Annual Report 2020

COUNTIES MANUKAU HEALTH

Counties Manukau District Health Board

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

Contents

Foreword from the Chair and Chief Executive

The 2019/20 financial year has been an unprecedented year for Counties Manukau Health. We have responded to a measles outbreak in September that disproportionately impacted Counties Manukau populations and the Whakaari White Island eruption that required our support and leadership as the provider of the National Burns Service. The response to the COVID-19 pandemic and the first two surges in New Zealand also continues to cast its shadow on our healthcare system. Despite these challenges we have achieved an immense amount over the past year, continuing to deliver high quality care to our community and returning a financial result for the year which was slightly favourable to budget.

These incidents and COVID-19 have had an enormous impact on the 2019/20 year, requiring us to make changes to how we see and treat patients to ensure their safety and that of our staff, affecting our volumes and waitlists. Primary and community care services were also severely impacted. However, some of the challenges of responding to COVID-19 also helped us to accelerate some of our digital transformation projects, including increasing use of telehealth and rapid development of real time data dashboards to inform good decision making.

Throughout the year we've maintained our focus on quality and safety of care and health equity, strengthening our partnership with Mana Whenua and focusing on supporting our Maaori, Pacific and Asian communities through the COVID-19 response. We look forward to completing the refresh of our Healthy Together Strategy - in its final year in 2020 – which will continue to have achieving health equity for our communities at its core.

A number of our major capital projects continued to develop throughout 2019/20 – we were pleased to open Stage 1 of Tiaho Mai, progress the long awaited cladding of Scott Building and begin design work on the new Cathlab, expanded Dialysis chairs and Grow Manukau business case. The second Tiaho Mai building was opened in the new financial year in September 2020, and the re-clad of the Scott building is ahead of schedule and should be completed in 2021.

When reflecting on the year, we are extremely proud of what we have achieved whilst also managing these major events successfully. There have, however, been consequences. In 20/21 this will mean we need to advance on recovery of planned care that has been deferred or delayed, and support primary and community services in the wake of COVID-19 surges. We aim to build our resilience to future surges so that we do not experience such delays and can continue provision while being safe for services users and our staff. These pressures, alongside the other challenges of 2019/20, can be seen borne out in some of our performance results for the year. Careful stewardship will be required over the next year to ensure we continue to recover activity lost due to COVID-19, deliver clinically for our patients, and continue to reduce our deficit and remain financially sustainable.

It is our people who have made achieving what we have this year possible; responding to the extraordinary events of the year whilst also continuing our day to day business of caring for our community is an enormous achievement. Thank you to all CM Health employees, our partner providers and community stakeholders for your continued hard work and commitment.

Vui Mark Gosche
Chair

Fepulea'i Margie Apa
Chief Executive

Message from the Chair and Kai Whakahaere of Mana Whenua i Taamaki Makaurau

Ka tangi tonu nei ki o taatou mate taaruuruu nui o roto i ngaa niiao o te Waka o Tainui

Koutou ngaa puananii o tua whakarere.

E au te moe kia koutou e.

Ka huri kia taatou te hunga ora, ngaa Maunga whakahii o ngaa wai tukukiri o ngaa maatua tupuna i ngaa roherohenga o Tamaki ki raro teenei a kupu whakamaanawa e rere atu ana kia koutou Katoa.

A Kaati, anei ngaa maatou ripoata o te tau kua huri.

Te Titiri Partnership with the Counties Manukau District Health Board strengthens each year especially with our multi-level responses to the COVID-19 pandemic this year. Our priority was two-fold, our people, and our Providers. Manawhenua i Taamaki Makaurau (MWiTM) members were front footing on border controls, delivering food and hygiene parcels and generally being the conjoint between the DHB and our people.

MWiTM will support and work alongside its Partner to develop a COVID-19 Strategy that will ensure readiness for both the DHB and Providers for future resurgences of this pandemic.

Mana Whenua i Taamaki Makaurau Trust Board (MWiTM) is a collective body which represents hapuu in the Counties Manukau District. Since 2000, the Counties Manukau District Health Board (CMDHB) has a formal Memorandum of Understanding (MOU) in place with the Trust Board, which is currently being reviewed. The hapuu represented include Te Aakitai, Ngaati Te Ata, Ngaati Tamaoho, Ngaai Tai ki Taamaki, Ngaati Paoa, Te Kawerau a Maki, Ngaati Naho, Ngaati Tiipa, Ngaati Amaru, Ngaati Tahinga.

MWiTM will ensure the following strategic priorities are met from 2020 - 2025:

1. Te Ranga Ora - Primary Care – improving access particularly reducing co-payments
2. Maaori Child Health – first 2000 days (Immunization)
3. Kuia and Kaumatua – specific by Maaori for Maaori services focused on living well and quality of life.
4. A focus on Maaori Mental Health Auahi Kore / No Smoking

MWiTM in working toward an equitable Partnership is reminded of its vision laid down by Princess Te Puea Herangi

"Ko te ohonga ake i aku moemoeaa, ko te puaawaitanga o ngaa whakaaro"
"The awakening of dreams and aspirations comes from the blossoming of ideas, thoughts and innovation".

Robert Clark
Ngaati Tiipa
Chair

Barry J Bublitz
Ngaai Tai i Taamaki
Kai Whakahaere

Board Members

Board members for the period 1 July 2019 to 30 June 2020
Vui Mark Gosche (Chair)
Ms Tipa Mahuta (Deputy Chair)[1]
Mrs Catherine Abel-Pattinson
Mr Apulu Reece Autagavaia
Mr Garry Boles [1]
Mrs Colleen Brown
Mrs Katrina Bungard
Dr Ashraf Choudhary [2]
Ms Kylie Clegg[2]
Mrs Dianne Glenn
Dr Lyn Murphy[2]
Mr George Ngatai[2]
Dr Lana Perese[1]
Mr Pat Snedden[2]
Mr Pierre Tohe[1]
Mr Paul Young[1]

[1] Appointed 9/12/2019

[2] Resigned 4/12/2019

Executive Leadership Team

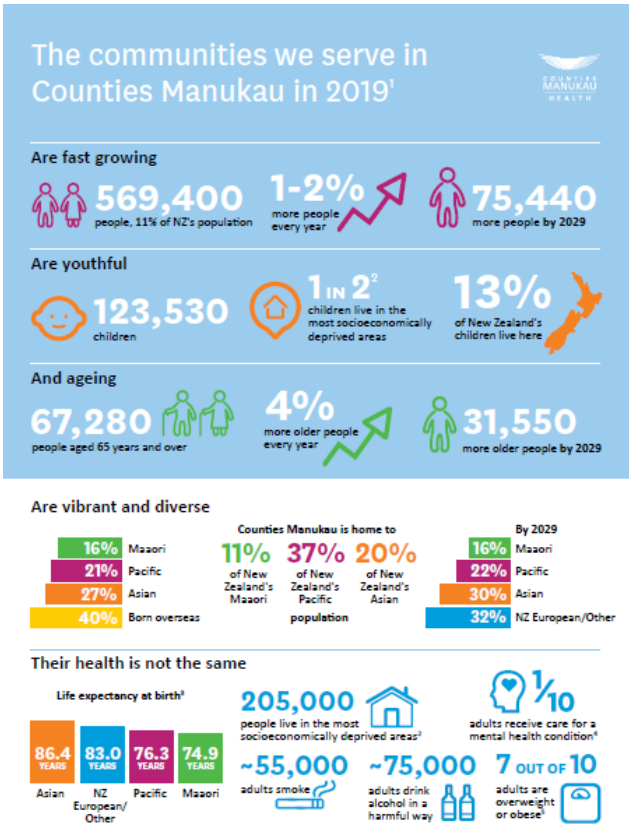
Executive Leadership Team	As at 30 June 2020
Margie Apa	Chief Executive Officer
Peter Watson[1]	Chief Medical Officer
Margaret White	Chief Financial Officer
Aroha Haggie	Director Funding & Health Equity
Jenny Parr	Chief Nurse & Director of Patient & Whaanau Experience
Elizabeth Jeffs	Director of Human Resources
Parekawhia McLean	Director of Strategy & Infrastructure
Campbell Brebner	Chief Medical Advisor Primary Care
Mary Seddon	Director of Ko Awatea
Stuart Bloomfield	Chief Information Officer
Sanjoy Nand	Chief of Allied Health, Scientific & Technical Professions
Gary Jackson	Director of Population Health

[1]Effective 2/12/2019

Snapshot of Counties Manukau Health in 2019/20

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

The Counties Manukau District Health Board provides and funds health and disability services to an estimated 569,400[1] people in 2019 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing district health board populations in New Zealand with simultaneously a youthful and ageing population.



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

Across our district, the health and circumstances of our communities are not the same. Thirty-six percent of our population live in areas of high socioeconomic deprivation (NZDep2013 9&10[2]). Over 123,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation. By 2025, our district is forecast to be 16 percent Maaori, 22 percent Pacific, 29 percent Asian and 34 percent European/Other ethnicity.[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.

Long-term mental and physical conditions do not affect all groups in our community equally[5]. Our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity[6], hazardous alcohol use) that contribute to a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. The rate of hospitalisation for circulatory diseases for our Maaori communities is estimated to be 88 percent higher than for non-Maaori.[7] Diabetes prevalence is higher amongst our Pacific (13.9 percent), Asian (6.9 percent) and Maaori (6.5 percent) communities compared to European/Other.[8] Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity is key to improving the health of our population.

[1] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – 2018 update.
[2] NZDep 2013 decile 9&10. New Zealand Index of Deprivation (NZDep) is an area-based measure of socioeconomic deprivation. It measures the level of deprivation for people in each small area. It is based on nine Census variables. NZDep can be displayed as deciles or quintiles. Quintile 5, or deciles 9 and 10, represents people living in the most deprived 20 percent of these areas.
[3] Due to numeric rounding the total is greater than 100 percent
[4] Chan WC, Winnard D, Papa D (2016). Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 update. Auckland: Counties Manukau Health.
[5] Winnard D, Papa D, Lee M, Boladuadua S et al (2013) populations who have received care for mental health disorders. CM Health, Auckland
[6] Based on unadjusted prevalence of overweight (BMI 25-25.9) and obese (BMI 30 or more) for CM Health adults aged over 15 years. Unadjusted prevalence for 2014-2017, New Zealand Health Survey. May 2018
[7] Source: Counties Manukau DHB Maaori Health Profile 2015. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare. Based on hospitalisation data 2011-2013. http://www.countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/2015-counties-manukau-DHB-maori-health-profile.pdf
[8] Source: Health Quality and Safety Commission Atlas of Health Care Variation, Diabetes management (2016 data for CMDHB)

Key Achievements in 2019/20

106,723 Emergency Department presentations

653,197 Outpatient appointments

16,753 Acute procedures

4,087 Elective procedures

118,386 Discharges

7,303 Births

Through 2019/20 CM Health has responded to significant incidents and challenges; rapid mobilization of community and hospital response to measles in September 2019; diversion of hospital and in particular theatre resources to respond to White Island/Whakaari Island in December 2019, and ongoing responses to COVID-19 from March 2020.

Measles Response

The measles outbreak had created urgency across the health sector, particularly concerning for Maaori and Pacific as these groups featured disproportionately in the admission rates. During the period of July 2019 to January 2020 there were a total of 363 measles related hospital admissions[9]. Of these admissions, 225 hospital admissions were patients under 15 years and 112 hospital admissions were patients 15 – 29 years old. The ethnicity breakdown for these hospital admissions across all ages is outlined below.

Table 1: Ethnicity breakdown of measles related hospital admissions during the period of July 2019 – January 2020

	Maaori	Pacific	Other	Total
July 2019	7	23	9	39
August 2019	39	66	17	122
September 2019	34	65	14	113
October 2019	9	41	3	53
November 2019	7	17	3	27
December 2019		7	1	8
January 2020		1		1
Total	**96**	**220**	**47**	**363**

The initiatives in the community were focused on reaching the most at risk populations within their local community including workplaces and local services with high community engagement.

Counties Manukau community response to the outbreak included:

College nurses working in low decile colleges actively recruited

- During the months of September and October 2019, 27 nurses were upskilled to be vaccinators with all the required equipment and processes put in place to deliver a community-friendly and safe programme
- 17 schools were involved in the programme with over 700 students, staff and families vaccinated. The ethnicity and age breakdown is outlined below.

Table 2: Ethnicity and age breakdown of students, staff and families vaccinated in programme between September and October 2019

Age	Pacific	Maaori	Other	Total
0-4 years	0	3	8	11
5-14 years	53	7	17	77
15-29 years	234	97	164	495
30+ years	64	16	68	148
Total	**351**	**123**	**257**	**731**

[9] Measles related hospital admissions is defined as all patients discharged with a ICD10 diagnosis of B05 Measles

Maternity teams provided post-delivery measles, mumps and rubella (MMR) vaccination to women in their care

- All women in Counties Birthing facilities were offered the MMR vaccine post-delivery in the absence of a documented history or record.

Community Clinics delivered by the Kidz First Public Health Team

- A total of 55 community clinics were provided by the Public Health Nurse (PHN) team across South Auckland between September and November, including Manukau Super Clinic and Middlemore Hospital.
- A one-day community immunisation clinic at the Mangere Town Centre was established and supported by the Pacific health providers in the area. The clinic was co-led by Moana Research and CM Health and was able to provide over 600 vaccinations to the community. An online campaign promoting that #itsoktovaccinate supported this outreach. The vaccines were provided across all ages. The table below outlines the ethnicity and age breakdown for vaccinations provided during this one-day event.
- Other community efforts included churches and marae, who had requested specific immunisation programmes for their communities.
- An ED clinic was also set up to provide vaccinations to patients and visitors who were well enough to receive the vaccine. This was a popular approach and was available from midday to late evening – seven days a week.
- Using a standing order, we were able to provide MMR to babies under one-year-old in the community, making this accessible to concerned families.

Table 3: Ethnicity and age breakdown of community vaccinated at the Mangere Community Clinic on 14 December 2019

Age	Pacific	Maaori	Other	Total
0-4 years	16	0	0	16
5-14 years	32	1	0	33
15-29 years	121	3	2	126
30+ years	453	3	12	468
Total	**622**	**7**	**14**	**643**

Workplace vaccinations

- The DHB was contacted by companies needing support with vaccinating staff who were either essential or shift workers. The target audience were Maaori and Pacific members of the team between the ages of 15-29 years old. The local Police force, The Warehouse, Fisher and Paykel and Air New Zealand were some of the companies we worked with.

CM Health will implement a measles catch-up programme in 2020-21 aimed at maximising the number of people aged 15-29 years old immunised with the MMR vaccine. The programme, funded by the Ministry of Health, will include a range of activities across primary care and community settings with a particular focus on Maaori and Pacific young people.

White Island/ Whakaari Island

The volcanic eruption on White Island/Whakaari on December 9 2019, in which 21 people lost their lives set in motion a massive local, national and international disaster response. Of the 47 people who were on White Island at the time of the eruption, 31 people received severe burn injuries and entered the National Burn Service Network. The average burn size was around 50% of their total body surface area. The National Burn Service (NBS) includes the National Burn Centre, based at Middlemore Hospital, and the Regional Burn Units at Waikato, Hutt and Christchurch Hospital. The complexity and severity of their injuries represented the average workload for an entire year.

The importance of the relationships between the teams that make up the National Burn Service (NBS) cannot be underestimated. Working collaboratively with agreed pathways and treatment guidelines, communication between the teams was key and critical to allow the optimal treatment of patients. Years of preparation and planning for a mass casualty event formed the foundation for a response which needed to adapt to the multiple challenges of presented by injuries from a volcano, international patients and scattered families. Patients were initially distributed throughout the hospitals of the NBS to allow initial optimal care. The mandated training at the National Burn Centre for all plastic surgery trainees ensured that there was sufficient expertise around the country to cope with the volume of patients.

Repatriation of Australian patients was assisted by key members of the National Burn Centre team having an established network of colleagues in Australia through the Australian and New Zealand Burn Association. Thirteen patients were repatriated to Australia, from around the country, in the first four days following the eruption.

The National Burn Centre which normally treats the most severe burn injuries in New Zealand and which was already working beyond capacity prior to the incident within days began to move the most severely injured patients to Middlemore Hospital. In all 14 of the 31 patients were treated at Middlemore Hospital during a 4-month period. The large team involved in the care of these patients worked continuously over the Christmas and New Year period and beyond. The operative requirements for these patients included over 130 operations involving in excess of 30,000 operative minutes. The final patients were transferred home overseas just as COVID-19 Level 4 lockdown took effect.

Support from both within the Department of Plastic Surgery at Middlemore Hospital, from other services around the Auckland region and around the country allowed the required resources to be increased to meet the initial challenge as well as to allow the required sustained response. Additional support was also obtained initially from overseas burn surgeons, and then later from burn specialist nurses and allied health staff as the clinical needs of the patients changed.

The facilitation and coordination of the incident response was recognised by both the Australian Embassy and the American Consulate in the support for their citizens during this tragedy. The Embassies were very grateful for the care and compassion shown to their citizens by all staff at CM Health. The standard of care for the patients treated as part of White Island/Whakaari, as well those who were here before, and the new ones admitted during were never compromised. The teamwork and support experienced as well as lessons learnt from the incident response will allow on-going improvements to ensure that the National Burn Centre based at CM Heath can continue to meet new challenges.

COVID-19

CM Health responded in many ways to the COVID-19 pandemic that started in March 2020 both locally and in collaboration with regional partners. This included implementing testing stations within general practice and other locations across the Auckland region and implementing an Emergency Management team to coordinate COVD-19 response activities both locally and regionally. Non-acute planned care was postponed to reduce risk of COVD-19 spreading and to create capacity that may have been required for patients suffering from COVID-19 related illness. Telehealth and virtual appointments were implemented to ensure minimal disruption in planned care where possible.

A significant response from the Facilities, Engineering and Asset Management (FEAM) team included the creation of negative pressure wards accommodating 160 beds by modifying the ventilation system of the top three levels of the Scott Building. The benefit of this was that all COVID-19 patients could be moved onto specialist wards to ensure isolation and whilst also enabling us to carry out best patient care while optimising healthcare staff welfare.

Further detail on the impact of COVID-19 on CM Health services can be found on page 73.

Key achievements across CM Health aligned to our Healthy Together strategic objectives

Key achievements are outlined below under our three Healthy Together strategic objectives (see *Our Strategic Intentions* on page 20) 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

- **Co-design approach to a new model of care for long term conditions:** Te Ranga Ora is an innovative, equity focused programme that aims to improve health, experience and wellbeing outcomes for Maaori, Pacific and people living in Quintile 5 in the Counties Manukau rohe who live with two or more long term conditions. The programme uses a co-design approach, to develop solutions by the community, for the community. Place based partnerships across multiple providers who have cultural capability are a key characteristic of the model. The key objective is for the service provider, in collaboration with other members of the prototype collective, CM Health and service user representatives to co-design and plan models of care for LTC services in the next 6-12 months. The collective has agreed that the objective is to achieve the defined outcomes for Maaori, Pacific Providers and people living in Quintile 5. In 2019/20 CM Health finalised contracts with the five prototype collectives. There has been a delay due to COVID-19, as providers were busy with delivering services in response to the global pandemic. We are currently planning to convene a hainatanga (signing) ceremony with all five collectives which will be an opportunity to meet and collectively discuss next steps.

People-Powered

- **Telehealth in Mental Health and Addictions:** The recent COVID-19 lock-down reaffirmed the clinical preference for tablets as the mobile device of choice in terms of size, safety and portability, privacy and ease of use, battery life, and connectivity. The ease with which MH&A clinicians continued to work through the COVID-19 lockdown was not only comfortable and de-stressing for our service users and clinicians alike, but also fast-tracked staff readiness to utilise Zoom when appropriate, and as per the guidelines; having already adapted to a mobile environment.

Closer to home

- **Fundamentals of Care:** The Fundamentals of Care (FoC) programme, introduced to Counties Manukau Health in October 2017, aims to ensure the consistent delivery of the 'fundamental' aspects of care for all patients. Results continue to show improvement with an overall organisational result of 84.1%. In July 2019, the FoC programme was one of two areas rated as continuous improvement from the Ministry of Health following the Certification audit. In March 2020 CM Health completed the fifth FoC review across 46 inpatient wards and units.
- **Protected Mealtimes:** The need for protected meal times for patients was a finding of the Fundamental of Care peer reviews. Protected mealtimes minimises interruptions when patients are eating. Patients are also prepared for their meals (seated comfortably and warm). Protected Mealtimes have been implemented in 24 wards. A Protected Mealtimes guideline to support and encourage staff has been implemented.

One Team

- **Early pregnancy assessment tool:** The Best Start Pregnancy Tool has been developed by CM Health Primary and Integrated Care in collaboration with the Northern region PHO's and National Hauora Coalition Generation 2040 team. Implementation of Best Start Pregnancy tool has been delayed due to COVID-19 pandemic response but is now underway. More than 80 practices in the Metro Auckland area (Alliance Health Plus, Tamaki Health and National Hauora Coalition practices) have the tool installed on their practice management systems and the tool is in use. This tool will enable SUDI (sudden unexpected death in infancy) risk factors to be identified and women supported to make changes early in pregnancy.

Smart System

- **Models of Care:** A number of additional wards and clinics were opened over the 2019/20 year in order to increase capacity and introduce new models of care. This included:
    - The permanent opening of Ward 17 to allow additional 26 beds for winter 2020.
    - The High Dependency unit (HDU) was reconfigured to accommodate rooms that would enable two nurses to work with an experienced critical care trained nurse to care for 3 patients in a room. A new model of care was developed so that these nurses would support a critical care trained nurse to care for 3 COVID-19 patients in a room.
    - The Respiratory Assessment Unit (RAU) opened in April to provide a self-contained separated area to assess, admit and treat possible COVID-19 related presentations with respiratory symptoms. The unit on Ward 7 is using aerosol generated procedures together with a step-down general medical COVID-19 ward on Ward 6.

      These modifications provided immediate capacity for the treatment of up to 60 COVID-19 confirmed patients safely and efficiently within a negative pressure environment. While the unit saw reasonably high throughput during the month, the number of positive COVID-19 patients was in keeping with the very low community prevalence detected across CMDHB's catchment population.

Value and High Performance

Value and High Performance

- **Asian Community Flu Fighters Programme:** The Asian Community Flu Fighters programme had a total of 945 participants (Chinese x 568, Indian x 85, Korean x 148, Cambodian x 9 & diverse x 135) over 18 organisations and 19 clinics (Chinese x 9, Indian x 3, Korean x 1, Cambodian x 1 & diverse x 5). About 43% of the respondents received flu vaccines the first time. The team was able to successfully engage with a Cambodian temple with the help of a volunteer community engagement coordinator to increase uptake.

People-Powered

Healthy Communities

- **Samoa Measles Response**: Counties Manukau Health staff members were key in the measles response in Samoa between November and December 2019. Members from the Pacific Health Development team were part of the ground team vaccinating patients in their homes during the response.

One Team

- **Fanau Ola COVID-19 Response:** Fanau Ola service referrals during the lockdown period increased as the team supported DHB services with language/translation assistance, patient surveys and ensuring patients could continue to attend appointments during this time. Fanau Ola staff also supported work on the frontline at community testing centres and Auckland Airport border control. The Fanau Ola service played a key function in engaging with the Pacific community in Counties Manukau so fanau were kept up to date and ensured key information around COVID-19 was shared.

People-Powered

- **COVID-19 Impact on Child Health:** The public health nursing (PHN) workforce showed immense flexibility and mobilised to support the Community Based Assessment Centres (CBACS) to complete community COVID-19 swabbing and managing the Port Border. The PHN's have also dispensed approximately 600 flu vaccines during COVID-19 to some of the most vulnerable children in the community.

One Team

- **Asian Community Response to COVID-19:** COVID-19 messages were translated into Asian languages to reach out to Asian communities via CM Health Asian Health & Wellbeing Community Network and paid advertising. Information has been shared in outlets such as Indian Weekender, Chinese Herald, Mandarin Pages, Korean Post, SkyKiwi, Punjabi Herald, Migrant News, Filipino News as well as community social media pages.

People-Powered

- **Awhinatia Community Mental Health Centre:** In June 2020, the Awhinatia Community Mental Health Centre at Papakura celebrated the completion of the site refit and services reconfiguration which enabled:
    - the integration of the Community Health, Public Health and Mental Health services sharing the site, to facilitate enhanced cultural capabilities and collegiality, and improved interdisciplinary integration to support holistic care based on Tikanga Maaori;
    - the shared workspaces designed around work-based activities and geographical clustering to support a mobile workforce and increased operational efficiencies;
    - the secure and separate service user and staff areas to increase safety and wellbeing;
    - the relocated consult and clinic rooms to increase clinician responsiveness;
    - a single reception which is warm and welcoming, to improve people's experience when using our services, and reflect the standard of care we want associated with secondary care;
    - a co-designed community garden to assist in improving health outcomes by establishing links with food and the land; and creating a space and activities focused on improved nutrition, increased physical activity, increased social interaction and enhanced mental and spiritual health.

