COUNTIES MANUKAU HEALTH
Healthy Together

CM Health 2017/18

Statement of Performance Expectations

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

Counties Manukau District Health Board
2017/18 Statement of Performance Expectations

Signed on behalf of the Board:

Dr Lester Levy
Chair

Rabin Rabindran
Deputy Chair

November 2017

2017/18 Statement of Performance Expectations

CM Health's Statement of Intent 2017-2021 sets out our strategic Healthy Together goal and objectives, in terms of improving the health of our population and ensuring the sustainability of the Counties Manukau health system, for the years 2017 to 2021.[1] To monitor progress towards Healthy Together over this period we use the Healthy Together Outcomes Measurement Framework which is included in our Statement of Intent.

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

The SPE is a requirement of the Crown Entities Act 2013 and sets the annual performance expectations of the DHB. Recent actual performance data are used as the baseline for targets.[2] Actual results of service performance against what was forecast here will be published in our 2017/18 Annual Report.[3] The following SPE presents Counties Manukau DHB's planned performance for 2017/18.

Note that the Healthy Together Outcomes Measurement Framework includes a number of measures that are being developed over the 2017/18 year. Where these measures are not currently measurable they have not been included in the 2017/18 SPE but will be included in future SPEs.

Health Equity

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

CM Health has published separate 2017/18 Maaori, Pacific and Asian health plans. A number of the performance indicators from these plans have been included in this SPE to highlight areas of particular significance and priority in terms of improving health outcomes for our Maaori, Pacific and Asian peoples living in Counties Manukau.

Crown Entities Amendment Act 2013

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

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

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

[1] CM Health's Statement of Intent is tabled in Parliament and is available on the DHB's website: www.countiesmanukau.health.nz
[2] For 2017/18 in order to align baseline data across the three Auckland metropolitan DHBs, 2015/16 baseline data is included in the 2017/18 Statement of Performance Expectations.
[3] CM Health's Annual Report is tabled in Parliament and is available on the DHB's website: www.countiesmanukau.health.nz.

1.0 Input levels against Output Classes

The following tables provide a prospective summary of revenue and expenses by Output Class. Note that we are working on a three year recovery plan that will return our organisation to a breakeven position. Accordingly outer year plans for 2018/19 to 2020/21 should be read as indicative and will be updated once the three year recovery plan has been agreed by the Executive Leadership Team and endorsed by the CM Health Board.

Prevention

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	4,656	10,960	11,311	11,673
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	4,656	10,960	11,311	11,673
Total Expenditure	4,656	10,960	11,311	11,673
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Early detection and management

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	231,300	242,145	249,893	257,888
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	231,300	242,145	249,893	257,888
Total Expenditure	231,300	242,145	249,893	257,888
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Intensive assessment and treatment

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	1,267,652	1,297,585	1,339,106	1,381,956
Personnel	621,253	638,399	657,461	677,175
Outsourced	79,707	81,906	84,356	86,883
Clinical Supplies	125,408	128,909	132,775	136,773
Infrastructure	135,001	129,425	133,038	136,796
Other	325,295	328,946	336,476	344,329
Total Expenditure	1,286,664	1,307,585	1,344,106	1,381,956
Net Surplus/(Deficit)	**(20,012)**	**(10,000)**	**(5,000)**	**-**

Rehabilitation and support

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	128,940	133,065	137,324	141,720
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	128,940	133,065	137,324	141,720
Total Expenditure	128,940	133,065	137,324	141,720
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Total

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	1,631,548	1,683,755	1,737,634	1,793,237
Personnel Costs	621,253	638,399	657,461	677,175
Outsourced	79,707	81,906	84,356	86,883
Clinical Supplies	125,408	128,909	132,775	136,773
Infrastructure	135,001	129,425	133,038	136,796
Other	690,191	715,116	735,004	755,610
Total Expenditure	1,651,560	1,693,755	1,742,634	1,793,237
Net Surplus / (Deficit)	**(20,012)**	**(10,000)**	**(5,000)**	**-**

2.0 Output Classes

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

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

In presenting CM Health's performance story, it is important to present a mix of measures that indicate performance in a range of different ways. For example, for some services the most important measure of performance will be how much of it is delivered (volume), whereas for other services the best measure of performance may be how quickly that service was provided (timeliness). This SPE therefore includes a spread of indicators that cover the following areas of performance: Volume (V), Timeliness (T), Coverage (C) and Quality (Q).

Each of the performance measures has a reference classification to assist with quick categorisation.

