WHITU TEKAU MA RIMA TAU
75
YEARS
MIDDLEMORE HOSPITAL 1947-2022

Annual Report
2021 / 22

COUNTIES MANUKAU HEALTH

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


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Foreword from the Interim District Director of Te Whatu Ora – Counties Manukau and Chair of Mana Whenua i Taamaki Makaurau

Aspirations of Te Ao Maaori, Matauranga Maaori, Taonga Tukuiho and Matariki provides equality and equity for Ahi Kaa, Ahi Tere Tere and Ahi Matao[*]

Te Whatu Ora - Counties Manukau district is one of Aotearoa New Zealand's largest providers of health services to a young ethnically diverse population with large areas of social deprivation and poor health. Population growth estimates are the highest in Aotearoa and as a result, demand for health services in the rohe is growing at a rate that is exceeding development of existing services. This is felt across the Primary and Community sector and across Hospital and Specialist services, which all have significant resource impacts.

Growth in demand is exacerbated by the challenging economic and social circumstances for many whaanau and this disproportionately affects Maaori and other communities with health disparities. Improving access to health and wellbeing services and improving health outcomes requires strategies across an array of social and public sectors as well as grasping the opportunities presented through the introduction of Pae Ora and the health system reforms.

Counties Manukau has shown strength and resilience over the past year which has seen continued challenges and impacts driven by the COVID-19 pandemic. Throughout 21/22 South Auckland bore the brunt of COVID-19 community cases, and subsequently experienced unprecedented demand and pressure on hospital and community services. Counties Manukau continues to experience high acute demand pressure which has been compounded further by high staff vacancy rates resulting in a stretched and fatigued workforce. The impact has included delays in planned care delivery that are very significant and will now require a highly focused and coordinated multi-year recovery plan.

Given all these challenges, we are very fortunate to have such a highly capable and committed workforce, an internationally respected innovation hub in Ko Awatea and a strengths-based partnership with Mana Whenua i Taamaki Makaurau, all of which continue to yield benefit for patients and their whaanau. Our relationship with Mana Whenua has grown in strength since a Memorandum of Understanding (MoU) was first established in 2001. The MoU formalised an agreement to work together to improve Maaori health outcomes and close the equity gap with non-Maaori. It is evident from the performance measures reported in this annual report that there is a lot more work to do to achieve ooritetanga for Maaori and other communities with health disparities including Pasifika whaanau.

The COVID-19 pandemic has required us to explore different service delivery models and to work much more cohesively as a region and a country. As a result, we are now using alternative ways of reaching those who need health services the most and we continue to collaborate with our partners across the rohe to share resources to meet demand. Counties Manukau and Mana Whenua i Taamaki Makaurau continue to lead the way in many aspects of community-based initiatives such as the South Auckland Social Well-being Board, the Te Ranga Ora programme, a consumer co-designed programme delivering co-ordinated community-based and whanau centred care to patients with long term conditions and the Kia Ora Ake programme, centred on tamariki hinengaro wellbeing. We will continue to build on these learnings and use them, with Te Tiriti, to help us deliver an improved health system.

The health system reform now provides a fresh and unique opportunity to partner and collaborate to create an equitable, accessible, cohesive and people centred system that delivers Pae Ora. We face significant challenges in meeting the population health needs and demand within current service capacity. However, I believe Counties Manukau is well placed to drive further system innovation and improvement and help model new ways of meeting the challenges facing our sector. Our continuing strong partnerships with Mana Whenua i Tamaki Makaurau, social sector agencies, and community and primary health providers, and our collaboration across the northern region and nationally, will enable us to drive towards our shared

[*] Ahi Kaa refers to Maaori people who have remained continuously living on tribal lands/whenua (people who keep the home fires burning). Ahi Tere Tere are those Maaori people who have moved away from their tribal lands/whenua but want to come back, and return home every so often for gatherings, hui etc. to keep the fire flickering. Ahi Matao refers to everyone else e.g. people who have come to live in Aotearoa with Maaori over the last 180 years. Please note the origin of these words are more extensive than this explanation provides.

goals and vision. Our pathway ahead is a positive one that will require the right level of investment, particularly across our workforce, technology and facilities.

Dr Vanessa Thornton
Interim District Director
(From October 2022)

Robert Clark
Chair Mana Whenua
i Taamaki Makaurau

Board Members

Board members for the period 1 July 2021 to 30 June 2022
Vui Mark Gosche (Chair)
Ms Tipa Mahuta (Deputy Chair)
Mrs Catherine Abel-Pattinson
Mr Apulu Reece Autagavaia
Mr Garry Boles
Mrs Colleen Brown
Mrs Katrina Bungard
Mrs Dianne Glenn
Dr Lana Perese
Mr Pierre Tohe
Mr Paul Young

Mana Whenua i Taamaki Makaurau members for the period 1 July 2021 to 30 June 2022
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

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 Paaoa, Te Kawerau a Maki, Ngaati Naho, Ngaati Tiipa, Ngaati Amaru, Ngaati Karewa / Tahinga.

Members of the Counties Manukau Health Board and Mana Whenua i Taamaki Makaurau at the Mihi Whakamutunga hui in May 2022.

Executive Leadership Team

Executive Leadership Team	As at 30 June 2022
Alan Greenslade	Director of Infrastructure
Andrew Connolly	Acting Chief Medical Officer
Campbell Brebner	Chief Medical Advisor, Primary & Integrated Care
Christina Mallon	Chief Midwife
Dana Ralph-Smith	Director, Ambulatory and Locality Care
Gary Jackson	Director of Population Health
Jenny Parr	Chief Nurse & Director of Patient & Whaanau Experience
Margaret White	Chief Financial Officer
Mary Seddon	Director of Ko Awatea
Megan Milmine	Acting Chief Digital Officer
Pauline McGrath	Chief Operating Officer
Peter Watson	Acting Chief Executive Officer / Chief Medical Officer
Sanjoy Nand	Chief of Allied Health, Scientific & Technical Professions
Tui Vito	Acting Director of Human Resources
Vanessa Thornton	Director of Hospital Services

Margie Apa[1]	Chief Executive Officer
Aroha Haggie[2]	Director of Funding & Health Equity
Elizabeth Jeffs[3]	Director of Human Resources
Stuart Bloomfield[4]	Chief Digital Officer

[1] Resigned 2 February 2022

[2] Resigned 3 June 2022

[3] Seconded to interim Health NZ, 27 June 2022

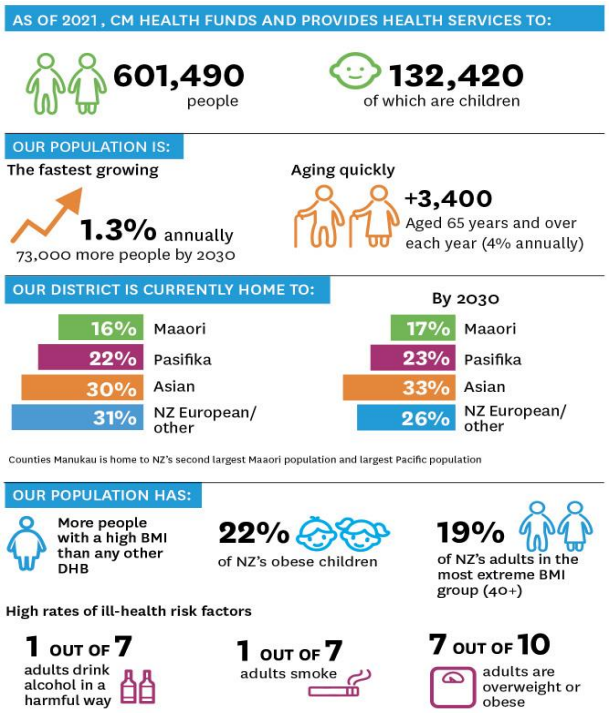
[4] Seconded to interim Health NZ, June 2022

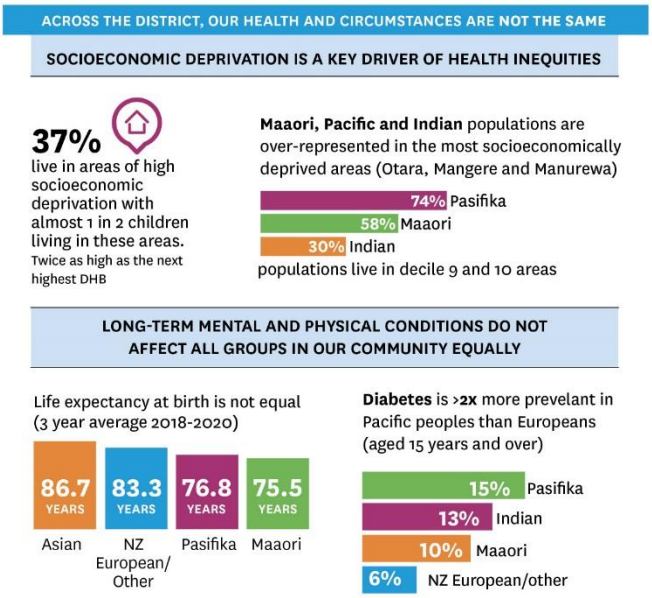
Snapshot of Counties Manukau Health in 2021/22

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

In the calendar year 2021, the Counties Manukau District Health Board provided and funded health and disability services to an estimated 601,490[1] people who resided in the local authorities of Auckland, Waikato and Hauraki District. Counties Manukau is one of the fastest growing district populations in New Zealand with simultaneously a youthful and ageing population.

The Counties Manukau 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 the Counties Manukau district, health outcomes and experiences of health across communities are not the same. 37% of the population, and almost 1 in 2 of the 132,000 children living within Counties Manukau, live in areas of high socioeconomic deprivation (NZDep2018 9&10[2]). Based on 2020 projections, by 2030, the ethnic composition of the Counties Manukau district population is forecast to be 17% Maaori, 23% Pacific, 33% Asian and 26% European/Other ethnicities. There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[3] Ootara, Maangere and Manurewa and Papakura, home to many Maaori and Pacific communities, are the most socioeconomically challenged areas in the district.

Long-term mental and physical conditions do not affect all groups in our community equally.[4] The population experiences relatively high rates of ill-health risk factors (such as smoking, obesity[5], hazardous alcohol use) that contribute to a 'package' of long-term physical conditions that are responsible for the majority of potentially avoidable deaths. Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity, are key to improving the health of the Counties Manukau population.

[1] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2018-Census Base) – 2020 update.

[2] NZDep 2018 decile 9&10. New Zealand Index of Deprivation (NZDep) is an area-based measure of socioeconomic deprivation. It measures the level of deprivation for people in each small area. It is based on nine Census variables. NZDep can be displayed as deciles or quintiles. Quintile 5, or deciles 9 and 10, represents people living in the most socioeconomically deprived 20 percent of these areas.

[3] Singh, H, Papaconstantinou D, Jackson G (2021) Life Expectancy and Mortality in Counties Manukau (2020 Update)

[4] Winnard D, Papa D, Lee M, Boladuadua S et al (2013) populations who have received care for mental health disorders. CM Health, Auckland.

[5] Based on unadjusted prevalence of overweight (BMI 25-25.9) and obese (BMI 30 or more) for CM Health adults aged over 15 years. Unadjusted prevalence for 2014-2017, New Zealand Health Survey. May 2018.

Key Achievements in 2021/22

105,546

Emergency Department presentations

445,985

Outpatient appointments[6]

15,200

Acute theatre procedures

23,986

Arranged and Elective theatre procedures[7]

115,505

Inpatient Discharges

7,419

Births

54%

Carbon emission reduction last 10 years

169,941

Radiology examinations and procedures[8]

5,458,479

Laboratory tests

9,031,923

Prescription items

99.99%

IT system uptime

Middlemore Hospital celebrates 75 years

3 May 2022 marked 75 years since Middlemore Hospital was first opened. Middlemore first started as the Otahuhu Military Hospital, which was built in 1943 to care for sick and injured servicemen returning from the war in the Pacific. However, with the end of the war, the hospital was purchased by the Auckland Hospital Board for public health care, and Middlemore Hospital was born.

First opened to the public in 1947, Middlemore is now a tertiary-level hospital facility that boasts the busiest emergency department in Australasia, a world-renowned plastic surgery and burns centre, a leading spinal unit, and award-winning mental health facilities within an organisation that serves the health needs of over half a million people.

Mana whenua and CM Health staff assemble to bless the Mauri stone

The 75th anniversary was commemorated with the opening of a memorial garden, where a small gathering of past and present staff and leaders assembled to oversee the blessing of a Mauri stone honouring this significant moment in Middlemore's history. Here's to 75 more years!

[6] Includes virtual appointments.
[7] Excludes 7,451 outsourced elective theatre procedures.
[8] Excludes 28,743 outsourced examinations and procedures.

Adapting to a COVID-19 environment

The continued disruptive presence of COVID-19 was widely felt throughout the organisation. With the arrival of the Delta and Omicron variants CM Health experienced significant demand on its health services due to high case prevalence within our rohe. The redeployment of staff to manage the high demand on our acute services was required throughout 2021/22 as the Omicron surge not only hit our community hard, but also our staff and their whaanau.

Requirements to manage COVID-19 risk in healthcare settings again impacted the delivery of planned care services through delays and reduced production, and the application of Covid-19 Alert Level settings meant access to patients and whaanau in the community was restricted, and this affected the ability of some services to deliver equitable and timely healthcare services.

The pandemic required the implementation of different and innovative service delivery models, and the organisation and staff displayed immense resilience, adaptability and leadership in a challenging environment. Close collaboration with non-governmental organisations resulted in reaching into all areas of the Counties Manukau rohe to ensure all peoples were given the opportunity to be vaccinated and/or tested for COVID-19.

The **Highbrook Vaccination Centre** made history as the first site to provide the COVID-19 vaccine in Aotearoa, drive-thru testing stations were established, and testing, vaccination and other support services were tailored to the needs of our population (see pages 53 to 58 for COVID-19 vaccination coverage data).

Maaori Health Providers were at the forefront of service delivery during the region's response to COVID-19. Services ranging from testing, vaccination, welfare support, community events and localised communication strategies were co-designed and co-commissioned in consultation with Mana Whenua i Tamaki Makaurau and Maaori health providers. CM Health's engagement and leadership forum, **Ngaa Amokura Haumaru**, provided a forum for effective engagement with Mana Whenua, community representatives, and Maaori health providers from across the rohe. This forum enabled the two-way exchange of information, testing of funding models and service provision, and collaborative troubleshooting of frontline issues. The combined efforts contributed to high testing and vaccination rates for Maaori across the district. Similarly, Pacific Health Providers and Primary Care providers also played an important role in managing the COVID-19 response in our communities.

CM Health also introduced vaccination initiatives to protect its staff and patients. COVID-19 vaccines were provided to staff onsite, and inpatients were provided the opportunity to be vaccinated while in hospital thanks to the collaborative efforts from teams across the organisation. The provision of rapid antigen tests (RATs), staff training, mask fitting, swabbing, and telehealth appointments to limit service disruption, are all examples of activities undertaken by staff that supported the COVID-19 response.

Roving ward COVID-19 vaccination trolley

CM Health's **Laboratory Service** has been the 'behind the scenes' engine enabling successful management of community cases in the Counties catchment area since the COVID-19 pandemic began. It led the way by being the first lab in the country to initiate COVID-19 PCR test pooling, considerably increasing processing capacity. On the 24 August 2021, the laboratory processed 6,475 samples, the highest testing volume for any single day since the pandemic began. In October 2021, with another surge in COVID-19 infections, laboratories across the motu (country) saw a huge increase in COVID-19 testing, with over 95,000 PCR tests performed in the month. At an average of 3,065 samples per day, this was the highest number of samples per month ever recorded.

COVID-19 screening was undertaken on entry to the **Emergency Department**, and on admission to the Birthing, Assessment and Primary Birthing Units. General Medical staff were significantly upskilled in the management of respiratory illnesses to support high acuity patient presentations. Through this training and through upgrades to general medical facilities, the Intensive Care Unit (ICU) bed capacity was protected. There was negligible patient to staff or staff to patient transmission of the SARS-CoV-2 virus, which is a testament to the level of discipline and vigilance of the staff to their infection control practices. Clinical and non-clinical staff continued to be redeployed from other areas to assist on the wards, and this has provided an opportunity to broaden the skillset of staff not ordinarily used to the ward environment.

When the Delta variant infection rates in South Auckland were high, the **Kidz First** team created a ward for children whose parents were in hospital or ICU with COVID-19. The nurses and care partners looked after the children while their parents were being cared for.

Facilities upgrades

In addition to staff and care activities to support the COVID-19 pandemic response, numerous COVID-19 related resilience infrastructure projects were completed throughout Middlemore Hospital. This included the conversion of hospital areas to improve infection control, infrastructure upgrades to improve indoor air quality and reduce potential exposure to COVID-19, and the setting up of a semi-permanent structure outside the Emergency Department for COVID-19 triaging and testing. In addition, multiple community COVID-19 testing centres were established, including in Ootara, Highbrook and Takanini.

In particular, the **Scott Building** at Middlemore Hospital was modified across three floors to establish dedicated COVID-19 wards. This set a new gold standard for safety in managing airborne infectious diseases in pandemic settings.

Regional leadership

CM Health took a leadership role in supporting the implementation of the northern region DHB COVID-19 **regional response for Maaori**, which responded to immediate issues experienced by whaanau affected by COVID-19, whilst maintaining a long-term view to redesign parts of the system that do not work for whaanau Maaori. Key initiatives from the response that CM Health's Maaori Health team led include:

- the co-designed **Whaanau HQ** programme, which was developed to care for COVID-19 positive whaanau in our communities and enable whaanau to exercise their right to mana motuhake over the care they receive, and
- the **Whaanau Guide to COVID-19**, a live Q&A video format streamed on Maaori Television's Facebook platform that provided whaanau living in the northern region with COVID-19 advice and information on accessing health services during different COVID-19 alert level settings.

The programme was, and continues to be Maaori led, ensuring the health system responds to the needs of Maaori, and provides full wrap around wellbeing services to whaanau across the Northern region.

CM Health led the development of the **Regional Kaitiaki and Visiting Policy**. This policy communicated and guided the actions that needed to be taken by all staff to prevent the transmission of COVID-19 and other viruses. At the end of 2021 this policy was implemented at the four northern regional DHBs to ensure consistent practice and equity for patients and their whaanau during the ongoing COVID-19 response. Of significance was the application of international evidence regarding the value of whaanau, family and friends as essential partners in care.

CM Health also took a leadership role in bringing together all regional DHBs and Heads of Schools for all health disciplines to ensure minimal disruption to graduate placements caused by COVID-19. It subsequently led the development of regional principles, which were adopted as national guidance. This guidance and our learning about the behaviour of COVID-19 variants, vaccinations and mask use greatly reduced the disruption to clinical placements, preserving the pipeline for the future health workforce.

Further detail on the impact of COVID-19 on CM Health services can be found on page 52.

Achieving Health Equity

On 14 June 2022 the royal assent of the Pae Ora (Healthy Futures) bill formalised the most significant reform of New Zealand's healthcare system in 20 years, resulting in a new structure and new accountability arrangements for the publicly funded health system. A primary objective of Pae Ora is to achieve equity by reducing health disparities among New Zealand's population groups, in particular for Maaori. Enabling equity of outcomes and access for Maaori, Pacific and communities with

health disparities has been a longstanding strategic priority for CM Health.

Since mid-2020 Mana Whenua i Taamaki Makaurau (MWiTM) and CM Health have been on a Tiriti-based partnership and design journey to develop a new approach to tamariki hinengaro wellbeing/child mental wellbeing. The MWiTM Board has provided mana whakahaere (governance) for the project, as well as actively participating in all project activities, including design. **Kia Ora Ake** is the name offered by MWiTM for the new tamariki hinengaro wellbeing approach, and in this context it means; may they be stronger, may they be better, and may they have wellbeing, now and into the future.

Tamariki Maaori and whaanau Maaori are at the centre of the approach, and participants involved in its design sought an approach that embraced ooritetanga – equality and equity. Recognition of the lasting impacts of colonisation on tamariki and whaanau hinengaro wellbeing has been the key in designing an approach that prioritises the development of culturally safe practice.

The new approach enables ringi raupa (messengers and navigators, people working in their own communities with tamariki and whaanau, including mana whenua) to take action on tamariki hinengaro wellbeing, and a Kia Ora Ake providers network will allow stakeholders to work together to create environments that support the mental and emotional health of our tamariki Maaori, and all our tamariki.

Expected benefits include improved hinengaro (mental) wellbeing for tamariki and whaanau, improved environments for hinengaro wellbeing, adults who are confident and well-supported to take care of and support tamariki hinengaro wellbeing, and greater cross-sector connections and collaboration.

In June 2022, the **Paahautea – Whaanau Maaori Mana Oorite and Oranga Plan 2022-2042**, which is designed to achieve Oranga Ake Tonu Atu (Sustained Intergenerational Whaanau Wellbeing) was endorsed by the CM Health Board. This Maaori health equity plan and MWiTM-derived framework will guide efforts to eliminate persistent inequities experienced by whanau Maaori in Counties Manukau. The plan also includes significant contributions from MWiTM, Waikato Iwi, multiple Maaori health providers, the Counties Manukau Health (CMH) Board and Senior Management, and Maaori staff.

CM Health, in collaboration with the Ministry of Health, Ministry of Social Development and Kaainga Ora, has continued its support of the development of **Te Ranga Ora** (TRO), a new system of care that provides comprehensive, culturally-capable services and models of care for Maaori, Pacific People and people living in quintile 5 with two or more long term conditions (LTCs). TRO aims to improve the experience of patients and their management of LTCs by taking a wider view of their needs and provider supports, and will enable them to access a responsive, integrated range of wellness, health and social services close to their homes. Models have been co-designed and delivered in partnership with local communities and delivered across the Counties Manukau rohe in a phased approach. Five prototype collectives made up of groups of providers working in partnership, both in primary and community networks that between them provide health and social services to support our whaanau with long term conditions, have been selected. CM Health is excited to herald the next phase of TRO as the five Collectives transition to a service delivery phase. Of note, several members of the TRO Collective(s) are also part of the 'Village of Providers' Ootara-Papatoetoe localities prototype, selected by Te Whatu Ora Health NZ for the CM district.

The **Fanau Ola** (FO) team continues to engage and provide support to approximately 3,000 Pacific patients with complex needs who are high users of the health system. The FO team works with these patients to improve their health outcomes by developing care plans with them and their families and helping them to reengage with their local general practitioners, specialists, and social agencies. The FO team also provides health education and language interpreter services, and the delivery of food parcels to these patients.

While CM Health is proud of the above initiatives, we acknowledge that there is a lot more work to do to achieve equitable health outcomes for both Maaori and Pacific populations. Results for the 2021/22 FY show that Maaori and Pasifika experience worse health outcomes than non-Maaori/non-Pasifika on several measures reported here. Maaori and Pasifika experience a lower life expectancy and have higher ambulatory sensitive hospitalisation, acute hospital bed day and amenable mortality rates than non-Maaori/non-Pasifika. Inequities in smoking prevalence, child oral health and obesity, and diagnostic and immunisation rates also persist for these populations.

Key Infrastructure upgrades

The development and expansion of facilities across the CM Health portfolio of properties continued through 2021/22 with the aim to better meet existing and future demand, and there were several successes in upgrading facilities:

- The **gastroenterology department** at Middlemore Hospital was expanded to increase procedural (gastroscopies and colonoscopies) capacity as well as add general anaesthetic capability, and the **Neonatal Unit** was upgraded, increasing capacity to an additional eight cots. The overall design was supported by consumer input and the layout of each cot space allows for a parent to remain with their infant throughout their transition to discharge. The feedback from whaanau has been hugely positive as they have felt more directly involved with their baby's care.
- Development of **community (health) hubs** continued with the expansion of clinic and staff hub capacity in Maangere, Ootara and at Pukekohe Hospital. The expansions enable more specialist services to be delivered from community hubs.
- In addition to the modification of some wards at Middlemore Hospital in response to the COVID-19 pandemic, internal reconfigurations of other wards and spaces were completed to add additional bed capacity. Work on the expansion of the renal dialysis unit and cardiac catheterisation suites also commenced with completion planned in late 2022 (see pages 21 and 23 for more detail).

CM Health was also fortunate in 2021/22 to receive funding confirmation for a number of proposed projects:

- The Ministers of Health and Finance confirmed funding of $135.4m to replace the Auckland Regional Spinal Rehabilitation Unit at Ootara and the General Rehabilitation Service at Middlemore Hospital. The funding will enable the development of a **specialised rehabilitation centre**, which will be located at Manukau Health Park. This will become a leading provider of rehabilitation services for stroke, spinal, amputee and other general rehab patients. During 2021, the concept design of the proposed 60 bed Specialised Rehabilitation Centre (SRC) was generated as a result of a co-design process involving patients, whanau and clinical staff. In addition, a new model of rehabilitation has been developed, and this was presented at the Rehab Medicine Society of Australia and New Zealand 2022 Conference and will continue to inform the next design phases. The new facility will be available for occupation from early 2026.

- The $229.3m **Grow Manukau Project** (approved in 2020) seeks to significantly expand Manukau Health Park's facilities and is a key regional strategic investment to increase surgical, diagnostic and outpatient capacity to address the significant growth in demand for health services. Planned benefits of the project include better health outcomes and reduced inequities, more cost-effective and sustainable services, improved patient, whaanau and staff experience with services at the site, and enabling the creation of more capacity at Middlemore Hospital. Plans for the expansion include increasing theatre outpatient capacity with four new theatres, 18 recovery beds, an isolation room, a new centralised sterile services unit, and 48 new clinical outpatient spaces in addition to the refurbishment of more than 40 existing clinic rooms. Along with the specialised rehabilitation centre, there will also be a new radiology hub that will include five ultrasound suites, two CT scanners and two MRI scanners, a fully integrated breast screening service, and an expanded renal dialysis service. Mana Whenua have been regularly engaged on the development and have endorsed each design stage. A close partnership has developed that will benefit

the project moving forward. Te Aakitai Waiohua, as the local iwi, have been separately engaged and provided input into the resource consents, and are providing cultural inductions for contractor staff. The first construction package is underway with civil infrastructure enabling works for the site commencing in February 2022.

- Following the completion of the Scott Building, $67m of funding was approved in December 2021 to undertake further **cladding remediation work** to resolve weather tightness issues in the McIndoe and Kidz First buildings at Middlemore Hospital and the Manukau Surgery Centre.

Scott Building cladding remediation work (before and after pictures)

- Government funding was also received to upgrade Middlemore Hospital's core infrastructure (power, water, and fire protection works). These upgrades will help to future proof the hospital and support future developments.

