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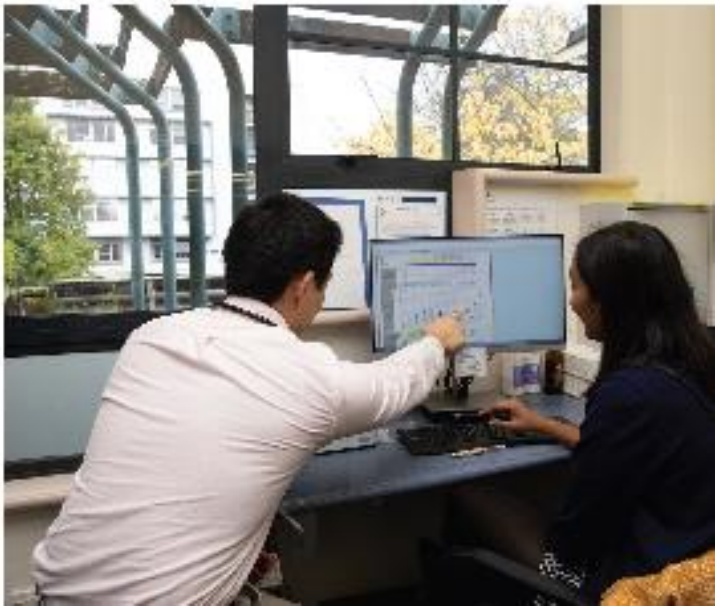
COUNTIES MANUKAU HEALTH

20/21 Annual Report



Presented to the House of Representatives pursuant to sections 150, 149, and 149(L) of the Crown Entities Act 2004

Noo reiraa tukua au akoranga kia puupuu ake i roto,

whakamahia katoatia ngaa taonga kei roto ia koe

hold fast to what you have been taught,

withdrawal all that you have for the betterment of the people

Te Arikinui Te Ataiarangikaahu, 2000

This word was given to us by her mokopuna

Matua Turongo Paki

Cultural advisor to CMDHB

Mana Whenua Itamaaki Makaurau Tautoko

Contents

Foreword from the Chair and Chief Executive of CMDHB and Chair and Kai Whakahaere of Mana Whenua i Taamaki Makaurau

The 2020/21 financial year for CM Health was dominated by the response to COVID-19. Early into the financial year, we took over the management of health provision in the Managed Isolation and Quarantine Facilities across Auckland. We have also, alongside other regional DHBs and health providers, been responding to outbreaks as they happen, and rolling out the COVID-19 vaccination to our communities. But, outside of the COVID-19 response, we have still been busy with our day to day work in providing care to those in our rohe.

Despite the impact of COVID-19 during the 2020/21 year on planned care, we were able to recover in a number of areas, ending the year having undertaken 113.7% of our total planned care volumes. However, we are still seeing the effects of COVID-19 lockdowns in many parts of the healthcare system – which has been further exacerbated by the extended lockdown after the end of the financial year - and ensuring equitable and timely access to planned care in this context is an on-going challenge that we are working hard to address alongside our regional colleagues.

Our focus on equity of access is also at the forefront of the COVID-19 vaccination efforts where we have been working closely with local Maaori and Pacific providers to ensure that vulnerable groups have the opportunity to access vaccination – there is still more to do in this space but the innovation shown by providers in working with communities has been excellent. Outside of the vaccination campaign local Maaori and Pacific providers have done a lot of wonderful work over the year supporting whaanau and communities, and we want to acknowledge and celebrate their mahi and take this opportunity to thank them for all that they do. The challenges posed by COVID-19 do, however, have a much wider impact than the health system. The last year has put pressure on whaanau and communities, especially in South Auckland, and it is only through working together that we have been able to manage and respond to COVID-19 as successfully as we have. Nationally, we are a team of five million but we are also a team of 600,000 in our rohe.

Our Te Tiriti partnership between CM Health and Mana Whenua i Taamaki Makaurau continued to develop during the 2020/21 year, with Mana Whenua representation now a feature on all CM Health Board and Board sub-committees, bringing a Treaty Partnership perspective to the governance of the Health Board which we see as essential in understanding our Whaanau Maaori and communities in serving their unique healthcare needs. We both immensely value our partnership, the strong relationships which have been built and the perspective this brings to the DHB, and we are looking to further strengthen this partnership during the 2021/22 year as we head into the health system transition; changes which will strengthen Mana Whenua's role as a leading voice for the community and district.

Despite the major pressures on the health system during the year, we were able to achieve our budgeted position at year end. This was despite CM Health's population continuing to be undercounted for the purposes of the Population Based Funding Formula by approximately 12,000 people in 2020/21, equating to ~$31.5m. We acknowledge that this position was partially corrected in the funding for 2021/22, however, in the coming year we are still underfunded by approximately 7,000 people or $19.9m. In the context of increasing acute demand, a high health burden in the community (including an 'excess' diabetic population of 11,000 estimated to incur costs of $39m per year that other DHBs do not carry at the same scale), and the on-going demands of COVID-19, which have thus far centred on South Auckland, this makes on-going deficit reduction and financial sustainability a challenge. We believe that further future resourcing to address acute demand, population and preventative health and community care is required to fully address the health needs of our rohe. The undercounting of Counties Manukau's population for the purposes of health funding in the current population based funding formula is a longstanding issue, dating back to 2008. It is vital that this undercount is addressed prior to the health reforms taking effect to ensure that the funding inequity which currently exists is not carried into the new system.

We have continued with an ambitious capital plan throughout the year under our 'Grow Manukau', 'Grow Middlemore' and 'Grow Community Hubs' portfolios of work. We have secured funding for a new Spinal Rehabilitation Unit in Manukau which will greatly enhance the experience of service users once completed. We have also progressed with several major facilities development projects including expansion of our Neonatal Unit, Cardiac Cath Lab, Dialysis and Gastroenterology facilities. Work is on-going to develop further plans and business cases to ensure our facilities are fit for purpose into the future.

We are very proud of what we as an organisation have achieved this year despite the challenges we have faced. As always, this is all attributable to the people who work in our healthcare system; those employed across the DHB, in our partner providers and in the community. Thank you to everyone for your commitment to caring for our patients and going above and beyond in what has been a challenging year. Thank you also to the communities in our rohe for your collective efforts in helping us to respond to the unique challenges of COVID-19.

Vui Mark Gosche
Chair, CMDHB

Fepulea'i Margie Apa
Chief Executive, CMDHB

Robert Clark
Ngaati Tiipa
Chair, MWiTM

Barry J Bublitz
Ngaai Tai i Taamaki
Kai Whakahaere, MWiTM

Board Members

Board members for the period 1 July 2020 to 30 June 2021
Vui Mark Gosche (Chair)
Ms Tipa Mahuta (Deputy Chair)
Mrs Catherine Abel-Pattinson
Mr Apulu Reece Autagavaia
Mr Garry Boles
Mrs Colleen Brown
Mrs Katrina Bungard
Mrs Dianne Glenn
Dr Lana Perese
Mr Pierre Tohe
Mr Paul Young

Members of the Counties Manukau Health Board, Mana Whenua I Tamaki Makaurau and Executive Leadership Teams at Umupuia Marae (Iwi Ngai Tai) during a leadership hui in December 2020.

Executive Leadership Team

Executive Leadership Team	As at 30 June 2021
Margie Apa	Chief Executive Officer
Peter Watson	Chief Medical Officer
Margaret White	Chief Financial Officer
Aroha Haggie	Director Funding & Health Equity
Jenny Parr	Chief Nurse & Director of Patient & Whaanau Experience
Elizabeth Jeffs	Director of Human Resources
Parekawhia McLean[1]	Director of Strategy & Infrastructure
Alan Greenslade[2]	Director of Infrastructure
Campbell Brebner	Chief Medical Advisor Primary Care
Mary Seddon	Director of Ko Awatea
Stuart Bloomfield	Chief Information Officer
Sanjoy Nand	Chief of Allied Health, Scientific & Technical Professions
Gary Jackson	Director of Population Health
Christina Mallon[3]	Chief Midwife
Dana Ralph-Smith[4]	Director Ambulatory Taskforce/Manukau Health Park
Vanessa Thornton[5]	Director of Hospital Services
Pauline McGrath[5]	Chief Operating Officer

[1] Resigned 20 November 2020

[2] Joined 24 November 2020

[3] Joined 20 October 2020

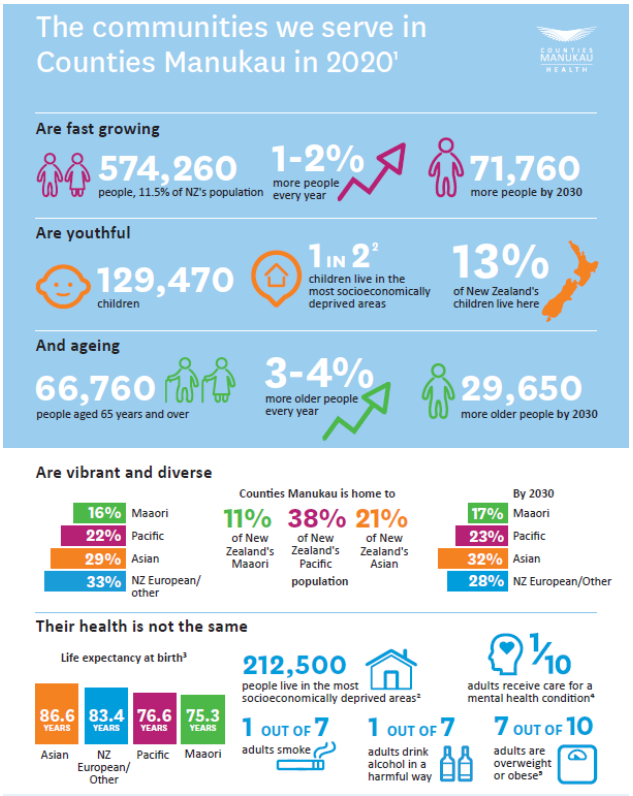
[4] Joined 8 June 2021

[5] Joined 1 July 2021

Snapshot of Counties Manukau Health in 2020/21

Counties Manukau District Health Board is one of twenty district health boards established under the New Zealand Public 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 574,260[1] people in 2020 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 simultaneously a youthful and ageing population.



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

Across our district, the health and circumstances of our communities are not the same. 37% of our population live in areas of high socioeconomic deprivation (NZDep2018 9&10[2]). Over 129,000 children live in Counties Manukau, with almost 1 in 2 living in areas of high socioeconomic deprivation. By 2030, our district is forecast to be 17% Maaori, 23% Pacific, 32% Asian and 28% 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 NZDep2018 measure, Ootara, Maangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.

Long-term mental and physical conditions do not affect all groups in our community equally.[4] 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% higher than for non-Maaori.[6] Diabetes prevalence is higher amongst our Pacific (13.1%), Asian (7.3%) and Maaori (6.7%) communities compared to European/Other (5.3%).[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) – 2019 update.

[2] NZDep 2018 decile 9&10. 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 (2019). Life Expectancy in Counties Manukau. 2018 update.

[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 (2018 data for CMDHB).

Key Achievements in 2020/21

111,266

Emergency Department presentations

495,407

Outpatient appointments[8]

16,867

Acute theatre procedures

32,110

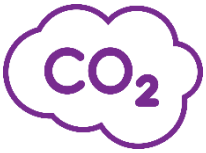
Arranged and Elective theatre procedures[9]

126,121

Inpatient Discharges

7,627

Births



42%

Carbon emission reduction last 10 years

214,906

Radiology examinations and procedures[10]

5,038,395

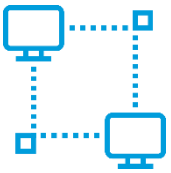
Laboratory tests

9,254,736

Prescription items

187,707

COVID-19 vaccinations[11]



99.99%

IT system uptime

COVID-19 Impact on Services

Service Impact

CM Health's response to the COVID-19 pandemic moved from containment to prevention in the 2020/21; through providing nursing and other leadership in the Managed Isolation and Quarantine Facilities (MIFs and MIQs), setting up and manning Community Testing Centres (CTCs) and the airport border, and implementing vaccination centres across the CM rohe.

The need to respond to this international pandemic with urgency has required all staff to participate in reducing the risks of COVID-19, impacting on normal service delivery and increased waiting times for some patients (653 theatre procedures were postponed as a consequence of the response to COVID-19 and by the end of the fiscal year some were recovered resulting in 593 theatre procedures which had been planned but that could not be performed by 30 June 2021).

Staff impacts

Many staff, a mixture of clinical staff and enabling staff, were seconded to regional COVID-19 related roles at the Northern Region Health Coordination Centre (NRHCC); into the MIFs and MIQs; into COVID-19 contact tracing; into Auckland Regional Public Health and more latterly into COVID-19 vaccination centres. Absence or reduced presence of roles assigned to the COVID-19 response has had a cumulative impact on those staff remaining in our centres delivering normal care and on DHB business as usual non-clinical work and projects, requiring a significant amount of overtime where staff are not able to be backfilled (See Figure 2 below).

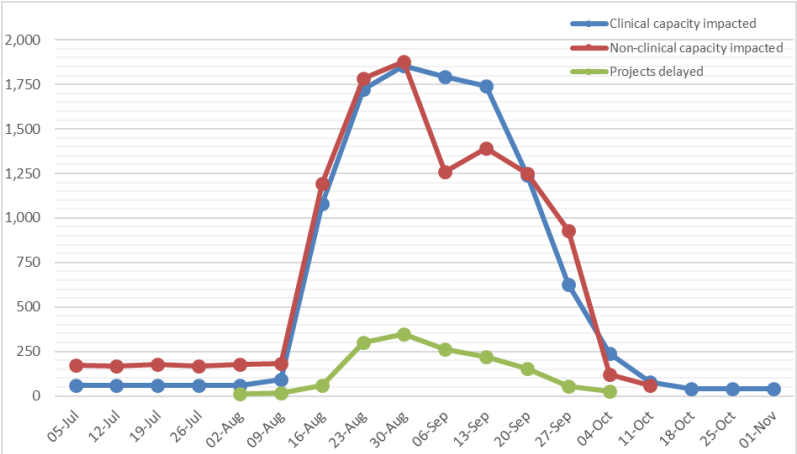
Coupled with the impact of COVID-19 on the ability to cover short notice unplanned leave, is the compounding issue of

[8] Includes virtual appointments.
[9] Excludes 9,785 outsourced elective theatre procedures.
[10] Excludes 10,902 outsourced examinations and procedures.
[11] Includes first and second doses.

shifts below target (in nursing) which is around 21%. This impacts on the ability of staff to take leave entitlements. Many nursing staff do not take leave when Alert Level 3 and 4 measures and border restrictions are in place.

In addition, there has been a noticeable gap in casual and agency staff who would normally be employed to grow our capacity and mitigate the increased demand experienced in our hospitals over the winter period. Despite the additional pressure this brings, staff have remained committed to reducing waiting times for patients whilst also planning for the future impact of borders re-opening. Together with the Ministry of Health, a plan has been created to return to normal service delivery and catch up on elective work. This was started in the latter part of 2020/21 through running additional clinics and surgery. By year end, the target for minor elective procedures (e.g. skin lesion removals, minor eye procedures) for CM Health domiciled patients had been exceeded, offset by reduced activity against more complex surgical interventions.

Figure 2: Total redeployed hours per week, by operational area impacted[12]



Implementing the COVID-19 vaccine strategy

The set up and operation of vaccination centres across South Auckland, and more regionally, began in 2020/21 and at 30 June 2021 one Super Vaccination Centre (Highbrook), four Locality Vaccination Centres (Manurewa Marae, Ootara, Pukekohe and Takaanini), fifteen General Practice centres, two Pharmacies and a number of outreach teams (who visit Aged Residential Care facilities) were operating in the CM rohe. By this time, 115,070 first doses and 72,637 second doses had been delivered to the CM Health population – equating to 15.01% of CM Health's eligible population (by DHB of residence) being fully vaccinated. Given nursing staff are predominantly providing vaccinations, the Northern Regions DHBs continue to explore alternative workforces who may safely administer the COVID-19 vaccines in 2021/22.

Table 3: Ministry of Health's Covid-19 vaccination disclosure statement for Counties Manukau DHB

Vaccine doses administered by DHB DHB of service	Dose 1	Dose 2	Total
Counties Manukau	**115,070**	**72,637**	**187,707**

[12] Figure 2 displays data from 5 July to 1 November 2020, and was also included in the 2019/20 Annual Report to illustrate the impact of COVID-19 on staffing (despite displaying results outside the 2019/20 financial year). Additional analysis has not been repeated as this was a manual and time-consuming process. That said, the burden on staff continues.

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 5)	
DHB of residence	**Proportion fully vaccinated (note 1)**
Counties Manukau	**15.01%**

Vaccine doses administered by age group (note 4)	Dose 1	Dose 2	Total
Age range (years)			
12 to 15	5	0	5
16 to 19	2,286	1,395	3,681
20 to 24	5,375	3,741	9,116
25 to 29	7,312	5,176	12,488
30 to 34	7,755	5,454	13,209
35 to 39	7,572	5,170	12,742
40 to 44	7,008	4,665	11,673
45 to 49	7,392	4,955	12,347
50 to 54	8,802	5,381	14,183
55 to 59	10,816	6,867	17,683
60 to 64	11,320	6,474	17,794
65 to 69	13,628	8,321	21,949
70 to 74	11,402	6,835	18,237
75 to 79	7,446	4,434	11,880
80 to 84	4,374	2,467	6,841
85 to 89	1,871	953	2,824
90+	706	349	1,055
Total	**115,070**	**72,637**	**187,707**

Eligible population fully vaccinated by age group (note 5)	Proportion fully vaccinated (note 1)
Age range (years)	
12 to 15	–
16 to 19	3.45%
20 to 24	7.12%
25 to 29	8.37%
30 to 34	9.62%
35 to 39	10.38%
40 to 44	10.73%
45 to 49	11.38%
50 to 54	12.29%
55 to 59	17.32%
60 to 64	19.52%
65 to 69	36.29%

70 to 74	39.22%
75 to 79	40.63%
80 to 84	40.69%
85 to 89	37.92%
90+	45.63%
Total	**15.01%**

Vaccine doses administered by ethnicity (note 4) **Ethnicity**	**Dose 1**	**Dose 2**	**Total**
Asian	37,346	22,276	59,622
European or other	49,224	31,442	80,666
Māori	8,096	5,468	13,564
Pacific peoples	19,561	12,929	32,490
Unknown	843	522	1,365
Total	**115,070**	**72,637**	**187,707**

Eligible population fully vaccinated by ethnicity (note 5) **Ethnicity**	**Proportion fully vaccinated (note 1)**
Asian	16.25%
European or other	17.56%
Māori	9.62%
Pacific peoples	12.39%
Unknown	23.32%
Total	**15.01%**

Vaccine doses administered by sequencing group (note 4) **Sequencing group** (note 3)	**Dose 1**	**Dose 2**	**Total**
Group 1	19,932	17,902	37,834
Group 2	76,086	46,389	122,475
Group 3	0	830	830
Group 4	19,053	7,515	26,568
Total	**115,071**	**72,636**	**187,707**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by Stats NZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by Stats NZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (e.g. location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, Stats NZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections Stats NZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 592,443. This is 3,057 below the Stats NZ total projected population of 595,500 (from the non-official population projections Stats NZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Maaori	86,271	96,400	(10,129)
Pacific	150,139	130,800	19,339
Asian	157,761	177,400	(19,639)
Other	198,272	190,900	7,372
Total	592,443	595,500	(3,057)

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Maaori and Pacific peoples cared for by whaanau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Maaori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Maaori and New Zealand European, the person is counted as Maaori.

According to Ministry of Health data 448,291 first doses and 421,179 second doses had been delivered to the CM Health population as of 1 December 2021 (ensuring 87% of the eligible population had been fully vaccinated).

Please refer to page 82 for information on the fiscal impact of COVID-19 on the DHB.

Despite the impacts of the COVID-19 pandemic, the 2020/21 year saw a number of successes in upgrading and planning for future growth of our facilities.

In September 2020, the final stage of the new Acute Mental Health facility, Tiaho Mai, was completed on the Middlemore Hospital site. Its innovative design resulted in a Gold Award at the 2021 New Zealand Commercial Project Awards in May 2021 and was also the National Category Winner for Health projects. The judges commented that "This building reflects the importance of changes in mental health treatment in New Zealand, with positive results in patient behaviour being observed since completion. The building is based on recent international innovations and is tailored to the unit's specific needs in Manukau and its wider catchment. The judges were impressed by the collaboration of everyone in the project, in particular the client for allowing staff involvement, which helped deliver a world-leading mental health facility." The project has also made it into the finalist list in the Civic, Health & Arts category for the 2021 Property Council Awards, which will be judged in August 2021.

Tiaho Mai courtyard

The Scott building is one of four major buildings on the Middlemore Hospital site that has suffered from water penetration, resulting in the need to treat the decay and replace the cladding. Given the building houses medical, surgical, and cardiac patients, as well as the dialysis day unit, and cardiac catheterisation laboratory, it was necessary to perform the remediation work whilst the hospital remained functional with minimal impact on patients, visitors and staff. The project was completed almost one year ahead of programme and returned significant financial savings against overall project budget. It has also provided a blueprint for further remediation to the remaining buildings.

Other capital projects that have received Board and budget approvals include the expansion of the renal dialysis unit and the neonatal intensive care ward (NICU), and the building of a second cardiac catheterisation laboratory, all at Middlemore Hospital. These projects have had substantial delays in commencement due to Council and Fire consenting issues. However, both projects commenced construction in July/August 2021. The NICU expansion is scheduled to be delivered late 2021 and the renal dialysis unit and second cardiac catheterisation laboratory is scheduled to be delivered second half of 2022.

CM Health was pleased to receive advisement of significant capital funding for expansion of facilities at the Manukau Health Park site. $216.4m was allocated by government in December 2020 (with an additional $13m contribution by CM Health) and this will provide new buildings and expanded services for Radiology, renal dialysis, breast screening and diagnostics, additional theatres and a range of surgical and medical specialty clinics. Subsequent to this, a further $110m was announced in April 2021 for a new Spinal and General Rehabilitation facility.

The development of community (health) hubs continued through 2020/21 with a review and rationalization of all CM Health owned or leased sites within the region. This has resulted in expansion of facilities at Maangere, Ootara and Pukekohe aligned to the CM Health locality planning, and consolidation of other leased facilities to ensure fiscal prudency and sustainability.

Further key achievements and highlights for the year are outlined below under our three Healthy Together strategic objectives (see *Our Strategic Intentions* on page 28) that are closely aligned to the April 2016 New Zealand Health Strategy (NZHS) themes. Each of these achievements has contributed to the national strategy, as highlighted by the NZHS themes: **People-Powered**, **Closer to Home**, **Value and High Performance, One Team, Smart System.**

Highlights and achievements across CM Health aligned to our Healthy Together strategic objectives

Healthy People, Whaanau and Families

- **Te Ranga Ora/Ministry of Health Learning Partnership:** TRO is a new system of care being developed to support Maaori, Pacific peoples and people living in the most deprived areas with two or more long term conditions (LTCs). It aims to improve the experience of patients and their management of LTCs by taking a wider view of their needs and provider supports. People will see their culture and what matters to them reflected in the care and support they receive.

  On 18 March 2021, CM Health and the Ministry of Health signed the system learning partnership contract to fund the evaluation of TRO. The Ministry is contributing $4.405m over five years, and will develop the evaluation approach in partnership with CM Health and TRO Partner Collectives. The aim of the evaluation and learning partnership with the Ministry is to support action learning, innovation, continuous improvement, and transferability of insights to: strengthen investment approaches to prevent and treat long-term conditions; and gain practical insights into the system-level changes needed to support whaanau-centred commissioning, to improve health and social sector commissioning.

  The COVID-19 pandemic has resulted in all five TRO Collectives turning their focus to actively supporting whaanau in the community. They have been heavily involved in COVID-19 community response work, including: foodbanks, food parcel drops, virtual check-ins and consults (social as well as medical), community testing and vaccination stations, MIQ testing and health services, local wraparound support and other initiatives. Despite this, progress has been made by all five Collectives in completing their Te Ranga Ora Phase 1A deliverables to move from 'co-design' to 'service delivery'. Currently, all five Collectives and their models of care represent diverse collaborations, approaches, cultural contexts, and geographic communities across Counties Manukau.

  People-Powered

- **Fundamentals of Care:** The Fundamentals of Care (FoC) programme, introduced to Counties Manukau Health in October 2017, aims to ensure the consistent delivery of the 'fundamental' aspects of care for all patients. Since beginning the journey in 2017, CM Health has conducted seven Fundamentals of Care peer reviews across 46 inpatient

  One Team

wards and units, and over 1,400 patients and staff have participated. The peer reviews occur bi-annually and consist of four data collections tools. Following the most recent Fundamentals of Care peer review in March 2021 the overall organisational score was 86.1%, which is the highest score to date. Eight of the care standards achieved above 80% and the care standard 'Respect, Privacy and Dignity' scored in the 90% range. The results reflect a sustained improvement in the delivery of fundamental care across the organisation.

- **Consumer engagement:** CM Health seeks engagement with, and feedback from, its consumers through a variety of channels including regular surveys and face to face interviews, feedback forms, and via the Patient and Whaanau Centered Care Board and the Consumer Council. The value of this engagement is high and helps CM Health improve its service delivery and design of services. The Consumer Council members not only provide valuable insights of their own, they are also able to access feedback from 100+ community organisations and groups.

People-Powered

In 2020/21, and after the COVID-19 threat had largely subsided, the $235.9m Manukau Health Park (MHP) development began its design journey with the aim of completion in 2024. In beginning this journey, it was imperative that co-design with consumers was a core principle. Accordingly, in December 2020, a Concept Design Consumer Workshop was held where nine consumers with lived experience provided feedback on concepts for changes to existing facilities and concepts for the new facilities. As a result, the MHP Consumer Advisory Group was established and continues to have input into the design process.

Two further public workshops and a Mana Whenua workshop in collaboration with the design team have been held. A staff and patient feedback station ran for two weeks, displaying information on the expansion plans and surveying people for their suggestions and issues of importance. Consumer and Mana Whenua impact on the design can be seen in the artist impressions of the North Building – introducing more colour and pattern for a welcoming, less institutional look.

Concept Design

Developed Design

The MHP Consumer Advisory Group is acutely aware that what happens inside the new and refurbished facilities will have the biggest impact on patients' experience of care; they are engaged with wayfinding, barrier-free access for all people, delivery of care and workforce development.

- **Infusions at Pukekohe Hospital:** As part of CM Health's strategy to move more services into the community, we have developed the Pukekohe Hospital site to provide more clinic rooms, and assist Middlemore Hospital in providing beds for people with general medical conditions living within the Franklin district. In addition, two new infusion chairs were set up to provide iron infusions for those that had been referred to Middlemore Hospital to receive the infusion. This has made a significant difference to the lives of patients receiving this treatment on a regular basis.

Closer to home

- **Te Kaahui Ora Maaori health team** re-configured its service delivery by using a POD approach to re-engage with our Maaori whaanau. It moves from a hospital management model, to a transitional model of care within the secondary and primary care setting. This approach enabled our team to address the immediate health and social needs and engage our patients with our community providers for continued support and care. The pilot POD approach was implemented from September to November 2020. The PODs were small teams consisting of a nurse, social worker and kaimanaaki (non-regulated worker), that focused on specialised services where a disproportionate number of Maaori present, such as Emergency Care, Mama-Pepe, Long Term Condition and Cancer services.

