Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

2019/20 –2022/23 Statement of Intent

Incorporating the 2019/20 Statement of Performance Expectations

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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 2011. Each DHB is categorised as a Crown Agent under the Crown Entities Act, 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 and nationally with DHBs and the Ministry of Health, 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**

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 4

1.1 The communities we serve 4

1.2 What we do 5

1.3 Our strategic direction and context 5

1.4 National, regional and local strategic direction 7

1.5 Health and safety 8

1.6 Organisational health and capability 8

1.7 Te Tiriti o Waitangi 8

1.8 Health gain approach 9

1.9 Equity 9

2.0 Our Direction – Healthy Together 10

2.1 Introduction 10

2.2 Strategic objectives 10

2.3 Delivering on our strategic direction 11

3.0 Improving Health Outcomes 12

3.1 Measuring our performance 12

3.2 Long term outcomes 15

3.3 Healthy Communities 16

3.4 Healthy People, Whaanau and Families 19

3.5 Healthy Services 20

4.0 Managing our business 24

4.1 Good Employer 24

4.2 Organisational performance management 24

4.3 Funding and financial management 24

4.4 Local and regional investment and asset management 24

4.5 Shared service arrangements and ownership interests 25

4.6 Risk management 25

4.7 Quality assurance and improvement 25

5.0 Statement of Performance Expectations 26

6.0 Financial performance 38

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 569,400[1] people in 2019 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.

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.

The communities we serve in Counties Manukau in 2019[1]

Are fast growing
569,400 people, 11% of NZ's population
1-2% more people every year
75,440 more people by 2029

Are youthful
123,530 children
1 in 2[2] children live in the most socioeconomically deprived areas
13% of New Zealand's children live here

And ageing
67,280 people aged 65 years and over
4% more older people every year
31,550 more older people by 2029

Are vibrant and diverse
16% Maaori
21% Pacific
27% Asian
40% Born overseas
Counties Manukau is home to
11% of New Zealand's Maaori
37% of New Zealand's Pacific
20% of New Zealand's Asian
population
By 2029
16% Maaori
22% Pacific
30% Asian
32% NZ European/Other

Their health is not the same
Life expectancy at birth[3]
86.4 years Asian
83.0 years NZ European/Other
76.3 years Pacific
74.9 years Maaori
205,000 people live in the most socioeconomically deprived areas[2]
1/10 adults receive care for a mental health condition[4]
~55,000 adults smoke[5]
~75,000 adults drink alcohol in a harmful way
7 out of 10 adults are overweight or obese[5]

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

By 2029, our district is forecast to be 16 percent Maaori, 22 Percent Pacific, 30 percent Asian and 32 percent NZ European/Other ethnicity. There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[3] 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[4] 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[5], 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.[6] Diabetes prevalence is higher amongst our Pacific (13.9 percent), Asian (6.9 percent) and Maaori (6.5 percent) communities compared to European/Other.[7] 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.

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[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] 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.

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

[5] 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

[6] 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

[7] 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 7000 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 46 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 Our strategic direction and context

Counties Manukau Health (CM Health)[8] strategic intentions and priorities are presented in our Healthy Together Strategic Plan 2015-2020. This plan was developed in acknowledgement of our diverse and changing population and health needs, and communicates CM Health’s strategic goal:

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

CM Health’s Healthy Together strategy comprises three key objectives: Healthy Communities, Healthy Services and Healthy People, Whaanau and Families. These objectives are underpinned by a goal of achieving equity in key indicators for Maaori, Pacific and other communities with health disparities:

- provide high-quality and high-performing modern specialist and hospital-based services,
- strengthen primary and community-based services to reduce the burden of disease and prevent ill health, and
- achieve health improvement for all with targeted support for CM Health’s most vulnerable people and communities.

The 2019/20 financial year is the last year of our Healthy Together strategy. The CM Health Board has committed to refreshing our Healthy Together strategy for 2020/21 and beyond.

[8] To better reflect a health system approach for effective resource planning to meet our population needs and health sector priorities, this document will refer to the collective delivery of all health services and related infrastructure as Counties Manukau Health (CM Health). This reflects the combined Counties Manukau DHB, PHO and related non-government organisation (NGO) service delivery and support resources.

Long term conditions, growth and poverty may overwhelm our healthcare system

Our strategic goals are challenged by the social and economic demographic characteristics of the resident population CM Health provides healthcare for:

Obesity, long term conditions and mental health – Seven out of ten adults in Counties Manukau are obese or overweight and an estimated 36,000 people are morbidly obese (BMI 40+). There are approximately 8000-9000 more people with morbid obesity than expected given the age and ethnicity structure of our population. Obesity-related conditions such as diabetes and cardiovascular disease are a major contributor to our burden of long term conditions. 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. In addition, 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 healthcare demand for our DHB.

Growing and ageing population - Counties Manukau is the third fastest growing DHB and our population is forecast to increase by 75,000 people by 2029. Our population is also ageing with an additional 2,700 - 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 a challenge particularly significant for the Franklin and Eastern localities.

Large high-needs population - Socioeconomic deprivation is a key driver of health inequities. In 2019 we estimate that 205,000 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 this presents a challenge for health and social sector agencies to best support our people to flourish.

The burden of long term conditions, rapidly ageing and high proportion of people living in highly deprived households adds an additional cost to the healthcare system. This is because people living with obesity and long term conditions such as diabetes cost an additional $3,800 in healthcare costs compared to their equivalents without the condition. Overall Maaori and Pacific people in Counties Manukau receive one third more health services than predicted from their age structure.

Sustaining future provision of healthcare in current funding environment will require strategic choices about priorities

Since Healthy Together was published in 2015, in CM Health's view, funding and revenue growth have been outpaced by population growth and increasing demand for healthcare. CM Health has experienced a widening gap between revenue and the cost of meeting extra demand. Consequently,it has become increasingly difficult for CM Health to fiscally operate within its means.

The demand for healthcare associated with our growing, ageing and changing population will quickly outstrip the supply of workforce needed to deliver using current models of care. Even if we did close our funding and revenue growth gaps, workforce development would need to be accelerated to meet demand.

We are also faced with 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. 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.

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[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.*

Refreshing our strategic direction for 2019/20 and beyond

We plan to refresh Healthy Together for the 2020 – 2025 years. Our strategy refresh will review our population, future revenue and cost structure of delivery assumptions. We will review our priorities for the next five years in context of the Government's priorities while working toward the achievement and maintenance of a sustainable financial position. The strategy process will commence from July 2019 and aim to complete two companion documents, Population Health Improvement and Clinical Services Plans, that show how we will deliver Healthy Together's strategic goal. The approach to clinical service planning will be considered further as part of our strategy refresh, with clinician and consumer engagement being a key element of the refresh process. We will do this in partnerhip with Mana Whenua i Tamaki Makaurau.

Within this context, our priorities 2019/20 are to achieve our planned reduced deficit position of $38.6m by:

- Focussing resources on improving the quality of life where patients present unplanned and acutely to the system, and where CM Health is the default provider of safe, high quality care.
- Prioritising resources as they become available on opportunities to accelerate service developments, where the healthcare system is achieving less than equitable access compared to the other Metro Auckland DHBs and for high-needs populations.

The tradeoffs are that some initiatives and/or projects will be progressed more slowly during the 2019/20 year as resources are diverted to focus on core services that the DHB is required to provide. In order to meet CM Health's financial objective to return to a sustainable financial position in subsequent years, a pipeline of additional savings and cost reduction opportunities is regularly reviewed. Please refer to our 2019/20 Annual Plan which outlines how our Every Hour Counts and Every Dollar Counts portfolios of work will be expanded to support our sustainability.

1.4 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. From 2019/20, the Ministry of Health has provided the health sector with the collective vision for the future of *Pae Ora- Healthy Futures*, the government's vision for Maaori Health.[11]

The Ministry of Health also expects that DHBs will continue to work toward achieving the vision of the 2016 New Zealand Health Strategy of *"All New Zealanders live well, stay well and get well,"* through targeting the following key health system outcomes[12]:

1. We live longer in good health
2. We have improved quality of life
3. We have health equity for Maaori and other groups

The 2019/20 DHB Annual Planning Guidance identifies how these three health system outcomes are linked to the government's priority outcomes and the government's overarching priority of "Improving the wellbeing of New Zealanders and their families."

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

[11] For further information please refer to the Ministry of Health's 2019/20 Annual Planning guidance for DHBs and 2019/20 Performance Measures Consultation Draft, both of which can befound at https://nsfl.health.govt.nz/dhb-planning-package/201920-planning-package.
[12] As above.

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.
- 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.

1.5 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 have in place Council of Trade Union (CTU) agreement to the Worker Participation Agreement. Worker participation is critical 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.

1.6 Organisational health and capability

Please refer to Section 4 of the 2019/20 Counties Manukau Health Annual Plan for information on how the DHB intends to manage its organisational health and capability.

1.7 Te Tiriti o Waitangi

Counties Manukau DHB aims to fulfil our obligations as agent of the Crown under the Te Tiriti o Waitangi (Treaty of Waitangi). 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 Te Tiriti o Waitangi can make to better health outcomes for all, inclusive of Maaori.

The articles of Te Tiriti and 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.

Please see Section 2.4.3 of CM Health's 2019/20 Annual Plan for detail of planned activities from 2019/20 that demonstrate how we are committed to meeting our engagement and obligations as a Treaty Partner.

1.8 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.

