COUNTIES MANUKAU HEALTH

Annual Report

30 June 2013

Counties Manukau District Health Board Annual Report 2013

Our Values

Care & Respect

Treating people with respect and dignity; valuing individual and cultural differences and diversity.

Teamwork

Achieving success by working together and valuing individual and cultural differences and diversity.

Professionalism

Acting with integrity and embracing the highest ethical standards.

Innovation

Constantly seeking and striving for new ideas and solutions.

Responsibility

Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions.

Partnership

Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population.

COUNTIES
MANUKAU
HEALTH

Contents

Chair and Chief Executive's Review

We are pleased to present the 2012/13 Counties Manukau District Health Board Annual Report. The 2012/13 year represented the first of a four year whole of health system journey to transform the way we deliver healthcare and excellent health services to our people in a manner which balances financial and resource sustainability.

Integration of healthcare services within our district is a key strategic priority for us. A new platform of locality clinical partnerships with primary and secondary care clinicians leading the planning and delivery of new integrated services was successfully implemented. Services such as Pulmonary and Cardiac Rehabilitation are now being delivered in the community, extension of our community geriatric services into residential care facilities, and better support and management of people with chronic conditions like diabetes are examples of our successes.

Development of localities has been supported by working together with our communities, health providers and staff to identify the right mix of services to meet their needs. Our primary care partners established Integrated Family Health Centres as a hub for our shared service networks across each of our four localities:

- Franklin
- Mangere and Otara (including Northern Papatoetoe)
- Manukau (including Southern Papatoetoe, Manurewa, Takanini and Papakura)
- Eastern (including Howick, Beachlands/Maraetai, Clevedon and Kawakawa/Orere)

We also invested an additional $500,000 to increase primary care clinician access to diagnostics (radiology services) to reduce wait times and improve convenience for patients and their whaanau. We have made further progress in bringing services closer to where people live through working together across the health system and using the quality improvement tools and expertise of our Centre for Health Service Excellence, Ko Awatea. The collaborative efforts of all those involved in eight key programmes to improve the patient and whaanau experience of care enabled reduction in our acute inpatient hospital bed demand by 23,060 days. This means that people are better supported in their communities, with services better matched to meet their needs.

In recognising the importance of further improving the experience of patients and their whaanau when they come into contact with our health system, we implemented 'Partners in Care' policy that welcomed close whaanau to be with their loved ones in hospital as partners, not visitors. The successful implementation of this policy change was supported by a programme that focussed on improving every staff interaction with patients and their whaanau.

We remain committed to our regional and national relationships in continuing to be a high performing health system. Through health sector collaboration, the Northern Region has achieved five of the six health targets and all but one of the nine other priority areas. These outcomes included significant progress on the Better Public Service focus on children with implementation of a school based health service to identify and treat Group A Streptococcal throat infections and skin infections.

A key regional initiative included the rebuild of 19 dental clinics and introduction of a fleet of 18 mobile dental facilities to take Oral Health to the schools, community and Marae throughout our district. This will enable our children to get the most up-to-date care for years to come in a more comfortable, quiet and clinically safer environment for children and their parents.

This report highlights significant progress by Counties Manukau Health in meeting the growing demand for health services and towards the achievement of the government's priorities such as providing advice and support to people who wish to quit smoking, more heart and diabetes checks, reduced waiting times for elective, emergency and cancer services and improved coverage of immunisation of our community's children. Our financial position for 2012/13 shows that despite increasing demand for services, increased

government expectations and constraints of funding, we have been able to collectively achieve a $3 million surplus for the year.

Audit New Zealand have qualified their audit opinion regarding certain non-financial performance information, as this information relies on the accuracy of data supplied by third parties such as GP practices. This information is collected by Primary Health Organisations, who then report this information to the Ministry of Health, who in turn publish the results to the public on a quarterly basis. Counties Manukau DHB includes this information in its reported performance information. While this information is unable to be audited in the required formal manner, the information is required to be collected based on standard nationally applied Ministry of Health instructions.

We thank our partners in our local healthcare system – primary care, non-government organisations and communities for their support and ongoing contribution to improving our community's health. This is a responsibility we share with them, and we thank them for their work over the last 12 months.

Finally, we thank all of our staff who have contributed to the exciting achievements of the past year, and we continue to look forward the challenges and opportunities to come. We also thank and acknowledge our outgoing Board and committee members who have provided strategic leadership to the organisation for the past 3 years.

Professor Gregor Coster, CNZM
Chair

Geraint A Martin
Chief Executive

Snapshot of Counties Manukau Health

Counties Manukau Health (CM Health) is responsible for the planning and funding of health and disability services, and the provision of hospital and community-based health services to the estimated 512,000 people of Counties Manukau.

Our population is growing at a rate of approximately 2% per year and continues to be one of the fastest growing areas in New Zealand. Counties Manukau is an ethnically diverse district with high numbers of Maaori, Pacific and Asian residents. Our population has high health and social needs, with 34% living in areas classified as being the most socioeconomically deprived. Counties Manukau has both a relatively youthful and growing aging population with persistent and wide life expectancy gaps for Maaori and Pacific populations compared with non-Maaori/non-Pacific.

We employ around 6,500 people in a number of different locations across the district and manage a budget of more than $1.4 billion a year.

Vision

Our vision is to work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities.

We will do this by:

- Leading the development of an improved system of healthcare that is more accessible and better integrated
- Dedicating ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting
- Being a leader in the delivery of successful secondary and tertiary healthcare, and supporting primary and community care

Board Members

Back row: Mr Bob Wichman, Mr Arthur Anae, Mr Donald Barker JP
Middle row: Mr Frank Soloman[1], Mrs Sandra Alofivae, Mrs Lyn Murphy, Mrs Colleen Brown MNZM JP, Mr David Collings
Seated: Mr Paul Cressey ONZM, Professor Gregor Coster CNZM (Chair), Mrs Jan Dawson (Deputy Chair),
Mr Geraint Martin (CEO)

Executive Leadership

Executive Leadership Team	
Geraint Martin	Chief Executive
Ron Pearson	Deputy Chief Executive/ Director, Corporate & Business Services
Dr Gloria Johnson	Chief Medical Officer
Dr Campbell Brebner	Chief Medical Advisor, Primary & Integrated Care
Karyn Sangster	Chief Nursing Advisor, Primary & Integrated Care (Acting)
Jenni Coles	Director, Hospital Services
Benedict Hefford[2]	Director, Primary Health & Community Services
Martin Hefford[3]	Director, Primary Health & Community Services
Denise Kivell	Director, Nursing Hospital Services
Margie Apa	Director, Strategic Development
Martin Chadwick	Director, Allied Health
Professor Jonathon Gray	Director, Ko Awatea

[1] Mr Frank Soloman resigned from the Board on 26 November 2013.
[2] Benedict Hefford was appointed as Director, Primary Health & Community Services on 23 January 2013.
[3] Martin Hefford resigned from Director, Primary Health & Community Services on 30 January 2013.

Key Achievements in 2012/13

2012/13 represented year one of a four year whole of system transformation journey for Counties Manukau Health (CM Health). It was a transformational year as we worked with our PHO partners to establish essential infrastructure and organisation changes to effect health system wide change. This section highlights some of our key health system achievements and milestones of 2012/13.

Better Health Outcomes for All

- Programme prioritisation of SmokeFree, housing and the First 2000 Days of life initiatives
- Strong performance against the national health targets (refer section Performance Against National Health Targets)
- 52 Mana Kidz clinics rolled out into Primary and Intermediate schools to provide comprehensive health care including throat swabbing, assessment and treatment of skin infections and health assessments
- Dental Services pilot for pregnant women with diabetes
- Before School Checks (B4SC) comprehensive health, behavioural and development check targets exceeded
- Significant progress reducing waiting times for elective and outpatient services supporting earlier health service access

First Do No Harm

- Care Connect Concerto (TestSafe Pharmacy) to support medicine reconciliation and medicine safety
- Regional Transfer of Clinical Information initiative
- Reduction in serious harm caused by falls by hospital patients
- Successful implementation of a New Zealand wide initiative to reduce the incidence of Central Line Associated Bacteraemia (CLAB)

Patient and Whaanau Centred Care

- Revised visitors policy where close whaanau/family are recognised as 'partners in care' and are able to come onto wards outside of normal visiting hours
- Improved patient experience (AI2DET programme roll out - 2146 staff completed training) with a focus on better face-to-face engagement with patients and their whaanau
- Roles established for patient and whaanau/family advisors on key decision making committees throughout the organisation

System Integration (Whole of System Commissioning)

- District Alliance Group and District Alliance Agreement with our five Primary Health Organisation (PHO) partners
- Locality Clinical Partnership Agreement to provide primary health care providers with greater opportunities to share system resources, and accountability to collectively ensure the best use of those resources
- Framework for global budget holding to incentivise general practice to take shared accountability and increased flexibility to best manage population health needs
- Four-year business plans for each of the four localities, and Locality Clinical Partnerships (LCP) and related Leadership groups established in Franklin and Eastern localities
- Establishment of Integrated Family Health Centres that form the hub of our network of shared services across each locality
- Initiative funding for reducing acute demand by improving the range of services available in the community
- Increase in funding for direct community referred radiology tests (plain film and ultrasound) by $500k
- 20,000 Days campaign cumulative bed savings of 23,060 days by 1 July 2013, achieved through hospital and localities based initiatives
- High risk patient identification tool in place for localities based service providers to target health interventions
- Very High Intensive User team transition to localities to better integrate support for patients in the community
- Whaanau Ora Centre Business Case at Manukau
- Community Geriatric service expansion to rest homes

Ensuring Financial Sustainability

- Efficiency programme savings over three years of approximately $60m
- IS/IT improvements that enable improved forecasting and management of our workload and resources

Enabling High Performing People

- Leadership Academy to grow internal leadership capability
- Development of organisational leadership statement to ensure alignment of training opportunities

What impact do these achievements have on people in our communities?

George Selwyn - VHIU (Very High Intensity User Programme)

Prior to VHIU'S involvement George presented to Emergency Care more than 28 times during 2011. VHIU staff enrolled George in November 2011 and by the end of 2012 his presentations reduced to 4 during the entire year. When we spoke to George in 2012, he spoke about a new outlook on life that included giving up smoking, going to the gym and regularly seeing his GP.

As part of VHIU's ongoing monitoring the team noted that George has been in hospital 4 times between May – June 2013. On further investigation it revealed these presentations were exacerbated by his social circumstances. For example George needs his rental property insulated as it is cold, damp and mouldy and needs continuous antibiotic cover over winter. Both of these needs are being actively followed up by the VHIU team.

George is now attending respiratory clinics and is back doing part time work. This has 'revolutionised' George's outlook on life and he has been able to plan financially for some of his personal goals.

For many patients like George, wrap around care, an understanding of their personal circumstances and continuous monitoring, is an ongoing feature of their preventative care.

Agnes Marshall - SMOOTH (Safer Medicines Outcomes on Transfer Home)

Agnes was admitted to Hospital with a heart attack and history of severe coronary artery disease. Her past medical history includes short term memory loss, which has significant effects on her ability to cope with taking her medications regularly. Agnes is also taking warfarin – a medication that requires close monitoring to ensure patient safety. Agnes was unfortunately caught up in the middle of a change in funding agreements for community pharmacies, which essentially meant that her previous weekly blister packs were changed to monthly packs. This created a significant amount of confusion and unnecessary stress for Agnes as she juggled between several blister packs instead of just one pack a week.

"I was doubling up on my breakfast pills, and sometimes not taking my dinner pills. I was over dosing and couldn't remember what I had taken." Agnes

Agnes was referred to the SMOOTH team by one of the team pharmacists, who was concerned Agnes wasn't coping with her medications at home. After identifying what was really troubling Agnes, the team reorganised her medications into weekly blister packs and ensured she had the financial support to cover the additional costs. In addition, Agnes was given a medication card and some ideas for how she could do to remember to take her medications regularly.

On the team's last visit Agnes was looking healthy and well. She explained how much better she was feeling and the difference the SMOOTH team had made to her life by simply communicating with her primary care providers.

Performance against National Health Targets

CM Health's strong performance against the national health target expectations in 2012/13 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with primary health care and PHOs, and their commitment and leadership to focus resources towards improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

Health Targets	Q1	Q2	Q3	Q4
 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	97% ✓	96% ✓	97% ✓	96% ✓
 The volume of elective surgery will be increased by at least 4,000 discharges per year	110% ✓	108% ✓	110% ✓	111% ✓
 All patients, ready-for-treatment, will wait less than four weeks for radiotherapy or chemotherapy	100% ✓	100% ✓	100% ✓	100% ✓
 85 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013	82% ✓	85% ✓	86% ✓	90% ✓
 75 percent of the eligible population will have had their cardiovascular risk assessed in the last five years by July 2013	53%	55%	61%	76% ✓
 **Secondary Care** 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking	95% ✓	95% ✓	96% ✓	95% ✓
Primary Care 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered advice and support to quit smoking	40%	43%	45%	56%

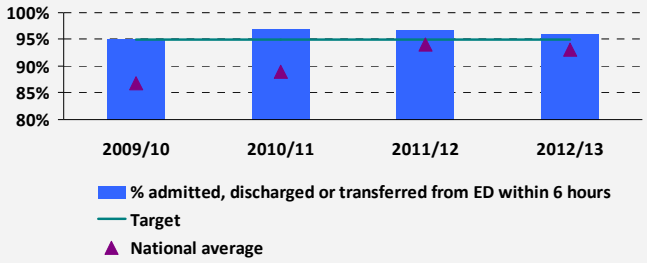
What difference have we made for our population?

Shorter stays in emergency departments

Shorter stays in emergency departments can improve both patient experience and clinical outcomes. Long waits in emergency departments are inconvenient, often uncomfortable for patients and are linked to overcrowding, poorer clinical outcomes and reduced privacy and dignity.

Despite continued growth in acute presentations and an increase in self referrals, CM Health has consistently achieved the national target throughout 2012/13, with at least 96% of people presenting to the CM Health emergency department being admitted, discharged or transferred within 6 hours of arrival in every quarter of 2012/13.

The percentage of people presenting to CM Health emergency department who were admitted, discharged or transferred within 6 hours	11/12 Baseline	12/13 Result	12/13 Target
	97%	96%	95%



CM Health's strong performance against this target reflects strong leadership by senior management and clinicians, a whole-of-system approach and commitment across secondary and primary care to achieve the target. There has been increased liaison between Senior Medical Officers and General Practice regarding management of medical patients, with renewed use of the 'SMO direct phone'. This enables GP's to discuss cases with a Medical SMO, rather than sending patients directly to emergency department for assessment.