One Team

- **COVID-19 Impact on Community Nursing:** COVID-19 had a great impact on community nursing services as we continued to have high demand during this period whilst the inpatient settings were preparing for increased admissions. Our community teams quickly adapted and had a focus on self-management with the support of virtual tools to ensure safety of care at this time. Patients were educated and reassured of the protection we had put in place when home visiting to ensure both their whaanau safety and our staff safety in relation to COVID-19 risks. The media information, alongside our Ministry of Health and CM Health information, had to be clearly communicated and the high levels of anxiety felt by our community when nurses did need to home visit required empathy and expertise.

Closer to home

- **Increased transparency in the allocation of the Flexible Funding Pool (FFP):** The FFP is a pool of funding distributed under the national Primary Health Organisation Services Agreement for the purposes of health promotion, services to improve access and care for people with long term conditions and management services. Over 2019/20 we have continued work to increase transparency in the way this funding is allocated across the district, and have completed development of a regional framework which aims to increase alignment of priorities and actions to improve equity.

Value and High Performance

- **He Ara Oranga**: In response to He Ara Oranga, the Wellbeing Budget 2019 proposed investment into primary mental health and addiction services, to improve access and choice for all those whose thoughts, feelings or actions are impacting their wellbeing. There have been a number of elements to this investment and CM Health has engaged in a number of Request for Proposals (RFP) and initiatives to enhance and support the wellbeing of our community and reduce the inequities in access and outcomes that currently exist.

People-Powered

- Recruitment and deployment of health improvement practitioners (HiP) and health coaches or non-government organisation (NGO) roles within general practice settings. The initial practices chosen for the new roles are those with high numbers of Maaori, Pasifika and youth enrolments. A key focus of the NGO roles will be to meet the cultural and social needs of Maaori and Pasifika populations.
- In addition, 'Wellness Support' received investment from the Integrated Primary Mental Health and Addiction Services RFP. Wellness Support is the CM Health new primary mental health and addictions model of care. It is flexible to anyone experiencing mental health distress, including those with no diagnosis through to those with Axis 1 diagnoses.
- **Auckland Dental School:** The University of Otago has opened the brand-new, state-of-the-art dental facility on the Manukau Super Clinic site, in partnership with CMH. Staff and students at the Auckland Dental School are providing a range of dental services to patients from Manukau and surrounding areas at low or no cost. When at full capacity, the facility will host 48 students and provide more than 18,000 appointments for the CM Health population. This makes a real difference to people's lives and the health and wellbeing of the community.

People-Powered

- **Pharmacy Immunisation:** In 2019/20, CMDHB pharmacies delivered 9,602 funded influenza vaccinations for people 65 years and over, pregnant or with chronic conditions. This is a 276% growth compared to the previous year when 2,551 influenza vaccinations were claimed. We have been targeting more pharmacies in high priority areas to provide vaccinations and help access for Maaori, Pacific and quintile 5, and look forward to further growth for 2021 in uptake in these population groups.

Value and High Performance

Healthy Services

- **Data visualisation:** We have implemented the advance analytics QlikSense business intelligence tool to improve accessibility to data for informed decision making. It has enabled visualisation of data which has increased and elevated the type of analysis possible across the patient journey and within specialties. We are now beginning to harness the vast amount of data collected, to learn from iterative tests of change, and to drive continuous improvement. Qlik applications have been developed over a wide range of datasets including inpatients, outpatients, community, mental health, clinical services, and in the corporate arena. This included a COVID-19 real-time dashboard and a number of Command Centre Dashboards. ***Smart System***
- **Core Clinical Systems:** We have implemented MedChart (ePrescribing and Administration), Trendcare and SmartPage for orderlies & cleaners organisation wide. This has been underpinned by upgrades to core systems and infrastructure including Clinical Portal, the Pharmacy Inventory System and creating a stable technology platform for future development. ***Smart System***
- **Telehealth:** There has been rapid uptake of telehealth to support new ways of working. We have introduced systems to support video consultations and non-contact reviews that included electronic prescribing to community pharmacies from hospital services/clinics, electronic ordering of blood tests at community laboratories by hospital services/clinics, electronic forms for clinics so that specialist services could conduct virtual clinics from home/anywhere**.** ***Smart System***
- **Every Hour Counts:** Over 2019/20 every Hour Counts portfolio has continued with the vision to improve patient flow to optimise the quality of care, the experience of care, and the experience of caring whilst improving the efficiency of the system. This covers both acute and ambulatory patient flow, with work programmes in each area. ***Value and High Performance***

  Acute Flow programmes have been established in the Emergency Department (ED) and General Medicine wards and have resulted in improved patient allocation and proactive discharge.

  - The implementation of a senior clinician at the front door in ED has resulted in a reduction in the number of patients who are waiting in areas that do not meet their need.
  - To enable flow from ED and reduce overcrowding ward coordinators have been trialed on the general medical wards who have a focus on patient flow. This has resulted in a 13% increase in the utilisation of the discharge lounge and more discharges occurring earlier in the day.
  - In the Medical Assessment Unit, a series of improvements have been trialed to ensure patients are moved to the correct ward the first time.
  - Proactive discharge planning has been implemented to remove the delays experienced in complex discharges. This involves specialist multidisciplinary teams that expedite challenges and the creation and monitoring of key performance indicators (KPI) to improve performance.
  - Waiting times for patients have been reduced in MRI by better matching demand and capacity. Whilst a multifactorial approach has been undertaken, the physical number of patients on the waiting list has reduced from a December 2018 baseline of 1954 to 605 in September 2020. More importantly the number of patients waiting over 42 days has fallen from 1312 to 101 and there is a concerted effort to reduce this further so that the P2 target[10] can be consistently achieved.

[10] The P2 target is 90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days)

Ambulatory flow programmes are contributing to implementation of revised models of care, linked appointments and the use of telehealth. This portfolio of work will support CM Health to deliver a more effective, timely, end to end, patient-focused system of care and also aims to optimise and value the time of staff, by reducing the steps in patient care to get the best out of the highly skilled workforce we have.

We are trialing improvements in ophthalmology outpatient services as well as optimising the surgical patient journey and supporting the testing of telehealth in ambulatory services.

In **ophthalmology services**, we are trialling and testing improvements to:

- simplify the cataract pathway by combining patient visits to reduce the need to see a SMO (senior medical officer) at multiple visits
- ensure that alternative workforces, such as optometrists, are working at the top of their scope by leading most of the cataract post-operative follow up appointments
- test a pre-screen, technician led, clinic for 'light' glaucoma referrals with a virtual SMO review
- increase clinical capacity by testing the use of SMO virtual reviews for patients that do not need a face-to-face appointment.
- reduce clinical risk and the number of patient appointments by combining patient review appointments with the first Avastin injection to reduce the delay in initiating the continued treatment plan.

In **operating theatres**, we have set up five working streams – information management, patient experience, two CSSD streams and operating theatre optimisation which aim to:

- decrease average waiting time from 94 days to 60 days
- decrease cancellations on day of surgery from 1,198 per year to 600
- decrease DNA rate by 30%
- increase overall theatre session utilisation from 90% up to 94% within the next 6 months.

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

- observing and testing the booking and scheduling process before, during and post telehealth appointment
- assisting in designing and capturing the experience of clinical and administration staff who are using telehealth methods
- reviewing literature and evidence regarding appropriate telehealth targets and measurements that represent both the patient and clinicians' perspectives

- **Every $ Counts:** The Every $ Counts portfolio supports CM Health's financial objective to improve efficiency to achieve high quality care while enabling a sustainable financial position. For the FY 2019/20 the portfolio delivered projects with the business across nine major workstreams including: NGO contract review and optimization, data capture and coding improvements, transitioning to electronic appointment letters, procurement and supply chain, improved bureau management, workforce opportunities and other savings areas.

  In FY 2019/20 the nine major workstreams consolidated under the Every $ Counts portfolio delivered a total savings of $15m.

  Value and High Performance

- **Auckland Regional HealthPathways** – a regional initiative and key enabler that supports Primary and Community based care by the provision of best practice guidance developed in collaboration with primary and secondary care clinicians. Community HealthPathways combines methods, tools, and clinical content to improve healthcare for patients, support greater clarity and confidence for clinicians, and increase health system performance. This was demonstrated during the COVID-19 response with the development of sixteen pathways to support across Primary and Community sectors, including Aged Residential Care. Auckland has acted as lead region in the development or localisation of the following national exemplars during the year: Pre-exposure Prophylaxis for HIV (PrEP), Death Certification, Endometriosis and Problem Gambling. More recently Auckland was the lead for localising the MOH Escalation Framework for Covid-19 into COVID-19 Primary Care Alert Response Framework. During the year the Measles Epidemic gave rise to increased advice and support resulting in over five thousand page views which doubled the usage from the previous outbreak.

  One Team

- **Accessibility Tick Award:**

  People Powered

Counties Manukau Health received the Accessibility Tick from Access Advisors in December. This is a significant milestone for our organisation as it represents our commitment to change and to serve the accessibility needs of disabled people in our community. The Tick (certificate) was presented at a small celebratory ceremony attended by the CEO and some board members including co-chair of RDiSAC Colleen Brown and other CM Health staff. The Accessibility Tick marks our commitment as an organisation on improving employment opportunities for disabled people. To be awarded an Accessibility Tick, an organisation needs to demonstrate it has an inclusive culture and is making active progress around improving accessibility and employment opportunities for disabled people. The Accessibility Tick requires us to make ongoing commitment to improving our systems, processes and culture so that we are able to employ more disabled people on staff and support their development. A three-year action plan has been developed to guide the work that needs to be done. This action plan addresses the broader work that needs to be done to improve accessibility for disabled people; not only employment but also better and equitable health services.

- **Health Science Academy:** In December 2019 the Health Science Academy (HSA) programme was evaluated by an external provider. The Health Science Academy Programme is an initiative designed to introduce Pacific and Maaori students to a career in the health sector. The HSA team has used the outcome of the evaluation as a blueprint to improve the programme going forward. In 2020/21 additional funding has been secured to increase the six HSAs to a total of 12 HSAs. Students in the programme have benefited through improved academic performance across science, numeracy and literacy subjects in 2019. Approximately 85 percent of the students passed Level 1, 2 and 3 NCEA, resulting in better performance than the national New Zealand Pacific or national Decile 1 to 3 school achievements.

People Powered

- **Wellness Support wins NZ Primary Healthcare Award for Best Mental Health Programme:** Our Wellness Support team won the NZ primary Healthcare Award for Best Mental Health Programme. Dr Sophie Ball, lead for Primary Mental Health, CM Health and Pam Hewlett, Portfolio Manager for MH&A developed and implemented the Wellness Support model for Primary Mental Health at CM Health. They won the Habit Group Best Mental Health Programme at the NZ Primary Healthcare Awards on 29th February 2020.

Value and High Performance

- **Nursing Strategy:** The Nursing Strategy was launched in May 2020 on International Nurses Day with the Clinical Nurse Directors hosting webinars to discuss components of the strategy. The strategy focuses the contribution of nurses in the domains of equity, safety, partners in care, improvement and leadership to deliver our DHB strategy. This is underpinned by our organisational values and commitment to equity.

People Powered

- **Interpreting & Translation Service:** The interpreting and translation service in collaboration with Cancer Support Service & Palliative Care delivered an upskilling workshop for 20 interpreters. Positive feedback received from interpreters and further workshops to be organised with other clinical services.

Value and High Performance

- **Embracing our diversity:** Diwali and Lunar New Year were celebrated with competitions, shared team lunches and special menus offered at the staff kitchen at both Middlemore Hospital (MMH) and Manukau Super Clinic (MSC) sites; to embrace the cultural diversity in CM Health. Positive feedback received from staff across MMH and MSC. Ramadan and Eid were also celebrated.

People Powered

Our Strategic Intentions

Healthy Together

2019/20 was the last year of our five-year Healthy Together strategy. Our Healthy Together strategy is a long term ambition with a transformational focus on integrated care in the community, supported by excellent hospital services. Achieving health equity in key indicators is critical to medium term population outcomes and longer term health system sustainability. Relying on treating people when they become unwell is not enough and will not achieve the health gains needed to achieve healthier longer lives in the community. The CM Health Board has committed to refreshing our Healthy Together strategy for 2020/21 and beyond.

"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" is our strategic goal and ambition.

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

Valuing everyone – we make everyone feel welcome and valued

Kind - we care for other people's wellbeing

Together – we include everyone as part of a team

Excellent - we are safe, professional and always improving

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

Our Strategic Objectives

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

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

Healthy Services support improved health outcomes through more collaborative ways of working to make services easier to access and more responsive/personalised to people's needs. This can enable earlier identification of diseases, earlier intervention and better management of health conditions to achieve **Healthy People, Whaanau and Families.** We aim to enable people to take a more active role in their own health and support them to self-manage for longer at home and in the community. To manage the challenges of our ageing facilities infrastructure and significant increase in service demand, we have accelerated our investment in facilities to ensure health and safety for patients, staff and visitors. At the same time, we are working regionally to address immediate demand pressure through enhanced inter-DHB planning and development of prioritised expanded and new facilities.

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

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

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

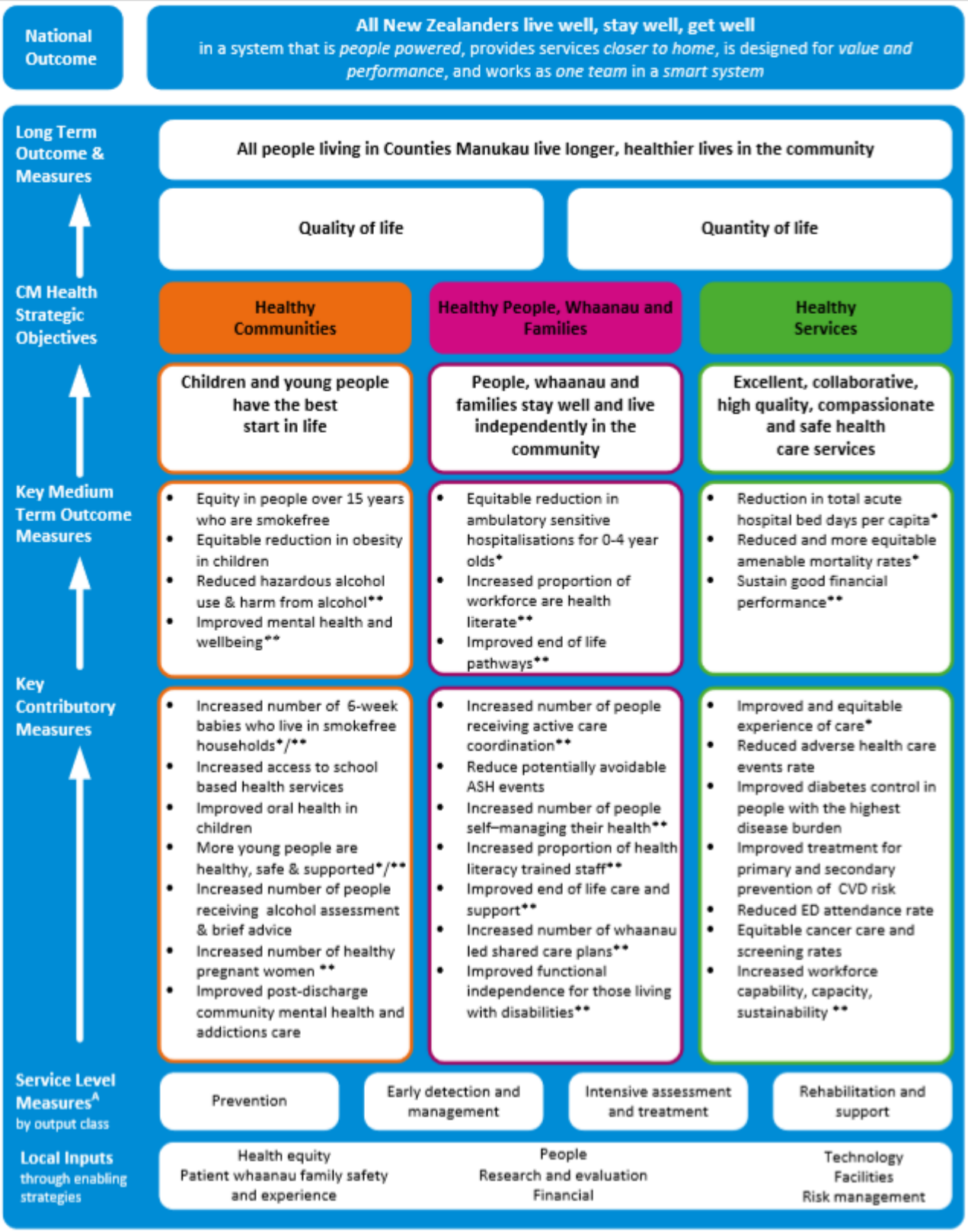
How we will measure our performance

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

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

CM Health's performance as at 2019/20 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 2019/20 performance for the outputs identified in our outcomes framework is provided in the *Statement of Service Performance* on page 37. Together these two sections provide a current picture of the progress CM Health made towards achieving our long-term outcomes and strategic goal in 2019/20.

Figure 1: Healthy Together Outcomes Measurement Framework



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

*Note** denotes measures in development*

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

Improving Outcomes

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

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

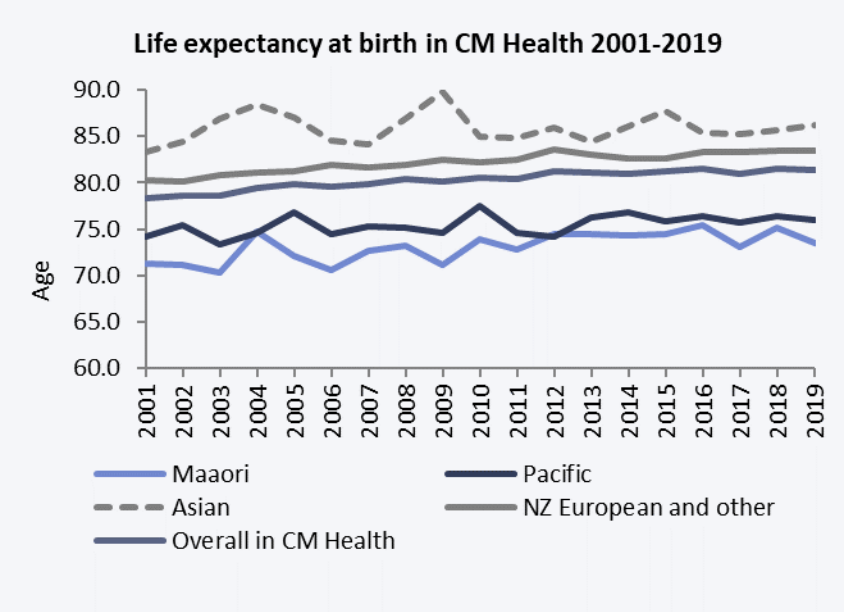
For the Counties Manukau community, we need to target outcome improvements to achieve health equity.[12]To better understand which people do not experience the same health outcomes, we report and compare results over time by ethnic group. Results are not always available for all ethnic groups and work is ongoing to improve the accuracy and scope of results by ethnic group.

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

Overall long-term outcomes

Reduce life expectancy at birth gap for Maaori and Pacific peoples[13]

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



The overall life expectancy at birth in Counties Manukau has steadily increased over the last ten years to 81.3 years in 2019, closely reflecting national trends. A gap of 10 years and 8 years persist between Maaori and Pacific peoples respectively and New Zealand European/Other, and has not shifted over the past five years. Our local and regional planning for 2020/21 is strongly focused on improving health equity for Maaori targeting those conditions and health outcomes that impact the most on amenable mortality and life expectancy, including cardiovascular disease, diabetes, long-term condition management and smoking cessation.

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

[12] Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need.
[13] Data source: Ministry of Health (MOH) mortality collection and estimated population from Stats NZ (2018 edition)

over 15-50 years of New Zealand residency[14], to sustain this relatively high life expectancy, we are focused on early risk factor prevention and effective management of long term conditions in our Indian and Chinese communities.

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

Equitable increase in healthy life years

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

As in other countries, the improvement in estimated healthy life expectancy for New Zealand has grown more slowly than the improvement in life expectancy.[15] This means both men and women are living longer with some degree of impairment of their health than previously. This has important implications for the individual, their whaanau and family, with impacts for health and disability service demand due to increased duration of unhealthy life years.

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

Healthy Communities – Improved population health and equity

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

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

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

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

Medium term outcome: Equitable smokefree rates across Counties Manukau

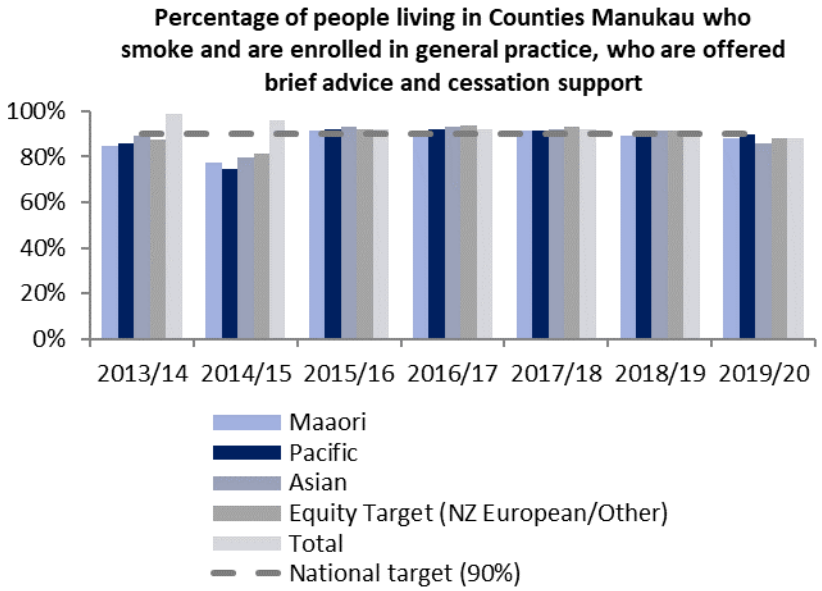
Smoking, a leading risk to health in Counties Manukau, disproportionately burdens Maaori and Pacific peoples.
Inequities in smoking prevalence contribute to differences in life expectancy and wellbeing between Maaori and Pacific and non-Maaori/non-Pacific peoples. At the time of Census 2018 Maaori (31 percent) and Pacific peoples (22 percent) in Counties Manukau were two and a half and nearly two times more likely to smoke respectively than people identifying as NZ European/Other ethnicities (12.3 percent).[16] The overall total smoking prevalence in 2018 was 14.4 percent against the total target of 10%.

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

Better help for smokers to quit (Primary)- 90% of Primary Healthcare Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking in the last 15 months[17]

In 2019/20, CM Health achieved the 90% target for Pacific (90%). CM Health reached 88% for total enrolled population, 88% for Maaori, and 86% for Asian populations. One PHO (Total Health Care) exceeded the target across all populations.

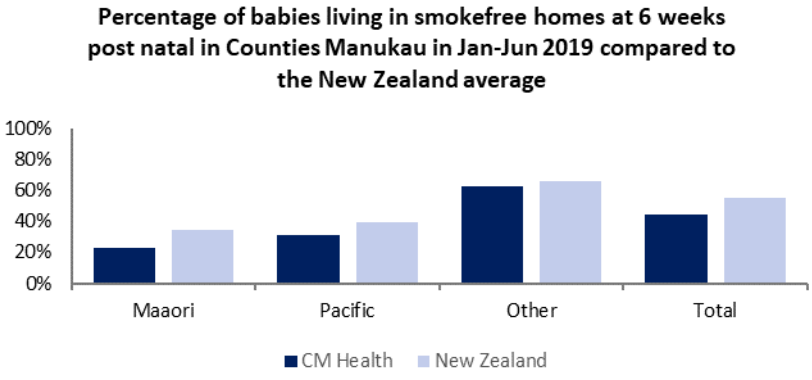
Although primary care's recent focus on COVID-19 testing and management has resulted in reduced capacity to focus on brief advice activity they have continued to work towards streamlined referral systems, priority population targeted outreach and increased cessation activities. In 2019/20, the CM Health Living Smokefree Service took 5,467 referrals of which 47% were for Maaori patients and 27% for Pacific, reflecting the strong equity focus of this service.