Reference Key			
NHT	National Health Target	**V**	Volume
SLM	System Level Measure	**T**	Timeliness
SLMc	System Level Measure Regional Contributory Measure as included in the 2017/18 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2017/18 Metro Auckland SLM Improvement Plan)	**Q**	Quality
		C	Coverage

2.1 Prevention services

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

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

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

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
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%	NHT C
	Maaori	91%		
	Pacific	92%		
	Asian	93%		
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking	Total	96%	95%	C
	Maaori	96%		
	Pacific	96%		
	Asian	94%		
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%	NHT C
	Maaori	97%		

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Percentage of PHO-enrolled patients who smoke who accepted smoking cessation support	Total	24.4%[4]	26.8%[5]	SLMc Q
Percentage of houses that are smokefree at two weeks postnatal[6]	Total	91%	95%	Q
	Maaori	72%		
Percentage of babies fully or exclusively breastfed at 3 months	Total	46%	60%	Q
	Maaori	37%		
	Pacific	39%		
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Total	29%[7]	95%	NHT Q
	Maaori	29%		
	Pacific	28%		
	Other	49%		
Number of children aged <5 years referred to Active Futures	Total	N/A[8]	350 (75% to be Maaori, Pacific or quintile 5)	V
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	125	171 (75% to be Maaori, Pacific or quintile 5)	V
Number of adult referrals to Green Prescription services	Total	5,896[9]	7,300	V
Immunisation Services				
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Total	95%	95%	NHT SLMc C
	Maaori	90%		
	Pacific	97%		
	Asian	99%		
Proportion of eligible girls fully immunised with HPV vaccine	Total	62%	75%	C
	Maaori	63%		
	Pacific	68%		
	Asian	61%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	47%	75%	C
	Maaori	44%		
	Pacific	64%		
	Asian	47%		
Health Screening				
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	69%	70%	C
	Maaori	65%		
	Pacific	76%		
	Other	68%		
Proportion of women aged 20 – 69 years who have had a cervical smear	Total	75%	80%	C

[4] 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.
[5] 2017/18 targets represent a 10% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[6] 2015/16 Baseline data as at March 2016. Note that from 2017/18 there is a developmental national System Level Measure focused on the proportion of babies living in smokefree households at six weeks of age. As baseline data and targets are still in development, in 2017/18 CM Health will continue to report on the 2 week post-natal measure.
[7] Baseline data for six months ending August 2016 (Q1) (new Health Target)
[8] New service (commenced March 2017) therefore baseline data not available.
[9] Total number of adult referrals received between 1 July 2015 and 30 June 2016 including repeat referrals.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
in the last three years	Maaori	69%		
	Pacific	82%		
	Asian	67%		
	Other	79%		
Percentage of four year olds receiving a B4 School Check	Total	101%	90%	C
	Maaori	100%		
	Pacific	90%		
	Other	109%		
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS assessment[10]	Total	91%	95%[11]	C
	Maaori	87%		
	Pacific	94%		
	Asian	N/A[12]		

2.2 Early detection and management services

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

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

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

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	98%	95%	C
	Maaori	93%		
	Pacific	117%		
	Asian	83%		
Amenable mortality rate per 100,000 population[13]	Total	104.4[14]	102.3[15]	SLM Q
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	92%	90%	C
	Maaori	89%		
	Pacific	92%		
	Other	93%		
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	73%	90%	C
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c < 64 mmol/mol)[16]	Total	65%	69%	Q
	Maaori	61%		
	Pacific	58%		

[10] Performance is measured using school/calendar year. Baseline data as at 31 December 2016.
[11] Performance against target to be measured at 31 December 2017.
[12] Asian data is being developed over the 2017/18 year. Baseline data is therefore not available for this population group.
[13] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30.
[14] 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.
[15] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[16] 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.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
	Other	73%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	49%[17]	52%[18]	Q
	Maaori	48%	51%	
	Pacific	49%	52%	
	Asian	43%	46%	
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	58%[19]	61%[20]	Q
	Maaori	55%	58%	
	Pacific	62%	65%	
	Asian	51%	53%	
% of each PHO's practices registered with an e-portal[21]	Total	52%	55%	SLMcV
Oral Health Services[22]				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	84%	95%	SLMcC
	Maaori	74%		
	Pacific	85%		
	Asian	87%		
	Other	90%		
Percentage of enrolled children Caries free at age 5 years	Total	48%	60%	Q
	Maaori	38%		
	Pacific	30%		
	Asian	56%		
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Total	0.96	0.81	Q
	Maaori	1.29		
	Pacific	1.42		
	Asian	0.72		
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	73.3%	85%	C
Diagnostics				
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	92%	95%	T
	MRI	62%	90%	
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	90%	90%	T
Proportion of patients accepted as non- diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	44%	70%	T
Ambulatory Sensitive Hospitalisations				
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population	Total	7,109[23]	6,754[24]	SLMQ
	Maaori	6,264	5,951	
	Pacific	11,977	11,378	
	Other	4,789	4,550	
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 0-4 year	Total	1,073[25]	1,019[26]	SLMc

