ANNUAL REPORT 2017

COUNTIES MANUKAU HEALTH

Counties Manukau District Health Board

Kind Manaakitanga | **Excellent** Rangatiratanga | **Valuing everyone** Whakawhanaungatanga | **Together** Kotahitanga

FRONT COVER: A collage of photos reflecting Counties Manukau's Whaanau & Families, Community and Services

Counties Manukau District Health Board Annual Report 2016/17. PUBLISHED NOVEMBER 2017

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Foreword from the Chair and Chief Executive

In 2016/17 Counties Manukau Health (CM Health) continued to deliver more care and a broader range of healthcare services than ever before to a population that is growing rapidly. The consequence of this population growth has been a level of demand not previously experienced. The latter half of the 2016/17 year in particular, has shown an unprecedented demand placed on our hospital services and we would like to thank all our staff across the organisation for their dedication and hard work, which has enabled us to continue to provide quality care to our patients and population during this time.

This increase in demand has impacted all Northern DHBs, in particular the metro-Auckland DHBs signalling the importance of now addressing long term planning collectively. This past year has seen a step change increase in the level of collaboration across metro-Auckland and the northern region, in particular relating to future regional service and investment planning. We are actively working with central government and regional DHBs to present to Government investment choices that we believe will best meet the increasing demand in the immediate term while also future proofing for growth.

2016/17 was the first year of CM Health's five year Healthy Together strategy, which continues our commitment to provide more care closer to home by growing the range of health services and integration of high quality services and workforces across primary health, community and hospital settings. Our strategic objectives and health equity goal have strong alignment with the April 2016 New Zealand Health Strategy to contribute to the national vision that "All New Zealanders live well, stay well, get well" released by the Ministry of Health.

We advanced our system integration commitment by working differently with social services. Our intersectoral social investment approach focused on improving care and support for children up to 5 years of age living in Mangere as a 'prototype' site for social investment. CM Health continues to be an active member agency of the Social Investment Board (SIB) and host to the SIB Implementation Office. This work is complemented by development of social networks across each of our four localities to build service linkages that benefit patient, whaanau and family experience of care.

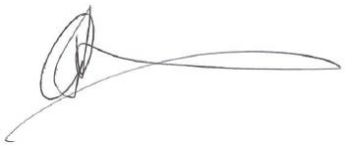
2016/17 also saw the introduction of the six national system level measures that support a shared approach to improving health outcomes. In the Northern Region, each of these measures is underpinned by an improvement plan. The development of this plan, led by our Primary Health Organisations in partnership with DHB clinical and service leaders, has highlighted the strength of this relationship and reflects shared system wide accountability and integration across community and hospital care providers.

We continued to strengthen our focus on actions that will improve the health of our Maaori, Pacific and Asian communities, including work undertaken as part of the Ko Awatea Health Equity Campaign. To further support this, we continued to build our workforce capacity and capability to reflect the diversity of the community we serve and better meet the needs of our people in Counties Manukau.

We would also like to thank our local community for their advice and contribution to service co-design to keep focus on what matters to them. We cannot achieve our goals without the dedication and hard work of our staff and providers across the district. Being truly healthy together relies on everyone coming together who will collectively transform our health system to enable people to live well in the community.

Dr Lester Levy

Chair



Dr Gloria Johnson

Acting Chief Executive Officer

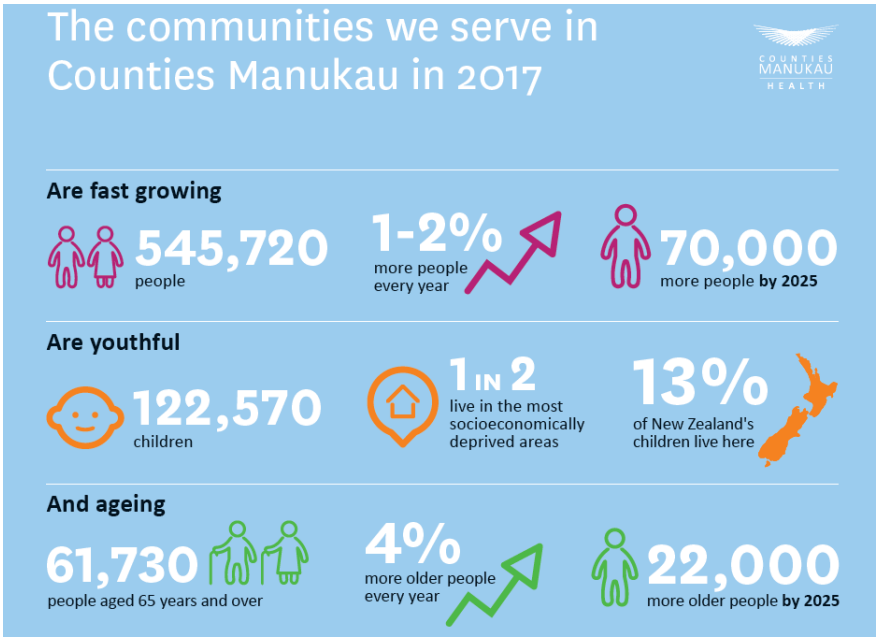
Snapshot of Counties Manukau Health

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, in 2016/17 Counties Manukau Health[1] provided and funded health and disability services to an estimated 545,720[2] people who reside in the local authorities of Auckland, Waikato and Hauraki District. The following outlines some of the key demographic features that inform our planning assumptions.

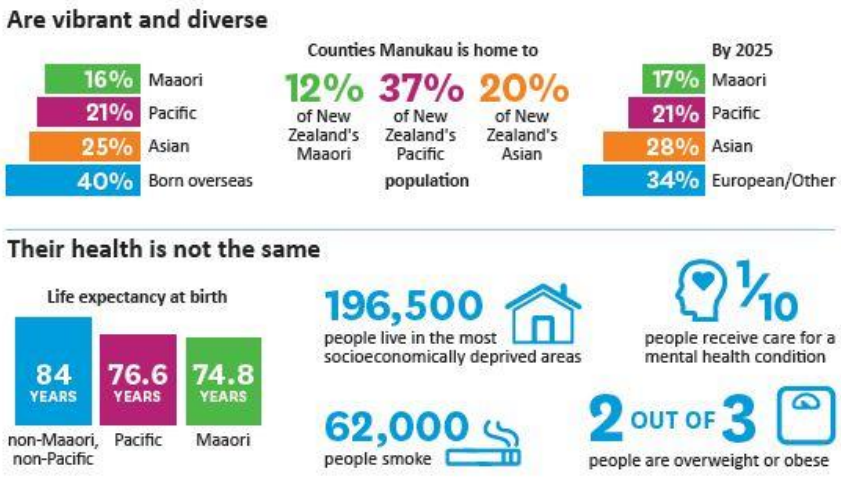
We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.

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[3]). There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau. [4] 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.



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

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

[3] 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 represents people living in the most deprived 20 percent of these areas.

[4] 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.

Board Members

Board members for the period 1 July 2016 to 2 December 2016
Dr Lee Mathias (Chair)
Ms Wendy Lai (Deputy Chair)
Mrs Colleen Brown
Dr Lyn Murphy
Mrs Sandra Alofivae
Mrs Kathy Maxwell
Mrs Dianne Glenn
Mr Arthur Anae
Apulu Reece Autagavaia
Mr George Ngatai
Mr David Collings

Board members for the period 5 December 2016 to 30 June 2017
Dr Lester Levy (Chair)
Mr Rabin Rabindran (Deputy Chair)
Mrs Colleen Brown
Dr Lyn Murphy
Mr Mark Darrow
Mrs Catherine Abel-Pattinson
Mrs Dianne Glenn
Dr Ashraf Choudhary
Apulu Reece Autagavaia
Mr George Ngatai
Mrs Katrina Bungard

Executive Leadership Team

Executive Leadership Team members as at 30 June 2017	
Dr Gloria Johnson	Acting Chief Executive Officer (member since 8 May 2017)
Ms Margaret White	Chief Financial Officer (member since 2 May 2017)
Dr Vanessa Thornton	Acting Chief Medical Officer (member since 8 May 2017)
Dr Campbell Brebner	Chief Medical Advisor, Primary Care
Mr Philip Balmer	Director of Hospital Services
Mr Benedict Hefford	Director of Primary Health & Community Services
Ms Margie Apa	Director of Population Health, Strategy & Investments
Mr David Lenihan	Director of Healthy Together 2020
Professor Jonathon Gray	Director of Ko Awatea
Ms Karen Didovich	Acting Director of Human Resources (member since 19 June 2017)
Ms Jenny Parr	Director of Patient Care & Chief Nurse and Allied Health Officer (member since 16 January 2017)

Key Achievements in 2016/17

Key achievements are outlined below under our three Healthy Together strategic objectives (see *Our Strategic Intentions* at page 9) 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

• A **community driven suicide prevention framework for Maaori** has been developed. This is supported by a Kaitiaki Roopu for suicide prevention in Counties Manukau which was established as a result of a community hui which included representation from over 17 provider and social sector organisations.	***People Powered***
• **Ambulatory sensitive (potentially avoidable) hospitalisations** in 0-4 year old tamariki Maaori have reduced by 5 percent. • CM Health and PHOs have worked collaboratively to design and deliver the **Enhanced Primary Care (EPC)** pilot, which aims to deliver a more sustainable model of general practice. In 2016/17 the EPC modular design was tested through a pilot of nine general practices. The key focus areas were: to understand and redesign patient access to general practice through promotion of patient portals; understanding telephone data and reconfiguring reception roles and space; and develop metrics required to quantify the model of care changes. • In 2016/17 CM Health began work implementing the newly developed **integrated model of care for mental health and addictions (MHA) services**. A key focus of this work is the development of new locality-based, primary care-facing teams (Integrated Locality Care Teams) with the purpose of supporting MHA care in primary care and providing easier, more timely access to MHA support closer to peoples' homes. The Franklin Integrated Locality Care Team was established in November 2016, with the three other locality teams planned for early in 2017/18.	***Closer to home***
• 92% of eligible adults living in Counties Manukau have had their **CVD Risk Assessment** in the last 5 years. • The number of children and young people discharged from **community mental health and addiction services** with a transition (discharge) plan has increased over 2016/17 to 95% in Q4.	***Value and High Performance***
• Through our primary care Alliance, over 29,000 patients have now been through the **Planned Proactive Care**[5]. This result was supported by at least 15 community multidisciplinary team meetings each month, and an over 50 percent increase in the number of secondary care clinicians using SharedCare, from approximately 775 in June 2016 to 1,275 in June 2017. • **Planned Proactive Care for children** was launched in March 2017. The Planned Proactive Model of Care for Children within Counties Manukau is a primary care led initiative targeted at children with long term conditions. In 2016/17 the roll out programme focused on eczema, asthma and constipation. • In 2016/17 CM Health piloted the **Owning My Gout Project** in which pharmacists work together with GPs and nurses to manage gout patients. This pilot project has been hugely successful and won Professional Service of the Year at the 2017 NZ Pharmacy Awards.	***One Team***

Healthy Communities

• Counties Manukau is home to approximately 15,000 Maaori youth (rangatahi) aged 15 to 24 years, with many experiencing poorer health outcomes compared to their peers. Between August and November 2016 YouMe NZ, a youth-led group, launched their **Love Your Life campaign** which was focused on improving mental health awareness through a wellness-focused and "love your life" social movement. • Ko Awatea launched a **Health Equity Campaign** to address the health inequities experienced by Maaori and Pacific people. The campaign has funded a range of initiatives focused on workforce	***People Powered***

[5] Formally known as the At Risk Programme (ARI).

development, responsiveness of services to Maaori and Pacific communities and initiatives for healthy and vibrant children. • In June 2017 the CM Health Board agreed that CM Health should, along with Auckland and Waitemata DHBs, become a Youth Employment Pledge Partner under the **Youth Employment Pledge** which aims to address rising youth unemployment within the Auckland Region, and focuses specifically on growing the Maaori and Pacific workforce. The Pledge was signed in July 2017.	
• The **Immunisation Health Target** was achieved for Pacific children with 96% of eight month old Pacific children being immunised on time. • CM Health achieved the **Better Help for Smokers to Quit** primary care Health Target equitably for all ethnicity groups in June 2017. • **Pre-school enrolment in oral health services** has increased for all ethnicity groups since December 2015. Enrolment rates for Pacific pre-schoolers have increased by 9.5% to 85% enrolment in December 2016, and from 69% to 87% for Asian children. • 60 percent of Pacific students enrolled in our **regional Pacific Workforce program (Program W&AT)** successfully secured a job in their respective areas in the health sector. • **Immunisation coverage for 8 month old pepi Maaori** has increased 3 percent to 89 percent since Q1 2016/17; with more improvements planned. • In 2016/17 there was a focus on strengthening our **school-based health service** model across Counties Manukau. A comprehensive model has been in place at Papakura High School since July 2016 and GP and Nurse Practitioner services in schools and kuras have been operating in 11 high schools during 2016/17.	***Closer to home***
• CM Health's performance towards the **Raising Healthy Kids National Health Target** has improved from 29% in Q1 to 98% in Q4, with equity across all ethnicity groups. This means that 98% of obese children identified in the B4 School Check programme in Counties Manukau were offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.	***Value and High Performance***
• A **Pacific Child Health Network** was established with 11 Pacific Childhood Education Centre and home bases. It is a forum for raising awareness of health issues affecting Pacific children. • The **South Auckland Social Investment Board** (SIB), of which CM Health is a member agency and host for the SIB Implementation Office, has achieved the deliverables set in the Cabinet endorsed Social Investment Plan for 2016/17. The SIB undertook a high level analysis of universal and targeted social service coverage for 0-5yr olds in Maangere. Since March, the SIB has funded small scale service changes to respond to the gaps identified, and get deeper insights on social investment opportunities for 0-5 year olds and their whaanau in Maangere.	***One Team***

Healthy Services

• **Rheumatic fever rates for Pacific** people living in Counties Manukau show an almost 40% reduction in rheumatic fever hospitalisations, from 48.4 per 100,000 back in 2013 down to 29.8 per 100,000 hospitalisations in 2017. • As at May 2017, CM Health has achieved scores equal to or above the national average for all four patient experience domains measured in the **National Patient Survey**: communication, coordination, partnership and physical and emotional needs.[6]	***People Powered***
• As at June 2017, CM Health achieved **three of the National Health Targets**, with significant improvement also having been made towards the Faster Cancer Treatment Health Target (performance has improved from 75% in Q1 to 78% in Q4). • In August 2016 construction started on CM Health's **new Mental Health Inpatient Unit, Tiaho Mai**. Construction is progressing well and the project is due for completion in 2018. • 2016/17 was year three of the regional **Safety in Practice Programme** and involved 42 practices	***Value and High Performance***

[6] As reported in the National patient experience survey: Results for patients treated in May 2017. Accessible via https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3016/

across three Metro Auckland DHB's[7] and six Primary Health Organisations. The programme aims to work with GP practices to create a consistent approach to enhancing quality improvement capability. In Counties Manukau in 2016/17, practices participated in area such as results handling, Warfarin and opioid prescribing, cervical smears, and CVD Risk Assessment.	
• **Contract work in the Pacific region** was successfully completed including training of clinical health professionals from Fiji and Kiribati. Also successfully launched Tele-health with the National Health Service of Samoa. • The Auckland-Metro DHBs and Alliance Leadership Teams submitted the jointly developed **System Level Measures Improvement Plan**. Development of this plan was led by our Primary Health Organisations in partnership with DHB clinical and service leaders, and has highlighted the strength of this relationship and reflects shared system wide accountability and integration across community and hospital care providers.	***One Team***
• **Community Central** became operational in 2016/17, processing all requests for Community Health Teams across all four CM Health localities, with efficiencies already recognised. Community Central provides centralised intake and triage for our community teams, supporting this through improved scheduling and rostering. • During 2016/17 the Division of Surgery, Anaesthesia and Perioperative Services has undertaken a large **Theatre Optimisation Project** which has resulted in an increase of five percent in theatre utilisation, increased electives sessions and list utilisation, reduction in day of surgery cancellations and enhanced booking processes. • In 2016/17 **electronic radiology orders** were implemented and the roll out across CM Health is underway. This new electronic system is working well and helps to improve visibility of the request, saves time, improves referral quality and reduces test duplication.	***Smart System***

[7] Auckland DHB, Waitemata DHB and Counties Manukau DHB together comprise the "Auckland Metro DHBs"

Our Strategic Intentions

Healthy Together

2016/17 was year one of our five year Healthy Together strategy. Our long term transformation ambition and focus is on integrated care in the community, supported by excellent hospital services. Achieving health equity in key indicators is critical to improved 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 for our diverse community to achieve healthier longer lives in the community.

