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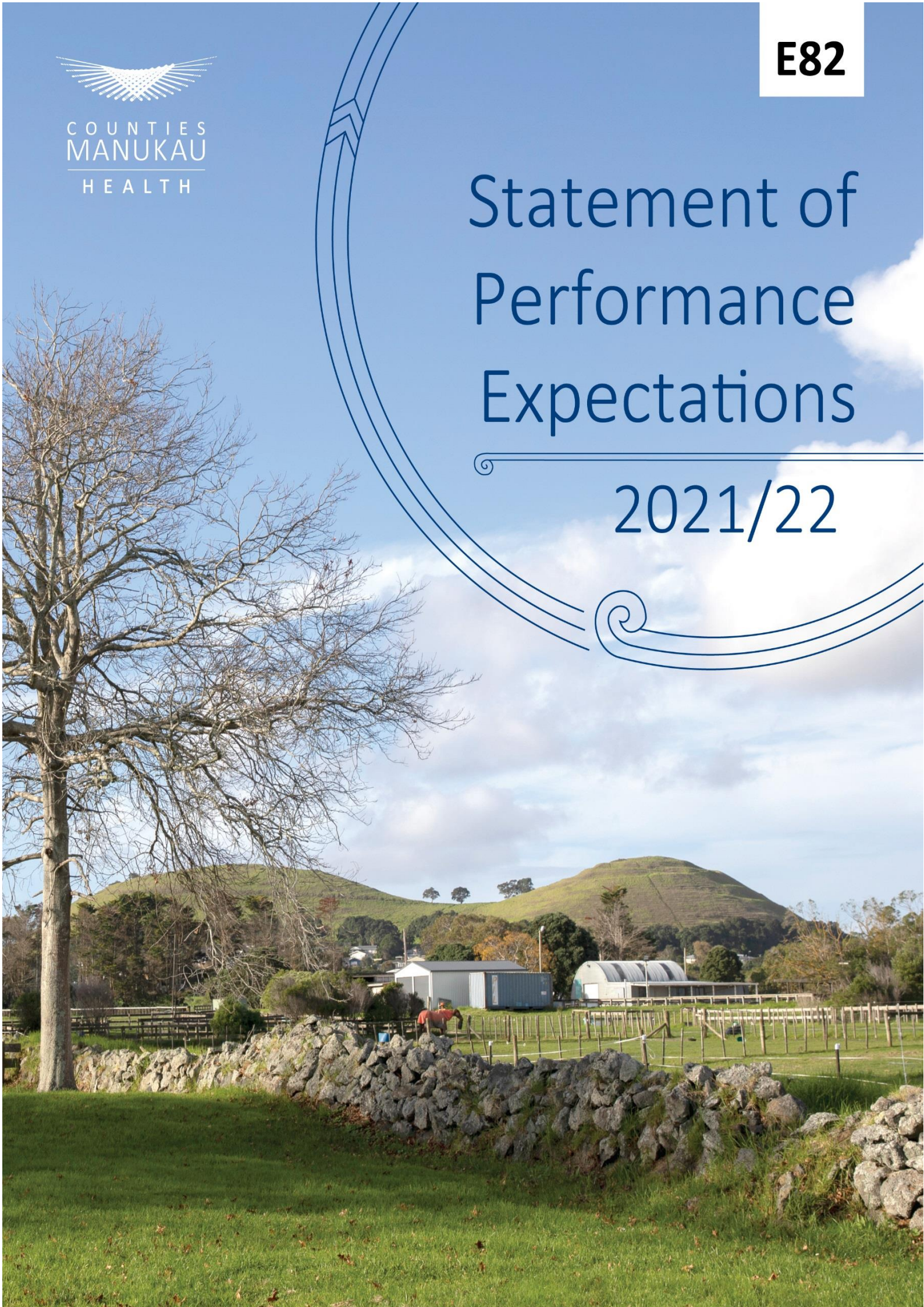
COUNTIES MANUKAU HEALTH

Statement of Performance Expectations

2021/22



Front Cover photograph: Mangere Mountain – Te Pane o Mataoho

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.

Signed on behalf of the Counties Manukau District Health Board

Vui Mark Gosche
Chair
Counties Manukau District Health Board

Tipa Mahuta
Deputy Chair
Counties Manukau District Health Board

Fepulea'i Margie Apa
Chief Executive
Counties Manukau District Health Board

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1.1 Statement of Performance Expectations

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 the 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 2021/22 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2021/22 Metro Auckland SLM Improvement Plan)	**T**	Timeliness
		Q	Quality
		C	Coverage

1.2 Note on the baselines and targets contained in the Statement of Performance Expectations

Unless otherwise indicated, CM Health's actual performance as at Quarter 4 2019/20 year has been used as the baseline measurement for CM Health's Statement of Performance Expectations. CM Health is unable to use Quarter 4 2020/21 performance as the baseline as this data will only be available after the SPE publication date.

Footnotes have been used throughout the document to identify those measures for which a different baseline has been used. This includes those measures reported in Quarters 1 and 3 only in which case the Quarter 3 2019/20 performance has been used as the baseline, and for Metro Auckland System Level Measures Improvement (SLM) Plan baselines.

Many of CM Health's performance targets are set by the Ministry of Health or through the Metro Auckland SLM Improvement Plan and represent the minimum level of performance that CM Health is aiming to achieve. In some cases, CM Health may have achieved results in Quarter 4 2019/20 that are higher than the stated target

for 2021/22. This does not indicate that CM Health intends to reduce the level of performance in 2021/22 but does show that CM Health exceeded the minimum level of performance in 2019/20.