[17] 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.
[18] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[19] 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.
[20] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[21] 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.
[22] Baseline data is based on the calendar year (to 31 December 2016), except for adolescent measure which is Q4 2015/16.
[23] 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.
[24] 2017/18 targets represent a 5% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[25] Baseline data for 12 months to September 2016. Source: cellulitis and dermatisis/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
[26] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
olds – skin infection subset	Maaori	1,288	1,224	Q
	Pacific	2,195	2,085	
	Other	334	317	
Rheumatic Fever				
Acute rheumatic fever first hospitalisations rates per 100,000 population	Total	7.0[27]	4.5	Q
	Maaori	13.1		
	Pacific	23.2		
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	0.96	0.40	Q
	Maaori	2.13		
Pharmacy				
Number of prescription items subsidised	Total	7,334,818	N/A[28]	V

2.3 Intensive assessment and treatment services

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

They include:

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

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

Performance Measure			Baseline 2015/16	Target 2017/18	Notes
Mental Health					
Percentage of population who access mental health services	Age 0-19 years	Total	3.9	3.15%	C
		Maaori	5.6	4.45%	
	Age 20-64 years	Total	3.8	3.15%	
		Maaori	8.5	7.75%	
	Age 65+ years	Total	2.5	2.60%	
		Maaori	2.8	2.60%	
Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years	Mental Health (Hospital Care Arm)	3 weeks	76%	80%	T
		8 weeks	96%	95%	
	Addictions (Hospital Care Arm and NGO	3 weeks	96%	80%	
		8 weeks	96%	95%	
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[29]		Total	78.1%	90%	T

[27] Baseline data Q1 2016/17
[28] Measure is demand driven – not appropriate to set target.

Performance Measure			Baseline 2015/16	Target 2017/18	Notes
Elective Services					
Number of Elective Surgical Discharges		Total	109% 21,650	100% 20,535	NHT V
Elective Services Standardised Intervention Rates (SIRs) per 10,000 population		Major Joints	22.39	21	C
		Cardiac Surgery	6.04	6.5	
		Cataracts	33.25	27	
Acute Services					
Emergency Department (ED) attendance rate per 100,000 population		Total	215.4[30]	211.1[31]	SLMc V
		Maaori	283.3	277.6	
		Pacific	337.6	330.8	
		Asian	135.9	133.2	
Readmissions – acute readmissions to hospital[32]		Total	7.7%	TBC[33]	V
		75+	9.7%	TBC	
Acute Inpatient Average Length of Stay		Acute LOS	2.57 days	2.50 days	Q
		Elective LOS	1.67 days	1.52 days	
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			96%	95%	NHT T
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%	T
		Maaori	100%		
		Pacific	100%		
	Chemotherapy	Total	100%	85%	
		Maaori	100%		
		Pacific	100%		
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%	NHT T
Cardiac Services					
Percentage of high risk patients who receive an angiogram within 3 days of admission		Total	80%	70%	T
		Maaori	74%		
		Pacific	75%		
		Other	81%		
Stroke Services					
Percentage of potentially eligible stroke patients thrombolysed			11%	8%	C
Quality and patient safety					
Percentage of admissions affected by four or more triggers[34]			1.4%	<1.4%	Q
Rate of falls with major harm per 1000 bed days			0.07	<0.09	Q

[29] 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.

[30] 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.

[31] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

[32] Note that the 2017/18 Metro Auckland SLM Improvement Plan includes a developmental contributory measure for acute readmission rates in 28 days. Methodology for this rate is currently in progress.

[33] The Ministry of Health OS8 Reducing Acute Readmissions to Hospital measure definition is currently under review. A target for this measure is therefore not able to be set at the time of writing (July 2017).