Data source: Ministry of Health Performance Reporting

Key contributory measure: increased percentage of babies living in smokefree homes at 6 weeks post-natal[18]

Increasing the number of babies living in smoke free homes will reduce potentially avoidable ill-health and hospitalisation (e.g. respiratory infections, asthma). Infant exposure to tobacco smoke contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. The System Level Measure "Babies living in Smokefree homes at 6 weeks post-natal" includes other household members and so focuses the attention beyond maternal smoking to the home and whaanau environment that an infant will be raised in. In 2019, there were marked inequities for Maaori and Pacific infants who were less likely to live in a completely smokefree home compared to New Zealand/Other households. The ethnic inequities in CM Health are similar to the national averages across New Zealand.



[16] Data on smoking prevalence is from the 2018 Census

[17] The data is for quarter four of each financial year

[18] In 2018/2019 a SLM was introduced focused on the proportion of babies in smokefree households at six weeks of age. This measure was included in CMDHB's 2019/20 Statement of Performance Expectations. It is now being used instead of the percentage of women who are smokefree at 2 weeks postnatal. The new data standards came into effect on 1 Jan 2019 which will improve data quality and accuracy.

In 2019 in Counties Manukau, an estimated 39% of Maaori women were identified as currently smoking at the time of admission for birth, compared to 12% of Pacific women, 5% of NZ European/Other women and 1% of Asian women. In 19/20 smoking cessation support was targeted for women during and after birth. The Smokefree Maternity Incentives programme has demonstrated a highly effective approach to supporting pregnant women to stop smoking during pregnancy. In 2020/21 efforts will focus on increasing reach and engagement in the existing whaanau incentives programme to support more babies to live in smokefree homes. This will have an equity focus to support Maaori and Pacific women and their whaanau.

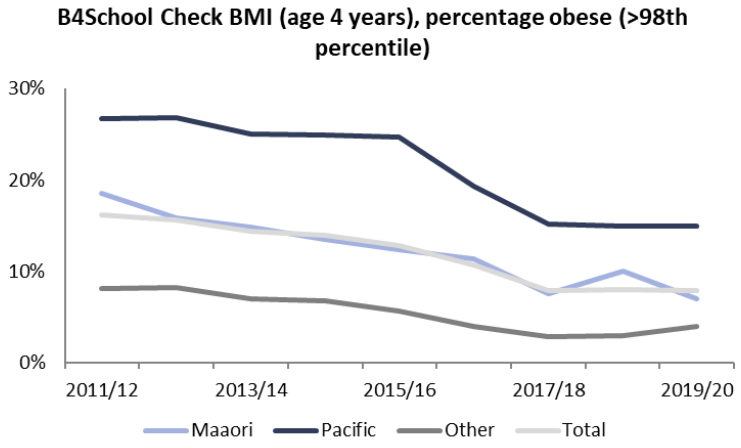
Data source: Ministry of Health Performance Reporting

Medium term outcome: Equitable reduction in obesity prevalence in children

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

Supporting healthy weight in children

Referral for children identified with a high Body Mass Index (BMI) at the B4School Check provides an opportunity for children and whaanau to participate in clinical assessment and family-based nutrition, activity and lifestyle programmes. In 2019/20, the percentage of four year olds with a BMI over the 98th percentile was 8% (achieving the target of <13%). This was lower for tamariki Maaori at 7% and higher Pacific children at 15%.



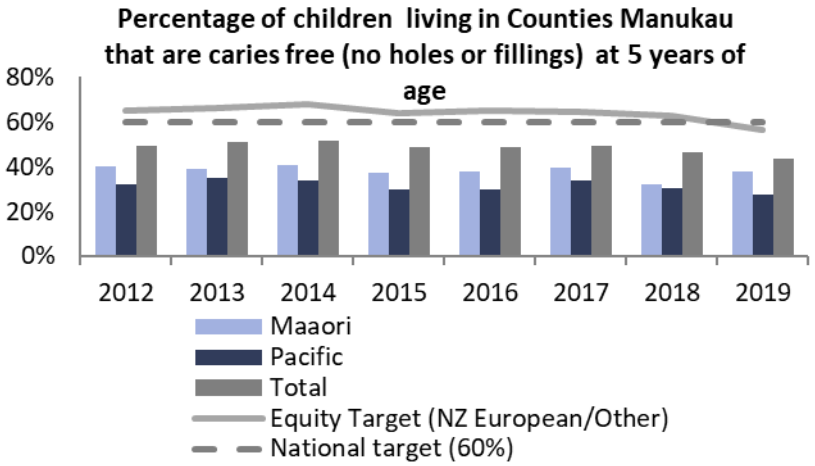
The decline rate for participation in assessment and healthy lifestyle intervention is higher in Counties Manukau than the national average, particularly for Maaori and Pacific whānau. One of the recommendations from a broader evaluation of child healthy weight activities in Counties Manukau is to engage with whaanau who have declined and better understand the reasons for declines for Maaori and Pacific whaanau. This work has yet to be undertaken.

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

Data source: Ministry of Health Performance Reporting

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

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



In 2019/20 the total percentage of children dental caries free at five years was 45%, still below the targeted level of 50% and a reduction from 2018/19. As in previous years, the target was only achieved for European/Other children. Early enrolment with dental services will support prevention and early detection of oral health problems, including dental caries. CM Health has worked with the Auckland Regional Dental Service (ARDS) to implement an automated enrolment from birth. In 2020/21 CM Health will continue to work with ARDS and other community oral health providers to expand the provision of preventative services to children at high risk of dental caries, particularly Maaori and Pacific children. CM Health will also continue to align oral health and obesity prevention messaging with a focus on new resources for Maaori and Pacific children

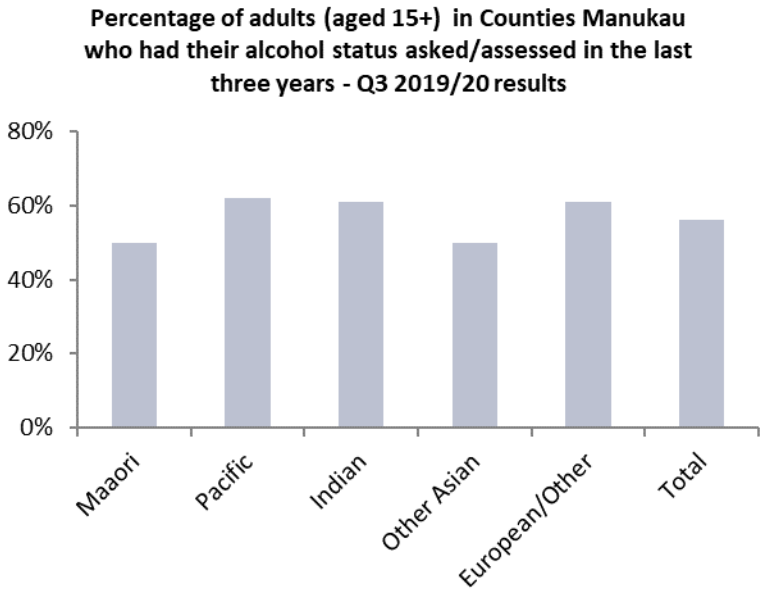
Data source: Ministry of Health Performance Reporting

Medium term outcome: Reduced hazardous alcohol use and harm

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

Key contributory measure: Increasing the percentage of enrolled patients in general practice who have had their alcohol status asked/assessed in the last three years[19]

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



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

To support Alcohol ABC approach in general practice, a data standard and specification has been developed and

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

implemented in collaboration with general practice partners and the Metro Auckland Data Sharing Programme. This enables standardised data collection and reporting of Alcohol ABC indicators across the Auckland region.

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

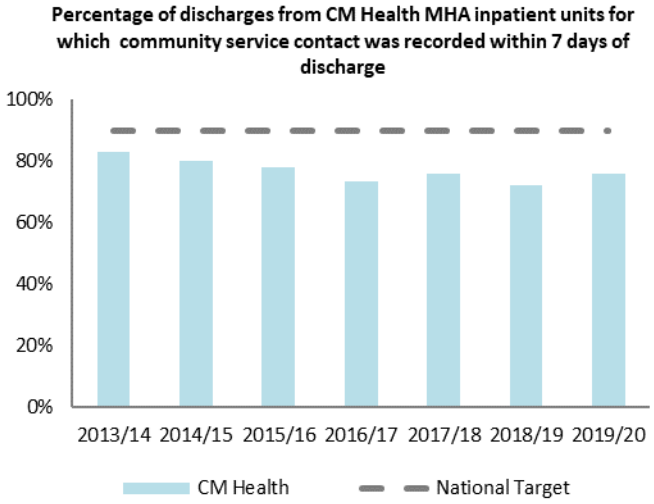
Medium term outcome: Improved mental health and wellbeing

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

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

Post discharge followup of tangata whaiora and whaanau within 7 days after an inpatient admission helps promote engagement with the local community mental health teams that has greater access to support services in the community.

In 2019/20, 76% of service users discharged from the CM Health acute adult inpatient mental health unit had a community mental health service contact recorded within 7 days of their discharge. This remains unchanged from the previous two years however still remains an area of focus for the community teams. Community and Inpatient teams are working with cultural liaison workers available at point of entry (Intake and Assessment) and Tiaho Mai (Kaimanaki) to support discharge to community teams.



The Health Quality Safety Commission (HQSC) national project Connecting Care, now in its second year aims to improve the transition of tangata whaiora between secondary and primary care services. The model pathway (clozapine pathway adapted), co-designed by staff from Tamaki Health PHO and Matariki Community Mental Health Team are now in the testing and evaluation phase. This information will help inform the way community MHS and primary care providers transition service users effectively between care settings while promoting effective engagement. The project team aims to have the project written up with implementation plans to the wider division by January 2021.

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

Improved youth mental health and well-being

In 2019/2020 CM Health has worked on increasing access to primary mental health support for young people. By June 2020, the Wellness Support model of care has now been implemented across all CM Health general practices, enabling the community to access funded medication and non-medication options to support their mental health. There are no age or symptom score criteria for accessing funded support. In the 2019/2020 year a total of 33,091 consultations were reported of which 2363 consultations have been provided to those under 18 years of age (7% of all consults, 874 people seen). Of those provided with support 17% were Maaori, 6% Pacific and 8.5% Asian.

Work was also completed to ensure youth are supported to access the right care first time. Where primary care are unclear if a referral to secondary services is required or not, or if a young person declines referral primary care are encouraged to contact the Integrated Locality Care teams or PHO Coordinator for support and advice. Mental Health and Addiction NGO support is also now accessible by primary care to support the cultural and social needs of young people.

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

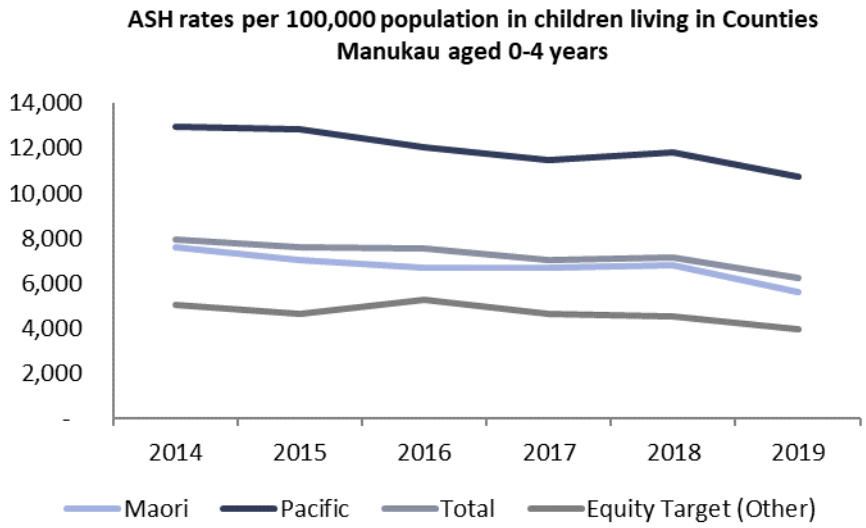
"Together we will involve people, whaanau and families as an active part of their health team"

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

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

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

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



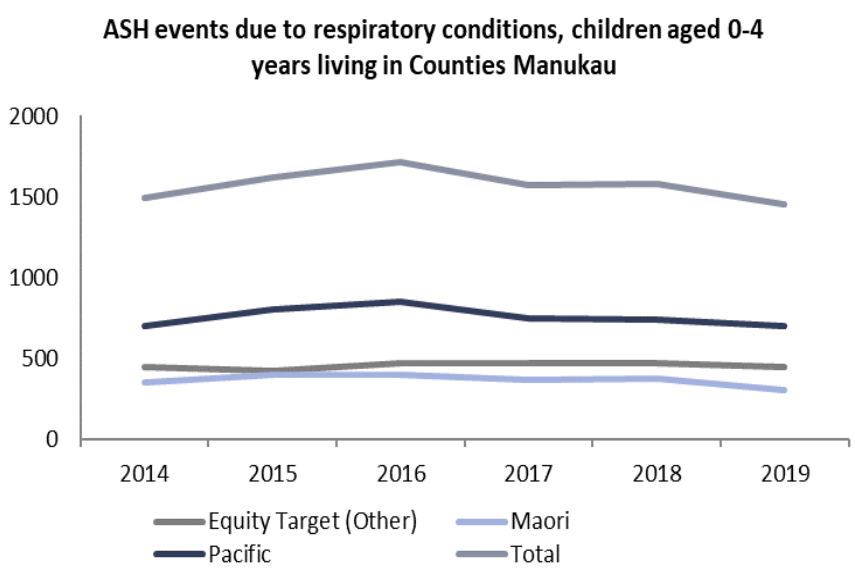
The ASH data presented is for the 12 months ending in December of each year. The 2019/20 Metro Auckland System Level Measures Improvement (SLM) Plan set a target of reducing the 0-4-year-old total, Maaori and Pacific ASH rates by 3% by June 2020. December 2019 data indicates that CM Health has achieved this target for total population, Maaori and for Pacific ethnic groups.

In 2019/20, there was a focus on groups who experience inequitable child outcomes by promoting enrolment with WTCO providers in primary care, particularly for Maaori and Pacific children. The other principal area of focus is reduction in admission for respiratory events.

Data source: Ministry of Health Performance Reporting

Key contributory measure : Reducing 0-4 year old ASH events – respiratory condition subset[20]

Counties Manukau Pacific and Maaori children are more likely than children of other ethnicities to be hospitalised with respiratory conditions including asthma and penumonia. The 2019/20 Metro Auckland SLM Improvement Plan targeted reduced ASH rates through focusing on respiratory admissions, the largest contributor to 0-4-year-old ASH rates across the three Auckland DHBs. Through both local and regional work, CM Health implemented a number of strategies to reduce respiratory admissions, including actions to improve child and maternal immunisation and smoking cessation. This is especially important for reducing inequities for our Pacific children, who have the highest total and respiratory ASH rates. The ASH data presented is for the 12 months ending in March of each year. Since 2016, there has been a decrease in ASH rates for Pacific tamariki for respiratory conditions (asthma, lower respiratory tract infections, pneumonia, upper and ear nose and throat respiratory tract infections). However, inequities have persisted over time.



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

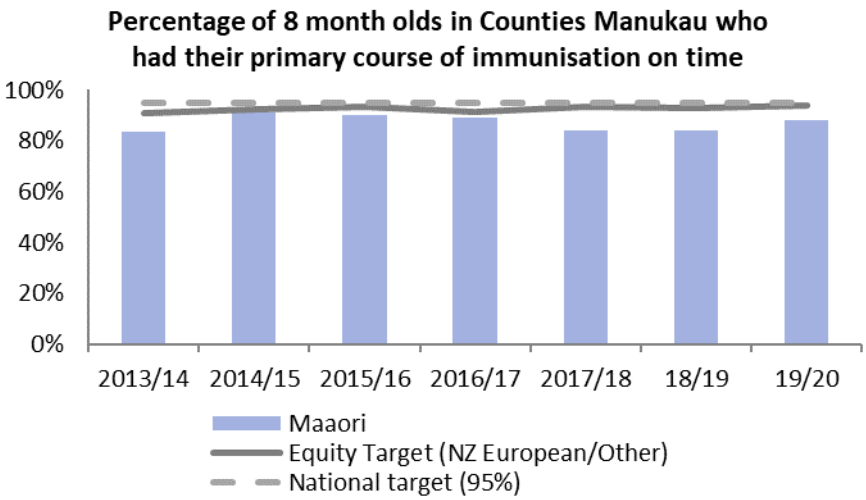
The 2020/21 SLM plan will continue to target reduced ASH rates through focusing on respiratory admissions. This is particularly important in a post COVID-19 environment. CM Health continues to support the implementation of the Best Start to Life tool. This decision support tool will prompt clinicians to offer vaccinations, to refer to Healthy Housing and to refer to smoking cessation for pregnant women and their whānau who smoke.

Data source: Ministry of Health Performance Reporting

Key contributory measure: improving immunisation coverage to reduce potentially avoidable hospitalisations

Immunisation Health Target – 95% of children will be fully immunised by the time they are 8 months old.

Tamariki Maaori have lower immunisation coverage and are disproportionately affected by vaccine- preventable diseases. Ensuring that vaccination coverage at 8 months achieves the national 95% target is important for enabling wellbeing for Maaori children and to avoid potentially avoidable hospitalisations. CM Health aims to achieve equity by increasing the percentage of pepi and tamariki Maaori who are immunised on time at 8 months, and 2 and 5 years. In 2019/20 CM Health did not meet the 95% target for tamariki Maaori, with performance improved from the previous year. Socioeconomic issues are a key challenge, with our Outreach Immunisation Service (OIS) experiencing more families in emergency housing where information cannot be shared, as well as families being



[20] The 2018/19 Metro Auckland SLM Improvement Plan targeted reduced ASH rates through focusing on respiratory admissions, the largest contributor to 0-4 year old ASH rates across the three Auckland DHBs. This new contributory measure has therefore been included in this Annual Report to reflect the large impact that it has on ASH rates for 0-4 year olds in Counties Manukau.

transient moving through multiple addresses.

The most effective strategy for engaging Maaori families has been multiple contacts to establish relationships and trust. CM Health has undertaken a pilot testing an incentivised programme for tamariki Maaori under 8 months where immunisation has been delayed. An evaluation to understand its effectiveness is underway.

Over the next year CM Health will continue to look for improvements and innovative ways of working to better meet the needs of whaanau and improve access.

Data source: National Immunisation Register Data Mart report

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

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

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

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

A key achievement of Poi has been the establishment of hospice multi-disciplinary teams, which provide expert mentoring and coaching to primary palliative care providers (chiefly ARRC facilities and GPs) in their local areas. Specialist support is received following submission of Palliative Pathway Activations (PPAs). These PPAs, or palliative care plans, are completed by primary palliative care providers for patients with identified palliative care needs, regardless of whether specialist palliative care is required. PPAs are reviewed by the Poi teams and attract a payment for the primary palliative care provider, to reflect the resources required to complete a plan. Support and guidance is provided to the primary care provider as required to improve capability in managing palliative care patients safely in the community. In 2019/20, 123 PPAs were completed by Totara and Franklin Hospice as part of Poi, with the number of PPAs steadily increasing across the region. 113 contacts (or 'proactive conversations') were recorded between the local hospices and primary palliative care providers as a result of the PPAs submitted.

Further to this, 260 link nurses have been trained within the Metro Auckland region since 2017. Link nurses act as champions within primary care and liaise between primary care providers and specialist palliative care services, to improve communication and co-ordination of care for patients with palliative care needs. Ten GPs with Special Interests (GPSI) have been employed by local hospices to progress palliative care capability and resources within primary and residential care settings for accredited 6-month rotations. GPSI are champions within the primary care workforce that will have expertise in both primary and palliative care.

The Metro Auckland DHBs have commissioned an evaluation of the programme with expectation of recommendations for improvement for 2021/22. In the interim, CM Health is continuing to support local hospices and the Poi Programme Office in further embedding the initiative.

Healthy Services – better value for public health resources

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

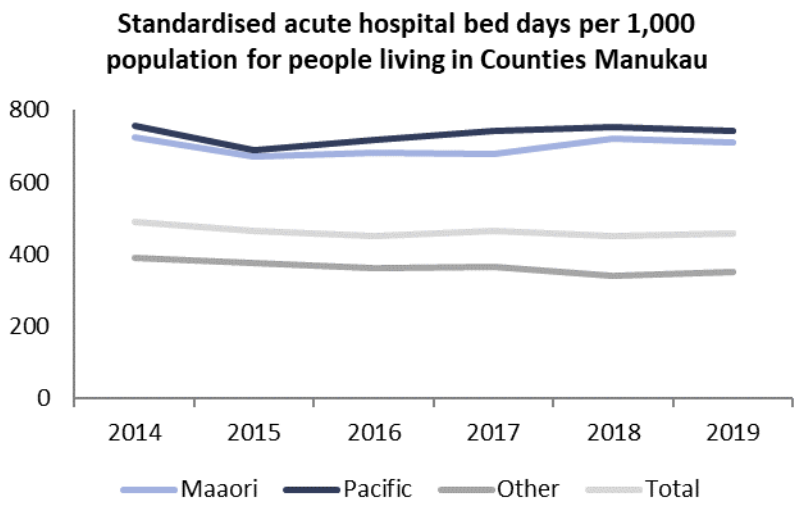
We will add healthy life years for Counties Manukau residents by reducing potentially avoidable (unplanned) hospital admissions. To achieve this, we need to ensure our workforces across the district are well trained, health literate, knowledgeable and come to work because they want to do their best for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

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

Medium term outcome: Reduction in acute hospital bed days

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

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



December 2019 results indicate that CM Health has meet the 2019/20 SLM Plan milestone for reducing the number of acute hospital bed days per capita for both the Maaori and Pacific populations. This is a challenging measure to shift due to the wide variety of factors (including socioeconomic deprivation) that impact on this measure.

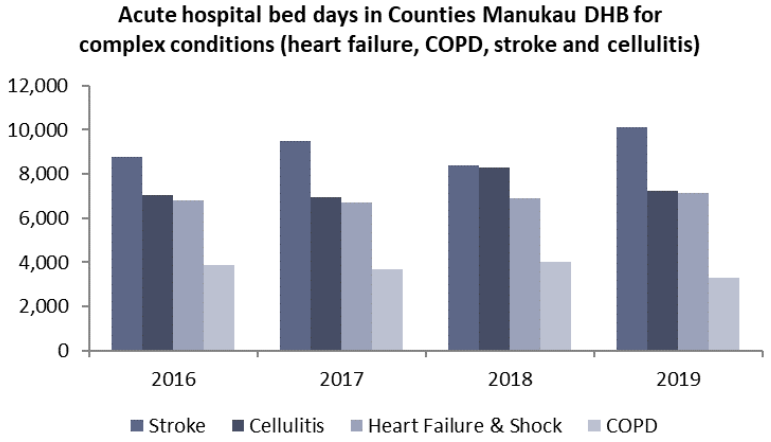
The 2020/21 SLM Plan will continue to focus on Maaori and Pacific populations so those with ASH conditions can be better targeted for preventative care. In CM Health the Te Ranga Ora initiative will seek co-designed care pathways to improve long-term condition care for Maaori and Pacific whaanau.

Data source: Ministry of Health Performance Reporting[23]

Key contributory measure: Focus on improving management for those with complex conditions

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

Four patient populations have been identified as contributing most to acute hospital bed days: patients with heart failure (HF), chronic obstructive pulmonary disease (COPD), stroke and underlying causes of reoccurring lower limb cellulitis. Together with our PHO partners, we are working to reduce the days our patients spend in acute care by improving the delivery of care for patients in these groups. The 2020/21 SLM Improvement Plan targets those patients most likely to be admitted or readmitted to hospital, with a focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. The System Level Measure 2020/21 milestone aims for a 3% reduction for Maaori and Pacific populations by 30 June 2021. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of primary options for acute care (POAC). It also targets improved coding for the top four priority conditions so that effective interventions can be targeted.



Data source: Ministry of Health Performance Reporting[24]

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

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

[24] Data is to March of each year.

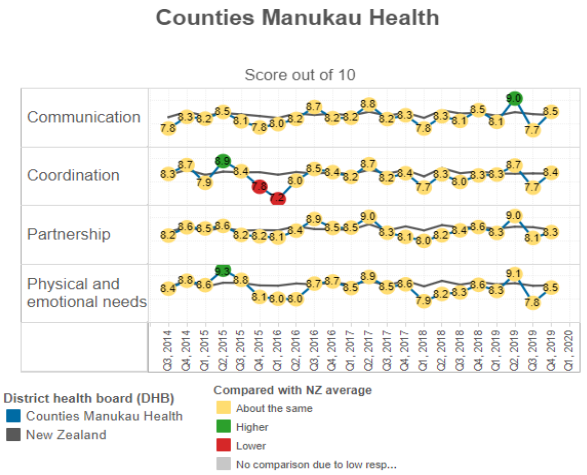
Key contributory measure: improved and more equitable experience of care

The Hospital Inpatient Patient Experience Survey (PES)

Understanding and improving patients' experience is vital to improving patient safety and the quality of care and contributes to better health outcomes.[25]

The national Hospital Patient Experience Survey provides insights into how to improve patient experiences by focusing on activities to improve the quality of care provided. As at Quarter 4 2019/20, CM Health's average score across all four domains of the survey (communication, coordination, partnership and physical & emotional needs) was 8.4, below our targeted average of 8.5. In 2020/21 CM Health will focus on improving the responses for the 'Communication' section of survey, which is our lowest scoring domain. Improving the average score in the inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' CM Health will join the ADHB and WDHB collaborative which has an action plan, enabling a regional approach to this shared problem. Target is a 5% improvement.

