COUNTIES MANUKAU HEALTH

Statement of Intent

Incorporating the Statement of Performance Expectations

2018-2022

This Statement of Intent covers the years 2018/19, 2019/20, 2020/21 and 2021/22.

Statement of Responsibility

The Counties Manukau District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2000. Each DHB is categorised as a Crown Agent under the Crown Entities Act 2004, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident population.

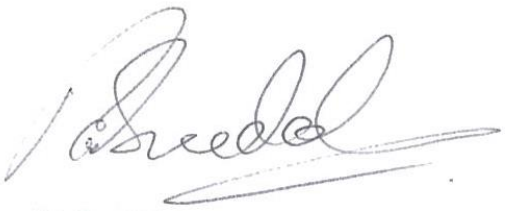
This Statement of Intent has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, and Public Finance Act and the expectations of the Minister of Health. In accordance with sections 100 and 141 of the Crown Entities Act 2004, CM Health will seek the Minister of Health's consent to its investment in any shares or interest in a company, trust or partnership.

The document sets out our goals and objectives and what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the Counties Manukau health system. This Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament as a separate public accountability document. This Statement of Intent can be read alongside the Counties Manukau District Health Board Statement of Performance Expectations and Counties Manukau District Health Board Annual Plan (both updated annually) to compare our planned and actual performance during each financial year, and audited results are presented each year in our Annual Report.

In signing this Statement of Intent, we are satisfied that it fairly represents our intentions and commitments. By working together as health system and in collaboration with Northern Region DHBs, we will continue to strive to improve the short to long term health and wellbeing of our community, and deliver against the expectations of Government.

Signed on behalf of the Counties Manukau District Health Board:

Vui Mark Gosche
Chair, Counties Manukau District Health Board



Pat Snedden
Chair, Audit Risk and Finance Committee

October 2018

He Pou Koorero

(A Statement of Intention)

Ko te tumanako a tenei poaari he whakarato i teetahi o ngaa taupori Maaori nui, taupori Maaori matatini, puta noa i te motu. Ko te whakakikokiko i te mana-taurite hauora Maaori teetahi o aa maatou tino whaainga.

Ko too maatou hiahia ko te whakamana, ko te whakatinana hoki i te wairua me ngaa maataapono o Te Tiriti o Waitangi hei tuuaapapa i taa maatou e whai nei, me te whakapono nui - maa te aata whakapakari i te ara whakawaiora Maaori e taea ai te whakatutuki i te mana taurite hauora moo te katoa.

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us.

Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

Table of Contents

1.0 About Counties Manukau Health

1.1 The communities we serve

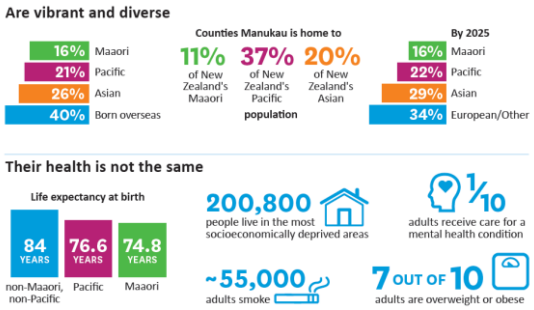
Counties Manukau District Health Board is one of twenty district health boards established under the New Zealand Health and Disability Act 2000 (NZPHD Act 2000) to plan and fund the provision of personal health, public health and disability support services for the improvement of the health of the population.

The Counties Manukau District Health Board provides and funds health and disability services to an estimated 557,790[1] people in 2018 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.

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 121,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation (NZDep2013 9&10[2]).

By 2025, our district is forecast to be 16 percent Maaori, 22 Percent Pacific, 29 percent Asian and 34 percent European/Other ethnicity.[3] There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[4] 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[5] 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[6], 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.[7] Diabetes prevalence is higher amongst our Pacific (13.9 percent), Asian (6.9 percent) and Maaori (6.5 percent) communities compared to European/Other.[8] 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.

[1] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – 2017 update.
[2] 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.
[3] Due to numeric rounding the total is greater than 100 percent
[4] 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.
[5] Winnard D, Papa D, Lee M, Boladuadua S et al (2013) populations who have received care for mental health disorders. CM Health, Auckland
[6] 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
[7] 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
[8] Source: Health Quality and Safety Commission Atlas of Health Care Variation, Diabetes management (2016 data for CMDHB)

1.2 What we do

The Counties Manukau District Health Board (DHB) acts as a 'planner', 'funder' and 'provider' of health services to our population, as well as an owner of Crown assets. As a DHB, we have an annual budget of over $1.7b to cover the provision and funding of health services for the people living in the Counties Manukau district. This includes funding for primary care, hospital services, some public health services, aged care services, and services provided by other non-government health providers including Maaori and Pacific providers. Some specialist services are provided by other DHBs through regional contracts. Collectively, we refer to this as the Counties Manukau Health system. In addition, regionally managed services are provided by the Auckland DHB and Waitemata DHB. These include cardiothoracic, neurosurgery, oncology, forensic mental health and school dental services. We also provide regional and national services for people from other DHBs for specific specialties (e.g. supraregional spinal service, national burns unit). We contribute to regional networks and service planning through the Northern Regional Alliance. Regional public health services are provided by Auckland Regional Public Health Service, under a Ministry of Health contract, managed through Auckland DHB.

Counties Manukau DHB operated services are largely delivered from seven inpatient facilities and numerous 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.

Over 6,700 people are employed by Counties Manukau District Health Board in addition to those employed by primary and community health services across the district. Nursing, midwifery and Health Care Assistant staff are by far the largest clinical workforce comprising 45 percent of DHB employed staff, medical 14 percent, and allied health and technical 18 percent. Over half of CM Health's workforce is on casual and part time contracts.

1.3 National, regional and local strategic direction

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.

The Counties Manukau DHB has an established district alliance with the five Primary Health Organisation (PHO) partners operating within the Counties Manukau district, reflecting shared system wide accountability and integration across community and hospital care providers. This includes Alliance Health Plus, East Health Trust, National Hauora Coalition, ProCare and Total Healthcare. Increasingly district Alliances are working regionally to improve health outcomes through planning and measuring performance through the regionally led Auckland Metro System Level Measures (SLM) Improvement Plan.

Given the proximity of the three metropolitan Auckland DHBs - Auckland, Waitemata and Counties Manukau – CM Health continues to contribute to a collaborative and more integrated and aligned approach to health services planning across the metro-Auckland region. In 2017 the Northern Region DHBs, along with other key stakeholders from our regional health system, were highly engaged in collaborative long term planning ensure that the capacity and capability of our regional health delivery system is ready to meet demand.

In 2018, each Auckland Metro DHB Board approved the first Northern Region Long Term Investment Plan (NRLTIP). The plan details regionally prioritised investments over a 10 to 15 year timeframe within the context of a 25 year horizon. The NRLTIP sets the Northern Region strategic investment path, and supports the Region to deliver optimal health gain for the Northern Region's population within available resources.

The NRLTIP identifies three investment themes for the Northern Region:

- Fixing our current facilities to ensure they are fit for purpose. This includes the concepts of asset resilience, renewal and refurbishment

- Future proofing our capacity for expected demand. This recognises that there are lead times of 5 to 10 years for some asset developments and that these cannot be developed in crisis
- Accelerating model of care change programmes. This includes enhancing levels of service and transformative change.

The NRLTIP signalled an immediate requirement for a significant lift in our Region's capital expenditure; particularly to address the issues identified against the NRLTIP 'Fix' and 'Future-proof' themes. Significant and urgent investment is needed in the Northern Region to ensure population health needs are met and to ensure the sustainability of existing health services. This plan identifies a long term need for a new acute Southern Hospital in the Counties Manukau district. CM Health's major facilities developments and information technology investments outlined in the Annual Plans are aligned with the NRLTIP priorities to remediate critical infrastructure issues and meeting immediate service capacity needs.

1.4 Health and safety

CM Health values our staff and the people with whom we work, and aims to provide a health and safety management system that is adaptable, functional and aligned with our organisational vision and values. CM Health is committed to achieving excellence in health and safety management and to working together, across our entire organisation, to prevent harm as a result of work activities.

CM Health will achieve this through incorporating and promoting a health and safety culture in the development of standard work practices, complying with, or exceeding the spirit of intent of relevant statutory requirements, codes of practice and other industry guidelines and standards. We encourage workers to participate in the review and improvement of the safety management system and use effective risk management methodologies to manage workplace hazards and risks. CM Health offers the appropriate rehabilitation to any worker who has suffered a work-related injury or illness.

1.5 Organisational health and capability

Refer to section 4 of the Counties Manukau Health Annual Plan for information on how the DHB intends to manage its organisational health and capability.

1.6 Te Tiriti o Waitangi

Counties Manukau DHB recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand and aims to fulfil our obligations as agent of the Crown. Our relationship with the tangata whenua of our district is expressed through a board-to-board relationship with Mana Whenua i Tamaki Makaurau. Counties Manukau DHB has adopted a principles based approach to recognising the contribution that the Treaty of Waitangi can make to better health outcomes for all, inclusive of Maaori.

The principles of partnership, protection and participation implicitly recognise the important role the health sector plays in recognising the indigenous rights of Maaori and therefore the status and rights of Maaori to achieve equitable health outcomes in comparison to the rest of the population.

1.7 Health gain approach

The health inequities for our Maaori and Pacific communities are stark. In addition to our Te Tiriti responsibilities to work to address Maaori inequities, we have nearly 40 percent of the Pacific population of NZ living in our rohe (district) and their well-being is a significant issue for CM Health. Counties Manukau is also home to 20 percent of the Asian population of NZ, and this diverse Asian community is growing faster than any other ethnic group. Health needs vary across our ethnic populations, and it is important to acknowledge our ethnic and health needs diversity to provide a better experience of health care and better health outcomes for our patients, their whaanau and families now and into the future.

While we acknowledge that the healthcare system is not the only determinant of health and wellbeing, we aspire to ensuring a high performing system that is accessible to all and contributes to healthy life years through the interventions we provide in collaboration with others.

1.8 Equity

Not everyone living in Counties Manukau experiences the same health outcomes and we care about achieving health equity for our community. Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need. This means we need to plan for evolving workforce health literacy and cultural capabilities to match changing community needs.

The Healthy Together strategic goal is centred on achieving health equity for our community:

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

We will measure the impact we have on healthy life years every year. This is our commitment to act and be deliberate in our choices and priorities. This means that people will live longer healthier lives in the community.

1.9 Key challenges

In partnership with our primary and community providers, CM Health is a high performing DHB. However, there are a number of social and health challenges facing our diverse and growing population that need to be considered in our role as a funder and provider of health services.

Growing and ageing population - Counties Manukau is the second fastest growing DHB and our population is forecast to increase by 78,000 people by 2028. Our population is also ageing with an additional 2,500 - 3,000 people aged 65 years and over each year. It is this group who will place the highest demands on health services in the years to come and is particularly significant for the Franklin and Eastern localities.

Large high-needs population - Socioeconomic deprivation is a key driver of health inequities. In 2018 we estimate that 200,800 people in Counties Manukau, over a third of all residents, are living in areas classified as being the most socioeconomically deprived in New Zealand. This is many more people living in these circumstances than any other DHB in New Zealand and presents a challenge for health and social sector agencies to best support our people to flourish.

Prevention and management of long term conditions and mental health – Long term conditions such as coronary heart disease, diabetes, cerebrovascular diseases and obstructive pulmonary disease are the leading causes of potentially amenable mortality in Counties Manukau. Nearly one in ten adults living in Counties Manukau received care for a mental health condition in 2011,[9] and in 2015 there were over 67,000 people in Counties Manukau living with one or more long term conditions.[10] The increasing prevalence of long term physical and mental health conditions is one of the major drivers of health care demand. Appropriate early detection and management of long term conditions and the associated risk factors are therefore essential to reducing potentially amenable mortality, improving the number of healthy life years and thereby protecting the sustainability of our health system.

Financial sustainability – 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 Counties Manukau Health. To continue to progress Healthy Together within this context, we have to make choices that achieve our goals but at a lower cost base and with prioritisation of resources. To respond to these challenges, CM Health's Annual Plan outlines a smaller number of specific actions that target stubborn inequities and commits to implementation of a Turn Around Plan that provides a roadmap to achieving a sustainable financial position and embeds a strong evaluation framework.

[9] Winnard D, Papa D, Lee M, Boladuadua S, Russell S, Hallwright S, Watson P, Ahern T (2013) Populations who have received care for mental health disorders. Counties Manukau Health. Auckland: Counties Manukau Health.
[10] Chan WC, Winnard D, Papa D (2017) People identified with selected Long Term Conditions in CM Health in 2015. Counties Manukau Health. *Unpublished.*

Ageing facilities infrastructure – The average age of our buildings is 40 years and certain buildings are not suitable for future long term use. In addition, national funding and affordability constraints over the last 5 years in particular have resulted in significant deferral of key hospital building maintenance. Constrained funding meant that we prioritised clinical equipment to support direct patient care services against capability enablers such as buildings, plant equipment and ICT infrastructure. The result is that we now face urgent remediation of our facilities and immediate service demand capacity expansion investment requirements. CM Health's Annual Plan outlines regionally prioritised major capital investments that will add critical service capacity as well as remediation of health and safety and clinical service risks due to aging facilities infrastructure.

1.10 Our response

While the above represents a significant challenge, our Healthy Together strategy provides the framework for enabling better community, patient, whaanau and family outcomes, improved experience of care and value for the health dollar.