[34] 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.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Percentage of inpatients (aged 75+) assessed for risk of falling		94%	90%	Q
Rate of S. aureus bacteraemia (SAB) per 1000 bed days		0.06	<0.06	Q
Compliance with good hand hygiene practice		82%	80%	Q
System Level Measures				
Acute hospital bed days per capita	Total	460.1[35]	450.9[36]	SLM Q
	Maaori	690.8	677.0[37]	
	Pacific	710.1	695.9[38]	
Patient experience of care – hospital inpatient survey aggregate score	Total	8.7[39]	8.5[40]	SLM Q

2.4 Rehabilitation and support services

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

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

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Age Related Residential Care (ARRC)				
Percentage of people in ARRC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of previous assessment		81.6%	95%	T
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six (6) months prior to that first LTCF assessment		53.3%	90%	T
Home Based and Community Support				
Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.		N/A[41]	95%	Q
Assessment, Treatment and Rehabilitation Services[42]				
Number of older people that have received in-home strength and balance retraining services	Aged 65-74	N/A	703	V
	Aged 75+			
Number of older people that have received community / group strength and balance retraining services	Aged 65+	N/A	2,325 places	V
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	V
	Aged 75-84		300	

[35] 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.
[36] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[37] 2017/18 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[38] 2017/18 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[39] 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.
[40] 2017/18 targets 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.
[41] New measure for 2017/18 therefore baseline data not available.
[42] Note that following falls and fractures measures are new in 2017/18 as part of the ACC, MOH and HQSC Live Stronger for Longer Programme. Baseline data is therefore not available.

Performance Measure	Baseline 2015/16	Target 2017/18	Notes
Aged 85+		300	
Palliative care[43]			
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District	N/A[44]	200[45]	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals	N/A[46]	200[47]	V

[43] The following measures are part of the regional Better Palliative Care Outcomes Service which is being implemented and delivered in the Auckland Region from 2017/18. This service will implement 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.
[44] This is a new measure in 2017/18 therefore baseline data is not available.
[45] 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.
[46] This is a new measure in 2017/18 therefore baseline data is not available.
[47] 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.

3.0 Financial Performance

3.1 Introduction

CM Health and its Primary Health Organisation (PHO) partners remain fully committed to achieving the government's priorities despite the increasing fiscal constraints the health sector is facing. Clear indications from the Minister and Ministry of Health are of a continued and significant tightening fiscal position. Despite capital and operational constraints, demand on CM Health system services is expected to grow at fiscally unsustainable levels unless significant change and related innovations are implemented. This funding forecast has accelerated the scale and pace of health system transformational change needed for future sustainability.

We continue to have significant cost pressures with respect to Multi Employer Collective Agreements (MECA) and related wage and salary increases. Capacity pressures associated with growth in demand for clinical services have also added significant cost. Recent unprecedented demand growth has placed significant strain on current budgets. A historical reliance on one off gains, not available in 2017/18 has contributed to our challenge for 2017/18. Despite our commitment to an ambitious savings plan, 2017/18 funding increases have been inadequate to meet overall cost increases.

Despite these considerable challenges, we are working on a three year recovery plan that will return our organisation to a breakeven position and refocus our resources to those functions that deliver evidence based care to our communities. This will be assisted by the Ministry of Health who will be working with us. Accordingly outer year plans for 2018/19 to 2020/21 (shaded grey) should be read as indicative and will be updated once the three year recovery plan has been agreed by the Executive Leadership Team and endorsed by the CM Health Board.

As part of developing our recovery plan, we will be revisiting our investments in context of long term regional planning and exploring other opportunities to do more regionally where there are benefits. In this context we commit to ensuring that the changes we make in our decision making approach will be transparent and focus on those priorities that matter to our workforce, communities and the Government.

Important to close with an acknowledgement to our very hard working frontline staff and support services including community based providers who do their best every day to meet the healthcare needs of CM Health populations.

3.2 Forecast Financial Statements

3.2.1 Summary by funding arm

Net Result	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Provider	(11,964)	(16,922)	(24,302)	(11,652)	(9,732)	(7,828)
Governance	(392)	(8,687)	(643)	(598)	(586)	(574)
Funder	15,226	12,669	4,933	2,250	5,318	8,402
Eliminations	-	-	-	-	-	-
Operating Surplus	**2,870**	**(12,940)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Surplus / (Deficit)	**48,270**	**47,501**	**(20,012)**	**(10,000)**	**(5,000)**	**-**

Note: The 2017/18 MOH funding increase of $41.19m has been top sliced for Mental Health and Inter District Flows. The residual balance has been provisionally allocated to Provider, Governance and Funder based on proportionate net surplus(deficit). This will be updated following confirmation of final Production Plans and Price Volume Schedules due for completion 31 August 2017.

