Annual Report 2018

COUNTIES MANUKAU HEALTH


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Contents

Foreword from the Chair and Chief Executive

2017/18 has been a challenging year for Counties Manukau Health – the third in a five year strategy of implementation of Healthy Together 2020. While we have continued to serve our growing and diverse communities the very public attention on our buildings and infrastructure have added to the real concerns we have – how we meet the needs of a rapidly growing youthful and aging population while addressing the burden of long term conditions and its impact on demand for services.

Every day, however, we are encouraged by the work of our hard working staff, colleagues and partners in primary and community services. They, alongside our community stakeholders, with particular emphasis on our key relationship with Manawhenua I Tamaki Makaurau – remind us that people are at the heart of our healthcare system.

We welcomed the 2017/18 health sector focus on achieving health equity as this concurs with our own strategic goal – "To work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020."

We advanced our system integration commitment by working differently with social services through the South Auckland Social Wellbeing Board, using a collective service approach to improving outcomes for children up to five years of age. The six national system level measures support a shared approach to improving health outcomes. Our key achievements in 2017/18 include achieving four of the six targets and reaching record levels of Maaori employment. We are proud of the way CM Health has worked together to reach these goals in the face of the substantial challenges to our health service capacity, financial pressures and aging facilities infrastructure. We were excited to see significant progress on the rebuild of our new Mental Health Inpatient Unit (Tiaho Mai) on the Middlemore site that will open in 2018/19.

The 2017/18 year has also been a year of change and learning for CM Health, during which we reshaped our response to enable choices that achieve our goals but at a lower cost base and with prioritisation of resources. In 2017/18 CM Health completed the first phase of our Turn Around Plan (TAP), which provides a roadmap for CM Health to achieve a sustainable financial position. Phase One of TAP has identified an initial suite of savings initiatives, with new opportunities explored through Phase Two in 2018/19. We will embed a strong evaluation framework to enable us to learn and adapt quickly as we plan for the following years.

We know that the increase in demand for services has affected all the Northern Region DHBs and recognise the importance of responding collectively to our planning and investment needs. In 2017/18, the Northern Region Long Term Investment Plan (NRLTIP) was endorsed by each Northern DHB Board. This plan supports CM Health's priorities for ongoing facilities developments and formed the foundation of 2018/19 business case developments.

2017/18 was also the second year of the Metro-Auckland System-Level Measures Improvement Plan, led by our Primary Health Organisations in partnership with DHB clinical and service leaders. In future years we will build on these successes by continuing to work actively with our regional partners and central government to progress our regional priorities.

We would like to thank our staff and providers across the district for their hard work and dedication to the communities we serve, particularly in the face of the challenges that we have experienced in the last year. We would also like to thank our local communities for their advice and involvement in service co-design, helping us deliver services that reflect what matters the most to them.

Vui Mark Gosche
Chair

Fepulea'i Margie Apa
Chief Executive

Board Members

Board members for the period 1 July 2017 to 24 January 2018
Dr Lester Levy (Chair)[1]
Mr Rabin Rabindran (Deputy Chair)
Mrs Colleen Brown
Dr Lyn Murphy
Mr Mark Darrow
Mrs Catherine Abel-Pattinson
Mrs Dianne Glenn (ONZM, JP)
Dr Ashraf Choudhary (QSO, JP)
Apulu Reece Autagavaia
Mr George Ngatai
Mrs Katrina Bungard

Board members for the period 25 January 2018 to 2 May 2018
Mr Rabin Rabindran (Chair)[2]
Mrs Colleen Brown
Dr Lyn Murphy
Mr Mark Darrow[3]
Mrs Catherine Abel-Pattinson
Mrs Dianne Glenn (ONZM, JP)
Dr Ashraf Choudhary (QSO, JP)
Apulu Reece Autagavaia
Mr George Ngatai
Mrs Katrina Bungard

Board members for the period 3 May 2018 to 13 August 2018
Vui Mark Gosche (Chair)[4]
Mrs Colleen Brown
Dr Lyn Murphy
Mrs Catherine Abel-Pattinson
Mrs Dianne Glenn (ONZM, JP)
Dr Ashraf Choudhary (QSO, JP)
Apulu Reece Autagavaia
Mr George Ngatai
Mrs Katrina Bungard

[1] Resigned 24 January 2018.
[2] Resigned 2 May 2018.
[3] Resigned 2 May 2018.
[4] Appointed 3 May 2018.

Board members for the period 14 August 2018 to 31 October 2018
Vui Mark Gosche (Chair)
Mrs Colleen Brown
Dr Lyn Murphy
Mrs Catherine Abel-Pattinson
Mrs Dianne Glenn (ONZM, JP)
Dr Ashraf Choudhary (QSO, JP)
Apulu Reece Autagavaia
Mr George Ngatai
Mrs Katrina Bungard
Pat Snedden [5]
Kylie Clegg[6]

[5] Appointed 14 August 2018.
[6] Appointed 14 August 2018.

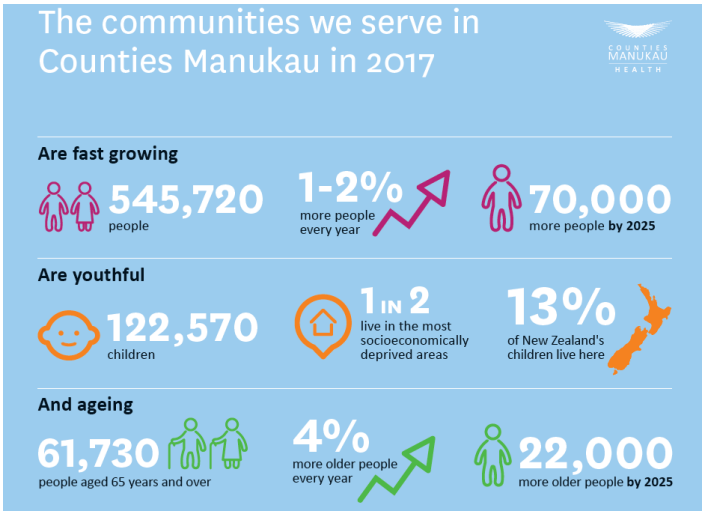
Executive Leadership Team

Executive Leadership Team	As at 31 October 2018
Fepulea'i Margie Apa	Chief Executive Officer (from 3 September 2018) Director of Population Health, Strategy and Investments (1 July 2017 to 2 September 2018)
Dr Gloria Johnson	Chief Medical Officer (from 3 September 2018) Acting Chief Executive Officer (1 July 2017 to 2 September 2018)
Dr Vanessa Thornton	Acting Chief Medical Officer (1 July 2017 to 2 September 2018)
Margaret White	Chief Financial Officer
Aroha Haggie	Acting General Manager Maaori Health (from 5 September 2018)
Philip Balmer	Director of Hospital Services
Benedict Hefford	Director of Primary, Integrated and Community Care
Jenny Parr	Chief Nurse & Director of Patient & Whaanau Experience
Elizabeth Jeffs	Director of Human Resources
Pauline Hanna	Acting Director of Strategy & Infrastructure (from 5 September 2018)
Campbell Brebner	Acting Director of Population Health (from 5 September 2018) & Chief Medical Advisor Primary Care
Mary Seddon	Director of Ko Awatea (from 16 July 2018)
Stuart Bloomfield	Chief Information Officer (from 30 July 2018)

Snapshot of Counties Manukau Health in 2017/18

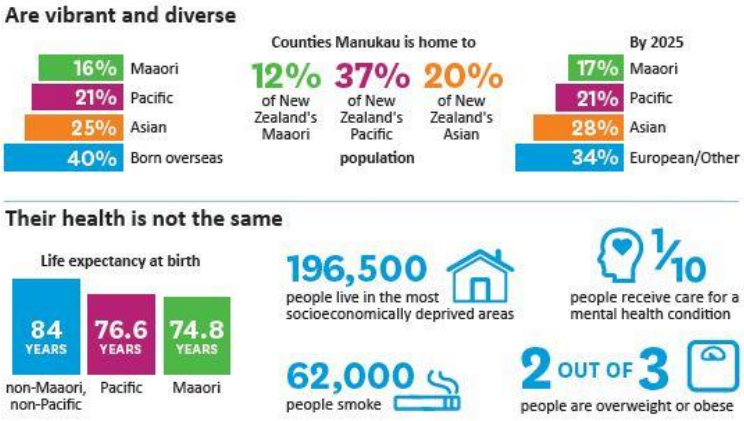
Counties Manukau District Health Board is one of twenty district health boards established under the New Zealand Health and Disability Act 2000 (NZPHD Act 2000) to plan and fund the provision of personal health, public health and disability support services for the improvement of the health of the population.

As a collective health system, Counties Manukau Health[7] provides and funds health and disability services to an estimated 545,720[8] people in 2017 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.



Our population is diverse and vibrant with strong cultural values. Statistics New Zealand's first survey on Maaori well-being, Te Kupenga (2013), highlighted a number of strengths in our local Maaori. A high level of connectedness with whaanau was reported and 83 percent said it was 'easy' or 'very easy' to get support from their whaanau. Counties Manukau is home to New Zealand's second largest Maaori population, largest population of Pacific peoples, as well as fast growing Asian communities.

Across our district, the health and circumstances of our communities are not the same. Over 122,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation (NZDep2013 9&10[9]). There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau. [10] On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.



Related to these inequities our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity, hazardous alcohol use) for a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity, and reducing obesity are key to improving the health of our population.

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[7] Our performance against the Health Targets and other non-financial measures reflects the combined activities and resources of Counties Manukau DHB (CMDHB), Primary Health Organisations (PHO) and related non-government organisations (NGOs).To better reflect a health system approach for effective resource planning to meet our population needs and health sector priorities, sections of this Annual Report relating to the collective delivery of all health services and related infrastructure use term Counties Manukau Health (CM Health). This reflects the combined CMDHB, PHO and related NGO service delivery and support resources that contribute to our non-financial performance, strategies and other collective activity. Those sections of this Annual Report that relate specifically to the operations of CMDHB use the term CMDHB instead of CM Health. This includes the financial sections of the report, which do not contain information on the financial performance of our PHOs or NGOs, as well as some of the employment-related content in the Good Employer section.

[8] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – October 2016 update.

[9] 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.

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

Key Achievements in 2017/18

Key achievements are outlined below under our three Healthy Together strategic objectives (see *Our Strategic Intentions* on page 12) that are closely aligned to the April 2016 New Zealand Health Strategy (NZHS) themes. Each of these achievements has contributed to the national strategy, as highlighted by the NZHS themes: **People-Powered**, **Closer to Home**, **Value and High Performance, One Team, Smart System.**

Healthy People, Whaanau and Families

- **Development of the Counties Manukau Patient Experience Plan 2018-20:** The plan identifies actions which are critical to achieve improvement of 'The Counties Manukau Experience' for our population. The plan reflects a review of international best practice, alongside the New Zealand context in relation to patient and whaanau centred care. The plan identifies 20 priority areas to progress over the next three years, covering the following work streams: engagement, feedback and measurement, quality improvement, building capability and connecting, sharing and showcasing. CM Health is currently in the process of allocating leads for the work streams and establishing objectives.

People Powered

- **Safe sleeping:** The supply of safe sleep baby beds (Pepi-pod and wahakura) within the safe sleep programme has increased substantially with around 130 baby beds being distributed per month by the DHB, with improved targeting achieved by reviewing the referral criteria and streamlining the referral process. Safe Sleep education has also increased with additional DHB teams, community groups and NGOs receiving face to face education and undertaking the sudden unexpected death in infancy (SUDI) online training. There is also an ongoing weekly audit of safe sleep in DHB facilities that care for mothers and babies.

- **Establishment of Feedback Central:** Following an extensive consultation process that included both patients and staff, Feedback Central was established in June to support the effective management of complaints and other types of feedback, as well as support the Serious Adverse Events process. Another purpose of Feedback Central is to facilitate organisational learning from complaints and adverse events thus 'closing the loop'. The Feedback Central team has been recruited and is now operational.

- **Fewer ambulatory sensitive (potentially avoidable) hospitalisations (ASH) due to skin infections for 0-4 year olds:** Between September 2016 and June 2018, the ASH rate for skin infections (cellulitis, dermatitis and eczema) decreased by 6.7% for our tamariki Maaori and by 9.8% for our Pacific children.

Closer to home

- **Improved access to after-hours care:** CM Health has successfully negotiated new agreements for after-hours care across the district, meaning that twice as many after-hours visits will be subsidised for low income residents (from 50,000 to 120,000 per year) and care will be available at eight clinics (rather than the previous four).

- **A Health Coaching Pilot** has begun with some primary care providers in the district, to explore whether a team based model of care will lead to improved engagement and flexible service delivery for our patients and whaanau with complex conditions.

- **Whaanau Ora packages of care:** In 2017/18, there were 2,127 referrals to Whaanau Ora services with 1,410 integrated packages of care delivered across the Whaanau Ora integrated services agreements (Mama, Pepi Tamariki, Rangatahi Oranga, Whanau Oranga, Oranga ki Tua and Kaumatau Kuia Oranga).

Value and High Performance

- **Breastfeeding:** In 2017/18 the Te Rito Ora breastfeeding service enabled 78 percent

of the mama they serve to be fully or exclusively breastfeeding at three months, higher than the national target of 70 percent. The Mum's Kitchen Rules cooking skills programme delivered by Te Rito Ora has been successful, with 67 people completing the course in 2017/18. There has also been a 5 percent increase in the percentage of total service users of the B4Baby programme, a kaupapa Maaori breastfeeding service delivered by Turuki Health Care.

Healthy Communities

- **Completion of the registered nurse designated prescribing in community health programme:** The programme was completed between April and November with all nurses gaining endorsement on their annual practicing certificate, to prescribe a limited range of medicines to treat a normally well population with minor health concerns. The programme used a blended learning model that allowed nurses to work at their own pace. We successfully trained 33 nurses working in primary schools, secondary schools and general practice. Evaluation is in progress for Nursing Council to determine next steps for implementation in other regions.

Closer to home

- **Better Help for Smokers to Quit:** The brief advice and support for smokers to quit primary care 90 percent target was achieved for our Maaori, Pacific and Asian patients. We also achieved 94 percent for the maternity brief advice and support for smokers to quit target for our wahine Maaori, contributing to a better start in life for pepe Maaori.

Value and High Performance

- **Reducing childhood obesity:**
  - 100 percent of our Maaori, Pacific and Asian tamariki identified as obese during the Before School Check were offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.
  - Of pre-schoolers and whaanau referred to the Active Futures (3-5 year old) healthy lifestyles programme delivered by Otara Health Charitable Trust, 84 percent were from our priority populations (Maaori, Pacific or quintile 5), exceeding our target of 75 percent. Eighty-five percent of whaanau on the programme agreed that they felt that their quality of life is now better and healthier than six months ago since working with Otara Health Charitable Trust.
  - All children registered on the Active Families (5-13 year old) programme for school aged children and their whaanau have reduced or maintained their Body Mass Index (index of weight status).
  - 369 general practitioners, primary care nurses and Well Child Tamariki Ora staff have been trained across the region on having child healthy weight conversations with whaanau.
- **Cancer treatment and screening:** CM Health has achieved the 90 percent Faster Cancer Treatment Health target[11] for all quarters in 2017/18. CM Health also continued to maintain its high levels of performance for Pacific women for breast screening, exceeding the 70 percent screening target in all quarters with 82 percent of Pacific women screened in Quarter 4 2017/18.
- **Mental health and addiction – building better mental health through the development of an integrated model of care:** The mental health and addiction system in Counties Manukau is partway through a programme of redesign to deliver an integrated response to community need, with a focus on improving people's

One Team

[11] Target: 90% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management).

health outcomes and their experience of accessing support for their mental health and addiction needs. The programme of work involves a level of change across all parts of the system, with the following key achievements in 2017/18:

- Enhanced focus on early intervention and holistic wellbeing through the development of primary care mental health and addiction capacity and capability, with introduction of both the Wellness Support Model of Care and specialist mental health and addiction **integrated locality care teams (ILoC)**. ILoC provides access to specialist liaison, advice and interventions delivered by multi-disciplinary DHB and NGO teams working in primary care settings. The ILoC teams currently work with 33 general practices, 10 schools, 20 aged-care providers and a marae-based clinic.
- **Wellness Support** has been implemented in eight practices, with GPs and nurses supported to work confidently with people to achieve their mental wellness goals, following the principles of kindness, clarity, continuity and effectiveness.
- **Better alignment of service provision with population need** through the reconfiguration of specialist community teams, with a focus on equity and the alignment of teams/resources with local population need. Improvements included new Maaori and Pacific senior clinical leadership positions, greater alignment of the community adult mental health service (CAMHS) life-course approach and an enhanced shared care model with primary care through a holistic response to people's physical and mental wellbeing.

Healthy Services

Value and High Performance

- **Record number of Maaori employed at CM Health:** Over this past year, a further 184 Maaori have been employed at CM Health raising the number of Maaori employees from 346 (as at 31 March 2017) to 529 (as at 31 March 2018). This has lifted the overall percentage of Maaori employed at CM Health from 5.36 percent (as at 31 March 2017) to 7.92 percent (as at 31 March 2018). The catalyst for these increases has been the establishment of the 2025 employment targets to ensure that the workforce employed at CM Health reflects the local population by 2025.
- **CM Health and Massey University team up with the Pūhoro STEM Academy in 8 Secondary Schools:** Launched in February 2018, the Massey University Pūhoro STEM Academy is a skills pipeline for Maaori into the health workforce. It aims to improve secondary school performance so that an increased number of Maaori students are academically and socially prepared to achieve in tertiary education, building increased capacity and capability within the Maaori health workforce. The Pūhoro STEM Academy focuses on the achievement of the NCEA standards for Physics, Chemistry and Biology. The programme requires one hour of scheduled time with students each week, and a weekend wānanga at the completion of each semester. The Pūhoro STEM Academy is being piloted in eight secondary schools in Auckland thanks to the support of the Tindall Foundation and CM Health. This pilot programme has 105 Maaori Year 11 students.
- **Whaanau Ora workforce development:** CM Health has supported 57 Trainees to complete Whaanau Ora qualifications from Level 3 to Level 5 through the Hauora training fund.