We are committed to maintaining this target in 2013/14, and improving the quality and timeliness of emergency department care. We recognise the ongoing commitment of leadership and resources necessary to maintain this target in the face of increasing demand.

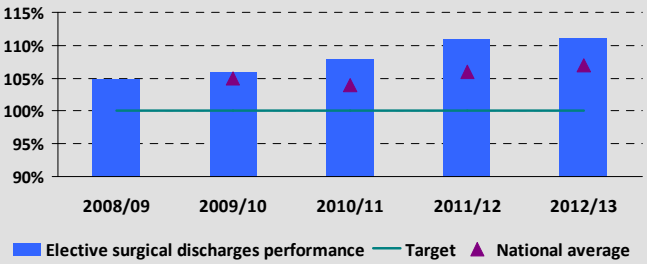
Improved access to elective surgery

Elective surgery can improve quality of life, independence and wellbeing, as well as reducing pain and discomfort. It is important that patients who need surgery are able to access it in a timely way so that disruption to their lives is minimised.

CM Health has continued to perform above the national target to increase the volume of elective surgery by at least 4000 discharges each year. The 2012/13 target was to have performed 15,381 discharges; CM Health exceeded this target by 1704 discharges.

We remain committed to delivering efficient and effective elective surgery productivity in 2013/14 and maintaining achievement of this target.

The elective surgical services discharge performance of CM Health	11/12 Baseline	12/13 Result	12/13 Target
	111%	111% 17,085 discharges	100% 15,381 discharge

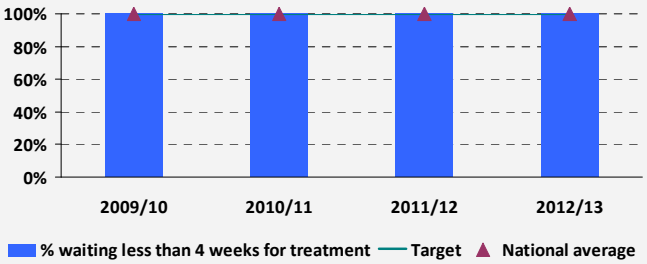


Shorter waits for cancer treatment

Cancer is a major health issue for New Zealand, and one of the country's leading causes of death. Timely access to specialist cancer treatment is essential in reducing the impact of cancer for patients, their whaanau and our communities.

The radiotherapy treatment target has been consistently met for the Counties Manukau population for the past 4 years and the chemotherapy treatment target since it was introduced in 2012/13. All patients, ready-for-treatment, have received their radiotherapy or chemotherapy within 4 weeks from the decision to treat.

The percentage of CM Health patients receiving radiation oncology treatment within four weeks of first specialist appointment[4]	11/12 Baseline	12/13 Result	12/13 Target
	100%	100%	100%



Reduction in wait time for all cancers is supported through strong multi-disciplinary meeting, Lead Cancer Care Coordinators and clinical management.

[4] Excluding those waiting by choice or co-morbidities

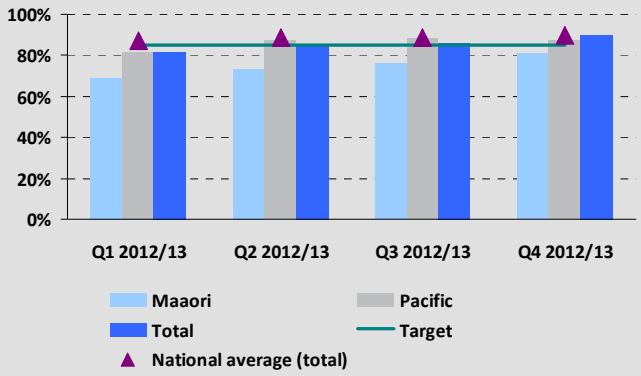
Increased immunisation

As of 1 July 2012, the national target for immunisation coverage changed to 85% of eight-month-olds will have completed their primary course of immunisation by July 2013. CM Health exceeded this target, with 90% of Counties Manukau children fully immunised at eight-months.

CM Health continues to make strong progress increasing Maaori and Pacific immunisation rates, with 2012/13 quarter 4 results of 81% and 87% respectively.

Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also protection at a population-level by reducing the incidence of infectious diseases and preventing spread to vulnerable populations. Immunisation is also an important mechanism to ensure that infants are engaged with primary care.

The percentage of Counties Manukau children fully immunised	12/13 Result	12/13 Target
	90%	85%



CM Health's strong performance against this target reflects the collaborative efforts of stakeholders across the region to raise awareness of the importance of timely immunisation; strong efforts in primary care; ongoing work to improve the quality of the National Immunisation Register (NIR) data and using these data to identify children overdue for immunisation; as well as the prioritisation of referrals to outreach immunisation services.

We are on track and committed to achieve the December 2014 target of 95% of eight-month-olds fully immunised.

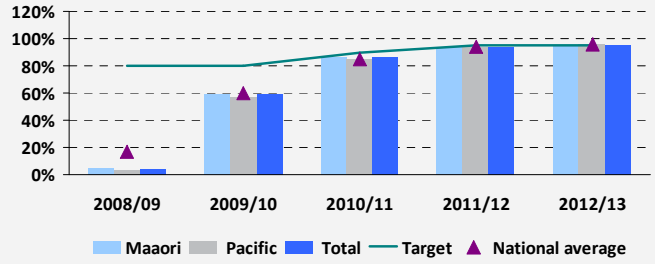
Better help for smokers to quit

Smoking is a leading cause of death in New Zealand, killing around 5,000 people every year and reducing the quality of life for thousands more. At the last Census, 21% of the Counties Manukau residents reported that they were smoking regularly, with Maaori and Pacific smoking rates significantly higher at 47% and 30% respectively. Smoking increases the risk of developing heart disease, respiratory infections and lung diseases, including cancer; all of which contribute to the differences in life expectancy between Maaori and Pacific and non-Maaori/non-Pacific in Counties Manukau.

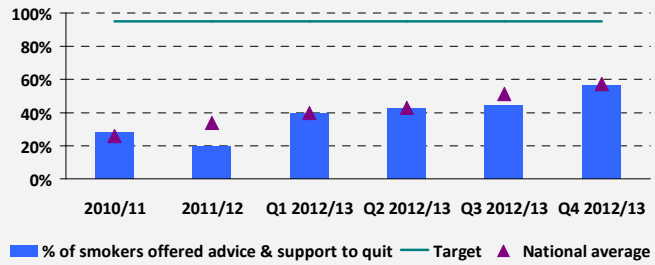
Most smokers want to quit and there is strong evidence to show that brief advice and support to quit smoking is effective at encouraging people to quit smoking and remain smokefree.

CM Health has consistently met the secondary care smokefree target throughout 2012/13, with at least 95% hospitalised smokers offered brief advice and support to quit smoking. CM Health's strong secondary care smokefree performance results from active leadership by senior management, ongoing monitoring and auditing, as well as regular training and refresher sessions for staff, and Hospital Smokefree Champions driving best practice on the wards. We will continue to focus on patient outcomes, with a particular focus in 2013/14 on increasing the number of identified smokers receiving support.

The percentage of CM Health hospitalised smokers offered brief advice and support to quit		11/12 Baseline	12/13 Result	12/13 Target
	Maaori	94%	95%	
	Pacific	94%	96%	95%
	Total	94%	95%	



Percentage of enrolled Counties Manukau smokers seen by a health practitioner in primary care and offered brief advice and support to quit	11/12 Baseline	12/13 Result	12/13 Target
	20%	56%	95%



We have made significant progress working towards the primary care smokefree target, with quarter 4 2012/13result 56%, compared to 20% in quarter 4 2011/12. Work continues with supporting PHOs and general practices through the establishment of call centres; Smokefree Coordinator and Clinical Champion support for primary care clinicians; and supporting general practices to implement systematic processes which result in sustainable results. We remain committed to working in partnership with Primary Care to increase support for our community to quit smoking.

The smokefree target strongly aligns to our strategic initiative for Counties Manukau to be smokefree by 2025.

More heart and diabetes checks

Diabetes and cardiovascular disease affect a substantial number of New Zealanders every year, reducing both quality of life and life expectancy. These diseases have a disproportionate effect on Maaori and Pacific people in the Counties Manukau community. Early detection and management of diabetes and cardiovascular disease can improve health outcomes and contribute to people living longer, healthier, more independent lives.

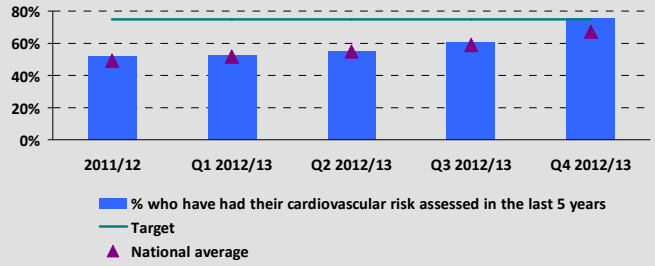
CM Health achieved the target around heart and diabetes checks in quarter 4 2012/13, with 76% of eligible adults in Counties Manukau having had a cardiovascular risk assessment in the last 5 years.

Considerable work has gone into achieving this result which was made possible by a coordinated approach by primary and secondary care providers across the district. Initiatives in place to maintain the target and continue the positive trend include Clinical Champion support for primary care clinicians, additional nurse support for risk assessments, quality improvement activity, regular practice reports on progress towards the targets, IT tools (including audits) and education.

Targeted initiatives for Maaori and Pacific include PHOs and general practices proactively identifying and inviting eligible patients to have their cardiovascular risk assessed; on-going engagement by Maaori and Pacific self-management educators; as well as opportunistic screening in primary, secondary and community settings.

The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessed in the last 5 years

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	55%	71%	
Pacific	62%	76%	
Other	48%	77%	75%
Total	52%	76%	



What are we trying to achieve for our population?

Our vision is to work in partnership with our communities to improve the health status of all, with a particular emphasis on Maaori and Pacific peoples and other communities with health disparities. In realising our vision, our strategic goal is to be the best health care system in Australasia by 2015 – delivering excellent healthcare services to our communities in a manner that is sustainable and provides best value for public resources.

Triple Aim Strategic Objectives

We will achieve our goal through implementation of our Triple Aim strategic objectives:

Improved health and equity for all populations

Working with our communities to address the barriers to good health to improve life expectancy, reduce inequalities in health and support individuals and whaanau to lead healthy lives.

Improved quality, safety and experience

Delivering quality and safe care to all of our patients, and improving experience of care for patients and their whaanau throughout the care continuum.

Best value for public health system resources

Managing our resources to deliver quality healthcare services in a manner that is sustainable.

Outcomes we are seeking for our population

Sitting beneath these strategic objectives are the long-term outcomes we are seeking for our population:

People live healthier, longer, more productive, disease free lives

A healthy Counties Manukau population, with equal opportunities for improved health and better health outcomes for all. People will live healthier, longer, more productive lives.

People are at the centre of our health system

A patient and whaanau centred health system where patients and their whaanau are enabled, resourced and in control of their health. Patients and their whaanau are engaged in decision making to co-design their care and develop our services.

People stay well in the community

People are supported to stay well and manage their conditions in the community maintaining their independence and quality of life.

The intervention logic on the following page demonstrates how our strategic objectives and the long term outcomes we are seeking, align with and contribute to the regional priorities and national overarching sector goal, and how the services we fund and deliver will make a measurable contribution to the long term outcomes.

Intervention Logic

<table>
<tr><th colspan="8">National and Regional</th></tr>
<tr><td>National Goal</td><td colspan="7">All New Zealanders live longer, healthier and more independent lives</td></tr>
<tr><td>Regional Vision</td><td colspan="7">To improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means</td></tr>
<tr><td>Regional Priorities</td><td colspan="2">Adding to and increasing the productive life of people in the Northern Region</td><td colspan="2">Delivering safe and good quality healthcare which is patient and family centred</td><td colspan="2">The region’s health resources are efficiently and sustainably managed to meet present and future health needs</td></tr>
<tr><th colspan="8">Counties Manukau Health</th></tr>
<tr><td>Vision</td><td colspan="7">To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific people and other communities with health disparities</td></tr>
<tr><td>Goal</td><td colspan="7">Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015</td></tr>
<tr><td>Outcomes (10+ years)</td><td colspan="2">People live healthier, longer more productive, disease free lives</td><td colspan="2">People are at the centre of our health system</td><td colspan="2">People stay well in the community</td></tr>
<tr><td>Outcome Measures (5-10+ years)</td><td colspan="2">▪ Narrowing of ethnic disparity in overall life expectancy
▪ Reduction in smoking prevalence
▪ Reduction in obesity prevalence
▪ Reduction in rheumatic fever</td><td colspan="2">▪ Improved patient experience of care</td><td colspan="2">▪ Increased ratio of home based support services to aged residential care services</td></tr>
<tr><td>Key Impacts (3-5 years)</td><td colspan="2">▪ Fewer young people started smoking
▪ More people engaged in physical activity and healthy eating
▪ Fewer children admitted to hospital for preventable conditions</td><td colspan="2">▪ More people had access to treatment when required
▪ People needing acute care were seen in a timely matter
▪ More people were engaged in managing their health and treatment decisions</td><td colspan="2">▪ Fewer people were admitted to hospital for preventable conditions
▪ People with long term conditions were supported to manage their condition
▪ Older people were support to live safely and independently in their own homes
▪ People with mental health conditions had fewer acute admissions</td></tr>
<tr><td>Impact Measures</td><td colspan="2">▪ Proportion of year 10 students who have never smoked
▪ Proportion of adults engaged in 30+ min of physical activity a day; and eating 3 servings of vegetables and 2 servings of fruit per day
▪ Children’s acute hospitalisation rate
▪ Proportion of five year olds caries free at 5 years old</td><td colspan="2">▪ Improved access to elective surgery
▪ Shorter stays in emergency departments
▪ Number of advance care conversations taken place</td><td colspan="2">▪ Ambulatory sensitive hospitalisation rate for 0-75+
▪ More heart and diabetes checks
▪ Proportion of emergency department admissions for 75+ year olds
▪ Mental health access rates</td></tr>
<tr><td>Outputs</td><td colspan="2">Prevention</td><td colspan="2">Early Detection and Management</td><td colspan="2">Intensive Assessment and Treatment</td><td>Rehabilitation and Support</td></tr>
<tr><td>Enablers</td><td>Workforce</td><td>Networks & Relationships</td><td>Financial Resources</td><td>Quality Systems Processes</td><td>Information Technology</td><td>Clinical & Sector Leadership</td><td>Assets & Infrastructure</td></tr>
</table>

How have we performed?