This commitment drives our **strategic goal**:

"Together, we will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020"

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 support people to take a more active role in their own health and better enable them to self-manage for longer at home and in the community.

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

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"*. In addition to this, the government's Better Public Health Services and six National Health Targets outlined in the Minister's Letter of Expectations provided the context for our priority setting in 2016/17. Translating these government priorities into improved outcomes for the Counties Manukau population requires alignment and integration of the many health system expectations – local, regional and national.

CM Health's success in meeting these challenges requires us to align with and leverage key initiatives with strategic partners including the Northern Region DHBs, Counties Manukau based PHO Alliance and related service providers, and intersectoral organisations. Since December 2016, the three Metropolitan Auckland DHBs - Auckland, Waitemata and Counties Manukau - share a Board Chair. This allows for a more integrated, collaborative and aligned regional approach to health services planning and delivery to increase the focus on health outcomes and quality improvement to provide greater value for public money. In 2016/17, CM Health contributed to regional service planning, long term investment planning, System Level Measures (SLM) improvement planning and clinical network work plans. Commitment to collaboration continues in 2017/18 and beyond.

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 at 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 gage 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 2016/17 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 2016/17 performance for the outputs identified in our outcomes framework is provided in the *Statement of Service Performance* at page 21. Together these two sections provide an acute picture of the progress CM Health made towards achieving our long term outcomes and strategic goal in 2016/17.

Our outcomes framework (Figure 1)

National Vision Roadmap	**All New Zealanders live well, stay well and get well**				
	People Powered	Care Closer to Home	High Value & Performance	One Team	Smart System
Northern Region Mission Triple Aim action areas	**Improve health outcomes and reduce disparities by delivering, better, sooner more convenient services; and doing this in a way that meets future demand whilst living within our means**				
	Quality and Safety		Life and Years		The Informed Patient
CM Health Strategic Goal	**Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020**				
	To give back over 500,000 healthy life years to our community				
OBJECTIVES	**Healthy Communities**		**Healthy People, Whaanau and Families**		**Healthy Services**
LONG TERM Outcomes What would success look like?	**Improved population health and equity**		**Improved quality, safety and experience of care**		**Better value for public health resources**
	• Reduced and more equitable amenable mortality • Improved and more equitable life expectancy at birth		• Improved and equitable patient experience of care • Reduced rate of adverse events [A]		• Reduced acute hospital bed days per capita • Reduced Hospital Standardised Mortality Ratio [B]
IMPACTS How will we measure our progress?	• Reduced and more equitable number of babies who live in a smoke-free household at 6 weeks post natal* • More babies are breastfed • Equitable proportion of 8-month olds immunised on time • Reduced and more equitable childhood obesity prevalence • Improved and more equitable childhood oral health • Reduced and more equitable hazardous alcohol use prevalence* • More adults and pregnant women are offered help to quit smoking • Reduced and more equitable smoking prevalence* • More women aged 50-69 years are screened for breast cancer		• Improved and equitable patient experience of communication when accessing health services* • Increased percentage of infants who are enrolled with a general practice by three months • Improved and equitable youth access to and utilisation of youth appropriate health services* • Improved access rates to specialist mental health and addictions services across the life course • More people with CVD dispensed triple therapy • Reduced and more equitable absolute number of people with poor control of their diabetes		• Reduced Acute Rheumatic Fever first hospitalisations rates • Lower and more equitable ambulatory sensitive hospitalisation rates for 0-4 and 45-64 year olds • Improved and equitable workforce participation and retention rates • Fewer acute readmissions to hospital within 28 days • Reduced and equitable waiting time for people referred and treated for cancer • Timely access to planned and elective services • Shorter stays in Emergency Departments
OUTPUTS Services provided (See the Statement of Service Performance for 2016/17 performance results)	**Prevention Services** Health Promotion & Education Statutory and Regulatory Population Health Screening Immunisation Well Child		**Early Detection and Management Services** Primary Health Care (GP) Oral Health Primary Community Care Pharmacist Diagnostics Mental Health		**Intensive Assessment & Treatment Services** Mental Health Elective Acute Maternity Assessment, Treatment and Rehabilitation **Rehabilitation and Support Services** NASC Palliative Care Rehabilitation ARRC Home Based Support Life Long Disability Respite Care Day Services
INPUTS Enabling strategies	Health Equity	Patient Safety & Experience	People	Research & Evaluation	Financial	Technology	Facilities	Risk Management

Note: Performance indicators and data collation/reporting processes in development in 2016/17*

A: CM Health's definition of an adverse health care event is based on the IHI Global Trigger Tool for Measuring Adverse Events, Innovation Series 2009: http://www.ihi.org/

B: for more information on this measure refer to the Health Quality & Safety Commission website: https://www.hqsc.govt.nz/

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

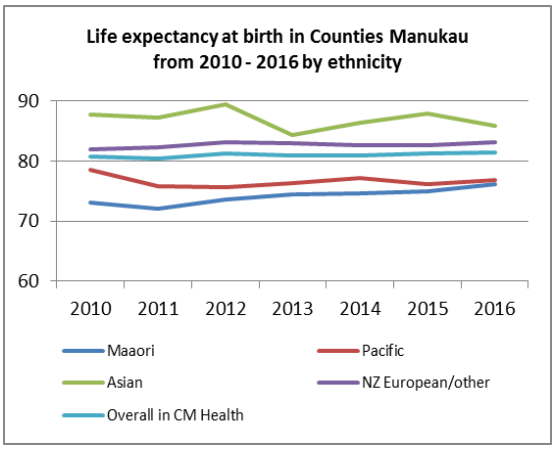
For the Counties Manukau community, we need to target outcome improvements to achieve health equity.[8] To better understand which people do not experience the same health outcomes, we report and compare results over time by ethnic group. Results are not always available for all ethnic groups and work 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 Outcome

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 ethnic inequities for Maaori and Pacific peoples are narrowing but 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[9] has consistently increased over the last ten years to 81.5 years in 2016, closely reflecting national trends. While there is modest narrowing of long-standing ethnic inequities, gaps of 7 and 6.3 years persist between Maaori and Pacific peoples respectively and Non-Maaori/Non-Pacific.



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 sub groups. 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.

Death at a young age from potentially preventable long term health conditions like cardiovascular disease, diabetes, respiratory diseases and cancer are 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 2016/17, we advanced our smoking cessation support to achieve health equity in both national 'Better Help for Smokers to Quit' targets. Encouragingly, the total Counties Manukau population smoking prevalence fell from 47 percent to 36 percent between the 2006 and 2013 Census. In 2016/17 CM Health also focused on activities and services to support healthier lifestyle choices in the community. Healthy lifestyle support was offered to approximately 7,300 adults through the Green Prescription initiative and approximately 790 children identified as obese in the Before School Check programme have been referred to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Alcohol is a contributing factor to many mental health problems, injuries, and more than 200 diseases and conditions, including alcohol dependence, liver cirrhosis, cardiovascular disease, and cancers. The use of alcohol can also result in harm to other individuals, including unborn babies through elevated risk of Foetal Alcohol Spectrum Disorder. In 2016/17 CM Health led development of a programme of collaborative alcohol harm minimisation actions with a view

[8] Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need.
[9] Data sourced from the Ministry of Health mortality collection and Estimated population from Stats NZ (2016 edition)

to working regionally across hospital and community settings to address social determinants contributing to hazardous alcohol use and related harm.[10] We look forward to progressing this programme with others in 2017/18.

Healthy Communities – Improved population health and equity

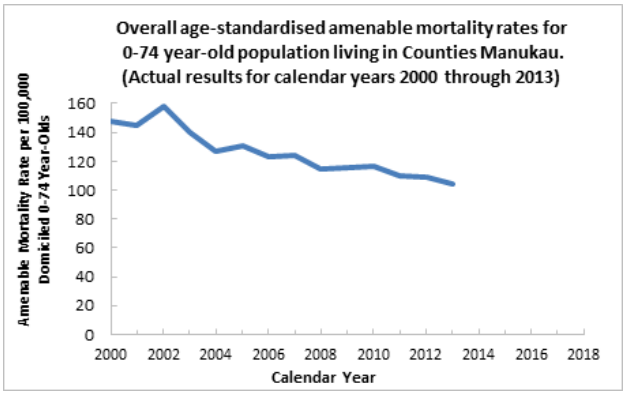
"Together we will help make healthy options easy options for everyone"

To achieve healthy communities, we continue to 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. Amenable mortality is a National System Level Measure and medium term outcome measure of healthy communities.

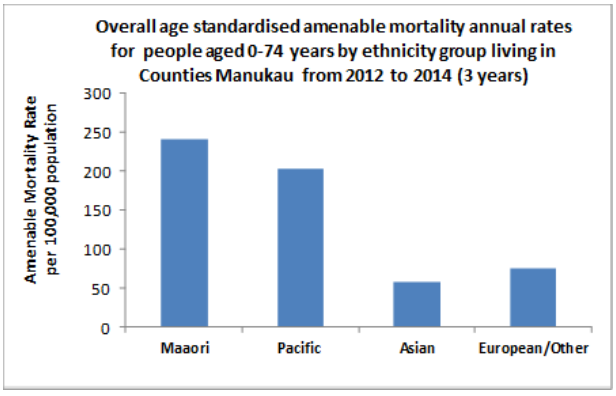
Outcome: Reduced and more equitable amenable mortality rates[11]

Amenable mortality is a measure of deaths that are considered 'untimely, unnecessary deaths in people aged less than 75 years that are amenable to health care'. The four leading causes of these premature deaths in Counties Manukau are cancer, cardiovascular disease (particularly heart attacks and stroke), chronic obstructive pulmonary disease (COPD) and diabetes - share common risk factors.[12]

Regional and local approaches focus on delivering actions to reduce unhealthy diet, physical inactivity, smoking and harmful use of alcohol risk factors. Proportionally, Maaori have a higher amenable mortality in smoking-related diseases such as cardiovascular disease and COPD. Pacific people have a higher proportion of diabetes related deaths.



In CM Health, the Planned Proactive Care (PPC) model of care aims to improve outcomes for patients with long term conditions, and other conditions which contribute to amenable mortality in Counties Manukau. Through our primary care Alliance, over 29,000 patients have now been through the PPC since it started in 2014. PPC focuses on providing a 'whole of person' approach, through enabling improved self-management and increased integration between primary and secondary care clinicians (via community multidisciplinary team meetings and the use of SharedCare).



In 2017/18 this focus will continue and PPC will move to strengthen and extend the care team supporting patients. There will be an increased focus on team-based care and joint person-centred care planning, utilising the emerging health coach workforce. This work will especially focus on patients identified as being at risk of poor health outcomes, including Maaori and Pacific living in areas of high socioeconomic deprivation, who have higher rates of amenable mortality.

[10] Note that the prevention of alcohol related harm is one of the domains of the developmental 2017/18 youth System Level Measure.
[11] 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. Note that due to the delay in mortality data being made available, the 2014 data is the most recent available.
[12] 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.

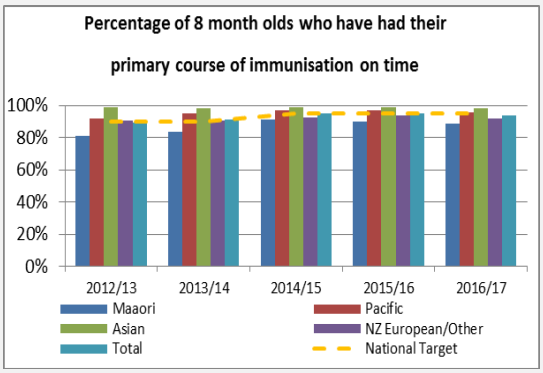
Impact: Equitable proportion of 8-month olds immunised on time

In addition to the direct benefits of being immunised, immunisation is an opportunity to engage families with other health care services. Ethnic inequities in immunisation coverage rates persists for pepi Maaori.

Increased immunisation (Health Target)

Total immunisation coverage for eight month olds living in Counties Manukau has been at 94 percent consistently across 2016/17. Pacific and Asian 8-month-olds in Counties Manukau have consistently exceeded the target throughout the year, achieving 96 percent and 98 percent respectively in quarter 4. Maaori 8 month immunisation rates have steadily increased from 86 percent in quarter 1 to 89 percent in quarter 4.

Approaches in 2016/17 that resulted in increased pepi Maaori immunisation coverage rates included outreach immunisation services, immunisation education and promotion strategies, and active targeting of populations with low coverage rate. Each of these approaches aimed to address feedback we had received from service providers and our Maaori mums about how CM Health can assist Maaori whaanau with the immunisation decision and accessing services. Further work is underway at CM Health, and in 2017/18 a targeted strategy "Awhi mai" is being piloted. This aims to educate and support mothers and caregivers on immunisations from 6 weeks to 4 years through Well Child Tamariki Ora (WCTO) and is supported by referral into Whanau Ora services.



Data source: National Immunisation Register Data Mart report

Impact: More adults and pregnant women are offered help to quit smoking

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

Inequities in smoking prevalence contribute to differences in life expectancy 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).[13] Brief advice can be effective at prompting quit attempts and long-term quit success.

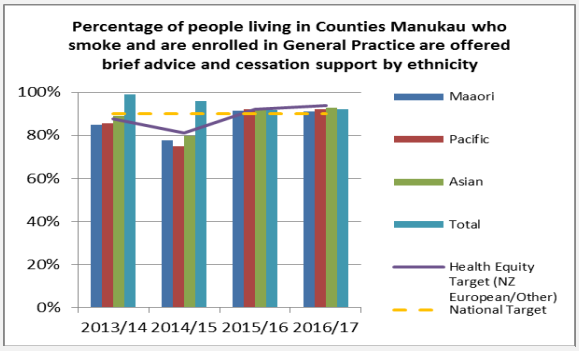
Better help for smokers to quit (Health Target)

PHO enrolled patients target

CM Health has exceeded the 90 percent target for the total PHO enrolled patient population in quarter 4.[14] Importantly, equity is demonstrated with all ethnicity groups exceeding the target. This primary care result reflects concerted effort by primary care across the region and has included the embedding of effective systems and processes as business as usual. Leadership from the DHB, Smokefree Advisor – primary care, PHO Smokefree coordinators and clinical target champions has continued to be effective. Slightly lower Maaori coverage in the first three quarters has responded well to targeted strategies in quarter 4 to increase coverage, such as evening calling of priority population groups by general practices.

Pregnant women target

Reducing the proportion of women who smoke during pregnancy will have benefits for the woman, her whaanau, family and health of her baby. Maaori mums are more likely to smoke during pregnancy. The Better Help for Smokers to Quit target was achieved for pregnant



Data source: Ministry of Health Performance Reporting Note, the difference in result from 14/15 baseline to 15/16 is due to the change in indicator definition and the removal of the Ministry of Health's applied adjustor.[15]

[13] Census 2013 data.
[14] Target exceeded in quarter 4 (92%). Quarter 1 to quarter 3 results were stable at 89%.
[15] The original indicator was defined as all people who smoke and are seen in General practice are provided brief advice and offered cessation support however after the change, General Practice are now responsible to ensuring that all enrolled people who smoke are provided brief advice and cessation support.

women (including for Maaori) in quarter 4 2016/17.[16]

CM Health's main focus to support Maaori waahine to stop smoking in early pregnancy and prevent relapse after birth is an incentives based programme. This programme is now into its fourth year and has doubled throughput and tripled the quit rate for Maaori waahine hapu.

Other actions to support the achievement of the target in 2016/17 have included education and training sessions for midwives, Well Child Tamariki Ora providers and medical students; and strategies to both identify barriers to quitting and to keep maternal Smokefree on the agenda.