1.9 Equity

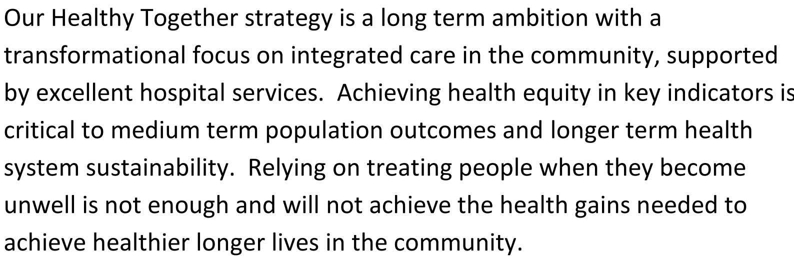
Not everyone living in Counties Manukau experiences the same health outcomes and we care about achieving health equity for our community. Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need. This means we need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

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.

The 2019/20 financial year is the last year of our Healthy Together strategy. We have committed to reviewing and refreshing our strategy prior to the start of the 2020/21 financial year. We will update our Statement of Intent to reflect our strategy refresh as part of the 2020/21 Annual Planning process.

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 **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.

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

1. Every Hour Counts

This portfolio aims to improve patient flow to optimise quality of care, the experience of care and the experience of caring whilst improving the efficiency of the system.

a) Acute Patient Flow

This programme of work 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 Emergency Department processes, more efficient management of beds, proactive discharge planning and optimisation of transition of patients into community based services.

b) Ambulatory Flow

This programme of work focuses on improving patient care in non-acute settings, including improving management and remodelling of Outpatient Management processes across a range of services, and planning for the next steps for the ongoing implementation of the Enhanced Model of Planned Proactive Care with Primary Care providers.

c) Choosing Wisely/Reducing Variation

This programme of work is focussing on review and delivery of a number of clinically led initiatives to reduce variation in line with best practice, and ensure that resources are used efficiently in order to better utilise clinician time, ensure consistent outcomes for patients as well as reduce costs for services

2. Every Dollar Counts (Financial Sustainability)

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, promotion of environmental sustainability, and ensuring clinical coding processes are optimised and revenue from Inter District Flows is managed effectively.

3. Healthy Together Technology

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.

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[13] 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 Counties Manukau 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 2017 the gap in life expectancy (LE) between Maaori (LE=73.9) and the non-Maaori/non-Pacific group (LE=83.2) was 9.4 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, [14] – 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 quality of life for our population. Through these activities, we will work toward achieving the national health system outcomes of improved quality of life and living longer in good health.

[13] 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

[14] 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, for example 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

2019/20 Ministry of Health government and health system outcomes		CM Health's key strategic objective alignment	
Government priority outcomes	Health system outcomes	CM Health strategic objective	Medium term outcomes linked to each strategic objective
Ensure everyone who is able to is earning, learning, caring or volunteering	We live longer in good health	Healthy Services	**Excellent, collaborative, high quality, compassionate and safe health care service** • Reduction in total acute hospital bed days per capita* • Reduced and more equitable amenable mortality rates* • Sustain good financial performance**
Support healthier, safer and more connected communities	We have improved quality of life	Healthy People, Whaanau & Families	**People, whaanau and families stay well and live independently in the community** • Equitable reduction in ambulatory sensitive hospitalisations for 0-4 year olds* • Increased proportion of workforce are health literate** • Improved end of life pathways**
Make New Zealand the best place in the world to be a child	We have health equity for Maaori and other groups	Healthy Communities	**Children and young people have the best start in life** • Equity in people over 15 years who are smokefree • Equitable reduction in obesity in children • Reduced hazardous alcohol use & harm from alcohol** • Improved mental health and wellbeing**

*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*

Figure 3-1: Healthy Together Outcomes Measurement Framework

National Outcome	**All New Zealanders live well, stay well, get well** in a system that is *people powered*, provides services *closer to home*, is designed for *value and performance*, and works as *one team* in a *smart system*			
Long Term Outcome & Measures	**All people living in Counties Manukau live longer, healthier lives in the community**			
	Quality of life		**Quantity of life**	
CM Health Strategic Objectives	**Healthy Communities**	**Healthy People, Whaanau and Families**	**Healthy Services**	
	Children and young people have the best start in life	**People, whaanau and families stay well and live independently in the community**	**Excellent, collaborative, high quality, compassionate and safe health care services**	
Key Medium Term Outcome Measures	• Equity in people over 15 years who are smokefree • Equitable reduction in obesity in children • Reduced hazardous alcohol use & harm from alcohol** • Improved mental health and wellbeing**	• Equitable reduction in ambulatory sensitive hospitalisations for 0-4 year olds* • Increased proportion of workforce are health literate** • Improved end of life pathways**	• Reduction in total acute hospital bed days per capita* • Reduced and more equitable amenable mortality rates* • Sustain good financial performance**	
Key Contributory Measures	• Increased number of 6-week babies who live in smokefree households*/** • Increased access to school based health services • Improved oral health in children • More young people are healthy, safe & supported*/** • Increased number of people receiving alcohol assessment & brief advice • Increased number of healthy pregnant women ** • Improved post-discharge community mental health and addictions care	• Increased number of people receiving active care coordination** • Reduce potentially avoidable ASH events • Increased number of people self–managing their health** • Increased proportion of health literacy trained staff** • Improved end of life care and support** • Increased number of whaanau led shared care plans** • Improved functional independence for those living with disabilities**	• Improved and equitable experience of care* • Reduced adverse health care events rate • Improved diabetes control in people with the highest disease burden • Improved treatment for primary and secondary prevention of CVD risk • Reduced ED attendance rate • Equitable cancer care and screening rates • Increased workforce capability, capacity, sustainability **	
Service Level Measures[A] by output class	Prevention	Early detection and management	Intensive assessment and treatment	Rehabilitation and support
Local Inputs through enabling strategies	Health equity Patient whaanau family safety and experience	People Research and evaluation Financial	Technology Facilities Risk management	

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

*Note** denotes measures in development*

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 2019/20, we will work regionally and nationally to adopt and monitor asset performance measures once they are agreed.

3.2 Long term outcomes

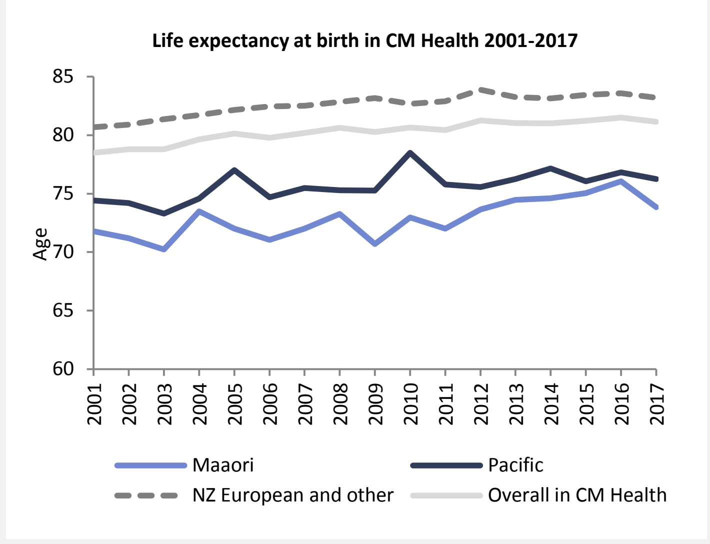
"More equitable quality and quantity life"

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 2017 was 81.1 years. Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern, increasing by 1.2 years from 2007 to 2017, but with some flattening in recent years. However, not everyone in our diverse community experiences the same health outcomes.In 2017 the gap in life expectancy between Maaori (life expectancy 73.9 years) and non-Maaori/non-Pacific (life expectancy 83.2 years) was 9.4 years. The gap between Pacific (life expectancy 76.2 years) and non-Maaori, non-Pacific was 7 years. We are committed to reducing these inequities through targeting those conditions and health outcomes that impact the most on amenable mortality and life expectancy, including cardiovascular disease, diabetes, long-term condition management and smoking cessation.



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

Long term outcome: Improved quality of life

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.

[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.

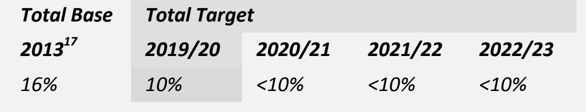
3.3 Healthy Communities

"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

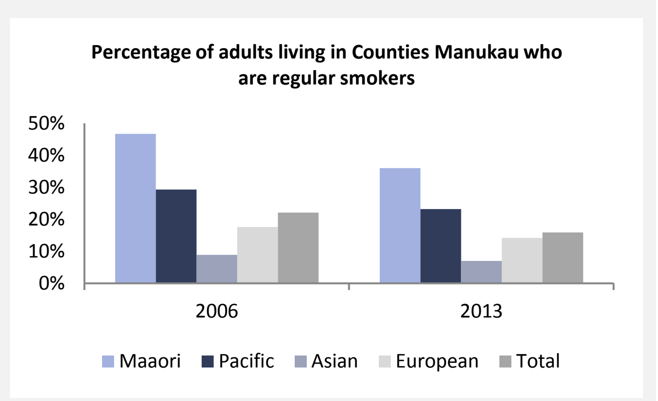
Smoking is a major contributor to preventable illness and long term health conditions



Total Base	*Total Target*			
2013[17]	*2019/20*	*2020/21*	*2021/22*	*2022/23*
16%	*10%*	*<10%*	*<10%*	*<10%*

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]



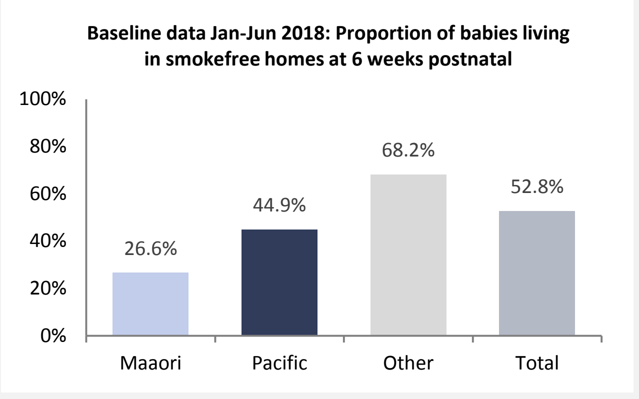
Key contributory measure: increased proportion of babies living in smokefree homes at 6-weeks postnatal[18]

Total Base	*Total Target*			
2018/19[19]	*2019/20*	*2020/21*	*2021/22*	*2022/23*
52.8%	*↑2%*	*↑2%*	*↑2%*	*↑2%*

The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. Maaori and Pacific babies are much less likely than Other babies to live in a smokefree home at six-weeks postnatal.

