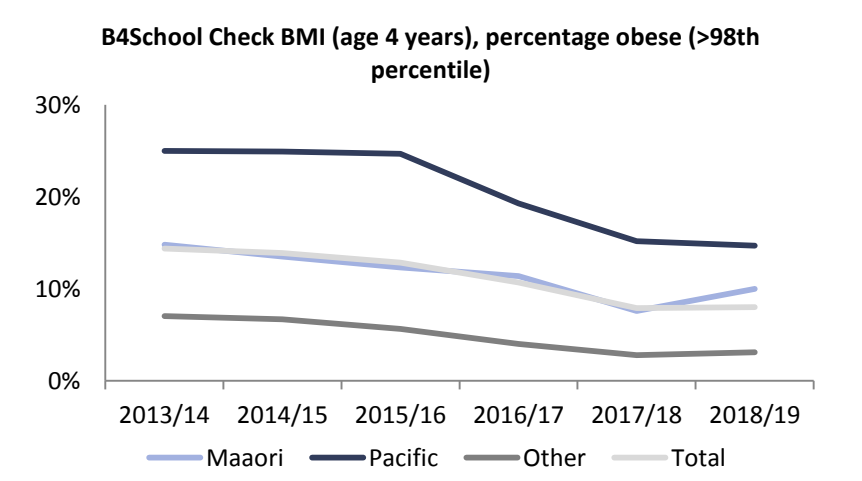
Medium term outcome: Equitable reduction in obesity prevalance in children

Childhood obesity is associated with a wide range of short to long term health impacts that are potentially avoidable. CM Health has a high prevalence of overweight and obese children and Maaori and Pacific children are disproportionately affected. Addressing obesity is complex requiring the health sector to work with other sectors to support wider environmental and societal change to reverse the growing prevalence of obesity in our community. In the last three years there has been an encouraging reduction in the prevalence of obesity in four years olds, as measured in the B4School Check, particularly for Pacific children. This trend in children in Counties Manukau is similar to the regional and national trends.

Supporting healthy weight in children

In 2018/19, the percentage of four year olds with a Body Mass Index (BMI) over the 98th percentile was 8% (achieving the target of <13%). This was higher for tamariki Maaori at 10% and Pacific children at 15%.

Referral for children identified with a high BMI at the B4School Check provides an opportunity for children and whaanau to participate in clinical assessment and family-based nutrition, activity and lifestyle programmes. In 2018/19, CM Health exceeded the 95% referral target for all ethnic groups.



The decline rate for participation in assessment and healthy lifestyle intervention is higher in Counties Manukau than the national average, particularly for Maaori and Pacific whaanau.[17] One of the recommendations from a broader evaluation of child healthy weight activities in Counties Manukau is to engage with whaanau who have declined and better understand the reasons for declines for Maaori and Pacific whaanau.

At CM Health, we acknowledge the need for a broad approach to reducing childhood obesity. We have worked with Auckland DHB and Waitematā DHB to develop the Metro Auckland DHB Healthy Weight Action Plan for Children 2017-2020. The Plan takes a life-course approach, identifying a number of actions to support children to maintain a healthy weight throughout childhood. CM Health is also part of the Healthy Auckland Together coalition and works with intersectoral partners such as schools and the University of Auckland to support wider environmental and cross-sectoral societal change.

Data source: Ministry of Health Performance Reporting

Key contributory measure: Improving oral health children - 60% of children are dental caries (holes or fillings) free at 5 years of age

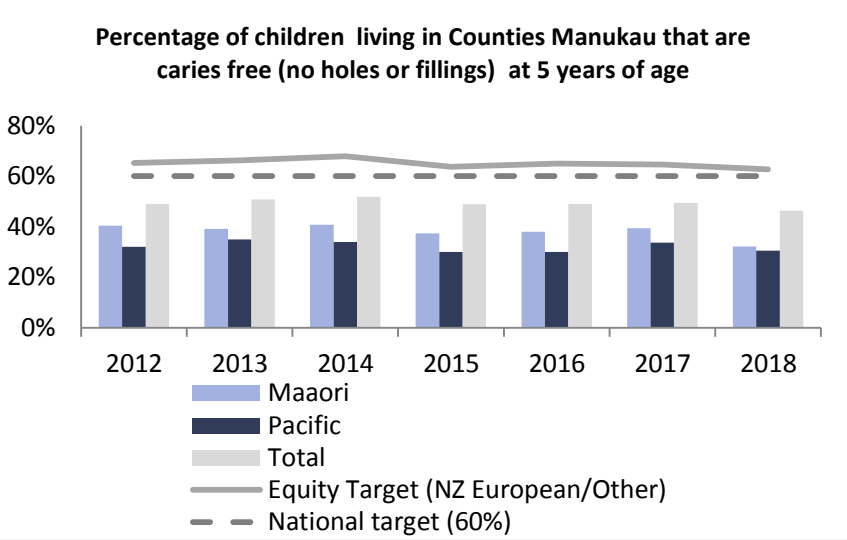
Nutrition is an important factor in reducing overweight and obesity. Poor nutrition is also directly linked to oral disease in infants and pre-schoolers and has negative impacts on long term oral health. Rates of early childhood caries (holes or fillings) are high in Counties Manukau with significant disparities for Maaori and Pacific children.

In 2018 the total percentage of children dental caries free at five years was 46%, still below the targeted level of 60%. As in previous years, the target was only achieved for European/Other children. Significant inequities have persisted over time.

[17] CM Health continues to closely monitor the rate at which families decline to participate in clinical assessment and healthy lifestyle programme. In Q2 18/19 the overall decline rate in Counties Manukau was 29% for the total population (national average is 23%), 36% for Maaori national average 25%) and 21% for Pacific (national average 16%). Strategies are in place to reduce the rate of declines.

Early enrolment with dental services will support prevention and early detection of oral health problems, including dental caries. In 2020CM Health will continue to work with the Auckland Regional Dental Service to improve early enrolment and the provision of preventative services to children at high risk of dental caries, including Maaori and Pacific children. CM Health will also continue to work on aligning oral health and obesity prevention messaging with a focus on new resources for Maaori and Pacific children.

Data source: Ministry of Health Performance Reporting

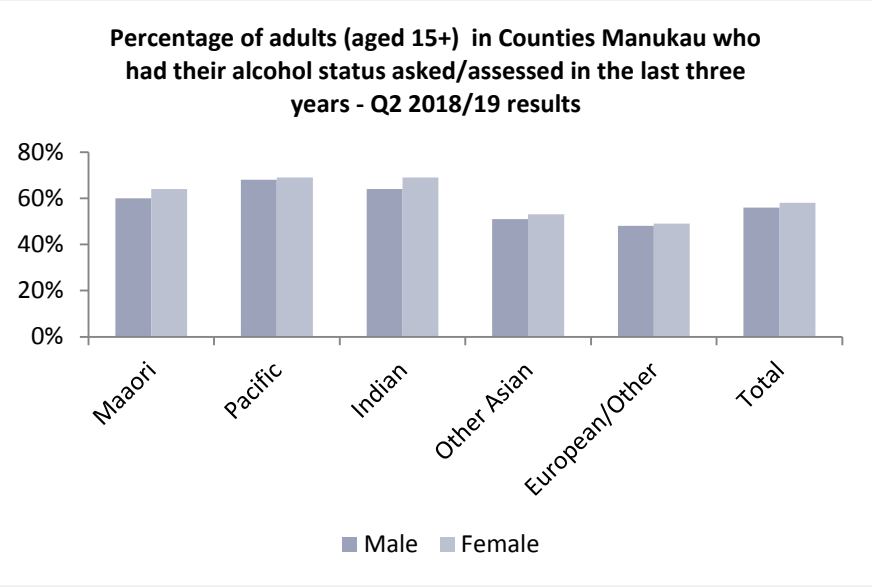


Medium term outcome: Reduced hazardous alcohol use and harm

Hazardous alcohol use and alcohol-related harms are major contributors to inequities in health and wellbeing outcomes in Counties Manukau, particularly for Maaori, males, young people, and people living in more socio-economically deprived areas.

Key contributory measure: Increasing the percentage of enrolled patients in general practice who have had their alcohol status asked/assessed in the last three years[18]

CM Health has been developing a programme of collaborative alcohol harm minimisation actions with a view to working regionally. This work includes equitable delivery of the Alcohol ABC (Ask, Brief Advice, Counselling) approach in general practice.The graph shows the 2018/19 data for quarter two for the percentage of enrolled patients in general practice who have had their alcohol status asked and/or assessed in the last three years.



Alcohol ABC work involves adaptation of the Alcohol ABC model to each setting, development of supporting systems and processes, and training and sustained support for front-line staff to enable them to have skilled and empathetic conversations with people and whaanau about alcohol use.

The 2018-2019 year saw the combining of the 'Working Together to Embed Alcohol ABC Approach in Primary Care' and 'Alcohol Brief Intervention in Primary Care' contracts that were previously separate. This allows us to better align reporting, define the data indicators and facilitate a quality improvement approach to embedding Alcohol ABC in general practice.

Data source: General practice ABC data

[18] The 2018-2019 year saw the combining of the 'Working Together to Embed Alcohol ABC Approach in Primary Care' and 'Alcohol Brief Intervention in Primary Care' contracts that were previously separate. As a result the measure reported in this Statement of Service Performance reports the new measure (percentage of adults (aged 15+) in Counties Manukau who had their alcohol status asked/assessed in the last three years) which incorporates work under both of these now combined contracts.

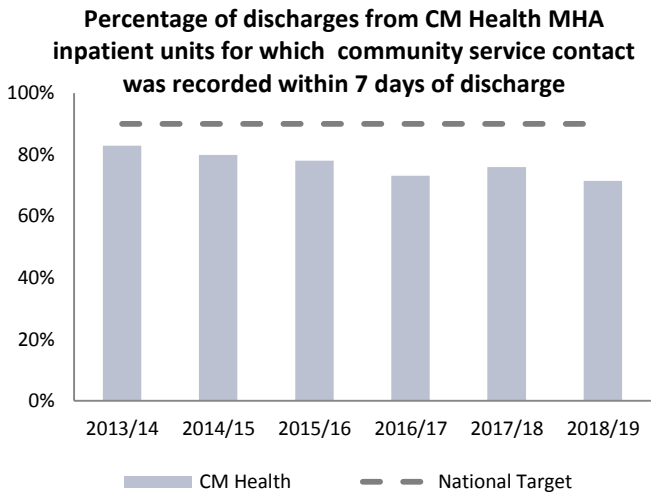
Medium term outcome: Improved mental health and wellbeing

Many New Zealanders will experience a mental illness and/or an addiction at some time in their lives. Maaori and Pacific peoples report higher levels of psychological distressthan non-Maaori, non-Pacific. They may also miss out on early interventions that might prevent progression to more significant ill-health.

Key contributory measure: Improved post-discharge community mental health and addictions care

Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes. For most service users discharged from the acute inpatient setting, early contact and engagement with community mental health services supports their recovery.

In 2018/19, 72% of service users discharged from the CM Health acute adult inpatient mental health unit had a community mental health service contact recorded within 7 days of their discharge. The is similar to the previous two years and is still below target.



During 2018/19 Mental Health and Addictions commenced the Health Quality and Safety Commission (HQSC) national project initiative Connecting Care: Ensuring that mental health and addiction service consumers receive continuous quality care between providers. The project is in partnership with Tamaki Health, Total Healthcare PHO with the project aim: Through an improved discharge process and communication at least 80% of people discharged from CM Health MHS to Primary Care will be seen by their GP for review within 28 days, by 1 December 2019

During 2019/20 the Connecting Care Project Team will test change ideas using PDSA ("Plan, Do, See, Act") cycles to support a 'Warm Handover' Transition of Care from Mental Health Services to Primary Care using the new pathway

Data source: Key Performance Indicators for the NZ Mental Health & Addiction Sector (www.mhakpi.health.nz)[19]

Improved youth mental health and well-being

Good mental health enables young people to make meaningful contributions to their families and communities. Maaori young people (rangatahi) have higher rates of mental health disorders, present later for treatment and suffer worse health outcomes than non-Maaori in Counties Manukau. CM Health aims to improve access to primary mental health services as well as a focus on 'youth friendly' primary care.

Additionally, 93% of Maaori year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities were provided with a HEADSSS (Home, Education and Employment, Eating and Exercise, Activities and peers, Drugs and Alcohol, Depression and suicide, Sexual health, Safety and Strengths) adolescent psychosocial assessment (target 95%). For those Maaori aged 0-19 years with severe mental illness, 5.9% accessed mental health services, exceeding the target of 4.45%.

In 2019/20 CM Health will build on these successes through focusing on greater mental health service integration for our young people.

[19] In the interim and as the suite of mental health and wellbeing measures is being developed, the timeliness of post-acute discharge community care contact being made provides a reasonable indication of how our MHA inpatient and community services are performing.

Healthy People, Whaanau and Families – improved equity, quality, safety and experience of care

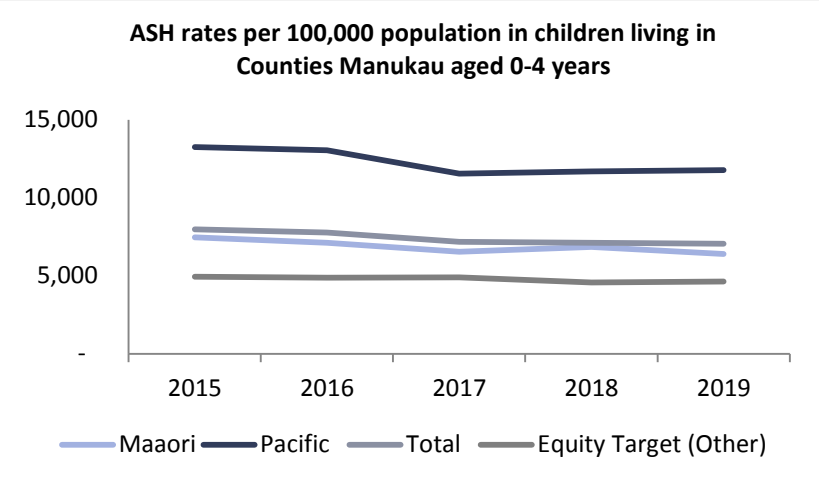
"Together we will involve people, whaanau and families as an active part of their health team"

By working better together with patients, whaanau and families, we aim to see reduced acute (unplanned) presentations for healthcare, and increased use of primary and community services including technology that enables self-management. We want patients, whaanau and family to report improved experiences due to more connected, accessible and co-ordinated care.

Medium term outcome: Equitable reduction in potentially avoidable hospitalisation in our 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are acute admissions that are considered potentially avoidable through access to quality, responsive primary health care.

Keeping children well and out of hospital is a key priority. Not only is it better for our community, but it frees up hospital resources for people who need more complex and urgent care. Maaori and Pacific babies and children experience health inequities in acute admissions that are considered potentially avoidable (ambulatory sensitive hospitalisations or ASH). Leading causes of ASH events for Maaori and Pacific children in Counties Manukau are respiratory infections, asthma, dental conditions, cellulitis, upper ear, nose and throat infections and gastroenteritis.



The ASH data presented is for the 12 months ending in March of each year. The 2018/19 Metro Auckland Sytem Level Measures Improvement (SLM) Plan set a target of reducing the 0-4 year old total, Maaori and Pacific ASH rates by 3% by June 2019.[20] March 2019 data indicates that CM Health is on track to achieve this target for Maaori but not for Pacific ethnic groups.

In 2018/19, there was a focus on groups who experience inequitable child outcomes by identifying Maaori children and their whaanau who are are not enrolled in primary care and supporting enrolment with a primary care provider of their choice, supporting a regional Pacific Providers forum, and promoting enrolment with WTCO providers in primary care, particularly for Maaori and Pacific children.

Data source: Ministry of Health Performance Reporting

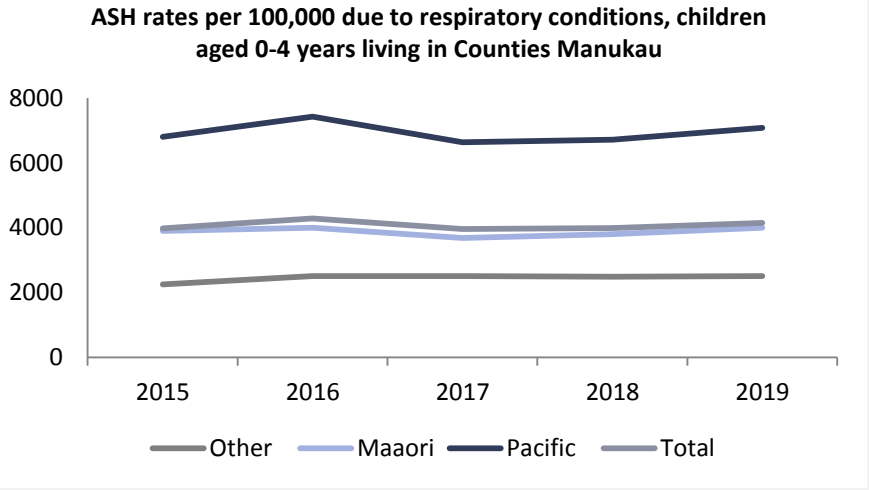
Key contributory measure : Reducing the 0-4 year old ASH rate per 100,000 – respiratory condition subset[21]

Counties Manukau Pacific and Maaori children are more likely than children of other ethnicities to be hospitalised with respiratory conditions including asthma and penumonia. The 2018/19 Metro Auckland SLM Improvement Plan targeted reduced ASH rates through focusing on respiratory admissions, the largest contributor to 0-4 year old ASH rates across the three Auckland DHBs.

[20] Baseline was set at 12 months to June 2018.

[21] The 2018/19 Metro Auckland SLM Improvement Plan targeted reduced ASH rates through focusing on respiratory admissions, the largest contributor to 0-4 year old ASH rates across the three Auckland DHBs. This new contributory measure has therefore been included in this Annual Report to reflect the large impact that it has on ASH rates for 0-4 year olds in Counties Manukau.

Through both local and regional work, CM Health implemented a number of strategies to reduce respiratory admissions, including actions to improve child and maternal immunisation and smoking cessation. This is especially important for reducing inequities for our Pacific children, who have the highest total and respiratory ASH rates.The ASH data presented is for the 12 months ending in March of each year. Since 2016, there has been a decrease in ASH rates by 4.7% for Pacific tamariki for respiratory conditions (asthma, lower respiratory tract infections, pneumonia, upper and ear nose and throat respirtory tract infections). However, inequities have persisted over time.

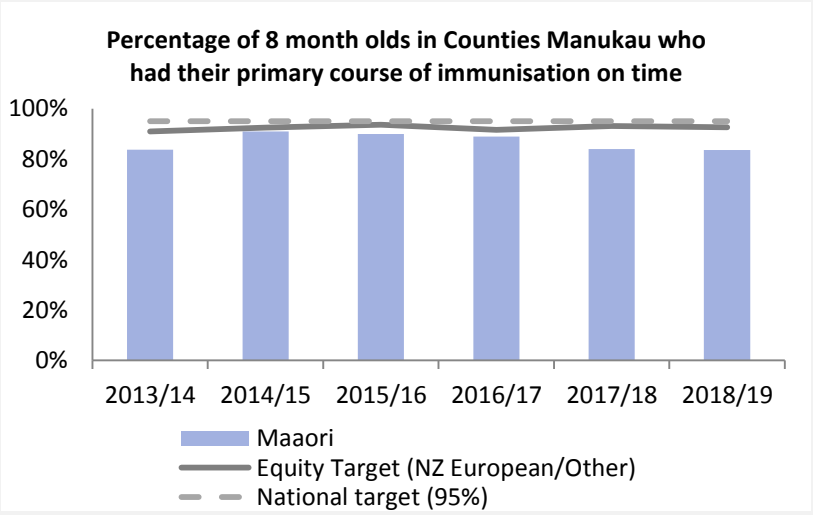


The 19/20 SLM plan will also target reduced ASH rates through focusing on respiratory admissions. CM Health will enhance efforts in a number of areas to increase influenza vaccination rates for eligible Maaori and Pacific, increase influenza and pertussis vaccine coverage rates for pregnant Maaori and Pacfic women, increase e-referrals to primary care healthy housing programmes and increase referrals to maternal incentives smoking cessation programmes.