Impact: Reduced and more equitable childhood obesity prevalence

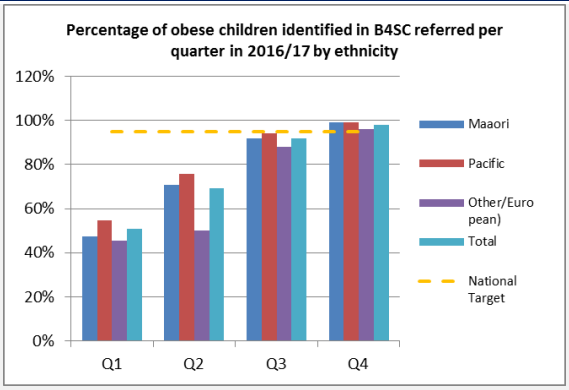
Childhood obesity negatively affects immediate and future health and quality of life. CM Health has a high prevalence of overweight and obese children and Maaori and Pacific children are disproportionately affected.

Raising healthy kids (Health Target)

Offering referral to obese children identified in the B4 School Check programme (B4SC) contributes to our childhood obesity strategy. Referral provides an opportunity for children and whaanau to participate in clinical assessment and family-based nutrition, activity and lifestyle programmes. 2016/17 was the first year of the Raising Healthy Kids Health Target and the target was achieved by quarter 4 for the total population and across all reported ethnicity groups through the establishment of an electronic referral pathway to primary care. The electronic referral pathway has been operational since 30 September 2016, however the acknowledgement of 100% referrals will not be reflected in the data until quarter one 2017/18 as the target results are based on six-month retrospective data.

At CM Health, we acknowledge the need for a broad approach to reducing childhood obesity and we have developed a Regional Healthy Weight Plan for children which details a range of actions.

CM Health is collaborating with Healthy Auckland Together, schools and the University of Auckland to ensure wider environmental and societal change.



Data source: Ministry of Health Performance Reporting

[16] Results over 2016/17: Q1: 86%, Q2:89% Q3: Data not available due to issues with the piloting of the MOH electronic maternity records system.

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.

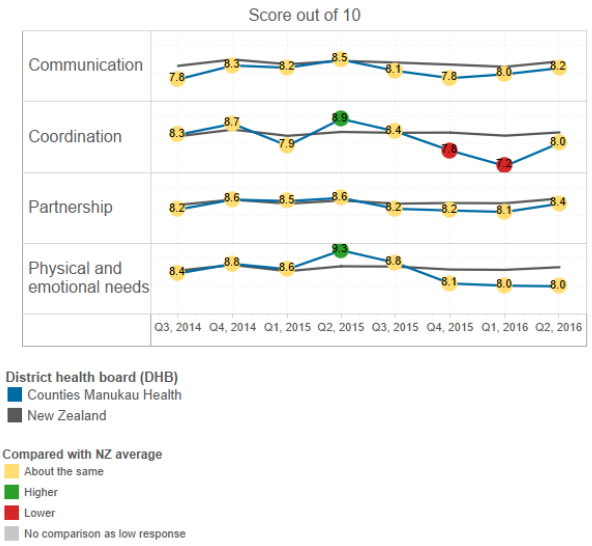
Outcome: Improved and more equitable experience of care

Understanding patients' experience is vital to improving patient safety and the quality of care. Improving their experience reflects the safety and quality of care[17] and contributes to better health outcomes.

In May 2017, CM Health achieved scores equal to or above the national average for all four patient experience domains measured in the National Patient Survey: communication, coordination, partnership and physical and emotional needs.[18]

The aim is to enable patients (and whaanau) to take a more active role in their own health. Current hospital patient surveys provide insights into how to improve patient experiences by focusing on activities to improve the quality of care provided.

More than half for our patients say that communication is an aspect of care that can make the most difference to them. Patients want to discuss their care and treatment with us and to have their views respected. In addition to the hospital survey, a primary care survey has been piloted[19] that focuses on coordination and integration of care and will be rolled out further in 2017/18. This will augment our current reporting with 'whole of health' system patient experience insights and opportunities for improvement.



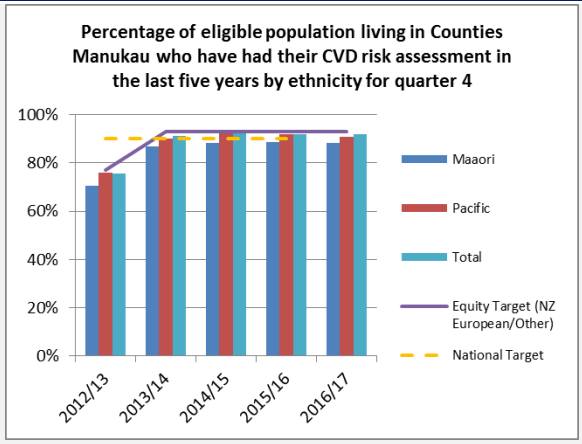
Data source: Health Quality and Safety Commission National Patient Experience Survey Report[20]

Impact: More people with CVD dispensed triple therapy

Cardiovascular disease (CVD) reduces both quality of life and life expectancy. Maaori and Pacific peoples are disproportionately burdened by CVD in Counties Manukau. Appropriate management of CVD risk factors can reduce both morbidity and mortality.

In the 2016/17 year, over 90 percent of the total eligible adult CM Health population had had a CVD Risk Assessment (CVDRA) in the last five years. Maaori CVDRA rates have been consistently just below the previous health target in 2016/17 at 88 percent despite CM Health actively working with PHOs and practices. Community and primary care strategies will be explored to attain equitable risk assessment for Maaori.

Management of CVD risk (both dual and triple therapy) is the goal of CVDRA. Forty-nine percent of the Counties Manukau population identified as having CVD risk greater than 20 percent received dual therapy and 58 percent of people with prior CVD received triple

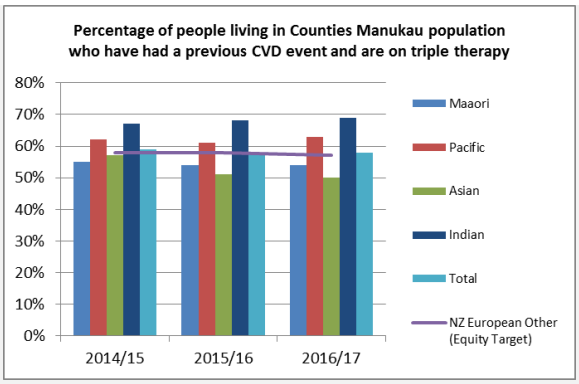


Data source: Ministry of Health Performance Reporting

[17] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203.
[18] As reported in the National patient experience survey: Results for patients treated in May 2017. Accessible via https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3016/
[19] Two PHOs in Counties Manukau were involved in the pilot phase in 2016 (Procare Networks, National Hauora Coalition) with roll out to other PHO practices in 2017/18. This primary care survey forms part of the SLM work for 2017/18 and the outer years.
[20] 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.

therapy.[21]

Performance has been consistent over the last three years across all ethnicities with triple therapy coverage lowest for Maaori and Asian ethnicities. Activities in 2016/17 have included improving systems to identify patients, gathering of more informative data, and interventions to improve uptake and adherence to therapy. The inclusion of CVD management as a contributory measure in the 2017/18 Metro Auckland System Level Measures Improvement Plan will focus activity on this area next year.



Data source: Northern Regional Alliance CVD Prevention Medication Six Monthly Report

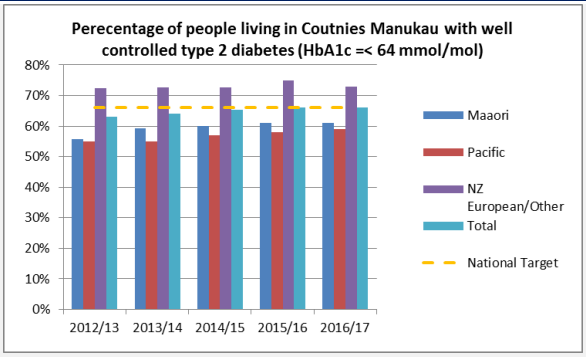
Impact: Reduced and more equitable absolute number of people with poor control of their diabetes

Diabetes reduces both quality of life and life expectancy. Maaori and Pacific peoples are disproportionately affected by poorly controlled diabetes in Counties Manukau. Better blood glucose control reduces the progression of some complications.

CM Health has the largest population in the country of people with diabetes. The proportion of the diabetes population with good glucose control (≤64mmol/mol) appears static over the last four years. Inequities persist with more Maaori (22 percent) and Pacific peoples (23 percent) having poor control (>80mmol/mol) than NZ European/Other ethnicities (13 percent).

We have actively worked with PHOs to improve data coverage and quality. An increase in the number of people with diabetes being counted in Counties Manukau has likely contributed towards this flat trend.

Actions to improve blood glucose control have focused on continued implementation of the holistic Diabetes Care Improvement Package (DCIP) and initiatives to increase community access to allied health services and support. In 2017/18 this package will be redesigned to focus on those who have poor glycaemic control. Clinical Governance Structures will be implemented with a strong focus on data, reporting and performance.



Data source: Ministry of Health Performance Reporting[22]

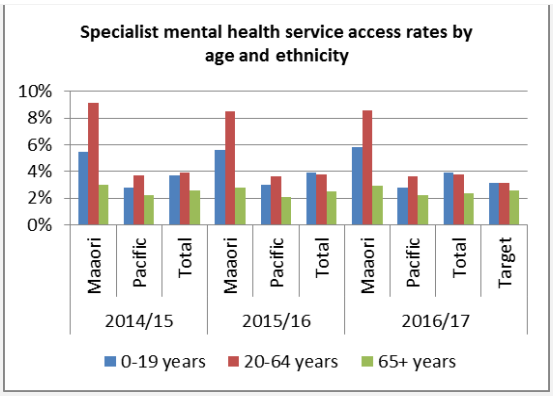
Impact: Improved access rates to specialist mental health and addictions services across the life course

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.[23]

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.

Maaori in Counties Manukau have higher access rates in all age bands reflecting the increased prevalence of serious mental disorders in Maaori communities. Pacific access rates are considerably less despite similarly high prevalence of psychological distress. Differential access rates by ethnicity may be related to variation in interpretations of symptoms, help seeking behaviour, access to services, and understanding and interpretation of diagnoses.[24]

Over 2016/17 CM Health exceeded access targets for the 0-19 and 20-64 age bands (3.15 percent) and fell just short of the 65+ target (2.60



Data source: Ministry of Health Performance Reporting

[21] Reporting on the 12 months ended 31 March 2017, source: Northern Regional Alliance CVD Prevention Medication Six Monthly Report.

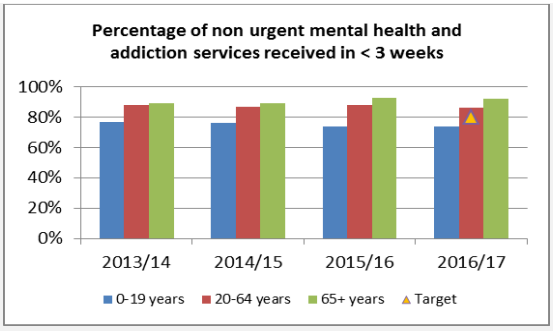
[22] This national performance measure (PP20) reflects the Ministerial priorities for improvement treatment for people with long term health conditions. Note that CM Health currently uses the PHO DCIP cohort based on the population aged 15-74 years enrolled with Counties Manukau practices as the denominator for this measure. Work is currently underway to mature and refine HbA1c reporting in CM Health.

[23] Winnard D, Papa D, Lee M, Boladuadua S, Russell S, Hallwright S, Watson P, Ahern T (2013) *Populations who have received care for mental health disorders.* Counties Manukau Health. Auckland: Counties Manukau Health.

[24] Winnard D, Papa D, Lee M, Boladuadua S, Russell S, Hallwright S, Watson P, Ahern T (2013) *Populations who have received care for mental health disorders.* Counties Manukau Health. Auckland: Counties Manukau Health.

percent). We are meeting the non-urgent mental health services timeliness target for 65+, indicating no wait list build up. A proposed integrated care programme is anticipated to increase access for the 65+ age group.

From April 2017 an out of hours call handling and intake and acute assessment triage service has been implemented. The service was developed with collaboration from clinical services and is overseen by a Clinical Governance group. Systems are in place to ensure that triaging of referrals is responsive and meets demand.



Data source: Ministry of Health Performance Reporting

Healthy Services – better value for public health resources

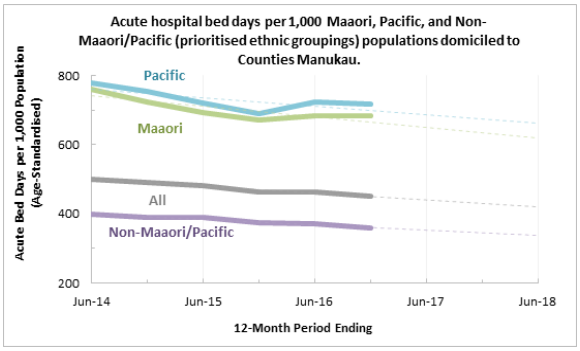
"Together we will provide excellent services that are well-supported to treat those who need us safely, with compassion and in a timely manner"

People are at the heart of healthcare services. Safe, quality healthcare services are provided by professionals who are well trained, knowledgeable and come to work because they want to do the best for patients and whaanau. By providing excellent services that are safe, timely and delivered with compassion, CM Health will reduce acute hospital bed days, readmissions and avoidable hospitalisations for our young and old residents, and provide better value for public health resources.

Outcome: Reduction in acute hospital bed days

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. CM Health aims to reduce inequities through an 'all of' system experience of care for patients and their families underpinned by teamwork and patient-centred care.

Reduction in acute hospital bed days was included as a national System Level Measure in 2016/17, with work during the year focused on data analysis by population groups and disease specific groups in order to identify areas for improvement. For people living in Counties Manukau, four disease areas were identified as key priorities: chronic obstructive pulmonary disease (COPD), atrial fibrillation, congestive heart failure and cellulitis. Activities to reduce acute bed days will be focused on these four key disease areas and be closely linked to activity aimed to reduce acute readmissions to hospital.



Data source: Ministry of Health Performance Reporting[25]

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

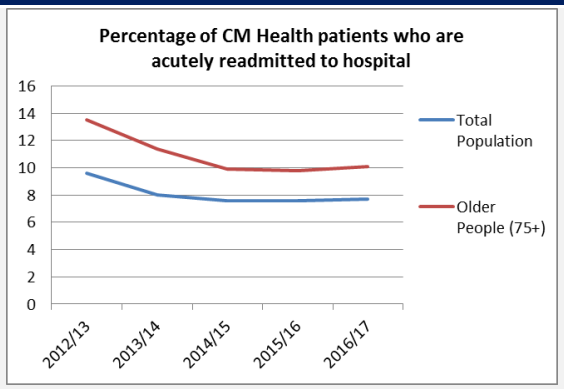
Impact: Reduced acute readmissions to hospital

Unplanned acute hospital readmissions are considered a measure of the quality of care provided to patients in our hospitals and health system more broadly. Reducing unplanned acute hospital admissions can not only be better for patients, but also help to reduce avoidable financial costs.

Unplanned acute hospital readmission can be a result of the care provided to the patient by the health system, including discharge planning processes and the transition of care from the hospital back into the community. The risk of readmission is partly determined by this care, but there is also evidence that suggests that factors such as presence of a social network after discharge and the patient's capacity for managing their own care influence the likelihood of someone being readmitted to hospital.

Acute readmissions in Counties Manukau have reduced since 2012/13 however they have remained stable over the last three years. In 2016/17 acute readmissions in Counties Manukau remained steady with the total population rate at 7.7 percent, and the rate for older people aged 75 years sitting between 9.9 and 10.1 percent.

Reduced acute readmission rates at 28 days is included as a contributory measure in the regional 2017/18 System Level Measures Improvement Plan. Activity proposed under this contributory measure will involve identifying patients discharged from hospital who have a relatively high risk of readmission and developing a care plan with them to prevent avoidable admissions in the future.



Data source: Ministry of Health Performance Reporting
Note that a National Target was not set for this measure in 2016/17.