1.3 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 the DHB's **Healthy Communities** strategic objective that is focused on primary (ill-health) prevention across the life course.

Performance Measure		Baseline 2019/20	Target 2021/22	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	88%[1]	90%	C
	Maaori	88%		
	Pacific	90%		
	Asian	86%		
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	94%	90%	C
	Maaori	94%		
Percentage of babies living in smokefree homes at six weeks postnatal	Total	44%[2]	45.6%[3]	SLMc
	Maaori	22%		
	Pacific	35%		
Percentage of babies fully or exclusively breastfed at 3 months	Total	49%	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	100%	95%	Q
	Maaori	100%		
	Pacific	100%		

[1] Baseline was impacted by COVID-19.
[2] Baseline for 2019/20 is from the period January 2020 – June 2020.
[3] The target represents a 2% relative increase from baseline as per the 2021/22 Metro Auckland SLM Improvement Plan.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
	Other	100%		
Number of eligible adult service users engaged in the Green Prescription programme each year	Total	2,921[4]	4,000	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	92%	95%	C
	Maaori	84%		
	Pacific	92%		
	Asian	98%		
Proportion of eligible boys and girls fully immunised with HPV vaccine	Total	60%[5]	75%	C
	Maaori	57%		
	Pacific	59%		
	Asian	73%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	53%[6]	75%	C
	Maaori	43%		
	Pacific	65%		
	Asian	54%		
Health Screening				
Proportion of women aged 50-69 years who have had a breast screen in the last 24 months	Total	70%[7]	70%	C
	Maaori	65%		
	Pacific	81%		
	Other	69%		
Proportion of women aged 25-69 years who have had a cervical smear in the last three years	Total	65%	80%	C
	Maaori	56%		
	Pacific	65%		
	Asian	61%		

[4] Data reported six-monthly. Baseline as at March 2019 (Q3).
[5] Results are reported annually in Q4 of each year. 2019/20 baseline are for the period 1 July 2019 to 30 June 2020.
[6] 2019/20 results are for the period 1 March 2019 to 30 September 2019.
[7] Baseline is as at Q3 – two years ending 31 March 2020, consistent to MOH Q4 reporting requirements.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
	Other	73%		
Percentage of four year olds receiving a B4 School Check	Total	87%	90%	C
	Maaori	82%		
	Pacific	84%		
	Other	91%		
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	93%[9]	95%	C
	Maaori	96%		
	Pacific	95%		
	Asian	82%		

1.4 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 the DHB's **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 2019/20	Target 2021/22	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	98%	90%	C
	Maaori	92%		
	Pacific	117%[10]		
	Asian	95%		

[8] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide
[9] Baselines are for the calendar year 1 January – 31 December 2020.
[10] The Census data is used for population denominators. As the Census has historically undercounted the Pacific population, the percentage is greater than 100%.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Percentage of newborns enrolled in general practice by 3 months	Total	90%[11]	85%	C
	Maaori	69%		
	Pacific	86%		
	Other	102%		
Amenable mortality rate per 100,000 population[12]	Total	99.8[13]	98.1%[14]	SLM Q
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	90%	90%	C
	Maaori	87%		
	Pacific	89%		
	Other	91%		
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)[15] and no inequity	Total	52%	60%	Q
	Maaori	43%		
	Pacific	44%		
	Other	62%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	53%	70%[16]	Q
	Maaori	52%	70%	
	Pacific	57%	70%	
	Asian	51%	70%	
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	58%	70%	SLMc Q
	Maaori	53%	70%	
	Pacific	63%	70%	
	Asian	62%	70%	

[11] Baselines are as at June 2020 for the full financial year.
[12] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[13] Result is at 2017, this is a draft result at time of publishing.
[14] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2022, as per the 2021/22 Metro Auckland SLM Improvement Plan. The 2021/22 Metro Auckland SLM Improvement Plan also includes a separate target for Maaori and Pacific peoples of a 2% relative reduction by 30 June 2022.
[15] 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.
[16] 2019/20 SLM Improvement plan targeted a 5% relative increase from baseline for this measure, however due to persistent inequities in CVD management for Maaori, CM Health has chosen to adopt the Metro Auckland Clinical Governance Forum target of 70% for all ethnic groups.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Oral Health Services				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	89%	≥95%	SLMc C
	Maaori	72%		
	Pacific	91%		
	Asian	N/A[17]		
	Other	96%		
Percentage of enrolled children caries free at age 5 years	Total	43%	49%[18]	Q
	Maaori	38%		
	Pacific	28%		
	Other	57%		
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Total	0.82	0.74[19]	Q
	Maaori	0.96		
	Pacific	1.28		
	Other	0.62		
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Total	71%	≥85%	C
Diagnostics				
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	63%	95%	T
	MRI	53%	90%	T
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	100%[20]	90%	T

[17] The Asian data was not available in the Ministry of Health data set provided for Q3 19/20.
[18] The 2020/21 Ministry of Health target for the percentage of children caries free at age 5 (49%) is lower than the 2019/20 target (51%). Awaiting confirmation MoH
[19] The 2020/21 Ministry of Health target for mean DMFT score for Year 8 children (0.74) is lower than the 19/20 target (0.75). Awaiting confirmation MoH
[20] Actual baseline for P1 within 14 days is 99.66% and thus rounded up to 100%.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	67%	70%	T
Ambulatory Sensitive Hospitalisations				
Ambulatory sensitive hospitalisation (ASH) rate in children aged 0-4 years per 100,000 population	Total	5,324[21]	6,062	SLM
	Maaori	5,134	5,421	Q
	Pacific	8,773	10,440	
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	1.18[22]	<0.1[23]	Q
	Maaori	2.40		
Pharmacy				
Number of prescription items subsidised	Total	8,313,812[24]	N/A[25]	V

1.5 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 the DHB's **Healthy Services** strategic objective that is focused on excellent, collaborative, high quality and safe health services.