The 2019/20 Metro Auckland SLM Improvement Plan targets a two percent improvement in the proportion of babies living in smokefree homes at six-weeks postnatal. The aim is to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whaanau environment, encouraging an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised.

Data source: Babies Living in Smoke-free Homes SLM data



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.

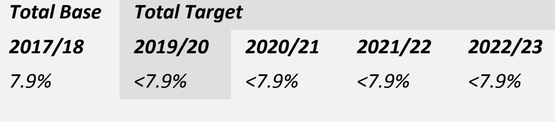
[16] The definition for the European category differs between 2006 and 2013 Census; in the 2006 census European and non-Maaori, non-Pacific other respondents were grouped, while 2013 Census used separate categories for European and non-Maaori, non-Pacific other groups.
[17] Updated baseline and forecast trend data will not be available for this measure until CM Health has received updated population counts arising from Census 2018.
[18] In 2018/19 a System Level Measure was introduced focused on the proportion of babies in smokefree households at six weeks of age. This measure was revised for 2019/20 and the revised measure has been included in CMDHB's 2019/20 Statement of Performance Expectations. As this is a new measure no trend data is currently available.
[19] The baseline is for the period Jan-Jun 2018, as per the 2019/20 Metro Auckland SLM Improvement Plan.

Medium term outcome: Equitable reduction in obesity prevalence in children

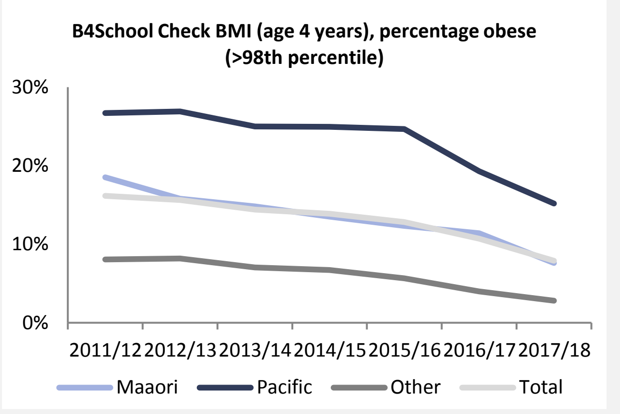
Childhood obesity is associated with a wide range of short to long term ill-health impacts that are potentially avoidable

Just under 8 percent of 4 year olds living in Counties Manukau are obese, with higher rates in Pacific children (15 percent, compared to 8 percent for Maaori children and 3 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



Total Base	*Total Target*			
2017/18	***2019/20***	***2020/21***	***2021/22***	***2022/23***
7.9%	*<7.9%*	*<7.9%*	*<7.9%*	*<7.9%*

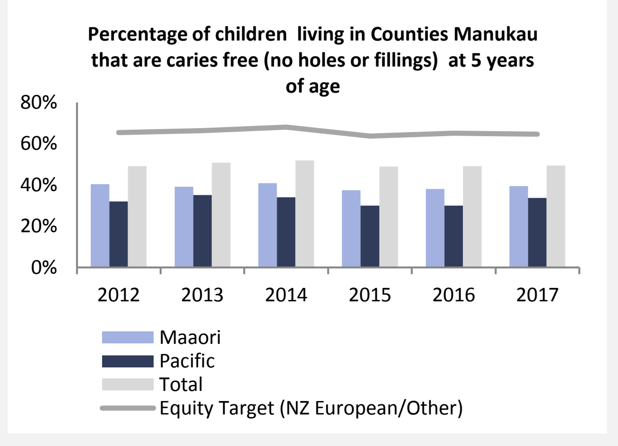


Key contributory measure: improved oral health in children

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 for Maaori, Pacific and Asian children.

Data source: Auckland Regional Dental Service[20]

Total Base	*Total Target*			
2017/18	***2019/20***	***2020/21***	***2021/22***	***2022/23***
49%	*50%*	*50%*	*>50%*	*>50%*



[20] This is national performance measure PP11 that includes children aged 5 years but before their 6th birthday at the time of their first examination.

Medium term outcome: Reduced hazardous use and harm from alcohol

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.[21] 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.

Percentage of adults (aged 15+) in Counties Manukau who had their alcohol status asked/assessed in the last three years - Q2 2018/19 results

100%
80%
60%
40%
20%
0%
Maaori
Pacific
Indian
Other Asian
European/Other
Total
Male
Female

CM Health has been developing a programme of collaborative alcohol harm minimisation actions with a view to working regionally. This work includes equitable delivery of the Alcohol ABC (Ask, Brief Advice, Counselling) approach in general practice and the Emergency Department. The graph shows Quarter 2 2018/19 results for the percentage of enrolled patients in primary care who have had their alcohol status asked and/or assessed in the last three years.

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

Data source: General practice ABC data

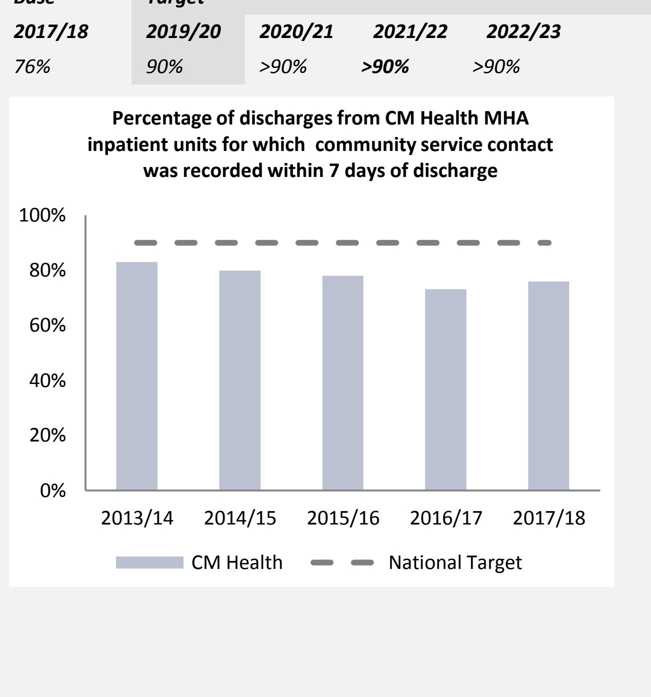
Medium term outcome: Improved mental health and wellbeing

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. 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)[22]

Base	***Target***			
2017/18	***2019/20***	***2020/21***	***2021/22***	***2022/23***
76%	*90%*	*>90%*	***>90%***	*>90%*



[21] New Zealand Health Survey data 2016/17. Available from the Regional Data Explorer: https://minhealthnz.shinyapps.io
[22] 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.**

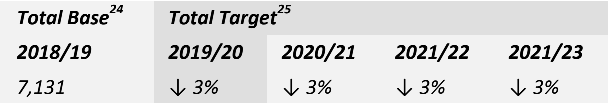
Medium term outcome: Equitable reduction in potentially avoidable hospitalisation in our 0-4 year olds

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

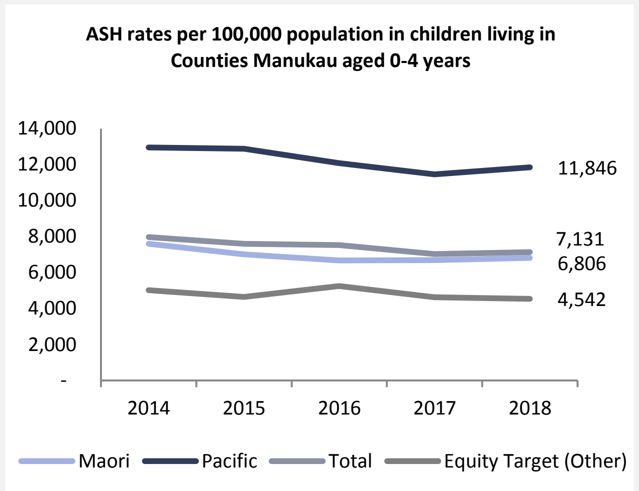
Keeping children well and out of hospital is a key priority. Not only is it better for our community, but it frees up hospital resources for people who need more complex and urgent care. Maaori and Pacific babies and children experience health inequities in acute admissions that are considered potentially 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 2019/20 Metro Auckland SLM Improvement Plan has a focus on smoking cessation and improving the housing environment, aligning with the broader focus on respiratory admissions which are 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[23]



Total Base[24]	*Total Target*[25]			
2018/19	***2019/20***	***2020/21***	***2021/22***	***2021/23***
7,131	*↓ 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.