- **Environmental sustainability:** CM Health made great progress with regard to environmental sustainability in 2017/18, receiving two 2020 Global Green and Healthy Hospitals Climate Champion Awards. A key achievement was meeting our five-year carbon emission reduction target, reducing carbon emissions by 21.2 percent between 2012 and 2017 (target: 20 percent). To achieve this result, we increased our recycling volumes to 388 tonnes (119 tonnes more than last year's volumes). Our work has also focussed on increasing the use of active transport, including extending our Travel Strategy to include visitors and the wider community. A combined saving of over $100,000 has been realised with our computer power saving project and one of the anaesthetics projects. Our environmental sustainability programme reduces costs, minimises the impact of our day to day operations on the environment and facilitates a sense of employee satisfaction.

Members of the Environmental Advisory Group hosted a Ministerial visit, late 2017.

Value and High Performance

- **Fundamentals of Care:** The Fundamentals of Care (FoC)[12] programme was introduced by CM Health in October 2017 to measure standards of care against nine fundamental elements of care at Middlemore Hospital and the Manukau Elective Surgery Centre. The programme aims to ensure the consistent, safe, and high quality delivery of the 'fundamental' aspects of care for all patients by all health professionals. In 2017/18, the baseline FoC review across thirty-four wards indicated an overall organisational result of 75 percent across all nine standards. Significant achievements were made in identifying data sources, collection and presentation of the quality of care at ward/unit level that will provide a basis for future work. For 2018/19 FoC will include a focus on baselining the winter delivery of care.

One Team

- **Improving patient outcomes through implementation of the Regional Hyper-acute Stroke Pathway:** The Regional Hyper-acute Stroke Pathway is being implemented as part of a programme of work led by the Regional Stroke Network. The pathway will introduce the provision of after-hours centralised hyper-acute stroke services at Auckland City hospital for the Metro Auckland DHBs. It also will formalise a supra-regional endovascular clot retrieval 24/7 Percutaneous Stroke Intervention (PSI) service also provided at Auckland City Hospital.
    - Phase 1 of implementation has been completed and included the PSI service going live across the Metro Auckland DHBs, as well as the limited roll out of the after-hours centralised service to West Auckland domiciled patients.
    - Phase 1 implementation has been a great success for both stroke patient outcomes and regional collaboration. Evaluation of Phase 1 shows that the pathway implementation has gone well and has been well received by stakeholders and consumers on the pathway. There are early indications that patient outcomes are very good and exceed those published in the medical literature. Median door-to-needle times have fallen across all the DHBs, especially for Counties Manukau.
    - CM Health is currently preparing for Phase 2, implementation of the hyper-acute

[12] FoC is based on the care standards developed and validated by Waitematā DHB in 2015.

stroke pathway for Counties Manukau residents.

- **Regional approach to using data for primary care quality improvement:** Under the Regional Data Sharing Framework, a number of key health outcome indicators have been agreed across DHBs and Primary Health Organisations (PHOs) in Auckland. Using Health Safe, quarterly uploads of this data are occurring and the information can be used for service quality improvement and planning.

Smart System

- **The Medinz Primary Care Communications Platform:** The Medinz platform has now been implemented across the district. Medinz provides a single place for all primary care staff, including GPs, pharmacists and staff in urgent care clinics to receive communications from DHBs, community laboratory organisations, regional public health units and PHOs. This supports consistent and timely communication across the whole primary care sector.

Our Strategic Intentions

Healthy Together

2017/18 was year two of our five-year Healthy Together strategy. Our Healthy Together strategy is a long term ambition with a transformational focus on integrated care in the community, supported by excellent hospital services. Achieving health equity in key indicators is critical to medium term population outcomes and longer term health system sustainability. Relying on treating people when they become unwell is not enough and will not achieve the health gains needed to achieve healthier, longer lives in the community.

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

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

Valuing everyone – we make everyone feel welcome and valued

Kind - we care for other people's wellbeing

Together – we include everyone as part of a team

Excellent - we are safe, professional and always improving

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

Our Strategic Objectives

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

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

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

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

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

Auckland and Northern Region DHBs, Counties Manukau-based PHO Alliance and related service providers, and intersectoral organisations.

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

Northern region health priorities

The Northern Region Health Plan (NRHP) demonstrates how the Government's objectives and the region's priorities will be met. The overall intent of the 2017/18 NRHP was to achieve gains across the Triple Aim Framework and the themes of the New Zealand Health Strategy, in addition to a strong focus on equity. The 2017/18 NRHP specifically focused on:

1. The Northern Region Long Term Investment Plan, to further align District Health Board Information Systems and capital plans.
2. Increasing the focus on health outcomes as well as the continuous drive for quality improvement, while providing much greater value for money.
3. The three Metro Auckland District Health Boards working together much more closely as an integrated system.

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.

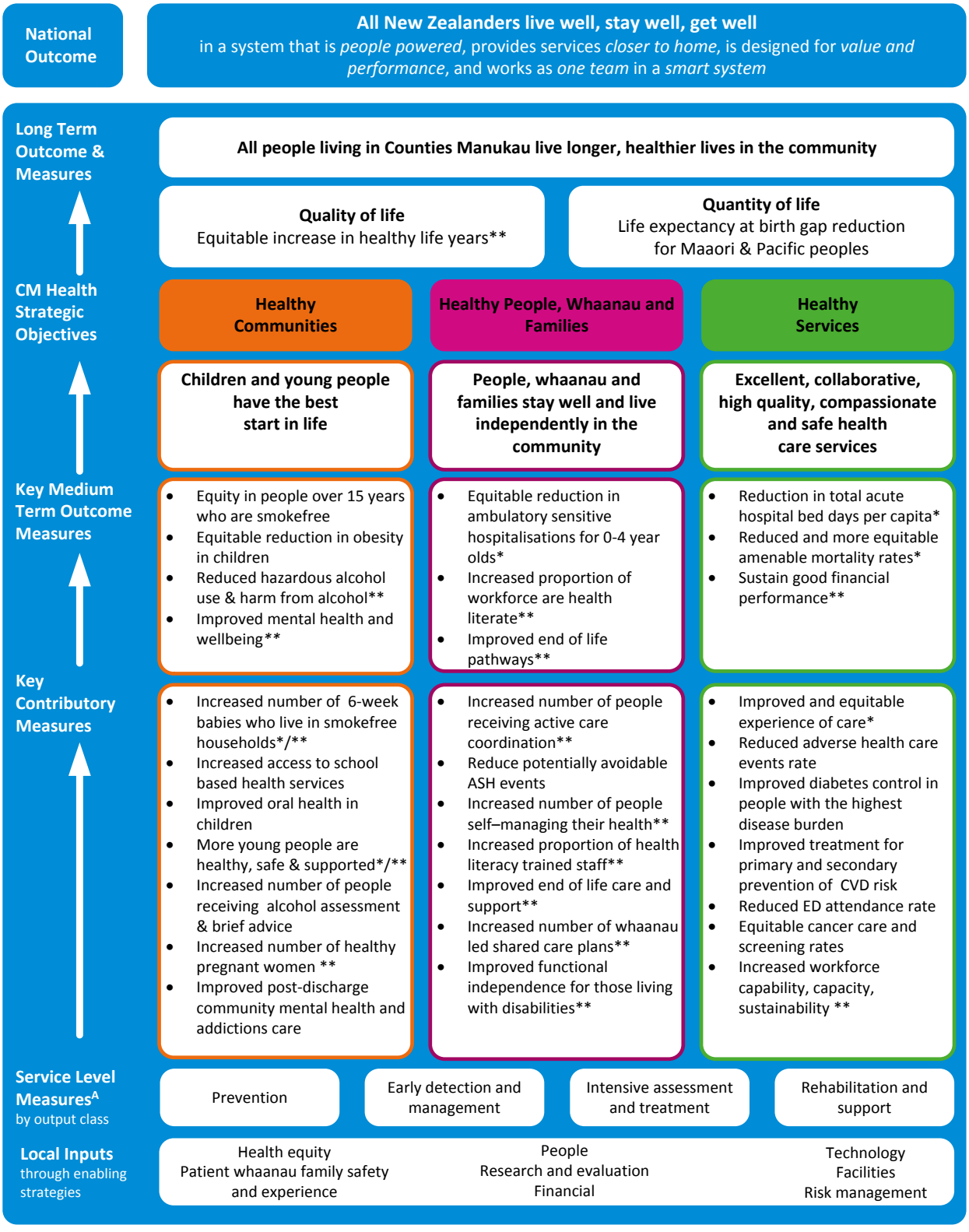
Our outcomes framework (Figure 1) reflects our three Triple Aim long-term outcomes and contributory impacts. It integrates national, regional and local performance priorities through long term outcomes, supported by (proxy) "impact" measures that best reflect the health priorities and challenges faced 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 2017/18 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 2017/18 performance for the outputs identified in our outcomes framework is provided in the *Statement of Service Performance* on page 25. Together these two sections provide a current picture of the progress CM Health made towards achieving our long-term outcomes and strategic goal in 2017/18.

Achieving financial sustainability

Despite meeting Budget, the financial results report a deficit, which has increased since 2016/17. The DHB is committed to achieving financial sustainability over the medium term and has the support of the Ministry of Health in its strategic plans to achieve this goal. This continued support will allow the DHB to make appropriate investments in services, facilities and people to remain on track to reach the goal of a break-even financial position whilst continuing to invest to achieve our strategic objectives.

Figure 1: Healthy Together Outcomes Measurement Framework



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

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

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

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.

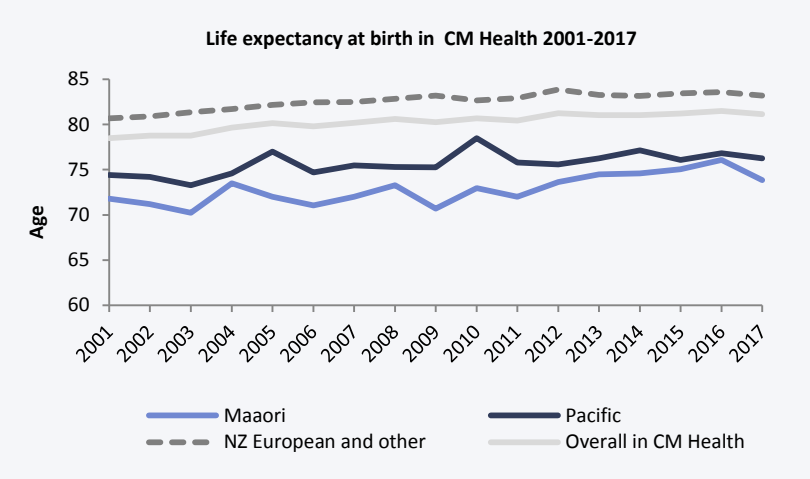
For the Counties Manukau community, we need to target outcome improvements to achieve health equity.[13] To better understand which people do not experience the same health outcomes, we report and compare results over time by ethnic group. Results are not always available for all ethnic groups and work is ongoing to improve the accuracy and scope of results by ethnic group.

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

Overall long-term outcomes

Reduce life expectancy at birth gap for Maaori and Pacific peoples[14]

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



The overall life expectancy at birth in Counties Manukau has steadily increased over the last ten years to 81.1 years in 2017, closely reflecting national trends. A gap of 9.3 years and 7 years persist between Maaori and Pacific peoples respectively and New Zealand European/Other. We note the concerning decline in life expectancy for Maaori in Counties Manukau and nationally in the last year. Our local and regional planning for 2018/19 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 overall and NZ European/Other ethnic groups. When we look deeper into the drivers of life expectancy, we see diversity of health status within the many Asian ethnicity subgroups. As the 'healthy migrant effect' typically reduces over 5-7 years of New Zealand residency, to sustain this relatively high life expectancy, we are focused on early ill-health prevention and effective management of long term conditions in our Indian and Chinese communities.

[13] Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need.
[14] Data source: Ministry of Health (MoH) mortality collection and estimated population from Stats NZ (2017 edition)

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, obesity and poor nutrition and early disease identification are important for this long term outcome.

In 2017/18, we continued to achieve health equity for our Maaori, Pacific and Asian populations in both national 'Better Help for Smokers to Quit' targets. In 2017/18 CM Health also offered healthy lifestyle support to approximately 6,142 adults through the Green Prescription initiative. Additionally, 312 children aged 3-18 were referred to the Active Futures and Active Families healthy lifestyles programmes. CM Health also led development of a programme of collaborative alcohol harm minimisation actions, including implementing alcohol assessment, brief advice and referral pathways in general practice, our Emergency Department (ED) and community settings. We look forward to progressing this programme with others in 2018/19.

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.[15] This means both men and women are living longer with some degree of impairment of their health than previously. This has important implications for the individual, their whaanau and family, with impacts for health and disability service demand due to increased duration of unhealthy life years.

CM Health is enhancing approaches that will reduce risk factors and improve management of long term health conditions. Approaches include preventing potentially avoidable ill-health (e.g. smoking cessation, immunisation), delaying onset of disease through early identification of disease (e.g. cardiovascular risk assessment, cancer screening, timely diagnostic services) and effective treatment (e.g. timely elective care, effective cardiovascular and diabetes treatment) and self-management.

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 providing our community with trusted advice on healthy nutrition. To achieve healthy communities, we will focus on reducing the prevalence of risk factors for ill-health and support the **best start in life for our children and young people that will have benefits for their whaanau, families and community**.

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

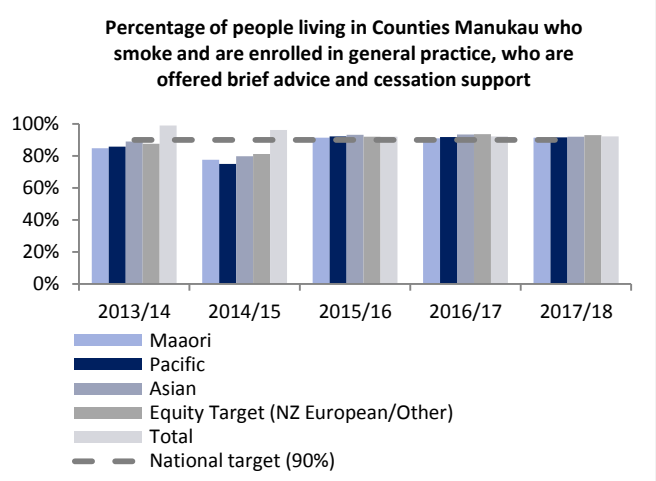
Medium term outcome: Equitable smokefree rates across Counties Manukau

Smoking, a leading risk to health in Counties Manukau disproportionately burden Maaori and Pacific peoples.
Inequities in smoking prevalence contribute to differences in life expectancy between Maaori and Pacific and non-Maaori/non-Pacific peoples. Maaori (36 percent) and Pacific peoples (22 percent) in Counties Manukau are three and nearly two times more likely to smoke respectively than NZ European/Other (12 percent). Brief advice and cessation support can be effective at prompting quit attempts and long-term quit success.

Health Target: 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

In 2017/18, CM Health achieved the 90% target for all ethnic groups (Maaori: 91%; Pacific: 92%; Asian: 92%) and for the total population (92%). This is a significant achievement in support of our Healthy Together equity goal. Performance increased between Quarter 3 and Quarter 4, reflecting PHOs' focus on supporting their low performing practices to improve performance. This has included strategies such as appointment scanning, improved coding systems and ensuring opportunities are not missed if the patient attends the practice with a family member.

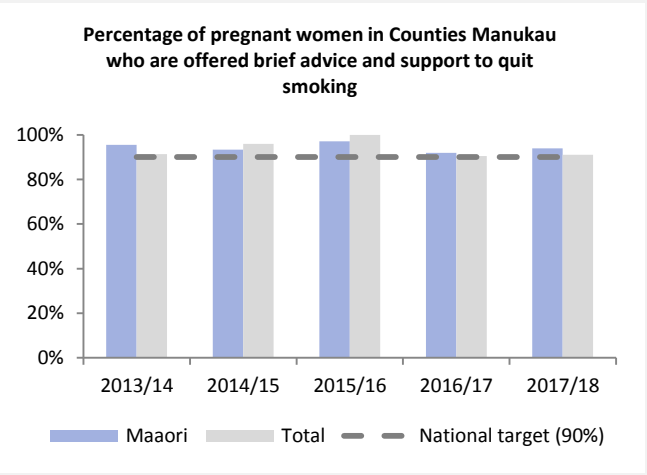
Data source: Ministry of Health Performance Reporting



Health Target: Better help for smokers to quit (Maternity)- 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support[16] to quit smoking

In 2017/18 CM Health also achieved the Maternity smokefree target for pregnant Maaori women (94%) and pregnant women in total (91%). The target was achieved for all quarters in 2017/18, reflecting the success of our Smokefree pregnancy incentives programme, health professional training in Smokefree best practice and networking activities of our Smokefree Advisor – maternity and health promoter.

Data source: Ministry of Health Performance Reporting



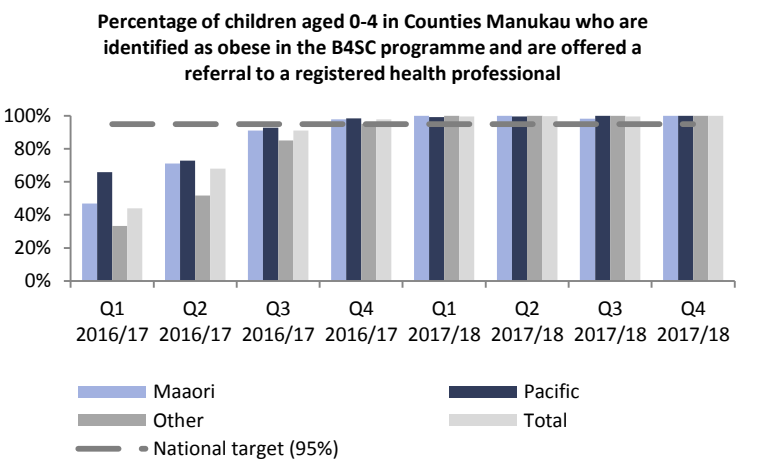
[16] The Ministry of Health applies the 90% target to the offer of brief advice only. In Q4 2017/18 79% of all women and 86% of Maaori women were offered both advice and support to quit, with 55% of all women and 57% of Maaori women accepting the cessation support offered.

Medium term outcome: Equitable reduction in obesity prevalance in children

Childhood obesity negatively affects immediate and future health and quality of life. CM Health has a high prevalence of overweight and obese children and Maaori and Pacific children are disproportionately affected.