[21] Data is year to June 2020.
[22] 2019/20 Result date source: This result is unavailable as relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 14th data report 2013-2017.
[23] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025.
[24] Volume is as at 30 June 2020 for a 12-month rolling period.
[25] Measure is demand driven – not appropriate to set target.

Performance Measure			Baseline 2019/20	Target 2021/22	Notes
Mental Health					
Percentage of population who access mental health services	Age 0-19 years	Total	3.99%	3.9%	C
		Maaori	5.8%	5.8%	
		Pacific	N/A	2.5%[26]	
		Other	N/A	3.4%[27]	
	Age 20-64 years	Total	4.02%	3.9%	
		Maaori	9.79%	9.0%	
		Pacific	N/A	4.0%[28]	
		Other	N/A	3.1%[29]	
	Age 65+ years	Total	2.21%	2.2%	
		Maaori	3.0%	3.0%	
		Pacific	N/A	2.5%[30]	
		Other	N/A	2.1%[31]	
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	72%	80%	T
		8 weeks	88%	95%	
	Addictions (Hospital Care Arm and NGO	3 weeks	99%	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[32]		Total	76%	95%	T
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 community treatment orders		Total	403	N/A	T
		Maaori	321	301	
Elective Services					
	Inpatient treatments		18,248	20,185	

[26] Pacific target added in 2021/22
[27] Other target was added in 2020/21
[28] Pacific target added in 2021/22
[29] Other target was added in 2020/21
[30] Pacific target added in 2021/22
[31] Other target was added in 2020/21
[32] 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 2019/20	Target 2021/22	Notes
Planned Care Measure 1: Planned Care Interventions	Minor interventions	13,186	10,611	V
	Non-surgical alternatives	1	326	
Acute Services				
Readmissions – acute readmissions to hospital	0-3 days	2.4%	≤2.3%	V
	0-28 days	10.8%	≤10.7%	
Inpatient average length of stay	Acute LOS	2.94 days	2.3 days	Q
	Elective LOS	2.07 days	1.50 days	
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		83%[33]	95%	T
Cancer Services				
Proportion of patients who receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	Total	85%[34]	90%	T
Cardiac Services				
Percentage of high-risk patients who receive an angiogram within 3 days of admission	Total	69%[35]	>70%	T
	Maaori	66%		
	Pacific	62%		
	Other	72%		
Stroke Services				
Percentage of potentially eligible stroke patients thrombolysed		12.6%	10%	C
Quality and patient safety				
Percentage of admissions with hospital acquired complication		2.8%[36]	<2.3%	Q
Rate of falls with major harm per 1000 bed days		0.08[37]	<0.04	Q
Percentage of inpatients (aged 75+) assessed for risk of falling		94%[38]	90%	Q

[33] 2019/20 baseline is for the full financial year. Q4 2019/20 result for the three-month period was 93%.
[34] 2019/20 baseline is for the full financial year. Q4 19/20 result for the three-month period was 87%.
[35] 2019/20 baseline is for the full financial year Q4 2019/20 result for the three-month period was Total: 73% Maaori: 62% Pacific: 62% Other: 80%.
[36] Baseline is from July 2019 to June 2020.
[37] Baseline is from July 2019 to June 2020.
[38] Baseline is from July 2019 to June 2020

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Rate of S. aureus bacteraemia (SAB) per 1000 bed days		0.13[39]	<0.09	Q
Compliance with good hand hygiene practice		86%[40]	80%[41]	Q
System Level Measures				
Acute hospital bed days per capita (standardised) [42]	Maaori	640[43]	686	SLM
	Pacific	680	718	Q

1.6 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 the DHB's **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 2019/20	Target 2021/22	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	92%[44]	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	92%[45]	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.	97%[46]	95%	Q

[39] Baseline is from July 2019 to June 2020.
[40] Compliance rate for 1 March to June 2020.
[41] Currently, the national hand hygiene compliance target for DHBs is set at 80 percent by HQSC. CM Health achieved the target as at June 2019 with 88% compliance.
[42] In line with the equity focus of the 2021/22 planning guidance, the targets for reducing bed days in the 2021/22 SLM Plan are for Māori and Pacific populations specifically.
[43] Baseline is as at June 2020.
[44] 2019/20 baseline is for the full financial year. Q4 2019/20 result was 92%.
[45] 2019/20 baseline is for the full financial year. Q4 2019/20 result was 89%.
[46] This measure is reported a quarter in arrears. The baseline for the financial year up to and including Q3 19/20. Q4 cannot be reported as, between late March and 26 July, providers were funded a fixed fortnightly amount and providers ceased fee for service claiming through MOH Sector Operations.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Assessment, Treatment and Rehabilitation Services				
Number of older people that have received in-home strength and balance retraining services	Aged 65+	823	1,118	V
Number of older people that have received community / group strength and balance retraining services	Aged 65+	659[47]	1,400	V
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	2,120	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	520	600	V
	Aged 75-84	355	300	
	Aged 85+	331	300	
Palliative care[48]				
Number of Palliative Pathway Activations (PPAs) in Counties Manukau		194	552	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals		190	552	V

[47] 659 new and unique attendees.