[23] 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.
[24] Baseline data is at December 2018 to align with the 2019/20 Metro Auckland SLM Improvement Plan.
[25] 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.

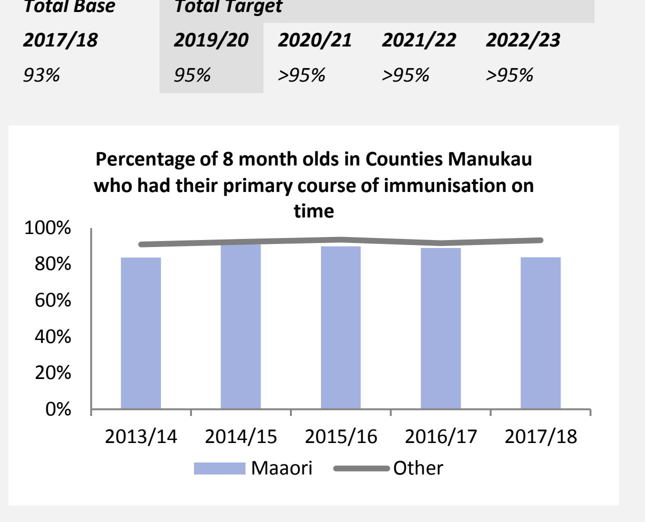
Contributory measure: improving immunisation coverage to reduce potentially avoidable hospitalisations

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*			
2017/18	***2019/20***	***2020/21***	***2021/22***	***2022/23***
93%	*95%*	*>95%*	*>95%*	*>95%*



Medium term outcome: Improved end of life pathways for patients and whaanau[26]

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**

[26] 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[27]

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[28]

Base	*Target (Maaori and Pacific)[29]*			
2018/19[30]	*2019/20*	*2020/21[31]*	*2021/22*	*2022/23*
720 (Maaori) *753 (Pacific)*	*↓ 3%*	*↓ 3%*	*↓ 3%*	*↓ 3%*

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

800
600
400
200
0
2014
2015
2016
2017
2018 (December)
753
720
450
339
Maaori
Pacific
Other
Total

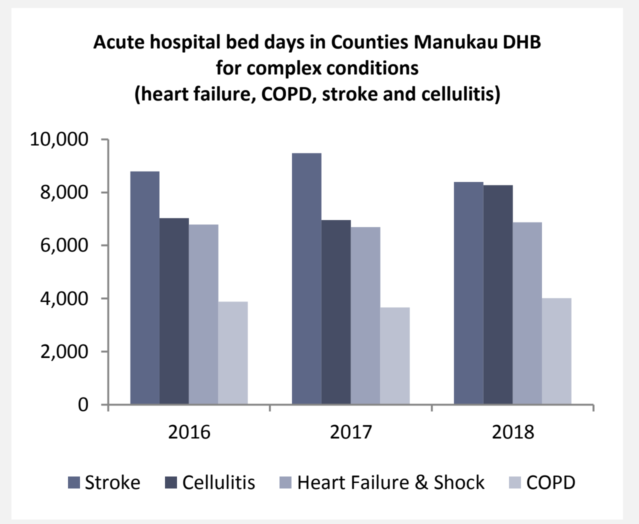
Note that the Metro Auckland SLM Improvement Plans sets annual targets. As such, the outer year targets will be reviewed annually and outlined in the Annual Plan.

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. The 2019/20 SLM Improvement Plan targets those patients most likely to be admitted or readmitted to hospital, with a focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. It also targets improved coding for the top four priority conditions so that effective interventions can be targeted. [32]

Data source: Ministry of Health Performance Reporting[33]



[27] 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.

[28] 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).

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

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

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

[32] 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.

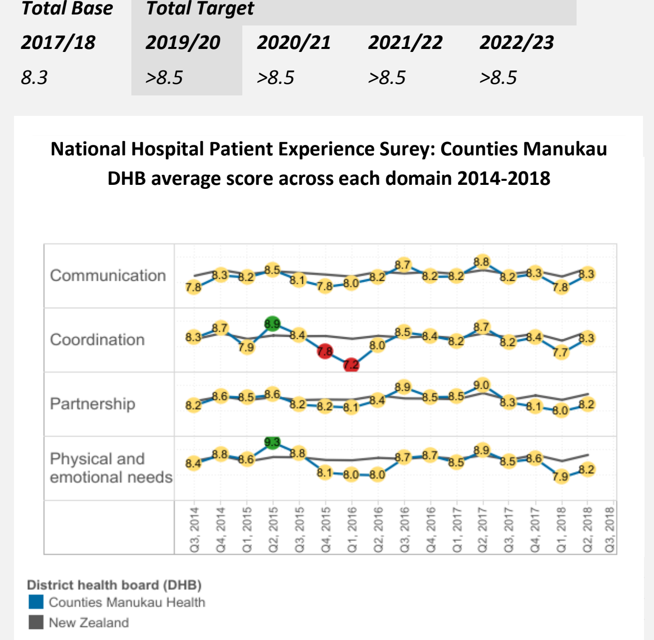
[33] Data is to March of each year.

Key contributory measure: improved and more equitable experience of care

Understanding patients' experience is vital to improving patient safety and the quality of care. Improving their experience reflects the safety and quality of care[34] 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[35] that focuses on coordination and integration of care and was 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[36]

Total Base	*Total Target*			
2017/18	*2019/20*	*2020/21*	*2021/22*	*2022/23*
8.3	*>8.5*	*>8.5*	*>8.5*	*>8.5*



Medium term outcome: Reduced and more equitable amenable mortality rates[37]

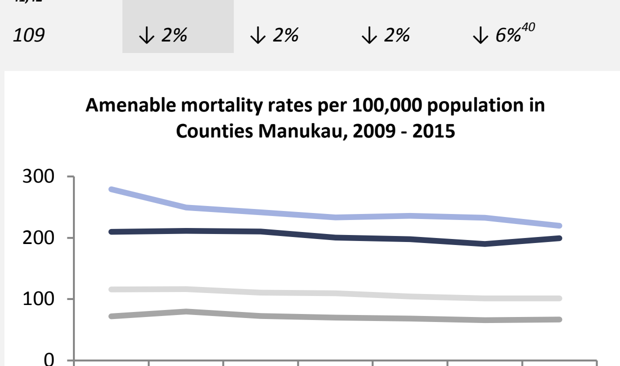
Target improvement in the leading causes of potentially preventable deaths

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.[38]

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[39] (definition based on MOH Sep 2016 version on defining amenable mortality)

Total Base	*Targets (Maaori, Pacific and total)[40]*			
2012-14[41,42]	*2019/20*	*2020/21*	*2021/22*	*2022/23*
109	*↓ 2%*	*↓ 2%*	*↓ 2%*	*↓ 6%[40]*



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.

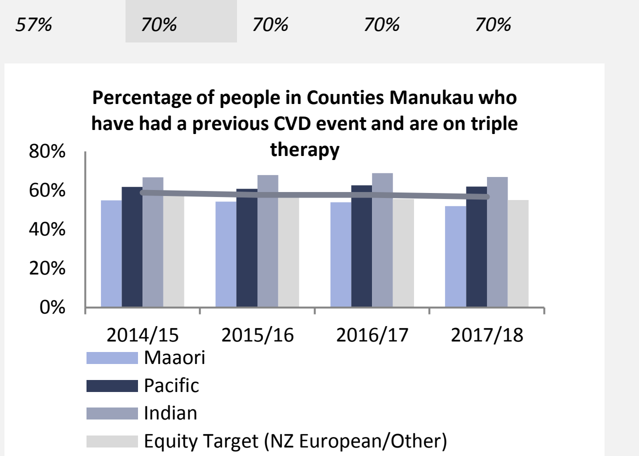
[34] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203
[35] The primary care survey forms part of the SLM work for 2018/19 and the outer years.
[36] Accessible online with national comparisons from the Health Quality Evaluation page of 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.
[37] 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.
[38] 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.
[39] 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.
[40] 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.
[41] Refered to as the '2013 baseline'
[42] 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'[43] 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.

Data source: Northern Region Cardiac KPI Report[44]

Total Base	*Total Target[45]*			
2017/18[46]	***2019/20***	***2020/21***	***2021/22***	***2022/23***
57%	*70%*	*70%*	*70%*	*70%*

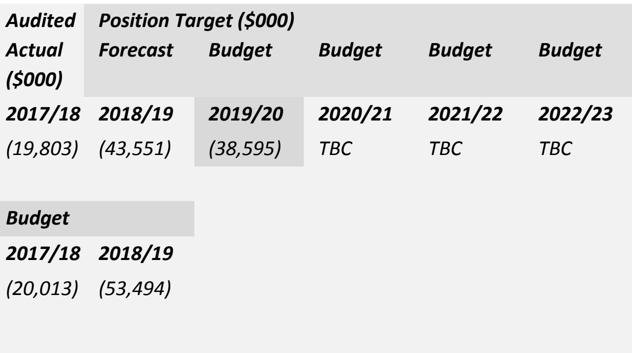


Key contributory measure: improved diabetes control in people with the highest disease burden

Better glucose control will reduce the progression of micro-vascular complications, chronic kidney disease, retinal disease and others. A modified Diabetes Care Improvement Package Programme is being rolled out. 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[47]

Total Base	*Total Target*			
2017/18	***2019/20***	***2020/21***	***2021/22***	***2022/23***
55%	*60%[48]*	*TBC*	*TBC*	*TBC*



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.