National Hospital Patient Experience Survey: Counties Manukau DHB average score across each domain 2014-2019

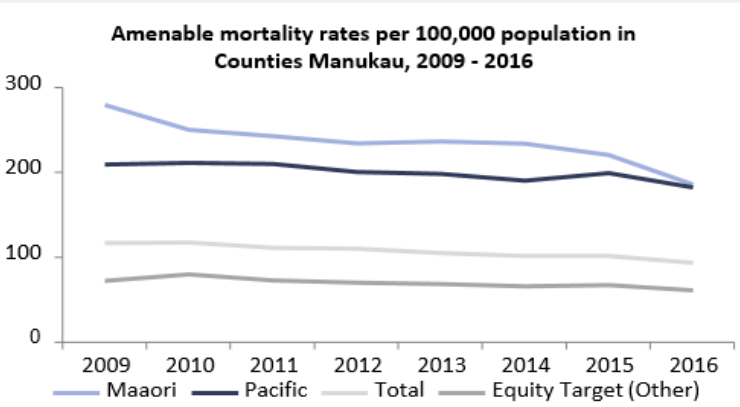


Data source: Health Quality and Safety Commission National Patient Experience Survey Report [26]

Medium term outcome: Reduced and more equitable amenable mortality rates

Target improvement in the leading causes of potentially preventable deaths.

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



The 2019/20 SLM Plan set has a five-year target set in 2016 of an amenable mortality rate reduction target of 2%, to be achieved by June 2021 for Maaori and Pacific (from previous year) and a 6% reduction by June 2021 for the entire DHB population (on 2013 baseline). Based on 5-year trends, Counties Manukau DHB shows a consistently declining total amenable mortality rate. Data from 2016[27] indicates we have already met the 6% reduction target for all ethnic groups with the most significant decline being for Maaori. The Maaori and Pacific targets have also been met.

The Maaori and Pacific amenable mortality rates have also been declining, except for a small increase in the Pacific rate between 2014 and 2015. The 2020/21 SLM Plan targets a further 2% reduction in the Maaori and Pacific amenable mortality rates by June 2020. This will be achieved through continued focus on improving smoking cessation and management of CVD, as well as a focus on the implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.

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

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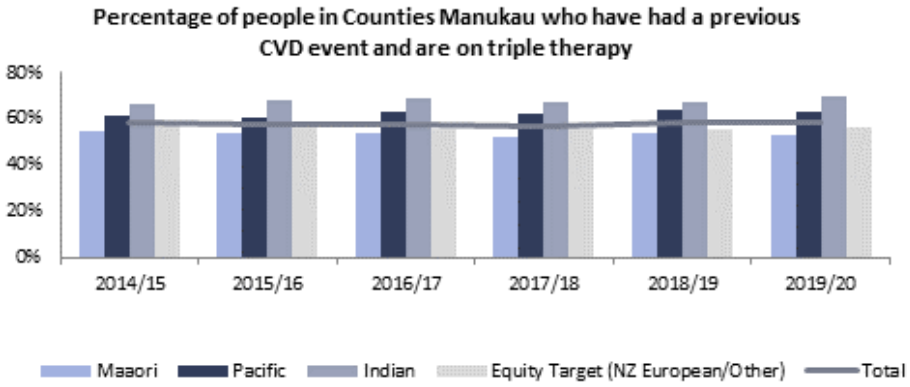
[25] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203

[26] Accessible online with national comparisons from the Health Quality Evaluation page of http://www.hqsc.govt.nz. There are four question domains that are scored out of 10, with average results reported each period. Targeted overall survey average is greater than 8.5. HQSC plan to add additional questions to assess patient experience according to cultural needs. Currently, CM Health's internal inpatient survey asks patients about the importance of respecting values, beliefs and cultural needs.

[27] Note that this is the latest available coded mortality data from the Ministry of Health as at July 2020.

Key contributory measure: better treatment of people with cardiovascular disease (CVD)

There is good evidence that for those with a previous CVD event, 'triple therapy' medicines can reduce the risk of future CVD events and death. Triple therapy as defined as statins, antiplatelet/coagulants, and blood pressure lowering medicines dispensed in at least three quarters in the year.[28]



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

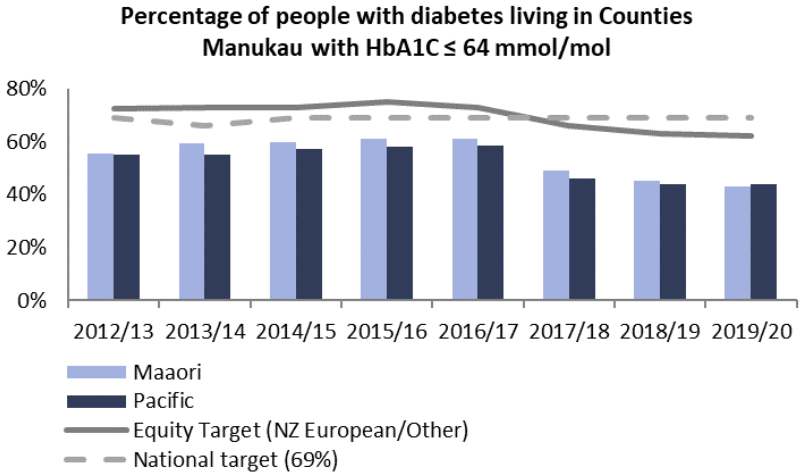
In 2019/20 we did not achieve our targets for increasing the percentage of people on triple therapy. In 2020/21 our focus will be on reducing inequity by improving CVD management for our population and for Maaori patients specifically through both local and regional initiatives with a greater focus on appropriate risk management.

The successful implementation of the 2018 CVD risk assessment algorithms will enable a focus on preventative medications in primary prevention. Both primary and secondary prevention will be improved through capturing when patients have either declined or are intolerant of medication. This will enable more targeted interventions

Data source: NRA CVD Prevention Medication Six Monthly Report[29]

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

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



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

Until 2017/18, CM Health used our Chronic Care Management for Diabetes (CCM) programme data as the data source for the HbA1c≤ 64 mmol/mol measure. This data source however only captured about 60-70% of eligible patients. In 2017/18 we transitioned to using PHO data submitted through HealthSafe, which captures closer to 90%

[28] Cardiovascular disease (CVD) management as measured by the percentage of Counties Manukau residents aged 30 to 80 who have a previous CVD event who are on triple therapy. Triple therapy as defined as statins, antiplatelet/coagulants, BP lowering dispensed in at least 3 quarters in the year.
[29] CVD Prevention Medication Report based on PHO enrolment for Quarter 4, CV Risk Assessment extracts and TestSafe dispensing data. Annual rates are based on data for 12 months until end March each year.

of patients. While it appears that the percentage of patients with good glycaemic control has decreased in 2017/18, this is in part due to the change of data source. Monitoring of TestSafe results suggests there has been an actual decrease in glycaemic control[30], likely linked to increasing obesity rates. For 2020/21 we will continue using HealthSafe for data on diabetes prevalence.

In 2019/20 the Long Term Condition Clinical Governance Group continues to review and support practices with poor performance for glycemic control. PHOs continue to work with poor performing practices by visiting them on a monthly basis or through project managers in the practices who work closely with GPs to help manage patients with high microalbuminuria levels.

Although there weren't significant improvements in HbA1c, we have made progress in processes that will help to achieve the targets

- A formal education programme is in development to support the primary care workforce in developing skills and capability to provide best practice and effective diabetes care and management.
- The retinal screening data match project is underway that is targeting people who do not have a record of retinal screening for the past two years. People with high HbA1c and no HbA1c recorded were proiritised to allow effective diabetes management and make these patients visible to primary care for better continuation of care.
- A working group has been established to support women with diabetes entering pregnancy or women who develop gestational diabetes. The purpose of this group is to enable primary care providers to better provider post-partum screening for HbA1c and ongoing care. The long term aim of the group is to work closely with this cohort to prevent congenital abnormalities in their babies.

In 2020/21 we are aiming to improve the percentage of patients with good glycaemic control through increased focus on improving the quality of diabetes care and proactive management of long-term conditions. This will include an emphasis on reducing unwarranted clinical variation between practices and ensuring practices have a quality improvement approach which is led by an improvement team. PHOs are currently offering virtual care through their practices and trials are underway to compare virtual care to traditional face to face appointments.

Data source: Ministry of Health Performance Reporting[31]

[30] Chan WC, Lee M (2020) *Update on diabetes prevalence in 2019 based on laboratory results*. Auckland: Counties Manukau Health

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

Key contributory measure: fiscal responsibility

District Health Boards (DHBs) exist to improve, promote and protect the health of the public and specifically the people that live in their districts. This is achieved through provision and funding of services, the allocation and long-term stewardship. To deliver this, each DHB must responsibly and effectively live within its means and achieve the best possible outcomes within available funding.

In 2019/20 the reported deficit is $79.672m. The Year End audited underlying financial position was a deficit of $38.2m (before one off adjustments of $41.4m for: COVID-19 costs ($11.3m) and an additional Holiday's Act provision ($36.5m), offset by an upside of $6.4m for revenue for Whakaari/White Island) compared to a budget deficit of $38.6m.

This was achieved through our focus on two key portfolios of work, both of which are targeted at extracting maximum value from all of our activities: 'Every Hour Counts' is not only about improving patient flow but also that our staff and partner health professionals are able to spend their time on activities that add value to the patient experience.

In addition, the 'Every $ Counts' portfolio supports CM Health's financial objective to return to a sustainable financial position. In 2019/20 a number of projects were consolidated under Every $ Counts with a total savings of $15m.

Our Health Service User population data for 2019 displays an undercount of approximately 12,000 residents when compared to our PBFF[1] allocation. Interactions between the undercount of the Census and the use of administrative data, in a setting with large amounts of household overcrowding (specifically prominent amongst Pacific families) have significant impacts for our community. Unfortunately, despite the adjustments made since, we have not seen a correction which adequately accounts for our population. When we apply the per capita rate to the remaining estimated undercount, this factor alone amounts to circa $32m in underfunding which has a significant impact on our ability to offer the full range of care relative to other DHBs and address some of our key clinical risk and equity concerns at scale. The effects of this undercount are compounded by the complexity of our population and its accompanying healthcare needs – the PBFF does not adequately capture socio-economic drivers of ill-health, nor the compounding effects of the unequal distribution of long term conditions. It is important to acknowledge the continuous and persistent undercounting of CM Health's population and the effect this has on our ability to meet our demand pressures, including implementing equity improvements on a large scale, and achieving sustainability.

Data source: CM Health Annual Reports[32]

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

[32] Accessible online from http://countiesmanukau.health.nz

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 2019/20 Statement of Performance Expectations. The services or 'outputs' we measure are grouped into four 'output classes' – prevention services, early detection and management services, intensive assessment and treatment services, rehabilitation and support services – that reflect the nature of the services provided, as presented in our outcomes framework.

CM Health's 2019/20 results are based on our performance as reported in Quarter 4 2019/20, unless otherwise specified.

Results are categorised based on the below key to demonstrate how far the result was from the target. This is important to demonstrate as although some measures were not achieved, the percentage difference is minor, while other measures are significantly off target. Numerators for the baseline and performance results have been included in the columns "18/19 Volume" and "19/20 Volume" where possible to provide context to final performance. The volumes for performance are for Quarter 4 2019/20, unless otherwise specified.

Key for 2019/20 results:

	Target met
	Less than 5% off target
	More than 5% off target

Prevention services

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

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

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

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Health Promotion and Education Services						
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months	Total	91%	90%	88%[33]	60,673	59,000
	Maaori	89%		88%	19,408	18,991
	Pacific	91%		90%	19,167	19,413
	Asian	91%		86%	5,703	5,670
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking[34]	Total	96%	95%	85%[35]	12,486	8,461
	Maaori	96%		86%	4,710	3,437
	Pacific	96%		85%	3,490	2,301
	Asian	97%		82%		200

[33] **Performance has been impacted by COVID-19**

[34] In 2019/20 CM Health was no longer required to report these results to the Ministry of Health due to the consistent and equitable secondary care health target performance over a number of years (95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking). However, at year end 2019/20 we have not met the target but the smoke free team are working closely with the emergency department and senior leaders to improve performance.

[35] Performance is as at Q4 19/20 for the full year (including numerators and denominators)

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking[36]	Total	94%	90%	94%	707	429[37]
	Maaori	96%		94%	410	291
Percentage of babies living in smokefree homes at six weeks postnatal[38]	Total	55%[39]	53.9%[40]	44%[41]	2,300	1,846
	Maaori	25%		22%	207	192
	Pacific	45%		35%	558	440
Percentage of babies fully or exclusively breastfed at 3 months[42]	Total	49%[43]	70%	49%	1,650	1,506
	Maaori	42%		39%	261	202
	Pacific	44%		45%	385	350
Percentage of children identified as obese in the B4 School Check programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle	Total	100%	95%	100%		190
	Maaori	100%		100%		43
	Pacific	100%		100%		116
	Other	100%		100%		43
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	234	171	292		
Number of adult referrals to Green Prescription services	Total	5,869	7,300	2,921[44]		
Immunisation Services						
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time[45]	Total	92%	95%	92%	7,640	7,812
	Maaori	83%		84%	1,412	1,535
	Pacific	93%		92%	2,347	2,390
	Asian	98%		98%	2,154	2,356
Percentage of two year olds who are fully immunised[46]	Total	93%	95%	92%	7,799	7,799
	Maaori	87%		87%	1,589	1,575
	Pacific	92%		93%	2,206	2,363
	Asian	97%		97%	2,282	2,197
Proportion of eligible boys and girls fully immunised with HPV vaccine[47]	Total	62%	75%	60%[48]	5,034	5,705
	Maaori	54%		57%	1,039	1,171
	Pacific	72%		59%	1,706	1,822
	Asian	60%		73%	1,090	1,317

[36] Baselines for this measure reflect a full financial year data (1 July to 30 June).
[37] Due to reduced reporting in Q3 as a result of COVID-19 there was no Q3 data reported and therefore a full financial year data set is not available. Percentages and volumes for 2019/20 are reflective of a sum of Q1, Q2 and Q4 19/20 performance only.
[38] Denominator is from the WCTO dataset.
[39]Baseline data is for the period July 2018 to December 2018, source: WCTO and NHI register data via the MOH. New data standards came into effect on 1 January 2019 which will improve data quality and accuracy over time. This data is provided for implementation of the System Level Measures programme and therefore should only be used for quality improvement purposes
[40]The target represents a 2% relative increase from baseline as per the 2019/20 Metro Auckland SLM Improvement Plan. This target is lower compared to the 2018/19 Ministry of Health target of 80% for all ethnic groups.
[41] Results for 2019/20 are from the period January 2020 – June 2020.
[42] Denominator is sourced from the Ministry of Health NHI register. Results are for the period January 2020 – June 2020.
[43] Data reported six-monthly. Baseline as at March 2019 (Q3).
[44] **Performance has been impacted by COVID-19**
[45] Results are provided for the full year including numerators and denominators – 1 July 2019 to 30 June 2020. Baselines in this annual report are for the full financial year however in the 2018/19 annual report these were reported for Q4 performance only.
[46] Results are provided for the full year including numerators and denominators – 1 July 2019 to 30 June 2020. Baselines in this annual report are for the full financial year however in the 2018/19 annual report these were reported for Q4 performance only.
[47] Note that from 2019/20, the indicator includes HPV immunisation coverage for both girls and boys. The baseline only includes girls as data for boys was not available in 2018/19. For 2019/20, the indicator measures coverage for those born in 2006.
[48] Results are reported annually in Q4 of each year. 2019/20 results are for the period 1 July 2019 to 30 June 2020.

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Percentage of people aged over 65 years who have had their flu vaccinations	Total	54%[49]	75%	53%[50]	36,002	36,252
	Maaori	47%		43%	2,196	2,163
	Pacific	68%		65%	4,140	5,225
	Asian	57%		54%	6,923	7,151
Health Screening						
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	72%	70%	70%[51]	42,736	42,689
	Maaori	65%		65%	4,535	4,644
	Pacific	83%		81%	7,861	7,939
	Other	72%		69%	30,340	30,103
Proportion of women aged 25 – 69 years who have had a cervical smear in the last three years	Total	66%	80%	65%	100,458	97,708
	Maaori	62%		56%	12,589	12,005
	Pacific	68%		65%	19,568	18,880
	Asian	66%		61%	29,309	29,512
	Other	67%		73%	39,001	37,311
Percentage of four year olds receiving a B4 School Check[52]	Total	90%	90%[53]	87%	7,821	6,785
	Maaori	91%		82%	1,726	1,393
	Pacific	92%		84%	2,324	1,978
	Other	89%		91%	3,771	3,414
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS[54]assessment	Total	93%	95%	93%[55]		2,940
	Maaori	93%		96%		894
	Pacific	95%		95%		1,379
	Asian	89%		82%		393

[49] 2018/19 baselines are for the period 1 March 2018 to 30 September 2018.
[50] 2019/20 results are for the period 1 March 2019 to 30 September 2019.
[51] Performance is as at Q3 – two years ending 31 March 2020, consistent to MOH Q4 reporting requirements.
[52] **Performance has been impacted by COVID-19.** 2019/20 results are for checks completed during the financial year 8 July 2019 – 7 July 2020. Results show progress against the target numerator and denominator rather than achievement against total eligible population – consistent to quarterly B4 School Check reporting.
[53] The 90% Ministry of Health target is based on the percentage of the eligible population who receive a B4 School Check. Baselines and results for the 2019/20 year are therefore presented in this format. Previously results have been reported as a percentage against the target (i.e. a result of 100% if the target was met, or of over 100% if the target was exceeded).
[54] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide
[55] Results are for the calendar year 1 January – 31 December

Early detection and management services

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

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

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

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Primary Health Care Services						
Percentage of population enrolled in a PHO *The Census data is used for population denominators. As the Census has historically undercounted the Pacific population, we have presented the Health Service User data as a more accurate representation of enrolment. This is displayed alongside the 2019/20 result in parentheses.*	Total	96%	90%	98% (97%)	546,193	566,032
	Maaori	91%		92% (96%)	81,553	83,143
	Pacific	114%[56]		117% (96%)	136,023	142,568
	Asian	90%		95% (97%)	135,426	147,469
Percentage of newborns enrolled in general practice by 3 months[57]	Total	89%	85%	90%[58]	1,888	1,754[59]
	Maaori	70%		69%	350	311
	Pacific	86%		86%	525	501
	Other	101%		102%	1,013	942
Amenable mortality rate per 100,000 population[60]	Total	101.2[61]	≤98.1[62]	93.7[63]		
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	90%	90%	90%	137,587	138,393
	Maaori	87%		87%	18,966	19,331
	Pacific	90%		89%	32,826	33,202
	Other	91%		91%	85,795	85,860

[56] For the baseline, 2018 Census results had not yet been released. 2018/19 results used the 2013 Census data for population denominators. As the Census historically has underestimated the Pacific population, the 2018/19 baseline and the 2019/20 result for Pacific are greater than 100%. More realistic estimates can be obtained by using the Health Service User population.

[57] Enrolments are based on the National Enrolment Service (NES). Populations are based on the National Immunisation Register (NIR). Volumes are for Q4 18/19 for baseline performance and Q4 19/20 for current performance.

[58] Results are as at 2019/20 for the full financial year. Q4 19/20 results are Total: 84% Maaori: 65% Pacific: 80% Other: 96%

[59] Full 2019/20 financial year volumes are Total: 7,503 Maaori: 1,347 Pacific: 2,174 Other: 3,897

[60] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016

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

[62] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2021, as per the 2019/20 Metro Auckland SLM Improvement Plan. The 2019/20 Metro Auckland SLM Improvement Plan also includes a separate target for Maaori and Pacific of a 2% relative reduction by 30 June 2020

[63] Result is at 2016, this is a draft result at time of publishing

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	71%	90%	N/A[64]		
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c < 64 mmol/mol)[65]	Total	52%	60%	52%	17,351	17,640
	Maaori	45%		43%	2,412	2,336
	Pacific	44%		44%	5,724	5,897
	Other	63%		62%	9,215	9,407
Percentage of patients with CVD risk >20% on dual therapy (prescribed)[66]	Total	52%	70%[67]	53%	5,174	8,449
	Maaori	49%		52%	978	1,380
	Pacific	59%		57%	2,086	3,322
	Asian	49%		51%	2,110	1,555
Percentage of patients with prior CVD who are prescribed triple therapy (prescribed)[68]	Total	62%[69]	70%	58%	7,422	6,192
	Maaori	59%		53%	1,045	841
	Pacific	65%		63%	1,731	1,483
	Asian	61%		62%	1,039	1,118
Oral Health Services[70]						
Proportion of children under 5 years enrolled in DHB-funded community oral health services[71]	Total	79%	≥95%	89%	32,443	37,224
	Maaori	68%		72%	6,520	7,279
	Pacific	82%		91%	9,036	10,624
	Asian	77%		N/A[72]		
	Other	101%		96%	16,887	19,321
Percentage of enrolled children Caries Free at age 5 years[73]	Total	46%	50%[74]	43%	2,283	1,975
	Maaori	32%		38%	338	389
	Pacific	31%		28%	460	391
	Other	56%		57%	1,485	1,195
Mean Decayed Missing or Filled Teeth (DMFT) Score for Year 8 Children [12/13 years][75]	Total	0.83	≤0.75[76]	0.82		
	Maaori	1.03		0.96		
	Pacific	1.17		1.28		
	Asian	0.62		0.62		
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	73%	>85%	71%	25,365	25,039
Diagnostics[77]						
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	93%	95%	68%	15,015	15,344
	MRI	33%	90%	53%	7,590	8,292

[64] Data from the Ministry of Health is no longer available as this measure is not required to be reported as part of MOH quarterly reporting.
[65] 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.
[66] Results are 12 months to 31 March 2020.
[67] 2019/20 SLM Improvement plan targets a 5% relative increase from baseline for this measure, however due to persistent inequities in CVD management for Maaori, CM Health has chosen to adopt the Metro Auckland Clinical Governance Forum target of 70% for all ethnic groups.
[68] Results are 12 months to 31 March 2020
[69] Baselines are at Q4 18/19
[70] Baseline data is based on the calendar year (to 31 December 2018), except for adolescent measure which is Q4 2018/19
[71] Results for this measure are reported annually in Q3. 2019/20 results are therefore at Q3 2019/20
[72] The Asian data was not available in the Ministry of Health data set provided for Q3 19/20
[73] Results for this measure are reported annually in Q3. 2018/20 results are therefore as at Q3 2019/20
[74] The 2019/20 Ministry of Health target for the percentage of children caries free at age 5 is slightly lower than the 2018/19 target (51%)
[75] Results for this measure are reported annually in Q3. 2018/20 results are therefore at Q3 2019/20
[76] The 2019/20 Ministry of Health target for mean DMFT score for Year 8 children is lower than the 2018/19 target (0.81).
[77] Baselines, targets and results for all diagnostics measures (CT, MRI and the two colonoscopy measures) are for the financial year and not Quarter 4.

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	99%	90%	100%[78]	938	887
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)[79]	Total	82%	70%	67%	7,872	9,090
Ambulatory Sensitive Hospitalisations						
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population	Total	7,043	≤6,917[80]	5,324[81]		
	Maaori	6,367	≤6,602	5,134		
	Pacific	11,774	≤11,491	8,773		
Rheumatic Fever						
Acute rheumatic fever first hospitalisations rates per 100,000 population[82]	Total	13.8	≤4.5	9.8		
	Maaori	13.6		16.2		
	Pacific	54.7		31.3		
Sudden Unexpected Death of an Infant (SUDI)						
SUDI deaths per 1,000 live births	Total	1.18[83]	≤0.1[84]	1.18[85]		
	Maaori	2.40		2.40		
Pharmacy						
Number of prescription items subsidised	Total	7,695,564	N/A[86]	8,313,812[87]		

[78] Actual result for P1 within 14 days is 99.66% and thus rounded up to 100%.
[79] Performance has been impacted by COVID-19.
[80] This measure targets a 3% relative reduction from baseline and is included in both the 2019/20 and 2018/19 Metro Auckland SLM Improvement Plans. The actual target ASH rates for the total population, Maaori and Pacific for 2019/20 are higher compared to 2018/19. This is because ASH rates increased between December 2017 (the baseline for the 2018/19 Metro Auckland SLM Improvement Plan) and December 2018 (the baseline for the 2019/20 Metro Auckland SLM Improvement Plan.
[81] Data is year to June 2020.
[82] Performance for 2019/20 is for the full year: July 2019 – June 2020
[83] Baseline sourced from Child and Youth Mortality Review Committee – 14th data report comprising years 2013 to 2017
[84] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025. This target aims for a greater reduction in SUDI than the target presented in the 2018/19 Statement of Performance Expectations (<0.40 per live births)
[85] 2019/20 Result date source: This result is unavailable as relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 14th data report 2013-2017
[86] Measure is demand driven – not appropriate to set target.
[87] Volume is as at 30 June 2020 for a 12-month rolling period.