[48] 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.

1.7 Output classes

The following tables provide a prospective summary of revenue and expenses by Output Class and should be viewed with reference to the financial narrative in section 2.0. These are a work in progress.

Prevention

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**47,927**	**49,310**	**50,692**	**50,915**
Personnel costs	21,259	21,684	22,118	21,685
Outsourced Services	2,005	2,045	2,086	2,045
Clinical Supplies	4,531	4,622	4,714	4,622
Infrastructure & Non-Clinical Supplies	1,122	1,144	1,167	1,144
Other	19,010	19,815	20,607	21,419
Total Expenditures	**47,927**	**49,310**	**50,692**	**50,915**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Early detection and management

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**304,704**	**317,634**	**330,286**	**343,215**
Personnel costs	816	833	849	833
Outsourced Services	77	79	80	79
Clinical Supplies	174	177	181	177
Infrastructure & Non-Clinical Supplies	43	44	45	44
Other	303,594	316,501	329,131	342,082
Total Expenditures	**304,704**	**317,634**	**330,286**	**343,215**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Intensive assessment and treatment

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**1,543,226**	**1,649,172**	**1,734,155**	**1,825,247**
Personnel costs	813,695	869,308	934,278	991,516
Outsourced Services	112,985	131,911	108,721	107,582
Clinical Supplies	143,273	153,483	160,107	170,436
Infrastructure & Non-Clinical Supplies	147,669	154,017	167,352	183,982
Other	375,325	394,672	412,278	430,685
Total Expenditures	**1,592,948**	**1,703,391**	**1,782,737**	**1,884,200**
Net Deficit	**(49,722)**	**(54,219)**	**(48,582)**	**(58,953)**

Rehabilitation and support

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**215,029**	**225,658**	**237,043**	**248,486**
Personnel costs	11,939	12,178	12,422	12,178
Outsourced Services	1,126	1,149	1,171	1,149
Clinical Supplies	2,545	2,596	2,648	2,596
Infrastructure & Non-Clinical Supplies	630	643	655	643
Other	198,789	209,092	220,147	231,920
Total Expenditures	**215,029**	**225,658**	**237,043**	**248,486**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Total

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**2,110,886**	**2,241,774**	**2,352,176**	**2,467,863**
Personnel costs	847,709	904,003	969,667	1,026,212
Outsourced Services	116,193	135,184	112,058	110,855
Clinical Supplies	150,523	160,878	167,650	177,831
Infrastructure & Non-Clinical Supplies	149,464	155,848	169,219	185,813
Other	896,718	940,080	982,163	1,026,106
Total Expenditures	**2,160,608**	**2,295,993**	**2,400,758**	**2,526,816**
Net Deficit	**(49,722)**	**(54,219)**	**(48,582)**	**(58,953)**

2. Financial performance

2.1 Introduction

CM Health remains fully committed to achieving the Government's priorities, despite the increasing fiscal constraints the health sector is facing. Capacity pressures associated with unprecedented growth in the demand for clinical services have placed significant strain on current budgets and staff across the system. Even when allowing for implementation of change and innovations to increase efficiency, projected increases in demand across the health system in the coming years will be difficult to accommodate whilst maintaining fiscal sustainability. We also continue to accommodate cost pressures with respect to current Multi Employer Collective Agreements (MECA). Sector pay restraint assumptions have been incorporated in FY22 and outer year forecasts.

While CM Health is pleased to have received an additional $108m Population Based Funding in the 2021/22 year, an estimated 7,000 of CM Health's population remains unfunded, amounting to a funding shortfall of ~$19.8m. In the 2021/22 year, of the $120m million of additional funding received (PBFF and other funding streams i.e. ACC, MoH MECA, planned care and CFA agreements outside PBFF), $64m (59%) of new funding is committed to price increases, $62.2m committed to volume or demand driven growth in mental health, primary and community services and critical hospital capacity. This essential cost growth cannot be adequately funded by new revenue and will need to be met by an ambitious savings target of $23.5m.

The impact of the DHB's response to COVID-19 through FY 20 and 21 has seen continued deployment of a significant number of DHB staff away from normal roles. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. This has resulted in a higher underlying cost structure carried forward into the FY22 year. In a deliberate strategy to achieve full value from resources already invested, services have been asked to absorb population growth where possible, limiting new capacity to those areas with highest clinical risk.

The current plan reflects a "standing still" underlying deficit of $29.7m (An additional provision of $20m is added to this recognising ongoing cost of compliance with the Holiday's Act). This plan represents best the attempt to prioritise across "short, medium and long term (transformational)" investment to align with our strategic priorities. The previous three budgets (FY 2018/19 - 2020/21) have taken a risk management approach to ensure that critical clinical risks are managed through limited investment in additional clinical capacity and initiatives to help manage demand growth. This has required considered trade-offs in what was chosen to be prioritised in the budgets. The proposed "standing still" budget position for 2021/22 continues to take this approach to ensure that ground is not lost on the improvements we have made in addressing clinical demand; reducing the 2021/22 budget further than the $29.7m deficit figure would be difficult to achieve without compromising our position with regards to maintaining clinical capacity to meet demand growth, and maintaining current thresholds for, and access to, treatment (i.e. "going backwards").