Impact: Reduced acute rheumatic fever first hospitalisations rates

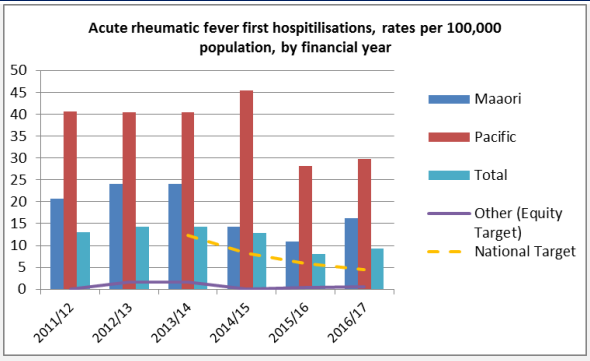
Acute rheumatic fever (ARF) is a potentially preventable, life-limiting illness that disproportionately affects Maaori and Pacific children in Counties Manukau. ARF can lead to rheumatic heart disease – a potentially avoidable chronic condition that extends into adulthood.

CM Health has the highest number of rheumatic fever cases and overall rheumatic fever rate of any DHB nationally.[26] Considerable gains have been made in the past five years with steady improvements in the total and Pacific rates, however end of year 2016/17 rates have risen slightly for all population groups, and particularly for Maaori (from 13.1 per 100,000 in 2015/16 to 16.2 per 100,000 in 2016/17).

The focus of development activity for 2016/17 was to strengthen the Maaori and Pacific input into the Mana Kidz service as well as increased information sharing and support for clinicians implementing the sore-throat management guideline.

CM Health acknowledges the broader determinants of ARF and the complexity of preventing this disease. We continue to offer school-based clinics, sore throat management programmes and community engagement activities with emphasis on equitable outcomes in all activities.

In 2017/18 CM Health will focus on improving our understanding of the progress we have made to date in our prevention activities for Maaori and Pacific and improving engagement with rangatahi Maaori and Pacific children and their whaanau.



Data source: Ministry of Health Performance Reporting

[26] The Ministry of Health website reports national progress by individual DHB. This is accessible from: http://www.health.govt.nz

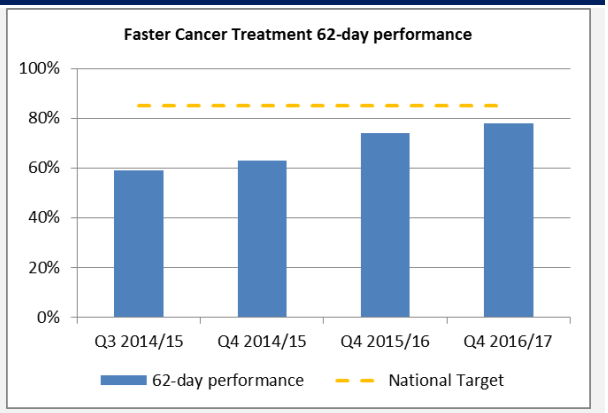
Impact: Reduced and equitable waiting time for people referred and treated for cancer

Cancer is one of the leading causes of morbidity and mortality in New Zealand, accounting for about 30 percent of deaths.

Faster Cancer Treatment (Health Target)

The Faster Cancer Treatment Health Target provides measures of system performance to ensure the time from referral to treatment start is optimised at 62 days or less. This health target is being used to drive system improvements across the cancer care pathway, ensuring timely treatment for patients with urgent cancer needs.

Steady progress towards achieving this target has been made by CM Health over the 2016/17 year. Actions include activities to improve throughput time such as tracking patients, tumour-stream level action plans and more efficient pathways and access to imaging. Performance has benefited from regional collaboration to ensure that cross-DHB pathways are timely and efficient.



Data source: Ministry of Health Performance Reporting
Note that quarterly results are based on six month retrospective data.

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 2016/17 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 (Figure 1).

National Health Target Performance

CM Health's performance against the National Health Target expectations in 2016/17 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	96% ✓	96% ✓	95% ✓	92%
Improved access to Elective Surgery	The volume of elective surgery will be increased by an average of 4,000 discharges per year	110% ✓	108% ✓	107% ✓	107% ✓
Faster Cancer Treatment	85% 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	75%	74%	76%	78%
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%	94%	94%	94%
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[27]	29%	62%	91%	98% ✓
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	89%	89%	89%	92% ✓
	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	86%	89%	Complete data not available [28]	90% ✓

[27] Performance against this target is based on the number of referrals sent and acknowledged. 2016/17 was the first year of the Raising Healthy Kids Health Target and the target was achieved by quarter 4 through the establishment of an electronic referral pathway to primary care. The electronic referral pathway has been operational since 30 September 2016, with target results based on six-month retrospective data.

[28] Results for this health target are based on data from two data sources - Maternity Clinical Information System (MCIS) and Midwifery and Maternity Providers Organisation (MMPO). Due to ongoing issues with the Maternity Clinical Information System (MCIS), complete results for the Maternity Smokefree Health Target were not available in Q3. The issue was resolved and full performance data was again available in Q4. The 97% result reported publically by the Ministry of Health in Q3 reflects data from the MMPO only (which accounts for approximately 25% of the Lead Maternity Carers in Counties Manukau).

Output Class: 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.

		2015/16 Baseline[29]	2016/17 Target[30]	2016/17 Result[31]	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		92%	90%	92%[32]	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 (LMC) who are offered brief advice and support to quit smoking		100%	90%	90%[33]	Achieved
Percentage of infants exclusively or fully breastfed at 4-6 weeks[34]	Total	58%	75%	58%	Not achieved[35]
	Maaori	52%		52%	
	Pacific	53%		53%	
Percentage of infants exclusively or fully breastfed at 3 months	Total	46%	60%	46%	Not achieved
	Maaori	37%		37%	
	Pacific	39%		39%	
Percentage of infants receiving breastmilk at 6 months	Total	62%	65%	62%	Not achieved
	Maaori	48%		48%	
	Pacific	59%		59%	
Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score (self-audit using AUT tool)[36]	Partner Abuse	98/100	=>180 combined score	97/100	Achieved
	Child Abuse & Neglect	99/100		100/100	
Immunisation Services					
Proportion of 8 month olds who have had their primary course of immunisation (six weeks, three months and five months immunisation events) on time (National Health Target)	Total	95%	95%	94%	Not achieved[37]
	Maaori	90%		89%	Not achieved
	Pacific	97%		96%	Achieved

[29] Baselines as 30 June 2016 (Q4) unless otherwise stated. All baselines audited unless otherwise stated.
[30] Targets to be achieved by 30 June 2017 (Q4) unless otherwise stated.
[31] Results as at 30 June 2017 (Q4) unless otherwise stated.
[32] Note that this target was achieved only in Q4. Q1 – Q3 results were stable at 89%.
[33] Not that the Maternity Smokefree Health Target was not met in quarters 1 and 2 (Q1:86%, Q2:89%). Due to ongoing issues with the Maternity Clinical Information System (MCIS), results for the maternity smokefree target were not available in Q3. The issue has now been resolved.
[34] Note that all breastfeeding data is sourced directly from Plunket. Due to a delay in data being made available, all breastfeeding baselines are as at 31 December 2015 with results also being at 31 December 2015 (most recent data available as at August 2017). Note that the wording of the 4-6 week measure has been amended from that included in the 2016/17 Annual Plan to reflect that this data is sourced from Plunket rather than from LMCs directly.
[35] There are a number of complex factors which impact on breastfeeding rates. Significant work is underway to improve breastfeeding rates in Counties Manukau, including strengthening and aligning community breastfeeding support services, development of a Counties Manukau Breastfeeding Action Plan and workforce development.
[36] The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training method.
[37] Immunisation rates at eight months have remained stable at 94% for total population over 2016/17 with rates being lower for Maaori (Q1: 86%, Q2 89%, Q3: 91%, Q4 89%). We implemented a range of approaches to address this including: process improvements to enable faster turnaround of overdue reports and earlier referral to Outreach Immunisation; prioritising Maaori babies for immunisation/outreach services; Immunisation Nurse Leader worked with all practices with low Maaori and high needs coverage rates to improve performance; continued to hold Saturday drop in outreach clinics to help reduce barriers to access. In 2017/18 we will be piloting a targeted strategy "Awhi mai" to educate and support mothers/ caregivers on immunisations from 6 weeks to 4 years through WCTO, supported by referral into whanau ora services, with the outcome that babies are immunised at GP practice or in home.

		2015/16 Baseline[29]	2016/17 Target[30]	2016/17 Result[31]	Achievement
Proportion of two year olds who are fully immunised	Total	95%	95%	95%	Achieved[38]
	Maaori	92%		90%	Not achieved
	Pacific	98%		97%	Achieved
Proportion of five year olds who are fully immunised[39]	Total	88%	95%	92%	Not achieved
	Maaori	83%		89%	Not achieved
	Pacific	88%		94%	Not achieved
Proportion of older people (65+) who have had their flu vaccinations	Total	47%	75%	50%	Not achieved
	Maaori	N/A[40]		49%	Not achieved
Health Screening and Well Child Tamariki Ora					
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	69%	70%	69%	Not achieved[41]
	Maaori	65%		63%	Not achieved[42]
	Pacific	76%		75%	Achieved
Proportion of women aged 20-69 years who have had a cervical smear in the last three years[43]	Total	75%	80%	73%	Not achieved[44]
	Maaori	69%		65%	Not achieved
	Pacific	82%		81%	Achieved
Proportion four year olds who have had their B4 School Checks	Total	91%[45] (8085 of which 3373 were high dep, Quintile 5)	90%	92% (8201 of which 3703 were high dep, Quintile 5)	Achieved
Proportion of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions[46]	Total	N/A[47]	95%	98%	Achieved[48]

[38] Note this target was achieved for the total population in quarter 4 (Q1 – Q3: 94%).
[39] This is a new measure included in the 2016/17 Statement of Performance Expectations therefore audited results are not available.
[40] Maaori flu vaccination rates not reported in 2015/16 therefore audited baseline not available.
[41] During Q1 and Q2, BreastScreen Counties Manukau (BSCM) were short of Medical Radiation Technologists which impacted screening volumes. Additional staff have since been recruited and screening volumes and coverage have improved. CM Health is confident that the total population target will be achieved moving forward.
[42] BSCM is working on a number of specific strategies to increase Maaori coverage. A social marketing campaign, including Maaori TV, radio, back of bus advertisements and outdoor advertising using promotional trailers ran through May and June 2017. We plan to repeat the advertising in the 2017/18 year. BSCM, in conjunction with the new Support to Screening Service team is also working hard to follow up Maaori women who did not respond to appointment letters or did not attend appointments. We are also identifying women who are not enrolled in the programme, or who may have new contact details through data matching with GP data bases and the DHB iPM data base.
[43] Note that the cervical screening programme is available for women aged 20-69 years, but the coverage reports include women who were aged 22,23 and 24 at the start of the monitoring period. CM Health funds PHOs and collects data to support screening of women aged 25-69, as the focus is on women who are unscreened or under-screened.
[44] CM Health continues to focus on increasing cervical screening coverage rates for Maaori women. National Screening Unit (NSU) data is matched with primary care records to help identify in screened and under-screened priority group women for invitation to screen and recall. The CM Health Support to Screening Service continues to promote opportunistic and out of hours screening opportunities. The clinics held at the Manukau Super Clinic and the Mangere Hub are well utilised. Women's health initiatives have been funded by the DHB through two PHOs and have had success in increasing coverage rates. Note that although the coverage for Maaori women has decreased in the last year, more women (179) were actually provided with a cervical screen in 2016/17 compared to 2015/16. To meet target an additional 2,851 Maaori women need to be screened.
[45] In 2015/16 8,085 four year olds had their B4 School Check. The baseline figure of 91% illustrates the total proportion of four year olds who had their B4 School Check in 2015/16. The 101% previously reported in the 2015/16 Annual Report represented that 101% of the target number of 8,026 children had received their B4 School Check in 2015/16.
[46] Note that this measure was excluded from CM Health's 2016/17 Statement of Service Expectation in error. It has therefore been added as a new measure to this Statement of Service Performance.
[47] This is a new measure included in 2016/17 therefore audited results are not available.
[48] Performance against this target is based on the number of referrals sent and acknowledged. 2016/17 was the first year of the Raising Healthy Kids Health Target and the target was achieved by quarter 4 through the establishment of an electronic referral pathway to primary care. The electronic referral pathway has been operational since 30 September 2016, with target results based on six-month retrospective data. Results for other quarters: Q1: 29%, Q2:62%, Q3:91%.

Output Class: 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. These 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.

		2015/16 Baseline[49]	2016/17 Target[50]	2016/17 Result[51]	Achievement
Primary Health Care Services					
Eligible people receiving cardiovascular (CVD) risk assessment in the last 5 years	Total	92%	90%	92%	Achieved
	Maaori	89%		89%	Not achieved[52]
	Pacific	92%		91%	Achieved
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)	Total	65%	69%	66%	Not achieved[53]
	Maaori	61%		61%	
	Pacific	58%		59%	
Proportion of PHO enrolled population enrolled within At Risk programme[54]	Total	5%	5%	6%	Achieved[55]
Percentage of all At Risk who have a: ▪ Care Plan ▪ Electronic Summary Record ▪ Self-Management Assessment ▪ Named Care Coordinator	Total	94%	80%	89%	Achieved
Oral Health Services[56]					
Proportion of children under five years enrolled in DHB-funded community oral health services		74%	95%	84%	Not achieved[57]
Proportion of enrolled preschool and school children who have not been examined at a community oral health service (within 30 days of their recall date)		15%	7%	21%	Not achieved[58]
Percentage of enrolled children caries free at age 5 years[59]		49%	55%	49%	Not achieved
Mean DMFT (Decayed Missing or Filled Teeth) Score for Year 8 children (12/13 years)[60]		1.05	1.00	0.96	Achieved
Proportion of Year 8 children who have their treatment		100%	100%	100%	Achieved

[49] Baselines as at 30 June 2016 (Q4) unless otherwise stated.
[50] Targets to be achieved by 30 June 2017 (Q4) unless otherwise stated.
[51] Results as at 30 June 2017 (Q4) unless otherwise stated.
[52] There are ongoing differences in performance between Maaori and other ethnicities. This has been difficult to shift despite the DHB actively working with PHOs and practices to target activities at Maaori groups. Work is ongoing in this area and in 2017/18 is supported by the inclusion of CVD risk assessment for Maaori and CVD management as contributory measures under the Amenable Mortality SLM for 2017/18, ensuring continued efforts by DHBs and PHOs in this area.
[53] Actions to improve blood glucose control have focused on continued implementation of the holistic Diabetes Care Improvement package (DCIP) and initiatives to increase community access to allied health services and support. In 2017/18 this package will be redesigned to focus on those who have poor glycaemic control. Clinical Governance Structures will be implemented with a strong focus on data, reporting and performance.
[54] The At Risk Programme allows for those with Chronic Conditions and complex health needs to actively manage their health in primary care in the community. This in turn leads to decreased acute admissions and avoidable mortality. Note that in 2016/17 the At Risk Programme was renamed as Planned Proactive Care (PPC).
[55] Note that this target was achieved in quarters 2-4 (Q1:4.8%, Q2:5.1%, Q3:5.7%, Q4:6.0%).
[56] Baselines for all oral health measures as at December 2015. Targets and results for all oral health measures as at December 2016.
[57] Enrolment rates have improved for Maaori, Pacific and Asian children in 2016/17, although these still remain below target. The current enrolment strategy sees WCTO core-contacts being leveraged to ensure that providers enrol children at 5 months of age and provide oral health education to parents.
[58] While enrolment rates are increasing, the Auckland Regional Dental Service (ARDS) is facing challenges in ensuring access to check-ups, especially for Maaori and Pacific children and their families. The main challenge has been improving the total headcount of the clinical workforce to handle the volume of patients, as well as opening services at times convenient to families. ARDS is currently working on recruitment strategies to address significant workforce shortages experienced in the 2016/17 Financial Year.
[59] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[60] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.

		2015/16 Baseline[49]	2016/17 Target[50]	2016/17 Result[51]	Achievement
completed and are transferred to the adolescent dental service					
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		73%	85%	72%	Not achieved[61]
Diagnostics					
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	92%	95%	95%	Achieved
	MRI	62%	85%	80%	Not achieved[62]
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		90%	85%	97%	Achieved
Proportion of patients accepted as non-diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		44%	70%	63%	Not achieved[63]
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		82%	70%	96%	Achieved[64]

Output Class: 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.