Further key achievements and highlights for the year are outlined below under our three Healthy Together strategic objectives (see *Our Strategic Intentions* on page 25) that are closely aligned to the April 2016 New Zealand Health Strategy (NZHS) themes. Each of these achievements has contributed to the national strategy, as highlighted by the NZHS themes: **People-Powered**, **Closer to Home**, **Value and High Performance**, **One Team**, **Smart System.**

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

Healthy People, Whaanau and Families

- **Consumer engagement:** A new survey platform ("Qualtrics") has been implemented at CM Health in partnership with Waitemata DHB allowing sharing of resources, tools and knowledge. This new cloud-based platform will be used for all patient and staff surveys and support the measuring of health outcomes. It has significant functionality that will allow staff to develop new survey tools and dashboards and it will assist CM Health to better understand the drivers of patient experience, and therefore allow more targeted responses for quality improvement purposes. *People-Powered*
- CM Health also continued to demonstrate leadership in the consumer engagement area by leading and coordinating a regional submission to the proposed 'Code of Expectations' for consumer and whaanau engagement (as enabled by the Pae Ora (Healthy Futures) Act) and were asked by the Health Quality and Safety Commission Partners in Care team to join a national working group to refine quality and safety measures for consumer engagement.
- We are sad to say goodbye to Rosalie Glynn, who was the Chair of the Consumer Council for over seven years. Rosalie was instrumental to the success of the Consumer Council at Counties and was pivotal to the creation of Feedback Central. She became a mentor and expert to many other DHBs during this time as they looked to develop their own consumer councils. Rosalie continues to mentor the new Counties Chair and play a significant role in promoting the consumer voice at the national level by participating in the National Consumer Council meetings as an 'expert' as we transition to Te Whatu Ora/Health New Zealand.
- The **Diabetes Clinical Nurse Specialist team** supported patients and their whaanau throughout COVID-19 surges with telehealth appointments and fielded an increase in phone calls from patients who were unable to access their GP. The team worked with patients to manage and titrate their insulin, provide prescriptions, advise whether further medical care was required, and respond to general health queries to keep patients safe and out of hospital. *Closer to Home*
- During the year **staff wellbeing** has been enhanced through the introduction of Schwartz Rounds. These provide a structured forum where clinical and non-clinical staff come together to discuss the emotional and social aspects of working in healthcare. Following the COVID-19 lockdowns Team Wellbeing Check-ins were also run, and third-party training workshops were held on Mental Health 101 and Financial Wellbeing. The reach of a Wellbeing Index app (an online self-assessment tool invented by the Mayo Clinic that measures mental distress and wellbeing) was extended and made available to nurses and health care assistants. *One Team*
- In celebrating the true spirit of Christmas, and **Manaakitanga (kindness)**, 54 staff from the **Radiology Department** generously donated their 2021 Christmas Westfield vouchers to the Middlemore Foundation, the charitable arm of CM Health. The vouchers were distributed through both the Papakura and Manurewa maraes and the Maaori and Pacific Health teams at CM Health, to help families in need.
- Maia Thackham, a paediatric and neonatal nurse at Kidz First, along with her friend Chloe Saxton, co-created a charity called outRUN. outRUN raises money to support children and families affected by abuse and poverty through participation in community sporting events such as marathons and distance running. So far, they have fundraised through two successful marathon events in Rotorua and Taupo. Determined not to let COVID-19 get in the way of their goals, Maia and the Team outRUN set about sourcing donations and creating gift bags to donate to children admitted to the Kidz First Emergency Department and inpatient wards.

- The **Acute Mental Health Project Delivery Team** won the Warren and Mahoney Civic, Health and Arts Property Award category in the prestigious Property Industry Awards 2021. The Tiaho Mai facility was awarded Excellence with Best in Class. The innovative and inspirational design of Tiaho Mai supports a tikanga Maaori approach to care offering a welcoming environment for whaanau to visit and be a part of the patients healing. Judges noted that Tiaho Mai placed the service users' dignity and choice at its heart, while maintaining safety and connectedness to culture, and the communities of CM Health.

- The **Fundamentals of Care (FOC)** programme, introduced to Counties Manukau inpatient services in 2017, measures and evaluates fundamental care delivery. The aim of the programme is to first provide participating wards and units with a core quality data set to identify critical areas to design and implement activities for improvement, and secondly, to ensure consistency in 'fundamental' aspects of care for patients. As well as instigating local ward based improvement projects, the programme has helped drive organisational led quality projects (e.g. a standardised quality board, and service-specific patient bedside status boards). Since implementing the programme, organisational results have demonstrated a sustained improvement with reduced variation in care delivery, and there has also been a significant improvement in eight of the nine care standards. Results have demonstrated inequity of experience for Maaori, so work is underway to align the programme with Maaori models of care. Progress has been made to map the existing 223 benchmarks to a framework that incorporates Maaori centred models of care concepts, including whakawhanaungatanga. 2021/22 also saw the expansion of the programme to community health settings, including localities and mental health.

  One Team

- A project was developed to implement **bedside Patient Status Boards** across CM Health, which aims to aid communication, improve patient and whaanau experience, while also promoting patient safety. The first phase of the project focused on developing, designing and implementing the Patient Status Boards across the divisions of Surgery, Anaesthesia and Perioperative Care (SAPS), Adult Rehabilitation & Health of Older People (ARHOP) and Medicine Services. The boards for these services were rolled out in November 2021. The second phase will include Kidz First Service and Women's Health services, and the third will involve Mental Health Services, Pukekohe Hospital and the Emergency Department.

- Despite disruptions from COVID-19 restrictions, the **Living Smokefree Service** engaged over 5000 people, with over 70% of referrals being for Maaori or Pasifika peoples. 71% of those setting a quit date successfully completed four weeks smokefree (biochemically validated), which is significantly higher than the national average of 48%. Of those successfully stopping smoking, over 80% were NZ Maaori or Pasifika, reflecting a strong equity focus. Over 200 waahine hapuu successfully stopped smoking over the year via the Smokefree Maternity incentives programme. The service also frequently provided smokefree health and service education, stop smoking drop-in clinics, and group-based treatment to workplaces, education providers and community organisations, and implemented a range of innovative initiatives to reach whaanau in the community (e.g. engaging and training smokefree champions, proactive referral systems, social media and locality outreach).

  Value and High Performance

Healthy Communities

- **Start Well** is an interdisciplinary team that was established as a prototype under the South Auckland Social Well-being Board to work with young pregnant mothers who were living with significant adversity in the Maangere locality. The team comprises of Clinical Nurse Specialists and Senior Social Workers who offer care to the whole whaanau across the life span but with a particular focus on well-child initiatives. They have a very clear equity lens and work to reduce

barriers to accessing health and well-being alongside the whaanau. Evaluation of the prototype found a significant improvement in the number of whaanau functioning well, and several of the young mothers are now enlisted back into further education, attained their drivers licence, and are planning career pathways to nursing, social work and business. Despite the challenges these families face, the team continue to see the children thrive and grow.

- In **a New Zealand first**, CM Health has made routine prophylactic anti-D (a blood product) available free on Lead Maternity Carer prescription from selected community pharmacies for pregnant rhesus negative women. Access to routine anti D prophylaxis in the early third trimester of pregnancy provides protection for up to 365 pregnancies a year in Counties Manukau from an undetected sensitising event during pregnancy. Such an event can cause significant neonatal morbidity and mortality, and is costly and challenging to manage. Availability through 12 community pharmacies across the district makes this accessible and convenient for women, and minimises the burden on the hospital. A multi-disciplinary team from Women's Health, Blood Bank, and Primary Care Planning and Funding developed the innovative approach, with input from the NZ Blood Service. The pharmacies managed this roll out during level four Covid-19 restrictions. To date approximately 200 doses of anti D have been administered in pharmacies.

Value and High Performance

- The **Asian Community VAX Heroes** programme (rebranded to **Community Flu Fighters**) successful engagement with Asian community leaders helped CM Health share information on COVID-19 vaccines and increase the uptake among Asian communities. Some community organisations promoted COVID-19 vaccines by creating Facebook posts and producing TV clips/interviews. Three of the programme's stakeholders were recognised for their work at the 2022 Minister of Health Volunteer Awards (Louisa Cheung, JP Chao Yu and Muskaan Care Trust). Louisa received the Outstanding Achievement award under the COVID Health Volunteer Individual Award category. In 2021 she began volunteering in Unichem's Pakuranga pharmacy. In this role she has been explaining the vaccination process, helping people who had never enrolled with a general practice to apply for a National Health Index number, translating consent forms and information, and booking appointments. In addition, the programme's lead pharmacist, Vicky Chan, was the recipient of the 2021 Pharmaceutical Society Pharmacist of the Year Award.

One Team

Left: Lead pharmacist of the Community VAX Heroes programme, Vicky Chan. Right: Louisa Cheung receiving her award from Andrew Little (Minister of Health), with Vicky in support.

- **Jammies in June - Warm Up Appeal:** Since 2011 the Middlemore Foundation with the support of its generous donors have given over 81,500 pairs of pyjamas to keep our tamariki warm through winter. Too many of the children who come to Kidz First are living in poorly ventilated, cold, and overcrowded homes – meaning increased susceptibility to winter illnesses. So this year, as well as distributing pyjamas, the Middlemore Foundation teamed up with Habitat for Humanity to get Winter Warm Up packs to as many whaanau as possible. Depending on what the family need, each pack can contain pyjamas, blankets, hot water bottles, heaters, draught stoppers, and window seals.

- A **new pregnancy ultrasound service** is being piloted at the maternity unit at Pukekohe Hospital. This pilot project seeks to test out the efficacy of CM Health providing a scanning service at the site that improves access to pregnancy ultrasound for women residing in a rural and semi-rural setting. Other objectives of the pilot are to improve the quality of ultrasound scans, increase the pregnancy scanning capacity in Franklin, and improve the integration and coordination of pregnancy care.

Closer to home

- The Pacific Regions continue to be supported by our Pacific team through the **Overseas Referral Scheme** (ORS). Through this scheme Pacific patients from Samoa, Tonga, Kiribati, Tuvalu, Vanuatu and Fiji can receive medical treatment in New Zealand that is not available in their own country. New Zealand's border controls in response to COVID-19 provided challenges but over the year we still managed to support over 60 Pacific patients to receive lifesaving treatments.

- **CM Health is committed to environmental sustainability**: An **Environmental Roadmap** for CM Health has been written that gives science based emission targets until FY 2025/26. The roadmap focusses on waste, energy and transportation for emission reductions, and highlights the need for clear, strong leadership from senior management in environmental sustainability and climate change mitigation and adaptation.

  In December 2021, **CM Health won the Toitū Brighter Future Award** in the category of 'Climate Action (large organisation).' The award acknowledges certified organisations leading the way in environmental sustainability. The criteria for the awards are around demonstrable impact, and the winners have been scientifically proven to be making a positive difference to the world around them. In winning the award it was acknowledged that CM Health has reduced 42% of its operational emissions since achieving certification in 2012. CM Health was the first DHB in Australasia to start measuring and reducing its carbon emissions. Other finalists for the award included Fletcher Steel, Auckland DHB, Kathmandu and Nelson City Council.

Smart System

  For the first time a **regional climate change risk assessment and adaptation framework** has been developed for the health sector in the northern region. The Sustainability and Risk Managers of the four DHB's along with the external partners of AECOM undertook a collaborative piece of work that concluded in June 2022. Clinical, administrative, public health experts, iwi and hapu, facilities and infrastructure stakeholders from all four DHB's were invited to participate in two workshops and give feedback on the final documents. The resulting documents are designed to work alongside the wider National Adaptation Plan and the Health National Adaption Plan. It is planned that the regional working group will remain together to progress the implementation of the adaptation framework.

  CM Health was thrilled to install two **EV charging stations** in the Western Campus carpark this year. The implementation of the EV charging stations was made possible by generous financial support from Fisher & Paykel Healthcare, and in collaboration with ChargeNet. Over the next few years CM Health's fleet will transition to EV's with the required infrastructure being added to sites.

  Dr Rob Burrell and the Anaesthetic Team have been undertaking valuable work to reduce CM Health's carbon footprint by 650 tonnes of CO_2 equivalents per year. In 2015, the Anaesthesia

Department embarked on a journey to reduce its drug-related carbon footprint, which makes up the largest fraction of anaesthesia's pollution profile. By measuring monthly use and allowing for monthly case load, the department has focused on managed reduction without impacts on patient safety or loss of clinician choice.

- **Hospital in the Home** is an alternative acute care pathway to inpatient admission, enabling patients to receive hospital-level care at home and thereby reducing demand for Middlemore Hospital beds. Patients remain under the care of a hospital doctor as well as having regular follow up by community nursing and Allied Health staff. In 2021/22, Hospital in the Home has adopted the use of remote patient monitoring, utilised more health care assistants (HCAs) to support nursing and Allied Health activity across a 7-day week, and used community liaison staff to support the transition of patients' home earlier from hospital.

  Closer to home

  In response to the surge in COVID-19 cases in the community, a COVID-19 Hospital in the Home Service has been established. This additional service provides clinical support for patients who remain unwell with COVID-19 but can be discharged from hospital to be safely treated and monitored in their home as they recover. IV Remdesivir for high co-morbid COVID-19 patients was utilised and administered in patient homes and allowed patients to be discharged at least three days earlier than before.

- 2021 marked the **10th anniversary of CM Health Asian Health & Wellbeing Community Network.** This network has grown from 10 members to 470 members. Initially set up to provide a forum for Asian staff to discuss service development, to network and to support each other, it expanded to include students from all disciplines and now some of these students are working as doctors, nurses, psychologists, social workers, nutritionists, advisors and managers across the health sector. The network allows members to connect and exchange ideas through the sharing of knowledge and experiences, and ultimately support members to be strong advocates for their communities' health and wellbeing.

  One Team

- The Food Service and kitchen teams supported the Middlemore Foundation with donations of fresh fruit for a wide range of regular community events, working alongside the Papakura Marae to assist vulnerable whaanau.

- A collaboration between Clinical Nurse Specialist, Claire Stewart, and a Pacific led midwifery practice in Papatoetoe (Niu Life) is **improving access to contraception/sexual health services** for pregnant and postnatal women who attend the midwifery practice, as well as their partners. Initially the nurse-led clinic was set up to increase access to long-acting contraception post birth, as funded by a Ministry of Health initiative. However, the service has expanded to provide a holistic approach to sexual health and family planning. The Clinical Nurse Specialist can prescribe and treat sexually transmitted infections, which if left untreated, can cause maternal and neonatal complications. The service has provided access to treatments and screening that the people are often accessing for the first time.

Value and High Performance

- The record number of graduating midwives choosing to join CM Health in 2021/22, and the high retention levels of the workforce, are testament to the Midwifery service's continued support of several growth and development opportunities. For example, CM Health supported the new nationally developed Maternity Care Assistant role (MCA). The MCA role enables student midwives to be employed and work alongside registered midwives in an auxiliary support and housekeeping role. Whilst employed, the students gain valuable industry experience and a student income. This new role has been highlighted as a valuable addition to workforce support and growth.

One Team

- This year the **Alcohol Harm Minimisation team** has worked with Maaori partners and mana whenua to develop a Te Tiriti-centred framework to transform the programme. Alongside communities, health agencies and other partners, the team also continued to support advocacy activities urging for stronger legislation for healthier environments and communities. In March 2022, CM Health contributed to a joint presentation to Auckland Council's governing body in support of a councillor's Notice of Motion to advocate for the Sale and Supply of Alcohol (Harm Minimisation) Amendment Bill (Private Members' Bill) and wider alcohol reform. Auckland Council subsequently voted unanimously in favour of supporting the Private Members' Bill, as well as requesting that the New Zealand Government completes a review of the liquor laws.

Healthy Services

- Throughout the year CM Health staff were provided the opportunity to participate in various cultural events and activities to celebrate the organisations cultural diversity and increase their awareness and knowledge of the diverse cultures in the Counties Manukau district. This year Matariki (Maaori New Year) celebrations involved live performances, Parakuiki (breakfast), workshops and presentations, and for Te Wiki o te Reo Maaori (Maaori Language Week), a series of videos were created to help staff corrrectly pronounce Maaori words and phrases. Other events celebrated throughout the calandar year included Chinese (Lunar) New Year, Pasifika language weeks, and Diwali.

- In July 2021, we celebrated the nine nurses who completed CM Health's inaugural Nightingale Challenge. This was a global initiative to empower the next generation of nurses to be leaders, practitioners, and advocates in health. Over the 18-month programme the Nightingale nurses were provided with access to a mentor, the opportunity to shadow senior nursing leaders, and attendance at a national conference.

One Team

They also undertook a service initiative project and participated in a leadership and self-awareness programme. To celebrate the ending of the Nightingale challenge, the nine participants were asked to present on what they had gained from being part of the challenge. All agreed that they were motivated to continue to learn and grow in their nursing careers, were more conscious of their role in supporting others, more confident in self and role, and had greater insights into other senior roles and the benefits of a holistic approach.

- The New Zealand Nurses Organisation (NZNO) announced CM Health registered nurse, **Daniel Mataafa**, as **Young Nurse of the Year**. Daniel was chosen from 20 nominations, and the award was presented to him at NZNO's online Annual General Meeting on 16 September 2021. Daniel is part of the Regional Pacific Team within Pacific Health Development, a team that he joined at a time of unprecedented increase in demand for services as a direct result of Covid-19 and New Zealand closing its borders. Daniel was noted to go above and beyond of what was expected to ensure patient journeys are seamless, respectful and safe, and had earned a reputation for providing outstanding, holistic care. His nominators lauded his courage and resilience in breaking through the stigma of being a Samoan male nurse and using his experience to support other young Pasifika men.

- Construction of CMH's **second Cardiac Cath Lab** began in September 2021 and was completed and operational by September 2022. It will help to increase access to the cardiology interventional service at CM Health. It will provide the ability for more specialised procedures to people with acute and long-term cardiac conditions, such as implanting more complex pacemakers, which prevents the need for patients to travel to Auckland City Hospital for the procedure. Having a second procedure room will also significantly reduce waiting times and related clinical risks to patients, improving health outcomes for people residing in the Counties Manukau rohe (district).

Value and High Performance

- In late 2021, CM Health Board and ELT endorsed a **Clinical Services Plan** that describes how hospital and specialist services will help to deliver the CM Health strategy through to 2025. This plan will also guide development of enablers such as workforce and facilities and is intended to be updated regularly in line with changes in the health environment.

- CM Health's **Laboratory Service** was recognised for its hard work and dedication during COVID-19 lockdowns throughout the year. It was the recipient of the Allied Health, Scientific and Technical Professions Supreme Award for 2021, and the Laboratory Service's Microbiology team won the 2021 Chief Executives Award at the Annual Staff Values Awards. Apart from processing PCR tests for the community, inpatients, Managed Isolation Facilities, border workers and CM Health staff, the laboratory team has also been instrumental in the implementation and facilitation of the organisation's Rapid Antigen Testing (RAT) process, working closely with the Emergency Department on an initial pilot, before roll out of RAT testing across the wider organisation. A full team effort by the service provided a train the trainer programme, IT enablement of a result entry portal for supervised RAT results, and a user-friendly RAT 'how-to' guide.

- The **Annual Staff Values Awards** were held on Monday 6 December 2021. These awards are one of many ways that CM Health celebrates and recognises its people for going above and beyond in living the organisation's values and delivering the best care. This year's winners were:
  - **Chief Executive Award** - Microbiology Team Laboratory
  - **Equity Award** – Summer Hawke and Kitty McQuilkan
  - **Supreme Local Hero Award** - Sifahula Leavai, Registered Nurse
  - **Valuing Everyone (Whakawhanaungatanga)** – Raewyn Maguire, Charge Nurse Manager
  - **Kind (Manaakitanga)** - Krishnee Naidoo, Charge Nurse Manager
  - **Together (Kotahitanga)** - Angela Hall, Secretary
  - **Excellent (Rangatiratanga) Award** - Ambigay Ramsamy, Charge Nurse Manager.
- In January 2022, the Executive Leadership Team approved the development and implementation of an **HCA Earn as you Learn programme** as a strategy to recruit and retain health care assistants (HCA's). Successful candidates join the programme as HCA Trainees (no prior Level 3 or 4 HCA qualifications) and are supported by the Workforce Development Team (Nurse Educator and Clinical Coaches) to complete the Level 3 qualification. The first cohort commenced in late April 2022.
- Neonatologist, **Dr Lindsay Mildenhall**, was recognised in the New Year Honours List 2022 and appointed an Officer of the New Zealand Order of Merit for his services to neonatal intensive care and resuscitation training. Lindsay specialises in the care of newborn babies and until recently held the position of Clinical Head of Kidz First's Neonatal Intensive and Special Care Service at Middlemore Hospital. Lindsay is passionate about improving outcomes for newborns and he has made a significant contribution through his work in this field. Lindsay was presented his medal in Wellington on 10 May 2022 from the Governor-General, Dame Cindy Kiro.

- A **new Transient Ischaemic Attack (TIA) service** commenced at Middlemore Hospital in May 2022. A person who has had a TIA ("mini-stroke") is more likely to have a major stroke resulting in devastating disabilities, or mortality, so prevention of stroke is the key feature of this service. Referrals to the service are made via Emergency Care services and GP practices in a fast-track process. The team, consisting of a Clinical Nurse Specialist, RMO and a Pharmacist, provide a care pathway for people to investigate their potential TIA signs and symptoms.
- CMH's **Fracture Liaison Services (FLS) team** was **awarded the Gold Star** for best practice by the 'Capture the Fracture' international committee. The Capture the Fracture programme provides recognition, resources, training and tools to support post-fracture care coordination programmes worldwide. To achieve the gold standard, the service was reviewed against best practice standards in the following four key fragility fracture groups: hip fractures, other inpatient fractures, outpatient fractures and vertebral fractures. Alongside this gold standard achievement our fracture liaison team has been working closely with ACC and Osteoporosis New Zealand to develop a fracture registry in New Zealand and support other DHBs to set up their own fracture liaison service.

- On 13 June 2022, the eastern side of the new Dialysis Unit in the Scott Building was opened with a blessing from our Kaumatua, and the first patients were welcomed. This state-of-the-art facility provides more capacity to treat our renal dialysis patients. The second half of the unit is due to open in late 2022.

- **Service Improvement:** In 2021/22, the 'Every Hour Counts' portfolio has continued with the vision to improve patient flow to optimise the quality of care, the experience of care, and the experience of caring whilst improving the efficiency of the care system. This covers both acute and ambulatory patient flow, with Ko Awatea led work programmes in each area.
  The **Acute Patient Flow** team has continued to look for solutions to the challenges of enabling flow, especially within the General Medicine wards:
  - Establishing a Health of People (HOP) squad in a General Medical ward has delivered a three-day length of stay reduction, and seen a greater number of patients accessed at either a public hospital or care home. The HOP squad is now expanding into additional areas.
  - The 'Consider Home Over Inpatient Care Everytime' (CHOICE) programme was developed in conjunction with the localities teams, that included working on a number of initiatives to support faster, safer and more sustainable patient discharges to home, or into appropriate community services
  - The non-standardised ASH rate for stroke at CM Health had been consistently higher than the rest of New Zealand and the Auckland region, so the team have been supporting clinicians to develop an improved TIA/Stroke service, with the aim of improving the rate of TIA patients seen by a specialist
  - Waiting for an echocardiogram was a significant reason for 'Red Days' - a demand and capacity study has been undertaken in the inpatient echo service. The aim is to increase the percentage of scans completed on the same day the referral is received from 64% to 80%. An ultra-portable device which allows echocardiograms to be performed at the bedside (rather than moving the patient to the cardiac department for the 'echo' scan) is currently being trialled to see if targeted echocardiograms can reduce the inpatient demand.

Value and High Performance

- Work undertaken by Ko Awatea's improvement team led to the delivery of additional service capacity to reduce the backlog of patients on the cataract clinical pathway. The existing model of care was modified through the rationalisation of appointments, utilising telehealth where appropriate, and managing surgery demand overflow by substituting outsourcing with wet lease arrangements (the DHB leasing non-DHB owned surgical theatre space/equipment/and in some circumstances personnel) where possible. These changes delivered 13% more surgeries, reduced the number of appointments an individual had to attend and meant CM Health could offer more people the opportunity for treatment.

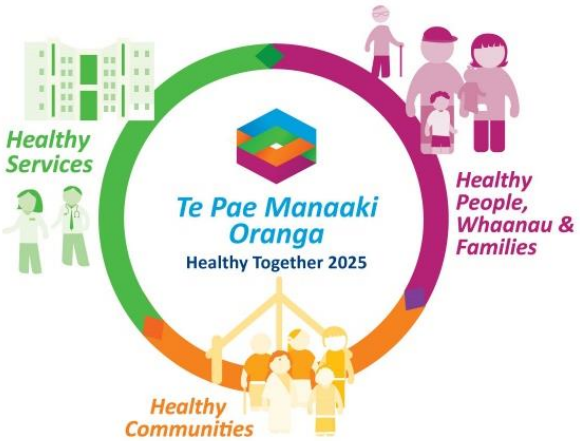
- Despite COVID-19 related delays, a **new Siemens acute CT scanner was installed** in the Emergency Department (ED). The project included deconstruction of existing walls to create more space for the ED, new reporting rooms, an additional patient bed space, and a shell space for a future ultrasound room. After a period of commissioning, physics testing and staff training, the new acute CT scanned its first patients on 13 June 2022.

Smart System

Our Strategic Intentions

Healthy Together

2021/22 was year two of our five-year strategy, which was updated to reflect a similar future long term journey that first started in 2015. Life expectancy and other population health indicators have improved; however, the gap in life expectancy for Maaori and Pacific peoples has not decreased at the rate that other groups have experienced improvements. Achieving health equity in key indicators is critical to medium term population outcomes and longer-term health system sustainability. Relying on treating people when they become unwell is not enough and will not achieve the health gains needed to achieve healthier, longer lives in the community. We remain confident that we are on the right track, and with renewed effort within the reformed health system, we will enable equity of outcomes and access for all in the years to come.



The DHB's strategic goal is Te Pae Manaaki Oranga – Healthy Together 2025 is:

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

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

Valuing everyone – we make everyone feel welcome and valued

Kind - we care for other people's wellbeing

Together – we include everyone as part of a team

Excellent - we are safe, professional and always improving

Achieving the Healthy Together strategic goal requires balancing resource investment and interventions across the three strategic objectives supported by our values as the foundation of future strategic actions.

Our Strategic Objectives

CM Health's Healthy Together strategy comprises three key objectives: **Healthy Communities, Healthy Services** and **Healthy People, Whaanau and Families.** The strategy is underpinned by Population Health and Clinical Service Plans, a Peoples' (workforce) Strategy and *Paahautea – Whaanau Maaori Mana Oorite and Oranga Plan 2022-2042*, the DHB's Maaori Equity Plan.

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

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

community. To manage the challenges of ageing facilities infrastructure and a significant increase in service demand, we have accelerated our investment in facilities to ensure the health and safety of 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[9] 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", while the *Whakamaua: Maaori Health Action Plan 2020-2025* and *Bula Sautu (Pacific health in the year of COVID-19)* sets the direction for Maaori and Pacific health advancement.

