Counties Manukau DHB
Annual Report
as at
30 June 2010

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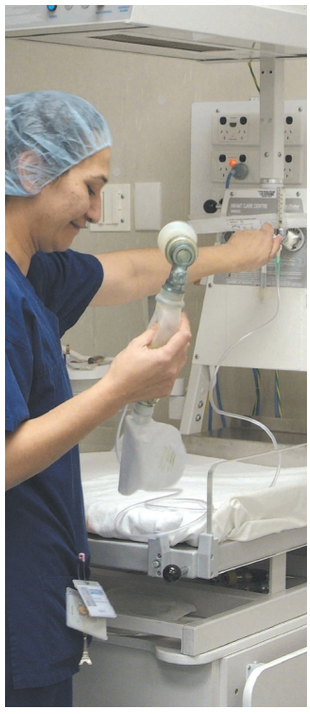


Vision & Values

Vision

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.

We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focused and cost effective healthcare, at the right place, right time and right setting.

Values

Care and Respect: Treating people with respect and dignity, valuing individual and cultural differences and diversity.

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

Professionalism: We will act with integrity and embrace the highest ethical standards

Teamwork: Achieving success by working together and valuing each other's skills and contributions.

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

We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focused and cost effective healthcare, at the right place, right time and right setting.

Counties Manukau District Health Board has adopted the Tainui spelling of Maaori and whaanau throughout this document

Chairman's and Chief Executive's Review

It is with great pleasure that we present the 2009/10 annual report for Counties Manukau District Health Board (CMDHB).

2009/10 was a challenging year for the DHB. The Ministerial requirement to deliver a zero deficit position in the face of ever-increasing demand for health services and a difficult economic climate meant that the DHB had to take a very close look at how well the organisation was using its current resources and if there was anything further that could be done to improve efficiency or reduce wastage through quality improvement.

An indication of the magnitude of demand can be seen in these volumes we experienced through our hospital facilities in 2009/10.

- A record 299,412 outpatient attendances
- 114,979 inpatient discharges
- 90,213 emergency presentations

In spite of these challenges, the DHB has once again been able to end the year within $3.0m better than budgeted breakeven, whilst increasing our service volumes and maintaining service delivery. We acknowledge the hard work, skills and the commitment of our staff who have contributed towards the achievement of this stellar performance.

In 2009/10, we successfully achieved the following targets including:

- 95 percent of people presenting at our Emergency Department (ED) were seen, transferred or discharged within six hours.
- Use of Primary Options for Acute Care (POAC) has led to 479 fewer acute hospital admissions.
- Rate of adolescents accessing dental care has increased by six percent to 62 percent
- 79 percent of our eligible residents were assessed for cardio vascular risk
- 86 percent of two year olds in the district were immunised
- There are now 99 primary and intermediate schools and 17 secondary schools in Counties Manukau who are Health Promoting Schools
- 789 more elective surgery procedures than the previous record year were delivered to the Counties Manukau community
- Mental health access targets for all age groups were achieved with services delivered to three percent of the population
- A record 1170 joint assessments were carried out through the Healthy Housing Programme
- 100 percent of patients requiring radiotherapy commenced treatment within six weeks of referral.

We were in fact the first major DHB in New Zealand to meet the six hour turnaround target for the Emergency Department. The DHB's "Six Hours can be Ours" project is an example of what can be achieved when there is commitment and attention to improving quality. We have successfully focused on timeliness, patient-centred care, clinical efficiency and patient safety enabled by strong clinical leadership and teamwork.

The last year we have also fully supported the development of three business cases with our PHO partners: National Maori PHO Coalition, Alliance health + and the Greater Auckland Integrated Health Network (GAIHN) to deliver the intention of Better, Sooner, More Convenient Primary Care (BSMC). The implementation of the business cases currently underway is working with an alliance contracting approach to ensure increased capacity and capability in primary care, greater integration between secondary and primary services, focused clinical leadership and involvement in decision making. These initiatives will collectively lead to provision of high quality care nearer to where people live and work.

Whilst assessing and planning the provision of primary care in Counties Manukau we have also taken a strong collaborative approach with our regional DHB colleagues to enable consistent implementation of BSMC. The regional plan includes eight projects fully aligned with BSMC and the business cases, all of which specify key deliverables for 2010/11.

Over the past year, there have been other significant initiatives completed by the Northern Region DHBs. Key areas include:

- Implementation of a diabetes and cardiovascular disease prevention programme, focussing on awareness amongst the South Asian population in Auckland.
- Establishment of key projects within the Northern Region Cancer Network including quality improvement initiatives for lung and bowel cancer
- Completion and sign off of the Regional Information Strategy (2010-2020) which establishes our vision and associated technical support required for the out years.
- Working towards the establishment of the Northern Regional Network (NRN): A clinical work-stream and business services work-stream were established to assist with reviewing earlier NRN activity and prioritising future activity. An implementation plan has been developed for each work-stream and signed off by the Regional Governance Group.
- Agreement on an Eating Disorder Services Implementation Plan which includes a proposal for residential and day programme services.
- Completion of a Regional Pacific Mental Health Plan. The launch is planned for late 2010.
- Development of a cultural and linguistic diversity training programme (CALD) for the DHBs' primary and secondary healthcare workforce.

With the continuing national focus on the need for DHBs to "break-even", and the unique challenge that Counties Manukau faces with demographic growth exceeding the national average, CMDHB initiated "Thriving in Difficult Times" (TiDT) in December 2009. The TiDT programme is clinically led and builds on the considerable quality improvement and productivity gains already achieved, taking these to the next level by continuing to improve clinical efficiency and patient safety. Counties Manukau DHB is a leader in health system quality improvement and in partnership with Canterbury DHB and the Ministry of Health, hosted the Improving the Patient Journey Forum in May 2010 looking at ways to improve experience of patients, remove waste, duplication and waiting times.

Along with our commitment to quality improvement and efficiency to maximise resources we continue to implement our

facilities programme to meet demand for healthcare services from our community. Key milestones during 2009/10 included completion of the Edmund Hillary Block, the new Ophthalmology and Breast-screening modules at Manukau Superclinic and an Assessment and Observation Unit at Middlemore Hospital.

Developing our future workforce is a focus for the DHB and we were delighted to receive a $1.0 million grant from the Tindall Foundation to develop the CMDHB Grow Our Own Workforce Project, aimed at encouraging more Maaori and Pacific people into the local health workforce. Our thanks to Mr Stephen Tindall for this generosity.

There are a number of other key initiatives being rolled out by CMDHB to ensure a quality heath workforce, not least is the role of Ko Awatea (previously the Centre of Health Service Innovation). The Centre will have several key functions, one of which will be as a hub for integrating training programmes across nursing, medical and allied health disciplines and a close industry/provider link for the development of a local workforce.

With the Stevenson Chair of Health Innovation and Improvement appointed in June 2010 we look forward to the opening of the Centre in April 2011 and the leadership this will bring to CMDHB and beyond with the enhanced focus on quality improvement, clinical leadership development , research and innovation activities.

As we celebrate Kidz First Hospital's 10th anniversary in 2010, we remember and acknowledge the many supporters who have made the vision of a children's hospital in South Auckland possible. We are especially grateful for the South Auckland Health Foundation without whose support, the children's hospital and many other initiatives, would not have been possible. In the last year, the Foundation's staff and volunteers have tirelessly fund-raised a total of $2.4m to support various projects to benefit children and families in the community.

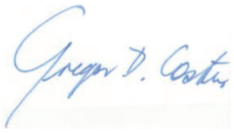
Other key initiatives coming on board in 2010/11 include:

- The launch of Creating a Better Future – a long term strategy created by CMDHB and community partners which is aimed at addressing the significant burden of disease in our community. It focuses on reducing smoking, unsafe use of alcohol and improving nutrition and physical activity whilst improving care for those already affected by conditions related to these risk factors. A website has now been completed and can be found at www.betterfuture.co.nz

- The development of Middlemore Central - a centralised information and action hub which joins up data from across the hospital giving a global view of all Middlemore activity and will support better planning, allocation of resources and patient safety; and

- The launch of the DHB's "Zero Patient Harm" campaign, which cements the DHB's commitment to patient safety.

Finally, we would like to thank everyone – staff, volunteers, our outgoing Board and Committee members, our partners in the sector and in the community - who have contributed to the exciting achievements of the past year, and we continue to look forward to the challenges and opportunities to come.



Professor Gregor Coster
Chair

Geraint Martin
Chief Executive

Executive Management Team as at 30 June 2010

Geraint Martin	Chief Executive Officer (CEO)		
Sam Bartrum	General Manager, Human Resources	Dr Donald Mackie	Chief Medical Officer (CMO)
Martin Chadwick	Director, Allied Health	Dr Allan Moffitt	Clinical Director, Primary Care
Sam Cliffe	Service Integration Director	Ron Pearson	Finance Director
Ron Dunham	Chief Operating Officer (COO)	Mary Seddon	Director, Quality Improvement
Pauline Hanna	Performance & Planning Director	Bernard Te Paa	General Manager, Maaori Health
Denise Kivell	Director of Nursing (DON) Health		

Board Committee Membership

as at 30 June 2010

Board Member	Award $	Committee
Professor Gregor Coster	54,167	Board (Chair), CPHAC, HAC, DiSAC, PHAC, ARF, POU, FMP
Mr Paul Cressey	34,062	Board (Deputy Chair), CPHAC, HAC (Chair), ARF, POU, FMP
Mr Donald Barker	31,042	Board, CPHAC, HAC, DiSAC, ARF, FMP (Chair)
Anae Arthur Anae	29,791	Board, CPHAC, HAC, PHAC (Chair), ARF, POU
Mr Robert Wichman	26,875	Board, HAC, PHAC, FMP
Ms Miria Andrews	31,042	Board, CPHAC, HAC, DiSAC, , POU
Mrs Colleen Brown	29,844	Board, CPHAC, HAC, DiSAC (Chair), ARF
Mrs Anne Candy	30,208	Board, CPHAC (Chair), HAC, DiSAC, PHAC, POU (Chair)
Mrs Penelope Ginnen	30,417	Board, CPHAC, HAC, PHAC, ARF
Mr Michael Williams	30,625	Board, CPHAC, HAC, ARF (Chair), FAC, FMP
Mrs Ruth DeSouza	28,333	Board, CPHAC, HAC, PHAC, FAC, POU

CPHAC	Community and Public Health Advisory Committee	HAC	Hospital Advisory Committee
DiSAC	Disability Support Advisory Committee	PHAC	Public Health Advisory Committee
ARF	Audit, Risk & Finance	POU	Maaori Governance
FMP	Facilities Management & Planning		

Committee Member	Award $	Committee	Committee Member	Award $	Committee
Ms Elizabeth Farrell	2,292	CPHAC	Ms Joanna Katipa	2,083	DiSAC
Mr Sefita Haouli	2,708	CPHAC, PHAC	Te Aomarama Wilson	1,667	DiSAC
Ms Malia Hamani	2,292	CPHAC, PHAC	Ms Alma Wilson	1,667	DiSAC
Ms Donna Richards		CPHAC, POU	Mrs Roine Lealaiauloto	625	PHAC
Ms Nganeko Minhinnick	2,500	CPHAC, POU	Ms Bernadette Pereira	833	PHAC
Mr Jonathan Frith	2,083	CPHAC	Ms Stephanie Erick-Peleti	625	PHAC
Dr Gary Jackson	1,875	CPHAC	Ms Louisa Lavakula	2,083	PHAC
Mr Michael Larmont	208	CPHAC	Leau Peter Skelton	1,875	PHAC
Mr Bob Clarke	2,292	HAC	Dr Etuate Lui Saafi	1,875	PHAC
Nuku Rapana	3,750	HAC, PHAC	Rev Uea Tuleia	1,667	PHAC
Rereokeroa Shaw	1,458	HAC	Dr Andrew Chan Mow	1,458	PHAC
Ms Heather Grace	1,875	DiSAC	Mr Martin Cooper	1,250	POU
Ms Chris Ellis	1,875	DiSAC	Mr Timi Maipi	833	POU
Mr Ezekiel Robson	3,692	DiSAC	Ms Te Pare Meihana	833	POU
Ms Joy Simpson	2,083	DiSAC	Ms Tania Kingi	-	POU
Mr Philip Beilby	2,292	DiSAC, PHAC	Ms Georgina Kupa	1,250	POU

Board Members Disclosure of Interest

Third Row from left:
Arthur Anae, Michael Williams, Robert Wichman, Don Barker

Second Row from left:
Ruth DeSouza, Penelope Ginnen, Colleen Brown, Miria Andrews