Health Target: Raising Healthy Kids – 95% of children identified as obese in the Before School Check (B4SC) programme are offered a referral to a registered health professional (referral sent and acknowledged)

Referral provides an opportunity for children and whaanau to participate in clinical assessment and family-based nutrition, activity and lifestyle programmes. In 2017/18, CM Health exceeded the 95% referral target for all ethnic groups, with 100% of referrals for all ethnic groups both sent and acknowledged.



The decline rate for participation in assessment and healthy lifestyle intervention is higher for Maaori and Pacific whaanau.[17] CM Health is currently engaging with whaanau to understand the reasons for declines and how programme uptake can be improved, as part of a broader evaluation of child healthy weight activities in Counties Manukau.

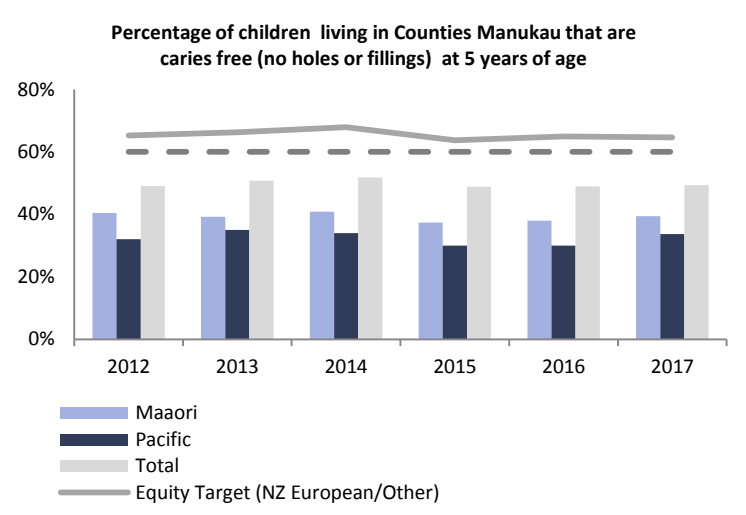
At CM Health, we acknowledge the need for a broad approach to reducing childhood obesity. We have worked with Auckland DHB and Waitematā DHB to develop the Metro Auckland DHB Healthy Weight Action Plan for Children 2017-2020. The Plan takes a life-course approach, identifying a number of actions to support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

Data source: Ministry of Health Performance Reporting

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

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

In 2017/18 the total percentage of children dental caries free at five years was 49%, still below the targeted level of 60%. As in previous years, the target was only achieved for European/Other children. Although there have been small improvements since 2015/16 for Maaori and Pacific children, significant inequities persist.



Early enrolment with dental services will support prevention and early detection of oral health problems, including dental caries. In 2018/19 CM Health will continue to work with the Auckland Regional Dental Service to improve early enrolment and the provision of preventative services to children at high risk of dental caries, including Maaori and Pacific children. CM Health will also continue to work on aligning oral health and obesity prevention messaging with a focus on new resources for Maaori and Pacific children.

Data source: Ministry of Health Performance Reporting

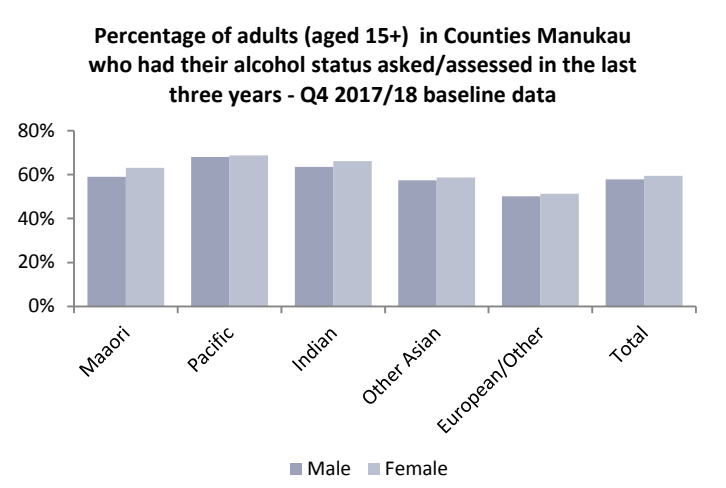
[17] CM Health continues to closely monitor the rate at which families decline to participate in clinical assessment and healthy lifestyle programme. The overall decline rate in Counties Manukau is 27% for the total population (national average is 22%), 30% for Maaori (national average 23%) and 23% for Pacific (national average 17%). Strategies are in place to reduce the rate of declines.

Medium term outcome: Reduced hazardous alcohol use

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 who have had their alcohol status asked/assessed in the last three years

CM Health has been developing a programme of collaborative alcohol harm minimisation actions with a view to working regionally. This work includes equitable delivery of the Alcohol ABC (Ask, Brief Advice, Counselling) approach in general practice and the Emergency Department. The graph shows the 2017/18 baseline data for the percentage of enrolled patients in primary care who have had their alcohol status asked and/or assessed in the last three years.

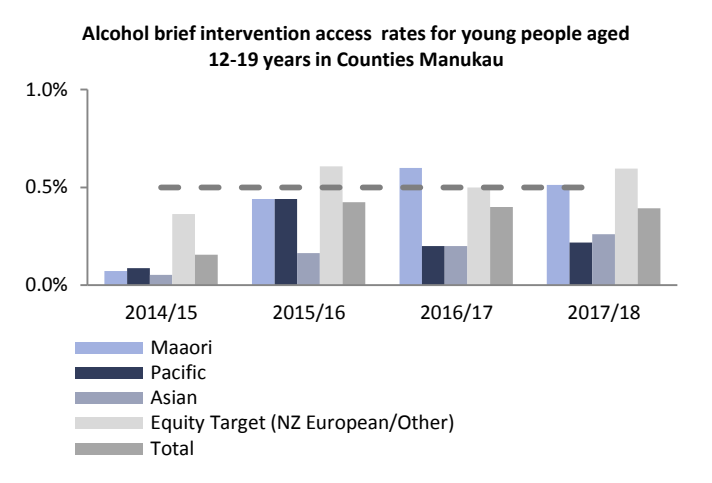


Alcohol ABC work involves adaptation of the Alcohol ABC model to each setting, development of supporting systems and processes and training and sustained support for front-line staff to enable them to have skilled and empathetic conversations with people and whaanau about alcohol use.

Data source: General practice ABC data

Alcohol brief intervention: Increasing the number of rangatahi receiving alcohol assessment and brief advice

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



In 2017/18 CM Health made good progress toward these goals for our rangatahi. CM Health achieved 0.7% against the alcohol brief intervention target for Maaori aged 12-19 years old (target: 0.5%). Additionally, 100%[18] of Maaori year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities were provided with a HEADSSS (Home, Education and Employment, Eating and Exercise, Activities and peers, Drugs and Alcohol, Depression and suicide, Sexual health, Safety and Strengths) adolescent psychosocial assessment (target 95%). For those Maaori aged 0-19 years with severe mental illness, 6.3% accessed mental health services, exceeding the target of 4.45%.

In 2018/19 CM Health will build on these successes through focusing on greater mental health service integration for our young people.

Data source: PHO alcohol brief intervention data

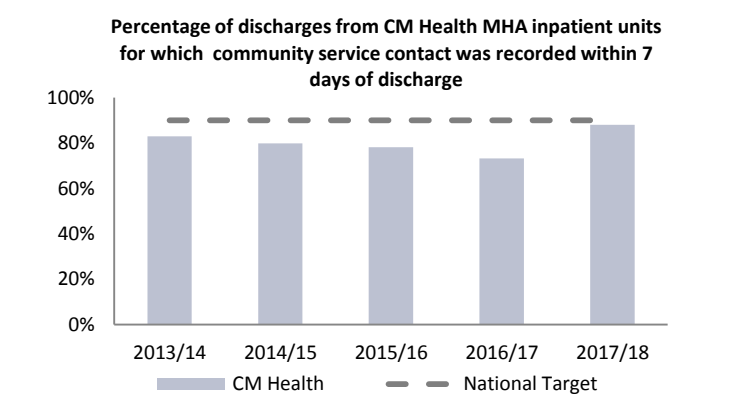
[18] Result is to the end of the school/calendar year (January 2017- December 2017). Actual figure is 102.2%, due to the transient nature of our population which can fluctuate significantly from the start to the end of a school term.

Medium term outcome: Improved mental health and wellbeing

Many New Zealanders will experience a mental illness and/or an addiction at some time in their lives. Maaori and Pacific peoples experience higher rates of anxiety and depressive disorders than non-Maaori, non-Pacific.

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

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



In 2017/18, 88% of service users discharged from the CM Health acute adult inpatient mental health unit had a community mental health service contact recorded within 7 days of their discharge. While this is still below the 90% target, this is a substantial improvement from previous years and is the highest rate recorded percentage to date.

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

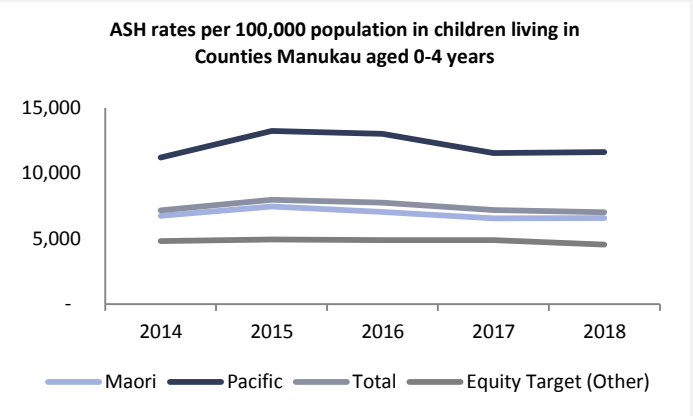
Healthy People, Whaanau and Families – improved equity, quality, safety and experience of care

"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, increased use of primary and community services including technology that enables self-management. We want patients, whaanau and family to report improved experiences due to more connected, accessible and co-ordinated care.

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

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



Keeping children well and out of hospital is a key priority. Not only is it better for our community, but it frees up hospital resources for people who need more complex and urgent care. Maaori and Pacific babies and children experience health inequities in acute admissions that are considered potentially avoidable (ambulatory sensitive hospitalisations or ASH events). 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 2017/18 Metro Auckland Sytem Level Measures Improvement (SLM) Plan set a target of reducing the 0-4 year old total, Maaori and Pacific ASH rates by 5% by June 2018.[20] CM Health did not achieve this target.

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

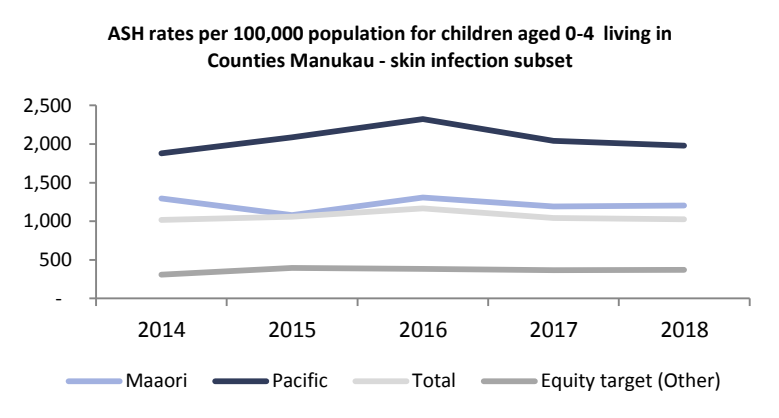
[20] Baseline was set at 12 months to September 2016. Baseline per 100,000 population: total – 7,109, Maaori – 6,254, Pacific – 11,977. Target rates per 100,000 population: total – 6,754, Maaori – 5,951, Pacific – 11,378.

The 2018/19 SLM Plan will target 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 will implement 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.

Data source: Ministry of Health Performance Reporting

Key contributory measure : Reducing the 0-4 year old ASH rate per 100,000 – skin infection subset

Counties Manukau Pacific and Maaori children are more likely than children of other ethnicities to be hospitalised with serious skin infections such as cellulitis. The 2017/18 Metro Auckland SLM Improvement Plan included a contributory measure focused on reducing the ASH rate for skin infections by 5%.

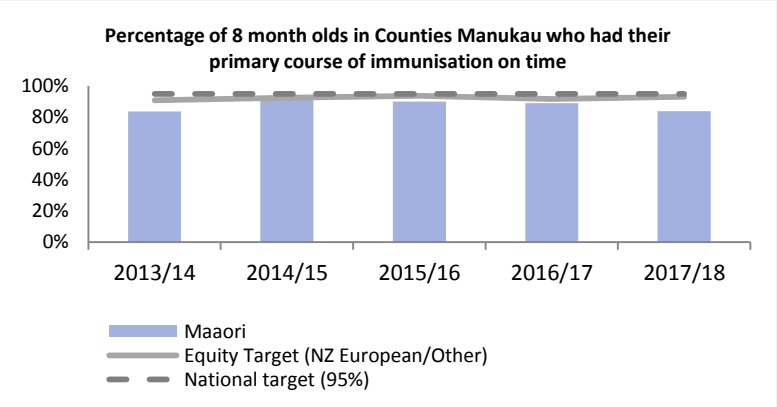


This target was achieved for our Maaori and Pacific tamariki; between September 2016 and June 2018, there was a 6.7% drop in the ASH rate due to skin infections (cellulitis, dermatitis and eczema) for Maaori and a 9.8% drop for Pacific. This was supported by activities such as the delivery of an education package for skin infections to primary care, urgent care, Well Child Tamariki Ora services and early childhood education centres to ensure that health promotion messages are reaching families with young children.

Data source: Ministry of Health Performance Reporting

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

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 Maaori children to achieve the best possible state of health and avoid potentially avoidable hospitalisations.



CM Health aims to achieve equity by increasing the percentage of pepi and tamariki Maaori who are immunised on time at 8 months, and 2 and 5 years. In 2017/18 CM Health did not meet the 95% target for tamariki Maaori, with performance dropping compared to 2016/17. An increase in whaanau deferring immunisation until their children are older has contributed to the declining Maaori immunisation rate at eight months. Socioeconomic issues are also a key challenge, with our Outreach Immunisation Service (OIS) experiencing more families in emergency housing where information cannot be shared, as well as families being transient moving through multiple addresses.

Based on previous quarters, the most effective strategy for engaging Maaori families has been multiple contacts to establish relationships and trust. In 2018/19 CM Health will continue to build on this work to proactively improve Maaori immunisation coverage, including through facilitating early enrolment of pepe in primary care and extension of the outreach immunisation service to weekends and home visits. CM Health is also planning to pilot a contract with the Maaori Women's Welfare League (MWWL) to work alongside OIS (funding dependent) to support Maaori engagement.

Data source: National Immunisation Register Data Mart report

Medium term outcome: Improved end of life pathways for patients and whaanau[21]

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

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

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

A key achievement of Poi has been the establishment of hospice Poi teams, which provide expert mentoring and coaching to primary palliative care providers (chiefly ARRC facilities and GPs) in their local areas. Specialist support is received following submission of Palliative Pathway Activations (PPAs). These PPAs, or palliative care plans, are completed by primary palliative care providers for patients with identified palliative care needs, regardless of whether specialist palliative care is required. PPAs are reviewed by the Poi teams and attract a payment for the primary palliative care provider, to reflect the resources required to complete a plan. Support and guidance is provided to the primary care provider as required to improve capability in managing palliative care patients safely in the community. In 2017/18, 36 PPAs were completed by local hospices as part of Poi, with the number of PPAs steadily increasing across the region. 141 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, 21 link nurses have been trained within the CM Health district. 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. Two GPs with Special Interests (GPSI) have been employed by local hospices to progress palliative care capability and resources within primary and residential care settings for accredited 6-month rotations. GPSI are champions within the primary care workforce that will have expertise in both primary and palliative care.

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

Healthy Services – better value for public health resources

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

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

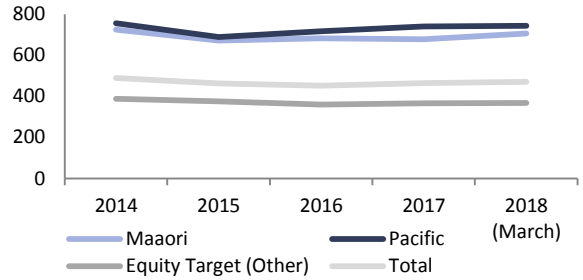
[21] As this is a new outcome measure, baseline and trend data are not yet available.

Medium term outcome: Reduction in acute hospital bed days

All of system approach to ensure safe delivery of care and reduce potentially avoidable hospitalisation[22]

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

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



March 2018 results indicate that CM Health will not meet the 2017/18 SLM Plan milestone for reducing the number of acute hospital bed days per capita by June 2018. This has been a challenging measure to shift due to the wide variety of factors (including deprivation) that impact on this measure. The 2018/19 SLM Plan aims to achieve a greater reduction in acute bed days through efforts focused on conditions that contribute the most to acute hospital bed days, including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), stroke and cellulitis. The Plan also aims to implement targeted initiatives to reduce the inequities in acute bed days experienced by our Maaori and Pacific people.

Data source: Ministry of Health Performance Reporting[23]

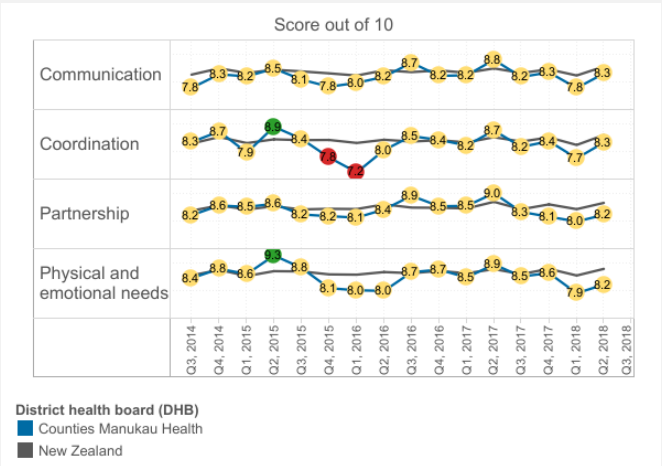
Key contributory measure: improved and more equitable experience of care

The Hospital Inpatient Patient Experience Survey (PES)

Understanding and improving patients' experience is vital to improving patient safety and the quality of care and contributes to better health outcomes. [24]

The national Hospital Patient Experience Survey provides insights into how to improve patient experiences by focusing on activities to improve the quality of care provided. As at Quarter 2 2017/18, CM Health's average score across all four domains of the survey (communication, coordination, partnership and physical & emotional needs) was 8.25, below our targeted average of 8.5. In 2018/19 CM Health will focus on improving the 'Coordination' section of survey, which is our lowest scoring domain. Improving participation of our Maaori and Pacific patients will also be a focus of 2018/19 and has been specifically included in the Counties Experience Work Plan for 18/19.