  The Cancer Service and Maaori Health jointly funded one full-time nursing position to focus on our high risk Maaori patients, some of whom had disengaged with cancer services i.e. not attending treatment or clinic appointments. The outcome from our cancer focused POD shows our team were able to contact 184 high risk Maaori whaanau, and provide care plans for 150 whaanau e.g. clinical support and information, outpatient support, scripts, kai parcels, work and income benefits and housing support. We were also able to re-engage 42 whaanau who for various reasons had disengaged with the service.

Value and High Performance

- **Pacific Health:** The Regional Pacific team successfully navigated the COVID-19 pandemic border closures by strengthening telehealth utilisation. Telehealth was used to support Overseas Referral Scheme consultations as well as for Strengthening In-Country Capacity teaching work. In addition, 20 registered nurses (19 from Fiji and one from Tonga) completed the first Post Graduate Certificate Child Health course using remote media in late 2020. Telehealth equipment was purchased and installed in Kiribati, Tuvalu and Vanuatu, with the latter two developing remote videoing in the outer islands.

Smart System

- The Fanau Ola (FO) team engaged and provided support for approximately 1,900 Pacific patients who presented with complex needs to the emergency department (ED). FO created care plans for over 800 Pacific patients, provided 2,261 health and social care interventions, re-engaged over 1,500 Pacific patients with their general practitioners, and connected about 900 patients to social services. A recent analysis comparing Pacific patients' utilisation of ED services six months before and six months after receiving FO support found a 26% reduction in both ED presentations and inpatient admissions.

Healthy Communities

- **Community Nursing team introduces a Pressure Injury Prevention workflow**: Pressure injuries occur largely as a result of immobility. This painful condition is a cause of admissions to the hospital when the pressure injury becomes significant. To reduce the prevalence of this condition, the community nursing team has introduced an assessment tool and a new workflow where patients receiving care at home are regularly screened. Regardless of who is completing the assessment, the workflow helps the community team decide on the appropriate action as a result of the assessment. When a threshold is reached, a bundle of care is initiated for the patient.

Smart System

- **Suicide Prevention Digital Innovation:** 2020/21 saw the development of the Manawa suicide safety plan mobile phone app sponsored by the Vodafone Innovation Fund. 'Manawa' means having hope in your heart. The app was developed in partnership with the Mental Health Foundation and is based on their booklet, 'Having suicidal thoughts and finding a way back', and the insert, 'my own survival plan'.

  The Manawa, My Own Survival Plan app can now be downloaded on Android or Apple phones. Manawa contains New Zealand helpline numbers such as 1737 and Lifeline, and the resources section contains links to local websites. There is also:
  - quotes from people who have experienced suicidal thoughts with the message that the person is not alone
  - suggestions to help people complete their "My own survival plan", with the ability to personalise by adding photos
  - the ability to immediately contact 111 if needed.

  This year Manawa will be promoted within CM Health specialist MH&A, primary care, schools and NGO providers.

People-Powered

- **Model of Care trials:** CM Health is consistently exploring ways to improve its service delivery and models of care. Through 2020/21, and as a result of being tested by the COVID-19 pandemic, we continued to look for ways to improve the care we provide to patients and whaanau. Here is an example of a trial conducted with patients suffering from a condition known as heart failure.

  2% of all New Zealand's population lives with heart failure (HF), with the prevalence moderately higher in Maaori (2.5%) and Pasifika (2.6%). There are approximately 12,000 hospital admissions, of approximately 5,500 patients, for HF each year. HF with reduced cardiac ejection fraction (HFrEF) is associated with considerable ill health and mortality and places a significant burden on our health services.

  The aim of the trial was to reduce reliance on clinic-based models of care and provide patients with the ability to manage their HF at home. This would require patients to undertake home based blood pressure and weight monitoring and medicine management with the aid of fortnightly phone calls by a cardiac nurse or specialist. During 2020, 50 patients with HFrEF were enrolled in a trial over a four-month period, resulting in the following outcomes:

Closer to home

- A reduction in 106 hours of time spent on the roads, which would normally involve travelling to and from clinic
- A reduction in patient cost spent on petrol and vehicle wear and tear
- A reduction in traffic pollution (approx. 607 kg of CO_2)
- A reduction in time spent away from work
- 73% of patients' medication was managed appropriately
- Patients reported feeling empowered and motivated to manage their health condition
- Patients expressed an understanding of the changes to their medication and felt that the alterations were beneficial to their health
- The majority of patients were confident in using and reading the BP monitor from home and were happy to have future follow-up appointments by telephone
- Some patients were confused about the purpose of appointments as they were having other telehealth appointments during the same period
- Some indicated the need for more frequent calls with clinicians initially to make sure they were tracking okay.

- **The Alcohol and Other Drug (AOD) Liaison Team:** Aligned with the Te Whare o Tiki: co-existing problems knowledge and skills framework, the AOD liaison team have taken a proactive approach to coaching and mentoring mental health (MH) clinicians about AOD responsiveness by:

  One Team

  - Adopting a "front door approach" by offering AOD support for every referral to ensure that any problematic substance use/gambling is assessed from the onset of contact with the service and that intervention for AOD is included in the treatment plan
  - Removing duplication by streamlining the HCC regional forms (CAR, Regional Coordinated Care Plan and Regional History form)
  - Building stronger links between MH and the AOD services by empowering MH clinicians with specialist information and knowledge, and encouraging more appropriate referrals to specialist AOD services
  - Establishing early engagement at point of referral to help shed light on any addiction issues
  - Utilising Peer Support Specialists in AOD work more effectively through continued knowledge transition to increase their capability.

  The results are impressive with increased AOD screening and assessment practices. They have increased the screening rate and the quality of documentation by integrating the screening/AOD assessment into treatment plans.

- **Asian community collaboration:** The DHB, primary care and Asian communities partnered to deliver a range of health initiatives related to keeping people well. This resulted in more than 800 people receiving Flu vaccines between April and June 2021, web promotion of COVID-19 vaccines in 16 Asian languages and several health workshops aimed at promoting healthy eating.

One Team

Healthy Services

- **Advancing our digital assets:** We have continued to invest in enhancing our digital capability, capacity and analytical capability through 2020/21 as we continue to move towards a fully digital environment. Upgrades were applied to the main patient administration system (iPM), the maternity system (Badgernet), a mental health system (Health Care Community), the electronic nursing observation tool (eVitals), and the main clinical interface (Clinical Portal). In addition, eNotes was introduced to two early adopter wards in November 2020 and further into the Older Peoples services, Pukekohe Hospital and Auckland Spinal Rehabilitation Unit in early 2021. This digital system replaces hand written clinical progress notes, increasing legibility, reducing paper use, and reducing the search for paper based files.

Smart System

- **Keeping your data safe:** On 31 May 2021, CM Health became a fax free environment. This milestone has been supported by the introduction of more secure electronic means of transferring information, both within the hospital environment and between health care providers. Many GPs and other providers can now send electronic referrals directly to hospital clinicians, reducing time to receipt of the referral.

Smart System

- The **Care Capacity Demand Management (CCDM) programme** is about matching staff resources to patient demand so we can improve care, make the best use of resources and provide a better work environment for our front-line staff. The programme is comprised of five key components – staffing (FTE) calculations, variance response management, core data set, governance and patient acuity.

  In the last 12 months, the CCDM at CM Health has moved from 45% to 63% implemented. TrendCare data accuracy, which informs the staffing need, has been maintained above 90% since April 2021. Because of this exceptional data we have been able to commence FTE calculations and progress at pace, with completion expected by December 2022. The pilot FTE calculation was being finalised at the end of the financial year. The Capacity at a Glance screen has been redesigned within the business intelligence tool Qlik sense, which has expanded its capability to assist with resource allocation.

Value and High Performance

- **Every Hour Counts:** Over 2020/21, the Every Hour Counts portfolio has continued with the vision to improve patient flow to optimise the quality of care, the experience of care, and the experience of caring whilst improving the efficiency of the system. This covers both acute and ambulatory patient flow, with Ko Awatea led work programmes in each area.

  The Acute Patient Flow programme has continued to look for solutions to the challenges of enabling flow, especially within the General Medicine wards.
  - Proof of concept testing of Health of People (HOP) squad in one General Medical ward has delivered a three-day length of stay reduction, and seen a greater number of patients accessed at either public hospital or care home. The HOP squad is now expanding in to a further three General Medical wards.
  - Standardising MDT Huddles across General Medicine wards to enable improved cross-functional and timely communication and information sharing. To improve the opportunity for clinicians to raise concerns and identify risks and reduce length of stay by timely decision making.

  - Developed phase one of the electronic frailty tool that identifies frailty at the front

Value and High Performance

door. This is now moving in to phase two to link to the ward areas so that effective care can be provided. Patients who are frail risk deconditioning once in hospital, which can extend length of stay. This will also connect to the work of the HOP squad.

- Waiting for an echocardiogram was one of the main reasons for 'Red Days' - a demand and capacity study has begun in inpatient echo. The aim is to increase the number of scans completed on the same day the referral is received from 64% to 80%. A point of care ultra sound is currently being trialed to see if targeted echocardiograms can reduce the inpatient demand.

In **operating theatres,** we have set up five working streams – information management, patient experience, two CSSD streams and operating theatre optimization, which so far has achieved the following:

- Increased overall theatre session utilisation from 90% to 94% within the next six months
- Increased efficiency of trays washing in CSSD by 5% thanks to better process compliancy
- Decreased paper SacPac defect rate to nearly 0%, and reduced turnaround time for the defective ones by one day
- Decreased the kit contamination rate by 5% by introducing an easier to sterilise version of the Kerrison Rongeur.

The program is also close to deliver the following:

- Implementation of the AS/NZ 4187 standards in CSSD
- Increased patient satisfaction on wards through the implementation of communication cards to allow patients to effectively communicate without interpreters (where not required by law and where clinically safe to do so)
- Decreased waiting time for ambulatory orthopaedic patients through a better alignment with radiology
- Support SAP (Surgical, Anaesthesia & Pain Management) in the implementation of the electronic eSacPac and Work Force Dimension (Onestaff replacement).

In **ambulatory services,** we are supporting a telehealth mode of delivery by:

- observing and testing the booking and scheduling process before, during and post telehealth appointment
- assisting in designing and capturing the experience of clinical and administration staff using telehealth methods
- reviewing literature and evidence regarding appropriate telehealth targets and measurements that represent both the patient and clinicians' perspectives
- devising and monitoring a change management plan to ensure everybody is properly engaged throughout the implementation of the telehealth solution.

- **Every $ Counts:** The Every $ Counts portfolio supports CM Health's financial objective to use our resources wisely to ensure best care for our patients and our community. For 2020/21 the portfolio delivered projects across four key work streams; workforce optimization, revenue maximization and cost reduction, system efficiencies, and individual service led initiatives.

Value and High Performance

Organizational capacity to both plan for and deliver to the portfolio projects in 2020/21 has been significantly impacted by COVID-19, with the continued deployment of many DHB staff away from their normal roles including senior leaders supporting the portfolio, many

of the portfolio staff themselves and partner staff leading projects within the services.

Key projects for the portfolio in 2020/21 included the ongoing delivery of electronic appointment letters, procurement opportunities and investment into improved documentation to capture complexity, as well as ongoing coding improvements. Ko Awatea supported these projects through project management and coordination activities.

A total of $9.5m savings were delivered in 2020/21 against a savings target of $17m.

- **Environmental Sustainability:** CM Health is committed to reducing its carbon footprint being the first hospital in New Zealand to receive CEMARS approval. Now in its tenth year of reporting its carbon emissions, there has been a 42% reduction in emissions[13] over this period; the largest reductions have been made in energy, transport and waste.

  Value and High Performance

  In December 2020 the public sector received a mandate from central government to be carbon neutral by 2025. At CM Health there has been significant planning towards making this as achievable as possible with a new environmental strategy in development and practical steps already underway, such as transitioning the vehicle fleet to electric vehicles, continued focus on reducing plastic waste, and ensuring all new buildings are at least Green Star 4 rated.

- **Research:** Research week was held in October 2020 and was attended by Dr Ashley Bloomfield with the Keynote Speaker being Dr Siouxsie Wiles, a well-known microbiologist, virologist and science communicator. The extensive programme included workshops as well as guest speakers in a range of categories representative of the clinical specialities at CM Health, including a Maaori and Pasifika showcase.

  People Powered

Dr Robyn Cronin, with Chris Mallon, Chief Midwife, and Dr Ashley Bloomfield, Director General of Health, receiving the award for the best presentation in the CM Health 2020 Research Week.

- In late July 2020, Middlemore Hospital hosted a **national Maaori Midwifery Research Symposium.** At the symposium Te Rau Ora, Nga Maia Maaori Midwives Aotearoa and CM Health presented a comprehensive proposal to the Ministry of Health and Health Workforce NZ to establish a National Maaori Maternal and Child Health Workforce Strategy. The strategy would ameliorate the Maaori health and workforce differences by expanding the Maaori maternal health care continuum**.** Te Rau Ora developed the evidence through four pieces of work:
  - Rapua te aronga-a-hine – a review of the literature about the Maaori midwifery workforce in Aotearoa. There is a wealth of Maaori research that substantiates the

[13] The severe restrictions on air travel during the COVID-19 pandemic positively contributed to the reduction in greenhouse gas emissions.

need for change to achieve equitable health and wellbeing for Maaori.

- Kimihia te aronga-a-hine – information was collected using a survey from the workforce tasked with caring for mama, peepi, tamariki and whaanau.
- Whaia te aronga-a-hine a nga kaiwhakawhaanau Maaori – a qualitative focus group looked at Maaori midwifery workforce needs in Aotearoa, as described by Maaori midwives.
- Whaia te aronga-a-hine nga mama – a kaupapa Maaori analysis was carried out of Maaori mama's shared experience of the maternity care workforce.

Participants at the Maaori Midwifery Research Symposium 2020

- **Leadership and People Performance:** We are always keen to share great moments in people's personal and professional achievements, whether that is individual achievements or team-based as we pursue our values of Rangatiratanga (Excellence), Manaakitanga (Kind), Kotahitanga (Together) and Whakawhanaungatanga (Valuing Everyone).

Value and High Performance

Dr Andrew Kerr, cardiologist, was awarded the New Zealand Cardiac Medal at the National Cardiac Society Annual Scientific Meeting on 17 June 2021. Dr Kerr was awarded the medal for his outstanding contributions to cardiology, which have positively impacted cardiac care across New Zealand.

- Lawrence Kingi, diabetic podiatrist, was awarded the Leadership Award at the National Podiatry Conference 2021. This award recognises an individual who has demonstrated outstanding leadership in clinical professional practice. Lawrence is involved with the 'Feet for Life' project, which helps to improve outcomes for renal patients, and he is also known for his passion for developing Tikanga based podiatry.

- The Local Heroes awards were initiated in mid-2020 to recognise and reward staff members who others feel have gone above and beyond in their service to other staff members, our patients and their whaanau.

- Truc Nguyen, surgical pharmacist, was one of the first contingent of deployed pharmacists to the Cook Islands NZ Medical Assistance Team, assisting in the COVID-19 vaccination rollout.

- The Pacific Health Development team, in conjunction with clinical staff, hosted 30 Manurewa High School Year 13 students, for a tour of some of our services. These students are part of the Health Science Academies (HSAs) set up to promote and develop interest in health careers, particularly amongst Pacific and Maaori students. The Year 13 students are creating a virtual tour of Middlemore Hospital as part of a school project. In 2020/21 additional funding was secured to increase the six HSAs to a total of 12 HSAs. Students in the programme have benefited through improved academic performance across science, numeracy and literacy subjects, and approximately 85% of the students passed Level 1, 2 and 3 NCEA, resulting in better performance than the national New Zealand Pacific or national decile 1 to 3 school achievements.

- **Embracing our diversity:** At CM Health we believe in embracing our diversity and each year we celebrate the different cultures of our staff and whaanau. In 2020/21, we not only celebrated Mataariki with a week of events in July, but also held language weeks from across the Pacific islands. On 29 April we celebrated for the first time a very important festival in the Filipino culture, called Bario Fiesta, meaning 'Neighbourhood Celebration' in Spanish. 600 staff at CM Health identify as Filipino.

One Team

- Mental Health and Addictions Services and the Faletoa Pacific Mental Health Liaison team have created a new Pacific Cultural Toolkit, providing insights into Pasifika cultural practices and worldviews on health and wellbeing within Aotearoa. This toolkit was created as part of a project for Lusia Seleti, a population health student at the University of Auckland, who worked alongside the Faletoa team.

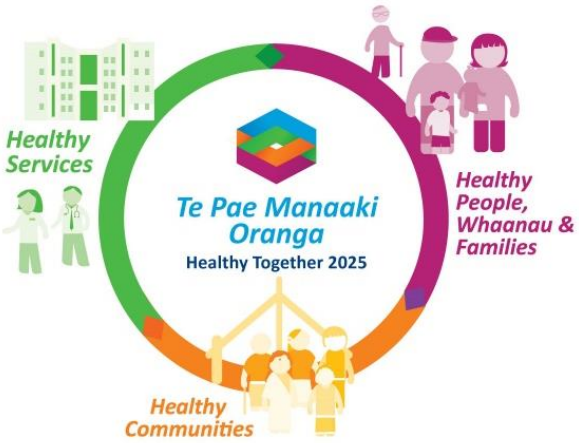
- **Healthy Food and Staff Café:** In May 2021 the staff cafeteria upgrade was completed as part of a partnership agreement between CM Health and Compass. The new menu complies with the CM Health Healthy Food and Drink Policy, has more contemporary dishes and offers more choices for those staff requiring more plant based foods, either for cultural or religious reasons, or because they are following a vegetarian or vegan lifestyle.

People Powered

Our Strategic Intentions

Healthy Together

In 2020/21, our five-year strategy was updated to reflect a similar future long term journey that we have been travelling on since 2015. We know that life expectancy in our rohe (district) has improved; however, the gap in life expectancy for Maaori and Pacific peoples has not decreased at the rate that other groups have experienced improvements. 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. We remain confident that we are on the right track and with renewed effort we will enable equity of outcomes and access for all in the years to come.



The DHB's strategic goal is now:

"Together, Counties Manukau Health will enable equity in access and outcomes for Maaori, Pacific and communities with health disparities".

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

Our Strategic Objectives

CM Health's refreshed Healthy Together strategy continues to comprise of three key objectives: **Healthy Communities, Healthy Services** and **Healthy People, Whaanau and Families.** The strategy is now underpinned by Population Health and Clinical Service Plans, a Peoples' (workforce) Strategy and Mana Oorite, the DHB's Maaori Equity Plan.

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.

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

CM Health operates as part of the New Zealand health system by contributing to national goals and performance expectations alongside local strategic priorities. The 2016 New Zealand Health Strategy provides the health sector with a collective vision for the future, that "All New Zealanders live well, stay well, get well". Translating this vision into improved outcomes for the Counties Manukau population requires alignment and integration of the many health system expectations – local, regional and national. Our strategic priorities and performance expectations are closely linked, and are guided by, the current and future needs of the people living in Counties Manukau. CM Health cannot succeed in meeting these challenges without aligning key initiatives with strategic partners, including the other Metro Auckland and Northern Region DHBs, Counties Manukau-based PHO Alliance and related service providers, and intersectoral organisations.

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

How we will measure our performance

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

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

CM Health's performance as at 2020/21 against the long-term outcomes and some of the related impacts in our outcomes framework is provided in the *Improving Outcomes* section of this Annual Report. CM Health's 2020/21 performance for the outputs identified in our outcomes framework is provided in the *Statement of Service Performance* on page 46. Together these two sections provide a current picture of the progress CM Health made towards achieving our long-term outcomes and strategic goal in 2020/21.

Figure 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

Healthy Communities	Healthy People, Whaanau and Families	Healthy Services
• 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

Healthy Communities	Healthy People, Whaanau and Families	Healthy Services
• 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.

Improving Outcomes

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

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

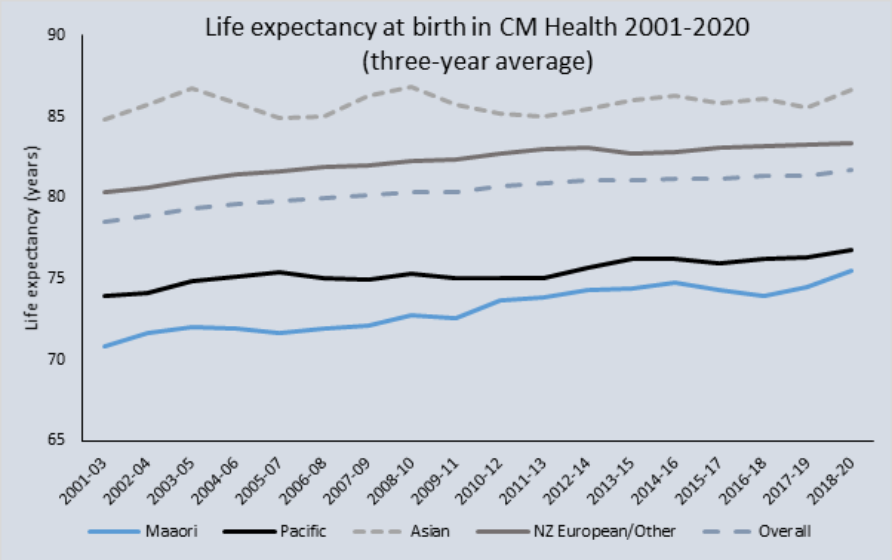
For the Counties Manukau community, we need to target outcome improvements to achieve health equity.[15] To better understand which people do not experience the same health outcomes, we report and compare results over time by ethnic group. Results are not always available for all ethnic groups and work is ongoing to improve the accuracy and scope of results by ethnic group.

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

Overall long-term outcomes

Reduce life expectancy at birth gap for Maaori and Pacific peoples[16]

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



The three-year average for overall life expectancy at birth in Counties Manukau has steadily increased over the last ten years to 81.7 years in 2018-20, closely reflecting national trends. A gap of 7.9 years and 6.6 years remain between Maaori and Pacific peoples respectively and New Zealand European/Other for the 2018-20 period. Our local and regional planning for 2021/22 is strongly focused on improving health equity for Maaori, targeting those conditions and health outcomes that impact the most on amenable mortality and life expectancy, including cardiovascular disease, diabetes, long-term condition management and smoking cessation.

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

[15] Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need.
[16] Data source: Ministry of Health (MOH) mortality collection and estimated population from Stats NZ (2020 edition).

over 15-50 years of New Zealand residency[17], to sustain this relatively high life expectancy, we are focused on early risk factor prevention and effective management of long term conditions in our Indian and Chinese communities.

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

Equitable increase in healthy life years

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

As in other countries, the improvement in estimated healthy life expectancy for New Zealand has grown more slowly than the improvement in life expectancy.[18] 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 continues to enhance approaches that will reduce risk factors and improve management of long term health conditions. Approaches include preventing potentially avoidable ill-health (e.g. smoking cessation, immunisation), delaying onset of disease through early identification of disease (e.g. cardiovascular risk assessment, cancer screening, timely diagnostic services) and effective treatment (e.g. timely elective care, effective cardiovascular and diabetes treatment) and self-management. Actions to improve healthy life expectancy also need to address areas of ill health such as mental health and musculoskeletal conditions (which impact morbidity and quality of life to a greater extent than length of life per se) and the importance of investment early in the life course to provide equitable opportunities for positive life outcomes. These are important complementary considerations taken into account in CM Health planning and prioritisation.

[17] Hajat A, Blakely T et al. Do New Zealand's immigrants have a mortality advantage? Evidence from the New Zealand Census-Mortality Study. *Ethnicity and Health* 2010 (Oct), 15:5; 531-47.

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

Medium Term Outcomes

Healthy Communities – Improved population health and equity

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

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

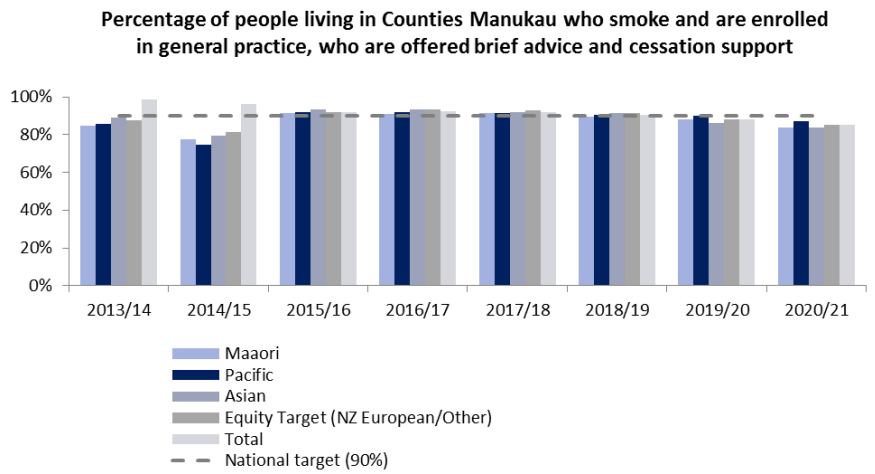
Equitable smokefree rates across Counties Manukau

Smoking, a leading risk to health in Counties Manukau, disproportionately burdens Maaori and Pacific peoples.

Inequities in smoking prevalence contribute to differences in life expectancy and wellbeing between Maaori and Pacific and non-Maaori/non-Pacific peoples. At the time of Census 2018 Maaori (31%) and Pacific peoples (22%) in Counties Manukau were two and a half and nearly two times more likely to smoke respectively than people identifying as NZ European/Other ethnicities (12.3%).[19] The overall total smoking prevalence in 2018 was 14.4% against the total target of 10%.

Brief advice and cessation support can be effective at prompting quit attempts and long-term quit success.

Key contributory measure: Better help for smokers to quit (Primary) - 90% of Primary Healthcare Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking in the last 15 months[20]



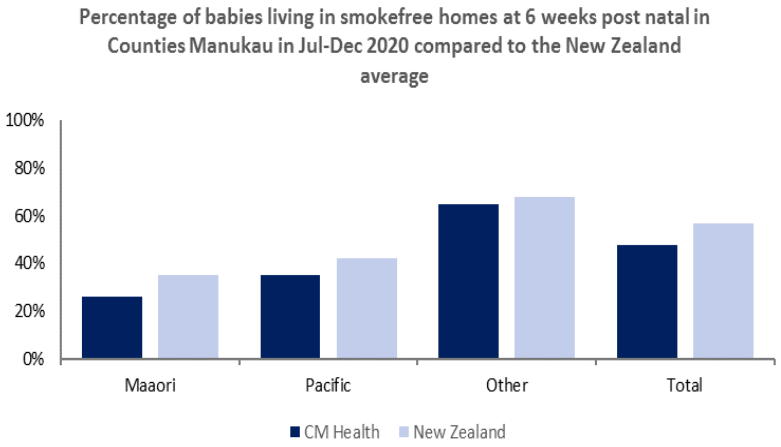
In 2020/21, CM Health achieved 85% for the total enrolled population against a target of 90%. 84% was achieved for Maaori and Asian populations, and 87% for Pacific.