Long-term Outcome Measures

In our 2012/13 Annual Plan we identified 6 long-term outcome measures which would enable us to measure our progress towards achieving the three long term outcomes we are seeking for our population. Given the long-term nature of these outcomes, we are seeking to make a measurable change over time as opposed to achieving a specific target.

What difference have we made for our population?

Narrowing of ethnic disparity in overall life expectancy

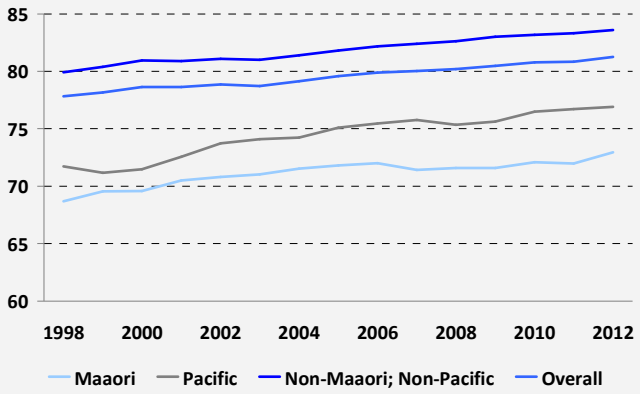
Life expectancy at birth is a key long term measure of health. Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern.

However, despite an overall increase in life expectancy, the gap between Maaori and Pacific, and non-Maaori and non-Pacific has decreased only marginally and large ethnic disparities remain. Of principle concern is the persistent wide gap for Maaori compared to non-Maaori groups as a result of levelling off in recent years of previous gains in Maaori life expectancy. In addition Maaori in Counties Manukau are falling behind Maaori nationally. The gap for Pacific, although smaller, is also of ongoing concern.

We remain committed to reducing these disparities, working with our communities to address the broader social determinants of the health gaps, and ensure that the highest quality health care is accessible and provided to our Maaori and Pacific communities.

The life expectancy gap of Maaori and Pacific in Counties Manukau compared to non-Maaori, non-Pacific

	2008 Baseline	2012 Result	12/13 Target
Maaori	11 yrs	10.6 yrs	Reduce baseline rates
Pacific	7.3 yrs	6.7 yrs	



The Life expectancy at birth for people living in Counties Manukau – 3 year rolling average

Data sourced from Mortality Collection, Ministry of Health; Estimated populations by DHB, Statistics New Zealand

Reduction in smoking prevalence

Smoking prevalence data is sourced from the Census and the latest results have not yet been released.

The percentage of adults in Counties Manukau who smoke

	2006 Baseline	2012 Result	12/13 Target
Maaori	47%	-	Reduce baseline rates
Pacific	30%	-	
Total	22%	-	

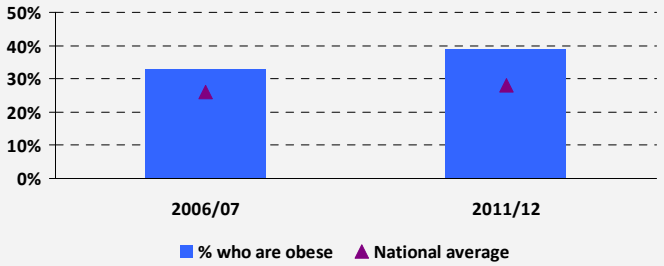
Reduction in obesity prevalence

The percentage of the Counties Manukau adult population who are obese has increased from 33% in 2006/07 to 39% in 2012. National obesity rates have also shown an upwards trend during this period increasing from 26% to 28%.

A healthy diet and regular physical activity are key elements to preventing and reducing overweight and obesity which are significant health concerns for the Counties Manukau population. Work continues within primary care to promote healthy eating, active lifestyles, improved self-management and supporting our communities and whaanau to become more active.

The percentage of adults in Counties Manukau who are obese

06/07 Baseline	2012 Result	12/13 Target
33%	39%	Reduce baseline rate



Targeted initiatives include our Beat Obesity Programme, healthy lifestyles grants to Maaori and Pacific organisations, Healthy Eating/Active lifestyle group courses and Men's camps that focus on healthy food options, physical activity and self-management. We also remain actively involved in the Green Prescription programme for adults and children (Active Families), the LotuMoui programme which

runs healthy lifestyle activities in over 80 Pacific churches throughout Counties Manukau and coordinating Maaori and Pacifica healthy lifestyle events.

Data Sourced from New Zealand Health Survey.

Reduction in rheumatic fever

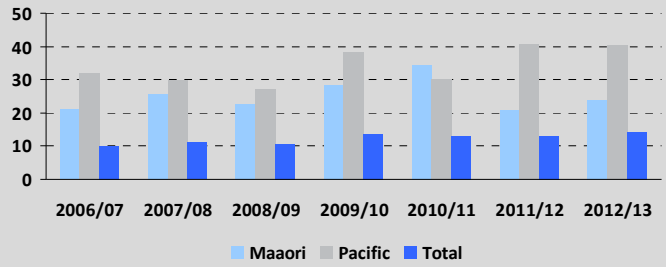
The acute rheumatic fever first hospitalisation rates in Counties Manukau have remained relatively static in 2012/13 at 14.2 first hospitalisations per 100,000 people, compared to 13.1 per 100,000 in 2011/12.

Reducing acute rheumatic fever rates is challenging because of the complex aetiology of the disease and the close association of with socio economic deprivation and household crowding. CM Health embarked on an ambitious rheumatic fever prevention programme at in the latter half of 2012 and it is expected that changes in acute rheumatic fever rates will be seen in the coming years.

Data sourced from Ministry of Health[5]

The acute rheumatic fever first hospitalisation rates per 100,000 people in Counties Manukau

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	20.7	24	Reduce
Pacific	40.7	40.1	baseline
Total	13.1	14.2	rates



Improved patient experience of care

The CM Health Patient Experience web-based system and development of a new suite of measures more reflective of patient and whaanau centred care will be completed and functional in 2013/14.

Increased ratio of home based support services to aged residential care

The ratio of the number of older people receiving home based support services to the number of older people in aged residential care services has decreased slightly from 2.35 in 2011/12 to 2.29 in 2012/13.

The ratio of people in Counties Manukau receiving home based support services to aged residential care services

11/12 Baseline	12/13 Result	12/13 Target
2.35	2.29*	2.6

When the first ratio was calculated in 2011/12 CM Health had not fully trained and rolled out the NASC comprehensive clinical assessment (interRAI) tool. Over 2012/13 all new assessments and reassessments of clients have used the Home Care or Contact Assessment interRAI tool and we now have 50% of our clients with a current InterRAI assessment. So while the ratio has decreased slightly, we are confident that introducing the standardised assessment tool has allowed us to more accurately provide services that reflect assessed needs. It is important to note that utilisation in rest home level of care has continued to decline compared to private hospital level of care and this reflects our commitment to support older people to remain at home longer with wrap around support services.

* as at March 2013

[5] The following criteria have been used to define acute rheumatic fever initial hospitalisations: ICD codes used: ICD-10-AM diagnosis codes: I00, I01, I02 (Acute rheumatic fever), ICD 9 CM-A diagnosis codes: 390, 391, 392 (Acute rheumatic fever) ICD-10-AM diagnosis codes: 105-109 (Chronic rheumatic heart disease) ICD 9 CM-A diagnosis codes: 393-398 (Chronic rheumatic heart disease). Inclusions: Principal diagnoses (Acute rheumatic fever) only Overnight admissions Day-case admissions. Exclusions: Previous acute rheumatic fever diagnosis (principal and additional) from 1988 Previous chronic rheumatic heart disease diagnosis (principal and additional) from 1988New Zealand non-residents. Transfers: Transfers with a principal diagnosis of acute rheumatic fever are counted as one acute rheumatic fever hospitalisation episode. Timeframe: Trends from 2002 onwards.

Medium-term Impact Measures

Sitting beneath the long-term outcome measures are 10 key impacts and associated measures. These impacts reflect health related areas where CM Health can influence change, promote healthy environments and lifestyles, and improve health and wellbeing. Targets against the 10 impact measures were set in the 2012/13 Annual Plan in order for us to evaluate the impact of our service delivery. This section provides an update on our progress.

Outcome: People live healthier, longer, more productive, disease free lives

What difference have we made for our population

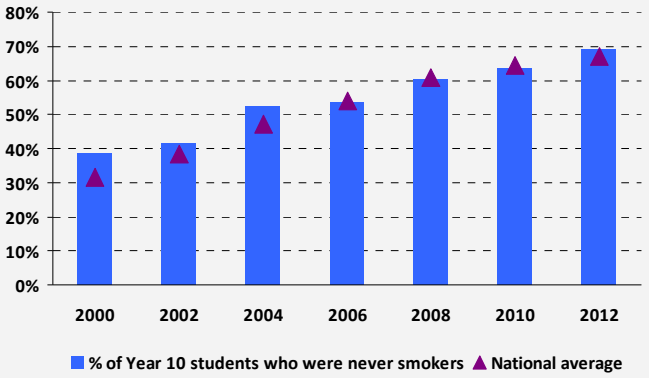
Fewer young people take up smoking

The uptake of smoking amongst young people in Counties Manukau continues to reduce as indicated by the Action on Smoking and Health (ASH)survey results. The 2012 ASH survey shows that 69% of Year 10 students in Counties Manukau have never smoked – an increase of 6% since 2010.

This reflects the impact of smokefree legislation and other national and local policies (e.g. increased taxation of tobacco and smokefree public spaces); supportive environments including the promotion of positive smokefree and anti-tobacco attitudes; and training and advice provided to tobacco retailers to regulate the access of tobacco to young people.

Data sourced from national Year 10 ASH Survey[6].

The percentage of year 10 students in Counties Manukau who have never Smoked	2010 Baseline	2012 Result	12/13 Target
	63%	69%	65%



More people are engaged in physical activity

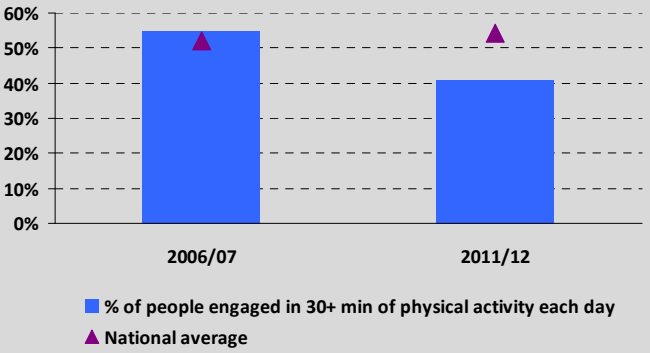
The percentage of adults in Counties Manukau who are regularly physically active fell in the New Zealand Health Survey from 55% of people being engaged in 30+ minutes of physical activity each day in 2006/07 to 41% in 2012. Counties Manukau physical activity levels are now below the national average.

Physical activity is an important component of maintaining a healthily lifestyle, and preventing and reducing overweight and obesity. Given that obesity is a significant issue for the Counties Manukau population, CM Health remain committed to increasing physical activity levels in our communities and whaanau and supporting healthy lifestyles.

Refer to "Reduction in obesity prevalence" section for further details on what we are doing to increase physical activity in our communities.

Data sourced from the NZ Health Survey.

The percentage of adults in Counties Manukau engaged in 30+ min of physical activity a day	06/07 Baseline	2012 Result	12/13 Target
	55%	41%	> 51%



[6] The ASH survey provides a point prevalence data set and is reported annually on calendar years

More people have healthier diets

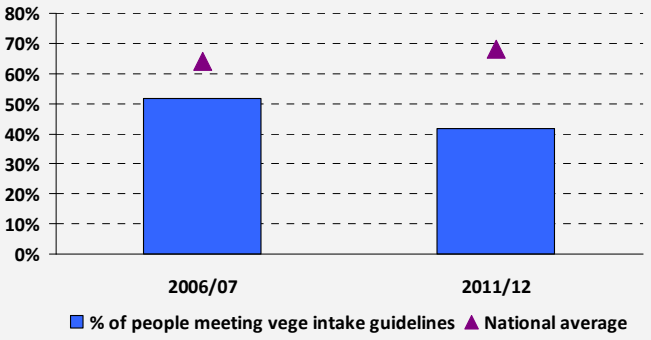
The percentage of the Counties Manukau adult population eating the recommended servings of fruit and vegetables fell in the 2011/12 New Zealand Health Survey.

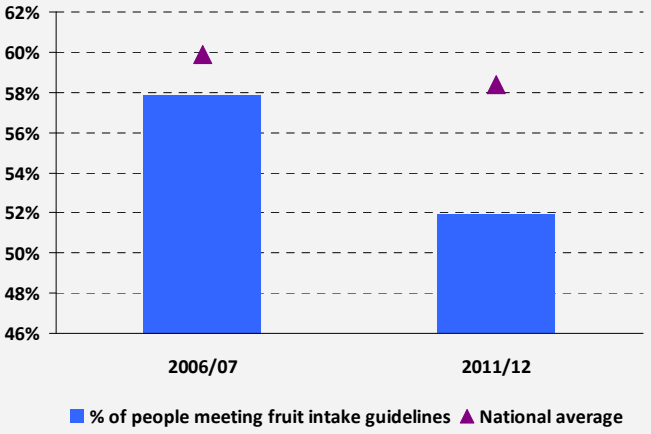
The 2011/12 survey results show that 52% of the CM Health population aged 15+ meet the fruit intake guidelines of 2+ servings per day, and 42% meet the vegetable intake guidelines of 3+ servings per day – a drop of 6% and 10% respectively since 2006/07. These rates remain below the national averages.

Refer to "Reduction in obesity prevalence" section for further details on what we are doing to support and encourage healthy eating in Counties Manukau.

The percentage of the Counties Manukau population (15+) meeting the fruit and vegetable intake guidelines

	06/07 Baseline	2012 Result	12/13 Target
Fruit 2+	58%	52%	> 52%
Veg 3+	52%	42%	> 52%





Data sourced from the NZ Health Survey.

Fewer children are admitted to hospital for preventable conditions

Overall acute hospitalisation rates for children in Counties Manukau have fallen slightly since 2011/12, indicating there are continuing incremental improvements in the health of children in Counties Manukau and a reduction in the number of children being admitted for preventable conditions.