			2015/16 Baseline[65]	2016/17 Target[66]	2016/17 Result[67]	Achievement
Mental Health						
Proportion of child and youth clients with a transition discharge plan			92%	95%	95%	Achieved[68]
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%	74%	Not achieved[69]
		8 weeks	96%	95%	95%	Achieved
	Addictions	3 weeks	96%	80%	96%	Achieved

[61] Factors affecting the proportion of adolescents using free oral health services include resistance by some local secondary schools to hosting Mobile Dental Clinics and that approximately 2500 young people aged 16-17 are outside of the education system and therefore aren't reached by current engagement strategies. ARDS will meet with the MOH Oral Health Team in September 2017 to progress engagement strategies for young people classified as NEET (Not in Education, Employment or Training).
[62] CM Heath is in the process of planning for additional MRI capacity at the Middlemore site due on stream in Q2 2018.
[63] Capacity issues, coupled with increased demand, have impacted CM Health's ability to meet the 6 week colonoscopy target since Q1 2016/17. A number of mitigating actions have been taken and will continue to be implemented in 2017/18 including the recruitment of two Senior Medical Officers (SMOs), increased SMO availability to cover vacant lists, further recruitment to the service, and outsourcing where efficient.
[64] Note this target was achieved in quarters 1, 2 and 4 (Q3:61%).
[65] Baselines as at 30 June 2016 (Q4) unless otherwise stated.
[66] Targets to be achieved by 30 June 2017 (Q4) unless otherwise stated.
[67] Results as at 30 June 2017 (Q4) unless otherwise stated.
[68] Note this target was met in quarters 3 and 4 (Q1:93%, Q2:93%).
[69] In 2017/18 CM Health is participating the national Child and Adolescent Mental Health Service (CAMHS) discussions regarding the review of this performance measure.

			2015/16 Baseline[65]	2016/17 Target[66]	2016/17 Result[67]	Achievement
	(Hospital Care Arm and NGO)	8 weeks	98%	95%	99%	Achieved
Elective Services						
ESPI 2: Proportion of patients who wait longer than four months for their first specialist assessment (FSA)			0	0	0	Achieved
ESPI 5: Proportion of patients given a commitment to treatment but not treated within four months			0.1%	0	0.4%	Not achieved
Number Elective Surgical Discharges (National Health Target)			109% 21,650	100% 20,395	107% 21,746	Achieved
Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population		Major joints	22.39	21	24.18	Achieved
		Cardiac Surgery	6.04	6.5	5.79	Not achieved[70]
		Cataracts	33.25	27	38.85	Achieved
Outpatient Did Not Attend (DNA) rates		Maaori	18%	10%	20%	Not achieved[71]
		Pacific	16%		19%	Not achieved
Acute Services[72]						
Acute readmissions to hospital[73]		Total	7.7%	No target provided	7.7%	N/A
		75+	9.7%		10.1%	N/A
Acute Inpatient Average Length of Stay[74]			2.57 days	2.60 days	2.64 days	Not achieved
Proportion of patients admitted, discharged or transferred from the ED within six hours (National Health Target)			96%	95%	92%[75]	Not achieved[76]
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment (and are ready to start treatment) who receive treatment within four weeks from decision to treat	Chemo-therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	
	Radio-therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	
Proportion of patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks (National Health Target)			76%	85%[77]	78%[78]	Not achieved[79]
Cardiac Services						
Proportion of all outpatients triaged to chest pain clinics who are seen within 3 weeks for cardiology assessment and			92%	80%	85%	Achieved

[70] Cardiac surgery for CM Health residents is provided by Auckland District Health Board.
[71] A number of quality improvement initiatives have been undertaken to improve results. Examples of initiatives to reduce DNA rates include processes such as allowing patients to select their appointment time, an appointment reminder process that includes numerous text messages, the effectiveness of such processes is being assessed on a locality by locality basis.
[72] Cancer treatment services for CM Health residents are provided through the Auckland District Health Board Regional Cancer and Blood Centre and CM Health Haematology.
[73] The MOH were reviewing this measure in 2016/17 and data was provided for information only. DHBs were not measured/assessed against any targets. Note that results are as at March 2017 (most recent data available).
[74] Inadequate length of stay (LOS) can lead to increased readmission. Optimal inpatient LOS ensures patients receive sufficient care to avoid readmission.
[75] Note that this target was achieved in quarters 1 – 3 (Q1:96%, Q2:96%, Q3:95%).
[76] Volumes over Q4 2016/17 presented a significant challenge and the 6 hour Health Target was not achieved (Q1:96%, Q2:96%, Q3:95%). A range of initiatives are underway to address underlying system challenges and manage demand.
[77] 2016/17 target has been corrected from the incorrectly noted 90% target that was included in the 2016/17 Annual Plan. National Health Target for 2016/17 was that 85 percent 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 two weeks.
[78] Result based on six-month retrospective data for January to June 2017. Quarterly results for 2016/17 were Q1:75%, Q2:74%, Q3:76%, Q4:78%.
[79] Key improvement activity over 2016/17 was focused on the development of individual tumour stream action plans, aligned to the overall FCT programme. The focus of FCT improvement activity in 2017/18 is to raise performance above 90% in a sustainable and patient centred manner.

	2015/16 Baseline[65]	2016/17 Target[66]	2016/17 Result[67]	Achievement
stress test[80]				
Proportion of outpatient coronary angiograms with a waiting time of <3 months	99%	95%	96%	Achieved
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission	81%	70%	74%	Achieved
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins	93%	80%	81%	Achieved[81]

Output Class: 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 palliative care services, home-based support services and residential care services.

On a continuum of care these services will provide support for individuals.

	2015/16 Baseline[82]	2016/17 Target[83]	2016/17 Result[84]	Achievement
Needs Assessment and Service Coordination (NASC)				
Percentage of Complex Patients see within five working days of referral for a home care assessment	26%[85]	65%	26%	Not achieved[86]
Percentage of Non-Complex Patients seen within fifteen working days of referral for a contact assessment	59%[87]	70%	67%	Not achieved
Assessment, Treatment and Rehabilitation Services				
Percentage of identified fragility fracture patients presenting in secondary care will be investigated and offered interventions to prevent second fragility fractures	71%	90%	87%	Not achieved[88]
Number of older people referred through the Fracture Liaison Service to a community strength and balance programme who participated in the programme	0%[89]	50%	0%	Not achieved[90]
Age Related Residential Care (ARRC)				
Number of potentially avoidable ED presentations from ARRC per month	Average 12 per month	<15 per month	Average 13 per month	Achieved
Percentage of people in ARRC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of previous assessment	82%[91]	95%	88%	Not achieved[92]

[80] The 3 week target is for CM Health whilst the Regional target is 6 weeks. Note that this measure definition has been corrected from that included in the 2016/17 SPE.
[81] This target was met in quarters 2 – 4 (Q1:78%).
[82] Baselines as at 30 June 2016 (Q4) unless otherwise stated.
[83] Targets to be achieved by 30 June 2017 (Q4) unless otherwise stated.
[84] Results as at 30 June 2017 (Q4) unless otherwise stated.
[85] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[86] CM Health has completed work to map the patient journey for complex patients and identified a number of administrative blockages in the referral pathway which have led to delays in the provision of timely home care assessment. Next steps identified to address these blockages include: increasing resources to remove service co-ordination and administration tasks from the assessors to improve capacity; monitor work practices to ensure assessments are closed off as completed in a more timely manner; and continue to monitor intake and triage to ensure minimal delay in getting referrals to the assessors.
[87] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[88] All fragility fractures identified in secondary care have been investigated and offered interventions if appropriate. Work to improve the data capture of falls and factures on presentation are continuing.
[89] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[90] The CM Health community strength and balance programme is not yet in place due to delays in ACC procuring this service. It is expected it will be in place from 1 September 2017.
[91] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[92] In 2017/18 CM Health plans to undertake an analysis of each provider's individual performance over the last year and will follow up with the outliers accordingly.

	2015/16 Baseline[82]	2016/17 Target[83]	2016/17 Result[84]	Achievement
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using and interRAI Home Care assessment tool in the six months prior to that first LTCF assessment	N/A[93]	95%	85%	Not achieved[94]
Home Based and Community Support				
Proportion of CM Health NASC clients receiving Home Base Support Services who have a comprehensive interRAI assessment completed at any time prior	95%[95]	90%	95%[96]	Achieved
Percentage of current clients receiving long term HBSS that have an interRAI clinical assessment within the previous 24 months	81%[97]	65%	75%[98]	Achieved

Maaori Health Plan indicators

As part of the annual planning cycle, DHBs are required to develop a Maaori Health Plan. The Maaori Health Plan provides a comprehensive collection of evidence based activities with performance indicators designed to reduce health inequities, accelerate Maaori health gain and progress the principles of the Treaty of Waitangi.

The Plan has a number of prescribed national indicators that link to the leading causes of mortality and morbidity for Maaori. DHBs also have the flexibility to develop their own local indicator set which reflects the specific needs of the Maaori population in the district. This section gives an overview of our performance against the indicators in the 2016/17 CM Health Maaori Health Plan.

			2015/16 Baseline[99]	2016/17 Target[100]	2016/17 Result[101]	Achievement
National Indicators						
Percentage of general practices in 2 CM Health PHOs who have completed the 3 stages of EDAT			99%	100%	99%	Not achieved[102]
Percentage of Maaori enrolled in PHOs			93%	100%	93%	Not achieved
Ambulatory Sensitive Hospitalisation rates per 100,000 population	Age 0-4	Maaori	7,056	5,650 per 100,000	6,529	Not achieved[103]
		Total	7,659	N/A	7,029	N/A
	Age 45-64	Maaori	8,648	6,029 per 100,000	8,953	Not achieved[104]
		Total	4,678	N/A	4,737	N/A
Breastfeeding – refer to preventative services output class table						
Cervical screening – refer to preventative services output class table						
Breast screening – refer to preventative services output class table						

[93] Measure commenced in Q1 2016/17 therefore baseline data not available.
[94] CM Health continues to monitor this measure on an NHI level basis. A dispensation process has now been put in place in which all NASC staff are required to request approval for a dispensation from completing an interRAI assessment prior to entry into ARRC in exceptional circumstances. These requests are monitored and we have found that the majority of the reasons that clients are entering ARRC without an up to date interRAI are valid i.e. terminal clients etc.
[95] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[96] Result as at Q3 2016/17.
[97] New measure in the 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[98] Result as at Q3 2016/17
[99] Baselines as at 30 June 2016 (Q4) unless otherwise stated.
[100] Targets to be achieved by 30 June 2017 (Q4) unless otherwise stated.
[101] Results as at 30 June 2017 (Q4) unless otherwise stated.
[102] The main focus of implementation and ongoing activity is to embed EDAT usage across the network of general practices. Achievement of the 100% is not anticipated due to the appropriateness of some practices in the network, such as those located in aged care facilities.
[103] In 2016/17 significant effort has gone into securing workforces to deliver training to frontline nursing staff, community providers, teachers and WCTO providers about skin infections. The Planned Proactive Care model of care has supported advances against ASH Targets by developing training packages relating to eczema management and children with asthma and constipation.
[104] The focus for adult ASH rates has been on training nursing staff in the identification, treatment and proactive care of adult skin infections.

		2015/16 Baseline[99]	2016/17 Target[100]	2016/17 Result[101]	Achievement
Percentage of women who are smokefree at two weeks postnatal	Maaori	72%[105]	95%	72%[106]	Not achieved[107]
	Total	91%		91%	Not achieved
Immunisation (tamariki) – refer to preventative services output class table					
Acute rheumatic fever first hospitalisation rates per 100,000 population	Maaori	13.1	4.5 per 100,000	16.2	Not achieved[108]
	Total	7.0		9.3	Not achieved
Oral health – refer to early detection and management output class table					
Mental Health Act: Section 29 Indefinite CTO rates per 100,000	Maaori	131	No target[109]	144.2	N/A
	Non-Maaori	33.7		37.1	N/A
SUDI deaths per 1,000 live births	Maaori	2.13[110]	0.4 per 100,000	2.38[111]	Not achieved
	Total	0.96		1.06	Not achieved
Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1	Maaori	73%	100%[112]	73%	Not achieved[113]
	Total	80%		80%	Not achieved
Local Indicators					
CVD – refer to early detection and management output class table					
Percentage of CM Health employees who are Maaori	Whole organisation	7.1%	8%	6.9%	Not achieved[114]
	Hospital directorate	6.6[115]		6.5%	Not achieved
Percentage of rangitahi accessing Alcohol Brief Interventions (via general practice)	Maaori	0.4%[116]	0.5%	0.6%	Achieved
Percentage of rangitahi accessing Mental Health Brief Interventions (via general practice)	Maaori	0.1%[117]	0.4%	0.1%	Not achieved

[105] Audited baselines as at December 2016.
[106] Note that most recent available results are as at December 2016.
[107] An increase in the proportion of smokefree Maaori waahine has occurred from 66% in Jan to June 2013 to 72% in July to December 2015. The main focus is to support Maaori waahine to stop smoking in early pregnancy and prevent relapse after birth using an incentives based programme. This programme is now into its fourth year and has doubled throughput and tripled quit rate for Maaori waahine hapu. In 2017 CM Health implemented a trial to extend the pregnancy incentives programme to the post-natal period. Since this trial began an increase in referrals and engagement has been observed and it is believed this change will increase quit rates and address the high relapse rate that occurs immediately after birth.
[108] The focus of development activity for the financial year has been to strengthen the Maaori and Pacific input into the Mana Kidz service as well as increased information sharing and support for clinicians implementing the sore-throat management guideline.
[109] No target set by MOH for 2016/17.
[110] Baseline sourced form MOH, SUDI mortality (number of deaths and rate per 1000 live births), by DHB of residence and ethnicity, 2010-2014 combined.
[111] Most recent SUDI results sourced from MOH, SUDI mortality (number of deaths and rate per 1000 live births), by DHB of residence and ethnicity, 2011-2015 combined.
[112] MOH target is 70%, CM health local target is 100%.
[113] Due to a delay in data being made available, all SUDI baselines are as at 31 December 2015 (audited) with results also being at 31 December 2015 (most recent data available as at August 2017).
[114] The reduction in overall percentages of Maaori people in the CM Health total workforce relates to an overall increase in the total number of staff (of all ethnicities) while the number of Maaori has remained static (358 Maaori in a total workforce of 6,296).
[115] New measure in 2016/17 Statement of Performance Expectations. Audited baseline data therefore not available.
[116] Note that the audited baseline for 2015/16 presented the absolute number of rangitahi accessing Alcohol Brief Interventions (ABIs). For 2015/16 the absolute number of rangitahi accessing ABIs was 61/ 13,800, or 0.4%.
[117] Note that the audited baseline for 2015/16 presented the number of rangitahi accessing Mental Health Brief Interventions (MHBIs). For 2015/16 the absolute number of rangitahi accessing MHBIs was 15/ 13,800, or 0.1%.

Performance by Output Classes (Includes agency costs)

1.1.1 Output Classes ($000)

	Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services	Total
Revenue (includes agency revenue)	**67,795**	**222,988**	**1,161,904**	**124,484**	**1,577,171**
Budget (includes agency revenue)	*66,380*	*198,132*	*1,207,910*	*122,481*	*1,594,903*
Personnel Costs	35,429		556,959		592,388
Outsourced Services	7,944		79,955		87,899
Clinical Supplies	3,818		115,584		119,402
Infrastructure and Non-Clinical Supplies	5,779		116,959		122,738
Other (includes agency costs)	14,825	222,988	305,387	124,484	667,684
Total Costs	**67,795**	**222,988**	**1,174,844**	**124,484**	**1,590,111**
Budget (includes agency costs)	*66,380*	*198,132*	*1,203,410*	*122,481*	*1,590,403*
Surplus (Deficit)	**0**	**0**	**(12,940)**	**0**	**(12,940)**
Budget	**0**	**0**	**4,500**	**0**	**4,500**

Agency revenue and costs for the year amounts to $17.6m.