Although primary care has not achieved target on brief advice activity they have continued to work towards streamlined referral systems, priority population targeted outreach and increased cessation activities. In 2020/21, the CM Health Living Smokefree Service received an increase of 72% in primary care referrals (Maaori 51%, Pacific 69% increase) with 2,093 referrals (Maaori 36%, Pacific 24%) compared to 1,214 referrals received in 2019/20 (Maaori 42%, Pacific 24%). Overall the Living Smokefree Service received 7,090 referrals in 2020/21 (Maaori 43%, Pacific 26%) compared to 5,376 referrals in 2019/20 (Maaori 46%, Pacific 27%) reflecting the strong equity focus of this service.

Data source: Ministry of Health Performance Reporting

[19] Data on smoking prevalence is from the 2018 Census.
[20] The data is for quarter four of each financial year.

Key contributory measure: Increased percentage of babies living in smokefree homes at six weeks post-natal[21]



Increasing the number of babies living in smokefree homes will reduce potentially avoidable ill-health and hospitalisation (e.g. respiratory infections, asthma). Infant exposure to tobacco smoke contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. The System Level Measure "Babies living in smokefree homes at six weeks post-natal" includes other household members and so focuses the attention beyond maternal smoking to the home and whaanau environment that an infant will be raised in. In 2020, marked inequities remained for Maaori and Pacific infants who were less likely to live in a completely smokefree home compared to New Zealand/Other households. The ethnic inequities in CM Health are similar to the national averages across New Zealand.

In 2020, across Counties Manukau, an estimated 38% of Maaori women were identified as currently smoking at the time of admission for birth, compared to 9% of Pacific women and 4% of NZ European, Asian and Other women. In 2020/21 smoking cessation support was targeted for women during and after birth. The Smokefree Maternity Incentives programme has demonstrated a highly effective approach to supporting hapuu maamaa to stop smoking during pregnancy with 730 referrals received for hapuu maamaa (Maaori 58%, Pacific 30%). 65% engaged and were supported on their smokefree journey resulting in 208 smokefree waahine at four weeks post a quit date, with others reducing consumption, trying nicotine replacement therapy and benefitting from the other interventions we support such as SUDI prevention education and safe sleep device delivery, alcohol harm minimisation, and breastfeeding support/antenatal classes/Family Start/Healthy Housing referrals. Whaanau of hapuu maamaa women are also incentivised to stop smoking.

In 2021/22, efforts will continue to focus on increasing reach and engagement in the existing whaanau incentives programme to support more babies to live in smokefree homes. This will have an equity focus to support Maaori and Pacific women and their whaanau.

Data source: Ministry of Health Performance Reporting

Equitable reduction in obesity prevalence in children

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

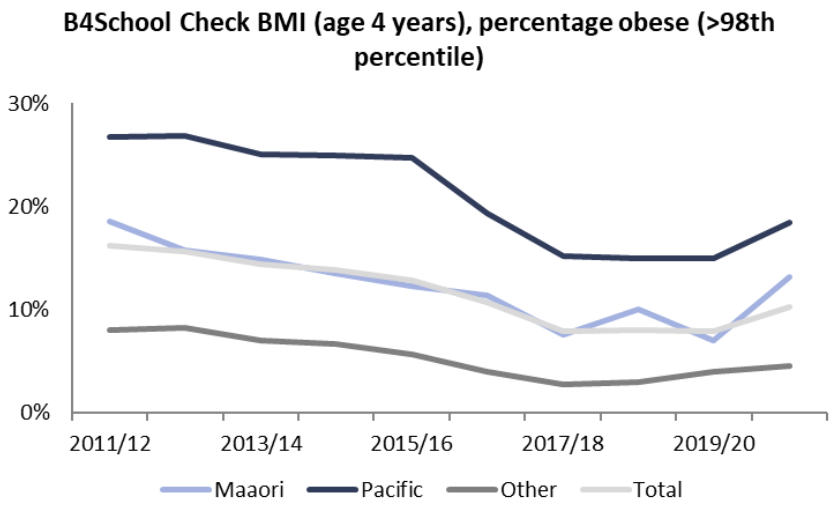
Supporting healthy weight in children

Referral for children identified with a high Body Mass Index (BMI) at the B4School Check provides an opportunity for children and whaanau to participate in clinical assessment and family-based nutrition, activity and lifestyle programmes. In 2020/21, the percentage of four year olds with a BMI over the 98th percentile was 10%. This was higher for tamariki Maaori at 13% and Pacific children at 18%.[22]

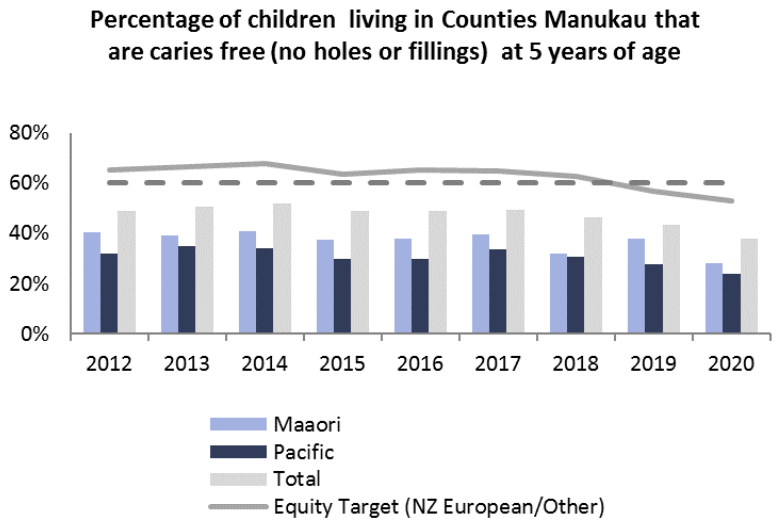
[21] In 2018/2019 an SLM was introduced focused on the proportion of babies in smokefree households at six weeks of age. This measure replaced the measure of percentage of women who are smokefree at 2 weeks postnatal. The new data standards came into effect on 1 Jan 2019.
[22] Data for 2020/21 is from six months of the year; 1 December 2020 – 31 May 2021.

At CM Health, we acknowledge the need for a broad approach to reducing childhood obesity. CM Health is part of the Healthy Auckland Together coalition, which works with intersectoral partners such as schools and the University of Auckland to support wider environmental and cross-sectoral societal change. "Raising Healthy Kids" funding has ceased. Lifestyle intervention programmes funded under this umbrella for children in South Auckland will be significantly impacted.

Data source: Ministry of Health Performance Reporting



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



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

In 2020/21 total percentage of dental caries-free children at five years was 38%, a 7% reduction from 2019/20; still below CM Health's targeted level of 49%. The target was only achieved for European/Other children; oral health inequities persist. Early enrolment and engagement with dental services will support early prevention and detection of oral health problems, including dental caries. Implementation of an automated enrolment from birth process increased Counties Manukau children's enrolment with the Auckland Regional Dental Service (ARDS). In 2021/22 CM Health will continue to work with ARDS to mitigate oral health inequities and to focus on preventative services to children at high risk of dental caries, including Maaori and Pacific children. CM Health will also continue working on aligning oral health and obesity prevention messaging, focusing on new resources for Maaori and Pacific children.

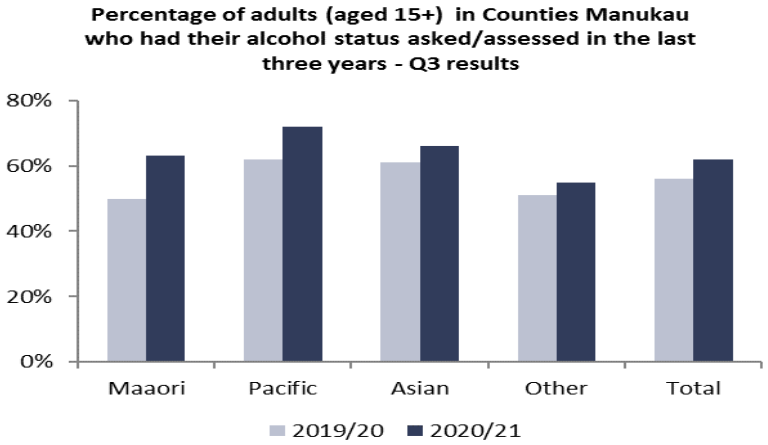
Data source: Ministry of Health Performance Reporting

Reduced hazardous alcohol use and harm

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

Key contributory measure: Increasing the percentage of enrolled patients in general practice who have had their alcohol status asked/assessed in the last three years[23]

CM Health has been developing a programme of collaborative alcohol harm minimisation actions with a view to working regionally. This work includes equitable delivery of the Alcohol ABC (Ask, Brief Advice, Counselling) approach in general practice. The graph shows the 2019/20 and 2020/21 data for quarter three for the percentage of enrolled patients in general practice who have been asked about their alcohol use in the last three years.



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

To support the Alcohol ABC approach in general practice, a data standard and specification has been developed and implemented in collaboration with general practice partners and the Metro Auckland Data Sharing Programme. This enables standardised data collection and reporting of Alcohol ABC indicators across the Auckland region.

Data source: General practice Alcohol ABC data, reported through HealthSafe, Metro Auckland Data Sharing Programme

Improved mental health and wellbeing

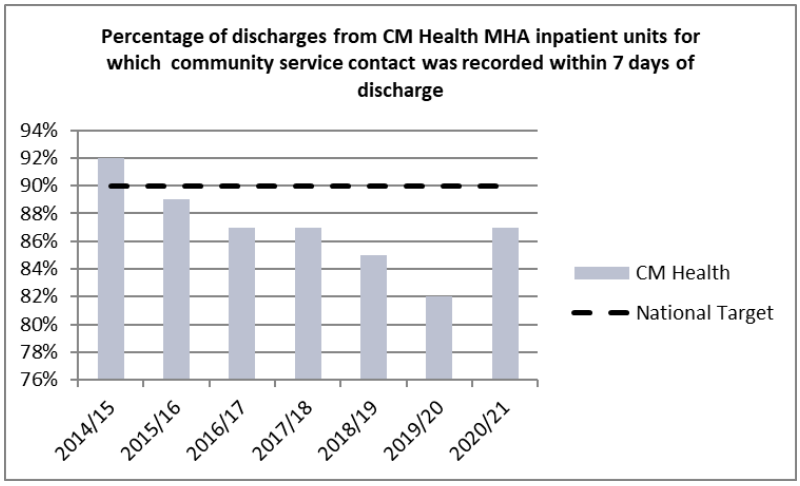
Many New Zealanders will experience a mental illness and/or an addiction at some time in their lives. Maaori and Pacific peoples report higher levels of psychological distress than non-Maaori, non-Pacific. They may also miss out on early interventions that might prevent progression to more significant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

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

Follow-up of tangata whaiora and whaanau within seven days of an inpatient discharge helps promote engagement with the local community mental health teams that have greater access to support services in the community. It also ensures that clinical care is provided within the community in a timely manner following the period of inpatient care.

In 2020/21, an average of 87% of service users discharged from CM Health's acute adult inpatient mental health unit, Tiaho Mai, had a community mental health service contact recorded within seven days of their discharge. This is an improvement on 2019/20 (82%), but remains an area of focus for the community teams. All managers continue to undertake a variety of strategies to monitor and implement improvements regarding this Ministry of Health key performance indicator. An example is the community consultant psychiatrist from the Early Psychosis Intervention Team (EPIT) now going into the inpatient unit on a weekly basis to support engagement prior to discharge.

[23] Data Source: HealthSafe, Metro Auckland Data Sharing Programme. Data covers 86% of the enrolled population in Counties Manukau aged 15+. The prioritised ethnicity method has been used for ethnicity data output.



The prioritisation of Maaori and Pacific candidates when recruiting to the four Consumer and Whaanau Engagement roles supported Tangata whaiora and whaanau to access information about their rights; promoted their voice within the community teams; and offered someone with lived experience to whom Tangata whaiora and whaanau could speak with, and have speak on their behalf, when required. These roles supported the improvement of the post-discharge process from within both the Inpatient and Community teams.

The percentage of Maaori discharged from Tiaho Mai who were seen within seven days of discharge closely reflects the overall service contact trends for the past three years. While the percentage of Pacific who were seen within seven days of discharge from Tiaho Mai remains high, it has unfortunately not exceeded the target as it did two years ago.

We continue to note that the data set includes all people who have been discharged, regardless of destination, and therefore includes Tangata whaiora who have been transferred out of the Counties Manukau catchment area (and are followed up by another district health board), those admitted into another inpatient facility (Middlemore Hospital/Tamaki Oranga Recovery Centre), and those whose care is transitioned directly back to primary care.

In these situations, the CM Health community teams are not providing follow up post discharge, and therefore the percentage of Tangata whaiora who should have been seen post discharge is recorded as lower than it actually is.

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

Improved youth mental health and well-being

2020/21 saw continued work with general practices to embed the Wellness Support model of care. An increase was seen in Maaori and Pacific people's access to social and cultural primary mental health support for young people. A total of 49,949 consultations were provided to 27,214 people; of which 2,667 consultations were provided to those between 12-19 years of age (9.8% of all consults). Of those provided with support 17.7% were Maaori and 9.4% were of Pacific origin.

The Tuu Whakaruruhau Programme Leadership Board is working with the Ministry of Health (MOH) to improve the model to better understand equity of outcomes. Feedback to MOH on the draft evaluation report was completed by Malatest in quarter three and identified a number of gaps, with further analysis suggested to better evaluate the effectiveness of the programme and outcomes achieved. Malatest has commenced interviewing a range of IPMHA practices including Kaupapa Maaori and Pacific providers. There is an opportunity to improve engagement of all priority populations with new access and choice services for Maaori, Pacific and youth in Counties Manukau. Strong integration across these initiatives will be key.

Development of the Alcohol and Other Drugs (AOD) model of care for co-existing disorders is part of the wider AOD continuum for the Northern region. It has sought to improve responses to co-existing problems via stronger integration and collaboration between other health and social services. 2020/21 has seen increased communication between mental health and the AOD sector by empowering clinicians with effective screening, assessment and management of co-existing problem knowledge. Confident and effective communication encourages more appropriate youth referrals to specialist AOD services.

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

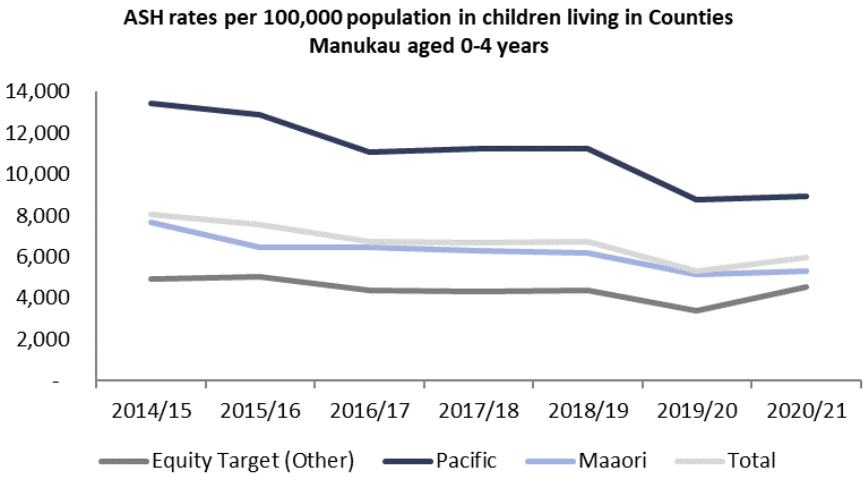
"Together we will involve people, whaanau and families as an active part of their health team"

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

Equitable reduction in potentially avoidable hospitalisation in our 0-4 year olds

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

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



The ASH data presented is for the 12 months ending in June of each year. The 2020/21 Metro Auckland System Level Measures (SLM) Improvement Plan set a target of reducing the 0-4-year-old total, Maaori and Pacific ASH rates by 3% by June 2021 (using the year to December 2018 results as the baseline). CM Health has achieved this target for total population, Maaori and for Pacific ethnic groups. Since the COVID-19 pandemic began there has been a significant decrease in respiratory hospitalisations in this age group in large part due to the restrictions put in place to stamp out COVID-19. The Metro Auckland region experienced several weeks of lockdown, during which transmission of respiratory illnesses, especially influenza, was significantly reduced. Beyond restrictions that limited personal contact, increased awareness of hand hygiene, wearing masks in public, and people being encouraged to stay home when unwell were also contributing factors in the decrease of respiratory illness resulting in hospitalisations. However, an increase in respiratory syncytial virus (RSV) cases in June 2021 is likely to have contributed to the higher ASH rate in the last quarter (when compared against quarters one to three) of 2020/21.

In 2020/21, there was a focus on groups who experience inequitable child outcomes by promoting enrolment with Well Child/Tamariki Ora (WTCO) providers in primary care, particularly for Maaori and Pacific children. The other principal area of focus is reduction in admission for respiratory events.

Data source: Ministry of Health Performance Reporting

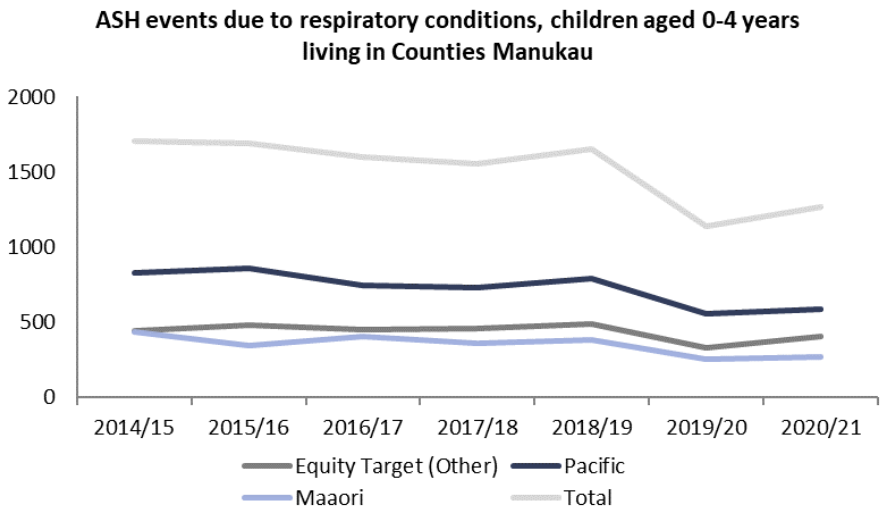
Key contributory measure: Reducing 0-4 year old ASH events – respiratory condition subset

Counties Manukau Pacific and Maaori children are more likely than children of other ethnicities to be hospitalised with respiratory conditions including asthma and pneumonia. The 2020/21 Metro Auckland SLM Improvement Plan targeted reduced ASH rates through focusing on respiratory admissions, the largest contributor to 0-4-year-old ASH rates across the three Auckland DHBs. Through both local and regional work, CM Health implemented a number of strategies to reduce

respiratory admissions, including actions to improve child and maternal immunisation and smoking cessation. This is especially important for reducing inequities for our Pacific children, who have the highest total and respiratory ASH rates. The ASH data presented is for the 12 months ending in June of each year. Since 2016, there has been a decrease in ASH rates for Pacific tamariki for respiratory conditions (asthma, lower respiratory tract infections, pneumonia, upper and ear nose and throat respiratory tract infections). However, inequities have persisted over time.

Influenza vaccination rates for children with previous hospital admissions continue to improve as do maternal vaccination rates for both influenza and pertussis.

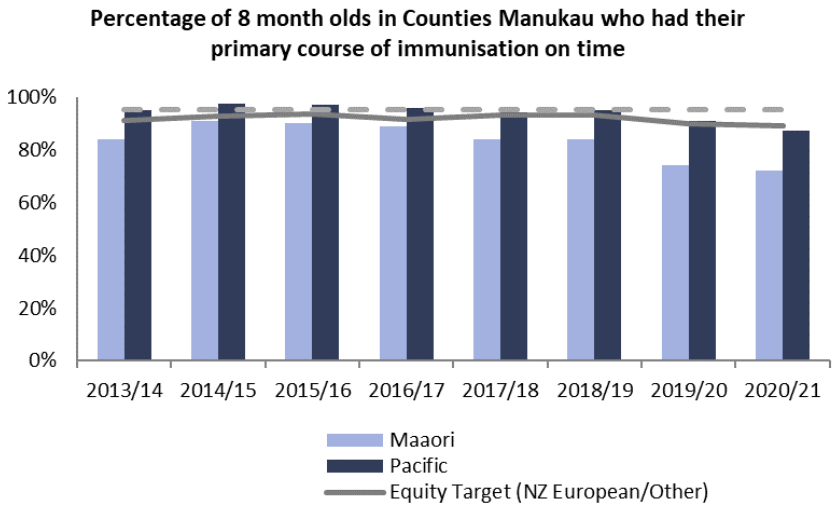
The 2021/22 SLM plan will continue to target reduced ASH rates through focusing on respiratory admissions. This is particularly important in a post COVID-19 environment. CM Health continues to support the implementation of the Best Start Pregnancy Assessment Tool. This decision support tool will prompt clinicians to offer vaccinations, to refer to Healthy Housing and to refer to smoking cessation for pregnant women and their whaanau who smoke.



Data source: Ministry of Health Performance Reporting

Key contributory measure: Improving immunisation coverage to reduce potentially avoidable hospitalisations
95% of children will be fully immunised by the time they are 8 months old

Tamariki Maaori have lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases. Ensuring that vaccination coverage at 8 months achieves the national 95% target is important for enabling wellbeing for Maaori children and to avoid potentially avoidable hospitalisations. CM Health aims to achieve equity by increasing the percentage of pepi and tamariki Maaori who are immunised on time at 8 months, and two and five years.



In 2020/21 CM Health did not meet the 95% overall target and 90% coverage for tamariki Maaori. Maaori coverage for the 8-month old target improved by 4% from quarter three; this is encouraging. Over the past year families have been plagued with vaccine misinformation causing them to be more hesitant. The COVID-19 related lockdown response has also had an impact on access to families and services, resulting in vaccine delay; however, many of these babies will complete their vaccinations outside of the immunisation target age range.

The evaluation of the 8 month Maaori incentivized immunisation programme did show an improvement in the engagement time between families and the Outreach Immunisation Service but not an improvement in vaccinations. Family feedback was that the incentive was nice but not necessary for decision making around immunisations for pepi.

Over 2021/22, CM Health will continue to work with PHOs and other health partners to seek improved and innovative ways of working to better meet the needs of whaanau and to remove barriers to access.

Data source: National Immunisation Register Qlik report

Improved end of life pathways for patients and whaanau

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

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

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

A key achievement of Poi has been the establishment of hospice multi-disciplinary teams, which provide expert mentoring and coaching to primary palliative care providers (chiefly ARRC facilities and GPs) in their local areas. Specialist support is received following submission of Palliative Pathway Activations (PPAs). These PPAs, or palliative care plans, are completed by primary palliative care providers for patients with identified palliative care needs, regardless of whether specialist palliative care is required. PPAs are reviewed by the Poi teams and attract a payment for the primary palliative care provider, to reflect the resources required to complete a plan. Support and guidance is provided to the primary care provider as required to improve capability in managing palliative care patients safely in the community. In 2020/21, 180 PPAs were completed by Totara and Franklin Hospice as part of Poi, with the number of PPAs steadily increasing across the region. 149 contacts (or 'proactive conversations') were recorded between the local hospices and primary palliative care providers as a result of the PPAs submitted.

Further to this, 383 link nurses have been trained within the Metro Auckland region since 2017. Link nurses act as champions within primary care and liaise between primary care providers and specialist palliative care services, to improve communication and co-ordination of care for patients with palliative care needs. 14 GPs with Special Interests (GPSI) have been employed by local hospices to progress palliative care capability and resources within primary and residential care settings for accredited six-month rotations. GPSI are champions within the primary care workforce that will have expertise in both primary and palliative care.

An evaluation of the programme has been commissioned through Martin Jenkins and this evaluation was published in April 2021. There were four key recommendations as a result of this review, and these are summarised as:

- What is Poi?
- How could Poi be better set up for success?
- How to measure success?
- How do we embed sustainable change?

The Metro Auckland DHBs will be working closely with the hospices to review and implement recommendations from the review over the next 12 months.

Healthy Services – better value for public health resources

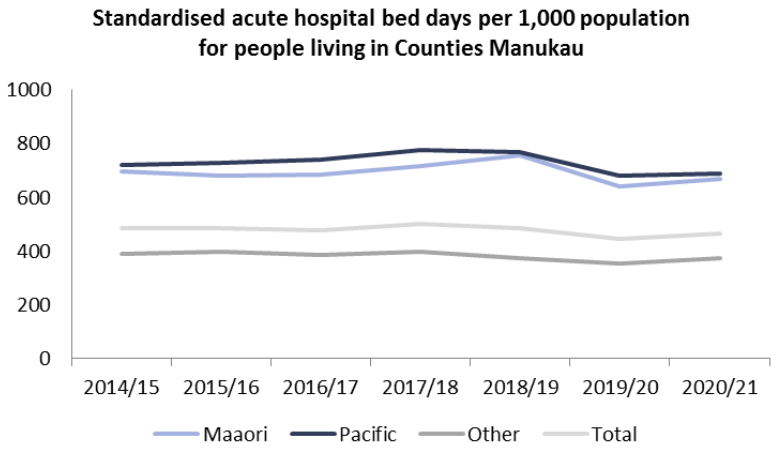
"Together we will provide excellent services that are well-supported to treat those who need us safely, with compassion and in a timely manner"

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

Reduction in acute hospital bed days

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

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



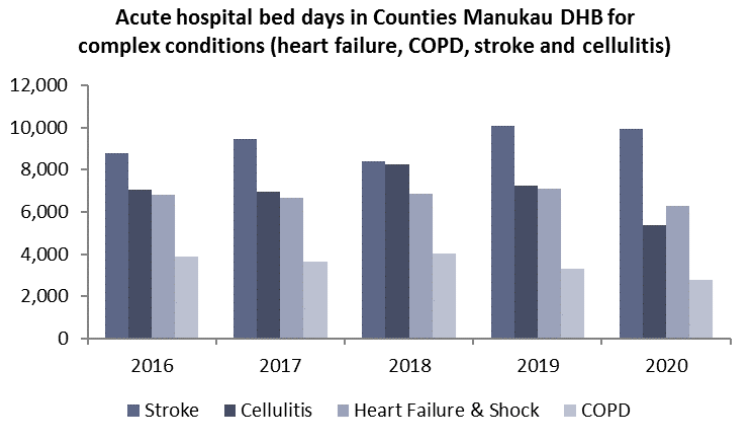
June 2021 results show that CM Health has met the 2020/21 SLM Plan milestone for reducing the number of acute hospital bed days per capita for both the Maaori and Pacific populations. This is a challenging measure to shift due to the wide variety of factors (including socioeconomic deprivation) that impact on this measure.

The 2021/22 SLM Plan will continue to focus on Maaori and Pacific populations so those with ASH conditions can be better targeted for preventative care. In CM Health the Te Ranga Ora initiative will seek co-designed care pathways to improve long-term condition care for Maaori and Pacific whaanau.

Data source: Ministry of Health Performance Reporting[25]

Focus on improving management for those with complex conditions

Acute hospital bed days in Counties Manukau DHB for complex conditions (heart failure, COPD, stroke and cellulitis)



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 2021/22 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. The System Level Measure 2021/22 milestone aims for a 3% reduction for Maaori and Pacific populations by 30 June 2022. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of primary options for acute care (POAC). It also targets improved coding for the top four priority conditions so that effective interventions can be targeted.

Data source: Ministry of Health Performance Reporting[26]

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

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

[26] Data is to March of each year.