A "standing still" budget does allow for a level of critical risk reduction and growth in capacity to address acute demand which is now crowding out elective and planned care. Investment in the Board and organisational priority areas of equity and population health are less than desired.

CM Health acknowledges the expectation from the MOH to work towards an underlying breakeven position. The Board and Executive team, together with the Mana Whenua Board, will continue to consider trade off decisions to balance expectations set by the Minister of Health against its obligations to balance value, risk, equity and sustainability on behalf of the community it serves.

2.2 Forecast financial statements

2.2.1 Summary by funding arm

Net Result	2019/20 Audited Actual $ 000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Provider	(110,903)	(129,462)	(193,618)	(214,894)	(232,559)	(267,976)
Governance	(2,064)	(3,881)	(7,033)	(7,358)	(6,474)	(6,169)
Funder	33,296	86,145	150,929	168,033	190,451	215,192
Eliminations	-	-	-	-	-	-
Operating Deficit	**(79,671)**	**(47,197)**	**(49,722)**	**(54,219)**	**(48,582)**	**(58,953)**
Other Comprehensive Income	-	86,228	-	-	-	-
(Deficit) / Surplus	**(79,671)**	**39,031**	**(49,722)**	**(54,219)**	**(48,582)**	**(58,953)**

Note: A funding increase assumption of $108m has been top sliced for Mental Health Ring fence and Inter District Flows. The residual balance will be allocated to the Provider based on volumes, with the remainder allocated to Governance and Funder based on proportionate net surplus (deficit). To be updated after funding envelope.

2.2.2 Statement of comprehensive income

Net Result	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Revenue						
Ministry of Health	1,726,278	1,895,001	1,932,380	2,056,295	2,159,858	2,268,450
Other Government	38,478	40,483	38,572	39,774	40,710	41,832
Other	41,817	43,950	46,170	47,509	48,600	49,709
Inter DHB and Internal	83,049	107,015	93,764	98,196	103,008	107,872
Total Revenue	**1,889,622**	**2,086,449**	**2,110,886**	**2,241,774**	**2,352,176**	**2,467,863**
Expenses						
Personnel	765,151	814,237	847,709	904,003	969,667	1,026,212
Outsourced	107,647	120,295	116,193	135,184	112,058	110,855
Clinical Support	131,630	142,268	139,663	149,087	153,431	158,762
Infrastructure	86,641	91,730	90,877	93,379	96,360	98,345
Personal Health	554,227	613,155	619,784	649,622	677,211	705,836
Mental Health	68,928	76,353	87,872	91,570	95,394	99,329
Disability Support	152,542	157,995	178,493	187,886	198,111	209,037
Public Health	25,915	48,579	7,578	7,888	8,207	8,535
Maaori	2,826	2,906	2,991	3,114	3,240	3,369
Operating Costs	**1,895,507**	**2,067,518**	**2,091,160**	**2,221,733**	**2,313,679**	**2,420,280**
Operating Surplus / (Deficit)	**(5,885)**	**18,931**	**19,726**	**20,041**	**38,497**	**47,583**
Depreciation	40,136	40,224	45,695	49,066	57,545	71,908
Capital Charge	33,625	25,814	23,511	24,865	29,219	34,328
Interest	25	90	242	329	315	300
Net Deficit	**(79,671)**	**(47,197)**	**(49,722)**	**(54,219)**	**(48,582)**	**(58,953)**
Other Comprehensive Income	-	86,228	-	-	-	-
(Deficit) / Surplus	**(79,671)**	**39,031**	**(49,722)**	**(54,219)**	**(48,582)**	**(58,953)**

Note: *Included in the 2019/20 audited result is an additional provision of $36.5m for the remediation of the areas of non-compliance in terms of the Holiday's Act that was not included in the budget. The 2021/22 plan includes an additional provision of $20m in terms of the Holiday's Act. The profit and loss for 2020/21 year included in the financial tables is the forecast year end position and is unaudited at the time of this publication.*

Note: *The 2022/23 plan includes a revenue correction assumption of $19.8m for the full correction of the estimated 7,000 uncounted population in the DHBs PBFF Revenue.*

2.2.3 Funder

Revenue	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Ministry of Health	1,660,871	1,789,722	1,875,566	1,988,903	2,087,354	2,190,990
Other Government	133	103	305	311	317	323
Other	462	19	60	61	62	64
Inter DHB and Internal	96,618	119,783	107,388	112,585	118,202	123,918
Total	**1,758,084**	**1,909,627**	**1,983,319**	**2,101,860**	**2,205,935**	**2,315,295**
Personal Health	1,328,157	1,384,084	1,404,749	1,485,948	1,546,067	1,608,038
Mental Health	167,732	181,960	190,580	198,479	206,632	215,006
Disability Support	184,628	190,080	210,578	221,674	233,761	246,680
Public Health	25,915	48,579	7,578	7,888	8,207	8,535
Maaori	2,826	2,906	2,991	3,114	3,240	3,369
Governance	15,530	15,873	15,914	16,724	17,577	18,475
Total Expenditure	**1,724,788**	**1,823,482**	**1,832,390**	**1,933,827**	**2,015,484**	**2,100,103**
Net Surplus	**33,296**	**86,145**	**150,929**	**168,033**	**190,451**	**215,192**