3.2.2 Statement of comprehensive income

Net Result	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Revenue						
Crown	1,496,414	1,538,144	1,593,800	1,645,078	1,697,920	1,752,046
Other	43,049	39,027	37,748	38,677	39,714	41,191
Total Revenue	**1,539,463**	**1,577,171**	**1,631,548**	**1,683,755**	**1,737,634**	**1,793,237**
Expenses						
Personnel	564,665	592,388	621,253	638,399	657,461	677,175
Outsourced	72,651	87,899	79,707	81,906	84,356	86,883
Clinical Support	113,865	110,384	117,481	120,898	124,684	128,601
Infrastructure	65,203	73,807	75,068	68,107	70,292	72,582
Personal Health	483,756	482,167	498,787	509,350	522,981	537,138
Mental Health	60,209	61,585	65,464	76,518	78,967	81,495
Disability Support	111,598	117,984	122,976	126,223	129,920	133,747
Public Health	2,577	3,200	1,140	1,151	1,206	1,243
Maaori	452	2,748	1,824	1,874	1,930	1,987
Operating Costs	**1,474,976**	**1,532,162**	**1,583,700**	**1,624,426**	**1,671,797**	**1,720,851**
Operating Surplus	**64,487**	**45,009**	**47,843**	**59,329**	**65,837**	**72,386**
Depreciation	30,637	31,889	31,932	32,251	32,573	32,898
Capital Charge	18,510	18,200	35,928	37,078	38,264	39,488
Interest	12,470	7,860	-	-	-	-
Net Surplus	**2,870**	**(12,940)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Surplus / (Deficit)	**48,270**	**(51,483)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**

3.2.3 Funder

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	1,433,837	1,472,838	1,528,692	1,577,608	1,628,092	1,680,191
Other	6,228	5,058	-	-	-	-
Total	**1,440,065**	**1,477,896**	**1,528,692**	**1,577,608**	**1,628,092**	**1,680,191**
Personal Health	1,115,813	1,145,816	1,196,551	1,229,444	1,266,120	1,304,060
Mental Health	143,970	146,909	153,964	167,849	173,220	178,763
Disability Support	145,098	151,720	156,048	160,353	165,141	170,094
Public Health	2,577	3,200	1,140	1,151	1,206	1,243
Maaori	452	2,748	1,824	1,874	1,930	1,987
Governance	16,929	14,834	14,232	14,687	15,157	15,642
Total Expenditure	**1,424,839**	**1,465,227**	**1,523,759**	**1,575,358**	**1,622,774**	**1,671,789**
Net Surplus	**15,226**	**12,669**	**4,933**	(2,250)	(5,318)	(8,402)

3.2.4 Eliminations

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	(766,247)	(797,543)	(833,568)	(860,242)	(887,770)	(916,179)
Other	-	-	-	-	-	-
Total	**(766,247)**	**(797,543)**	**(833,568)**	**(860,242)**	**(887,770)**	**(916,179)**
Personal Health	(632,057)	(663,649)	(697,764)	(720,094)	(743,139)	(766,922)
Mental Health	(83,761)	(85,324)	(88,500)	(91,331)	(94,253)	(97,268)
Disability Support	(33,500)	(33,736)	(33,072)	(34,130)	(35,221)	(36,347)
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	(16,929)	(14,834)	(14,232)	(14,687)	(15,157)	(15,642)
Total Expenditure	**(766,247)**	**(797,543)**	**(833,568)**	**(860,242)**	**(887,770)**	**(916,179)**
Net Surplus	**-**	**-**	**-**	**-**	**-**	**-**

3.2.5 Provider

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	811,895	848,015	884,558	912,864	942,075	972,221
Other	35,889	32,790	37,406	38,603	39,838	41,113
Total	**847,784**	**880,805**	**921,964**	**951,467**	**981,913**	**1,013,334**
Personnel	554,003	580,568	609,223	626,037	644,729	664,062
Outsourced	71,645	83,346	77,571	79,711	82,095	84,554
Clinical Support	113,585	110,100	117,337	120,750	124,531	128,443
Infrastructure	58,898	65,764	74,275	67,292	69,453	71,717
Operating Costs	**798,131**	**839,778**	**861,533**	**885,930**	**913,140**	**941,288**
Operating Surplus	**49,653**	**41,027**	**62,698**	**67,877**	**71,188**	**74,538**
Depreciation	30,637	31,889	31,932	32,251	32,573	32,898
Capital Charge	18,510	18,200	35,928	37,078	38,264	39,488
Interest	12,470	7,860	-	-	-	-
Net Surplus	**(11,964)**	**(16,922)**	**(24,302)**	**(11,652)**	**(9,732)**	**(7,828)**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Total Comprehensive Income	**33,436**	**(47,501)**	**(24,302)**	**(11,652)**	**(9,732)**	**(7,828)**