Our transformational challenge is *"To systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality."*

To achieve this, we need to prioritise actions that will improve our performance across our three strategic objectives and government priorities. We will organise our resources to address these challenges through strategic initiatives and programmes of work (section 2.3) and measure our progress through our outcomes measurement framework (Figure 1) and national performance measurement outlined in each Annual Plan's Statement of Performance Expectations.

2.0 Our Direction – Healthy Together

2.1 Introduction

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, we will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020" is our strategic goal and ambition.

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.

2.2 Strategic objectives

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

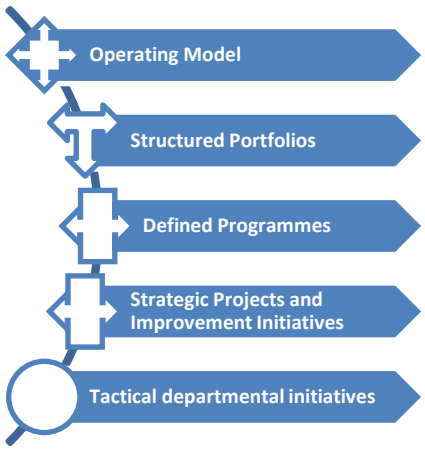
Progressing **Healthy Communities** through primary (ill-health) prevention across the life course is important. There is great potential to reduce the prevalence of long term health conditions by reducing risks early in life from conception to the young adult years, e.g. smoking (direct and indirect 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. To manage the challenges of our ageing facilities infrastructure and significant increase in service demand, we have accelerated our investment in facilities to ensure health and safety for patients, staff and visitors. At the same time, we are working regionally to address immediate demand pressure through enhanced inter-DHB planning and development of prioritised expanded and new facilities.

2.3 Delivering on our strategic direction

Our outcomes framework aligns with our strategic objectives and recognises that progress in one strategic objective frequently requires concurrent improvement in others. Our strategic directions do not operate in isolation.

Our **transformation challenge** is to select and clearly describe what, where, how and when we will make changes and how we will know we are progressing in the right direction. In reality this is an iterative process and prudent use of resources means that we need to monitor progress regularly, periodically assess impacts (what difference are we making) and adapt or change direction when there is evidence to do so.



Respecting this, the Executive Leadership Team acts as a single Portfolio Board to monitor overall strategic activity progress and ongoing portfolio development as we learn what works and consider emerging opportunities. The Counties Manukau DHB Board Audit Risk and Finance Committee of the Counties Manukau DHB Board provides investment and financial oversight and advice to the Board. In 2018, a new Board committee will be established to oversee major capital projects.

To deliver on our strategic direction, we have created **four structured portfolios** that will integrate all related programme and project delivery activities. Based upon best practice portfolio management, they will help design and delivery synergies, more effectively allocate resources and link strategic and tactical activities and benefits realisation.

(i) Acute Patient Flow

This portfolio aims to take a whole of system approach to improving how care is provided and patients move through acute care pathways. This includes improvements to models of care for acute care such as Choosing Wisely / Tackling Variation initiatives to reduce variation, better Emergency Department pathways and improved integrated management of long stay patients.

(ii) Non Acute Patient Management

This portfolio focuses on improving patient care in non acute settings, including the ongoing implementation of the Enhanced Model of Planned Proactive Care with Primary Care providers, along with improving management and remodelling of Outpatient Management processes

(iii) Non Clinical Improvement

This portfolio focuses on delivering a number of initiatives in non-clinical or 'back office' areas, including workforce management and payroll opportunities, procurement and contracting efficiencies, and ensuring clinical coding processes are optimised and revenue from Inter District Flows is managed effectively.

(iv) Infrastructure and Assets

This portfolio focuses on effective and fit for purpose management (business) processes, information and communication technologies (ICT) upgrades, local planning integrated with the Northern Region Long Term Investment Plan for major capital developments and remediation of facilities and related assets.

The **operating model** (or blueprint) is a tool to align and 'layer' all the aspects of strategy delivery in a way that includes the 'business as usual' systems, services and interventions. This will enable CM Health to **actively engage and participate in regional** service review and investment forums. Within this model are seven core business capabilities that are most critical to delivery of our Healthy Together strategy. These capabilities will evolve over the Statement of Intent four year period with the following examples of programme activities:

1. **Access**: e.g. ICT to support more mobile and remote access to information systems, community out of hours and rapid response for urgent care, referral processes and protocols for triage and screening
2. **Assess Need**: e.g. integrated multi-disciplinary team assessments, general practice clusters working together, directory of services/interventions, population health data analytics systems
3. **Plan Care**: e.g. evidence based practice for delivering care, case management supported by ICT devices and systems that enable mobile services and portals to access health care plans

4. **Deliver Coordinated Care**: e.g. electronic decision support tools, supported hospital discharge and reablement, systems to coordinate all community services, quality improvement, case management
5. **Monitor and Respond**: e.g. as per Assess, Plan and Deliver to respond to changing needs
6. **Predict and Prevent**: e.g. single accurate information repository, analytic and modelling expertise

3.0 Improving Health Outcomes

3.1 Measuring our performance

To monitor progress towards Healthy Together we require a district wide outcomes framework. This framework of outcomes (medium and longer term) and contributory measures (impacts) needs to join up a complicated system of district wide health resources (inputs) and related services delivered (outputs) by a large number of providers and care setting every day. At the same time, we need to monitor and challenge progress of our Healthy Together portfolio of strategic and system wide transformation while at the same time meeting government performance expectations.

The framework is organised through our three Healthy Together strategic objectives (**Healthy Communities** - **Healthy Services** - **Healthy People, Whaanau and Families**) to provide:

- complementary perspectives in telling our overall strategy performance story,
- underpinned by the national Triple Aim[11] and aligned with the New Zealand Health Strategy (Table 1); and
- performance reporting through the Healthy Together Outcomes Framework (Figure 1)

This measurement framework includes national and local measures that encompass care across a range of district wide acute and planned health services. CM Health's performance against the outcome and contributory measures in this framework is also impacted by our activity towards the other national and local measures that exist within our broader performance context. In addition to those included in this framework, CM Health is committed to meeting and exceeding all our local and national health targets, a full list of which can be found in each year's Annual Plan.

Partnership within and outside health services is critical to achieving equitable health outcomes. For many services, the people living in Counties Manukau rely on regionally delivered services, e.g. radiotherapy, and collaboration across DHB boundaries is essential to a positive experience of care.

The CM Health Alliance Leadership Team is working regionally to implement System Level Measure Improvement Plans as part of a national health sector expectation. These activities are integrated with day-to-day service delivery, health equity campaign and other local strategic initiatives. In addition, CM Health is working with social sector leaders in developing a social investment approach combined with localised decision making to enable greater flexibility to respond to local circumstances in a more integrated way.

Two long term outcomes to monitor progress towards our health equity strategic goal

We know that not everyone in our diverse community experiences the same health outcomes. In Counties Manukau in 2015 the gap in life expectancy (LE) between Maaori (LE=74.8) and the non-Maaori /non-Pacific group (LE=84.0) was 9 years; for Pacific peoples that gap was 7 years. Consistent with most developed countries, New Zealanders are living longer lives, both healthy and unhealthy life years. **Our strategic ambition is longer healthier life years**.

Our two long term outcomes are:

- Quantity of life in terms of mortality measured by **'life expectancy at birth'** – targeting ill health risk factors, e.g. smoking and unhealthy weight, which have multiple impacts on diseases that are the leading causes of amenable mortality. The bigger changes will be in the future decades when those changes means communities will have lower ill-health risk exposure.
- Quality of life in terms of morbidity, measured by **'healthy life years'**[12] – targeting ill health risk factors plus early identification, high quality and collaborative interventions/treatment and effective disease management/self-management are all important for improving healthy life years.

[11] New Zealand Triple Aim for Quality Improvement: i) improved quality, safety and experience of care, ii) improved health and equity for all populations, and iii) better value for public health system resources. Further information is available from http://www.hqsc.govt.nz

[12] Note that recommendations for the development of this measure are being discussed with the Regional Population Health Peer Group. As a result, this measure may evolve over the Statement of Intent period.

Progress towards reducing inequities in these outcomes will require contributions from quality urgent, acute and elective universal services and targeted approaches focused on specific population groups. Our contributory measures need to engage with this scope of activities and be contextualised within physical environment and economic and social realities of our community. We also need to work with whaanau and community strengths that contribute to longer lives, e.g. whaanau support, community connectedness in a way that honours diversity, individual, whaanau and family roles.

Align our medium term outcomes and measures around the Healthy Together strategic objectives

Our outcomes measurement framework outlines the integrated contribution of CM Health's strategic objectives to the two long term outcomes. For example, a 'healthy start in life' requires a combination of 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.

There is considerable complexity in the relationship between services/activities and performance measure contribution to health (and health system) outcomes. CM Health's key medium term outcome alignment was based on the medium term outcomes that have the most significant contribution. This simplifies the true contribution story but is necessary to monitor progress, achievements, challenges and opportunities to improve, in a way that enables responsive actions.

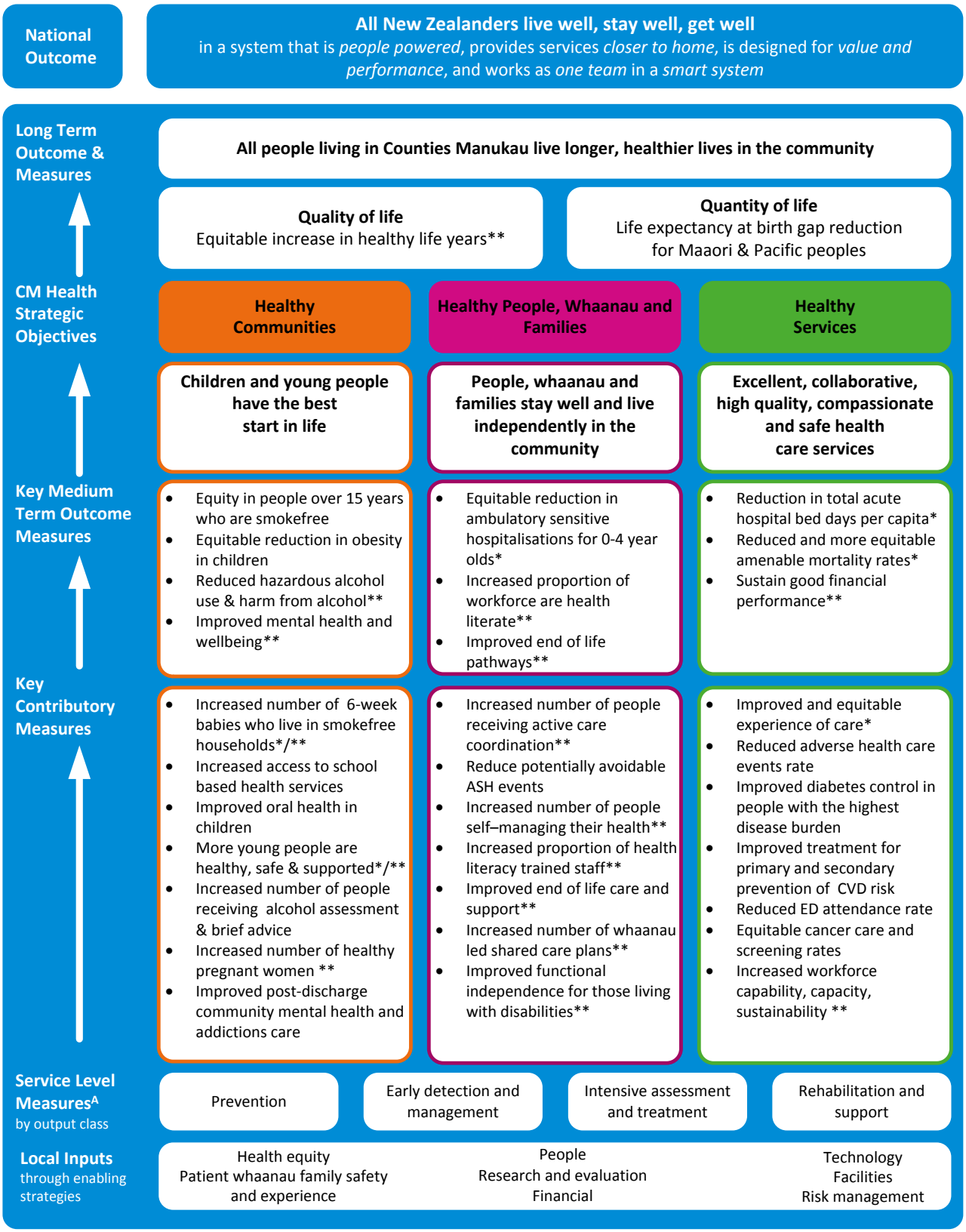
Table 1: National to local strategy and outcome measurement alignment

NZ Health Strategy Theme	CM Health's Key Strategic Objective Alignment	CM Health Medium Term Outcome Alignment[13]
People-Powered – understanding people's preferences, supporting their navigation and enabling individuals to make choices		Children and young people have the best start in life: ▪ Equitable reduction in obesity in children ▪ Equity in adults who are smokefree ▪ Reduced hazardous use and harm from alcohol**
Closer to Home – integrated health services closer to where people live that promote wellness, prevent long term conditions and support a good start in life for children, whaanau and families		Healthy people, whaanau and families stay well and live independently in the community: ▪ Equitable reduction in ambulatory sensitive hospitalisation for 0-4 year olds*
Value and High Performance - delivering better experience of care and equitable health outcomes with a culture of quality improvement and innovative investment approaches.		Excellent, collaborative, high quality, compassionate and safe health services: ▪ Reduced and more equitable amenable mortality rates* ▪ Financial sustainability** ▪ Asset performance **
One Team – effective and flexible teams working together with people at the centre of care		Healthy people, whaanau and families stay well and live independently in the community: ▪ Health literate workforce** ▪ Improved end of life pathways**
Smart System – reliable, accurate information at the point of care with systems that improve evidence based decisions and evaluation		Excellent, collaborative, high quality, compassionate and safe health services: ▪ Reduction in total acute hospital bed days per capita*

*Note * indicates national System Level Measures (SLMs). All of the national SLMs align to CM Health's strategic objectives and underpin the NZ Health Strategy theme alignments in Table 1 above.*
*Note ** denotes measures or reporting processes in development*

[13] Refer Healthy Together Outcomes Measurement Framework (Figure 1) for aligned key contributory measures.