Translating the visions set out in these strategic documents 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. Our future context will also be shaped by the priorities set by Te Whatu Ora Health New Zealand, Te Aka Whai Ora and other national agencies. Counties Manukau District 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 have measured our performance

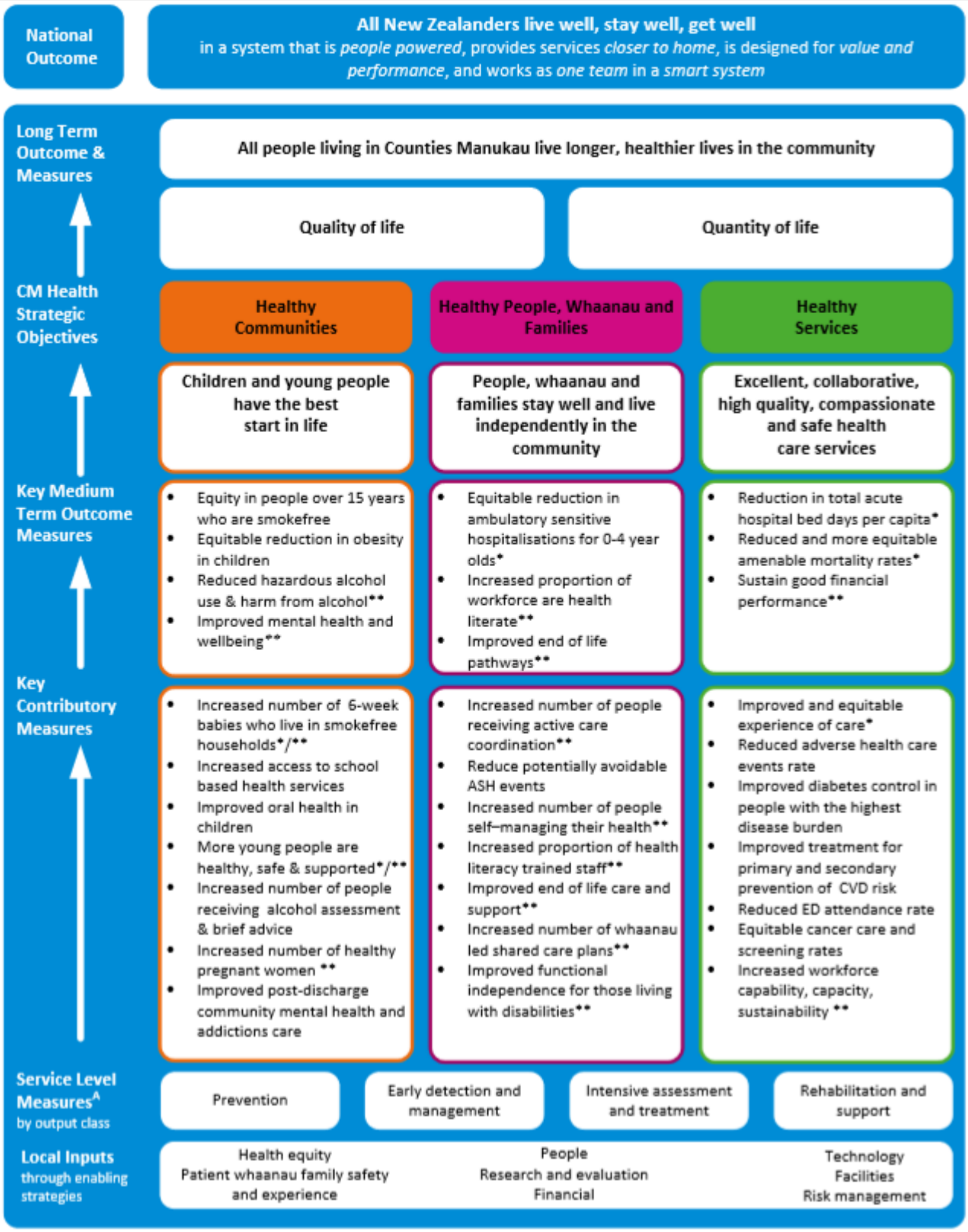
Our performance story is aligned with CM Health's strategic objectives and their contribution to our health equity strategic goal. Workforces and services need to be challenged and supported to work out what a health equity approach means in their services, their role and to implement change. To support this, we have used 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 three Triple Aim long-term outcomes and contributory impacts. It has integrated 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 not only affects long-term outcomes but measuring these also enables us to gauge progress in the shorter term. Also included in this framework are "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 this has allowed us to report exactly how CM Health is performing year on year, against national and local performance expectations.

CM Health's performance as at 2021/22 against the long-term outcomes and some of the related impacts in our outcome's framework is provided in the *Improving Outcomes* section of this Annual Report. CM Health's 2021/22 performance for the outputs identified in our outcome's framework is provided in the *Statement of Service Performance* on page 44. Together these two sections provide a current picture of the progress CM Health made towards achieving our long-term outcomes and strategic goal in 2021/22.

[9] CM Health ceased to exist as a public entity on 1 July 2022 and has been amalgamated into Te Whatu Ora Health New Zealand and will be known as Counties Manukau District.

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

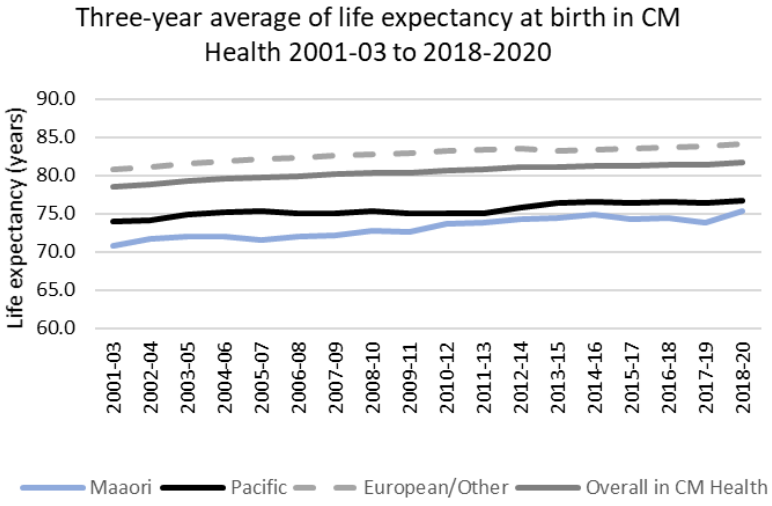
For the Counties Manukau community, we need to target outcome improvements to achieve health equity.[11] To better understand which people do not experience the same health outcomes, we have reported and compared results over time by ethnic group.[12] Results are not always available for all ethnic groups and work is ongoing to improve the accuracy and scope of results by ethnic group.

To make health equity gaps more visible, we have chosen the 'New Zealand European/Other'[13] 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 the life expectancy at birth gap for Maaori and Pacific peoples[14]

2020 was an unusual year and substantial changes in life expectancy may be attributable to the impacts of preventative measures put in place in response to the global COVID-19 pandemic. Therefore, more weight should be given to the three-year rolling averages.



From 2011-2013 to 2018-2020, the overall total life expectancy trend in Counties Manukau improved by 0.8 years from 80.9 years to 81.7 years. This is similar to the national improvement over the same time period. However, not everyone in our diverse communities experiences the same health outcomes. In 2018-2020, the gap in life expectancy between Maaori (life expectancy 75.4 years) and non-Maaori/non-Pacific (life expectancy 84.1 years) was 8.8 years. The gap between Pacific (life expectancy 76.8 years[15]) and non-Maaori/non-Pacific was 7.4 years. We are committed to reducing these inequities through targeting those conditions and health outcomes that impact the most on amenable mortality and life expectancy, including cardiovascular disease, long-term condition management, and smoking cessation.

[11] Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need.
[12] From 1 July 2022, equity reporting will include disability and geographical elements.
[13] Some measures report 'non-Maaori non- Pacific' to align with Ministry of Health reporting.
[14] Data source: Mortality Collection, Ministry of Health; Estimated Resident Population January 2021, Statistics New Zealand.
[15] Pacific and Maaori life expectancy gap values have been rounded to the first decimal place.

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

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

Medium Term Outcomes

Healthy Communities – Improved population health and equity

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

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

Equitable smokefree rates across Counties Manukau

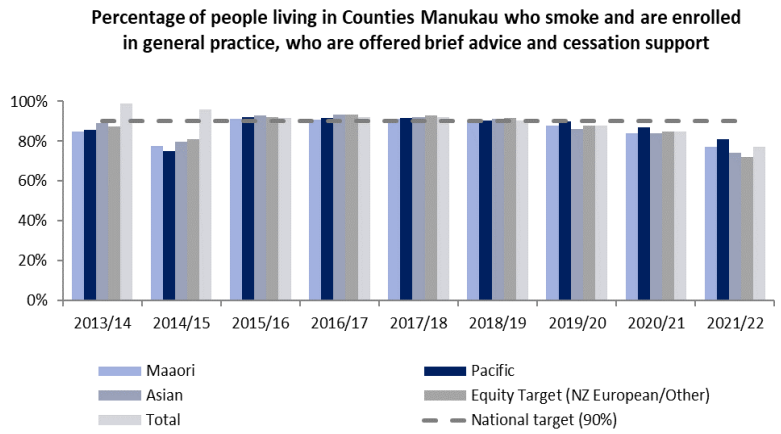
Smoking, a leading risk to health in Counties Manukau, disproportionately burdens Maaori and Pacific peoples.

Inequities in smoking prevalence contribute to differences in life expectancy and wellbeing between Maaori and Pacific and non-Maaori/non-Pacific peoples. At the time of Census 2018, Maaori (31%) and Pacific peoples (22%) in Counties Manukau were two and a half and nearly two times more likely to smoke respectively than people identifying as NZ European/Other ethnicities (12.3%).[17] The overall total smoking prevalence in 2018 was 14.4% against the total target of 10%.

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

[16] Singh H, Papa D, Jackson G (2021). Life Expectancy and Mortality in Counties Manukau (2020 Update). Auckland: Counties Manukau Health.
[17] Data on smoking prevalence is from the 2018 Census.

Key contributory measure: Better help for smokers to quit (Primary) - 90% of patients enrolled with a Primary Healthcare Organisation (PHO) who smoke have been offered help to quit smoking in the last 15 months[18]



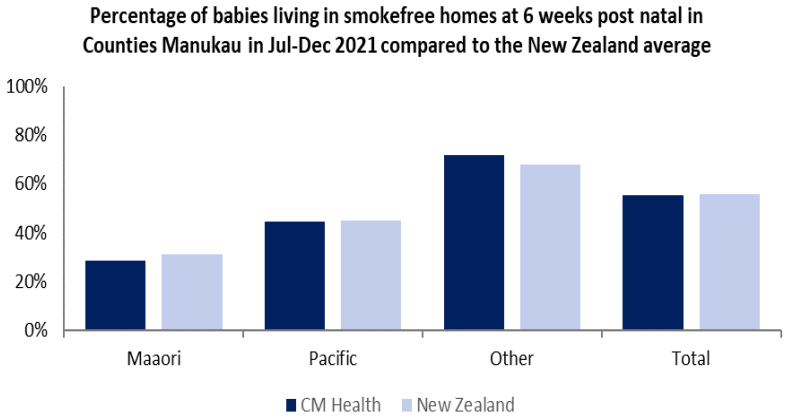
In 2021/22, CM Health achieved 77% for the total enrolled population against a target of 90%. 77% was achieved for Maaori, 81% for Pacific, and 74% for Asian populations.

Although primary care has not achieved target on brief advice activity, they have continued to work towards streamlined referral systems, priority population targeted outreach and increased cessation activities. In 2021/22, the CM Health Living Smokefree Service received a total of 4,995 referrals (Maaori 45%, Pacific 30%), with 1,304 of these from primary care (Maaori 38%, Pacific 33%). There were less referrals this year compared to 2020/21 and may indicate that COVID-19 has had a greater impact this year on services who refer to the Living Smokefree service. The proportion of Maaori and Pacific referrals demonstrates the continued focus on achieving equitable outcomes.

Data source: Ministry of Health Performance Reporting

Key contributory measure: Increased percentage of babies living in smokefree homes at six weeks post-natal[19]

Increasing the number of babies living in smokefree homes will reduce potentially avoidable ill-health and hospitalisation (e.g. respiratory infections, asthma). Infant exposure to tobacco smoke contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. The System Level Measure "Babies living in smokefree homes at six weeks post-natal" includes all household members and so focuses the attention beyond maternal smoking to the home and whaanau environment that an infant will be raised in.



All ethnicities saw improvement in the percentage of babies living in smokefree homes compared to 2020/21. Pasifika in particular saw a marked improvement (10 percentage point increase). However, marked inequities remain for Maaori and Pacific infants who are 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.

In 2021, across Counties Manukau, an estimated 35% of Maaori women were identified as currently smoking at the time of admission for birth, compared to 12% of Pacific women and 4% of NZ European, Asian and Other women. In 2021/22, smoking cessation support was targeted for women during and after birth. The Smokefree Maternity Incentives programme has demonstrated a highly effective approach to supporting hapuu maamaa to stop smoking during pregnancy with 484 referrals received for hapuu maamaa (Maaori 59%, Pacific 31%) despite COVID-19 restrictions (484 represents 63% of the identified waahine hapuu smoking at booking). 61% engaged and were supported on their

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

[19] In 2018/2019 an SLM was introduced focused on the proportion of babies in smokefree households at six weeks of age. This measure replaced the measure of percentage of women who are smokefree at 2 weeks postnatal. The new data standards came into effect on 1 Jan 2019.

smokefree journey resulting in 171 smokefree waahine at four weeks post a quit date, with others reducing consumption, trying nicotine replacement therapy and benefitting from the other interventions we support such as SUDI prevention education and safe sleep device delivery, alcohol harm minimisation, and breastfeeding support/antenatal classes/Family Start/Healthy Housing referrals. Whaanau of hapuu maamaa women are also incentivised to stop smoking.

In 2022/23, efforts will continue to focus on increasing reach and engagement in the existing whaanau incentives programme to support more babies to live in smokefree homes. This will continue to have an equity focus to support Maaori and Pacific women and their whaanau.

Data source: Ministry of Health Performance Reporting

Equitable reduction in obesity prevalence in children

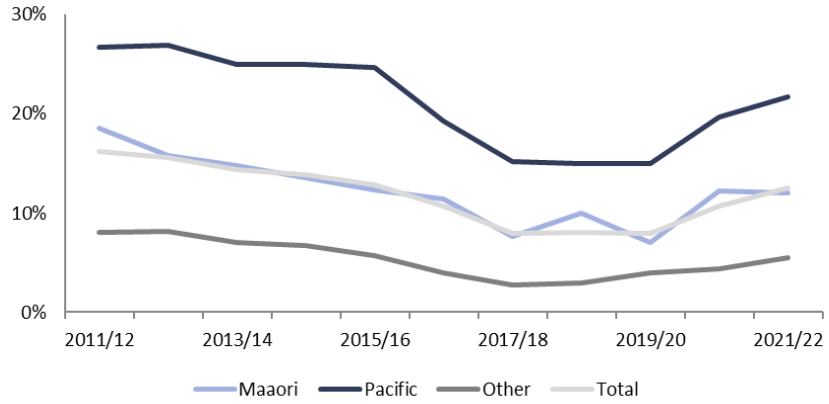
Childhood obesity is associated with a wide range of short to long term health impacts that are potentially avoidable. CM Health has a high prevalence of overweight and obese children and Maaori and Pacific children are disproportionately affected. Addressing obesity is complex requiring the health sector to work with other sectors to support wider environmental and societal change to reverse the growing prevalence of obesity in our community. Over the period between 2012/13 and 2017/18 there was an encouraging reduction in the prevalence of obesity in four years olds as measured by the B4School Check programme, particularly for Pacific children. This trend in children in Counties Manukau was similar to the regional and national trends[20]. However, available data appears to suggest that this trend may have slowed and even reversed in recent years, potentially impacted by the COVID-19 pandemic. In 2021/22, B4School check coverage was only 49% compared to 78% and 90% in 2019/20 and 2020/21. Despite efforts to prioritise Maaori and Pasifika children, coverage for these groups in 2021/22 was only 55% and 49% respectively (compared to 48% of other children in Counties Manukau).

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 2021/22, the percentage of four year olds with a BMI over the 98th percentile was 13% (up from 11% in the preceding year). This was similar for tamariki Maaori at 12% (holding steady) and higher for Pasifika children at 22% (up from 20%).

At CM Health, we acknowledge the need for a broad approach to reducing childhood obesity. CM Health is part of the Healthy Auckland Together coalition, which works with intersectoral partners such as schools and the University of Auckland to support wider environmental and cross-sectoral societal change. In 2022/23, there will be new funding for a range of initiatives aimed at supporting families impacted by obesity, including supporting healthy nutrition and physical activity for children and their whanau.

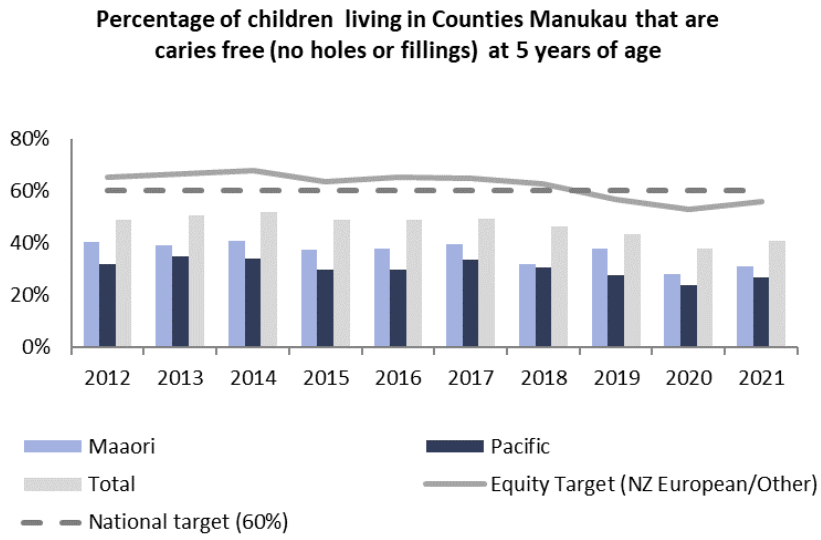
B4School Check BMI (age 4 years), percentage obese (>98th percentile)



Data source: Ministry of Health Performance Reporting

[20] Further reductions in the prevalence of obesity in 4-year-old New Zealand children from 2017 to 2019. Daniels, L., Taylor, B.J., Taylor, R.W., Milne, B.J., Camp, J., Richards, R., Shackleton, N., Feb 2022. International Journal of Obesity.

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



In 2021, the total percentage of dental caries-free children at five years was 41%, a 3% increase from 2020, but still below CM Health's targeted level of 46.9%. The target was only achieved for European/Other children (56%) and oral health inequities persist.

To mitigate the existing inequities in oral health, the Auckland Regional Dental Service (ARDS) and CM health have increased outreach programmes to improve and enhance community awareness of the service by actively seeking opportunities to participate in community events. The fluoride varnish programme has also been re-established at early childhood centres with high enrolment numbers of high-needs children. Additionally, Saturday clinics have re-established across the Counties Manukau region to increase capacity and access for many families.

Other contributing factors to the existing oral health inequities are the high did-not-attend rates for Maaori and Pacific children. Providing community-suited service delivery, including the re-distribution of mobile units to schools with a high number of arrears and where children experience barriers to attending the service, have proved to be successful in reducing the number of did-not-attend appointments. The aim is to maintain a consistent outreach service for children and whaanau in high-need areas. This will support equitable service delivery.

Dental caries is a multi-faceted disease. Poor nutrition is a common factor causing poor oral health and obesity in children. We recognise the importance of early education and engagement with whaanau in the community to reduce the prevalence of both dental disease, and obesity. Early enrolment and engagement with whaanau will remain as one of the primary focuses for children in the Counties Manukau region. In 2022/23 the Ko Awatea improvement team will also be leading the development of a new model of care for child oral health that is to be co-designed with stakeholders. This design work sits within a wider context of oral health improvement and development for the northern region and is one of five key work streams.

Data source: Ministry of Health Performance Reporting

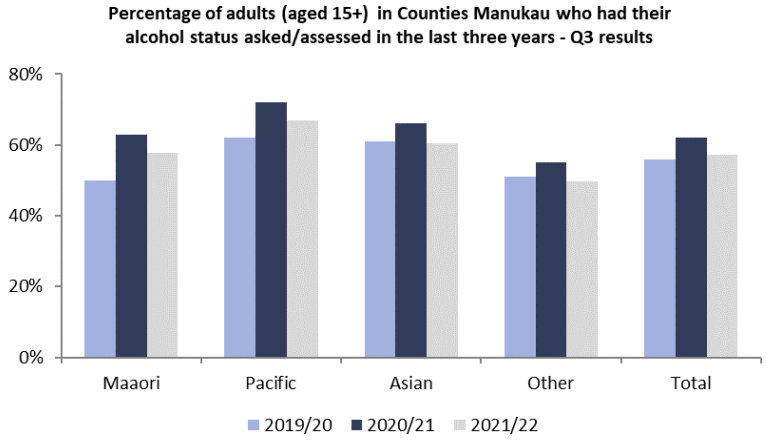
Reduced hazardous alcohol use and harm

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

Key contributory measure: Increasing the percentage of enrolled patients in general practice who have had their alcohol status asked/assessed in the last three years[21]

[21] Data Source: HealthSafe, Metro Auckland Data Sharing Programme. Data covers 89% of the enrolled population in Counties Manukau aged 15+. The prioritised ethnicity method has been used for ethnicity data output.

CM Health developed and implemented a programme of collaborative alcohol harm minimisation actions. This work includes equitable delivery of the Alcohol ABC (Ask, Brief Advice, Counselling) approach in General Practice. The graph shows the 2019/20, 2020/21 and 2021/22 data for quarter three for the percentage of enrolled patients in General Practice who have been asked about their alcohol use in the last three years. The ongoing pressures of COVID-19 and related lockdowns have had an impact on our health system and delivering the Alcohol ABC Approach.



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

The Alcohol Harm Minimisation Programme was evaluated in 2021 and recommendations supported continuing and retaining many components of the Programme, including the dual focus on Alcohol ABC Approach delivery and advocacy to influence more upstream determinants of alcohol-related harms. A key change is working with Maaori partners and mana whenua to develop a Te Tiriti-centred framework to transform the programme of work. In addition, alongside communities, health agencies and other partners, the team continues to support advocacy activities urging for stronger alcohol legislation to enable healthier environments and communities.

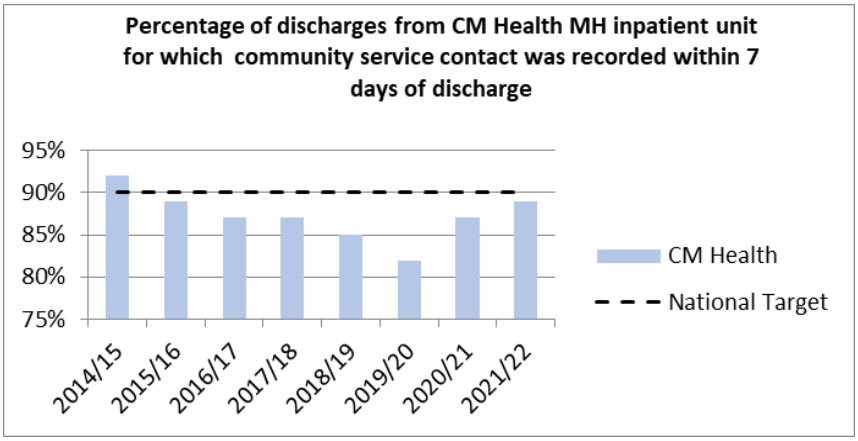
Data source: General practice Alcohol ABC data, reported through HealthSafe, Metro Auckland Data Sharing Programme

Improved mental health and wellbeing

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

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

The follow-up of Tangata whai ora (clients) within seven days of their discharge from the Tiaho Mai inpatient unit is crucial to continuity of care. The Mental Health (MH) Community Teams working within the Counties Manukau catchment area continue to strive to deliver uninterrupted care for whaiora (clients) and whaanau who have been hospitalised due to an acute psychiatric episode. All clinicians are aware of the importance of a formal transition/discharge plan and timely clinical care within the community in order to to support the independence of the Tangata whai ora at such a vulnerable time.



In 2021/22, an average of 89% of Tangata whai ora discharged from CM Health's acute adult inpatient mental health unit, Tiaho Mai, had a community mental health service contact recorded within seven days of their discharge. This is an improvement on 2020/21 despite Auckland's COVID-19 lockdown (August – November 2021) as well as further restrictions in February – March

2022. The service did note that whaiora and their whaanau were at times reluctant to engage with clinical providers even if face-to-face and virtual services continued to be offered, and this created additional challenges for engagement post discharge. The percentage of Maaori discharged from Tiaho Mai who were seen within seven days of discharge continues to improve and exceeded the target in quarters 3 and 4 of 2021/22. The Pacific post discharge follow up rate also continues to improve; but at 89.2% did not quite reach the target.

Post discharge follow-up rates remain an area of focus for the community teams. All managers continue to undertake a variety of strategies within their teams to monitor and implement improvements. Some of the barriers to engagement/follow up occurring within seven days include early unplanned discharge from Tiaho Mai (prior to community clinician allocation and engagement with whaiora), and whaiora moving addresses without notice. The clinical teams try to mitigate these barriers and utilise the acute community service (Home Based Treatment team) and NGO partners to assist.

We continue to note that the data set includes all people who have been discharged, regardless of destination, and therefore includes Tangata whai ora who have been transferred out of the Counties Manukau catchment area (and are followed up by another district health board), those admitted into another inpatient facility (Middlemore Hospital/Tamaki Oranga Recovery Centre), and those whose care is transitioned directly back to primary care. In these situations, the CM Health community teams are not providing follow up post discharge, and therefore the percentage of Tangata whai ora who should have been seen post discharge is recorded as lower than it actually is.

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

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

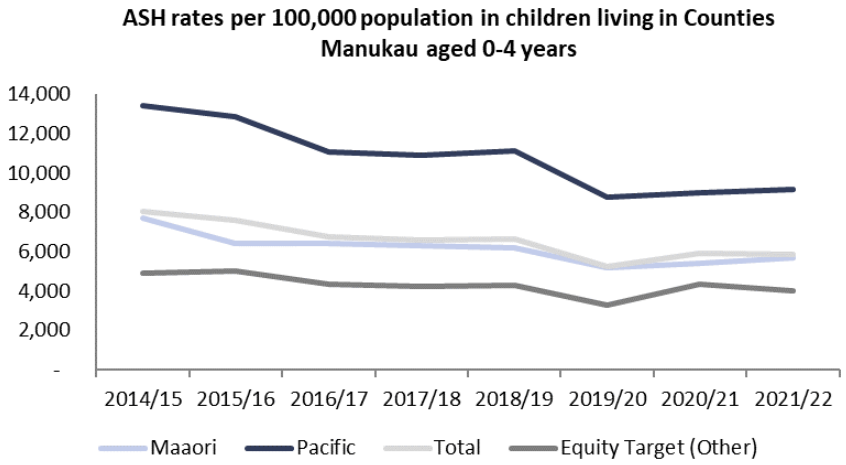
"Together we will involve people, whaanau and families as an active part of their health team"

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

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

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

Keeping children well and out of hospital is a key priority. Not only is it better for our community, but it frees up hospital resources for people who need more complex and urgent care. Maaori and Pasifika 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 Pasifika children in Counties Manukau are respiratory infections, asthma, dental conditions, cellulitis, upper ear, nose and throat infections.



The ASH data presented is for the 12 months ending in June of each year. The 2021/22 Metro Auckland System Level Measures (SLM) Improvement Plan set a target of reducing the 0-4-year-old total ASH rate by 3%, and Maaori and Pasifika ASH rates by 6%, by 30 June 2022 (using the year to December 2019 results as the baseline). Annual data to June 2022 shows CM Health did not achieve this target for Maaori, however the rates for total population and Pasifika peoples met the target.