3.2.6 Governance

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	16,929	14,834	14,388	14,848	15,323	15,813
Other	932	1,179	72	74	76	78
Total	**17,861**	**16,013**	**14,460**	**14,922**	**15,399**	**15,891**
Personnel	10,662	11,820	12,030	12,362	12,732	13,113
Outsourced	1,006	4,553	2,136	2,195	2,261	2,329
Clinical Support	280	284	144	148	153	158
Infrastructure	6,305	8,043	793	815	839	865
Total Expenditure	**18,253**	**24,700**	**15,103**	**15,520**	**15,985**	**16,465**
Net Surplus	**(392)**	**(8,687)**	**(643)**	**(598)**	**(586)**	**(574)**

3.2.7 Balance sheet

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Current Assets						
Cash and Bank	31,778	20,902	(6,474)	(29,364)	(36,485)	(42,338)
Trust Funds	899	883	895	906	917	928
Debtors	50,335	49,297	53,439	53,439	53,439	53,439
Inventory	1,468	7,484	7,484	7,484	7,484	7,484
Assets Held for Sale	-	33,743	5,320	-	-	-
Current Assets Total	**84,480**	112,309	60,664	32,465	25,355	19,513
Non Current Assets	**731,550**	764,338	825,393	868,004	860,164	850,386
Total Assets	**816,030**	**876,647**	**886,057**	**900,469**	**885,519**	**869,899**
Current Liabilities						
Creditors	110,047	112,752	114,234	128,296	117,466	100,966
Loans	-	-	-	-	-	-
Employee Provisions	105,845	115,170	117,718	114,187	114,187	114,187
Total Current Liabilities	**215,892**	227,922	231,952	242,483	231,653	215,153
Working Capital	**(131,412)**	(115,613)	(171,288)	(210,018)	(206,298)	(195,640)
Net Funds Employed	**600,138**	**648,725**	**654,105**	**657,986**	**653,866**	**654,746**
Non-current Liabilities						
Employee Provision	21,221	18,717	20,017	21,317	22,617	23,917
Term Loans	292,500	-	-	-	-	-
Restricted funds	873	898	898	898	898	898
Other	931	931	931	931	930	929
Total Non-Current Liabilities	**315,525**	**20,546**	**21,846**	**23,146**	**24,445**	**25,744**
Crown Equity	**284,613**	**628,179**	**632,259**	**634,840**	**629,421**	**629,002**
Net Funds Employed	**600,138**	**648,725**	**654,105**	**657,986**	**653,866**	**654,746**

3.2.8 Movement of equity

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Equity at beginning of Period	236,762	284,613	(628,179)	(632,259)	(634,840)	(629,421)
Surplus / (Deficit) for period	2,870	(12,940)	(20,012)	(10,000)	(5,000)	-
Crown Equity injection	-	292,500	24,500	13,000	-	-
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	45,400	64,423	-	-	-	-
Total Equity at beginning of Period	**284,613**	**(628,179)**	**(632,259)**	**(634,840)**	**(629,421)**	**(629,002)**

3.2.9 Cash flows

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Operating Activities						
Crown Revenue	1,494,489	1,545,461	1,585,764	1,645,078	1,697,596	1,751,915
Other	36,647	37,403	34,874	35,990	37,141	38,329
Interest rec.	3,355	2,075	2,604	2,687	2,773	2,862
Suppliers	(913,172)	(935,060)	(957,536)	(972,082)	(1,025,166)	(1,060,176)
Employees	(570,954)	(591,931)	(617,407)	(640,630)	(656,162)	(675,876)
Interest paid	(12,470)	(9,518)	-	-	-	-
Capital charge	(19,225)	(18,200)	(35,928)	(37,078)	(38,264)	(39,488)
GST (Net)	1,250	(1,114)	637	-	-	-
Net cash from Operations	**19,920**	**29,116**	**12,997**	**33,965**	**17,918**	**17,566**
Investing activities						
Sale of Fixed assets	-	9,987	28,423	5,320	-	-
Total Fixed Assets	(34,652)	(45,455)	(82,707)	(68,656)	(19,620)	(18,000)
Investments and Restricted Trust Funds	(8,323)	(4,105)	(10,181)	(6,100)	(5,000)	(5,000)
Net cash from Investing	**(42,975)**	**(39,573)**	**(64,465)**	**(69,436)**	**(24,620)**	**(23,000)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity – Capital	(419)	(419)	24,081	12,581	(419)	(419)
Net cash from Financing	**(419)**	**(419)**	**24,081**	**12,581**	**(419)**	**(419)**
Net increase / (decrease)	**(23,474)**	**(10,876)**	(27,376)	(22,890)	(7,121)	(5,853)
Opening cash	**55,252**	**31,778**	**20,902**	(6,474)	(29,364)	(36,485)
Closing cash	**31,778**	**20,902**	(6,474)	(29,364)	(36,485)	(42,338)