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 Expectations and Statement of Service Performance

In 2018/19, we will work regionally and nationally to adopt and monitor asset performance measures once they are agreed.

3.2 Long term outcomes

"More equitable quality and quantity life"

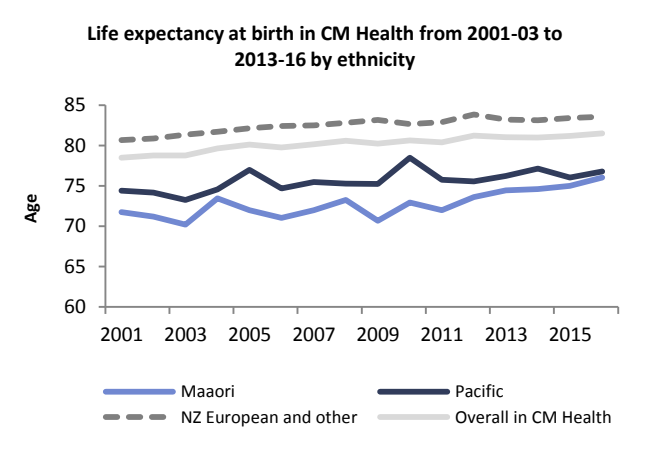
We want to achieve progress towards two long term outcomes to monitor progress towards our health equity strategic goal. What matters is that people live **longer healthier lives in the community**.

Long term outcome: Reduce the life expectancy at birth gap for Maaori and Pacific peoples

Life expectancy at birth is a key long term measure of health

The overall life expectancy at birth in Counties Manukau in 2016 was 81.5 years. Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern; increasing by 1.7 years from 2006 to 2016. However, not everyone in our diverse community experiences the same health outcomes.

In 2016 the gap in life expectancy between Maaori (life expectancy 76.1 years) and non-Maaori/non-Pacific (life expectancy 83.6 years) was 7.5 years. The gap between Pacific (life expectancy 76.8 years) and non-Maaori, non-Pacific was 6.7 years. We are committed to reducing these inequities.



To do so we will reduce ill-health risk factors where it matters most. We will deliver actions to reduce smoking prevalence, reduce the harmful use of alcohol, and prevent and manage cardiovascular and diabetes risk factors. We aim to intervene earlier to improve the quality of life for future generations through better disease management and identifying disease earlier. In addition, we will work to support our communities to address the broader social determinants of health and to ensure that the highest quality health care is accessible and provided to our Maaori, Pacific and other communities with health disparities.

Data source: MOH mortality collection and estimated population from Stats NZ (2016 edition)

Long term outcome: Equitable increase in healthy life years[14]

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.[15] 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.

[14] As this is a new outcome measure, baseline and trend data is not yet available. Note that recommendations for the development of this measure are currently being discussed with the Regional Population Health Peer Group.

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

3.3 Healthy Communities

"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; with 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 providing our community with trusted advice on healthy nutrition. To achieve healthy communities, we will 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**.

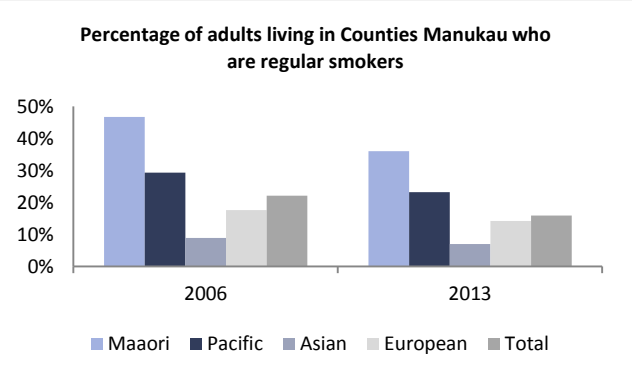
Medium term outcome: Equitable smokefree rates across Counties Manukau

Smoking is a major contributor to preventable illness and long term health conditions

Smoking increases the risk of developing heart disease, respiratory conditions and many types of cancer; all of which contribute to life expectancy inequities. Based on 2013 Census data, we estimate there are approximately 55,000 people that smoke in the Counties Manukau district and clear inequities between ethnic groups. We continue to advance our interventions to improve the chances of people who smoke making a successful quit attempt with targeted actions for ethnic groups with health disparities and working towards achieving equity for our communities and Smokefree New Zealand 2025 (5 percent prevalence).

Data source: Census 2006 and 2013, usually resident population[16]

Total Base	*Total Target*			
2013[17]	*2019*	*2020*	*2021*	*2022*
16%	*10%*	*<10%*	*<10%*	*<10%*

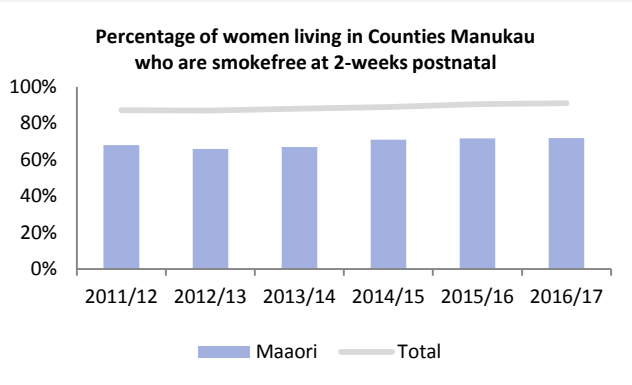


Key contributory measure: increased number of women who are smokefree at 2-weeks post natal[18]

Reducing the proportion of women who smoke during and after pregnancy will have benefits for the woman, her whaanau, family and health of her baby. This will reduce potentially avoidable ill-health and hospitalisation (e.g. respiratory infections, asthma). Smoking in pregnancy also has important risks to the baby (small for gestational age, prematurity) and contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. In Counties Manukau an estimated 51 percent of Maaori women smoke at the time of birth (hospital data). We are targeting smoking cessation support during and after birth.

Data source: Well Child Tamariki Ora

Base	*Target (for Maaori)*			
2016/17[19]	*2018/19*	*2019/20*	*2020/21*	*2021/22*
72%	*95%*	*95%*	*95%*	*95%*



[16] The definition for the European category differs between 2006 and 2013 Census; in the 2006 census European and non-Maaori, non-Pacific other respondents were grouped, while 2013 Census used separate categories for European and non-Maaori, non-Pacific other groups.
[17] Updated baseline and forecast trend data will not be available for this measure until CM Health has received updated population counts arising from Census 2018.
[18] 2016/17 data is at September 2016. In 2018/19 a System Level Measure 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. The 2-week indicator will continue to be important to monitor as additional improvements to the quality of the six-week indicator data are required.
[19] Baseline is at September 2016.

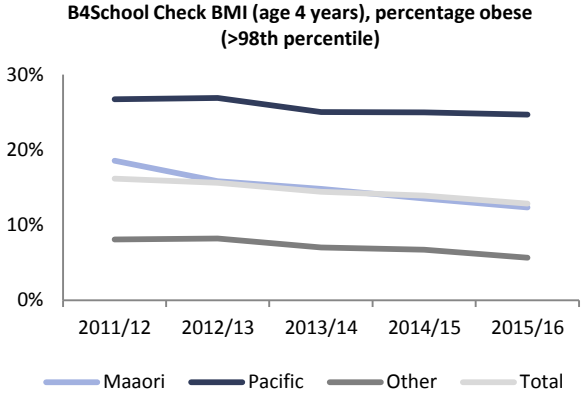
Medium term outcome: Equitable reduction in obesity prevalence in children

Childhood obesity is associated with a wide range of short to long term ill-health impacts that are potentially avoidable

Just over 13 percent of 4 year olds living in Counties Manukau are obese, with higher rates in Maaori and Pacific children (12 percent and 25 respectively, compared 6 percent for children of other ethnicities). Obesity impacts on people's quality of life and is a risk factor for many long term health conditions including diabetes, stroke, cardiovascular disease, musculoskeletal conditions and some cancers. 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. CM Health is committed to progressing the national Childhood Obesity Plan and regional Childhood Healthy Weight Action Plan.

Data source: Well Child Tamariki Ora B4School Checks[20]

Total Base	*Total Target*			
2015/16[21]	*2018/19*	*2019/20*	*2020/21*	*2021/22*
13%	*<13%*	*<13%*	*<13%*	*<13%*

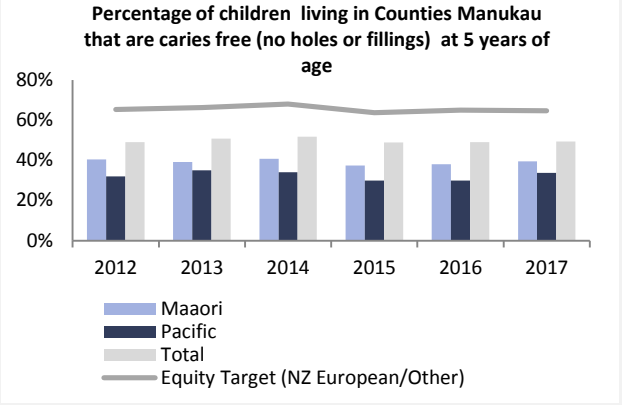


Key contributory measure: improved oral health in children

Nutrition is an important factor in reducing 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. The regional dental service and related provider partners are focusing on promoting good oral health (dental pain and caries free) and independence through child oral health programmes (health promotion, prevention and treatments) to reduce the prevalence of oral disease in children of pre-school age. To achieve this, district wide and targeted oral health improvement actions aim to reduce inequities in Maaori, Pacific and Asian children.

Data source: Auckland Regional Dental Service[22]

Total Base	*Total Target*			
2017	*2019*	*2020*	*2021*	*2022*
49%	*51%*	*51%*	*>51%*	*>51%*



Medium term outcome: Reduced hazardous use and harm from alcohol[23]

Hazardous alcohol use and alcohol-related harm cause large health, social, and economic burdens.

Alcohol is a contributing factor to many mental health problems, injuries, and more than 200 diseases and conditions, including alcohol dependence, liver cirrhosis, cardiovascular disease, and cancers. The use of alcohol can also result in harm to other individuals, including unborn babies through elevated risk of Foetal Alcohol Spectrum Disorder.

There is an inequitable burden of alcohol related harm in Maaori, males, young people and socio-economically deprived populations. There are estimated to be approximately 75,000 hazardous drinkers in Counties Manukau.[24] Addressing this will require broad and comprehensive public health approaches and working with a wide range of agencies and partners within and outside of the health sector.

CM Health has developed a programme of collaborative alcohol harm minimisation actions with a view to working regionally. This includes equitable delivery of the Alcohol ABC approach in general practice, the ED, the CM Health Living Smokefree Service, and community settings, and working with regional and intersectoral partners to address determinants contributing to hazardous alcohol use and related harm.[25]

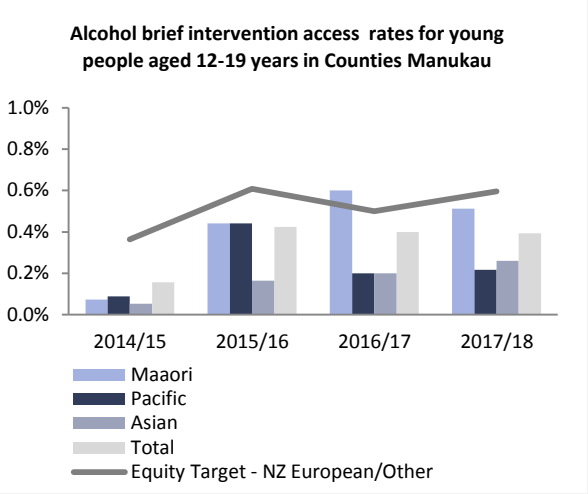
[20] Data sourced from Ministry of Health and is yet to be validated (as at April 2018).
[21] Updated baseline data (2016/17) is not yet available for this measure.
[22] This is national performance measure PP11 that includes children aged 5 years but before their 6th birthday at the time of their first examination.
[23] As this is a new outcome measure, baseline and trend data are not yet available.
[24] New Zealand Health Survey data 2016/17. Available from the Regional Data Explorer: https://minhealthnz.shinyapps.io

Key contributory measure: increased number of rangatahi Maaori receiving alcohol assessment and brief advice[26]

Good 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 and alcohol brief intervention services in general practice, as well as a focus on 'youth friendly' primary care. We will improve access to assessment and provide more integrated care pathways. We will ensure that school-based health services are widely available to all eligible rangatahi Maaori.

Data source: Quarterly PHO reports. Note: ethnicity stratified data first made available in Q1 2014/15.