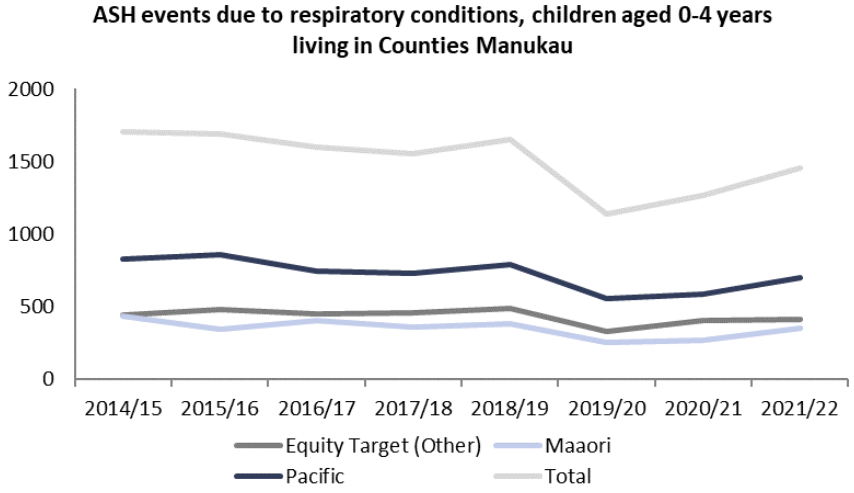
The strict restrictions (border closures and nationwide lockdown) put in place in Autumn 2020 to 'stamp out' COVID-19, and other public health measures (e.g. increased awareness of hand hygiene/mask wearing), helped to reduce the transmission of respiratory illnesses that contributed to lower 0-4 year-old ASH rates in the first year of the COVID-19 pandemic. However, rates have rebounded since New Zealand's initial nationwide lockdown. This increase is likely due to a combination of factors, including New Zealand transitioning to the 'manage it' phase for COVID-19 and an easing of restrictions over time, reduced adoption of COVID-19 public health measures like social distancing and mask wearing, and the return of respiratory illnesses like influenza. Winter 2021 saw a significant increase in respiratory syncytial virus (RSV) cases, and the 2022 influenza (flu) season began early, with the number of 0-4 year olds presenting to ED with influenza surpassing the peaks of the last five years.

While a 2022/23 SLM Plan has not been developed, given the transitional phase of the health reforms, CM Health has continued to work with metro Auckland partners to ensure the focus remains on recovery post COVID-19 lockdowns. The System Level Measures (SLM) implementation portfolio leads have agreed to post-pandemic recovery priorities that include childhood scheduled immunisations for influenza, and vaccinating women in pregnancy against influenza and pertussis (whooping cough). The SLM implementation group is accountable for the action plan and tracking progress against targets.

Data source: Ministry of Health Performance Reporting

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

The ASH data presented is for the 12 months ending in June of each year. Inequities have persisted over time, and Counties Manukau Pasifika and Maaori children are more likely than children of other ethnicities to be hospitalised with respiratory conditions including asthma and pneumonia. In particular, Pasifika children continue to have the highest total and highest respiratory ASH rates. Since 2016, there has been a significant decrease in the pneumonia ASH rate for Pasifika children, however, the general progress in reducing asthma and lower respiratory infection ASH rates (that had been seen since 2016) has been negated in 2021/22.



The 2021/22 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 aimed at reducing respiratory admissions, including actions to improve child and maternal immunisation and smoking cessation.

The majority of 0-4 year-old vaccinations occur in general practice (93%). In 2021/22, CM Health supported General Practices by working with practice leaders to ensure vaccination messaging was clear, and also began implementing its integrated immunisation project that prioritises Maaori and Pasifika tamariki and their whaanau. Outreach immunisation services have also been expanded, including a mobile nurse vaccinator for maternity services.

The Northern Region Health Coordination Centre, developed in response to the COVID pandemic, has focused on leveraging off the COVID-19 infrastructure to assist in delivering flu vaccinations. Maaori and Pasifika providers have been supported with workforce development, communications, and organisation of vaccination events.

CM Health continued to support the implementation of the Best Start Pregnancy Assessment Tool. This decision support tool prompts clinicians to offer vaccinations and refer patients to Healthy Housing and smoking cessation services.

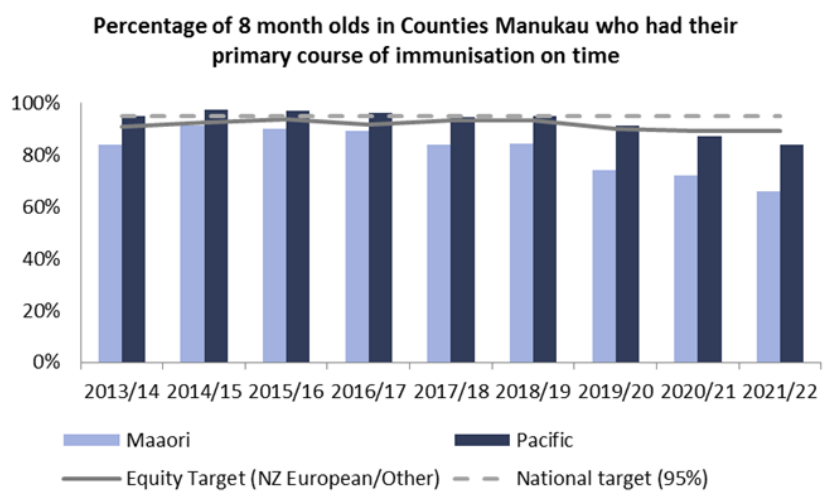
The Counties Manukau District will continue to focus on reducing ASH rates through reducing respiratory admissions. This is particularly important in a post COVID-19 environment, and COVID-19 and influenza vaccination remain a priority.

Data source: Ministry of Health Performance Reporting

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

In 2021/22, CM Health did not meet the 95% overall target and 90% coverage for tamariki Maaori.

At the end of December 2021 CM Health was 7.6 percentage points below the national Maaori immunisation coverage rate at the 8-month milestone. By year end this had reduced to 6.3 percentage points. The equity gap for Maaori is a significant risk and in an outbreak of vaccine preventable disease Maaori and Pasifika children will be disproportionately affected.



During the past year a number of factors such as COVID-19, community vaccine fatigue and the childhood immunisation workforce capacity being stretched, have impacted on access to families and services, resulting in delays to immunisation of tamariki. However, many children complete their primary series vaccinations outside of the immunisation target age range.

In December 2021, CM Health undertook a deep dive into childhood immunisation coverage and implemented an equity focussed recovery and business-as-usual acceleration plan to disrupt current service provision, and sustainably recover from decreasing immunisation rates and growing inequities of immunisation coverage for Maaori and Pasifika children, and pregnant and postnatal women. The COVID-19 pandemic and workforce shortages have presented some challenges in implementing new services but early signs of improvement look promising. In particular, one project is working with 20 Kohanga Reo Early Childhood Education Centres in Counties Manukau to provide tamariki and their whanau with tailored and integrated immunisation, and wrap-around health services.

Over 2022/23, Counties Manukau District will continue to work with PHOs and other health partners to seek improved and innovative ways of working to better meet the needs of whaanau and remove barriers to access.

Data source: National Immunisation Register Qlik report

Improved end of life pathways for patients and whaanau

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

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 Aged Residential Care 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.

Further to this, 421 link nurses have been trained within the Metro Auckland region since 2017. Link nurses act as champions within primary care and liaise between primary care providers and specialist palliative care services, to improve communication and co-ordination of care for patients with palliative care needs. 14 GPs with Special Interest (GPwSI) have been employed by local hospices to progress palliative care capability and resources within primary and residential care settings for accredited six-month rotations. GPwSI's are champions within the primary care workforce that will have expertise in both primary and palliative care.

An evaluation of the programme was commissioned through an external party and this evaluation was published in April 2021. The northern region is working closely with the hospices to review and implement recommendations from the review.

Healthy Services – better value for public health resources

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

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

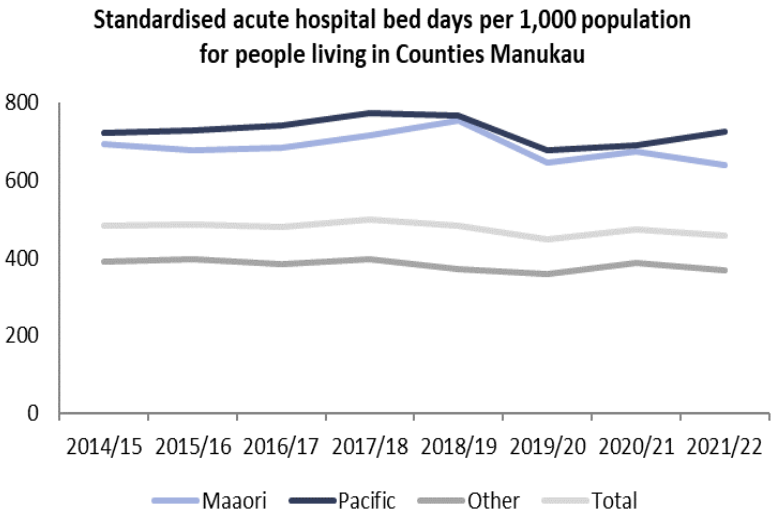
Reduction in acute hospital bed days

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

[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 is measured every 3 months for the preceding (rolling) 12-month period. Age-standardised to overall New Zealand 2018 Census Usually Resident population. Annual data presented is until end of June each year.

June 2022 results show that CM Health met the 2021/22 SLM Plan milestone for reducing the number of acute hospital bed days per capita for the Maaori population but not for the Pasifika population. This is a challenging measure to shift due to the wide variety of factors (including socioeconomic deprivation) that impact on this measure.



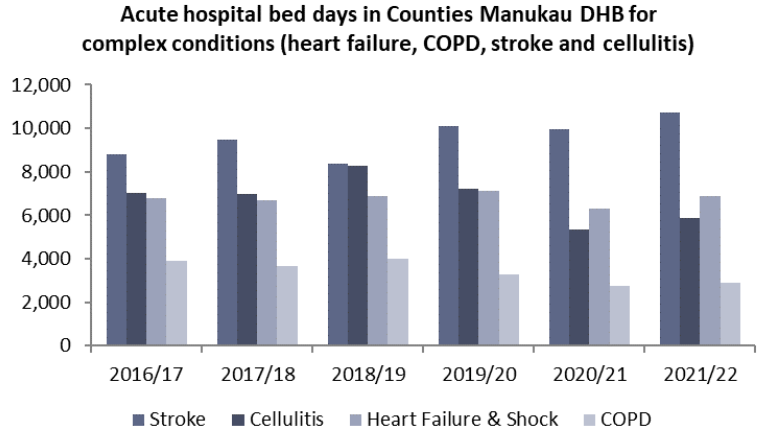
With COVID-19 restrictions lifting, winter illnesses such as respiratory infections are challenging capacity in both the primary and hospital sectors. Primary care is stretched with continuing workforce challenges, resulting in reduced rural, after hours and weekend clinics. Ongoing infection control measures affect workflow efficiencies and access acceptability. The immediate effect is a reduced number of appointments across the system. In June 2022 an emergency initiative to provide free GP visit and scripts over a long weekend (and the following weekend) provided short relief for emergency departments and was welcomed by the community. While this is not envisaged as a permanent solution, an upcoming review of the initiative will provide valuable learnings for the future.

Counties Manukau District will continue to focus on Maaori and Pasifika populations so those with ASH conditions can be better targeted for preventative care. Additional workforce and new or enhanced models of care focused on primary care can ensure team-based, culturally appropriate care is available to meet the immediate and longer-term needs of patients and avoid long term condition acute episodes and/or acerbations requiring hospitalisation. In addition, the Te Ranga Ora initiative and regional locality networks will seek co-designed care pathways to improve long-term condition care for Maaori and Pasifika whaanau.

Data source: Ministry of Health Performance Reporting[23]

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. There was a slight increase of stroke indicating cardiovascular disease management may have been compromised over lockdowns and with reduced General Practice accessibility to "care as usual". A recent community Cardiovascular Disease Risk Assessment (CVDRA) pilot found increasingly younger people with high risk factors for CVD, while CVDRA rates in General Practice has been difficult to maintain due to competing COVID-19 related activities. Treatment for cellulitis is now well established in the community using the Primary Options for Acute Care (POAC) model, which may explain the reduction in acute hospital bed days for this condition in 2020/21 and 2021/22.

[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).

Together with PHO partners, we are working to reduce the days patients spend in acute care by improving the delivery of preventative care for people in these categories of population. This includes targeted initiatives for Maaori and Pasifika for alcohol harm reduction, CVD management and flu vaccine uptake. COVID-19 pandemic response infrastructure and outreach increased uptake of the flu vaccine for Maaori and Pasifika patients who are unenrolled or do not engage with primary care.

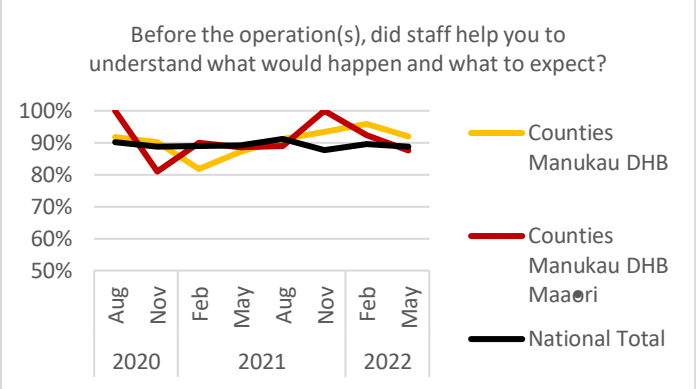
Data source: Ministry of Health Performance Reporting[24]

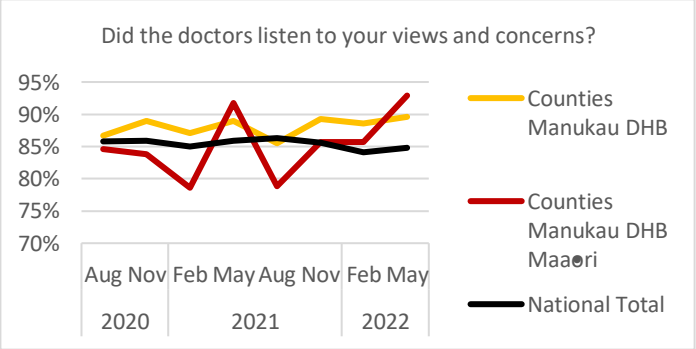
Improved and more equitable experience of care

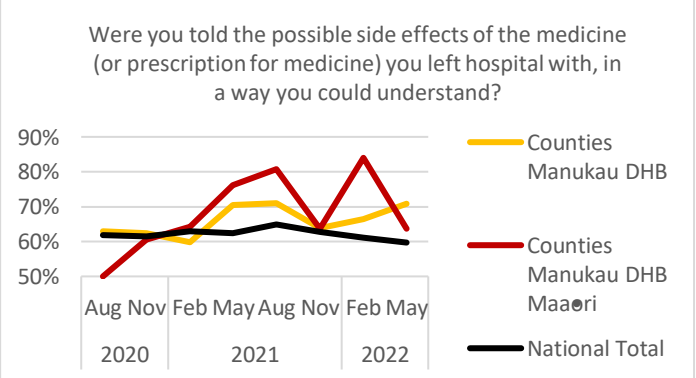
The Hospital Inpatient Patient Experience Survey (PES)

Understanding and improving a patient's experience is vital to improving patient safety, quality and enhancing health outcomes. The national Hospital Inpatient Experience Survey is coordinated by the Ministry of Health and provides insights from patients on what matters to them most during their hospital stay. Given health and wellbeing inequities are experienced by many Maaori patients and whaanau across New Zealand, the national survey is a useful tool to monitor the experiences of Maaori. The local and national benchmarking with our broader hospital population enables comparison of our performance against a range of care domains. Key themes measuring performance against these domains highlight where improvements are required to enhance patient experience. This information is vital to driving targeted improvement activities.

In 2021/22, during both the Delta and Omicron COVID-19 responses, patients continued to rate communication as the most important element of a good patient experience. Several examples over this time period show communication has improved in some clinical contexts, and in particular, pre-operative communication supporting patients for surgery has improved over time in relation to the national total (sustaining a rating above 90% for the year amidst COVID-19 pressures). There was also increased engagement with medical staff and the broader care team during this COVID-19 period. By year-end the broader Counties Manukau population rated their comfort at asking questions of the care team at least 7% higher than the national total. A total of 93% of Maaori patients compared to 85% nationally, said they felt comfortable asking questions of the care team. A similar end of year trend was seen in relation to doctor's engagement with patients.







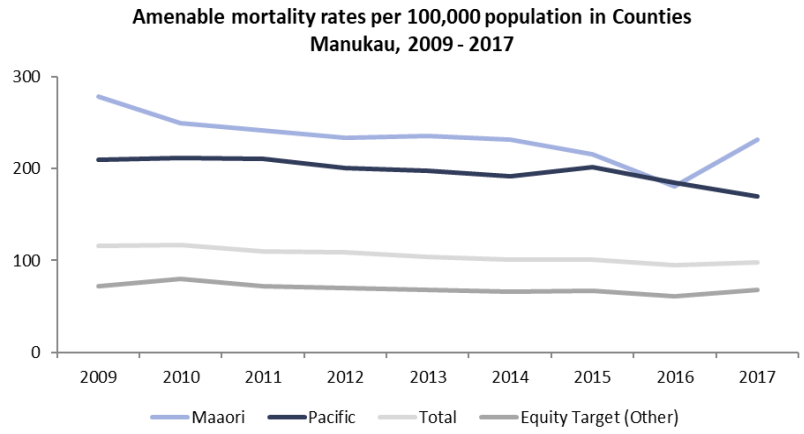
Key care elements at discharge from hospital persist as an area requiring further attention to increase patient ratings in both Counties Manukau and nationally. Communication regarding medication side effects at discharge sits at 60% nationally at the end of the reporting period. While the broader Counties score is higher at 71%, the Maaori rating has dropped to 64% at year end, after fluctuating across 2021/22.

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

[24] Data is to March of each year.

Reduced and more equitable amenable mortality rates

Targeting improvements in the leading causes of potentially preventable deaths



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

In 2021/22, CM Health continued to promulgate collaborative and coordinated approaches across metro Auckland. The SLM implementation group focused on improving the accuracy of regional reporting for Cardiovascular Disease Risk Assessment (CVDRA) priority populations. Community CVDRA was also successfully piloted at COVID-19 vaccination sites, and future events will utilise a newly developed web-based tool that automatically communicates results to General Practices. The metro-Auckland clinical indicators will also include atrial fibrillation and gestational diabetes data, following approval from the Regional Service Level Alliance Team.

The 2021/22, SLM Plan sets an annual cumulative reduction target of 5% for Maaori under age 50, 3% annual cumulative reduction for Maaori over age 50, 3% annual cumulative reduction for Pasifika under age 50, 5% annual cumulative reduction for Pasifika over age 50, and 3% annual reduction for the entire DHB population to be achieved by June 2030 (on 2017 baseline). This will be achieved through continued focus on improving smoking cessation and management of CVD, as well as a focus on the implementation of the Alcohol ABC programme (this is an evidence-based programme to decrease harm from excessive alcohol consumption). National-led initiatives like the proposal to limit the number of tobacco retailers and set nicotine limits will also support the achievement of this goal.

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

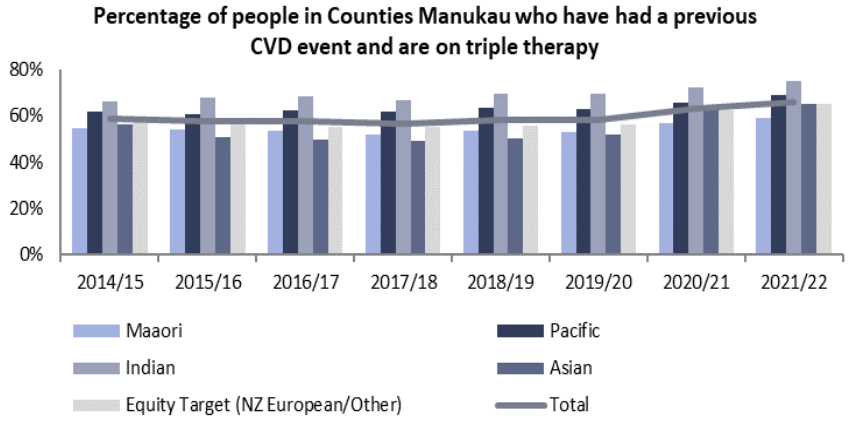
Key contributory measure: Better treatment of people with cardiovascular disease (CVD)

There is good evidence that for those with a previous CVD event, 'triple therapy' medicines can reduce the risk of future CVD events and death. Triple therapy is defined as statins, antiplatelet/coagulants, and blood pressure lowering medicines dispensed in at least three quarters of the year.[25]

In 2021/22, there has been an increase in the number of people on triple therapy. The focus remains on reducing inequity by improving CVD management for our population and for Maaori patients specifically, through both local and regional initiatives. Cardiovascular Disease Risk Assessments (CVDRA) for the newly eligible cohort of younger Maaori, Pasifika, and South Asian males and females, and integrating management of cardiovascular disease and diabetes, have been identified as key recovery priorities for metro-Auckland PHOs. The Regional CVD working group has done considerable work in supporting primary care to implement the new CVD risk assessment algorithms and to increase the accuracy of

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

identifying patients with a previous CVD event. There remain existing equity gaps in CVD risk assessment rates for Maaori but the new algorithms should have a positive impact for Maaori and Pasifika as the algorithms have been specifically configured for these groups.



COVID-19 has had a huge impact on CVDRA completions. Patients have been reluctant to see their GP for fear of catching COVID-19, and it was difficult for practices to undertake CVDRAs as part of business as usual during the Omicron outbreak, as they faced overwhelming demands for testing, vaccinating and managing COVID-19 in the community. This was further exacerbated by staffing recruitment and retention issues. To engage with the newly eligible cohort, who may not access General Practices regularly, COVID-19 pandemic response infrastructure was used to run a pilot for CVDRA in the community. A web-based tool was developed to support this successful pilot, with key features being:

- it is PHO and Practice Management System (PMS) agnostic, and can be used by NGOs such as Maaori and Pacific providers or the Heart Foundation
- it enables NHI and enrolment lookup
- the assessment can be started on site in a community setting and "parked" while waiting for lab results to be returned

In 2022/23, CM District will continue to pursue opportunities to improve coverage of CVDRA rates for Maaori, Pasifika and younger cohorts, support General Practices to improve CVDRA rates, and improve outcomes for patients with CVD and those with increased risk of CVD.

Primary care is also implementing processes to understand where preventative medications are not indicated, or why patients have declined to take them. This will support further targeted interventions such as addressing missed opportunities, patient education, clinical education, and improved communication between GPs and specialists.

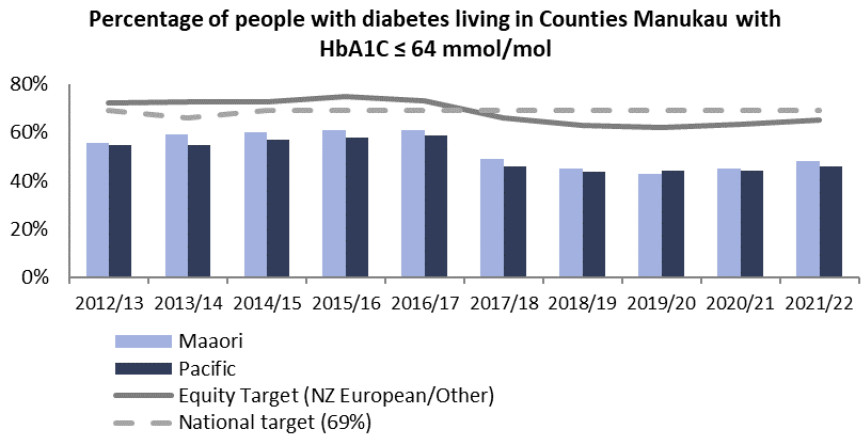
There is potential for improvement in CVD secondary prevention performance through further system integration, including strengthening stakeholder relationships (including cross-sectoral partnerships), comparing prescribing to dispensed data to identify more effective interventions to promote concordance with medication, and embedding a community pharmacist in General Practice teams to improve prescribing practices.

Data source: NRA CVD Prevention Medication Six Monthly Report[26]

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

CM Health has utilised the Quality Standards for Diabetes Care, which provides guidance for clinical quality service planning and implementation of equitable and comprehensive patient-centred care. CM Health has also aligned its priorities for diabetes with those previously identified in the Ministry of Health's *Living Well with Diabetes* plan, and more recently, the National Diabetes Action plan, which includes improving the number and percentage of patients with good glycaemic control (good control of blood sugar levels). Better glucose control for people with diabetes will reduce the progression of micro-vascular complications (e.g. chronic kidney disease and retinal disease). CM Health has used HbA1c≤ 64 mmol/mol, a measure of average blood glucose levels, as an indicator of good glycaemic control. The focus has also

[26] CVD Prevention Medication Report based on PHO enrolment for quarter four, CV Risk Assessment extracts and TestSafe dispensing data. Annual rates are based on data for 12 months until end March each year prior to 2020/21. 2020/21 and 2021/22 annual results are based on data for 12 months until end of December 2020 and 2021 respectively due to a reduction in the frequency of reporting.



been on appropriate cardiovascular risk management, and prevention and management of diabetes related complications such as albuminuria, neuropathy and retinopathy.

In 2021/22, the Long-Term Condition Clinical Governance Group continued monitoring and advising the podiatry, retinal screening, new medications/ medication intensification, pharmacy and gout, primary care diabetes education, and diabetes in pregnancy working groups. Key activities for 2021/22 include:

- In 2021 new diabetes medicines Empagliflozin and Dulaglutide became fully funded in New Zealand. A regional group was established to improve the uptake of new medication for diabetes by understanding and improving the utilisation of Empagliflozin and Dulaglutide and the characteristics of the patients and practices that have not been offered these medications. The intended outcome for the project is to apply the eligibility criteria for Empagliflozin and Dulaglutide to the metro-Auckland type 2 diabetic population to understand who is eligible for these medications, and from this eligible group determine who would benefit the most, as well as determine the impact that the introduction of these medications have had at a population level on HbA1c and microalbuminuria.
- The Diabetes Management Working Group focused on:
    - improving the accessibility and quality of nutrition support and foot care for people living in Counties Manukau.
    - point of care testing through pharmacies, medication intensification, and improving recall mechanisms.
    - improving communications around new medications by utilising different communication channels available in the community. There is impetus through the group to work with workforce prescribers (pharmacy advisors, nurse practitioners and pharmacists).
- As a continuum of the retinal screening data match project, monitoring and reporting of retinal screening was improved this year with the introduction of a Northern Region DHB Diabetic Retinal Screening Quarterly Report. A proposal was subsequently made to the Metro Auckland Clinical Governance Forum (MACGF) to include diabetic retinal screening indicators as part of the performance reporting to this group. Nesting diabetic retinal screening reporting alongside other diabetes indicators would ensure diabetic retinal screening is included in whole of diabetes care improvement activities.

In 2022/23, CM District is 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 team-based care, and delivering an effective self-management programme, with flexible self-management interventions and modalities, aimed at improving health literacy and equity.

Data source: Ministry of Health Performance Reporting[27]

Key contributory measure: Fiscal responsibility

District health boards (DHBs) existed to improve, promote and protect the health of the public and specifically the people that live in their districts. This was 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

[27] 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 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.

outcomes within available funding.

In 2021/22, the reported deficit is $71.647m (Budget $49.7m). The Year End audited underlying financial position was a deficit of $33.16m before one off adjustments of $6.95m upside for COVID-19 and $65m (Budget $20m) unfavourable expensed in the year to reflect the continued cost of non-compliance with the Holidays Act.