Front Row from left:
Anne Candy, Gregor Coster, Paul Cressey, Geraint Martin (CEO)

Professor Gregor Coster (Chair)

- Dean of Graduate Studies – University of Auckland
- Wife works with AC Research Associates New Zealand
- Deputy Chair, DHBNZ
- Joint Chair Ministry / DHBNZ Productivity Working Group
- Member National Capital Committee (ceased Dec 09)
- Deputy Chair, Health Workforce New Zealand (Appointed Dec 09)

Mr Paul Cressey (Deputy Chair)

- Chairman, South East Auckland Life Education Trust
- Chairman, Injury Surveillance Ministerial Advisory Panel (ISMAP) (ceased Jan 10)
- Board Member, GS1 New Zealand
- Chairman, Safe Medication Management Programme Sector Stakeholders Group
- Member, SMM Steering Group
- Chairman, National Universal Medicines List Steering Group
- Member, Plunket Steering Group related to innovation around the Child Health Information System

Mr Arthur Anae

- Manukau City Councillor
- Board Member, Phobic Trust
- Board Member, Counties Manukau Sport
- Member, MIT Council (ceased May 10)
- Member Tourism Auckland (ceased Nov 09)
- Member, The John Walker 'Find Your Field of Dreams'
- Chairman, NZ Good Samaritan Heart Mission to Samoa Trust

Ms Miria Andrews

- Chief Executive, Tainui MAPO
- Board Member, Taikura Trust
- Member, Regional Cancer Collaboration Group
- Board Member, Bright Mortar Trust
- Board representative, LBD Partnership Steering Group
- Chair, Raukura Hauora O Tainui Iwi Advisory for Breast and Cervical Screening Programme
- Chair, Maori Leadership Group, Northern Regional Cancer Network

Mr Donald Barker

- Trustee, West Franklin Community Trust

Ms Colleen Brown

- Manukau City Councillor
- Member, SRG Watercare
- Chair, Parent and Family Resource Centre Board (Auckland Metropolitan Area)
- Member, Advisory Committee for Disability Programme Manukau Institute of Technology
- Member, NZ Down Syndrome Association
- Member, Maori Women's Welfare League (Manukau)
- Husband – Barry Brown – Director Fraser Thomas Ltd Consulting Engineers and Determination Referee for Department of Building and Housing
- Member, Advisory Board for Paradigm (disability service)
- Chair, Early Childhood Education Taskforce for COMET
- Member, Manurewa Advisory Group
- Chair,Southern Auckland Computers in Homes Steering Committee

Ms Anne Candy

- Member Tainui Beneficiary Register
- Member Iwi Register, Ngaiterangi
- Manukau City Councillor, Manurewa Ward
- Chair, Environmental Hearings Committee
- Member, Te Tiriti o Waitangi Committee
- Life Member, Maaori Women's Welfare League (Nga Wahine Atawhai o Matukutureia Branch holds current and potential contracts with CMDHB)
- Patron, Manurewa RSA
- Trustee, Taonga Education Centre (current and potential contracts with CMDHB)
- Patron, Manukau National Council of Women
- Member, 28th Maaori Battalion Association
- Ex officio Member, Toi o Manukau Maaori Arts and Culture Trust
- Member, Liaison Committee, Auckland Region Women's Corrections Facility
- Member, MIT Advisory Committee
- Trust Board Member, Te Whare Ruruhau o Meri
- Chair, Manukau Pan Pacific South East Asia Women's Association (PPSEAWA)
- Member, Quality Council for Presbyterian Support Northern
- Tamaki Makaurau elected representative on the Maori Advisory Committee to LGNZ National Council

Ms Ruth DeSouza

- Board Member Asia New Zealand Foundation
- Member of the ARMS Trustee Appointment Committee (ceased Jan10)
- Guidelines Technical Advisory Group (GTAG) (ceased Jan 10)
- Member, Lottery Community Sector Research Committee
- Councillor, New Zealand Asian Studies Society
- Co-ordinates the Aotearoa Ethnic Network (AEN) and edits the AEN Journal
- Editorial Board Member, Diversity in Health and Social Care and Transcultural Nursing journals
- Staff Member, Auckland University of Technology
- Reference Group, Weight Management Implementation Guidelines
- Maori, Pacific and Asian Advisory Committee on ARCOS IV (Auckland Regional Community Stroke Study 2010-2015
- Reference Group attached to the Mental Health Literacy Programme of the Ministry of Health (ceased Jan 10)
- Member, Sterring Group for Punket Breast Feeding Support (Ceased Jan 10)
- Nationwide Services Framework Project for Mental Health and addictions (Asian and Refugee) Technical group. (ceased Jan 10)

Ms Penelope Ginnen

- Barrister, regularly appointed by the Family Court to represent children who reside in the Counties Manukau area, some of whom have health issues
- Member, Housing New Zealand Corporation
- Chair, Brainwave Trust
- Director and Shareholder of Ginnen Alarms Ltd
- Sister-in-law of Naumati Heath, CIU nurse, currently employed by Auckland District Health Board
- Member, Housing New Zealand Corporation Board

Mr Robert Wichman

- Director Bob Wichman Papatoetoe Ltd (Appliance servicing arrangement with CMDHB through healthAlliance)
- Manukau City Councillor

Mr Michael Williams

- Manukau City Councillor
- CFO, Treescape Ltd (associated with Vector Ltd)
- Elder, St Columba Church, Botany

What We Have Achieved This Year

Minister's Priorities and Policy Priorities

- The DHB achieved a breakeven financial result which was $3m better than budgeted. This has been achieved in the face of continuing volume pressures within the hospital and significant demand driven growth within the Funder arm. Continued financial pressure means that the implementation of the Thriving in Difficult Times project, which looks at reducing waste and improving patient safety through quality improvement initiatives, will be a key plank to the DHB meeting its financial targets next year.

- The DHB's Emergency Department achieved the national target of turning around at least 95 percent of patients from the emergency department within six hours in the third quarter of the financial year. This performance continues to be maintained. The DHB was awarded the 2010 Institute of Public Administration New Zealand Treasury Gold Award which recognises public sector organisations for improving public value through business transformation. The project also won Best Improvement Project at the Australasian Process Excellence Awards in June 2010, and a number of poster awards at national and international conferences

- With the help of partner organisations, the DHB exceeded the 85 percent national immunisation target for two year olds. The immunisation rate for Pacific children is at its highest ever rate of 89 percent, and even though the target for Maaori children was not met, there was an eight percent improvement from the previous year.

- The DHB has continued to provide more elective surgery for its population. The DHB delivered 14, 753 elective procedures in 2009/10. This included delivering 789 extra procedures more than was planned due to efficiencies arising from productivity and quality improvement initiatives in Surgical Services.

- The target for annual diabetes checks was met, with 69 percent of people who were diabetic receiving their check last year. The DHB is unique amongst other DHBs in the provision of a Chronic Care Management programme which entitles people with complicated diabetes three monthly checks.

- The DHB met the 79 percent target set for ensuring residents who were eligible for a heart disease risk assessment were reviewed.

- Mental Health access targets for all age groups were achieved with services delivered to three percent of the population. This is a great achievement for the DHB's Mental Health Service given that access rates were at 2.47 percent a year ago.

- The DHB continues to work with the Auckland DHB Cancer Service, to ensure that patients from Counties Manukau with cancer, receive radiation therapy in a timely manner. In the last quarter, 100 percent of all Counties Manukau patients received radiation therapy within six weeks of their first specialist assessment.

- The rate of adolescents accessing dental care has improved six percent in the last year to 62 percent. This is due to a combination of increased mobile oral health clinic activity, an increase in the number of contracted dentists and efficiencies gained from the improved management of the transfer of Year 8 students from the school oral health service to adolescent services.

- The DHB's family violence prevention programme received a good audit score in October 2009 highlighting the progress the DHB is making in response to family violence prevention. Efforts are now being made to integrate child abuse and neglect prevention policies, interventions and training into this programme. The DHB also has a separate clinical-based Child Protection service for children identified with abuse and is piloting an Assessment for Children in Care programme.

Improve community wellbeing

- The DHB has increased the support given to inpatient smokers to help them quit smoking as more medical and nursing staff are trained to encourage smokers to stop. Smoking cessation advice is now given to 100 percent of all mental health inpatient smokers, over 60 percent of Emergency Department patients and over 80 percent of patients in many other wards.

- A record 1170 joint housing and health assessments were carried out as a part of the Healthy Housing Programme.

- There are now 99 primary and intermediate schools and 17 secondary schools in Counties Manukau who are Health Promoting Schools

- The Creating a Better Future Strategy was developed in 2009/10 and launched on 1 July 2010. This strategy builds upon the foundation laid by the Let's Beat Diabetes programme and will see the DHB take a long term view of creating healthier communities with a range of initiatives to be implemented in 2010/11.

- A number of community grants to support improved nutrition and physical activity occurred through the Let's Beat Diabetes programme in 2009/10. These included:
  - 17 schools and 23 Early Childhood Education Centres

  - 12 Maaori, 18 Pacific and three South Asian Community Action grants
  - 115 Counties Manukau community members were provided with training to become physical activity leaders through Counties Manukau Active, an initiative supported by Let's Beat Diabetes. In addition, over 1300 people registered to participate in Counties Manukau Active physical activity programmes which are provided free or with a gold coin donation. These activities occur in the areas of Counties Manukau that have the lowest recorded levels of physical activity.

- A Community Gardening programme started by Let's Beat Diabetes in 2009 received funding so the initiative can develop across the Auckland region. This also was the case for a Healthy Cooking programme.

- The Lotu Moui Summit was held in February 2010 with an attendance of over 350 members of churches including Ministers, community leaders, congregation members, providers and youth. Lotu Moui is a church based programme that CMDHB supports with the backing of the Church Ministers and their Health Committees to deliver health education, health information and resource members of the churches to participate in healthy lifestyles learning. The theme 'Our Health Our Wealth' was an adaption of the founding scriptures of good health and wellbeing as a key to prosperity. The summit allowed the CMDHB Pacific Health Team to work with the participants to develop a plan for the benefit of the Pacific community.

Improving child and youth health

- Birthing volumes for CMDHB's Women's Health services increased by 103 on the previous year to 8,160 with 1,230 of these births occurring in the primary maternity units.

- Breastfeeding advocates were introduced to the maternity ward to support postnatal mothers during their inpatient stay

- The school based human papillomavirus vaccination (HPV) programme exceeded the targets for the 2009/10 year with a 97 percent return rate of consent forms and 65 percent of eligible girls consenting to be vaccinated. Of those who consented 80.5 percent received dose one and 60 percent received dose two at the end of the financial year.

- Newborn Hearing Screening services were progressively implemented across all CMDHB maternity facilities (Middlemore maternity ward, neonatal unit and three primary maternity units) including a mop-up community programme for those babies that missed their screening in hospital.

- A Child, Youth and Family (CYF) Social Worker position, a joint initiative between CYF and CMDHB, has been implemented working from Middlemore Hospital, with a focus on maternity and neonatal areas

- The past year has seen the launch of a number of programmes which focus on the emotional and social needs of infants in our community:
  - A DVD demonstrating the emotional and social needs of babies in their first three months of life was launched in November 2009 and is now provided free to all women who give birth in Counties Manukau.
  - Independent evaluation has shown the CMDHB funded Mellow Parenting/Hoki ki te Rito programme to be effective in improving maternal mental health and reducing parenting stress for families/whaanau who have significant relationship problems with their babies and young toddlers.
  - CMDHB is one of the first DHBs in the country to fund and provide a specialist Infant Mental Health Service. This service, Whakatupu Ora, consists of six fulltime clinicians who provide specialist clinical services for families/whaanau experiencing significant problems in relation to the emotional and social development of babies and toddlers up to the age of four years.

Reducing the incidence and impact of priority conditions

- The use of the Primary Options for Acute Care (POAC) service continues to be strong with over 479 people seen in a month on average over the last year. This equates to 479 fewer acute hospital admissions.

- In the last year, Tiaho Mai (Acute Mental Health Inpatient Unit) has had an over 60 percent reduction in incidents of seclusion and in the duration of incidents. The service went through a cultural shift in the way they supported their clients and this has made a huge contribution to the client experience of admission to a mental health facility.

- A survey of 1200 people in Counties Manukau entitled "Living with Diabetes" was undertaken. This survey, now available at www.betterfuture.co.nz, was used to inform the development of the Creating a Better Future strategy and will be used to inform improved service delivery for people with diabetes.