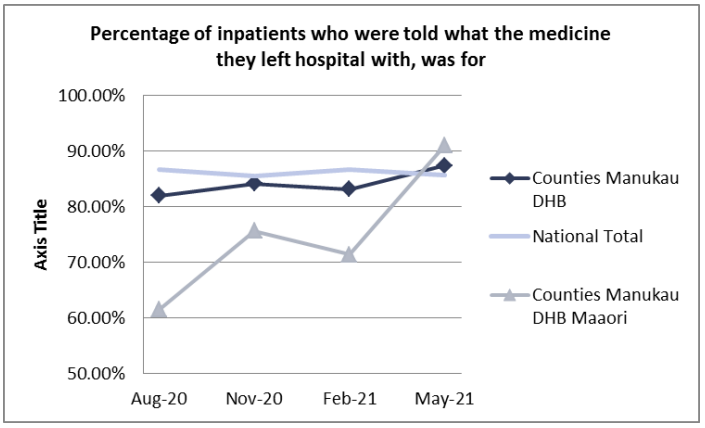
Improved and more equitable experience of care

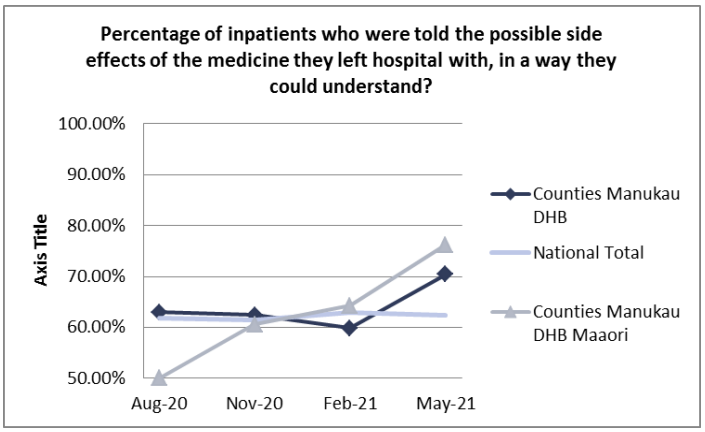
The Hospital Inpatient Patient Experience Survey (PES)

Understanding and improving patients' experience is vital to improving patient safety and the quality of care, and contributes to better health outcomes.[27]

The national Hospital Patient Experience Survey provides insights into how to improve patient experiences by focusing on activities to improve the quality of care provided. In 2020/21, CM Health focused on the lowest scoring domain in the inpatient survey related to 'Communication'. This was related to communication about medicines provided to inpatients who were heading home after a stay in hospital. The target improvement was 5% for the two measures shown in the graphs to the right. CM Health achieved an improvement of 5.4% between August 2020 and May 2021 for the question 'Were you told what the medicine you left hospital with, was for?', and an improvement of 7.4% for the same period for the question 'Were you told the possible side effects of the medicine you left hospital with, in a way you could understand?'. The improvement in communication with Maaori was significantly greater with increases of 29.6% and 26.2% respectively.

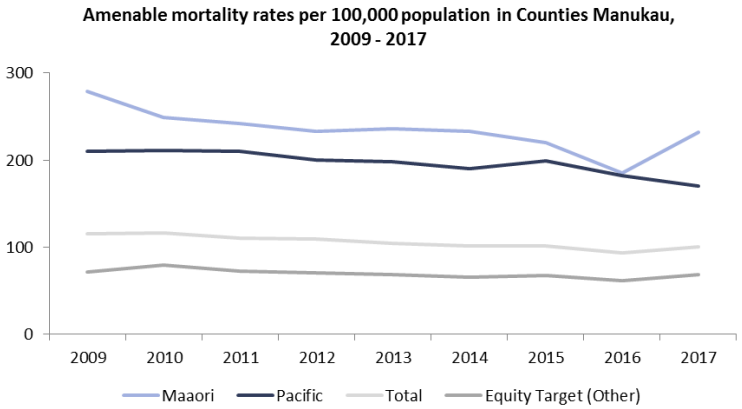
Data source: Health Quality and Safety Commission National Patient Experience Survey Report [28]





Reduced and more equitable amenable mortality rates

Targeting improvements in the leading causes of potentially preventable deaths.



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

The 2020/21 SLM Plan has a target set of an amenable mortality rate of 2% annual reduction for Maaori and Pacific, and 6% annual reduction for the entire DHB population to be achieved by June 2021 (on 2013 baseline). Based on five-year trends, Counties Manukau DHB shows a

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

[28] 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. HQSC plan to add additional questions to assess patient experience according to cultural needs. Currently, CM Health's internal inpatient survey asks patients about the importance of respecting values, beliefs and cultural needs.

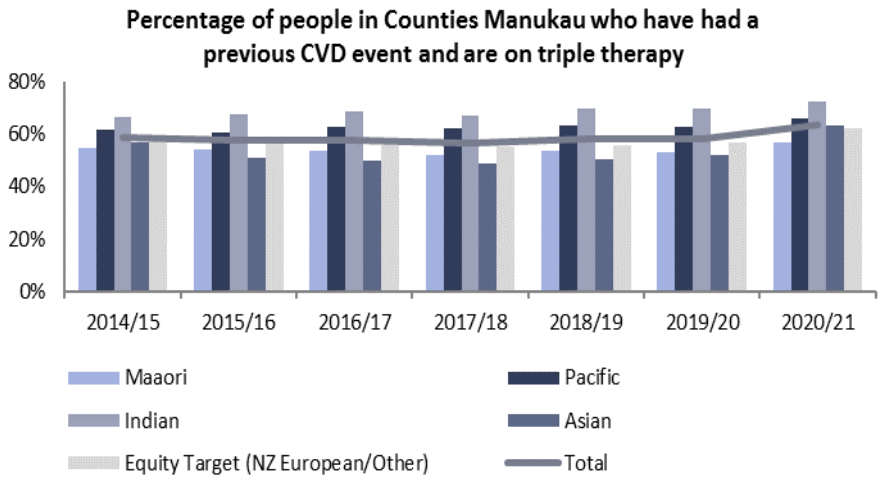
general decline in the total amenable mortality rate. Data from 2017[29] indicates we have not met the reduction target for all ethnic groups and have not met the reduction target for Maaori, but did meet the reduction target for Pacific.

The 2021/22 SLM Plan sets an annual cumulative reduction target of 5% for Maaori under age 50, 3% annual cumulative reduction for Maaori over age 50, 3% annual cumulative reduction for Pacific under age 50, 5% annual cumulative reduction for Pacific over age 50, and 3% annual reduction for the entire DHB population to be achieved by June 2030 (on 2017 baseline). This will be achieved through continued focus on improving smoking cessation and management of CVD, as well as a focus on the implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.

Data source: National Mortality Data Collection (definition based on Ministry of Health (MOH) September 2016 version on defining amenable mortality)

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' medicines can reduce the risk of future CVD events and death. Triple therapy as defined as statins, antiplatelet/coagulants, and blood pressure lowering medicines dispensed in at least three quarters in the year.[30]



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

In 2019/20 we did not achieve our targets for increasing the percentage of people on triple therapy. In 2020/21 there has been a slight increase in the number of people on triple therapy. The focus remains on reducing inequity by improving CVD management for our population and for Maaori patients specifically through both local and regional initiatives with a greater focus on appropriate risk management. The focus is on CVD screening for the newly eligible cohort i.e. Maaori, Pacific, Indian and South Asian population (men 30-34 years and women 40-44 years).

Most of the PHOs have started implementing the 2018 CVD risk assessment algorithms. Both primary and secondary prevention will be improved through capturing when patients have either declined or are intolerant of medication. This will enable more targeted interventions.

Data source: NRA CVD Prevention Medication Six Monthly Report[31]

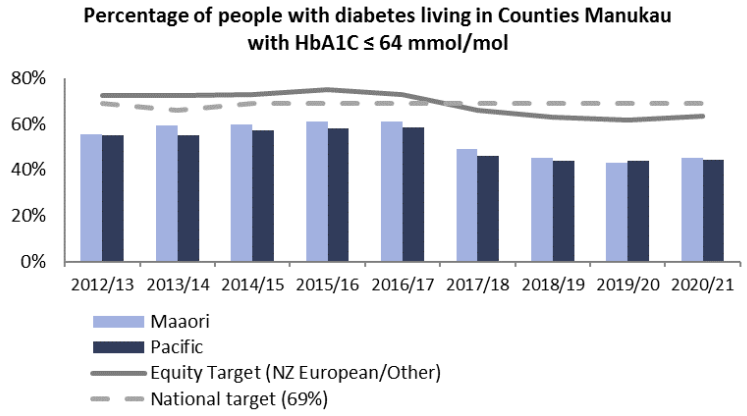
Key contributory measure: Improved diabetes control in people with the highest disease burden

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

[29] Note that this is the latest available coded mortality data from the Ministry of Health as at July 2021.

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

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



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

In 2020/21 the Long Term Condition Clinical Governance Group continues to review and support practices with poor performance for glycemic control. The Long Term Condition Clinical Governance group has now established smaller working groups that will work on – podiatry, retinal screening, new medications, pharmacy and gout, primary care diabetes education, and diabetes in pregnancy.

- A formal education programme has been developed and we are working with the PHOs to choose practices based on equity. The criteria are i) Equity - who is struggling with caring for their patient with diabetes ii) Practices that have the highest number of people with uncontrolled diabetes iii) Practices that have a high number of people with no record of HbA1c in the last 15 months. The programme will be strongly underpinned by equity and the delivery will be augmented by a mentorship model. The programme will be offered to all primary care teams, not only nurses. This will encourage effective patient management. The programme is aimed at improving skills and capability to provide best practice and effective diabetes care and management.
- The retinal screening data match project is progressing well. People with high HbA1c and no HbA1c recorded are prioritised to allow effective diabetes management and make these patients visible to primary care for better continuation of care. CM Health does not take patients off the waiting list. The retinal screening team continues to make contact with patients. The DNA (did not attend) patients are parked in a separate waitlist for follow up.
- The diabetes in pregnancy working group is currently working on E-lab forms that are automatically generated and a reminder is sent to the GP and patient regarding due date for HbA1c checkup. The group is also working towards developing stickers to remind women about their six month and 12 month HbA1c checkups. The stickers could be attached to the Well Child Tamariki Ora book. They could also be given to new mothers (with GDM) in the maternity ward. CM Health is currently supporting the Best Start Pregnancy decision support tool. We would also like to develop a congenital abnormality register.

In 2021/22 we are aiming to improve the percentage of patients with good glycaemic control through increased focus on improving the quality of diabetes care and proactive management of long-term conditions. This will include an emphasis on nurse led care and delivering an effective self-management programme to address health literacy and equity.

Data source: Ministry of Health Performance Reporting[32]

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.

In 2020/21, the reported deficit is $43.8m. The Year End audited underlying financial position was a deficit of $30.4m before one off adjustments of $1.6m upside for COVID-19 and an additional Holiday's Act provision of ($15m), compared to a budget deficit of $29.8m.

The unfavourable YTD result reflects continued unprecedented demand for acute services causing significant periods of

[32] 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.

over occupancy, specifically during the last quarter. This acute demand has had a significant impact on planned care recovery volumes meaning the DHB has not been able to deliver volumes lost during the COVID-19 Alert Levels 2 and 3. During 2020/21, planned care recovery revenue has been lost due to procedures disrupted during these periods (not recovered by year end); this has been coded to COVID-19 as lost revenue.

The DHB's response to COVID-19 through 2020/21 has seen continued deployment of a significant number of DHB staff away from normal roles. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. Lower than expected savings from this programme in 2020/21 have been offset by vacancies and lower spend in other areas. However, by not realising our cost reduction programme in full, we have moved into 2021/22 with a higher cost base.

Our Health Service User population data for 2020 displays an undercount of approximately 7,000 residents in 2021/22 (2020/21 21,000 residents) when compared to our PBFF[1] allocation. Interactions between the undercount within the Census data and the use of administrative data, in a setting with large amounts of household overcrowding (specifically prominent amongst Pacific families), has significant impacts for our community. For the 2021/22 budget, while we did see some correction to our revenue in relation to the undercount of our population, we have not seen the full correction which adequately accounts for our population. When we apply the per capita rate to the remaining estimated undercount, this factor alone amounts to circa $19.8m (2020/21 $32m) in underfunding which has a significant impact on our ability to offer the full range of care relative to other DHBs and address some of our key clinical risk and equity concerns at scale. The effects of this undercount are compounded by the complexity of our population and its accompanying social and healthcare needs – the PBFF does not adequately capture socio-economic drivers of ill-health, nor the compounding effects of the unequal distribution of long term conditions. It is important to acknowledge the continuous and persistent undercounting of CM Health's population and the effect this has on our ability to meet our demand pressures, including implementing equity improvements on a large scale, and achieving sustainability.

[1] The Population-Based Funding Formula (PBFF) is a technical tool used to help equitably distribute the bulk of district health board funding according to the needs of each DHB's population.

Statement of Service Performance

This section presents CM Health's actual performance against the forecast outputs presented in our 2020/21 Statement of Performance Expectations. The services or 'outputs' we measure are grouped into four 'output classes' – prevention services, early detection and management services, intensive assessment and treatment services, rehabilitation and support services – that reflect the nature of the services provided, as presented in our outcomes framework.

CM Health's 2020/21 results are based on our annual performance, unless otherwise specified.

Results are categorised based on the key below to demonstrate how far the result was from the target. This is important to demonstrate as although some measures were not achieved, the percentage difference is minor, while other measures are significantly off target. Numerators for the baseline and performance results have been included in the columns "19/20 Volume" and "20/21 Volume" where possible to provide context to final performance.

Key for 2020/21 results:

	Target met
	≤ 5 percentage points off target (for results displayed as a percentage) *or* ≤ 5 percent off target (for all other results)
	> 5 percentage points off target (for results displayed as a percentage) *or* > 5 percent off target (for all other results)

Prevention services

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

Preventive services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

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

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
Health Promotion and Education Services						
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months	Total	88%	90%	85%	59,000	55,006
	Maaori	88%		84%	18,991	17,642
	Pacific	90%		87%	19,413	18,549
	Asian	86%		84%	5,670	5,431
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking	Total	94%	90%	95%	429[33]	364
	Maaori	94%		95%	291	230

[33] Due to reduced reporting in quarter three as a result of COVID-19 full quarter three data was not reported, and therefore a full financial year data set was not available. Percentages and volumes for 2019/20 are reflective of a sum of quarter's one, two and four 2019/20 performance only.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
Percentage of babies living in smokefree homes at six weeks postnatal[34]	Total	44%[35]	55.9%[36]	48%	1,846	2,117
	Maaori	22%		26%	192	226
	Pacific	35%		35%	440	469
Percentage of babies fully or exclusively breastfed at 3 months[37]	Total	49%	70%	48%	1,506	1,574
	Maaori	39%		35%	202	196
	Pacific	45%		44%	350	377
Percentage of children identified as obese in the B4 School Check programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	100%	95%	100%	190	370
	Maaori	100%		99%	43[38]	106
	Pacific	100%		100%	116	186
	Other	100%		100%	43	78
Number of eligible adult service users engaged in the Green Prescription programme each year[39]	Total	2,921	4,000	3,046		
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[40]	Total	92%	95%	87%	7,812	7,353
	Maaori	84%		72%	1,535	1,226
	Pacific	92%		87%	2,390	2,183
	Asian	98%		98%	2,356	2,330
Proportion of eligible boys and girls fully immunised with HPV vaccine	Total	60%[41]	75%	61%	5,705	6,242
	Maaori	57%		55%	1,171	1,115
	Pacific	59%		60%	1,822	2,067
	Asian	73%		73%	1,317	1,534
Percentage of people aged over 65 years who have had their flu vaccinations[42]	Total	53%	75%	63%	36,252	44,304
	Maaori	43%		53%	2,163	2,735
	Pacific	65%		76%	5,225	6,370
	Asian	54%		57%	7,151	9,386
Health Screening						
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	70%[43]	70%	65%	42,689	39,202
	Maaori	65%		59%	4,644	4,447
	Pacific	81%		73%	7,939	7,357

[34] Denominator is from the WCTO dataset.
[35] Results for 2019/20 are from the period January 2020 – June 2020. 2020/21 results are for the period July 2020-December 2020.
[36] The target represents a 2% relative increase from baseline as per the 2020/21 Metro Auckland SLM Improvement Plan.
[37] Data reported six-monthly. Baseline and results are for the period July – December, as reported at March (quarter three). Denominator is sourced from the Ministry of Health NHI register.
[38] The 2019/20 volumes for Maaori, Pacific and Other differ slightly from those published in the 2019/20 Annual Report due to the refinement of this data over time.
[39] During 2020/21 the Green Prescription measure was updated: the reporting outcome measure has now changed from 'number of referrals' to the 'number of eligible service users engaged in the programme'.
[40] Results are provided for the full year – 1 July 2020 to 30 June 2021.
[41] Results are provided for the full year – 1 July 2020 to 30 June 2021.
[42] Results are for the period 1 March to 30 September each year to reflect New Zealand's influenza flu season and aligned immunisation programme for people aged 65 and over.
[43] Performance is as at quarter three – two years ending 31 March 2021, consistent to MOH quarter four reporting requirements.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
	Other	69%		64%	30,103	27,368
Proportion of women aged 25 – 69 years who have had a cervical smear in the last three years	Total	65%	80%	65%	97,708	100,264
	Maaori	56%		55%	12,005	11,941
	Pacific	65%		63%	18,880	18,973
	Asian	61%		62%	29,512	31,312
	Other	73%		75%	37,311	38,038
Percentage of four year olds receiving a B4 School Check[44]	Total	87%	90%[45]	90%	6,785	7,957
	Maaori	82%		93%	1,393	1,792
	Pacific	84%		96%	1,978	2,349
	Other	91%		86%	3,414	3,816
Percentage of Year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS[46]assessment	Total	93%[47]	95%	71%[48]	2,940	2,510
	Maaori	96%		78%	894	786
	Pacific	95%		69%	1,379	1,175
	Asian	82%		65%	393	353

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. They include general practice, community and Maaori health services, pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

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

On a continuum of care these services are preventive and treatment services are 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, easier to access and providing support for people to self-manage at home.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
Primary Health Care Services						
Percentage of population enrolled in a PHO[49] *The Census data is used for population denominators. As the Census has historically undercounted the Pacific population, we have presented the Health Service User data as a more accurate representation*	Total	98% (97%)	90%	98% (97%)	566,032	567,892 (568,401)
	Maaori	92% (96%)		86% (96%)	83,143	81,608 (84,250)
	Pacific	117%[50] (96%)		112% (96%)	142,568	142,392 (135,377)

[44] 2020/21 results are for checks completed during the financial year 8 July 2020 – 7 July 2021. Results show progress against the target numerator and denominator rather than achievement against total eligible population – consistent to quarterly B4 School Check reporting.
[45] The 90% Ministry of Health target is based on the percentage of the eligible population who receive a B4 School Check. Baselines and results for the 2019/20 year are therefore presented in this format. Previously results have been reported as a percentage against the target (i.e. a result of 100% if the target was met, or over 100% if the target was exceeded).
[46] This is an interview based assessment tool for adolescents about home education/employment activities/drugs/sexuality/suicide.
[47] Results are for the calendar year 1 January – 31 December.
[48] 2020/21 results are for the calendar year 1 January 2020 – 31 December 2020. HEEADSSS assessments are delivered during the school term. COVID-19 Alert Level 3 and 4 lockdown periods significantly impacted nurses' ability to complete the assessment.
[49] Census data is usually used for population denominators. We are aware that the 2018 census data was inaccurate in counting our population. Health Service Utilisation (HSU) population data is more accurate and results in parentheses represent this HSU data with the numerator taken from PHO enrolment data up to January 2021.
[50] As the Census historically has underestimated the Pacific population, the 2019/20 baseline and the 2020/21 result for Pacific are greater than 100%.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
of enrolment. This is displayed in parentheses.	Asian	95% (97%)		90% (97%)	147,469	153,215 (159,898)
Percentage of newborns enrolled in general practice by 3 months[51]	Total	90%	85%	87%	7,503	7,434
	Maaori	69%		68%	311	323
	Pacific	86%		83%	501	498
	Other	102%		100%	942	1,044
Amenable mortality rate per 100,000 population[52]	Total	93.7[53]	≤98.1[54]	99.8		
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	90%	90%	83%	138,393	144,856
	Maaori	87%		78%	19,331	20,364
	Pacific	89%		81%	33,202	36,476
	Other	91%		85%	85,860	88,016
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c < 64 mmol/mol)[55]and no inequity	Total	52%	60%	53%	17,640	18,947
	Maaori	43%		45%	2,336	2,513
	Pacific	44%		44%	5,897	6,268
	Other	62%		63%	9,407	10,166
Percentage of patients with CVD risk >20% on dual therapy (prescribed)	Total	53%	60%[56]	52%[57]	8,449	2,498
	Maaori	52%		46%	1,380	570
	Pacific	57%		56%	3,322	1,060
	Asian	51%		56%	1,555	327
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)[58]	Total	58%	70%	64%	6,192	6,419
	Maaori	53%		57%	841	869
	Pacific	63%		66%	1,483	1,718
	Asian	62%		69%	1,118	1,169
Oral Health Services						
Proportion of children under 5 years enrolled in DHB-funded community oral health services[59]	Total	89%	≥95%	93%	37,224	38,760
	Maaori	72%		75%	7,279	7,563
	Pacific	91%		95%	10,624	11,229
	Asian	N/A[60]				
	Other	96%		100%	19,321	19,968
Percentage of enrolled children Caries Free at age 5 years[61]	Total	43%	49%	38%	1,975	1,065
	Maaori	38%		28%	389	187

[51] Enrolments are based on the National Enrolment Service (NES). Populations are based on the National Immunisation Register (NIR).
[52] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[53] Baseline is at 2017 as there is a two and half year delay before mortality data is released. It takes several years for some coronial cases to return verdicts. As a result, the Ministry is unable to release provisional cause of death information until around two years after the end of the year. Reports are made available annually with a rolling five years' data set.
[54] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2021, as per the 2020/21 Metro Auckland SLM Improvement Plan. The 2020/21 Metro Auckland SLM Improvement Plan also includes a separate target for Maaori and Pacific of a 2% relative reduction by 30 June 2021.
[55] Note that CM Health currently uses the PHO DCIP cohort based on the population aged 15 – 74 years enrolled with Counties Manukau practices as the denominator for this measure.
[56] In 2019/20, CM Health adopted the Metro Auckland Clinical Governance Forum target. In 2020/21, this was set at 60% for all ethnic groups.
[57] 2020/21 results are based on the latest available CVDRA scores and includes those patients on dual therapy with a CVD risk >15%. The change in the CVD risk threshold from >20% to >15% reflects the latest algorithm for determining CVD risk, which was updated in 2018.
[58] Results are 12 months to 31 March 2020. 2020/21 results are 12 months to December 2020.
[59] Results for this measure are reported annually as at quarter three.
[60] The Asian data was not available in the Ministry of Health data set provided for quarter three in 2019/20 or 2020/21.
[61] Results for this measure are reported annually as at quarter three.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
	Pacific	28%		24%	391	221
	Other	57%		53%	1,195	657
Mean Decayed Missing or Filled Teeth (DMFT) Score for Year 8 Children [12/13 years][62]	Total	0.82	≤0.74	0.55		
	Maaori	0.96		0.59		
	Pacific	1.28		0.83		
	Other	0.62		0.34		
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Total	71%	≥85%	54%	25,039	19,814
Diagnostics						
Proportion of patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	68%	95%	87%	15,344	16,610
	MRI	53%	90%	74%	8,292	10,127
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	100%[63]	90%	100%	887	835
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	67%	70%	65%	9,090	9,076
Ambulatory Sensitive Hospitalisations						
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population	Total	5,324	6,062[64]	5,952		
	Maaori	5,134	5,421	5,308		
	Pacific	8,773	10,440	8,907		
Sudden Unexpected Death of an Infant (SUDI)						
SUDI deaths per 1,000 live births	Total	1.18[65]	≤0.1[66]	1.00 [67]	49	42
	Maaori	2.40		2.21	26	23
Pharmacy						
Number of prescription items subsidised	Total	8,313,812	N/A[68]	9,254,736		

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.

[62] Results for this measure are reported annually as at quarter three.
[63] Actual result for P1 within 14 days is 99.66% and thus rounded up to 100%.
[64] This measure targets a 3% relative reduction from baseline for all populations. The actual target ASH rates for the total population, Maaori and Pacific for 2020/21 are higher compared to 2019/20. This is because ASH rates increased between December 2017 (the baseline for the 2019/20 Metro Auckland SLM Improvement Plan) and December 2018 (the baseline for the 2020/21 Metro Auckland SLM Improvement Plan).
[65] 2019/20 Result data source: This result is unavailable as relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 14th data report **2013-2017**.
[66] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025.
[67] 2020/21 Result data source: This result is unavailable as relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 15th data report **2015-2019**.
[68] Measure is demand driven – not appropriate to set target.

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 focused on individuals. Intensive assessment and treatment services are aligned with our **Healthy Services** strategic objective that is focused on excellent, collaborative, high quality and safe health services.

Performance Measure			2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
Mental Health							
Percentage of population who access mental health services[69]	Age 0-19 years	Total	3.99%	3.9%	3.4%	6,509	5,880
		Maaori	5.8%	5.8%	4.9%	2,233	1,991
		Other	N/A	3.4%	2.8%	N/A	3,889
	Age 20-64 years	Total	4.02%	3.9%	3.6%	13,773	12,971
		Maaori	9.79%	9.0%	8.1%	4,534	4,180
		Other	N/A	3.1%	2.9%	N/A	8,791
	Age 65+ years	Total	2.21%	2.2%	2.2%	1,519	1,514
		Maaori	3.0%	3.0%	2.7%	152	142
		Other	N/A	2.1%	2.1%	N/A	1,372
Proportion of 0-19 year olds referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks[70]	Mental Health (Hospital Care Arm)	3 weeks	72%[71]	80%	73%	1,323	1,369
		8 weeks	88%	95%	91%	1,602	1,691
	Addictions (Hospital Care Arm and NGO)	3 weeks	99%	80%	98%		250
		8 weeks	99%	95%	98%		252
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[72]		Total	82%	95%	87%		
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 compulsory treatment orders		Non-Maaori	82	N/A	92		
		Maaori	321	301	325		
Elective Services							
Planned Care Measure 1: Planned Care Interventions		Inpatient treatment	18,269	20,185	19,935[73]		

[69] This data is an annual rolling rate from April – March each year.
[70] Note that in line with Ministry of Health definition and expectations the results for this measure include all referral types, not just non-urgent referrals. The inclusion of urgent referrals has the effect of raising reported performance against this target. Also to note is that in line with the Ministry of Health's definition, the "starting point" of this measure is when a referral is opened in the Patient Management System and not when the referral was first made (if these dates are different).
[71] Baselines are for the period ending 31 March 2020.
[72] Data used for period 1 April 2020 – 31 March 2021.
[73] Total intervention target was exceeded at 114%.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
	Minor interventio	13,592	10,611	15,378		
	Non-surgical	1	326	57		
Acute Services						
Readmissions – acute readmissions to hospital[74]	0-3 days	2.4%	≤2.3%	2.4%		
	0-28 days	10.8%[75]	≤10.7%	10.7%		
Inpatient Average Length of Stay[76]	Acute LOS	2.94 days	2.30 days	2.83 days		
	Elective LOS	2.07 days	1.50 days	1.44 days		
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		83%	95%	85%	82,219	81,248
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[77]	Total	85%	90%	87%	347	375
Cardiac Services						
Percentage of high risk patients who receive an angiogram within 3 days of admission	Total	69%	>70%	72%	657[78]	637
	Maaori	66%		70%	76	61
	Pacific	62%		69%	123	153
	Other	72%		73%	458	423
Stroke Services[79]						
Percentage of potentially eligible stroke patients thrombolysed		12.6%	10%	16%	81	96
Quality and patient safety						
Percentage of admissions with a hospital acquired complication[80]		2.8%	<2.3%	2.3%	2,985	2,496
Rate of falls with major harm per 1,000 bed days		0.08	≤0.04	0.03	25	11
Percentage of inpatients (aged 75+) assessed for risk of falling		94%	90%	92%	758	1,070
Rate of S. aureus bacteraemia (SAB) per 1,000 bed days		0.13	≤0.09	0.12	41	40
Compliance with good hand hygiene practice[81]		86%[82]	80%	86%	33,674	42,406

[74] Acute readmissions are the standardized result for the year until March.
[75] 2019/20 baseline is as at March 2020.
[76] Local target.
[77] The faster cancer treatment data is reported by the MOH on a six-month rolling basis. The quarter four period is 1 January - 30 June.
[78] 2019/20 and 2020/21 volumes displayed are for the full year. Volumes reported in the previous 2019/20 Annual Report were for quarter four only, and is why the volume figures reported this year are higher.
[79] Note that stroke services baselines and results are provided for the full 2020/21 year (12 month annualised results). This differs from the baseline included in the Statement of Intent and has been revised to reflect that for this measure the target is to be measured against annualised data (rather than year-end data).
[80] Data is sourced from the Health Round Table coded discharge data.
[81] The volume figures for this measure represent the total number of hand hygiene (i.e. hand washing) events observed from all random audits conducted for the full year.
[82] Compliance rate for 1 March to June 2020. 2020/21 result is full year compliance rate.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
System Level Measures						
Acute hospital bed days per capita (standardized)	Maaori	640	686.3[83]	667		
	Pacific	680	717.8	687		

Rehabilitation and support services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordinated input by the Needs Assessment and Service Coordination (NASC) Services for a range of services including day care, home-based support services and residential care services. Rehabilitation services are provided by specialised multidisciplinary teams overseen by a geriatrician and/or rehabilitation medicine specialist medical officer.