Data source: CM Health Annual Reports[49]

Audited Actual ($000)	***Position Target ($000)***				
	Forecast	***Budget***	***Budget***	***Budget***	***Budget***
2017/18	***2018/19***	***2019/20***	***2020/21***	***2021/22***	***2022/23***
(19,803)	*(43,551)*	*(38,595)*	*TBC*	*TBC*	*TBC*

Budget	
2017/18	***2018/19***
(20,013)	*(53,494)*

[43] 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.
[44] *CVD Prevention Medication Report* based on PHO enrolment for Quarter 4, CV Risk Assessment extracts and TestSafe dispensing data
[45] Note that the target for the outer years is a five percent increase on the previous year.
[46] The baseline data is taken from Q3 2017/18 – as this measure is reported biannually, in Quarters 1 and 3.
[47] 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.
[48] The diabetes target is currently under review, to be confirmed in 2019/20.
[49] Accessible online from http://countiesmanukau.health.nz

4.0 Managing our business

This section provides a brief overview of the scale and scope of the DHB's services and the extent of resources required to provide these services. Further information on the DHB's stewardship of its assets, workforce, IT/IS and other infrastructure needed to deliver planned services is provided in Section 4: Stewardship in CM Health's 2019/20 Annual Plan.

CM Health commits to working with its Alliance partners and Auckland Regional Public Health Service, within its fiscal and resource capabilities, to promote and deliver services that enhance the effectiveness of prevention activities, and to undertake its functions within regulatory parameters.

4.1 Good Employer

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

For more information on our commitments as a good employer please refer to our 2017/18 Annual Report.[50]

4.2 Organisational performance management

In our role as provider of hospital and specialist services, we have an agreed set of financial and non-financial performance indicators with an established structure for reporting and review. Productivity and quality indicators are reported at operational and clinical management forums and to the Board and related Board committees, i.e. the Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC) and others.

In 2019/20 we will continue regional work to mature the national System Level Measures reporting processes to reflect greater sharing of accountability for population health outcomes with our primary care alliances.

4.3 Funding and financial management

CM Health utilises business and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable through the Chief Financial Officer to the Chief Executive and Board. Additional financial savings plans including Every $ Counts and Every Hour Counts and monitoring controls are in place while the DHB is recovering the financial deficit position. At a micro level, procuring and funding of non-government organisation (NGO) provider services requires a commercial approach, including meeting "Government Rules of Sourcing" requirements, to ensure value for money services and financially sustainable NGO providers.

Refer to the Financial Performance Summary in Section 6.0 of this Statement of Intent for further information about Counties Manukau DHB's planned financial position for 2019/20 and out years.

4.4 Local and regional investment and asset management

In 2016 all DHBs completed a 10-year Long Term Investment Plan (LTIP) as part of the new Treasury Investment Management and Asset Management Performance (IMAP) system for monitoring investments across government. The Northern Region DHBs chose to collaborate and align investment plans and collective priorities.

The first Northern Region Long Term Investment Plan (NRLTIP) was completed and approved by each DHB Board in 2018. 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.

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[50] Accessible online from https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Annual-reports-and-plans/2017-18-CM-Health-Annual-Report-Final-for-online-publication-December-2018.pdf.

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.

The plan was developed under our regional governance structure with contribution from the Region's clinical networks, clinical governance groups and other region wide work groups; these workgroups included representation from across the continuum of care and from within different health care settings. The NRLTIP Programme Steering Group ensured a collaborative approach to the planning work and, in addition to regional health sector representatives, included local representation from Auckland Council as well as national representation from the Ministry of Health and Treasury.

The NRLTIP investment logic directly reflects the Northern Regional Intervention Logic and Regional Business Objectives to ensure that the investment plans, that shape the capital works to be progressed across our Region, are based on a shared view of the priorities for our Region.

4.5 Shared service arrangements and ownership interests

Counties Manukau DHB has a part ownership interest in the Northern Regional Alliance Ltd, healthAlliance NZ Ltd and NZ Health Innovation Hub Limited Partnership. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

4.6 Risk management

Counties Manukau DHB has a formal risk management and reporting system. CM Health is currently reviewing and refining its risk management system, including the internal risk register. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

4.7 Quality assurance and improvement

Counties Manukau DHB's approach to improvement science is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

5.0 Statement of Performance Expectations

5.1 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 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 2019/20 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2019/20 Metro Auckland SLM Improvement Plan)	**T**	Timeliness
		Q	Quality
		C	Coverage

5.2 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 2017/18 year has been used as the baseline measurement for CM Health's Statement of Performance Expectations. CM Health is unable to use Quarter 4 2018/19 performance as the baseline as this data will only be available after the SPE publication date (30 June 2019).

Footnotes have been used throughout the document to identify those measures for which a different baseline has been used. This includes those measures reported only in Quarters 1 and 3 only in which case the Quarter 3 2017/18 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 2017/18 that are higher than the stated target for 2019/20. This does not indicate that CM Health intends to reduce the level of performance in 2019/20 but does shows that CM Health exceeded the minimum level of performance in 2017/18.

5.3 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 our **Healthy Communities** strategic objective that is focused on primary (ill-health) prevention across the life course.

Performance Measure		Baseline 2017/18	Target 2019/20	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	92%		
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking	Total	96%	95%	C
	Maaori	96%		
	Pacific	96%		
	Asian	93%		
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	92%	90%	C
	Maaori	94%		
Percentage of babies living in smokefree homes at six weeks postnatal	Total	52.8%[51]	53.9%[52]	SLMc
	Maaori	26.6%	*TBC*[53]	
	Pacific	44.9%	*TBC*	
	Other[54]	68.2%	*TBC*	

[51] Baseline is for the period January 2018 to June 2018, to align with the 2019/20 Metro Auckland SLM Improvement Plan. Baseline data is not currently available by ethnicity as this measure was recently changed.
[52] The target represents a 2% relative increase from baseline as per the 2019/20 Metro Auckland SLM Improvement Plan. This target is lower compared to the 2018/19 Ministry of Health target of 80% for all ethnic groups.
[53] The draft 2019/20 Metro Auckland SLM Improvement Plan currently includes one target for the total population. This may be revised for the final draft SLM Plan.
[54] In this instance the Other category includes Asian ethnic groups, as per the Data to Support System Level Measures provided by the Nationwide Service Framework Library at https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/babies.

Performance Measure		Baseline 2017/18	Target 2019/20	Notes
Percentage of babies fully or exclusively breastfed at 3 months	Total	49%[55]	70%	Q
	Maaori	42%		
	Pacific	44%		
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%		
	Other	100%		
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	140[56]	171	V
Number of adult referrals to Green Prescription services	Total	6,142	*TBC*[57]	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	93%	95%	C
	Maaori	84%		
	Pacific	94%		
	Asian	98%		
Proportion of eligible boys and girls fully immunised with HPV vaccine *Note – boys have been included in the target from 2019/20, therefore baseline data is currently available for girls only.*	Total	71%	75%	C
	Maaori	65%		
	Pacific	84%		
	Asian	68%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	46%[58]	75%	C
	Maaori	40%		
	Pacific	45%		
	Asian	46%		
Health Screening				
Proportion of women aged 50-69 years who have had a breast screen in the last 24 months	Total	71%	70%	C
	Maaori	65%		
	Pacific	82%		
	Other	70%		

[55] Baseline data is as at Q3 2017/18.
[56] In 2017/18 140 children were engaged, with a total of 285 referred.
[57] Services are currently being re-procured and targets are likely to be set by end of July 2019. The SPE will be updated once the target has been confirmed.
[58] Results are reported annually in Q1 of each year, covering a six month period of 1 March to 30 September. Baseline data is for the period 1 March 2017 to 30 September 2017.

Performance Measure		Baseline 2017/18	Target 2019/20	Notes
Proportion of women aged 25-69 years who have had a cervical smear in the last three years	Total	69%	80%	C
	Maaori	65%		
	Pacific	75%		
	Asian	66%		
	Other	70%		
Percentage of four year olds receiving a B4 School Check	Total	101%	90%	C
	Maaori	105%		
	Pacific	101%		
	Other	99%		
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS[59] assessment	Total	100%[60]	95%	C
	Maaori	102%[61]		
	Pacific	99%		
	Asian	101%		

5.4 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 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.

[59] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide
[60] Baseline data is at December 2017 as data is reported to the end of the calendar year.
[61] 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.

Performance Measure		Baseline 2017/18	Target 2019/20	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	97%	90%	C
	Maaori	92%		
	Pacific	116%[62]		
	Asian	90%		
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[63]	Total	104.4[64]	98.1[65]	SLM
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	92%	90%	C
	Maaori	90%		
	Pacific	91%		
	Other	92%		
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	74%	90%	C
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)[66]	Total	55%	60%[67]	Q
	Maaori	49%		
	Pacific	46%		
	Other	66%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	49%	70%[68]	Q
	Maaori	48%	70%	
	Pacific	55%	70%	
	Asian	49%	70%	

[62] As the 2018 Census results have yet to be released, calculation of the 2017/18 results for PHO enrolment used the 2013 Census data for population denominators. As the Census historically has underestimated the Pacific population, the 2017/18 result for Pacfic is greater than 100%.
[63] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[64] 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.
[65] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2021, as per the 2019/20 Metro Auckland SLM Improvement Plan. The 2019/20 Metro Auckland SLM Improvement Plan also includes a separate target for Maaori and Pacific of a 2% relative reduction by 30 June 2020.
[66] 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.
[67] This is a tentative target suggested by the MoH that is currently under review at CM Health, due to be confirmed by Q1 2019/20. The tentative target for 2019/20 is lower than the target of 69% set for 2018/19.
[68] 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.