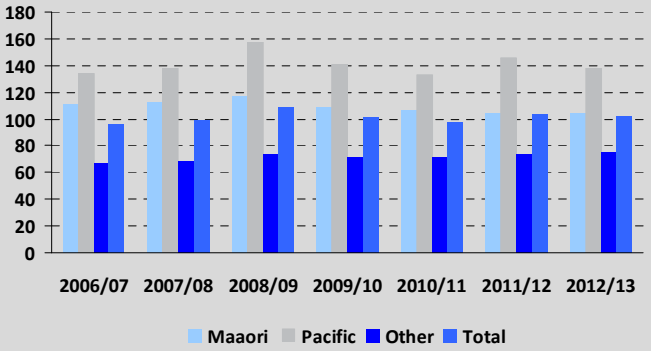
While Maaori and Other rates remained relatively flat over the past year, there was a reduction in acute hospitalisation rates for Pacific children – falling from 146 acute hospitalisations per 100,000 in 2011/12 to 138 per 100,000 in 2012/13.

Data sourced from NMDS, Ministry of Health.

Definition: Acutes, arranged, no transfer adjustment, crude rates

The acute hospitalisation rates for children (0-14 yrs) per 100,000 in Counties Manukau

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	105	105	Reduce baseline rate
Pacific	146	138	
Other	74	75	
Total	104	102	



More children have good oral health

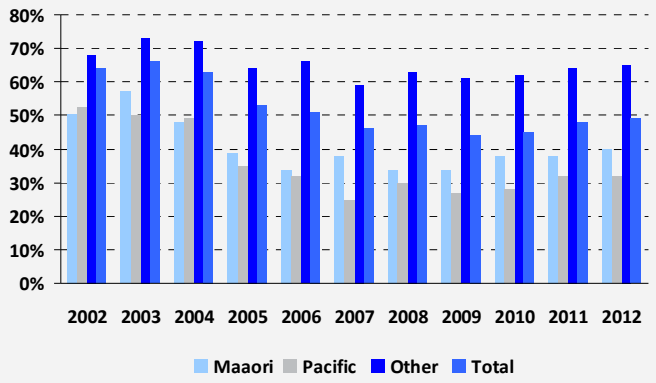
Early enrolment in oral health services is an important factor in improving the oral health of children. CM Health continues to make steady progress increasing the number of children enrolled in oral health services, with 71% of children under 5 years in Counties Manukau being enrolled – an increase of 5% since 2011.

While the percentage of children in Counties Manukau who are caries-free at age five has remained stable, dental caries remains a significant issue for Maaori and Pacific children with only 40% and 32% respectively caries-free at age five.

We are committed to improving the oral health of children in Counties Manukau and have comprehensive preschool oral health strategy. The strategy focuses on early engagement with preschool children living in high deprivation communities, increased preventative treatment to medium to high risk children, and increased access to dental services. Our preschool tooth-brushing programme delivered to preschools and Kohanga Reo promotes healthy attitudes and behaviours around oral hygiene, nutrition and engagement with dental services. The CM Health Pacific Health Development team continue to work closely with the Oral Health Team to support innovative fanau-centred oral health strategies.

The percentage of Counties Manukau children caries-free at age 5

	2011 Baseline	2012 Result	12/13 Target
Maaori	38%	40%	
Pacific	32%	32%	52%
Other	64%	65%	
Total	48%	49%	



Outcome: People are at the centre of our health system

What difference have we made for our population

More people had access to treatment when required

Refer to Performance against National Health Targets section

CM Health elective surgical services discharge performance

11/12 Baseline	12/13 Result	12/13 Target
107%	111%	100%

People needing acute care were seen in a timely matter

Refer to Performance against National Health Targets section

The percentage of people presenting to CM Health emergency departments who were admitted, discharged or transferred within 6 hours

11/12 Baseline	12/13 Result	12/13 Target
97%	96%	95%

More people were engaged in managing their health and treatment decisions

The number of advance care conversations with CM Health patients

11/12 Baseline	12/13 Result	12/13 Target
50	1400	240

CM Health completed 1400 advance care conversations with patients in 2012/13, exceeding the target by 1160 conversations.

Advance care planning is a process of discussion and shared planning for future health care. Advance care conversations and planning provides patients, and their whaanau, with the opportunity to develop and express their preferences for care informed by their personal beliefs and values and an understanding of their current and anticipated future health status and the treatment and care options available.

The result achieved by CM Health in advance care conversations reflects the success of the CM Health's Advance Care Plan (ACP) training packages and tools; the support provided to staff and patients to complete ACP's and the enhanced profile of ACP in primary and secondary care.

Outcome: People stay well in the community

What difference have we made for our population

Fewer people were admitted to hospital for preventable conditions

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital that are considered potentially avoidable by effective of primary care.

CM Health exceeded the target for reduction of ASH admissions in the 0-4 year age group in 2012/13. Factors contributing to this include improved childhood immunisation rates and increased uptake of the 'Warm Up Counties Manukau' home insulation programme.

Whilst target was not achieved for the 45-64 age group, there was a substantial reduction in ASH admissions. This is the second year where there has been a reduction and signals a reversal in the previous longstanding upward trend. The reduction is driven mostly by reduced admissions for cellulitis and heart failure. The Primary Options for Acute Care scheme is continuing to support general practice manage such conditions, and the 20,000 Day campaign will have contributed as well.

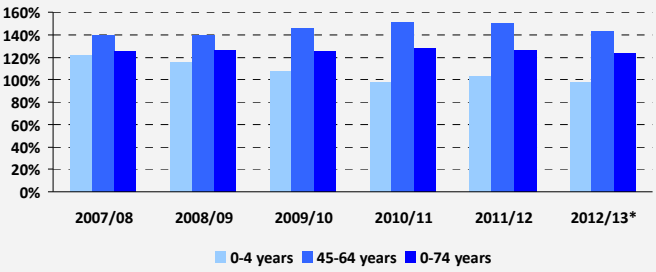
Similar results are demonstrated for the 0-74 age group.

* Year ended March 2013

Data sourced from Ministry of Health: DHB Quarterly Report March 2013

The ambulatory sensitive hospitalisation rates for people in Counties Manukau

	11/12 Baseline	12/13* Result	12/13 Target
0-4 years	103%	98%	102%
45-64 years	150%	143%	135%
0-74 years	126%	123%	118%



More people with long terms conditions are supported to manage their condition

Refer to Performance against National Health Targets section

The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessed in the last 5 years

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	55%	71%	75%
Pacific	62%	76%	
Other	48%	77%	
Total	52%	76%	

More older people are supported to live safely and independently in their own homes

The percentage of people aged 75+ presenting to CM Health emergency departments has remained relatively stable at 10%.

The percentage of 75+ year olds presenting to CM Health emergency departments

2011 Baseline	12/13 Result	12/13 Target
11%	10%	Reduce baseline rate

A number of inter-related programmes have been put in place to support older people to maintain their independence and live safely in their own homes. These include the Community Geriatric Service that provides medical and nursing support in the community and the Needs Assessment Service (NASC) which arranges community based services to support older people to stay well in the community and maintain their quality of life.

Fewer people have acute mental health episodes

Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes.

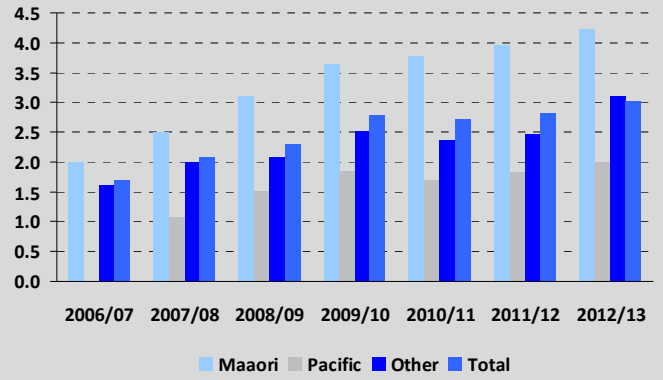
CM Health continues to make steady progress improving access to mental health services for people living in Counties Manukau. In 2012/13 we increased access to mental health services and exceeded the target for both the 0-19 year age group and 20-64 year age group. Access rates for the 65+ age group dropped slightly from 2.77 in 2011/12 to 2.66 in 2012/13, narrowly missing the target by 0.04. Wait time targets for the 65+ age group were achieved, indicating that demand for this age group is being met.

These results reflect the success of CM Health's targeted initiatives to improve access to mental health services. Initiatives include increased community and primary care based work; establishment of Mental Health Peer Review Groups in primary care; and service user and whaanau focused group activity. Communication with Referrers and GP Liaisons has been improved and we continue to work collaboratively with Child, Youth and Family, and the education sector.

*2011/12 Baseline figure taken from Q3

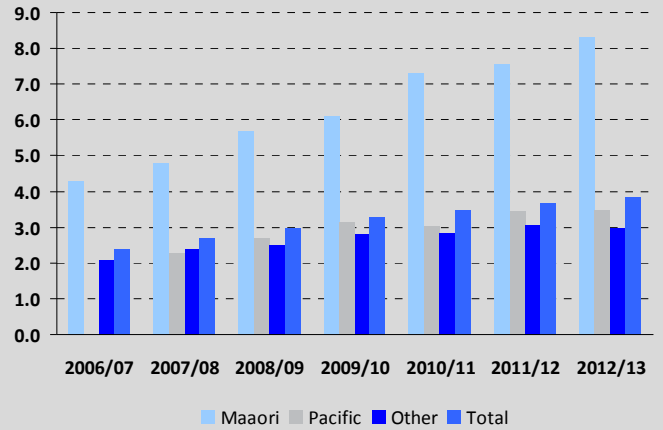
The mental health access rates for 0-19 year olds in Counties Manukau

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	3.95	4.22	4.00
Pacific	1.83	2.00	-
Other	2.46	3.10	-
Total	2.82	3.02	3.00



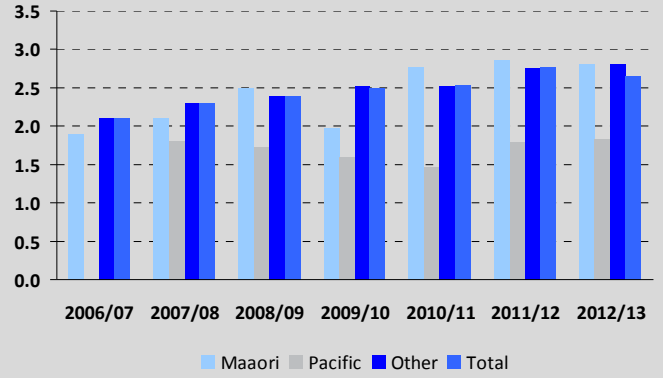
The mental health access rates for 20-64 year olds in Counties Manukau

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	7.58	8.31	7.55
Pacific	3.46	3.49	-
Other	3.04	3.00	-
Total	3.69	3.83	3.63



The mental health access rates for 65+ year olds in Counties Manukau

	11/12 Baseline	12/13 Result	12/13 Target
Maaori	2.86	2.80	-
Pacific	1.79	1.83	-
Other	2.76	2.80	-
Total	2.77	2.66	2.70



Statement of Service Performance

As part of our annual planning cycle, we provide an annual forecast of the services we plan to deliver. In developing the annual forecast, we consider the health needs of our population and select those 'measures' or activities and services that have the greatest potential to contribute to improving the health and wellbeing of our community and those which are markers of broader system-level change, or those where we expect to see a significant change in activity level. Against each measure we set performance targets. This section presents CM Health's actual performance against the forecast outputs presented in our 2012/13 Statement of Intent.

The services or 'outputs' we measure are grouped into four 'output classes' that reflect the nature of the services provided: Prevention Services, Early Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support.

Prevention Services

Prevention health services protect, promote and enhance the health and wellbeing of the population by influencing and improving physical and social environments, and supporting people to increase control over, and to improve, their health. These services include health promotion and education, immunisation and health screening, as well as statutory and regulatory public health services.

Health Promotion and Education Services		2011/12 Result	2012/13 Result	2012/13 Target
Smoking Cessation				
Proportion of hospitalised smokers provided with advice and help to quit		94%	95%	95%
Proportion of enrolled primary care patients who are smokers and are seen in General Practice are provided with advice and help to quit		-	56%	90%
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Care are offered advice and support to quit		-	New measure - baseline to be established	90%
Breastfeeding education and promotion services				
Number of community providers participating in Baby Friendly Community Initiative (BFCI) accreditation		3	3	3
Proportion of infants fully and exclusively breastfed at 6 weeks	Maaori	52	51	67
	Pacific	57	56	
	Total	58	57	
Proportion of infants fully and exclusively breastfed at 3 months	Maaori	36	36	55
	Pacific	44	43	
	Total	44	45	
Proportion of infants fully and exclusively breastfed at 6 months	Maaori	11	10	26
	Pacific	19	17	
	Total	18	18	
Healthy Environments				
Completed health and housing assessments		328	331	320
Number of homes insulated		983	917	1,000
Family Violence Prevention				
Proportion of woman over 16 years of age presenting to designated areas routinely screened for partner and child abuse	Adults - EC	5%	16%	20%
	Kidz First - EC	2%	10%	20%
	Kidz First Medical ward	6%	52%	5%
	Kidz First Surgical ward	0%	11%	

Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score (self audit using AUT tool)	Partner Abuse	92/100	96/100	90/100
	Child Abuse and Neglect	91/100	98/100	90/100
Immunisation Services		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Proportion of 8 month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time		-	90%	85%
Proportion of eligible children fully immunised at 24 months	Maaori	92	90	95%
	Pacific	97	94	
	Other	95	91	
Proportion of older people (65+) who have had their flu vaccinations		62%	62%	Dec 2012 63.95%
Health Screening		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Proportion of women aged 45 – 69 years who have had a breast screen in the last 24 months	Maaori	69%	70%	70%
	Pacific	67%	72%	
	Other	69%	70%	
Proportion of women aged 20 - 70 years who have had a cervical smear in the last three years		Mar 2012 69%	Mar 2013 69%	75%
Proportion of the eligible population who have had their B4 School Checks	Vision and Hearing (2 components)	7061 (80% of eligible population)	7,022 (80% including 3,058 of high dep)	80% of eligible population (including 80% of high dep)
	Nurse (Well child – 8 components)			
	Children who have 1 component missing from their check	0	-	
Statutory and Regulatory Services		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Proportion of premises who submit a liquor licence application to ARPHS and all problematic premises that receive a compliance check		(Dec 2011) 82%	96%	100%
Proportion of liquor licensing alcohol compliance protocol for visits adhered to		(Dec 2011) 97%	97%[7]	100%
Numbers of submissions made		12	26 written by ARPHS and 1 endorsement of a submission written by Paediatric Society	15

[7] 3% variance from target is due to human error.