Developing a workforce that will meet the community's need for services

- CMDHB was awarded the contract to lead on the Kia Ora Hauora national Maaori Health Workforce development plan which aims to have 1000 new recruits by 2012.

- The Grow Our Own Workforce Project received $1.0 million from the Tindall Foundation. The goal of the project is to get more Maaori and Pacific people in the health workforce pipeline. Key projects include Return to Practice initiatives, the Health Could B 4 U schools programme, Health Science Academy establishment and Earn and Learn employment model development.

- A total of 108 South Auckland Health Foundation scholarships were awarded.

- Regional collaboration on recruitment now exists between Counties Manukau, Waitemata and Auckland DHBs with healthAlliance and Auckland Regional Resident Medical Officers (ARRMOS). Together our recruitment teams share quality candidates and a talent pool and work on collaborative strategies that reduce costs and add value.

- The DHB received accreditation as part of the ACC Partnership Programme for the fourth year. Work injury management processes were highlighted positively in the audit.

- The DHB responded to the Ministry of Health Early Protection Programme for the H1N1 vaccine in February 2009. This was followed by the Staff Seasonal Influenza Immunisation Programme. The programme aims to reach front-line staff and CMDHB staff uptake continues to increase from 32 percent in 2009 to 40 percent in 2010.

- The DHB employed Midwifery workforce increased by 6.7 full time equivalents for the year ending June 2010 and self-employed midwives increased by 23 to 131. Although CMDHB is pleased with the small gain in the midwifery numbers, significant shortages across all the areas remain.

- CMDHB and Auckland University of Technology (AUT) are working together to implement innovative strategies to attract and retain more local midwifery students. AUT's South Auckland Midwifery School has 22 first year students in their 2010 intake compared with four students three years ago. Students are able to access lectures at Middlemore Hospital via video conferencing, have local clinical placements and tutor support.

- The Tindall Foundation Grant has also enabled an extension to the Pu Ora Matatini programme, providing scholarships to support eight Maaori Midwifery students in their first year as well as five Return to Midwifery students.

- Implementation of a new model of student placement for AUT occupational therapy students across physical and mental health in CMDHB. This supports students from the Counties Manukau region, and nearby Auckland suburbs, to experience clinical practice in CMDHB throughout the three years of their training.

- The DHB initiated a workplace literacy strategy/action plan and cultural diversity programme to support the development of a diverse workforce. A pilot Language, Literacy and Numeracy (LLN) programme was run in collaboration with the Manukau Institute of Technology (MIT) in 2009 for cleaners and orderlies and completed in March 2010.

- Funding was also received from the Department of Labour to develop an organisation-wide LLN Strategy and from the Tertiary Education Commission for a range of initiatives within the DHB (currently underway) which support the LLN Strategy and Action Plan.

- The CMDHB Pacific Return to Nursing Programme has helped 14 Pacific trained nurses to become registered nurses in New Zealand. Each has passed their International English Language Test (IELT) and their Clinical Assessment Programme (CAP) to now be employed in a nursing role within primary and secondary care. This is the first group to complete the pilot. Another 14 trainees will be completing their IELT and CAP through the Pacific Return to Nursing Programme before applying for registration.

- Capacity issues with undergraduate Nursing clinical placements lead to the Dedicated Education Unit (DEU) pilot being established with support from MIT and a research grant from AKO Aotearoa. The Gastroenterology and Adult Rehabilitation/Health of Older People wards plus a community facility (working with Pro Care) have enabled the model to be adapted for three other areas. There has been a great deal of national and international interest "in the model" with presentations being made as a result.

- Record levels of nursing staff undertaking post graduate study has been achieved across the DHB.

- The DHB currently has its lowest level of nursing vacancies in several years.

Implementing the Health Services Plan and the Facilities Modernisation Plan to ensure the future needs of the community are met

- The Edmund Hillary Block was completed on time, on budget and officially opened by the New Zealand Prime Minister, The Honourable John Key. The facility provides the DHB with 240 inpatient beds.
- The DHB's Tunnels and Corridors project won the NZ Institute of Building Award for excellence in the building profession.
- The Ophthalmology Module at the Manukau Super Clinic opened in 2009/10. It has seven clinics and allows up to 300 outpatients to be seen a week.
- Collaborative work between CMDHB, the NZ Police and Child, Youth & Family Services has led to the development of a Counties Manukau Multi-agency Centre (MAC) for children, youth and adults who experience assault or sexual abuse. The co-location of different professional disciplines will promote better inter-sectoral working and a better service for vulnerable clients.
- The Assessment and Observation Unit was opened in April 2010. This fifteen bed unit is used to see patients referred by a general practitioner or accident/emergency clinics who would otherwise present at the Emergency Department.
- The Ko Awatea (previously the Centre for Health Service Innovation) project is underway with the appointment of Jonathan Gray to the chair of the Stevenson Professor of Health Innovation and Improvement. Dr Gray will be the Director of Ko Awatea and also Director of the National Institute for Health Innovation at the University of Auckland. This will be launched in April 2011.

Delivering safer care and more efficient health services with quality improvement

- All the surgical and medical wards, Kidz First, Adult Rehabilitation/Health of Older People (ARHOP) and Women's Health are now regularly auditing a number of patient safety standards as a part of our patient safety programme. Some of the off-site wards will come online in the new financial year.
- Direct admission from the Emergency Department to ARHOP beds now occurs regularly at 25 percent of all admissions to this area, so patients go directly to the most appropriate location and avoid unnecessary stays in hospital wards
- The "5 Moments for Hand Hygiene" programme rolled out across the hospital in January 2010
- The Pyxis rollout programme has seen the technology introduced into most inpatient wards. Work continues to improve processes around medication safety, and collaboration with Canterbury DHB and Capital and Coast DHB to standardise the measurement of Adverse Drug Event (ADE) rates has been running since January.
- CMDHB was one of three pilot sites for the Safe Staffing Healthy Workplaces Demonstration initiative (joint work with District Health Board NZ, NZ Nurses' Organisation and the Public Service Association). This involved Nursing, Midwifery and support staff resulting in the development of rostering standards, improved working relationships with the unions, a stronger focus on capacity planning and healthy work environments.
- The Theatre Admission & Discharge Unit has now been open for one year and exceeded the year's monthly targets within its first month of operation.
- A Patient at Risk nursing team has been established to cover a 24/7 strong focus on clinical safety and leadership.

Supporting information exchange amongst health professionals for safer and more effective service delivery

The Regional Information Strategy 2010-2020 (RIS10-20) was signed off by the Northern region DHBs in December 2009. RIS10-20 sets out the regional vision and strategy for information management and technology needed to support the delivery of healthcare services over the next five years. Some key regional and local projects undertaken by the DHB in the last year include:

- Introducing Medicine Reconciliation (MedRec) in electronic discharge summaries (EDS) to provide general practitioners with accurate information on their patients' medication history when discharged. This will reduce medication errors during transfer of care from the DHBs to primary care.
- Piloting "My Practice", a practice management system, to send outpatient clinic letters electronically to forty general practices. The DHB intends to roll this out to as many general practices as possible if the pilot is successful.
- Commissioning of the Kidz First Computer Room in April 2010. This state-of-the-art facility now contributes significantly to extending existing computer room capacity to December 2015 based on current growth projects. This challenging initiative was completed on time and to budget.

- Completing the integrated Community Information Technology System for our teams (Home Health Care and Needs Assessment Service). This enables better communication with colleagues in Primary and Secondary care settings. The arrangement includes the use of laptop computers for direct entry of information while visiting clients at home.

In addition, CMDHB has been working with our Northern Region DHB partners on other projects, specifically:

- Implementing of an Internal Audit System:
  - Work on leave balance audits has been completed at CMDHB and procedures are in place to capture savings.
  - An information services assurance project was completed and further project assurance audits for information services, buildings and service procurement were completed or are in progress.
  - Developing a cultural and linguistic diversity training (CALD) programme for the DHB's primary and secondary healthcare workforce which is now active.

Responding to patients and their family/ whanaau need for services

- Establishment of a multidisciplinary Chronic Pain Management Service for CMDHB, which includes psychologists as a component of the multidisciplinary team, along with physiotherapy, occupational therapy, and potentially social work input from Allied Health.

- Training District Nurses, Physiotherapists, Health Assistants in Home Health Care, and Occupational Therapy Assistants in Acute Allied Health to assess need, and where necessary, prescribe simple equipment to assist patients at home to manage their showering, toileting and transfers from sitting to standing.

- Continuing the ongoing work of the Community Based Geriatric Team and Community Based Rehabilitation Teams to provide assessment and rehabilitation in the community, including supporting residential care providers. This is resulting in reductions in Emergency Department presentations from residential care (from an average of over 60 per month in 2008/09 to under 48 per month in 2009/10) with fewer of these admissions deemed to be 'potentially avoidable' types.

- Implementing new funding for Community Respite Options has enabled greater numbers of older people to be cared for by family at home and receive funded respite on a regular basis through a range of facilities. In the 2009/10 year an average of 220 funded bed days were available. In 2010/11 over 380 bed days per month will be available.

- To support people ageing in place, new services providing care 'close to home' have been set up including the Lymphodema Service and Continence Service.

Hats off to our supporters and volunteers

- The South Auckland Health Foundation has had another busy and successful year raising over $2.4m from supporters for various hospital and community-based initiatives for the children and families of South Auckland.
  Some of the larger projects included
  - A digital mammography machine which has been installed at the Manukau Superclinic and has enabled the service to screen more women.
  - Equipment for Men's Health projects in the Department of Urology
  - A retinal screening camera for the Neonatal Intensive Care Unit
  - A new ultrasound for Women's Health
  - Equipment for the new Multi-Agency Centre.

- Progressive Enterprises raised $200,000 for the National Burns Centre, Emergency Care and Anaesthetics for treatment of burns patients.

- CMDHB led the national tsunami response Emergency Operations Centre when Samoa and Tonga were affected in September 2009. 580 CMDHB staff responded to the call for medical professional volunteers and numerous others pitched in to help with the manning of the Emergency Operations Centre.

We have had another exceptional year, working with our many partners for the benefit of our Counties Manukau community and leading the way in excellence in healthcare for the sector. There is much to look forward to in 2010/11 as we launch into a new year:

- Our continued partnership with primary care and our region's DHBs as we work to enhance primary and community services

- The development of Middlemore Central, a centralised information and action hub which joins up data from across the hospital giving a global view of all Middlemore activity and will support better planning, allocation of resources and patient safety.

- The introduction of a new bed management system – iBeds - to replace the current ward information management system (WiMs).

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 seek to actively 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

Responsibility for implementation of this EEO policy and the delivery of results rests explicitly with each Service General Manager and will be supported by the organisational EEO Plan.

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.

	Females		Males	
Employee Group	**Number**	**Average Salary**	**Number**	**Average Salary**
SMO	132	197,005	253	219,253
RMO	159	102,576	158	103,668
IEA's	266	86,827	115	101,987
Clerical	653	46,098	24	47,103
Cleaners & Orderlies	173	32,774	84	34,087
Home aids	10	32,487		
Medical Laboratory	111	50,755	30	54,039
Radiology	84	67,153	14	61,011
Allied Health	637	56,850	152	55,452
Security & Trades	6	37,278	32	40,141
Mental Health Nursing & Health care Assistants	270	62,200	72	58,026
Midwives	64	65,720		
Nursing & Health care Assistants	1,983	58,432	164	55,311
Interpreters	112	48,054	59	47,825

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.

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.