Information on appropriations

An appropriation is a statutory authority from Parliament allowing the Crown or an Office of Parliament to incur expenses or capital expenditure. The Minster of Health is responsible for appropriations in the health sector. Each year, the Ministry of Health allocates the health sector appropriations through 'Vote Health' to DHBs, who use this funding to plan, purchase and provide health services, including public hospitals and the majority of public health services, within their areas.

An assessment of what has been achieved with Counties Manukau DHB's 2016/17 appropriations is detailed below:

Appropriations allocated and scope

Health and Disability Support Services appropriation allocated to Counties DHB reflects non-departmental output expenses incurred by the Crown.

The funding of personal and mental health services includes services for the health of older people, provision of hospital and related services and management outputs from Counties Manukau DHB.

What is intended to be achieved with this appropriation

The DHB provides services that align with:

- the Government priorities;
- the strategic direction set for the health sector by the Ministry of Health;
- the needs of the district's population; and
- regional considerations.

How performance will be assessed and end of year reporting

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

	Amount of Appropriations ($000)				
	2015/16	2016/17			
	Budgeted	Estimated Actual	Estimates	Supplementary estimates[118]	Total
Total Appropriations	1,274,349	1,274,349	1,329,104	(7,369)	1,321,735

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.

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

Good Employer

Counties Manukau District Health Board (CMDHB) is committed to being good employer for all its 7,935 staff who serve the most diverse population in New Zealand. CMDHB is committed to fulfilling its legal requirements in Section 118 of the Crown Entities Act 2004 and as an Equal Employment Opportunities (EEO) employer, and to providing its people with a safe healthy place to work while achieving our shared goal of health equity for our community. CMDHB has a wide variety of programmes available 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 165 different ethnic groups
- Recognise the aims, aspirations, cultural differences and employment requirements of Maaori
- Recognise the aims, aspirations, cultural differences and employment requirements of Pacific peoples, and people from other ethnic or minority groups, women and person with disabilities
- Develop programmes for Asian workforces which comprise 31% of our workforce
- Provide safe and healthy working conditions – we aspire to have a healthy workforce in same way that we aspire to have health communities
- Have an Equal Opportunities programme
- Impartially select suitably qualified persons for employment with a focus in the last year 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
- Through our "Grow our Own" programme, have more Maaori and Pacific people consider health as a career, and then ideally be employed within South Auckland.

As a good employer, Counties Manukau District Health Board 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 Counties Manukau District Health Board being a good employer.

1. Leadership, accountability and culture

Organisational culture and values

CM Health has a clear strategic direction of "Healthy Together 2020" with the strategic goal of achieving health equity. Our culture and organisational structures are focused on working in our community and our people are patient and whaanau centred. 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.

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

- A Workforce Development and Flexible Learning Strategy of which a key initiative in 2016 was enabling over 2,000 nursing staff to access their Professional Development and Recognition Programme process (PDRP) using an electronic portfolio (ePortfolio) system called Mahara. The new nursing "ePDRP" is the first of the new ePortfolio initiatives to rollout and can be accessed directly through Ko Awatea LEARN using existing login details. The new system will be supported by learning materials built into LEARN
- A new leadership programme in 2016 for doctors as leaders which was co-designed with the New Zealand Leadership Institute University of Auckland
- Advance eLearning capacity and content which is accessible to all staff
- Education communities and forums including strong alliances with our joint venture partners (University of Auckland, Auckland University of Technology, and Manukau Institute of Technology) and other organisations such as the University of Waikato
- Clinical staff involvement in improvement initiatives, campaigns, innovation and improvement intensives
- Pipeline initiatives such as the Health Science Academy
- Mindfulness, system innovation and improvement, and patient centred care workshops and master classes and service co-design with patients and whaanau.

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. Some of our initiatives are:

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 then with their job search and match them to roles within our organisation. CM Health is the pilot organisation for this project and to date we have successfully recruited 2 people from our community into full time paid work at CM Health.

Ministry of Social Development (MSD) partnership - We have recently connected with MSD and began a partnership 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 help them into graduate level roles upon completion of their study.

Youth Pledge – CM Health has signed 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.

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. We have been recognised at the Ministry of Health Volunteer awards - Volunteer Service Team Award in 2015 and 2016, as winners and runners up the past 2 years.

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. Over the past year we have put 220 hiring managers through our values-based training programmes.

We have implemented checking to comply with the Vulnerable Children's Act and have nearly completed the checking of Core-Workers.

During the application process we ask our candidates if there are any medical conditions, injury or illness which may affect their work. From this we know how we can assist and accommodate the needs of the successful candidates.

3. Employee development, promotion and exit

Employee development

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.

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
- People development consultant team which work across the four clusters and throughout the organisation
- Interprofessional post registration and PDRP team
- Interprofessional 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.

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. It represents a partnership between Allied Health and Ko Awatea.

CMDHB has an undergraduate team working closely with tertiary providers to plan, co-ordinate and support clinical placements of Nursing, Midwifery and Allied Health students within the Counties Manukau district, including but not limited to CM Health, private providers and NGOs to prepare students for meeting registration competencies and future employment.

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.

The name Te Taki Paeora is derived from concepts of leadership and the Southern Cross constellation, which captures the aspiration to reach for the stars as well as our pursuit of Paeora (healthy and well Maaori and Pacific people), and in actuality the skills learned help all people.

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 85 people from a variety of services. The programme is offering forty hours of work-based learning to improve numeracy and literacy skills.

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 from the employee spectrum to prepare both psychologically and financially for retirement.

Our Allied Health staff lead empathy sessions on a regular basis so that our people can put themselves in someone else's shoes, and form some understanding of what they are feeling. The experiences include:

- What it is like to mobilise on crutches
- How it feels to be hoisted from bed to chair (dignity - participants will have clothes on but patients are wearing a hospital gown)
- How difficult it can be to write or use a keyboard with stiff arthritic hands
- How it feels to be on an operating table, waiting to have surgery
- How difficult it is to ask someone a question when you can't find the right words, are having trouble speaking or are hearing voices inside your head.

An area of focus in the past year and for the next few years is around working with people who have disabilities. In the last year we have held four focus groups with patients/carers with a disability, students, allied health, nursing and qualified staff to understand the drivers of patient experience for people identifying as having a disability.

We continue to run regular CALM effective communication courses in the general specialities and Safe Practice Effective Communication (SPEC) within mental health. SPEC has helped mental health services to reduce the number of seclusions that patients experience. The course has also been held up as the national standard and so it is being shared across the whole of New Zealand.

We now have 617 people across the DHB who have received the health literacy learning module.

We have access to working with CALD families - Disability Awareness and this was offered to staff for the first time this year.

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.

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. The DHB has written a guideline to provide clarity and consistency to these arrangements. This guideline is currently under review.

50% of the workforce is full time with the majority of the remainder 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 provides 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
- Long service recognition (managed by each service/department)
- Annual Diversity Ball
- 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.

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 reviewed our Bullying and Harassment policy and support for staff in the workplace. We are in the process of training designated Contact People to be the first point of contact for anyone who want to talk about bullying and harassment issues.

The role of a contact person

Contact Persons provide an important function in an overall strategy to prevent workplace bullying and harassment. They are employees within an organisation who are trained to be first points of contact for anyone who wants to talk about bullying or harassment issues, and who may not be ready to raise issues with management.

The Contact Person's role involves provision of information and basic support within the work environment. Contact Persons are trained to listen non-judgmentally, provide information on workplace bullying and harassment, discuss options with people, assist in decision making, and maintain strict confidentiality. They also act as catalysts for change, challenging mind-sets and spreading the message of zero tolerance.

They act as a non-judgmental "sounding board" where enquirers can be heard and helped to determine what actions they can take to manage situations. The opportunity to discuss personal matters with a caring and knowledgeable person can enable an enquirer to make well-informed decisions that may lead to effective resolutions.

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 consists of two Case Managers who will support you back to work safely. We can also provide guidance with 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.

There are monthly audits of workplaces by managers and formally reported quarterly audits to identify hazards and management strategies. There is an Executive Health and Safety Group which provides direction, focus and responds any emerging safety issues for staff.

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.

Quarterly newsletter

CMDHB's Occupational Health and Safety Service has introduced a new quarterly newsletter – Safety Link - which is available to all staff. This has been produced to provide all staff information on general and specific health and safety topics that arise across CMDHB.

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 the Human Resources Service Manager.

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.

Counties Manukau District Health Board Workforce

What our workforce looked like by age and ethnicity

Of the total workforce in 2016/17, women comprised 79% (6,229) and men 21% (1,660). The average age for women was 42 years and 41 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.[119]

Employee Age Distribution	Percentage of All Employees
Under 20	0.7
20-29	19.6
30-39	25.6
40-49	21.9
50-59	21.1
60-69	9.7
70+	1.5

Ethnicity	FTE	FTE Percentage	Headcount	Headcount Percentage
Asian	1,873	31%	2,421	30%
Maaori	312	5%	414	5%
NZ European and Other	2,874	48%	3,769	47%
Pasifika	679	11%	953	12%
Not Disclosed	239	4%	382	4%
Grand Total	**5,978**	**100%**	**7,889**	**100%**

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.

Employee Group[120]	Females		Males	
	Number	Average salary	Number	Average salary
Administration & Management				
Individual Employee Agreements	260	108,083.58	94	119,392.62
Clerical	736	52,641.32	44	56,936.34
Allied Health & Technical				
Allied Health	746	65,751.04	130	65,258.97
Laboratory	167	58,815.24	36	64,773.08
Radiology	197	65,375.21	81	65,504.28
Medical				
Specialist Medical Officer	225	223,034.92	321	246,706.18
Resident Medical Officer	267	106,691.00	262	108,136.84
Non-Clinical Support				
Cleaners & Orderlies	311	37,646.26	165	37,336.16
Security & Trades	6	58,213.33	68	62,202.55
Interpreters	97	48,071.73	28	46,869.54
Other Support Staff	29	48,671.79	18	48,847.17
Nursing/Midwifery/Health Care Assistant				
Healthcare Assistants	304	42,994.14	92	44,862.49
Midwifery	172	64,451.59		
Nursing	2,712	66,772.25	321	65,746.57

[119] 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.

[120] All employee groups, with the exception of the Individual Employee Agreements, are governed by MECAs and grading steps based on the competency, skill and service of the employee. There is no differential between a female and a male on the same grade.

Financial Statements

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.

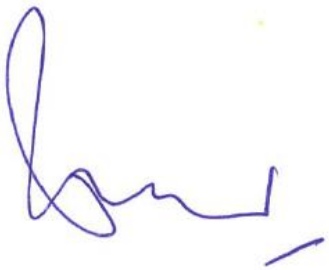
The Board of the Counties Manukau District Health Board has the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

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 2017.

Signed on behalf of the Board:

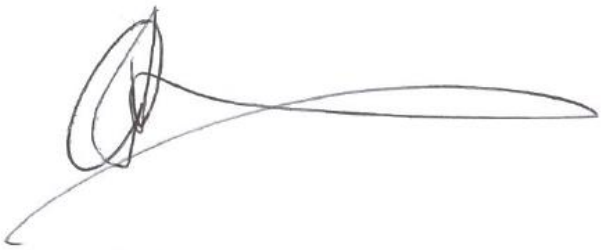
Dr Lester Levy

Chairman



Mark Darrow

Chair Audit Risk & Finance Committee



Gloria Johnson

Acting Chief Executive Officer

Margaret White

Chief Financial Officer

25 October 2017

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2017

	Notes	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Income				
Patient Care Revenue	2	1,558,737	1,563,070	1,498,670
Interest Income		2,076	2,000	3,355
Other Income	3	16,763	29,834	18,614
Total Income		**1,577,576**	**1,594,904**	**1,520,639**
Expenditure				
Personnel costs	4	592,391	594,801	564,668
Depreciation and amortisation expense	13/14	31,367	34,733	30,637
Outsourced services		87,864	79,006	72,268
Clinical supplies		110,592	104,948	113,285
Infrastructure and non-clinical expenses		57,312	61,190	51,914
Other District Health boards		236,166	283,792	218,688
Non-health board provider expenses		431,871	383,567	421,470
Capital Charge	5	18,200	18,149	18,510
Interest expense		7,860	14,700	12,470
Other expenses	6	16,893	15,518	13,859
Total expenditure		**1,590,516**	**1,590,404**	**1,517,769**
Surplus (Deficit)		**(12,940)**	**4,500**	**2,870**
Other comprehensive income				
Revaluation of Land	13	69,633	-	21,524
Revaluation of Buildings	13	(5,210)	-	23,876
Total Other comprehensive income (expense)		**64,423**	**-**	**45,400**
Total comprehensive income (expense) for the year		**51,483**	**4,500**	**48,270**

Statement of Changes in Equity

For the year ended 30 June 2017

	Notes	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Balance 1 July		**285,486**	**286,344**	**237,644**
Comprehensive income				
Surplus for the year		(12,940)	4,500	2,870
Other comprehensive income		64,423	-	45,400
Total comprehensive income		**51,483**	**4,500**	**48,270**
Capital contributions from the Crown		292,500	-	-
Repayment of capital to the Crown		(419)	(419)	(419)
Movement in restricted funds	19 & 29	25	38	(9)
Balance at 30 June		**629,075**	**290,463**	**285,486**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2017

	Notes	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Assets				
Current Assets				
Cash and cash equivalents	7	21,785	40,077	32,676
Debtors and other receivables	8	46,989	48,843	50,045
Inventories	10	7,484	1,468	1,468
Prepayments		2,307	292	292
Non-Current Assets held for Sale	11	33,743	-	-
Total current assets		**112,308**	**90,680**	**84,481**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	36,055	36,925	31,925
Property, plant and equipment	13	713,631	701,762	685,091
Intangible assets	14	13,023	6,576	13,007
Other Non-Current Assets	9	1,626	1,527	1,527
Total Non-Current assets		**764,335**	**746,790**	**731,550**
Total assets		**876,643**	**837,470**	**816,031**
Liabilities				
Current liabilities				
Creditors and other payables	15	112,743	92,893	103,680
Borrowings and overdraft	16	-	35,000	5,000
Employee entitlements	17	115,177	126,774	116,293
Total current liabilities		**227,920**	**254,667**	**224,973**
Non-current liabilities				
Borrowings	16	-	267,500	287,500
Employee entitlements	17	18,717	23,909	17,141
Provisions	18	931	931	931
Total non-current liabilities		**19,648**	**292,340**	**305,572**
Total liabilities		**247,568**	**547,007**	**530,545**
Net assets		**629,075**	**290,463**	**285,486**
Equity				
Crown equity	19	399,788	123,240	107,707
Accumulated deficits	19	(55,163)	(53,675)	(42,223)
Revaluation reserves	19	283,552	219,987	219,129
Trust funds	19	898	911	873
Total Equity		**629,075**	**290,463**	**285,486**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2017

	Notes	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,428,809	1,417,604	1,370,147
Other		154,055	162,456	136,704
Interest received		2,076	2,000	3,277
Payments to suppliers		(935,076)	(921,208)	(890,464)
Payments to employees		(591,931)	(586,764)	(570,531)
Capital charge		(18,200)	(17,819)	(19,225)
Interest payments		(9,518)	(14,700)	(12,325)
Goods and services tax (net)		(1,114)	-	722
Net cash flow from operating activities	20	**29,101**	**41,569**	**18,305**
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		9,987	-	-
Purchase of property, plant, equipment and intangible assets		(45,455)	(38,796)	(33,025)
Acquisition/roll over of investments		(4,130)	(4,966)	(8,314)
Net cash flow from investing activities		**(39,598)**	**(43,762)**	**(41,339)**
Cash flows from financing activities				
Repayment of capital to the Crown		(419)	(419)	(419)
Proceeds from borrowings		-	10,000	-
Net Appropriation to/from Trust Funds		25	-	(9)
Net cash flow from financing activities		**(394)**	**9,581**	**(428)**
Net increase/(decrease) in cash and cash equivalents		**(10,891)**	7,388	**(23,462)**
Cash and cash equivalents at the start of the year		**32,676**	**32,689**	**56,138**
Cash and cash equivalents at the end of the year		**21,785**	**40,077**	**32,676**

Explanations of major variances against budget are provided in note 30.

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 2017 comprise CMDHB and its interest in associates and jointly controlled entities.