Data source: Ministry of Health Performance Reporting

Key contributory measure: improving immunisation coverage to reduce potentially avoidable hospitalisations- Immunisation Health Target – 95% of children will be fully immunised by the time they are 8 months old[22]

Tamariki Maaori have lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases. Ensuring that vaccination coverage at 8 months achieves the national 95% target is important for enabling wellbeing for Maaori children and to avoid potentially avoidable hospitalisations.



CM Health aims to achieve equity by increasing the percentage of pepi and tamariki Maaori who are immunised on time at 8 months, and 2 and 5 years. In 2018/19 CM Health did not meet the 95% target for tamariki Maaori, with performance similar to 2017/18. An increase in whaanau deferring immunisation until their children are older has contributed to the declining Maaori immunisation rate at eight months. Socioeconomic issues are also a key challenge, with our Outreach Immunisation Service (OIS) experiencing more families in emergency housing where information cannot be shared, as well as families being transient moving through multiple addresses.

Based on previous quarters, the most effective strategy for engaging Maaori families has been multiple contacts to establish relationships and trust. In 19/20 CM Health will continue to build on this work with the OIS prioritising Maaori and Pacific families, continuing to offer opportunistic immunisation for siblings, an incentivised programme for tamariki Maaori under 8 months where immunisation has been delayed and supporting a local community clinic for whaanau who cannot get to Manukau SuperClinic for catch up immunisations, to improve access.

Data source: National Immunisation Register Data Mart report

[22] The data is for quarter four of each financial year

Medium term outcome: Improved end of life pathways for patients and whaanau[23]

Ensuring that the patients, whaanau and family are at the centre of end of life care

The increase in the proportion of people living with chronic health conditions along with the ageing population means there is a gradual increase in the number of deaths. This has impacted on the demand and complexity of palliative care services. CM Health aims to strengthen the capacity and capability of district wide services to enable living well and dying well regardless of where the patient is in their journey.

Poi, a system-based approach to enable six hospices across the Auckland region to work together with the Metro Auckland DHBs, Age Related Residential Care (ARRC) facilities and primary care stakeholders, was implemented in 2017/18. The purpose of Poi is to support better palliative care outcomes for patients and family/whaanau during a person's final months, regardless of where in the system palliative care is provided.

A key achievement of Poi has been the establishment of hospice Poi teams, which provide expert mentoring and coaching to primary palliative care providers (chiefly ARRC facilities and GPs) in their local areas. Specialist support is received following submission of Palliative Pathway Activations (PPAs). These PPAs, or palliative care plans, are completed by primary palliative care providers for patients with identified palliative care needs, regardless of whether specialist palliative care is required. PPAs are reviewed by the Poi teams and attract a payment for the primary palliative care provider, to reflect the resources required to complete a plan. Support and guidance is provided to the primary care provider as required to improve capability in managing palliative care patients safely in the community. In 2018/19, 123 PPAs were completed by Totara and Franklin Hospice as part of Poi, with the number of PPAs steadily increasing across the region. 113 contacts (or 'proactive conversations') were recorded between the local hospices and primary palliative care providers as a result of the PPAs submitted.

Further to this, 48 link nurses have been trained within the CM Health district since 2017. Link nurses act as champions within primary care and liaise between primary care providers and specialist palliative care services, to improve communication and co-ordination of care for patients with palliative care needs. Three GPs with Special Interests (GPSI) have been employed by local hospices to progress palliative care capability and resources within primary and residential care settings for accredited 6-month rotations. GPSI are champions within the primary care workforce that will have expertise in both primary and palliative care.

CM Health is continuing to support local hospices, the lead DHB, and the Poi Programme Office in further embedding the initiative.

Healthy Services – better value for public health resources

"Together we will provide excellent services that are well-supported to treat those who need us safely, with compassion and in a timely manner"

We will add healthy life years for Counties Manukau residents by reducing potentially avoidable (unplanned) hospital admissions. To achieve this we need to ensure our workforces across the district are well trained, health literate, knowledgeable and come to work because they want to do their best for patients and whaanau. For the current Counties Manukau residents living with long term health conditions, we will support them to better manage and control their health through excellent, collaborative, high quality, compassionate and safe health care services to improve experience of care.

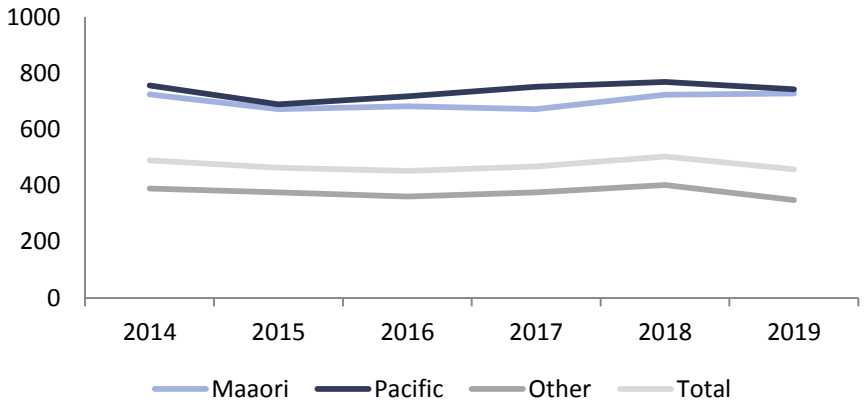
[23] As this is a new outcome measure, baseline and trend data are not yet available.

Medium term outcome: Reduction in acute hospital bed days

All of system approach to ensure safe delivery of care and reduce potentially avoidable hospitalisation[24]

Acute hospital bed days per capita is a measure of acute demand on hospital care that is potentially amenable to reduction or avoidance. This is positively impacted by good upstream primary and community care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors and good communication between primary and secondary care.

Standardised acute hospital bed days per 1,000 population for people living in Counties Manukau



March 2019 results indicate that CM Health may meet the 2018/19 SLM Plan milestone for reducing the number of acute hospital bed days per capita by June 2019 for the Pacific population but not for the Maaori population. This has been a challenging measure to shift due to the wide variety of factors (including socioeconomic deprivation) that impact on this measure. In 2018/19, CM Health focused efforts on conditions that contribute most to acute bed days, including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), stroke and cellulitis. Activities undertaken in CM Health include refinement of the end to end patient journey for patients with CHF and COPD, testing of appropriate primary care based bundles of care for COPD and CHF patients, and referral of Maaori and Pacific patients who present in primary care with ASH conditions to appropriate self-management or wellness services.

The 2019/20 SLM Plan aims to focus on Maaori and Pacific populations in addition to the prioritised conditions because of the marked inequities in acute hospital bed rates compared to non-Maaori, non-Pacific rates.

Data source: Ministry of Health Performance Reporting[25]

Key contributory measure: improved and more equitable experience of care

The Hospital Inpatient Patient Experience Survey (PES)

Understanding and improving patients' experience is vital to improving patient safety and the quality of care and contributes to better health outcomes. [26]

Counties Manukau Hospital Inpatient Survey: Average score across each domain 2014-2018

The national Hospital Patient Experience Survey provides insights into how to improve patient experiences by focusing on activities to improve the quality of care provided. As at Quarter 2 2018/19, CM Health's average score across all four domains of the survey (communication, coordination, partnership and physical & emotional needs) was 8.25, below our targeted average of 8.5. In 2019/20 CM Health will focus on improving the responses for the 'Communication' section of survey, which is our lowest scoring domain. Improving the average score in the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' is a priority with a 5% improvement target. .

Data source: Health Quality and Safety Commission National Patient Experience Survey Report[27]

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[24] The acute hospital bed days (acute inpatient event) per capita rates will be illustrated using the number of bed days for acute hospital stays per 1,000 population (estimated resident) domiciled to Counties Manukau. This will be measured every six months for the preceding (rolling) 12-month period. Age-standardised to overall New Zealand 2013 Census Usually Resident population. Data presented is until end March each year.

[25] This is a national performance measure SI7 – reporting through PP22. DHBs are expected to provide jointly agreed (by district alliances) System Level Measure improvement plans, including improvement milestones (and related targets).

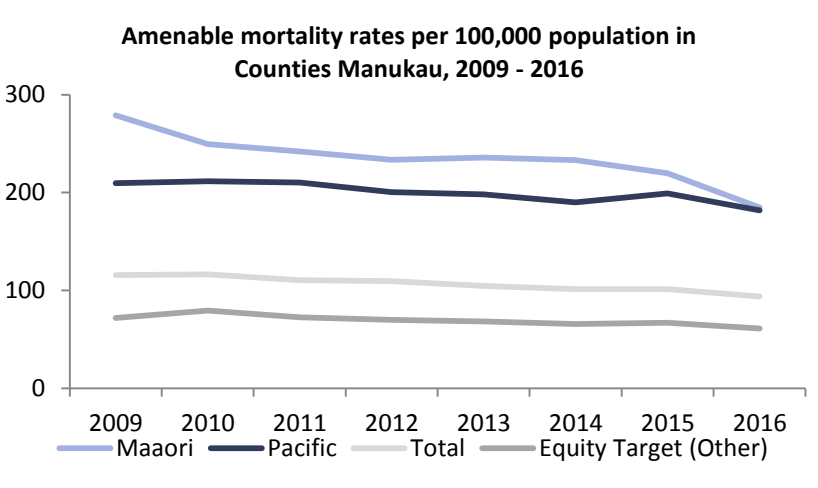
[26] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203

[27] Accessible online with national comparisons from the Health Quality Evaluation page of http://www.hqsc.govt.nz. There are four question domains that are scored out of 10, with average results reported each period. Targeted overall survey average is greater than 8.5.

Medium term outcome: Reduced and more equitable amenable mortality rates[28]

Target improvement in the leading causes of potentially preventable deaths

The four leading causes of amenable mortality Counties Manukau - cancer, cardiovascular disease (CVD) (particularly heart attacks and stroke), chronic obstructive pulmonary disease (COPD) and diabetes - share common risk factors. [29] Regional and local approaches focus on delivering actions to reduce unhealthy diet, physical inactivity, smoking and harmful use of alcohol risk factors. Proportionally, Maaori have a higher amenable mortality in smoking-related diseases such as cardiovascular disease and COPD. Pacific people have a higher proportion of diabetes related deaths.



The 2018/19 SLM Plan set an amenable mortality rate reduction target of 2%, to be achieved by June 2019 for Maaori and Pacific (from previous year) and a 6% reduction by June 2020 for the entire DHB population (on 2013 baseline). Based on 5-year trends, Counties Manukau DHB shows a consistently declining total amenable mortality rate. Data from 2016 indicates we have already met the 6% reduction target for all ethnic groups with the most significant decline being for Maaori.

The Maaori and Pacific amenable mortality rates have also been declining, except for a small increase in the Pacific rate between 2014 and 2015. The 2019/20 SLM Plan targets a further 2% reduction in the Maaori and Pacific amenable mortality rates by June 2020 This will be achieved through continued focus on improving smoking cessation and management of CVD, as well as a focus on the implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.

Data source: National Mortality Data Collection[30] *(definition based on Ministry of Health (MoH) September 2016 version on defining amenable mortality)*

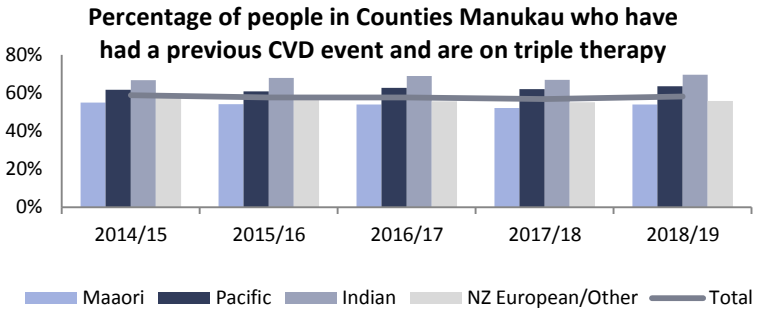
[28] Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

[29] Chan WC, Papa D, Winnard D (2015) Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 Update. Auckland: Counties Manukau Health.

[30] It takes several years for some coronial cases to return verdicts. As a result the Ministry is unable to release provisional cause of death information until around two years after the end of the year. Reports are made available annually with a rolling five years data set.

Key contributory measure: better treatment of people with cardiovascular disease (CVD)

There is good evidence that for those with a previous CVD event, 'triple therapy'[31] medicines can reduce the risk of future CVD events and death. Triple therapy as defined as statins, antiplatelet/coagulants, and blood pressure lowering medicines dispensed in at least three quarters in the year.



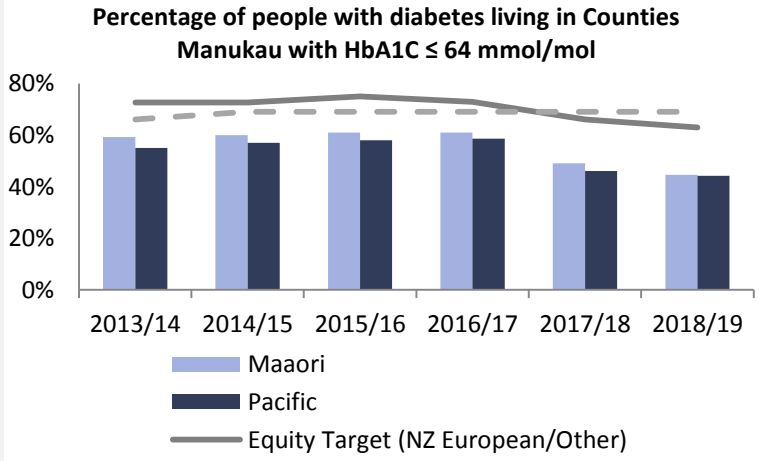
Although the total percentage of people receiving triple therapy in Counties Manukau is at the upper end of results for the Northern Region DHBs, there is considerable room for improvement for people of all ethnicities. As a region, we aim to increase the rates of people who have had a prior CVD event and are on triple therapy by 5 percent each year.

In 2018/19 we did not achieve our targets for increasing the percentage of people on triple therapy. In 2019/20 our focus will be on reducing inequity by improving CVD management for our Maaori and Pacific patients through both local and regional initiatives as well as going beyond equity (e.g. the current best group) with a greater focus on appropriate risk management to improve Maaori health as well as overall population cardiovascular health.

Data source: NRA CVD Prevention Medication Six Monthly Report [32]

Key contributory measure: improved diabetes control in people with the highest disease burden

Better glucose control for people with diabetes will reduce the progression of micro-vascular complications - chronic kidney disease, retinal disease and others. CM Health utilises 'Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015 - 2020 ' (MoH) as the strategic plan for diabetes as well as the Quality Standards for Diabetes Care, which provides guidance for clinical quality service planning and implementation of equitable and comprehensive patient-centred care.



The priorities of the Living Well with Diabetes plan include improving the number and percentage of patients with good glycaemic control (good control of blood sugar levels). CM Health uses HbA1c≤ 64 mmol/mol, a measure of average blood glucose levels, as an indicator of good glycaemic control. Living Well with Diabetes also focuses on appropriate cardiovascular risk management, prevention and management of diabetes related complications such as albuminuria, neuropathy and retinopathy.

Until 2017/18, CM Health used our Chronic Care Management for Diabetes (CCM) programme data as the data source for the HbA1c≤ 64 mmol/mol measure. This data source however only captured about 60-70% of eligible patients. In 2017/18 we transitioned to using PHO data submitted through Health Safe, which captures closer to 90% of patients. While it appears that the percentage of patients with good glycaemic control has decreased in 2017/18, this is more due to the change of data source rather than an actual decrease in performance.

In 2019/20 we are aiming to improve the percentage of patients with good glycaemic control through increased focus on improving the quality of diabetes care and proactive management of long-term conditions. This will include an emphasis on reducing unwarranted clinical variation between practices and ensuring practices have a quality improvement approach which is led by an improvement team.

Data source: Ministry of Health Performance Reporting[33]

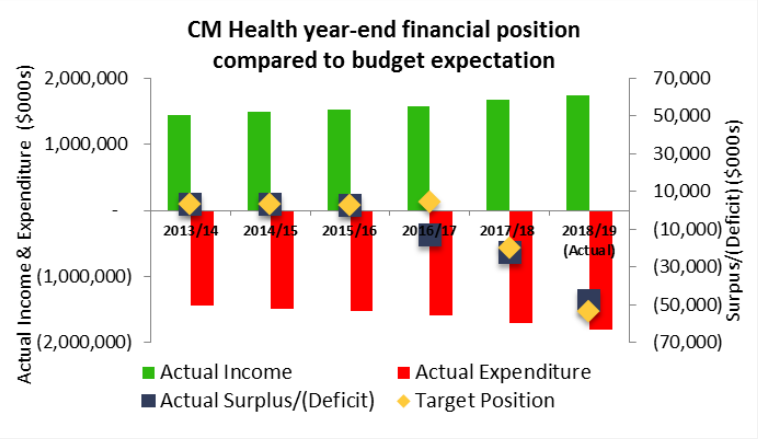
[31] Cardiovascular disease (CVD) management as measured by the percentage of Counties Manukau residents aged 30 to 80 who have had a previous CVD event who are on triple therapy. Triple therapy as defined as statins, antiplatelet/coagulants, BP lowering dispensed in at least 3 quarters in the year.

[32] *CVD Prevention Medication Report* based on PHO enrolment for Quarter 4, CV Risk Assessment extracts and TestSafe dispensing data. Annual rates are based on data for 12 months until end March each year.

Key contributory measure: fiscal responsibility

District Health Boards (DHBs) exist to improve, promote and protect the health of the public and specifically the people that live in their districts. This is achieved through provision and funding of services, the allocation and long-term stewardship. To deliver this, each DHB must responsibly and effectively live within its means and achieve the best possible outcomes within available funding.

2017/18 Actual Audited ($000)	*2018/19 Position Target ($000)*	*2018/19 Audited Underlying Position Result ($000)*
(22,223)	*(53,495)*	**($43,949)**



In 2018/19 our Year End audited underlying financial position was a deficit of $43.949m (before one off adjustments of $2.9m for the FPIM impairment and an additional Holiday's Act provision) compared to a budget deficit of $53.5m. The reported deficit of $152.8m includes an additional provision for Holiday's Act remediation in 2018/19 of $105.9m.

This was achieved through our focus on two key portfolios of work, both of which are targeted at extracting maximum value from all of our activities: 'Every Hour Counts' is not only about improving patient flow but also that our staff and partner health professionals are able to spend their time on activities that add value to the patient experience.

In addition, the 'Every $ Counts' portfolio supports CM Health's financial objective to return to a sustainable financial position. In 2018/19 a number of projects were consolidated under Every $ Counts with a total savings of $8.15m.

Data source: CM Health Annual Reports[34]

[33] This is a national performance measure PP20 reflects the Ministerial priorities for improvement treatment for people with long term health conditions. Note that CM Health currently uses the PHO CDIP cohort based on the population aged 15-74 years enrolled with Counties Manukau practices as the denominator for this measure. Work is currently underway to mature and refine HbA1c reporting in CM Health.

[34] Accessible online from http://countiesmanukau.health.nz

Statement of Service Performance

This section presents CM Health's actual performance against the National Health Targets and against the forecast outputs presented in our 2018/19 Statement of Performance Expectations. The services or 'outputs' we measure are grouped into four 'output classes' – prevention services, early detection and management services, intensive assessment and treatment services, rehabilitation and support services – that reflect the nature of the services provided, as presented in our outcomes framework.

CM Health's 2018/19 results are based on our performance as reported in Quarter 4 2018/19, unless otherwise specified.

Prevention services

Preventive services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventive services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They 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. On a continuum of care these services are public wide preventive services.

Preventative services are aligned with our **Healthy Communities** strategic objective that is focused on primary (ill-health) prevention across the life course.