Number of license premises risk assessed (on and club) by Auckland Regional Public Health Service (ARPHS). (new measure year 2013/14)	1269[8]	Not calculated for year 2012/13. New tool was only applied from October 2012	1,200 est.
Number of license premises assessed as high risk. (new measure year 2013/14)	608[9]	Not calculated for year 2012/13. New tool was only applied from October 2012	400 est.
Numbers of joint Controlled Purchase Operations conducted - alcohol (new measure year 2013/14)	237	227	200 est.

[8] From October 2012, a new risk assessment tool was implemented. Before the tool was used, the risk of premises was not able to be systematically assessed. The number included here represents the number of license applications processed in the year 2011/12 as a base to estimate the number of licenses that may be risk assessed in the year 2013/14. 100% of license applications will be risk assessed.

[9] The number included here represents the number of premises that were considered of high risk according to the criteria used before the implementation of the new assessment tool and that received a compliance check. It is expected that the assessment tool will provide a better method for identification of high risk premises; the target for 2013/14 has been set accordingly.

Early Detection and Management Services

Early detection and management services are preventative and treatment focused services that support people to improve their health through early diagnosis and treatment, and better management of long term conditions. These services are provided in the community by a range of health professionals that include general practice, Maaori and Pacific health services, pharmacy services and oral health and dentistry services. Early detection and management services are focused on individuals and small groups of people.

Primary Health Care Services (GP)		2011/12 Result	2012/13 Result	2012/13 Target
Rate of GP consultations for high needs population compared with non-high needs population		3.2	2.9	>1
Number of bed days saved through our Saving 20,000 Days Campaign initiatives		20,060		20,000
Long Term Conditions Management		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Proportion of people with diabetes who have had an annual check		82%	67%	82%
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)	Maaori	56%	58%	66%
	Pacific	50%	53%	
	Total	62%	64%	
Number of additional patients enrolled in Self Management (SM) programmes		551	488	1100
Number of patients registered in all Chronic Care Management (CCM) programmes		19,910	20,305	>19,000
Number of enrolments / referrals in Primary Options for Acute Care (POAC)		9,788	8,309	11,600
Oral Health Services		**Dec 2011 Result**	**Dec 2012 Result**	**Dec 2012 Target**
Proportion of children under 5 years enrolled in DHB-funded oral health services		66%	71%	73%
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)		12%	19%	12%
Number of preschool centres engaged in the oral health education and tooth brushing programme		0	103	July 2013 150
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service		100%	100%	100%
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		67%	66%	80%
Diagnostics		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Proportion of accepted referrals for CT and MRI scans will receive their scan within 6 weeks		-	CT 87% MRI 80%	75%
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		35%	53%	50%
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		22%	25%	50%
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		99%	98%	50%

Intensive Treatment and Assessment Services

Intensive treatment and assessment services are complex and specialist services that tend to be provided in settings that enable co-location of clinical expertise and specialist equipment, for example a hospital or surgery centre. These services include ambulatory services such as outpatient, district nursing and day patient services; acute and elective inpatient services; as well as emergency department services.

Mental Health		2011/12 Result	2012/13 Result	2012/13 Target
Proportion of people referred for non-urgent mental health or addiction services seen within:	3 weeks	-	61%	75%
	8 weeks	-	81%	85%
Proportion of long term clients with Relapse Prevention Plan (RPP)	Child and Youth	86%	95%	June 2014 95%
	Adult (20+)	95%	96%	
Elective Services		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Elective and Arranged Day of Surgery Admission		60%	89%	90%
Elective Theatre Utilisation Rate		87%	89%	85%
		Q3 2011/12	Q3 2012/13	
	Major joints	20.17	21.79	21.0
	Cardiac	6.8	6.77	6.5
	Cataracts	38.19	36.06	27.0
ESPI 1: DHB services that appropriately acknowledge and process all patient referrals within 10 working days		100%	100%	100%
ESPI 2: Patients waiting longer than six months for their first specialist assessment (FSA) by July 2013		0-0.1%	0%	0%
ESPI 3: Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)		0.1-0.3%	0.1%	0%
ESPI 5: Patients given a commitment to treatment but not treated within six months by July 2013		0-0.6%	0%	0%
ESPI 6: Patients in active review who have not received a clinical assessment within the last 6 months		0%	2.6%	0%
ESPI 8: Proportion of patients treated who were prioritised using nationally recognised tools and processes		100%	100%	100%
Acute Services		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
All Medical Oncology and Haematology patients needing Radiation Therapy treatment (and are ready to start treatment) will have this within four weeks from decision to treat	Maaori	100%	100%	100%
	Pacific	100%		
	Total	100%		
All Medical Oncology and Haematology patients needing Chemotherapy treatment (and are ready to start treatment) will have this within four weeks from decision to treat	Maaori	100%	100%	100%
	Pacific	100%		
	Total	100%		
Proportion of patients referred urgently with high suspicion of Lung cancer to first cancer treatment (62 days)		-	75%	60%
Proportion of patients referred urgently with high suspicion of lung cancer to first specialist appointment (all treatment types) within 14 days	Radiation oncology	-	62%	50%
	Medical oncology	-	62%	50%
Proportion of patients with confirmed lung cancer diagnosis who receive first cancer treatment within 31 days of decision of treat (all treatment types)		-	97%	50%

Cardiac Services				
Proportion of all outpatients triaged to chest pain clinics who are seen within 6 weeks for cardiology assessment and stress test		-	99%	70%
Proportion of outpatient coronary angiograms with a waiting time of < 3 months		-	93%	85%
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission		-	75%	70%
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins		-	86%	80%
Maternity Services		2011/12 Result	2012/13 Result	2012/13 Target
Proportion of women who have not been managed according to their assigned status (ESPI)		0%	0%	0%
Proportion of CMDHB newborns screened within 4 weeks of birth		62%	66%	90%
Additional Patient Safety Measures for our hospital services		2011/12 Result	2012/13 Result	2012/13 Target
Acute readmissions to hospital (Readmissions to ARHOP within 28 days of discharge)	Total	9.42%	9.63%	9.52%
	65+	-	10%	<=13.8%
	75+	-	10.4%	<=14.2%
Inpatient Average Length of Stay		4.26 days (elective & arranged)	3.89 days	3.63 days
Wards (excluding Mental Health) that have electronic medication reconciliation systems in place		Implemented in 5 wards	65% (Implemented in 20 wards)	100%
Rate of Central Line Associated Bacteraemia (CLAB) in the Intensive Care Unit (including High Dependency Unit) per 1000 line days		2.0/1000 line days	1.1/1000 line days	0
Number of in-hospital falls causing harm per year		2	2	By Dec 2013 <3.5/1000 bed-days
Number of pressure injuries hospital wide		3.5%	3.3%	By Dec 2013 3% per 100 patients
Hand hygiene compliance rate (based on Gold Audit)		60%	67%	80%
Outpatient Did Not Attend (DNA) rates for:	Maaori	19%	19%	<10%
	Pacific	17%	17%	<15%

Rehabilitation and Support Services

Rehabilitation and support services assist people to manage their needs, regain independence and stay well in the community following a hospital admission or illness. Rehabilitation and support services are also provided to older people with complex health needs, people with long term disabilities and people needing palliative care. These services include assessment, treatment, rehabilitation and support; palliative care services, as well as home based support and residential care services.

NASC		2011/12 Result	2012/13 Result	2012/13 Target
Proportion of CMDHB NASC staff who have participated in interRAI training and can deliver appropriate assessments in the community and allocate support using CMDHB contracted HBSS		71% (May 2012)	100%	100%
Proportion of CMDHB NASC clients who have a comprehensive interRAI assessment completed		20% (new clients) 6.7% (of all clients)	45%	100%
Assessment, Treatment and Rehabilitation Services		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Community Services				
Provision of AT & R services for the Franklin locality through Pukekohe hospital. Pilot increase from 2 to 8 AT&R beds at Pukekohe Hospital and monitor occupancy		78% (May 2011)	67%	80% occupancy of 8 AT&R beds at Pukekohe Hospital
Number of referrals to the Very High Intensive User (VHIU) programme		800	1470	1000
Provide VHIU community based care where possible to avoid hospital admissions		-	30% (728 bed days saved	20% saving in bed days for identified high risk individuals (1880 bed days saved)
Hospital Services				
Average length of stay in AT&R (Pukekohe hospital beds)		15.1	18.35	< 15 days
Reduced inpatient length of stay for orthogeriatric patients > 75 years of age		15.72	15.62	< = 16 days
Reduced inpatient length of stay for frail elderly patients > 75 years of age		15.72	15.62	< = 14 days
Reduction in hospital readmissions of elderly patients > 75 years of age who represent to hospital within 28 days of admission with the same condition as previously in hospital		9.3	9.2	< = 10%
Palliative Care		**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Advanced Care Planning (ACP) in aged residential and secondary care: Completion of ACP training rollout to first and second pilot sites (designated secondary and primary care services)		50 conversations have been had to date	1400+ conversations, 110+ plans completed, 60 Staff L2 Trained	240 conversations
Increase utilisation of palliative care beds at:	Pukekohe Hospital	52% (Jan – Jun 2012)	47%	59%
	Franklin Hospital	20% (Jan – Jun 2012)	16%	84%

Aged Related Residential Care (ARRC)	2011/12 Result	2012/13 Result	2012/13 Target
Proportion of long term residents who have a Long Term Care Facility Assessment completed	5.9%	20.4%[10]	20%
Proportion of residential care service providers who meet required certification standards	100%	100%	100%
Number of EC presentations from ARC	34	33	< 45 presentations per month
Home Based Support	**2011/12 Result**	**2012/13 Result**	**2012/13 Target**
Proportion of clients receiving long term HBSS have an interRAI Comprehensive Clinical Assessment	25%	50.4%	25%
Proportion of new clients receiving HBSS who have an interRAI assessment completed either while in hospital or on their return to the community	100%	100%	95%

[10] Two larger trained facilities did not carry out any interRAI due to retraining, those bed numbers are not included

Good Employer

Counties Manukau District Health Board (CMDHB) applies the following "Good Employer Principles".

Principle

CMDHB believes that a good employer is one who operates a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment.

CMDHB is committed to this principle and will actively seek to uphold any legislative requirements in this regard.

Good Employer principles in practice

Provisions which reflect the General Principles include:

- Good and safe working conditions
- An equal opportunities programme
- The impartial selection of suitably qualified persons for employment
- Recognition of the aims, aspirations and employment requirements of Maaori people
- Recognition of the aims, aspirations cultural differences and employment requirements of Pacific peoples, and people from other ethnic or minority groups
- Opportunities for the enhancement of the abilities of individual employees
- Recognition of the employment requirements of women
- Recognition of the employment requirements of men
- Recognition of the employment requirements of persons with disabilities

Standards

CMDHB shall ensure that employees maintain proper standards of integrity and conduct, in keeping with the "Vision and Values" of CMDHB.

Complaints and appeals

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

Equal Employment Opportunities (EEO)

Principles

CMDHB believes that by ensuring our workplaces reflect and value the differences within our workforce, we will be able to deliver quality health services more efficiently, effectively, and appropriately.

CMDHB believes that by removing seen and unseen barriers which prevent people from reaching their full potential, we can deliver top performance at every level of the organisation.

Equal Employment Opportunities (EEO) is an integral part of being a good employer.

Policy

CMDHB is committed to the concept of EEO and will work towards the elimination of all forms of unfair discrimination in employment evidenced by:

- Inclusive, respectful and responsible organisational culture which enable access to work, equitable career opportunities and maximum participation for members of designated groups and all employees
- Procedural fairness as a feature of all human resource strategies, systems, and practices
- Employment of EEO groups at all levels in the workplace

In the past year CMDHB has joined the Equal Employment Opportunity (EEO) trust. This assists the organisation to champion our EEO goals.

Over the next year EEO initiatives will continue to develop as we grow and celebrate our diverse workforce.

Discrimination

Discrimination in employment occurs whenever factors or personal characteristics which are not relevant to the job are used. Discrimination can be direct (e.g. by refusing to hire people with certain characteristics) or, more often, indirect (e.g. when people appear to be treated in the same way but are in fact denied equal opportunity).

CMDHB's Human Resource policies and practices will be free from any discriminatory element that has the potential to deny a person equal opportunity.

Benefits

EEO will help CMDHB develop a more united and diverse workforce which is responsive to change, is more flexible and has a richer workplace culture.

EEO is a way of honouring our obligations under the Treaty of Waitangi.

EEO will assist CMDHB to:

- Deliver improved customer service by better matching our services with our clients
- Improve its productivity through valuing its employees and treating them fairly

EEO can improve staff relations and morale, lower absenteeism and reduce staff turnover. CMDHB has one of the lowest staff turnover rates within the public health sector.

Policies, Procedures and Guidelines

CMDHB has over 50 policies, procedures and guidelines relating from topics such as "Breastfeeding in the workplace", "Harassment", "Code of Conduct", "Conflict of Interest", "A Safe Way of Working" to "Employee Welfare and Wellbeing Management".

The table below breaks down the CMDHB workforce (head count) into selected groups.

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

	Females		Males	
Employee Group	Number	Average salary	Number	Average salary
SMO	184	211,200	286	240,549
RMO	219	110,180	219	112,380
IEA's	192	106,658	68	117,150
Clerical	682	49,932	20	49,099
Cleaners & Orderlies	189	35,559	98	35,913
Medical Laboratory	127	55,314	32	61,355
Radiology	73	72,544	15	64,457
Allied Health	851	62,327	174	62,264
Security & Trades	5	63,752	68	59,859
Mental Health Nursing & Health Care Assistants	250	65,587	84	58,699
Midwives	159	61,478		
Nursing & Health Care Assistants	2,140	62,799	234	60,697
Interpreters	16	47,022	6	47,134

Number of ethnic groups employed?

Ethnic data is collected through the leader payroll system with 92% of employees disclosing ethnicity. This allows for greater access to valuable planning data for services who are working to meet the organisations' objective of having a workforce which more accurately reflects the population we serve.

Financial Statements

Statement of Responsibility

The Board are responsible for the preparation of the Counties Manukau District Health Board and group's financial statements and the statement of service performance, and for the judgements made in them.

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

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2013.