Overview of CMDHB Population, Health Issues

A snapshot of health in Counties Manukau

Every week for the people of Counties Manukau:

44	people die
7	of the deaths are tobacco-related
23	people die under the age of 75, 14 of them from potentially preventable conditions
162	babies are born, 30 by Caesarean section, 10 are low birth weight (<2,500g), 15 have teenage mothers
33	of the 162 babies will be re-admitted acutely to hospital in their first year of life
700	women have cervical smears performed
2,240	people are admitted to a public hospital
340	of these are aged 0-74 and have a potentially preventable condition (excluding injury)
12	are admitted for mental health conditions
209	adults are admitted electively for surgery
63	children are admitted electively for surgery
130	people are admitted to private hospitals for surgical procedures
3,440	people received 51,600 hours of home based support care visits
580	people are in DHB-supported residential care
830	people are in private hospital care
113	people are in dementia services care
23,700	adults consult their general practitioner
7,900	children visit their general practitioner
37,600	people have prescriptions dispensed, with 110,200 items costing $1.9m
12,200	people have 54,300 laboratory tests costing $0.5m
1,360	free influenza vaccines are administered to people aged 65+ (March to June)
610	vaccinations are given to children under 2 (as per Immunisation Schedule)
860	people have a free diabetes check
250	people with diabetes are admitted to hospital
170	people are admitted to hospital due to injury
110	people are admitted to hospital due to cardiovascular disease
160	people are admitted to hospital due to respiratory conditions
30	people are admitted to hospital due to asthma
1,900	people are admitted to hospital
240	children are admitted to hospital (excluding newborns)
500	theatre procedures are performed (excluding maternity)
370	people are admitted electively
6,400	people are seen in outpatients
1,700	people are seen in Emergency Care
150	births occur
1,900	people are visited by Home Health community workers

People of Counties Manukau DHB

Counties Manukau has been and remains one of the fastest growing areas in New Zealand. It is a diverse population with complex health needs and service requirements. Key features of the CMDHB population are:

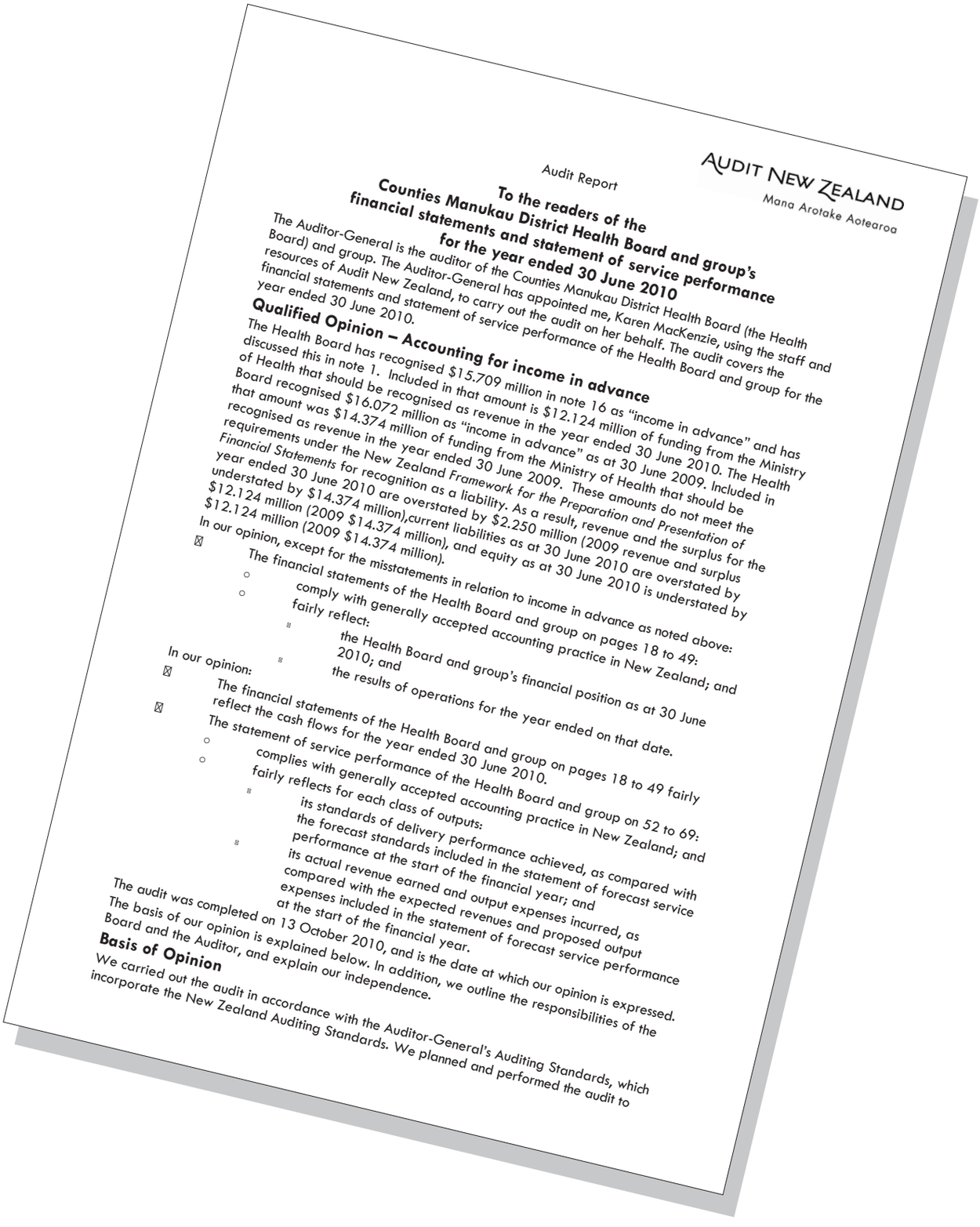
- a high proportion of Maaori
- a high proportion of Pacific people
- a high proportion of Asian people
- the relative youthfulness of these populations, and the population as a whole
- the fast growth of this population
- the high proportion of the population who are socio-economically deprived.

The Counties Manukau Population Health Indicators 2006 document (available on www.cmdhb.org.nz) provides a detailed analysis of the health of Counties Manukau residents. Key themes in this report, along with other work show:

- CMDHB residents' health is improving. For example life expectancy at birth is similar to the New Zealand average despite the material socio-economic disadvantage in Counties Manukau
- Despite this improvement, health disparities remain undiminished. Males, Maaori and Pacific people and those socio-economically deprived all do worse than their counterparts
- Hospitalisation volumes growth has slowed, and is now similar to population growth at around 3% per year. Of all hospitalisations, 34% would be considered potentially avoidable, much of the scope for prevention of these lies in the primary healthcare sector
- Infectious disease rates for Counties Manukau people, particularly children, remain high. Meningococcal meningitis disease rates halved in 2004/05 with the vaccination campaign to the fore
- Diabetes prevalence (type II diabetes) is likely to double in Counties Manukau by 2020
- Primary care is under-resourced in Counties Manukau compared with the rest of New Zealand. The implementation of the Primary Care Strategy, including the establishment of Primary Health Organisations (PHOs), is providing additional resourcing for primary care in Counties Manukau to ease this situation
- Teenage pregnancy rates are very high for Maaori and Pacific young people
- Elective surgery utilisation is up 11% over the past 4 years in Counties Manukau. Relative to the rest of New Zealand there is still a backlog of need to be assessed, but there has been a distinct improvement in access
- Total birth numbers continue to increase due to the relative youthfulness and cultural makeup of the Counties Manukau population, and counter to trends elsewhere in New Zealand
- Mental health care is under-resourced in Counties Manukau compared with the rest of New Zealand. The additional Blueprint funding allocated to CMDHB is assisting to move Counties Manukau closer to national averages for access to mental health services.

Financial Statements

Report of the Audit Office



Audit Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of the
Counties Manukau District Health Board and group's
financial statements and statement of service performance
for the year ended 30 June 2010

The Auditor-General is the auditor of the 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 on her behalf. The audit covers the financial statements and statement of service performance of the Health Board and group for the year ended 30 June 2010.

Qualified Opinion – Accounting for income in advance

The Health Board has recognised $15.709 million in note 16 as "income in advance" and has discussed this in note 1. Included in that amount is $12.124 million of funding from the Ministry of Health that should be recognised as revenue in the year ended 30 June 2009. These amounts do not meet the Board recognised $16.072 million as "income in advance" as at 30 June 2009. Included in that amount was $14.374 million of funding from the Ministry of Health that should be recognised as revenue in the year ended 30 June 2009. These amounts do not meet the requirements under the New Zealand *Framework for the Preparation and Presentation of Financial Statements* for recognition as a liability. As a result, revenue and the surplus for the year ended 30 June 2010 are overstated by $2.250 million (2009 revenue and surplus understated by $14.374 million),current liabilities as at 30 June 2010 are overstated by $12.124 million (2009 $14.374 million), and equity as at 30 June 2010 is understated by $12.124 million (2009 $14.374 million).

In our opinion, except for the misstatements in relation to income in advance as noted above:

- The financial statements of the Health Board and group on pages 18 to 49:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board and group's financial position as at 30 June 2010; and
    - the results of operations for the year ended on that date.

In our opinion:

- The financial statements of the Health Board and group on pages 18 to 49 fairly reflect the cash flows for the year ended 30 June 2010.
- The statement of service performance of the Health Board and group on 52 to 69:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 13 October 2010, and 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 the Auditor, and explain our independence.

Basis of Opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards. We planned and performed the audit to

obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. We found a material misstatement in relation to how the Health Board has accounted for income in advance, which we referred to in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2010 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

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

Independence

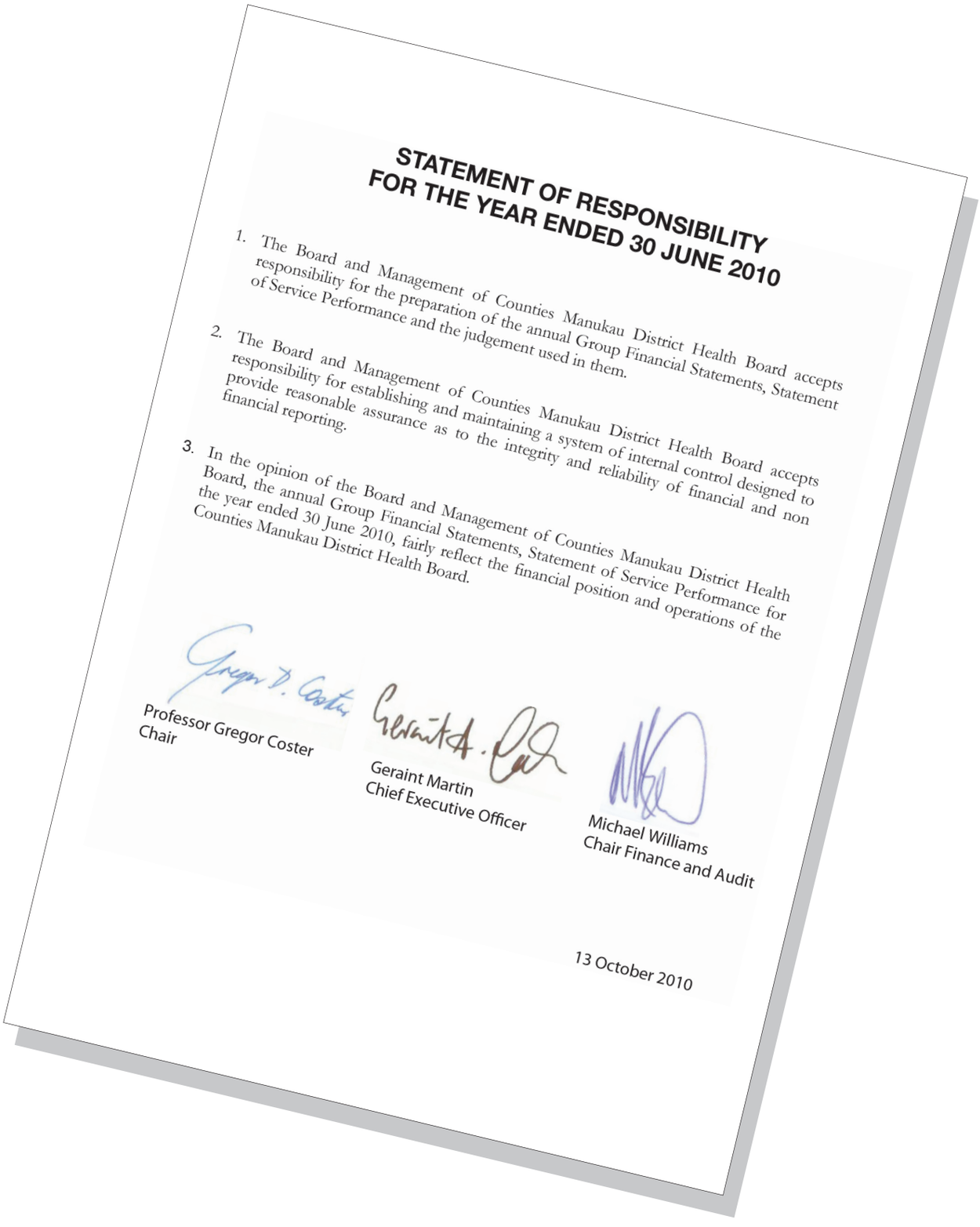
When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

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

KS MacKenzie

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

Statement of Responsibility



STATEMENT OF RESPONSIBILITY
FOR THE YEAR ENDED 30 JUNE 2010

1. The Board and Management of Counties Manukau District Health Board accepts responsibility for the preparation of the annual Group Financial Statements, Statement of Service Performance and the judgement used in them.