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



Data source: Health Quality and Safety Commission National Patient Experience Survey Report[25]

[22] 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.

[23] 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).

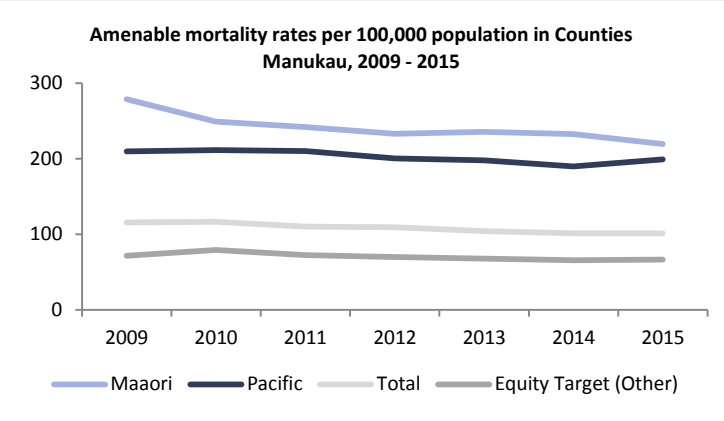
[24] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203

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

Medium term outcome: Reduced and more equitable amenable mortality rates[26]

Target improvement in the leading causes of potentially preventable deaths

The four leading causes of amenable mortality Counties Manukau - cancer, cardiovascular disease (particularly heart attacks and stroke), chronic obstructive pulmonary disease (COPD) and diabetes - share common risk factors.[27] Regional and local approaches will focus on delivering actions to reduce unhealthy diet, physical inactivity, smoking and harmful use of alcohol risk factors. Proportionally, Maaori have a higher amenable mortality in smoking-related diseases such as cardiovascular disease and COPD. Pacific people have a higher proportion of diabetes related deaths.



The 2017/18 SLM Plan set an amenable mortality rate reduction target of 2%, to be achieved by June 2018. This has since been increased to 6%, to be achieved by June 2020. Based on 5-year trends, Counties Manukau DHB shows a consistently declining total amenable mortality rate. Acknowledging that there will always be some annual fluctuation, we should be on track to meet the 6% reduction by 2020.

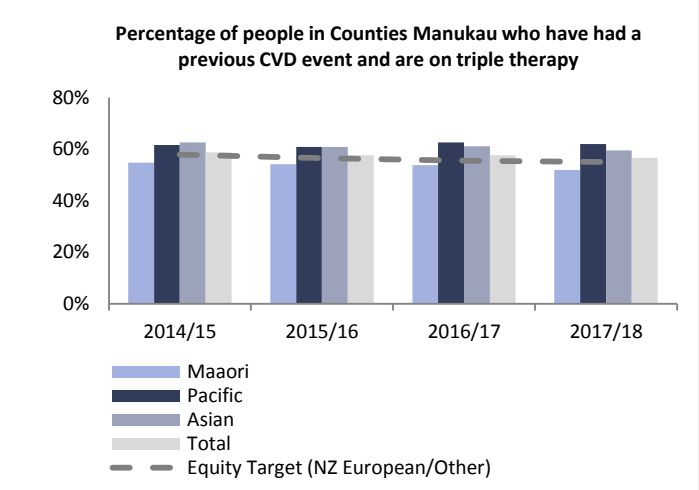
The Maaori and Pacific amenable mortality rates have also been declining, except for a small increase in the Pacific rate between 2014 and 2015. The 2018/19 SLM Plan targets a 2% reduction in the Maaori and Pacific amenable mortality rates by June 2019. This will be achieved through continued focus on improving smoking cessation and management of CVD, two areas with the greatest evidence-based impact on amenable mortality.

Data source: National Mortality Data Collection[28] *(definition based on MoH Sep 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'[29] medicines can reduce future risk of CVD events and death. Triple therapy as defined as statins, antiplatelet/coagulants, and blood pressure lowering medicines dispensed in at least three quarters in the year.

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



In 2017/18 we did not achieve our targets for increasing the percentage of people on triple therapy. In 2018/19 our focus will be on reducing inequity by improving CVD management for our Maaori and Pacific patients through both local and regional initiatives.

Data source: NRA CVD Prevention Medication Six Monthly Report [30]

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

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

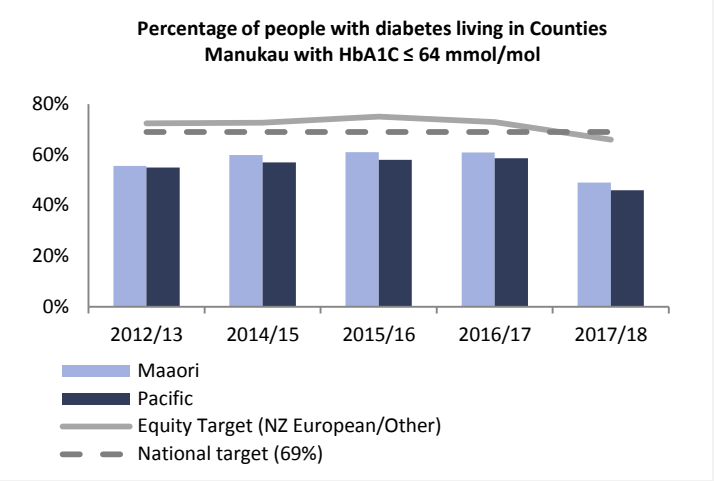
[28] It takes several years for some coronial cases to return verdicts. As a result the Ministry is unable to release provisional cause of death information until around two years after the end of the year. Reports are made available annually with a rolling five years data set.

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

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

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

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



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

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

In 2018/19 we are aiming to improve the percentage of patients with good glycaemic control through increased focus on improving the quality of diabetes care and proactive management of long-term conditions. This will include an emphasis on reducing unwarranted clinical variation between practices and ensuring practices have a quality improvement approach which is led by an improvement team.

Data source: Ministry of Health Performance Reporting[31]

[31] 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.

Statement of Service Performance

This section presents CM Health's actual performance against the National Health Targets and against the forecast outputs presented in our 2017/18 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.

Please note that 2017/18 results are based on our performance as reported in Quarter 4 2017/18, unless otherwise specified.

National Health Target Performance

CM Health's performance against the National Health Target expectations in 2017/18 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with primary health care and Primary Health Care Organisations (PHOs), and their commitment and leadership to focus resources towards improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

Health Targets		Quarter			
		1	2	3	4
Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours	88%	90%	90%	**91%**[32]
Improved access to Elective Surgery	The volume of elective surgery will be increased by an average of 4,000 discharges per year[33]	99.6%	97.9%	98.7%	**101.5%**[34]
Faster Cancer Treatment	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	94%	94%	95%	**93%**
Increased Immunisation	95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time	94%	93%	93%	**93%**[35]
Raising Healthy Kids	95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017	100%	100%	100%	**100%**
Better help for Smokers to Quit	**Primary Care** 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	90%	89%	90%	**92%**

[32] Patient volume and bed demand mean the hospital has been unable to reach the six-hour ED Health Target. This is due to a variety of factors, including high consistent surge presentation rates and consistent high hospital occupancy.
[33] Performance against the Electives Health Target is reported one month in arrears. The Quarter 4 result is therefore at May 2018.
[34] Performance for the Electives Health Target is measured as a percentage of the targeted number of discharges, therefore if the number of actual discharges exceeds the targeted number the percentage performance will exceed 100%. In 2017/18, at May 2018 there were 20,841 actual exceeding the target of 20,535 discharges, leading to a percentage performance greater than 100%.
[35] The Immunisation Health Target was not achieved in 2017/18, due to the social barriers experienced by families and more families choosing to defer immunisation until their children are older. More families are in emergency housing where information cannot be shared which makes unimmunised babies difficult to identify. Families are also more transient moving through multiple addresses and have other competing responsibilities, with babies older and unimmunised when found.

Health Targets	Quarter			
	1	2	3	4
Maternity Care 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	94%	91%	91%	**92%**

Prevention services

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

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

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

Performance Measure		2015/16 Baseline	2017/18 Target	2017/18 Result	Achievement
Health Promotion and Education Services					
Proportion of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit	Total	92%	90%	92%	Achieved
	Maaori	91%		91%	Achieved
	Pacific	92%		92%	Achieved
	Asian	93%		92%[36]	Achieved
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking	Total	96%	95%	96%	Achieved
	Maaori	96%		96%	Achieved
	Pacific	96%		96%	Achieved
	Asian	94%		93%[37]	Not achieved
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer who are offered brief advice and support to quit smoking	Total	100%	90%	92%	Achieved
	Maaori	97%		94%	Achieved
Percentage of PHO-enrolled patients who smoke who accepted smoking cessation support	Total	24.4%[38]	26.8%[39]	25.7%	Not achieved
Percentage of houses that are smokefree at two weeks postnatal	Total	91%	95%	N/A[40]	N/A
	Maaori	72%		N/A	N/A
Percentage of babies fully or exclusively breastfed at 3 months	Total	46%	60%	51%	Not achieved
	Maaori	37%		41%	Not achieved

[36] The Ministry of Health combines data for Asian and Other (non-Maaori, non-Pacific) groups. The 2017/18 result for Asian has therefore been calculated internally by the CMDHB Health Intelligence and Informatics team.
[37] The Ministry of Health combines data for Asian and Other (non-Maaori, non-Pacific) groups. The 2017/18 result for Asian has therefore been calculated internally by the CMDHB Health Intelligence and Informatics team.
[38] Baseline data is as at 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[39] 2017/18 targets represent a 10% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[40] This measure has been discontinued by the Ministry of Health and there is no 2017/18 data available for this measure. The Ministry of Health replaced this measure with a new measure during 2017/18: the percentage of babies living in smokefree homes at six weeks. CM Health will report on the six-week indicator from 2018/19.

Performance Measure		2015/16 Baseline	2017/18 Target	2017/18 Result	Achievement
	Pacific	39%		46%	Not achieved
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Total	29%[41]	95%	100%	Achieved
	Maaori	29%		100%	Achieved
	Pacific	28%		100%	Achieved
	Other	49%		100%	Achieved
Number of children aged <5 years referred to Active Futures	Total	N/A[42]	350 (75% to be Maaori, Pacific or quintile 5)	172 (84% Maaori, Pacific or quintile 5)	Not achieved
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	125	171[43] (75% to be Maaori, Pacific or quintile 5)	140[44] (87% Maaori, Pacific or quintile 5)	Not achieved
Number of adult referrals to Green Prescription services	Total	5,896[45]	7,300	6,142	Not achieved
Immunisation Services					
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Total	95%	95%	93%	Not achieved
	Maaori	90%		84%	Not achieved
	Pacific	97%		94%	Not achieved
	Asian	99%		98%	Achieved
Proportion of eligible girls fully immunised with HPV vaccine	Total	62%	75%	71%	Not achieved
	Maaori	63%		65%	Not achieved
	Pacific	68%		84%	Achieved
	Asian	61%		68%	Not achieved
Percentage of people aged over 65 years who have had their flu vaccinations	Total	47%	75%	46%[46]	Not achieved
	Maaori	44%		40%	Not achieved
	Pacific	64%		45%	Not achieved
	Asian	47%		46%	Not achieved
Health Screening					
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	69%	70%	71%	Achieved
	Maaori	65%		65%	Not achieved
	Pacific	76%		82%	Achieved
	Other	68%		70%	Achieved
Proportion of women aged 20 – 69 years who have had a cervical smear in the last three years	Total	75%	80%	69%	Not achieved
	Maaori	69%		65%	Not achieved
	Pacific	82%		75%	Not achieved
	Asian	67%		66%	Not achieved
	Other	79%		70%	Not achieved

[41] Baseline data for six months ending August 2016 (Q1) (target first introduced in 2016)
[42] New service (commenced March 2017) therefore 2015/16 baseline data not available.
[43] Target is for children aged 5-18 years is for children who are both referred and engaged in the programme.
[44] In 2017/18 140 children were engaged, with a total of 285 referred.
[45] Total number of adult referrals received between 1 July 2015 and 30 June 2016 including repeat referrals.
[46] Results are reported annually in Q1 of each year, covering a six month period of 1 March to 30 September. 2017/18 results are for the period 1 March 2017 to 30 September 2017.

Performance Measure		2015/16 Baseline	2017/18 Target	2017/18 Result	Achievement
Percentage of four year olds receiving a B4 School Check	Total	101%	90%	101%[47]	Achieved
	Maaori	100%		105%	Achieved
	Pacific	90%		101%	Achieved
	Other	109%		99%	Not achieved
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS (Home, Education and Employment, Eating and Exercise, Activities and peers, Drugs and Alcohol, Depression and suicide, Sexual health, Safety and Strength) adolescent psychosocial assessment[48]	Total	91%	95%	100%[49]	Achieved
	Maaori	87%		102%	Achieved
	Pacific	94%		99%	Achieved
	Asian	N/A[50]		101%	Achieved

Early detection and management services

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Maaori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

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

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

Performance Measure		Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Primary Health Care Services					
Percentage of population enrolled in a PHO	Total	98%	95%	97%	Achieved
	Maaori	93%		92%	Not achieved
	Pacific	117%[51]		116%[52]	Achieved
	Asian	83%		90%	Not achieved
Amenable mortality rate per 100,000 population[53]	Total	104.4[54]	102.3[55]	101.2[56]	N/A[57]

[47] The 90% Ministry of Health target is based on the percentage of the eligible population who receive a B4 School Check. The baselines used in the 2017/18 Statement of Performance Expectations were based on performance against the 90% target (rather than the percentage of eligible population reached). A baseline of >=100% in the 2017/18 Statement of Performance Expectations therefore indicated the 90% eligible population coverage target was met or exceeded, while a result below 100% indicated that the target was not met. Results for 2017/18 are against the target rather than eligible population to align with the baseline achievement figures used in the 2017/18 Statement of Performance Expectations and may therefore be greater than 100%.

[48] Performance is measured using school/calendar year to December. Baseline data as at 31 December 2016.

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

[50] Asian data was developed over the 2017/18 year. Baseline data is therefore not available for this population group.

[51] The denominator for the PHO enrolment measure is based on the population projections provided from StatsNZ which at the moment are still based on the 2013 Census. Historically the Census underestimated the Pacific population compared to the numbers that we see appearing in the PHO registers. The 2015/16 result for Pacific people is therefore greater than 100% due to the underestimation of the Pacific population size.

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

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

[54] Baseline data is for the 12 months ended 30 June 2013. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.

[55] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

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

[57] Reduction timeframe has been extended from June 2018 as per the 2017/18 SLM Plan to June 2020. This will allow for achievement to be measured using 2017 data, which is expected to be released in 2019. A new target has also been set in the 2018/19 SLM Plan, for a reduction of 6%

Performance Measure		Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	92%	90%	92%	Achieved
	Maaori	89%		90%	Achieved
	Pacific	92%		91%	Achieved
	Other	93%		92%	Achieved
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	73%	90%	74%	Not achieved
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c < 64 mmol/mol)	Total	65%	69%	55%[58]	Not achieved
	Maaori	61%		49%	Not achieved
	Pacific	58%		46%	Not achieved
	Other	73%		66%	Not achieved
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	49%[59]	52%[60]	49%	Not achieved
	Maaori	48%	51%	48%	Not achieved
	Pacific	54%[61]	57%[62]	55%	Not achieved
	Asian	43%[63]	46%	42%	Not achieved
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)[64]	Total	58%[65]	61%[66]	57%	Not achieved
	Maaori	55%	58%	52%	Not achieved
	Pacific	62%	65%	62%	Not achieved
	Asian	51%[67]	53%	49%	Not achieved
Percentage of each PHO's practices registered with an e-portal[68]	Total	52%	55%	67%	Achieved
Oral Health Services[69]					
Proportion of children under 5 years enrolled in DHB-funded community oral health services[70]	Total	84%	95%	84%	Not achieved
	Maaori	74%		71%	Not achieved
	Pacific	85%		83%	Not achieved
	Asian	87%		75%	Not achieved
	Other	90%		90%	Not achieved

by June 2020. Based on 5-year trends, Counties Manukau DHB shows a consistently declining total amenable mortality rate. Acknowledging that there will always be some annual fluctuation, we should be on track to meet the new 6% reduction target by 2020.

[58] The apparent decrease in performance against this target is due to a change in the data source used in Quarter 4 2017/18. Previously for this measure (including for the 15/16 baseline presented here) data from the Chronic Care Management programme at Counties was used to calculate achievement of the target, however this database only captured 60-70% of patients. From Q4 17/18 CM Health started using the HealthSafe database to calculate target achievement, this database captures closer to 90%.

[59] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.

[60] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

[61] The 2015/16 baseline figure for Pacific patients on dual therapy presented in the 2017/18 Statement of Performance Expectations was incorrect (incorrect figure: 49%). The correct 2015/16 baseline to use was 54.2%. The 2017/18 Statement of Service Performance uses this updated figure.

[62] The 2017/18 Metro Auckland SLM Improvement Plan targeted a 5% increase in the percentage of patients on dual therapy. Due to the error in the baseline figure for Pacific patients in the 2017/18 Statement of Performance Expectations, the 2017/18 target was also incorrect (incorrect figure: 52%). The correct target to use was 57%. The 2017/18 Statement of Service Performance uses this updated figure.

[63] For the dual and triple therapy CVD measures, the baseline figures and targets used in the 2017/18 Statement of Performance Expectation excluded Indian patients in error. The 2017/18 results presented here for these measures are therefore for Asians excluding Indians. The 2018/19 Statement of Performance Expectations will include Indian patients for the dual and triple therapy CVD measures.

[64] Results for this measure are reported six-monthly in Q1 and Q3. 2017/18 results are at Q3 2017/18.

[65] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.