CMDHB is a public benefit entity for financial reporting purposes.

The financial statements for CMDHB are for the year ended 30 June 2017, and were approved by the Board on 25th October 2017.

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.

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 during the financial year.

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.* PBE IFRS 9 replaces PBE IPSAS 29 *Financial Instruments: Recognition and Measurement*. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early adoption permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value of amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

The DHB is considering early adoption of this standard for the 30 June 2019 financial statements. The DHB has not yet assessed the effects of adopting this standard.

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.

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 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;
- work in progress

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

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

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

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

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

prior to other comprehensive income will be recognised first in the surplus or deficit prior to other comprehensive income up to the amount previously expensed, and then recognised in other comprehensive income.

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

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

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

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

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

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

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

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

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 22.

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.

2. Patient care revenue

	Actual 2017 $000	Actual 2016 $000
Health and disability services (MoH contracted revenue)	1,423,714	1,369,296
ACC contract revenue	25,141	24,460
Revenue from other district health boards	85,024	79,402
Other patient care related revenue	24,858	25,512
Total patient care revenue	**1,558,737**	**1,498,670**

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. $17.6m (2016 $18.1m).

3. Other income

	Actual 2017 $000	Actual 2016 $000
Donations and bequests received	1,498	2,146
Other income	13,411	14,604
Rental income	1,853	1,864
Gain on Disposal of Assets	1	-
Total other income	**16,763**	**18,614**

4. Personnel costs

	Actual 2017 $000	Actual 2016 $000
Salaries and wages	575,395	553,741
Contributions to defined contribution schemes	17,844	17,026
Increase/(Decrease) in liability for employee entitlements	(848)	(6,099)
Total personnel costs	**592,391**	**564,668**

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 7% at 31 December 2016, and 6% at 30 June 2017 (2016: 8%).

6. Other expenses

Other expenses include:	Actual 2017 $000	Actual 2016 $000
Audit fees – audit of financial statements	212	204
Operating leases expense	9,547	8,184
Impairment of debtors	6,761	5,104
Board and committee members fees and expenses	373	367
Total Other expenses	**16,893**	**13,859**

7. Cash and cash equivalents

	Notes	Actual 2017 $000	Actual 2016 $000
Cash at bank and on hand		34	77
NZ Health Partnerships Limited		20,853	31,726
Trust / Special purpose Funds	19	898	873
Cash and cash equivalents for the purposes of the statement of cash flows		**21,785**	**32,676**

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 12 November 2012. This Agreement enables NZHPL to "sweep' DHB bank accounts and invest surplus funds on their behalf.

8. Debtors and other receivables

	Actual 2017 $000	Actual 2016 $000
Ministry of Health receivables	3,332	4,307
Other receivables	15,542	14,091
Other accrued revenue	32,338	36,151
Less: provision for impairment	(4,223)	(4,504)
Total Debtors and other receivables	**46,989**	**50,045**

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:

	2017			2016		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	40,709	-	40,709	42,790	-	42,790
Past due 1-30 days	2,265	-	2,265	2,315	-	2,315
Past due 31-60 days	1,192	(526)	666	2,723	(416)	2,307
Past due 61-90 days	972	(590)	382	727	(395)	332
Past due > 90 days	6,074	(3,107)	2,967	5,994	(3,693)	2,301
Total	**51,212**	**(4,223)**	**46,989**	**54,549**	**(4,504)**	**50,045**

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.

The collective impairment assessment is based on an analysis of past collection history and write-offs.

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 2017 $000	Actual 2016 $000
Reversionary interest in car park building	1,626	1,527
Total Other non-current assets	**1,626**	**1,527**

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 6.5% was used (2016: 6.5%).

10. Inventories

	Actual 2017 $000	Actual 2016 $000
Pharmaceuticals	863	766
Other Supplies net of provision for obsolete stock	6,621	702
Total inventories	**7,484**	**1,468**

No inventories are pledged as security for liabilities (2016 $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 have now reassessed this practice and expense inventory items when they are consumed.

The amount of inventories recognised as an expense during the year was $18.0m (2016 $17.02m) which is included in the Clinical supplies line item in the Statement of Comprehensive Income.

11. Non-current Assets held for Sale

	Actual 2017 $000	Actual 2016 $000
Land	33,743	-
Total Non-current Assets held for Sale	**33,743**	**-**

The DHB owns land which was determined to be surplus to requirements. Subsequent to balance date, a sale and purchase agreement has been entered into for one parcel of land held for sale. The other parcel of land 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 2017	Interest held at 30 June 2016	Balance date
Northern Regional Alliance Ltd	Provision of health support services	Associate	33.3%	33.3%	30 June
healthAlliance NZ 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 NZ 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 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 2017 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	10,322	8,767	1,555	14,469	40
healthAlliance NZ 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

Year end 30 June 2016 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	10,556	8,831	1,725	15,587	215
healthAlliance NZ Ltd	154,951	26,549	128,402	125,839	(900)
NZ Health Innovation Hub Limited Partnership	1,759	699	1,060	505	(602)
NZ Health Partnerships Limited	342,217	281,401	60,816	54,026	(4,098)

Share of profit of associate entities and Jointly Controlled Entities

	Actual 2017 $000	Actual 2016 $000
Share of profit/(loss)	**343**	**(509)**

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 2017 $000	Actual 2016 $000
healthAlliance NZ Ltd	**36,055**	**31,925**

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 2015	144,682	452,480	159,478	22,060	5,860	784,560
Additions	-	-	-	-	28,936	28,936
Work In Progress capitalised	-	14,244	11,671	390	(26,305)	-
WIP Misclassified in 2015	-	(3,593)	(4,284)	(1,941)	9,818	-
Revaluation of Assets	21,524	23,876	-	-	-	45,400
Depreciation written back on Revaluation	-	(41,197)	-	-	-	(41,197)
Disposals/transfers	-	-	(892)	(8)	-	(900)
Transferred from Assets held for Resale (see note 11)	10,323	2,180	-	-	-	12,503
Balance at 30 June 2016	**176,530**	**447,989**	**165,973**	**20,501**	**18,309**	**829,302**
Balance at 1 July 2016	**176,530**	**447,989**	**165,973**	**20,501**	**18,309**	**829,302**
Additions	-	-	-	-	40,886	40,886
Work In Progress capitalised	-	20,758	7,910	30	(28,698)	-
Revaluation of Assets	69,633	(5,210)	-	-	-	64,423
Depreciation written back on Revaluation	-	(21,284)	-	-	-	(21,284)
Disposals/transfers	-	-	(14,445)	(237)	-	(14,682)
Transferred from Assets held for Resale (see note 11)	(33,743)	-	-	-	-	(33,743)
Balance at 30 June 2017	**212,420**	**442,253**	**159,438**	**20,294**	**30,497**	**864,902**
Accumulated depreciation and impairment losses						
Balance at 1 July 2015	-	21,465	117,628	16,389	-	155,482
Depreciation expense	-	19,732	9,808	987	-	30,527
Elimination on disposal/transfer	-	-	(593)	(8)	-	(601)
Elimination on revaluation	-	(41,197)	-	-	-	(41,197)
Balance at 30 June 2016	**-**	**-**	**126,843**	**17,368**	**-**	**144,211**
Balance at 1 July 2016	**-**	**-**	**126,843**	**17,368**	**-**	**144,211**
Depreciation expense	-	21,388	8,997	862	-	31,247
Misstatement 2016	-	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**
Carrying amounts						
At 1 July 2015	**144,682**	**431,015**	**41,850**	**5,671**	**5,860**	**629,079**
At 30 June and 1 July 2016	**176,530**	**447,989**	**39,130**	**3,133**	**18,309**	**685,091**
At 30 June 2017	**212,420**	**440,356**	**28,188**	**2,170**	**30,497**	**713,631**

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.

As part of the DHB's internal review process, the DHB is currently conducting a review of the condition of the major buildings in its portfolio, including assessments around seismic strengthening and estimates of costs to repair. Amendments to useful lives and values ascribed to the buildings have been made in the valuation report based on the preliminary results of this review. Upon completion of the review, a further reassessment of the useful lives and values ascribed to the buildings in the DHB's portfolio will be undertaken.

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.

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 1 July 2015	**5,779**	**514**	**4,494**	**10,787**
Additions	-	239	4,798	5,037
Work in Progress Capitalised	-	-	-	-
Impairment	-	-	(1,553)	(1,553)
Transfers/Adjustments	-	(192)	(756)	(948)
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	**5,779**	**561**	**7,119**	**13,459**
Accumulated amortisation and impairment losses				
Balance at 1 July 2015	-	**206**	**-**	**206**
Amortisation expense	-	110	-	110
Balance at 30 June 2016/1 July 2016	**-**	**316**	**-**	**316**
Amortisation expense	-	120	-	120
Balance at 30 June 2017	**-**	**436**	**-**	**436**
Carrying amounts				
At 1 July 2015	5,779	308	4,494	10,580
At 30 June and 1 July 2016	5,779	245	6,983	13,007
At 30 June 2017	**5,779**	**125**	**7,119**	**13,023**

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)
During the year to 30 June 2017, CMDHB had capitalised payments totalling $nil (2016: $nil) in relation to the National Oracle Solution. This is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHPL).

In return for these payments, CMDHB gained rights to access the NOS asset. In the event of liquidation or dissolution of NZHPL, CMDHB shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total NOS rights that have been issued.

The NOS rights have been tested for impairment at 30 June 2017, 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. No impairment charge has been recorded in the year to 30 June 2017 (2016: Nil)

15. Creditors and other payables

	Actual 2017 $000	Actual 2016 $000
Payables under exchange transactions		
Creditors and accrued expenses	100,774	95,392
Income in advance	6,164	1,917
Total payables under exchange transactions	**106,938**	**97,309**
Payables under non-exchange transactions		
GST payable	6,130	6,696
Capital charge payable	(325)	(325)
Total payables under non-exchange transactions	**5,805**	**6,371**
Total creditors and other payables	**112,743**	**103,680**

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 2017 $000	Actual 2016 $000
Current portion		
Crown loans – fixed interest	-	5,000
Total current portion	**-**	**5,000**
Non-current portion		
Crown loans – fixed interest	-	287,500
Total non-current portion	**-**	**287,500**
Total borrowings	**-**	**292,500**
Borrowing facility limits		
Crown loan facility limit	-	297,600
Overdraft facility	75,000	69,939
Total borrowing facility limits	**75,000**	**367,539**

Conversion of existing Crown loans to Crown equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On 15 February 2017 all Crown loans were converted to equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

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.

The fair value of Crown loans in 2016 was $319.4m. Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.30% to 6.36% in 2016.

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 (2016 $69.9m).

17. Employee entitlements

	Actual 2017 $000	Actual 2016 $000
Current portion		
Accrued salaries and wages	38,927	40,098
Annual leave	57,014	54,937
Sick leave	410	375
Long service leave	1,193	1,557
Retirement gratuities	2,338	2,148
Sabbatical leave	1,123	1,550
Continuing medical education	14,172	15,628
Total current portion	**115,177**	**116,293**
Non-current portion		
Long service leave	6,963	6,056
Retirement gratuities	9,814	9,253
Sick leave	1,940	1,832
Total non-current portion	**18,717**	**17,141**
Total employee entitlements	**133,894**	**133,434**

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 1.97% - 4.75% (2016 1.93% - 3.00%) and an inflation factor of 1.5% (2016 1.0%) were used.

18. Provisions

	Actual 2017 $000	Actual 2016 $000
Non-current portion		
ACC Partnership Programme	931	931
Total provisions	**931**	**931**

Movements for each class of provision are as follows:

	ACC Partnership Programme 2017 $000	ACC Partnership Programme 2016 $000
Balance at 1 July	931	1,337
Actuarial valuation movement	-	(406)
Balance at 30 June	**931**	**931**

19. Equity

	Actual 2017 $000	Actual 2016 $000
Crown equity		
Balance at 1 July	107,707	108,126
Conversion of Crown Loans to equity	292,500	-
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**399,788**	**107,707**

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. Refer note 16 for further discussion.

Accumulated surpluses/(deficits)		
Balance at 1 July	(42,223)	(45,093)
Surplus/(deficit) for the year	(12,940)	2,870
Balance at 30 June	**(55,163)**	**(42,223)**
Revaluation reserves		
Balance at 1 July	219,129	173,729
Revaluations	64,423	45,400
Balance at 30 June	**283,552**	**219,129**
Revaluation reserves consist of:		
Land	242,558	172,925
Buildings and Infrastructure	40,994	46,204
Total revaluation reserves	**283,552**	**219,129**
Trust funds		
Balance at 1 July	873	882
Transfer to/(from) accumulated surpluses	25	(9)
Balance at 30 June	**898**	**873**

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	**629,075**	**285,486**

Included in accumulated surpluses/deficits are $54.6m (2016 $43.1m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established, with $35.0m authorised and committed to be used for partial funding of the new Mental Health facility on the Middlemore site.

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

	Actual 2017 $000	Actual 2016 $000
Net surplus/(deficit)	**(12,940)**	**2,870**
Add/(less) non-cash items		
Impairment of Intangibles	6,144	1,553
Depreciation and amortisation expense	31,367	30,637
Total non-cash items	**37,511**	**32,190**
Add/(less) movements in working capital items		
Debtors and other receivables	1,041	(4,395)
Inventories	(6,016)	(148)
Creditors and other payables	3,006	(6,352)
Income in advance	4,247	-
Employee entitlements	460	(5,863)
Net movements in working capital items	**2,738**	**(16,758)**
Add/(less) items classified as investing or financing activities	**1,792**	**3**
Net cash flow from operating activities	**29,101**	**18,305**

21. Capital Commitments and Operating Leases

Capital Commitments

	Actual 2017 $000	Actual 2016 $000
Property , plant and equipment	51,825	4,604
Total Capital commitments	**51,825**	**4,604**

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

Non-cancellable operating lease commitments

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

	Actual 2017 $000	Actual 2016 $000
Not later than one year	5,363	2,906
Later than one year and not later than five years	12,586	4,248
Later than five years	1,593	434
Total Non-cancellable operating leases	**19,542**	**7,588**

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.

22. 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.

Kingseat
There is the potential for a claim to be received by CMDHB in respect of historical water supply obligations to land at Kingseat, which was formerly owned by CMDHB. The Board has made a provision for a potential claim however there is a low probability that the claimant will be successful.

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 2017, the DBP Scheme had a past service surplus of $8.0m (6.2% of the liabilities) (2016:$11.7m (7.4% 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 (2017 $40k, 2016 Nil) are not considered to be material and if required to be settled, would be expensed in the year of settlement.

Contingent assets

The DHB has contingent assets of $3.0m (2016: $nil) in relation to a contractual dispute on a building.

23. 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 $1.559m (2016 $1.499m) to provide health services in the Counties Manukau area for the year ended 30 June 2017 (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 2017 totalled $8.4m (2016 $9.5m). 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 2017 FTE	Actual 2016 FTE	Actual 2017 $000	Actual 2016 $000
Executive management team	10	12	3,943	3,632
Total key management personnel compensation	**10**	**12**	**3,943**	**3,632**

In addition to the above, the total actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $89.5k (2016 $84.9k).

Key management personnel includes the Chief Executive, and nine (2016: eleven) members of the management team.

Board and Committee Members compensation

	Actual 2017 FTE	Actual 2016 FTE	Actual 2017 $000	Actual 2016 $000
Board	11	11	353	347
Committee	6	7	6	12
Total board and committee members compensation	**17**	**18**	**359**	**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 $6.2m (2016 $5.6m) and a surplus of $0.6m (2016 $0.4m) which may be subject to restrictions on distribution as at 30 June 2017. The financial statements of the Foundation for 2017 are not publicly available as they have not yet been approved by the Foundation's trustees.