3.2.10 Capital expenditure

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Baseline Capital	34,652	45,455	42,671	27,956	19,620	18,000
Strategic Capital	-	-	40,036	40,700	-	-
Total	**34,652**	**45,455**	**82,707**	**68,656**	**19,620**	**18,000**

3.3 Accounting Policies

The Counties Manukau Health (CM Health) financial statements 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 NZ International Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

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

3.4 Significant Assumptions

3.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2017/18 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities. To ensure we achieve a breakeven financial position where cost growth is higher than forecast revenue, CM Health will cap the level of allowable and fundable growth within hospital care and primary and community care.

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

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

3.4.2 Personnel costs

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

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

3.4.3 Third party and shared services provision

Our focus for 2017/18 continues to be alignment of localities development and related primary care/community services. The form that investment will take is still evolving and there is an expectation of increased third party participation and provision of public services integrated with core/essential CM Health services. Regional service planning and the Northern Region Long Term Investment Plan priorities will inform this.

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

3.4.4 Supplies

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

3.4.5 Services by other DHBs and regional providers

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

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

3.4.6 Other primary and community care contracts

Historically there has been Mental Health under-spends which are essentially timing issues rather than permanent under-spends. These benefits have been approved to fund urgently needed mental health facilities planned for 2017/18.

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

3.4.7 Enabling technology infrastructure

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

3.4.8 Capital investment

CM Health's Long Term Investment Plan supports the strategic priority to move away from reliance on physical brick and mortar solutions to manage capacity growth and adopt whole of system solutions with a focus on community based service expansion. The realities of high hospital service demand now means we need to augment this strategic priority with a regional approach to investments to address urgent inpatient bed capacity and related hospital services and site investments.

Development of the Northern Regional Long Term Investment Plan (NRLTIP) is evaluating where and when potential new hospital sites will be required to manage the region's significant future growth. Regional service planning continues to seek opportunities to leverage regional capacity as a means of meeting short to medium term demand for health services.

CM Health's changing financial position has requires a reassessment of local capital investment prioritisation. Figure 1 below illustrates the likely cash-flow profile for major capital projects approved or currently within the pathway for approval. This includes a new 76-bed acute mental health facility approved in the 2015/16 year with construction and commissioning continuing through 2017/18.

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

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

Figure 1: Major capital investment projects – approved

Major Capital Projects	Approved	2017/18 $000	2018/19 $000	2019/20 $000	2020/21 $000	Status
Acute Mental Health Unit	2014/15	25,356	14,172	1,620	-	Construction
Ko Awatea II	2015/16	8,780	368	-	-	Construction
Healthy Together Technology	2016/17	11,446	7,660	-	-	Implementation
MRI (addition and relocation)	2016/17	4,490	3,296	-	-	Design and construct
Scott Dialysis Expansion	2016/17	1,500	2,004	-	-	Design and construct
Scott Building Recladding	2016/17	2,800	13,200	-	-	Design and construct
Histology Expansion	2016/17	1,600	-	-	-	Design and construct
Chilled Water	2016/17	2,225	7	-	-	Design
Interventional X Ray	2016/17	1,453	80	-	-	Design
Total		**59,650**	**40,787**	**1,620**	-	