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

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
Age Related Residential Care (ARRC) [84]						
Percentage of people in ARRC who have a subsequent International Resident Assessment Instrument (interRAI) long term care facility (LTCF) assessment completed within 230 days of previous assessment		92%	95%	97%	3,674	3,896
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI home care assessment tool in the six (6) months prior to that first LTCF assessment		92%	90%	93%	770	871
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%	98%[85]	3,567	3,589
Assessment, Treatment and Rehabilitation Services						
Number of older people that have received in-home strength and balance retraining services	Aged 65+	823	1,118	389		
Number of older people that have received community / group strength and balance retraining services	Aged 65+	659[86]	1,400	580		
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	2,120 places	2,325 places	2,922 places		
Number of older people that have been seen by the Fracture Liaison Service (FLS)	Aged 50-74	520	600	448		

[83] This measure targets a 3% relative reduction from baseline and is included in both the 2019/20 & 2020/21 Metro Auckland SLM Improvement Plans. The actual target number of acute hospital bed days per capita for Maaori and Pacific for 2020/21 is higher compared to 2019/20. This is because the number of acute hospital bed days per capita for these groups increased between December 2017 (the baseline for the 2019/20 Metro Auckland SLM Improvement Plan) and December 2018 (the baseline for the 2020/21 Metro Auckland SLM Improvement Plan).

[84] The denominator of the reporting is the number of LTCF assessments completed in the previous quarter against the numerator which is the number of LTCF assessments completed in the reported quarter. The assessment denominator and numerator numbers can vary between quarters for a number of reasons (e.g. increased assessments due to resident deterioration and admission timing or fewer assessments due to resident stability).

[85] This measure is reported a quarter in arrears. The result for the financial year is up to and including quarter three 2020/21.

[86] 659 new and unique attendees.

Performance Measure		2019/20 Baseline	2020/21 Target	2020/21 Result	19/20 Volume	20/21 Volume
or similar fracture prevention service	Aged 75-84	355	300	302		
	Aged 85+	331	300	279		
Palliative care[87]						
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District		194	552[88]	180		
Number of Hospice Proactive Advisory Conversations between the hospice service, primary care and ARRC health professionals		190	552[89]	149		

[87]The following measures are part of the regional Better Palliative Care Outcomes Service, which was implemented in the Auckland Region in 2017/18. This service implements a system-based approach to enable six hospices across the Auckland region to work together with the Metro Auckland DHBs, Age Related Residential Care (ARRC) and primary care stakeholders to achieve better palliative care outcomes for those with a terminal illness and their families regardless of where in the system palliative care is provided.

[88] The 2019/20 targets were forecast numbers from the original service development proposal, and have been reviewed (lowered) for 2020/21 as better data has been provided to estimate the need of palliative care in primary care.

[89] The 2019/20 targets were forecast numbers from the original service development proposal, and have been reviewed (lowered) for 2020/21 as better data has been provided to estimate the need of palliative care in primary care.

Performance by Output Classes [Includes agency costs]

Output Classes ($000)

	Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services	Total
Revenue (includes agency revenue)	**86,557**	**283,325**	**1,515,837**	**192,124**	**2,077,843**
*Budget (includes agency revenue)**	*47,332*	*278,591*	*1,423,520*	*198,305*	*1,947,748*
Personnel Costs	18,575	713	791,411	10,431	821,130
Outsourced Services	1,579	61	120,629	887	123,156
Clinical Supplies	4,275	163	147,030	2,401	153,869
Infrastructure and Non-Clinical Supplies	991	38	142,603	557	144,189
Other (includes agency costs)	61,137	282,350	357,990	177,848	879,325
Total Costs	**86,557**	**283,325**	**1,559,663**	**192,124**	**2,121,669**
*Budget (includes agency costs)**	*47,332*	*278,591*	*1,453,399*	*198,305*	*1,977,629*
Deficit	-	-	**(43,826)**	-	**(43,826)**
Budget	**-**	**-**	***(29,879)***	**-**	***(29,879)***

Agency revenue and costs for the year amounts to $59.4m.

Information on appropriations

How performance will be assessed and end of year reporting

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

	Amount of Appropriations ($000)				
	2019/20		2020/21		
	Budget	Total Actual	Budget	Supplementary	Total Actual
Total Appropriations	1,524,353	1,554,621	1,646,763	3,002	1,649,765

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

Asset Performance Indicators for Counties Manukau District Health Board

Counties Manukau Health's Asset Portfolio

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

Table 1 Asset Portfolios

Asset Portfolio	Asset Purpose	Quantity/Capacity	Book Value 30 June 2021
Property	To enable the delivery of high quality health services through the provision of facilities that meet accreditation requirements	• 700 adult medical, surgical, rehab, Assessment Treatment and Rehabilitation, community medical inpatient beds • 66 paediatric inpatient beds • 43 Intensive Care Unit/High Dependency Unit/Paediatric Intensive Care Unit/Coronary Care Unit/Cardiac Step Down Unit beds • 110 maternity beds, 25 gynaecology beds, 7 assessment rooms and 29 delivery suites (hospital & community) • 70 acute mental health beds • 67 community mental health beds • 146 ED cubicles & short stay beds • 24 operating theatres; 14 + 2 procedure rooms at Middlemore and 10 + 2 procedure rooms at Manukau Surgical Centre • 14 owned community facilities • 20 leased community facilities • 18 owned dental clinics and 48 mobile unit sitepads	$589m buildings, plant and infrastructure & land with a value of $280m
Clinical Equipment	To enable the delivery of high quality, timely clinical services through the availability of equipment that meets required	• 3 x MRI machines • 4 x CT machines owned • 1 cardiac catheter suite	$37m Net Book Value and Original cost was $101m

	clinical and safety standards	• 34,006 (24,462 in-hospital & 9,544 community-based) items[90]	(Estimated Replacement cost is now around $155.9m)
ICT	To enable the delivery of high quality health services through the availability of timely, accurate and accessible patient and business information	Regionally shared hardware and software. 11,900 users within Counties Manukau Health	$58m healthAlliance C-Class shares; $3.8m in FPIM rights & $0.7m hardware & software; $8m work in progress (WIP) as at 30 June 2021

Property Assets

Property Assets Performance Measures

Services operated by CM Health are largely delivered from seven inpatient facilities and 20 leased or owned outpatient and community health facilities across the district. Manukau SuperClinic and Middlemore Hospital sites contain the largest elective, ambulatory, and inpatient facilities. In addition, a range of DHB and contracted community services are provided across the district e.g. Community Mental Health, Kidz First Community and others. The performance of assets is vital to CM Health to provide better health services to all people of the Counties Manukau and surrounding regions. For this reason, CM Health is fully committed on developing a solid Asset Management Plan and strategy plan in order to improve its asset capability and maturity.

The asset portfolios are separated into three subgroups (Property, Clinical Equipment and Information Communications and Technology (ICT)) and the performance is being measured by three key indicators (Condition, Utilisation and Functionality) and it is a mandatory requirement for CMDHB to provide such information as outlined in the Cabinet Office Circular CO (15)5.

Occupancy rates continue to exceed capacity for medical and surgical beds.

[90] Includes only in-hospital devices that are managed by CM Health Clinical Engineering and excludes items managed through other service provider support, e.g. leased items, laboratory and major radiology equipment. Includes clinical items not meeting financial definition for a financial asset.

Table 2 Property Asset Performance Measures

Asset	Measure	2019/20 Target	2019/20 Actual	2020/21 Target	2020/21 Actual
Medical beds *Occupancy % for Medical beds at 7 am*	Utilisation	90%	103.1% [91]	90%	100.9%[2]
Surgical beds *Occupancy % for Surgical beds at 7 am*	Utilisation	90%	101.5% [92]	90%	89.6%[2]
Operating Theatres *The percentage of theatres utilisation is calculated based on the total turnaround time, cumulative turnover and the theatre session duration*	Utilisation	90%	87.0%[93]	90%	75.0%[3]
Building compliance requirements *Percentage of buildings used that possess a valid Building Warrant of Fitness (BWOF)*	Condition	100%	100%	100%	100%
Seismic Compliance[94] *Percentage of buildings assessed as being earthquake prone (<34% New Building Standard (NBS) is classified as earthquake prone)*	Functionality	0%	5.5%	0%	7.7%
Facilities assets meeting or exceeding performance uptime *Facilities assets comprise of hot water boilers, steam boilers and chiller plants. The 'Utilisation' results of these assets are based onthe total asset available time minusthe unplanned downtime and divided by the total asset available time.*	Utilisation	99%	98.1%	99%	99.0%

Clinical Equipment Assets

Clinical Equipment Assets – Condition and Utilisation

Safe clinical service delivery requires that all assets are fully functional and fit for purpose. Where clinical equipment assets fail against required standards they are taken out of service. Asset availability is managed via Service Level

[91] There were 140 days in the 2019/20 year where occupancy rate of medical services had reached 100% or above against open capacity and for surgical services there were four days where occupancy rate had reached 100% or above.

[92] As a consequence of the IPM upgrade in February 2021, occupancy against open beds will no longer be available. Therefore, occupancy against budgeted beds will be reported annually for both measures (medical and surgical beds) from 2020/21 onwards. There were 238 days in the 2019/20 year where occupancy rate of medical services had reached 100% or above against budgeted capacity and for surgical services there were two days where occupancy rate had reached 100% or above.

[93] It was approved by the ELT that the calculation method for theatre utilisation has been changed from method three in 2019/20 (i.e. (all cases duration + cumulative turnover)/ session duration) to method one (i.e. all cases duration/ session duration) from 2020/21 onwards.

[94] The number of Earthquake Prone Buildings has not changed between 2019/20 and 2020/21. The percentage change between financial years is due to a different number of buildings being assessed in each year. The "building assessed" figure for 2019/20 was 71 versus 52 for 2020/21. The assessment for 2019/20 considered all buildings (including those not assessed), while the 2020/21 assessment only included those buildings that had been assessed by ISA, DSA, IEP, desktop and formal structural assessments.

Agreements for large assets (some of which are leased) and through built-in redundancy within the asset fleet to enable replacement as required.

Table 3 Clinical Equipment Condition, Availability & Utilisation

Asset	Measure	2018/19 Target	2018/19 Actual	2019/20 Target	2019/20 Actual	2020/21 Target	2020/21 Actual
MRI	Availability/Uptime	>98%	98%	>98%	>98%	>98%	>98%
	Service Level/ Utilisation	>85% elective patients waiting & scanned within 42 days	34%	>85% elective patients waiting & scanned within 42 days	52% [1]	>85% elective patients waiting & scanned within 42 days	75% [1]
CT Scanners	Availability/Uptime	>98%	98%	>98%	>98%	>98%	>98%
	Service Level/ Utilisation	>95% elective patients waiting & scanned within 42 days	93%	>95% elective patients waiting & scanned within 42 days	70%[2]	>95% elective patients waiting & scanned within 42 days	84% [2]
Angiography (Catheter Lab)	Availability/Uptime	>98%	98%	>98%	99%	>98%	99.2%
	Utilisation	85%	84%	85%	84% [3]	85%	86.2% [3]
All non-fixed assets (Minor Assets) [4]	Current Warrant of Fitness/Certificate of Compliance [4]	95%	94.2% (average) 95.9% (at 30 June)	95%	94.2% (average) 93.5% (at 30 June)[5]	95%	93.5% (average) 90.8% (at 30 June)[5]
	Asset Performance[6]	--	--	69% (Tentative)	32% (or 6,517) assets did not meet the APM target of 69%. 68% (or 14,099) assets met APM target of 69%.	69% (Tentative)	38% (or 8,653) assets did not meet the APM target of 69%. 62% (or 14,251) assets met APM target of 69%.

(1) MRI results for 2020/21 have not achieved the six-week target despite achievement of significant gains as a result of a collaborative improvement programme between the MRI team and the Ko Awatea improvement

team. The reasons for this are multifactorial:

- Staffing issues – reduced staffing through the third and fourth quarters of 2020/21 due to parental leave and resignations (recruiting is difficult with much reduced ability to recruit from overseas)
- Increased repatriation from ADHB of CMDHB patients - which although funded add to the volumes
- Increase in demand for MRI over the last two FY of >25% with no increase in resources (scan availability or staffing).

(2) CT results are down - however they are improving and we believe we will make target by the end of the 2021 calendar year. As with MRI the reasons for the 2020/21 results are multifactorial:

- Staffing issues – reduced staffing through the fourth quarter of 2020/21 due to vacancies and recruiting difficulties. Extremely limited ability in overseas recruitment
- Added demand from inpatient services for CT, increased repatriation from ADHB of CMDHB patients
- Increase in referrals for CT over the last two FY of >20% with no increase in resources (scan availability or staffing).

(3) Catheter Lab utilisation is based on 8.5 hour per day session times, Monday to Friday – noting the after-hours and weekend volumes are managed regionally through Auckland DHB.

(4) Includes only in-hospital devices that are managed by CM Health Clinical Engineering and excludes items managed through other service provider support, e.g. leased items, laboratory and major radiology equipment. Includes clinical items not meeting the financial definition for a financial asset.

(5) A target of 94.4% was achieved at the end of January 2021, however, the gains made were lost due to the redeployment of the limited Clinical Engineering resources to manage the exchange of 633x infusion pumps following a consumables recall, assisting with setting up a number of COVID-19 vaccination centres and staff vacancies.

(6) Asset Performance is based on National Clinical Engineering Advisory Group's Asset Performance Measurement (APM) Guidance Notes for Medical Devices to District Health Boards. New concept being evaluated to measure asset performance for Non-Community based equipment.

(i) The 69% Asset Performance Target is tentative and used for capital planning.

ICT Assets

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

ICT Assets – Availability

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

The table below summarises actual for 2018/19 – 2020/21 versus target for 2020/21:

Asset type	Service Level Agreement Target	2018/19 Actual	2019/20 Actual	2020/21 Target	2020/21 Actual
Tier 1 Information systems (Critical)	• No more than 10 Tier 1 systems per annum less than 99.8% available • Average availability per annum >99.8% • Target outage recovery 4 hours	99.93%	99.99%	99.8%	99.99%
Tier 2 information systems (Urgent)	• No more than 10 Tier 2 systems less than 99.8% available • Average availability per annum >99.8% • Target outage recovery time 2 days	99.93%	99.99%	99.8%	99.99%

ICT Assets – Condition

Asset Type	Service Level Agreement Target	Indicator	2019/20 Target	2019/20 Actual	2020/21 Target	2020/21 Actual
End User Devices – Asset Age	% of devices compliant with asset age replacement policy	Condition	>75%	93.89%	>75%	86.90%
End User Devices – Security	% of End User Devices (SOEs) compliant with security update policy	Condition	>80%	58.20%	>80%	94.34%
Software (Application) - Condition	% of Apps with installed version no older than n-1	Condition	>55%	63.48%	>55%	72.37%
Software (Application) – Service Interruption	% of Apps not experiencing SLA breaches ('service interruptions') over a 12-month period	Condition	>80%	94%	>80%	98.57%
Technology Platforms (Physical and Virtual) – Condition	% of Windows systems have been checked and patched, across all PROD and non-PROD environments	Condition	>75%	72.96%	>75%	93%
Technology (Tier 1 and Tier 2 systems) – Service Interruptions	Number of SLA breaches ('service interruptions') recorded against application asset over a 12 month-period	Condition	<20	6.70	<20	3.075

ICT Asset – Functionality

Asset Type	Service Level Agreement Target	Indicator	2019/20 Target	2019/20 Actual	2020/21 Target	2020/21 Actual
Software (Application) – Redundancy or Resiliency	% asset architected for redundancy or resiliency	Functionality	>30%	48.39%	>30%	52.32%
Software (Application) – Supportability	% asset supportable under TIER 1 SLA guidelines	Functionality	>30%	58.06%	>30%	61.84%

ICT Asset - Utilisation

Asset Type	Service Level Agreement Target	Indicator	2019/20 Target	2019/20 Actual	2020/21 Target	2020/21 Actual
Technology (Remote Platform) Utilisation	% staff have accessed clinical/non-clinical system platforms remotely	Utilisation	35%	50.13%	>35%	58.41%

Good Employer

CM Health is one of the largest employers in the Counties Manukau area and we take pride in employing the local community, employing staff that reflects the local population, and those who wish to contribute to this population and area being a thriving part of New Zealand.

Treaty of Waitangi and commitment to Maaori population and staff

The DHB is committed to deliver its obligations under the Treaty of Waitangi through workforce development and learning. The Maaori Health Team has developed an Equity Plan which will be implemented in 2021/22.

Workforce Development

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.

Goal for 2025

CM Health is one of the largest employers in the Counties Manukau area. With over 7,126 FTE in more than 100 different jobs at 20+ sites across the region, CM Health serves an estimated population of 598,520 people of which 97,470 are of Maaori decent and 132,020 are Pacifica.

In June 2017, the CM Health Board approved the establishment of Maaori and Pacific workforce targets with a goal that by 2025 CM Health will have a workforce that reflects the population it services. This would mean increasing the Maaori workforce by an additional 661 FTE and increasing the overall percentage of Maaori employed by CM Health from 7% (532) to 17% (1193) by 30 June 2025.

CM Health's Pacific workforce would need an additional 617 FTE, increasing the overall percentage of Pacifica employed by CM Health from 14% (990) to 23% (1607) by 30 June 2025.

The number of Maaori and Pacific staff at CM Health has increased by over 50% in the last two years.

	2013	2015	2017	2019	2021
CM Health Maaori Staff FTE	314	320	316	491	532
CM Health Pacific Staff FTE	538	611	670	1,008	990

Key Focus Areas

Maaori Workforce Development is the process of strengthening the capacity and capability of the Maaori health and disability workforce in order to maximise its contribution to improved health outcomes for Maaori. The primary purpose of Maaori development is to contribute to building a representative New Zealand health and disability workforce that through evidence-based practice facilitates the best possible health outcomes for Maaori.

The six key focus areas for Maaori Workforce Development are:

1. Promotion of Health as a Career
2. Supporting Rangatahi Maaori achievement in NCEA
3. Supporting Tauira Maaori success in Tertiary Education
4. Increasing the number of Maaori employed at CM Health
5. Improving the retention of Maaori employees
6. Building Maaori Leadership

Learning

The DHB offers a number of learning programmes for staff, including an online training programme which provides participants with knowledge and understanding of Te Tiriti O Waitangi (Treaty of Waitangi) and the impacts it has on Maaori.

The Te Pookaitahi Reo - Te Reo Maaori Programme is delivered in with Te Whare Waananga O Awanuiaarangi (TWWoA) and is NZQA accredited. The programme is designed to build confidence and capability in Te Reo Maaori and to do so within a workplace context. Graduates of this qualification will have the confidence to converse in Te Reo Maaori at an intermediate level.

CM Health offers a programme to develop cultural competency in practice including the cultural safety of those with whom we have contact: patients, families, whaanau, customers and work colleagues – "Engaging Effectively with Maaori".

Governance of work force, employees and safety

CM Health is committed to being a good employer for its entire staff who serve one of the most diverse and fastest growing populations in New Zealand. It 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. CM Health has a wide variety of policies, programmes and projects being undertaken to fulfil our good employer objectives and obligations. We strive to:

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

Diversity and Equal employer

Disability

CM Health's Disability Action Plan 2019 – 2022 sets out five key priorities and outcomes that encourages proactive responses to people who have a disability:

1. Increase employment opportunities and potential for disabled people in our organisation
2. Improve the health outcomes and wellbeing of disabled people
3. Improving accessibility to our services and buildings
4. Improving the experience for disabled people
5. Working together with disabled people to improve our services.

CM Health proudly received the Accessibility Tick on 2 December 2019. In June 2021 the Accessibility Tick organisation

found that Counties has continued to show a commitment to disability inclusion and accessibility, and has endorsed our continued use of the Accessibility Tick.

Within CM Health's Disability Action Plan 2019 – 2022, specific actions that have been made to influence the diversity of our workforce include:

1. Increasing employment opportunities through CM Health's job advertisements and careers webpage that encourages job seekers with disabilities to apply.
2. Utilising our partnership with Workbridge to reduce barriers for job seekers with disabilities and to identify potential applicants
3. Creation of an Employment Disability Support Services (EDSS) contact email for job seekers, employees, and managers. This helps Counties to be a safe place to seek support, advice, and guidance about issues relating to disability and accessibility in the workplace. This service has been used by employees during their recruitment process, and by existing staff. Having a colleague dedicated to providing this support has been invaluable.
4. We have continued to update communication and information for employees and managers about disability, accessibility, and support services.

Pay equity contribution to national work

In late 2020, the district health boards and the Public Service Association (PSA) reached an initial agreement about the PSA Pay Equity Claim for Clerical and Administration employees. As part of that agreement, an interim adjustment was agreed for those employees paid less than the national pay equity benchmark rate. For Counties Manukau DHB, there are approximately just over a thousand positions covered by this pay equity claim.

Counties Manukau DHB conducted the nationally agreed work required to ensure the interim adjustment payment was made to eligible employees before June 2021. The interim adjustment was based on the results of the role mapping exercise conducted in 2020. Further work was required in early 2021 to role map employees employed between September 2020 and February 2021, as well as data analysis to ensure accuracy of the calculation prior to seeking funding from the Ministry to fund the interim adjustment payment. This payment was made to eligible employees in May 2021.

Staff employed on individual employment agreements whose work is covered by the pay equity were assessed to establish eligibility for the interim adjustment payment.

In March 2021, in partnership with PSA, Counties Manukau DHB, spent a significant amount of time role mapping positions in scope of the pay equity claim to the national role profiles. Some positions were referred to the national working group at Technical Advisory Services (TAS) for review as it did not fit any of the available role profiles. The role mapping exercise is expected to be completed in July/August 2021 and will be required for translation to the final role profiles and associated remuneration scales once bargaining is completed between the DHBs and PSA.

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

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

Gender Pay

The status of gender pay is:

	Male	Female	Difference
Allied Health	$81,492	$76,571	-6.0%
Executive Staff	$261,295	$289,743	10.9%
Management and Administration - IEA	$113,835	$106,531	-6.4%
Management and Administration - MECA	$56,753	$59,306	4.5%
Medical	$195,729	$164,369	-16.0%
Nursing	$77,386	$77,386	0.0%
Support Personnel	$53,360	$53,360	0.0%
All Counties Manukau	$81,492	$77,386	-5.0%

The Seven Key Elements

There are seven key elements to Counties Manukau DHB being a good employer.

1. Leadership, accountability and culture

Organisational culture and values

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

This year we commenced offering Team and People Effectiveness workshops to teams at CM Health. Numerous teams, involving 100s of employees, have requested the Organisational Development team to facilitate workshops to help them improve their culture, work more effectively together, and better live our values in our work.

Values Visibility

Our ongoing employee recognition scheme, Local Heroes, is directly aligned with our four values. We recognize these awardees and promote our values by displaying large format posters around our sites. Specific values posters remain visible in every meeting room in Ko Awatea, and are available online for services to print. We also reference the values and how to bring them alive in every Team Workshop that we facilitate.

Annual Staff Values Awards

Our Annual Staff Values Awards were continued this year. These awards promote the importance of living our values and recognise staff for doing so. The nomination process gives staff the opportunity to nominate each other for demonstrating values-aligned behaviour.

Staff Survey

In 2019, we conducted a Staff Survey to hear how our staff experience working at CM Health. The engagement of staff was measured by the likelihood that employees would recommend Counties as a place to work to their friends and families. 74% of responding staff agreed or strongly agreed that they would do so. On this measure Counties scored well above the average for other DHBs utilising the same measure. However, there is always more we can do to improve, and with this in mind we created a Counties-wide Action Plan focusing on four areas:

Staff Wellbeing
We introduced several new employee wellbeing initiatives:

- Team Wellbeing Check-ins, conducted in partnership with our EAP provider.
- The Wellbeing Index app. This app helps staff measure their own levels of stress at work and provides tools and targeted information. We implemented this for SMOs, nurses, and HCAs in 2020, and commenced implementation for Allied employees in 2021.
- Schwartz Rounds. These sessions provide a forum for a structured discussion about the social and emotional experiences of caregiving. They address real life situations arising for Counties staff and are facilitated by experienced clinical colleagues.
- Stress First Aid (SFA) is under development for implementation starting in the second half of 2021. SFA provides a framework for psychological peer support, with a set of supportive actions designed to promote self-care and collegial support. The overarching aim of SFA is to identify and mitigate the negative impacts of stress at work before they impair staff health and wellbeing.

Speak Up - Me koorero atu
We began work on refreshing our Speak Up process, including:

- Contact People – we plan to expand the pool of trained Contact People and refresh the training for existing ones.
- Refreshing the bullying and harassment training for managers.
- Promote better team communication and dynamics via 'Team Development' (see 'Team and People Development' below).

Leadership Development – Leading for Success programme
We implemented Leading for Success, which is aimed at developing leadership capability in middle managers.

- We designed content for the programme based on input and feedback from Service Managers, the CEO, General Managers, and HR. The programme has fours themes, which are deployed over a four to five-month period. The themes are People & Culture, Te Tiriti & Health Equity, Business & Operational, and Improvement & Quality.