Base	*Target*			
2016/17	*2018/19*	*2019/20*	*2020/21*	*2021/22*
0.4%	*0.5%*	*>0.5%*	*>0.5%*	*>0.5%*



Medium term outcome: Improved mental health and wellbeing

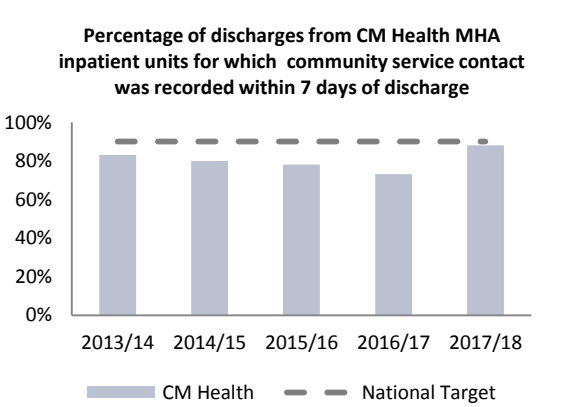
Mental health disorders are common in New Zealand and worldwide. Many New Zealanders will experience a mental illness and/or an addiction at some point in their lives with an estimated one in five people affected every year. Overall, Maaori and Pacific peoples experience higher rates of mental illness than non-Maaori, non-Pacific.

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. CM Health's current emphasis is on responsiveness and effectiveness of the specialist interventions, reducing inequities and earlier intervention through service integration between mental health and addictions services and primary and community care.

Mental health access rates have historically been used as an indicator for determining the impact of CM Health mental health service delivery on improving the quality of life for those who are suffering from mental illness or with alcohol or drug addiction. While CM Health will continue to monitor access rates, we are also working to mature our suite of mental health and wellbeing indicators to present a more meaningful picture of the mental health and wellbeing of our community.

Source: Key Performance Indicators for the NZ Mental Health & Addiction Sector (www.mhakpi.health.nz)[27]

Base	*Target*			
2016/17	*2018/19*	*2019/20*	*2020/21*	*2021/22*
76.1%	*90%*	*>90%*	***>90%***	*>90%*



[25] Note that alcohol harm reduction activities are included in the 2018/19 System Level Measures Improvement Plan (Section 5.4) and contribute to the Amenable Mortality, Total Acute Hospital Bed Days, and Youth Access to and Utilisation of Youth Appropriate Health Services System Level Measures.

[26] To note is that this indicator does not form part of the Alcohol Harm Minimisation Programme. Over 2018/19 this indicator will be matured and a more comprehensive suite of meaningful Alcohol ABC indicators (Assess, Brief Advice, Counselling/referral) will be developed.

[27] 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.

3.4 Healthy People, Whaanau and Families

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

The chief co-ordinator of care may not be, and does not always need to be, a healthcare professional. Where patients agree, whaanau and families need to be part of our planning, conversations about what is possible and are often required to support people at home. It matters that healthcare is more holistic, that our staff and services listen, understand and are responsive to physical, mental, spiritual, and psychological needs. By working better together with patients, whaanau and families, we aim to see to see reduced acute (unplanned) presentations for healthcare, 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. This will support **people, whaanau and families to stay well and live independently.**

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

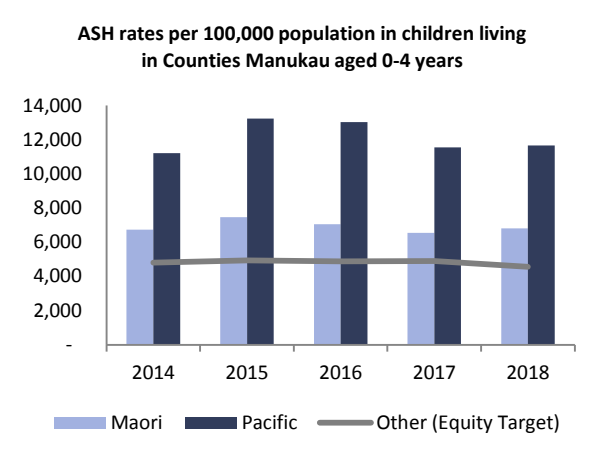
Ambulatory sensitive hospitalisations (ASH) are acute admissions that are considered potentially avoidable through access to quality, responsive primary health care

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 (ASH events). Leading causes of ASH events for Maaori and Pacific children in Counties Manukau are respiratory infections, asthma, dental conditions, cellulitis, upper and ear nose and throat infections and gastroenteritis. CM Health will focus on better integrating services, improving primary health services engagement and condition specific interventions to reduce Pacific and Maaori 0-4 year olds.

The 2018/19 Metro Auckland SLM Improvement Plan has a focus on reducing respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three Auckland DHBs. CM Health and regional plans identify actions that target the drivers of respiratory ASH, including actions to improve child and maternal immunisation and smoking cessation.

Data source: Ministry of Health Performance Reporting[28]

Total Base[29]	*Total Target*[30]			
2017/18	*2018/19*	*2019/20*	*2020/21*	*2021/22*
6,835	*↓ 3%*	*↓ 3%*	*↓ 3%*	*↓ 3%*



Note that the Metro Auckland SLM Improvement Plans sets annual targets. As such, the outer year targets will be reviewed annually and outlined in the Annual Plan.

[28] Data is 12 months to Q3 of each year. This is a national performance measure SI1 reflects the Ministerial priorities of timely patient care closer to home and value for money. This is also a national System Level Measure and reports are lagged by one quarter. There were national changes to the calculation of this result from quarter 1 2015/16 onwards impacting the comparability to historic results.

[29] Baseline data is at December 2017 to align with the 2018/19 Metro Auckland SLM Improvement Plan.

[30] The CM Health and Auckland Waitemata Alliances have committed to an annual 3% reduction in the child (0-4 years) ASH rate for total, Maaori and Pacific populations, as part of their shared regional aspiration to reduce ambulatory sensitive hospitalisations.The target for the outer years is a 3% reduction from the previous year.

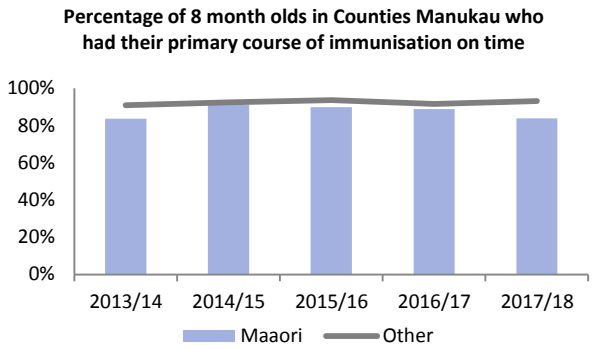
Contributory measure: improving immunisation coverage to reduce potentially avoidable hospitalisations

Tamariki Maaori have lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases compared with other children in Counties Manukau. Ensuring that vaccination coverage at 8 months exceeds the national target is an important component to enabling Maaori children to achieve the best possible state of health and 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.

Data source: National Immunisation Register Data Mart report

Total Base	*Total Target*			
2016/17	*2018/19*	*2019/20*	*2020/21*	*2021/22*
94%	*>95%*	*>95%*	*>95%*	*>95%*



Medium term outcome: Improved end of life pathways for patients and whaanau[31]

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 and the need for more personalised and culturally appropriate advance care planning in a range of health care settings. There are important differences in the place of death between ethnic groups therefore CM Health strategies will engage with hospices, aged residential care facilities, hospital and home based 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. This means ensuring that patients and whaanau are at the centre of end of life care approaches and that the social, financial, emotional and spiritual needs of patients, families and whaanau are recognised in that care.

3.5 Healthy Services

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

People are at the heart of healthcare services. We will add healthy life years and reduce the potentially avoidable rate of acute (unplanned) hospitalisations. 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 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**

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

Medium term outcome: Reduction in acute hospital bed days

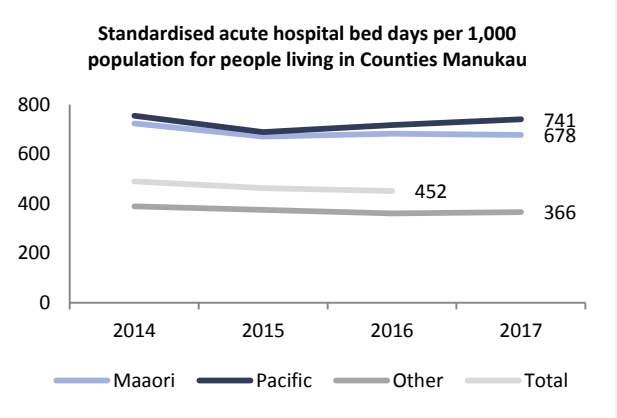
All of system approach to ensure safe delivery of care and reduce potentially avoidable hospitalisation[32]

Acute hospital bed days per capita is a measure of acute demand on hospital care that is 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, transitions between care sectors, and good communication between primary and secondary care.

CM Health aims to reduce inequities through an 'all of' system experience of care for patients and their families underpinned by teamwork and patient-centred care.

Data source: Ministry of Health Performance Reporting[33]

Base	*Target (Maaori and Pacific)*[34]			
2017/18[35]	*2018/19*	*2019/20*[36]	*2020/21*	*2021/22*
678(Maaori) 741(Pacific)	*↓ 3%*	*↓ 3%*	*↓ 3%*	*↓ 3%*

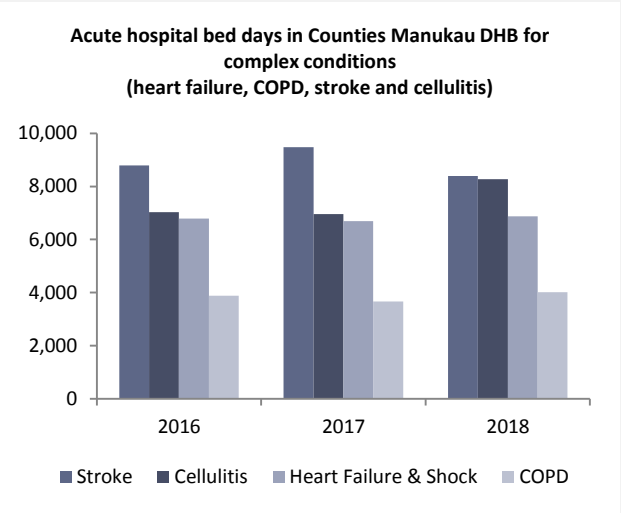


Key contributory measure: Focus on improving management for those with complex conditions

Four patient populations have been identified as contributing most to acute hospital bed days: patients with heart failure (HF), chronic obstructive pulmonary disease (COPD), stroke and underlying causes of reoccurring lower limb cellulitis.

Together with our PHO partners, we are working to reduce the days our patients spend in acute care by improving the delivery of care for patients in these groups. This includes focussing on effective care transitions, supporting primary care to reduce variation, optimising rehabilitation and improving end of life care. These changes will improve the value of the care we deliver across the whole of system by reducing hospital activity, improving quality outcomes, and improving patient experience. This is part of the 2018/19 Metro Auckland SLM Improvement Plan.[37]

Data source: Ministry of Health Performance Reporting[38]



[32] 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.

[33] Data is to December of each year. 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).

[34] Note that the target for the outer years is a two percent reduction from the previous year's rate.

[35] Baseline is at December 2017 to align with the 2018/19 Metro Auckland SLM Improvement Plan.

[36] Note that the Metro Auckland SLM Improvement Plans set annual targets. As such the outer years will be reviewed annually.

[37] The 2018/19 Metro Auckland SLM Improvement Plan includes two contributory measures related to reducing adult acute hospital bed days: a 2% reduction ASH rates for COPD and HF for adults aged 45-64 years old and a 2% reduction in the overall ASH rate for both Maaori and Pacific adults aged 45-64 years old.

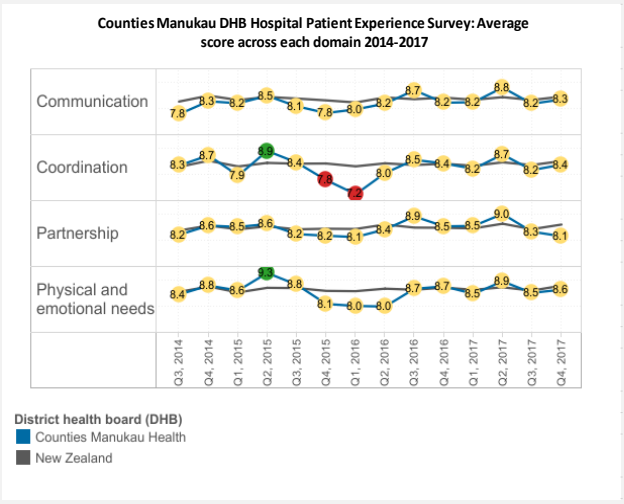
[38] Data is to March of each year.

Key contributory measure: improved and more equitable experience of care

Total Base	Total Target			
2016/17	2018/19	2019/20	2020/21	2021/22
8.8	>8.5	>8.5	>8.5	>8.5

Understanding patients' experience is vital to improving patient safety and the quality of care. Improving their experience reflects the safety and quality of care[39] and contributes to better health outcomes. The aim is to enable patients (and whaanau) to take a more active role in their own health. Current hospital patient surveys provide insights into how to improve patient experiences by focusing on activities to improve the quality of care provided. More than half of our patients say that communication is an aspect of care that can make the most difference to them. Patients want to discuss their care and treatment with us and to have their views respected. In addition to the hospital survey, a primary care survey was piloted in 2017/18[40] that focuses on coordination and integration of care and will be rolled out further in 2018/19. This will augment our current reporting with 'whole of health' system patient experience insights and opportunities for improvement.