2.2.4 Eliminations

Revenue	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Ministry of Health	-	-	-	-	-	-
Other Government	-	-	-	-	-	-
Other	-	-	-	-	-	-
Inter DHB and Internal	920,350	924,494	935,672	993,747	1,033,321	1,073,997
Total	**920,350**	**924,494**	**935,672**	**993,747**	**1,033,321**	**1,073,997**
Personal Health	773,930	770,929	784,965	836,326	868,856	902,202
Mental Health	98,804	105,607	102,708	106,909	111,238	115,677
Disability Support	32,086	32,085	32,085	33,788	35,650	37,643
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	15,530	15,873	15,914	16,724	17,577	18,475
Total Expenditure	**920,350**	**924,494**	**935,672**	**993,747**	**1,033,321**	**1,073,997**
Net Surplus	-	-	-	-	-	-

2.2.5 Provider

Revenue	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Ministry of Health	49,877	89,406	40,900	50,668	54,927	58,985
Other Government	38,345	40,380	38,267	39,463	40,393	41,509
Other	41,022	43,431	45,940	47,275	48,361	49,465
Inter DHB and Internal	906,781	911,726	922,048	979,358	1,018,127	1,057,951
Total	**1,036,025**	**1,084,943**	**1,047,155**	**1,116,764**	**1,161,808**	**1,207,910**
Personnel	754,041	801,749	833,108	889,029	954,302	1,010,436
Outsourced	106,051	116,664	112,851	131,741	108,512	107,203
Clinical Support	131,507	142,218	139,663	149,087	153,431	158,762
Infrastructure	81,543	87,646	85,703	87,541	91,043	92,949
Operating Costs	**1,073,142**	**1,148,277**	**1,171,325**	**1,257,398**	**1,307,288**	**1,369,350**
Operating Deficit	**(37,117)**	**(63,334)**	**(124,170)**	**(140,634)**	**(145,480)**	**(161,440)**
Depreciation	40,136	40,224	45,695	49,066	57,545	71,908
Capital Charge	33,625	25,814	23,511	24,865	29,219	34,328
Interest	25	90	242	329	315	300
Net Deficit	**(110,903)**	**(129,462)**	**(193,618)**	**(214,894)**	**(232,559)**	**(267,976)**
Other Comprehensive Income	-	86,228	-	-	-	-
Total Comprehensive Income	**(110,903)**	**(43,234)**	**(193,618)**	**(214,894)**	**(232,559)**	**(267,976)**

2.2.6 Governance

Revenue	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Ministry of Health	15,530	15,873	15,914	16,724	17,577	18,475
Other Government	-	-	-	-	-	-
Other	333	500	170	173	177	180
Inter DHB and Internal	-	-	-	-	-	-
Total	**15,863**	**16,373**	**16,084**	**16,897**	**17,754**	**18,655**
Personnel	11,110	12,489	14,601	14,974	15,365	15,776
Outsourced	1,596	3,631	3,342	3,443	3,546	3,652
Clinical Support	123	50	-	-	-	-
Infrastructure	5,098	4,084	5,174	5,838	5,317	5,396
Total Expenditure	**17,927**	**20,254**	**23,117**	**24,255**	**24,228**	**24,824**
Net Deficit	**(2,064)**	**(3,881)**	**(7,033)**	**(7,358)**	**(6,474)**	**(6,169)**

2.2.7 Balance Sheet

	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Current Assets						
Cash and Bank	26,328	13,383	(27,819)	(62,039)	(90,272)	(120,031)
Trust Funds	837	835	835	835	835	835
Debtors	63,991	86,955	86,955	86,955	86,955	86,955
Inventory	11,305	10,805	10,805	10,805	10,805	10,805
Assets Held for Sale	5,320	5,320	5,320	5,320	5,320	5,320
Current Assets Total	**107,781**	**117,298**	**76,096**	**41,876**	**13,643**	**(16,116)**
Non-Current Assets	**919,622**	**1,019,276**	**1,090,282**	**1,174,375**	**1,291,713**	**1,315,936**
Total Assets	**1,027,403**	**1,136,574**	**1,166,378**	**1,216,251**	**1,305,356**	**1,299,820**
Current Liabilities						
Creditors	139,796	154,507	154,507	154,507	154,507	154,507
Borrowings	-	265	279	293	308	324
Employee Provisions	317,091	352,397	372,397	393,363	415,347	438,402
Total Current Liabilities	**456,887**	**507,169**	**527,183**	**548,163**	**570,162**	**593,233**
Working Capital	**(349,106)**	**(389,871)**	**(451,087)**	**(506,287)**	**(556,519)**	**(609,349)**
Net Funds Employed	**570,516**	**629,405**	**639,195**	**668,088**	**735,194**	**706,587**
Non-Current Liabilities						
Employee Provision	37,267	40,267	40,267	40,267	40,267	40,267
Borrowings	-	1,811	1,532	1,239	931	607
Restricted funds	-	-	-	-	-	-
Other	13,182	15,204	14,860	14,518	14,178	13,840
Total Non-Current Liabilities	**50,449**	**57,282**	**56,659**	**56,024**	**55,376**	**54,714**
Crown Equity	**520,067**	**572,124**	**582,537**	**612,065**	**679,820**	**651,874**
Net Funds Employed	**570,516**	**629,405**	**639,195**	**668,088**	**735,194**	**706,587**