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

Performance Measure			2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Mental Health							
Percentage of population who access mental health services[88]	Age 0-19 years	Total	3.9%	3.10%[89]	3.99%	6,318	6,509
		Maaori	5.9%	4.25%[90]	5.8%	2,240	2,233
	Age 20-64 years	Total	3.9%	3.10%[91]	4.02%	13,080	13,773
		Maaori	9.3%	7.50%[92]	9.79%	4,236	4,534
	Age 65+ years	Total	2.0%	2.60%	2.21%	1,342	1,519
		Maaori	2.7%	2.60%	3.0%	129	152
Proportion of 0-19 year olds referred for non- urgent mental health or addiction services who are seen within 3 weeks and 8 weeks[93]	Mental Health (Hospital Care Arm)	3 weeks	70%[94]	80%	72%	1,146	1,323
		8 weeks	89%	95%	88%	1,469	1,602
	Addictions (Hospital Care Arm and NGO)	3 weeks	99%	80%	99%		
		8 weeks	100%	95%	99%		
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[95]		Total	72%	90%	76%		
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section		Non-Maaori	94	N/A	82		

[88] There is a three-month delay on the data. This data is an annual rolling rate from April 2019 – March 2020
[89] In 2018/19 this target was 3.15%.
[90] In 2018/19 this target was 4.45%.
[91] In 2018/19 this target was 3.15%.
[92] In 2018/19 this target was 7.75%.
[93] Note that in line with Ministry of Health definition and expectations the results for this measure include all referral types, not just non-urgent referrals. The inclusion of urgent referrals has the effect of raising reported performance against this target. Also to note is that in-line with the Ministry of Health's definition, the "starting point" of this measure is when a referral is opened in the Patient Management System and not when the referral was first made (if these dates are different).
[94] Baselines are for the period ending 31 March 2019
[95] Source: www.mhakpi.health.nz. CM Health is in the process of developing a suite of mental health and wellbeing measures. As these measures are being developed, the timeliness of post-acute discharge community care contact being made provides a reasonable indication of how our MHA inpatient and community services are performing.

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
29 compulsory treatment orders	Maaori	334	356[96]	321		
Elective Services						
Planned Care Measure 1: Planned Care Interventions[97]	Inpatient treatments	N/A	19,892	18,269[98]		
	Minor interventions	N/A	10,579	13,592		
	Non-surgical interventions	N/A	110	1		
Acute Services						
Readmissions – acute readmissions to hospital[99]	0-3 days	2.4%	≤2.3%	2.4%		
	0-28 days	10.9%[100]	≤10.7%	10.8%		
Acute Inpatient Average Length of Stay	Acute LOS	2.75 days	2.30 days	2.94 days		
	Elective LOS	1.59 days	1.50 days	2.07 days		
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		80%	95%	83%[101]	20,232	17,597[102]
Cancer Services						
Proportion of patients who receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks[103]	Total	83%	90%	85%[104]	183	164[105]
Cardiac Services						
Percentage of high risk patients who receive an angiogram within 3 days of admission	Total	60%	>70%	69%[106]	141	164
	Maaori	46%		66%	11	19
	Pacific	60%		62%	31	31
	Other	59%		72%	60	73
Stroke Services[107]						
Percentage of potentially eligible stroke patients thrombolysed		13.3%	10%	12.6%	80	81
Quality and patient safety						

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

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

[98] Total planned care interventions for 19/20 were 31,862 which is 104.2% of the target of 30,581. Overall target has been met.

[99] Acute readmissions are the standardized result for 19/20 for the year until March 2020.

[100] 2018/19 baseline is as at March 2019.

[101] 2019/20 result is for the full financial year however baseline is for Q4 18/19 only. Q4 2019/20 result for the three-month period is 93%

[102] Full year volume is 82,129

[103] The faster cancer treatment data is reported by the MOH on a 6 month rolling basis. The Q4 period is 1 January 2020 – 30 June 2020

[104] 2019/20 result is for the full financial year however baseline is Q4 18/19 only. The Q4 19/20 result for the three-month period is 87%.

[105] Full year volume is 347

[106] 2019/20 result and volumes are for a full financial year however baseline is for Q4 18/19 only. Q4 2019/20 result for the three-month period is Total: 73% Maaori: 62% Pacific: 62% Other: 80%

[107] Note that stroke services baselines and results are provided for the full 2019/20 year (12 month annualised results). This differs from the baseline included in the Statement of Intent and has been revised to reflect that for this measure the target is to be measured against annualised data (rather than year-end data).

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Percentage of admissions affected by a hospital acquired complication[108]		1.9%[109]	<1.8%	2.8%[110]	3,129	2,985
Rate of falls with major harm per 1,000 bed days		0.04	≤0.00	0.08[111]	22	25
Percentage of inpatients (aged 75+) assessed for risk of falling		95%[112]	90%	94%[113]	789	758
Rate of S. aureus bacteraemia (SAB) per 1,000 bed days		0.09	≤0.00	0.13[114]	32	41
Compliance with good hand hygiene practice		88%	80%	86%[115]		33,674
System Level Measures						
Acute hospital bed days per capita	Maaori	739	698[116]	640[117]		
	Pacific	764	730	680		

[108] Data is sourced from the Health Round Table coded discharge data.
[109] Baseline as at Quarter 3 2018/19. From July 2018, data has been refreshed using a new coding version HAC v2 versus previous data using HAC v1. From July 2018 to June 2019, the average is 2.7%
[110] Performance is from July 2019 to June 2020
[111] Performance is from July 2019 to June 2020
[112] Baseline as at Quarter 3 2018/19.
[113] Performance is from July 2019 to June 2020
[114] Performance is from July 2019 to June 2020
[115] Compliance rate for 1 March to June 2020
[116] This measure targets a 3% relative reduction from baseline and is included in both the 2019/20 & 2018/19 Metro Auckland SLM Improvement Plans. The actual target number of acute hospital bed days per capita for Maaori and for Pacific are higher for 2019/20 compared to 2018/19. This is because the number of acute hospital bed days per capita for these groups increased between December 2017 (the baseline for the 2018/19 Metro Auckland SLM Improvement Plan) and December 2018 (the baseline for the 2019/20 Metro Auckland SLM Improvement Plan).
[117] Performance is as at June 2020.

Rehabilitation and support services

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

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

Performance Measure		2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Age Related Residential Care (ARRC) [118]						
Percentage of people in ARRC who have a subsequent International Resident Assessment Instrument (interRAI) long term care facility (LTCF) assessment completed within 230 days of previous assessment		92%	95%	92%[119]		3674
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI home care assessment tool in the six (6) months prior to that first LTCF assessment		88%	90%	92%[120]		770
Home Based and Community Support						
Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.		97%	95%	97%[121]		11,130
Assessment, Treatment and Rehabilitation Services						
Conversion rate of contact assessment (CA)to home care assessment where CA scores are 4 – 6 for assessment urgency	Aged 65+	0%[122]	N/A[123]	4: 8% 5: 22% 6: 17%		
Number of older people that have received in-home strength and balance retraining services	Aged 65+	588	1,118	823		
Number of older people that have received community / group strength and balance retraining services	Aged 65+	1,530	1,400	659[124]		
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	1,723	2,325 places	2,120 places		
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 50-74	639	600	520		
	Aged 75-84	424	300	355		
	Aged 85+	361	300	331		

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

[119] 2019/20 result is for the full financial year. Q4 2019/20 result is 92%

[120] 2019/20 result is for the full financial year. Q4 2019/20 result is 89%

[121] This measure is reported a quarter in arrears. The result for the financial year up to and including Q3 19/20. Q4 cannot be reported as, between late March and 26 July, providers were funded a fixed fortnightly amount and providers ceased fee for service claiming through MoH Sector Operations.

[122] Note that the full year annualised baseline for 2018/19 is 6.1% (Q1: No result, Q2: 18.2%, Q3: 7.1%, Q4: 0%).

[123] Due to uncertainties around data quality and the need for further work to be completed to understand what best practice looks like for interRAI Contact Assessment to interRAI Home Care Assessment conversion rates, the Ministry of Health has yet to release a target for this measure.

[124] 659 new and unique attendees

Performance Measure	2018/19 Baseline	2019/20 Target	2019/20 Result	18/19 Volume	19/20 Volume
Palliative care[125]					
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District	123	866[126]	194		
Number of Hospice Proactive Advisory Conversations between the hospice service, primary care and ARRC health professionals	113	866[127]	190		

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

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

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

Performance by Output Classes [Includes agency costs]

Output Classes [$000]

	Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services	Total
Revenue (includes agency revenue)	**62,716**	**266,925**	**1,375,325**	**184,659**	**1,889,625**
Budget (includes agency revenue)*	*46,722*	*254,530*	*1,345,875*	*185,636*	*1,832,763*
Personnel Costs	20,138	773	732,931	11,310	765,152
Outsourced Services	1,201	46	105,726	674	107,647
Clinical Supplies	4,019	154	135,140	2,257	141,570
Infrastructure and Non-Clinical Supplies	1,045	40	148,814	587	150,486
Other (includes agency costs)	36,313	265,912	332,386	169,831	804,442
Total Costs	**62,716**	**266,925**	**1,454,997**	**184,659**	**1,969,297**
Budget (includes agency costs)	*46,722*	*254,530*	*1,384,467*	*185,636*	*1,871,356*
Deficit	-	-	**(79,672)**	-	**(79,672)**
Budget	-	-	***(38,594)***	-	***(38,594)***

Agency revenue and costs for the year amounts to $23.4m.

Information on appropriations

How performance will be assessed and end of year reporting

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

	Amount of Appropriations ($000)				
	2018/19		2019/20		
	Budget	Total Actual	Budget	Supplementary	Total Actual
Total Appropriations	1,439,807	1,439,807	1,524,353	$30,268	1,554,621

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

Asset Performance Indicators for Counties Manukau District Health Board

Counties Manukau Health's Asset Portfolio

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

Facilities, Engineering and Asset Management (FEAM) response to COVID-19

A number of projects were undertaken by the FEAM team in response to COVID-19. One of the most significant pieces of works undertaken was to create negative pressure wards accommodating 160 beds by modifying the ventilation system of the top three levels of the Scott Building. The benefit of this was that all COVID-19 patients could be moved onto specialist wards to ensure isolation and whilst also enabling us to carry out best patient care while optimising healthcare staff welfare.

Staff recognised a unique opportunity due to the historical set up of the ventilation within these floors. The team identified that it could significantly increase the output of an existing extraction fan and thus increase air extraction from the rooms and by altering the extraction ducts and air input creating a negative pressure flow into and out of patient rooms. Sealing off different ports then allowed the creation of pressure differentials creating negative pressure rooms for patient care, 'red zone', a transition point for donning and doffing of PPE, 'orange zone", and a 'Safe Zone' or 'green zone' for staff to come into to rest, recover and work. Whilst we are fortunate not to have to use this space to date it can be easily converted again in the future should the need arise.

Other work undertaken in this period included:

- Setting up a public information office in a temporary building outside Middlemore Hospital Emergency Department entrance to provide advice to the public and directions to testing stations.
- Setting up community based Assessment Centres in Takanini, Botany, Mangere, Pukekohe, Wiri, and Otara.
- Extra partitioning in the Emergency Department to control use of resus rooms.
- Installation of standard Bioquell switches and motorized dampers to ensure that each bay could be blocked off individually and airflow did not circulate to other bays.
- Reconfiguration of ICU into isolated cells to increase the number of individuals to be treated.
- Alterations as required to allow the creation of a safe route from the assessment area to the new ward areas noted above with minimum exposure to other staff and members of the public. This also involved the reprogramming of lifts to provide a direct COVID-19 only route up the building.

Table 1 Asset Portfolios

Asset Portfolio	Asset Purpose	Quantity/Capacity	Book Value 30 June 2020
Property	To enable the delivery of high quality health services through the provision of facilities that meet accreditation requirements	• 716 adult medical, surgical, rehab, Assessment Treatment and Rehabilitation, community medical inpatient beds • 66 paediatric inpatient beds • 43 Intensive Care Unit / High Dependency Unit /Paediatric Intensive Care Unit/ Coronary Care Unit / Cardiac Step Down Unit beds • 90 maternity beds, 15 gynaecology beds, 7 assessment rooms and 29 delivery suites (hospital & community) • 77 acute mental health beds • 58 community mental health beds • 146 ED cubicles & short stay beds • 24 operating theatres; 14 at Middlemore and 10 + 2 procedure rooms at Manukau Surgical Centre • 14 owned community facilities • 18 leased community facilities • 19 owned dental clinics (84 chairs) plus 9 mobile dental units and 48 mobile unit site pads	$567m buildings, plant and infrastructure & land with a value of $193m
Clinical Equipment	To enable the delivery of high quality, timely clinical services through the availability of equipment that meets required clinical and safety standards	• 3 x MRI machines • 4 x CT machines owned • 1 cardiac catheter suite • 29,421 (20,899 in-hospital & 8,522 community-based) items[128]	$37m Net Book Value ($91m original cost)
ICT	To enable the delivery of high quality health services through the availability of timely, accurate and accessible patient and business information	Regionally shared hardware and software. 7,800 users within Counties Manukau Health	$53m healthAlliance C-Class shares; $2.9m in FPIM rights & $1.3M hardware & software; $7m work in progress (WIP) as at 30 June 2020

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

1. Property Assets

Property Assets Performance Measures

Services operated by CM Health are largely delivered from seven inpatient facilities and 18 leased or owned outpatient and community health facilities across the district. Manukau SuperClinic and Middlemore Hospital sites contain the largest elective, ambulatory, and inpatient facilities. In addition, a range of DHB and contracted community services are provided across the district e.g. Community Mental Health, Kidz First Community and others. The performance of assets is vital to CM Health to provide better health services to all people of the Counties Manukau and surrounding regions. For this reason, CM Health is fully committed on developing a solid Asset Management Plan and strategy plan in order to improve its asset capability and maturity.

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

Occupancy rates continue to exceed capacity for medical and surgical beds

Table 2 Property Asset Performance Measures

Asset	Measure	2018/19 Target	2018/19 Actual	2019/20 Target	2019/20 Actual
Medical beds *Occupancy % for opened beds at 7 am*	Utilisation	90%	102.4%[1]	90%	103.1%[2]
Surgical beds *Occupancy % for opened beds at 7 am - Middlemore only*	Utilisation	90%	103.2%[1]	90%	101.5%[2]
Operating Theatres [3] *The percentage of theatres utilisation is calculated based on the total turnaround time + theatre duration divided by the session duration (in minutes)*	Utilisation	90%	84%	90%	87%
Building compliance requirements *Percentage of buildings used that possess a valid Building Warrant of Fitness (BWOF)*	Condition	100%	100%	100%	100%
Seismic Compliance *Percentage of buildings assessed as being earthquake prone (<34% New Building Standard (NBS) is classified as earthquake prone)*	Functionality	0%	5.5%	0%	5.5%
Facilities assets meeting or exceeding performance uptime *Facilities assets comprise of hot water boilers, steam boilers and chiller plants. The 'Utilisation' results of these assets are based on the total asset available time minus the unplanned downtime and divided by the total asset available time.*	Utilisation	99%	98.8%	99%	98.1%[4]

Asset	Measure	2018/19 Target	2018/19 Actual	2019/20 Target	2019/20 Actual
Area fit for the provision of clinical or administration functions *Percentage of areas are rated in the range from Adequate to Excellent (Levels are categorized as :Not suitable, Barely adequate, Adequate, Good and Excellent)*	Functionality	90%	86%	90%	86%

(1) There were 88 days in the 2018/19 year where occupancy rate of medical services had reached 100% or above against open capacity and for surgical services there were 47 days where occupancy rate had reached 100% or above. (2) There were 140 days in the 2019/20 year where occupancy rate of medical services had reached 100% or above against open capacity and for surgical services there were 4 days where occupancy rate had reached 100% or above. (3) Only elective theatres have been considered in computation of utilisation%. (4) In FY2018/19 the boiler located in Middlemore Hospital's "Energy Centre" building was shut down to carry out flue remediation works. Even though this outage did not cause any disruption to service due to CM Health having a relevant redundancy system in place, this event has still been captured and reflected in our calculations for the purpose of this report.

2. Clinical Equipment Assets

Clinical Equipment Assets – Condition and Utilisation

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

Table 3 Clinical Equipment Condition, Availability & Utilisation

Asset	Measure	2017/18 Target	2017/18 Actual	2018/19 Target	2018/19 Actual	2019/20 Target	2019/20 Actual
MRI	Availability/Uptime	>98%	>98%	>98%	98%	>98%	>98%
	Service Level/ Utilisation	>85% elective patients waiting & scanned within 42 days	35%	>85% elective patients waiting & scanned within 42 days	34%	>85% elective patients waiting & scanned within 42 days	52% [1]
CT Scanners	Availability//Uptime	>98%	>98%	>98%	98%	>98%	>98%
	Service Level/ Utilisation	>95% elective patients waiting & scanned within 42 days	90% elective patients waiting & scanned within 42 days	>95% elective patients waiting & scanned within 42 days	93%	>95% elective patients waiting & scanned within 42 days	70%[2]
Angiography (Catheter Lab)	Availability//Uptime	>98%	>98%	>98%	98%	>98%	99%
	Utilisation	-	82%	85%	84%	85%	84% [3]

All non-fixed assets (Minor Assets) [4]	Current Warrant of Fitness/ Certificate of Compliance	95%	88% (average) 90.2% (at 30 June)	95%	94.2% (average) 95.9% (at 30 June)	95%	94.2% (average) 93.5% (at 30 June)[5]

(1) MRI results for the 19/20 year are less than we would like. This result is multifactorial:

- Staffing issues – reduced staffing through 1st and 2nd quarter of the 19/20 FY due to vacancies: recruiting difficulties.
- Extended industrial action from September 2019- November 2019 resulting in reduced volumes.
- Increased repatriation from ADHB of CMDHB patients- which although funded add to the volumes.
- Increase in referrals for MRI over the last 3 FY of 29% with no increase in resources.

(2) CT results are down- as with MRI the reasons are multifactorial:

- Staffing issues – reduced staffing through 1st and 2nd quarter of the 19/20 FY due to vacancies: recruiting difficulties.
- Extended industrial action from September 2019- November 2019 resulting in reduced volumes.
- Added demand from inpatient services for CT, increased repatriation from ADHB of CMDHB patients
- Increase in referrals for CT over last 3 years of 25% with no increase in resources.

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

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

(5) A target of 95.5% was achieved at end of Jan 2020, however, the gains made was lost due the impact COVID-19 had on the work programme.

3. ICT Assets

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

ICT Assets – Availability

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

The table below summarises actual for 2017/18 – 2019/20 versus target for 2019/20:

Asset type	Service Level Agreement Target	2017/18 Actual (Regional)	2018/19 Actual (Regional)	2019/20 Target (CM Health)	2019/20 Actual (CM Health)
Tier 1 Information systems (Critical)	• No more than 10 Tier 1 systems per annum less than 99.8% available • Average availability per annum >99.8% • Target outage recovery 4 hours	99.987%	99.93%	99.8% (max 8 unplanned outages and 0 exceeding 90 min restoration time)	99.99%

Tier 2 information systems (Urgent)	• No more than 10 Tier 2 systems less than 99.8% available • Average availability per annum >99.8% • Target outage recovery time 2 days	99.985%	99.93%	99.8% (max 3 unplanned outages and 0 exceeding 120 min restoration time)	99.99%

ICT Assets – Condition

Asset type	Service Level Agreement Target	2019/20 Target (CM Health)	2019/20 Actual (CM Health)
Access to network and systems remotely	% of devices compliant with asset age replacement policy	86%	92.47%

ICT functionality – Access to network and systems remotely

Indicator type	Service Level Agreement Target	2019/20 Target (CM Health)	2019/20 Actual (CM Health)
Access to network and systems remotely	Remote access available to any staff who require it	35%	55.17%

ICT Utilisation – Services completed in the digital environment

Indicator type	Programme Target	2019/20 Target (CM Health)	2019/20 Actual (CM Health)
Services completed in the digital environment	eRadiology orders uptake	95%	98%
	Ward coverage of eVitals	35 wards	35 wards
	Ward coverage of MedChart	18 wards	20 wards

ICT Utilisation – Front line staff utilising mobile technology with clients

Indicator type	Programme Target	2019/20 Target (CM Health)	2019/20 Actual (CM Health)
Frontline staff utilising mobile technology with clients	Availability of mobile devices across the DHB (according to the Point of Care Devices Business Case)	82%	90%

Good Employer

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

Treaty of Waitangi and commitment to Maaori population and staff

The DHB is committed to deliver its obligations under the Treaty of Waitangi through workforce development and learning.

Workforce Development

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us. Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

Goal for 2025

CM Health is one of the largest employers in the Counties Manukau area. With over 6,527 FTE in more than 100 different jobs at 20+ sites across the region, CM Health serves an estimated population of 568,730 people of which 89,360 are of Maaori decent and 120,110 are Pacifica. In June 2017, the CM Health Board approved the establishment of Maaori and Pacific workforce targets with a goal that by 2025 CM Health will have a workforce that reflect the population it services. This would mean increasing the Maaori workforce by an additional 554 FTE and increasing the overall percentage of Maaori employed by CM Health from 7.5% (491) to 16% (1044) by 30 June 2025.

CM Health Pacific workforce would need an additional 402 FTE increasing the overall percentage of Pacifica employed by CM Health from 15.4% (1008) to 21% (1409) by 30 June 2025

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

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

Key Focus Areas

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

The six key focus areas for Maaori Workforce Development are:

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

Learning

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

The Te Pookaitahi Reo - Te Reo Maaori Programme is delivered in with Te Whare Waananga O Awanuiaarangi (TWWoA) and is NZQA accredited. The programme is designed to build confidence and capability in the Te Reo Maaori and to do so

within a workplace context. Graduates of this qualification will have the confidence to converse in Te Reo Maaori at an intermediate level.

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

Governance of work force, employees and safety

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

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

Diversity and Equal employer

Disability

CM Health's Disability Action Plan 2019 – 2022 sets out 5 key priorities and outcomes that encourages proactive responses to people who have a disability:

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

CM Health proudly received the Accessibility Tick on 2nd December 2019. Receiving the Accessibility Tick and certificate represents CM Health's ongoing committed to changing the disparities that exist for disabled people.

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

1. Increasing employment opportunities through CM Health's job advertisements and careers webpage that encourages job seekers with disabilities to apply.
2. Forming a working partnership with Workbridge to reduce barriers for job seekers with disabilities.

3. Creation of an Employment Disability Support Services (EDSS) contact email for job seekers, employees, and managers. A safe place to seek support, advice, and guidance about issues relating to disability and accessibility in the workplace.
4. Updated training content for recruiting managers on being more inclusive of people with disabilities.
5. Updated communication information for employees and managers about disability, accessibility, and support services.

Pay equity contribution to national work

For employees on Individual Employee Agreements (IEAs), we addressed the gap in pay between women and men on the same salary bands. We conducted a gender pay gap analysis to understand whether men and women in our IEA salary bands, in fact received equal pay for equal work or work of equal value. At CMH we assess work as equal (or approximately equal) through our salary bands. Our analysis showed we had a gender pay gap of around 3.3%. We took action by applying pay review increases for women, where their pay was lower than the overall men's median pay in each respective salary band. After making these adjustments, the gender pay gap for employees on IEAs was 0% - that is the median pay of women in each salary band was the same as the median pay of men in the same salary bands. These adjustments were effective 1 January 2019.

Pay equity for MECA based employees is happening via the National Pay Equity Working Group.

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

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

This year our CEO, Margie Apa, put an emphasis on seeing our Values in Action and so we've been working hard to imbed our values in everything we do.

Values Visibility

Values posters remain visible in every meeting room in Ko Awatea, and are available online for services to print. Departments are strongly encouraged to have these on display in the wards where both staff and patients can view them. Our values have also been added permanently to our online intranet site Paanui.