Data source: Health Quality and Safety Commission National Patient Experience Survey Report[41]



Medium term outcome: Reduced and more equitable amenable mortality rates[42]

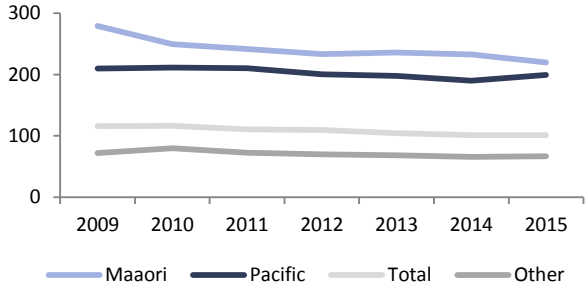
Target improvement in the leading causes of potentially preventable deaths

Total Base	Targets (Maaori, Pacific and total)[45]			
2012-14[46,47]	2018/19	2019/20	2020/21	2021/22
109	↓ 2%	↓ 2%	↓ 2%	↓ 6%[45]

The four leading causes of amenable mortality Counties Manukau - cancer, cardiovascular disease (particularly heart attacks and stroke), chronic obstructive pulmonary disease (COPD) and diabetes - share common risk factors.[43]

Regional and local approaches will 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.

Data source: National Mortality Data Collection[44] *(definition based on MOH Sep 2016 version on defining amenable mortality)*



[39] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203
[40] The primary care survey forms part of the SLM work for 2018/19 and the outer years.
[41] 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.
[42] 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.
[43] 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.
[44] 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.
[45] Consisent with the 2018/19 Metro Auckland System Level Measures Improvement Plan the following reduction in amenable mortality rates targets have been set for CM Health: 2% reduction (on single year baseline) by June 2019 for Maaori and Pacific populations and a 6% reduction (on the 2013 baseline) for the total population by 2021/22.
[46] Refered to as the '2013 baseline'
[47] Updated baseline data (2013-2015) is not yet available for this measure

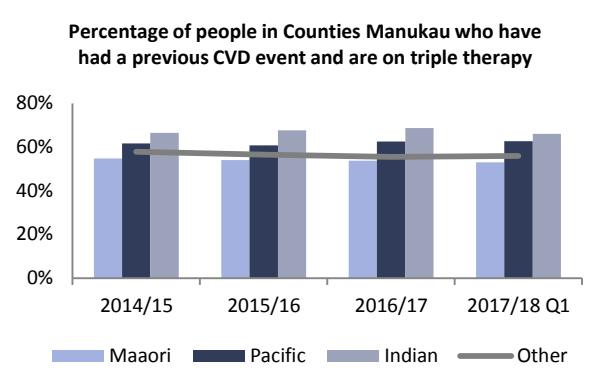
Key contributory measure: better treatment of people with cardiovascular disease (CVD)

There is good evidence that for those with a previous CVD event, 'triple therapy'[48] medicines can reduce future risk of 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. While the current percentage of people who have had a previous CVD event who are receiving triple therapy for the CM Health population 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.

Data source: Northern Region Cardiac KPI Report[49]

Total Base	*Total Target*[50]			
2016/17[51]	*2018/19*	*2019/20*	*2020/21*	*2021/22*
58%	*↑5%*	*↑5%*	*↑5%*	*↑5%*



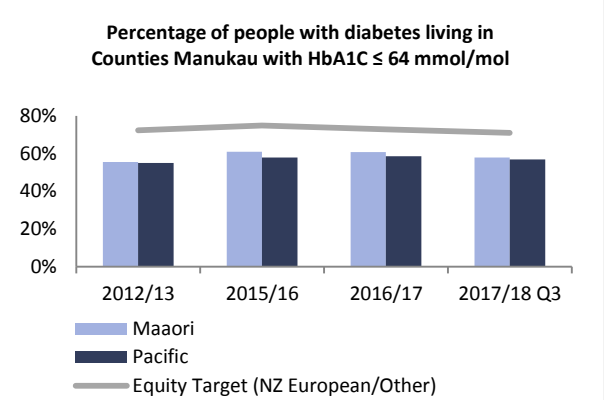
Key contributory measure: improved diabetes control in people with the highest disease burden

Better glucose control will reduce the progression of micro-vascular complications, chronic kidney disease, retinal disease and others. Patients with diabetes will be identified and supported to manage their own condition through planned proactive care, self-management including health coaching and improved access to allied health services in the community. The objective is to provide optimal clinical management for all people with diabetes, which includes good glycaemic control (HbA1c ≤ 64 mmol/mol), appropriate cardiovascular risk management, prevention and management of diabetes related complications such as albuminuria, neuropathy and retinopathy.

We aim to reduce inequities with a focus on those with the highest disease burden, i.e. Pacific, Maaori and Indian residents.

Data source: Ministry of Health Performance Reporting[52]

Total Base	*Total Target*			
2016/17	*2018/19*	*2019/20*	*2020/21*	*2021/22*
66%	*>69%*[53]	*>69%*	*>69%*	*>69%*



[48] 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.

[49] *CVD Prevention Medication Report* based on PHO enrolment for Quarter 4, CV Risk Assessment extracts and TestSafe dispensing data

[50] Note that the target for the outer years is a five percent increase on the previous year.

[51] The baseline data is taken from Q3 2016/17 – as this measure is reported biannually, in Quarters 1 and 3.

[52] 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.

[53] In Q4 2017/18 CM Health began using Health Safe as the data source for diabetes control, which captures a greater proportion of patients. For this reason the diabetes control target is likely to be raised above 69% 2018/19, with the exact target to be confirmed during Q2 2018/19.

Key contributory measure: fiscal responsibility

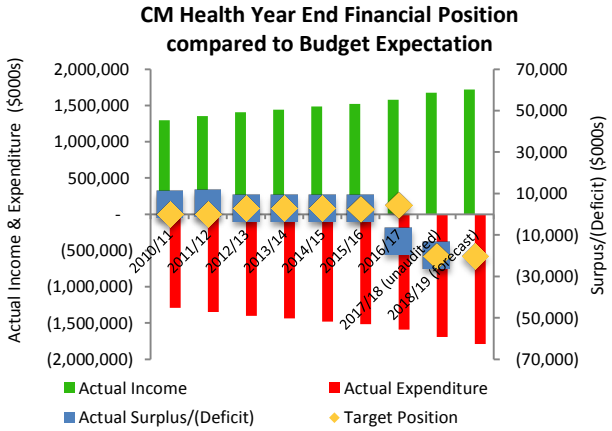
District Health Boards (DHBs) exist to improve, promote and protect the health of the public and specifically the people that live in their districts. This is achieved through provision and funding of services, the allocation and long-term stewardship. To deliver this, each DHB must responsibly and effectively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

CM Health works to be efficient in its service delivery now, while at the same time investing in innovation and future health system changes so that we can be financially sustainable in the medium to long term.

This includes working collaboratively with locally and regionally to provide the full range short to long-term services for our community.

Data source: CM Health Annual Reports[54]

Unaudited Actual ($000)	*Position Target ($000)*			
2017/18	***2018/19***	***2017/18***	***2018/19***	***2017/18***
(19,803)	*(20,000)*	*TBC*	*TBC*	*TBC*



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

COUNTIES MANUKAU HEALTH

HealthyTogether

CM Health

Statement of Performance Expectations 2018/19

Counties Manukau District Health Board
2018/19 Statement of Performance Expectations

Signed on behalf of the Board:

Vui Mark Gosche
Chair
Counties Manukau District Health Board

Pat Snedden
Chair
Audit Risk and Finance Committee

October 2018

2018/19 Statement of Performance Expectations

CM Health's Statement of Intent 2018-2022 sets out our strategic Healthy Together goal and objectives. We aim to improve the health of our population and ensure the sustainability of the Counties Manukau health system, for the years 2018 to 2022.[1]

We also monitor and evaluate our performance towards our Healthy Together goal and objectives on an annual basis in our Statement of Performance Expectations (SPE). This SPE includes a number of important strategic outcomes and contributory measures from our Healthy Together Outcomes Measurement Framework alongside a range of other indicators which we believe are significant to our community and stakeholders, and provide a fair representation and monitoring of our DHB's performance.

The SPE is a requirement of the Crown Entities Act 2013 and sets the annual performance expectations of the DHB. Recent actual performance data are used as the baseline for targets.[2] Actual results of service performance against what was forecast here will be published in our 2018/19 Annual Report.[3] The following SPE presents Counties Manukau DHB's planned performance for 2018/19.

Key priorities for financial sustainability

A selection of proposals has been notified to the Ministry of Health and will be further investigated over 2018/19 to assess and manage risk as well as planned implementation to ensure fiscal integrity. To achieve this, CM Health established a Turn Around Plan (TAP) project to engage stakeholders across CM Health to collectively identify a suite of financial savings opportunities, to enable CM Health to achieve a sustainable break-even budgetary position. It was intended that these opportunities focused on quality as well as efficiency.

The TAP work to date has not identified sufficient opportunities to fully bridge the deficit and requires a multi-year phased approach to reach financial sustainability. Please refer to section 1.1. and the Fiscal Responsibility section in our Annual Plan for further information.

Health equity

Not everyone living in Counties Manukau experiences the same health outcomes and we care about achieving health equity for our community. All targets in this SPE are universal with the aim of reducing equity gaps that exist in health outcomes for some population groups in Counties Manukau. To further support this, wherever possible, performance data in this SPE will be provided by ethnicity.

Counties Manukau Health continues to work with iwi through its board-to-board relationship with the Mana whenua i Tamaki Makaurau to address inequities faced by whaanau in the district. In response to this year's planning guidance, our 2018/19 annual plan identifies explicit actions to improve health equity for our Maaori and Pacific communities across all government planning priorities. CM Health is also committed to continuing to improve the health of our diverse and growing Asian communities.

Crown Entities Amendment Act 2013

The 2013 amendments to the Crown Entities Act 2004 provide for DHBs to have a Statement of Intent with a four year focus, and to be updated every three years instead of annually. The current Counties Manukau DHB Statement of Intent can be accessed here: http://countiesmanukau.health.nz

The requirement under Sections 142 and 143 of the Crown Entities Act 2004 to provide an annual Statement of Forecast Service Performance within the Statement of Intent has now been replaced with the requirement to have a SPE.

This SPE has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, and Public Finance Act and the expectations of the Minister of Health. The annual forecast financial statements will be provided as part of the SPE in accordance with the Crown Entities Amendment Act 2013.

[1] CM Health's Statement of Intent is tabled in Parliament and is available on the DHB's website: www.countiesmanukau.health.nz
[2] For 2018/19 in order to align baseline data across the three Auckland metropolitan DHBs, 2016/17 baseline data is included in the 2018/19 Statement of Performance Expectations.
[3] CM Health's Annual Report is tabled in Parliament and is available on the DHB's website: www.countiesmanukau.health.nz.

1.0 Input levels against Output Classes

The following tables provide a prospective summary of revenue and expenses by Output Class. Note that through our Turn Around Plan (TAP) we are working on a roadmap to achieve a more sustainable financial position. Accordingly outer year plans for 2019/2020 to 2021/22 should be read as indicative only until endorsed by the Counties Manukau DHB Board.

Prevention

	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Total Revenue	**50,737**	**52,297**	**53,917**	**54,259**
Personnel Costs	25,480	25,990	26,509	25,990
Outsourced Services	2,516	2,566	2,617	2,566
Clinical Supplies	2,741	2,796	2,852	2,796
Infrastructure & Non-Clinical Supplies	1,767	1,802	1,838	1,802
Other	18,233	19,143	20,100	21,105
Total Expenditures	**50,737**	**52,297**	**53,917**	**54,259**
Net Surplus/ (Deficit)	-	-	-	-

Early detection and management

	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Total Revenue	**246,436**	**258,722**	**271,621**	**285,111**
Personnel Costs	978	998	1,018	998
Outsourced Services	97	99	101	99
Clinical Supplies	105	107	110	107
Infrastructure & Non-Clinical Supplies	68	69	71	69
Other	245,188	257,449	270,322	283,838
Total Expenditures	**246,436**	**258,722**	**271,621**	**285,111**
Net Surplus / (Deficit)	-	-	-	-

Intensive assessment and treatment

	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Total Revenue	**1,246,167**	**1,334,763**	**1,400,326**	**1,471,234**
Personnel Costs	633,830	670,710	709,150	751,528
Outsourced Services	78,081	80,458	82,905	85,595
Clinical Supplies	131,543	134,175	136,859	139,777
Infrastructure & Non-Clinical Supplies	150,949	150,331	151,109	152,483
Other	305,258	320,525	336,552	353,384
Total Expenditures	**1,299,661**	**1,356,199**	**1,416,575**	**1,482,767**
Net Surplus / (Deficit)	**(53,494)**	**(21,436)**	**(16,249)**	**(11,533)**

Rehabilitation and support

	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Total Revenue	**182,603**	**191,187**	**200,189**	**208,877**
Personnel Costs	14,310	14,596	14,888	14,596
Outsourced Services	1,413	1,441	1,470	1,441
Clinical Supplies	1,539	1,570	1,602	1,570
Infrastructure & Non-Clinical Supplies	992	1,012	1,032	1,012
Other	164,349	172,568	181,197	190,258
Total Expenditures	**182,603**	**191,187**	**200,189**	**208,877**
Net Surplus / (Deficit)	-	-	-	-

Total

	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Total Revenue	**1,725,943**	**1,836,969**	**1,926,052**	**2,019,481**
Personnel Costs	674,598	712,293	751,565	793,111
Outsourced Services	82,106	84,563	87,093	89,700
Clinical Supplies	135,929	138,649	141,422	144,251
Infrastructure & Non-Clinical Supplies	153,776	153,215	154,050	155,367
Other	733,028	769,685	808,171	848,585
Total Expenditures	**1,779,437**	**1,858,405**	**1,942,301**	**2,031,014**
Net Surplus / (Deficit)	**(53,494)**	**(21,436)**	**(16,249)**	**(11,533)**

2.0 Output Classes

Four 'output classes' are used by all District Health Boards (DHBs) to reflect the nature of services they fund and provide. These output classes reflect the continuum of care and are: prevention services, early detection and management services, intensive assessment and treatment services and rehabilitation and support services.