Figure 2: Major capital investment projects (>$10m) – unapproved

Major Project $000	2017/18 $000	Year 2-5 $000	Year 6-10 $000	Year 10+ $000	Total $000	Status
Kidz First Building Re-Cladding		12,000			12,000	Assessment
McIndoe Building Re-Cladding		8,000			8,000	Assessment
Manukau Building Re-Cladding		11,000			11,000	Assessment
Specialised Rehabilitation & Community Wellness		115,000			115,000	Re-scoping
Manukau Community Hub		15,000			15,000	Assessment
Mangere Community Hub		20,000			20,000	Assessment
Manukau Radiology Hub-Phase 1			21,400		21,400	Subject to NRLTIP
Papakura Community Maternity Unit			10,000		10,000	Subject to NRLTIP
Papakura Community Hub			20,000		20,000	Subject to NRLTIP
Manukau Infrastructure (Phased)			30,000		30,000	Subject to NRLTIP
Manukau Support Services			31,800		31,800	Subject to NRLTIP
Elective Surgery Centre			240,000		240,000	Subject to NRLTIP
Manukau Outpatients (Phased fit out)			28,600		28,600	Subject to NRLTIP
Radiology Department Harley Gray			16,300		16,300	Subject to NRLTIP
Manukau Radiology Hub-Phase 2			10,500		10,500	Subject to NRLTIP
Middlemore Car Parking			20,500		20,500	Subject to NRLTIP
Single Wing Ward Block				43,500	43,500	Subject to NRLTIP
Franklin (Pukekohe) Health Hub (5 stages)				54,000	54,000	Subject to NRLTIP
Botany Community Hub (6 rolling stages)				30,000	30,000	Subject to NRLTIP
New Women's Health Building				71,000	71,000	Subject to NRLTIP
Harley Grey Stage 2				80,000	80,000	Subject to NRLTIP
Manukau Education and Research				53,400	53,400	Subject to NRLTIP
Healthy Together Technology (Core Regional, Hospital, Community)	28,049	79,653	72,007		179,709	In progress

Note: (i) Annual capital investments to replace and/or maintain equipment and facilities is excluded in this table but incorporated in the financial statements; (ii) Capital costs outlined above are indicative and will be clarified as part of business case and procurement processes. This includes service capacity expansion that may be amenable to "as a service" provision rather a bricks and mortar capital investment; (iii) Current Northern Regional Long Term Investment Plan (NRLTIP) may change CM Health 2016 LTIP planned major investments after 2021.

3.4.9 Capital investment funding

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

3.4.10 Banking

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

Figure 3: Banking facilities

Facilities	Existing Limit $000,000	Utilisation at 30 June 2013 $000,000	Available Facility at 1 July 2017 $000,000
NZ Health Partnerships (working capital)	$69.9	-	$69.9
Westpac (lease facility)	$10.0	-	$10.0
Commonwealth Bank (lease facility)	$10.0	-	$10.0

Note: On 15 February 2017 the existing Crown loans held by DHBs were converted to equity.

3.4.11 Property, plant and equipment

CM Health revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CM Health land and buildings are revalued every three years or where there is a material change. The last revaluation occurred in June 2018 on an "Optimised Depreciated Replacement Costs" basis.

There is recognition of the rising burden of clinical equipment replacement and this has accelerated CM Health's commitment to an Enterprise Asset Management System, with continued roll out in 2017/18.

3.5 Additional Information and Explanations

3.5.1 Disposal of land

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

3.6 Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by Counties Manukau DHB. Counties Manukau DHB does not consolidate its subsidiaries as they are not material.

Investments in Associates and Jointly Ventures

Associates are those entities in which Counties Manukau DHB has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when Counties Manukau DHB holds between 5-33 percent of the voting power of another entity. Joint ventures are those entities over whose activities Counties Manukau DHB has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions. Associates and Joint Ventures are not accounted for using the equity method or proportionate method, as they are not material.

Revenue

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

MOH Revenue

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

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

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

ACC Contract Revenues

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

Rental revenue

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

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

Leases

Finance leases

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

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

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

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

Figure 4: Depreciation rates of assets

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	10 - 100 years	1% - 10%
Electrical Services	10 - 15 years	6% - 10%
Other Services	15 - 25 years	4% - 6%
Fit out	5 - 10 years	10% - 20%
Infrastructure	20-100 years	1% - 5%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	3 - 25 years	4% - 33%
Information Technology	3 - 5 years	20% - 33%
Vehicles	3 - 6 years	16% -33%
Other Equipment	3 - 25 years	4% - 33%

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

FPSC Rights

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by NZ Health Partnerships, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZ Health Partnerships through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Amortisation

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

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

- Acquired computer software 2-5 years (20% - 50%)

Impairment of Property, Plant & Equipment and Intangible Assets

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

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit scheme

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

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

Provisions

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

Provisions are not recognised for future operating losses.

Restructuring

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

ACC Partnership Programme

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

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

All items in the 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 Intent (SOI) as approved by the Counties Manukau District Health Board at 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

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

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

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

Critical accounting estimates and assumptions

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

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant

risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings.

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

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

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

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

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

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

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

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

Agency relationship

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

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