The favourable YTD variance of $16.6m does not reflect the continued unprecedented demand for acute services causing significant periods of over occupancy. This acute demand has had a significant impact on planned care and planned care recovery volumes, with the DHB unable to deliver these volumes lost as a direct result of the impact of COVID-19. During 2021/22, planned care recovery revenue has been lost due to procedures disrupted during these periods (not recovered by year end), this has been coded to COVID-19 as lost revenue of circa $1.5m.

The DHB's response to COVID-19 through 2021/22 has seen continued deployment of a significant number of DHB staff away from normal roles and a significant impact on staff sickness. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. Lower than expected savings from this programme in 2021/22 have been offset by vacancies and lower spend in other areas.

The result includes the favourable impact of delayed spend and unbudgeted one –off items including lower depreciation, higher interest received, lower bad debts, increased ACC revenue, higher annual leave balances and delayed implementation of additional capacity and priority initiatives, largely driven by the impact of COVID-19.

Funding for 2021/22 increased, which reflected a partial correction to our revenue in relation to the undercount of our population, however we have not seen the full correction which adequately accounts for our population. When we apply the per capita rate to the remaining estimated undercount, this factor alone amounts to circa $19.8m (Based on NHI number counts rather than Stats NZ estimates) in underfunding which has a significant impact on our ability to offer the full range of care relative to other DHBs and address some of our key clinical risk and equity concerns at scale. The effects of this undercount are compounded by the complexity of our population and its' accompanying social and healthcare needs – the PBFF does not adequately capture socio-economic drivers of ill-health, nor the compounding effects of the unequal distribution of long-term conditions. It is important to acknowledge the continuous and persistent undercounting of CM Health's population and the effect this had on our ability to meet our demand pressures, including implementing equity improvements on a large scale, and achieving sustainability.

Statement of Service Performance

This section presents CM Health's actual performance against the forecast outputs presented in our 2021/22 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 outcome's framework.

CM Health's 2021/22 results are based on our annual performance, unless otherwise specified.

Results are categorised based on the key below to demonstrate how far the result was from the target. This is important to demonstrate as although some measures were not achieved, the percentage difference is minor, while other measures are significantly off target. Numerators for the baseline and performance results have been included in the columns "20/21 Volume" and "21/22 Volume" where possible to provide context to final performance.

Key for 2021/22 results:

	Target met
	≤ 5 percent off target
	> 5 percent 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.

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

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 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	85%	90%	77%	55,006	44,357
	Maaori	84%		77%	17,642	14,328
	Pacific	87%		81%	18,549	14,231
	Asian	84%		74%	5,431	4,375
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking	Total	95%	90%	95%	364	277
	Maaori	95%		96%	230	175
Percentage of babies living in smokefree homes at six weeks postnatal[28]	Total	48%[29]	45.6%[30]	55.2%[31]	2,117	2,726

[28] Denominator is sourced from the Ministry of Health NHI register.
[29] Results for 2020/21 are for the period July 2020-December 2020.
[30] The target represents a 2% relative increase from baseline (December 2020) as per the 2021/22 Metro Auckland SLM Improvement Plan.
[31] Results for 2021/22 are for the period July 2021-December 2021.

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
	Maaori	26%		28.6%	226	288
	Pacific	35%		44.7%	469	618
Percentage of babies fully or exclusively breastfed at 3 months[32]	Total	48%	70%	49%	1,574	1,684
	Maaori	35%		39%	196	207
	Pacific	44%		42%	377	388
Percentage of children identified as obese in the B4 School Check programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	100%	95%	100%[33]	370	445
	Maaori	99%		99%	106	104
	Pacific	100%		100%	186	258
	Other	100%		100%	78	83
Number of eligible adult service users engaged in the Green Prescription programme each year	Total	3,046	4,000	2,804		
Immunisation Services						
Proportion of 8-month-olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Total	87%	95%	85%	7,353	7,463
	Maaori	72%		66%	1,226	1,185
	Pacific	87%		84%	2,183	2,099
	Asian	98%		96%	2,330	2,461
Proportion of eligible boys and girls fully immunised with HPV vaccine	Total	61%	75%	43%	6,242	4,292
	Maaori	55%		41%	1,115	835
	Pacific	60%		43%	2,067	1,454
	Asian	73%		48%	1,534	1,005
Percentage of people aged over 65 years who have had their flu vaccinations[34]	Total	63%	75%	57%	44,304	41,650
	Maaori	53%		47%	2,735	2,510
	Pacific	76%		65%	6,370	5,736
	Asian	57%		50%	9,386	8,944
Health Screening						
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months[35]	Total	65%	70%	64%	39,202	53,372
	Maaori	59%		58%	4,447	6,358
	Pacific	73%		69%	7,357	10,357
	Other	64%		64%	27,368	36,657
Proportion of women aged 25 – 69 years who have had a cervical smear in the last three years	Total	65%	80%	59%	100,264	94,587
	Maaori	55%		46%	11,941	10,930
	Pacific	63%		54%	18,973	17,867
	Asian	62%		58%	31,312	30,146
	Other	75%		70%	38,038	35,644

[32] Data reported six-monthly. Baseline and results are for the period July – December, as reported in March (quarter three). Denominator is sourced from the Ministry of Health NHI register.

[33] 2021/22 results are for the period 8 June 2021 to 7 June 2022 which aligns to the Ministry of Health reporting of this data.

[34] Results are for the period 1 March to 30 September each year to reflect New Zealand's influenza flu season and aligned immunisation programme for people aged 65 and over.

[35] Baseline performance is as at quarter three – two years ending 31 March 2021. Note the age range for this performance measure was adjusted this financial year. The 2021/22 result and volumes are for women aged 45-69 (two years ending 30 June 2022).

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
Percentage of four year olds receiving a B4 School Check[36]	Total	90%	90%[37]	49%[38]	7,957	4,259
	Maaori	93%		55%	1,792	958
	Pacific	96%		49%	2,349	1,249
	Other	86%		48%	3,816	2,052
Percentage of Year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS[39]assessment	Total	71%[40]	95%	63%[41]	2,510	2,100
	Maaori	78%		73%	786	690
	Pacific	69%		55%	1,175	865
	Asian	65%		64%	353	302

Early detection and management services

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

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

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

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
Primary Health Care Services						
Percentage of population enrolled in a PHO[42] *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 in parentheses.*	Total	98% (97%)	90%	95%	567,892 (568,401)	583,335
	Maaori	86% (96%)		95%	81,608 (84,250)	84,294
	Pacific	112%[43] (96%)		95%	142,392 (135,377)	147,650
	Asian	90% (97%)		92%	153,215 (159,898)	159,572
Percentage of newborns enrolled in general practice by 3 months[44]	Total	87%	85%	82%	7,434	7,273
	Maaori	68%		60%	1,292	1,201
	Pacific	83%		77%	2,170	1,970
	Other	100%		95%	3,972	4,102

[36] 2021/22 results are for checks completed during the financial year 8 July 2021 – 7 July 2022. Results show progress against the total eligible population.
[37] The 90% Ministry of Health target is based on the percentage of the eligible population who receive a B4 School Check.
[38] In 2021/22 COVID-19 had a large impact on the B4 school check programme due to lockdown resulting in the cancellation of clinics and closure of preschools and schools. During the Omicron surge high absenteeism amongst pre-school children and staff also had an impact, along with some families being hesitant about COVID-19, and not open to having visitors in their homes.
[39] This is an interview-based assessment tool for adolescents about home education/employment activities/drugs/sexuality/suicide.
[40] 2020/21 baseline results are for the calendar year 1 January 2020 – 31 December 2020. HEEADSSS assessments are delivered during the school term.
[41] 2021/22 results are for the calendar year 1 January 2021 – 31 December 2021
[42] Census data is usually used for population denominators. We are aware that the 2018 census data was inaccurate in counting our population. Health Service Utilisation (HSU) population data is more accurate, and therefore a decision has been made to only present HSU data for 2021/22. 2021/22 results represent PHO enrolment data from January 2021 to December 2021. For 2020/21 baseline both census and HSU data is provided. HSU results are in parentheses, with the numerator taken from PHO enrolment data up to January 2021.
[43] As the Census historically has underestimated the Pacific population, the 2020/21 baseline for Pacific is greater than 100%.
[44] Enrolments are based on the National Enrolment Service (NES). Populations are based on the National Immunisation Register (NIR).

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
Amenable mortality rate per 100,000 population[45]	Total	97.8[46]	≤98.1[47]	96.0[48]		
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	83%	90%	77%	144,856	129,963
	Maaori	78%		70%	20,364	17,559
	Pacific	81%		76%	36,476	33,092
	Other	85%		80%	88,016	79,312
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)[49]and no inequity	Total	53%	60%	55%	18,947	19,435
	Maaori	45%		48%	2,513	2,572
	Pacific	44%		46%	6,268	6,534
	Other	63%		65%	10,166	10,329
Percentage of patients with CVD risk >20% on dual therapy (prescribed)[50]	Total	52%	70%	56%	2,498	2,935
	Maaori	46%		51%	570	652
	Pacific	56%		60%	1,060	1,111
	Asian	56%		62%	327	440
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)[51]	Total	64%	70%	66%	6,419	6,702
	Maaori	57%		59%	869	879
	Pacific	66%		69%	1,718	1,832
	Asian	69%		71%	1,169	1,264
Oral Health Services						
Proportion of children under 5 years enrolled in DHB-funded community oral health services[52]	Total	93%	≥95%	97%	38,760	40,864
	Maaori	75%		82%	7,573	8,039
	Pacific	95%		101%[53]	11,229	11,974
	Asian	N/A[54]				
	Other	100%		101%	19,968	20,851
Percentage of enrolled children Caries Free at age 5 years[55]	Total	38%	46.9%[56]	41%	1,065	1,325
	Maaori	28%		31%	187	203
	Pacific	24%		27%	221	278
	Other	53%		56%	657	844
	Total	0.55		0.53		

[45] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[46] Baseline is at 2017 as there is a two and half year delay before mortality data is released. It takes several years for some coronial cases to return verdicts. As a result, the Ministry is unable to release provisional cause of death information until around two years after the end of the year. Reports are made available annually with a rolling five years' data set.
[47] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2022.
[48] Result is at 2018, this is a draft (provisional) result at time of publishing.
[49] Note that CM Health currently uses the PHO 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.
[50] The reporting for this performance measure is based on prescribing data rather than dispensed data (as stated in the CMH's 21/22 Annual Plan) due to a change in the available data source. Baseline and 2021/22 results are based on the latest available CVDRA scores and includes those patients on dual therapy with a CVD risk >15%. The change in the CVD risk threshold from >20% to >15% reflects the latest algorithm for determining CVD risk, which was updated in 2018.
[51] Both the 2020/21 baseline and 2021/22 results are for 12 months to December for 2020 and 2021 respectively.
[52] 21/22 results are for the 2021 calendar year. Results for this measure are reported annually as at quarter three.
[53] The Ministry of Health's population denominators for DHBs' oral health reporting for the year to December 2021 are derived from Statistics New Zealand's latest population projections for the 2021 calendar year (based on Census 2018 information).
[54] The Asian data was not available in the Ministry of Health data set provided for quarter three in 2020/21 or 2021/22.
[55] 21/22 results are for the 2021 calendar year. Results for this measure are reported annually as at quarter three.
[56] The 2021/22 target has been updated after CM Health's 2021/22 Annual Plan was finalised and represents the latest Ministry of Health oral health targets for 2021/22 (released October 2021).

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
Mean Decayed Missing or Filled Teeth (DMFT) Score for Year 8 Children [12/13 years][57]	Maaori	0.59	≤0.65[56]	0.71		
	Pacific	0.83		0.67		
	Other	0.34		0.35		
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years[58]	Total	54%	≥85%	59%	19,814	22,219
Diagnostics						
Proportion of patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	87%	95%	70%	16,610	13,992
	MRI	74%	90%	33%	10,127	8,428
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	100%	90%	95%	835	870
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	65%	70%	50%	9,076	7,477
Ambulatory Sensitive Hospitalisations						
Ambulatory Sensitive Hospitalisation (ASH) rate in children aged 0-4 years per 100,000 population	Total	5,952	6,062	5,864		
	Maaori	5,308	5,421	5,711		
	Pacific	8,907	10,440	9,181		
Sudden Unexpected Death of an Infant (SUDI)						
SUDI deaths per 1,000 live births	Total	1.00[59]	≤0.1[60]	1.00[61]	42	N/A
	Maaori	2.21		2.21	23	N/A
Pharmacy						
Number of prescription items subsidised	Total	9,254,736	N/A[62]	9,031,923[63]		

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

[57] 21/22 results are for the 2021 calendar year. Results for this measure are reported annually as at quarter three.
[58] Baseline and results are for the calendar year (2020 and 2021 respectively).
[59] 2020/21 Result data source: This result is unavailable as relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 15th data report **2015-2019**.
[60] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025.
[61] 2021/22 Result date source: This result is unavailable as it relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 15th data report 2015-2019.
[62] Measure is demand driven – not appropriate to set target.
[63] 2021/22 result is for the 12-month period 1 April 2021 to 31 March 2022.

- 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			2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
Mental Health							
Percentage of population who access mental health services[64]	Age 0-19 years	Total	3.4%	3.9%	3.3%	5,880	5,803
		Maaori	4.9%	5.8%	4.5%	1,991	1,832
		Pacific	N/A	2.5%	2.1%	N/A	1,036
		Other	2.8%	3.4%	3.0%	3,889	3,971
	Age 20-64 years	Total	3.6%	3.9%	3.5%	12,971	12,609
		Maaori	8.1%	9.0%	7.4%	4,180	3,976
		Pacific	N/A	4.0%	3.3%	N/A	2,558
		Other	2.9%	3.1%	2.8%	8,791	8,633
	Age 65+ years	Total	2.2%	2.2%	2.1%	1,514	1,544
		Maaori	2.7%	3.0%	3.0%	142	164
		Pacific	N/A	2.5%	2.3%	N/A	209
		Other	2.1%	2.1%	2.1%	1,372	1,380
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[65]		Total	87%	95%	89%		
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 compulsory treatment orders[66]		Total	130	N/A	123		
		Maaori	325	301	302		
Elective Services							
Planned Care Measure 1: Planned Care Interventions	Inpatient treatments		19,935	20,185	15,893		
	Minor interventions		15,378	10,611	15,179		
	Non-surgical alternatives		57	326	43		
Acute Services							
Readmissions – acute readmissions to hospital[67]	0-3 days		2.4%	≤2.3%	2.5%		

[64] This data is an annual rolling rate from April – March each year. 'Pacific' targets for all age groups added in 2021/22. 'Other' targets for all age groups added in 2020/21.
[65] Baseline and 21/22 results are for the period 1 April – 31 March.
[66] Baseline and 21/22 results are for the period 1 April – 31 March
[67] 2020/21 baseline and 2021/22 results for acute readmissions are standardised results for 12 months to end of March.

Performance Measure		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
	0-28 days	10.7%	≤10.7%	10.5%		
Inpatient Average Length of Stay[68]	Acute LOS	2.83 days	2.30 days	2.96 days		
	Elective LOS	1.44 days	1.50 days	1.44 days		
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		85%	95%	76%	81,248	69,452
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	Total	87%	90%	80%	375	290
Cardiac Services						
Percentage of high risk patients who receive an angiogram within 3 days of admission	Total	72%	>70%	60%	637	573
	Maaori	70%		56%	61	61
	Pacific	69%		57%	153	106
	Other	73%		61%	423	406
Stroke Services[69]						
Percentage of potentially eligible stroke patients thrombolysed		16%	10%	23%	96	120
Quality and patient safety						
Percentage of admissions with a hospital acquired complication[70]		2.3%	<2.3%	2.5%[71]	2,496	1,858
Rate of falls with major harm per 1,000 bed days		0.03	<0.04	0.04	11	12
Percentage of inpatients (aged 75+) assessed for risk of falling		92%	90%	82%	1,070	550
Rate of S. aureus bacteraemia (SAB) per 1,000 bed days		0.12	<0.09	0.14	40	44
Compliance with good hand hygiene practice[72]		86%	80%	86%	42,406	27,768
System Level Measures						
Acute hospital bed days per capita (standardised)	Maaori	667	686[73]	638		
	Pacific	687	718	726		

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.

[68] Local target. Baseline and 2021/22 results are 12 months to end of March.
[69] Note that stroke services baselines and results are provided for the full financial 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).
[70] Data is sourced from the Health Round Table coded discharge data.
[71] The 2021/22 result is for the period 1 July 2021 to 31 March 2022.
[72] Both baseline and 21/22 result are the full year compliance rate. The volume figures for this measure represent the total number of hand hygiene (i.e. hand washing) events observed from all random audits conducted for the full year.
[73] This measure targets a 3% relative reduction from baseline (December 2019) and is included in the 2021/22 Metro Auckland SLM Improvement Plan.

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		2020/21 Baseline	2021/22 Target	2021/22 Result	20/21 Volume	21/22 Volume
Age Related Residential Care (ARRC) [74]						
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		97%	95%	93%	3,896	3,872
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		93%	90%	94%	871	771
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[75]		98%	95%	98%	3,589	3,421
Assessment, Treatment and Rehabilitation Services						
Number of older people that have received in-home strength and balance retraining services	Aged 65+	389	1,118	202		
Number of older people that have received community / group strength and balance retraining services	Aged 65+	580	1,400	291		
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	2,922 places	2,325 places	3,705 places		
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 50-74	448	600	467		
	Aged 75-84	302	300	326		
	Aged 85+	279	300	272		
Palliative care[76]						
Number of Palliative Pathway Activations (PPAs) in Counties Manukau		180	552	95[77]		
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals		149	552	73		

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

[75] This measure is reported a quarter in arrears for both baseline and the 2021/22 result e.g. the 2021/22 result for the financial year is up to and including quarter three 2021/22.

[76] The following measures are part of the regional Better Palliative Care Outcomes Service, which has been implemented and delivered in the Auckland Region from 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.

[77] 2021/22 palliative care results are significantly less than our target and previous year's volumes and is due to the significant pressure on both primary care (PC) and age-related residential care (ARRC) providers with the COVID-19/winter response, and ongoing workforce challenges.

COVID-19 Impact on Services

Service Impacts

Counties Manukau's response to the COVID-19 pandemic shifted from prevention and containment earlier in the pandemic to 'living with COVID' during 2021/22. This shift aligned with the Government's introduction of the COVID-19 Protection Framework.

Both the Delta outbreak from August to December 2021 and the Omicron surge in February and March 2022 provided unique challenges for CM Health and the wider care sector. In mid-August 2021 Auckland moved to Alert Level 4 Lockdown for five weeks after Delta was detected in the community, and Alert Level 3 restrictions remained thereafter for several months. During this period, members of the public generally stayed away from healthcare facilities, with presentations to Middlemore Hospital Emergency Department remaining very low, and the proportion of outpatient appointments conducted without the patient being physically present increasing significantly. The lockdown and COVID-19 restrictions particularly impacted the performance of services like the B4 School Check programme where access to children in the community was restricted due to the cancellation of clinics and closure of preschools and schools.

The Omicron surge throughout February and March 2022 put significant strain on health services across the system due to high acute presentations and increased inpatient demand, coupled with unprecedented rates of unplanned leave across the health workforce. At the peak of the Omicron surge Middlemore Hospital operated with five inpatient wards dedicated to inpatient COVID-19 occupancy.

High acute demand continued during winter, driven by further surges in COVID-19 community transmission and winter respiratory illnesses and influenza. This significantly impacted acute occupancy and limited the ability to maintain planned care activity.

Throughout the year projects across the organisation were postponed, including research, evaluation, and improvement initiatives.

Staff Impacts

Staff who were previously deployed to support the Managed Isolation Facilities were supported to return to roles across the organisation when these facilities closed. Some staff remain seconded to support the Northern Regional Health Coordination Centre (NRHCC), Whanau HQ and community testing and vaccination.

Staffing pressures have been impacted further by the implementation of the vaccine mandate, high underlying vacancies, and a competitive labour market caused by opportunities in other parts of the health sector and borders reopening. Conversely, New Zealand's ongoing border restrictions and gradual reopening hampered access to international staff for services reliant on this resource pool.

Where possible work from home policies were implemented during Auckland's lockdown and periods of high community transmission.

Planned Care Impacts

The impact on patients waiting for treatment as a direct result of the COVID-19 pandemic is significant and will require a multi-year recovery plan. Throughout the past year extended periods of lockdowns across Auckland under Alert Levels 4 and 3 limited the capacity to deliver planned care activity both internally and through outsourcing. Counties Manukau has had to prioritise acute demand during Omicron surges and amid significant unplanned leave across the wider healthcare workforce. Planned care activity has also been significantly less efficient due to testing and infection prevention and control measures necessitated by the pandemic. By year-end the number of inpatient surgical procedures delivered was approximately 20% below target, although there was an improvement in the number of minor procedures performed.

Waitlists for both patient clinician consults and treatment are anticipated to grow whilst Counties Manukau continues to deliver lower than usual levels of planned care activity. The cost of recovery of these volumes is expected to be higher than current national or base prices due to lost productivity within the district and across external providers. The recovery will

largely be limited by the available shared capacity across districts and in the private market, however, this is also impacted by ongoing workforce pressures.

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health (the Ministry) uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Counties Manukau DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[78]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

[78] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[79] (HSU 2021 vs HSU 2020)

Year[80]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	13.32%	14.07%
2021/2022	77.27%	81.65%
Total	90.58%	95.72%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 90.58%, compared with 95.72 % using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Counties Manukau DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[81]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[82]
2020/21	104,785	67,006	0	0	171,791
2021/22	394,029	407,035	284,406	2,554	1,088,024
Total	498,814	474,041	284,406	2,554	1,259,815

By 30 June 2022, a total of 1,259,815 COVID-19 vaccinations had been administered, of which 86% were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore, deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

[79] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[80] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.
[81] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[82] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[83]

Age group	Primary course				
(years)[84]	Dose 1	Dose 2	Booster 1	Booster 2	Total[85]
0 to 11	36,889	17,253	0	0	54,142
12 to 15	34,868	33,580	20	0	68,468
16 to 19	29,002	29,309	9,076	1	67,388
20 to 24	34,590	35,220	17,383	4	87,197
25 to 29	38,123	39,084	20,813	9	98,029
30 to 34	39,236	40,541	25,502	23	105,302
35 to 39	33,983	35,707	25,953	19	95,662
40 to 44	29,679	31,536	25,234	26	86,475
45 to 49	27,864	29,597	24,928	46	82,435
50 to 54	26,876	29,643	26,433	96	83,048
55 to 59	22,453	25,891	25,957	121	74,422
60 to 64	17,160	21,463	23,382	180	62,185
65 to 69	8,590	13,494	19,570	346	42,000
70 to 74	6,099	10,161	15,978	481	32,719
75 to 79	3,855	6,664	11,078	485	22,082
80 to 84	2,678	4,496	7,368	400	14,942
85 to 89	1,401	2,308	3,737	217	7,663
90+	683	1,088	1,994	100	3,865
Total	394,029	407,035	284,406	2,554	1,088,024

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

[83] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[84] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[85] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

COVID-19 people vaccinated by age group during 2021/22[86]

Age group[87] (years)	Partial [88]		Primary course [89]			Booster course		
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	31,576	29%	15,006	14%	0	0%	0	0%
12 to 15	30,409	84%	26,874	74%	0	0%	0	0%
16 to 19	30,346	90%	30,242	90%	4,918	42%	0	0%
20 to 24	34,827	81%	35,537	83%	17,298	46%	0	0%
25 to 29	36,981	76%	38,042	78%	19,907	48%	0	0%
30 to 34	40,114	78%	41,548	81%	24,937	54%	0	0%
35 to 39	35,233	79%	36,853	82%	25,920	63%	0	0%
40 to 44	31,124	78%	32,977	83%	25,675	69%	0	0%
45 to 49	27,700	75%	29,467	80%	24,471	73%	0	0%
50 to 54	27,798	74%	30,272	80%	26,623	76%	94	3%
55 to 59	23,301	66%	26,630	76%	25,751	80%	113	3%
60 to 64	18,991	63%	22,768	76%	24,144	85%	173	4%
65 to 69	10,595	43%	15,581	64%	20,212	88%	332	7%
70 to 74	6,561	34%	10,832	56%	16,539	91%	468	9%
75 to 79	4,333	33%	7,479	57%	12,036	93%	495	12%
80 to 84	2,910	33%	5,004	57%	7,935	94%	410	15%
85 to 89	1,628	37%	2,711	62%	4,224	97%	236	16%
90+	820	35%	1352	57%	2276	103%	114	14%
Total	395,247	64%	409,175	66%	282,866	68%	2,435	8%

[86] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[87] Age groupings in this table reflect age of the persons at end of financial year.
[88] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[89] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[90] administered by ethnicity[91] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	115,171	121,346	91,155	254	327,926
European/other	122,531	132,725	110,683	2,019	367,958
Maaori	54,231	51,998	24,799	140	131,168
Pacific peoples	99,572	98,282	55,570	119	253,543
Unknown	2,524	2,684	2,199	22	7,429
Total	394,029	407,035	284,406	2,554	1,088,024

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as:

Maaori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Maaori and New Zealand European, the person is counted as Maaori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[92]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated(12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	104,017	72%	115,750	80%	90,922	73%	207	4%
Maaori	50,348	76%	50,636	76%	24,596	52%	130	5%
European /other	115,199	67%	128,850	75%	109,826	77%	1,973	12%
Pacific peoples	91,483	74%	95,980	77%	55,307	58%	103	2%
Unknown	2,624	78%	2,953	87%	2,215	65%	22	9%
Total	363,671	71%	394,169	77%	282,866	68%	2,435	8%

[90] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[91] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.
[92] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Maaori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Maaori and New Zealand European, the person is counted as Maaori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	137,575	95%	136,248	95%	90,928	73%	207	4%
Maaori	58,376	88%	56,052	85%	24,596	52%	130	5%
European /other	158,321	92%	156,601	91%	109,827	77%	1,973	12%
Pacific peoples	112,512	91%	109,641	88%	55,308	58%	103	2%
Unknown	3,688	109%	3,571	105%	2,216	65%	22	9%
Total	470,472	92%	462,113	91%	282,875	68%	2,435	8%

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Maaori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Maaori and New Zealand European, the person is counted as Maaori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ:[93]

[93] https://www.stats.govt.nz/methods/population-statistics-user-guide.

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [94]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

[94] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there are an estimated 618,969 health service users in the HSU 2021. This is an increase of 26,526 people from the HSU 2020 (an approximate 4.5% increase), and 17,669 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.[95]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Maaori	88,663	99,000	10,337
Pacific peoples	156,721	134,700	22,021
Asian	173,928	176,800	2,872
European/other	196,067	190,800	5,267
Unknown	3,590	0	3,590
Total (Note 1)	618,969	601,300	17,669

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 618,969. This is 17,669 above the Stats NZ total projected population of 601,300 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison.

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[96]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Maaori	86,271	96,700	10,429
Pacific peoples	150,139	132,300	17,839
Asian	157,761	175,300	17,539
European/other	196,109	190,500	5,609
Unknown	2,163	0	2,163
Total (Note 1)	592,443	594,800	2,357

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 592,443. This is 2,357 below the Stats NZ total projected population of 594,800 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[97] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

[95] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021.
[96] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.
[97] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health.