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Health Promotion and Education Services					
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months	Total	92%	90%	91%	Achieved
	Maaori	91%		89%	Not Achieved
	Pacific	92%		91%	Achieved
	Asian	92%		91%	Achieved
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking[35]	Total	96%	95%	96%	Achieved
	Maaori	96%		96%	Achieved
	Pacific	96%		96%	Achieved
	Asian	93%		97%	Achieved
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking[36]	Total	92%	90%	94%	Achieved
	Maaori	94%		96%	Achieved
Percentage of PHO-enrolled patients who smoke who accepted smoking cessation support	Total	25.7%	28.2%[37]	25.1%	Not Achieved
Percentage of babies living in smokefree homes at six weeks postnatal	Total	53%[38]	80%[39]	55%[40]	Not Achieved
	Maaori	27%		25%	Not Achieved
	Pacific	45%		45%	Not Achieved

[35] Baselines and results for this measure reflect a full financial year data (1 July to 30 June).
[36] Baselines and results for this measure reflect a full financial year data (1 July to 30 June).
[37] 2018/19 targets represent a 10% increase from baseline per the 2018/19 Metro Auckland SLM Improvement Plan.
[38] Baseline data is for the period Jan 2018 to June 2018, source: WCTO and NHI register data via the MOH.
[39] The 2018/19 Metro Auckland SLM Improvement Plan targets a 2% relative increase in the percentage of babies living in smokefree homes, however due to the importance of this measure for improving health equity for our Maaori and Pacific populations, CM Health has adopted a target of 80% for all ethnic groups.
[40] Result is for the period July 2018 to December 2018, source: WCTO and NHI register data via the MOH. New data standards came into effect on 1 January 2019 which will improve data quality and accuracy over time. This data is provided for implementation of the System Level Measures programme and therefore should only be used for quality improvement purposes.

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Percentage of babies fully or exclusively breastfed at 3 months	Total	51%[41]	70%	49%[42]	Not Achieved
	Maaori	41%		42%	Not Achieved
	Pacific	46%		44%	Not Achieved
Percentage of children identified as obese in the B4 School Check programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	100%	95%	100%	Achieved
	Maaori	100%		100%	Achieved
	Pacific	100%		100%	Achieved
	Other	100%		100%	Achieved
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	140[43]	171	234	Achieved
Number of adult referrals to Green Prescription services	Total	6,142	7,300	5,869	Not Achieved
Immunisation Services					
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Total	93%	95%	93%	Not Achieved
	Maaori	84%		84%	Not Achieved
	Pacific	94%		95%	Achieved
	Asian	98%		98%	Achieved
Percentage of two year olds who are fully immunised	Total	93%	95%	93%	Not Achieved
	Maaori	87%		87%	Not Achieved
	Pacific	94%		93%	Not Achieved
	Asian	98%		99%	Achieved
Proportion of eligible girls fully immunised with HPV vaccine	Total	71%	75%	62%	Not Achieved
	Maaori	65%		54%	Not Achieved
	Pacific	84%		72%	Not Achieved
	Asian	68%		60%	Not Achieved
Percentage of people aged over 65 years who have had their flu vaccinations	Total	46%[44]	75%	54%[45]	Not Achieved
	Maaori	40%		47%	Not Achieved
	Pacific	45%		68%	Not Achieved
	Asian	46%		57%	Not Achieved
Health Screening					
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	71%	70%	72%	Achieved
	Maaori	65%		65%	Not Achieved
	Pacific	82%		83%	Achieved
	Other	70%		72%	Achieved
Proportion of women aged 25 – 69 years who have had a cervical smear in the last three years	Total	69%	80%	66%	Not Achieved
	Maaori	65%		62%	Not Achieved
	Pacific	75%		68%	Not Achieved
	Asian	66%		66%	Not Achieved
	Other	70%		67%	Not Achieved
Percentage of four year olds receiving a B4 School Check	Total	91%[46]	90%	90%	Achieved
	Maaori	94%		91%	Achieved
	Pacific	91%		92%	Achieved

[41] Data reported six-monthly. Baseline is as at March 2018 (Q3).
[42] Data reported six-monthly. Results as at March 2019 (Q3).
[43] In 2017/18 140 children were engaged, with a total of 285 referred.
[44] Results are reported annually in Q1 of each year, covering a six month period of 1 March to 30 September. 2017/18 results are for the period 1 March 2017 to 30 September 2017.
[45] 2018/19 results are for the period 1 March 2018 to 30 September 2018.
[46] The 90% Ministry of Health target is based on the percentage of the eligible population who receive a B4 School Check. Baselines and results for the 2018/19 year are therefore presented in this format. Previously results have been reported as a percentage against the target (i.e. a result of 100% if the target was met, or of over 100% if the target was exceeded). Previously reported baseline results per the 2018 Annual Report are therefore: Total: 101%, Maaori: 100%, Pacific: 90%, Other: 109%).

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
	Other	87%		89%	Not Achieved
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS[47] assessment	Total	100%[48]	95%	93%	Not Achieved
	Maaori	102%		93%	Not Achieved
	Pacific	99%		95%	Achieved
	Asian	101%		89%	Not Achieved

Early detection and management services

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. Include general practice, community and Maaori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventive and treatment services focused on individuals and smaller groups of individuals. Early detection and management services are aligned with our **Healthy Services** and **Healthy People, Whaanau and Families** strategic objectives which focus on making services more responsive and easier to access and providing support for people to self-manage at home.

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Primary Health Care Services					
Percentage of population enrolled in a PHO	Total	97%	95%	96%	Achieved
	Maaori	92%		91%	Not Achieved
	Pacific	116%[49]		114%	Achieved
	Asian	90%		90%	Not Achieved
Percentage of newborns enrolled in general practice by 3 months	Total	71%	85%	89%[50]	Achieved
	Maaori	69%		70%	Not Achieved
	Pacific	70%		86%	Achieved
	Other	73%		101%	Achieved
Amenable mortality rate per 100,000 population[51]	Total	101.2[52]	≤98.1[53]	101.2[54]	Not Achieved
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	92%	90%	90%	Achieved
	Maaori	90%		87%	Not Achieved
	Pacific	91%		90%	Achieved
	Other	92%		91%	Achieved
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	74%	90%	71%	Not Achieved
Proportion of people with diabetes who have	Total	55%	60%	52%	Not Achieved

[47] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide

[48] Results are for the school/calendar year (1 January 2017 – 31 December 2017). Results for the HEADSSS assessment indicator greater than 100% are due to the transient nature of our population which can fluctuate significantly from the start to the end of a school term.

[49] As the 2018 Census results have yet to be released, calculation of the 2017/18 results for PHO enrolment used the 2013 Census data for population denominators. As the Census historically has underestimated the Pacific population, the 2017/18 baseline and the 2018/19 result for Pacific are greater than 100%.

[50] Note that 2018/19 results have improved as a result of the introduction of the National Enrolment Service from 1 April 2019. Under NES patients are now enrolled and funded from the point of enrolment rather than having to wait to be enrolled and funded in the next quarter's ASR under the old system.

[51] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.

[52] Baseline is at 2015 as there is a two and half year delay before mortality data is released. It takes several years for some coronial cases to return verdicts. As a result the Ministry is unable to release provisional cause of death information until around two years after the end of the year. Reports are made available annually with a rolling five years data set.

[53] 2018/19 target for the total population represents a 6% relative reduction from the 2013 baseline as per the 2018/19 Metro Auckland SLM Improvement Plan. Updated baseline data will depend on the 2018 Census information, which is not yet available.

[54] Result is at 2015, more recent data is not available at time of drafting (August 2019).

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
satisfactory or better diabetes management (HbA1c < 64 mmol/mol)[55]	Maaori	49%		45%	Not Achieved
	Pacific	46%		44%	Not Achieved
	Other	66%		63%	Achieved
Percentage of patients with CVD risk >20% on dual therapy (prescribed)	Total	49%	70%[56]	52%	Not Achieved
	Maaori	48%		49%	Not Achieved
	Pacific	55%		59%	Not Achieved
	Asian	42%		49%	Not Achieved
Percentage of patients with prior CVD who are prescribed triple therapy (prescribed)[57]	Total	57%	70%[58]	62%	Not Achieved
	Maaori	52%		59%	Not Achieved
	Pacific	62%		65%	Not Achieved
	Asian	49%		61%	Not Achieved
Oral Health Services[59]					
Proportion of children under 5 years enrolled in DHB-funded community oral health services[60]	Total	84%	≥95%	79%	Not Achieved
	Maaori	71%		68%	Not Achieved
	Pacific	83%		82%	Not Achieved
	Asian	75%		77%	Not Achieved
	Other	90%		101%	Achieved
Percentage of enrolled children Caries free at age 5 years[61]	Total	49%	51%	46%	Not Achieved
	Maaori	39%		32%	Not Achieved
	Pacific	34%		31%	Not Achieved
	Asian	57%		56%	Achieved
Mean Decayed Missing or Filled Teeth (DMFT) Score for Year 8 Children [12/13 years][62]	Total	0.88	≤0.81	0.83	Not Achieved
	Maaori	1.26		1.03	Not Achieved
	Pacific	1.24		1.17	Not Achieved
	Asian	0.62		0.62	Achieved
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	74%	>85%	73%	Not Achieved
Diagnostics[63]					
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	88%	95%	93%	Not Achieved
	MRI	46%	90%	33%	Not Achieved
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	98%	90%	99%	Achieved
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	69%	70%	82%	Achieved
Ambulatory Sensitive Hospitalisations					
Ambulatory Sensitive Hospitalisation rate in	Total	7,012	≤6,630[64]	7,043[65]	Not Achieved

[55] Note that CM Health currently uses the PHO DCIP cohort based on the population aged 15 – 74 years enrolled with Counties Manukau practices as the denominator for this measure. Work is currently underway to mature and refine HbA1c reporting in CM Health.
[56] 2018/19 SLM Improvement plan targets a 5% relative increase from baseline for this measure, however due to persistent inequities in CVD management for Maaori, CM Health has chosen to adopt the Metro Auckland Clinical Governance Forum target of 70% for all ethnic groups.
[57] Baselines are at Q3 2017/18. Results are at Q4 2018/19.
[58] 2018/19 SLM Improvement plan targets a 5% relative increase from baseline for this measure, however due to persistent inequities in CVD management for Maaori, CM Health has chosen to adopt the Metro Auckland Clinical Governance Forum target of 70% for all ethnic groups.
[59] Baseline data is based on the calendar year (to 31 December 2017), except for adolescent measure which is Q4 2017/18.
[60] Results for this measure are reported annually in Q3. 2018/19 results are therefore at Q3 2018/19.
[61] Results for this measure are reported annually in Q3. 2018/19 results are therefore at Q3 2018/19.
[62] Results for this measure are reported annually in Q3. 2018/19 results are therefore at Q3 2018/19.
[63] Baselines, targets and results for all diagnostics measures (CT, MRI and the two colonoscopy measures) are for the financial year and not Quarter 4.
[64] 2018/19 targets represent a 3% reduction from baseline by 30 June 2019 as per the 2018/19 Metro Auckland SLM Improvement Plan.
[65] 2018/19 result is as at March 2019.

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
children aged 0-4 years per 100,000 population	Maaori	6,578	≤6,386	6,367	Achieved
	Pacific	11,618	≤10,853	11,774	Not Achieved
Rheumatic Fever					
Acute rheumatic fever first hospitalisations rates per 100,000 population	Total	10.9	≤4.5	13.8	Not Achieved
	Maaori	12.6		13.6	Not Achieved
	Pacific	40.3		54.7	Not Achieved
Sudden Unexpected Death of an Infant (SUDI)					
SUDI deaths per 1,000 live births	Total	1.00[66]	≤0.40	1.18[67]	Not Achieved
	Maaori	2.06		2.40	Not Achieved
Pharmacy					
Number of prescription items subsidised	Total	7,748,436[68]	N/A[69]	7,695,564	N/A

Intensive assessment and treatment services

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

They include:

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

On a continuum of care these services are at the complex end of treatment services and focussed on individuals. Intensive assessment and treatment services are aligned with our **Healthy Services** strategic objective that is focused on excellent, collaborative, high quality and safe health services.

Performance Measure			2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Mental Health						
Percentage of population who access mental health services	Age 0-19 years	Total	4.1%	3.15%	3.9%	Achieved
		Maaori	6.3%	4.45%	5.9%	Achieved
	Age 20-64 years	Total	3.9%	3.15%	3.9%	Achieved
		Maaori	9.3%	7.75%	9.3%	Achieved
	Age 65+ years	Total	2.3%	2.60%	2.0%	Not Achieved
		Maaori	2.8%	2.60%	2.7%	Achieved
Proportion of 0-19 year olds referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks[70]	Mental Health (Hospital Care Arm)	3 weeks	68%[71]	80%	70%[72]	Not Achieved
		8 weeks	89%	95%	89%	Not Achieved
	Addictions (Hospital Care Arm and NGO)	3 weeks	95%	80%	99%	Achieved
		8 weeks	98%	95%	100%	Achieved

[66] Note that the baseline data differs from that reported in the 2017/18 Statement of Service Performance which reported unconfirmed 2016/17 data. Updated baseline data is sourced from Child and Youth Mortality review Committee – 13th data report comprising years 2012 to 2016.
[67] Results sourced from Child and Youth Mortality review Committee – 14th data report comprising years 2013 to 2017.
[68] Results are preliminary, final results will be available in 3-6 months due to the time taken to ensure data accuracy.
[69] Measure is demand driven – not appropriate to set target.
[70] Note that in line with Ministry of Health definition and expectations the results for this measure include all referral types, not just non-urgent referrals. The inclusion of urgent referrals has the effect of raising reported performance against this target. Also to note is that in-line with the Ministry of Health's definition, the "starting point" of this measure is when a referral is opened in the Patient Management System and not when the referral was first made (if these dates are different).
[71] Baselines for this measure are cumulative for the 2017/18 financial year (June 2017 to June 2018).
[72] Results are for the period ending 31 March 2019.

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[73]	Total	76%[74]	90%	72%	Not Achieved
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 compulsory treatment orders	Non-Maaori	96	N/A	94	N/A
	Maaori	395	366	334	Achieved
Elective Services					
Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	Total	101.5%[75] 20,841	100% 20,930	96.5% 20,200	Not Achieved
Elective Services Standardised Intervention Rates (SIRs) per 10,000 population	Major Joints	22.10	21	23.63	Achieved
	Cardiac Surgery	5.67	6.5	5.83	Not Achieved
	Cataracts	38.01	27	46.62	Achieved
	Coronary Angiography	28.08	34.7	30.22	Not Achieved
Acute Services					
Readmissions – acute readmissions to hospital[76]	0-3 days	2.4%[77]	≤2.3%	2.4%[78]	Not Achieved
	0-28 days	10.9%[79]	≤10.7%	10.9%[80]	Not Achieved
Acute Inpatient Average Length of Stay	Acute LOS	2.75 days	2.30 days	2.75 days	Not Achieved
	Elective LOS	1.66 days	1.50 days	1.59 days	Not Achieved
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		91%	95%	80%	Not Achieved
Cancer Services					
Proportion of patients who receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks[81]	Total	93%[82]	90%	83%	Not Achieved
Cardiac Services					
Percentage of high risk patients who receive an angiogram within 3 days of admission	Total	81%	>70%	60%	Not Achieved
	Maaori	82%		46%	Not Achieved
	Pacific	76%		60%	Not Achieved
	Other	80%		59%	Not Achieved

[73] Source: www.mhakpi.health.nz. CM Health is developing a suite of mental health and wellbeing measures. As these measures are being developed, the timeliness of post-acute discharge community care contact being made provides a reasonable indication of how our MHA inpatient and community services are performing.
[74] Note that the 2017/18 Annual Report incorrectly reported the 2017/18 result as 88%. This has now been amended.
[75] Performance for this measure is measured as a percentage of the targeted number of discharges, therefore if the number of actual discharges exceeds the targeted number the percentage performance will exceed 100%. In 2017/18, at May 2018 there were 20,841 actual discharges, exceeding the target of 20,535 discharges, leading to a percentage performance greater than 100%.
[76] Note that the 2017/18 Metro Auckland SLM Improvement Plan included a developmental contributory measure for acute readmission rates in 28 days.
[77] 2017/18 baseline for this measure are as reported in Quarter 4 2017/18 by the Ministry of Health, 12 months to the end of March 2018.
[78] 2018/19 result is as at March 2019.
[79] 2017/18 baseline for this measure are as reported in Quarter 4 2017/18 by the Ministry of Health, 12 months to the end of March 2018.
[80] 2018/19 result is as at March 2019.
[81] Note that this measure was omitted in error from the 2018/19 Statement of Service Expectations.
[82] Baseline reflects six-month achievement of the target, from January to June 2018.

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Stroke Services[83]					
Percentage of potentially eligible stroke patients thrombolysed		12.4%[84]	10%	13.3%	Achieved
Quality and patient safety					
Percentage of admissions affected by a hospital acquired complication[85]		2.1%[86]	<2.0%	1.9%[87]	Achieved
Rate of falls with major harm per 1,000 bed days		0.05[88]	≤0.00	0.04	Not Achieved
Percentage of inpatients (aged 75+) assessed for risk of falling		94%[89]	90%	95%[90]	Achieved
Rate of S. aureus bacteraemia (SAB) per 1,000 bed days		0.06[91]	≤0.00	0.09	Not Achieved
Compliance with good hand hygiene practice		87%	80%	88%	Achieved
System Level Measures					
Acute hospital bed days per capita	Maaori	706.0	658[92]	739	Not Achieved
	Pacific	744.1	695.9[93]	764	Not Achieved

Rehabilitation and support services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordinated input by the Needs Assessment and Service Coordination (NASC) Services for a range of services including day care, home-based support services and residential care services. Rehabilitation services are provided by specialised multidisciplinary teams overseen by a Geriatrician and/or Rehabilitation Medicine Specialist Medical Officer.

On a continuum of care these services will provide support for individuals. Rehabilitation and support services are aligned to our **Healthy People, Whaanau and Families** strategic objective which is focused on supporting people, whaanau and families to stay well and live independently in the community.

Performance Measure	2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
Age Related Residential Care (ARRC)				
Percentage of people in ARRC who have a subsequent international Resident Assessment Instrument (interRAI) long term care facility (LTCF) assessment completed within 230 days of previous assessment	88%	95%	92%[94]	Not Achieved
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six (6) months prior to that first LTCF assessment	59%	90%	88%[95]	Not Achieved
Home Based and Community Support				
Percentage of older people who have received long-term	97%[96]	95%	97%	Achieved

[83] Note that stroke services baselines and results are provided for the full 2018/19 year (12 month annualised results). This differs from the baseline included in the Statement of Intent and has been revised to reflect that for this measure the target is to be measured against annualised data (rather than year end data).
[84] Note that this baseline has been updated to reflect a full 2017/18 year (12 month annualised result). Previous baseline of 16% represented the result only for Q4 2017/18.
[85] Note that over the 2018/19 financial year CM Health has moved from reporting against the Copeland Risk Adjusted Barometer (CRAB) tool, as included in our Statement of Service Expectations, to reporting against the Health Round Table measure. Data is sourced from the Health Round Table coded discharge data.
[86] Baseline is for year to June 2018.
[87] Result as at Quarter 3 2018/19.
[88] Baseline is for year to June 2018.
[89] Baseline is as at Quarter 3 2017/18.
[90] Result is as at Quarter 3 2018/19.
[91] Baseline is for year to June 2018.
[92] 2018/19 target represents a 3% reduction from baseline per the 2018/19 Metro Auckland SLM Improvement Plan.
[93] 2018/19 target represents a 3% reduction from baseline per the 2018/19 Metro Auckland SLM Improvement Plan.
[94] Note that the full year annualised result for 2018/19 is 89%.
[95] Note that the full year annualised result for 2018/19 is 87%
[96] Baseline as at March 2018 (measure reported one quarter in arrears).