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

3. In the opinion of the Board and Management of Counties Manukau District Health Board, the annual Group Financial Statements, Statement of Service Performance for the year ended 30 June 2010, fairly reflect the financial position and operations of the Counties Manukau District Health Board.

Professor Gregor Coster
Chair

Geraint Martin
Chief Executive Officer

Michael Williams
Chair Finance and Audit

13 October 2010

Statement of Comprehensive Income

(Parent and Group)

For the year ending 30 June 2010
in thousands of New Zealand Dollars

	Note	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Revenue	1	1,188,154	1,186,637	1,112,554
Other operating income	2	27,555	19,391	24,202
Finance income	5a	647	2,000	1,771
Total income		**1,216,356**	**1,208,028**	**1,138,527**
Employee benefit costs	4	427,485	435,818	393,775
Depreciation and amortisation expense	7,8	23,283	28,604	23,346
Outsourced services		50,169	41,216	49,495
Clinical supplies		86,894	76,182	79,950
Infrastructure and non-clinical expenses		47,367	53,498	54,887
Payments to non-health board providers		549,047	548,386	509,961
Other operating expenses	3	10,926	3,685	7,960
Finance costs	5b	8,436	9,595	7,831
Capital charge	6	12,586	14,000	14,316
Total expenses		**1,216,193**	**1,210,984**	**1,141,521**
Surplus/(Loss)	**13**	**163**	**(2,956)**	**(2,994)**
Other Comprehensive Income				
Loss on Land Revaluation		(8,775)	-	(18,645)
Total Comprehensive Income		**(8,612)**	**(2,956)**	**(21,639)**

Note: Over the last five years, MOH has allowed DHBs to roll forward any previous year's surpluses. This is to ensure the delivery of health services is maximised with the DHB, while still maintaining a breakeven operating position. At the end of the previous financial year 30 June 2009, CMDHB had $13.1m of carried forward surpluses. Within the approved DAP, the DHB planned to spend $3.0m in the year ending June 2010. The actual amount spent was $0.0m. It is intended, with the approval of MOH, that these surpluses be retained or increased in future periods, to offset anticipated commencement costs related to the facility development programme.

The accompanying accounting policies & notes form part of these financial statements

Statement of Changes in Equity

(Parent and Group)

For the year ending 30 June 2010
in thousands of New Zealand Dollars

	Note	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Balance at 1 July 2009	**13**	**160,487**	**178,973**	**181,484**
Total Comprehensive Income		(8,612)	(2,956)	(21,639)
Interest received on Restricted Funds	13	10	24	24
Crown Equity injection	13	3,009	-	1,037
Crown Equity withdrawal	13	(419)	-	(419)
Balance at 30 June 2010		**154,475**	**176,041**	**160,487**

The accompanying accounting policies & notes form part of these financial statements

Statement of Financial Position

(Parent and Group)

As at 30 June 2010
in thousands of New Zealand Dollars

	Note	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Assets				
Property, plant and equipment	7	445,894	480,400	433,531
Intangible assets	8	3,192	496	1,196
Total non-current assets		**449,086**	**480,896**	**434,727**
Inventories	9	613	619	493
Trade and other receivables	11	46,737	33,594	51,064
Cash and cash equivalents	12	733	1,013	1,128
Trust/special fund assets	12	844	810	834
Total current assets		**48,927**	**36,036**	**53,519**
Total assets		**498,013**	**516,932**	**488,246**
Equity				
Crown equity	13	105,004	102,597	102,414
Revaluation reserves	13	110,298	137,718	119,073
Retained earnings/(losses)	13	(61,671)	(65,108)	(61,834)
Trust/Special funds	13	844	834	834
Total equity		**154,475**	**176,041**	**160,487**
Liabilities				
Interest-bearing loans and borrowings	14	150,000	149,569	120,000
Employee benefits	15	13,499	11,327	12,982
Total non-current liabilities		**163,499**	**160,896**	**132,982**
Interest-bearing loans and borrowings	14	7,500	13,968	18,500
Trade and other payables	16	91,926	96,476	98,305
Employee benefits	15	80,613	69,551	77,972
Total current liabilities		**180,039**	**179,995**	**194,777**
Total liabilities		**343,538**	**340,891**	**327,759**
Total equity and liabilities		**498,013**	**516,932**	**488,246**

The accompanying accounting policies & notes form part of these financial statements

Statement of Cash Flows

(Parent and Group)

For the year ending 30 June 2010
in thousands of New Zealand Dollars

	Note	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and patients		1,219,689	1,225,552	1,129,586
Cash paid to suppliers		(749,766)	(744,239)	(707,983)
Cash paid to employees		(424,327)	(435,808)	(381,689)
Interest received		647	2,004	1,771
Interest paid		(8,737)	(9,636)	(7,598)
Net taxes refunded/(paid) (goods and services tax)		(317)	(9,803)	(767)
Capital charge paid		(13,404)	(14,000)	(11,883)
Net cash flows from operating activities	**12**	**23,785**	**14,070**	**21,437**
Cash flows from investing activities				
Acquisition of property, plant and equipment		(45,770)	(49,492)	(61,850)
Net appropriation from trust funds	13	10	-	24
Net cash flows from investing activities		**(45,760)**	**(49,492)**	**(61,826)**
Cash flows from financing activities				
Proceeds from/(Repayment of) equity injection		2,590	-	618
Borrowings raised		19,000	35,427	50,000
Repayment of borrowings		-	-	(10,500)
Other Movements		-	-	-
Net cash flows from financing activities		**21,590**	**35,427**	**40,118**
Net increase in cash and cash equivalents		(385)	5	(271)
Cash and cash equivalents at beginning of year		1,962	1,823	2,233
Cash and cash equivalents at end of year	**12**	**1,577**	**1,828**	**1,962**

The GST (net) component of operating activities reflects the net GST paid to and received from the Inland Revenue Dept. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for the financial statement purposes

The accompanying accounting policies & notes form part of these financial statements

Statement of Contingent Liabilities

(Parent and Group)

As at 30 June 2010
in thousands of New Zealand Dollars

The Board is aware of a number of possible claims involving employment and medical issues, which may ultimately, result in legal action. However, the potential liability to the Board is not considered material. The position for this year is unchanged from the 2008/09 year.

Asbestos

There may be a potential cost relating to the discovery of asbestos on the Middlemore site. However if any were to be found it would be expensed in the year it is found as is the current practice.

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.

The accompanying accounting policies & notes form part of these financial statements

Statement of Commitments

(Parent and Group)

As at 30 June 2010
in thousands of New Zealand Dollars

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Capital commitments		
Capital Commitments approved and contracted	**18,706**	**12,280**
Operating Commitments		
To the Crown, SOEs or other Crown entities	411	411
To third parties	205,992	192,251
	206,403	**192,662**
Total Commitments	**225,109**	**204,942**
Non-cancellable commitments – Total		
Not more than one year	83,590	55,384
One to two years	52,893	34,551
Two to three years	31,390	30,306
Three to four yeas	27,071	27,259
Four to five years	27,650	27,274
Over five years	2,515	30,168
	225,109	**204,942**

Non-cancellable commitments – operating lease commitments

As At 30 June 2009	Leased Properties	Leased Vehicles	Leased Equipment	Total
Not more than one year	2,334	861	1,500	4,695
One to two years	2,268	585	1,500	4,353
Two to three years	2,251	205	875	3,331
Three to four years	2,108	28	-	2,136
Four to five years	1,386	-	-	1,386
Over five years	3,571	-	-	3,571
	13,918	**1,679**	**3,875**	**19,472**

As At 30 June 2010	Leased Properties	Leased Vehicles	Leased Equipment	Total
Not more than one year	2,225	278	1,500	4,003
One to two years	2,203	133	875	3,211
Two to three years	2,086	46	-	2,132
Three to four years	1,365	-	-	1,365
Four to five years	1,054	-	-	1,054
Over five years	2,515	-	-	2,515
	11,448	**457**	**2,375**	**14,280**

NOTE - a commitment to Ministry's Contract Management System ($12.236m) which was included in the 2009 narrative disclosure note, has been included in the 2009 operating commitments comparative table above

The accompanying accounting policies & notes form part of these financial statements

Notes to the Financial Statements

(Parent and Group)
Significant 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. Counties Manukau DHB is a crown entity in terms of the Crown Entities Act 2004 owned by the Crown and domiciled in New Zealand.
The CMDHB group consists of the ultimate parent, Counties Manukau District Health Board and its "deemed" subsidiaries, Manukau Health Trust (0% owned), and South Auckland Health Foundation (0% owned) - these are not considered to be material and have not been consolidated into the accounts. Its associate companies are healthAlliance Ltd (50%), Auckland Regional RMO Services Ltd (33%) and the Northern DHB Support Agency (33.3%) – these entities are not equity accounted as they are not considered material to CMDHB. All CMDHB subsidiaries and associates are incorporated and domiciled in New Zealand.
Counties Manukau DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Public Finance Act 1989 and the Crown Entities Act 2004.
Counties Manukau DHB is a public benefit entity, as defined under NZIAS 1.
Counties Manukau DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.
The financial statements were authorised for issue by the Board on 13/10/10.

Statement of compliance
The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Changes in accounting policies
There have been no changes in accounting policies during the financial year. The DHB and group has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

- NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners.
  The DHB and group has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.
- Amendments to NZ IFRS 7 Financial Instruments: Disclosures. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used. A maturity analysis of financial assets is also required to be prepared if this information is necessary to enable users of the financial statements to evaluate the nature and extent of liquidity risk. The transitional provisions of the amendment do not require disclosure of comparative information in the first year of application. The DHB and group has elected to disclose comparative information.

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 CMDHB include:

- NZ IAS 24 Related Party Disclosures Presentation – revised September 2010. The revised standard requires information to be disclosed in the financial statements regarding transactions with Ministers of the Crown who are "key management personnel" of the Government. CMDHB intends to adopt this standard for the year ending 30 June 2011.
- NZ IFRS 9 Financial Instruments will eventually 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 on the classification and measurement of financial assets 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 instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. CMDHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

Borrowing costs
The DHB and group has elected to defer the adoption of NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with its transitional provisions that are applicable to public benefit entities.
Consequently, all borrowing costs are recognised as an expense in the period in which they are incurred.

Basis of preparation
The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (interest rate swap contracts) and financial instruments classified as available-for-sale and land and buildings.
The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

Critical accounting estimates and assumptions
In preparing these financial statements the DHB 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. Refer to note 1 for the treatment of income in-advance
Management discussed with the Audit Risk & Finance Committee, the development, selection and disclosure of CMDHB's critical accounting policies and estimates and the application of these policies and estimates.

Basis for consolidation
Subsidiaries
Counties Manukau District Health Board 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 to Counties Manukau District Health Board. This is irrespective of legal ownership.
The Manukau Health Trust Board which is operated by a group of trustees includes nominees from Counties Manukau District Health Board. This entity is not consolidated as it is not material to Counties Manukau District Health Board.
The South Auckland Health Foundation operates as a registered Charitable Trust controlled by a group of trustees and includes three nominees from Counties Manukau District Health Board. Counties Manukau District Health Board has no legal right or equally, obligation in respect of SAHF. This entity is not consolidated as it is not material to Counties Manukau District Health Board.
Associates
The Board holds share holdings in associate companies. The interests in these associates are not accounted for as they are not material to Counties Manukau District Health Board.

Budget figures
The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by CMDHB for the preparation of these financial statements.