Performance Measure		Baseline 2017/18	Target 2019/20	Notes
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	57%[69]	70%	SLMc
	Maaori	52%	70%	Q
	Pacific	62%	70%	
	Asian	60%	70%	
Oral Health Services[70]				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	84%	≥95%	SLMc
	Maaori	71%		C
	Pacific	83%		
	Asian	75%[71]		
	Other	90%		
Percentage of enrolled children caries free at age 5 years	Total	49%	50%[72]	Q
	Maaori	39%		
	Pacific	34%		
	Asian	57%		
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Total	0.88	0.75[73]	Q
	Maaori	1.26		
	Pacific	1.24		
	Asian	0.62		
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	74%	≥85%	C
Diagnostics				
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	88%	95%	T
	MRI	46%	90%	
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	98%	90%	T
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	69%	70%	T

[69] Baseline data is as at Quarter 3 2017/18.
[70] Baseline data is based on the calendar year (to 31 December 2017), except for adolescent measure which is Q4 2016/17.
[71] Baseline data for Asian children is at 2015/2016 as updated baseline data is not yet available.
[72] The 2019/20 Ministry of Health target for the percentage of children caries free at age 5 is slightly lower than the 2018/19 target (51%).
[73] The 2019/20 Ministry of Health target for mean DMFT score for Year 8 children is lower than the 2018/19 target (0.81).

Performance Measure		Baseline 2017/18	Target 2019/20	Notes
Ambulatory Sensitive Hospitalisations				
Ambulatory sensitive hospitalisation (ASH) rate in children aged 0-4 years per 100,000 population	Total	7,131[74]	6,917[75]	SLM
	Maaori	6,806	6,602	Q
	Pacific	11,846	11,491	
Rheumatic Fever				
Acute rheumatic fever first hospitalisations rates per 100,000 population	Total	10.9	≤4.5	Q
	Maaori	12.61		
	Pacific	40.3		
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	1.06[76]	<0.1[77]	Q
	Maaori	2.38		
Pharmacy				
Number of prescription items subsidised	Total	7,748,436[78]	N/A[79]	V

5.5 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 our **Healthy Services** strategic objective that is focused on excellent, collaborative, high quality and safe health services.

[74] Baseline data is at December 2018 to align with the 2019/20 Metro Auckland SLM Improvement Plan. The 2018/19 Metro Auckland SLM Improvement Plan used the December 2017 results as the baseline (December 2017 results - Total: 6,835; Maaori: 6,583; Pacific: 11,189).
[75] This measure targets a 3% relative reduction from baseline and is included in both the 2019/20 and 2018/19 Metro Auckland SLM Improvement Plans. The actual target ASH rates for the total population, Maaori and Pacific for 2019/20 are higher compared to 2018/19. This is because ASH rates increased between December 2017 (the baseline for the 2018/19 Metro Auckland SLM Improvement Plan) and December 2018 (the baseline for the 2019/20 Metro Auckland SLM Improvement Plan).
[76] Baseline data Q3 2016/17.
[77] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025. This target aims for a greater reduction in SUDI than the target presented in the 2018/19 Statement of Performance Expectations (<0.40 per live births).
[78] Baseline data is at 2015/2016 as updated baseline data is not yet available.
[79] Measure is demand driven – not appropriate to set target.

Performance Measure			Baseline 2017/18	Target 2019/20	Notes
Mental Health					
Percentage of population who access mental health services[80]	Age 0-19 years	Total	4.1%	3.10%[81]	C
		Maaori	6.3%	4.25%[82]	
	Age 20-64 years	Total	3.9%	3.10%[83]	
		Maaori	9.3%	7.50%[84]	
	Age 65+ years	Total	2.3%	2.60%	
		Maaori	2.8%	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	68%	80%	T
		8 weeks	89%	95%	
	Addictions (Hospital Care Arm and NGO	3 weeks	95%	80%	
		8 weeks	98%	95%	
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[85]		Total	88%	90%	T
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 community treatment orders		Total	96	N/A	T
		Maaori	395	356[86]	
Elective Services					
Planned Care Measure 1: Planned Care Interventions[87]	Inpatient treatments		N/A	19,892	V
	Minor interventions		N/A	10,579	
	Non-surgical alternatives		N/A	110	
Acute Services					
Readmissions – acute readmissions to hospital		0-3 days	2.4%[88]	≤2.3%	V
		0-28 days	10.8%	≤10.7%	
Inpatient average length of stay		Acute LOS	2.75 days	2.3 days	Q
		Elective LOS	1.66 days	1.50 days	

[80] The 2019/20 access targets for 0-19 year olds and 20-64 year olds are lower than the 2018/19 access targets. CM Health is developing a much wider range of services across the continuum of mental health presentations in the non-referral specialist part of the sector and hence the decrease of the specialist access rate target. This is in line with the transformational agenda outlined in He Ara Oranga and to align with the focus of the Ministry of Health, driving a shift in CM Health's focus to enhanced choice and access to community and primary care mental health responses. A new target beyond 3% of up to 20% is also being developed for specialist services that provide to those with the most severe, complex, acute presentations.

[81] In 2018/19 this target was 3.15%.

[82] In 2018/19 this target was 4.45%.

[83] In 2018/19 this target was 3.15%.

[84] In 2018/19 this target was 7.75%.

[85] 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.

[86] The 2019/20 target represents a 10% decrease from baseline by Q4 2019/20.

[87] New measures for 2019/20 therefore baseline data not available.

[88] Baseline data for this measure is at June 2018.

Performance Measure		Baseline 2017/18	Target 2019/20	Notes
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		91%	95%	
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	93%	90%	
Cardiac Services				
Percentage of high-risk patients who receive an angiogram within 3 days of admission	Total	81%	>70%	T
	Maaori	77%		
	Pacific	76%		
	Other	80%		
Stroke Services				
Percentage of potentially eligible stroke patients thrombolysed		16%	10%	C
Quality and patient safety				
Percentage of admissions with hospital acquired complication		2.2%[89]	1.8%	Q
Rate of falls with major harm per 1000 bed days		0.07[90]	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		0.07[91]	0.00	Q
Compliance with good hand hygiene practice		84%	80%	Q
System Level Measures				
Acute hospital bed days per capita (standardised) [92]	Maaori	720[93]	698[94]	SLM
	Pacific	753	730	Q

5.6 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 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

[89] Baseline is year to June 2017.
[90] Baseline is year to June 2017.
[91] Baseline is year to June 2017.
[92] 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.
[93] Baseline data is at December 2018 to align with the 2019/20 Metro Auckland SLM Improvement Plan. The 2018/19 Metro Auckland SLM Improvement Plan used the December 2017 results as the baseline (December 2017 results - Maaori: 678; Pacific: 741).
[94] This measure targets a 3% relative reduction from baseline and is included in both the 2019/20 & 2018/19 Metro Auckland SLM Improvement Plans. The actual target number of acute hospital bed days per capita for Maaori and for Pacific are higher for 2019/20 compared to 2018/19. This is because the number of acute hospital bed days per capita for these groups increased between December 2017 (the baseline for the 2018/19 Metro Auckland SLM Improvement Plan) and December 2018 (the baseline for the 2019/20 Metro Auckland SLM Improvement Plan).

Performance Measure		Baseline 2017/18	Target 2019/20	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%	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		59%	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%	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[95]	Aged 65+	TBC[96]	N/A[97]	V
Number of older people that have received in-home strength and balance retraining services	Aged 65+	239	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	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[98]	600	V
	Aged 75-84	405	300	
	Aged 85+	315	300	
Palliative care[99]				
Number of Palliative Pathway Activations (PPAs) in Counties Manukau		36	866[100]	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals		141	866[101]	V

[95] New measure introduced in 2018/19.
[96] As this is a new measure for 2018/19, the baseline will be established during the 2018/19 year.
[97] 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, the Ministry of Health has yet to release a target for this measure.
[98] 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.
[99] 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.
[100] The 2019/20 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.
[101] The 2019/20 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.

5.7 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 6.0.