Team Values Discussions & Charters

We have also been working with managers and staff to support them to articulate how each of our values relates to their team and service specifically. For example, what Kotahitanga looks like in their team, how they can behave in ways that align with Kotahitanga, how they keep each other accountable for demonstrating Kotahitanga and how they can celebrate each other when they do demonstrate Kotahitanga! Research shows that recognition of great effort and mahi is a key component to increasing positive behaviour. Feedback from teams who have engaged in this discussion has been very positive and they have appreciated the opportunity to articulate and agree how they want to work together. Staff have also found the creation of a Team Charter (a summary of the facilitated discussion) to be really useful to refer to in future team meetings and on-going planning.

A range of Team Check-up discussion tools (slide decks, discussion templates and team charter templates) have been developed and are now available on Paanui for Managers to access. These discussions have been rolled out across the organisation in a network approach, whereby success stories of services who engage in these conversations is shared and so ripples across the organisation. We have already had successful uptake of this values discussion opportunity with many services and continue to promote this resource to other teams. We are now responding to multiple requests to support these conversations in other services.

Values awards

As a result of much discussion and planning, organisational Values Awards have been incorporated in the organisation's Annual awards held in December each year. These awards promote the importance of living our values and rewarding staff for doing so. The nomination process will allow staff the opportunity to nominate each other for demonstrating values-aligned behaviour.

Staff Survey

In 2019, we conducted a Staff Survey to hear how our staff experience working at CM Health. As a DHB, we are committed to creating a positive working environment (organizational culture) across the organization and a key part of this is to first listen and understand what our staff experience on a daily basis. The employee survey is all about knowing what's going well at work and how we might work together where we have opportunities to improve. When we're happy and healthy at work, we perform better for our colleagues and our patients. We wanted to give our staff the opportunity to have a say, every staff member view is important. All of survey answers were completely anonymous with no answers attributed to individuals.

The overall engagement score across the DHB was strong and we performed well compared to our DHB counterparts in NZ. Employee response to the question: "How likely are you to recommend this DHB to friends and family as a place to work?" indicated that 74% of CM Health employees were likely or very likely to do so. We also found that we have some

work to do when it comes to Bullying, Harassment and Discrimination as well as staff Wellbeing.

CM Health is now working on turning the staff insights into action. Surveys remain an invaluable source of insight and information; however, they are just that: the source, the start, the catalyst for change. The true value will only come from taking effective action, based on what our people are saying. Managers are the key stakeholder group when it comes to turning that insight to action. Theirs is an integral role, one of supporting their teams in understanding the survey data and selecting the right local survey actions.

Implementation of the survey results and the deconstructing what that means to staff will always connect back to our values of

- Manaakitanga/to be kind
- Kotahitanga/ to do this together, include everyone
- Rangatiratanga / to be excellent in all our mahi and dealings with others
- Whakawhanaungatanga / to value everyone

We are engaging with employees at the team/unit level to seek their ideas and inputs into improving their experience of working at CM Health. At the organisation, we are reviewing organisation wide programmes, such as Speak Up and Leadership Development, to ensure we weave into them the feedback from employees and their experience of working at CM Health.

2. Recruitment, selection and induction

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

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

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

CMH Interview process including interview guides have been reviewed and changes made to support the cultural requirements of our candidates.

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

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

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

Workbridge – New Partnership - We have recently been awarded the Disability Tick. We are working on reviewing our policies and processes to ensure that we attract and support more staff with disabilities at CM Health.

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

Health Science Academies supporting Maaori and Pacific Success and Achievement in NCEA -The Health Science Academies (HSAs) were initiated by Counties Manukau District Health Board (CM Health) in 2011 as part of their drive to build a workforce that better reflects the community they serve. Partnered with the Tindall Foundation, they supported

two health science learning communities based at James Cook High School and Tangaroa College. A Health Science Academy is basically a school within a school – with a specific focus on the achievement of NCEA core sciences. The initial academies in James Cook High School and Tangaroa College demonstrated significant increases in Maaori and Pacific student achievement in NCEA 1, NCEA 2 and NCEA 3 in comparison to National Data sets. Students engaged in the HSAs also had higher attainment of Merit and Excellent endorsements compared to the total Pacific population and other students in Decile 1-3 schools. The table below highlights these comparative results for 2019/20. The academies also demonstrated a high retention rate for students between years and fewer absentees.

Table 4: Percentage of students in HSA programme attaining merit endorsement compared to total population

	HSA students	Total NZ	Total Pacific	Total students in decile 1-3 schools
Percentage attaining NCEA level 1 with merit endorsement	39%	34%	28%	24%
Percentage attaining NCEA level 2 with merit endorsement	37%	25%	17%	16%
Percentage attaining NCEA level 3 with merit endorsement	32%	27%	15%	14%

Table 5: Percentage of students in HSA programme attaining excellence endorsement compared to total population

	HSA students	Total NZ	Total Pacific	Total students in decile 1-3 schools
Percentage attaining NCEA level 1 with excellence endorsement	14%	21%	8%	10%
Percentage attaining NCEA level 2 with excellence endorsement	17%	17%	5%	7%
Percentage attaining NCEA level 3 with excellence endorsement	11%	15%	5%	8%

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

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

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

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

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

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

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

Limited Service Volunteers (LSV) – this is a programme which supports young people who are not currently in employment, education or training by providing a 6 week motivational hands on training programme run by New Zealand Defence Force on behalf of Work and Income. The aim of this programme is to help increase young peoples' confidence, help them learn new skills and gain employment. We have been engaging with LSV to establish a relationship and support

some of these young people into work at CM Health. From September 2018 we will be engaging with the participants in LSV and providing their details to managers who are recruiting for suitable roles. We are also exploring options for providing paid work experience or cadetships to these groups.

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

We also continue to work on attracting Maaori talent into our workforce. Over this past year, a further 120 Maaori have been employed at CM Health raising the number of Maaori employees from 561 employees (as at 30 June 2019) to 681 employees (as at 30 June 2020). This has lifted the overall percentage of Maaori employed at CM Health from 5.55% (as at 30 June 2019) to 7.60% (as at 30 June 2020).

We employ 3,630 nurses. 583 (16%) are Pacific nurses and CM Health wants to grow that to 21% by 2025. We are proud to be the employer of the largest Pacifica nursing workforce in NZ and possibly in the world. 197 (5%) of our nurses are Maaori. CM Health's target is to lift that to 16% (1004) by 2025. That makes us the second largest employer of Maaori nurses amongst the DHBs. We are working towards the recruitment process encouraging more Maaori and Pacific candidates. As an example for our nursing graduate recruitment we have special and separate processes for Maaori and Pacifica. We know that we will only achieve Health Equity when our workforce is as diverse as the population we serve.

3. Employee development, promotion and exit

Employee Performance Development Culture

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

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

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

- Active partnership, each participant is responsible for making performance development practices as effective as possible.
- Helping both the manager and the employee assess how performance and development fits into the bigger picture.
- Learning needs and opportunities are planned and agreed based on the discussions and agreements reached during the performance and development process.

Ultimately the gains can be seen in our employees through:

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

This inclusive process fosters a supportive environment and drives the highest levels of individual, team and organizational performance in support of achieving CM Health's vision.

With the recent developments in the provision of Human Resource data to managers through the HR dashboard and access to accurate and useful information around the Performance & Development process through the myHR and myPeople pages, things have progressed significantly in the last 2 years.

Nursing

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

- Four Professional Development Nurse Educators and Midwifery clusters for: Adult Rehabilitation and Health of Older People (ARHOP) and Mental Health, Medical and Emergency Care, Surgical and Critical Care, Kidz First and Women's Health. In total there are 29 full time equivalent positions in these clusters supporting nurses' development.

- People development consultant team which work across the four clusters and throughout the organisation
- Interprofessional post registration and Professional Development and Recognition Programme (PDRP) team
- Interprofessional undergraduate and entry to practice team.

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

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

Allied Health

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

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

All disciplines

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

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

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

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

We have also been working to improve cultural competency within CM Health. In 2017/18, CM Health introduced the Effectively Engaging with Maaori Programme as a Mandatory programme for all new employees. This programme is promoted through all new staff orientation and induction programmes, along with E-Learning Programmes on the Treaty of Waitangi, cultural competency and Tikanga Best Practice. In the past 12 months, 2054 employees have completed these programmes. All face to face trainings were cancelled from March 2020 to May 2020 due to COVID-19.

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

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

Many opportunities are available for our unregulated workforce with the support of our external training providers and funding from Tertiary Education Commission (TEC). The successful StepUp programme continues to benefit staff to

increase confidence to speak up when any issue or concern arises. Some staff are looking for other jobs within CM Health due to the StepUp programme. Feedback included comments from participants such as "StepUp is one of the greatest things to happen to me and I encourage anyone who needs to build up their confidence to go for it. StepUp is a great tool as it changes your mind-set to be positive. If it hadn't been for this, I would not have achieved and become what I am today. I can't believe myself. I have changed so much".

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

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

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

We currently have 8 different Cultural and Linguistically Diverse (CALD) courses, including Working with CALD families – Disability Awareness, working with migrant and refugee patients and culture and cultural competency available for staff. These courses can be accessed using two different formats (face to face or online via e-learning). The CALD – Disability Awareness e-learning course is also now compulsory for all clinical staff.

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

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

Exit interviews

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

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

4. Flexibility and work design

Workplace flexibility

CM Health is committed to creating a flexible work environment in order to attract and retain our amazing people. We acknowledge the many benefits which flexible working arrangements can deliver for employees and the organization. Whilst COVID-19 raised a heighted awareness and forced all employers to provide flexibility, Counties recognizes that flexible working is integral to supporting the healthy work/life balance of employees whilst continuing to deliver excellent services.

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

- Part time working hours – part time employees make up 39% of our workforce
- Job share arrangements whereby two or more employees undertaking one role on a shared basis to cover a full time position within the organization.
- Time off in lieu – If a staff member works extra hours over and above their contracted hours during busy periods

e.g. COVID-19 staff can request to take the time back at a mutually convenient time.

- Career break – some employees may request an extended period of leave to focus on professional development or pursue other interest.
- Flexi time – allows employees to vary start and finish times within core working hours to better fit their domestic responsibilities, travel arrangements or for work purposes.
- Remote working – employees may request to work from home for all or part of their hours for a specified amount of time due to a particular requirement over that time.

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

Flexible return to work for parents

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

Volunteers

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

5. Remuneration, recognition and conditions

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

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

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

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

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

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

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

6. Harassment and bullying prevention

Organisational Commitment

CM Health is committed to providing a healthy, safe and supportive organisational culture based on our shared values. CM Health has a zero-tolerance for all forms of harassment and bullying. Bullying and Harassment policy, processes, guides and resources are in place for all employees to help them better understand and work through the situation. CM Health leadership and management programmes equipped managers with skills to provide feedback and coaching in the moment of any inappropriate behaviours and unsafe work practices.

Speak Up

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

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

7. Safe and healthy environment

Safety at Work – Compliance

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

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

Counties Manukau is in the ACC Accredited Employers program which means we manage our work related injury and illness claims at a tertiary level and assist ACC to help workers get back to work for non-work injury. CMH have a partnership with WellNZ who provide additional support in helping workers back into the workplace safely.

The Occupational Health team carries out clinical and assessment functions for CM Health workers including pre-employment screening, blood and body fluid exposure assessments, contact tracing surveillance, general wellness and vaccination clinics, including the very successful annual influenza vaccination campaign. Our professional and experienced Occupational Health team also provides guidance on the rehabilitation of staff members back to work from non- accident related and/or medical conditions via the manager referral system.

The Occupational Safety team support workers when managing workplace safety and provide assistance to support CM Health worker wellbeing across all business units. CMH has engaged with Safe365 to assist in managing safety compliance.

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

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

- Monitors, evaluates and ensures continuous improvement

Health and Safety Representatives (HSRs) play an essential role in keeping workers and visitors safe, educating their workmates on related issues, and ensuring procedures and processes are followed correctly. We have over 250 HSRs. Training is provided to HSRs and we work with this group to obtain worker feedback and improve our processes.

In addition to managing health and safety, the Health and Safety team work on various projects in line with our known critical risks. The approach is to engage with working groups to ensure the actions we take consider trends in incidents and risks and ensure continuous improvement from our incident trends, which then enables us to share our learning's.

Employee Assistance Programme at work

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

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

Wellness

CM Health continues to recognise the importance of supporting employees' physical and mental health, and strives to support employees to stay well. Code Orange, an initiative supporting staff to respond to incidents involving aggression, has been implemented in Emergency Care.

A Wellbeing Audit highlighted recommendations and specific areas of focus for 2020. Workshops, for example Mental Health 101 and Addiction 101 are well underway.

The Wellbeing Guide (a collection of tools, strategies, websites and resources on how to seek help and support) has had an overwhelming response from staff. The Paanui Wellbeing Website is updated regularly and COVID-19 resources have been included to ensure that staff were well prepared for level changes and more importantly, they continue to pay attention to their wellbeing.

Courageous Coaching sessions are delivered and provide staff with an opportunity to self-reflect and gain new knowledge and workplace safety skills, for example, a Hand Hygiene workshop on how to deliver feedback.

Health Roundtable WELL-BEING Index for physicians has been launched for CM Health SMO's and the purpose of this initiative is to gather feedback and for SMO's to improve their wellbeing and to get help when help is needed.

Complaints and appeals

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

Policies, procedures and guidelines

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

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

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

Counties Manukau District Health Board Workforce

What our workforce looked like by age, gender and ethnicity

Of the total workforce in 2019/20, women comprised 80% (7,130) and men 20% (1,835). The average age for women was 42 years and 41 years for men. The younger workforce less than 40 years of age represented 49% of the total workforce. Our employee data also highlights an ethnically diverse workforce.

Age brackets	Percentage of all employees
Under 25	7%
25 – 29	13%
30 – 34	16%
35 – 39	13%
40 – 44	10%
45 – 49	10%
50 – 54	9%
55 – 59	10%
60 – 64	8%
65 – 69	3%
70+	1%
Date of Birth Not Specified	0.12%

Gender	Headcount	Headcount in %	Average Age
Female	7,130	80%	42
Male	1,835	20%	41
Grand Total	8,965		

Ethnicity	FTE	FTE in %	Headcount	Headcount in %
Asian	2241	34%	2943	33%
Maori	502	8%	681	8%
Other	2571	39%	3518	39%
Pacific	1105	17%	1558	17%
Unknown	182	3%	265	3%
Grand Total	**6601**		**8965**	

What our workforce looked like by employee group

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

	FEMALE		MALE	
Occupational Groups	Headcount	Average of Salary	Headcount	Average of Salary
Allied Health	1189	$72,458	284	$72,438
Management and Administration	1019	$75,508	138	$101,950
Medical	523	$184,077	560	$215,138
Nursing	3849	$71,365	524	$69,215
Support Personnel	550	$48,506	329	$55,216
Grand Total	**7130**	**$78,644**	**1835**	**$114,198**

Financial Statements for the year ended 30 June 2020

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 2020.

Signed on behalf of the Board:

Vui Mark Gosche
CMDHB Board Chair

Tipa Mahuta
CMDHB Board Deputy Chair

Fepulea'i Margie Apa
Chief Executive Officer

Margaret White
Chief Financial Officer

9 December 2020

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Revenue				
Patient Care Revenue	2	1,860,841	1,805,093	1,716,293
Interest Revenue		1,007	1,200	1,725
Other Revenue	3	27,777	26,470	28,860
Total Income		**1,889,625**	**1,832,763**	**1,746,878**
Expenditure				
Personnel costs	4	765,152	724,892	778,616
Depreciation and amortisation expense	13/14	40,136	39,203	34,778
Outsourced services		107,647	94,304	96,118
Clinical supplies		126,219	118,710	119,763
Infrastructure and non-clinical expenses		70,322	71,525	67,690
Other District Health Boards		267,230	267,413	259,905
Non-health board provider expenses		537,211	501,228	487,017
Capital Charge	5	33,462	33,905	36,424
Other expenses	6	21,918	20,177	19,386
Total expenditure		**1,969,297**	**1,871,357**	**1,899,697**
Deficit		**(79,672)**	**(38,594)**	**(152,819)**
Other comprehensive income				
Revaluation of Land	13/19	-	-	(18,990)
Revaluation of Buildings	13/19	-	-	120,976
Total Other comprehensive income (expense)		**-**	-	**101,986**
Total comprehensive income (expense) for the year		**(79,672)**	**(38,594)**	**(50,833)**

Statement of Changes in Equity
For the year ended 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Balance 1 July		**566,159**	**565,324**	**617,612**
Deficit for the year		(79,672)	(38,594)	(152,819)
Total Comprehensive income		-	-	101,986
Total comprehensive income		**(79,672)**	**(38,594)**	**(50,833)**
Capital contributions from the Crown		33,996	34,538	1,774
Repayment of capital to the Crown		(419)	(419)	(419)
Movement in restricted funds		2	-	(1,975)
Balance at 30 June	19	**520,068**	**561,685**	**566,159**

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

The accompanying notes form part of these financial statements.

Statement of Financial Position
As at 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Assets				
Current Assets				
Cash and cash equivalents	7	27,165	(23,865)	15,280
Debtors and other receivables	8	61,114	52,937	52,936
Inventories	10	11,304	8,868	8,868
Prepayments		2,877	742	742
Non-Current Assets held for Sale	11	5,320	5,320	5,320
Total current assets		**107,780**	**44,002**	**83,146**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	52,769	57,180	52,180
Property, plant and equipment	13	854,093	851,555	818,739
Intangible assets	14	10,712	8,680	8,327
Other Non-Current Assets	9	2,050	1,934	1,933
Total Non-Current assets		**919,624**	**919,349**	**881,179**
Total assets		**1,027,404**	**963,351**	**964,325**
Liabilities				
Current liabilities				
Creditors and other payables	15	150,092	116,375	116,374
Borrowings and overdraft	16	-	-	-
Employee entitlements	17	306,995	245,403	245,404
Total current liabilities		**457,087**	**361,778**	**361,778**
Non-current liabilities				
Employee entitlements	17	37,267	38,853	35,353
Provisions	18	990	1,035	1,035
Creditors and other payables	15	11,992	-	-
Total non-current liabilities		**50,249**	**39,888**	**36,388**
Total liabilities		**507,336**	**401,666**	**398,166**
Net assets		**520,068**	**561,685**	**566,159**
Equity				
Crown equity	19	442,147	442,690	408,570
Accumulated deficits	19	(316,298)	(275,220)	(236,626)
Revaluation reserves	19	393,380	393,379	393,380
Other reserves		-	-	-
Trust funds	19	837	836	835
Total Equity		**520,068**	**561,685**	**566,159**

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

The accompanying notes form part of these financial statements

Statement of Cash Flow
For the year ended 30 June 2020

	Notes	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,695,878	1,654,591	1,573,385
Other		184,523	176,971	171,366
Interest received		1,007	1,200	1,725
Payments to suppliers		(1,106,687)	(1,069,857)	(1,047,686)
Payments to employees		(701,537)	(724,892)	(651,668)
Capital charge		(33,462)	(33,905)	(36,424)
Interest payments		-	-	-
Goods and services tax (net)		230	-	383
Net cash flow from operating activities		**39,952**	**4,108**	**11,081**
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		62	-	433
Purchase of property, plant, equipment and intangible assets		(61,118)	(73,326)	(29,314)
Acquisition/roll over of investments		(586)	(4,046)	(402)
Movement in Restricted Funds		(2)	-	(1,975)
Net cash flow from investing activities		**(61,644)**	**(77,372)**	**(31,258)**
Cash flows from financing activities				
Repayment of capital to the Crown		(419)	(419)	(419)
Capital Contributions from the Crown		33,996	34,538	1,774
Net cash flow from financing activities		**33,577**	**34,119**	**1,355**
Net increase/(decrease) in cash and cash equivalents		**11,885**	**(39,145)**	**(18,822)**
Cash and cash equivalents at the start of the year	7	15,280	15,280	**34,102**
Cash and cash equivalents at the end of the year	7	**27,165**	**(23,865)**	**15,280**

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

The accompanying notes form part of these financial statements.

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

	Actual 2020 $000	Actual 2019 $000
Net deficit	**(79,672)**	**(152,819)**
Add/(less) non-cash items		
Movement in Restricted Funds	-	-
Gain on Disposal of Assets	324	(960)
Write off of WIP	2,214	1,229
Impairment of Debtors	2,318	5,875
Depreciation and amortisation expense	40,136	34,778
Impairment of Intangibles	-	2,941
Total non-cash items	**44,992**	**43,863**
Add/(less) movements in working capital items		
Debtors and other receivables	(12,630)	(2,362)
Inventories	(2,437)	(341)
Creditors and other payables	23,438	(7,149)
Income in advance	2,646	3,051
Employee entitlements	63,615	126,949
Net movements in working capital items	**74,632**	**120,148**
Add/(less) items classified as investing or financing activities	0	(110)
Net cash flow from operating activities	**39,952**	**11,081**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

COVID-19 Impact on Services

Healthcare services were the front line in the response to the threat of the COVID-19 pandemic. The COVID-19 pandemic response impact was most acute during the period February to the end of May 2020, particularly during the Level 3 and 4 lockdown periods. While not as acute, the duration of the August 2020 resurgence has also had a significant impact. The impact was felt across the continuum of health care from primary care and community NGOs to acute services on all hospital and health care sites and also by private healthcare facilities who provide some services to CM Health.

At time of writing CM Health maintains a significant contribution to the Northern Regions COVID-19 pandemic response.

Staff redeployment

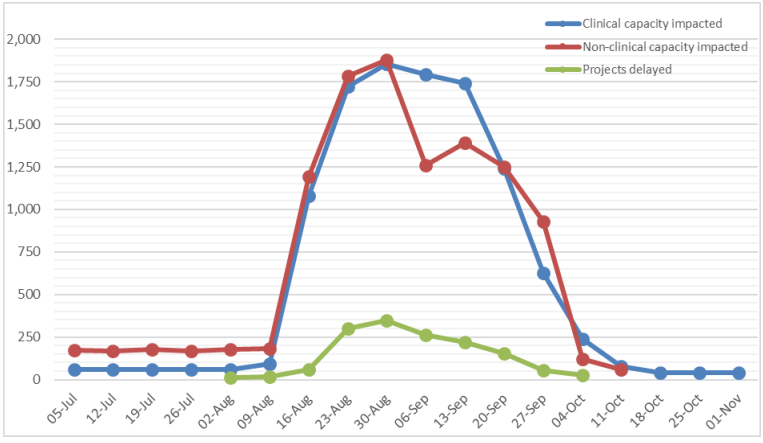
Since the emergence of COVID-19, CM Health has redeployed over 100 staff into COVID-19 related efforts across the region including supporting the Auckland Regional Public Health Service (ARPHS) with contact tracing, the Community Based Assessment Centres (CBACs) and mobile COVID-19 testing, Managed Isolation and Quarantine Facilities, Northern Region Health Coordination Centre (NRHCC) and Regional Isolation and Quarantine Command Centre (RIQCC). As at 29 September 2020, the DHB has employed 60 new staff for specific COVID-19 roles including Middlemore Hospital front entrance visitor screening and the Managed Isolation and Quarantine Facilities.

A high-level retrospective analysis was undertaken in October to understand the impact of COVID-19 on redeployment of staff between July and October 2020, with particular focus on the resurgence in Auckland in August 2020. Although this time period is outside the 2019/20 financial year, it illustrates the system wide impact of this pandemic. As time goes on the DHB is committed to securing a sustainable workforce that is agile enough to efficiently flex up and down in a timely manner in response to COVID-19 resurgence.

This analysis confirmed that a total of 149 CM Health staff had greater than a total of 23,000 hours deployed to the COVID-19 response since 1 July 2020. Redeployments peaked shortly after the Level 3 lockdown was set in place in Auckland on 12th August, refer Figure 1 below, with redeployments tapering off in late September as activities returned towards business as usual.

There was a roughly even distribution of impact across Clinical and Non-Clinical operational staffing. There was a notable impact on project teams, meaning many projects were unable to proceed effectively during this period.

Figure 1: Total redeployed hours per week, by operational area impacted



Public impact

Members of the public generally stayed away from health care facilities with many general practices, accident and medical centres and the Middlemore Hospital Emergency Department reporting very low attendance for non-urgent presentations (triage categories 1 and 2 remained consistent to regular volumes before the COVID-19 pandemic). As a consequence, in-patient admissions were low in comparison to the same period in previous years. Planned care activity dropped to 26% of normal with only urgent and cancer services running as usual.