Signed on behalf of the Board:

Professor Gregor Coster CNZM

Chair

Jan Dawson

Chair Audit, Risk and Finance

Geraint Martin

Chief Executive

Ron Pearson

Deputy Chief Executive / Director
Corporate & Business Services

Statement of Comprehensive Income

For the year ended 30 June 2013

	Notes	Parent and Group		
		Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Income				
Patient Care Revenue	2	1,381,090	1,387,989	1,325,522
Interest Income		1,400	936	890
Other Income	3	23,164	29,743	26,081
Total income		**1,405,654**	**1,418,668**	**1,352,493**
Expenditure				
Personnel costs	4	511,413	511,984	481,244
Depreciation and amortisation expense	12	23,594	25,453	22,732
Outsourced services		62,506	52,942	57,361
Clinical supplies		101,448	95,201	99,352
Infrastructure and non-clinical expenses		46,979	57,595	53,359
Other District Health boards		200,560	271,777	273,613
Non-health board provider expenses		423,056	374,713	327,446
Capital Charge	5	12,738	12,108	12,441
Interest expense		8,134	9,458	9,626
Other expenses	6	12,215	4,432	9,910
Total expenditure		**1,402,642**	**1,415,663**	**1,347,084**
Surplus		**3,012**	**3,005**	**5,409**
Other comprehensive income				
Revaluation	12	19,645		
Impairment of buildings and plant	12		-	(2,500)
Other comprehensive income		**19,645**	**-**	**(2,500)**
Total comprehensive income for the year		**22,657**	**3,005**	**2,909**

Explanations of major variances against budget are provided in note 29.

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

For the year ended 30 June 2013

	Notes	Parent and Group		
		Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Balance 1 July		**166,354**	**166,076**	**161,708**
Comprehensive income				
Surplus for the year		3,012	3,005	5,409
Other comprehensive income		19,645		(2,500)
Total comprehensive income		**22,657**	**3,005**	**2,909**
Capital contributions from the Crown			3,009	2,148
Repayment of capital to the Crown		(419)	(420)	(416)
Interest on restricted funds		5	12	5
Balance at 30 June		**188,597**	**171,682**	**166,354**

Explanations of major variances against budget are provided in note 29.

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2013

	Notes	Parent and Group		
		Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Assets				
Current Assets				
Cash and cash equivalents	7	1,028	1,862	6,166
Debtors and other receivables	8	35,442	48,961	32,366
Inventories	10	946	1,161	835
Prepayments		321	605	190
Total current assets		**37,737**	**52,589**	**39,557**
Non-current assets				
Investments in Associates and Jointly Controlled Entities.	11	15,829	-	10,081
Property, plant and equipment	12	588,153	576,163	522,535
Intangible assets	13	8,139	1,020	-
Other Non-Current Assets	9	1,277	1,277	1,199
Total non-current assets		**613,398**	**578,460**	**533,815**
Total assets		**651,135**	**631,049**	**573,372**
Liabilities				
Current liabilities				
Overdraft	15	7,350	-	-
Creditors and other payables	14	95,965	106,463	94,530
Borrowings	15	5,000	7,500	30,005
Employee entitlements	16	106,691	126,096	100,512
Total current liabilities		**215,006**	**240,059**	**225,407**
Non-current liabilities				
Borrowings	15	232,600	203,713	167,600
Employee entitlements	16	13,595	14,498	13,159
Provisions	17	1,337	1,097	1,212
Total non-current liabilities		**247,532**	**219,308**	**181,971**
Total liabilities		**462,538**	**451,370**	**407,018**
Net assets		**188,597**	**171,682**	**166,354**
Equity				
Crown equity	18	108,964	109,383	109,383
Accumulated deficits	18	(48,664)	(48,849)	(51,675)
Revaluation reserves	18	127,443	110,298	107,798
Trust funds	18	854	850	848
Total Equity		**188,597**	**171,682**	**166,354**

Explanations of major variances against budget are provided in note 29.

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2013

	Notes	Parent and Group		
		Actual 2013 $000	Budget 2013 $000	Actual 2012 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,275,020	1,273,391	1,214,828
Other		148,632	142,236	166,460
Interest received		1,322	936	895
Payments to suppliers		(867,495)	(851,895)	(853,639)
Payments to employees		(504,673)	(504,762)	(474,140)
Capital charge		(12,925)	(12,204)	(12,441)
Interest payments		(8,134)	(9,144)	(9,559)
Goods and services tax (net)		(1,305)		974
Net cash flow from operating activities	**19**	**30,442**	**38,558**	**33,378**
Cash flows from investing activities				
Purchase of property, plant, equipment and intangible assets		(81,928	(91,848)	(67,715)
Acquisition/roll over of investments		(584)		
Net cash flow from investing activities		**(82,512),**	**(91,848)**	**(67,715)**
Cash flows from financing activities				
Capital contributions from the Crown				2,148
Repayment of capital to the Crown		(419)	(420)	(416)
Repayment of loans		(30,005)	(30,005)	(6,603)
Proceeds from borrowings		70,000	83,718	47,600
Repayment of Finance Leases				-
Net Appropriation from Trust Funds		6	3	9
Net cash flow from financing activities		**39,582**	**53,296**	**42,738**
Net increase in cash and cash equivalents		**(12,488)**	**6**	**8,401**
Cash and cash equivalents at the start of the year		6,166	1,856	(2,235)
Cash and cash equivalents at the end of the year		**(6,322)**	**1,862**	**6,166**

Explanations of major variances against budget are provided in note 29.

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") is a Health Board established by the New Zealand Public Health and Disability Act 2000. CMDHB is a crown entity in terms of the Crown Entities Act 2004 owned by the Crown and domiciled in New Zealand.

Financial statements for CMDHB and consolidated financial statements are presented. The consolidated financial statements of CMDHB as at and for the year ended 30 June 2013 comprise CMDHB and its subsidiaries (together referred to as the "Group" and individually as "Group entities") and the Group's interest in associates and jointly controlled entities.

CMDHB is a public benefit entity for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements for CMDHB are for the year ended 30 June 2013, and were approved by the Board on 4 October 2013

Basis of Preparation

Statement of compliance

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

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

In preparing these financial statements, the Management 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 outlined later.

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

There have been no revisions to accounting standards during the financial year which had an effect on the DHB's financial statements.

Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by CMDHB.

Investments in Associates and Jointly Ventures

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

Revenue

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

MOH Revenue

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

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 DHB's

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

Borrowing costs are capitalised on construction projects with a capital cost greater than $100m, all other costs are treated as an expense in the financial year in which they are incurred with the exception of those cost deemed to relation to a capital project over $100m.

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 over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

The amount of any write-down for the loss of service potential is recognised in surplus or deficit 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 and plant
- Clinical equipment, IT and motor vehicles
- Other equipment
- Infrastructure

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 re valued 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 will be recognised first in the surplus or deficit 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 initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, 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 re valued 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 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	10 - 100 years	1% - 10%
Electrical Services	10 - 15 years	6% - 10%
Other Services	15 - 25 years	4% - 6%
Fit out	5 - 10 years	10% - 20%
Infrastructure	20-100 years	5% - 1%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	3 - 25 years	4% - 33%
Information Technology	3 - 5 years	20% - 33%
Vehicles	3 - 6 years	16% - 33%
Other Equipment	3 - 25 years	4% - 33%

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

Amortisation

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

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

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

Impairment of Property, Plant & Equipment and Intangible Assets

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 re valued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is based on an independent actuarial calculation which is 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 sabbatical 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

- 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, sabbatical 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 as incurred.

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

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

The budget figures are derived from the statement of intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements. CMDHB post budget approval, changed its policy to capitalise borrowing costs against capital projects greater than $10m.

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.

Critical accounting estimates and assumptions

In preparing these financial statements, Management 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 12.

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

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Agency relationship

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

CMDHB has entered into a contract for services with several providers for laboratory services. Services are provided across several DHBs' districts. CMDHB makes payments to the service providers on behalf of the all DHBs receiving services and these DHBs will then reimburse CMDHB for the costs of the services provided in their districts. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between CMDHB and the other DHBs, Counties Manukau has assessed that it has acted as an agent for the other DHBs. Therefore, the payments and receipts in relation to the other DHBs are not recognised in the Counties Manukau's financial statements.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB, are:

- NZ IFRS 9 Financial Instruments will replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

  The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. The DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still

under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

2 Patient care revenue

	Actual 2013 $000	Actual 2012 $000
Health and disability services (MoH contracted revenue)	1,267,390	1,206,614
ACC contract revenue	16,516	17,318
Revenue from other district health boards	80,033	88,543
Other patient care related revenue	17,151	13,047
Total patient care revenue	**1,381,090**	**1,325,522**

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. $22.5m (2012 $20.6m)

3 Other income

	Actual 2013 $000	Actual 2012 $000
Donations and bequests received	2,570	2,492
Rental income	1,473	1,792
Gain on Disposal of Assets	85	1,608
Other income	19,036	20,189
Total other income	**23,164**	**26,081**

4 Personnel costs

	Actual 2013 $000	Actual 2012 $000
Salaries and wages	492,572	464,222
Contributions to defined contribution schemes	11,916	9,917
Increase in liability for employee entitlements	6,615	7,104
Restructuring provision for employee exit costs	310	-
Total personnel costs	**511,413**	**481,244**

5 Capital Charge

The DHB pays a six monthly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2013 was 8% (2012: 8%).

6 Other expenses

Other expenses include:	Actual 2013 $000	Actual 2012 $000
Audit fees	181	172
Operating leases expense	6,800	6,071
Impairment of debtors	4,819	3,221
Board and committee members fees and expenses	415	446
Total Other Expenses	**12,215**	**9,910**

7 Cash and cash equivalents

	Actual 2013 $000	Actual 2012 $000
Cash at bank and on hand (overdraft)	14	318
Trust / Special purpose Funds note 18	854	848
Call deposits	160	5,000
Total cash at bank and on hand	1,028	6,166
Overdraft figure as disclosed in Note 15	**(7,350)**	**-**
Cash and cash equivalents for the purposes of the statement of cash flows	**(6,322)**	**6,166**

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value.

8 Debtors and other receivables

	Actual 2013 $000	Actual 2012 $000
Ministry of Health receivables	4,176	11,806
Other receivables	11,995	11,762
Other accrued revenue	21,655	11,895
Less: provision for impairment	(2,384)	(3,097)
Total Debtors and other receivables	**35,442**	**32,366**

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:

	2013			2012		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	28,997		28,997	22,309	-	22,309
Past due 1-30 days	2,740		2,740	4,869	(634)	4,235
Past due 31-60 days	896	(438)	459	465	(186)	279
Past due 61-90 days	836	(446)	390	1,042	(532)	510
Past due > 90 days	4,356	(1,500)	2,856	6,778	(1,745)	5,033
Total	**37,825**	**(2,384)**	**35,442**	**35,463**	**(3,097)**	**32,366**

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

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

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

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

Movements in the provision for impairment of receivables are as follows:

	Actual 2013 $000	Actual 2012 $000
Balance at 1 July	3,097	5,979
Charged to 'Other Expenses' (additional provisions made)	4,819	3,221
Receivables written off	(5,532)	(6,103)
Balance at 30 June	**2,384**	**3,097**

9 Other Non-Current Assets

	Actual 2013 $000	Actual 2012 $000
Reversionary interest in car park building	1,277	1,199
Total Other Non-Current Assets	**1,277**	**1,199**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to them in 18 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 6.5% was used.

10 Inventories

	Actual 2013 $000	Actual 2012 $000
Pharmaceuticals	848	727
Other Supplies net of provision for obsolete stock	98	108
Total inventories	**946**	**835**

Some inventories are subject to retention of title clauses.

The amount of inventories recognised as an expense during the year was $20.2m which is included in the Clinical supplies line item for the Statement of Comprehensive Income.

11 Investments in Associates and Jointly Controlled Entities

CMDHB does not consolidate its subsidiaries as they are not material. Associates and Jointly Controlled Entities are not accounted for using the equity method or proportionate method as they are not material.

a) General information

Name of entity	Principal activities	Interest held at 30 June 2013	Balance date
Northern Regional Alliance Ltd	Provision of health support services	33.3%	30 June-13
healthAlliance NZ Ltd	Provision of shared services	20.0%	30 June-13
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	25.0%	30 June-13

b) Summary of financial information (unaudited) of associate

Year end 30 June 2013 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	14,156	13,353	803	12,184	148
healthAlliance NZ Ltd	86,426	20,140	66,286	99,222	32
NZ Health Innovation Hub Limited Partnership	894	526	368	1,752	368

Year end 30 June 2012 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Training Hub Ltd	2,414	2,365	49	3,033	47
Northern DHB Support Agency Ltd	6,059	5,387	672	8,253	38
healthAlliance NZ Ltd	61,453	19,629	61,453	90,485	-
NZ Health Innovation Hub Limited Partnership	-	-	-	-	-

Note: the Northern DHB Support Agency Ltd changed it's name during the year to Northern Regional Alliance Ltd (NRA). The Northern Regional Training Hub Ltd was incorporated into NRA during the year.

c) Share of profit of associate entities and Jointly Controlled Entities

	Parent and Group	
	2013 Actual	2012 Actual
Share of profit/(loss)	148	28

Investments in Associates and Jointly Controlled Entities

	2013 Actual $000	2012 Actual $000
healthAlliance NZ Ltd	15,829	10,081
Total Investments	**15,829**	**10,081**

12 Property, plant and equipment

	Land	Buildings & Plant	Infra-structure	Clinical Equipment, IT & Motor Vehicles	Other Equipment	Work in progress	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or valuation							
Balance at 1 July 2011	**72,753**	**347,475**	**-**	**110,231**	**15,487**	**48,137**	**594,083**
Additions	-	-	-	-	-	75,909	75,909
Work in Progress	-	28,144	-	7,403	88	(35,635)	-
Impairment of Assets	-	(2,500)	-	-	-	-	(2,500)
Disposals/transfers	-	(6)	-	(929)	(10)	-	(945)
Balance at 30 June 2012	**72,753**	**373,113**	**-**	**116,705**	**15,565**	**88,411**	**666,547**
Balance at 1 July 2012	**72,753**	**373,113**	**-**	**116,705**	**15,565**	**88,411**	**666,547**
Additions			-			73,393	73,393
Work In Progress capitalised		15,071	-	11,493	793	(31,568)	(4,211)
Revaluation of Assets			19,645				19,645
Disposals/transfers			-	(531)	(53)		(584)
Balance at 30 June 2013	**72,753**	**388,184**	**19645**	**127,667**	**16,305**	**130,236**	**754,790**
Accumulated depreciation and impairment losses							
Balance at 1 July 2011	**-**	**23,467**	**-**	**83,738**	**12,994**	**-**	**120,199**
Depreciation expense	-	13,495	-	8,584	654	-	22,732
Elimination on disposal/transfer	-	(14)	-	1,104	(10)	-	1,081
Balance at 30 June 2012	**-**	**36,948**	**-**	**93,426**	**13,638**	**-**	**144,012**
Balance at 1 July 2012	**-**	**36,948**	**-**	**93,426**	**13,638**	**-**	**144,012**
Depreciation expense	-	14,057	-	8,810	684		23,551
Elimination on disposal/transfer		(373)	-	(505)	(48)		(926)
Balance at 30 June 2013	**-**	**50,632**	**-**	**101,731**	**14,274**		**166,637**
Carrying amounts							
At 1 July 2011	72,753	324,008	-	26,493	2,493	48,137	473,884
At 30 June and 1 July 2012	72,753	336,165	-	23,279	1,927	88,411	522,535
At 30 June 2013	**72,753**	**337,552**	**19,645**	**25,936**	**2,031**	**130,236**	**588,153**

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, Telfer Young Limited, and the valuation is effective as at 30 June 2010 and amounted to $72.75m.