[66] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

[67] For the dual and triple therapy CVD measures, the baseline figures and targets used in the 2017/18 Statement of Performance Expectation excluded Indian patients in error. The 2017/18 results presented here for these measures are therefore for Asians excluding Indians. The 2018/19 Statement of Performance Expectations will include Indian patients for the dual and triple therapy CVD measures.

[68] Note that this is a regional (Auckland DHB, Waitemata DHB and CM Health) target as included in the 2017/18 Metro Auckland SLM Improvement Plan.

[69] Baseline data is based on the calendar year (to 31 December 2016), except for adolescent measure which is Q4 2015/16.

[70] Results for this measure are reported annually in Q3. 2017/18 results are therefore at Q3 2017/18.

Performance Measure		Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Percentage of enrolled children Caries free at age 5 years[71]	Total	48%	60%	49%	Not achieved
	Maaori	38%		39%	Not achieved
	Pacific	30%		34%	Not achieved
	Asian	56%		57%	Not achieved
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children [12/13 years])[72]	Total	0.96	0.81	0.88	Not achieved
	Maaori	1.29		1.26	Not achieved
	Pacific	1.42		1.24	Not achieved
	Asian	0.72		0.62	Achieved
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	73.3%	85%	74%	Not achieved
Diagnostics[73]					
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	92%	95%	88%	Not achieved
	MRI	62%	90%	46%	Not achieved
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	90%	90%	98%	Achieved
Proportion of patients accepted as non- urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)[74]	Total	44%	70%	69%	Not achieved
Ambulatory Sensitive Hospitalisations					
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population	Total	7,109[75]	6,754[76]	7,012	Not achieved
	Maaori	6,264	5,951	6,578	Not achieved
	Pacific	11,977	11,378	11,618	Not achieved
	Other	4,789	4,550	4,539	Achieved
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 0-4 year olds – skin infection subset	Total	1,073[77]	1,019[78]	1,024	Not achieved
	Maaori	1,288	1,224	1,202	Achieved
	Pacific	2,195	2,085	1,980	Achieved
	Other	334	317	371	Not achieved
Rheumatic Fever					
Acute rheumatic fever first hospitalisations rates per 100,000 population	Total	7.0[79]	4.5	10.9	Not achieved
	Maaori	13.1		12.6	Not achieved
	Pacific	23.2		40.3	Not achieved
Sudden Unexpected Death of an Infant (SUDI)					
SUDI deaths per 1,000 live births	Total	0.96	0.40	1.06[80]	Not achieved

[71] Results for this measure are reported annually in Q3. 2017/18 results are therefore at Q3 2017/18.
[72] Results for this measure are reported annually in Q3. 2017/18 results are therefore at Q3 2017/18.
[73] Baselines, targets and results for all diagnostics measures (CT, MRI and the two colonoscopy measures) are for the financial year and not Quarter 4.
[74] The description for this measure was incorrect in the 2017/18 Statement of Performance Expectations (incorrect description: Proportion of patients accepted as **non-diagnostic colonoscopy** who receive their procedure within six weeks). The description has been corrected in this document.
[75] Baseline data for 12 months to September 2016. Source: Ministry of Health SI1 Quarterly data. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[76] 2017/18 targets represent a 5% reduction from baseline by 30 June 2018 as per the 2017/18 Metro Auckland SLM Improvement Plan.
[77] Baseline data for 12 months to September 2016. Source: cellulitis and dermatitis/eczema dataset via Ministry of Health SI1 Quarterly data. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan
[78] 2017/18 targets represent a 5% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[79] Baseline data Q1 2016/17

Performance Measure		Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
	Maaori	2.13		2.38	Not achieved
Pharmacy					
Number of prescription items subsidised	Total	7,334,818	N/A[81]	7,748,436[82]	N/A

Intensive assessment and treatment services

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

They include:

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

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

Performance Measure			Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Mental Health						
Percentage of population with severe mental illness who access mental health services	Age 0-19 years	Total	3.9%	3.15%	4.1%	Achieved
		Maaori	5.6%	4.45%	6.3%	Achieved
	Age 20-64 years	Total	3.8%	3.15%	3.9%	Achieved
		Maaori	8.5%	7.75%	9.3%	Achieved
	Age 65+ years	Total	2.5%	2.60%	2.3%	Not achieved
		Maaori	2.8%	2.60%	2.8%	Achieved
Proportion of 0-19 year olds referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks	Mental Health (Hospital Care Arm)	3 weeks	76%	80%	68%[83]	Not achieved
		8 weeks	96%	95%	89%	Not achieved
	Addictions (Hospital Care Arm and NGO)	3 weeks	96%	80%	95%	Achieved
		8 weeks	96%	95%	98%	Achieved
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[84]		Total	78.1%	90%	88%	Not achieved
Elective Services						
Number of Elective Surgical Discharges[85]		Total	109%[86] 21,650	100% 20,535	101.5%[87] 20,841	Achieved

[80] The results are the unconfirmed SUDI rate as reported in January 2017 by the Ministry of Health, based on 2015 mortality data. A delay period in the release of results is standard for mortality statistics in New Zealand, due to the time taken for coroners to confirm and code deaths. A small number of provisional SUDI deaths will be reclassified after a coroner's investigation and attributed to another cause of death. It takes at least a year before the coroner releases the findings.

[81] Measure is demand driven – not appropriate to set target.

[82] Results are preliminary, final results will be available in 3-6 months due to the time taken to ensure data accuracy.

[83] Results for this measure are cumulative for the 2017/18 financial year (June 2017 to June 2018).

[84] Source: www.mhakpi.health.nz. CM Health is developing a suite of mental health and wellbeing measures over 2017/18. As these measures are being developed, the timeliness of post-acute discharge community care contact being made provides a reasonable indication of how our MHA inpatient and community services are performing.

[85] Performance against the Electives Health Target is reported one month in arrears. The Quarter 4 result is therefore at May 2018.

[86] Performance for the Electives Health Target is measured as a percentage of the targeted number of discharges, therefore if the number of actual discharges exceeds the targeted number the percentage performance will exceed 100%.

Performance Measure			Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Elective Services Standardised Intervention Rates (SIRs) per 10,000 population	Major Joints		22.39	21	22.1	Achieved
	Cardiac Surgery		6.04	6.5	5.67	Not achieved
	Cataracts		33.25	27	38.01	Achieved
Acute Services						
Emergency Department (ED) attendance rate (age standardised) per 1,000 population[88]		Total	215.4[89]	211.1[90]	222.4	Not achieved
		Maaori	283.3	277.6	296.8	Not achieved
		Pacific	337.6	330.8	352.7	Not achieved
		Asian	135.9	133.2	138.9	Not achieved
Readmissions – acute readmissions to hospital within 0-28 days[91]		Total	7.7%	N/A[92]	10.9%[93]	N/A[94]
		75+	9.7%	N/A	11.0%	N/A
Acute Inpatient Average Length of Stay		Acute LOS	2.57 days	2.50 days	2.75	Not achieved
		Elective LOS	1.67 days	1.52 days	1.66	Not achieved
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			96%	95%	91%	Not achieved
Cancer Services						
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment (and are ready to start treatment) who receive this within four weeks from decision to treat	Radiotherapy	Total	100%	85%	99%[95]	Achieved
		Maaori	100%		100%	Achieved
		Pacific	100%		100%	Achieved
	Chemotherapy	Total	100%	85%	99%[96]	Achieved
		Maaori	100%		100%	Achieved
		Pacific	100%		100%	Achieved

[87] Performance for the Electives Health Target is measured as a percentage of the targeted number of discharges, therefore if the number of actual discharges exceeds the targeted number the percentage performance will exceed 100%. In 2017/18, at May 2018 there were 20,841 actual exceeding the target of 20,535 discharges, leading to a percentage performance greater than 100%.

[88] In the 2017/18 CM Health Statement of Performance Expectations, this measure was described incorrectly as 'Emergency Department (ED) attendance rate per 100,000 population.' It has been updated in this Statement of Service Performance to reflect the correct definition from the 2017/18 Metro Auckland System Level Measures Improvement Plan.

[89] Baseline data for 12 months to September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan. Baselines, targets and results for ED attendance rates are age standardised as per the NZ 2013 standard population (NZpop13MOH).

[90] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

[91] Note that the 2017/18 Metro Auckland SLM Improvement Plan included a developmental contributory measure for acute readmission rates in 28 days.

[92] The Ministry of Health OS8 Reducing Acute Readmissions to Hospital measure definition is currently under review. A target for this measure was therefore not able to be set at the time the 2017/18 Statement of Performance Expectations was finalised (July 2017).

[93] 2017/18 results for this measure are as reported in Quarter 4 2017/18 by the Ministry of Health, 12 months to the end of March 2018.

[94] As no target was set for this measure during 2017/18 it is not appropriate to report on achievement.

[95] Results are based on three-month achievement of the target, April to June 2018. Only breaches due to capacity constraints are included when calculating achievement of the targets for the radiotherapy and chemotherapy measures, as per the Ministry of Health definitions of the targets.

[96] Results are based on three month achievement of the target, April to June 2018.Only breaches due to capacity constraints are included when calculating achievement of the targets for the radiotherapy and chemotherapy measures, as per the Ministry of Health definitions of the targets.

Performance Measure		Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Proportion of patients who receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	Total	76%	90%	93%[97]	Achieved
Cardiac Services					
Percentage of high risk patients who receive an angiogram within 3 days of admission	Total	80%	70%	81%	Achieved
	Maaori	74%		77%	Achieved
	Pacific	75%		76%	Achieved
	Other	81%		80%	Achieved
Stroke Services					
Percentage of potentially eligible stroke patients thrombolysed		11%	8%	16%	Achieved
Quality and patient safety					
Percentage of admissions affected by four or more triggers[98]		1.4%	<1.4%	1.2%[99]	Achieved
Rate of falls with major harm per 1,000 bed days		0.07	<0.09	0.05[100]	Achieved
Percentage of inpatients (aged 75+) assessed for risk of falling		94%	90%	94%[101]	Achieved
Rate of S. aureus bacteraemia (SAB) per 1,000 bed days		0.06	<0.06	0.06[102]	Not achieved
Compliance with good hand hygiene practice		82%	80%	87%	Achieved
System Level Measures					
Acute hospital bed days per capita	Total	460.1[103]	450.9[104]	470.3[105]	Not achieved
	Maaori	690.8	677.0[106]	706.0	Not achieved
	Pacific	710.1	695.9[107]	744.1	Not achieved
Patient experience of care – hospital inpatient survey aggregate score	Total	8.7[108]	8.5[109]	8.25[110]	Not achieved

Rehabilitation and support services

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

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

[97] Result is based on six-month achievement of the target, from January to June 2018. Breaches of the target due to patient choice or clinical consideration are excluded when calculating target achievement, as per the Ministry of Health's definition of the target.
[98] Note that this measure replaced the previously reported 'number of adverse health care events'. This measure is from the Copeland Risk Adjusted Barometer (CRAB) tool which provides a risk adjusted view of complications, patient harm and mortality of inpatient admissions. An algorithm is applied to coded discharge data equivalent to the Trigger Tool.
[99] Result is year to June 2018.
[100] Result is year to June 2018.
[101] Result is at Quarter 3.
[102] Result is year to June 2018.
[103] Baseline data for 12 months to September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[104] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[105] 2017/18 results for this measure are as reported in Quarter 4 2017/18 by the Ministry of Health, 12 months rolling to March 2018.
[106] 2017/18 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[107] 2017/18 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[108] Baseline data as at Q1 2016/17. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[109] 2017/18 target is an aggregate score of 8.5 across all four domains measured (communication, partnership, coordination, physical and emotional needs) per the 2017/18 Metro Auckland SLM Improvement Plan.
[110] Result is at Q2 2017/18 as the Q4 result has not yet been published by the Ministry of Health.

Performance Measure		Baseline 2015/16	Target 2017/18	Result 2017/18	Achievement
Age Related Residential Care (ARRC)					
Percentage of people in ARRC who have a subsequent international Resident Assessment Instrument (interRAI) long term care facility (LTCF) assessment completed within 230 days of previous assessment		81.6%	95%	88%	Not achieved
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six (6) months prior to that first LTCF assessment		53.3%	90%	59%	Not achieved
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.		N/A[111]	95%	97%[112]	Achieved
Assessment, Treatment and Rehabilitation Services[113]					
Number of older people that have received in-home strength and balance retraining services	Aged 65-74	N/A	703	239	Not achieved
	Aged 75+				
Number of older people that have received community / group strength and balance retraining services	Aged 65+	N/A	2,325 places	1,135	Not achieved
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 65-74	N/A	300	291	Not achieved
	Aged 75-84		300	405	Achieved
	Aged 85+		300	315	Achieved
Palliative care[114]					
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District		N/A[115]	200[116]	36	Not achieved
Number of Hospice Proactive Advisory Conversations between the hospice service, primary care and ARRC health professionals		N/A[117]	200[118]	141	Not achieved

[111] New measure for 2017/18 therefore baseline data not available.
[112] Results are reported one quarter in arrears, therefore the 2017/18 result is at March 2018.
[113] Note that following falls and fractures measures were introduced in 2017/18 as part of the ACC, MoH and HQSC Live Stronger for Longer Programme. Baseline data is therefore not available.
[114] 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.
[115] This was a new measure introduced in 2017/18 therefore baseline data is not available.
[116] Target volume of PPAs for hospices in the Counties Manukau District (Franklin and Totara hospices). Regional 2017/18 target volume of 656 PPAs across all 6 hospices in the Auckland Region.
[117] This was a new measure introduced in 2017/18 therefore baseline data is not available.
[118] Target volume of Proactive Advisory conversations in the Counties Manukau District (Franklin and Totara hospices). Regional 2017/18 target volume of 656 Proactive Advisory conversations across all 6 hospices in the Auckland Region.

Performance by Output Classes [Includes agency costs]

Output Classes [$000]

	Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services	Total
Revenue (includes agency revenue)	**45,476**	**240,865**	**1,215,485**	**172,976**	**1,674,802**
Budget (includes agency revenue)*	*46,304*	*243,847*	*1,182,456*	*158,943*	*1,631,550*
Personnel Costs	23,821	915	589,337	13,378	627,451
Outsourced Services	5,814	223	81,554	3,265	90,856
Clinical Supplies	2,339	90	124,042	1,314	127,785
Infrastructure and Non-Clinical Supplies	1,331	51	135,660	748	137,790
Other (includes agency costs)	12,171	239,586	304,695	154,271	710,723
Total Costs	**45,476**	**240,865**	**1,235,288**	**172,976**	**1,694,605**
Budget (includes agency costs)*	*46,304*	*243,847*	*1,202,469*	*158,943*	*1,651,563*
Deficit	-	-	**(19,803)**	-	**(19,803)**
Budget	**-**	**-**	***(20,013)***	**-**	***(20,013)***

*The budget revenue and costs presented in the table above does not align to the budget numbers presented in the 2017/18 Annual Plan. There appears to have been an error in the classification of the revenue and expenditure across the output classes as presented in the final 2017/18 Annual Plan. The budget numbers for revenue and costs for 2017/18 output classes has been updated to more accurately reflect the classification across the classes and aligns with the methodology applied in the 2016/17 and 2018/19 Annual Plan output class budget classification.

Agency revenue and costs for the year amounts to $15.9m.

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)				
	Estimates	2016/17 Supplementary estimates[119]	Total	2017/18 Budgeted	Estimated Actual
Total Appropriations	1,329,104	(7,369)	1,321,735	1,377,805	1,377,805

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.

[119] Reasons for change in appropriation can be found in Vote Health – Supplementary Estimates of Appropriations 2016/17

Asset Performance Indicators for Counties Manukau District Health Board

Counties Manukau Health's Asset Portfolios

Assets have been grouped into Property (Buildings & Plant), Clinical Equipment and Information and Communication Technology (ICT). ICT assets are owned by the Northern Region shared services company, healthAlliance N.Z. Limited and asset performance is managed via a Service Level Agreement. Counties Manukau Health[120] has a vehicle fleet with a value of less than $737k comprising 252 owned (plus 167 leased) assets and so has not been considered as a separate portfolio for reporting purposes.

Table 1 Asset Portfolios

Asset Portfolio	Asset Purpose	Quantity/Capacity	Book Value 30 June 2018
Property	To enable the delivery of high quality health services through the provision of facilities that meet accreditation requirements	• 742 adult medical, surgical, rehab, AT&R, community medical inpatient beds • 66 paediatric inpatient beds • 36 ICU / HDU / CCU / CSDU beds • 80 maternity beds, 15 gynaecology beds, 7 assessment rooms and 29 delivery suites (hospital & community) • 70 acute mental health beds • 58 community mental health beds • 146 ED cubicles & short stay beds • 24 operating theatres; 14 at Middlemore and 10 + 2 procedure rooms at Manukau Surgical Centre • 14 owned community facilities • 15 leased community facilities • 16 owned dental clinics (84 chairs) plus 9 mobile dental units and 48 mobile unit site pads	$419m buildings, plant and infrastructure & land with a value of $212m
Clinical Equipment	To enable the delivery of high quality, timely clinical services through the availability of equipment that meets required clinical and safety standards	• 1 MRI machine owned & 1 leased • 1 CT machine owned & 3 leased • 1 cardiac catheter suite • Almost 23,000 other items	$36m Net Book Value ($172m original cost)
ICT	To enable the delivery of high quality health services through the availability of timely, accurate and accessible patient and business information	Regionally shared hardware and software. 7,800 users within Counties Manukau Health	$40m healthAlliance C-Class shares; $6m in NOS rights & $12m hardware & software WIP as at 30 June 2018

[120] Counties Manukau Health reflects a whole of health system view of health service partners. For Asset Performance Reporting at this time, the assets are those owned or leased by Counties Manukau District Health Board (CMDHB)

1. Property Assets

Property Assets – Building Condition Measures

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

As part of the DHB's internal review process, the DHB is currently conducting a multi-year review of the condition of the major buildings in its portfolio, including assessments around seismic strengthening, asbestos, critical building services infrastructure and cladding remediation. In 2017/18, the DHB commissioned two major infrastructure assessments. Completed in April 2018 was a detailed seismic assessment and independent peer review of the Middlemore Galbraith building that confirmed this as an earthquake prone building. The CMDHB Board is working through related remediation or replacement investment decisions in 2018/19. The second assessment related to asset assessment of the Middlemore, Manukau and Pukekohe site infrastructure is scheduled for completion in 2018/19. Risk prioritisation and remediation strategies will be 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 2017 based on an independent valuation conducted as at 11 August 2017. Based on information obtained to date, an estimate of the movement in the net book value of land, buildings and infrastructure assets has concluded that as at 30 June 2018 there has been no material net movement in the carrying amount of land, buildings and infrastructure assets, and therefore independent revaluation is not required.