2.2.8 Movement in equity

	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Total Equity at beginning of Period	**565,324**	**520,067**	**572,124**	**582,537**	**612,065**	**679,820**
Deficit for period	(79,671)	(47,197)	(49,722)	(54,219)	(48,582)	(58,953)
Crown Equity injection	33,996	13,446	60,554	84,168	116,756	31,428
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	-	86,228	-	-	-	-
Movement in restricted funds	-	-	-	-	-	-
Other movements	837	(1)	-	(2)	-	(2)
Total Equity at end of Period	**520,067**	**572,124**	**582,537**	**612,065**	**679,820**	**651,874**

2.2.9 Cashflow

	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Operating Activities						
Crown Revenue	1,705,634	1,902,964	1,916,466	2,039,571	2,142,282	2,249,975
Other	174,767	209,082	193,836	201,362	209,054	217,052
Interest receivable	1,007	627	230	500	500	500
Suppliers	(1,106,687)	(1,281,234)	(1,243,959)	(1,318,341)	(1,344,622)	(1,394,679)
Employees	(701,537)	(776,651)	(827,708)	(883,037)	(947,683)	(1,003,157)
Interest paid	-	-	-	-	-	-
Capital charge	(33,462)	(25,977)	(23,511)	(24,865)	(29,219)	(34,328)
GST (Net)	230	(2,077)	-	-	-	-
Net cash from Operations	**39,952**	**26,734**	**15,354**	**15,190**	**30,312**	**35,363**
Investing activities						
Sale of Fixed assets	62	(366)	9	-	-	-
Total Fixed Assets	(61,118)	(52,177)	(116,701)	(133,159)	(174,883)	(96,131)
Investments and Restricted Trust Funds	(588)	(165)	-	-	-	-
Net cash from Investing	**(61,644)**	**(52,708)**	**(116,692)**	**(133,159)**	**(174,883)**	**(96,131)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity – Capital	33,577	13,027	60,135	83,749	116,337	31,009
Net appropriation to/from Trust funds	-	-	-	-	-	-
Net cash from Financing	**33,577**	**13,027**	**60,135**	**83,749**	**116,337**	**31,009**
Net increase / (decrease)	11,885	(12,947)	(41,202)	(34,220)	(28,234)	(29,759)
Opening cash	**15,280**	**27,165**	**14,218**	**(26,984)**	**(61,204)**	**(89,437)**
Closing cash	**27,165**	**14,218**	**(26,984)**	**(61,204)**	**(89,437)**	**(119,196)**

2.2.10 Capital expenditure

	2019/20 Audited Actual $000	2020/21 Forecast $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000	2024/25 Plan $ 000
Baseline Capital	25,646	19,331	36,430	49,066	50,935	71,908
Strategic Capital	35,472	32,846	80,271	84,093	123,948	24,223
Total	**61,118**	**52,177**	**116,701**	**133,159**	**174,883**	**96,131**

2.3 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: https://countiesmanukau.health.nz

2.3.1 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); HealthSource New Zealand 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.

2.3.2 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.

2.3.3 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.

2.3.4 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).

2.3.5 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 profit and loss for 2020/21 year included in the financial tables is the forecast year end position and is unaudited at the time of this publication.

The accounting policies applied in the projected financial statements are set out in section 2.6

2.4 Significant assumptions

2.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2021/22 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing un-utilised/approved debt facilities. Continued cash flow support from the MoH will be required to manage any Holiday's Act and COVID19 related cash flow impacts.

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.

2.4.2 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 1.9 percent – 5 percent 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. Acknowledging the State Service Commission advice following COVID, assumptions for 2021/22 have been applied at 1.5% for staff < $100k and 0% for all others.

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.

2.4.3 Third party and shared services provision

Focus for 2021/22 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 HealthSource New Zealand Limited (HealthSource) with heightened reliance around realisation of tangible savings.

2.4.4 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 HealthSource will be included in the living within our means projects.

2.4.5 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 of the region's 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.

2.4.6 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 to 2020/21.

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.

2.4.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally and funded by healthAlliance 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 the Data and Digital Priority in Section 2.7.6 and Section 4.5.2 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.

2.4.8 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 mean 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 required 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 second Cardiac Cath lab
- an additional Gastro procedure room
- a Renal dialysis unit expansion
- additional cots in Neonates
- increased capacity at Manukau Health Park incorporating additional Theatres, Outpatients, Radiology and the enabling infrastructure costs.

Figure 2 below outlines likely major capital (projects greater than $5m) 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 the 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: Approved Major Facilities Capital Projects >$5m as presented in the 2021/22 – 2024/25 Annual Plan

Major Facilities Project	Planned Funding Source	Forecast 2020/21 $000	2021/22 $000	Year 2-5 $000	Year 6-10 $000	Outer years > 10 years $000	Total $000
Acute Mental Health Unit	Crown	25,600	-	-	-	-	25,600
Scott Building Recladding	Crown + CM Health	26,500	1,000	-	-	-	27,500
Scott Dialysis & Cath Lab	CM Health	4,371	11,736	-	-	-	16,107
Gastroenterology Expansion	CM Health	3,839	3,035	-	-	-	6,873
Harley Gray Radiology Relocation	Crown	486	1,835	19,679	-	-	22,000
Manukau Health Park - Phase 1	Crown + CM Health	8,762	47,623	172,975	6,540	0	235,900
Building recladding - Kidz First, McIndoe and Manukau Elective Surgical Hospital	Crown	630	11,570	42,800	-	-	55,000
Neonates (additional cots)	Crown	1,528	3,472	-	-	-	5,000
Sub Total		**71,716**	**80,271**	**235,454**	**6,540**	**-**	**393,980**