Financial instruments
Non-derivative financial instruments
Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.
Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through comprehensive income, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.
A financial instrument is recognised if CMDHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if CMDHB's contractual rights to the cash flows from the financial assets expire or if CMDHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset
Cash and cash equivalents
Cash and cash equivalents includes cash on hand, deposits held at call with the banks, other short term highly liquid investments with original maturities of three months or less, and bank overdrafts.
Bank overdrafts are shown within borrowings as a current liability in the statement of financial position.
Instruments at fair value through surplus or loss
An instrument is classified as at fair value through surplus or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments (interest rate swaps) are designated at fair value through surplus or loss if CMDHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in surplus or loss when incurred. Subsequent to initial recognition, financial instruments at fair value through surplus or loss are measured at fair value, and changes therein are recognised in the surplus or loss.
Other non-derivative financial instruments
Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.
Trade and other receivables
Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.
Interest-bearing loans and borrowings
Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or loss over the period of the borrowings on an effective interest basis.
Trade and other payables
Trade and other payables are initially measured at fair value and subsequently at amortised cost using the effective interest rate
Derivative financial instruments
CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments that do not qualify for hedge accounting are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the surplus or loss. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.
The fair value of interest rate swaps is the estimated amount that CMDHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Property, plant and equipment
Classes of property, plant and equipment
The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- plant and equipment
- clinical equipment
- motor vehicles
- other equipment

Owned assets
Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. 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, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised in other comprehensive income unless it offsets a previous decrease in value recognised in the surplus or loss. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive income.
Additions to property, plant and equipment between valuations are recorded at cost.
Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Counties Manukau Health Ltd (a hospital and health service company) vested in COUNTIES MANUKAU DHB on 1 January 2001. Accordingly, assets were transferred to COUNTIES MANUKAU DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment
Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive income is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets
Leases where CMDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.
An operating lease is a lease that does not transfer substantially all risks and rewards incidental to ownership of an asset.

Subsequent costs
Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to CMDHB. All other costs are recognised in the statement of comprehensive income as an expense as incurred.

Depreciation

- Depreciation is recognised as an expense using the straight line method.
  Land and Work in Progress are not depreciated.
- Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
• Buildings		
- Structure/Envelope	10 - 50 years	2% - 10%
- Electrical Services	10 - 15 years	6% - 10%
- Other Services	15 - 25 years	4% - 6%
- Fit out	5 - 10 years	10% - 20%
• Plant and equipment	5 - 10 years	10% - 20%
• Clinical Equipment	3 - 25 years	4% - 33%
• Information Technology	3 - 5 years	20% - 33%
• Vehicles	3 - 5 years	20% - 33%
• Other Equipment	3 - 25 years	4% - 33%

The residual value of assets is reassessed annually.
Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets
Other intangibles
Intangible assets comprise of software that is acquired by CMDHB and are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure
Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation
Amortisation is recognised as an expense on a straight-line basis over the estimated useful lives of intangible assets. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
• Software	2 - 5 years	20% - 50%

Inventories
Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Inventories held for distribution
Inventories held for distribution are stated at the lower of cost and current replacement cost.
Impairment
The carrying amounts of CMDHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.
If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive income.
An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.
When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive income.
Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

Calculation of recoverable amount
Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount. An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of comprehensive income.
An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Employee benefits
Defined contribution plans
Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Long service leave, sabbatical leave and retirement gratuities
CMDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave
Annual leave, conference leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount CMDHB expects to pay. CMDHB accrues the obligation for paid absences when the obligation relates to employees' past services.

Provisions
A provision is recognised when CMDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation

Restructuring
A provision for restructuring is recognised when CMDHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

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

Goods and services tax
All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue
Crown funding
The majority of revenue is provided through an appropriation in association with 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.

Goods sold and services rendered
Revenue from goods sold is recognised when CMDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and CMDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.
Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to CMDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by CMDHB.

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

Revenue relating to service contracts
CMDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or CMDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Mental Health Ring Fenced Revenue
In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the statement of comprehensive income. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods. As at 30 June 2010, there was $3.602m unspent in respect of Mental Health Ring Fenced Revenue (as at 30 June 2009 - $1.892m).

Expenses
Operating lease payments
Payments made under operating leases are recognised as an expense on a straight-line basis over the term of the lease. Lease incentives received are recognised over the lease term as an integral part of the total lease expense.
Finance lease payments
Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.
Interest Expense
The interest expense component of finance lease payments is recognised in the statement of comprehensive income using the effective interest rate method.
Cost of Service (Statement of Service Performance)
The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of CMDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.
Cost Allocation
CMDHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.
Cost Allocation Policy
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.
Criteria for Direct and Indirect Costs
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.
Cost Drivers for Allocation of Indirect Costs
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.

1 Revenue

	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Health and disability services (MOH contracted revenue)	1,085,620	1,076,793	1,011,316
ACC contract	18,760	23,419	25,123
Inter District Patient Inflows	80,413	83,240	73,114
Other revenue	3,361	3,185	3,001
	1,188,154	**1,186,637**	**1,112,554**

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.
Revenue received for Service contracts still to commence has been treated as Income in Advance, as has Revenue for the uncompleted portion of partially completed Service contracts. While this is not strictly in compliance with GAAP, the Board considers that this is the appropriate treatment in order to ensure that the readers of the Accounts have a true and fair view of the performance of the organisation. Recognition of this unearned (unspent) income would distort both this year's and next year's Accounts by an amount of approximately $12.124m, favourably overstating the operating financial performance in the year ending June 2010 and negatively impacting the year ending June 2011 result. The matching principles have been applied, despite GAAP requirements, to ensure that Expenses are matched against associated Revenue. While this treatment is contrary to IPSAS 23, it is believed to be appropriate under NZIAS 18, relating to Service contracts.

2 Other operating income

	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Donations and bequests received	3,098	3,019	2,835
Rental income	1,016	1,225	986
Other	23,441	15,147	20,381
	27,555	**19,391**	**24,202**

3 Other operating expenses

Note	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Impairment of trade receivables (bad and doubtful debts)	4,214	3,200	3,361
Audit fees (for the audit of the financial statements)	140	-	136
Audit related fees - other	5	-	12
Board fees and expenses	446	476	458
Operating lease expenses	4,912	-	955
Increase/(decrease) in provisions	1,202	-	3,022
Koha	7	9	16
	10,926	**3,685**	**7,960**

The accompanying accounting policies & notes form part of these financial statements

4 Employee benefit costs

	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Wages and salaries	424,331	435,818	380,193
Changes in Employee Benefits	3,154	-	13,582
	427,485	**435,818**	**393,775**

5 Finance income

	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Interest income	**647**	**2,000**	**1,771**

5 Finance costs

	Parent and Group 2010 Actual	Parent and Group 2010 Budget	Parent and Group 2009 Actual
Interest expense	8,345	9,595	7,831
Finance Lease expense	91	-	-
Finance cost	**8,436**	**9,595**	**7,831**

6 Capital charge

Counties Manukau DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2010 was 8 per cent (2009: 8 per cent).

The accompanying accounting policies & notes form part of these financial statements

7 Property, plant and equipment

	Freehold land (at valuation)	Buildings & Plant (at valuation)	Clinical equipment, IT and vehicles	Leased assets-buildings	Other equipment	Work in progress	Total
Cost							
Balance at 1 July 2008	84,066	295,073	113,076	1,419	13,722	19,116	526,472
Additions	-	54,812	7,921	-	397	(2,030)	61,100
Disposals	-	-	-	-	-	-	-
Revaluations	(2,538)	(16,107)	-	-	-	-	(18,645)
Balance at 30 June 2009	**81,528**	**333,778**	**120,997**	**1,419**	**14,119**	**17,086**	**568,927**
Balance at 1 July 2009	81,528	333,778	120,997	1,419	14,119	17,086	568,927
Additions	-	28,076	13,624	101	813	600	43,214
Disposals	-	-	-	-	-	-	-
Revaluations	(8,775)	-	-	-	-	-	(8,775)
Balance at 30 June 2010	**72,753**	**361,854**	**134,621**	**1,520**	**14,932**	**17,686**	**603,366**
Depreciation and impairment losses							
Balance at 1 July 2008	-	18,566	82,953	380	11,066	-	112,965
Depreciation charge for year	-	11,965	9,536	127	804	-	22,432
Disposals	-	-	(2)	-	1	-	(1)
Balance at 30 June 2009	**-**	**30,531**	**92,487**	**507**	**11,871**	**-**	**135,396**
Balance at 1 July 2009	-	30,531	92,487	507	11,871	-	135,396
Depreciation charge for year	-	11,102	10,234	97	649	-	22,082
Disposal	-	-	(6)	-	-	-	(6)
Balance at 30 June 2010	**-**	**41,633**	**102,715**	**604**	**12,520**	**-**	**157,472**
Carrying amounts							
At 1 July 2008	84,066	276,507	30,123	1,039	2,656	19,116	413,507
At 30 June 2009	81,528	303,247	28,510	912	2,248	17,086	433,531
At 1 July 2009	81,528	303,247	28,510	912	2,248	17,086	433,531
At 30 June 2010	72,753	320,221	31,906	916	2,412	17,686	445,894

The Work in Progress balance of $17,686 as at 30 June 2010 ($17,086 2009) was made up of the following classifications

Buildings & Plant $11,732k ($7,032k 2009), Clinical Equipment, IT & Motor Vehicles $5,918k ($9,975k 2009), Other Equip $36k ($79k 2009)

The accompanying accounting policies & notes form part of these financial statements

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the Treasury for the valuation of hospitals and tertiary institutions.

There was a review of land and buildings valuation as at 30 June 2010 by Telfer Young Ltd, an independent registered valuer and a member of the New Zealand Institute of Valuers. The review conforms to International Valuation Standards and was based on an optimised depreciation replacement cost methodology for building and market value for land. The valuer was contracted as an independent valuer. The next full valuation will be completed by 30 June 2012.

The review of the Land & Buildings resulted in a write-down of $8,775k and no adjustment in the year for buildings.

Restrictions

CMDHB does not have full title to crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to CMDHB are subject to the 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 claims under the Treaty of Waitangi Act 1975 cannot be quantified.

Leased assets

CMDHB leases equipment under a number of operating and finance lease agreements

Property, plant and equipment under construction

During the year ended 30 June 2010, CMDHB continued with construction of new hospital buildings on the Middlemore site, notably the new Edmund Hillary ward block was opened and progress has been made towards the planned Clinical Services block.

The accompanying accounting policies & notes form part of these financial statements

8 Intangible assets (Software)

Cost	Parent and Group 2010 Actual	Parent and Group 2009 Actual
At 1 July	26,205	25,202
Additions	3,198	1,003
Balance at 30 June	**29,403**	**26,205**
Amortisation and impairment losses		
At 1 July	25,009	24,095
Amortisation Charge	1,202	914
Balance at 30 June	**26,211**	**25,009**
Carrying amounts		
At 1 July	1,196	1,107
Balance at 30 June	**3,192**	**1,196**

There are no restrictions over the title of CMDHB's Intangible Assets, nor are there any Intangible Assets pledged as security for liabilities

9 Inventories

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Central stores - net of provision for obsolete stock	108	143
Pharmaceuticals	505	350
Total	**613**	**493**

Write-down of inventories amounted to NIL for 2010 (2009: NIL).
The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2010 was $613k (2009: $493k).

No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

10 Investments in associates

CMDHB has the following investments in associates:

a) General information

Name of entity	Principal activities	Interest held at 30 June 2010	Balance date
Auckland Regional RMO Services Ltd	Provision of health training services	33.0%	30 June 2010
Northern DHB Support Agency Ltd	Provision of health support services	33.3%	30 June 2010
healthAlliance Ltd	Provision of shared services	50.0%	30 June 2010

b) Summary of financial information (unaudited) on associate entities (100 per cent)

Year end 2010	Assets	Liabilities	Equity	Revenues	Profit/(loss)
Auckland Regional RMO Services Ltd	2,085	2,083	2	2,862	-
Northern DHB Support Agency Ltd	8,098	7,469	629	9,293	96
healthAlliance Ltd	8,738	8,738	-	33,210	-

Year end 2009	Assets	Liabilities	Equity	Revenues	Profit/(loss)
Auckland Regional RMO Services Ltd	2,130	2,129	1	2,878	-
Northern DHB Support Agency Ltd	6,093	5,563	530	8,904	249
healthAlliance Ltd	7,771	7,771	-	33,646	-

c) Share of profit of associate entities

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Share of profit/(loss)	32	83

The accompanying accounting policies & notes form part of these financial statements

11 Trade and other receivables

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Trade receivables due from related parties	849	1,287
Trade receivables from non-related parties	4,704	5,015
Ministry of Health receivables	6,555	7,742
Accrued income	34,285	35,204
Prepayments	344	1,816
	46,737	**51,064**

Trade receivables are shown net of provision for doubtful debts amounting to $4,413k (2009: $3,211k) recognised in the current year and arising mainly from unrecoverable Non-Resident debt.