Property Assets – Utilisation Measures

Reflecting population demand and available capacity, CM Health operates Middlemore Hospital at high levels of utilisation. This is achieved through a streamlined operations centre, Middlemore Central and pooling of adult medical and surgical beds to more flexibly use our available resources.

Table 2 Property Asset Utilisation

Asset	Measure	2015/16 Target	2015/16 Actual	2016/17 Target	2016/17 Actual	2017/18 Target	2017/18 Actual
Medical beds	Utilisation	85%	90%	85%	92%[1]	90%	93%
Surgical beds	Utilisation	85%	90%	85%	91%[2]	90%	90%
Operating Theatres	Utilisation	85%	90%	85%	91%[3]	90%	82%[4]

(1) Occupancy % for opened beds (2) Occupancy % for opened beds - Middlemore only (3) theatre list utilisation including turnover time (4) SAPS experienced high volumes of acute presentations resulting in two of the highest months ever recorded for surgical outputs in July and August 2017. Alongside this we had to manage ongoing anaesthetic workforce shortages and the Central Sterile Supplies Department (CSSD) refurbishment project over January and February 2018 at Manukau Surgery Centre, both of which impacted on theatre outputs.

Table 3 Power use on m^2 basis

	Building Area m^2	Yearly Usage KWhr / m^2	Average KWhr usage per month 2016/17	Average Monthly Cost 2016/17 $	Yearly Usage KWhr / m^2	Average KWhr usage per month 2017/18	Average Monthly Cost 2017/18 $
Middlemore Hospital	137,193	176	14.7	$250,000	179	14.9	$255,150
Manukau (Super Clinic & Surgery Centre)	19,763	248	20.6	$50,200	213	17.8	$47,403

2. Clinical Equipment Assets

Clinical Equipment Assets – Condition and Utilisation

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

Table 4 Clinical Equipment Condition, Availability & Utilisation

Asset	Measure	2015/16 Target	2015/16 Actual	2016/17 Target	2016/17 Actual	2017/18 Target	2017/18 Actual
MRI	Availability	>98%	>98%	>98%	>98%	>98%	98%
	Service Level/Utilisation	>85% elective patients waiting & scanned within 42 days	62% elective patients waiting & scanned within 42 days	>85% elective patients waiting & scanned within 42 days	79% elective patients waiting & scanned within 42 days	>85% elective patients waiting & scanned within 42 days	35%[3]
CT Scanners	Availability	>98%	>98%	>98%	>98%	>98%	98%
	Service Level/Utilisation	>95% elective patients waiting & scanned within 42 days	92% elective patients waiting & scanned within 42 days	>95% elective patients waiting & scanned within 42 days	97% elective patients waiting & scanned within 42 days	>95% elective patients waiting & scanned within 42 days	90%[4]
Angiography (Catheter Lab)[2]	Availability	>98%	>98%	>98%	>98%	>98%	98%
	Utilisation		79%	-	80%	-	82%
All non-fixed assets	Current Warrant of Fitness/ Certificate of Compliance	95%	90%	95%	87%[1] (average) 85.5% (at 30 June)	95%	88%[1] (average) 90.2% (at 30 June)

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

The National Clinical Engineering Manager Forum (NCEMF advisory Group) has been working to develop and refine a model to meet the expectations as set out in paragraphs 61 and 62 of the Cabinet Office Circular CO 15(5) by using a criticality framework (to determine the criticality of the DHB's medical assets) and a Performance Measure framework (to measure medical assets' performance).

The NECMF are developing Asset Performance Measurement Implementation Guidance Notes that will guide the use of the above frameworks. Once the frameworks and guidance have been agreed and approved, CMDHB will implement the frameworks in our database to ensure compliance with the required data elements.

3. ICT Assets

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

ICT Assets – Availability

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

The table below summarises actual for 2015/16 – 2017/18 versus target for 2017/18:

Asset type	Service Level Agreement Target	2015/16 Actual (Regional)	2016/17 Actual (Regional)	2017/18 Target (CM Health)	2017/18 Actual (CM Health)
Tier 1 Information systems (Critical)	• No more than 10 Tier 1 systems per annum less than 99.8% available • Average availability per annum >99.8% • Target outage recovery 4 hours	99.97%	99.99%1	99.995% (max 8 unplanned outages and 0 exceeding 90 min restoration time)	99.987%
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	99.98%	99.99%1	99.995% (max 3 unplanned outages and 0 exceeding 120 min restoration time)	99.985%

ICT Assets – Condition

Asset type	Service Level Agreement Target	2017/18 Target (CM Health)	2017/18 Actual (CM Health)
ICT assets with condition rating of poor	All ICT fleet assets are replaced on a 5 yearly rolling cycle	6% (of fleet replaced)	6.8% (of fleet replaced)

ICT functionality– Access to network and systems remotely

Indicator type	Service Level Agreement Target	2017/18 Target (CM Health)	2017/18 Actual (CM Health)
Access to network and systems remotely	Remote access available to any staff who require it	65%	70.9%

ICT Utilisation – Services completed in the digital environment

Indicator type	Programme Target	2017/18 Target (CM Health)	2017/18 Actual (CM Health)
Services completed in the digital environment	eRadiology orders uptake	80%	84%
	eLaboratory orders uptake	N/A	N/A
	Ward coverage of eVitals	30 wards	24 wards
	Ward coverage of MedChart	2 wards	5 wards

ICT Utilisation – Front line staff utilising mobile technology with clients

Indicator type	Programme Target	2017/18 Target (CM Health)	2017/18 Actual (CM Health)
Frontline staff utilising mobile technology with clients	Availability of mobile devices across the DHB	50%	54%

Good Employer

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

- Provide strong governance, leadership and management development programmes, structures which encourage accountability, and be at the lead of innovation which implements best practice clinical approaches
- Have a work force which reflects the community we serve. We employ over 125 different ethnic groups
- 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 have a healthy workforce in same way that we aspire to have healthy communities
- Have an Equal Opportunities programme
- Impartially select suitably qualified persons for employment with a focus in on increasing the number of Maaori and Pacific peoples working for CMDHB
- Provide opportunities for the enhancement of the abilities of individual employees though our innovation service, Ko Awatea and our people and capability development programmes

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

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

The Seven Key Elements

There are seven key elements to CMDHB being a good employer.

1. Leadership, accountability and culture

Organisational culture and values

CM Health's Healthy Together strategy has the strategic goal of achieving health equity. Underpinning the way we work together are our Shared Values and Shared Values Pledge which define the behaviours we are committed to when working together with our population.

Our values are integral to CMDHB and underpin the work we do. We have also been integrating these values into our processes such as our interviews, to ensure new employees understand and share our values. They form a core part of our Welcome Day, letting people know what they can expect of their time working with us.

In 2018 CM Health launched its "Speak Up" campaign. This is encouraging staff to raise issues when they see them, promoting a culture of accountability for all staff and empowering them to feel comfortable questioning behaviours or practices that do not belong at CM Health. This covers a range of issues such as inappropriate behaviour, unsafe work practices, bullying and employee wellness.

A number of resources have been developed for staff and managers to support them in how to raise, and deal with, issues that arise. The overall aim of this programme is to promote a safe, healthy and supportive environment for all CM Health employees.

Leading Quality Care Programme

In addition, the Leading Quality Care Programme is designed for those staff who are looking to develop their leadership capability to empower and enable others to improve both patient outcomes and patient whaanau and staff experiences.

2. Recruitment, selection and induction

CMDHB is committed to attracting and employing a workforce that reflects our community. People are attracted to work at CM Health as the heart of our organisation is he tangata, he tangata, he tangata. It is the people, it is the people, it is the people.

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

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

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

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

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

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

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

Youth Pledge – CM Health is signed up to the Auckland Youth Pledge as an Employer who will support young people into work and career pathways. This demonstrates CM Health's commitment to ensuring that we grow our own local

talent. The responsibility for this programme now sits within our Organisational Development team. This allows us to think about the whole employee lifecycle commitment to delivering on the youth pledge.

Career Shows at AUT and MIT– CM Health promotes health career options at AUT/MIT as part of our "Grow Our Own" strategy .

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

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

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

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

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

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

We also continue to work on attracting Maaori talent into our workforce. Over this past year, a further 184 Maaori have been employed at CM Health raising the number of Maaori employees from 346 employees (as at 31 March 2017) to 529 employees (as at 31 March 2018). This has lifted the overall percentage of Maaori employed at CM Health from 5.36% (as at 31 March 2017) to 7.92% (as at 31 March 2018).

CM Health is the second largest employer of Maaori nurses amongst the DHBs and the largest employer of Pacific nurses in New Zealand and possibly the world. We employ 2,730 nurses, 5.7% of whom are Maaori and 10.6 % of whom are Pacific. CM Health aims to increase these percentages further by 2025, to 14.1% for Maaori nurses and 21% for Pacific nurses. 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 Pacific applicants. 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

Part of CM Health's strategy is to establish a performance development culture. This can be viewed as one in which staff are encouraged to continuously learn and to convert that learning into action to bring about positive and sustained change.

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

- A continuous process requiring the engagement and active participation of all parties involved
- Aligned with the strategic requirements of CM Health, with a focus on excellence in all outcomes

- Learning needs and opportunities shall be planned and agreed based on the discussions and agreements reached during the performance development process.

Over the past year we have been working on simplifying our performance development system, moving from a 'tick box' exercise to a process which is based on quality conversations between managers and employees. The aim of this new process is to encourage staff and managers to think more widely about development, and facilitate meaningful discussions. We believe a refreshed Performance and Development system, underpinned by our organisational capabilities, guided by our strategic plan, and used consistently across the organisation will help us achieve our collective outcomes.

The new performance development process has recently been introduced, and the aim is for this to ultimately become the consistent approach across all workforces, although it is not yet compulsory for all staff to use the new system. The process is based on strengths based development – identifying and developing the strengths of employees and focusing on growth and contribution to CM Health success. We are optimistic that this new process will lead to improved employee engagement and satisfaction by supporting their personal and professional development, giving transparency to expectations and driving a clear shared purpose.

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
- Inter-professional post registration and PDRP team
- Inter-professional undergraduate and entry to practice team.

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

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

Allied Health

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

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

All disciplines

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

- Advance eLearning capacity and content which is accessible to all staff
- Education communities and forums including strong alliances with our joint venture partners and other organisations such as the University of Waikato
- Clinical staff involvement in improvement initiatives, campaigns, innovation and improvement intensives

- Several other short courses, talks and workshops including: system innovation and improvement, patient centred care workshops and master classes, service co-design with patients and whaanau.

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

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

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

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

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

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

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

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

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

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

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

Exit interviews

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

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

4. Flexibility and work design

Workplace flexibility

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

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

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

Flexible return to work for parents

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

Volunteers

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

5. Remuneration, recognition and conditions

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

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

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

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

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

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

6. Harassment and bullying prevention

Organisational Commitment

CMDHB is committed to providing a healthy and safe working environment and organisational culture based on our shared values. CMDHB has a zero-tolerance for all forms of harassment and bullying. We strive to ensure that the best practice policies, procedures and processes are in place for all employees to maintain proper standards of integrity and conduct at all times. CMDHB has a robust Bullying and Harassment policy and support for staff in the workplace.

Speak Up

Speak Up was launched in CM Health in 2018, and provides a structure and resources to enable employees to raise issues in the workplace. This includes inappropriate behaviours and bullying and harassment, but also includes a wider range of concerns such as unsafe clinical practice or unacceptable behaviour.

There have been a number of resources developed to support employees and managers understand how they can raise and deal with these issues. The aim of this campaign is to instil confidence in employees to raise issues when they see them, equip managers with the skills to be able to address issues when they are raised, and create 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 patients.

7. Safe and healthy environment

Safety at Work – Compliance

The Health and Safety team offer advice and support to all areas of CMDHB when it comes to managing the health and safety of our workers. Occupational Health provide services which include pre-employment screening, blood and body fluid exposure assessments, contact tracing surveillance, general wellness and vaccination clinics for staff at CMDHB. The Work Injury Management team includes a Case Manager who supports staff back to work safely. We also have a partnership with WellNZ who provide additional support in helping employees back into the workplace safely.

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

Health and Safety Representatives play an essential role in keeping staff and visitors safe, educating their workmates on related issues, and ensuring procedures and processes are followed correctly. We have over 30 staff trained as representatives. We work with this group to obtain staff feedback and improve our processes.

One of the roles of the Occupational Health and Safety Service (OHSS) is to provide baseline and ongoing environmental and personal health monitoring where it is required in relation to exposure to any work related health hazard. Health monitoring is appropriate for assessing if an exposure is a significant health hazard or for detecting changes in the individual's health that is known to be associated with exposure to a particular hazard.

CMDHB conducts baseline monitoring for the following work-related hazards:

- Hepatitis B
- methicillin-resistant staphylococcus aureus (MRSA)
- audiology

- tuberculosis
- asbestosis.

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

Employee Assistance Programme at work

CMDHB works to promote positive wellbeing in the workplace and understands the specific issues affecting people working in the health sector. The Employee Assistance Programme (EAP) is a contracted service provided by Occupational Health and Safety Services.

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

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

Wellness

CM Health recognises the importance of supporting employees' physical and mental health, and strives to support employees to stay well. Mindfulness courses are regularly run for any staff to participate in in Ko Awatea. The DHB will be focusing on Mental Health Awareness Week this year as an awareness raising opportunity to encourage staff to recognise the importance of looking after their mental health.

In 2017 CM Health ran Mental Health First Aid courses for staff. Mental health first aid is the help given by lay people to someone developing a mental health issue, such as depression, anxiety, or substance misuse or who is in a mental health crisis, like panic attacks, self-injury, aggressive behaviour. Mental health first aid is given until appropriate professional treatment is received or until the crisis resolves.

Complaints and appeals

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

Policies, procedures and guidelines

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

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

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

Counties Manukau District Health Board Workforce

Caveats- *– Data is as of 30th June 2018 and all the terminated staff and staff on long-term leave have been excluded from the dataset. Ethnicities disclosed by the staff have been aligned with the NZ Census Level 1 Ethnic Groups.*

What our workforce looked like by age, gender and ethnicity

Of the total workforce in 2017/18, women comprised 79% (5,552) and men 21% (1,453). The average age for women was 42 years and 42 years for men. The younger workforce less than 40 years of age represented almost 46% of the total workforce. Our employee data also highlights an ethnically diverse workforce.[121]

Age brackets	Percentage of all employees
Under 20	0.10%
20 - 29	19.60%
30 - 39	26.34%
40 - 49	21.46%
50 - 59	20.61%
60 - 59	10.39%
70+	0.70%
DOB Not Specified	0.80%

Gender	Headcount	Headcount in %	Average Age
Female	5,552	79%	42
Male	1,453	21%	42
Grand Total	**7,005**	**100%**	**42**

Ethnicity	FTE	FTE in %	Headcount	Headcount in %
Asian	2,082.86	34.31%	2,330	33.26%
European	2,479.65	40.84%	2,966	42.34%
Maori	319.96	5.27%	362	5.17%
Pacific	731.99	12.06%	822	11.73%
Middle Eastern/Latin American/African	108.18	1.78%	118	1.68%
Not Disclosed/Other	233.18	3.84%	276	3.94%
Other Ethnicity	115.39	1.90%	131	1.87%
Grand Total	**6,071.21**	**100.00%**	**7,005**	**100.00%**

What our workforce looked like by employee group

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

	FEMALE		MALE	
Occupational Groups	Headcount	Average of Salary	Headcount	Average of Salary
Administration & Management	972	$67,388	140	$97,090
Allied Health	899	$66,116	203	$64,324
Medical	455	$177,809	505	$208,015
Non-clinical Support	258	$42,005	184	$46,264
Nursing/Midwifery/HCA	2828	$65,916	387	$63,964
Technical & Scientific	140	$62,389	34	$62,914
Grand Total	**5552**	**$74,176**	**1453**	**$115,006**

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

Financial Statements for the year ended 30 June 2018

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 2018.