Buildings

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

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

The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.

The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.

The remaining useful life of assets is estimated.

Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

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

The most recent valuation of buildings was performed by a registered independent valuer, Telfer Young Limited, and the valuation is effective as at 30 June 2009 and amounted to $254.36m.

Infrastructure

Darroch carried out a desktop review of infrastructure assets in 2012 using depreciated replacement cost because no reliable market data is available for such assets. The assets have been revalue by $19.6m.

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.

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 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.

13 Intangible assets

Movements for each class of intangible assets are as follows:

	Shares HBL $000	Software $000	Total $000
Balance at 1 July 2011	-	-	-
Balance at 30 June 2012 / 1 July 2012	-	-	-
Additions	3,791	4,391	8,182
Balance at 30 June 2013	3,791	4,391	8,182
Accumulated amortisation and impairment losses			
Balance at 1 July 2011	-	-	-
Balance at 30 June 2012/1 July 2012	-	-	-
Amortisation expense	-	43	43
Balance at 30 June 2013	-	43	43
Carrying amounts			
At 1 July 2011	-	-	-
At 30 June and 1 July 2012	-	-	-
At 30 June 2013	**3,791**	**4,348**	**8,139**

There are no restrictions over the title of the DHB's intangible assets; nor are any intangible assets pledged as security for liabilities. The DHB owned IT and software assets which were classified as held for sale following the Board's approval of the sale to healthAlliance NZ Ltd. Ownership of the assets transferred to healthAlliance NZ Ltd in July 2012.

Shares in Health Benefits Limited

The Shares in Health Benefits are deemed to be an Intangible asset.

Number of $1.00 B class shares held: 3,791 accounting for 10.67% of the total shares issued.

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service
- 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 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 Shares confers no right to a share in the distribution of the surplus assets

14 Creditors and other payables

	2013 Actual $000	2012 Actual $000
Creditors and accrued expenses	88,133	85,926
GST payable	6,571	5,266
Capital charge payable (over payment)	(187)	20
Income in advance	1,448	3,318
Total creditors and other payables	**95,965**	**94,530**

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.

15 Borrowings

	2013 Actual $000	2012 Actual $000
Current portion		
Overdraft facility (HBL)	7,350	-
Finance leases	-	5
Crown loans – fixed interest	5,000	30,000
Total current portion	**12,350**	**30,005**
Non-current portion		
Crown loans – fixed interest	232,600	167,600
Total non-current portion	**232,600**	**167,600**
Total borrowings	**237,600**	**197,605**
Borrowing facility limits		
Crown loan facility limit	297,600	297,600
Overdraft facility	64,428	50,000
Total borrowing facility limits	**362,028**	**347,600**

Crown loans

The loans are secured by a negative pledge.

The DHB must also meet the following covenants:

- A cash flow covenant, under which the accumulated annual operating cash flow must be greater than zero
- The fair value of Crown loans is $245.1m (2012 $216.7m)). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.30% to 6.36% (2012 3.32% to 6.51%)

Overdraft facility

CMDHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have an overdraft facility with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum overdraft balance ($64.4m) that is available to the DHB is the value of provider arm's planned monthly Crown revenue.

Finance leases

Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance lease is $0k.

The fair value of finance leases is $0k (2012 $5k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 8.59% to 8.66% (2012 8.59% to 8.66%).

Analysis of finance leases

	2013 Actual $000	2012 Actual $000
Minimum lease payments payable:		
No later than one year	-	5
Later than one year and not later than five	-	-
Later than five years	-	-
Total minimum lease payments	-	5
Future finance charges		-
Present value of minimum lease payments	-	5
Present value of minimum lease payments payable:		
No later than one year	-	5
Later than one year and not later than five years	-	-
Later than five years	-	-
Total present value of minimum lease payments	-	5

16 Employee entitlements

	2013 Actual $000	2012 Actual $000
Current portion		
Accrued salaries and wages	37,250	34,638
Annual leave	51,313	45,283
Sick Leave	300	304
Long Service Leave	661	467
Retirement Gratuities	1,820	1,421
Sabbatical leave	1,737	1,479
Continuing medical education leave	13,610	16,920
Total current portion	**106,691**	**100,512**
Non-current portion		
Long service leave	5,098	5,243
Retirement gratuities	7,106	6,718
Sick leave	1,391	1,198
Total non-current portion	**13,595**	**13,159**
Total employee entitlements	**120,286**	**113,671**

The present value of sabbatical leave, long service leave, and retirement gratuities 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 2.71% - 5.50% (2012 2.43% - 4.29%) and an inflation factor of 3.0% (2012 1.5%) were used.

17 Provisions

	2013 Actual $000	2012 Actual $000
Non-current portion		
ACC Partnership Programme	1,337	1,212
Total provisions	1,337	1,212

Movements for each class of provision are as follows:	ACC Partnership Programme 2013 $000	ACC Partnership Programme 2012 $000
Balance at 1 July	1,212	1,013
Additional provisions made	125	199
Balance at 30 June	**1,337**	**1,212**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON Hewitt, last calculated the liability as at 30 June 2012. The actuary has attested they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 20% (2011 20%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

The risk margin has been determined after consideration of past claims history, costs, and trends.

The risk margin is intended to achieve a 80% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Key assumptions

The key assumptions used in determining the outstanding claims liability are:

- An average assumed rate of inflation of 3.0% for 30 June 2012 and 2013
- A weighted average discount factor of 3.5% for 30 June 2012 and for 30 June 2013 that has been applied to future payment streams; and
- Claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 11% of claims will result in no payment, 86% will result in medical claims, and 21% will result in an element of time off work

Insurance risk

The DHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.

The DHB is responsible for managing claims for a period of up to 48 months following the lodgement date. At the end of 48 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

A stop loss limit of 183% of the industry premium is used. The stop loss limit means the DHB will carry the total cost of all claims only up to a total of $4.147m per annum.

18 Equity

	2013 Actual $000	2012 Actual $000
Crown equity		
Balance at 1 July	109,383	107,654
Capital contributions from the Crown	-	2,148
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**108,964**	**109,383**
Accumulated surpluses/(deficits)		
Balance at 1 July	(51,675)	(57,084)
Surplus/(deficit) for the year	3,012	5,409
Balance at 30 June	**(48,664)**	**(51,675)**
Revaluation reserves		
Balance at 1 July	107,798	110,298
Impairment	-	(2,500)
Revaluations	19,645	-
Balance at 30 June	**127,443**	**107,798**
Revaluation reserves consist of:		
Land	69,149	69,149
Buildings	38,649	38,649
Infrastructure	19,645	-
Total revaluation reserves	**127,443**	**107,798**
Trust funds		
Balance at 1 July	848	839
Transfer from/(to) accumulated surpluses	6	9
Balance at 30 June	**854**	**848**
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	**188,597**	**166,354**

Included in accumulated surpluses/deficits are $NIL (2012 $15.453m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established

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

	2013 Actual $000	2012 Actual $000
Net surplus/(deficit	**3,012**	**5,409**
Interest on Restricted Funds	4	5
Add/(less) non-cash items		
Depreciation and amortisation expense	23,594	22,732
Total non-cash items	23,594	22,732
Add/(less) items classified as investing or financing activities		
Gain on disposal of assets	85	(1,608)
Total items classified as investing or financing activities	85	(1,608)
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(3,076)	5,560
Inventories	(111)	33
Creditors and other payables	317	(5,857)
Employee entitlements	6,615	7,104
Net movements in working capital items	3745	6,838
Net cash flow from operating activities	**30,442**	**33,378**

20 Capital Commitments and Operating Leases

Capital commitments

	2013 Actual $000	2012 Actual $000
Property , plant and equipment	19,865	68,565
Total capital commitments	**19,865**	**68,565**

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

Non-cancellable operating lease commitments

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

	2013 Actual $000	2012 Actual $000
Not later than one year	2,879	2,857
Later than one year and not later than five years	4,689	6,326
Later than five years	247	2,538
Total other non-cancellable contractual operating commitments	**7,815**	**11,721**

The DHB leases a number of buildings, vehicles, and items of office equipment (mainly photocopiers) under operating leases.

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

21 Contingencies

Contingent liabilities

Asbestos

Given the age of some of the remaining buildings on some sites there may be a potential cost relating to the discovery of asbestos. If any were to be found it would be expensed in the year it is found.

Kingseat

There is a potential claim in respect of water supply obligations to land at Kingseat, which was formerly owned by CMDHB. The Board has made a provision for the potential claim and any amount in excess of this provision is not considered to be material and would be expensed in the year that it is incurred.

Superannuation schemes

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

Contingent assets

The DHB has no contingent assets (2012 $nil).

22 Related Party Transactions

All related party transactions have been entered into on an arms' length basis.

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

Significant transactions with government-related entities

The DHB has received funding from the MoH, ACC and other DHBs of $1,381m (2012 $1,337m) to provide health services in the Counties Manukau area for the year ended 30 June 2013 (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 2013 totalled $10.9m (2012 $11.8m). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post, and blood from NZ Blood Service.

Transactions with key management personnel

Key management personnel compensation

	2013 Actual FTE	2012 Actual FTE	2013 Actual $000	2012 Actual $000
Executive Management Team[11]	11	10	3,287	2,476
Board[12]	10*	11	364	379
Committee	24	33	39	43
Total key management personnel compensation	45	54	$3,690	$ 2,898

The actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $75k (2012 $58k).

All the above payments relate to salaries and other short term benefits

Key management personnel include all Board members, the Chief Executive, and ten members of the management team.

Related party transactions involving key management personnel (or their close family members)

During the year, the DHB transacted with Bob Wichman Limited in which CMDHB Board member R Wichman, is a Director and shareholder. The value of the expenditure totalled $17k (2012 $49k) and was incurred on normal commercial terms. There is a balance of $nil (2012 $nil) outstanding for unpaid invoices at year end.

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.

Under this technical definition CMDHB would be required to consolidate The Manukau Health Trust (MHT) and the Middlemore Foundation for Health Innovation (Foundation) (formerly the South Auckland Health Foundation) accounts into its final statutory accounts.

CMDHB has decided not to follow this requirement as both the MHT and Foundation are registered Charitable Trusts and as such are independent legal entities and are not under the control of CMDHB. In the Board's view, to consolidate these accounts into those of CMDHB would overstate the financial position of CMDHB as well as give a misleading picture of CMDHB's legal right or ability to access MHT and Foundation funds.

The Board has received independent legal advice that has confirmed that it has no legal right or equally, obligation in respect of MHT and Foundation. While CMDHB has been the major beneficiary of the Trusts, they must meet all normal Charitable Trust requirements in terms of applications for funding.

[11] A number of the Executive Management Team in 2012 were only for a part year if their salaries were annualised then the value for 2012 would have been $3,119k.

[12] Mr Frank Solomon resigned from the Board on 26 November 2012

The Manukau Health Trust

The MHT was formed to conduct health screening and other health activities to promote and provide for the health, wellbeing and benefit of a health nature to South Auckland Communities.

CMDHB has had one nominee for the past two years on the six person MHT Board of Trustees.

In the interests of full disclosure and transparency, CMDHB is, with the consent of MHT, disclosing through this Note, the unaudited financial position of MHT for the year ending 30 June 2013.

Statement of Financial Performance $000	**Parent and Group**	
	2013 Actual $000	**2012 Actual $000**
Income	1,355	1,354
Surplus (Deficit)	(131)	(98)
Statement of Financial Position		
Total Equity	**581**	**711**
Non-Current Assets	2	3
Current Assets	876	878
Total Assets	**878**	**881**
Current Liabilities	297	170
Net Assets	**581**	**711**

Post balance date a decision has been made to wind-up the Manukau Health Trust.

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $4.1m (2012 $4.3m) and a deficit of $0.3m (2012 $0.2m) as at 30 June 2013. The financial statements of the Foundation for 2013 are not publicly available as they have not yet been approved by the Foundation's trustees.

Revenue from Related Parties

	Parent and Group	
	2013 Actual $000	**2012 Actual $000**
healthAlliance NZ Ltd	99	187
Northern Regional Alliance Ltd	1,421	902
Air New Zealand	-	1
Health Quality & Safety Commission	1,632	987
Manukau Institute of Technology	1,151	-
ProCare Health Ltd	13	8
University of Auckland	1,705	2,142
Total	**6,021**	**4,227**

Purchases from Related Parties

	Parent and Group	
	2013 Actual $000	2012 Actual $000
healthAlliance NZ Ltd	26,802	24,614
Health Benefits Ltd	2,077	-
Northern Regional Alliance Ltd	9,631	7,253
Auckland Council	132	560
Bob Wichman Ltd	17	49
Manukau Institute of Technology	26	-
ProCare Health Ltd	229	
Raukura Hauora O Tainui Iwi Advisory	14	-
Sapere Research Group	58	109
University of Auckland	2	1,533
Total	**38,988**	**34,118**

Receivables from Related Parties

	Parent and Group	
	2013 Actual $000	2012 Actual $000
Northern Regional Alliance Ltd	69	55
healthAlliance NZ Ltd	49	3
Health Quality & Safety Commission	23	-
Manukau Institute of Technology	2	
ProCare Health Ltd	-	7
University of Auckland	351	611
Total	**494**	**676**

Payables to Related Parties

	Parent and Group	
	2013 Actual $000	2012 Actual $000
healthAlliance NZ Ltd	1,494	71
Northern DHB Support Agency Ltd	-	452
Auckland Council	-	14
University of Auckland	-	5
Total	**1,494**	**542**

The DHB has no Non-Cancellable Contractual Commitments with any of its Related Parties.