Prevention

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**46,722**	**46,722**	**46,722**	**46,722**
Personnel costs	23,944	23,944	23,944	23,944
Outsourced Services	853	853	853	853
Clinical Supplies	4,020	4,020	4,020	4,020
Infrastructure & Non-Clinical Supplies	1,497	1,497	1,497	1,497
Other	16,408	16,408	16,408	16,408
Expenditures (includes agency costs)	**46,722**	**46,722**	**46,722**	**46,722**
Net Surplus (Deficit)	-	-	-	-

Early detection and management

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**254,530**	**254,530**	**254,530**	**254,530**
Personnel costs	919	919	919	919
Outsourced Services	33	33	33	33
Clinical Supplies	154	154	154	154
Infrastructure & Non-Clinical Supplies	57	57	57	57
Other	253,367	253,367	253,367	253,367
Expenditures (includes agency costs)	**254,530**	**254,530**	**254,530**	**254,530**
Net Surplus (Deficit)	-	-	-	-

Intensive assessment and treatment

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**1,345,873**	**1,345,873**	**1,345,873**	**1,345,873**
Personnel costs	686,582	686,582	686,582	686,582
Outsourced Services	92,938	92,938	92,938	92,938
Clinical Supplies	128,699	128,699	128,699	128,699
Infrastructure & Non-Clinical Supplies	145,994	145,994	145,994	145,994
Other	330,255	330,255	330,255	330,255
Expenditures (includes agency costs)	**1,384,467**	**1,384,467**	**1,384,467**	**1,384,467**
Net Surplus (Deficit)	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

Rehabilitation and support

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**185,636**	**185,636**	**185,636**	**185,636**
Personnel costs	13,447	13,447	13,447	13,447
Outsourced Services	479	479	479	479
Clinical Supplies	2,258	2,258	2,258	2,258
Infrastructure & Non-Clinical Supplies	841	841	841	841
Other	168,611	168,611	168,611	168,611
Expenditures (includes agency costs)	**185,636**	**185,636**	**185,636**	**185,636**
Net Surplus (Deficit)	-	-	-	-

Total

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Total Revenue (includes agency revenue)	**1,832,762**	**1,832,762**	**1,832,762**	**1,832,762**
Personnel costs	724,892	724,892	724,892	724,892
Outsourced Services	94,303	94,303	94,303	94,303
Clinical Supplies	135,131	135,131	135,131	135,131
Infrastructure & Non-Clinical Supplies	148,388	148,388	148,388	148,388
Other	768,642	768,642	768,642	768,642
Total Expenditures (includes agency costs)	**1,871,356**	**1,871,356**	**1,871,356**	**1,871,356**
Net Surplus (Deficit)	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

6.0 Financial performance

6.1 Introduction

CM Health remains 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, in CM Health's view, funding increases have been inadequate to meet overall cost increases and adequately fund capital requirements.

Despite these considerable challenges, we continue work to return our organisation to a breakeven position and refocus resources to those functions that deliver evidence based care to our communities. We are revisiting our investments in context of long term regional planning and exploring other opportunities to do more regionally where there are benefits.

The requirement for austerity in 2018/19 and 2019/20 has required the deferral of significant expenditure and investment to outer years. Further work is underway to understand implications for outer year financials together with options to mitigate. In accordance with the statutory requirement to submit forecast financials, the 2019/20 Planned deficit has been included as a placeholder for years 2020/21, 2021/22 and 2022/23 pending completion of the work referred above.

Forecast financial statements

6.1.1 Summary by funding arm

Net Result	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Provider	(24,103)	(137,941)	(76,876)	(76,876)	(76,876)	(76,876)
Governance	(1,375)	1,361	(2,487)	(2,487)	(2,487)	(2,487)
Funder	5,675	(16,239)	40,769	40,769	40,769	40,769
Eliminations	-	-	-	-	-	-
Operating Deficit	**(19,803)**	**(152,819)**	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**
Other Comprehensive Income	7,842	101,984	-	-	-	-
Deficit	**(11,961)**	**(50,835)**	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

Note: The 2019/20 MOH funding increase of $73m 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).

6.1.2 Statement of comprehensive income

Net Result	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Revenue						
Ministry of Health	1,500,497	1,588,449	1,669,448	1,669,448	1,669,448	1,669,448
Other Government	44,549	37,081	36,465	36,465	36,465	36,465
Other	48,317	43,524	40,471	40,471	40,471	40,471
Inter DHB and Internal	81,439	76,863	86,379	86,379	86,379	86,379
Total Revenue	**1,674,802**	**1,745,917**	**1,832,763**	**1,832,763**	**1,832,763**	**1,832,763**
Expenses						
Personnel	627,450	778,616	724,892	724,892	724,892	724,892
Outsourced	90,858	96,118	94,303	94,303	94,303	94,303
Clinical Support	119,556	124,202	123,725	123,725	123,725	123,725
Infrastructure	75,614	81,675	86,688	86,688	86,688	86,688
Personal Health	508,928	523,101	537,694	537,694	537,694	537,694
Mental Health	61,159	63,709	71,657	71,657	71,657	71,657
Disability Support	137,561	148,553	150,430	150,430	150,430	150,430
Public Health	1,317	8,783	7,422	7,422	7,422	7,422
Maaori	1,835	2,776	1,439	1,439	1,439	1,439
Operating Costs	**1,624,278**	**1,827,533**	**1,798,250**	**1,798,250**	**1,798,250**	**1,798,250**
Operating Surplus / (Deficit)	**50,524**	**(81,616)**	**34,513**	**34,513**	**34,513**	**34,513**
Depreciation	32,906	34,779	39,202	39,202	39,202	39,202
Capital Charge	37,421	36,424	33,905	33,905	33,905	33,905
Interest	-	-	-	-	-	-
Net Deficit	**(19,803)**	**(152,819)**	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**
Other Comprehensive Income	7,842	101,984	-	-	-	-
Deficit	**(11,961)**	**(50,835)**	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

Note: *Included in the 2018/19 unaudited result is an additional provision for the remediation of the areas of non-compliance in terms of the Holiday's Act. This provision may be subject to change during the finalisation of the 30 June 2019 audit.*

6.1.3 Funder

Revenue	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Ministry of Health	1,455,419	1,539,361	1,618,922	1,618,922	1,618,922	1,618,922
Other Government	450	183	277	277	277	277
Other	4,108	779	183	183	183	183
Inter DHB and Internal	93,295	90,275	99,870	99,870	99,870	99,870
Total	**1,553,272**	**1,630,598**	**1,719,252**	**1,719,252**	**1,719,252**	**1,719,252**
Personal Health	1,210,278	1,283,084	1,303,159	1,303,159	1,303,159	1,303,159
Mental Health	148,814	156,429	169,093	169,093	169,093	169,093
Disability Support	170,646	180,637	182,514	182,514	182,514	182,514
Public Health	1,317	8,783	7,422	7,422	7,422	7,422
Maaori	1,835	2,776	1,439	1,439	1,439	1,439
Governance	14,707	15,128	14,856	14,856	14,856	14,856
Total Expenditure	**1,547,597**	**1,646,837**	**1,678,483**	**1,678,483**	**1,678,483**	**1,678,483**
Net Surplus / (Deficit)	**5,675**	**(16,239)**	**40,769**	**40,769**	**40,769**	**40,769**

6.1.4 Eliminations

Revenue	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Ministry of Health	-	-	-	-	-	-
Other Government	-	-	-	-	-	-
Other	-	-	-	-	-	-
Inter DHB and Internal	836,797	899,915	909,841	909,841	909,841	909,841
Total	**836,797**	**899,915**	**909,841**	**909,841**	**909,841**	**909,841**
Personal Health	701,350	759,983	765,465	765,465	765,465	765,465
Mental Health	87,655	92,720	97,436	97,436	97,436	97,436
Disability Support	33,085	32,084	32,084	32,084	32,084	32,084
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	14,707	15,128	14,856	14,856	14,856	14,856
Total Expenditure	**836,797**	**899,915**	**909,841**	**909,841**	**909,841**	**909,841**
Net Surplus	-	-	-	-	-	-

6.1.5 Provider

Revenue	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Ministry of Health	30,371	33,960	35,670	35,670	35,670	35,670
Other Government	41,456	35,950	36,188	36,188	36,188	36,188
Other	40,975	42,309	40,207	40,207	40,207	40,207
Inter DHB and Internal	824,609	886,503	896,350	896,350	896,350	896,350
Total	**937,411**	**998,722**	**1,008,415**	**1,008,415**	**1,008,415**	**1,008,415**
Personnel	614,925	767,951	713,091	713,091	713,091	713,091
Outsourced	86,088	95,094	92,669	92,669	92,669	92,669
Clinical Support	119,529	124,142	123,725	123,725	123,725	123,725
Infrastructure	70,645	78,273	82,699	82,699	82,699	82,699
Operating Costs	**891,187**	**1,065,460**	**1,012,184**	**1,012,184**	**1,012,184**	**1,012,184**
Operating Surplus / (Deficit)	**46,224**	**(66,738)**	**(3,769)**	**(3,769)**	**(3,769)**	**(3,769)**
Depreciation	32,906	34,779	39,202	39,202	39,202	39,202
Capital Charge	37,421	36,424	33,905	33,905	33,905	33,905
Interest	-	-	-	-	-	-
Net Deficit	**(24,103)**	**(137,941)**	**(76,876)**	**(76,876)**	**(76,876)**	**(76,876)**
Other Comprehensive Income	7,842	101,984	-	-	-	-
Total Comprehensive Income	**(16,261)**	**(35,957)**	**(76,876)**	**(76,876)**	**(76,876)**	**(76,876)**

6.1.6 Governance

Revenue	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Ministry of Health	14,707	15,128	14,856	14,856	14,856	14,856
Other Government	2,643	948	-	-	-	-
Other	3,234	437	81	81	81	81
Inter DHB and Internal	332	-	-	-	-	-
Total	**20,916**	**16,513**	**14,937**	**14,937**	**14,937**	**14,937**
Personnel	12,525	10,665	11,801	11,801	11,801	11,801
Outsourced	4,770	1,024	1,634	1,634	1,634	1,634
Clinical Support	27	60	-	-	-	-
Infrastructure	4,969	3,403	3,989	3,989	3,989	3,989
Total Expenditure	**22,291**	**15,152**	**17,424**	**17,424**	**17,424**	**17,424**
Net Surplus / (Deficit)	**(1,375)**	**1,361**	**(2,487)**	**(2,487)**	**(2,487)**	**(2,487)**