Performance Measure		2017/18 Baseline	2018/19 Target	2018/19 Result	Achievement
home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.					
Assessment, Treatment and Rehabilitation Services					
Conversion rate of Contact Assessment (CA)to Home Care assessment where CA scores are 4 – 6 for assessment urgency[97]	Aged 65+	N/A	N/A[98]	0%[99]	N/A
Number of older people that have received in-home strength and balance retraining services	Aged 65+	239	1,118	588	Not Achieved
Number of older people that have received community / group strength and balance retraining services	Aged 65+	1,135	1,400	1,530	Achieved
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	848	2,325 places	1,723	Not Achieved
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 50-74	512	600	639	Achieved
	Aged 75-84	405	300	424	Achieved
	Aged 85+	315	300	361	Achieved
Palliative care[100]					
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District		36	866[101]	123	Not Achieved
Number of Hospice Proactive Advisory Conversations between the hospice service, primary care and ARRC health professionals		141	866[102]	113	Not Achieved

[97] New measure introduced in 2018/19 therefore baseline data not available.
[98] Due to uncertainties around data quality and the need for further work to be completed to understand what best practice looks like for interRAI Contact Assessment to interRAI Home Care Assessment conversion rate, there is no target for this measure in 2018/19.
[99] Note that the full year annualised result for 2018/19 is 6.1% (Q1: No result, Q2: 18.2%, Q3: 7.1%, Q4: 0%).
[100] The following measures are part of the regional Better Palliative Care Outcomes Service which was implemented in the Auckland Region in 2017/18. This service implements a system-based approach to enable six hospices across the Auckland region to work together with the Metro Auckland DHBs, Age Related Residential Care (ARRC) and primary care stakeholders to achieve better palliative care outcomes for those with a terminal illness and their families regardless of where in the system palliative care is provided.
[101] The 2018/19 targets are forecast numbers from the original service development proposal, and may be subject to review based on discussions with the Hospices of Auckland Delivery Alliance and the Ministry of Health.
[102] The 2018/19 targets are forecast numbers from the original service development proposal, and may be subject to review based on discussions with the Hospices of Auckland Delivery Alliance and the Ministry of Health.

Performance by Output Classes [Includes agency costs]

Output Classes [$000]

	Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services	Total
Revenue (includes agency revenue)	**45,101**	**242,164**	**1,278,776**	**180,838**	**1,746,879**
Budget (includes agency revenue)*	44,508	242,558	1,259,773	179,106	1,725,945
Personnel Costs	21,658	832	743,964	12,163	778,617
Outsourced Services	1,373	53	93,923	771	96,119
Clinical Supplies	1,853	71	130,270	1,041	133,235
Infrastructure and Non-Clinical Supplies	1,531	59	142,371	860	144,821
Other (includes agency costs)	18,687	241,150	321,067	166,003	746,907
Total Costs	**45,101**	**242,164**	**1,431,595**	**180,838**	**1,899,698**
Budget (includes agency costs)*	44,508	242,558	1,313,267	179,106	1,779,439
Deficit	-	-	**(152,819)**	-	**(152,819)**
Budget	-	-	**(53,495)**	-	***(53,495)***

*The budget revenue and costs presented in the table above does not align to the budget numbers presented in the 2018/19 Annual Plan. The budget numbers for revenue and costs for 2018/19 output classes has been updated to more accurately reflect the recent changes of Responsibility Centres reporting restructure across the DHB during the 2018/19 financial year.

Agency revenue and costs for the year amounts to $16.8m.

Information on appropriations

How performance will be assessed and end of year reporting

The performance measures outlined in Counties Manukau DHB's Statement of Performance Expectations are used to assess our performance. For performance results, refer to our Statement of Service Performance.

	Amount of Appropriations ($000)			
	2017/18		2018/19	
	Final Budget	Estimated Actual	Budget	Estimated Actual
Total Appropriations	1,375,692	1,375,692	1,439,807	1,439,807

The appropriation revenue received by Counties Manukau DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act 1989.

Asset Performance Indicators for Counties Manukau District Health Board

Counties Manukau Health's Asset Portfolio

Counties Manukau DHB's assets have been grouped into Property (Buildings and Plant), Clinical Equipment and Information and Communications Technology (ICT). Summarised in the table below are Counties Manukau DHB's asset portfolios and their purpose, capacity and relevant values. The relevant performance measures for the facilities portfolio highlight the need to ensure that CMDHB's facilities are in acceptable condition, are well utilised and comply with regulatory requirements.

Table 1 Asset Portfolios[103]

Asset Portfolio	Asset Purpose	Quantity/Capacity	Book Value 30 June 2019
Property	To enable the delivery of high quality health services through the provision of facilities that meet accreditation requirements	• 716 adult medical, surgical, rehab, Assessment Treatment and Rehabilitation, community medical inpatient beds • 66 paediatric inpatient beds • 43 Intensive Care Unit / High Dependency Unit /Paediatric Intensive Care Unit/ Coronary Care Unit / Cardiac Step Down Unit beds • 90 maternity beds, 15 gynaecology beds, 7 assessment rooms and 29 delivery suites (hospital & community) • 77 acute mental health beds • 58 community mental health beds • 146 ED cubicles & short stay beds • 24 operating theatres; 14 at Middlemore and 10 + 2 procedure rooms at Manukau Surgical Centre • 14 owned community facilities • 18 leased community facilities • 19 owned dental clinics (84 chairs) plus 9 mobile dental units and 48 mobile unit site pads	$570m buildings, plant and infrastructure & land with a value of $193m
Clinical Equipment	To enable the delivery of high quality, timely clinical services through the availability of equipment that meets required clinical and safety standards	• 3 x MRI machines • 4 x CT machines owned • 1 cardiac catheter suite • Almost 23,000 other items	$30m Net Book Value ($90.8m original cost)

[103] Unless otherwise referenced, all asset portfolio data is based on figures as at 9th May 2019.

ICT	To enable the delivery of high quality health services through the availability of timely, accurate and accessible patient and business information	Regionally shared hardware and software. 7,800 users within Counties Manukau Health	$52m healthAlliance C-Class shares; $3.3m in NOS rights & $1.6m hardware & software; $4.2m work in progress (WIP) as at 30 June 2019

1. Property Assets

Property Assets Performance Measures

Services operated by CM Health are largely delivered from seven inpatient facilities and 18 leased or owned outpatient and community health facilities across the district. Manukau SuperClinic and Middlemore Hospital sites contain the largest elective, ambulatory, and inpatient facilities. In addition, a range of DHB and contracted community services are provided across the district e.g. Community Mental Health, Kidz First Community and others.
The performance of assets is vital to Counties Manukau DHB to provide better health services to all people of the Counties Manukau and surrounding regions. For this reason, Counties Manukau DHB is fully committed on developing a solid Asset Management Plan and strategy plan in order to improve its asset capability and maturity.
The asset portfolios are separated into three subgroups (facilities, clinical equipment and Information Communications and Technology (ICT)) and the performance is being measured by three key indicators (Condition, Utilisation and Functionality) and it is a mandatory requirement for Counties Manukau DHB to provide such information as outlined in the Cabinet Office Circular CO (15) 5.

Table 2 Property Asset Performance Measures

Asset	Measure	2017/18 Target	2017/18 Actual	2018/19 Target	2018/19 Actual
Medical beds *Occupancy % for opened beds at 7 am*	Utilisation	90%	104.9%[4]	90%	102.4%[3]
Surgical beds *Occupancy % for opened beds at 7 am - Middlemore only*	Utilisation	90%	102.3%[4]	90%	103.2%[3]
Operating Theatres *The percentage of theatres utilisation is calculated based on the total turnaround time + theatre duration divided by the session duration (in minutes)*	Utilisation	90%	82%	90%	84%
Building compliance requirements *Percentage of buildings used that possess a valid Building Warrant of Fitness (BWOF)*	Condition	100%	100%	100%	100%
Seismic Compliance *Percentage of buildings assessed as being earthquake prone (<34% New Building Standard (NBS) is classified as earthquake prone)*	Functionality	0%	5.5%	0%	5.5%

Asset	Measure	2017/18 Target	2017/18 Actual	2018/19 Target	2018/19 Actual
Facilities assets meeting or exceeding performance uptime *Facilities assets comprise of hot water boilers, steam boilers, air handling units and chiller plants. The 'Utilisation' results of these assets are based on the total asset available time minus the unplanned downtime and divided by the total asset available time.*	Utilisation	99%	99.87%	99%	98.83%[1]
Area fit for the provision of clinical or administration functions *Percentage of areas are rated in the range from Adequate to Excellent (Levels are categorised as :Not suitable, Barely adequate, Adequate, Good and Excellent)*	Functionality	90%	-%[2]	90%	86%

(1)The boiler located in Middlemore Hospital's "Energy Centre" building was shut down to carry out flue replacement works. Even though this outage did not cause any disruption to service due to CM Health having a relevant redundancy system in place, this event has still been captured and reflected in our calculations for the purpose of this report. (2) Functionality measurement of building assets has only been implemented by CM Health in FY 2019 and hence no data is available for the FY 2017/18 period. (3) There were 88 days in the2018/19 year where occupancy rate of medical services had reached 100% or above against budgeted capacity and for surgical services there were 47 days where occupancy rate had reached 100% or above. (4) There were 215 days in the 2017/18 year where occupancy rate of medical services had reached 100% or above against budgeted capacity and for surgical services there were 32 days where occupancy rate had reached 100% or above.

2. Clinical Equipment Assets

Clinical Equipment Assets – Condition and Utilisation

Safe clinical service delivery requires that all assets are fully functional and fit for purpose. Where clinical equipment assets fail against required standards they are taken out of service. Asset availability is managed via Service Level Agreements for large assets (some of which are leased) and through built-in redundancy within the asset fleet to enable replacement as required.

Table 3 Clinical Equipment Condition, Availability & Utilisation

Asset	Measure	2017/18 Target	2017/18 Actual	2018/19 Target	2018/19 Actual
MRI	Availability	>98%	>98%	>98%	98%
	Service Level	>85% elective patients waiting & scanned within 42 days	35%[3]	>85% elective patients waiting & scanned within 42 days	34%[5]
CT Scanners	Availability	>98%	>98%	>98%	98%
	Service Level	>95% elective patients waiting & scanned within 42 days	90% elective patients waiting & scanned within 42 days	>95% elective patients waiting & scanned within 42 days	93%[4]

Angiography (Catheter Lab)[2]	Availability		>98%	>98%	>98%	98%
	Utilisation		-	82%	85	84%
All non-fixed assets	Current Warrant of Fitness/ Certificate of Compliance		95%	88%[1] (average) 90.2% (at 30 June)	95%	94.2%[1] (average) 95.9% (at 30 June)

(1) Includes only in-hospital devices that are managed by CM Health Clinical Engineering and excludes items managed through other service provider support, e.g. leased items, laboratory and radiology equipment. (2) Catheter Lab utilisation is based on 8.5 hour per day session times Monday to Friday – noting the after-hours and weekend volume are managed regionally through Auckland DHB. (3) MRI results are poor- this is a result of staffing issues (recruiting difficulties and long term staff sick leave). Our new suite with the 2 co-located machines will allow us to run both with greater efficiency. (4) Due to staff shortages and the increased complexity of patient assessments the CT scanner volumes have decreased. (5) Subsequent to year end these result have significantly improved (Average for July '19 - Sept '19 is 64%).

3. ICT Assets

healthAlliance N.Z. Limited is responsible for the management and maintenance of the Northern Region ICT assets, consisting of information technology hardware, clinical applications, non-clinical business applications and operating systems.

ICT Assets – Availability

ICT Assets are categorised based on their level of criticality into Tier 1 (critical) and Tier 2 (urgent) systems. Due to the importance of fully functioning clinical ICT systems in delivery of health services, there is low tolerance for downtime.

The table below summarises actual for 2016/17 – 2018/19 versus target for 2018/19:

Asset type	Service Level Agreement Target	2016/17 Actual (Regional)	2017/18 Actual (Regional)	2018/19 Target (CM Health)	2018/19 Actual (CM Health)
Tier 1 Information systems (Critical)	• No more than 10 Tier 1 systems per annum less than 99.8% available • Average availability per annum >99.8% • Target outage recovery 4 hours	99.99%	99.987%	99.8% (max 8 unplanned outages and 0 exceeding 90 min restoration time)	99.93%
Tier 2 information systems (Urgent)	• No more than 10 Tier 2 systems less than 99.8% available • Average availability per annum >99.8% • Target outage recovery time 2 days	99.998%	99.985%	99.8% (max 3 unplanned outages and 0 exceeding 120 min restoration time)	99.93%

ICT Assets – Condition

Asset type	Service Level Agreement Target	2018/19 Target (CM Health)	2018/19 Actual (CM Health)
ICT assets with condition rating of poor	% of devices compliant with asset age replacement policy	75%	86%

ICT functionality– Access to network and systems remotely

Indicator type	Service Level Agreement Target	2018/19 Target (CM Health)	2018/19 Actual (CM Health)
Access to network and systems remotely	Remote access available to any staff who require it	35%	41.7%

ICT Utilisation – Services completed in the digital environment

Indicator type	Programme Target	2018/19 Target (CM Health)	2018/1 Actual (CM Health)
Services completed in the digital environment	eRadiology orders uptake	95%	95%
	Ward coverage of eVitals	35 wards	35 wards
	Ward coverage of MedChart	18 wards	20 wards

ICT Utilisation – Front line staff utilising mobile technology with clients

Indicator type	Programme Target	2018/19 Target (CM Health)	2018/19 Actual (CM Health)
Frontline staff utilising mobile technology with clients	Availability of mobile devices across the DHB (according to the Point of Care Devices Business Case)	80%	82%

Good Employer

Counties Manukau District Health Board (CMDHB) is committed to being good employer for its entire staff who serve one of the most diverse and fastest growing populations in New Zealand. CMDHB is committed to not only fulfilling its legal requirements as an employer, but also aspiring to best practice in all its employment practices, providing its people with a safe and healthy place to work while achieving our shared goal of health equity for our community. CMDHB has a wide variety of policies, programmes and projects being undertaken to fulfil our good employer objectives and obligations. We strive to:

- Deliver on our obligations under the Treaty of Waitangi by working closely with Manawhenua to deliver equitable health outcomes for Maaori
- Provide strong governance, leadership and management development and structures which encourage accountability
- Have clinical leadership for key areas to ensure the patient is at the centre of what we do and
- Be innovative in implementing best practice clinical approaches
- Have a work force which reflects the community we serve - we employ over 125 different ethnic groups and is culturally competent to work with the community
- Recognise the aims, aspirations, cultural differences and employment requirements of Maaori, Pacific peoples, and people from other ethnic or minority groups, women and persons with disabilities
- Provide safe and healthy working conditions – we aspire to provide a healthy and safe place to work in same way that we aspire to have healthy communities
- Provide Equal Opportunities
- Impartially select suitably qualified persons for employment with a focus in on increasing the number of Maaori and Pacific peoples working for CMDHB
- Provide opportunities for the enhancement of the abilities of individual employees though our innovation service, Ko Awatea and our people and capability development programmes

As a good employer, Counties Manukau District Health Board is committed to the equal employment of all employees and as set out in its Good Employer Policy:

- By ensuring our workplaces reflect and value the diversity within our workforce, we will be able to deliver quality health services more efficiently, effectively, and appropriately
- By removing seen and unseen barriers which prevent people from reaching their full potential, we can deliver top performance at every level of the organisation
- By being an organisation where patient and staff safety comes first
- By living our values - Kind, Valuing Everyone, Together and Excellent - we create a culture in which people act as a team, working together toward common goals.

The Seven Key Elements

There are seven key elements to Counties Manukau District Health Board being a good employer.

1. Leadership, accountability and culture

Organisational culture and values

At CM Health, our Strategic Goal is to achieve health equity for our community. To deliver this important (and often challenging) mahi, we need to continue to work together to create a great organisational culture. Evidence shows that one of the best ways to achieve a great workplace culture, and deliver excellent patient outcomes, is to remember our purpose and passion for why we work at CM Health and what's important to us. In 2015, our values were developed with input from over 3,000 staff, patients and their whaanau. We Whakawhanaungatanga (Value Everyone), we are Manaakitanga (Kind), we work Kotahitanga (Together) and we strive for Rangatiratanga (Excellence). We share these

values with our patients and their whaanau, they unite us together, remind us of what's important and we refer to them to guide our daily actions.

This year our CEO, Margie Apa, put an emphasis on seeing our Values in Action and so we've been working hard to imbed our values in everything we do.

Values Survey

We started by surveying our staff to gauge the level of awareness of our values and strategic goal throughout the organisation. Whilst results showed that the number of responses was not very high, it was pleasing to note that 64% of staff who did respond correctly identified all four of our organisational values, and 65% correctly identified our current Strategic Goal. Results also indicated that more work needs to be done to raise awareness of our strategic goal and values. A range of Values in Action initiatives have since been implemented or planned to continue to imbed our values across our organisation.

Values Visibility

We conducted an audit of how visible our values are in our organisation (online and in print), which showed that our values are not as visible as they could be around the DHB. Values posters are now visible in every meeting room in Ko Awatea, which prove useful to refer to when having discussions and making discussions. Values posters are also available online for services to print and departments are strongly encouraged to have these on display in the wards where both staff and patients can view them. Our values have also been added permanently to our online intranet site Paanui, so that staff are reminded of them whenever accessing information. Permanent values decal options for walls and entrance ways are also being explored.

Team Values Discussions & Charters

We have also been working with managers and staff to support them to articulate how each of our values relates to their team and service specifically. For example, what Kotahitanga looks like in their team, how they can behave in ways that align with Kotahitanga, how they keep each other accountable for demonstrating Kotahitanga and how they can celebrate each other when they do demonstrate Kotahitanga! Research shows that recognition of great effort and mahi is a key component to increasing positive behaviour. Feedback from teams who have engaged in this discussion has been very positive and they have appreciated the opportunity to articulate and agree *how* they want to work together. Staff have also found the creation of a Team Charter (a summary of the facilitated discussion) to be really useful to refer to in future team meetings and on-going planning.

A range of Team Check-up discussion tools (slide decks, discussion templates and team charter templates) have been developed and are now available on Paanui for Managers to access. These discussions have been rolled out across the organisation in a network approach, whereby success stories of services who engage in these conversations is shared and so ripples across the organisation. We have already had successful uptake of this values discussion opportunity with many services and continue to promote this resource to other teams. We are now responding to multiple requests to support these conversations in other services.

Values awards

As a result of much discussion and planning, organisational Values Awards are being implemented from September on a quarterly basis (in addition to any recognition awards in local services). These awards will again promote the importance of living our values in action and reward staff for doing so. The nomination process will allow staff the opportunity to nominate each other for demonstrating values-aligned behaviour.

2. Recruitment, selection and induction

CMDHB is committed to attracting and employing a workforce that reflects our community. Along with our regional colleagues the DHB measure whether its Maaori and Pacific workforces match its population.

Our Talent Acquisition Centre works with our community to source local talent, promote health careers and support people from our community into paid employment. The DHB has a set of employment targets which means that we have committed to ensuring that the workforce employed at CM Health, reflects the local population by 2025.

We continue to work on a number of initiatives which have been in place for over a year and are well embedded. These include:

LEAP (Local Employment Access Project) - This is a partnership project with Accelerating Aotearoa, Ministry of Social Development (MSD), Auckland Library and CM Health. We help support our local community with skills and tools to

become work ready, assisting them with CV writing, readiness for interviews, building confidence and public speaking skills. We help them with their job search and match them to roles within our organisation. CM Health was the pilot organisation for this project, and it continues to run here with successful placements being made.

Ministry of Social Development (MSD) partnership - We have a standing partnership with MSD where we work with their clients to help support them into paid employment. This helps these individuals to become independent and self-supporting. We offer recruitment training to the MSD work brokers who in turn work directly with their clients to ensure they are ready and prepared to enter the workforce. We receive applications from clients at MSD directly and we market them internally to our hiring managers for interviews for a variety of roles to match them to suitable positions with us.

Maaori and Pacific Scholarships – CM Health offers financial scholarship support to Maaori and Pacific students within our community who want to study for a career in health. Once they have enrolled at University for a health-related qualification, we provide them with on-going pastoral support, mentor sessions, clinical placements at CM Health as well as helping them into graduate level roles upon completion of their study.

Health Science Academies supporting Maaori and Pacific Success and Achievement in NCEA -The Health Science Academies (HSAs) were initiated by Counties Manukau District Health Board (CMDHB) in 2011 as part of their drive to build a workforce that better reflects the community they serve. Partnered with the Tindall Foundation, they supported two health science learning communities based at James Cook High School and Tangaroa College. A Health Science Academy is basically a school within a school – with a specific focus on the achievement of NCEA core sciences. The initial academies in James Cook High School and Tangaroa College demonstrated significant increases in Maaori and Pacific student achievement in NCEA 1, NCEA 2 and NCEA 3 in comparison to National Data sets. The academies also demonstrated a high retention rate for students between years and fewer absentees.