CM Health response

CM Health responded in many ways including:

- The COVID-19 response is being managed according to the New Zealand Coordinated Incident Management System (CIMS) which provides for a National, regional, and local command-and-control structure to make timely decisions to source and deploy resources to manage the emergency response.
- Each DHB has an incident management team and incident controller, with the Northern Region Health Co-ordination Centre (NRHCC) under a regional incident controller, responsible for decisions with impact beyond an individual DHB, in line with CIMS protocols and the NZ Health Emergency Plan under the direction of the regional lead CE for Emergency Management.
- Implementing testing stations within general practice and in many locations across the Auckland region
- Postponing non-acute planned care to reduce the risk of COVID-19 spreading and to create capacity that may have been required for patients suffering from COVID-19 related illness
- Implementing telehealth and virtual appointments to ensure continuity of planned care where possible and appropriate
- Re-purposing facilities to create negative pressure wards to accommodate 160 beds by modifying the ventilation system of the top three levels of the Scott Building. This enabled specialist wards for a potential surge of patients with COVID-19 infection
- Implementing self-care and remote monitoring of clients in the last trimester of pregnancy or at risk of diabetes from pregnancy
- Assisting in establishing facilities for the vulnerable, transient, and homeless, and supporting them during their stay to ensure they were able to self-isolate
- Assisting in training of non-DHB staff in the use of Personal Protective Equipment (PPE) and infection control measures, including being the conduit of PPE to NGOs
- Supporting COVID-19 laboratory testing
- Release of non-clinical staff and non-acute clinical staff to work in other areas supporting the community effort, public health contact tracing and regional co-ordination
- Implementing work from home policies where possible.

An area that requires further analysis is the reduction in occupancy for the neonatal unit at CM Health. The number of births in April was the same as preceding months. The gestational age profile of the babies born during April was the same as preceding months apart from slightly fewer 36 week babies. However, we had 30% fewer admissions in April. We are discussing this change with our colleagues both at the regional and national levels.

Given many staff were deployed in the COVID-19 pandemic response preparation normal reporting of performance measures to the Ministry of Health largely ceased for the Q3 period.

Recovery

The recovery from the COVID-19 pandemic response is underway with an enhanced focus by services to quickly improve planned care waiting lists. The total planned care interventions for June 2020 was 104.2% - highlighting the volume increases to catch-up on the postponements made during lockdown. An insourcing initiative delivered 232 cases booked for surgery over four Saturdays in June. This equates to 15% based on 1,500 of the deferred cases due to COVID-19. There were 1,731 additional appointments. This has given the organisation a good start to the recovery from COVID-19 and the impact on planned care, however return to pre-COVID-19 levels or better for waiting lists is expected to take the rest of 2020/21 for most services.

Presentations to General Practice, the Emergency Department and in-patient services has returned to pre-COVID-19 levels and CM Health staff are assisting in the health response to the governments COVID-19 border response. Many services will continue with the innovations put into practice during the lockdown period.

COVID-19 Impact on the Financial Statements

Through 2019/20 CM Health has responded to significant incidents and challenges: rapid mobilization of community and hospital response to measles in September 2019; diversion of hospital and in particular theatre resources to respond to White Island/Whakaari Island in December 2019 and ongoing responses to COVID-19 from March 2020.

Since mid-March 2020 CM Health has been reporting weekly to the MOH the financial impacts of the pandemic in the COVID-19 financial reporting template. CM Health was able to easily adapt its financial reporting systems and internal controls to enable weekly reporting as this process had been set up by CM Health during the Whakaari/White Island emergency response.

For the year ended 30 June 2020 the DHB incurred unfunded costs of over $11m in operational costs and $3.4m in capital costs. These unfunded costs have put additional pressure on the DHBs cash flow and ability to accurately forecast cash flow timings during the year. These costs include a significant increase in the annual leave liability vs budget as staff were not able to take leave during lockdown and the uptake since lockdown has been slow. Despite these additional unfunded costs the DHB cashflow remains positive and we have not had to draw on overdraft facilities during the year.

The DHB did not incur any financial penalties in relation to planned care clawback as the DHB was on budget prior to the COVID-19 lockdown. Recovery of planned care and ensuring available capacity to meet acute demand growth will be an ongoing challenge for 2020/21.

On 17 March 2020 the Minister of Health issued a direction to all DHBs. The Direction was issued to ensure that there was a nationally consistent and well-coordinated response to COVID-19. In practical terms this meant that board Chief Executives were not required to seek approval from Boards to enact significant policy decisions within the Government's COVID-19 response

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

As the Northern Region's decision making processes has evolved, on 28 October 2020 the CMDHB Board has agreed to approve the harmonisation level of sub-delegation to the named positions of Chief Executive (CE) of $3 million operational expenditure per proposal and $1 million capital expenditure per proposal, where required to progress the continuing response to the COVID-19 pandemic in the region. The CMDHB Board also approved the delegation to Board Chairs (and in their absence a named deputy), the responsibility to agree with their CE proposals which exceed the limits set out above where these fall within the directions provided by the Minister of Health on 17th March 2020.

CM Health has assessed the impact of COVID-19 on all balance sheet accounts. Overall the DHB does not consider there to be any material impacts as at 30 June 2020. In terms of the valuation of land and buildings, the DHB engaged an independent valuer to do a desktop assessment to determine whether there had been a material movement in our land and buildings for the 30 June 2020 year-end. Our last valuation was done 30 June 2019. Their assessment took into account market evidence and information as a result of the impacts of COVID-19. Their conclusion is that there is not sufficient market evidence to suggest there has been any material impact on our land and building values as a result of COVID-19. The DHB concurs with this assessment and there have been no fair value adjustments to land and buildings as at 30 June 2020.

Subsequent to year-end CM Health has, on behalf of the Northern Region DHBs, become the lead contractor with the Ministry of Health for establishing and shifting the Managed Isolation and Quarantine Facilities ("MIQ") to DHB management. While we have a letter of comfort assuring us of cost recovery, these costs do put additional pressure on our cash flow requirements if the MIQ costs are not immediately covered. These costs are estimated to be $2.3m monthly.

As part of the NZ National response to the COVID-19 pandemic, the MOH purchased centrally, a large quantity of Personal Protective Equipment, from a special fund approved by Cabinet. This equipment was stored centrally and subsequently issued, at a nominal sum, to DHBs nationally as required. The value of the stock issued to CMDHB to 30 June 2020 was $787k, the adjustment is considered immaterial and therefore the financial statements for 2019/20 year have not been adjusted. The adjustment would have a neutral impact on the profit/loss position for the year.

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 2020 comprise CMDHB and its interest in associates and jointly controlled entities.

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

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

CMDHB is a public benefit entity for financial reporting purposes.

The financial statements for CMDHB are for the year ended 30 June 2020, and were approved by the Board on 9 December 2020

Basis of Preparation

Statement of compliance

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

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

Going concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2019/20 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Annual Plan). The key considerations are set out below:

Letter of comfort

The Board has received a letter of comfort dated 29 September 2020 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Holidays Act

As at 30 June 2020 the DHB has a provision of $147.4m for Holidays Act non-compliance (an increase of $36.5m during 2019/20). Remediation of the Metro Auckland DHB's Holidays Act liability is expected to commence in the 2021 calendar year. Remediation will require full cash support from the MOH.

COVID-19 costs including Managed Isolation and Quarantine Facilities

To date a number of COVID-19 costs incurred remain unfunded by the MOH, including any funding for capital.

With effect from 1 August 2020, Counties Manukau District Health Board has taken on the leadership and delivery of the health and well-being services within the managed isolation and quarantine facilities in Auckland. CMDHB will require continued support (monthly payments) from the MOH to fund reasonable costs associated with the establishment and implementation of these services, which includes the costs of health service delivery and Personal Protective Equipment.

Operating and cash flow forecasts

Current cash flow forecasts confirm that, excluding anticipated cash payments in relation to Holidays Act or COVID-19, CMDHB has access to adequate resources, including overdraft (working capital and cash flows) to continue business as usual operations as per the 2020/21 Annual Plan for one year from the 9 December 2020 (date the 2019/20 Annual Report is planned to be approved by the CMDHB Board). These forecasts include the need to intermittently access the DHBs overdraft facility with NZHPL. The DHB is maintaining a watching brief, particularly in regard to implications of COVID-19 costs not funded.

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

PBE IPSAS 34 – 38 Interest 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 were effective for annual periods beginning on or after 1 January 2019, with early adoption permitted.

The DHB has applied these new standards in preparing the 30 June 2020 financial statements. Adoption of these new standards has had no impact on the financial statements.

PBE IPSAS 39

The DHB has adopted PBE IPSAS 39: Employee Benefits from 1 July 2019 (updating the existing standard PBE IPSAS 25: Employee Benefits). The key changes relevant to CMDHB are the introduction of the net interest approach, which is to be used when determining the defined benefit cost for defined plans, and to structure the disclosures of defined benefit plans accounting to explicit disclosure objectives for defined benefit plans. CMDHB currently accounts for its Defined Benefit Plan Contributors Scheme as a defined contribution scheme due to insufficient information to determine defined benefit accounting. Refer note 20: Contingencies. There was no effect as a result of these changes.

Intangible assets – Finance procurement and Information Management System (FPIM)

The DHB has changed the accounting treatment for the recognition and subsequent measurement of the FPIM investment. The DHB previously accounted for the investment as an indefinite life intangible asset.

Further to a recent accounting opinion obtained by NZHPL, the DHB will use a combination of accounting treatments to account for this investment. The new treatment of this investment is disclosed in the intangible assets accounting policy.

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 IPSAS 41 Financial Instruments

PBE IPSAS 41 Financial Instruments replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement and PBE IFRS9 Financial Instruments and is effective for financial years beginning on or after 1 January 2022, with earlier adoption permitted.

The main changes compared to PBE IPSAS 29 that are relevant to the DHB are:

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

The DHB intends to adopt PBE IPSAS 41 for the 30 June 2023 financial year. The DHB has not yet assessed in detail the impact of the new standard.

Amendment to PBE IPSAS 2 Statement of Cash Flows
An amendment to PBE IPSAS 2 *Statement of Cash Flows* requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The DHB does not intend to early adopt the amendment.

PBE FRS 48 Service Performance Reporting
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. The DHB has not yet assessed in detail how the application of PBE FRS 48 will affect its statement of service performance.

Significant Accounting Policies

Investments in Associates and Joint Ventures

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

Revenue

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

Ministry of Health Population Based Revenue

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

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

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

ACC Contract revenues

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

Rental income

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Finance leases

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

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

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

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The cost of self-

constructed assets includes the cost of materials, direct labour, the costs of dismantling and removing the items and restoring the site on which they are located if relevant, an appropriate proportion of direct overheads and capitalised borrowing costs.

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

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

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

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

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

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

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

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

Intangible assets

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

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

Staff training costs are recognised as an expense when incurred.

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

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

Finance, Procurement and Information Management System (FPIM)

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

CMDHB holds:

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

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

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows: Acquired computer software 2-5 years [20% - 50%]

Impairment of Property, Plant and Equipment and Intangible Assets

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

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

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

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

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

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

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

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

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

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

Superannuation schemes

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

Defined benefit schemes

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

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

Provisions

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

Provisions are not recognised for future operating losses.

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

ACC Partnership Programme
The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of four

years up to a specified maximum amount. At the end of the four-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

The DHBs Statement of Performance Expectations (SPE) is required to be prepared before the 1 July each financial year. The Minister of Health agreed to extend the timeline for finalising and publishing the 2020/21 SPE to 15 August 2020. The reason the extension was granted was to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and to ensure quality SPE/SOI documents are produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

Cost allocation

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

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

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

Critical accounting estimates and assumptions

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

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

Land and buildings revaluations

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

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

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

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

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

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

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

Retirement and long service leave

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

Holiday's Act provision for non compliance

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

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

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

Agency relationship

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

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

Comparative Figures

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

2. Patient care revenue

	Actual 2020 $000	Actual 2019 $000
Health and disability services (MOH contracted revenue)	1,710,748	1,573,386
ACC contract revenue	27,777	29,872
Revenue from other district health boards	98,578	90,275
Other patient care related revenue	23,738	22,760
Total patient care revenue	**1,860,841**	**1,716,293**

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 $23.4m (2019: $16.8m).

3. Other revenue

	Actual 2020 $000	Actual 2019 $000
Donations and bequests received	1,199	1,513
Other revenue	25,031	24,410
Rental revenue	1,547	1,977
Gain on Disposal of Property, Plant & Equipment	-	960
Total other income	**27,777**	**28,860**

Material items included in Other revenue are Retail Pharmacy revenue $7.8m (2019: $5.9m), New Zealand Medical Treatment Scheme funding $4.2m (2019: $3.5m), Radiology Services $2.1m (2019: $1.9m), Pharmac Rebate $0.9m (2019: $0.9m) and one-off bond recovery $0.0m (2019: $2.0m).

4. Personnel costs

	Actual 2020 $000	Actual 2019 $000
Salaries and wages	679,035	728,366
Contributions to defined contribution schemes	22,612	19,886
Increase in liability for employee entitlements	63,505	30,364
Total personnel costs	**765,152**	**778,616**

5. Capital Charge

The DHB pays a half-yearly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the months of June and December. The capital charge rate levied during the year was 6% at 30 June 2020 (2019: 6%).

6. Other expenses

Other expenses include:	Actual 2020 $000	Actual 2019 $000
Audit fees – audit of financial statements – current year	255	232
Audit fees – under-provision prior year	1	-
Audit fees – other audit services	36	22
Operating leases expense	10,882	11,649
Impairment of debtors	7,783	5,875
Board and committee members fees and expenses	422	379
Loss on Disposal of Property, Plant & Equipment	325	-
Impairment of WIP	2,214	1,229
Total other expenses	**21,918**	**19,386**

Non-cancellable operating lease commitments

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

	Actual 2020 $000	Actual 2019 $000
Not later than one year	7,056	8,648
Later than one year and not later than five years	11,378	11,966
Later than five years	1,284	2,502
Total Non-cancellable operating leases	**19,718**	**23,116**

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.

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

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

	Actual 2020 $000	Actual 2019 $000
healthAlliance N.Z. Limited (refer Note 12)		
Not later than one year	735	760
Later than one year and not later than five years	2,897	3,667
Later than five years	724	1,558
Total Non-cancellable operating leases	**4,356**	**5,985**

7. Cash and cash equivalents

	Actual 2020 $000	Actual 2019 $000
Cash at bank and on hand	8	50
NZ Health Partnerships Limited	26,320	14,387
Trust / Special purpose Funds	837	843
Cash and cash equivalents for the purposes of the statement of cash flows	**27,165**	**15,280**

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

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

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

8. Debtors and other receivables

	Actual 2020 $000	Actual 2019 $000
Ministry of Health receivables	8,972	3,381
Other receivables	16,400	16,608
Other accrued revenue	42,176	37,063
Less: provision for impairment	(6,434)	(4,116)
Total Debtors and other receivables	**61,114**	**52,936**

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.

	2020			2019		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	53,219	(53)	53,166	44,834	-	44,834
Past due 1-30 days	3,329	(516)	2,813	2,056	(606)	1,450
Past due 31-60 days	980	(445)	535	1,034	(422)	612
Past due 61-90 days	1,317	(488)	829	1,655	(452)	1,203
Past due > 90 days	8,703	(4,932)	3,771	7,474	(2,636)	4,838
Total	**67,548**	**(6,434)**	**61,114**	**57,053**	**(4,116)**	**52,937**

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

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

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

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

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

9. Other non-current assets

	Actual 2020 $000	Actual 2019 $000
Reversionary interest in car park building	2,050	1,933
Total Other non-current assets	**2,050**	**1,933**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to us in 10 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 6.0% was used (2019: 6.0%).

10. Inventories

	Actual 2020 $000	Actual 2019 $000
Pharmaceuticals	1,019	840
Other Supplies net of provision for obsolete stock	10,285	8,028
Total inventories	**11,304**	**8,868**

No inventories are pledged as security for liabilities (2019: $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 amount of inventories recognised as an expense during the year was $126.5m (2019: $114.8m) which is included in the Clinical supplies line item in the Statement of Comprehensive Revenue and Expense

11. Non-current Assets held for Sale

	Actual 2020 $000	Actual 2019 $000
Land	5,320	5,320
Total Non-current Assets held for Sale	**5,320**	**5,320**

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

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

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2020	Interest held at 30 June 2019	Balance date
Northern Regional Alliance Limited	Provision of health support services	Associate	33.3%	33.3%	30 June
healthAlliance N.Z. Limited	Provision of shared services	JV	25.0%	25.0%	30 June
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	JV	0%	34.0%	30 June
NZ Health Partnerships Limited	Provision of services to provide savings to the NZ health sector	JV	5.0%	5.0%	30 June
HealthSource New Zealand Limited	Provision of shared services	JV	25%	0%	30 June

healthAlliance N.Z. Limited

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

HealthSource New Zealand Limited

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

NZ Health Partnerships Limited

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

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

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

NZ Health Innovation Hub Limited Partnership

Following the withdrawal by Waitemata DHB from the partnership in August 2018, the equity from Waitemata DHB was transferred to the other shareholders and accordingly CMDHB's interest in NZ Health Innovation Hub Limited Partnership changed from 25% to 34%.

On 1 July 2019, all Shareholders agreed to proceed with the transfer of shares from Auckland DHB and Counties Manukau DHB to Canterbury DHB.

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

Year end 30 June 2020 $000 (unaudited)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Limited	23,771	20,214	3,557	18,230	1,099
healthAlliance N.Z. Limited	224,292	34,286	190,006	137,819	(2,087)
NZ Health Innovation Hub Limited Partnership	-	-	-	-	-
NZ Health Partnerships Limited	459,769	430163	29,606	33,881	692
HealthSource New Zealand Limited	8,194	7,558	636	34,131	(41)

Year end 30 June 2019 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Limited	22,347	19,891	2,456	14,897	913
healthAlliance N.Z. Limited	212,935	31,366	181,570	155,137	291
NZ Health Innovation Hub Limited Partnership	289	88	201	85	(327)
NZ Health Partnerships Limited	287,199	258,720	28,929	34,345	(38,014)

Contingencies

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

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

In the unlikely event that there was a discontinuance of FPIM Hardware platform and a requirement to stop the contract, for any resulting stop-cost penalties NZHP would have a contingent liability to the supplier, and an equal and corresponding contingent asset as a receivable from the DHBs. (2018/19: $nil).

Share of profit of Associate entities and Jointly Controlled Entities

	Actual 2020 $000	Actual 2019 $000
Share of profit – healthAlliance N.Z. Limited	**(522)**	**73**
Share of loss – HealthSource New Zealand Limited	**(11)**	**-**

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

Investments in Associates and Jointly Controlled Entities

	Actual 2020 $000	Actual 2019 $000
healthAlliance N.Z. Limited	**52,600**	**52,180**
HealthSource New Zealand Limited	**169**	**-**

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

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 2018	**212,420**	**444,338**	**172,189**	**22,438**	**60,617**	**912,002**
Additions	**-**	**-**	**-**	**-**	27,367	27,367
WIP capitalised	-	54,305	4,776	938	(60,709)	(690)
Revaluation increase/(decrease)	(18,990)	71,489	-	-	-	52,499
Disposals/transfers	-	-	(82,031)*	(13,481)	(6,243)	(101,755)
Balance at 30 June 2019 / 1 July 2019	**193,430**	**570,132**	**94,934**	**9,895**	**21,032**	**889,423**
Additions	-	16,112	282	-	60,919	77,313
WIP capitalised	-	8,453	17,248	1,107	(27,070)	(262)
Revaluation increase/(decrease)	-	-	-	-	-	-
Write offs / Impairment	-	-	-	-	(1,943)	(1,943)
Disposals/transfers	-	(592)	(17,132)*	-	(913)	(18,637)
Balance at 30 June 2020	**193,430**	**594,105**	**95,332**	**11,002**	**52,025**	**945,894**
Accumulated depreciation and impairment losses						
Balance at 1 July 2018	**-**	**25,563**	**136,636**	**18,654**	**-**	**180,853**
Depreciation expense	-	24,515	9,381	783	-	34,679
Elimination on disposal/transfer		-	(81,882)*	(13,480)	-	(95,362)
Revaluation increase/(decrease)		(49,486)	-	-	-	(49,486)
Balance at 30 June 2019 / 1 July 2019	**-**	**592**	**64,135**	**5,957**	**-**	**70,684**
Depreciation expense		27,134	10,483	1,006	-	38,623
Elimination on disposal/transfer	-	(592)	(16,914)*	-	-	(17,506)
Revaluation increase/(decrease)	-	-	-	-	-	-
Balance at 30 June 2020	**-**	**27,134**	**57,704**	**6,963**	**-**	**91,801**
Carrying amounts						
At 1 July 2018	**212,420**	**418,775**	**35,553**	**3,784**	**60,617**	**731,149**
At 30 June and 1 July 2019	**193,430**	**569,540**	**30,799**	**3,938**	**21,032**	**818,739**
At 30 June 2020	**193,430**	**566,971**	**37,628**	**4,039**	**52,025**	**854,093**

Note *: During the 2018/19 and the 2019/20 years, a significant amount of Nil Net Book Value assets have been removed from the Fixed Asset Ledger, resulting in the removal of the Cost and corresponding Accumulated Depreciation amounts from the Fixed Asset Ledger and the General Ledger.

Capital Commitments

	Actual 2020 $000	Actual 2019 $000
Property , plant and equipment	18,709	42,311
Total Capital commitments	**18,709**	**42,311**

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

CMDHB Share of Capital Commitments held by Jointly Controlled Entities

	Actual 2020 $000	Actual 2019 $000
healthAlliance N.Z. Limited (refer Note 12)		
Property , plant and equipment	642	552
Total Capital commitments	**642**	**552**

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

Valuation

Land

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

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

The most recent valuation of land was performed by a registered independent valuer, Darroch, as at 30 June 2019. The total land valuation amounted to $193.43m, resulting in a 2018/19 downwards revaluation adjustment of $18.99m.

Buildings

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

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

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

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

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

Subsequent to the 30 June 2019 balance date the DHB received the following building assessments. All the reports identify impairment issues with these buildings. However due to the fact that the impairments are immaterial, and would not impact the loss for the year (because the impairment would be offset against historical revaluation increases), no adjustments have been made to the year end valuation or building values as disclosed as at 30 June 2020:

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

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

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

For the year ended 30 June 2020 the DHB has assessed the impact of COVID-19 on the valuation of land and buildings. The DHB engaged an independent valuer to do a desktop assessment to determine whether there had been a material movement in our land and buildings for the 30 June 2020 year end. Their assessment took into account market evidence and information as a result of the impacts of COVID-19. Their conclusion is that there is not sufficient market evidence to suggest there has been any material impact on our land and building values as a result of COVID-19. The DHB concurs with this assessment and there have been no fair value adjustments to land and buildings as at 30 June 2020.

Restrictions on title

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

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

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

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

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

Dental training facility

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

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

On expiry of the lease, ownership of the dental facility will transfer to the DHB and Counties Manukau will be required to compensate the University for the value of the Dental facility at the date of expiry. The net present value of this obligation has been recognised for the year ended 30 June 2020 and will be wound up over the 30 year lease period.

The difference between the current construction costs and the net present value of the liability has been recognised as income in advance for the year ended 30 June 2020 and will be wound down as revenue income over the term of the 30 year lease.

14. Intangible assets

Movements for each class of intangible assets are as follows:

	FPIM Rights $000	Software $000	Work in Progress $000	Total $000
Balance at 30 June 2018/1 July 2018	**6,037**	**693**	**11,807**	**18,537**
Additions	190	-	1,757	1,947
Work in Progress Capitalised	-	1,349	(660)	689
Impairment	(2,941)	-	-	(2,941)
Transfers / Disposals	-	(318)	(9,275)	(9,593)
Balance at 30 June 2019/1 July 2019	**3,286**	**1,724**	**3,629**	**8,639**
Additions	-	-	4,090	4,090
Work in Progress Capitalised	-	690	(428)	262
Impairment	-	-	(270)	(270)
Transfers / Disposals	-	(248)	-	(248)
Balance at 30 June 2020	**3,286**	**2,166**	**7,021**	**12,473**
Accumulated amortisation and impairment losses				
Balance at 1 July 2018	**-**	**531**	**-**	**531**
Amortisation expense	-	99	-	99
Transfers / Disposals		(318)	-	(318)
Balance at 30 June 2019/1 July 2019	**-**	**312**	**-**	**312**
Amortisation expense	373	1,144	-	1,517
Transfers / Disposals	-	(68)	-	(68)
Balance at 30 June 2020	**373**	**1,388**	**-**	**1,761**
Carrying amounts				
At 1 July 2018	**6,037**	**162**	**11,807**	**18,005**
At 30 June and 1 July 2019	**3,286**	**1,412**	**3,629**	**8,327**
At 30 June 2020	**2,913**	**778**	**7,021**	**10,712**

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

Finance, Procurement and Information Management System (FPIM)

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

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

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

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

The FPIM programme has been restarted following a pause during COVID-19. The Full programme has a full "go live" target for all entities to be transitioned by October 2021.

Based on the information and assumptions known to it, CMDHB considers that, in all material respects, the FPIM asset costs capitalized now exceed the DRC. CMDHB has therefore not recognised any impairment (2019: $2.941m) of the FPIM asset in the Statement of Comprehensive Income for the year ended 30 June 2020, keeping it at a level that approximates its estimated future recoverable service amount.