6.1.7 Balance sheet

	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Current Assets						
Cash and Bank	33,269	14,437	(24,708)	(63,853)	(102,998)	(142,142)
Trust Funds	833	843	843	843	843	843
Debtors	57,087	53,679	53,679	53,679	53,679	53,679
Inventory	8,527	8,868	8,868	8,868	8,868	8,868
Assets Held for Sale	5,320	5,320	5,320	5,320	5,320	5,320
Current Assets Total	**105,036**	**83,147**	**44,002**	**4,857**	**(34,288)**	**(73,432)**
Non-Current Assets	**790,939**	**881,179**	**919,349**	**957,519**	**995,689**	**1,033,860**
Total Assets	**895,975**	**964,326**	**963,351**	**962,376**	**961,401**	**960,428**
Current Liabilities						
Creditors	115,354	116,374	107,340	110,840	114,340	117,841
Employee Provisions	130,063	245,404	254,438	254,438	254,438	254,439
Total Current Liabilities	**245,417**	**361,778**	**361,778**	**365,278**	**368,778**	**372,280**
Working Capital	**(140,381)**	**(278,631)**	**(317,776)**	**(360,421)**	**(403,066)**	**(445,712)**
Net Funds Employed	**650,558**	**602,548**	**601,573**	**597,098**	**592,623**	**588,148**
Non-Current Liabilities						
Employee Provision	22,948	35,353	38,853	38,853	38,853	38,853
Restricted funds	2,810	836	836	836	836	836
Other	1,155	1,035	1,035	1,035	1,035	1,035
Total Non-Current Liabilities	**26,913**	**37,224**	**40,724**	**40,724**	**40,724**	**40,724**
Crown Equity	**623,645**	**565,324**	**560,849**	**556,374**	**551,899**	**547,424**
Net Funds Employed	**650,558**	**602,548**	**601,573**	**597,098**	**592,623**	**588,148**

6.1.8 Movement of equity

	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Total Equity at beginning of Period	**628,179**	**623,645**	**565,324**	**560,849**	**556,374**	**551,899**
Deficit for the period	(19,803)	(152,819)	(38,594)	(38,594)	(38,594)	(38,594)
Crown Equity injection	7,846	1,774	34,538	34,538	34,538	34,538
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	7,842	101,984	-	-	-	-
Movement in restricted funds	-	(8,841)	-	-	-	-
Total Equity at beginning of Period	**623,645**	**565,324**	**560,849**	**556,374**	**551,899**	**547,424**

6.1.9 Cashflow

	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Operating Activities						
Crown Revenue	1,485,790	1,574,724	1,654,591	1,654,591	1,654,591	1,654,591
Other	177,610	170,027	176,971	176,971	176,971	176,971
Interest rec.	2,207	1,725	1,200	1,200	1,200	1,200
Suppliers	(987,705)	(1,047,790)	(1,069,857)	(1,069,857)	(1,069,857)	(1,069,857)
Employees	(616,704)	(651,668)	(724,892)	(724,892)	(724,892)	(724,892)
Interest paid	(12)	-	-	-	-	-
Capital charge	(37,096)	(36,424)	(33,905)	(33,905)	(33,905)	(33,905)
GST (Net)	2,046	383	-	-	-	-
Net cash from Operations	**26,136**	**10,977**	**4,108**	**4,108**	**4,108**	**4,108**
Investing activities						
Sale of Fixed assets	28,423	433	-	-	-	-
Total Fixed Assets	(48,152)	(29,210)	(73,326)	(73,326)	(73,326)	(73,326)
Investments and Restricted Trust	(1,522)	(2,377)	(4,046)	(4,046)	(4,046)	(4,046)
Net cash from Investing	**(21,251)**	**(31,154)**	**(77,372)**	**(77,372)**	**(77,372)**	**(77,372)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity – Capital	7,427	1,355	34,119	34,119	34,119	34,119
Net appropriation to/from Trust	55	(10)	-	-	-	-
Net cash from Financing	**7,482**	**1,345**	**34,119**	**34,119**	**34,119**	**34,119**
Net increase / (decrease)	12,367	(18,832)	(39,145)	(39,145)	(39,145)	(39,145)
Opening cash	20,902	**33,269**	**14,437**	**(24,708)**	**(63,853)**	**(102,998)**
Closing cash	**33,269**	**14,437**	**(24,708)**	**(63,853)**	**(102,998)**	**(142,142)**

6.1.10 Capital expenditure

	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Baseline Capital	14,670	17,596	31,533	31,533	31,533	31,533
Strategic Capital	33,482	11,614	41,793	41,793	41,793	41,793
Total	**48,152**	**29,210**	**73,326**	**73,326**	**73,326**	**73,326**

6.2 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

6.2.1 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.

6.2.2 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.

6.2.3 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.

6.2.4 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).

6.2.5 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 requirement for austerity in 2018/19 and 2019/20 has required the deferral of significant expenditure and investment to outer years. Further work is required to understand implications for outer year financials. In accordance with the statutory requirement to submit forecast financials, the 2019/20 Planned deficit has been included as a placeholder for years 2020/21, 2021/22 and 2022/23 pending completion of the work referred above.

The financial statements for the year ended 30 June 2019 are unaudited at the time of publishing.

The accounting policies applied in the projected financial statements are set out in section 6.5.

6.3 Significant assumptions

6.3.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2019/20 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.

6.3.2 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 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.

6.3.3 Third party and shared services provision

Our focus for 2019/20 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.

6.3.4 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.

6.3.5 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.

6.3.6 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 and 2019/20.

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.

6.3.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally (refer 6.3.8) 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 the Data and Digital Priority in Section 2.4.4. and Section 4.2.2 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.

6.3.8 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 to 2020/21 for Stage 2 (Stage 1 was commissioned November 2018).

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 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: Approved Major Facilities Capital Projects >$5m

Major Facilities Project	Planned Funding Source	2019/20 $000	Year 2-5 $000	Year 6-10 $000	Total $000
Acute Mental Health Unit	Crown	25,617	2,026	-	27,643
Scott Building Recladding	Crown	12,811	9,882	-	22,693
Scott Dialysis & Cath Lab	CM Health	1,000	13,610	-	14,610
Gastroenterology Expansion	CM Health	3,365	1,683	-	5,048
Sub Totals		**42,793**	**27,201**	**-**	**69,994**

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

Major Facilities Project	Planned Funding Source	2019/20 $000	Year 2-5 $000	Year 6-10 $000	Total $000
Decongest Middlemore					
Interim Manukau Theatres	Crown	250	29,950	-	30,200
Manukau Radiology Hub Phase 1	Crown + CM Health	1,100	45,200	-	46,300
Short Term Capacity	Crown	10,800	55,200	-	66,000
Immediate Remediation					
Specialised Rehabilitation Centre	Crown + CM Health	2,500	88,800	-	91,300
Manukau Infrastructure (Phase 1)	Crown + CM Health	3,200	30,200	-	33,400
Kidz First Recladding	Crown	2,120	17,880	-	20,000
McIndoe and Manukau Elective Surgical Hospital Building Recladding	Crown	3,180	27,020	-	30,200
Core Infrastructure Upgrade	Crown	250	16,000	3,750	20,000
Galbraith Replacement					
Critical Infrastructure	Crown	-	6,400	13,600	20,000
Harley Gray Radiology	Crown	400	21,600	-	22,000
New Womens Health Clinical Building	Crown	250	98,100	11,650	110,000
Harley Gray Stage 2	Crown	-	22,400	57,600	80,000
Community Development					
Mangere/Otara & Manukau Health Hubs	Crown	212	35,534	33,612	69,358
Franklin Health Hub	Crown	-	8,352	-	8,352
Botany Health Hub	Crown	-	2,466	8,478	10,944
Grow Manukau					
Manukau Infrastructure (Phase 2+)	Crown	-	66,898	30,050	96,948
Manukau Support Services	Crown	-	16,500	36,000	52,500
Manukau Outpatients	Crown	-	-	127,550	127,550
Manukau Radiology Hub Phase 2	Crown	-	-	5,000	5,000
Manukau Community Dialysis	Crown	-	24,500	5,500	30,000
Elective Surgery Centre	Crown	-	21,600	218,400	240,000
Grow Middlemore					
Single Wing Ward Block	Crown	-	36,000	84,000	120,000
Middlemore Carparking	Crown	-	10,250	10,250	20,500
New Acute Hospital					
Southern site land acquisition	Crown	-	40,000	-	40,000
New Southern Hospital Stage 1	Crown	-	160,000	640,000	800,000
New Southern Hospital Stage 2	Crown	-	-	205,000	205,000
Sub Totals		**24,262**	**880,850**	**1,490,440**	**2,395,552**

6.3.9 Capital investment funding

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

6.3.10 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 2: Banking facilities

Facilities	Available Facility at 1 July 2019 $000,000
NZ Health Partnerships (working capital)	$75.5
Westpac (lease facility)	$15.0

6.3.11 Property, plant and equipment

CM Health revalue 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 revaluation occurred in 30 June 2019 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 2019/20.

6.4 Additional Information and Explanations

6.4.1 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.

6.5 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 prior to other comprehensive income and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Capital charge

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

Interest expense

Borrowing costs are recognised as an expense in the financial year in which they are incurred (2017/18 and prior: Borrowing costs were capitalised on qualifying assets in accordance with Counties Manukau DHB's policy and all other costs 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 prior to other comprehensive income over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

Figure 3: 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) (Formerly known as National Oracle Solution)

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 FPIM. 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.

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.