CM Health is now supporting 7 Health Science Academies (HSAs) with over 390 Maaori and Pacific secondary students engaged. These Academies continue to achieve higher success rates for Maaori and Pacific Achievement in NCEA and have been a key vehicle for increasing Maaori and Pacific student participation in NCEA Science. 134 secondary school students have graduated from HSAs with most continuing onto tertiary education in health or health related qualifications. Four graduates of the HSAs are employed by CM Health, with a further 22 supported in part-time and casual positions while they complete tertiary studies.

Career Shows at Auckland University of Technology (AUT) and Manukau Institute of Technology (MIT) – CM Health promotes health career options at AUT/MIT as part of our "Grow Our Own" strategy.

Working and Achieving Together Programme (WAT) - Regional collaboration project where we focus on getting Maaori and Pacific students into health careers.

Volunteers - Volunteers have been an integral part of our volunteer team who have helped enhance patient experience at CM Health. We have also had volunteer school students on our programme who are keen to study for health careers.

Further to these existing programmes, in the past year we have also been working on establishing the following initiatives:

Open days/work experience and university internships – we have been working to provide opportunities for young students to visit the organisation and get a taste of what working here is like. The goal of these initiatives is to inform young people about the careers that are available in health, across an array of different disciplines, not only in clinical settings. We hope that this will encourage students and young people to consider a career in health.

Limited Service Volunteers (LSV) – this is a programme which supports young people who are not currently in employment, education or training by providing a 6 week motivational hands on training programme run by New Zealand Defence Force on behalf of Work and Income. The aim of this programme is to help increase young peoples' confidence, help them learn new skills and gain employment. We have been engaging with LSV to establish a relationship and support some of these young people into work at CM Health. From September 2018 we will be engaging with the participants in LSV and providing their details to managers who are recruiting for suitable roles. We are also exploring options for providing paid work experience or cadetships to these groups.

Our goal is to make CM Health a great place to work. We continue to support hiring managers with training, tools and techniques to hire staff who will reflect our values in their daily work. Our comprehensive Values-Based Recruitment Programme continues as part of our recruitment and selection process. This guides the recruitment process, from attraction, screening, interviewing and employment.

We also continue to work on attracting Maaori talent into our workforce. Over this past year, a further 184 Maaori have been employed at CM Health raising the number of Maaori employees from 346 employees (as at 31 March

2017) to 529 employees (as at 31 March 2018). This has lifted the overall percentage of Maaori employed at CM Health from 5.36% (as at 31 March 2017) to 7.92% (as at 31 March 2018).

We employ 2,730 nurses. 10.6 % are Pacific nurses and CM Health wants to grow that to 21% by 2025. We are proud to be the employer of the largest Pacifica nursing workforce in NZ and possibly in the world. 5.7% of our nurses are Maaori. That is 529 people and with a target of lifting that to 14.1% by 2025. That makes us the second largest employer of Maaori nurses amongst the DHBs. We are working towards the recruitment process encouraging more Maaori and Pacific candidates. As an example for our nursing graduate recruitment we have special and separate processes for Maaori and Pacifica. We know that we will only achieve Health Equity when our workforce is as diverse as the population we serve.

3. Employee development, promotion and exit

Employee Performance Development Culture

We are progressing well with our strategy to establish a performance and development culture within CM Health. We see this culture as being one in which staff are encouraged to continuously learn and to convert that learning into action by using a much more open and proactive style, promoting a two-way conversation based approach between the employee and their manager.

The following three principles underpin CM Health's approach to performance and development:

- A continuous process of performance conversations, requiring the engagement and active participation of all parties involved
- Alignment with the strategic requirements of CM Health, with a focus on excellence in all outcomes
- Learning needs and opportunities are planned and agreed based on the discussions and agreements reached during the performance and development process.

We have now moved to a simpler process for supporting performance and development, this has involved:

- moving from a 'tick box' exercise to a process which is based on regular quality conversations between managers and employees
- the addition of an online Performance & Development module on the kiosk system, which was launched earlier this year, has a number of benefits for both managers and employees and includes:
    - *Easier to access on a regular basis*
    - *Secure, confidential electronic format*
    - *The ability to Record ongoing conversations*
    - *Email notifications to both parties*
    - *Central online storage*
    - *Status for statistical & data reporting*

We see this as leading to improved employee engagement and satisfaction by supporting their personal and professional development, giving transparency to expectations and driving a clear shared purpose.

The next step in the process is to improve the reporting of data and access to information on performance and development for managers utilising the HR Dashboard.

Nursing

For nursing, being the largest workforce, there is a dedicated team of:

- Four Professional Development Nurse Educators and Midwifery clusters for: Adult Rehabilitation and Health of Older People (ARHOP) and Mental Health, Medical and Emergency Care, Surgical and Critical Care, Kidz First and Women's Health. In total there are 29 full time equivalent positions in these clusters supporting nurses' development.
- People development consultant team which work across the four clusters and throughout the organisation
- Interprofessional post registration and Professional Development and Recognition Programme (PDRP) team
- Interprofessional undergraduate and entry to practice team.

The Nurse Entry to Practice programme available at CMDHB is a comprehensive 12 month programme. The aim is to provide a supportive environment in which the graduate nurse can progress and ensure competency is maintained throughout their first year of practice enabling him/her to provide a high standard of care and promote continuing professional development.

CM Health adopted an electronic portfolio (ePortfolio) system for nursing staff to access their Professional Development and Recognition Programme (PDRP). The nursing "ePDRP" can be accessed directly through Ko Awatea LEARN using existing login details. This system is now being well utilised by our nursing staff and receiving lots of positive feedback.

Allied Health

The Allied Health Initiative for Education and Development (AHIED) was initiated by the Director of Allied Health in 2016 to better understand and build on existing professional development practice for Allied Health staff. This was carried out as a partnership between Allied Health and Ko Awatea.

As a result of this, a new position of Allied Health & Technical Workforce Educator was established in 2017. The role has enabled the implementation of a regular Allied Health Grand Round for shared learning, and is improving the accessibility of education for the allied and technical workforce.

All disciplines

CMDHB has a highly developed learning capability (Ko Awatea LEARN) for its people including:

- Advance eLearning capacity and content which is accessible to all staff
- Education communities and forums including strong alliances with our joint venture partners and other organisations such as the University of Waikato
- Clinical staff involvement in improvement initiatives, campaigns, innovation and improvement intensives
- Several other short courses, talks and workshops including: system innovation and improvement, patient centred care workshops and master classes, service co-design with patients and whaanau.

To deliver on its commitment to Maaori and Pacific workforce development, CMDHB has a specific leadership programme. Te Taki Paeora is a 12 month programme that develops and encourages growth in leadership capability and confidence. It is designed for health workers from Maaori and Pacific backgrounds who demonstrate leadership potential and are aligned to organisational values.

The programme provides staff with the tools, confidence and pathways to enact their ideas and ambitions (for themselves, their peers or their community) in service leadership. Participants will have a positive service level impact on the patient experience and community health, while holding true important personal and cultural values.

We have also been working to improve cultural competency within CM Health. In 2017/18, CM Health introduced the Effectively Engaging with Maaori Programme as a Mandatory programme for all new employees. This programme is promoted through all new staff orientation and induction programmes, along with E-Learning Programmes on the Treaty of Waitangi, Cultural Competency and Tikanga Best Practice. In the past 12 months, 1539 employees have completed these programmes.

We are also attempting to increase knowledge and use of Te Reo Maaori. CM Health has also formed a partnership with Te Whare Waananga o Awanuiarangi to offer fee free NZQA level certificates in Te Reo Maaori programmes to staff. The first two cohorts of learners commenced in February 2018, with the following two cohorts in July 2018.

Opportunities to develop the unregulated workforce are also being realised. Funding from Tertiary Education Commission (TEC) has enabled the delivery of Step Up programmes to employees from a variety of services. The programme has been in place for a number of years and offers forty hours of work-based learning to improve literacy, numeracy and communication skills.

The most recent cohort of 50 employees completing this programme successfully included Healthcare Assistants, Rehab Assistants, Cleaners, Administration, Central Sterile Supply Department staff and many more. Due to the ongoing success of the programme, two more courses have been planned, beginning in September 2018 and running for ten weeks. Feedback included comments from participants such as *"the learnings gained from the workshop were highly relevant and enjoyable"* and from a manager of a participant that *"This is a big investment, yet it has given so much value to the individual as well as to our organisation. I highly recommend that other managers invest in this training opportunity".*

Recognising that we need to offer support across the employee life cycle we have worked in partnership with Age Concern to offer pre-retirement courses that enable staff aged over 45 from the employee spectrum to prepare both psychologically and financially for retirement and help them create a positive active aging plan. A recent participant in the course provided feedback that *"It gave me much more insight into what I needed to think about and who I needed to have conversations with".*

We currently have 8 different Cultural and Linguistically Diverse (CALD) courses, including Working with CALD families – Disability Awareness, working with migrant and refugee patients and culture and cultural competency available for staff. These courses can be accessed using two different formats (face to face or online via e-learning). Over the period July 2016 – June 2018, we had 151 staff access and successfully complete a CALD course face to face. The CALD – Disability Awareness e-learning course is also now compulsory for all clinical staff.

We continue to run regular communicating effectively courses, which include the key principles of AI²DET and the three steps to better health literacy. The workshop runs once a month and is available to all CM Health employees.

We are also focussed on developing leaders within CM Health. We run a course for newly appointed managers called "Foundations of Management", which covers off a number of practical topics which managers commonly encounter, as well as increasing knowledge of participants' own selves and others, and communication skills. The course consists of 10 full day sessions over a period of 20 weeks.

In line with CM Health's grow your own strategy, we are also eager to support and develop promising employees, and in collaboration with the University of Waikato we have been providing the "Emerging Leaders" programme for four years. The course contains a blend of academic and experiential learning over the course of a year, and results in the participants gaining a Postgraduate Certificate from the University of Waikato.

Exit interviews

CMDHB is committed to improving the work environment for its employees. Exit surveys and interviews provide valuable information about an employee's perception of the workplace, and his or her reasons for leaving. They may provide an opportunity to identify issues that need to be addressed by the organisation. Completion of either an exit survey or interview is entirely voluntary.

We are currently reviewing our exit survey to improve the data we acquire from the process. We are undertaking an analysis of the information we would like to gather through exit surveys, and streamlining the process so that it is easy for staff to undertake to try and gain as much insightful data as possible. Exit interviews continue to be offered to exiting staff, and are either undertaken by their direct manager, or a member of the HR team.

4. Flexibility and work design

Workplace flexibility

As a health care provider we are a 24/7 roster environment. Many staff work in a rostered and rotated arrangement which is included in the multi-employer arrangements (MECA).

CMDHB also offers flexible hours as is reflected in our large part time workforce and requires roster flexibility that meets organisational and personal needs. Staff may undertake part of their work away from their normal place of work at CMDHB premises for a number of reasons. Whilst it is expected that normally staff will be in the workplace, it is accepted that there will be circumstances where an individual and the relevant General Manager and/or Director decide that it is mutually beneficial for that individual to work from home.

45% of the workforce is full time and 55% being part-time. This reflects our commitment to flexible working and that our staff have a focus on their families and whaanau.

Flexible return to work for parents

The flexible return to work for parents provisions specifically relate to employees who are returning from parental leave and require support to ensure they can continue to breastfeed their infant. The employer obligations are to ensure that employees are able to either breastfeed their child or express and store breast milk while at work. As well as our obligations for infant feeding, employees returning from parental leave can request flexible work arrangements if they need it; as parental leave can be shared between partners.

Volunteers

CM Health has over 400 people who provide services on a voluntary basis to our communities, including drivers for people who do not have the means to access services and way finders to help people navigate their way throughout the facilities.

5. Remuneration, recognition and conditions

CMDHB shows that it values its multi-disciplinary diverse workforce through:

- Annual Nursing and Midwifery Awards
- Allied Health Celebration Day and Awards
- House Officer of the Month Awards
- Long service recognition (managed by each service/department)
- Telling our staff stories through our internal and external channels.

All employee groups, with the exception of the Individual Employee Agreements (IEA), are governed by Multi Employer Collective Agreements (MECAs) and remuneration and conditions are in line with the collective agreements. Specific merit criteria are available for most employee groups.

Employee remuneration practices include an annual review of IEAs, and consultation with employees on service reviews and conditions.

We also have a number of scholarships and grants available to nursing and allied health staff to help them to develop in their professions, including:

- Esme Green Nursing Scholarship for Professional Development
- Allied Health Scholarship
- The Arthur Bronlund Trust Fund (unavailable in 2018, but will be available again in 2019)
- Grants to support attendance at conferences

6. Harassment and bullying prevention

Organisational Commitment

CMDHB is committed to providing a healthy, safe and supportive organisational culture based on our shared values. CMDHB has a zero-tolerance for all forms of harassment and bullying. Bullying and Harassment policy, processes, guides and resources are in place for all employees to help them better understand and work through the situation. CMDHB leadership and management programmes equipped managers with skills to provide feedback and coaching in the moment of any inappropriate behaviours and unsafe work practices.

Speak Up

Speak Up is our programme to help and encourage anyone who experiences or witnesses any concern to safely raised the issue. This includes a wide range of concerns such as bullying and harassment, inappropriate behaviours, unsafe clinical practice or staff safety and wellness.

CMDHB is committed to creating a culture of openness, fairness and accountability where we hold each other to account for acting in accordance with our values and in the best interests of our employees and patients. Besides their managers, employees have access to other sources of support to help them raise and deal with the issue, for example, access to an independent trained Contact Persons, Employee Assistance Programme, Health Integrity Line, Pastoral Care Support Group, Chief Executive Officer.

7. Safe and healthy environment

Safety at Work – Compliance

The Health and Safety team offer advice and support to all areas of CMDHB when it comes to managing the health and safety of our workers. Occupational Health provide services which include pre-employment screening, blood and body fluid exposure assessments, contact tracing surveillance, general wellness and vaccination clinics for staff at CMDHB. One of the roles of the Occupational Health and Safety Service (OHSS) is to provide baseline and ongoing

environmental and personal health monitoring where it is required in relation to exposure to any work related health hazard. Health monitoring is appropriate for assessing if an exposure is a significant health hazard or for detecting changes in the individual's health that is known to be associated with exposure to a particular hazard.

CMDHB conducts baseline monitoring for the following work related hazards:

- hepatitis b
- methicillin-resistant staphylococcus aureus (MRSA)
- audiology
- tuberculosis
- asbestosis.

The Work Injury Management team includes a Case Manager who supports staff back to work safely. We also have a partnership with WellNZ who provide additional support in helping employees back into the workplace safely.

Our Occupational Health team also provide guidance on the rehabilitation of staff members back to work from non-accident related and/or medical conditions via the manager referral system.

Health and Safety Representatives play an essential role in keeping staff and visitors safe, educating their workmates on related issues, and ensuring procedures and processes are followed correctly. We have over 300 staff trained as representatives. We work with this group to obtain staff feedback and improve our processes.

Over the past year the Occupational Health and Safety Services (OHSS) team has focussed on increasing the vaccination rates of staff. All new employees who have regular contact with patients are screened for basic immunisations, and if they are missing any then we will provide them. This service is also available to existing staff, and rates have improved this year. This was also a very successful year for the team in flu vaccinations; 5000 people were vaccinated, representing 71% compliance. The team are currently planning a new project to target existing staff in our Women's Health division to improve vaccination rates in the department.

Employee Assistance Programme at work

CMDHB works to promote positive wellbeing in the workplace and understands the specific issues affecting people working in the health sector. The Employee Assistance Programme (EAP) is a contracted service provided by OHSS. EAP services are also offered on site in certain areas.

This is a confidential service and participation will not adversely affect an employee's work at CMDHB. All counsellors are qualified, registered EAP professionals with expertise in the wide range of areas affecting people. Up to three sessions are available for each staff member and no details are placed on an employee's record. The programme is supportive, confidential, and available to all CMDHB staff and offers assistance with a wide range of problems, including:

- Work issues
- Grief and loss
- Relationship issues
- Drug and alcohol issues
- Anger / conflict management / domestic violence
- Stress – work or personal
- Parenting / family issues
- Life transition / direction
- Health and wellbeing
- Mentoring and coaching
- Career planning
- Budgeting.

Wellness

CM Health continues to recognise the importance of supporting employees' physical and mental health, and strives to support employees to stay well. Code Orange, an initiative supporting staff to respond to incidents involving aggression, has been implemented in Emergency Care.

A Wellbeing Audit has been completed and a gap analysis (SWOT) was carried out. Recommendations and specific areas of focus for 2020 are being developed.

Mental Health Awareness Week, an awareness raising opportunity to encourage staff to recognise the importance of looking after their mental health, has been planned. Three Mental Health (MH) 101 programmes, designed specifically for managers and leaders, have been delivered and one more is planned for November 2019.

A wellbeing Guide has been launched and there has been an overwhelming response from staff. The Paanui Wellbeing Website is live and ongoing updates are undertaken regularly.

Courageous Coaching sessions are delivered and provide staff an opportunity to self-reflect and gain new knowledge and workplace safety skills.

Complaints and appeals

CMDHB supports the right of all employees to pursue resolution of any complaint through the procedures contained in the relevant legislation (e.g. Human Rights Act, Race Relations Act, and Employment Relations Act). In the first instance, an employee can obtain assistance in the pursuit of a complaint or appeal, by contacting their Human Resources Business Partner.

Policies, procedures and guidelines

CMDHB has over 50 policies, procedures and guidelines to support a safe and healthy environment relating from topics such as:

- Breastfeeding in the workplace
- Harassment
- Code of Conduct
- Privacy
- Social Media policy
- Conflict of Interest
- A Safe Way of Working
- Employee Welfare and Wellbeing Management.

We are currently undertaking a review of a number of our HR policies to ensure they are updated and remain relevant and in line with best practice.

Counties Manukau District Health Board Workforce

What our workforce looked like by age, gender and ethnicity

Of the total workforce in 2018/19, women comprised 79% (7,945) and men 21% (2,159). The average age for women was 42 years and 40 years for men. The younger workforce less than 40 years of age represented 51% of the total workforce. Our employee data also highlights an ethnically diverse workforce.[104]

Age brackets	Percentage of all employees
Under 20	0.34%
20 - 29	21.51%
30 - 39	29.50%
40 - 49	19.08%
50 - 59	18.24%
60 - 59	9.78%
70+	0.94%
Date of Birth Not Specified	0.61%

Gender	Headcount	Headcount in %	Average Age
Female	7,945	79%	42
Male	2,159	21%	40
Grand Total	**10,104**	**100%**	**41**

Ethnicity	FTE	FTE in %	Headcount	Headcount in %
Asian	2,400.0	32.39%	3,169	31.36%
European	2,970.7	40.09%	4,093	40.51%
Maaori	419.4	5.66%	561	5.55%
Pacific	1,071.0	14.45%	1,538	15.22%
Other	300.8	4.06%	403	3.99%
Unknown/Not Specified	248.5	3.35%	340	3.37%
Grand Total	**7,410.5**	**100.00%**	**10,104**	**100.00%**

What our workforce looked like by employee group

The table below breaks down the Counties Manukau District Health Board workforce profile (head count) into selected groups.

	FEMALE		MALE	
Occupational Groups	Headcount	Average of Salary	Headcount	Average of Salary
Administration & Management	1,448	$64,682.69	303	$81,914.31
Allied Health	851	$70,885.04	162	$71,549.17
Medical	786	$148,847.52	809	$175,114.14
Non-clinical Support	317	$49,326.57	222	$46,907.68
Nursing/Midwifery/Health care assistant	4,149	$68,580.39	565	$66,637.70
Technical & Scientific	394	$67,973.57	98	$70,256.18
Grand Total	**7,945**	**$75,259.41**	**2,159**	**$107,932.96**

[104] Ethnic data is collected through the Leader Payroll system with 94% of employees disclosing ethnicity. This allows for greater access to valuable planning data for services who are working to meet the organisation's objective of having a workforce which more accurately reflects the population we serve.