Movements in the provision for impairment of receivables are as follows

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Balance of provision I July	3,211	3,072
Additional provision made during the year	4,214	3,499
Receivables written off during the year	(3,012)	(3,360)
Closing Balance 30 June	**4,413**	**3,211**

12 Cash and cash equivalents

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Bank balance	721	1116
Cash on hand	12	12
Cash and cash equivalents as per Statement of Financial Position	**733**	**1,128**
Trusts & Special Funds	844	834
Cash and cash equivalents in the statement of cash flows	**1,577**	**1,962**

CMDHB administers certain funds on behalf of patients, these funds being held in a separate bank account. The transactions during the year are not recognised in the Statement of Financial Performance. However, the bank account balance of $49k is included in the Statement of Financial Position and the related Cash flows are included in the Statement of Cash Flows of CMDHB

Working capital facility

CMDHB has a working capital facility supplied by Commonwealth Bank (limit of $50m), which was established in December 2003. The facility consists of a revolving cash advances facility.

The Commonwealth Bank, revolving cash advances facility is unsecured and is governed by a negative pledge agreement.

CMDHB Group must have a "net cash flow from operating activities" greater than zero. At all times since the facility was established the covenant has been met.

Reconciliation of surplus/(loss) for the period with net cash flows from operating activities

	Note	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Surplus/(Loss) for the period	**13**	**163**	**(2,994)**
Add back non-cash items:			
Depreciation and assets written off		23,283	23,346
Other non-cash items (movement in non-current staff entitlements)		517	3,013
Add back items classified as financing activity:			
Movements in working capital:			
(Increase)/decrease in trade and other receivables		2,778	(17,174)
(Increase)/decrease in inventories		(120)	126
Increase/(decrease) in trade and other payables		(6,679)	4,412
Increase/(decrease) in employee benefits		2,641	10,569
Increase/(decrease) in provision for doubtful debts		1,202	139
Net movement in working capital		**(178)**	**(1,928)**
Net cash inflow/(outflow) from operating activities		**23,785**	**21,437**

13 Capital and reserves

	Crown equity	Land revaluation reserve	Buildings revaluation reserve	Trust/ Special funds	Retained earnings	Total equity
At 1 July 2008	**101,796**	**80,462**	**57,256**	**810**	**(58,840)**	**181,484**
Surplus/(Loss)	-	-	-	24	(2,994)	(2,970)
Contribution from the Crown	1,037	-	-	-	-	1,037
Repayment to the Crown	(419)	-	-	-	-	(419)
Revaluation	-	(2,538)	(16,107)	-	-	(18,645)
Balance at 30 June 2009	**102,414**	**77,924**	**41,149**	**834**	**(61,834)**	**160,487**
At 1 July 2009	**102,414**	**77,924**	**41,149**	**834**	**(61,834)**	**160,487**
Surplus/(Loss)	-	-	-	10	163	173
Contribution from the Crown	3,009	-	-	-	-	3,009
Repayment to the Crown	(419)	-	-	-	-	(419)
Revaluation	-	(8,775)	-	-	-	(8,775)
Balance at 30 June 2010	**105,004**	**69,149**	**41,149**	**844**	**(61,671)**	**154,475**

Revaluation reserve
The revaluation reserve relates to land and buildings. Where buildings are reclassified as investment property, the cumulative increase in the fair value of the buildings at the date of reclassification in excess of any previous impairment losses is included in the revaluation reserve.

Trust/ Special funds
Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the statement of financial performance. Disbursements from restricted funds accumulated prior to 1993 are not recognised in the Statement of Financial Performance but are directly debited to the Restricted Funds component of Equity.

Trust/ Special funds	**Parent and Group 2010 Actual**	**Parent and Group 2009 Actual**
Balance at beginning of year	834	810
Interest received on Restricted Funds	10	24
Balance at end of year	**844**	**834**

14 Interest-bearing loans and borrowings

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Non-current		
Crown Health Financing Agency	150,000	120,000
Current		
Unsecured bank loan	7,500	18,500

Crown Health Financing Agency loans

CMDHB has unsecured loans with the Crown Health Financing Agency.
CHFA loans are subject to a negative pledge.
CMDHB Group must have a "net cash flow from operating activities" greater than zero. At all times since the facility was established the covenant has been met.

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Interest rate summary		
Crown Health Financing Agency	3.75% - 6.51%	3.75% - 6.51%

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Repayable as follows:		
One to five years	85,000	45,000
Later than five years	65,000	75,000

Bank loans

CMDHB has an unsecured bank loan denominated in NZD with Commonwealth Bank with the maximum facility of $50.0m. Of this $7.5m (2009: $18.5m) has been drawn down at balance date, leaving an available balance of $42.5m. Interest is charged based on market rate (2.45%).

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Term loan facility limits		
Crown Health Financing Agency	297,600	197,600
Bank loan facility	50,000	50,000

The Government of New Zealand does not guarantee term loans.

15 Employee benefits

Non-current liabilities	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Liability for Accident Insurance (ACC)	959	455
Liability for long-service leave	5,140	4,722
Liability for sick leave	525	543
Liability for retirement gratuities	6,875	7,262
Total	**13,499**	**12,982**
Current liabilities		
Liability for sabbatical leave	209	390
Liability for annual leave	39,205	35,111
Liability for sick leave	156	421
Liability for continuing medical education leave	1,744	1,744
Salary and wages accrual	39,299	40,306
Total	**80,613**	**77,972**

16 Trade and other payables

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Trade Payables to Related Parties	1,130	1,737
Trade Payables to Non Related Parties	9,327	11,592
ACC Levy Payable	3,292	3,542
GST & PAYE	10,070	9,874
Income in Advance	15,709	16,072
Capital Charge due to Crown	3,100	3,919
Other Non Trade payables and Accrued expenses	49,298	51,569
Total	**91,926**	**98,305**

Creditors and other payables are non-interest bearing and are normally settled on a 30-day term basis, therefore the carrying value of creditors and other payables approximates their fair value

17 Operating and finance leases

Operating leases: Leases as lessee	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	4,003	3,195
Greater than one year	10,277	12,402
	14,280	**15,597**
Finance leases: Leases as lessee		
Less than one year	413	-
Greater than one year	99	-
	512	**-**

CMDHB leases a number of buildings and vehicles under operating leases. The leases typically run for a period of 3 - 4 years (for buildings and vehicles), with an option to renew the lease.

The accompanying accounting policies & notes form part of these financial statements

18 Non-current assets held for sale

As at 30 June 2010, CMDHB held no non-current assets for sale. (2009: nil).

19 Financial instruments

Exposure to credit, interest rate and currency risks arise in the normal course of CMDHB's operations. Derivative financial instruments are used to hedge exposure to fluctuations in foreign exchange rates and interest rates.

Credit risk

Financial instruments, which potentially subject the health board to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The health board places its cash and short-term deposits with high-quality financial institutions and the health board has a policy that limits the amount of credit exposure to any one 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 58 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.

The status of trade receivables at the reporting date is as follows:

	Gross Receivable 2010	Impairment 2010	Gross Receivable 2009	Impairment 2009
Trade receivables				
Current	6,865	-	9,695	(154)
Past due 0-30 days	3,568	(228)	1,301	(474)
Past due 31-180 days	3,620	(2,088)	3,069	(977)
Past due 181-360 days	807	(605)	927	(496)
Past due more than 1 year	1,661	(1,492)	1,610	(1,110)
Total	**16,521**	**(4,413)**	**16,602**	**(3,211)**

In summary, trade receivables are determined to be impaired as follows:

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Trade receivables		
Gross trade receivables	16,521	16,602
Individual impairment	(4,413)	(3,211)
Net total trade receivables	**12,108**	**13,391**

At the balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

Liquidity risk

Liquidity risk represents the CMDHB's ability to meet its contractual obligations. The CMDHB evaluates its liquidity requirements on an ongoing basis. In general, the CMDHB generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and has credit lines in place to cover potential shortfalls.

19 Financial instruments (continued)

Liquidity risk

The following table sets out the contractual cash flows for all financial liabilities and for derivatives that are settled on a gross cash flow basis.

	Note	Balance sheet	Contractual cash flow	Less than 1 year	1 – 5 years	More than 5 years
2010						
CHFA loans	14	150,000	196,742	-	104,191	92,551
Unsecured bank loans	14	7,500	7,500	7,500	-	-
Trade and other payables	16	91,926	91,926	91,926	-	-
Total		**249,426**	**296,168**	**99,426**	**104,191**	**92,551**

	Note	Balance sheet	Contractual cash flow	Less than 1 year	1 – 5 years	More than 5 years
2009						
CHFA loans	14	120,000	161,530	-	77,923	83,607
Unsecured bank loans	14	18,500	18,500	18,500	-	-
Trade and other payables	16	98,305	98,305	98,305	-	-
Total		**236,805**	**278,335**	**116,805**	**77,923**	**83,607**

Market risk

CMDHB has entered into derivative arrangements in the ordinary course of business to manage foreign currency and interest rate risks. An Audit Risk & Finance committee, composed of Board appointees, provides oversight for risk management and derivative activities. This committee determines the CMDHB's financial risk policies and objectives, and provides guidelines for derivative instrument utilisation. This committee also establishes procedures for control and valuation, risk analysis, counterparty credit approval, and ongoing monitoring and reporting.

Interest rate risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate or, the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

CMDHB adopts a policy of ensuring that between 40 and 100 per cent of its exposure to changes in interest rates on borrowings is on a fixed rate basis. Interest rate swaps, denominated in NZD, have been entered into in the past to achieve an appropriate mix of fixed and floating rate exposure within CMDHB's policy. At 30 June 2010, CMDHB had no interest rate swaps (2009: nil).

The net fair value of swaps at 30 June 2010 was $0k; (2009: $0k). These amounts were recognised as fair value derivatives.

Effective interest rates and repricing analysis

In respect of income-earning financial assets and interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance sheet date and the periods in which they reprice.

		Group and Parent 2010 Actual				Group and Parent 2009 Actual			
	Effective interest rate %	Total	Less than 1 year	1 to 5 years	More than 5 years	Total	Less than 1 year	1 to 5 years	More than 5 years
Cash and cash equivalents	**2.5 – 3.0%**	1,577	1,577	-	-	1,962	1,962	-	-
CHFA loans:	**3.75 – 6.51%**	150,000	-	85,000	65,000	120,000	-	45,000	75,000
Bank loans:	**2.45%**	7,500	7,500	-	-	18,500	18,500	-	-

The accompanying accounting policies & notes form part of these financial statements

19 Financial instruments (continued)

Foreign currency risk

Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

CMDHB is exposed to foreign currency risk on purchases that are denominated in a currency other than NZD. The currency giving rise to this risk is primarily U.S. Dollars.

As at year end CMDHB had no direct exposure to foreign currency risk (2009 nil).

Capital management

The CMDHB's capital is its equity, which comprises Crown equity, reserves, Trust/Special funds and retained earnings. Equity is represented by net assets. The CMDHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes.

The CMDHB's policy and objectives of managing the equity is to ensure the CMDHB effectively achieves its goals and objectives, whilst maintaining a strong capital base. The CMDHB policies in respect of capital management are reviewed regularly by the governing Board.

There have been no material changes in the CMDHB's management of capital during the period.

Sensitivity analysis

In managing interest rate and currency risks CMDHB aims to reduce the impact of short-term fluctuations on CMDHB's earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

At 30 June 2010, it is estimated that a general movement of one percentage point in interest rates would either increase or decrease CMDHB's surplus before tax by approximately $1.570m (2009: $1.380m).

Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows:

2010	Note	Financial Liabilities at Amortised Cost	Loans and receivables	Carrying amount Actual	Fair value Actual
Trade and other receivables	11	-	46,737	46,737	46,737
Cash and cash equivalents	12	-	1,577	1,577	1,577
CHFA loans	14	(150,000)	-	(150,000)	(157,355)
Unsecured bank loans	14	(7,500)	-	(7,500)	(7,500)
Trade and other payables	16	(91,926)	-	(91,926)	(91,926)

19 Financial instruments (continued)

Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows:

2009	Note	Financial Liabilities at Amortised Cost	Loans and receivables	Carrying amount Actual	Fair value Actual
Trade and other receivables	11	-	51,063	51,063	51,063
Cash and cash equivalents	12	-	1,962	1,962	1,962
CHFA loans	14	(120,000)	-	(120,000)	(122,654)
Unsecured bank loans	14	(18,500)	-	(18,500)	(18,500)
Trade and other payables	16	(98,305)	-	(98,305)	(98,305)

Estimation of fair values analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

Securities

Fair value is based on quoted market prices at the balance sheet date without any deduction for transaction costs.

Derivatives

Interest rate swaps are marked to market using listed market prices. Those quotes are back tested using pricing models or discounted cash flow techniques.