This SPE is organised by output class and describes the services CM Health plans, funds, provides and promotes within each output class. Each output class includes a number of key measures of output and impact that are significant to CM Health's achievement of key strategic objectives, and that provide a fair representation of our DHB's performance. Note that these measures are not intended to be a comprehensive outline of all performance measurement activity within the organisation.

In presenting CM Health's performance story, it is important to present a mix of measures that indicate performance in a range of different ways. For example, for some services the most important measure of performance will be how much of it is delivered (volume), whereas for other services the best measure of performance may be how quickly that service was provided (timeliness).

This SPE therefore includes a spread of indicators that cover the following areas of performance: Volume (V), Timeliness (T), Quality (Q) and Coverage (C). Each of the performance measures has a reference classification to assist with quick categorisation.

Reference Key			
SLM	System Level Measure	**V**	Volume
SLMc	System Level Measure Regional Contributory Measure as included in the 2018/19 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2018/19 Metro Auckland SLM Improvement Plan)	**T**	Timeliness
		Q	Quality
		C	Coverage

2.1 Prevention Services

Preventative 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.

Preventative 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 preventative 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		Baseline 2016/17	Target 2018/19	Notes
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%	C
	Maaori	91%		
	Pacific	92%		
	Asian	93%		
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking	Total	96%	95%	C
	Maaori	96%		
	Pacific	97%		
	Asian	96%		
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	Total	90%	90%	C
	Maaori	92%		

Performance Measure		Baseline 2016/17	Target 2018/19	Notes
Percentage of PHO-enrolled patients who smoke who accepted smoking cessation support	Total	25.6%	28.2% [4]	SLMcQ
Percentage of babies living in smokefree homes at six weeks postnatal	Total	75.3%[5]	80%[6]	SLMQ
	Maaori	47.2%		
	Pacific	63.8%		
Percentage of babies fully or exclusively breastfed at 3 months	Total	50%[7]	70%	Q
	Maaori	39%		
	Pacific	45%		
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	98%	95%	Q
	Maaori	98%		
	Pacific	99%		
	Other	95%		
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	139	171	V
Number of adult referrals to Green Prescription services	Total	6,406	7,300	V
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	94%	95%	C
	Maaori	89%		
	Pacific	96%		
	Asian	98%		
Percentage of two year olds who are fully immunised	Total	95%	95%	C
	Maaori	90%		
	Pacific	97%		
	Asian	98%		
Proportion of eligible girls fully immunised with HPV vaccine	Total	62%	75%	C
	Maaori	63%		
	Pacific	72%		
	Asian	60%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	50%	75%	C
	Maaori	49%		
	Pacific	69%		
	Asian	51%		
Health Screening				
Proportion of women aged 50-69 years who have had a breast screen in the last 24 months	Total	69%	70%	C
	Maaori	64%		
	Pacific	76%		
	Other	68%		
Proportion of women aged 25-69 years who have had a cervical smear in the last three years	Total	73%	80%	C
	Maaori	65%		
	Pacific	81%		
	Asian	68%		
	Other	77%		
Percentage of four year olds receiving a B4 School Check	Total	92%	90%	C

[4] 2018/19 targets represent a 10% increase from baseline as per the 2017/18 Metro Auckland SLM Improvement Plan.
[5] The proportion of babies living in smokefree homes at 6 weeks was previously a developmental measure (DV7 in 2017/18). Baseline data is for the period July 2017 - December 2017 to align with the 2018/19 Metro Auckland SLM Improvement Plan.
[6] The 2018/19 Metro Auckland SLM Improvement Plan targets a 3% 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.
[7] Baselines are at Q1 2017/18 as 2016/17 data is unavailable.

Performance Measure		Baseline 2016/17	Target 2018/19	Notes
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS[8] assessment	Total	100%[9]	95%	C
	Maaori	102%[10]		
	Pacific	99%		
	Asian	101%		

2.2 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 preventative 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		Baseline 2016/17	Target 2018/19	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	97%	95%	C
	Maaori	93%		
	Pacific	116%		
	Asian	86%		
Percentage of newborns enrolled in general practice by 3 months	Total	71%	85%	C
	Maaori	69%		
	Pacific	70%		
	Other	73%		
Amenable mortality rate per 100,000 population[11]	Total	104.4[12]	98.1[13]	SLM Q
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	92%	90%	C
	Maaori	89%		
	Pacific	91%		
	Other	93%		
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	73%	90%	C

[8] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide
[9] Baseline data is at December 2017 as data is reported to the end of the calendar year.
[10] Results greater than 100% are due to the transient nature of the Counties Manukau DHB population. School roll can fluctuate significantly from the start to the end of a school term.
[11] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[12] Baseline data is for the 12 months ended 30 June 2013. This baseline period has been used in order to align with the 2018/19 Metro Auckland SLM Improvement Plan. Updated baseline data will rely on the 2018 Census information, which is not yet available.
[13] 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, with performance against target to be measured at 30 June 2020. The 2018/19 Metro Auckland SLM Improvement Plan includes a separate target for Maaori and Pacific of a 2% relative reduction by June 2019.

Performance Measure		Baseline 2016/17	Target 2018/19	Notes
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)[14]	Total	66%	TBC in Q2[15]	Q
	Maaori	61%		
	Pacific	59%		
	Other	73%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	49%	70%[16]	Q
	Maaori	48%	70%	
	Pacific	55%	70%	
	Asian	48%	70%	
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	58%	70%[17]	SLMc Q
	Maaori	54%	70%	
	Pacific	63%	70%	
	Asian	61%	70%	
Oral Health Services[18]				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	84%	≥95%	SLMc C
	Maaori	74%		
	Pacific	85%		
	Asian	87%[19]		
	Other	90%		
Percentage of enrolled children Caries free at age 5 years	Total	49%	51%	Q
	Maaori	38%		
	Pacific	30%		
	Asian	56%[20]		
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Total	0.96	0.81	Q
	Maaori	1.29		
	Pacific	1.42		
	Asian	0.72[21]		
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	72.1%	>85%	C
Diagnostics				
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	95%	95%	T
	MRI	80%	90%	
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	97%	90%	T
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	63%	70%	T
Ambulatory Sensitive Hospitalisations				
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population	Total	6,835[22]	6,630[23]	SLM Q
	Maaori	6,583	6,386	
	Pacific	11,189	10,853	

[14] 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.
[15] The previous target for this measure was 69%. Due to a change to using Health Safe as the data source for this measure which captures a greater proportion of patients than the previously used data source (CCDM), this target is in the process of being raised. The new target will be confirmed in Quarter 2 2018/19.
[16] The 2017/18 SLM Improvement Plan targeted a 5% relative increase from baseline for this measure, however due to the 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.
[17] The 2018/19 SLM Improvement Plan targets a 5% relative increase from baseline for this measure, however due to the 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.
[18] Baseline data is based on the calendar year (to 31 December 2017), except for adolescent measure which is Q4 2016/17.
[19] Baseline data for Asian children is at 2015/2016 as updated baseline data is not yet available.
[20] Baseline data for Asian children is at 2015/2016 as updated baseline data is not yet available
[21] Baseline data for Asian children is at 2015/2016 as updated baseline data is not yet available.
[22] Baseline data is at December 2017 to align with the 2018/19 Metro Auckland SLM Improvement Plan.
[23] 2018/19 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

Performance Measure		Baseline 2016/17	Target 2018/19	Notes
Rheumatic Fever				
Acute rheumatic fever first hospitalisations rates per 100,000 population	Total	7.0[24]	≤4.5	Q
	Maaori	13.1		
	Pacific	23.2		
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	1.06[25]	0.40	Q
	Maaori	2.38		
Pharmacy				
Number of prescription items subsidised	Total	7,334,818[26]	N/A[27]	V

2.3 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			Baseline 2016/17	Target 2018/19	Notes
Mental Health					
Percentage of population who access mental health services	Age 0-19 years	Total	3.9%	3.15%	C
		Maaori	5.8%	4.45%	
	Age 20-64 years	Total	3.8%	3.15%	
		Maaori	8.6%	7.75%	
	Age 65+ years	Total	2.4%	2.60%	
		Maaori	2.9%	2.60%	
Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years	Mental Health (Hospital Care Arm)	3 weeks	74%	80%	T
		8 weeks	95%	95%	
	Addictions (Hospital Care Arm and NGO	3 weeks	96%	80%	
		8 weeks	99%	95%	
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[28]		Total	76.1%	90%	T

[24] Baseline data Q1 2016/17.
[25] Baseline data Q3 2016/17.
[26] Baseline data is at 2015/2016 as updated baseline data is not yet available.
[27] Measure is demand driven – not appropriate to set target.
[28] Source: www.mhakpi.health.nz. CM Health is in the process of 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.

Performance Measure		Baseline 2016/17	Target 2018/19	Notes
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 community treatment orders	Total	98.1	N/A	T
	Maaori	406.7	366[29]	
Elective Services				
Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	Total	107%[30] 21,746	100% 20,930	V
Elective Services Standardised Intervention Rates (SIRs) per 10,000 population	Major Joints	24.18	21	C
	Cardiac Surgery	5.79	6.5	
	Cataracts	38.85	27	
	Coronary angiography	28.57	34.7	
Acute Services				
Readmissions – acute readmissions to hospital[31]	0-3 days	2.4%[32]	≤2.3%	V
	0-28 days	10.8%	≤10.7%	
Acute Inpatient Average Length of Stay	Acute LOS	2.64 days	2.3 days	Q
	Elective LOS	1.61 days	1.50 days	
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		92%	95%	
Cardiac Services				
Percentage of high risk patients who receive an angiogram within 3 days of admission	Total	73%	>70%	T
	Maaori	61%		
	Pacific	59%		
	Other	76%		
Stroke Services				
Percentage of potentially eligible stroke patients thrombolysed		11%	10%	C
Quality and patient safety				
Percentage of admissions affected by four or more triggers[33]		1.3%[34]	N/A	Q
Rate of falls with major harm per 1000 bed days		0.05[35]	0.00	Q
Percentage of inpatients (aged 75+) assessed for risk of falling		93%	90%	Q
Rate of S. aureus bacteraemia (SAB) per 1000 bed days		0.02[36]	0.00	Q
Compliance with good hand hygiene practice		84%	80%	Q
System Level Measures				
Acute hospital bed days per capita[37]	Maaori	678[38]	658[39]	SLM
	Pacific	741	719[40]	Q

[29] The target is to reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year. The target set represents a 10% reduction.
[30] Baseline data based on previous Electives health target of an increase in discharge volumes by 4,000 per year. 2018/19 target to be confirmed by the Ministry of Healtharly De13
[31] Note that the 2017/18 Metro Auckland SLM Improvement Plan includes a developmental contributory measure for acute readmission rates in 28 days. Methodology for this rate is currently in progress.
[32] Baseline data for this measure is at June 2018.
[33] Note that this measure replaced the previously reported 'number of adverse health care events'. This measure is from the Copeland Risk Adjusted Barometer (CRAB) tool which provides a risk adjusted view of complications, patient harm and mortality of inpatient admissions. An algorithm is applied to coded discharge data equivalent to the Trigger Tool.
[34] Baseline is year to June 2017.
[35] Baseline is year to June 2017.
[36] Baseline is year to June 2017.
[37] In line with the equity focus of the 2018/19 planning guidance, the targets for reducing bed days in the 2018/19 SLM Plan are for Maaori and Pacific populations specifically.
[38] Baseline data is at December 2017 to align with the 2018/19 Metro Auckland SLM Improvement Plan.
[39] 2018/19 targets represent a 3% reduction from baseline per the 2018/19Metro Auckland SLM Improvement Plan.
[40] 2018/19 targets represent a 3% reduction from baseline per the 2018/19 Metro Auckland SLM Improvement Plan.

2.4 Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including 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		Baseline 2016/17	Target 2018/19	Notes
Age Related Residential Care (ARRC)				
Percentage of people in ARRC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of previous assessment		88.4%	95%	T
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		53.3%	90%	T
Home Based and Community Support				
Percentage of older people who have received long-term 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.		95%[41]	95%	Q
Assessment, Treatment and Rehabilitation Services				
Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4 – 6 for assessment urgency[42]	Aged 65+	TBC[43]	N/A[44]	V
Number of older people that have received in-home strength and balance retraining services	Aged 65+	239[45]	1,118	V
Number of older people that have received community / group strength and balance retraining services	Aged 65+	N/A	1,400	V
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	1,135[46]	2,325 places	
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 50-74	N/A[47]	600	V
	Aged 75-84	405[48]	300	
	Aged 85+	315	300	
Palliative care[49]				
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District		36[50]	866[51]	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals		141[52]	866[53]	V

[41] New measure introduced in 2017/18 therefore baseline data not available.
[42] New measure introduced in 2018/19.
[43] As this is a new measure for 2018/19, the baseline will be established during the 2018/19 year.
[44] 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 rates., there is no target for this measure in 2018/19.
[45] Baseline data is at Quarter 4 2017/18 as this was a new measure introduced in 2017/18.
[46] Baseline data is at Quarter 4 2017/18 as this was a new measure introduced in 2017/18.
[47] Due to the demographic profile of the Counties Manukau Region, we have extended the age-range from 65-74 (range used in 2017/18) to 50-74. Baseline data for this group is therefore not available.
[48] Baseline data is at Quarter 4 2017/18 as this was a new measure introduced in 2017/18.
[49] The following measures are part of the regional Better Palliative Care Outcomes Service which has been implemented and delivered in the Auckland Region from 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.
[50] This measure was introduced in 2017/18, therefore baseline data is at Quarter 4 2017/18.
[51] 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.
[52] This measure was introduced in 2017/18, therefore baseline data is at Quarter 4 2017/18.
[53] 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.