'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Counties Manukau DHB by age group at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	0
20 to 29	1
30 to 39	3
40 to 49	5
50 to 59	12
60 to 69	15
70 to 79	19
80 to 89	32
90+	23
Total	**110**

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Counties Manukau DHB by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	
Asian	10
European/other	40
Maaori	16
Pacific peoples	44
Unknown[98]	0
Total	**110**

[98] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

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)	**272,520**	**285,428**	**1,713,790**	**211,277**	**2,483,015**
*Budget (includes agency revenue)**	*49,125*	*304,351*	*1,541,972*	*215,701*	*2,111,149*
Personnel Costs	21,195	814	961,552	11,903	995,464
Outsourced Services	885	34	134,567	497	135,983
Clinical Supplies	6,632	255	149,414	3,724	160,025
Infrastructure and Non-Clinical Supplies	1,273	49	156,476	715	158,513
Other (includes agency costs)	242,535	284,276	383,428	194,438	1,104,677
Total Costs	**272,520**	**285,428**	**1,785,437**	**211,277**	**2,554,662**
*Budget (includes agency costs)**	*49,125*	*304,351*	*1,591,693*	*215,701*	*2,160,870*
Deficit	-	-	**(71,647)**	-	**(71,647)**
Budget	**-**	**-**	***(49,721)***	**-**	***(49,721)***

*Agency revenue and costs for the year amounts to $62.5m.

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)			
	2020/21		2021/22	
	Budget	Total Actual	Budget	Total Actual
Total Appropriations	1,645,763	1,649,765	1,816,318	1,816,318

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 Health

Counties Manukau Health's Asset Portfolio

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

Table 1 Asset Portfolios

Asset Portfolio	Asset Purpose	Quantity/Capacity	Book Value 30 June 2022
Property	To enable the delivery of high quality health services through the provision of facilities that meet accreditation requirements	• 723 adult medical, surgical, rehab, Assessment Treatment and Rehabilitation, community medical inpatient beds • 65 paediatric inpatient beds • 43 Intensive Care Unit/High Dependency Unit/Paediatric Intensive Care Unit/Coronary Care Unit/Cardiac Step Down Unit beds • 110 maternity beds, 25 gynaecology beds, 7 assessment rooms and 30 delivery suites (hospital & community) • 80 acute mental health beds • 67 community mental health beds • 146 ED cubicles & short stay beds • 24 operating theatres; 14 + 2 procedure rooms at Middlemore and 10 + 2 procedure rooms at Manukau Surgical Centre • 14 owned community facilities • 24 leased community facilities • 16 owned dental clinics and 48 mobile unit sitepads	$941m buildings, plant and infrastructure & land with a value of $275m
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 • 35,408 (25,221 in-hospital & 10,187 community-based) items[99]	$39.6m Net Book Value and Original cost was $113m (Estimated Replacement cost is now around

[99] 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.

			$202m)[100]
ICT	To enable the delivery of high quality health services through the availability of timely, accurateand accessible patient and business information	Regionally shared hardware and software. 11,705 users within Counties Manukau Health	$59m healthAlliance C-Class shares; $3.9m in FPIM rights & $0.6m hardware & software; $15m work in progress (WIP) as at 30 June 2022

Property Assets

Property Assets Performance Measures

Services operated by CM Health are largely delivered from seven inpatient facilities and 24 leased or owned outpatient and community health facilities across the district. Manukau Health Park 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 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.

[100] Note the estimated replacement value includes minor assets and accessories that are not captured on the financial fix asset register.

Table 2 Property Asset Performance Measures

Asset	Measure	2020/21 Target	2020/21 Actual	2021/22 Target	2021/22 Actual
Medical beds[101] *Occupancy % for Medical beds at7 am*	Utilisation	90%	100.9%	90%	89.7%[102]
Surgical beds[101] *Occupancy % for Surgical beds at7 am*	Utilisation	90%	89.6%	90%	77.8%[102]
Operating Theatres[103] *The percentage of theatres utilisation is calculated based on the total turnaround time, cumulative turnover and the theatre session duration*	Utilisation	90%	74.7%	90%	72.2%
Building compliance requirements *Percentage of buildings used that possess a valid Building Warrant of Fitness (BWOF)*	Condition	100%	100%	100%	99.0%
Seismic Compliance[104] *Percentage of buildings assessed as being earthquake prone (<34%New Building Standard (NBS) is classified as earthquake prone)*	Functionality	0%	7.7%	0%	11.5%
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 onthe total asset available time minusthe unplanned downtime and divided by the total asset available time.*	Utilisation	99%	99.0%	99%	98.4%

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

[101] As result of the IPM upgrade in February 2021, occupancy against open beds will no longer be available. Therefore, occupancy against budgeted beds is reported annually for both measures (Medical beds and Surgical beds) from FY2020/21 onwards. There were 238 days in FY2020/21 and 36 days in FY2021/22 where occupancy rate of medical services had reached 100% or above against budgeted capacity, as for surgical services there were 2 days in FY2020/21 and 0 days in FY2021/22 where the occupancy rate had reached 100% or above.

[102] There was a reduction in the number of patients presented in FY2021/22, which is 9% less compared to volume in FY2020/21. There was an increase in the budgeted bed number by 9 for FY2021/22 compared to FY2020/21 and as the denominator increases the occupancy decreases, especially with reduction on inpatient events.

[103] It was approved by the ELT that the calculation method for theatre utilisation has been changed from method three (i.e. (all cases duration + cumulative turnover)/ session duration) to method one (i.e. all cases duration/ session duration) from 2020/21 onwards. The theatre utilisation results are calculated based on calendar year.

[104] Assessed buildings include buildings that had been assessed by ISA, DSA, IEP, desktop and formal structural assessments. The increasing number of Earthquake Prone Buildings (EPB) in FY2021/22 compared to FY2020/21 is due to the results from detailed assessments conducted in FY2021/22 that override the initial assessment results for some of the assessed buildings.

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	2019/20 Target	2019/20 Actual	2020/21 Target	2020/21 Actual	2021/22 Target	2021/22 Actual
MRI	Availability/Uptime	>98%	>98%	>98%	>98%	>98%	98%
	Service Level/ Utilisation	>85% elective patients waiting & scanned within 42 days	52% [1]	>85% elective patients waiting & scanned within 42 days	75% [1]	>85% elective patients waiting & scanned within 42 days	33% [1]
CT Scanners	Availability/Uptime	>98%	>98%	>98%	>98%	>98%	98%
	Service Level/ Utilisation	>95% elective patients waiting & scanned within 42 days	70% [2]	>95% elective patients waiting & scanned within 42 days	84% [2]	>95% elective patients waiting & scanned within 42 days	70% [2]
Angiography (Catheter Lab)	Availability/Uptime	>98%	99%	>98%	99.2%	>98%	99.49%
	Utilisation	85%	84% [3]	85%	86.2% [3]	85%	88% [3]
All non-fixed assets (Minor Assets) [4]	Current Warrant of Fitness/Certificate of Compliance [4]	95%	94.2% (average) 93.5% (at 30 June)[5]	95%	93.5% (average) 90.8% (at 30 June)[5]	95%	87.2% (average) 85.59% (at 30 June)[5]
	Asset Performance [6]	69% (Tentative)	32% (or 6,517) assets did not meet the APM target of 69%. 68% (or 14,099) assets met APM target of 69%.	69% (Tentative)	38% (or 8,653) assets did not meet the APM target of 69%. 62% (or 14,251) assets met APM target of 69%.	69% (Tentative)	26% (or 6,532) assets did not meet the APM target of 69%. 74% (or 18,689) assets met APM target of 69% [7].

(1) MRI results for 2021/22 have not achieved the six-week target, and there has been a reversal of the significant gains seen over the previous two FYs following a collaborative improvement programme between the MRI team and the Ko Awatea improvement team. The reasons for this are multifactorial:

- Staffing issues – reduced staffing through 2021/22 due to COVID-19 (closed borders) and difficulties with recruiting from within New Zealand.
- Increased repatriation from ADHB of CMDHB patients - which although funded, add to the volumes needing to be done by a service already struggling to meet demand.
- Increase in demand for high tech imaging over the last two FYs with no increase in resources (machine availability or staffing).

(2) CT results are down from 2020/21 - however improvement was seen over the latter part of 2021/22. As with MRI the reasons for the 2021/22 results are multifactorial:

- Staffing issues – staffing shortages through 2021/22 due to COVID-19 (closed borders) and difficulties with recruiting from within New Zealand.
- Added demand from inpatient services for CT, increased repatriation from ADHB of CMDHB patients
- Increase in demand for high tech imaging over the last two FYs with no increase in resources (machine availability or staffing).

(3) Catheter Lab utilisation is based on 8 hour per day session times, Monday to Friday – noting the after-hours and weekend volumes are managed regionally through Auckland DHB.

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

(5) A result of 92% was achieved at the end of July 2021, however, the gains made were lost due to the redeployment of the limited Clinical Engineering resources to assist with COVID-19 resilience work undertaken by Counties Manukau, an increase in vacancies and difficulties in filling vacancies, as well as the impact that absenteeism from COVID-19 and the flu had on the small workforce.

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

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

(7) Excludes community-based equipment.

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 2019/20 – 2021/22 versus target for 2021/22:

Asset type	Service Level Agreement Target	2019/20 Actual	2020/21 Actual	2021/22 Target	2021/22 Actual
Tier 1 Information systems (Critical)	• No more than 10 Tier 1 systems per annum less than 99.8% available • Average availability per annum >99.8% • Target outage recovery 4 hours	99.99%	99.99%	99.8%	99.996%
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	99.99%	99.99%	99.8%	99.996%

ICT Assets – Condition

Asset Type	Service Level Agreement Target	Indicator	2020/21 Target	2020/21 Actual	2021/22 Target	2021/22 Actual
End User Devices – Asset Age	% of devices compliant with asset age replacement policy	Condition	>75%	86.90%	>75%	91.38%
End User Devices – Security	% of End User Devices (SOEs) compliant with security update policy	Condition	>80%	94.34%	>80%	52.35%
Software (Application) - Condition	% of Apps with installed version no older than n-1	Condition	>55%	72.37%	>55%	78.21%
Software (Application) – Service Interruption	% of Apps not experiencing SLA breaches ('service interruptions') over a 12-month period	Condition	>80%	98.57%	>80%	82.45%
Technology Platforms (Physical and Virtual) – Condition	% of Windows systems have been checked and patched, across all PROD and non-PROD environments	Condition	>75%	93%	>75%	91.50%
Technology (Tier 1 and Tier 2 systems) – Service Interruptions	Number of SLA breaches ('service interruptions') recorded against application asset over a 12 month-period	Condition	<20	3.075	<20	3.93

ICT Asset – Functionality

Asset Type	Service Level Agreement Target	Indicator	2020/21 Target	2020/21 Actual	2021/22 Target	2021/22 Actual
Software (Application) – Redundancy or Resiliency	% asset architected for redundancy or resiliency	Functionality	>30%	52.32%	>30%	51.80%
Software (Application) – Supportability	% asset supportable under TIER 1 SLA guidelines	Functionality	>30%	61.84%	>30%	60.48%

ICT Asset - Utilisation

Asset Type	Service Level Agreement Target	Indicator	2020/21 Target	2020/21 Actual	2021/22 Target	2021/22 Actual
Technology (Remote Platform) Utilisation	% staff have accessed clinical/non-clinical system platforms remotely	Utilisation	>35%	58.41%	>35%	60.92%

Good Employer

CM Health is one of the largest employers in the Counties Manukau area and we take pride in employing the local community, employing staff that reflect the local population, and 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 7,361 FTE in more than 100 different jobs at 20+ sites across the region, CM Health serves an estimated population of 601,490 people of which 96,000 are of Maaori decent and 132,020 are Pasifika.

In June 2017, the CM Health Board approved the establishment of Maaori and Pacific workforce targets with a goal that by 2025 CM Health will have a workforce that reflects the population it services. This would mean increasing the Maaori workforce by an additional 714 FTE and increasing the overall percentage of Maaori employed by CM Health from 7% (538) to 17% (1,251) by 30 June 2025.

CM Health's Pacific workforce would need an additional 600 FTE, increasing the overall percentage of Pasifika employed by CM Health from 15% (1,093) to 23% (1,693) by 30 June 2025.

The Maaori and Pacific staff FTE at CM Health over the years

	2013	2015	2017	2019	2021	2022
CM Health Maaori Staff FTE	314	320	316	491	532	538
CM Health Pacific Staff FTE	538	611	670	1,008	990	1,093

Key Focus Areas

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

The six key focus areas for Maaori Workforce Development are:

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

Learning

The DHB offers a number of learning opportunities for staff. In 2021, to help facilitate our people to access these opportunities, we launched 'myLearning', a newly created intranet page designed to act as a one-stop-shop for accessing a variety of CM Health's learning programmes, education and development resources, and e-Learning.

Governance of work force, employees and safety

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

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

Diversity and Equal employer

Disability

CM Health's Disability Action Plan 2019 – 2022 set out five key priorities and outcomes that encourages proactive responses to people who have a disability, who identify as neurodiverse, or who have additional mental health needs and/or chronic health conditions:

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.

In 2021, The Accessibility Tick organisation found that Counties has continued to show a commitment to disability inclusion and accessibility sufficient to retain the use of the Accessibility Tick. The tick demonstrates our ongoing commitment to disability inclusion and accessibility, yearly assessments are undertaken by an Accessibility Tick Assessor.

CM Health continues to work towards being a disability confident organisation by:

- Maintaining and strengthening our partnership with Workbridge to reduce barriers for job seekers with disabilities and to identify potential applicants.
- Increasing employment opportunities through CM Health's job advertisements and careers webpage that encourages job seekers with disabilities to apply.
- Ongoing use of an internal Employment Disability Support Services (EDSS) contact email for job seekers, employees, and managers. This service provides Counties employees with a safe, confidential place to seek support, advice, and guidance about issues relating to disability and accessibility in the workplace.
- Commitment to updating communication and information through both internal and external avenues for employees and managers about disability, accessibility, and support services.
- Ensuring people with additional mental health needs, who identify as neurodiverse or have chronic health conditions are also included in accessibility and are acknowledged for the benefits they bring as employees.

Pay equity contribution to national work

The pay equity proposed settlement for administration and clerical staff was ratified in April 2022. This was a momentous occasion to bring about pay equity for our administration and clerical workforce, which is predominately made up of women.

Work is well underway to implement the settlement agreement and it is expected to be completed by the end of September 2022.

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

- By ensuring our workforce reflects the community we serve
- By removing barriers that prevent people from reaching their full potential
- By being an organisation where patient and staff safety comes first
- By living our values – Kind (Manaakitanga), Valuing Everyone (Whakawhanaungatanga), Together (Kotahitanga) and Excellent (Rangatiratanga) - we create a culture in which people act as a team, working together toward common goals.

Gender Pay

The status of gender pay is:

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

The Seven Key Elements

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

1. Leadership, accountability and culture

Organisational culture and values

At CM Health, our Strategic Goal is to achieve health equity for our community. To deliver this important (and often challenging) mahi, we must work together to create a great organisational culture. Evidence shows that one of the best ways to achieve a great workplace culture, and deliver excellent patient outcomes, is to remember our purpose and passion for why we work at CM Health and what's important to us.

In 2020/21, the organisation's People Strategy was refreshed. The purpose of CM Health's People Strategy is to outline a culture and workforce that enables Health Equity, and that makes Counties a better place to work. We conducted a series of workshops with over 250 employees, managers, and mana whenua to seek their input and ideas.

Values Visibility

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

Annual Staff Values Awards

These awards promote the importance of living our values and recognise staff for doing so. The nomination process gives staff the opportunity to nominate each other for demonstrating values-aligned behaviour. The awards are hosted and presented by the CEO, signifying the importance we place on recognising excellence.

Employee Wellbeing

CM Health continues to recognise the importance of supporting employees' physical and mental health, and strives to support employees to stay well. We have introduced or progressed several employee wellbeing initiatives:

1. Wellbeing Index: Our membership of the Health Roundtable Workforce Wellbeing Improvement Group provides us with access to the Well-Being Index, a self-assessment tool provided via an app, with linked resources to help staff make decisions about actions to improve their wellbeing. This has been rolled out sequentially to physicians, nurses, midwives, HCAs, Allied Health, and Managers/Executive Leaders. De-identified data is accessible by our clinical champions and fed back to teams and Executive Leadership. Other benefits of our membership of this group include collaboration and sharing of ideas with other hospitals who belong to the group in New Zealand and Australia, along with educational opportunities.
2. Schwartz Rounds are held every two months and continue to be popular since they were introduced at the end of 2020. Each of our rounds to date has been attended by around 90 staff and feedback has been overwhelmingly positive. The Rounds are open to all CM Health staff and provide an opportunity to reflect on the shared social and emotional experience of working in healthcare.
3. A Wellbeing Calendar. The calendar schedules different wellbeing activities and sessions through the year, including our participation in relevant external initiatives such as Mental Health Awareness Week and Pink Shirt Day.
4. A Wellbeing Steering Group meets quarterly to co-ordinate work across the hospital and improve communication about wellbeing resources.
5. Bespoke Team Wellbeing Sessions: These sessions are designed to equip our employees with a practical ranges of wellbeing resources and tools to support their personal wellbeing.
6. Financial Wellbeing Sessions and 1:1 Financial Health Checks have been delivered online to provide practical and tailored advice and support to help employees with their financial wellbeing needs. These are delivered by BNZ, Rutherford Rede and the Retirement Commission.

7. The Seasonal Wellbeing pages on Paanui were established in 2021 with a focus on providing a seasonal approach to wellbeing. Each season, we introduce wellbeing content linked to that season. This content provides employees with an extensive range of wellbeing resources which they can access at their convenience.

8. Internal communications: work continues to ensure Wellbeing pages on Paanui updated and relevant.

We plan to introduce the Stress First Aid (SFA) programme next year. SFA is a self-care and peer support framework, with a set of supportive actions designed to preserve wellbeing, prevent further harm and promote recovery from negative impacts of stress at work. The model was developed by the National Centre for PTSD in the USA, for those in occupations like military, fire and rescue and police. It has been adapted for healthcare workers, who particularly need this now.

Speak Up - Me koorero atu

We refreshed and updated Speak Up including updating our documents and processes, the intranet pages, and the Champion recruitment process. We plan to relaunch Speak Up next year and to train additional Speak Up Champions.

Leadership Development

We place emphasis on leadership development and support our people leaders at all levels through formal programmes and provide the relevant tools and resources. The leadership programmes are:

People Leader Essentials

This is designed for new frontline people leaders or leaders who are new to CM Health and aim to provide the fundamentals of being a CM Health manager.

Leading for Success

Leading for Success is designed for mid-level leaders. The programme was launched in 2021 with the aim to strengthen the leadership and whole-of-system knowledge and skills to deliver safe care and equity outcomes. The first two cohorts (of 16 participants began in 2021 with additional cohorts planned. It is delivered through a series of facilitated and interactive learning sessions and 1:1 coaching over five months. About half is delivered via external experts, with the balance being facilitated by CM Health colleagues. The key sections of content are:

- People & Culture, including Personal Leadership, and Leading People and Teams
- Te Tiriti o Waitangi & Health Equity
- Business and Operational, including Project Management, and Financial Management
- Quality Improvement

Team and People Development

This year we expanded our offering of Team and People Effectiveness workshops to teams at CM Health. Numerous teams, involving 100s of employees, have requested the Organisational Development team to facilitate workshops to help them improve their culture, work more effectively together, and better live our values in our work. We have worked with many departments including Women's Health, Emergency Department, Spinal Unit, Surgical, Anesthesia and Perioperative Services, Kidz First, Security, Pharmacy, and Laboratories.

We have tailored workshops around several topics including Psychological Safety, Courageous Conversations, Leading Through Change, and Civility – Working Effectively Together. The content of these sessions deliberately reinforces the values, and acts as an antidote to bullying and harassment.

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 a Recruitment policy that prioritises all Maaori candidates to roles. All candidates who identify as Maaori will be considered, prioritised and interviewed if they meet the requirements for the role. If they are unsuccessful at interview stage, they will be provided with specific written and verbal feedback from Hiring Managers. 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.

The CM Health interview process, including interview guides, has been reviewed and changes made to support the cultural requirements of our candidates. We are reviewing the content of our current Recruiting for Results sessions for Managers and will be adding more content around bias, diversity, cultural contexts, disability etc.

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

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

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

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

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

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

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

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

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

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

CM Health is now supporting 12 Health Science Academies (HSAs) with over 600 Pacific secondary students engaged. These Academies continue to achieve higher success rates for Pacific Achievement in NCEA and have been a key vehicle for increasing Pacific student participation in NCEA Science.

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

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

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

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

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

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

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

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 the past three years, a further 109 Maaori have been employed at CM Health raising the number of Maaori employees from 561 employees (as at 30 June 2019) to 670 employees (as at 30 June 2022). This has lifted the overall percentage of Maaori employed at CM Health from 5% (as at 30 June 2019) to 7% (as at 30 June 2022).

We employ 3,414 FTE nursing and support staff. 14% (466 FTE) are Pasifika and CM Health wants to grow that to 21% by 2025. We are proud to be the employer of the largest Pasifika nursing and support workforce in New Zealand and possibly the world.

6% (198 FTE) of our nursing and support staff are Maaori. CM Health's target is to lift that to 17% (580 FTE) by 2025. That makes us the third largest employer of Maaori nurses amongst 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 Pasifika. 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 organisation that enables our people to be fully engaged and reach their full potential. At CM Health we are deeply committed to the success and growth of every employee throughout their career with us.

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

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

1. Active partnership, each participant is responsible for making performance development practices as effective as possible
2. Helping both the manager and the employee assess how performance and development fits into the bigger picture
3. 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:

1. Growth in their current role
2. Advancement towards future opportunities
3. Enhancement of their engagement at work.

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

Nursing

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

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

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

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

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

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

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

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

Exit interviews

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

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

4. Flexibility and work design

Workplace flexibility

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

Covid-19 to provide staff and Managers with a framework and tools to enable and support flexible work arrangements where appropriate.

We continue to refresh tools and information available to our staff and leaders that enable flexibility to attract and retain talent.

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

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

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 can 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. For example, it is common for staff to request a return to work from parental leave initially on a part time basis before resuming full time duties.

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, except for 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
- 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.

The health and safety of our workers is important to us and we have over 250 health and safety representatives (HSRs) who carry out fabulous work assisting the Occupational Health and Safety team in the proactive work they undertake and providing support for their work colleagues in their management of health, safety and wellbeing. As a way of thanking our HSR's we have refreshed our H&S recognition program. This year we asked HSR's to present a H&S initiative they have undertaken with their work colleagues. The quality of the activities presented was exceptional and all teams who put forward an entry received a reward.

6. Harassment and bullying prevention

Organisational Commitment

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

Speak Up

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

CM Health is committed to creating a culture of openness, fairness and accountability where we hold each other to account for acting in accordance with our values and in the best interests of our employees and patients. Besides their managers, employees have access to other sources of support to help them raise and deal with the issue, for example, access to an independent trained Speak Up Champions; Raise (Employee Assistance Programme), Health Integrity Line, 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 with the aim of ensuring a safe and healthy workplace for our workers. The support provided by OHSS includes Occupational Health, Health and Safety and Injury Management.

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

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

The Occupational Health team carries out clinical and assessment functions for CM Health workers including pre-employment screening, blood and body fluid exposure assessments, contact tracing, health surveillance, manager and self-referrals, general wellness and vaccination clinics, including the 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. Respiratory mask fit testing is completed by the Occupational Health Service for workers using the N95 masks as part of their workflow. This process is fully embedded and continuous assessments are made to check the ongoing fitting of masks. The Occupational Health team has been instrumental in coordinating COVID-19 related work in the last 2 years across CM Health.

The Occupational Safety team support managers and workers when managing workplace safety. The managers H&S online self-assessment was completed in late 2021 and the refreshed H&S audit and monitoring program will commence in 2022. An induction program provides the most up to date H&S information for our new starters. Ongoing H&S communications to our workers include monthly topics sent to HSRs and the addition of Safety Alerts to notify workers of critical risks resulting from incidents and inspections.

Health and Safety Representatives (HSRs) play an essential role in keeping workers and visitors safe, educating their workmates on related issues, and ensuring procedures and processes are followed correctly. We have over 250 HSRs. Training is provided to HSRs and we work with this group to obtain worker feedback and improve our processes. From 2021, additional specialised training programs were offered to HSRs who have completed the initial HSR training. This training includes Hazard and Risk Management and Incident Investigation and Prevention as standard sessions and newly agreed training for 2022 includes Fatigue Management and Positive Workplace H&S Culture for HSR's. The training options are increased each year to provide ongoing development opportunities to HSR's.

In addition to managing health and safety, the Health and Safety team work on various projects in line with our known critical risks. The approach assists us to engage with our work groups to ensure the actions we take consider trends in incidents, including near misses and risks and ensure continuous improvement, 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 (Raise) is a contracted service provided by OHSS. EAP services are also offered on site and with facilitated debrief sessions after critical incidents have occurred as well as offering coaching and support to teams through group sessions.

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

Wellness

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

Our membership of the Health Roundtable Workforce Wellbeing Improvement Group provides us with access to the Well-

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

Schwartz Rounds are held every two months and continue to be popular since they were introduced at the end of 2020. Each of our rounds to date has been attended by around 90 staff and feedback has been overwhelmingly positive. The Rounds are open to all CM Health staff and provide an opportunity to reflect on the shared social and emotional experience of working in healthcare.

We plan to introduce the Stress First Aid (SFA) programme. SFA is a self-care and peer support framework, with a set of supportive actions designed to preserve wellbeing, prevent further harm and promote recovery from negative impacts of stress at work. The model was developed by the National Centre for PTSD in the USA, for those in occupations like military, fire and rescue and police. It has been adapted for healthcare workers, who particularly need this now.

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:

1. Breastfeeding in the workplace
2. Harassment
3. Code of Conduct
4. Privacy
5. Social Media policy
6. Conflict of Interest
7. A Safe Way of Working
8. 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 Health Workforce

What our workforce looked like by age, gender and ethnicity

Of the total workforce in 2021/22, women comprised 80% (7,406) and men 20% (1,879).

As at June 2022, 60% of the total workforce is less than 44 years of age. Our employee data also highlights an ethnically diverse workforce.