Financial Statements for the year ended 30 June 2019

Statement of Responsibility

The Board is responsible for the preparation of the Counties Manukau District Health Board's financial statements and the statement of performance and for the judgements made in them.

The Board is responsible for any end-of-year performance information provided by Counties Manukau District Health Board under section 19A of the Public Finance Act 1989.

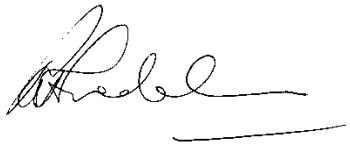
The Board of the Counties Manukau District Health Board has the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2019.

Signed on behalf of the Board:

Vui Mark Gosche

Counties Manukau District Health Board Chair



Pat Snedden

Chair Audit Risk & Finance Committee

Fepulea'i Margie Apa

Chief Executive Officer

Margaret White

Chief Financial Officer

31 October 2019

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2019

	Notes	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Revenue				
Patient Care Revenue	2	1,716,293	1,702,995	1,644,023
Interest Revenue		1,725	700	2,207
Other Revenue	3	28,860	22,249	28,572
Total Income		**1,746,878**	**1,725,944**	**1,674,802**
Expenditure				
Personnel costs	4	778,616	683,283	629,871
Depreciation and amortisation expense	13/14	34,778	37,955	32,907
Outsourced services		96,118	82,106	90,856
Clinical supplies		119,763	118,900	115,444
Infrastructure and non-clinical expenses		68,919	65,218	63,258
Other District Health Boards		259,905	249,072	249,318
Non-health board provider expenses		487,017	483,956	461,481
Capital Charge	5	36,424	37,292	37,421
Interest expense		-	-	7
Other expenses	6	18,157	21,657	16,462
Total expenditure		**1,899,697**	**1,779,439**	**1,697,025**
Deficit		**(152,819)**	**(53,495)**	**(22,223)**
Other comprehensive income				
Revaluation of Land	13/19	(18,990)	-	-
Revaluation of Buildings	13/19	120,976	-	7,842
Total Other comprehensive income (expense)		**101,986**	-	**7,842**
Total comprehensive income (expense) for the year		**(50,833)**	**(53,495)**	**(14,381)**

Statement of Changes in Equity

For the year ended 30 June 2019

	Notes	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Balance 1 July		**617,612**	**623,645**	**629,075**
Prior Period adjustment – Retirement Gratuity valuation	17	-	-	(6,421)
Restated opening balance 1 July		**617,612**	**623,645**	**622,654**
Deficit for the year		(152,819)	(53,495)	(22,223)
Total Comprehensive income		101,986	-	7,842
Total comprehensive income		**(50,833)**	**(53,495)**	**(14,381)**
Capital contributions from the Crown		1,774	16,580	7,846
Repayment of capital to the Crown		(419)	(419)	(419)
Movement in restricted funds		(1,975)	1	1,912
Balance at 30 June	19	**566,159**	**586,312**	**617,612**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2019

	Notes	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Assets				
Current Assets				
Cash and cash equivalents	7	15,280	916	34,102
Debtors and other receivables	8	52,936	65,009	56,449
Inventories	10	8,868	8,590	8,527
Prepayments		742	637	637
Non-Current Assets held for Sale	11	5,320	5,320	5,320
Total current assets		**83,146**	**80,472**	**105,035**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	52,180	50,702	39,961
Property, plant and equipment	13	818,739	753,054	731,149
Intangible assets	14	8,327	6,533	18,005
Other Non-Current Assets	9	1,933	1,824	1,824
Total Non-Current assets		**881,179**	**812,113**	**790,939**
Total assets		**964,325**	**892,585**	**895,974**
Liabilities				
Current liabilities				
Creditors and other payables	15	116,374	104,156	123,398
Borrowings and overdraft	16	-	52,361	-
Employee entitlements	17	245,404	124,821	122,020
Total current liabilities		**361,778**	**281,338**	**245,418**
Non-current liabilities				
Employee entitlements	17	35,353	22,948	31,789
Provisions	18	1,035	1,155	1,155
Total non-current liabilities		**36,388**	**24,103**	**32,944**
Total liabilities		**398,166**	**305,448**	**278,362**
Net assets		**566,159**	**587,144**	**617,612**
Equity				
Crown equity	19	408,570	423,377	407,215
Accumulated deficits	19	(236,626)	(128,462)	(83,807)
Revaluation reserves	19	393,380	291,395	291,394
Other reserves		-	2	-
Trust funds	19	835	832	2,810
Total Equity		**566,159**	**587,144**	**617,612**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2019

	Notes	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Cash flows from operating activities				
Receipts from patient care:				
MoH		1,573,385	1,554,756	1,487,363
Other		171,366	161,928	171,216
Interest received		1,725	700	2,207
Payments to suppliers		(1,047,686)	(1,045,762)	(982,879)
Payments to employees		(651,668)	(673,777)	(616,704)
Capital charge		(36,424)	(37,292)	(37,096)
Interest payments		-	-	(12)
Goods and services tax (net)		383	(957)	2,046
Net cash flow from operating activities		**11,081**	**(40,404)**	**26,141**
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		433	-	28,423
Purchase of property, plant, equipment and intangible assets		(29,314)	(57,931)	(48,152)
Acquisition/roll over of investments		(402)	(3,373)	(1,522)
Movement in Restricted Funds		(1,975)	1,978	-
Net cash flow from investing activities		**(31,258)**	**(59,326)**	**(21,251)**
Cash flows from financing activities				
Repayment of capital to the Crown		(419)	(419)	(419)
Capital Contributions from the Crown		1,774	16,580	7,846
Net cash flow from financing activities		**1,355**	**16,161**	**7,427**
Net increase/(decrease) in cash and cash equivalents		**(18,822)**	**(83,569)**	**12,317**
Cash and cash equivalents at the start of the year	7	**34,102**	**32,124**	**21,785**
Cash and cash equivalents at the end of the year	7	**15,280**	**(51,445)**	**34,102**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Reconciliation of net surplus/ (deficit) to net cash flow from operating activities

	Actual 2019 $000	Actual 2018 $000
Net deficit	**(152,819)**	**(22,223)**
Add/(less) non-cash items		
Movement in Restricted Funds	-	1,912
Gain on Disposal of Assets	(960)	-
Write off of WIP	1,229	-
Impairment of Intangibles	2,941	488
Depreciation and amortisation expense	34,778	32,907
Impairment of debtors	5,875	4,821
Total non-cash items	**43,863**	**40,128**
Add/(less) movements in working capital items		
Debtors and other receivables	(2,362)	(14,281)
Inventories	(341)	(1,043)
Creditors and other payables	(7,149)	10,190
Income in advance	3,051	(265)
Employee entitlements	126,949	13,494
Net movements in working capital items	**120,148**	**8,095**
Add/(less) items classified as investing or financing activities	(110)	141
Net cash flow from operating activities	**11,081**	**26,141**

Explanations of major variances against budget are provided in note 26.

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Statement of Accounting Policies

Reporting Entity

Counties Manukau District Health Board ("CMDHB" or "the DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. CMDHB is a Crown Entity in terms of the Crown Entities Act 2004 owned by the Crown and domiciled in New Zealand.

The financial statements of CMDHB as at and for the year ended 30 June 2019 comprise CMDHB and its interest in associates and jointly controlled entities.

Patient Trust money that CMDHB administers is reported in Note 19.

CMDHB is a public benefit entity for financial reporting purposes.

The financial statements for CMDHB are for the year ended 30 June 2019, and were approved by the Board on 31 October 2019.

Basis of Preparation

Statement of compliance

The financial statements of the CMDHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements comply with Public Benefit Entity (PBE) and other applicable Financial Reporting Standards, as appropriate for public benefit entities. They have been prepared in accordance with Tier 1 PBE accounting standards and are on a going-concern basis.

Going concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2018/19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Annual Plan). The key considerations are set out below:

Letter of comfort

The Board has received a letter of comfort dated 21 October 2019 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Operating and cash flow forecasts

Operating and cash flow forecasts show that there will be a significant operating cash flow deficit for the 2019/20 year. The DHB's forecasts indicate it will be reliant on accessing its overdraft facility with NZ Health Partnerships Limited (NZHPL) to meet this operating cash flow deficit and to meet the investing cash flow requirements of the DHB for the 2019/20 financial year.

Measurement base

The financial statements have been prepared on a historical cost basis, except for the revaluation of land and buildings at fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB, its associates and its jointly controlled entity is New Zealand dollars (NZ$).

Changes in accounting policies

There have been two changes in accounting policies since the date of the last audited Financial Statements.

PBE IFRS 9 Financial Instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier application permitted. The main changes under the relevant standard to DHBs are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.

Classification and measurement of financial asset

CMDHB classifies its financial assets as subsequently measured at either amortised cost or fair value depending on business model for managing the financial assets and the contractual cash flow characteristics of the financial assets.

On adoption of PBE IFRS 9, investments previously classified as loans and receivables are now classified as financial assets at amortised cost. However there is no material impact as these are still measured at amortised cost

- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year

The DHB has also early adopted PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments.

PBE IRFS 9 prescribes an "expected loss model" instead of the previous "incurred loss" model, so it is no longer necessary for an event to have occurred before recognising credit losses. NZ IFRS 9 requires the entity to base the measurement of expected credit losses on forward-looking information, as well as current and historic information. As the entity has been providing for credit losses based on historic patterns and there is no information to indicate that there has been any material change to this, there is no significant increase in credit risk.

The following table and accompanying notes below explain the original measurement categories under PBE IPSA 29 and the new categories under PBE IFRS 9 for each class of financial assets as at 1 July 2018.

Financial Asset	Note	PBE IPSAS 29 classification	PBE IFRS9 classification	Original carrying amount under IPSAS 29	Current carrying amount under IFRS 9
Cash and cash equivalents and Short TermDeposits	7	Loans and receivables	Amortised Cost	15,280	15,280
Debtors and other Receivables	8	Loans and receivables	Amortised Cost	52,936	52,936
Trusts and Special Purpose Funds	19	Amortised cost	Amortised cost	835	835
Assets held for Sale	11	Fair Value through Surplus/Deficit	Fair Value through Surplus/Deficit	5,320	5,320
Prepayments	-	Amortised cost	Amortised cost	742	742

Interest Expense

Borrowing costs are no longer capitalised on qualifying assets. This has resulted in the Fair Values of Property, Plant and Equipment to be less in the recent Independent valuation performed on Land, Buildings and Infrastructure for the 30 June 2019 year. The value of capitalised interest included in the 30 June 2018 Building and Infrastructure was $10.3m.

Standards issued but 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 34 – 38 Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34- 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6- 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early adoption permitted.

The DHB intends to apply these new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

Significant Accounting Policies

Investments in Associates and Joint Ventures

Associates are those entities in which CMDHB has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when CMDHB holds between 20% and 50% of the voting power of another entity. Joint ventures are those entities over whose activities CMDHB has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions. Associates and Joint Ventures are not accounted for using the equity method or proportionate method, as they are not material.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Ministry of Health revenue

Funding is provided by the Ministry of Health (MoH) through 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.

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantially linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as CMDHB provides the service.

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.

ACC Contract revenues

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

Rental income

Rental income is recognised as revenue on a straight-line basis over the term of the lease.

Revenue relating to service contracts

Revenue from services rendered is recognised in profit or loss in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is assessed by reference to surveys of work performed.

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/ (deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit prior to other comprehensive income and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/ (deficits).

Capital charge

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

Interest expense

Borrowing costs are recognised as an expense in the financial year in which they are incurred (2017/18 and prior: Borrowing costs were capitalised on qualifying assets in accordance with Counties Manukau DHB's policy and all other costs were treated as an expense in the financial year in which they were incurred).)..

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit prior to other comprehensive income over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty that the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit prior to other comprehensive income over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown as borrowings in current liabilities in the statement of financial position.

Debtors and other receivables

Debtors and other receivables are recorded at their face value, less provision for impairment.

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

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

Inventories

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

The amount of any write-down for the loss of service potential is recognised in surplus or deficit prior to other comprehensive income in the period of the write-down.

Non-Current assets held for sale

Non-Current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-Current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of Non-Current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-Current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes:

- land;
- buildings, plant and infrastructure;
- clinical equipment, IT and motor vehicles;
- other equipment and
- work in progress.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

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

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The cost of self-constructed assets includes the cost of materials, direct labour, the costs of dismantling and removing the items and restoring the site on which they are located if relevant, an appropriate proportion of direct overheads and capitalised borrowing costs.

Work in progress is recognised at cost, less impairment, and is not depreciated.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs

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

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit prior to other comprehensive income as they are incurred.

Depreciation

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

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	5 - 100 years	1% - 20%
Electrical Services	5 - 15 years	6% - 20%
Other Services	5 - 25 years	4% - 20%
Fit out	5 - 10 years	10% - 20%
Infrastructure	2-100 years	1% - 50%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	1 - 15 years	6% - 100%
Information Technology	1 - 8 years	12.5% - 100%
Vehicles	1 – 12.5 years	8% - 100%
Other Equipment	1 - 14 years	7% - 100%

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

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

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

Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Finance Procurement and Information Management (FPIM) System (previously NOS))

FPIM is a national initiative funded by DHBs and facilitated by NZHPL to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. CMDHB holds an asset at cost of capital invested by CMDHB in the FPIM Programme. This investment represents the right to access the FPIM assets and is considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows: Acquired computer software 2-5 years [20% - 50%]

Impairment of Property, Plant and Equipment and Intangible Assets

CMDHB does not hold any cash generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.

Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables

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

Borrowings

Borrowings are initially recognised at their fair value. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, sabbatical leave and sick leave.

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

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past, practice that has created a constructive "obligation".

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements

Continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, retirement gratuities and sick leave 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.

Superannuation schemes

Defined contribution schemes

Employer contributions to Kiwi Saver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit prior to other comprehensive income as incurred.

Defined benefit schemes

CMDHB makes employer contributions 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 in the plan will affect future contributions by individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in Note 20.

Provisions

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

Provisions are not recognised for future operating losses.

Restructuring

A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme

The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of four years up to a specified maximum amount. At the end of the four-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date.

Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Revaluation reserves

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

Trust funds

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

Goods and services tax

All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense. The GST (net) component of cash flows from operating activities reflects the net GST paid to and received from the Inland Revenue Department (IRD). The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of the other primary financial statements.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Budget figures

The budget figures are derived from the Statement of Performance Expectation as approved by the Board before the beginning of the financial year. 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.

Cost allocation

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

- Direct costs are those costs directly attributable to an output class.
- Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.
- Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.
- 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.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions concerning the future.

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events

that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 13.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed.

Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit prior to other comprehensive income and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset replacement programs
- Review of second-hand market prices for similar assets
- Analysis of prior asset sales

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

Retirement and long service leave

Note 17 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases 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 recognised no leases as finance leases.

Agency relationship

Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

For a number of contracts CMDHB makes payments to the service providers on behalf of the DHBs receiving services and these DHBs will then reimburse CMDHB for the costs of the services provided in their districts. Where CMDHB has assessed that it has acted as an agent for the other DHBs, payments and receipts in relation to the other DHBs are not recognised in CMDHB's financial statements.

Comparative Figures

Comparative information has been reclassified as appropriate to achieve consistency in disclosure with the current year.

2. Patient care revenue

	Actual 2019 $000	Actual 2018 $000
Health and disability services (MoH contracted revenue)	1,573,386	1,487,568
ACC contract revenue	29,872	36,570
Revenue from other district health boards	90,275	93,295
Other patient care related revenue	22,760	26,590
Total patient care revenue	**1,716,293**	**1,644,023**

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

Income received from other District Health Boards for agency contracts has been offset against the cost of those contracts $16.8m (2018: $15.9m).

3. Other revenue

	Actual 2019 $000	Actual 2018 $000
Donations and bequests received	1,513	1,439
Other revenue	24,410	25,164
Rental revenue	1,977	1,969
Gain on Disposal of Property, Plant & Equipment	960	-
Total other income	**28,860**	**28,572**

Material items included in Other revenue are Retail Pharmacy revenue $5.9m (2018: $4.0m), New Zealand Medical Treatment Scheme funding $3.5m (2018: $2.4m), Radiology Services $1.9m (2018: $1.7m), Pharmac Rebate $0.9m (2018: $2.0m) and one-off bond recovery $2m (2018: $0.0m).

4. Personnel costs

	Actual 2019 $000	Actual 2018 $000
Salaries and wages	728,366	597,245
Contributions to defined contribution schemes	19,886	19,132
Increase in liability for employee entitlements	30,364	13,494
Total personnel costs	**778,616**	**629,871**

5. Capital Charge

The DHB pays a half-yearly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the months of June and December. The capital charge rate levied during the year was 6% at 30 June 2019 (2018: 6%).

6. Other expenses

Other expenses include:	Actual 2019 $000	Actual 2018 $000
Audit fees – audit of financial statements – current year	232	219
Audit fees – other audit services	22	46
Operating leases expense	11,649	10,837
Impairment of debtors	5,875	4,821
Board and committee members fees and expenses	379	398

Loss on Disposal of Property, Plant & Equipment	-	141
Total other expenses	**18,157**	**16,462**

Non-cancellable operating lease commitments

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

	Actual 2019 $000	Actual 2018 $000
Not later than one year	8,648	6,949
Later than one year and not later than five years	11,966	8,661
Later than five years	2,502	1,427
Total Non-cancellable operating leases	**23,116**	**17,037**

The DHB leases a number of buildings, vehicles, clinical equipment and items of office equipment (mainly photocopiers) under operating leases. There are no restrictions placed on CMDHB by any of its leasing arrangements.

The thirteen various buildings which CMDHB occupies under leasehold terms are leased for periods ranging from one to ten years.

7. Cash and cash equivalents

	Actual 2019 $000	Actual 2018 $000
Cash at bank and on hand	50	84
NZ Health Partnerships Limited	14,387	31,208
Trust / Special purpose Funds	843	2,810
Cash and cash equivalents for the purposes of the statement of cash flows	**15,280**	**34,102**

The carrying value of cash at bank approximates it's fair value.

CMDHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) and all District Health Boards dated November 2017. This Agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds on their behalf.

Financial assets recognised subject to restrictions

Included in cash and cash equivalents are unspent funds with restrictions that relate to the delivery of health services by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in Note 19.

8. Debtors and other receivables

	Actual 2019 $000	Actual 2018 $000
Ministry of Health receivables	3,381	3,866
Other receivables	16,608	15,432
Other accrued revenue	37,063	40,535
Less: provision for impairment	(4,116)	(3,384)
Total Debtors and other receivables	**52,936**	**56,449**

Fair value

The carrying value of debtors and other receivables approximates their fair value.

Impairment

The ageing profile of receivables at year end is detailed below.

	2019 Gross $000	Impairment $000	Net $000	2018 Gross $000	Impairment $000	Net $000
Not past due	44,834	-	44,834	46,913	(2)	46,911
Past due 1-30 days	2,056	(606)	1,450	3,018	(589)	2,429
Past due 31-60 days	1,034	(422)	612	1,408	(421)	987
Past due 61-90 days	1,655	(452)	1,203	1,627	(447)	1,180
Past due > 90 days	7,474	(2,636)	4,838	6,867	(1,925)	4,942
Total	**57,053**	**(4,116)**	**52,937**	**59,833**	**(3,384)**	**56,449**

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

The provision for impairment has been calculated based on a review of significant debtor balances and a collective assessment of all debtors (other than those determined to be individually impaired) for impairment.

Individually impaired receivables are assessed as impaired due to the significant financial difficulties being experienced by the debtor and management concluding that the likelihood of the overdue amounts being recovered is remote.

PBE IRFS 9 prescribes an "expected loss model" instead of the previous "incurred loss" model. As the entity has been providing for credit losses based on historic patterns and there is no information to indicate that there has been any material change to this, there is no significant increase in credit risk.

9. Other non-current assets

	Actual 2019 $000	Actual 2018 $000
Reversionary interest in car park building	1,933	1,824
Total Other non-current assets	**1,933**	**1,824**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to us in 11 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 6.0% was used (2018: 6.0%).