15. Creditors and other payables

	Actual 2020 $000	Actual 2019 $000
Payables under exchange transactions		
Creditors and accrued expenses	128,762	98,336
Income in advance	24,535	9,480
Total payables under exchange transactions	**153,297**	**107,816**
Payables under non-exchange transactions		
GST payable	8,787	8,558
Total payables under non-exchange transactions	**8,787**	**8,558**
Total creditors and other payables	**162,084**	**116,374**
Creditors and other payables - current	150,092	116,374
Creditors and other payables – non- current	11,992	-
Total creditors and other payables	**162,084**	**116,374**

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 2020 $000	Actual 2019 $000
Borrowing facility limits		
Overdraft facility	75,000	75,000
Total borrowing facility limits	**75,000**	**75,000**

Overdraft facility

CMDHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) and the participating DHBs. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue. This is used in determining working capital limits, being defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST, for CMDHB that equates to $75.0m (2019: $75.0m).

17. Employee entitlements

	Actual 2020 $000	Actual 2019 $000
Current portion		
Accrued salaries and wages	43,535	41,552
Annual leave	81,305	68,547
Liability for Holidays Act remediation provision	147,430	110,930
Sick leave	380	440
Long service leave	892	271
Retirement gratuities	6,064	4,614
Sabbatical leave	1,343	850
Continuing medical education	26,046	18,200
Total current portion	**306,995**	**245,404**
Non-current portion		
Long service leave	10,639	10,408
Retirement gratuities	24,968	22,915
Sick leave	1,660	2,030
Total non-current portion	**37,267**	**35,353**
Total employee entitlements	**344,262**	**280,757**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 0.22% - 1.60% (2019: 1.26% - 4.30%) and an inflation factor of 1.90% (2019: 2.5%) were used. A movement of 1% in the salary growth rate would change the actuarial valuation by $4.2m more if the growth assumption was 1% higher or $3.6m less if the growth assumption was 1% lower.

Holidays Act

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

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. DHB readiness and availability of resources (internal and external to the DHB) has determined when a DHB can commence the process. CMDHB has made progress in its review and it now believes it can determine a reliable estimate of its obligation to address historic non-compliance under the MoU.

As a result, as at 30 June 2020, in preparing these financial statements, CMDHB recognises it has an obligation to address any historical non-compliance under the MOU. The DHB has made estimates and assumptions to determine a potential liability based on its review of payroll processes for instances of non-compliance with the Act and against the requirements of the MOU.

The liability has been estimated by:

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

This liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees. For CMDHB the liability amount as at 30 June 2020 is $147.4m (2019: $110.9m).

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

18. Provisions

	Actual 2020 $000	Actual 2019 $000
Non-current portion		
ACC Partnership Programme	990	1,035
Total provisions	**990**	**1,035**

Movements for each class of provision are as follows:

	Actual 2020 $000	Actual 2019 $000
Balance at 1 July	1,035	1,155
Actuarial valuation movement	(45)	(120)
Balance at 30 June	**990**	**1,035**

19. Equity

	Actual 2020 $000	Actual 2019 $000
Crown equity		
Balance at 1 July	408,570	407,215
Equity injections from the Crown	33,996	1,774
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**442,147**	**408,570**
Accumulated surpluses/(deficits)		
Balance at 1 July	(236,626)	(83,807)
Deficit for the year	(79,672)	(152,819)
Balance at 30 June	**(316,298)**	**(236,626)**
Revaluation reserves		
Balance at 1 July	393,380	291,394
Revaluations	-	101,986
Balance at 30 June	**393,380**	**393,380**
Revaluation reserves consist of:		
Land	223,568	223,568
Buildings and Infrastructure	169,812	169,812
Total revaluation reserves	**393,380**	**393,380**
Trust/Special funds		
Balance at beginning of year	835	2,810
Funds expended	(2)	(2)
Funds received	-	-
Interest received on Restricted Funds	4	5
Other transfers/movements	-	(1,978)
Balance at end of year	**837**	**835**

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	**520,068**	**566,159**

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 2019/20 financial year.

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

20. Contingencies

Asbestos

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

Superannuation schemes

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

As at 31 March 2020, the DBP Scheme had a past service loss of $2.78m (4.1% of the liabilities) (2019: loss $1.8m (1.9% 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 IPSAS 39.

In March 2018, the Actuary recommended employer contribution rate should be set at 1.0 times contributor contributions effective from 1 April 2019. In the latest actuarial review, conducted March 2019, the Actuary recommended employer contribution rate should be set at 3.0 times contributors contributions effective from 1 April 2020 and this was accepted and endorsed by the Board.

Legal Matters

There are a number of matters of a legal nature to which the DHB may have an exposure. The amounts involved (2020: $3m (2019: $3.0m)), if required to be settled, would be expensed in the year of settlement.

Contingent asset

Encroaching structures

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

21. Related Party Transactions

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

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

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

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $1,861m (2019 $1,716m) to provide health services in the Counties Manukau area for the year ended 30 June 2020 (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 2020 totalled $8.86m (2019: $8.34m). These purchases included the purchase of air travel from Air New Zealand, postal services from New Zealand Post, and blood products from NZ Blood Service.

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

Transactions with key management personnel

Key management personnel compensation

	Actual 2020 FTE	Actual 2019 FTE	Actual 2020 $000	Actual 2019 $000
Executive management team	11.5	11.5	3,685	3,949
Total key management personnel compensation	**11.5**	**11.5**	**3,685**	**3,949**

In addition to the above, the total actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $116.1k (2019: $139.2k).

Key management personnel includes the Chief Executive, and eleven (2019: eleven) members of the management team.

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

Board and Committee Members compensation

	Actual 2020 FTE	Actual 2019 FTE	Actual 2020 $000	Actual 2019 $000
Board	11	11	392	344
Committee	4	1	16	2
Total board and committee members compensation	**116**	**12**	**408**	**346**

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 draft financial position of the Foundation shows that it had net assets of $4.67m (2019: $4.66m) and a surplus/(deficit) of $11k (2019: ($0.7m)) which may be subject to restrictions on distribution as at 30 June 2020. The financial statements of the Foundation for 2020 are not publicly available as they have not yet been approved by the Foundation's trustees.

22. Board member remuneration

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

	Actual 2020 $	Actual 2019 $
Vui Mark Gosche (Chair)	59,512	54,500
Ms Tipa Mahuta (Deputy Chair)(1)	24,657	-
Mrs Catherine Abel-Pattinson	32,589	30,000
Mr Apulu Reece Autagavaia	31,151	27,750
Mr Garry Boles (1)	19,526	-
Mrs Colleen Brown	32,839	30,000
Mrs Katrina Bungard	31,401	27,000
Dr Ashraf Choudhary (2)	12,875	28,750
Ms Kylie Clegg (2)	12,625	25,375
Mrs Dianne Glenn	33,151	30,250
Dr Lyn Murphy (2)	12,812	30,688
Mr George Ngatai (2)	13,625	29,000
Dr Lana Perese (1)	19,526	-
Mr Pat Snedden (2)	15,094	30,719
Mr Pierre Tohe (1)	20,276	-
Mr Paul Young (1)	20,213	-
Total board member remuneration	**391,672**	**344,032**

Committee Members, not Board Members or Employees	Award 2020 $	Award 2019 $
Mr Barry Bublitz (3) (CPHAC)	500	-
Mr Robert Clark (3) (CPHAC, HAC)	750	-
Ms Kaye Clarke (5) (MCW)	-	-
Ms Lale Ieremia (4) (MCW)	-	-
Mr Pat Snedden (Chair ARF, MCW) (1 & 4)	14,000	-
Mr John Wong (2) (CPHAC)	833	1,667
Total	**16,083**	**1,667**

1- Appointed 9/12/2019

2- Resigned 4/12/2019

3- Appointed 26/2/2020

4- Appointed 2/3/20

5- Appointed 2/3/20 – resigned 29/05/2020

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

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

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

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

No Board members received compensation or other benefits in relation to cessation (2019: $nil).

23. Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:	Actual 2020	Actual 2019
Total remuneration paid or payable:		
$100,000 – 109,999	378	300
$110,000 – 119,999	202	166
$120,000 – 129,999	124	101
$130,000 – 139,999	87	78
$140,000 – 149,999	96	53
$150,000 – 159,999	55	35
$160,000 – 169,999	35	34
$170,000 – 179,999	33	21
$180,000 – 189,999	29	33
$190,000 – 199,999	28	25
$200,000 – 209,999	19	24
$210,000 – 219,999	19	16
$220,000 – 229,999	31	20
$230,000 – 239,999	20	29
$240,000 – 249,999	33	26
$250,000 – 259,999	34	36
$260,000 – 269,999	35	25
$270,000 – 279,999	27	32
$280,000 – 289,999	20	18
$290,000 – 299,999	17	26
$300,000 – 309,999	26	21
$310,000 – 319,999	21	17
$320,000 – 329,999	14	18
$330,000 – 339,999	14	10
$340,000 – 349,999	7	10
$350,000 – 359,999	11	7
$360,000 – 369,999	8	4
$370,000 – 379,999	8	7
$380,000 – 389,999	10	4
$390,000 – 399,999	6	4
$400,000 – 409,999	3	3
$410,000 – 419,999	3	1
$420,000 – 429,999	4	1
$430,000 – 439,999	2	1
$440,000 – 449,999	1	5
$450,000 – 459,999	2	5
$460,000 – 469,999	4	3
$470,000 – 479,999	4	2
$480,000 – 489,999	-	1
$500,000 – 509,999	1	-
$510,000 – 519,999	1	-
$520,000 – 529,999	-	1
$540,000 – 549,999	-	1
$550,000 – 559,999	1	-

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 2020	Actual 2019
$580,000 – 589,999	1	-
$600,000 - $609,999	-	1
Grand total	**1,474**	**1,225**

During the Year Ended 30 June 2020, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 1,250 (2019: 1,043) are Medical Staff and 224 (2019: 182) are Management.

During the year ended 30 June 2020, 18 (2019: 12) employees received compensation and other benefits in relation to cessation totalling $579,061 (2019: $823,142).

24. Events after the balance date

With effect from 1 August 2020 Counties Manukau DHB Board has taken on the leadership and delivery of the health and well-being services within the managed isolation and quarantine facilities in Auckland. The DHB will require continued support from the MOH to fund reasonable costs associated with the establishment and implementation of these services, which includes the costs of health service delivery and PPE.

The resurgence of COVID-19 in New Zealand may have a significant impact on the DHBs resources and the ability to deliver on the planned care recovery plan and ensuring available capacity to meet acute demand growth.

25. Financial instruments

Financial instrument categories

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

	Actual 2020 $000	Actual 2019 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	27,165	15,280
Debtors and other receivables	61,114	52,936
Total financial assets measured at amortised cost	**88,279**	**68,216**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	128,762	98,336
Total financial liabilities measured at amortised cost	**128,762**	**98,336**

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 2020, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have minimal impact (2019: $0.69m).

Credit risk

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

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

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

Credit quality of financial assets

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

	Actual 2020 $000	Actual 2019 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	837	885
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	26,320	14,387
- NZHPL – no defaults in the past		
Total debtors and other receivables	**61,114**	**52,936**

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
2019						
Creditors and other payables	98,336	98,336	98,336	-	-	-
Total	**98,336**	**98,336**	**98,336**	**-**	**-**	**-**
2020						
Creditors and other payables	128,762	128,762	128,762	-	-	-
Total	**128,762**	**128,762**	**128,762**	**-**	**-**	**-**

26. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expense

Overall the DHB reported an operating deficit which came in $41m unfavourable to budget. While there were variances in both Revenue and Expenses, these largely offset one another. The variance from Budget results from additional costs in relation to COVID-19 response ($11.3m), an additional provision for Holidays Act non-compliance ($36.5m), offset by a Whakaari White Island upside in funding of $6.4m (after deducting incremental costs). The underlying result (after accounting for the above mentioned items) was marginally favourable to Budget.

In Personnel expenditure, salaries and wages variances are offset by outsourced services, whilst non-health board provider expenses have increased due to demographic growth, cost inflation and pay equity payments (offset by funding).

Statement of Financial Position

The most significant variances are in creditors, accruals and employee entitlement liabilities resulting primarily from unbudgeted COVID-19 related exposures, additional IDF exposure provisions payable to other DHBs for services to Counties population not budgeted for, additional $36.5m provision for Holidays Act non-compliance and recognition of $12.5m Revenue In Advance liability for the University of Otago Dental School.

Statement of Cashflow

Net cash flow was $51.0m favourable to budget, mainly due to pay equity funding for NGO community and unplanned COVID-19/Whakaari White Island funding. Reduced capital expenditure has also resulted in significantly lower cash outflows from investing activities.

Significant effort has been placed on cash management to ensure the DHB is adequately forecasting and living within its means.

Board and Committee Membership Attendances

1 July 2019 to 30 June 2020

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC/ RDiSAC
Vui Mark Gosche (Chair)	8	2	-	8	1
Ms Tipa Mahuta (Deputy Chair)[1]	5	3	2	3	-
Mrs Catherine Abel-Pattinson	7	7	-	7	-
Mr Apulu Reece Autagavaia	4	2	8	-	-
Mr Garry Boles[1]	4	-	-	4	-
Mrs Colleen Brown	8	6	6	-	2
Mrs Katrina Bungard	5	3	7	-	1
Dr Ashraf Choudhary[2]	3	4	4	-	-
Ms Kylie Clegg[2]	6	3	-	3	-
Mrs Dianne Glenn	8	7	8	-	2
Dr Lyn Murphy[2]	2	2	2	2	-
Mr George Ngatai[2]	2	4	2	4	-
Dr Lana Perese[1]	5	3	3	3	-
Mr Pat Snedden[2]	3	-	-	7	-
Mr Pierre Tohe[1]	3	-	3	3	-
Mr Paul Young[1]	4	2	3	-	-

[1]Appointed 9/12/2019

[2]Resigned 4/12/2019

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

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

Note: Counties Manukau District Health Board remains committed to fulfilling our obligations as agent of the Crown under the Te Tiriti o Waitangi (Treaty of Waitangi). Over the years relationship with local tangata whenua has been expressed through the development of a number of forums including, the Maaori Health Advisory Committee (MHAC) and partnership agreement with Mana Whenua.

The MHAC was disestablished in 2018/19 to enable Counties Manukau District Health Board to give effect to a more strategic and direct partnership with Mana Whenua i Taamaki Makaurau

Mana Whenua i Taamaki Makaurau represent the collective interests of a number of Iwi and Hapuu, including: Te Aakitai, Ngaati Te Ata, Ngaati Tamaoho, Ngaai Tai ki Taamaki, Ngaati Paoa, Te Kawerau a Maki, Ngaati Naho, Ngaati Tiipa, Ngaati Amaru, Ngaati Karewa / Tahinga. Counties Manukau District Health Board has established a Memorandum of Understanding with the Mana Whenua i Taamaki Makaurau Board that outlines our strategic intent and commitment to improve Maaori Health outcomes in the Counties Manukau district.

Current members of Mana Whenua i Taamaki Makaurau:

- Robert Clark (Chair) & Rangipipi Bennett - Ngaati Tiipa
- Barry Bublitz (Kai Whakahaere) - Ngaai Tai Ki Taamaki
- Malcolm Wara & Raymond Katipa - Ngaati Naho

- Matiu Brown & Matua Jeff Tukua - Ngaati Tahinga
- Tamara Taka-Jones & Joanna Katipa - Ngaati Tamaoho
- Moana Brown & Nanaia Rawiri - Ngaati Amaru

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

Note: The People & Culture Sub Committee was established by the Board on 17 December 2019. Their function is to provide advice to the Board in relation to the appointment and remuneration of the CMDHB Chief Executive, governance oversight of health and safety and assurance of leadership conduct and organisation culture is aligned to strategy.

Board Members' Disclosure of Interests

As at 23 September 2020

Vui Mark Gosche (Chair)	• Trustee, Mt Wellington Licensing Trust • Director, Mt Wellington Trust Hotels Ltd. • Director, Keri Corporation Ltd • Trustee, Mt Wellington Charitable Trust • Chair, Kainga Ora Homes & Communities • Director, Housing NZ Build Ltd (subsidiary of KO Homes & Comms) • Director, Housing NZ Ltd (subsidiary of KO Homes & Comms) • Member, Expert Advisory Group to the Retirement Commissioner working on retirement income.
Ms Tipa Mahuta[129] (Deputy Chair)	• Deputy Chair, Te Whakakitenga o Waikato • Councillor, Waikato Regional Council

Mrs Catherine Abel-Pattinson	• Board Member, healthAlliance NZ Ltd.
	• Board Member, International Accreditation NZ (IANA)
	• Member, NZNO
	• Member, Directors Institute
	• Husband (John Abel-Pattinson):
	  ○ Director, Blackstone Group Ltd
	  ○ Director and Shareholder, Blackstone Partners Ltd
	  ○ Director Blackstone Treasury Ltd
	  ○ Director Bspoke Group Ltd
	  ○ Director, Barclay Management (2013) Ltd
	  ○ Director, AZNAC (JAP) Ltd
	  ○ Director Chatham Management Ltd
	  ○ Director, MAFV Ltd
	  ○ Director Wolfe No. 1 Ltd
	  ○ Director, 540 Great South Motels Ltd
	  ○ Director Silverstone Property Group Ltd
	  ○ Director, various single purpose property owning companies
	  ○ Director and Shareholder, various Trustee Companies related to shareholding in the above

Mr Apulu Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation • Board of Trustees Member, Holy Cross School • Member of the Cadastral Surveyors Board • Assessor of the Creative Communities Scheme South & East Auckland
Mr Garry Boles[130]	• NZ Police Constable

[129] Appointed 9/12/2019
[130] Appointed 9/12/2019

Mrs Colleen Brown MNZM	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Director, Charlie Starling Production Ltd • District Representative, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited
Mrs Katrina Bungard	• Chairperson MECOSS – Manukau East Council of Social Services. • Deputy Chair Howick Local Board • Member of Amputee Society • Member of Parafed disability sports • Member of NZ National Party
Dr Ashraf Choudhary QSO, JP[131]	• Board Member, Otara-Papatoetoe Local Board • Member, NZ Labour Party • Chairperson, Advisory Board Pearl of Islands Foundation • Co-Patron, Bharatiya Samaj Charitable Trust
Ms Kylie Clegg[132]	• Deputy Chair, Waitemata District Health Board • Trustee (ex officio) - Well Foundation (charity supporting Waitemata District Health Board) • Director, Auckland Transport • Director, Sport New Zealand • Director, High Performance Sport New Zealand • Trustee & Beneficiary, Mickyla Trust • Trustee & Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies but less than 1% of the shares in those companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, NextMinute Holdings Limited). It also includes a shareholding of less than 1% in Orion Health Holdings Limited.
Mrs Dianne Glenn ONZM, JP	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • Past President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities. • Member, Lottery Individuals with Disabilities Committee

[131] Resigned 4/12/2019
[132] Resigned 4/12/2019

Dr Lyn Murphy[133]	• Shareholder, Bizness Synergy Training Ltd • Shareholder, Synergex Holdings Ltd • Trustee, Synergex Trust • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ) • Member, New Zealand Association of Clinical Research (NZACRes) • Senior Lecturer, AUT University School of Inter professional Health Studies • Member, Public Health Association of New Zealand
Mr George Ngatai QSM, JP[134]	• Director, Transitioning Out Aotearoa • Director, The Whanau Ora Community Clinic Huakina Ltd • Chair, Safer Aotearoa Family Violence Prevention Network • Lotteries Community (Auckland) • Board Member, Counties Manukau Rugby League Zone • Member, NZ Maori Council • Director & Shareholder, BDO Marketing & Business Solutions Limited • Director & Shareholder, Ngatai Bhana Limited • Director & Shareholder, Family Care Limited • Member, Restorative Justice Aotearoa
Dr Lana Perese[135]	• Director & Shareholder, Malatest International & Consulting • Director, Emerge Aotearoa Limited Trust • Trustee, Emerge Aotearoa Housing Trust • Director, Vaka Tautua • Director, Malologa Trust • Director & Shareholder, Perese Wood Investments Limited
Mr Pat Snedden MNZM[136]	• Chair, Auckland District Health Board • Chair, The Big Idea Charitable Trust • Chair, National Science Challenge – E Tipu E Rea • Chair, Manaiakalani Education Trust • Director, Ports of Auckland (and subsidiaries) • Trustee, Emerge Aotearoa Trust (and subsidiaries) • Director & Shareholder, Snedden Publishing & Management Consultants Ltd • Director & Shareholder, Ayers Contracting Services Ltd • Director & Shareholder, Data Publishing Ltd • Director, Ngati Kuri tourism Ltd* • Director, Te Paki Ltd* • Director, Waimarama Orchards Ltd* • Director, Wharekapua Ltd* • Member, Health Partners Shareholder Review Group • Director and Shareholder, Recovery Solutions Services Limited • Shareholder, Ayers Snedden Consultants Ltd • *subsidiaries of Te Urungi o Ngati Kuri Limited
Mr Pierre Tohe[137]	• Senior Executive, Tainui Group Holdings • Trustee, Taniwha Marae

[133] Resigned 4/12/2019
[134] Resigned 4/12/2019
[135] Appointed 9/12/2019
[136] Resigned 4/12/2019
[137] Appointed 9/12/2019

Mr Paul Young[138]	• Director, Paul Young International Ltd • Councillor, Auckland City Council
Mr Ken Whelan, Crown Monitor[139]	• Board Member, Royal District Nursing Service NZ • Contracts with Francis Health & GE Healthcare (mainly Australia & Asia) • Crown Monitor, Waikato District Health Board
Brittany Stanley-Wishart, Board Observer	• Deputy Chair, Pasifika Students in Health in NZ (charity that receives funding from CM Health for its biennial conference)
Tori Ngataki, Board Observer	• Board member, Ngāti Tamaoho Trust 2016 to 2020 (restanding) • Board member, Second natures trust 2016 to 2021 • Marae Rep, Te Whakakitenga o Waikato Inc 2017 to 2021 (restanding) • Director, Keep it Māori Ltd (social enterprise) 2019

[138] Appointed 9/12/2019

[139] In 2018 the Minister for Health appointed a Crown Monitor to Counties Manukau DHB, Ken Whelan.

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 2020

The Auditor-General is the auditor of Counties Manukau District Health Board (the DHB). 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 appropriations, of the DHB on his behalf.

Opinion

We have audited:

- the financial statements of the DHB on pages 69 to 107, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flow for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the DHB on pages 20 to 48.

In our opinion:

- the financial statements of the DHB on pages 69 to 107:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2020; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the DHB on pages 20 to 48:
    - presents fairly, in all material respects, the DHB's performance for the year ended 30 June 2020, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriations; 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 17 December 2020. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures in the financial statements.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 17 on page 99 outlines that the DHB has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The DHB has made progress during the 30 June 2020 year, and estimated a provision of $147.4 million, as at 30 June 2020 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The DHB is reliant on financial support from the Crown

Note 1 on page 76 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the DHB will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the DHB over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Pages 73 to 75 of the financial statements outline the impact of Covid-19 on the DHB.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New-Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the DHB for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the DHB for assessing the DHB's ability to continue as a going concern. 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 DHB or there is no realistic alternative but to do so.

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

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

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

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

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

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

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

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

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

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

- We conclude on the appropriateness of the use of the 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 DHB'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 DHB to cease to continue as a going concern.

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

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 4 to 19, 49 to 68, 108 to 113, and 119 to 120, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

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

Independence

We are independent of the DHB in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: *International Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the DHB.

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

Ministerial Directions

The following Ministerial Direction was issued during the 2019/20 year.

- COVID-19 Response Direction 2020, issued on 17 March 2020 under section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004. The purpose of this direction is to ensure a nationally coordinated and consistent approach to the outbreak of COVID-19 across District Health Boards.

  Direction to act consistently with national plans

  In accordance with District Health Boards' responsibilities under section 23 of the New Zealand Public Health and Disability Acct 2000 to plan and coordinate at local regional and national levels for the most effective and efficient delivery of health services, all District Health Boards must act consistently with the following national-level plans and policies:

  a. The Government Response to the COVID-19 pandemic, informed by the New Zealand Influenza Pandemic Plan, a framework for action (Ministry of Health 2017); and

  b. The National Health Emergency Plan (Ministry of Health 2015)

Ministerial Directions that remain current are as follows:

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

Directory

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Auditor

Audit New Zealand on behalf of the Auditor-General

Solicitors

Anthony Holmes

Chapman Tripp

Claro

Mark O-Brien

Peter Le Cren

Ponsonby Chambers – Finnie Andrew Keith

Simpson Grierson

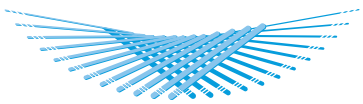
Vida Law

Bankers

Bank of New Zealand

Westpac Banking Corp

ASB Bank Limited



COUNTIES
MANUKAU
HEALTH