Age brackets	Percentage of all employees
Under 25	7%
25 – 29	13%
30 – 34	16%
35 – 39	14%
40 – 44	10%
45 – 49	9%
50 – 54	9%
55 – 59	9%
60 – 64	8%
65 – 69	4%
70+	1%
Date of Birth Not Specified	0.01%

Gender	Headcount	Headcount in %	Average Age
Female	7,406	79.76%	41.59
Male	1,879	20.24%	41.97
Grand Total	**9,285**		

Ethnicity	FTE	FTE in %	Headcount	Headcount in %
Asian	3,011	41%	3,687	40%
Maaori	538	7%	670	7%
Other	2,564	35%	3,309	36%
Pacific	1,092	15%	1,408	15%
Unknown	156	2%	211	2%
Grand Total	**7,361**		**9,285**	

What our workforce looked like by employee group

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

	FEMALE		MALE	
Occupational Groups	Headcount	Average of Salary	Headcount	Average of Salary
Allied Health	1,234	$74,602	298	$74,198
Management and Administration	1,081	$78,232	195	$105,448
Medical	584	$174,184	560	$194,149
Nursing	4,014	$77,441	548	$77,201
Support Personnel	493	$55,937	278	$63,885
Grand Total	**7,406**	**$83,021**	**1,879**	**$111,549**

Financial Statements for the year ended 30 June 2022

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Counties Manukau DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Counties Manukau District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Counties Manukau District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson

Acting Chair

Hon Amy Adams

Board member

Vanessa Thornton

Interim District Director
Counties Manukau

Timneen Taljard

Acting Chief Financial Officer
Counties Manukau

Dated: 13 March 2023

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Revenue				
Patient Care Revenue	2	2,449,896	2,079,176	2,046,793
Interest Revenue		1,375	230	600
Other Revenue	3	31,744	31,743	30,450
Total Income		**2,483,015**	**2,111,149**	**2,077,843**
Expenditure				
Personnel costs	4	995,464	850,994	821,130
Depreciation and amortisation expense	13/14	42,264	45,695	40,872
Outsourced services		135,983	117,687	123,156
Clinical supplies		142,534	131,145	136,922
Infrastructure and non-clinical expenses		85,299	71,719	76,343
Other District Health Boards		302,287	300,723	283,667
Non-health board provider expenses		802,390	595,995	595,658
Capital Charge	5	28,539	23,511	24,986
Interest expenses		-	242	-
Other expenses	6	19,902	22,978	18,935
Total expenditure		**2,554,662**	**2,160,870**	**2,121,669**
Deficit		**(71,647)**	**(49,721)**	**(43,826)**
Other comprehensive revenue				
Revaluation of Land	13/19	-	-	86,228
Revaluation of Buildings	13/19	381,616	-	-
Total Other comprehensive revenue		**381,616**	-	**86,228**
Total comprehensive revenue (expense) for the year		**309,969**	**(49,721)**	**42,402**

Statement of Changes in Equity
For the year ended 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Balance 1 July		**575,495**	**575,495**	**520,068**
Deficit for the year		(71,647)	(49,721)	(43,826)
Other Comprehensive revenue		381,616	-	86,228
Total comprehensive revenue		**309,969**	**(49,721)**	**42,402**
Capital contributions from the Crown		21,169	60,789	13,446
Repayment of capital to the Crown		(419)	(419)	(419)
Movement in restricted funds		4	-	(2)
Balance at 30 June	19	**906,218**	**586,144**	**575,495**

Explanations of major variances against budget are provided in note 24.

The accompanying notes form part of these financial statements.

Statement of Financial Position
As at 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Assets				
Current Assets				
Cash and cash equivalents	7	89,218	(22,626)	19,177
Debtors and other receivables	8	250,248	108,496	108,496
Inventories	10	12,793	11,586	11,586
Prepayments		5,731	2,900	2,899
Non-Current Assets held for Sale	11	9,906	5,320	5,320
Total current assets		**367,896**	**105,676**	**147,478**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	59,093	66,015	58,015
Property, plant and equipment	13	1,329,305	1,022,722	949,468
Intangible assets	14	18,699	3,028	12,443
Other Non-Current Assets	9	2,461	2,344	2,344
Total Non-Current assets		**1,409,558**	**1,094,108**	**1,022,270**
Total assets		**1,777,454**	**1,199,784**	**1,169,748**
Liabilities				
Current liabilities				
Creditors and other payables	15	363,834	185,730	201,680
Borrowings and overdraft	16	298	279	265
Employee entitlements	17	466,646	371,748	335,804
Total current liabilities		**830,778**	**557,757**	**537,749**
Non-current liabilities				
Employee entitlements	17	37,576	39,386	39,385
Provisions	18	1,245	1,095	1,095
Borrowings and overdraft	16	1,637	1,532	1,811
Creditors and other payables	15	-	13,870	14,214
Total non-current liabilities		**40,458**	**55,883**	**56,505**
Total liabilities		**871,236**	**613,640**	**594,254**
Net assets		**906,218**	**586,144**	**575,495**
Equity				
Crown equity	19	475,924	515,545	455,174
Accumulated deficits	19	(431,771)	(409,845)	(360,124)
Revaluation reserves	19	861,224	479,607	479,608
Other reserves		-	-	-
Trust funds	19	839	835	835
Total Equity		**906,218**	**586,144**	**575,495**

Explanations of major variances against budget are provided in note 24.

The accompanying notes form part of these financial statements

Statement of Cash Flow
For the year ended 30 June 2022

	Notes	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		2,241,499	1,916,245	1,894,709
Other		165,444	194,321	175,469
Interest received		1,375	230	600
Payments to suppliers		(1,410,208)	(1,240,886)	(1,220,427)
Payments to employees		(866,280)	(830,994)	(789,690)
Capital charge		(28,539)	(23,511)	(25,149)
Interest Payments		(101)	(50)	-
Goods and services tax (net)		12,164	-	(546)
Net cash flow from operating activities		**115,355**	**15,355**	**34,966**
Cash flows from investing activities				
Receipts from sale of property, plant, and equipment		-	9	-
Purchase of property, plant, equipment and intangible assets		(65,432)	(117,536)	(55,252)
Acquisition/roll over of investments		(353)	-	(727)
Movement in Restricted Funds		(4)	-	(2)
Net cash flow from investing activities		**(65,789)**	**(117,527)**	**(55,981)**
Cash flows from financing activities				
Repayment of capital to the Crown		(419)	(419)	(419)
Capital Contributions from the Crown		21,169	60,789	13,446
Proceeds from Borrowings		(274)	-	-
Net cash flow from financing activities		**20,475**	**60,370**	**13,027**
Net increase/(decrease) in cash and cash equivalents		**70,041**	**(41,802)**	**(7,988)**
Cash and cash equivalents at the start of the year	7	19,177	19,176	27,165
Cash and cash equivalents at the end of the year	7	**89,218**	**(22,626)**	**19,177**

Explanations of major variances against budget are provided in note 24.

Equipment totalling $133k (2021: $2.1m) were acquired by means of finance lease during the year.

The accompanying notes form part of these financial statements.

Reconciliation of net deficit to net cash flow from operating activities

	Actual 2022 $000	Actual 2021 $000
Net deficit	**(71,647)**	**(43,826)**
Add/(less) non-cash items		
Loss on Disposal of Assets	35	81
Write off of WIP	1,011	632
Impairment of Debtors	(1,935)	(1,339)
Depreciation and amortisation expense	41,424	40,872
Impairment of Intangibles	840	-
Interest in Car Park	(117)	-
Total non-cash items	**41,258**	**40,246**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(139,815)	(46,043)
Inventories	(1,208)	(281)
Creditors and other payables	156,630	36,394
Income in advance	953	17,549
Employee entitlements	129,184	30,927
Net movements in statement of financial position items	**145,744**	**38,546**
Add/(less) items classified as investing or financing activities	-	-
Net cash flow from operating activities	**115,355**	**34,966**

Explanations of major variances against budget are provided in note 24.

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Statement of Accounting Policies

Reporting Entity

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

The financial statements of CMDHB as at and for the year ended 30 June 2022 comprise CMDHB and its interest in associates and jointly controlled entities.

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

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

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

The financial statements for CMDHB are for the year ended 30 June 2022, and were approved for issue by the Te Whatu Ora Health New Zealand Board on 13 March 2023.

Basis of Preparation

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Maaori Health Authority (Te Aka Whai Ora) to monitor the state of Maaori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Counties Manukau DHB's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

Key considerations are set out below:

Holidays Act

As at 30 June 2022 the DHB has a provision of $225.4m for Holidays Act non-compliance (an increase of $63m during 2021/22). Remediation of the Metro Auckland DHB's Holidays Act liability is expected to commence in the 2023 calendar year. Remediation will require full cash support from the Treasury.

COVID-19 costs

CMDHB would require continued support (monthly payments) to fund reasonable costs associated with the response, establishment and implementation of COVID-19 related programs.

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 operations as usual. These forecasts include the need to intermittently access the DHB's overdraft facility. The DHB is maintaining a watching brief, particularly in regard to implications of COVID-19 costs not funded.

Statement of compliance

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

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

Measurement base

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

Presentation currency and rounding

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

Changes in accounting policies

There have been no new standards, amendments and interpretations issued and effective, which are relevant to the DHB, applied in the 30 June 2022 financial statements, aside from amendment to PBE IPSAS 2 Cash Flow Statements.

New Amendment Applied

An amendment to PBE IPSAS 2 Cash Flow Statements 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. The information required by this amendment has been disclosed in Note 16.

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 for the 30 June 2022 financial statements are:

PBE IPSAS 41 Financial instruments

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information would need to be disclosed on those judgements that have the most significant impact on the selection, measurement, aggregation and presentation of service performance information.

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.

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 multiyear funding agreements.

ACC Contract revenues

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

Rental income

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

Capital charge

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

Interest expense

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

Salaries and wages

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

Leases

Finance leases

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

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

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

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

Finance, Procurement and Information Management System (FPIM)

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

CMDHB holds:

- an intangible asset for the cost of capital invested by CMDHB in the FPIM application. This is amortised over 14 years and amortisation commenced in the 2019/20 year;
- an intangible asset for the cost of capital invested by CMDHB in the share based FPIM asset. This will be amortised over 5 years when the asset is brought into use in October 2020;
- an intangible asset for the cost of capital invested by CMDHB in the FPIM central implementation costs. This will be amortised over 12.75 years when the asset is brought into use in October 2020 and
- a prepayment for the costs paid in relation to the core build of the FPIM Hardware. This will be recognised as an expense over a five-year period from October 2020.

Health System Catalogue (HSC)

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

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

CMDHB holds:

- a prepayment for the costs paid in relation to the HSC. This will be recognised as an expense over a 10-year period from when the National Catalogue goes live (forecast during the 2022/23 year).

Amortisation

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

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

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

Impairment of Property, Plant and Equipment and Intangible Assets

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

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term entitlements

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

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit in the plan will affect future contributions by individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in Note 4.

Provisions

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

Provisions are not recognised for future operating losses.

Restructuring

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

ACC Partnership Programme

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

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

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

Equity

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

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

Revaluation reserves

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

Trust funds

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

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

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

Cost allocation

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

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

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

Critical accounting estimates and assumptions

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

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

Land and buildings revaluations

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

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

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

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

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

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

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

Retirement and long service leave

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

Holiday's Act provision for non-compliance

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

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

The DHB has exercised its judgement on the appropriate classification of leases.

Agency relationship

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

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

Comparative Figures

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

Impact of COVID-19 on the DHB

For the 2021/22 financial year the vast majority of costs incurred by CM Health have been reimbursed. We continue to work with the region and Ministry of Health to improve the accuracy and transparency of the COVID-19 financial reporting to enable consistent treatment across the sector.

All decisions were formally minuted and retrospective endorsements were 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.

The impact of the DHB's response to COVID-19 has seen deployment of DHB staff away from normal roles during times of resurgence. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's operational and strategic programmes, most notably planned care and the DHBs financial sustainability programme resulting from reduced organisational capacity to engage in sustainability projects and planning. Lower than expected savings in 2021/22 have been offset by vacancies and lower spend in other areas.

COVID lockdowns and surges during the financial year significantly impacted our ability to proceed with the planned capital plan. The Board and Government approved additional COVID capital funding during the financial year to address the immediate need for facility modifications to accommodate increased acute COVID patient admissions. As a result, significant resources were deployed to focus on COVID capital priorities, which delayed other projects.

CM Health has assessed the impact of COVID-19 on all balance sheet accounts. Any material impacts have been disclosed in the relevant notes to the financial statements.

2. Patient care revenue

	Actual 2022 $000	Actual 2021 $000
Health and disability services (MOH contracted revenue)	2,309,557	1,904,617
ACC contract revenue	33,524	32,259
Revenue from other district health boards	79,330	78,943
Other patient care related revenue	27,485	30,974
Total patient care revenue	**2,449,896**	**2,046,793**

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 $62.5m (2021: $59.4m).

3. Other revenue

	Actual 2022 $000	Actual 2021 $000
Donations and bequests received	1,496	2,330
Other revenue	28,601	26,457
Rental revenue	1,647	1,663
Total other income	**31,744**	**30,450**

Material items included in Other revenue are Retail Pharmacy revenue $11.23m (2021: $9.87m), New Zealand Medical Treatment Scheme funding $2.33m (2021: $3.68m) and Radiology Services $4.27m (2021: $2.55m).

4. Personnel costs

	Actual 2022 $000	Actual 2021 $000
Salaries and wages	839,189	764,190
Contributions to defined contribution schemes	27,242	26,013
Increase in liability for employee entitlements	129,033	30,927
Total personnel costs	**995,464**	**821,130**

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 2022, the DBP Scheme had a past service loss of $0.6m (1.7% of the liabilities) (2021: loss $1.26m (2.2% of the liabilities)) - this amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSA – 39.

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

5. Capital Charge

The DHB pays a half-yearly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the months of June and December. The capital charge rate levied during the year was 5% at 30 June 2022 (2021: 5%).

6. Other expenses

Other expenses include:	Actual 2022 $000	Actual 2021 $000
Audit fees – audit of financial statements – current year	332	265
Audit fees – under-provision prior year	-	10
Audit fees – other audit services *	-	-
Operating leases expense	15,485	13,833
Finance Lease expense	175	99
Impairment of debtors	2,328	3,539
Board and committee members fees and expenses	536	476
Loss on Disposal of Property, Plant & Equipment	35	81
Impairment of WIP	1,011	632
Total other expenses	**19,902**	**18,935**

* During the year Audit New Zealand provided other audit services for Probity Assurance totalling $34k. These costs have been capitalised to the relevant capital projects.

Non-cancellable operating lease commitments

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

	Actual 2022 $000	Actual 2021 $000
Not later than one year	6,747	8,644
Later than one year and not later than five years	11,371	12,157
Later than five years	1,038	806
Total Non-cancellable operating leases	**19,156**	**21,608**

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

The twenty-one (2021: twenty) various buildings which CMDHB occupies under leasehold terms are leased for periods ranging from one to seven years.

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

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

	Actual 2022 $000	Actual 2021 $000
healthAlliance N.Z. Limited (refer Note 12)		
Not later than one year	786	827
Later than one year and not later than five years	2,357	3,206
Later than five years	-	-
Total Non-cancellable operating leases	**3,143**	**4,033**

7. Cash and cash equivalents

	Actual 2022	Actual 2021

	$000	$000
Cash at bank and on hand	8	9
NZ Health Partnerships Limited	88,371	18,333
Trust / Special purpose Funds	839	835
Cash and cash equivalents for the purposes of the statement of cash flows	**89,218**	**19,177**

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

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

Financial assets recognised subject to restrictions

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

While cash and cash equivalents at 30 June 2022 are subject to expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

8. Debtors and other receivables

	Actual 2022 $000	Actual 2021 $000
Ministry of Health receivables	172,160	37,167
Other receivables	24,626	17,441
Other accrued revenue	56,622	58,983
Less: provision for impairment	(3,160)	(5,095)
Total Debtors and other receivables	**250,248**	**108,496**

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.

	2022			2021		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	216,354	(45)	216,309	75,820	(42)	75,779
Past due 1-30 days	4,326	(376)	3,950	5,611	(677)	4,934
Past due 31-60 days	7,851	(162)	7,689	1,728	(350)	1,378
Past due 61-90 days	9,156	(236)	8,920	11,048	(298)	10,750
Past due > 90 days	15,720	(2,340)	13,380	19,383	(3,728)	15,655
Total	**253,407**	**(3,159)**	**250,248**	**113,590**	**(5,095)**	**108,496**

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.

The receivables from the Ministry of Health include COVID-19 funding of $89,759k for the other Northern region DHBs. This was requested by the DHB, which has taken the lead role in the Northern Region to handle the leadership and delivery of the health and wellbeing services, including the facilitation of funding from the Ministry and to other DHBs.

9. Other non-current assets

	Actual 2022 $000	Actual 2021 $000
Reversionary interest in car park building	2,461	2,344
Total Other non-current assets	**2,461**	**2,344**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to us in 8 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 5% was used (2021: 5%).

10. Inventories

	Actual 2022 $000	Actual 2021 $000
Pharmaceuticals	7,186	1,046
Other Supplies net of provision for obsolete stock	5,607	10,540
Total inventories	**12,793**	**11,586**

No inventories are pledged as security for liabilities (2021: $0), however, some inventories are subject to retention of title clauses. The majority of supplies were expensed when purchased with only ward stock held on the balance sheet.

The amount of inventories recognised as an expense during the year was $139.1m (2021: $138.8m) 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 2022 $000	Actual 2021 $000
Land	9,721	5,320
Buildings	185	-
Total Non-current Assets held for Sale	**9,906**	**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.

The DHB owns three non-residential houses which have been determined to be surplus to requirements. The Board has received Ministerial approval in April 2022 to dispose of these properties and has resolved to commence action to sell the three houses and associated land.

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2022	Interest held at 30 June 2021	Balance date
Northern Regional Alliance Limited	Provision of health support services	Associate	33.3%	33.3%	30 June
healthAlliance N.Z. Limited	Provision of shared services	JV	25.0%	25.0%	30 June
NZ Health Partnerships Limited	Provision of services to provide savings to the NZ health sector	JV	5.0%	5.0%	30 June
HealthSource New Zealand Limited	Provision of shared services	JV	25%	25%	30 June

healthAlliance N.Z. Limited

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

HealthSource New Zealand Limited

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

NZ Health Partnerships Limited

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

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

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

- On liquidation or dissolution of the Company, each unpaid Class B Share confers no right to a share in the distribution of the surplus assets.

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

Year end 30 June 2022 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Limited (unaudited)	24,904	20,689	4,214	20,751	(549)
healthAlliance N.Z. Limited (unaudited)	241,452	51,912	189,540	177,497	(5,804)
NZ Health Partnerships Limited (audited)	760,003	737,889	22,115	49,942	(5,004)
HealthSource New Zealand Limited (audited)	11,034	10,252	782	44,604	71

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

Contingencies

NZHP has contracts for the provision of Infrastructure as a Service (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. (2021: $nil).

Share of profit of Associate entities and Jointly Controlled Entities

	Actual 2022 $000	Actual 2021 $000
Share of loss – healthAlliance N.Z. Limited	**(1,451)**	**(20)**
Share of profit – HealthSource New Zealand Limited	**18**	**19**

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 2022	Actual 2021

	$000	$000
healthAlliance N.Z. Limited	58,924	57,846
HealthSource New Zealand Limited	169	169
Total Investments in Associates	**59,093**	**58,015**

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

13. Property, plant and equipment

	Land $000	Buildings, Plant & Infrastructure $000	Clinical Equipment, IT & Motor Vehicles $000	Other Equipment $000	Work in progress $000	Total $000
Cost or valuation						
Balance at 1 July 2020	**193,430**	**594,105**	**95,332**	**11,002**	**52,025**	**945,894**
Additions	-	-	-	-	49,122	49,122
WIP capitalised	-	51,301	10,168	1,058	(62,527)	-
Revaluation increase/(decrease)	86,228	-	-	-	-	86,228
Disposals/transfers	-	-	(484)	-	-	(484)
Balance at 30 June 2021 / 1 July 2021	**279,658**	**645,406**	**105,016**	**12,060**	**38,620**	**1,080,760**
Additions	-	-	-	-	60,850	60,850
WIP capitalised	-	14,171	13,204	786	(28,380)	(219)
Revaluation increase/(decrease)	-	296,700	-	-	-	296,700
Reversal of University of Otago asset cost	-	(15,094)	-	-	-	(15,094)
Write offs / Impairment	-	-	-	-	(1,011)	(1,011)
Disposals/transfers	(4,401)	(261)	(54)	1	(1,067)	(5,782)
Balance at 30 June 2022	**275,257**	**940,923**	**118,165**	**12,847**	**69,012**	**1,416,204**
Accumulated depreciation and impairment losses						
Balance at 1 July 2020	**-**	**27,134**	**57,704**	**6,963**	**-**	**91,801**
Depreciation expense	**-**	28,799	10,181	902	-	39,882
Elimination on disposal/transfer	-	-	(389)	-	-	(389)
Balance at 30 June 2021 / 1 July 2021	**-**	**55,933**	**67,496**	**7,865**	**-**	**131,294**
Depreciation expense		30,049	10,500	875	-	41,423
Elimination on disposal/transfer	**-**	(75)	(21)	-	-	(96)
Revaluation increase/(decrease)	-	(83,771)	-	-	-	(83,771)

Reverse University of Otago accumulated depreciation	-	(1,951)	-	-	-	(1,951)
Balance at 30 June 2022	**-**	**185**	**77,975**	**8,740**	**-**	**86,899**
Carrying amounts						
At 1 July 2020	**193,430**	**566,971**	**37,628**	**4,039**	**52,025**	**854,093**
At 30 June and 1 July 2021	**279,658**	**589,473**	**37,520**	**4,195**	**38,620**	**949,468**
At 30 June 2022	**275,257**	**940,738**	**40,190**	**4,108**	**69,012**	**1,329,305**

Finance leases

The net carrying amount of assets held under finance lease is $1.9m (2021: $2.1m) for equipment. Note 16 provides further information about finance leases.

Capital Commitments

	Actual 2022 $000	Actual 2021 $000
Buildings	33,760	33,349
Other Equipment	5,550	7,654
Intangible Assets	1,793	2,683
Total Capital commitments	**41,103**	**43,686**

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

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.

On expiry of the lease in February 2050, 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 as at 30 June 2022 included in the capital commitments disclosed above is $3.718m.

CMDHB Share of Capital Commitments held by Jointly Controlled Entities

	Actual 2022 $000	Actual 2021 $000
healthAlliance N.Z. Limited (refer Note 12)		
Property, plant and equipment	1,976	3,366
Total Capital commitments	**1,976**	**3,366**

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 2022. There was no material movement to the land valuation performed in 2020/21. The 2020/21 valuation resulted in an upwards revaluation adjustment of $86.23m.

Buildings

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

The most recent valuation of buildings & plant was performed by a registered independent valuer, RS Valuations Ltd, as at 30 June 2022. The total buildings & infrastructure valuation resulted in a 2021/22 upwards revaluation adjustment of $380.4m.

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

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

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

As part of the DHB's internal review process, the DHB is currently conducting a multi-year review of the condition of the major buildings in its portfolio, including assessments around seismic strengthening, asbestos, critical building services infrastructure and cladding remediation. In 2017/18, the DHB commissioned two major infrastructure assessments. Completed in April 2019 was a detailed seismic assessment and independent peer review of the Middlemore Galbraith building that confirmed this as an earthquake prone building. The CM Health Board continued to work through related remediation and replacement investment decisions in 2021/22. 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 2022 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).

- Franklin Memorial Hospital: Initial Seismic Assessment
- Pukekohe Hospital Plant Room: Initial Seismic Assessment
- Esme Green Building: Detailed Seismic Assessment

- Colvin building complex: Detailed Seismic Assessment
- Building 58 Western Campus: Detailed Seismic Assessment

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

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.

As at 30 June 2020 (as a result of an external accounting technical opinion received) the DHB accounted for the development as an operating lease. The value of construction costs was recognised by the DHB as Property, Plant and Equipment.

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. For the year ended 30 June 2020 and 2021 the net present value of this obligation was recognised as a liability, being wound up over the 30-year lease period.

The difference between the current construction costs and the net present value of the liability was recognised as income in advance for the years ended 30 June 2020 and 2021 and was being wound down as revenue income over the term of the 30-year lease.

For the 30 June 2022 year end, CMDHB adopted a simpler alternative accounting approach. As a result, the above accounting transactions were removed from the financial statements. For the year ended 30 June 2022 only the net present value of the estimated future obligation has been disclosed in the capital commitments note 13 above. Comparatives were not restated as the amounts are considered immaterial.

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 1 July 2020	**3,286**	**2,166**	**7,021**	**12,473**

	FPIM Rights $000	Software $000	Work in Progress $000	Total $000
Additions	1,388	-	6,478	7,866
Work in Progress Capitalised	-	-	-	-
Impairment	-	-	(632)	(632)
Transfers / Disposals	-	-	(4,513)	(4,513)
Balance at 30 June 2021/1 July 2021	**4,674**	**2,166**	**8,354**	**15,194**
Additions	649	218	6,229	7,096
Balance at 30 June 2022	**5,323**	**2,384**	**14,583**	**22,290**
Accumulated amortisation and impairment losses				
Balance at 1 July 2020	**373**	**1,388**	**-**	**1,761**
Amortisation expense	455	535	-	990
Balance at 30 June 2021/1 July 2021	**828**	**1,923**	**-**	**2,751**
Amortisation expense	560	280	-	840
Balance at 30 June 2022	**1,388**	**2,203**	**-**	**3,591**
Carrying amounts				
At 1 July 2020	**3,286**	**778**	**7,021**	**11,085**
At 30 June and 1 July 2021	**3,846**	**243**	**8,354**	**12,443**
At 30 June 2022	**3,935**	**181**	**14,583**	**18,699**

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

Finance, Procurement and Information Management System (FPIM)

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

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

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

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

The IT shared services project was undertaken for the purpose of reducing costs for the public health sector. The project is funded by the DHBs across the country. As at 30 June 2022, the DHB has paid $3.935m (2021: $3.846m) as its share of the project funding, which represents its rights to use the systems when developed.

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

CMDHB was planning to go onto the FPIM platform on 2 November 2021, however owing to the resurgence of COVID 19 in August 2021, CMDHB go live was postponed and now took place on 1 November 2022. The Northern Region DHB's shared services entities went onto the FPIM platform from 1 August 2021.

Accounting for software as a service (SaaS)

Entities can sometimes incur significant costs when implementing cloud computing arrangements. Until recently, there has been no specific guidance on this subject in New Zealand accounting standards.

An agenda decision issued by the IFRS Interpretations Committee (IFRIC) has provided some clarity on the accounting for certain costs in implementing such arrangements under the International Financial Reporting Standards (IFRS).

For public benefit entities, the agenda decision can be referred to in determining the accounting treatment because the underlying intangible asset standards are consistent between IFRS and PBE IPSAS.

The key issues are whether such costs should be:

- capitalised as an intangible asset and amortised;
- expensed when incurred; or
- expensed over the term of the SaaS arrangement (including capitalising as a prepaid service if paid upfront).

The DHB does not have any material SaaS arrangements and consequently has no disclosure to make for the current year (2021: Nil).

15. Creditors and other payables

	Actual 2022 $000	Actual 2021 $000
Payables under exchange transactions		
Creditors and accrued expenses	300,812	165,568
Income in advance	42,618	42,084
Total payables under exchange transactions	**343,430**	**207,652**
Payables under non-exchange transactions		
GST payable	20,404	8,242
Total payables under non-exchange transactions	**20,404**	**8,242**
Total creditors and other payables	**363,834**	**215,894**
Creditors and Other Payables - current	363,834	201,680
Creditors and Other Payables – non-current	-	14,214
Total creditors and other payables	**363,834**	**215,894**

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.

Accrued expenses include COVID-19 funding of $102,292k received by the DHB from the Ministry of Health on behalf of the other Northern Region DHBs. This is greater than the amount disclosed in Note 8 Debtors and other receivables due to an extra month of funding that has not yet been transferred to the other DHBs.

16. Borrowings and overdraft

	Actual 2022 $000	Actual 2021 $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 $75m (2021: $75m).

	Actual 2022 $000	Actual 2021 $000
Borrowings		
Current Portion		
Finance Leases	298	265
Total Current Portion	**298**	**265**
Non-Current Portion		
Finance Leases	1,637	1,811
Total Non-Current Portion	**1,637**	**1,811**
Total Borrowings	**1,935**	**2,076**

The fair value of finance leases is $1.9m (2021: $2.1m). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date of 5%.

	Actual 2022 $000	Actual 2021 $000
Analysis of Finance Leases Minimum lease payments payable		
No later than one year	388	363
Later than one year and not later than five years	1,842	1,815
Later than five years	-	272

Total Minimum Lease Payments	**2,230**	**2,450**
Future Finance Charges	-	(374)
Present Value of Minimum Lease Payments	**2,230**	**2,076**
Present Value of Minimum Lease Payments		
No later than one year	298	265
Later than one year and not later than five years	1,637	1,544
Later than five years	-	267
Total Present Value of Minimum Lease Payments	**1,935**	**2,076**

Description of finance leasing arrangements

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

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

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

Reconciliation of movements in liabilities arising from financing activities

The table below provides a reconciliation between the opening and closing balance of finance lease liabilities.