Team and People Development

- In late 2020 we began Team Effectiveness workshops. These workshops are tailored to support specific team requirements and include topics such as Team Purpose, Psychological Safety, Collaboration for Success, Civility and Incivility, and Team Culture. The content of these sessions deliberately reinforces the values, and also acts as an antidote to bullying and harassment. 100s of employees have participated in these workshops since they began in late 2020.

2. Recruitment, selection and induction

CM Health is committed to attracting and employing a workforce that reflects our community by meeting our obligations and requirements regarding the Treaty of Waitangi specifically, and other legislation in general, in our selection and recruitment processes.

To achieve this, we have updated our Recruitment policy so that all Maaori candidates will have a priority to roles. All candidates who identify as Maaori will be considered, prioritised and provided with specific written and verbal feedback by Hiring Managers if unsuccessful in their application. This policy will articulate how we recruit quality staff that will meet the skills, experience reflect a workforce that matches our population with focus on increasing our Maaori and Pacific workforce.

Managers and other staff involved in recruitment must be competent in the process of recruitment, selection, and interviewing (including aspects of cultural competency). Managers can attend Recruiting for Results/HR master class sessions to further equip them to competently recruit staff to the organisation. Engaging with Maaori effectively and Pacific Cultural courses should be referred to and training is available for staff around the provision of cultural competency training.

The CM Health interview process, including interview guides, has been reviewed and changes made to support the cultural

requirements of our candidates. We are reviewing the content of our current Recruiting for Results sessions for Managers and will be adding more content around bias, diversity, cultural contexts, disability etc.

Our Recruitment Team works with our community to source local talent, promote health careers and support people from our community into paid employment. Building a positive Employer brand is key for us. We have updated our Career website to reflect our community and patient population to help attract our future workforce. We are also creating a workforce page on our career website to encourage people from our community to consider a career in health, this could be school leavers, people that want a career change etc.

We continue to work on a number of initiatives, which include:

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

Workbridge – Disability Tick. We continue to build our relationship, and continue to work towards reviewing our current policies and processes to ensure that we attract and support more staff with disabilities to CM Health.

NETP – We offer employment to all Maaori and Pacific New grad nurses that choose CM Health as their first preference.

Health Science Academies supporting Pacific Success and Achievement in NCEA -The Health Science Academies (HSAs) were initiated by Counties Manukau DHB (CM Health) in 2011 as part of their drive to build a workforce that better reflects the community they serve. Partnered with the Tindall Foundation, they supported two health science learning communities based at James Cook High School and Tangaroa College. A Health Science Academy is basically a school within a school – with a specific focus on the achievement of NCEA core sciences. The initial academies in James Cook High School and Tangaroa College demonstrated significant increases in Pacific student achievement in NCEA 1, NCEA 2 and NCEA 3 in comparison to National Data sets. Students engaged in the HSAs also had higher attainment of Merit and Excellent endorsements compared to the total Pacific population and other students in decile 1-3 schools. The table below highlights these comparative results for 2019/20. The academies also demonstrated a high retention rate for students between years and fewer absentees.

Table 1: Percentage of students in HSA programme attaining merit endorsement compared to total population

	HSA students	Total NZ	Total Pacific	Total students in decile 1-3 schools
Percentage attaining NCEA level 1 with merit endorsement	39%	32%	28%	24%
Percentage attaining NCEA level 2 with merit endorsement	34%	25%	17%	15%
Percentage attaining NCEA level 3 with merit endorsement	28%	27%	17%	17%

Table 2: Percentage of students in HSA programme attaining excellence endorsement compared to total population

	HSA students	Total NZ	Total Pacific	Total students in decile 1-3 schools
Percentage attaining NCEA level 1 with excellence endorsement	20%	21%	9%	10%
Percentage attaining NCEA level 2 with excellence endorsement	18%	18%	6%	7%
Percentage attaining NCEA level 3 with excellence endorsement	18%	17%	6%	8%

CM Health is now supporting 12 Health Science Academies (HSAs) with over 600 Pacific secondary students engaged. These Academies continue to achieve higher success rates for Pacific Achievement in NCEA and have been a key vehicle for increasing Pacific student participation in NCEA Science. 104 secondary school students graduated from HSAs in the year 2020, with 65 students enrolled into a health related degree at a tertiary institution, and a further 30 students enrolled into tertiary education. Four graduates of the HSAs are employed by CM Health, with a further 22 supported in part-time and casual positions while they complete tertiary studies.

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

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

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

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

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

LEAP (Local Employment Access Project) - This is a partnership project with Accelerating Aotearoa, Ministry of Social Development (MSD), Auckland Library and CM Health. We help support our local community with skills and tools to become work ready, assisting them with CV writing, readiness for interviews, building confidence and public speaking skills. We help them with their job search and match them to roles within our organisation. CM Health was the pilot organisation for this project, and it continues to run here with successful placements being made.

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

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

We also continue to work on attracting Maaori talent into our workforce. Over this past year, a further 129 Maaori have been employed at CM Health raising the number of Maaori employees from 561 employees (as at 30 June 2019) to 690 employees (as at 30 June 2021). This has lifted the overall percentage of Maaori employed at CM Health from 5.55% (as at 30 June 2019) to 8 % (as at 30 June 2021).

We employ 3,704 nurses. 492 (13%) are Pacific nurses and CM Health wants to grow that to 21% by 2025. We are proud to be the employer of the largest Pacifica nursing workforce in New Zealand and possibly in the world. 204 (6%) of our nurses are Maaori. CM Health's target is to lift that to 16% (1,004) by 2025. That makes us the second largest employer of Maaori nurses amongst the DHBs. We are working towards the recruitment process encouraging more Maaori and Pacific candidates. As an example for our nursing graduate recruitment we have special and separate processes for Maaori and Pacifica. We know that we will only achieve Health Equity when our workforce is as diverse as the population we serve.

3. Employee development, promotion and exit

Employee Performance Development Culture

Performance and development is an active partnership between the managers, employees, and the organization that enables our people to be fully engaged and reach their full potential. At CM Health we are deeply committed to the success and growth of every employee throughout their career with us.

We see this commitment in the performance and development culture, being one in which performance and development is an ongoing process that enables two-way conversation, addressing goal setting, development planning, ongoing coaching and feedback, performance reviews and ongoing engagement.

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

- Active partnership, each participant is responsible for making performance development practices as effective as possible

- Helping both the manager and the employee assess how performance and development fits into the bigger picture
- Learning needs and opportunities are planned and agreed based on the discussions and agreements reached during the performance and development process.

Ultimately the gains can be seen in our employees through:

- Growth in their current role
- Advancement towards future opportunities
- Enhancement of their engagement at work.

Our Team and People Development workshops also support this. Some of them are specifically about giving managers the tools to help their staff develop, such as coaching and providing feedback. Others focus on the communication process between managers and staff. This approach fosters a supportive environment and helps improve individual, team and organizational performance in support of achieving CM Health's vision.

Nursing

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

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

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

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

Allied Health

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

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

All disciplines

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

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

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

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

We have also been working to improve cultural competency within CM Health. In 2017/18, CM Health introduced the Effectively Engaging with Maaori Programme as a Mandatory programme for all new employees. This programme is promoted through all new staff orientation and induction programmes, along with E-Learning Programmes on the Treaty of Waitangi, cultural competency and Tikanga Best Practice. In the past 12 months, 2,054 employees have completed these programmes. All face to face trainings were cancelled from March to May 2020 due to COVID-19.

CM Health also runs a monthly introductory course on 'Pacific Cultural Competency in Health' which provides participants an opportunity to journey and participate in an applied, interactive and fun training programme. This is a face to face session which is aimed at improving skills, knowledge and understanding in order to better engage with our Pacific patients, their families and our communities. Staff learn about Pacific peoples, their culture and values with an emphasis on how these can influence their views of health and wellness and gain insight of Pacific people's holistic world view and approach to life. They will also understand how intercultural communication can impact on the quality of service delivery.

We are also attempting to increase knowledge and use of Te Reo Maaori. CM Health has also formed a partnership with Te Whare Waananga o Awanuiarangi to offer fee free NZQA level certificates in Te Reo Maaori programmes to staff. We currently have 50 students enrolled in two courses running concurrently.

Many opportunities are available for our unregulated workforce with the support of our external training providers and funding from Tertiary Education Commission (TEC). The successful StepUp programme continues to benefit staff to increase confidence to speak up when any issue or concern arises. Some staff are looking for other jobs within CM Health due to the StepUp programme. Feedback included comments from participants such as "StepUp is one of the greatest things to happen to me and I encourage anyone who needs to build up their confidence to go for it. StepUp is a great tool as it changes your mind-set to be positive. If it hadn't been for this, I would not have achieved and become what I am today. I can't believe myself. I have changed so much".

Over the past year, 56 staff completed the StepUp programme with a mixture of positions from: Cleaners, Orderlies, Health Care Assistants, Central Sterile Supply Department, Community Health Workers, Rehab Assistants, Admin/Ward Clerks, Psychiatric Assistant and Peer Support staff. More courses will be planned for later in the year and next year.

A new initiative is the Development Pathway Model for the Cleaners and Orderlies. Staff complete online assessments for literacy and numeracy to help guide what support they will require to complete their Level 3 NZQA qualification. Some staff require ESOL (English second other language) or a 25 hour programme specifically designed to provide support before and during the NZQA Level 3 qualification. We want staff to enjoy learning as many say 'it has been a long time since they went to school'.

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

We currently have eight different Cultural and Linguistically Diverse (CALD) courses, including Working with CALD families – Disability Awareness, working with migrant and refugee patients and culture and cultural competency available for staff. These courses can be accessed using two different formats (face to face or online via e-learning). The CALD – Disability Awareness e-learning course is also now compulsory for all clinical staff.

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

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

Exit interviews

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

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

4. Flexibility and work design

Workplace flexibility

CM Health continues to commit to providing a flexible work environment to attract and retain our people. The benefits of flexible working arrangements, especially during COVID-19 time, is well known and widely supported by staff. Availability of flexible work arrangement is becoming a more common question asked by candidates at interview stage, especially for candidates seeking employment in support or non-patient facing functions where it might be possible to work remotely from home if required.

Flexible employment options available to staff that illustrates this commitment includes but is not limited to:

- Part time working hours – part time employees make up 38% of our workforce
- Job share arrangements whereby two or more employees undertaking one role on a shared basis to cover a full time position within the organisation
- Time off in lieu – If a staff member works extra hours over and above their contracted hours during busy periods e.g. COVID-19 staff can request to take the time back at a mutually convenient time
- Career break – some employees may request an extended period of leave to focus on professional development or pursue other interest
- Flexi time – allows employees to vary start and finish times within core working hours to better fit their domestic responsibilities, travel arrangements or for work purposes
- Remote working – employees may request to work from home for all or part of their hours for a specified amount of time due to a particular requirement over that time.

There is work underway to refresh our flexible working arrangements in light of lessons learnt during the COVID-19 pandemic.

Flexible return to work for parents

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

Volunteers

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

5. Remuneration, recognition and conditions

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

- Annual Nursing and Midwifery Awards
- Allied Health Celebration Day and Awards

- House Officer of the Month Awards
- Long service recognition (managed by each service/department)
- Telling our staff stories through our internal and external channels.

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

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

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

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

In recognition of the impact of COVID-19 on the CMDHB community, the Board Chair and the CEO donated a share of their respective salaries to the Middlemore Foundation for Health Innovation. This donation is to be used for funding a support sponsorship of "Our Local Heroes" prizes and if there are surplus funds, then to fund a scholarship for a Student Tertiary Health Studies scheme.

6. Harassment and bullying prevention

Organisational Commitment

CM Health is committed to providing a healthy, safe and supportive organisational culture based on our shared values. CM Health has a zero-tolerance for all forms of harassment and bullying. Bullying and Harassment policy, processes, guides and resources are in place for all employees to help them better understand and work through the situation. CM Health leadership and management programmes equipped managers with skills to provide feedback and coaching in the moment of any inappropriate behaviours and unsafe work practices. Importantly, we are also taking specific steps at building a Psychological Safe work environment, such as with our Team and People Development workshops, and our Leadership Development programme.

Speak Up

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

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

7. Safe and healthy environment

Safety at Work – Compliance

The Occupational Health and Safety Service team (OHSS) provides three key services to support all areas of CM Health in regards to ensuring a safe and healthy workplace for our workers. The support provided by OHSS includes Occupational Health, Health and Safety and Injury Management.

Within these groups are a mix of support workers including Occupational Health Nurses, Physicians, Respiratory Mask Fit Testers, H&S Manager, Business Partner and Advisors, H&S Risk and Assurance, ACC Case Manager and Administration and Coordination workers.

Counties Manukau DHB is in the ACC Accredited Employers program which means we manage our work related injury and illness claims at a tertiary level and assist ACC to help workers get back to work for non-work injury. CM Health have a partnership with WellNZ who provide additional support in helping workers back into the workplace safely. The Occupational Health and Safety Service also manage the counseling and support services provided across the DHB by Raise (employee assistance program).

The Occupational Health team carries out clinical and assessment functions for CM Health workers including pre-employment screening, blood and body fluid exposure assessments, contact tracing, health surveillance, general wellness and vaccination clinics, including the very successful annual influenza vaccination campaign. Our professional and experienced Occupational Health team also provides guidance on the rehabilitation of staff members back to work from non- accident related and/or medical conditions via the manager referral system. In 2020 the OHSS implemented an in-house respiratory mask fit testing program to check the correct and effective fitting of N95 masks for our clinical workers using this mask type as part of their work. The respiratory mask fit test team has carried out in excess of 7,000 fit tests in 2020/21 and now has an on-going annual retest program. The Occupational Health team has been instrumental in coordinating COVID-19 related work in the last year across CM Health and the Auckland Managed Isolation Facilities including the worker vaccination program.

The Occupational Safety team support workers when managing workplace safety and provide assistance to support CM Health worker wellbeing across all business units. CM Health has engaged with Safe365 to assist in managing safety compliance. The OHSS have reviewed H&S monitoring and auditing across the DHB and have implemented an additional managers H&S online self-assessment in 2021 and a new H&S audit program which will be implemented in 2022. A refreshed worker induction program has been implemented in 2021 providing the most up to date H&S information for our new starters. Ongoing H&S communications to our workers has been revamped with the introduction of monthly Communication Topics sent to HSRs and the addition of Safety Alerts to notify workers of critical risks resulting from incidents and inspections.

OHSS have a Safety and Wellbeing Management Systems (HSWMS) which is the framework for how Occupational Health and Safety is managed at CM Health. The key elements and purpose of this HSWMS are outlined below;

- Reinforces the CM Health Occ Health, Safety & Wellbeing Vision: Te Pae Manaaki (the Southern Cross) which aligns with the Counties Manukau values
- Provides the framework for all workers that are compliant with the relevant legislative requirements and the ACC Accredited Employers Program. The platform provides clear direction for managing occupational health and safety matters and has strong connections to the community we embrace
- Demonstrates our commitment to keeping our people safe, building a safe workplace culture across all work areas and furthermore supports our people in their physical and psychological wellbeing
- Outlines Occupational Health and Safety risks across the business and provides clear mitigation steps and ongoing monitoring of those risks, including following up on incidents
- Invites and encourages Worker Participation through the Health and Safety Representatives program (HSRs)
- Ensures ongoing training and up-skilling our people
- Monitors, evaluates and ensures continuous improvement.

Health and Safety Representatives (HSRs) play an essential role in keeping workers and visitors safe, educating their workmates on related issues, and ensuring procedures and processes are followed correctly. We have over 250 HSRs. Training is provided to HSRs and we work with this group to obtain worker feedback and improve our processes. From 2021, additional specialized training programs are being offered to HSRs who have completed the initial HSR training. This training includes Hazard and Risk Management and Incident Investigation and Prevention. The training options will be further expanded in 2022 as CM Health embraces the continued engagement and support of HSRs in the workplace.

In addition to managing health and safety, the Health and Safety team work on various projects in line with our known critical risks. The approach assists us to engage with our work groups to ensure the actions we take consider trends in incidents, including near misses and risks and ensure continuous improvement from our incident trends, which then enables us to share our learning's. To support this workflow, an Occupational Health and Safety Risk and Assurance Manager has been appointed to manage this portfolio on behalf of CM Health.

Employee Assistance Programme at work

CM Health works to promote positive wellbeing in the workplace and understands the specific issues affecting people working in the health sector. The Employee Assistance Programme (Raise) is a contracted service provided by OHSS. EAP services are also offered on site in certain areas and as facilitated debrief sessions after critical incidents have occurred.

This is a confidential service and all counselors are qualified, registered EAP professionals with expertise in the wide range of areas affecting people. Up to three sessions are available for each staff member. The program is supportive, confidential, and available to all CM Health staff and offers assistance within a wide range of areas.

Wellness

CM Health continues to recognise the importance of supporting employees' physical and mental health, and strives to support employees to stay well. A Wellbeing Steering Group has been established to co-ordinate work across the hospital and improve communication about wellbeing resources. Work continues to keep Wellbeing pages on Paanui updated and relevant.

Our membership of the Health Roundtable Workforce Wellbeing Improvement Group provides us with access to the Well-Being Index, a self-assessment tool provided via an app, with linked resources to help staff make decisions about actions to improve their wellbeing. This has been rolled out sequentially to physicians, nurses, midwives, HCAs, Allied Health, and Managers/Executive Leaders. De-identified data is accessible by our clinical champions and fed back to teams and Executive Leadership. Other benefits of our membership of this group include collaboration and sharing of ideas with other hospitals who belong to the group in New Zealand and Australia, along with education opportunities.

We held our first Schwartz Round at the end of 2020 and have a programme of six rounds planned for 2021. Each of our rounds to date has been attended by around 90 staff and feedback has been overwhelmingly positive. The Rounds are open to all CM Health staff and provide an opportunity to reflect on the shared social and emotional experience of working in healthcare.

A team of staff are working on developing a Stress First Aid programme for the organisation, accessible to all staff. This will follow a peer-to-peer support model and also help with self-care. It will encourage a culture where we check in on colleagues we are concerned about and seek help when we need it.

Complaints and appeals

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

Policies, procedures and guidelines

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

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

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

Counties Manukau District Health Board Workforce

What our workforce looked like by age, gender and ethnicity

Of the total workforce in 2020/21, women comprised 80% (7,324) and men 20% (1,872). The average age for women was 41.74 years and 41.93 years for men.

As at June 2021, 50% of the total workforce is less than 44 years of age. Our employee data also highlights an ethnically diverse workforce.

Age brackets	Percentage of all employees
Under 25	7%
25 – 29	13%
30 – 34	17%
35 – 39	13%
40 – 44	10%
45 – 49	10%
50 – 54	9%
55 – 59	9%
60 – 64	8%
65 – 69	3%
70+	1%
Date of Birth Not Specified	0.12%

Gender	Headcount	Headcount in %	Average Age
Female	7,324	80%	41.74
Male	1,872	20%	41.93
Grand Total	**9,196**		

Ethnicity	FTE	FTE in %	Headcount	Headcount in %
Asian	2,755	39%	3,445	37%
Maaori	532	7%	690	8%
Other	2,676	38%	3,460	38%
Pacific	990	14%	1,356	15%
Unknown	173	2%	235	3%
Grand Total	**7,126**		**9,186**	

What our workforce looked like by employee group

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

	FEMALE		MALE	
Occupational Groups	Headcount	Average of Salary	Headcount	Average of Salary
Allied Health	1,201	$73,966	296	$73,642
Management and Administration	1,048	$77,430	152	$102,833
Medical	561	$174,095	553	$195,320
Nursing	3,974	$71,213	544	$69,703
Support Personnel	540	$51,971	327	$58,986
Grand Total	**7,324**	**$79,016**	**1,872**	**$108,252**

Financial Statements for the year ended 30 June 2021

Statement of Responsibility

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

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

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

In the Board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2021.

Signed on behalf of the Board:

Vui Mark Gosche
CMDHB Board Chair

Tipa Mahuta
CMDHB Board Deputy Chair

Fepulea'i Margie Apa
Chief Executive Officer

Margaret White
Chief Financial Officer

16 December 2021

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Revenue				
Patient Care Revenue	2	2,046,793	1,916,456	1,860,841
Interest Revenue		600	1,000	1,007
Other Revenue	3	30,450	30,292	27,777
Total Income		**2,077,843**	**1,947,748**	**1,889,625**
Expenditure				
Personnel costs	4	821,130	763,591	765,152
Depreciation and amortisation expense	13/14	40,872	40,861	40,136
Outsourced services		123,156	97,477	107,647
Clinical supplies		136,922	125,671	126,219
Infrastructure and non-clinical expenses		76,343	73,216	70,322
Other District Health Boards		283,667	280,454	267,230
Non-health board provider expenses		595,658	540,914	537,211
Capital Charge	5	24,986	32,512	33,462
Interest expenses		-	72	-
Other expenses	6	18,935	22,858	21,918
Total expenditure		**2,121,669**	**1,977,627**	**1,969,297**
Deficit		**(43,826)**	**(29,879)**	**(79,672)**
Other comprehensive revenue				
Revaluation of Land	13/19	86,228	-	-
Revaluation of Buildings	13/19	-	-	-
Total Other comprehensive revenue (expense)		**86,228**	-	**-**
Total comprehensive revenue (expense) for the year		**42,202**	**(29,879)**	**(79,672)**

Statement of Changes in Equity
For the year ended 30 June 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Balance 1 July		**520,068**	**542,495**	**566,159**
Deficit for the year		(43,826)	(29,879)	(79,672)
Total Comprehensive revenue		86,228	-	-
Total comprehensive revenue		**42,402**	**(29,879)**	**(79,672)**
Capital contributions from the Crown		13,446	23,963	33,996
Repayment of capital to the Crown		(419)	(419)	(419)
Movement in restricted funds		(2)	9	2
Balance at 30 June	19	**575,495**	**536,169**	**520,068**

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

The accompanying notes form part of these financial statements.

Statement of Financial Position
As at 30 June 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Assets				
Current Assets				
Cash and cash equivalents	7	19,177	(179)	27,165
Debtors and other receivables	8	108,496	61,114	61,114
Inventories	10	11,586	11,305	11,304
Prepayments		2,899	2,877	2,877
Non-Current Assets held for Sale	11	5,320	5,320	5,320
Total current assets		**147,478**	**80,437**	**107,780**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	58,015	66,626	52,769
Property, plant and equipment	13	949,468	875,454	854,093
Intangible assets	14	12,443	4,511	10,712
Other Non-Current Assets	9	2,344	2,050	2,050
Total Non-Current assets		1,022,270	**948,641**	**919,624**
Total assets		**1,169,748**	**1,029,078**	**1,027,404**
Liabilities				
Current liabilities				
Creditors and other payables	15	201,680	152,460	150,092
Borrowings and overdraft	16	265	-	-
Employee entitlements	17	335,804	304,044	306,995
Total current liabilities		**537,749**	**456,504**	**457,087**
Non-current liabilities				
Employee entitlements	17	39,385	35,214	37,267
Provisions	18	1,095	990	990
Borrowings and overdraft	16	1,811	-	-
Creditors and other payables	15	14,214	200	11,992
Total non-current liabilities		**56,505**	**36,404**	**50,249**
Total liabilities		**594,254**	**492,908**	**507,336**
Net assets		**575,495**	**536,169**	**520,068**
Equity				
Crown equity	19	455,174	465,021	442,147
Accumulated deficits	19	(360,124)	(323,077)	(316,298)
Revaluation reserves	19	479,608	393,379	393,380
Other reserves		-	9	-
Trust funds	19	835	837	837
Total Equity		**575,495**	**536,169**	**520,068**

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

The accompanying notes form part of these financial statements

Statement of Cash Flow
For the year ended 30 June 2021

	Notes	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,894,709	1,765,757	1,695,878
Other		175,469	181,981	184,523
Interest received		600	1,000	1,007
Payments to suppliers		(1,220,427)	(1,140,665)	(1,106,687)
Payments to employees		(789,690)	(755,591)	(701,537)
Capital charge		(25,149)	(32,512)	(33,462)
Goods and services tax (net)		(546)	-	230
Net cash flow from operating activities		**34,966**	**18,972**	**39,952**
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		-	10	62
Purchase of property, plant, equipment and intangible assets		(55,252)	(69,258)	(61,118)
Acquisition/roll over of investments		(727)	(612)	(586)
Movement in Restricted Funds		(2)	-	(2)
Net cash flow from investing activities		**(55,981)**	**(69,860)**	**(61,644)**
Cash flows from financing activities				
Repayment of capital to the Crown		(419)	(419)	(419)
Capital Contributions from the Crown		13,446	23,963	33,996
Net cash flow from financing activities		**13,027**	**23,544**	**33,577**
Net (decrease)/increase in cash and cash equivalents		**(7,988)**	**(27,344)**	**11,885**
Cash and cash equivalents at the start of the year	7	27,165	27,165	15,280
Cash and cash equivalents at the end of the year	7	**19,177**	**(179)**	**27,165**

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

Equipment totalling $2.1m (2020: $0m) were acquired by means of finance lease during the year.

The accompanying notes form part of these financial statements.

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

	Actual 2021 $000	Actual 2020 $000
Net deficit	**(43,826)**	**(79,672)**
Add/(less) non-cash items		
Loss on Disposal of Assets	81	324
Write off of WIP	632	2,214
Impairment of Debtors	(1,339)	2,318
Depreciation and amortisation expense	40,872	40,136
Total non-cash items	**40,246**	**44,992**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(46,043)	(12,630)
Inventories	(281)	(2,437)
Creditors and other payables	36,394	23,438
Income in advance	17,549	2,646
Employee entitlements	30,927	63,615
Net movements in statement of financial position items	**38,546**	**74,632**
Add/(less) items classified as investing or financing activities	-	-
Net cash flow from operating activities	**34,966**	**39,952**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Impact of COVID-19 on the DHB

During August and September 2020, and February and March 2021, the Auckland region moved into Alert Levels 3 and 2, and other parts of the country, which includes the DHB's service area, moved into Alert Level 2.

At Alert Level 2, the operating capacity of the DHB was reduced. At Alert Level 1, the DHB resumed to normal business activity and in some instances at a higher level than pre-COVID-19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower alert levels.

Fiscal impact

During 2020/21 the region has invested resources to mature the COVID-19 financial reporting. CMDHB is leading the collation of monthly centralised reporting and invoicing to the MOH of most COVID-19 workstreams, resulting in the timely reimbursements of COVID-19 costs incurred, helping provide more certainty regarding COVID-19 cash flow requirements. For the 2020/21 financial year the vast majority of costs incurred by CMDHB have been reimbursed. We continue to work with the region and MOH to improve the accuracy and transparency of the COVID-19 financial reporting to enable consistent treatment across the sector.

The impact of the DHB's response to COVID-19 through 2019/20 and 2020/21 has seen continued deployment of a significant number of DHB staff away from normal roles. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. This has resulted in a higher underlying cost structure carried forward into the 2021/22 year.

The target for the 2020/21 savings plan was $17m comprised of $12m projects and $5m vacancies. However, organisational capacity to engage in planning was severely impacted by Whakaari White Island and COVID-19 with only $4.84m worth of projects being identified going into the financial year.

$9.5m in savings has been achieved for 2020/21 (56% of the overall DHB savings target). Project derived cost avoidance and cost savings accounted for $5.2m of the DHBs actual savings over 2020/21; DHB vacancies accounting for the remaining $4.3m of actual savings.