Signed on behalf of the Board:

Vui Mark Gosche

CMDHB Board Chair

Pat Snedden

Chair Audit Risk & Finance Committee

Fepulea'i Margie Apa

Chief Executive Officer

Margaret White

Chief Financial Officer

31 October 2018

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Revenue				
Patient Care Revenue	2	1,644,023	1,605,925	1,558,737
Interest Revenue		2,207	2,600	2,076
Other Revenue	3	28,572	23,026	17,286
Total Income		**1,674,802**	**1,631,551**	**1,578,099**
Expenditure				
Personnel costs	4	627,451	621,254	592,391
Depreciation and amortisation expense	13/14	32,907	31,932	31,367
Outsourced services		90,856	79,718	87,864
Clinical supplies		115,444	117,473	110,592
Infrastructure and non-clinical expenses		63,258	56,594	57,835
Other District Health Boards		249,318	238,990	236,166
Non-health board provider expenses		461,481	451,205	431,871
Capital Charge	5	37,421	35,928	18,200
Interest expense		7	322	7,860
Other expenses	6	16,462	18,148	16,893
Total expenditure		**1,694,605**	**1,651,564**	**1,591,039**
Deficit		**(19,803)**	**(20,013)**	**(12,940)**
Other comprehensive income				
Revaluation of Land	13/19	-	-	69,633
Revaluation of Buildings	13/19	7,842	-	(5,210)
Total Other comprehensive income (expense)		**7,842**	-	**64,423**
Total comprehensive income (expense) for the year		**(11,961)**	**(20,013)**	**51,483**

Statement of Changes in Equity

For the year ended 30 June 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Balance 1 July		**629,075**	**629,075**	**285,486**
Comprehensive income (expense)				
Deficit for the year		(19,803)	(20,013)	(12,940)
Total Comprehensive income (expense)		7,842	-	64,423
Total comprehensive income		**(11,961)**	**(20,013)**	**51,483**
Capital contributions from the Crown		7,846	24,500	292,500
Repayment of capital to the Crown		(419)	(419)	(419)
Movement in restricted funds		1,912	12	25
Balance at 30 June	19	**626,453**	**633,155**	**629,075**

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 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Assets				
Current Assets				
Cash and cash equivalents	7	34,102	944	21,785
Debtors and other receivables	8	56,449	51,132	46,989
Inventories	10	8,527	7,484	7,484
Prepayments		637	2,307	2,307
Non-Current Assets held for Sale	11	5,320	5,320	33,743
Total current assets		**105,035**	**67,187**	**112,308**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	39,961	43,692	36,055
Property, plant and equipment	13	731,149	756,051	713,631
Intangible assets	14	18,005	23,924	13,023
Other Non-Current Assets	9	1,824	1,726	1,626
Total Non-Current assets		**790,939**	**825,393**	**764,335**
Total assets		**895,974**	**892,580**	**876,643**
Liabilities				
Current liabilities				
Creditors and other payables	15	123,398	114,234	112,743
Borrowings and overdraft	16	-	6,523	-
Employee entitlements	17	122,020	117,718	115,177
Total current liabilities		**245,418**	**238,475**	**227,920**
Non-current liabilities				
Employee entitlements	17	22,948	20,017	18,717
Provisions	18	1,155	931	931
Total non-current liabilities		**24,103**	**20,948**	**19,648**
Total liabilities		**269,521**	**259,423**	**247,568**
Net assets		**626,453**	**633,157**	**629,075**
Equity				
Crown equity	19	407,215	423,869	399,788
Accumulated deficits	19	(74,966)	(75,174)	(55,163)
Revaluation reserves	19	291,394	283,552	283,552
Other reserves		-	12	-
Trust funds	19	2,810	898	898
Total Equity		**626,453**	**633,157**	**629,075**

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 2018

	Notes	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Cash flows from operating activities				
Receipts from patient care:				
MoH		1,487,363	1,457,801	1,428,809
Other		176,037	162,843	154,055
Interest received		2,207	2,604	2,076
Payments to suppliers		(987,700)	(957,530)	(935,076)
Payments to employees		(616,704)	(617,407)	(591,931)
Capital charge		(37,096)	(35,928)	(18,200)
Interest payments		(12)	-	(9,518)
Goods and services tax (net)		2,046	637	(1,114)
Net cash flow from operating activities		**26,141**	**13,020**	**29,101**
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		28,423	28,423	9,987
Purchase of property, plant, equipment and intangible assets		(48,152)	(82,707)	(45,455)
Acquisition/roll over of investments		(1,522)	(10,181)	(4,130)
Net cash flow from investing activities		**(21,251)**	**(64,465)**	**(39,598)**
Cash flows from financing activities				
Repayment of capital to the Crown		(419)	(419)	(419)
Proceeds from equity injection		7,846	24,500	-
Net Appropriation to/from Trust Funds		-	-	25
Net cash flow from financing activities		**7,427**	**24,081**	**(394)**
Net increase/(decrease) in cash and cash equivalents		**12,317**	**(27,364)**	**(10,891)**
Cash and cash equivalents at the start of the year	7	**21,785**	**21,785**	**32,676**
Cash and cash equivalents at the end of the year	7	**34,102**	**(5,579)**	**21,785**

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

The accompanying notes form part of these financial statements.

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

	Actual 2018 $000	Actual 2017 $000
Net surplus/(deficit)	**(19,803)**	**(12,940)**
Add/(less) non-cash items		
Movement in Restricted Funds	1,912	-
Impairment of Intangibles	488	6,144
Depreciation and amortisation expense	32,907	31,367
Total non-cash items	**35,307**	**37,511**
Add/(less) movements in working capital items		
Debtors and other receivables	(9,460)	1,041
Inventories	(1,043)	(6,016)
Creditors and other payables	10,190	3,006
Income in advance	(265)	4,247
Employee entitlements	11,074	460
Net movements in working capital items	**10,496**	**2,738**
Add/(less) items classified as investing or financing activities	141	1,792
Net cash flow from operating activities	**26,141**	**29,101**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Statement of Accounting Policies

Reporting Entity

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

The financial statements of CMDHB as at and for the year ended 30 June 2018 comprise CMDHB and its interest in associates and jointly controlled entities.

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

CMDHB is a public benefit entity for financial reporting purposes.

The financial statements for CMDHB are for the year ended 30 June 2018, and were approved by the Board on 31 October 2018.

Basis of Preparation

Statement of compliance

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

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

Going concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2017/18 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Annual Plan). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort dated 2 October 2018 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Operating and cash flow forecasts

Operating and cash flow forecasts show that there will be a significant operating cash flow deficit for the 18/19 year. The DHB's forecasts indicate it will be reliant on accessing its overdraft facility with NZHPL to meet this operating cash flow deficit and to meet the investing cash flow requirements of the DHB for the 2018/19 financial year.

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies since the date of 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:

PBE IFRS 9 Financial Instruments

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

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

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

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

The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial position.

PBE IPSAS 34 – 38 Interests in other entities

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

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

Significant Accounting Policies

Investments in Associates and Joint Ventures

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

Revenue

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

Ministry of Health revenue

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

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

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied.

ACC Contract revenues

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

Rental income

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

Borrowing costs are capitalised on qualifying assets in accordance with CMDHB's policy. All other borrowing costs are treated as an expense in the financial year in which they are incurred.

Leases

Finance leases

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

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

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

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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 - 20 years	5% - 100%
Information Technology	1 - 8 years	12.5% - 100%
Vehicles	1 – 12.5 years	8% - 100%
Other Equipment	1 - 18 years	5.5% - 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.

National Oracle Solution (NOS) (previously part of the Finance, Procurement and Supply Chain programme)

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

Amortisation

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

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

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

Impairment of Property, Plant and Equipment and Intangible Assets

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

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Provisions

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

Provisions are not recognised for future operating losses.

Restructuring

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

ACC Partnership Programme

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

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

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

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

Critical accounting estimates and assumptions

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

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

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

Land and buildings revaluations

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

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

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

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

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

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

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

Retirement and long service leave

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

Critical judgements in applying accounting policies

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

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of leases, and has recognised no leases as finance leases.

Agency relationship

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

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

Comparative Figures

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

2. Patient care revenue

	Actual 2018 $000	Actual 2017 $000
Health and disability services (MoH contracted revenue)	1,487,568	1,423,714
ACC contract revenue	36,570	25,141
Revenue from other district health boards	93,295	85,024
Other patient care related revenue	26,590	24,858
Total patient care revenue	**1,644,023**	**1,558,737**

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 $15.9m (2017: $17.6m).

3. Other revenue

	Actual 2018 $000	Actual 2017 $000
Donations and bequests received	1,439	1,498
Other revenue	25,164	13,411
Rental revenue	1,969	1,853
Gain on Disposal of Assets	-	524
Total other income	**28,572**	**17,286**

4. Personnel costs

	Actual 2018 $000	Actual 2017 $000
Salaries and wages	597,245	575,395
Contributions to defined contribution schemes	19,132	17,844
Increase/(Decrease) in liability for employee entitlements	11,074	(848)
Total personnel costs	**627,451**	**592,391**

5. Capital Charge

The DHB pays a half-yearly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the months of June and December. The capital charge rate levied during the year was 6% at 30 June 2018 (2017: 7% at 31 December 2016, and 6% at 30 June 2017).

6. Other expenses

Other expenses include:	Actual 2018 $000	Actual 2017 $000
Audit fees – audit of financial statements – current year	219	212
Other audit fees and prior year under-provision	46	-
Operating leases expense	10,837	9,547
Impairment of debtors	4,821	6,761
Board and committee members fees and expenses	398	373
Loss on Disposal of Property, Plant & Equipment	141	-
Total other expenses	**16,462**	**16,893**

Non-cancellable operating lease commitments

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

	Actual 2018 $000	Actual 2017 $000
Not later than one year	6,949	5,363
Later than one year and not later than five years	8,661	12,586
Later than five years	1,427	1,593
Total Non-cancellable operating leases	**17,037**	**19,542**

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

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

7. Cash and cash equivalents

	Actual 2018 $000	Actual 2017 $000
Cash at bank and on hand	84	34
NZ Health Partnerships Limited	31,208	20,853
Trust / Special purpose Funds	2,810	898
Cash and cash equivalents for the purposes of the statement of cash flows	**34,102**	**21,785**

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

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

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and investments (refer to Note 8) are unspent funds with restrictions that relate to the delivery of health services by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in Note 19.

8. Debtors and other receivables

	Actual 2018 $000	Actual 2017 $000
Ministry of Health receivables	3,866	3,332
Other receivables	15,432	15,542
Other accrued revenue	40,535	32,338
Less: provision for impairment	(3,384)	(4,223)
Total Debtors and other receivables	**56,449**	**46,989**

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.

	2018			2017		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	46,913	(2)	46,911	40,709	-	40,709
Past due 1-30 days	3,018	(589)	2,429	2,265	-	2,265
Past due 31-60 days	1,408	(421)	987	1,192	(526)	666
Past due 61-90 days	1,627	(447)	1,180	972	(590)	382
Past due > 90 days	6,867	(1,925)	4,942	6,074	(3,107)	2,967
Total	**59,833**	**(3,384)**	**56,449**	**51,212**	**(4,223)**	**46,989**

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.

9. Other non-current assets

	Actual 2018 $000	Actual 2017 $000
Reversionary interest in car park building	1,824	1,626
Total Other non-current assets	**1,824**	**1,626**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to us in 12 years time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 6.0% was used (2017: 6.5%).

10. Inventories

	Actual 2018 $000	Actual 2017 $000
Pharmaceuticals	893	863
Other Supplies net of provision for obsolete stock	7,634	6,621
Total inventories	**8,527**	**7,484**

No inventories are pledged as security for liabilities (2017 $0), however, some inventories are subject to retention of title clauses. Historically, the majority of supplies were expensed when purchased with only ward stock held on the balance sheet. The DHB has now reassessed this practice and expense inventory items when they are consumed.

The amount of inventories recognised as an expense during the year was $115.1m (2017: $105.6m) 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 2018 $000	Actual 2017 $000
Land	5,320	33,743
Total Non-current Assets held for Sale	**5,320**	**33,743**

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

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2018	Interest held at 30 June 2017	Balance date
Northern Regional Alliance Ltd	Provision of health support services	Associate	33.3%	33.3%	30 June
healthAlliance N.Z. Ltd	Provision of shared services	JV	25.0%	25.0%	30 June
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	JV	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

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

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. Class B shares do not have voting rights, nor any rights to dividends.

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

Year end 30 June 2018 $000 (unaudited)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	12,660	11,224	1,436	14,289	(107)
healthAlliance N.Z. Ltd	193,793	33,135	160,660	136,513	(491)
NZ Health Innovation Hub Limited Partnership	573	47	526	56	(191)
NZ Health Partnerships Limited	370,091	312,401	57,690	37,439	(4,122)
Year end 30 June 2017 $000	**Assets**	**Liabilities**	**Equity**	**Revenues**	**Profit/ (loss)**
Northern Regional Alliance Ltd	10,322	8,767	1,555	14,469	40
healthAlliance N.Z. Ltd	172,978	27,394	145,584	135,152	1,334
NZ Health Innovation Hub Limited Partnership	755	(2)	757	-	(303)
NZ Health Partnerships Limited	344,520	282,254	62,266	59,140	1,447

Share of profit of Associate entities and Jointly Controlled Entities

	Actual 2018 $000	Actual 2017 $000
Share of profit/(loss)	**(123)**	**343**

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 2018 $000	Actual 2017 $000
healthAlliance N.Z. Ltd	**39,961**	**36,055**

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

13. Property, plant and equipment

	Land	Buildings, Plant & Infrastructure	Clinical Equipment, IT & Motor Vehicles	Other Equipment	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance at 1 July 2016	**176,530**	**447,989**	**165,973**	**20,501**	**18,309**	**829,302**
Additions	-	-	-	-	40,886	40,886
WIP capitalised	-	20,758	7,910	30	(28,698)	-
Depreciation Written Back on Revaluation	-	(21,284)	-	-	-	(21,284)
Revaluation increase/(decrease)	69,633	(5,210)	-	-	-	64,423
Transferred to Assets held for Resale	(33,743)	-	-	-	-	(33,743)
Disposals/transfers	-	-	(14,445)	(237)	-	(14,682)
Balance at 30 June 2017	**212,420**	**442,253**	**159,438**	**20,294**	**30,497**	**864,902**
Balance at 1 July 2017	**212,420**	**442,253**	**159,438**	**20,294**	**30,497**	**864,902**
Additions	**-**	**-**	**-**	**-**	48,130	48,130
WIP capitalised	-	2,085	15,937	2,217	(20,239)	-
Revaluation increase/(decrease)	-	-	-	-	7,842	7,842
Disposals/transfers	-	-	(3,186)	(73)	(5,613)	(8,872)
Balance at 30 June 2018	**212,420**	**444,338**	**172,189**	**22,438**	**60,617**	**912,002**
Accumulated depreciation and impairment losses						
Balance at 1 July 2016	**-**	**-**	**126,843**	**17,368**	**-**	**144,211**
Depreciation expense	-	21,388	8,997	862	-	31,247
Misstatement 2017	-	1,793	-	-	-	1,793
Elimination on disposal/transfer		-	(4,590)	(106)	-	(4,696)
Elimination on revaluation	-	(21,284)	-	-	-	(21,284)
Balance at 30 June 2017	**-**	**1,897**	**131,250**	**18,124**	**-**	**151,271**
Balance at 1 July 2017	**-**	**1,897**	**131,250**	**18,124**	**-**	**151,271**
Depreciation expense		23,666	8,541	605	-	32,812
Elimination on disposal/transfer	-	-	(3,155)	(75)	-	(3,230)
Balance at 30 June 2018	**-**	**25,563**	**136,636**	**18,654**	**-**	**180,853**
Carrying amounts						
At 1 July 2016	**176,530**	**447,989**	**39,130**	**3,133**	**18,309**	**685,091**
At 30 June and 1 July 2017	**212,420**	**440,356**	**28,188**	**2,170**	**30,497**	**713,631**
At 30 June 2018	**212,420**	**418,775**	**35,553**	**3,784**	**60,617**	**731,149**

Capital Commitments

	Actual 2018 $000	Actual 2017 $000
Property , plant and equipment	41,831	51,825
Total Capital commitments	**41,831**	**51,825**

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 2017. The total land valuation amounted to $212.42m, resulting in a 2016/17 upwards revaluation adjustment of $69.6m.

Buildings

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

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

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

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

As part of the DHB's internal review process, the DHB is currently conducting a multi-year review of the condition of the major buildings in its portfolio, including assessments around seismic strengthening, asbestos, critical building services infrastructure and cladding remediation. In 2017/18, the DHB commissioned two major infrastructure assessments. Completed in April 2018 was a detailed seismic assessment and independent peer review of the Middlemore Galbraith building that confirmed this as an earthquake prone building. The CMDHB Board is working through related remediation or replacement investment decisions in 2018/19. The second assessment related to asset assessment of the Middlemore, Manukau and Pukekohe site infrastructure is scheduled for completion in 2018/19. Risk prioritisation and remediation strategies will be 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 2017 based on an independent valuation conducted as at 11 August 2017.

Based on information obtained to date, an estimate of the movement in the net book value of land, buildings and infrastructure assets has concluded that as at 30 June 2018 there has been no material net movement in the carrying amount of land, buildings and infrastructure assets, and therefore independent revaluation is not required.

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 2017. The total building valuation amounted to $440.01m, resulting in a 2016/17 downwards revaluation adjustment of $5.21m. During 2017/18 an adjustment to the 30 June 2017 Building valuation was required in the General Ledger to reconcile to the 2017 valuation figures. This resulted in an increase in the Building Revaluation Reserve of $7.842m in the 2017/18 year.

Restrictions on title

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

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

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

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

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

14. Intangible assets

Movements for each class of intangible assets are as follows:

	NOS Rights $000	Software $000	Work in Progress $000	Total $000
Balance at 30 June 2016/1 July 2016	**5,779**	**561**	**6,983**	**13,323**
Additions	-	-	6,280	6,280
Impairment	-	-	(6,144)	(6,144)
Balance at 30 June 2017/1 July 2017	**5,779**	**561**	**7,119**	**13,459**
Additions	746	-	6,274	7,020
Work in Progress Capitalised	-	132	(132)	-
Impairment	(488)	-	-	(488)
Transfers / Disposals			(1,454)	(1,454)
Balance at 30 June 2018	**6,037**	**693**	**11,807**	**18,537**
Accumulated amortisation and impairment losses				
Balance at 1 July 2016	**-**	**316**	**-**	**316**
Amortisation expense	-	120	-	120
Balance at 30 June 2017/1 July 2017	**-**	**436**	**-**	**436**

	NOS Rights $000	Software $000	Work in Progress $000	Total $000
Amortisation expense	-	95	-	95
Balance at 30 June 2018	**-**	**531**	**-**	**531**
Carrying amounts				
At 1 July 2016	5,779	245	6,983	13,007
At 30 June and 1 July 2017	**5,779**	**125**	**7,119**	**13,023**
At 30 June 2018	**6,037**	**162**	**11,807**	**18,005**

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

National Oracle Solution (NOS) (previously part of the Finance, Procurement and Supply Chain programme)

The NOS rights have been tested for impairment at 30 June 2018, by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to CMDHB's share of the DRC of the underlying NOS assets. On 28 February 2018 the Director-General of Health wrote to NZ Health Partnerships and DHB Chairs about Cabinet's decisions on the next steps for the NOS programme. Specifically the letter spelt out three expectations: deploy the system to Wave 1 DHBs in July 2018 and pause the remainder of the programme; provide a plan for business case development and develop a new NOS programme business case. As a result of Cabinet's decision to pause the program an impairment assessment was performed by NZHPL on the NOS asset. There has been a change to the target operating model which has meant that the costs incurred on Change Management should be fully impaired and Supply Chain should be partially impaired for those costs which related to these developments. Accordingly CMDHB has booked a $488k impairment to the FPSC asset for the year ended 30 June 2018 relating to pre-2015 spend and as a result of the change to the target operating model.

There is also a level of risk and ambiguity regarding continuation of the National Technical Solution of NOS. The eventual outcome will be influenced by the outcome of the revised business case and any subsequent contract negotiations to mitigate any penalties. For prudence, the worst case outcome has been estimated by NZHPL and CMDHB has noted its share of these costs as a contingent liability in the financial statements as at 30 June 2018.