	Actual 2022 $000	Actual 2021 $000
Balance at 1 July	2,076	-
Cash Outflows	(274)	-
New Leases	**133**	**2,076**
Balance at 30 June	**1,935**	**2,076**

17. Employee entitlements

	Actual 2022 $000	Actual 2021 $000
Current portion		
Accrued salaries and wages	89,980	43,221
Annual leave	106,446	93,081
Liability for Holidays Act remediation provision	225,398	162,430
Sick leave	720	560
Long service leave	941	1,005
Retirement gratuities	6,802	6,521
Sabbatical leave	1,208	1,316
Continuing medical education	35,151	27,670

Total current portion	**466,646**	**335,804**
Non-current portion		
Long service leave	11,391	11,553
Retirement gratuities	23,925	26,082
Sick leave	2,260	1,750
Total non-current portion	**37,576**	**39,385**
Total employee entitlements	**504,222**	**375,189**

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 3.34% - 4.31% (2021: 0.38% - 2.98%) and an inflation factor of 4.0% (2021: 3.0%) were used. A movement of 0.5% (2021: 0.5%) in the salary growth rate would change the actuarial valuation by $1.9m more if the growth assumption was 0.5% (2021: 0.5%) higher or $1.8m less if the growth assumption was 0.5% (2021: 0.5%) lower.

Holidays Act

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

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

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

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

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

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

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

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

As at 30 June 2022 the DHB has a provision of $225.4m (2021: $162.4m) for Holidays Act non-compliance. Remediation of the Metro Auckland DHB's Holidays Act liability is expected to commence in calendar year 2023. Cash support from the Treasury is therefore required during calendar year 2023.

18. Provisions

	Actual 2022 $000	Actual 2021 $000
Non-current portion		
ACC Partnership Programme	1,245	1,095
Total provisions	**1,245**	**1,095**

Movements for each class of provision are as follows:	Actual 2022 $000	Actual 2021 $000
Balance at 1 July	1,095	990
Actuarial valuation movement	150	105
Balance at 30 June	**1,245**	**1,095**

19. Equity

	Actual 2022 $000	Actual 2021 $000
Crown equity		
Balance at 1 July	455,174	442,147
Equity injections from the Crown	21,169	13,446
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**475,924**	**455,174**
Accumulated surpluses/(deficits)		
Balance at 1 July	(360,124)	(316,298)
Deficit for the year	(71,647)	(43,826)
Balance at 30 June	**(431,771)**	**(360,124)**
Revaluation reserves		
Balance at 1 July	479,608	393,380
Reversal of University of Otago - arrangement	1,145	-
Revaluations	380,471	86,228
Balance at 30 June	**861,224**	**479,608**
Revaluation reserves consist of:		
Land	309,796	309,796
Buildings and Infrastructure	551,428	169,812
Total revaluation reserves	**861,224**	**479,608**
Trust/Special funds		

	Actual 2022 $000	Actual 2021 $000
Balance at beginning of year	835	837
Withdrawals	(1)	(2)
Interest received on Restricted Funds	5	-
Balance at end of year	**839**	**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	**906,218**	**575,495**

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 2021/22 financial year.

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

20. Contingencies

Asbestos

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

Legal Matters

There are a number of matters of a legal nature to which the DHB may have an exposure. The amounts involved 2022: $4m (2021: $3m), if required to be settled, would be expensed in the year of settlement.

Contingent asset

Encroaching structures

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

21. Related Party Transactions

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

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

- within a normal supplier or client/recipient relationship.

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

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $2,460m (2021 $2,047m) to provide health services in the Counties Manukau area for the year ended 30 June 2022 (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 2022 totalled $9.36m (2021: $9.59m). 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.

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

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

The Middlemore Foundation

The Middlemore Foundation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly, the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. While CMDHB has been the major beneficiary of the Trust, it must meet all normal Charitable Trust requirements in terms of applications for funding. The DHB has not calculated the financial effect of a consolidation. The latest draft financial position of the Foundation shows that it had net assets of $4.39m (2021: $4.18m) and a surplus/(deficit) of $320k (2021: $(419)k) which may be subject to restrictions on distribution as at 30 June 2022. The financial statements of the Foundation for 2022 are not publicly available as they have not yet been approved by the Foundation's trustees.

22. Events after the balance date

The resurgence of COVID-19 in August 2021 in New Zealand has had a significant impact on the DHB's resources and the ability to deliver on the planned care recovery plan and ensuring available capacity to meet acute demand growth. The DHB is working both Regionally and Nationally to develop a planned care recovery plan.

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Health New Zealand (Te Whatu Ora) and the Maaori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

23. Financial instruments

Financial instrument categories

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

	Actual 2022 $000	Actual 2021 $000
Financial assets measured at amortised cost		
Cash and cash equivalents	89,218	19,177
Debtors and other receivables	250,248	108,496
Total financial assets measured at amortised cost	**339,466**	**127,673**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	300,812	165,568
Total financial liabilities measured at amortised cost	**300,812**	**165,568**

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 2022, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have a minimal impact (2021: Minimal).

Credit risk

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

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

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

Credit quality of financial assets

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

	Actual 2022 $000	Actual 2021 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	839	835
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	88,371	18,333
- NZHPL – no defaults in the past		

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and maintaining an overdraft facility.

Contractual maturity analysis of financial liabilities.
The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future interest payments on floating rate debt are based on the floating rate of the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows.

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2021						
Creditors and other payables	165,568	165,568	165,568	-	-	-
Borrowings	2,076	2,450	363	363	1,452	272
Total	**167,644**	**168,018**	**165,931**	**363**	**1,452**	**272**

2022						
Creditors and other payables	300,812	300,812	300,812	-	-	-
Borrowings	1,935	2,230	388	388	1,454	-
Total	**302,747**	**303,042**	**301,200**	**388**	**1,454**	**-**

24. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expense

Counties Manukau DHB has reported a deficit of $71.647m for the year ended 30 June 2022. This result includes $65m (Budget $20m) expensed in the year to reflect continued cost of non-compliance with the Holidays Act, and a COVID-19 upside of $6.95m. After allowing for these exceptional items ***the DHB reported an underlying deficit of $33.16m, being $16.6m favourable to budget.***

The favourable YTD variance of $16.6m does not reflect the continued unprecedented demand for acute services causing significant periods of over occupancy. This acute demand has had a significant impact on planned care and planned care recovery volumes, with the DHB unable to deliver these volumes lost as a direct result of the impact of COVID-19. During 2021/22, planned care recovery revenue has been lost due to procedures disrupted during these periods (not recovered by year end), this has been coded to COVID-19 as lost revenue of circa $1.5m.

The DHB's response to COVID-19 through 2021/22 has seen continued deployment of a significant number of DHB staff away from normal roles and a significant impact on staff sickness. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. Lower than expected savings from this programme in 2021/22 have been offset by vacancies and lower spend in other areas.

The result also includes the favourable impact of delayed spend and unbudgeted one–off items. The main areas that have contributed to the underlying favourable variance for the year are:

- Funder expenditure provision releases $3.9m favourable (based on the final close out of provisions)
- Release of income in advance (Funder Arm) $3.5m favourable (final wash up of completed initiatives)
- Net Inter District Flow result, including 2020-21 wash up provision over estimate, ($2.7m) unfavourable
- Delayed implementation of Funder spend $10.7m favourable (due to capacity constraints)
- MoH additional funding (including Planned Care & Capital Charge funding) plus other unbudgeted revenues $22.7m favourable
- Staff costs (including provision for MECA settlements, Pay Equity, lower uptake of annual leave, overtime to cover unplanned leave and approved additional capacity), net of funding ($12.5m) unfavourable
- Outsourced staffing (including Care Partners) and cover for vacancies in difficult to recruit area's ($11.2m) unfavourable
- Interest revenue $1.1m favourable as a result of higher than forecast cash balances
- Capital charge expense ($5m) unfavourable due to prior year land revaluations offset by additional revenue
- ACC revenue $2.6m favourable due to Non-Acute Rehabilitation price increase back dated to Dec-2020.
- Patient revenue ($4.4m) unfavourable, compensated by lower Bad Debt provision movement $4.7m favourable (lower non-resident bad debts due to closed borders)
- Depreciation $3.4m favourable as a result of delayed capital spend
- Clinical supplies $2.5m favourable as a result of less planned care volumes
- Infrastructure and other operating expenses ($2.7m) unfavourable.

Statement of Financial Position

Significant variances in cash balances, debtors and creditors result primarily from unbudgeted COVID-19 related exposures, primarily due the Counties Manukau DHB managing the Regional response for Community Testing, Vaccinations, Managed Isolation & Border Control, Care in the Community and Hospital incremental capacity spend. Non-current assets have been impacted by revaluations of buildings.

Statement of Cashflow

Net cash flow was $112m favourable to budget, mainly due to Ministry of Health funding (including COVID-19 funding received on behalf of the Region) and reduced capital expenditure given COVID-19 related interruptions.

Continued effort has been placed on cash management to ensure the DHB is adequately forecasting and living within its means, in particular given the exposures arising from the impact of COVID-19.

25. Breach of statutory reporting deadline

The 2021/22 annual report of CMDHB was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

Statutory Remuneration Disclosure

Transactions with key management personnel

Key management personnel compensation

	Actual 2022 FTE	Actual 2021 FTE	Actual 2022 $000	Actual 2021 $000
Executive management team	15.4	12.2	5,266	4,048
Total key management personnel compensation	**15.4**	**12.2**	**5,266**	**4,048**

In addition to the above, the total actual expense for the Executive Management team includes other long-term benefits (KiwiSaver and Other) amounting to $292k (2021: $216k).

Key management personnel includes the Chief Executive, and fifteen (2021: thirteen) members of the management team.

Board and Committee Members compensation

	Actual 2022 FTE	Actual 2021 FTE	Actual 2022 $000	Actual 2021 $000
Board	11	11	429	429
Committee	3	4	19	23
Total board and committee members compensation	**14**	**15**	**448**	**452**

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.

Board member remuneration

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

	Actual 2022 $	Actual 2021 $
Vui Mark Gosche (Chair)	66,022	66,213
Ms Tipa Mahuta (Deputy Chair)(1)	42,448	44,198
Mrs Catherine Abel-Pattinson	37,696	35,696
Mr Apulu Reece Autagavaia	35,259	35,509
Mr Garry Boles (1)	34,259	34,009
Mrs Colleen Brown	34,946	36,259
Mrs Katrina Bungard	34,009	35,259
Mrs Dianne Glenn	36,509	35,759
Dr Lana Perese (1)	37,759	36,759
Mr Pierre Tohe (1)	35,259	34,571
Mr Paul Young (1)	35,259	34,759
Total board member remuneration	**429,426**	**428,991**

Committee Members, not Board Members or Employees	Award 2022 $	Award 2021 $
Mr Barry Bublitz (3) (CPHAC)	3,250	1,750
Mr Robert Clark (3) (CPHAC, HAC)	6,000	3,250
Mr Leopino Foliaki (Chair ARF) (5)	10,000	2,000
Mr Pat Snedden (Chair ARF, MCW) (4)	-	16,000
		-
Total	**19,250**	**23,000**

1- Appointed 9/12/2019
2- Resigned 4/12/2019
3- Appointed 26/2/2020
4- Resigned 1/3/2021
5- Appointed 3/3/2021

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 (2021: $nil).

Board Observers, not Board Members or Employees	Award 2022 $	Award 2021 $
Ms Brittany Stanley-Wishart	1,750	2,750
Ms Ngataki Tori	1,250	2,250
Total	**3,000**	**5,000**

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

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

The programme was started August 2020 and the observer/s been part of the board's governing of a District Health Board. The observer/s participate as a board member in all aspects but do not have voting rights and do not form part of the quorum of a board meeting.

They have been provided with a board member as a mentor and there are opportunities to meet with board observers on other District Health Boards to share learnings. Observers attend board meetings and committee meetings, where possible, to further develop governance skills.

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

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 2022	Actual 2021
Total remuneration paid or payable:		
$100,000 – 109,999	635	476
$110,000 – 119,999	469	255
$120,000 – 129,999	289	146
$130,000 – 139,999	169	121
$140,000 – 149,999	130	85
$150,000 – 159,999	100	67
$160,000 – 169,999	57	59
$170,000 – 179,999	51	30
$180,000 – 189,999	36	25
$190,000 – 199,999	36	24
$200,000 – 209,999	25	25
$210,000 – 219,999	28	26
$220,000 – 229,999	29	27
$230,000 – 239,999	32	20
$240,000 – 249,999	27	23
$250,000 – 259,999	32	35
$260,000 – 269,999	36	26
$270,000 – 279,999	23	33
$280,000 – 289,999	27	34
$290,000 – 299,999	21	26
$300,000 – 309,999	31	15
$310,000 – 319,999	15	28
$320,000 – 329,999	27	15
$330,000 – 339,999	10	17
$340,000 – 349,999	10	10
$350,000 – 359,999	6	16
$360,000 – 369,999	10	11
$370,000 – 379,999	5	8
$380,000 – 389,999	14	1
$390,000 – 399,999	3	11
$400,000 – 409,999	6	10
$410,000 – 419,999	6	6
$420,000 – 429,999	5	4
$430,000 – 439,999	-	3
$440,000 – 449,999	1	-
$450,000 – 459,999	3	6
$460,000 – 469,999	2	2
$470,000 – 479,999	1	2
$480,000 – 489,999	2	1
$490,000 – 499,999	-	3
$500,000 – 509,999	-	1
$510,000 – 519,999	1	3
$520,000 – 529,999	2	1
$530,000 - 539,999	-	1
$540,000 – 549,999	1	-
$550,000 – 559,999	-	1
$560,000 – 569,999	1	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 2022	Actual 2021
$600,000 – 609,999	-	-
$620,000 - 629,999	1	1
Grand total	**2,415**	**1,741**

During the Year Ended 30 June 2022 the above numbers of employees received remuneration of at least $100,000 – of these employees, 2,145 (2021: 1,475) are Medical Staff and 270 (2021: 266) are Management.

During the year ended 30 June 2022: 8 (2021: 8) employees received compensation and other benefits in relation to cessation totaling $372,528 (2021: $459,248).

Board and Committee Membership Attendances

1 July 2021 to 30 June 2022

Number of Meetings	Board	HAC	CPHAC	AR&F	DiSAC/ RDiSAC
Vui Mark Gosche (Chair)	11	1	-	9	-
Ms Tipa Mahuta (Deputy Chair)	9	1	1	7	2
Mrs Catherine Abel-Pattinson	10	7	-	10	5
Mr Apulu Reece Autagavaia	11	7	7	-	-
Mr Garry Boles	10	5	-	5	-
Mrs Colleen Brown	11	4	7	-	-
Mrs Katrina Bungard	10	4	5	-	-
Mrs Dianne Glenn	11	7	7	-	5
Dr Lana Perese	8	5	6	8	5
Mr Pierre Tohe	10	-	5	8	-
Mr Paul Young	10	7	7	-	-

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 the relationship with local tangata whenua has been expressed through the development of a number of forums and strategic partnership agreement with Mana Whenua i Taamaki Makaurau.

Board Members' Disclosure of Interests

As at 30 June 2022

Vui Mark Gosche (Chair)[105]	• 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) • Board Member, Health New Zealand
Ms Tipa Mahuta[106] **(Deputy Chair)**	• Councilor, Waikato Regional Council • Chair, Waikato River Authority • Co-Chair, Maaori Health Authority

Mrs Catherine Abel-Pattinson[107]	• Board Member, healthAlliance NZ Ltd.
	• Board Member, International Accreditation NZ (IANZ)
	• Member, NZNO
	• Member, Nurses Society NZ
	• 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, Bspoke Services Ltd.
	  ○ Director, Barclay Management (2013) Ltd.
	  ○ Director, Chatham Management Ltd.
	  ○ Director, Wolfe No. 1 Ltd./a Secret Garden Spa
	  ○ 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

Apulu Reece Autagavaia[108]	• Member, Pacific Lawyers' Association • Member, Labour Party • Member, Mapu Maia • Trustee, Epiphany Pacific Trust • Chair, Otara-Papatoetoe Local Board • 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[109]	• NZ Police Constable

[105] Appointed 9/12/2019
[106] Appointed 9/12/2019
[107] Elected 9/12/2019
[108] Elected 9/12/2019
[109] Elected 9/12/2019

Mrs Colleen Brown MNZM[110]	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • District Representative & Board member, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited • Member, MoH Disabled People's Engagement Group
Mrs Katrina Bungard[111]	• Chairperson MECOSS – Manukau East Council of Social Services • Elected Member, Howick Local Board • President, Amputee Society Auckland/Northland • Member of Parafed disability sports • Member of NZ National Party
Mrs Dianne Glenn ONZM, JP[112]	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • Life Member, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities • Member, Lottery Individuals with Disabilities Committee
Dr Lana Perese[113]	• Director & Shareholder, Malatest International & Consulting • Director, Emerge Aotearoa Limited Trust • Trustee, Emerge Aotearoa Housing Trust • Director, Vaka Tautua • Director, Malologa Trust • Director & Shareholder, Perese Wood Investments Limited
Mr Pierre Tohe[114]	• Senior Executive, Tainui Group Holdings
Mr Paul Young[115]	• Director, Paul Young International Ltd. • Councilor, Auckland City Council • Managing Director, idphoto.co.nz

[110] Elected 9/12/2019
[111] Elected 9/12/2019
[112] Elected 9/12/2019
[113] Appointed 9/12/2019
[114] Appointed 9/12/2019
[115] Elected 9/12/2019

Barry Bublitz, Board Observer	• Director, International Indigenous Council for Healing Our Spirits Worldwide • Patron, Te Mauri Pimatisiwin • Chair, Maaori Research Review Committee • Chair, Wikitoria King Whaanau Trust • Chair, Eva Newa Wallace Whaanau Trust • Secretary, Mataitai Farm Trust • Employee, Turuki Health Care • Co-Chair, Mana Whenua – Tamaki Makaurau • Co-Chair, Whakangako te Mauri o te Tangata
Robert Clark, Board Observer	• Trustee, Ngati Tipa Lands Trust • Chair, Mana Whenua - Tamaki Makaurau • Member, Te Whakakitenga • Deputy Chair, Huakina Marae Forum • Deputy Chair, Waikato Tainui Appointments Committee • Chair, Counties Maaori Rugby • Crown Appointed, Tangata Kaitiaki for Waikato Awa & West Coast Harbours • Cultural Advisor, Counties Manukau Police • Deputy Chair, Te Hiku o te Ika
Brittany Stanley-Wishart, Board Observer	• No disclosures to note
Tori Ngataki, Board Observer	• Chair, Ngāti Tamaoho Trust • Board Member, Ngāti Tamaoho SettlementTrust • Board Member, Second Natures Trust changed to Waka Pacific Trust • Member, Te Arataura committee of Te Whakakitenga o Waikato Incorporated • Co-Chair, Appointments committee for Te Whakakitenga o Waikato Incorporated • Managing Director & Shareholder, Te Arotahi Ltd. • Ngāti Tamaoho Representative, Tāmaki Makaurau Mana Whenua Forum • Trustee, Waikato Endowed College Trust • Shareholder, Keep It Maaori Limited • Employee, Winstone Aggregates • Trustee, Waikato Raupatu Lands Trust • Trustee, Waka Pacific Trust • Director & Shareholder, Te Arotahi Limited • Shareholder, Ngati Tamaoho Charitable Limited • Shareholder, Ngati Tamaoho Custodian Trustee Limited

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 2022

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

Opinion

We have audited:

- the financial statements of the Health Board on pages 86 to 123, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 25 to 62.

In our opinion:

- the financial statements of the Health Board on pages 86 to 123, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2022; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 25 to 62:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, including:
        - for each class of reportable outputs:

- its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;

- what has been achieved with the 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 13 March 2023. 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 of Te Whatu Ora - Health New Zealand 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 matters:

The financial statements have been prepared on a disestablishment basis

Note 1 on page 90 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora - Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 17 on page 115 to 117, which outlines that the Health Board 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 matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $225 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Pages 53 to 61 outline the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 58 to 60. The notes outline that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is

classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Page 101, note 22 on page 120, and note 24 on pages 122 to 123 of the financial statements and Pages 52 to 53 of the performance information, outline the ongoing impact of Covid-19 on the Health Board.

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 of Te Whatu Ora - Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

The Board of Te Whatu Ora is responsible on behalf of the Health Board for preparing the disestablishment financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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

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

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

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

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

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

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

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

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

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.

- 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 of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 4 to 24, 63 to 85, 124 to 131, and 137 to 138, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

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

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1*: International Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

In addition to the audit, we have carried out engagements in the areas of procurement assurance, which are compatible with those independence requirements. Other than the audit and these engagements, we had no relationship with or interests in the Health Board.

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

Ministerial Directions

The following Ministerial Direction was issued during the 2021/22 year:

- COVID-19 Vaccine Eligibility Direction 2022 was issued on 21 December 2021 pursuant to section 32 of the New Zealand Public Health and Disability Act 2000 (the Act) and section 103 of the Crown Entities Act 2004. It came into force on 1 January 2022 following the expiry of the COVID-19 Vaccine Eligibility Direction 2021. The purpose of this direction is to specify persons who are eligible to receive publicly funded COVID-19 vaccination under the Act and is planned to expire on 31 December 2022.

The following Ministerial Direction was issued during the 2020/21 year:

- COVID-19 Vaccine Eligibility Direction 2021 was issued on 12 February 2021 pursuant to section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004. The purpose of this direction is to specify persons who are eligible to receive publicly funded COVID-19 vaccination under the Act and is planned to expire on 31 December 2021 unless earlier extended or revoked.

The following Ministerial Direction was issued during the 2019/20 year:

- COVID-19 Response Direction 2020, issued on 17 March 2020 under section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004. The purpose of this direction is to ensure a nationally coordinated and consistent approach to the outbreak of COVID-19 across District Health Boards.

  Direction to act consistently with national plans

  In accordance with District Health Boards' responsibilities under section 23 of the New Zealand Public Health and Disability Act 2000 to plan and coordinate at local regional and national levels for the most effective and efficient delivery of health services, all District Health Boards must act consistently with the following national-level plans and policies:

  a. The Government Response to the COVID-19 pandemic, informed by the New Zealand Influenza Pandemic Plan, a framework for action (Ministry of Health 2017); and

  b. The National Health Emergency Plan (Ministry of Health 2015).

Ministerial Directions that remain current are as follows:

- New Zealand Business Number Direction. https://www.mbie.govt.nz/dmsdocument/3462-nzbn-2018-direction-to-crown-entities. In August 2018, 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. https://gazette.govt.nz/notice/id/2011-go2492
- 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. https://www.parliament.nz/resource/en-NZ/50DBHOH_PAP26152_1/5297806ab80f1f633214450932adedd4d5c03b74
- 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. https://gazette.govt.nz/notice/id/2008-go6913

Directory

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Auditor

Audit New Zealand on behalf of the Auditor-General

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Anthony Holmes

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Claro

Gemma Mayes

Kelly Rowell

Mark O'Brien

Meredith Connell

Peter Le Cren

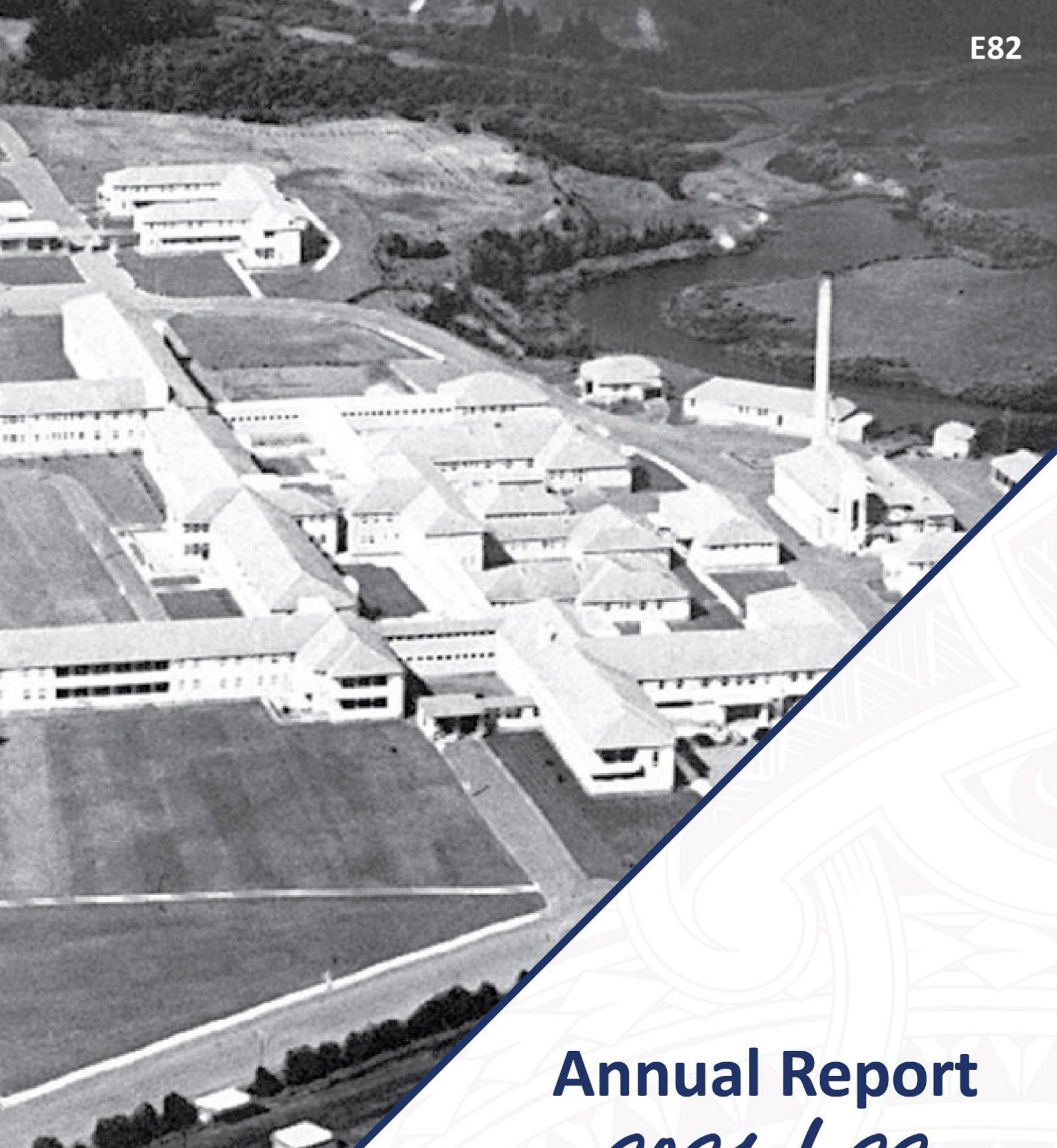
Ponsonby Chambers – Andrew Keith Finnie

Simpson Grierson

Bankers

Bank of New Zealand

Westpac Banking Corp



WHITU TEKAU MA RIMA TAU
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YEARS
MIDDLEMORE HOSPITAL 1947-2022

Annual Report

2021 / 22

COUNTIES MANUKAU HEALTH