To balance proper stewardship with timely decision making, in March 2020 the Board set up an Executive Sub-Committee (made up of three members) to enable the Chief Executive to consult with the Board regarding out of the ordinary expenditure to support COVID-19 expenses. The Chief Executive worked to normal financial delegations and consulted with the subcommittee when required. All decisions were formally minuted and retrospective endorsement was ratified at normal Board meetings. During the DHB's response to COVID-19 we have maintained delegated authority levels and internal controls which have been tested by Internal audit.

As the Northern Region's decision making processes has evolved over the year and several delegations were put in place to enable efficient and timely decision making:

- CM Health, on behalf of the Northern Region DHBs, became the lead contractor with the MOH for establishing and shifting the Managed Isolation and Quarantine Facilities to DHB management.
- On 28 October 2020, the CMDHB Board has agreed to approve the harmonisation level of sub-delegation to the named positions of Chief Executive (CE) of $3m operational expenditure per proposal and $1m capital expenditure per proposal, where required to progress the continuing response to the COVID-19 pandemic in the region. The CMDHB Board also approved the delegation to Board Chairs (and in their absence a named deputy), the responsibility to agree with their CE proposals which exceed the limits set out above where these fall within the directions provided by the Minister of Health on 17 March 2020.
- On 27 January 2021, the Director-General of Health wrote to DHB CEs stating that all reasonable costs associated with the delivery of the COVID-19 vaccination programme will be met by the Ministry of Health as part of an agreed structure for various funded service models. On 3 March 2021, the Board approved the delegation to a sub-committee of the Board to approve any out of cycle and/or endorsements of unplanned expenditure, and risk mitigation decisions relating to responding to the implementation of the COVID-19 vaccination programme.
- On 26 May 2021, the CMDHB Board agreed to approve contract renewals for Community Testing Infrastructure and

COVID-19 primary options for acute care from 1 July 2021 for a further 12 months.

- On 3 August 2021, the Board resolved to commission and contract capacity to deploy the proposed Metro-Auckland COVID-19 vaccination plan to 31 December 2021.

CM Health has assessed the impact of COVID-19 on all balance sheet accounts. Overall the DHB does not consider there to be any material impacts as at 30 June 2021. In terms of the valuation of land and buildings, the full impact of fair value movements has been outlined in note 13 to the financial statements.

Statement of Accounting Policies

Reporting Entity

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

The financial statements of CMDHB as at and for the year ended 30 June 2021 comprise CMDHB and its interest in associates and jointly controlled entities.

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

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. The DHB does not operate to make a financial return.

The DHB is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice (GAAP).

The financial statements for CMDHB are for the year ended 30 June 2021, and were approved by the Board on 16 December 2021.

Basis of Preparation

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand. Key considerations are set out below:

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Holidays Act

As at 30 June 2021 the DHB has a provision of $162.4m for Holidays Act non-compliance (an increase of $15m during 2020/21). Remediation of the Metro Auckland DHB's Holidays Act liability is expected to commence in the 2022 calendar year. Remediation will require full cash support from the MOH.

COVID-19 costs

CMDHB will require continued support (monthly payments) from the MOH to fund reasonable costs associated with the response, establishment and implementation of COVID-19 related programs. This includes the costs of Hospital and Community health service delivery, Managed Isolation and Quarantine facilities, vaccination roll out and Personal Protective Equipment.

Operating and cash flow forecasts

Current cash flow forecasts confirm that, excluding anticipated cash payments in relation to Holidays Act or COVID-19, CMDHB has access to adequate resources, including overdraft (working capital and cash flows) to continue business as usual operations as per the 2021/22 Annual Plan for one year from the 16 December 2021 (date the 2020/21 Annual Report is planned to be approved by the CMDHB Board). These forecasts include the need to intermittently access the DHB's overdraft facility with NZHPL. The DHB is maintaining a watching brief, particularly in regard to implications of COVID-19 costs not funded.

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the CEA and the New Zealand Public Health and Disability Act 2000, which include the requirement to comply with GAAP.

The financial statements have been prepared in accordance with and comply with PBE Accounting Standards.

Measurement base

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

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000), other than Board remuneration noted in note 22. The functional currency of the DHB, its associates and its jointly controlled entity is New Zealand dollars (NZ$).

Changes in accounting policies

There have been no changes in the DHBs accounting policies since the last audited financial statements.

Standards issued but not yet effective, and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the DHB are:

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 *Statement of Cash Flows* requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2022, with early application permitted. The DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The DHB does not intend to early adopt the standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 30 June 2023. The DHB has not yet assessed in detail how the application of PBE FRS 48 will affect its statement of service performance. It does not plan to early adopt the standard.

Significant Accounting Policies

Investments in Associates and Joint Ventures

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

Revenue

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

Ministry of Health Population Based Revenue

Funding is provided by the Ministry of Health (MOH) through a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the Appropriation equally throughout the year.

MOH contract revenue

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

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Judgement is required in determining the timing of revenue recognition for contracts that span balance date or multi year funding agreements.

ACC Contract revenues

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

Rental income

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions, and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

Volunteer services received are not recognised as revenue or expenses by the group.

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.

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

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 or its useful life.

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

initially based on the historical observed default rates. The DHB will adjust historical credit loss experience with forecast economic conditions if they are expected to change over the next year.

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

Investments

Bank deposits
Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes:
- land;
- buildings, plant and infrastructure;
- clinical equipment, IT and motor vehicles;
- other equipment; and
- work in progress.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

Finance, Procurement and Information Management System (FPIM)

The Finance, Procurement and Information Management System (FPIM) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme.

CMDHB holds:

- an intangible asset for the cost of capital invested by CMDHB in the FPIM application. This is amortised over 14 years and amortisation commenced in the 2019/20 year;
- an intangible asset for the cost of capital invested by CMDHB in the FPIM central implementation costs. This will be amortised over 15 years when the asset is brought into use in October 2020 (as at 30 June 2021 these costs paid to date are recognised as a prepayment); and
- a prepayment for the costs paid in relation to the core build of the FPIM Hardware. This will be recognised as an expense over a five-year period from October 2020.

Health System Catalogue (HSC)

The FPIM Business Case specified the need for all DHBs to adopt a single national procurement catalogue, national data standards, a central and enhanced data repository of actual spend, and a framework for procurement compliance. These enablers would address the data and compliance requirements for PHARMAC national procurement of medical devices, representing significant future savings.

The Health System Catalogue (HSC) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits.

CMDHB holds:

- a prepayment for the costs paid in relation to the HSC. This will be recognised as an expense over a 10 year period from when the National Catalogue goes live (forecast during the 2021/22 year).

Amortisation

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

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

- Acquired computer software 2-5 years [20% - 50%]

Impairment of Property, Plant and Equipment and Intangible Assets

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

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term entitlements

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

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

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

Presentation of employee entitlements
Continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, retirement gratuities and sick leave expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

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

Defined benefit schemes

CMDHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit in the plan will affect future contributions by individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in Note 20.

Provisions

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

Provisions are not recognised for future operating losses.

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

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

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

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

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Crown equity;
- accumulated surplus or deficit;
- property revaluation reserves; and

- trust funds.

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 restricted donations and bequests provided to the DHB. The restrictions generally specify how the donations and bequests are required to be spent in providing specified deliverables of the bequest.

The receipt of, and investment revenue earned on, trust funds is recognised as revenue and then transferred to the trust funds' reserve from accumulated surplus or deficit. Application of trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated surplus or deficit from the trust funds' reserve.

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

The budget figures are derived from the Statement of Performance Expectation as approved by the Board before the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

The DHB's Statement of Performance Expectations (SPE) is required to be prepared before the 1 July each financial year.

Cost allocation

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

- Direct costs are those costs directly attributable to an output class.
- Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.
- Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.
- The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

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

Critical accounting estimates and assumptions

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

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

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

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

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

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

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

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

Retirement and long service leave

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

Holiday's Act provision for non compliance

Note 17 provides a summary of the estimated exposure and uncertainly in relation to the provision for remediation in terms of the Holiday's Act non-compliance.

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.

Agency relationship

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

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

Comparative Figures

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

2. Patient care revenue

	Actual 2021 $000	Actual 2020 $000
Health and disability services (MOH contracted revenue)	1,904,617	1,710,748
ACC contract revenue	32,259	27,777
Revenue from other district health boards	78,943	98,578
Other patient care related revenue	30,974	23,738
Total patient care revenue	**2,046,793**	**1,860,841**

Revenue for health services includes all revenue received from the Crown (via the Ministry of Health), Accident Rehabilitation and Compensation Insurance Corporation (ACC), and other sources.

Income received from other District Health Boards for agency contracts has been offset against the cost of those contracts $59.4m (2020: $23.4m).

3. Other revenue

	Actual 2021 $000	Actual 2020 $000
Donations and bequests received	2,330	1,199
Other revenue	26,457	25,031
Rental revenue	1,663	1,547
Total other income	**30,450**	**27,777**

Material items included in Other revenue are Retail Pharmacy revenue $9.87m (2020: $7.8m), New Zealand Medical Treatment Scheme funding $3.68m (2020: $4.2m), Radiology Services $2.55m (2020: $2.1m) and Pharmac Rebate $0m (2020: $0.9m).

4. Personnel costs

	Actual 2021 $000	Actual 2020 $000
Salaries and wages	764,190	679,035
Contributions to defined contribution schemes	26,013	22,612
Increase in liability for employee entitlements	30,927	63,505
Total personnel costs	**821,130**	**765,152**

Superannuation schemes

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

As at 31 March 2021, the DBP Scheme had a past service loss of $1.26m (2.2% of the liabilities) (2020: loss $2.78m (4.1% of the liabilities)) - this amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE FRS – 43.

In March 2019, the Actuary recommended employer contribution rate should be set at 3.0 times contributor contributions effective from 1 April 2020. In the latest actuarial review, conducted March 2020, the Actuary recommended employer contribution rate should be set at 4.0 times contributors contributions effective from 1 April 2021 with a further scheduled increase in 2022 to 6 times contributor contributions and this was accepted and endorsed by the Board.

5. Capital Charge

The DHB pays a half-yearly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the months of June and December. The capital charge rate levied during the year was 5% at 30 June 2021 (2020: 6%).

6. Other expenses

Other expenses include:	Actual 2021 $000	Actual 2020 $000
Audit fees – audit of financial statements – current year	265	255
Audit fees – under-provision prior year	10	1
Audit fees – other audit services	-	36
Operating leases expense	13,833	10,882
Finance Lease expense	99	-
Impairment of debtors	3,539	7,783
Board and committee members fees and expenses	476	422
Loss on Disposal of Property, Plant & Equipment	81	325
Impairment of WIP	632	2,214
Total other expenses	**18,935**	**21,918**

Non-cancellable operating lease commitments

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

	Actual 2021 $000	Actual 2020 $000
Not later than one year	8,644	7,056
Later than one year and not later than five years	12,157	11,378
Later than five years	806	1,284
Total Non-cancellable operating leases	**21,608**	**19,718**

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

The twenty (2020: thirteen) various buildings which CMDHB occupies under leasehold terms are leased for periods ranging from one to seven years.

CMDHB Share of Non-cancellable operating lease commitments held by Jointly Controlled Entities

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

	Actual 2021 $000	Actual 2020 $000
healthAlliance N.Z. Limited (refer Note 12)		
Not later than one year	827	838
Later than one year and not later than five years	3,206	3,309
Later than five years	-	724
Total Non-cancellable operating leases	**4,033**	**4,871**

7. Cash and cash equivalents

	Actual 2021 $000	Actual 2020 $000
Cash at bank and on hand	9	8
NZ Health Partnerships Limited	18,333	26,320
Trust / Special purpose Funds	835	837
Cash and cash equivalents for the purposes of the statement of cash flows	**19,177**	**27,165**

The carrying value of cash at bank approximates its fair value.

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

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

While cash and cash equivalents at 30 June 2021 are subject to expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

8. Debtors and other receivables

	Actual 2021 $000	Actual 2020 $000
Ministry of Health receivables	37,167	8,972
Other receivables	17,441	16,400
Other accrued revenue	58,983	42,176
Less: provision for impairment	(5,095)	(6,434)
Total Debtors and other receivables	**108,496**	**61,114**

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

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

	2021			2020		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	75,820	(42)	75,779	53,219	(53)	53,166
Past due 1-30 days	5,611	(677)	4,934	3,329	(516)	2,813
Past due 31-60 days	1,728	(350)	1,378	980	(445)	535
Past due 61-90 days	11,048	(298)	10,750	1,317	(488)	829
Past due > 90 days	19,383	(3,728)	15,655	8,703	(4,932)	3,771
Total	**113,590**	**(5,095)**	**108,496**	**67,548**	**(6,434)**	**61,114**

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

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

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

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

The DHB has assessed there to be no material change in the credit risk of debtors or trade receivables as a result of COVID-19.

9. Other non-current assets

	Actual 2021 $000	Actual 2020 $000
Reversionary interest in car park building	2,344	2,050
Total Other non-current assets	**2,344**	**2,050**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to us in 9 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 5% was used (2020: 6%).

10. Inventories

	Actual 2021 $000	Actual 2020 $000
Pharmaceuticals	1,046	1,019
Other Supplies net of provision for obsolete stock	10,540	10,285
Total inventories	**11,586**	**11,304**

No inventories are pledged as security for liabilities (2020: $0), however, some inventories are subject to retention of title clauses. The majority of supplies were expensed when purchased with only ward stock held on the balance sheet.

The amount of inventories recognised as an expense during the year was $138.8m (2020: $126.5m) which is included in the Clinical supplies line item in the Statement of Comprehensive Revenue and Expense

11. Non-current Assets held for Sale

	Actual 2021 $000	Actual 2020 $000
Land	5,320	5,320
Total Non-current Assets held for Sale	**5,320**	**5,320**

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

The CMDHB Board is committed to the sale of land Classified as a Non-current Asset held for sale commonly known as Area B, and will endeavour to sell the land within 12 months. Due to several items to resolve regarding the sale, we cannot guarantee the sale within 12 months.

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2021	Interest held at 30 June 2020	Balance date
Northern Regional Alliance Limited	Provision of health support services	Associate	33.3%	33.3%	30 June
healthAlliance N.Z. Limited	Provision of shared services	JV	25.0%	25.0%	30 June
NZ Health Partnerships Limited	Provision of services to provide savings to the NZ health sector	JV	5.0%	5.0%	30 June
HealthSource New Zealand Limited	Provision of shared services	JV	25%	25%	30 June

healthAlliance N.Z. Limited

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

HealthSource New Zealand Limited

HealthSource New Zealand Limited was previously wholly owned by healthAlliance N.Z. Limited. On 19 February 2020 the CMDHB Board approved the purchase of 25% of the direct shareholding of HealthSource New Zealand Limited for an amount of $169k, which was 25% of the company's net assets value.

NZ Health Partnerships Limited

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

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

- Class B Shares confer no voting rights.
- Class B shareholders shall have the right to access the FPIM programme shared services.

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

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

Year end 30 June 2021 $000 (unaudited)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Limited	26,653	21,889	4,764	18,576	1,207
healthAlliance N.Z. Limited	239,647	41,697	197,950	152,357	(80)
NZ Health Partnerships Limited	572,335	545,216	27,119	38,394	(2,487)
HealthSource New Zealand Limited	9,081	8,370	711	42,265	76

Year end 30 June 2020 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Limited	23,771	20,214	3,557	18,230	1,099
healthAlliance N.Z. Limited	224,292	34,286	190,006	137,819	(2,087)
NZ Health Partnerships Limited	459,769	430,163	29,606	33,881	692
HealthSource New Zealand Limited	8,194	7,558	636	34,131	(41)

Contingencies

NZHP has contracts for the provision of IaaS relating to the NTS Programme (FPIM Hardware platform), for which stop-cost contract penalties could result in the event FPIM Hardware platform was discontinued.

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

In the unlikely event that there was a discontinuance of FPIM Hardware platform and a requirement to stop the contract, for any resulting stop-cost penalties NZHP would have a contingent liability to the supplier, and an equal and corresponding contingent asset as a receivable from the DHBs. (2020: $nil).

Share of profit of Associate entities and Jointly Controlled Entities

	Actual 2021 $000	Actual 2020 $000
Share of profit – healthAlliance N.Z. Limited	**(20)**	**(522)**
Share of loss – HealthSource New Zealand Limited	**19**	**(11)**

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

Investments in Associates and Jointly Controlled Entities

	Actual 2021 $000	Actual 2020 $000
healthAlliance N.Z. Limited	57,846	52,600
HealthSource New Zealand Limited	169	169
Total Investments in Associates	**58,015**	**52,769**

The increase in healthAlliance N.Z. Limited represents the issue of additional Class C shares – these shares are non-voting and have no impact on the calculation of the DHB's share of profit/ (loss). With the additional shares issued, the DHB's ownership percentage remains at 25%. Investments in associates and joint ventures are unlisted companies, accordingly, there is no quoted market price for these investments.

13. Property, plant and equipment

	Land $000	Buildings, Plant & Infrastructure $000	Clinical Equipment, IT & Motor Vehicles $000	Other Equipment $000	Work in progress $000	Total $000
Cost or valuation						
Balance at 1 July 2019	**193,430**	**570,132**	**94,934**	**9,895**	**21,032**	**889,423**
Additions	-	16,112	282	-	60,919	77,313
WIP capitalised	-	8,453	17,248	1,107	(27,070)	(262)
Revaluation increase/(decrease)	-	-	-	-	-	-
Write offs / Impairment	-	-	-	-	(1,943)	(1,943)
Disposals/transfers	-	(592)	(17,132)*	-	(913)	(18,637)
Balance at 30 June 2020 / 1 July 2020	**193,430**	**594,105**	**95,332**	**11,002**	**52,025**	**945,894**
Additions	-	-	-	-	49,122	49,122
WIP capitalised	-	51,301	10,168	1,058	(62,527)	-
Revaluation increase/(decrease)	86,228	-	-	-	-	86,228
Write offs / Impairment	-	-	-	-	-	-
Disposals/transfers	-	-	(484)	-	-	(484)
Balance at 30 June 2021	**279,658**	**645,406**	**105,016**	**12,060**	**38,620**	**1,080,760**
Accumulated depreciation and impairment losses						
Balance at 1 July 2019	**-**	**592**	**64,135**	**5,957**	**-**	**70,684**
Depreciation expense		27,134	10,483	1,006	-	38,623
Elimination on disposal/transfer		(592)	(16,914)*	-	-	(17,506)
Revaluation increase/(decrease)		-	-	-	-	-
Balance at 30 June 2020 / 1 July 2020	**-**	**27,134**	**57,704**	**6,963**	**-**	**91,801**
Depreciation expense		28,799	10,181	902	-	39,882
Elimination on disposal/transfer	-	-	(389)	-	-	(389)

Revaluation increase/(decrease)	-	-	-	-	-	-
Balance at 30 June 2021	**-**	**55,933**	**67,496**	**7,865**	**-**	**131,294**
Carrying amounts						
At 1 July 2019	**193,430**	**569,540**	**30,799**	**3,938**	**21,032**	**818,739**
At 30 June and 1 July 2020	**193,430**	**566,971**	**37,628**	**4,039**	**52,025**	**854,093**
At 30 June 2021	**279,658**	**589,473**	**37,520**	**4,195**	**38,620**	**949,468**

Note *: During the 2019/20 year, a significant amount of Nil Net Book Value assets have been removed from the Fixed Asset Ledger, resulting in the removal of the Cost and corresponding Accumulated Depreciation amounts from the Fixed Asset Ledger and the General Ledger.

Finance leases

The net carrying amount of assets held under finance lease is $2.077m (2020: $0m) for equipment. Note 16 provides further information about finance leases.

Capital Commitments

	Actual 2021 $000	Actual 2020 $000
Buildings	33,349	10,947
Other Equipment	7,654	4,891
Intangible Assets	2,683	2,871
Total Capital commitments	**43,686**	**18,709**

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

CMDHB Share of Capital Commitments held by Jointly Controlled Entities

	Actual 2021 $000	Actual 2020 $000
healthAlliance N.Z. Limited (refer Note 12)		
Property , plant and equipment	3,366	642
Total Capital commitments	**3,366**	**642**

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

Valuation

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely.

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

The most recent valuation of land was performed by a registered independent valuer, Darroch, as at 30 June 2021. The total land valuation amounted to $279.66m, resulting in a 2020/21 upwards revaluation adjustment of $86.23m.

Buildings
Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- The remaining useful life of assets is estimated. Specifically, useful lives ascribed to individual buildings are estimated. Resulting changes to useful lives can have a significant impact on asset values if the useful life of a building decreases significantly.
- Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

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

As part of the DHB's internal review process, the DHB is currently conducting a multi-year review of the condition of the major buildings in its portfolio, including assessments around seismic strengthening, asbestos, critical building services infrastructure and cladding remediation. In 2017/18, the DHB commissioned two major infrastructure assessments. Completed in April 2019 was a detailed seismic assessment and independent peer review of the Middlemore Galbraith building that confirmed this as an earthquake prone building. The CM Health Board is working through related remediation and replacement investment decisions in 2020/21. The second assessment related to asset assessment of the Middlemore, Manukau and Pukekohe site infrastructure has also since been completed. Risk prioritisation and remediation strategies are currently being generated from the assessments and will include estimates of costs to repair or replace DHB building assets. Amendments to useful lives and values ascribed to buildings were accounted for as at 30 June 2019 based on an independent valuation.

Subsequent to the 30 June 2019 balance date the DHB received the following building assessments. All the reports identify impairment issues with these buildings. However due to the fact that the impairments are immaterial, and would not impact the loss for the year (because the impairment would be offset against historical revaluation increases), no adjustments have been made to the year end valuation or building values as disclosed as at 30 June 2021:

- Franklin Memorial Hospital: Detailed Seismic Assessment
- Pukekohe Hospital Plant Room: Detailed Seismic Assessment
- Esme Green Building: Detailed Seismic Assessment
- Colvin building complex: Initial Seismic Assessment and Building condition assessment
- Building 58 Western Campus: Initial Seismic Assessment

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

The most recent valuation of buildings was performed by a registered independent valuer, Darroch, as at 30 June 2019. The total building valuation amounted to $569.54m, resulting in a 2018/19 upwards revaluation adjustment of $120.976m.

Readers are asked to note the following in relation to the DHB's fair value of buildings for the year ended 30 June 2021

For the year ended 30 June 2021, the DHB engaged an independent valuer to do a desktop assessment on the fair value of the DHBs buildings to determine whether there had been a material movement. The initial assessment performed in March 2021 did not highlight a material movement in buildings and accordingly no adjustments were made in the DHB's financials as at 30 June 2021. The sharp increase in costs in the last few months of the year, driven by international supply chain shortages and shipping costs as a result of COVID-19, resulted in a subsequent assessment in July/August 2021 which took

into account market evidence and information, using the Department of Statistics website for the Capital Goods Price Increase Index as a benchmark. This assessment determined that there has been an estimated cumulative 10.5% replacement cost increase for buildings compared to the carrying value as at 30 June 2021.

When the full land and building revaluation was carried out in June 2019, CMDHB management and Board considered that, despite the current use of the Galbraith building, the remediation costs (specifically the seismic strengthening costs) of the building far outweighed its "value in use". For that reason the Galbraith building was fully impaired to $0 in the 30 June 2019 financial statements. Audit NZ reported CMDHB's impairment as an error as they considered that, because the Galbraith building is still being occupied and providing services, and as there is no budgeted plan to remediate the building issues, there was still value in use. The adjustment was not material for audit purposes and accordingly there was no adjustment to the audit report for the year ended 30 June 2019 and for the year ended 30 June 2020.

At time of writing, and due to lack of other viable options the Galbraith building continues to be used an integral facility to enable clinical and support service capacity. The building remains fully impaired in the DHB's financial statements.

Taking into account the above mentioned 10.5% and the Galbraith impairment, the fair value of CMDHB buildings is understated by approximately $76m as at 30 June 2021. The DHB has not adjusted the values of buildings as at 30 June 2021 as it is expected that construction costs will continue to grow in the medium term, due to the supply issues of materials and labour forces. The movement is not considered material by management or the Board. The timeframe and extent of these changes will be largely dependent on international responses to the pandemic and associated recovery time for increasing economic activity and trade. Management are planning to undertake a full building valuation to inform the 30 June 2022 financial statements, which will also provide a current valuation for transition to Health NZ with effect from 1 July 2022.

Restrictions on title

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

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

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

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

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

Dental training facility

In 2018 the DHB obtained Ministerial approval to enter into a co-operative agreement with the University of Otago whereby the University was granted approval to lease DHB land for up to 30 years for the purposes of developing a dental training facility at Manukau Health Park. The dental facility construction was completed in February 2020.

The DHB has accounted for the development as an operating lease. The value of construction costs was recognised by the DHB as Property, Plant and Equipment for the year ended 30 June 2020.

On expiry of the lease, ownership of the dental facility will transfer to the DHB and Counties Manukau will be required to compensate the University for the value of the Dental facility at the date of expiry. The net present value of this obligation has been recognised for the year ended 30 June 2021 and will be wound up over the 30 year lease period.

The difference between the current construction costs and the net present value of the liability has been recognised as income in advance for the year ended 30 June 2021 and will be wound down as revenue income over the term of the 30 year lease.

14. Intangible assets

Movements for each class of intangible assets are as follows:

	FPIM Rights $000	Software $000	Work in Progress $000	Total $000
Balance at 30 June 2019/1 July 2019	**3,286**	**1,724**	**3,629**	**8,639**
Additions	-	-	4,090	4,090
Work in Progress Capitalised	-	690	(428)	262
Impairment	-	-	(270)	(270)
Transfers / Disposals	-	(248)	-	(248)
Balance at 30 June 2020/1 July 2020	**3,286**	**2,166**	**7,021**	**12,473**
Additions	1,388	-	6,478	7,866
Work in Progress Capitalised	-	-	-	-
Impairment	-	-	(632)	(632)
Transfers / Disposals	-	-	(4,513)	(4,513)
Balance at 30 June 2021	**4,674**	**2,166**	**8,354**	**15,194**
Accumulated amortisation and impairment losses				
Balance at 1 July 2019	**-**	**312**	**-**	**312**
Amortisation expense	373	1,144	-	1,517
Transfers / Disposals	-	(68)	-	(68)
Balance at 30 June 2020/1 July 2020	**373**	**1,388**	**-**	**1,761**
Amortisation expense	455	535	-	990
Transfers / Disposals	-	-	-	-
Balance at 30 June 2021	**828**	**1,923**	**-**	**2,751**
Carrying amounts				
At 1 July 2019	**3,286**	**1,412**	**3,629**	**8,327**
At 30 June and 1 July 2020	**2,913**	**778**	**7,021**	**10,712**
At 30 June 2021	**3,846**	**243**	**8,354**	**12,443**

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

Finance, Procurement and Information Management System (FPIM)

The FPIM Programme asset is deemed to be a non-cash-generating asset. This is on the basis that there are no cash flows directly linked to the asset. Rather, the benefit to each DHB is the potential cost savings from a negotiated national contract above the cost of each DHB negotiating a similar contract themselves. Therefore, the applicable accounting standard for considering if impairment exists is PBE IPSAS 21 Impairment of Non-Cash-Generating Assets. PBE IPSAS 21 requires an annual test for impairment by comparing the asset carrying value with its recoverable service amount.

The FPIM Business Case approved by Cabinet 24 on June 2019 materially changed from the FPIM Programme paused by the Cabinet decision of 28 June 2018 and the judgements that were assumed in assessing the FPIM Programme carrying value at 30 June 2018. Key changes being:

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

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

The IT shared services project was undertaken for the purpose of reducing costs for the public health sector. The project is funded by the DHBs across the country. As at 30 June 2021, the DHB has paid $3.846 million (2020: $2.913 million) as its share of the project funding, which represents its rights to use the systems when developed.