24. Board member remuneration

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

	Actual 2017 $	Actual 2016 $
Dr Lester Levy [1] (Chair)	44,250	-
Mr Rabin Rabindran [1] (Deputy Chair)	20,594	-
Mr Mark Darrow [1]	14,875	-
Mrs Catherine Abel-Pattinson [1]	16,375	-
Mr Reece Autagavaia	27,500	29,250
Mrs Katrina Bungard [1]	15,125	-
Dr Ashraf Choudary [1]	16,125	-
Mrs Dianne Glenn	30,000	30,500
Mrs Colleen Brown	29,000	29,625
Dr Lyn Murphy	29,438	29,813
Mr George Ngatai	28,250	30,500
Dr. Lee Mathias [2]	29,500	59,750
Ms Wendy Lai [2]	313	19,563
Mrs Sandra Alofivae [2]	22,704	29,438
Mr Arthur Anae [3]	2,625	27,500
Mr David Collings [2]	13,625	31,500
Mrs Kathryn Maxwell [2]	12,625	28,750
Total board member remuneration	**352,924**	**346,189**

1 Appointed 5 December 2016
2 Resigned 5 December 2016
3 Resigned 19 July 2016

Committee Members	Award $ 2017	Award $ 2016
Ms Wendy Bremner	1,250	2,292
Mr Sefita Hao'uli	1,042	1,875
Mr Nicholas Main	417	1,250
Ms Tangihaere MacFarlane	208	417
Mr Ezekiel Robson	1,250	2,917
Mr John Wong	1,500	2,500
Ms Hine Joyce-Tahere	-	417
Total	**5,667**	**11,668**

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 (2016 $nil).

25. 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 2017	Actual 2016
Total remuneration paid or payable:		
$100,000 – 109,999	170	179
$110,000 – 119,999	127	123
$120,000 – 129,999	86	73
$130,000 – 139,999	54	51
$140,000 – 149,999	45	40
$150,000 – 159,999	33	32
$160,000 – 169,999	24	19
$170,000 – 179,999	25	18
$180,000 – 189,999	22	24
$190,000 – 199,999	20	23
$200,000 – 209,999	13	26
$210,000 – 219,999	26	21
$220,000 – 229,999	22	20
$230,000 – 239,999	28	37
$240,000 – 249,999	31	30
$250,000 – 259,999	23	19
$260,000 – 269,999	24	38
$270,000 – 279,999	31	20
$280,000 – 289,999	23	22
$290,000 – 299,999	18	11
$300,000 – 309,999	16	12
$310,000 – 319,999	7	13
$320,000 – 329,999	11	2
$330,000 – 339,999	7	10
$340,000 – 349,999	11	6
$350,000 – 359,999	7	9
$360,000 – 369,999	6	3
$370,000 – 379,999	4	-
$380,000 – 389,999	4	2
$390,000 – 399,999	5	2
$400,000 – 409,999	-	1
$410,000 – 419,999	2	2
$420,000 – 429,999	7	2
$430,000 – 439,999	2	-
$440,000 – 449,999	4	2
$450,000 – 459,999	1	2
$460,000 – 469,999	3	1
$470,000 – 479,999	3	-
$480,000 – 489,999	1	-
$490,000 – 499,999	-	-
$500,000 – 509,999	2	-
$510,000 – 519,999	-	1
$520,000 – 529,999	-	-
$530,000 – 539,999	-	1
$540,000 – 549,999	-	-
$550,000 – 559,999	-	-
$560,000 – 569,999	1	-
$570,000 – 579,999	-	-
$580,000 – 589,999	1	-
Grand total	**950**	**897**

During the Year Ended 30 June 2017, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 758 (2016 - 735) are Medical Staff and 192 (2016 - 162) are Management.

During the year ended 30 June 2017, 30 (2016:12) employees received compensation and other benefits in relation to cessation totalling $687,294 (2016 $157,868).

26. Events after the balance date

On 17 August 2017, agreement was reached with the supplier in relation to the contractual dispute on a building (as referred to in Note 22).

Subsequent to balance date, the DHB entered into a conditional agreement to sell a portion of the land classified as held for sale. The value of the land sale is consistent with the value that it is recorded in these financial statements.

27. Financial instruments

Financial instrument categories

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

	Actual 2017 $000	Actual 2016 $000
Loans and receivables		
Cash and cash equivalents	21,785	32,676
Debtors and other receivables	46,989	50,045
Total loans and receivables	**68,774**	**82,721**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	98,640	95,156
Borrowings	-	292,500
Total financial liabilities measured at amortised cost	**98,640**	**387,656**

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 2017, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have no impact as all loans were fixed (2016 $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 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 2017 $000	Actual 2016 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	932	940
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	20,853	31,726
Total debtors and other receivables	46,989	50,045

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
2016						
Creditors and other payables	95,067	95,067	95,067	-	-	-
Crown Loans	292,500	353,883	17,435	46,279	147,839	142,330
Total	**387,567**	**448,950**	**112,502**	**46,279**	**147,839**	**142,330**
2017						
Creditors and other payables	98,640	98,640	98,640	-	-	-
Crown loans	-	-	-	-	-	-
Total	**98,640**	**98,640**	**98,640**	**-**	**-**	**-**

28. 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 2016-17 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.

29. Trust & Special Purpose Funds

	Actual 2017 $000	Actual 2016 $000
Trust/Special funds		
Balance at beginning of year	873	882
Funds expended	(2)	(19)
Interest received on Restricted Funds	27	10
Balance at end of year	**898**	**873**

30. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expenditure

The overall result for the year was impacted by the decision to impair software assets held as work in progress (as shown in Note 14). Other fluctuations reflected normal variation in demand and clinical work, however our budget for the year did not include adequate provision for the washup of Inter District Flows (funding for services performed by one DHB when the patient is domiciled in another DHB's jurisdiction). The result of this wash up process was a net payment position for CMDHB.

Statement of Financial Position

During the year, the Crown loans were repaid and replaced with an equity injection, therefore significantly reducing our liability position. Our asset base has increased as a result of the upwards revaluation of our land and building assets, which are subject to revaluation on a regular basis. The timing of operational payments and capital investment decisions has also impacted our balance sheet this year.

Statement of Cashflow

During the year the DHB entered into a sale and leaseback arrangement for some clinical equipment. This removed the need for budgeted borrowings, as the funds received from the sale of the equipment meant external borrowings were not required. In addition, the conversion of the Crown loans to equity reduced the overall interest payable to the Crown. This cash saving was offset by higher payments to suppliers and employees and a marginally higher capital charge.

Operating cashflows were down on budget, but remain positive. Increases in payments to suppliers and employees reduced our overall operating cashflow position.

Board and Committee Membership Attendances

Number of meetings attended by CM Health Board members for the period 1 July 2016 to 2 December 2016

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC	MHAC
Dr Lee Mathias (Chair)	4	3	4	3	1	1
Ms Wendy Lai (Deputy Chair)				1		
Mrs Colleen Brown	3	4	3		1	1
Dr Lyn Murphy	4	4		3		2
Mrs Sandra Alofivae	4	3	4			
Mrs Kathy Maxwell	4	4		3		
Mrs Dianne Glenn	4	4	4		2	2
Mr Arthur Anae						
Apulu Reece Autagavaia	2	2	3		1	
Mr George Ngatai		1	2	3		2
Mr David Collings	4	3	3	3	2	1

Number of meetings attended by CM Health Board members for the period 5 December 2016 to 31 June 2017

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC	MHAC
Dr Lester Levy (Chair)	4			2		
Mr Rabin Rabindran (Deputy Chair)	3	3	2	3		
Mrs Colleen Brown	4		3			1
Dr Lyn Murphy	3	3		3		
Mr Mark Darrow	4	2		3		1
Mrs Catherine Abel-Pattinson	4	3		3		
Mrs Dianne Glenn	4	3	3			
Dr Ashraf Choudhary	4	3	3			1
Apulu Reece Autagavaia	3		1			1
Mr George Ngatai	3		2	2		1
Mrs Katrina Bungard	4		2			

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 that Board, HAC, CPHAC & ARF meet six weekly. DiSAC & MHAC meet twelve weekly.

Board Members' Disclosure of Interests

Disclosures for CM Health Board members for the period 1 July 2016 to 2 December 2016

Dr Lee Mathias (Chair)	▪ Chair, Health Promotion Agency ▪ Chairman, Unitec ▪ Deputy Chair, Auckland District Health Board ▪ Acting Chair, New Zealand Health Innovation Hub ▪ Director, healthAlliance NZ Ltd ▪ Director, New Zealand Health Partners Ltd ▪ External Advisor, National Health Committee ▪ Director, Pictor Limited ▪ Director, John Seabrook Holdings Limited ▪ MD, Lee Mathias Limited ▪ Trustee, Lee Mathias Family Trust ▪ Trustee, Awamoana Family Trust ▪ Trustee, Mathias Martin Family Trust
Ms Wendy Lai (Deputy Chair)	▪ Partner, Deloitte ▪ Board Member Te Papa Tongarewa, the Museum of New Zealand ▪ Chair, Ziera Shoes ▪ Board Member, Avanti Finance
Mr Arthur Anae	▪ Councillor, Auckland Council ▪ Member, The John Walker 'Find Your Field of Dreams'
Mrs 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 ▪ Chair, IIMuch Trust ▪ Director, Charlie Starling Production Ltd ▪ Member, Auckland Council Disability Advisory Panel ▪ Member, NZ Disability Strategy Reference Group
Dr Lyn Murphy	▪ Member, ACT NZ ▪ Director, Bizness Synergy Training Ltd ▪ Director, Synergex Holdings Ltd ▪ Trustee, Synergex Trust ▪ Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ) ▪ Member, New Zealand Association of Clinical Research (NZACRes)

	▪ Member, Franklin Local Board ▪ Senior Lecturer, AUT University School of Inter professional Health Studies ▪ Member, Public Health Association of New Zealand
Mrs Sandra Alofivae	▪ Member, Fonua Ola Board ▪ Director, Housing New Zealand ▪ Member, Ministerial Advisory Council for Pacific Island Affairs ▪ Member, Social Housing Reference Group ▪ Chair, Social Investment Board
Mr David Collings	▪ Chair, Howick Local Board of Auckland Council ▪ Member, Auckland Council Southern Initiative
Mrs Kathy Maxwell	▪ Director, Kathy the Chemist Ltd ▪ Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd) ▪ Editorial Advisory Board, New Zealand Formulary ▪ Member, Pharmaceutical Society of NZ ▪ Trustee, Maxwell Family Trust ▪ Member, Manukau Locality Leadership Group, CMDHB ▪ Board Member, Pharmacy Guild of New Zealand
Mrs Dianne Glenn	▪ Member, NZ Institute of Directors ▪ Member, District Licensing Committee of Auckland Council ▪ 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. ▪ Vice President, National Council of Women of New Zealand ▪ Justice of the Peace ▪ Member, Pacific Women's Watch (NZ) ▪ Member, Auckland Disabled Women's Group
Apulu Reece Autagavaia	▪ Member, Pacific Lawyers' Association ▪ Member, Labour Party ▪ Member, Auckland Council Pacific People's Advisory Panel ▪ Member, Tangata o le Moana Steering Group ▪ Employed by Tamaki Legal ▪ Board Member, Governance Board, Fatugatiti Aoga Amata Preschool ▪ Trustee, Epiphany Pacific Trust
Mr George Ngatai	▪ Chair, Safer Aotearoa Family Violence Prevention Network ▪ Director, Transitioning Out Aotearoa ▪ Director, BDO Marketing

	▪ Board Member, Manurewa Marae ▪ Conservation Volunteers New Zealand ▪ Maori Gout Action Group ▪ Nga Ngaru Rautahi o Aotearoa Board ▪ Transitioning out Aotearoa provides services and back office support to Huakina Development Trust and also provide GP Services to their people ▪ Chair, Restorative Practices NZ

Disclosures for CM Health Board members for the period 5 December 2016 to 30 June 2017

Dr Lester Levy (Chair)	▪ Chairman, Waitemata District Health Board (includes Trustee Well Foundation, ex-officio member) ▪ Chairman, Auckland District Health Board ▪ Chairman, Auckland Transport ▪ Chairman, Health Research Council ▪ Chairman, Regional Governance Group, Northern DHBs ▪ Independent Chairman, Tonkin & Taylor ▪ Adjunct Professor of Leadership, University of Auckland Business School ▪ Lead Reviewer, State Services Commission, Performance Improvement Framework ▪ Director & Sole Shareholder, Brilliant Solutions Ltd ▪ Director & Shareholder – Mentum Ltd ▪ Director & Shareholder – LLC Ltd ▪ Trustee, Levy Family Trust ▪ Trustee, Brilliant Street Trust
Mr Rabin Rabindran (Deputy Chair)	▪ Chairman, Bank of India (NZ) Ltd ▪ Director, Auckland Transport ▪ Director, Solid Energy NZ Ltd ▪ Director, Swift Energy NZ Ltd ▪ Director, Swift Energy NZ Holdings Ltd ▪ Director, Kowhai Operating Ltd ▪ Director, NZ Liaoning International Investment & Development Co Ltd ▪ Singapore Chapter Chairman – ASEAN New Zealand Business Council
Mrs 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 ▪ Chair, IIMuch Trust ▪ Director, Charlie Starling Production Ltd ▪ Member, Auckland Council Disability Advisory Panel ▪ Member, NZ Disability Strategy Reference Group
Dr Lyn Murphy	▪ Member, ACT NZ ▪ Director, Bizness Synergy Training Ltd ▪ Director, 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
Mrs Dianne Glenn	▪ Member, NZ Institute of Directors ▪ Member, District Licensing Committee of Auckland Council ▪ 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. ▪ Vice President, National Council of Women of New Zealand ▪ Justice of the Peace ▪ Member, Pacific Women's Watch (NZ) ▪ Member, Auckland Disabled Women's Group
Mr George Ngatai	▪ Director, Transitioning Out Aotearoa ▪ Director, The Whanau Ora Community Clinic ▪ Chair, Safer Aotearoa Family Violence Prevention Network ▪ Board Member, Manurewa Marae ▪ Huakina Development Trust (Partnership Clinic) ▪ Community Organisation Grants Scheme (Auckland) ▪ Lotteries Community (Auckland)
Apulu Reece Autagavaia	▪ Member, Pacific Lawyers' Association ▪ Member, Labour Party ▪ Member, Tangata o le Moana Steering Group ▪ Trustee, Epiphany Pacific Trust ▪ Trustee, The Good The Bad Trust ▪ Member, Otara-Papatoetoe Local Board
Mrs 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, Chairman, Lifetime Design ▪ Husband, Director, various single purpose property owning companies

Mr Mark Darrow	▪ Chairman, Primary Industry Training Organisation Incorporated (ITO) ▪ Independent Director, Motor Trade Association ▪ Director, New Zealand Transport Agency (NZTA) ▪ Independent Director, Balle Bros Group ▪ Chairman, Courier Solutions Ltd (Advisory Board) ▪ Chairman, The Lines Company Ltd ▪ Chairman, Armstrong Motor Group (Advisory Board) ▪ Director, MCD Capital Ltd ▪ Chairman, Signum Holdings Ltd ▪ Chairman, Toloda Properties Ltd ▪ Trustee, Tudor Park Trust ▪ Director, Tudor Park Farm Ltd
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
Mrs Katrina Bungard	▪ Chairperson MECOSS – Manukau East Council of Social Services. ▪ Deputy Chair Howick Local Board ▪ Member of Amputee Society ▪ Member of Parafed disability sports ▪ Member of NZ National Party

Report of the Audit Office

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 2017

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.

We have audited:

- the financial statements of the Health Board on pages 39 to 70, that comprise the statement of financial position as at 30 June 2017, 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 8 to 29.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board on pages 39 to 70:

- present fairly, in all material respects:
    - its financial position as at 30 June 2017; 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 Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year

In respect of the 30 June 2016 comparative information only, some significant performance measures of the Health Board (including some of the national health targets), relied on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the Health Board's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the Health Board on pages 8 to 29:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2017, 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;
    - 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 25 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. 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.

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 qualified 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 it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the 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. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

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 achieved 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 2 to 7, 30 to 37, 71 to 77, and page 79 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 2016/17 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, and Property. 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

Registered Office

Counties Manukau District Health Board

19 Lambie Drive

Manukau 2241

Postal Address: Private Bag 94052

South Auckland Mail Centre

Auditor

Audit New Zealand on behalf of the Auditor General

Solicitors

Buddle Findlay

Chapman Tripp

Meredith Connell

Simpson Grierson

Chen Palmer

Bankers

Westpac Banking Corp

ASB Bank Limited

Commonwealth Bank

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