3.0 Financial Performance

3.1 Introduction

CM Health is fully committed to achieving the Government's priorities, despite the increasing fiscal constraints the health sector is facing. Demand on CM Health system is expected to grow at fiscally unsustainable levels unless significant change and related innovations are implemented. We continue to have significant cost pressures with respect to Multi Employer Collective Agreements (MECA) and related wage and salary increases. Capacity pressures associated with unprecedented growth in the demand for clinical services have placed significant strain on current budgets and staff across the system. Despite our commitments to an ambitious savings plan, funding increases have been inadequate to meet overall cost increases and adequately fund capital requirements.

Despite these considerable challenges, we are working on a financial recovery plan with the objective to return our organisation to a breakeven position and refocus resources to those functions that deliver evidence based care to our communities. As part of developing our financial recovery plan, we are revisiting our investments in context of long term regional planning and exploring other opportunities to do more regionally where there are benefits.

Outer year plans for 2019/20 to 2021/22 reflect a combination of cost efficiency and improvements to models of care, combined with a level of MOH funding correction. These plans are provisional and remain subject to Counties Manukau DHB Board approval and confirmation.

3.2 Forecast Financial Statements

3.2.1 Summary by funding arm

Net Result	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Provider	(16,569)	(24,103)	(44,046)	(40,827)	(39,061)	(37,864)
Governance	(8,687)	(1,375)	(91)	(381)	(71)	277
Funder	12,316	5,675	(9,357)	19,772	22,883	26,054
Eliminations	-	-	-	-	-	-
Operating Surplus	**(12,940)**	**(19,803)**	**(53,494)**	**(21,436)**	**(16,249)**	**(11,533)**
Other Comprehensive Income	64,423	7,842	-	-	-	-
Surplus / (Deficit)	**51,483**	**(11,961)**	**(53,494)**	**(21,436)**	**(16,249)**	**(11,533)**

Note: The 2018/19 MOH funding increase of $66m has been top sliced for Mental Health Ring fence and Inter District Flows. The residual balance has been provisionally allocated to Provider, Governance and Funder based on proportionate net surplus (deficit).

Note: Additional costs relating to NZNO and expired MECAs have been accounted for in the 2017/18, 2018/19 and outer year financials. MoH revenue in relation to NZNO expired MECAs has been included in 2018/19 and outer years as advised by the MoH. To enable the DHB to continue its trajectory to return to a breakeven position in the outer years, an assumption of additional revenue has been included.

3.2.2 Statement of comprehensive income

Net Result	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Revenue						
Ministry of Health	1,423,882	1,486,003	1,563,315	1,672,171	1,759,045	1,850,226
Other Government	28,216	44,336	34,668	34,835	35,004	35,174
Other	38,390	48,317	35,705	35,888	36,072	36,256
Inter DHB and Internal	87,088	96,146	92,255	94,075	95,931	97,825
Total Revenue	**1,577,576**	**1,674,802**	**1,725,943**	**1,836,969**	**1,926,052**	**2,019,481**
Expenses						
Personnel	592,391	627,450	674,598	712,293	751,565	793,111
Outsourced	87,864	90,858	82,106	84,563	87,093	89,700
Clinical Support	110,592	127,786	135,929	138,649	141,422	144,251
Infrastructure	74,205	67,384	78,529	81,007	83,606	86,279
Personal Health[54]	482,520	508,928	511,471	537,046	563,898	592,093
Mental Health	61,585	61,159	65,470	68,746	72,184	75,798
Disability Support	117,984	137,561	146,659	153,994	161,695	169,781
Public Health	3,200	1,317	7,097	7,451	7,823	8,214
Maaori	2,748	1,835	2,331	2,448	2,571	2,699
Operating Costs	**1,533,089**	**1,624,278**	**1,704,190**	**1,786,197**	**1,871,857**	**1,961,926**
Operating Surplus	**44,487**	**50,524**	**21,753**	**50,772**	**54,195**	**57,555**
Depreciation	31,367	32,906	37,955	38,335	38,719	39,106
Capital Charge	18,200	37,421	37,292	33,873	31,725	29,982
Interest	7,860	-	-	-	-	-
Net Surplus	**(12,940)**	**(19,803)**	**(53,494)**	**(21,436)**	**(16,249)**	**(11,533)**
Other Comprehensive Income	64,423	7,842	-	-	-	-
Surplus / (Deficit)	**51,483**	**(11,961)**	**(53,494)**	**(21,436)**	**(16,249)**	**(11,533)**

3.2.3 Funder

Revenue	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Ministry of Health	1,387,577	1,455,632	1,530,143	1,638,999	1,725,873	1,817,054
Other Government	237	237	237	237	237	237
Other	5,058	4,108	173	177	182	187
Inter DHB and Internal	85,024	93,295	90,984	92,804	94,660	96,554
Total	**1,477,896**	**1,553,272**	**1,621,537**	**1,732,217**	**1,820,952**	**1,914,032**
Personal Health	1,146,169	1,210,278	1,268,117	1,331,528	1,398,104	1,468,012
Mental Health	146,909	148,814	159,793	167,783	176,174	184,984
Disability Support	151,720	170,646	178,743	187,681	197,065	206,920
Public Health	3,200	1,317	7,097	7,451	7,823	8,214
Maaori	2,748	1,835	2,331	2,448	2,571	2,699
Governance	14,834	14,707	14,813	15,554	16,332	17,149
Total Expenditure	**1,465,580**	**1,547,597**	**1,630,894**	**1,712,445**	**1,798,069**	**1,887,978**
Net Surplus	**12,316**	**5,675**	**(9,357)**	**19,772**	**22,883**	**26,054**

[54] Pacific Health expenditure of $1.7m is included in the Personal Health budget for 2018/19.

3.2.4 Eliminations

Revenue	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Ministry of Health	(797,543)	(836,797)	(897,866)	(942,760)	(989,898)	(1,039,393)
Other Government	-	-	-	-	-	-
Other	-	-	-	-	-	-
Inter DHB and Internal	-	-	-	-	-	-
Total	**(797,543)**	**(836,797)**	**(897,866)**	**(942,760)**	**(989,898)**	**(1,039,393)**
Personal Health	(663,649)	(701,350)	(756,646)	(794,482)	(834,206)	(875,919)
Mental Health	(85,324)	(87,655)	(94,323)	(99,037)	(103,990)	(109,186)
Disability Support	(33,736)	(33,085)	(32,084)	(33,687)	(35,370)	(37,139)
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	(14,834)	(14,707)	(14,813)	(15,554)	(16,332)	(17,149)
Total Expenditure	**(797,543)**	**(836,797)**	**(897,866)**	**(942,760)**	**(989,898)**	**(1,039,393)**
Net Surplus	-	-	-	-	-	-

3.2.5 Provider

Revenue	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Ministry of Health	819,014	852,461	916,225	960,378	1,006,738	1,055,416
Other Government	27,979	41,456	33,431	33,598	33,767	33,937
Other	32,153	40,975	35,143	35,320	35,497	35,674
Inter DHB and Internal	2,064	2,519	1,271	1,271	1,271	1,271
Total	**881,210**	**937,411**	**986,070**	**1,030,567**	**1,077,273**	**1,126,298**
Personnel	580,571	614,925	663,745	700,542	739,483	780,702
Outsourced	83,311	86,088	80,903	83,330	85,830	88,405
Clinical Support	110,308	127,759	135,669	138,382	141,148	143,970
Infrastructure	66,162	62,415	74,552	76,932	79,429	81,997
Operating Costs	**840,352**	**891,187**	**954,869**	**999,186**	**1,045,890**	**1,095,074**
Operating Surplus	**40,858**	**46,224**	**31,201**	**31,381**	**31,383**	**31,224**
Depreciation	31,367	32,906	37,955	38,335	38,719	39,106
Capital Charge	18,200	37,421	37,292	33,873	31,725	29,982
Interest	7,860	-	-	-	-	-
Net Surplus	**(16,569)**	**(24,103)**	**(44,046)**	**(40,827)**	**(39,061)**	**(37,864)**
Other Comprehensive Income	64,423	7,842	-	-	-	-
Total Comprehensive Income	**47,854**	**(16,261)**	**(44,046)**	**(40,827)**	**(39,061)**	**(37,864)**

3.2.6 Governance

Revenue	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Ministry of Health	14,834	14,707	14,813	15,554	16,332	17,149
Other Government	0	2,643	1,000	1,000	1,000	1,000
Other	1,179	3,234	389	391	393	395
Inter DHB and Internal	-	332	-	-	-	-
Total	**16,013**	**20,916**	**16,202**	**16,945**	**17,725**	**18,544**
Personnel	11,820	12,525	10,853	11,751	12,082	12,409
Outsourced	4,553	4,770	1,203	1,233	1,263	1,295
Clinical Support	284	27	260	267	274	281
Infrastructure	8,043	4,969	3,977	4,075	4,177	4,282
Total Expenditure	**24,700**	**22,291**	**16,293**	**17,326**	**17,796**	**18,267**
Net Surplus	**(8,687)**	**(1,375)**	**(91)**	**(381)**	**(71)**	**277**

3.2.7 Balance sheet

	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Current Assets						
Cash and Bank	20,887	31,291	(52,278)	(76,093)	(89,210)	(94,157)
Trust Funds	898	2,811	833	833	833	833
Debtors	49,296	57,087	65,646	65,646	65,646	65,647
Inventory	7,484	8,527	8,590	8,590	8,590	8,590
Assets Held for Sale	33,743	5,320	5,320	5,320	-	-
Current Assets Total	**112,308**	**105,036**	**28,111**	**4,296**	**(14,141)**	**(19,087)**
Non-Current Assets	**764,335**	**788,764**	**812,113**	**829,500**	**839,177**	**832,521**
Total Assets	**876,643**	**893,800**	**840,224**	**833,796**	**825,036**	**813,434**
Current Liabilities						
Creditors	112,743	113,179	96,114	96,114	96,114	96,114
Loans	-	-	-	-	-	-
Employee Provisions	115,177	130,063	132,863	132,863	132,863	132,863
Total Current Liabilities	**227,920**	**243,242**	**228,977**	**228,977**	**228,977**	**228,977**
Working Capital	**(115,612)**	**(138,206)**	**(200,866)**	**(224,681)**	**(243,118)**	**(248,064)**
Net Funds Employed	**648,723**	**650,558**	**611,247**	**604,819**	**596,059**	**584,457**
Non-Current Liabilities						
Employee Provision	18,717	22,948	22,948	22,948	22,948	22,948
Term Loans	-	-	-	-	-	-
Restricted Funds	-	-	-	-	-	-
Other	931	1,155	1,155	1,155	1,155	1,155
Total Non-Current Liabilities	**19,648**	**24,103**	**24,103**	**24,103**	**24,103**	**24,103**
Crown Equity	**629,075**	**626,455**	**587,144**	**580,716**	**571,956**	**560,353**
Net Funds Employed	**629,075**	**626,455**	**587,144**	**580,716**	**571,956**	**560,354**

3.2.8 Movement of equity

	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Total Equity at beginning of Period	**285,486**	**629,075**	**626,455**	**587,144**	**580,716**	**571,956**
Surplus / (Deficit) for period	(12,940)	(19,803)	(53,494)	(21,436)	(16,249)	(11,533)
Crown Equity injection	292,500	7,846	16,580	15,424	7,906	344
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	64,423	7,842	-	-	-	-
Movement in restricted funds	25	1,914	(1,978)	3	2	5
Total Equity at beginning of Period	**629,075**	**626,455**	**587,144**	**580,716**	**571,956**	**560,353**

3.2.9 Cash flows

	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Operating Activities						
Crown Revenue	1,428,809	1,617,290	1,681,679	1,801,081	1,889,980	1,983,225
Other	154,055	46,110	35,005	35,184	35,364	35,544
Interest rec.	2,076	2,207	700	704	708	712
Suppliers	(935,076)	(989,863)	(1,045,762)	(1,073,901)	(1,120,290)	(1,168,810)
Employees	(591,931)	(616,704)	(673,777)	(712,293)	(751,565)	(793,111)
Interest paid	(9,518)	(12)	-	-	-	-
Capital charge	(18,200)	(37,096)	(37,292)	(33,873)	(31,725)	(29,982)
GST (Net)	(1,114)	2,046	(957)	-	-	-
Net cash from Operations	**29,101**	**23,978**	**(40,404)**	**16,902**	**22,472**	**27,578**
Investing activities						
Sale of Fixed assets	9,987	28,423	-	-	5,320	-
Purchase of Fixed Assets	(45,455)	(46,036)	(57,931)	(51,622)	(45,396)	(29,450)
Investments and Restricted Trust Funds	(4,130)	(3,388)	(1,395)	(4,100)	(3,000)	(3,000)
Net cash from Investing	**(39,598)**	**(21,001)**	**(59,326)**	**(55,722)**	**(43,076)**	**(32,450)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity – Capital	(419)	7,427	16,161	15,005	7,487	(75)
Net appropriation to/from Trust funds	25	-	-	-	-	-
Net cash from Financing	**(394)**	**7,427**	**16,161**	**15,005**	**7,487**	**(75)**
Net increase / (decrease)	(10,891)	10,404	(83,569)	(23,815)	(13,117)	(4,947)
Opening cash	31,778	20,887	31,291	(52,278)	(76,093)	(89,210)
Closing cash	**20,887**	**31,291**	**(52,278)**	**(76,093)**	**(89,210)**	**(94,157)**

3.2.10 Capital expenditure

	2016/17 Actual Audited $000	2017/18 Actual Unaudited $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Baseline Capital	27,387	12,554	35,026	35,152	28,719	26,626
Strategic Capital	18,068	33,482	22,905	16,470	16,677	2,824
Total	**45,455**	**46,036**	**57,931**	**51,622**	**45,396**	**29,450**

3.3 Accounting Policies

The forecast financial statements have been prepared on the basis of the significant accounting policies, which are expected to be used in the future for reporting historical financial statements. The significant accounting policies used in the preparation of these forecast financial statements included in this Annual Plan are summarised below. A full description of accounting policies used by CM Health for financial reporting is provided in the Annual Reports that are published on the CM Health website: mailto:https://countiesmanukau.health.nz

3.3.1 Reporting entity

CM Health is a Crown entity as defined by the Crown Entities Act (2004) and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown. CM Health has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes. CM Health's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions e.g. laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.