As the project is work in progress, these rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the group's share of the DRC of the underlying IT assets. There was no impairment.

CMDHB was planned to go onto the FPIM platform on 2 November 2021, however owing to the resurgence of COVID-19 in August 2021, CMDHB go live has been postponed to a date yet to be determined. The Northern Region DHB's shared services entities have gone onto the FPIM platform from 1 August 2021.

15. Creditors and other payables

	Actual 2021 $000	Actual 2020 $000
Payables under exchange transactions		
Creditors and accrued expenses	165,568	128,762
Income in advance	42,084	24,535
Total payables under exchange transactions	**207,652**	**153,297**
Payables under non-exchange transactions		
GST payable	8,242	8,787
Total payables under non-exchange transactions	**8,242**	**8,787**
Total creditors and other payables	**215,894**	**162,084**
Creditors and Other Payables - current	201,680	150,092
Creditors and Other Payables – non-current	14,214	11,992
Total creditors and other payables	**215,894**	**162,084**

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

16. Borrowings and overdraft

	Actual 2021 $000	Actual 2020 $000
Borrowing facility limits		
Overdraft facility	75,000	75,000
Total borrowing facility limits	**75,000**	**75,000**

Overdraft facility

CMDHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) and the participating DHBs. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue. This is used in determining working capital limits, being defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST, for CMDHB that equates to $75.0m (2020: $75.0m).

Borrowings	Actual 2021 $000	Actual 2020 $000
Current Portion		
Finance Leases	265	-
Total Current Portion	**265**	-
Non-Current Portion		
Finance Leases	1,811	-
Total Non-Current Portion	**1,811**	-
Total Borrowings	**2,076**	-

The fair value of finance leases is $2,076k (2020: $0k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date of 5%.

Analysis of Finance Leases Minimum lease payments payable	Actual 2021 $000	Actual 2020 $000
No later than one year	363	-
Later than one year and not later than five years	1,815	-
Later than five years	272	-
Total Minimum Lease Payments	**2,450**	-
Future Finance Charges	(374)	-
Present Value of Minimum Lease Payments	**2,076**	-
Present Value of Minimum Lease Payments		
No later than one year	265	-
Later than one year and not later than five years	1,544	-
Later than five years	267	-

Total Present Value of Minimum Lease Payments	**2,076**	**-**

Description of finance leasing arrangements

The DHB has entered into finance leases for the lease of:

- Stryker Power Tools. The lease is for a period of 7 years ending 31 March 2028.

The net carrying amount of the leased items within each class of property, plant, and equipment is shown in Note 13. There are no restrictions placed on the DHB by any of the finance leasing arrangements. Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

17. Employee entitlements

	Actual 2021 $000	Actual 2020 $000
Current portion		
Accrued salaries and wages	43,221	43,535
Annual leave	93,081	81,305
Liability for Holidays Act remediation provision	162,430	147,430
Sick leave	560	380
Long service leave	1,005	892
Retirement gratuities	6,521	6,064
Sabbatical leave	1,316	1,343
Continuing medical education	27,670	26,046
Total current portion	**335,804**	**306,995**
Non-current portion		
Long service leave	11,553	10,639
Retirement gratuities	26,082	24,968
Sick leave	1,750	1,660
Total non-current portion	**39,385**	**37,267**
Total employee entitlements	**375,189**	**344,262**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 0.38% - 2.98% (2020: 0.22% - 1.6%) and an inflation factor of 3.0% (2020: 1.9%) were used. A movement of 0.5% (2020: 1%) in the salary growth rate would change the actuarial valuation by $2.1m more if the growth assumption was 0.5% (2020: 1%) higher or $1.9m less if the growth assumption was 0.5% (2020: 1%) lower.

Holidays Act

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 (the Holidays Act).

Work has been ongoing since 2016 on behalf of all DHBs and the New Zealand Blood Service, with the Council of Trade Unions, health sector unions, and the Ministry of Business, Innovation and Employment Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act noncompliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all noncompliance progressed during the 2019/20 and current financial years. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine the liability based on its own review of payroll processes which identified instances of non-compliance with the Holidays Act and the requirements of the MOU. The liability was estimated by:

- selecting a sample of current and former employees;
- calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result.

This liability recognised is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

As at 30 June 2021 the DHB has a provision of $162.4m (2020: $147.4m) for Holidays Act non-compliance. Remediation of the Metro Auckland DHB's Holidays Act liability is expected to commence in 2021/22. Cash support from the MOH is therefore required during the 2021/22 year.

18. Provisions

	Actual 2021 $000	Actual 2020 $000
Non-current portion		
ACC Partnership Programme	1,095	990
Total provisions	**1,095**	**990**

Movements for each class of provision are as follows:

	Actual 2021 $000	Actual 2020 $000
Balance at 1 July	990	1,035
Actuarial valuation movement	105	(45)
Balance at 30 June	**1,095**	**990**

19. Equity

	Actual 2021 $000	Actual 2020 $000
Crown equity		
Balance at 1 July	442,147	408,570
Equity injections from the Crown	13,446	33,996
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**455,174**	**442,147**

	Actual 2021 $000	Actual 2020 $000
Accumulated surpluses/(deficits)		
Balance at 1 July	(316,298)	(236,626)
Deficit for the year	(43,826)	(79,672)
Balance at 30 June	**(360,124)**	**(316,298)**
Revaluation reserves		
Balance at 1 July	393,380	393,380
Revaluations	86,228	-
Balance at 30 June	**479,608**	**393,380**
Revaluation reserves consist of:		
Land	309,796	223,568
Buildings and Infrastructure	169,812	169,812
Total revaluation reserves	**479,608**	**393,380**
Trust/Special funds		
Balance at beginning of year	837	835
Funds expended	(2)	(2)
Funds received	-	-
Interest received on Restricted Funds	-	4
Other transfers/movements	-	-
Balance at end of year	**835**	**837**

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

Total equity	**575,495**	**520,068**

Capital management

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

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. The DHB has complied with these provisions in the 2020/21 financial year.

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

20. Contingencies

Asbestos

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

Legal Matters

There are a number of matters of a legal nature to which the DHB may have an exposure. The amounts involved 2021: $3m (2020: $3m), if required to be settled, would be expensed in the year of settlement.

Contingent asset

Encroaching structures

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

21. Related Party Transactions

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

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

- within a normal supplier or client/recipient relationship.
- on terms and conditions no more or less favourable than those that it is reasonable to expect that the DHB would have adopted in dealing with the party at arm's length in the same circumstances.
- Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $2,047m (2020 $1,861m) to provide health services in the Counties Manukau area for the year ended 30 June 2021 (note 2).

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

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

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2021 totalled $9.59m (2020: $8.86m). These purchases included the purchase of air travel from Air New Zealand, postal services from New Zealand Post, and blood products from NZ Blood Service.

During the COVID-19 lockdown emergency, the DHB purchased Personal Protective Equipment (PPE) under the Government's National Emergency Supplies arrangement - these supplies, in part, were purchased at a nominal cost - the full value of the purchases are not reflected in these accounts.

Transactions with key management personnel

Key management personnel compensation

	Actual 2021 FTE	Actual 2020 FTE	Actual 2021 $000	Actual 2020 $000
Executive management team	12.2	11.5	4,048	3,685
Total key management personnel compensation	**12.2**	**11.5**	**4,048**	**3,685**

In addition to the above, the total actual expense for the Executive Management team includes other long-term benefits (KiwiSaver and Other) amounting to $216.0k (2020: $187.1k).

Key management personnel includes the Chief Executive, and thirteen (2020: eleven) members of the management team.

In recognition of the impact of COVID-19 on the CMDHB community, the Board Chair and the CEO donated a share of their respective salaries to the Middlemore Foundation for Health Innovation. This donation is to be used for funding a support sponsorship of "Our Local Heroes" prizes and if there are surplus funds, then to fund a scholarship for a Student Tertiary Health Studies scheme.

Board and Committee Members compensation

	Actual 2021 FTE	Actual 2020 FTE	Actual 2021 $000	Actual 2020 $000
Board	11	11	429	392
Committee	4	4	23	16
Total board and committee members compensation	**15**	**15**	**452**	**408**

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

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

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

The Middlemore Foundation

The Middlemore Foundation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly, the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. While CMDHB has been the major beneficiary of the Trust, it must meet all normal Charitable Trust requirements in terms of applications for funding. The DHB has not calculated the financial effect of a consolidation. The latest draft financial position of the Foundation shows that it had net assets of $4.18m (2020: $4.67m) and a surplus/(deficit) of $(419)k (2020: $11k) which may be subject to restrictions on distribution as at 30 June 2021. The financial statements of the Foundation for 2021 are not publicly available as they have not yet been approved by the Foundation's trustees.

22. Board member remuneration

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

	Actual 2021 $	Actual 2020 $
Vui Mark Gosche (Chair)	66,213	59,512
Ms Tipa Mahuta (Deputy Chair)(1)	44,198	24,657
Mrs Catherine Abel-Pattinson	35,696	32,589
Mr Apulu Reece Autagavaia	35,509	31,151
Mr Garry Boles (1)	34,009	19,526
Mrs Colleen Brown	36,259	32,839
Mrs Katrina Bungard	35,259	31,401
Mrs Dianne Glenn	35,759	33,151

Dr Lana Perese (1)	36,759	19,526
Mr Pierre Tohe (1)	34,571	20,276
Mr Paul Young (1)	34,759	20,213
Mr Pat Snedden (2)	-	15,094
Dr Lyn Murphy (2)	-	12,812
Mr George Ngatai (2)	-	13,625
Dr Ashraf Choudhary (2)	-	12,875
Ms Kylie Clegg (2)	-	12,625
Total board member remuneration	**428,991**	**391,672**

Committee Members, not Board Members or Employees	**Award 2021 $**	**Award 2020 $**
Mr Barry Bublitz (3) (CPHAC)	1,750	500
Mr Robert Clark (3) (CPHAC, HAC)	3,250	750
Mr Leopino Foliaki (Chair ARF) (5)	2,000	-
Mr Pat Snedden (Chair ARF, MCW) (4)	16,000	14,000
Mr John Wong (2) (CPHAC)	-	833
Total	**23,000**	**16,083**

1- Appointed 9/12/2019
2- Resigned 4/12/2019
3- Appointed 26/2/2020
4- Resigned 1/3/21
5- Appointed 3/3/21

In March 2020, the DHB established a new Board Sub Committee – Major Capital Works Board sub-committee (MCW). The Committee has been set up for the purpose of providing guidance and advice to the Audit Risk and Finance Committee on major capital projects.

In December 2019, the People & Culture Sub Committee was established by the Board. Their function is to provide advice to the Board in relation to the appointment and remuneration of the CMDHB Chief Executive, governance oversight of health and safety and assurance of leadership conduct and organisation culture is aligned to strategy.

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

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

No Board members received compensation or other benefits in relation to cessation (2020: $nil).

Board Observers, not Board Members or Employees	**Award 2021 $**	**Award 2020 $**
Ms Brittany Stanley-Wishart	2,750	-
Ms Ngataki Tori	2,250	-
Total	**5,000**	**-**

Counties Manukau DHB is taking part in a District Health board governance programme called 'A Seat at the Table.' The programme aims to mentor young adults interested in health board governance, in particular Māori, Pacific and disabled people.

The programme also aims to increase the diversity on District Health Boards by providing opportunities to develop governance skills for board observers.

The programme is for 12 months (starting August 2020) and observer/s been part of the board's governing a District Health Board. The observer/s participate as a board member in all aspects but do not have voting rights and do not form part of the quorum of a board meeting.

They have been provided with a board member as a mentor and there are opportunities to meet with board observers on other District Health Boards to share learnings. Observers attend board meetings and committee meetings, where possible, to further develop governance skills. Board observer costs are recovered from the Ministry of Health through the 'A Seat at the Table' programme.

While the board will make final decisions, any contribution from the observer/s is welcomed.

23. Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

	Actual 2021	Actual 2020
Total remuneration paid or payable:		
$100,000 – 109,999	476	378
$110,000 – 119,999	255	202
$120,000 – 129,999	146	124
$130,000 – 139,999	121	87
$140,000 – 149,999	85	96
$150,000 – 159,999	67	55
$160,000 – 169,999	59	35
$170,000 – 179,999	30	33
$180,000 – 189,999	25	29
$190,000 – 199,999	24	28
$200,000 – 209,999	25	19
$210,000 – 219,999	26	19
$220,000 – 229,999	27	31
$230,000 – 239,999	20	20
$240,000 – 249,999	23	33
$250,000 – 259,999	35	34
$260,000 – 269,999	26	35
$270,000 – 279,999	33	27
$280,000 – 289,999	34	20
$290,000 – 299,999	26	17
$300,000 – 309,999	15	26
$310,000 – 319,999	28	21
$320,000 – 329,999	15	14
$330,000 – 339,999	17	14
$340,000 – 349,999	10	7
$350,000 – 359,999	16	11
$360,000 – 369,999	11	8
$370,000 – 379,999	8	8
$380,000 – 389,999	1	10
$390,000 – 399,999	11	6
$400,000 – 409,999	10	3
$410,000 – 419,999	6	3

	Actual 2021	Actual 2020
$420,000 – 429,999	4	4
$430,000 – 439,999	3	2
$440,000 – 449,999	-	1
$450,000 – 459,999	6	2
$460,000 – 469,999	2	4
$470,000 – 479,999	2	4
$480,000 – 489,999	1	-
$490,000 – 499,999	3	-
$500,000 – 509,999	1	1
$510,000 – 519,999	3	1
$520,000 – 529,999	1	-
$530,000 - 539,999	1	-
$540,000 – 549,999	-	-
$550,000 – 559,999	1	1
$560,000 – 569,999	1	-
$580,000 – 589,999	-	1
$600,000 - 609,999	1	-
Grand total	**1,741**	**1,474**

During the Year Ended 30 June 2021 the above numbers of employees received remuneration of at least $100,000 – of these employees, 1,475 (2020: 1,250) are Medical Staff and 266 (2020: 224) are Management.

During the year ended 30 June 2021: 8 (2020: 18) employees received compensation and other benefits in relation to cessation totaling $459,248 (2020: $579,061).

24. Events after the balance date

The Auckland and South Auckland resurgence of COVID-19 in August 2021 has had a significant impact on the DHBs resources to meet acute demand growth and the ability to deliver on the planned care, including recovery from earlier COVID-19 resurgences. The DHB is working both Regionally and Nationally to develop a planned care recovery plan together with the development of a workforce and resource strategy to build resilience for Hospital and Community services.

25. Financial instruments

Financial instrument categories

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

	Actual 2021 $000	Actual 2020 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	19,177	27,165
Debtors and other receivables	108,496	61,114
Total financial assets measured at amortised cost	**127,673**	**88,279**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	165,568	128,762
Total financial liabilities measured at amortised cost	**165,568**	**128,572**

Financial instrument risks

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. The DHB has no financial instruments that give rise to price risk.

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2021, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have a minimal impact (2020: Minimal).

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

Credit quality of financial assets

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

	Actual 2021 $000	Actual 2020 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	835	837
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	18,333	26,320
- NZHPL – no defaults in the past		

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

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

Contractual maturity analysis of financial liabilities.
The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate of the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows.

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2020						
Creditors and other payables	128,762	128,762	128,762	-	-	-
Total	**128,762**	**128,762**	**128,762**	**-**	**-**	**-**
2021						
Creditors and other payables	165,568	165,568	165,568	-	-	-
Borrowings	2,076	2,450	363	363	1,452	272
Total	**167,644**	**168,018**	**165,931**	**363**	**1,452**	**272**

26. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expense

Counties Manukau DHB has reported a provisional unaudited financial deficit of $43.826m for the year ended 30 June 2021. This result includes a $15m provision to reflect continued cost of non- compliance with the Holidays Act, and a COVID-19 upside of $1.591m (reversal of 2019/20 provision). After allowing for these exceptional items ***the DHB reported an underlying deficit of $30.419m, being $540k unfavourable to budget.***

The unfavourable underlying YTD result reflects continued unprecedented demand for acute services causing significant periods of over occupancy, specifically during the last quarter. This acute demand has had a significant impact on planned care recovery volumes meaning the DHB has not been able to deliver volumes lost during the COVID-19 Alert Levels 2 and 3. An estimated $3.06m planned care recovery revenue has been lost due to procedures disrupted during these periods (not recovered by year end), this has been coded to COVID-19 as lost revenue. Discussions are ongoing with the MoH planned care team regarding funding of the DHBs wet lease commitment associated with planned care recovery volumes as lost planned care revenue continues to have obvious implications on the DHBs cash position.

The DHB's response to COVID-19 through FY 20 and 21 has seen continued deployment of a significant number of DHB staff away from normal roles. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. Lower 2020/21 savings has been offset by lower demand for primary and community care during the year,

and to some degree vacancies. The delay to achieve sustainable savings has resulted in a higher underlying cost structure carried forward into the FY22 year.

Statement of Financial Position

The most significant variances are in debtors and other receivables as well as creditors and other payables resulting primarily from unbudgeted COVID-19 related exposures, additional IDF exposure provisions payable to other DHBs for services to Counties population not budgeted for, and an additional $15m provision for Holidays Act non-compliance. Non-current assets have been impacted by revaluations on land of $86m.

Statement of Cashflow

Net cash flow was $19.4m favourable to budget, mainly due to reduced capital expenditure given COVID-19 related interruptions and lower capital charge resulting from a rate reduction from 6% to 5%.

Continued effort has been placed on cash management to ensure the DHB is adequately forecasting and living within its means, in particular given the exposures arising from the impact of COVID-19.

Board and Committee Membership Attendances

1 July 2020 to 30 June 2021

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC/ RDiSAC
Vui Mark Gosche (Chair)	7	-	-	8	-
Ms Tipa Mahuta (Deputy Chair)	8	4	8	8	-
Mrs Catherine Abel-Pattinson	8	8	-	7	2
Mr Apulu Reece Autagavaia	4	8	9	-	-
Mr Garry Boles	8	4	-	5	-
Mrs Colleen Brown	7	8	9	-	-
Mrs Katrina Bungard	5	7	7	-	-
Mrs Dianne Glenn	8	8	9	-	2
Dr Lana Perese	8	7	8	7	2
Mr Pierre Tohe	8	-	6	6	-
Mr Paul Young	5	6	8	-	-

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

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

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

The MHAC was disestablished in 2018/19 to enable Counties Manukau District Health Board to give effect to a more strategic and direct partnership with Mana Whenua i Taamaki Makaurau

Mana Whenua i Taamaki Makaurau represent the collective interests of a number of Iwi and Hapuu, including: Te Aakitai, Ngaati Te Ata, Ngaati Tamaoho, Ngaai Tai ki Taamaki, Ngaati Paoa, Te Kawerau a Maki, Ngaati Naho, Ngaati Tiipa, Ngaati Amaru, Ngaati Karewa / Tahinga. Counties Manukau District Health Board has established a Memorandum of Understanding with the Mana Whenua i Taamaki Makaurau Board that outlines our strategic intent and commitment to improve Maaori Health outcomes in the Counties Manukau district.

Current members of Mana Whenua i Taamaki Makaurau:

- Robert Clark (Chair) & Rangipipi Bennett - Ngaati Tiipa
- Barry Bublitz (Kai Whakahaere) - Ngaai Tai Ki Taamaki
- Malcolm Wara & Raymond Katipa - Ngaati Naho
- Matiu Brown & Matua Jeff Tukua - Ngaati Tahinga
- Tamara Taka-Jones & Joanna Katipa - Ngaati Tamaoho
- Moana Brown & Nanaia Rawiri - Ngaati Amaru

Note: In March 2020, the DHB established a new Board Sub Committee –Major Capital Works Board sub-committee (MCW). The Committee has been set up for the purpose of providing guidance and advice to the Audit Risk and Finance Committee on major capital projects.

Note: The People & Culture Sub Committee was established by the Board on 17 December 2019. Their function is to provide advice to the Board in relation to the appointment and remuneration of the CMDHB Chief Executive, governance oversight of health and safety and assurance of leadership conduct and organisation culture is aligned to strategy.

Board Members' Disclosure of Interests

As at 30 July 2021

Vui Mark Gosche (Chair)	• Trustee, Mt Wellington Licensing Trust • Director, Mt Wellington Trust Hotels Ltd. • Director, Keri Corporation Ltd • Trustee, Mt Wellington Charitable Trust • Chair, Kainga Ora Homes & Communities • Director, Housing NZ Build Ltd (subsidiary of KO Homes & Comms) • Director, Housing NZ Ltd (subsidiary of KO Homes & Comms) • Member, Expert Advisory Group to the Retirement Commissioner working on retirement income.
Ms Tipa Mahuta[95] (Deputy Chair)	• Councillor, Waikato Regional Council • Chair, Waikato River Authority

Mrs Catherine Abel-Pattinson	• Director, healthAlliance NZ Ltd.
	• Board Member, International Accreditation NZ (IANZ)
	• Member, NZNO
	• Member, Directors Institute
	• Husband (John Abel-Pattinson):
	  ○ Director, Blackstone Group Ltd
	  ○ Director and Shareholder, Blackstone Partners Ltd
	  ○ Director Blackstone Treasury Ltd
	  ○ Director Bspoke Group Ltd
	  ○ Director, Barclay Management (2013) Ltd
	  ○ Director, AZNAC (JAP) Ltd
	  ○ Director Chatham Management Ltd
	  ○ Director, MAFV Ltd
	  ○ Director Wolfe No. 1 Ltd
	  ○ Director, 540 Great South Motels Ltd
	  ○ Director Silverstone Property Group Ltd
	  ○ Director, various single purpose property owning companies
	  ○ Director and Shareholder, various Trustee Companies related to shareholding in the above

[95] Appointed 9/12/2019

Mr Apulu Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation • Board of Trustees Member, Holy Cross School • Member of the Cadastral Surveyors Board • Assessor of the Creative Communities Scheme South & East Auckland
Mr Garry Boles[96]	• NZ Police Constable
Mrs Colleen Brown MNZM	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • District Representative & Board member, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited
Mrs Katrina Bungard	• Chairperson MECOSS – Manukau East Council of Social Services. • Member of Howick Local Board • President, Amputee Society Auckland/Northland • Member of Parafed disability sports • Member of NZ National Party
Mrs Dianne Glenn ONZM, JP	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • Life Member, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities. • Member, Lottery Individuals with Disabilities Committee

[96] Appointed 9/12/2019

Dr Lana Perese[97]	• Director & Shareholder, Malatest International & Consulting • Director, Emerge Aotearoa Limited Trust • Trustee, Emerge Aotearoa Housing Trust • Director, Vaka Tautua • Director, Malologa Trust • Director & Shareholder, Perese Wood Investments Limited
Mr Pierre Tohe[98]	• Senior Executive, Tainui Group Holdings
Mr Paul Young[99]	• Director, Paul Young International Ltd • Councillor, Auckland City Council
Brittany Stanley-Wishart, Board Observer	• Deputy Chair, Pasifika Students in Health in NZ (charity that receives funding from CM Health for its biennial conference)
Tori Ngataki, Board Observer	• Board Member, Ngāti Tamaoho Trust 2016 to 2020 (restanding) • Board Member, Second natures trust 2016 to 2021 • Trustee, Waikato Endowment College Trust • Member, Te Arataura (Executive Board of Te Whakakitenga o Waikato) • Co-Chair, Appointments committee for Te Whakakitenga o Waikato • Director, Keep it Māori Ltd • Staff Member, Winstone Aggregates

[97] Appointed 9/12/2019
[98] Appointed 9/12/2019
[99] Appointed 9/12/2019

Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Counties Manukau District Health Board's financial statements and performance information for the year ended 30 June 2021

The Auditor-General is the auditor of Counties Manukau District Health Board (the DHB). The Auditor-General has appointed me, Lauren Clark, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the DHB on his behalf.

We have audited:

- the financial statements of the DHB on pages 78 to 116, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flow for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the DHB on pages 10 to 15 and 28 to 55.

Opinion

In our opinion:

- the financial statements of the DHB on pages 78 to 116, which have been prepared on a disestablishment basis:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2021; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the DHB on pages 10 to 15 and 28 to 55:
  - presents fairly, in all material respects, the DHB's performance for the year ended 30 June 2021, including:
    - for each class of reportable outputs:

        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 21 December 2021. This is the date at which our opinion is expressed.

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

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 83 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity is expected to come into effect on 1 July 2022. The DHB therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 17 on page 107 to 108 outlines that the DHB has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The DHB has estimated a provision of $162.4 million as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The DHB is reliant on financial support from the Crown

Note 1 on pages 83 to 84 outlines the DHB's financial performance difficulties. There is uncertainty whether the DHB will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The DHB therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the DHB with financial support, where necessary.

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

Pages 11 to 15 outlines the information used by the DHB to report on its Covid-19 vaccine coverage. The DHB uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in pages 13 to 14. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The DHB has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Page 10 to 11, pages 82 to 83, note 24 on page 114, and note 26 on page 116 of the financial statements which outline the impact of Covid-19 on the DHB.

Basis for our opinion

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

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

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

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

The Board is responsible on behalf of the DHB for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the DHB for assessing the DHB's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

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

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

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

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

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 5 to 9, 16 to 27, 56 to 77, 117 to 120, and 126 to 127, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the DHB in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: *International Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

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

Lauren Clark
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Ministerial Directions

The following Ministerial Direction was issued during the 2020/21 year:

- COVID-19 Vaccine Eligibility Direction 2021 was issued on 12 February 2021 pursuant to section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004. The purpose of this direction is to specify persons who are eligible to receive publicly funded COVID-19 vaccination under the Act and is planned to expire on 31 December 2021 unless earlier extended or revoked.

The following Ministerial Direction was issued during the 2019/20 year:

- COVID-19 Response Direction 2020, issued on 17 March 2020 under section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004. The purpose of this direction is to ensure a nationally coordinated and consistent approach to the outbreak of COVID-19 across District Health Boards.

  Direction to act consistently with national plans

  In accordance with District Health Boards' responsibilities under section 23 of the New Zealand Public Health and Disability Act 2000 to plan and coordinate at local regional and national levels for the most effective and efficient delivery of health services, all District Health Boards must act consistently with the following national-level plans and policies:

  a. The Government Response to the COVID-19 pandemic, informed by the New Zealand Influenza Pandemic Plan, a framework for action (Ministry of Health 2017); and

  b. The National Health Emergency Plan (Ministry of Health 2015).

Ministerial Directions that remain current are as follows:

- New Zealand Business Number Direction. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn. In May 2016, the Government issued a Direction under section 107 of the Crown Entities Act 2004 which set out a number of New Zealand Business Number (NZBN) implementation requirements for District Health Boards. Implementation of the NZBN requirements is expected to support Counties Manukau Health to streamline its interactions with businesses (e.g. suppliers and providers) and reduce the time spent on administrative activities relating to such interactions. Counties Manukau Health has been liaising with its shared services providers to identify systems and processes impacted by the Direction and look at options for incorporating NZBN requirements into those systems and processes.

- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. http://www.health.govt.nz/system/files/documents/pages/eligibility- direction-2011.pdf

- Directions to support a whole of government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property, and the former two apply to DHBs. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013

- The direction on the use of authentication services, issued in July 2008, continues to apply to all Crown agents apart from those with sizeable ICT business transitions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

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Bankers

Bank of New Zealand

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