10. Inventories

	Actual 2019 $000	Actual 2018 $000
Pharmaceuticals	840	893
Other Supplies net of provision for obsolete stock	8,028	7,634
Total inventories	**8,868**	**8,527**

No inventories are pledged as security for liabilities (2018: $0), however, some inventories are subject to retention of title clauses. Historically, the majority of supplies were expensed when purchased with only ward stock held on the balance sheet.

The amount of inventories recognised as an expense during the year was $114.8m (2018: $115.1m) which is included in the Clinical supplies line item in the Statement of Comprehensive Revenue and Expense

11. Non-current Assets held for Sale

	Actual 2019 $000	Actual 2018 $000
Land	5,320	5,320
Total Non-current Assets held for Sale	**5,320**	**5,320**

The DHB owns land which was determined to be surplus to requirements. On 16th November 2017, one parcel of land was sold, while another parcel remains available for sale.

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2019	Interest held at 30 June 2018	Balance date
Northern Regional Alliance Ltd	Provision of health support services	Associate	33.3%	33.3%	30 June
healthAlliance N.Z. Ltd	Provision of shared services	JV	25.0%	25.0%	30 June
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	JV	34.0%	25.0%	30 June
NZ Health Partnerships Limited	Provision of services to provide savings to the NZ health sector	JV	5.0%	5.0%	30 June

healthAlliance N.Z. Ltd

CMDHB holds both Class A and Class C shares in healthAlliance N.Z. Ltd. Class A shares carry the ability to appoint directors and have voting rights. Class C shares have rights to the distributions of capital or income, rights to dividends, however confer no ability to appoint directors and have no voting rights. As the Class A shares carry voting rights, they determine the extent of the interest CMDHB has in healthAlliance N.Z. Ltd.

NZ Health Partnerships Limited

CMDHB holds both Class A and Class B shares in NZ Health Partnerships Limited. Class A shares carry the right to vote and appoint directors, they have rights to dividends, and share of distribution of surplus assets on liquidation.

NZ Health Partnerships Limited has issued Class B Shares to DHBs for the purpose of funding the development of the FPIM programme shared services. The following rights are attached to these shares:

- Class B Shares confer no voting rights.
- Class B shareholders shall have the right to access the FPIM programme shared services.
- Class B Shares confer no right to a dividend, other than a dividend to be made out of any surplus earned by NZ Health Partnerships from the FPIM programme shared services only.
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.
- On liquidation or dissolution of the Company, each Class B shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the FPIM Programme shared services assets based upon the proportion of the total number of issued and paid up Class B Shares that it holds. Otherwise, each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.

- On liquidation or dissolution of the Company, each unpaid Class B Share confers no right to a share in the distribution of the surplus assets.

NZ Health Innovation Hub Limited Partnership

Following the withdrawal by Waitemata DHB from the partnership in August 2018, the equity from Waitemata DHB was transferred to the other shareholders and accordingly CMDHBs interest in NZ Health Innovation Hub Limited Partnership changed from 25% to 34%.

On 1 July 2019, all Shareholders agreed to proceed with the transfer of shares from Auckland DHB and Counties Manukau DHB to Canterbury DHB.

Summary - financial information on a gross basis (unaudited) of associates and jointly controlled entities

Year end 30 June 2019 $000 (unaudited)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	22,347	19,891	2,456	14,897	913
healthAlliance N.Z. Ltd	212,935	31,366	181,570	155,137	291
NZ Health Innovation Hub Limited Partnership	289	88	201	85	(327)
NZ Health Partnerships Limited	287,199	258,720	28,929	34,345	(38,014)

Year end 30 June 2018 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	12,756	11,213	1,543	14,183	0
healthAlliance N.Z. Ltd	193,793	33,135	160,660	136,513	(491)
NZ Health Innovation Hub Limited Partnership	579	51	528	59	(189)
NZ Health Partnerships Limited	372,867	308,567	57,943	37,103	(4,737)

Contingencies

NZ Health Partnerships has contracts for the provision of Infrastructure as a Service (IaaS) relating to the NTS programme, for which stop-cost contract penalties could result in the event NTS was discontinued.

If any IaaS provision was required as a result of the FPIM programme and IT infrastructure risk mitigation reviews, and after any subsequent negotiations to mitigate any potential contract penalties, these costs would be passed through to DHBs as FPIM programme operating expenditure.

In the unlikely event that there was a discontinuance of NTS and a requirement to stop the contract, for any resulting stop-cost penalties NZ Health Partnerships would have a contingent liability to the supplier, and an equal and corresponding contingent asset as a receivable from the DHBs (2017/18: none).

healthAlliance group has contingent liabilities relating to bank guarantees issued under the parent company healthAlliance NZ Ltd by Westpac NZ Ltd in favour of Goodman Nominees for $2,894k for the future lease payments of its premises in Penrose, Auckland (2018: $2,894k).

Share of profit of Associate entities and Jointly Controlled Entities

	Actual 2019 $000	Actual 2018 $000
Share of profit/(loss)	**73**	**(123)**

The DHB's share of profits of all Associates and Joint Ventures are not recorded in the financial statements of the DHB as they are not considered material to the financial position or performance of the DHB.

Investments in Associates and Jointly Controlled Entities

	Actual 2019 $000	Actual 2018 $000
healthAlliance N.Z. Ltd	**52,180**	**39,961**

The increase represents the issue of additional Class C shares – these shares are non-voting and have no impact on the calculation of the DHB's share of profit/ (loss). With the additional shares issued, the DHB's ownership percentage remains at 25%.

13. Property, plant and equipment

	Land	Buildings, Plant & Infrastructure	Clinical Equipment, IT & Motor Vehicles	Other Equipment	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance at 1 July 2017	**212,420**	**442,253**	**159,438**	**20,294**	**30,497**	**864,902**
Additions	**-**	**-**	**-**	**-**	48,130	48,130
WIP capitalised	-	2,085	15,937	2,217	(20,239)	-
Revaluation increase/(decrease)	-	-	-	-	7,842	7,842
Disposals/transfers	-	-	(3,186)	(73)	(5,613)	(8,872)
Balance at 30 June 2018 / 1 July 2018	**212,420**	**444,338**	**172,189**	**22,438**	**60,617**	**912,002**
Additions	**-**	**-**	**-**	**-**	27,367	27,367
WIP capitalised	-	54,305	4,776	938	(60,709)	(690)
Revaluation increase/(decrease)	(18,990)	71,489	-	-	-	52,499
Disposals/transfers	-	-	(82,031)*	(13,481)	(6,243)	(101,755)
Balance at 30 June 2019	**193,430**	**570,132**	**94,934**	**9,895**	**21,032**	**889,423**
Accumulated depreciation and impairment losses						
Balance at 1 July 2017	**-**	**1,897**	**131,250**	**18,124**	**-**	**151,271**
Depreciation expense	-	23,666	8,541	605	-	32,812
Elimination on disposal/transfer		-	(3,155)	(75)	-	(3,230)
Balance at 30 June 2018 / 1 July 2018	**-**	**25,563**	**136,636**	**18,654**	**-**	**180,853**
Depreciation expense		24,515	9,381	783	-	34,679
Elimination on disposal/transfer	-	-	(81,882)*	(13,480)	-	(95,362)
Revaluation increase/(decrease)	-	(49,486)	-	-	-	(49,486)
Balance at 30 June 2019	**-**	**592**	**64,135**	**5,957**	**-**	**70,684**
Carrying amounts						
At 1 July 2017	**212,420**	**440,356**	**28,188**	**2,170**	**30,497**	**713,631**
At 30 June and 1 July 2018	**212,420**	**418,775**	**35,553**	**3,784**	**60,617**	**731,149**
At 30 June 2019	**193,430**	**569,540**	**30,799**	**3,938**	**21,032**	**818,739**

Note *: During the year a significant amount of Nil Net Book Value assets have been removed from the Fixed Asset Ledger, resulting in the removal of the Cost and corresponding Accumulated Depreciation amounts from the Fixed Asset Ledger and the General Ledger.

Capital Commitments

	Actual 2019 $000	Actual 2018 $000
Property , plant and equipment	42,311	41,831
Total Capital commitments	**42.311**	**41,831**

Capital commitments represent capital expenditure approved and contracted at balance date.

Valuation

Land

Land is valued at fair value using market-based evidence, which is based 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 value of the land where an owner is unable to use the land more intensely.

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

The most recent valuation of land was performed by a registered independent valuer, Darroch, as at 30 June 2019. The total land valuation amounted to $193.43m, resulting in a 2018/19 downwards revaluation adjustment of $18.99m.

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 cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- The remaining useful life of assets is estimated. Specifically, useful lives ascribed to individual buildings are estimated. Resulting changes to useful lives can have a significant impact on asset values if the useful life of a building decreases significantly.
- Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

CMDHB's buildings are spread across two major sites (Middlemore Hospital and Manukau SuperClinic & Surgery Centre) and smaller community based sites in Pukekohe, Papakura, Waiuku, Botany, Otara and numerous leased facilities. Buildings with an Importance Level 4 (IL4) rating which have special post disaster functions are concentrated on the Middlemore and the Elective Surgery Hospital on the Manukau site. In addition to these major property assets, CMDHB manages assets for national services such as Spinal Rehabilitation.

As part of the DHB's internal review process, the DHB is currently conducting a multi-year review of the condition of the major buildings in its portfolio, including assessments around seismic strengthening, asbestos, critical building services infrastructure and cladding remediation. In 2017/18, the DHB commissioned two major infrastructure assessments. Completed in April 2018 was a detailed seismic assessment and independent peer review of the Middlemore Galbraith building that confirmed this as an earthquake prone building. The CM Health Board is working through related remediation and replacement investment decisions in 2019/20. The second assessment related to asset assessment of the Middlemore, Manukau and Pukekohe site infrastructure has also since been completed. Risk prioritisation and remediation strategies are currently being generated from the assessments and will include

estimates of costs to repair or replace DHB building assets. Amendments to useful lives and values ascribed to buildings were accounted for as at 30 June 2019 based on an independent valuation

Subsequent to balance date the DHB received the following building assessments. All the reports identify impairment issues with these buildings. However due to the fact that the impairments are immaterial, and would not impact the loss for the year (because the impairment would be offset against historical revaluation increases), no adjustments have been made to the year end valuation or building values as disclosed as at 30 June 2019:

- Franklin Memorial Hospital: Detailed Seismic Assessment
- Pukekohe Hospital Plant Room: Detailed Seismic Assessment
- Esme Green Building: Detailed Seismic Assessment
- Colvin building complex: Initial Seismic Assessment and Building condition assessment

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

The most recent valuation of buildings was performed by a registered independent valuer, Darroch, as at 30 June 2019. The total building valuation amounted to $569.54m, resulting in a 2018/19 upwards revaluation adjustment of $120.98m.

Restrictions on title

The DHB does not have full title to the Crown land it occupies but transfer is arranged if and when land is sold.

No Property or Plant & Equipment assets have been pledged as security for liabilities.

Some of the DHB's land is subject to Waitangi Tribunal claims. The disposal of CMDHB land is subject where applicable to section 40 of the Public Works Act 1981 and, in relation to some land, a right of first refusal (RFR) in favour of the Tamaki Collective pursuant to the provisions of a Deed of Settlement with the Crown in relation to Treaty of Waitangi claims.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

All titles are subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act (which restricts disposal, including leasing of the land). Values have not been adjusted to reflect the imposition of Section 148 of The Act. Restrictions on CMDHB's ability to sell land would normally not impair the value of the land because CMDHB has operational use of the land for the foreseeable future and will substantially receive the full benefits of outright ownership.

14. Intangible assets

Movements for each class of intangible assets are as follows:

	NOS Rights $000	Software $000	Work in Progress $000	Total $000
Balance at 30 June 2017/1 July 2017	**5,779**	**561**	**7,119**	**13,459**
Additions	746	-	6,274	7,020
Work in Progress Capitalised	-	132	(132)	-
Impairment	(488)	-	-	(488)
Transfers / Disposals	-	-	(1,454)	(1,454)
Balance at 30 June 2018/1 July 2018	**6,037**	**693**	**11,807**	**18,537**
Additions	190	-	1,757	1,947
Work in Progress Capitalised	-	1,349	(660)	689
Impairment	(2,941)	-	-	(2,941)

	NOS Rights $000	Software $000	Work in Progress $000	Total $000
Transfers / Disposals	-	(318)	(9,275)	(9,593)
Balance at 30 June 2019	**3,286**	**1,724**	**3,629**	**8,639**
Accumulated amortisation and impairment losses				
Balance at 1 July 2017	**-**	**436**	**-**	**436**
Amortisation expense	-	95	-	95
Balance at 30 June 2018/1 July 2018	**-**	**531**	**-**	**531**
Amortisation expense	-	99	-	99
Transfers / Disposals	-	(318)	-	(318)
Balance at 30 June 2019	**-**	**312**	**-**	**312**
Carrying amounts				
At 1 July 2017	**5,779**	**125**	**7,119**	**13,023**
At 30 June and 1 July 2018	**6,037**	**162**	**11,807**	**18,005**
At 30 June 2019	**3,286**	**1,412**	**3,629**	**8,327**

There are no restrictions over the title of the DHB's intangible assets; nor are any intangible assets pledged as security for liabilities.

Finance Procurement and Information Management (FPIM) System (previously NOS)

The FPIM Programme asset is deemed to be a non-cash-generating asset. This is on the basis that there are no cash flows directly linked to the asset. Rather, the benefit to each DHB is the potential cost savings from a negotiated national contract above the cost of each DHB negotiating a similar contract themselves. Therefore, the applicable accounting standard is PBE IPSAS 21 Impairment of Non-Cash-Generating Assets. PBE IPSAS 21 requires an annual test for impairment by comparing the asset carrying value with its recoverable service amount
.
The FPIM Business Case approved by Cabinet 24 June 2019 materially changed from the FPIM Programme paused by the Cabinet decision of 28 June 2018 and the judgements that were assumed in assessing the FPIM Programme carrying value at 30 June 2018. Key changes being:

- the Business Case has crystallised that only 10 DHBs are committing to a single system in the short to medium term;
- the Business Case conservatively reduced the benefits to only identifiable procurement spend of $642m by PHARMAC and $102m by NZ Health Partnerships. This impacts on Net Present Value calculations which formed part of the assessment of carrying value of the asset and the requirement for any impairment; and
- NZ Health Partnerships now have visibility of a working system, which has been operational since July 2018 at four DHBs, on which user feedback is available in evaluating the broader initial scope and activities capitalised under Health Benefits Limited ownership prior to June 2014. It has considered how much of that work still holds value for the pared back system that was finally deployed.

CMDHB tested the FPIM asset for impairment by determining the asset's value in use based on its depreciated replacement cost (DRC).

Based on the information and assumptions known to it, CMDHB considers that, in all material respects, the FPIM asset costs capitalized now exceed the DRC. CMDHB has therefore recognised a further $2.941m (2018: $488k) impairment of the FPIM asset in the Statement of Comprehensive Income for the year ended 30 June 2019, to a level that approximates its estimated future recoverable service amount.

15. Creditors and other payables

	Actual 2019 $000	Actual 2018 $000
Payables under exchange transactions		
Creditors and accrued expenses	98,336	108,794
Income in advance	9,480	6,429
Total payables under exchange transactions	**107,816**	**115,223**
Payables under non-exchange transactions		
GST payable	8,558	8,175
Total payables under non-exchange transactions	**8,558**	**8,175**
Total creditors and other payables	**116,374**	**123,398**

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

16. Borrowings and overdraft

	Actual 2019 $000	Actual 2018 $000
Borrowing facility limits		
Overdraft facility	75,000	75,000
Total borrowing facility limits	**75,000**	**75,000**

Overdraft facility

CMDHB is a party to the "DHB Treasury Services Agreement" between NZHPL and the participating DHBs. 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 debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue. This is used in determining working capital limits, being defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST, for CMDHB that equates to $75.0m (2018: $75.0m).

17. Employee entitlements

	Actual 2019 $000	Actual 2018 $000
Current portion		
Accrued salaries and wages	152,482	40,440
Annual leave	68,547	60,638
Sick leave	440	470
Long service leave	271	461
Retirement gratuities	4,614	2,529
Sabbatical leave	850	845
Continuing medical education	18,200	16,637
Total current portion	**245,404**	**122,020**
Non-current portion		
Long service leave	10,408	9,044
Retirement gratuities	22,915	20.845
Sick leave	2,030	1,900
Total non-current portion	**35,353**	**31,789**
Total employee entitlements	**280,757**	**153,809**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 1.26% - 4.30% (2018: 1.78% - 4.75%) and an inflation factor of 2.5% (2018: 3.0%) were used.

Prior period error

During the independent actuarial valuation of the Retirement Gratuity liability for the year ended 30 June 2019, it was identified that since 2013 valuers had been working off an outdated summary of staff who were eligible for Retirement Gratuities. As a consequence, the employee entitlement provision for Retirement Gratuities has been understated since 2013.

The error has been assessed as material and has been corrected retrospectively by restating each of the following financial statement line items for the prior period as follows:

Statement of Comprehensive Revenue and Expense

	Notes	As previously reported 2018 $000	Change $000	Restated 2018 $000
Expenditure				
Personnel costs	4	627,451	2,420	629,871
Total expenditure		**1,694,605**	**2,420**	**1,697,025**
Deficit		**(19,803)**	**(2,420)**	**(22,223)**
Total comprehensive income (expense) for the year		**(11,961)**	**(2,420)**	**(14,381)**

Statement of Changes in Equity

	Notes	As previously reported 2018 $000	Change $000	Restated 2018 $000
Balance 1 July		**629,075**	**(6,421)**	**622,654**
Comprehensive income (expense)				
Deficit for the year		(19,803)	(2,420)	(22,223)
Total comprehensive income		**(11,961)**	**(2,420)**	**(14,381)**
Balance at 30 June	19	**626,453**	**(8,841)**	**617,612**

Statement of Financial Position

	Notes	As previously reported 2018 $000	Change $000	Restated 2018 $000
Non-current liabilities				
Employee entitlements	17	22,948	8,841	31,789
Total non-current liabilities		**24,103**	**8,841**	**32,944**

Total liabilities		**269,521**	**8,841**	**278,362**
Net assets		**626,453**	**(8,841)**	**617,612**
Equity				
Accumulated deficits	19	(74,966)	(8,841)	(83,807)
Total Equity		**626,453**	**(8,841)**	**617,612**

Reconciliation of net surplus/ (deficit) to net cash flow from operating activities

	As previously reported 2018 $000	$000	Restated 2018 $000
Net deficit	**(19,803)**	**(2,420)**	**(22,223)**
Employee entitlements	11,074	2,420	13,494
Net movements in working capital items	**10,496**	**2,420**	**12,916**

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 on-going 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 the Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act 2003 non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and the New Zealand Blood Service (NZBS), expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, CMDHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

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

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

The CMDHB Board signed the MOU on 23 October 2019.

18. Provisions

	Actual 2019 $000	Actual 2018 $000
Non-current portion		
ACC Partnership Programme	1,035	1,155
Total provisions	**1,035**	**1,155**

Movements for each class of provision are as follows:

	ACC Partnership Programme 2019 $000	ACC Partnership Programme 2018 $000
Balance at 1 July	1,155	931
Actuarial valuation movement	(120)	224
Balance at 30 June	**1,035**	**1,155**

19. Equity

	Actual 2019 $000	Actual 2018 $000
Crown equity		
Balance at 1 July	407,215	399,788
Equity injections from the Crown	1,774	7,846
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**408,570**	**407,215**
Accumulated surpluses/(deficits)		
Balance at 1 July	(83,807)	(61,584)
Deficit for the year	(152,819)	(22,223)
Balance at 30 June	**(236,626)**	**(83,807)**
Revaluation reserves		
Balance at 1 July	291,394	283,552
Revaluations	101,986	7,842
Balance at 30 June	**393,380**	**291,394**
Revaluation reserves consist of:		
Land	223,568	242,558
Buildings and Infrastructure	169,812	48,836
Total revaluation reserves	**393,380**	**291,394**
Trust/Special funds		
Balance at beginning of year	2,810	898
Funds expended	(2)	(23)
Funds received	-	1,978
Interest received on Restricted Funds	5	12
Other transfers/movements	(1,978)	(55)
Balance at end of year	**835**	**2,810**

CMDHB has established Trust and Special Funds for specific purposes. The conditions for use of these funds are imposed by deed of gift or by the terms of endowments and bequests.