Figure 2: Unapproved Major Facilities Capital Projects >$5m

Unapproved Major Facilities Capital Projects >$5m

Major Facilities Project	Planned Funding Source	Forecast 2020/21 $000	2021/22 $000	Year 2-5 $000	Year 6-10 $000	Outer years > 10 years $000	Total $000
Grow Manukau							
Cancer Centre (incl Linac)	Crown	-	-	40,000	-	-	40,000
Manukau Carparking	Crown	-	-	20,000	-	-	20,000
Manukau Infrastructure - Phase 2	Crown	-	-	-	60,000	60,000	120,000
Manukau Support Services - Phase 2	Crown	-	-	-	31,500	31,500	63,000
Manukau Outpatients - Phase 2	Crown	-	-	-	80,000	80,000	160,000
Manukau Radiology Hub - Phase 2	Crown	-	-	-	12,000	12,000	24,000
Elective Surgery Centre - Phase 2	Crown	-	-	-	145,000	145,000	290,000
Immediate Remediation							
Otara Spinal Unit and Adult Rehabilitation Replacement	Crown + CM Health + Donations	-	-	82,500	37,000	-	119,500
Grow Middlemore							
Replace Galbraith & growth							
Core Infrastructure (Galbraith - phase 1)	Crown	2,000	4,000	14,000	-	-	20,000
Maternity & Gynaecology (100 beds)	Crown	-	-	37,500	112,500	-	150,000
Inpatient Ward block (6 wards)	Crown	-	-	75,000	225,000	-	300,000
Critical Infrastructure (MMH - phase 2)	Crown	-	-	20,000	20,000	-	40,000
Colvin Replacement	Crown	-	-	-	55,000	55,000	110,000
Theatres & radiology expansion (Harley Gray - Stage 2)	Crown	-	-	-	96,000	-	96,000
ED and Critical Care refurbishment and expansion	Crown	-	-	-	144,000	-	144,000
Helipad	Crown	-	-	-	10,000	-	10,000
Cath lab (additional capacity)	Crown	-	-	-	20,000	20,000	40,000
Gastro procedure theatres (additional capacity)	Crown	-	-	-	-	10,000	10,000
Middlemore Carparking	Crown	-	-	-	24,600	-	24,600
Critical Infrastructure (MMH - phase 3)	Crown	-	-	-	20,000	20,000	40,000

Whanau support / accommodation (10 suites)	Donations	-	-	-	5,000	-	5,000
Grow community hubs							
Botany Hub and replace Primary Maternity unit	Crown	-	-	-	40,000	-	40,000
Otara Hub and replace Tamaki Oranga (Adult Mental Health)	Crown	-	-	-	-	49,600	49,600
Manukau Station Rd - arrangement with a developer (Clin Equip, FF&E)	Crown	-	-	15,000	-	-	15,000
Community Hubs	Crown	-	-	47,000	53,000	-	100,000
New Acute Hospital							
Southern site land acquisition	Crown	-	-	50,000	-	-	50,000
New Southern Hospital Stage 1	Crown	-	-	-	-	960,000	960,000
Sub Total		**2,000**	**4,000**	**401,000**	**1,190,600**	**1,443,100**	**3,040,700**
Totals		**73,716**	**84,271**	**636,454**	**1,197,140**	**1,443,100**	**3,434,680**

2.4.9 Capital investment funding

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

2.4.10 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 1: Banking facilities

Facilities	Available Facility at 1 July 2021 $000,000
NZ Health Partnerships (working capital)	$75.5
Lease facilities	$15.0

2.4.11 Property, plant and equipment

CM Health revalues property, plant and equipment in accordance with the Public Benefit Entity International Public Sector Accounting Standard 17: Property, Plant and Equipment. CM Health land and buildings are revalued every five years or where there is a material change. The last building revaluation occurred in 30 June 2019 on an 'Optimised Depreciated Replacement Costs' basis. The forecast 2020/21 balance sheet includes an unaudited adjustment for the revaluation of land as at 30 June 2021.

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 2021/22.

2.5 Additional Information and Explanations

2.5.1 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.

2.6 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. Judgement is required in determining the timing of revenue recognition for contracts that span balance date and multi-year funding agreements

ACC Contract Revenues

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

Rental Income

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

Revenue relating to service contracts

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

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the 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 income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Finance leases

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

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit prior to other comprehensive income over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired. The DHB uses a provision matrix to calculate the expected credit loss (ECL) for non-resident debtors. The provision rates are based on days past due. The ECL calculation is initially based on the historical observed default rates. The DHB will adjust historical credit loss experience with forecast economic conditions if they are expected to change over the next year.

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 2: Depreciation rates of assets

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

Finance Procurement and Information Management System (FPIM)

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

CMDHB holds:

- an intangible asset for the cost of capital invested by CMDHB in the FPIM application. This is amortised over 14 years and amortisation commenced in the 2019/20 year;
- an intangible asset for the cost of capital invested by CMDHB in the FPIM central implementation costs. This will be amortised over 15 years when the asset is brought into use in October 2020 (as at 30 June 2020 these costs paid to date are recognised as a prepayment); and
- a prepayment for the costs paid in relation to the core build of the FPIM Hardware. This will be recognised as an expense over five-year period from October 2020.

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.