The forecast consolidated financial statements of CM Health comprise our interest in associates and jointly controlled entities. The CM Health group consists of the parent, CM Health and its Joint ventures healthAlliance N.Z. Limited (25 percent); New Zealand Health Innovation Hub Management Limited (25 percent) and NZ Health Partnerships Limited (5 percent). It has an Associate investment in Northern Regional Alliance Limited (33.3 percent). The DHB's associates and joint venture are incorporated and domiciled in New Zealand.

3.3.2 Basis of preparation

The forecast financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

3.3.3 Statement of compliance

The forecast financial statements of the DHB 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 includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). These forecast financial statements have been prepared in accordance with *PBE-FRS 42: Prospective Financial Statements*. These forecast financial statements comply with Public Sector PBE accounting standards. The forecast financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

3.3.4 Presentation currency and rounding

The consolidated forecast financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

3.3.5 Forecast information

In preparation of the forecast financial statements, the DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results. The forecast financial statements for the year ended 30 June 2018 incorporate the result currently being audited.

The accounting policies applied in the projected financial statements are set out in section 3.6.

3.4 Significant Assumptions

3.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2018/19 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing un-utilised/approved debt facilities. To ensure we achieve a breakeven financial position where cost growth is higher than forecast revenue, CM Health will cap the level of allowable and fundable growth within hospital care and primary and community care.

Where previously there appeared to be significant opportunity to continue to improve efficiencies and limit the cost impact of growth, the current outlook provides much more limited opportunities in these historical areas.

In response, CM Health has taken a whole of system approach to value creation, quality and safety, productivity enhancement and efficiency. This approach includes consistent focus on clinical leadership, process realignment, integration and new models of care.

3.4.2 Personnel costs

Despite the international economic position, the anticipated level of clinical wage settlements will continue to be an on-going challenge in relation to the mismatch of health worker wage/salary expectations and affordability. The annualised on-going cost of settlement is 3 percent – 5 percent[55] due to automatic on-going step functions, on-cost implications and increasing entitlements. Combined, these costs are greater than the Crown Funding growth and need to be absorbed by internal efficiencies and other initiative savings.

We continue to manage management and administration FTEs. Despite this, we have prioritised personnel costs to support acceleration of essential health system integration, whole of system programmes and related activities. This requires commitment to project, programme, analytical and change management resource to be successful.

3.4.3 Third party and shared services provision

Our focus for 2018/19 continues to be alignment of localities development and related primary care/community services. The form that investment will take is still evolving and there is an expectation of increased third party participation and provision of public services integrated with core/essential CM Health services. Regional service planning and the Northern Region Long Term Investment Plan priorities will inform this.

Capital investment constraints and increasing health target expectations are likely to require a closer look at third party and shared regional capacity expansion. This will include a strong direction regarding increased provision of shared services, through healthAlliance with heightened reliance around realisation of tangible savings.

3.4.4 Supplies

CM Health is working very closely with and contributing to, the national procurement and supply chain efficiency objectives. Regional efficiencies through shared services provided by healthAlliance will be included in our living with our means projects.

3.4.5 Services by other DHBs and regional providers

There is a significant commitment to regional cooperation and alignment of service provision to reduce wastage from unnecessary variation and better leverage our collective expertise. CM Health contributes to the regional Service Review Group, Clinical Networks and range of other forums to support effective service delivery across the metropolitan Auckland region.

The continuing commitment (albeit constrained) to investment in priority initiatives aligned with the Northern Region Health Plan and Long Term Investment Plan; including those focused on slowing the growth of hospital services and the improving quality and consistency of care.

[55] As at 30 June 2018, MECA negotiations with the NZNO, and potentially other employee group negotiations over 2018/19, remain unresolved and may change personnel cost assumptions.

3.4.6 Other primary and community care contracts

Historically there has been Mental Health under-spends which are essentially timing issues rather than permanent under-spends. These benefits have been approved to fund urgently needed mental health facilities planned for 2018/19.

Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CM Health expects to offset any downside by further opportunities or enhancement of existing contracts.

3.4.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally (refer 3.4.8) and is essential for health system business continuity and effective implementation of integration models of care between secondary and primary/community care settings. The capital commitment for the regional DHBs collectively is significant. This investment will target IS infrastructure resilience that will provide a sound foundation for shared clinical and business information systems. Refer to section 2.3 of the Annual Plan for an outline of regional IS investments and local innovations. The net financial impacts will include both capital and operational costs.

3.4.8 Capital investment

CM Health's Long Term Investment Plan supports the strategic priority to move away from reliance on physical brick and mortar solutions to manage capacity growth and adopt whole of system solutions with a focus on community based service expansion. The realities of high hospital service demand now means we need to augment this strategic priority with a regional approach to investments to address urgent inpatient bed capacity and related hospital services and site investments. Development of the Northern Regional Long Term Investment Plan (NRLTIP) is evaluating where and when potential new hospital sites will be required to manage the region's significant future growth. Regional service planning continues to seek opportunities to leverage regional capacity as a means of meeting short to medium term demand for health services.

CM Health's changing financial position has requires a reassessment of local capital investment prioritisation. Figure 1 below illustrates the likely cash-flow profile for major capital projects approved or currently within the pathway for approval. This includes a new 76-bed acute mental health facility approved in the 2015/16 year with construction and commissioning continuing through 2018/19.

Figure 2 below outlines likely major capital (projects greater than $10m) investment projects, which are dependent on confirmation of Northern Region Long Term Investment Plan priorities, related service change reviews in progress and confirmation of affordability. These investments reflect a mix of repair for existing facilities, expansion to meet service capacity demands and model of care changes for future sustainability.

Once the abovementioned evaluation is complete Counties Manukau District Health Board will submit indicative and detailed business cases to the Northern Region governance groups, then onto the MOH and Treasury. Many capital investments require regional service review processes to ensure the most effective allocation of resources and quality of service. Local and regional Information and Communication Technology investments are planned regionally through the Regional Information Services Strategic Plan.

Figure 1: Major capital investment projects – approved

Approved Major Capital Projects	Project Status as at 30 June 2018	2018/19 $000	2019/20 $000	2020/21 $000	2021/22 $000
Acute Mental Health Unit	Construction	15,797	-	-	-
Ko Awatea II	Commissioning	1,452	-	-	-
Healthy Together Technology	Planning	3,800	3,000	3,000	3,000
MRI (addition and relocation) (Note1)	Construction	6,662	-	-	-
Scott Building Recladding	Construction	4,958	13,840	7,907	344
Histology Expansion	Planning	1,410	357		
Chilled Water	Construction	2,632	-	-	-
Interventional X Ray (Note1)	Procurement	1,534	-	-	-
Kidz First Stage 1 (Note 2)	Procurement	401			
Total		**38,646**	**17,197**	**10,907**	**3,344**

Note 1: Includes equipment obtained via operating lease.
Note 2: Charitable funding for equipment only, refer to the table on the following page for Kidz First Stage 2 unapproved.

Figure 2: Major capital investment projects – unapproved

Major Facilities Project	Planned Funding Source	2018/19 $000	Year 2-5 $000	Year 6-10 $000	Total $000
Immediate Service Capacity					
Scott Dialysis & Catheter Laboratory	CM Health	730	2,630	8,770	14,610
Gastroenterology Expansion	CM Health	440	3,960		4,400
Kidz First Stage 2	Charitable	1,500	1,000		2,500
Decongest Middlemore					
Interim Manukau Theatres	Crown	200	28,300	-	28,500
Manukau Radiology Hub Phase 1	Crown	400	21,000	-	21,400
Immediate Remediation					
Manukau Power Resilience	CM Health	1,500	2,500	-	4,000
Specialised Rehabilitation Centre	Crown	1,000	82,720	4,490	88,210
Manukau Infrastructure	Crown	500	26,500	3,000	30,000
Kidz First Recladding	Crown	-	17,100	900	18,000
McIndoe Building Recladding	Crown	-	11,050	5,950	17,000
Manukau Elective Surgical Hospital Recladding	Crown	-	12,350	650	13,000
Core Infrastructure Upgrade	Crown	-	14,000	6,000	20,000
Galbraith Replacement					
Critical Infrastructure	Crown	-	400	19,600	20,000
Radiology Harley Gray	Crown	300	16,000	-	16,300
New Women's Health Clinical Building	Crown	-	99,100	10,900	110,000
Harley Gray Stage 2	Crown	-	76,000	4,000	80,000
Elective Surgery Centre	Crown	-	21,600	218,400	240,000
Community Development Stage 1					
Community Hubs (3)	Crown	-	36,500	1,000	37,500
Manukau Community Dialysis	Crown	-	5,400	600	6,000
Long Term Demand Manukau					
Manukau Support Services	Crown	-	15,900	15,900	31,800
Manukau Outpatients	Crown	-	25,000	3,600	28,600
Manukau Radiology Hub Phase 2	Crown	-	-	10,500	10,500
Medium Term Demand Middlemore					
Single Wing Ward Block	Crown	-	36,000	84,000	120,000
Carparking					
Middlemore Carparking	Crown	-	2,050	18,450	20,500
Community Development Stage 2					
Franklin Health Hub	Crown	-	5,400	48,600	54,000
Botany Hub / Sub Acute Capacity	Crown	-	3,000	27,000	30,000
Papakura Community Maternity Unit	Crown	-	3,000	17,000	20,000
Mangere Community Hub	Crown	-	2,000	18,000	20,000
New Acute Hospital					
Southern site land acquisition	Crown		40,000	-	-
New Southern Hospital Stage 1	Crown	-	240,000	560,000	800,000
New Southern Hospital Stage 2	Crown	-	5,000	495,000	500,000
Sub Totals		**6,570**	**866,710**	**1,573,540**	**2,406,820**

3.4.9 Capital investment funding

Capital investment will be funded from a number of sources including working capital, crown funding and operating surpluses.

3.4.10 Banking

CM Health operates under no banking covenant; all previous crown debt has now been converted to Equity. The Counties Manukau District Health Board maintains a working capital facility with New Zealand Health Partnerships via the Bank of New Zealand, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 3: Banking facilities

Facilities	Available Facility at 1 July 2018 $000,000
NZ Health Partnerships (working capital)	$75.5
Westpac (lease facility)	$15.0

3.4.11 Property, plant and equipment

CM Health revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CM Health land and buildings are revalued every three years or where there is a material change. The last revaluation occurred in June 2017 on an 'Optimised Depreciated Replacement Costs' basis.

There is recognition of the rising burden of clinical equipment replacement and this has accelerated CM Health's commitment to an Enterprise Asset Management System, with continued roll out in 2018/19.

3.5 Additional Information and Explanations

3.5.1 Disposal of land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, CM Health will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. CM Health will comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any processes related to the Crown's good governance obligations in relation to Maaori sites of significance.

3.6 Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by Counties Manukau DHB. Counties Manukau DHB does not have any subsidiaries to consolidate.

Investments in Associates and Jointly Ventures

Associates are those entities in which Counties Manukau DHB has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when Counties Manukau DHB holds between 5-33 percent of the voting power of another entity. Joint ventures are those entities over whose activities Counties Manukau DHB 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.

MOH Revenue

Funding is provided by the 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 Counties Manukau DHB 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 revenue

Rental revenue 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 Counties Manukau DHB region is domiciled outside of Counties Manukau. The MOH credits Counties Manukau DHB 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 Counties Manukau DHB.

Interest revenue

Interest revenue 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 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 capitalised on qualifying assets in accordance with Counties Manukau DHB's policy. All other costs are treated as an expense in the financial year in which they are 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 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:

Figure 4: Depreciation rates of assets

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	10 - 100 years	1% - 20%
Electrical Services	10 - 15 years	6% - 20%
Other Services	15 - 25 years	4% - 20%
Fit out	5 - 10 years	10% - 20%
Infrastructure	20-100 years	1% - 50%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	3 - 25 years	6% - 100%
Information Technology	3 - 5 years	12.5% - 100%
Vehicles	3 - 6 years	8% -100%
Other Equipment	3 - 25 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.

FPSC Rights

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs. The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by NZ Health Partnerships, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services. The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZ Health Partnerships through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely. As the FPSC 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 percent – 50 percent)

Impairment of Property, Plant & Equipment and Intangible Assets

Counties Manukau DHB 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 re valued 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, 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 scheme

Counties Manukau DHB 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.

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 forecast 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 IRD. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for the forecast financial statement purposes and to be consistent with the presentation basis of the other primary forecast 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.

Cost Allocation

Counties Manukau DHB 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 forecast 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.

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; and
- 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

Retirement and long service leave provisions are subject to a number of estimates and uncertainties surrounding the timing of retirement and the uptake.

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 Counties Manukau DHB makes payments to the service providers on behalf of the DHBs receiving services. These DHBs will then reimburse Counties Manukau DHB for the costs of the services provided in their districts. Where Counties Manukau DHB 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 the Counties Manukau DHB forecast financial statements.