Total equity	**566,159**	**617,612**

Capital management

The DHB's capital is its equity, which comprises Crown equity, accumulated surpluses, revaluation reserves, and trust funds. Equity is represented by net assets.

The 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. The DHB has complied with these provisions in the 2018/19 financial year.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that the DHB effectively achieves its objectives and purposes, while remaining a going concern.

20. Contingencies

Asbestos

Given the age of some of the remaining buildings on some sites there will be a cost relating to the discovery of asbestos, and these costs may be substantial. If any were to be found it would be accounted for in the year that the costs to remove were incurred.

Superannuation schemes

The DHB is a participating employer in the DBP Contributors Scheme (the Scheme), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the DHB could be responsible for any deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, the DHB could be responsible for an increased share of any deficit.

As at 31 March 2019, the DBP Scheme had a past service loss of $1.8m (1.9% of the liabilities) (2018: surplus $8.0m (6.2% of the liabilities)) - this amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS25.

The Actuary to the Scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended the employer contribution rate should be set at 1.0 effective from 1 April 2019 and this was accepted and endorsed by the Board.

Legal Matters

There are a number of matters of a legal nature to which the DHB may have an exposure. The amounts involved (2019: $3m (2018: $621k)), if required to be settled, would be expensed in the year of settlement.

Contingent asset

Encroaching structures

During a recent survey of the land held for sale (refer Note 11), it was identified that residential developers from an adjoining property have installed certain structures and landscaping works too close to, or in some cases over, the boundary. CMDHB has notified the developers and Auckland Council of the encroachments. Legal advice has been sought to consider what options the DHB might have to resolve this issue. The outcome of this issue is currently unknown.

21. Related Party Transactions

The DHB is a wholly-owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties, including associates, that are:

• within a normal supplier or client/recipient relationship; and

• on terms and conditions no more or less favourable than those that it is reasonable to expect that the group would have adopted in dealing with the party at arm's length in the same circumstances.

• Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $1,716m (2018 $1,644m) to provide health services in the Counties Manukau area for the year ended 30 June 2019 (note 2).

Collectively, but not individually, significant transactions with government-related entities

In conducting its activities, the DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2019 totalled $8.34m (2018: $7.56m). These purchases included the purchase of air travel from Air New Zealand, postal services from New Zealand Post, and blood products from NZ Blood Service.

Transactions with key management personnel

Key management personnel compensation

	Actual 2019 FTE	Actual 2018 FTE	Actual 2019 $000	Actual 2018 $000
Executive management team	11.5	9	3,949	3,260
Total key management personnel compensation	**11.5**	**9**	**3,949**	**3,260**

In addition to the above, the total actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $139.2k (2018: $98.5k).

Key management personnel includes the Chief Executive, and eleven (2018: eight) members of the management team.

Board and Committee Members compensation

	Actual 2019 FTE	Actual 2018 FTE	Actual 2019 $000	Actual 2018 $000
Board	11	11	344	341
Committee	1	1	2	1
Total board and committee members compensation	**12**	**12**	**346**	**342**

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board Members.

Related party transactions with the DHB's subsidiaries and Jointly Controlled Entities

CMDHB is required under the Crown Entities Act, to consolidate into its statutory Accounts those entities "deemed" subsidiaries under this Act. The definition of subsidiaries extends to those entities, whose sole or primary purpose gives "benefit", in this case to CMDHB. This is irrespective of legal ownership. CMDHB does not have any subsidiaries.

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. While CMDHB has been the major beneficiary of the Trust, it must meet all normal Charitable Trust requirements in terms of applications for funding. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $5.05m (2018: $5.46m) and a (deficit)/surplus of $(0.5)m (2018: ($0.6m)) which may be subject to restrictions on distribution as at 30 June 2019. The financial statements of the Foundation for 2019 are not publicly available as they have not yet been approved by the Foundation's trustees.

22. Board member remuneration

The total value of remuneration to each Board member during the year was:

	Actual 2019 $	Actual 2018 $
Vui Mark Gosche (Chair)	54,500	8,750
Mr Pat Snedden (Deputy Chair) 3	30,719	-
Mrs Catherine Abel-Pattinson	30,000	28,750
Mr Reece Autagavaia	27,750	27,000
Mrs Katrina Bungard	27,000	25,375
Dr Ashraf Choudhary	28,750	28,750
Ms Kylie Clegg 3	25,375	-
Mrs Dianne Glenn	30,250	29,750
Mrs Colleen Brown	30,000	28,563
Dr Lyn Murphy	30,688	29,375
Mr George Ngatai	29,000	28,500
Dr Lester Levy [1] (Chair)	-	44,250
Mr Rabin Rabindran [2] (Deputy Chair)	-	37,563
Mr Mark Darrow [2]	-	24,938
Total board member remuneration	**344,032**	**341,564**

1 Resigned 24 January 2018

2 Resigned 2 May 2018

3 Appointed 14 August 2018

Committee Members, not Board Members or Employees	Award 2019 $	Award 2018 $
Mr John Wong	1,667	1,042
Total	**1,667**	**1,042**

The DHB has provided a deed of indemnity to Directors for certain activities undertaken in the performance of the DHB's functions.

The DHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2018: $nil).

23. 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:	Actual 2019	Actual 2018
Total remuneration paid or payable:		
$100,000 – 109,999	300	185
$110,000 – 119,999	166	148
$120,000 – 129,999	101	90
$130,000 – 139,999	78	52
$140,000 – 149,999	53	44
$150,000 – 159,999	35	43
$160,000 – 169,999	34	14
$170,000 – 179,999	21	13
$180,000 – 189,999	33	26
$190,000 – 199,999	25	24
$200,000 – 209,999	24	14
$210,000 – 219,999	16	28
$220,000 – 229,999	20	26
$230,000 – 239,999	29	30
$240,000 – 249,999	26	29
$250,000 – 259,999	36	35
$260,000 – 269,999	25	24
$270,000 – 279,999	32	17
$280,000 – 289,999	18	28
$290,000 – 299,999	26	19
$300,000 – 309,999	21	22
$310,000 – 319,999	17	14
$320,000 – 329,999	18	11
$330,000 – 339,999	10	2
$340,000 – 349,999	10	7
$350,000 – 359,999	7	7
$360,000 – 369,999	4	8
$370,000 – 379,999	7	3
$380,000 – 389,999	4	4
$390,000 – 399,999	4	-
$400,000 – 409,999	3	3
$410,000 – 419,999	1	-
$420,000 – 429,999	1	4
$430,000 – 439,999	1	2
$440,000 – 449,999	5	3
$450,000 – 459,999	5	1
$460,000 – 469,999	3	2
$470,000 – 479,999	2	-
$480,000 – 489,999	1	-
$490,000 – 499,999	-	1
$500,000 – 509,999	-	-
$520,000 – 529,999	1	-
$530,000 – 539,999	-	1
$540,000 – 549,999	1	-

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:	Actual 2019	Actual 2018
$560,000 – 569,999	-	-
$600,000 – 609,999	1	-
$680,000 - $689,999	-	1
Grand total	**1,225**	**985**

During the Year Ended 30 June 2019, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 1,043 (2018: 828) are Medical Staff and 182 (2018: 157) are Management.

During the year ended 30 June 2019, 12 (2018: 15) employees received compensation and other benefits in relation to cessation totalling $823,142 (2018: $253,015).

24. Events after the balance date

There were no significant events after balance date.

25. Financial instruments

Financial instrument categories

The carrying amounts of financial assets and liabilities are as follows:

	Actual 2019 $000	Actual 2018 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	15,280	34,102
Debtors and other receivables	52,936	56,449
Total financial assets measured at amortised cost	**68,216**	**90,551**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	98,336	108,794
Total financial liabilities measured at amortised cost	**98,336**	**108,794**

Financial instrument risks

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The 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 that 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 is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the DHB as investments and borrowings are generally held to maturity.

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. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2019, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have been $0.69m lower/higher (2018: $Nil).

Credit risk

Credit risk is the risk that a third party will default on its obligations to the DHB, causing it to incur a loss. Financial instruments, which potentially subject the DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The DHB places its investments with high-quality financial institutions and the DHB has a policy that limits the amount of credit exposure to any financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. 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.

Credit quality of financial assets

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

	Actual 2019 $000	Actual 2018 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	893	2,894
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	14,387	31,208
NZHPL – no defaults in the past		
Total debtors and other receivables	**52,936**	**56,449**

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the 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.

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities.
The table below analyses financial liabilities into 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 of the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows.

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2018						
Creditors and other payables	108,794	108,794	108,794	-	-	-
Crown Loans	-	-	-	-	-	-
Total	**108,794**	**108,794**	**108,794**	**-**	**-**	**-**
2019						
Creditors and other payables	98,336	98,336	98,336	-	-	-
Crown loans	-	-	-	-	-	-
Total	**98,336**	**98,336**	**98,336**	**-**	**-**	**-**

26. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expense

Overall the underlying DHB operating deficit came in $5.98m favourable to budget. While there were variances in both Revenue and Expense, the significant difference came from additional Ministry of Health revenue for Pay Equity, which was offset by additional expenditure in NGO community services. The Personnel expenditure variance is offset by outsourced services, whilst delayed capital spend has resulted in lower than budgeted depreciation and capital charge.

An additional provision of $105.9m for the remediation in terms of non-compliance with the Holiday's Act 2003 has been made during the current financial year.

Statement of Financial Position

The most significant variance was the delay in spend against the 2018/19 Capital Plan as a result of delayed procurement of clinical equipment to ensure compliance with the Government Rules of Sourcing, receivership of the main contractor on the Acute Mental Health Construction Project and the delayed start on the Scott Re-clad building.

An additional provision of $105.9m for the remediation in terms of non-compliance with the Holiday's Act 2003 has been made during the current financial year.

Statement of Cashflow

Net cash flow was $64.75m favourable to budget, mainly due to pay equity funding for NGO community and MECA funding for DHB payroll costs. Reduced capital expenditure has also resulted in significantly lower cash outflows from investing activities and this has in turn delayed the need for any equity injection funding (capital contributions).

Significant effort has been placed on cash management to ensure the DHB is adequately forecasting and living within its means.

Board and Committee Membership Attendances

1 July 2018 to 30 June 2019

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC/ RDiSAC	MHAC
Vui Mark Gosche (Chair)	8			8		
Mr Pat Snedden (Deputy Chair)[105]	7			7		
Mrs Colleen Brown[106]	6	4	7		5	2
Dr Lyn Murphy[107]	8	7	3	7	2	
Mrs Catherine Abel-Pattinson	7	5		7	4	0
Mrs Dianne Glenn	8	7	7		5	
Dr Ashraf Choudhary	7	6	6			1
Apulu Reece Autagavaia	6		6		2	2
Mr George Ngatai[108]	5	4	4	8		2
Mrs Katrina Bungard	5		4		2	1
Ms Kylie Clegg[109]	6	4		6		

AR&F	Audit Risk and Finance Committee
CPHAC	Community and Public Health Advisory Committee
DiSAC	Disability Support Advisory Committee
HAC	Hospital Advisory Committee
MHAC	Maaori Health Advisory Committee
RDiSAC	Regional Disability Support Advisory Committee

Note: Board, HAC, CPHAC and AR&F meet six-weekly; DiSAC/rDiSAC & MHAC meet 12-weekly.

Note: In November 2018 the CM Health DiSAC was cancelled and replaced by a regional DiSAC with attendees from CM Health, Waitemata District Health Board and Auckland District Health Board.

Note: Counties Manukau District Health Board remains committed to fulfilling our obligations as agent of the Crown under the Te Tiriti o Waitangi (Treaty of Waitangi). Over the years relationship with local tangata whenua has been expressed through the development of a number of forums including, the Maaori Health Advisory Committee (MHAC) and partnership agreement with Mana Whenua.

The MHAC was recently disestablished to enable Counties Manukau District Health Board to give effect to a more strategic and direct partnership with Mana Whenua i Tamaki Makaurau. Mana Whenua i Tamaki Makaurau represent the collective interests of a number of Iwi and Hapuu, including: Te Akitai, Ngaati Te Ata, Ngaati Paaoa, Ngaai Tai Ki Tamaki, Te Kawerau aa Maki, Ngaati Tahinga, Ngaati Tipa, Ngaati Tamaoho and Ngaati Amaru. Counties Manukau District Health Board has established a Memorandum of Understanding with the Mana Whenua i Tamaki Makaurau Board that outlines our strategic intent and commitment to improve Maaori Health outcomes in the Counties Manukau district.

[105] Appointed to Board and AR&F 14 August 2018.
[106] Appointed to HAC 12 December 2018.
[107] Appointed to CHPAC 12 December 2018.
[108] Appointed to HAC 12 December 2018.
[109] Appointed to Board and AR&F 14 August 2018, appointed to HAC 12 December 2018.

Board Members' Disclosure of Interests

As at 7 August 2019

Vui Mark Gosche (Chair)	• Trustee, Mt Wellington Licensing Trust • Director, Mt Wellington Trust Hotels Ltd. • Director, Keri Corporation Ltd • Trustee, Mt Wellington Charitable Trust • Life Member, Labour Party • Life Member, ETU Union • Chairman, Housing NZ Corporation • Director, Housing NZ Limited
Catherine Abel-Pattinson RN Comp NZ, CATT, MBA, ICU Certificate, EHLP (Insead), BHS	• Board Member, Health Promotion Agency • Board Member, healthAlliance NZ Ltd. • National Party Policy Committee Northern Region • Member, New Zealand Nurses Organisation • Member, Directors Institute • Co-Chair, National Party Health Policy Committee • Husband (John Abel-Pattinson): • Director, Blackstone Group Ltd • Director and Shareholder, Blackstone Partners Ltd • Director and Shareholder, Blackstone Treasury Ltd • Director and Shareholder, Bspoke Group Ltd • Director, Barclay Management (2013) Ltd • Director, AZNAC (JAP) Ltd • Director and Shareholder, Chatham Management Ltd • Director and Shareholder, GCA Trustee Ltd • Director, MAFV Ltd • Director and Shareholder, Manaia No. 4 Trustees Ltd • Director and Shareholder, Wolfe No. 1 Ltd • Director, Greenstone Motels Ltd • Director and Shareholder, Silverstone Property Group Ltd • Director, various single purpose property owning companies • Director and Shareholder, Abel-Pattinson Trustee Ltd
Colleen Brown MNZM	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Director, Charlie Starling Production Ltd • District Representative, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited
Dr Ashraf Choudhary QSO, JP	• Board Member, Otara-Papatoetoe Local Board • Member, NZ Labour Party • Chairperson, Advisory Board Pearl of Islands Foundation • Co-Patron, Bharatiya Samaj Charitable Trust
Dianne Glenn ONZM, JP	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ)

	• Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities
Katrina Bungard	• Chairperson MECOSS – Manukau East Council of Social Services. • Deputy Chair Howick Local Board • Member of Amputee Society • Member of Parafed disability sports • Member of NZ National Party
Dr Lyn Murphy	• Shareholder, Bizness Synergy Training Ltd • Shareholder, Synergex Holdings Ltd • Trustee, Synergex Trust • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ) • Member, New Zealand Association of Clinical Research (NZACRes) • Senior Lecturer, AUT University School of Inter professional Health Studies • Member, Public Health Association of New Zealand
Apulu Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, District Licensing Committee of Auckland Council • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation • Board of Trustees Member, Holy Cross School
George Ngatai QSM, JP	• Director, Transitioning Out Aotearoa • Director, The Whanau Ora Community Clinic Huakina Ltd • Chair, Safer Aotearoa Family Violence Prevention Network • Lotteries Community (Auckland) • Board Member, Counties Manukau Rugby League Zone • Member, NZ Maori Council • Director & Shareholder, BDO Marketing & Business Solutions Limited • Director & Shareholder, Ngatai Bhana Limited • Director & Shareholder, Family Care Limited • Member, Restorative Justice Aotearoa
Pat Snedden MNZM	• Chair, Auckland District Health Board • Chair, The Big Idea Charitable Trust • Chair, National Science Challenge – E Tipu E Rea • Chair, Manaiakalani Education Trust • Director, Ports of Auckland (and subsidiaries) • Trustee, Emerge Aotearoa Trust (and subsidiaries) • Director & Shareholder, Snedden Publishing & Management Consultants Ltd • Director & Shareholder, Ayers Contracting Services Ltd • Director & Shareholder, Data Publishing Ltd • Director, Ngati Kuri tourism Ltd* • Director, Te Paki Ltd* • Director, Waimarama Orchards Ltd* • Director, Wharekapua Ltd* • Member, Health Partners Shareholder Review Group • Director and Shareholder, Recovery Solutions Services Limited • Shareholder, Ayers Snedden Consultants Ltd

	* subsidiaries of Te Urungi o Ngati Kuri Limited
Kylie Clegg	• Deputy Chair, Waitemata District Health Board • Trustee (ex officio) - Well Foundation (charity supporting Waitemata District Health Board) • Director, Auckland Transport • Director, Sport New Zealand • Director, High Performance Sport New Zealand • Trustee & Beneficiary, Mickyla Trust • Trustee & Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies but less than 1% of the shares in those companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, NextMinute Holdings Limited). It also includes a shareholding of less than 1% in Orion Health Holdings Limited. Orion Health has commercial.

Note: In 2018 the Minister for Health appointed a Crown Monitor to Counties Manukau DHB, Ken Whelan. Mr Whelan is a board member of the Royal District Nursing Service NZ, contracts with Francis Health & GE Healthcare (mainly Australia & Asia) and is also the Crown Monitor to Waikato District Health Board.

Report of the Audit Office

Independent Auditor's Report

To the readers of Counties Manukau District Health Board's financial statements and performance information for the year ended 30 June 2019

The Auditor-General is the auditor of Counties Manukau District Health Board (the Health Board). The Auditor-General has appointed me, Athol Graham, 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 Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 53 to 89, that comprise the statement of financial position as at 30 June 2019, 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 Health Board on pages 13 to 37.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the *Basis for our qualified opinion* section of our report:

- the financial statements of the Health Board on pages 53 to 89:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 13 to 37 :
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, 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 of the financial statements and the performance information was completed on 31 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we draw outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 17 on page 81, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $110.9 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

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

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

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in the Statement of Accounting Policies on page *58* that outline the financial difficulties being experienced by the Health Board. The Health Board has determined that it is a going concern, because it has obtained a letter of support from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

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

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is also responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 12, 38 to 52, 90 to 93 and 99 to 100 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 Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): *Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

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

Athol Graham
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Ministerial Directions

No Ministerial Directions were issued during the 2018/19 year. Ministerial Directions that remain current are as follows:

- New Zealand Business Number Direction. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn. In May 2016, the Government issued a Direction under section 107 of the Crown Entities Act 2004 which set out a number of New Zealand Business Number (NZBN) implementation requirements for District Health Boards. Implementation of the NZBN requirements is expected to support Counties Manukau Health to streamline its interactions with businesses (e.g. suppliers and providers) and reduce the time spent on administrative activities relating to such interactions. Counties Manukau Health has been liaising with its shared services providers to identify systems and processes impacted by the Direction and look at options for incorporating NZBN requirements into those systems and processes.
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. http://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf.
- Directions to support a whole of government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property, and the former two apply to DHBs. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on the use of authentication services, issued in July 2008, continues to apply to all Crown agents apart from those with sizeable ICT business transitions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

Directory

Registered Office

Counties Manukau District Health Board

19 Lambie Drive

Manukau 2241

Postal Address: Private Bag 94052

South Auckland Mail Centre

Auditor

Audit New Zealand on behalf of the Auditor-General

Solicitors

Buddle Findlay

Carter Nick

Chapman Tripp

Claro

Gemma Mayes Barrister

Lane Neave Ltd

Meredith Connell

Perkins Aaron t/a AJH Perkins QC

Ponsonby Chambers – Finnie Andrew Keith

Simpson Grierson

Bankers

Bank of New Zealand

Westpac Banking Corp

ASB Bank Limited