15. Creditors and other payables

	Actual 2018 $000	Actual 2017 $000
Payables under exchange transactions		
Creditors and accrued expenses	108,794	100,774
Income in advance	6,429	6,164
Total payables under exchange transactions	**115,223**	**106,938**
Payables under non-exchange transactions		
GST payable	8,175	6,130
Capital charge payable	-	(325)
Total payables under non-exchange transactions	**8,175**	**5,805**
Total creditors and other payables	**123,398**	**112,743**

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 2018 $000	Actual 2017 $000
Borrowing facility limits		
Crown loan facility limit	-	-
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 Ltd (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 (2017: $75.0m).

17. Employee entitlements

	Actual 2018 $000	Actual 2017 $000
Current portion		
Accrued salaries and wages	40,440	38,927
Annual leave	60,638	57,014
Sick leave	470	410
Long service leave	461	1,193
Retirement gratuities	2,529	2,338
Sabbatical leave	845	1,123
Continuing medical education	16,637	14,172
Total current portion	**122,020**	**115,177**
Non-current portion		
Long service leave	9,044	6,963
Retirement gratuities	12,004	9,814
Sick leave	1,900	1,940
Total non-current portion	**22,948**	**18,717**
Total employee entitlements	**144,968**	**133,894**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 1.78% - 4.75% (2017: 1.97% - 4.75%) and an inflation factor of 3.0% (2017: 1.5%) were used.

Compliance with Holidays Act 2003

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements. For employers such as the DHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

In the meantime, a number of DHBs have made preliminary assessments of their liability.

CMDHB has estimated its liability as at 30 June 2018 to be $5m (2017:$0)

This provision is largely consistent with estimates made by other regional DHBs operating on the same payroll system, and is based on the best information available to the DHB at balance date but, due to the uncertainties involved, the actual liability is likely to be different.

18. Provisions

	Actual 2018 $000	Actual 2017 $000
Non-current portion		
ACC Partnership Programme	1,155	931
Total provisions	**1,155**	**931**

Movements for each class of provision are as follows:

	ACC Partnership Programme 2018 $000	ACC Partnership Programme 2017 $000
Balance at 1 July	931	931
Actuarial valuation movement	224	-
Balance at 30 June	**1,155**	**931**

19. Equity

	Actual 2018 $000	Actual 2017 $000
Crown equity		
Balance at 1 July	399,788	107,707
Conversion of Crown Loans to equity	-	292,500
Equity injection	7,846	-
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**407,215**	**399,788**

In February 2017 all Crown Debt was converted to equity by way of an equity injection. As per the termination agreements the investment equity amount is equal to the amount of the Crown debt therefore there is no gain or loss on conversion.

Accumulated surpluses/(deficits)		
Balance at 1 July	(55,163)	(42,223)
Deficit for the year	(19,803)	(12,940)
Balance at 30 June	**(74,966)**	**(55,163)**
Revaluation reserves		

	Actual 2018 $000	Actual 2017 $000
Balance at 1 July	283,552	219,129
Revaluations	7,842	64,423
Balance at 30 June	**291,394**	**283,552**
Revaluation reserves consist of:		
Land	242,558	242,558
Buildings and Infrastructure	48,836	40,994
Total revaluation reserves	**291,394**	**283,552**
Trust/Special funds		
Balance at beginning of year	898	873
Funds expended	(23)	(2)
Funds received	1,978	-
Interest received on Restricted Funds	12	27
Other transfers/movements	(55)	-
Balance at end of year	**2,810**	**898**

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	**626,453**	**629,075**

Included in accumulated surpluses/deficits are $34.4m (2017: $54.6m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established. $33.4m of the Mental Health ring fenced funding was spent in 2016/17 and 2017/18 years for partial funding of the new Mental Health facility on the Middlemore site.

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 2017/18 financial year.

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

20. Contingencies

Asbestos

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

Superannuation schemes

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

As at 31 March 2018, the DBP Scheme had a past service surplus of $8.0m (6.2% of the liabilities) (2017: $8.0m (6.2% of the liabilities)) - this amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS25.

The Actuary to the Scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended employer contributions remain suspended.

Legal Matters

There are a number of matters of a legal nature to which the DHB may have an exposure. The amounts involved (2018: $621k (2017: $40k)) are not considered to be material and if required to be settled, would be expensed in the year of settlement.

Contingent assets

The DHB had contingent assets of $0m (2017: $3.0m) in relation to a contractual dispute on a building.

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 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 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 and undertaken on the normal terms and conditions for such transactions.

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $1,644m (2017 $1,559m) to provide health services in the Counties Manukau area for the year ended 30 June 2018 (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 2018 totalled $7.56m (2017: $8.4m). These purchases included the purchase of air travel from Air New Zealand, postal services from New Zealand Post, and blood products from NZ Blood Service.

Transactions with key management personnel

Key management personnel compensation

	Actual 2018 FTE	Actual 2017 FTE	Actual 2018 $000	Actual 2017 $000
Executive management team	9	10	3,260	3,943
Total key management personnel compensation	**9**	**10**	**3,260**	**3,943**

In addition to the above, the total actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $98.5k (2017: $89.5k).

Key management personnel includes the Chief Executive, and eight (2017: nine) members of the management team.

Board and Committee Members compensation

	Actual 2018 FTE	Actual 2017 FTE	Actual 2018 $000	Actual 2017 $000
Board	11	11	341	353
Committee	1	6	1	6
Total board and committee members compensation	**12**	**17**	**342**	**359**

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

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

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

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. While CMDHB has been the major beneficiary of the Trust, it must meet all normal Charitable Trust requirements in terms of applications for funding. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $5.46m (2017: $6.2m) and a (deficit)/surplus of $(0.7)m (2017: $0.6m) which may be subject to restrictions on distribution as at 30 June 2018. The financial statements of the Foundation for 2018 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 2018 $	Actual 2017 $
Vui Mark Gosche [1]	8,750	-
Mrs Catherine Abel-Pattinson	28,750	16,375
Mr Reece Autagavaia	27,000	27,500
Mrs Katrina Bungard	25,375	15,125
Dr Ashraf Choudary	28,750	16,125
Mrs Dianne Glenn	29,750	30,000
Mrs Colleen Brown	28,563	29,000
Dr Lyn Murphy	29,375	29,438
Mr George Ngatai	28,500	28,250
Dr Lester Levy [5] (Chair)	44,250	44,250
Mr Rabin Rabindran [4] (Deputy Chair)	37,563	20,594
Mr Mark Darrow [4]	24,938	14,875
Dr. Lee Mathias [2]	-	29,500
Ms Wendy Lai [2]	-	313
Mrs Sandra Alofivae [2]	-	22,704
Mr Arthur Anae [3]	-	2,625
Mr David Collings [2]	-	13,625
Mrs Kathryn Maxwell [2]	-	12,625
Total board member remuneration	**341,564**	**352,924**

1 Appointed 3 May 2018
2 Resigned 5 December 2016
3 Resigned 19 July 2016
4 Resigned 2 May 2018
5 Resigned 24 January 2018

Committee Members, not Board Members or Employees	Award 2018 $	Award 2017 $
Mr John Wong	1,042	1,500
Ms Wendy Bremner	-	1,250
Mr Sefita Hao'uli	-	1,042
Mr Nicholas Main	-	417
Ms Tangihaere MacFarlane	-	208
Mr Ezekiel Robson	-	1,250
Total	**1,042**	**5,667**

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 (2017: $nil).

23. Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:	Actual 2018	Actual 2017
Total remuneration paid or payable:		
$100,000 – 109,999	185	170
$110,000 – 119,999	148	127
$120,000 – 129,999	90	86
$130,000 – 139,999	52	54
$140,000 – 149,999	44	45
$150,000 – 159,999	43	33
$160,000 – 169,999	14	24
$170,000 – 179,999	13	25
$180,000 – 189,999	26	22
$190,000 – 199,999	24	20
$200,000 – 209,999	14	13
$210,000 – 219,999	28	26
$220,000 – 229,999	26	22
$230,000 – 239,999	30	28
$240,000 – 249,999	29	31
$250,000 – 259,999	35	23
$260,000 – 269,999	24	24
$270,000 – 279,999	17	31
$280,000 – 289,999	28	23
$290,000 – 299,999	19	18
$300,000 – 309,999	22	16
$310,000 – 319,999	14	7
$320,000 – 329,999	11	11
$330,000 – 339,999	2	7
$340,000 – 349,999	7	11
$350,000 – 359,999	7	7
$360,000 – 369,999	8	6
$370,000 – 379,999	3	4
$380,000 – 389,999	4	4
$390,000 – 399,999	-	5

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 2018	Actual 2017
$400,000 – 409,999	3	-
$410,000 – 419,999	-	2
$420,000 – 429,999	4	7
$430,000 – 439,999	2	2
$440,000 – 449,999	3	4
$450,000 – 459,999	1	1
$460,000 – 469,999	2	3
$470,000 – 479,999	-	3
$480,000 – 489,999	-	1
$490,000 – 499,999	1	-
$500,000 – 509,999	-	2
$530,000 – 539,999	1	-
$560,000 – 569,999	-	1
$580,000 – 589,999	-	1
$680,000 – 689,999	1	-
Grand total	**985**	**950**

During the Year Ended 30 June 2018, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 828 (2017: 758) are Medical Staff and 157 (2017: 192) are Management.

During the year ended 30 June 2018, 15 (2017:30) employees received compensation and other benefits in relation to cessation totalling $253,015 (2017: $687,294).

24. Events after the balance date

On 1 August 2018 Ebert Construction, the construction firm engaged in building the new Acute Mental Health Unit on the Middlemore campus, was placed in receivership. As a result the construction site was locked down under the control of the receivers. Construction of stage one is already very well-advanced and we were anticipating that it would be complete at the end of August 2018. We are working urgently to clarify and address the risks associated with the receivership. This will include taking steps to ensure that we can engage directly with subcontractors and others to enable resumption of work and to minimise delays to completion of stage one and its opening for clinical use. We will also be looking at our options for the subsequent construction of the second, final stage of the unit.

25. Financial instruments

Financial instrument categories

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

	Actual 2018 $000	Actual 2017 $000
Loans and receivables		
Cash and cash equivalents	34,102	21,785
Debtors and other receivables	56,449	46,989
Total loans and receivables	**90,551**	**68,774**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	108,794	100,774
Total financial liabilities measured at amortised cost	**108,794**	**100,774**

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 2018, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have minimal impact. (2017: $Nil).

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

Credit quality of financial assets

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

	Actual 2018 $000	Actual 2017 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	2,894	932
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	31,208	20,853
- NZHPL – no defaults in the past		
Total debtors and other receivables	56,449	46,989

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
2017						
Creditors and other payables	100,774	100,774	100,774	-	-	-
Crown Loans	-	-	-	-	-	-
Total	**100,774**	**100,774**	**100,774**	**-**	**-**	**-**
2018						
Creditors and other payables	108,794	108,794	108,794	-	-	-
Crown loans	-	-	-	-	-	-
Total	**108,794**	**108,794**	**108,794**	**-**	**-**	**-**

26. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expense

Overall the DHB came in $210k favourable to budget. While there were variances in Revenue and Expense, the significant difference came from additional Ministry of Health revenue for Pay Equity, which was offset by additional expenditure in non-health board provider expenses. Additional funding was received for PHO System Level Measures, after hours service and the Social Investment Board, all offset by additional expenditure. Additional funding was received to offset the additional capital charge expenditure and additional revenue was recovered through the DHBs ACC arrears programme.

Statement of Financial Position

The most significant variance was in the delayed spending against the 2017/18 Capital Plan as a result of delayed approval of the plan and considerable effort to ensure the timing of cash flow spend was affordable.

Statement of Cashflow

Net operating cash flow was $13m favourable to budget, mainly due to an ACC arrears recovery programme and delayed capital spend, as a result of late 2017/18 Board approval of the 2017/18 Capital Plan. Significant effort has been placed on cash management to ensure the DHB is adequately forecasting and living within its means.

27. Compliance with Crown Entities Act 2004

The CMDHB Board approved the draft 2018/19 Statement of Performance Expectations (SPE) on 27 June 2018 and this was submitted to the Ministry of Health on 29 June 2018. In accordance with the Crown Entities Act 2004 the final SPE is required to be completed in final before 1 July 2018. The CMDHB Board did not approve the SPE in final as there were still uncertainties with regards to the quantum (if any) of funding from the MoH with regards to a contribution to the additional costs of the NZNO settlement. The Board completed its SPE on 31 October 2018.

Board and Committee Membership Attendances

1 July 2017 to 30 June 2018

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC	MHAC
Dr Lester Levy	3			2		
Rabin Rabindran	6	7	5	7		
Colleen Brown	8		7		2	2
Dr Lyn Murphy	8	7		7	2	
Dianne Glenn	8	8	7		2	
Reece Autagavaia	5		5		1	1
George Ngatai	7		4	8		2
Catherine Abel-Pattinson	8	8		6	1	2
Katrina Bungard	7		5		2	3
Mark Darrow	5	6		7		
Dr Ashraf Choudhary	7	7	6			2
Vui Mark Gosche	2			1		

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

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

Board Members' Disclosure of Interests

As at 31 October 2018

Vui Mark Gosche (Chair)	• Trustee, Mt Wellington Licensing Trust • Director, Mt Wellington Trust Hotels Ltd. • Director, Keri Corporation Ltd • Trustee, Mt Wellington Charitable Trust • Chief Executive, Vaka Tautua • Trustee, Pacific Information Advocacy & Support Services Trust • Life Member, Labour Party • Life Member, ETU Union • Deputy Chair & Board Member, Housing NZ
Catherine Abel-Pattinson	• Board Member, Health Promotion Agency • National Party Policy Committee Northern Region • Member, NZNO • Member, Directors Institute • Husband (John Abel-Pattinson), Director, Blackstone Group Ltd • Husband, Director, Blackstone Partners Ltd • Husband, Director, Bspoke Ltd • Husband, Director, 540 Great South Ltd • Husband, Director, Barclay Suites • Husband, Director, various single purpose property owning companies
Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Director, Charlie Starling Production Ltd • Member, Auckland Council Disability Advisory Panel • Member, NZ Disability Strategy Reference Group • District Representative, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Travers Brown Trustee Limited (shareholder and director)
Dr Ashraf Choudhary	• Board Member, Otara-Papatoetoe Local Board • Member, NZ Labour Party • Chairperson, Advisory Board Pearl of Island Foundation • Co-Patron, Bharatiya Samaj Charitable Trust
Dianne Glenn	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ
Katrina Bungard	• Chairperson Manukau East Council of Social Services (MECOSS) • Deputy Chair Howick Local Board • Member of Amputee Society • Member of Parafed disability sports • Member of NZ National Party

Dr Lyn Murphy	• Member, ACT NZ • Director and Shareholder, Bizness Synergy Training Ltd • Director and Shareholder, Synergex Holdings Ltd • Trustee, Synergex Trust • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ) • Member, New Zealand Association of Clinical Research (NZACRes) • Senior Lecturer, AUT University School of Inter professional Health Studies • Member, Public Health Association of New Zealand
Apulu Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, District Licensing Committee of Auckland Council • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation
George Ngatai	• Director, Transitioning Out Aotearoa • Director, The Whanau Ora Community Clinic • Chair, Safer Aotearoa Family Violence Prevention Network • Huakina Development Trust (Partnership Clinic) • Community Organisation Grants Scheme (Auckland) • Lotteries Community (Auckland) • Board Member, Counties Manukau Rugby League Zone • Member, NZ Maori Council • BDO Marketing & Business Solutions Limited (shareholder and director) • Ngatai Bhana Limited (shareholder and director) • Family Care Limited (shareholder and director)
Pat Snedden	• Chair, Auckland District Health Board • Chair, The Big Idea Charitable Trust • Director, Te Urungi o Ngati Kuri Ltd (and subsidiaries) • Chair, National Science Challenge – E Tipu E Rea • Chair, Manaiakalani Education Trust • Director, Ports of Auckland (and subsidiaries) • Trustee, Emerge Aotearoa Trust (and subsidiaries) • Director & Shareholder, Snedden Publishing & Management Consultants Ltd • Director & Shareholder, Ayers Contracting Services Ltd • Director & Shareholder, Data Publishing Ltd
Kylie Clegg	• Deputy Chair, Waitematā District Health Board • Trustee (ex officio) - Well Foundation (charity supporting Waitematā District Health Board) • Director, Auckland Transport • Director, Sport New Zealand • Director, High Performance Sport New Zealand Limited • Trustee & Beneficiary, Mickyla Trust • Trustee & Beneficiary, M&K Investments Limited (includes a share of less than 1% in Orion Health Group)

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

Report of the Audit Office

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 2018

The Auditor-General is the auditor of Counties Manukau District Health Board (the Health Board). The Auditor-General has appointed me, Athol Graham, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

Opinion

We have audited:

- the financial statements of the Health Board on pages 55 to 86, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 14 to 38.

In our opinion:

- the financial statements of the Health Board on pages 55 to 86:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 14 to 38:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2018, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriation; and

- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we highlight that the Health Board is reliant on financial support from the Crown. We also draw attention to a matter in relating to compliance with the Holidays Act 2003. 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.

The Health Board is reliant on financial support from the Crown

Without modifying our opinion, we draw your attention to the disclosures made in the notes to the financial statements on page 59 that outline that the Board, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 17 on page 79. Our opinion is not modified in respect of this matter.

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 Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

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

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

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

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

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

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

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information. As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

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

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

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

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

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

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

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit. Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 13, 39 to 54 and 87 to 89, but does not include the financial statements and the performance information, and our auditor's report thereon. Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board. Other than the audit, we have no relationship with, or interests in, the Health Board.

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

Ministerial Directions

Directions issued by a Minister during the 2017/18 year, or that remain current are as follows:

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

Directory

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Auditor

Audit New Zealand on behalf of the Auditor-General

Solicitors

Buddle Findlay
Chapman Tripp
Chen Palmer Ltd
Claro
Day Jones
Jonathan Kaye Law
Lane Neave Ltd
Meredith Connell
Neilsons Lawyers Ltd
Paul White
Ponsonby Chambers
SBM Legal Barristers & Solicitors
Simpson Grierson
Sutton Holdings Ltd

Bankers

Bank of New Zealand
Westpac Banking Corp
ASB Bank Limited