23 Board member remuneration

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

	2013 Actual	2012 Actual
Professor Gregor Coster	65,558	59,969
Mrs Jan Dawson	39,945	35,781
Mr Anae Arthur Anae	28,250	33,500
Mr David Collings	28,500	21,500
Mr Donald Barker	34,574	36,375
Mr Paul Cressey	32,000	32,750
Mr Robert Wichman	29,000	30,250
Mrs Colleen Brown	30,937	37,375
Mrs Lyn Murphy	33,878	33,000
Mrs Sandra Alofivae	29,500	29,750
Mr Frank Solomon	11,417	27,250
Total board member remuneration	363,559	379,500

Committee Members

	Award $ 2013
Ms Wendy Bremner	1,250
Ms Moana Brown	625
Dr Andrew Chan Mow	1,458
Mr Bob Clark	2,083
Mr Robert Clark	3,542
Ms Elizabeth Farrell	1,458
Mr Jonathan Frith	1,250
Ms Heather Grace	2,658
Ms Malia Hamani	1,042
Mr Sefita Hao'uli	3,125
Ms Susan Haynes	208
Ms Raewyn Hodges	1667

	Award $ 2013
Dr Gary Jackson	1,250
Ms Cynthia Kiro	1,458
Ms Louisa Lavakula	3,333
Mrs Roine Lealaiauloto	625
Mr Josaia Maka	833
Ms Nganeko Minhinnick	833
Ms Bernadette Pereira	1,042
Mr Nuku Rapana	2,917
Mr Ezekiel Robson	1,875
Dr Gerhard Sunborn	1,250
Rev Uea Tuleia	1,546
Ms Te Aomarama Wilson	1,667
Total	**38,995**

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 (2012 $nil).

24 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:	2013 Actual $000	2012 Actual $000
Total remuneration paid or payable:		
$100,000 – 109,999	134	109
$110,000 – 119,999	84	78
$120,000 – 129,999	63	46
$130,000 – 139,999	52	28
$140,000 – 149,999	29	27
$150,000 – 159,999	20	24
$160,000 – 169,999	23	25
$170,000 – 179,999	15	24
$180,000 – 189,999	27	17
$190,000 – 199,999	20	20
$200,000 – 209,999	23	27
$210,000 – 219,999	21	28
$220,000 – 229,999	18	25
$230,000 – 239,999	29	28
$240,000 – 249,999	19	20
$250,000 – 259,999	31	12
$260,000 – 269,999	20	18
$270,000 – 279,999	17	14
$280,000 – 289,999	14	14
$290,000 – 299,999	11	11
$300,000 – 309,999	9	8
$310,000 – 319,999	9	4
$320,000 – 329,999	13	5
$330,000 – 339,999	6	2
$340,000 – 349,999	6	6
$350,000 – 359,999	4	2
$360,000 – 369,999	3	4
$370,000 – 379,999	2	3
$380,000 – 389,999	3	-
$390,000 – 399,999	4	6
$400,000 – 409,999	-	-
$410,000 – 419,999	6	1
$420,000 – 429,999	2	-
$430,000 – 439,999	2	-
$440,000 – 449,999	2	1
$450,000 – 459,999	-	-
$460,000 – 469,999	-	1
$470,000 – 479,999	1	-
$480,000 – 489,999	-	-
$490,000 – 499,999	-	-
$500,000 – 509,999*	2	1

* Note: - paid includes a payment relating to the prior period.

During the year ended 30 June 2013, 4 (2012: 7) employees received compensation and other benefits in relation to cessation totalling $143,399 (2012 $255,598).

During the Year Ended 30 June 2013, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 635 (2012 - 545) are Medical Staff and 109 (2012 - 94) are Management.

NOTE – the above table is inclusive of all benefits paid and in the case of clinical salaries / wages includes, in some cases, substantial amounts of overtime, allowances, benefits, in-lieu payments or similar. It is therefore difficult and potentially very misleading to determine average clinical salaries / wages on this basis

25 Events after the balance date

The Ko Awatea education and innovation centre, located at Middlemore Hospital, has been established to provided infrastructure and facilities to support workforce development, education and service improvement activities in the district.

The proposal to establish an unincorporated joint venture with three tertiary education organisations – University of Auckland, AUT University and Manukau Institute of Technology -to jointly operate and develop the centre and grow a future workforce that meets the needs of our community was signed by the Minister of Health July 2013.

26 Financial instruments

Financial instrument categories

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

	2013 Actual $000	2012 Actual $000
Loans and receivables		
Cash and cash equivalents	(6,322)	6,166
Debtors and other receivables	35,442	32,366
Total loans and receivables	**29,120**	**38,532**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	88,133	85,946
Borrowings	237,600	197,600
Total financial liabilities measured at amortised cost	**325,733**	**283,546**

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 2013, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have no impact as all loans are fixed (2012 $85.2k).

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 cash and short-term deposits 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 (approximately 26 per cent of trade debtors). 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:

	2013 Actual $000	2012 Actual $000
Counterparties with credit ratings		
Cash and cash equivalents and investments		
AA-	1,028	6,166
AA		-
Total cash and cash equivalents and investments	1,028	6,166
Counterparties without credit ratings		
Total debtors and other receivables	35,442	32,366

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
2012						
Creditors and other payables	85,946	85,946	85,946	-	-	-
Finance leases	5	5	5	5	-	-
Crown loans	197,600	249,179	36,556	5,437	47,072	160,114
Total	**283,551**	**335,130**	**122,507**	**5,437**	**47,072**	**160,114**
2013						
Creditors and other payables	95,965	95,965	95,965			
Overdraft	7,350	7,350	7,350			
Crown loans	237,600	297,869	16,233	50,515	64,301	166,820
Total	**340,915**	**401,184**	**119,548**	**50,515**	**64,301**	**166,820**

27 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 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.

28 Trust & Special Purpose Funds

	Parent and Group	
Trust/Special funds	**2013 Actual $000**	**2012 Actual $000**
Balance at beginning of year	848	839
Funds expended		(3)
Interest received on Restricted Funds	6	12
Balance at end of year	**854**	**848**

29 Explanation of major variances against budget

Explanations for major variances from the DHB's budgeted figures in the statement of intent are as follows:

Statement of comprehensive income

The major variances in the Statement of Comprehensive Income are due to:

- Total Income for the year (excluding donations) was $11.9m lower than budget. The budget including agency revenue ($22.5m), offset by additional funding $10.5m received for services from the Crown after the finalisation of the budget.
- Expenditure for the year was $13.0m lower than budget. The budget including agency costs ($22.5m), offset by additional services provided $9.4m after the finalisation of the budget.
- Donation were lower by $1.1m

The major variances in the Statement of Financial Position are due to:

- Drawing down funding facilities
- Improved collection of Trade receivables
- Catch-up on spending on property, plant and equipment due to timing of construction
- Investment in Heath Benefit Limited

The major variances in the Statement of Cashflow are attributed to:

- Weakened operating cashflow of $8.5m due to:
    - Higher payments to suppliers to match increased purchases from Crown
    - Lower interest payments and capitalisation of interest
- Lower investing led to lower financing requirements for the year.

30 Performance by Output Classes

(Includes agency costs)

$000	Prevention	Early Detection	Intensive	Rehabilitation	Total
Revenue (includes agency revenue)	**18,905**	**217,866**	**1,082,971**	**108,355**	**1,428,097**
Budget (includes agency revenue)	*20,222*	*222,703*	*1,064,085*	*108,653*	*1,415,663*
Personnel costs	3,992		507,421		511,413
Outsourced Services	1,094		61,412		62,506
Clinical Supplies	3,097		98,351		101,448
Infrastructure & Non-Clinical Supplies	356		46,623		46,979
Other (includes agency costs)	10,366	217,866	366,152	108,355	702,739
Total costs	18,905	217,866	1,079,959	108,355	1,425,085
Budget (includes agency costs)	*20,222*	*222,703*	*1,064,085*	*108,653*	*1,415,663*
Surplus (Deficit)			**3,012**		**3,012**
Budget			*3,005*		*3,005*

Agency revenue and costs for the year amounts to $22,443k

Board and Committee Membership

Number of meetings	Board *11*	CPHAC* *10*	DISAC* *9*	ARF *4*	HAC* *10*	PHAC* *9*	CHAC *2*
Professor Gregor Coster CNZM (Chair)	11	7	1	4	7	-	2
Mrs Jan Dawson (Deputy Chair)	9	8	-	4	8	-	2
Mrs Sandra Alofivae	9	8	-	-	6	4	2
Mr Arthur Anae	8	5	-	-	5	5	2
Mr Donald Barker JP	10	8	7	3	8	-	2
Mrs Colleen Brown MNZM, JP	9	6	7	-	7	-	2
Mr David Collings	10	6	-	-	5	-	2
Mr Paul Cressey ONZM	10	10	-	3	10	-	2
Mrs Lyn Murphy	10	7	8	4	7	-	2
Mr Frank Soloman[13]	5	2	-	-	2	-	-
Mr Bob Wichman	10	8	6	-	-	-	2

CPHAC	Community and Public Health Advisory Board
DISAC	Disability Support Advisory Committee
ARF	Audit, Risk and Finance
HAC	Hospital Advisory Committee
PHAC	Pacific Health Advisory Committee
CHAC	Combined Hospital Advisory Committee

* In May 2013, CPHAC, DISAC, HAC and PHAC were merged to form the Combined Health Advisory Committee (CHAC)

[13] Mr Frank Soloman resigned from the Board on 26 November 2013. He attended 5/5 meetings from July to November 2012.

Board Members' Disclosure of Interests

As at June 2013

Professor Gregor Coster CNZM (Chair)	▪ Deputy Chair, Health Workforce New Zealand ▪ Fellow Royal New Zealand College of General Practitioners (Dist) ▪ Director, Better Value Healthcare Asia-Pacific ▪ Board Member, UNICEF New Zealand ▪ Director, Marama Global Ltd ▪ Member, Bevan Commission, Wales ▪ Visiting Professor, School of Government, Victoria University of Wellington
Mrs Jan Dawson (Deputy Chair)	▪ Erua Ltd (Director) ▪ Yachting New Zealand Inc (President/Director) ▪ Disciplinary Tribunal of the Institute of Chartered Accountants (Member) ▪ Counties Manukau District Health Board (Deputy Chair) ▪ Capital Investment Committee – NHB (Member) ▪ Director, Air New Zealand ▪ Director, Westpac New Zealand ▪ Council Member, The University of Auckland ▪ Jan Dawson Ltd ▪ Trustee, Voyager Museum ▪ Director, Goodman Fielder ▪ Director, Meridian Energy
Mrs Sandra Alofivae	▪ Chair of the Auckland South Community Response Forum (MSD appointment) ▪ Secretary for the Tausa'afia Trust (Aoga Amata PIC Mangere) ▪ MSD Member, Auckland Social Policy Forum, Auckland Council ▪ Chair, Pacific Advisory Group to Counties Manukau Police Headquarters ▪ Member, Fonua Ola Board
Mr Arthur Anae	▪ Councillor, Auckland Council ▪ Board Member Phobic Trust ▪ Member The John Walker 'Find Your Field of Dreams' ▪ Chairman, NZ Good Samaritan Heart Mission to Samoa Trust
Mr Donald Barker JP	Nil
Mrs Colleen Brown MNZM, JP	▪ Local Board Member ▪ Chair Parent and Family Resource Centre Board (Auckland Metropolitan Area) ▪ Member of Advisory Committee for Disability Programme Manukau Institute of Technology ▪ Member NZ Down Syndrome Association ▪ Husband, Determination Referee for Department of Building and Housing ▪ Chair, Early Childhood Education Taskforce for COMET ▪ Member, Manurewa Advisory Group ▪ Member, Child Advocacy Group – Manukau ▪ MSD Member, Auckland Social Policy Forum, Auckland Council ▪ Deputy Chair, Auckland City Council Disability Strategic Advisory Group ▪ Chair ECE Implementation Team Auckland South ▪ Member, Auckland Council Local Alcohol Political Working Party

Mr David Collings	▪ Member, Howick Local Board of Auckland Council ▪ Member Auckland Council Southern Initiative
Mr Paul Cressey ONZM	▪ Chairman, South East Auckland Life Education Trust ▪ Board Member, GS1 New Zealand ▪ Member Plunket Plus Steering Group ▪ Chairman, Medication Safety Programme Steering Group ▪ Director, Cressey Pharmacy Ltd, Personal Administration ▪ Director, CLA Enterprises Ltd, Non Trading ▪ Board Member, NZ Plunket Society
Mrs Lyn Murphy	▪ Member, International Society for Pharmacoeconomics and Outcomes Research (ISPOR). ▪ Member of the New Zealand Association of Clinical Research (NZACRes) ▪ Senior lecturer in management and leadership at Manukau Institute of Technology ▪ Member, ACT NZ ▪ Director, Bizness Synergy Training Ltd ▪ Director, Synergex Holdings Ltd ▪ Associate Editor NZ Journal of Applied Business Research
Mr Frank Soloman[14]	▪ Managing Director, Solomon Group Education and Training Academy – Ngatiporou, Ngati Kahu ki Whangaroa, funded by TEC and MSD. The level 3 Foundation Course is MIT ▪ Member, Counties Manukau DHB 'Grow Your Own Workforce' Project ▪ Member, 'Panmure Transformation' Project ▪ Member, Manurewa Marae 'Te Rau Korowai' Advisory Komiti ▪ Member, Waikato Tainui Whanau Ora Project – 'Te Ope Koiora' ▪ Chair 'Te Ringa Awhina/Helping Hand Charitable Trust', has applied to the Tindall Foundation re: School Leavers Support for the Mangere Youth Initiative ▪ Te Manuka – Tamakimakaurau Maori PTEs ▪ Ex-Chair MIT Runanga, Executive and Board member ▪ Trustee, Youth Mentoring Network
Mr Bob Wichman	▪ Director Bob Wichman Papatoetoe Ltd (Appliance servicing arrangement with CMDHB through healthAlliance)

[14] Mr Frank Soloman resigned from the Board on 26 November 2013. He attended 5/5 meetings from July to November 2012.

Report of the Audit Office

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Counties Manukau district health board and group's financial statements and performance information for the year ended 30 June 2013

The Auditor-General is the auditor of Counties Manukau District Health Board (the Health Board) and group. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 33 to 71, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, 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 that comprises the statement of service performance on pages 22 to 29 and page 72 and the report about outcomes and impacts on pages 15 to 21.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 33 to 71:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 22 to 29, 15 to 21 and page 75:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2013. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control 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 and group's internal control.

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We obtained all the information and explanations we required about the financial statements. However, as referred in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Health Board or any of its subsidiaries.

Karen MacKenzie
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Directory

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South Auckland Mail Centre

Auditor

Audit New Zealand on

behalf of the Auditor General

Solicitors

Buddle Finlay

Chapman Tripp

Meredith Connell

Russell McVeah

Simpson Grierson

Bankers

ASB Bank Limited

Commonwealth Bank

Westpac Banking Corp[15]

[15] Appointed for the sector

Care & Respect

Teamwork

Professionalism

Innovation

Responsibility

Partnership

COUNTIES
MANUKAU
HEALTH