Where discounted cash flow techniques are used, estimated future cash flows are based on management's best estimates and the discount rate is a market related rate for a similar instrument at the balance sheet date. Where other pricing models are used, inputs are based on market related data at the balance sheet date.

Interest-bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

Trade and other receivables / payables

For receivables / payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables / payables are discounted to determine the fair value.

Interest rates used for determining fair value

The entity uses the government yield curve as of 30 June 2010 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows

:

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Loans and borrowings	3.75 – 6.51%	3.75 – 6.51%

20 Performance by Output Classes

	Public Health	Primary & Community	Hospital	Support	Total
Revenue					
Crown	14,436	471,118	628,749	74,119	1,188,422
Other	4	143	27,761	26	27,934
Total Revenue	**14,440**	**471,261**	**656,510**	**74,145**	**1,216,356**
Budget Revenue	*6,220*	*456,860*	*656,632*	*88,316*	*1,208,028*
Expenditure					
Personnel	6,977	2,737	416,965	574	427,253
Depreciation	-	-	23,283	-	23,283
Capital Charge	-	-	12,586	-	12,586
Other	7,463	468,184	196,255	81,169	753,071
Total expenditure	**14,440**	**470,921**	**649,089**	**81,743**	**1,216,193**
Budget Expenditure	*6,220*	*459,567*	*654,259*	*90,938*	*1,210,984*
Net surplus/(deficit)	**-**	**340**	**7,421**	**(7,598)**	**163**
Budget Surplus/(Deficit)	*-*	*(2,707)*	*2,373*	*(2,622)*	*(2,956)*

The surplus for the year of $163k is $3,119k better than the budgeted loss of $2,956k. Refer note 23 for an explanation of this variance.

21 Related parties

Identity of related parties

CMDHB has a related party relationship with its subsidiaries, associates, and with its board members and executive officers.

Key management personnel compensation

	FTE 2010	FTE 2009	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Board and Committee members	40	36	410	458
Executive Management team	12	12	3,101	3,040
Total	**52**	**48**	**3,511**	**3,498**

No Board member or Executive team member receives a vehicle, parking or medical insurance. Some Executive team members may be members of a Kiwi saver scheme or have life insurance.

21 Related parties (continued)

Termination Payments
During the year ended 30 June 2010, 10 Employees (2009: 9) received a total of $167,312 (2009: $195,192) in compensation and other benefits in relation to cessations.

During the year ended 30 June 2010, the following numbers of employees received remuneration of at least $100,000 on an annualised basis - of these employees, 509 (441) are Medical Staff and 70 (76) are Management.

Total Remuneration Banding	Number of Employees 2010	Number of Employees 2009
$100,000 – 109,999	98	80
$110,000 – 119,999	75	47
$120,000 – 129,999	52	50
$130,000 – 139,999	42	30
$140,000 – 149,999	24	24
$150,000 – 159,999	22	35
$160,000 – 169,999	14	18
$170,000 – 179,999	28	22
$180,000 – 189,999	16	24
$190,000 – 199,999	19	19
$200,000 – 209,999	25	23
$210,000 – 219,999	29	15
$220,000 – 229,999	22	18
$230,000 – 239,999	20	24
$240,000 – 249,999	17	14
$250,000 – 259,999	16	11
$260,000 – 269,999	12	9
$270,000 – 279,999	7	8
$280,000 – 289,999	5	9
$290,000 – 299,999	7	9
$300,000 – 309,999	3	7
$310,000 – 319,999	5	7
$320,000 – 329,999	2	1
$330,000 – 339,999	6	4
$340,000 – 349,999	3	1
$350,000 – 359,999	4	2
$360,000 – 369,999	-	1
$370,000 – 379,999	2	-
$380,000 – 390,999	1	1
$420,000 – 429,999	-	1
$430,000 – 439,999	1	1
$440,000 – 449,999	-	1
$450,000 – 459,999	1	-
$470,000 – 480,999	1	1
Total	**579**	**517**

21 Related parties (continued)

Sales to related parties

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Northern DHB Support Agency Ltd	506	503
Manukau Health Trust	1,194	1,689
Dept of Building & Housing	6	19
Manukau City Council	1	12
Manukau Institute of Technology	334	802
Taikura Trust	5	6
University of Auckland	1,353	1,491
Total	**3,399**	**4,522**

Purchases from related parties

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
AAuckland Regional RMO Services Ltd	3,075	2,554
Northern DHB Support Agency Ltd	1,559	1,807
healthAlliance Ltd	15,480	15,426
Bob Wichman Ltd	40	26
Counties Manukau Sport	97	-
Manukau City Council	145	313
Manukau Institute of Technology	250	191
Manukau Water	788	963
PHARMAC	325	360
Raukura Hauora O Tainui Iwi Advisory	104	74
Total	**21,863**	**21,714**

Outstanding balances to related parties

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Auckland Regional RMO Services Ltd	261	252
Northern DHB Support Agency Ltd	308	420
healthAlliance Ltd	448	961
Bob Wichman Ltd	-	1
Manukau City Council	-	27
Manukau Institute of Technology	47	4
Manukau Water	66	64
Raukura Hauora O Tainui Iwi Advisory	-	8
Total	**1,130**	**1,737**

21 Related parties (continued)

Outstanding balances from related parties

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Auckland Regional RMO Services Ltd	465	458
Northern DHB Support Agency Ltd	-	39
healthAlliance Ltd	59	22
Manukau Health Trust	323	115
Dept of Building & Housing	-	2
Manukau Institute of Technology	-	194
Taikura Trust	2	-
University of Auckland	-	457
Total	**849**	**1,287**

Ownership

COUNTIES MANUKAU DHB is a crown entity in terms of the Crown Entities Act 2004, and is owned by the Crown.

Transactions with other entities controlled by the Crown

There have been transactions with other entities controlled by the Crown that have not been separately disclosed because the transactions have been carried out on the same terms as if the transactions had been carried out at arms length.

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 South Auckland Health Foundation [SAHF] accounts into its final statutory accounts. CMDHB has determined not to follow this requirement as both the MHT and SAHF are registered Charitable Trusts and as such are independent legal entities and are not under the control of CMDHB. In our 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 SAHF funds.

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

21 Related parties (continued)

The Manukau Health Trust
The Manukau Health Trust 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 historically had two nominees on the five person MHT Board of Trustees, now reduced to one during 2009/10, with the external Trustees having control under the Constitution.

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 period ending 30 June 2010.

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Statement of Financial Performance		
Income	1,153	1,807
Net Surplus (Deficit)	(128)	235
Statement of Financial Position		
Total Equity	**781**	**906**
Non-Current Assets	1	125
Current Assets	1,149	957
Total Assets	**1,150**	**1,082**
Current Liabilities	369	176
Net Assets	**781**	**906**

21 Related parties (continued)

South Auckland Health Foundation (SAHF)
CMDHB has historically had three nominees on the twelve person SAHF Board of Trustees, with the external Trustees having control under the Constitution.

In the interests of full disclosure and transparency, CMDHB is with the consent of SAHF , disclosing through this Note, the unaudited financial position of SAHF for the period ending 30 June 2010

	Parent and Group 2010 Actual	Parent and Group 2009 Actual
Statement of Financial Performance		
Income	3,691	3,456
Operating Surplus	2,989	3,016
Distributions	3,059	3,623
Net Surplus (Deficit)	**(70)**	**(607)**
Statement of Financial Position		
Total Equity	**3,918**	**3,988**
Non-Current Assets	742	6
Current Assets	3,216	4,986
Total Assets	**3,958**	**4,992**
Current Liabilities	40	1,004
Net Assets	**3,918**	**3,988**

22 Subsequent events

There were no material events to report which took place after Balance date

23 Explanation of financial variances from budget

The budget figures are those approved by the Board at the beginning of the period in the initial Statement of Intent. The budget figures have been prepared in accordance with Generally Accepted Accounting Practice and NZIFRS, and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

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

- Total Income for the year (excluding Donations) was $8.3m greater than budget, while expenditure for the year was $5.2m greater than budget. These increases reflect additional volumes and services purchased by the Crown during the year, as well as specific programmes.

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

- Under spending on property, plant and equipment due to timing of construction as well as Land & Buildings not being devalued in the 2008/09 year and land being devalued in 2009/10.
- Trade receivables due to timing of collections
- Revaluation reserves affected by the revaluation of Land and Buildings.

Major variances in Statement of Cashflow are attributed to

- Improved operating cash flows $9.7m due to lower payments to employees, lower interest payments, offset by higher outsourced costs.
- Delayed spending on property, plant, equipment $3.6m
- Improved operating cash and lower investing lead to lower financing requirements for the year

Governance & Accountability Statement

Role of the Board

The Board's governance responsibilities include:

- Communicating with the Minister and other stakeholders to ensure their views are reflected in the DHB's planning
- Delegating responsibility for achievement of specific objectives to the Chief Executive
- Monitoring organisational performance towards achieving objectives
- Reporting to stakeholders on plans and progress against them
- Maintaining effective systems of internal control.

Structure of the DHB

DHB operations

The Board appointed the Chief Executive (Geraint Martin), to manage all DHB operations. All other employees of the DHB have been appointed by the Chief Executive either directly or via the Chief Executive's delegated authority. The Board directs the Chief Executive by delegating responsibility and authority for the achievement of objectives through setting policy.

Quality Assurance

Counties Manukau DHB has numerous processes to ensure the quality of the governance, funder and provider outputs.

Governance Philosophy

Board membership

The elected and appointed Board members have diverse skills and experience in order to bring a wide range of thought to bear on policy issues. All members are required to act in the best interests of the DHB. Members are encouraged to contribute to Board decision-making processes, acknowledging that the Board must stand unified behind its decisions once made; individual members have no separate governing role outside the boardroom.

The Board acknowledges its responsibility to maintain communication with stakeholders and in particular remain cognisant of the Minister's expectations.

Division of responsibility between the Board and Management

Key to the efficient running of the DHB is that there is a clear division between the roles of the Board and Management. The Board concentrates on setting policy, approving strategy and monitoring progress toward meeting objectives. Management is concerned with implementing policy and strategy. The Board has clearly distinguished these roles by ensuring that the delegation of responsibility and authority to the Chief Executive is concise and complete.

Accountability

The Board holds monthly meetings to monitor progress toward its strategic objectives and to ensure that the affairs of the DHB and its subsidiaries are being conducted in accordance with the DHB's policies.

Disclosure of interest

The Board maintains an interests' register. Board members are aware of their obligations to declare any potential conflicts of interests to ensure transparency in the decision making process.

Internal audit

While many of the Board's functions have been delegated, the overall responsibility for maintaining effective systems of internal control ultimately rests with the Board.

The DHB uses external resources to maintain an internal audit function which is responsible for monitoring its systems of internal control and the quality and reliability of financial and non financial information reported to the Board. Internal Audit reports its findings directly to the Chief Executive. Internal Audit liaises closely with the external auditors, who review the systems of internal control to the extent necessary to support their audit opinion.

Risk management

The Board acknowledges that it is ultimately responsible for the management of risks to the DHB. The Board has charged the Chief Executive through its risk management policy with establishing and operating a risk management programme in accordance with the Joint Australian/ New Zealand Standard guideline (including 'AS/NZS 4360:2004' and 'HB 228:2001') requirements on risk management.

Legislative compliance

The Board acknowledges its responsibility to ensure the organisation complies with all relevant legislation.

Directions issued by Ministers

During the 2008-09 financial year, a "Whole of Government" direction was made jointly by the Ministers of Finance and State Services that affects CMDHB. The direction was that the DHB (and other Crown Agents) must consult with State Services Commission about online credential management or identify verification capability. If agreed, the DHB may proceed but, if after consultation, State Services Commission does not agree, the DHB must obtain Ministerial approval before proceeding. CMDHB made no such application during the year ending 30 June 2010.

Ethics
The Board has adopted a code of conduct and regularly monitors whether staff maintain high standards of ethical behaviour and practice the principles of "good corporate citizenship".

- Commit to provide a safe and healthy working environment, which is considerate also of philosophies of fairness and equality

- To select, educate and counsel our Managers, Clinical Directors, Clinical Heads and Service Centre Co-ordinators according to these principles in order that employees grasp the opportunities offered to them

- To encourage our Managers, Clinical Directors, Clinical Heads and Service Centre Co-ordinators to involve employees in the development of Counties Manukau DHB, to take into account employee suggestions for policy changes which will benefit the organisation and to foster creativity and ideas for improvement

- In return, Counties Manukau DHB looks for a commitment from its staff by way of integrity, good conduct and concern for colleagues, patients and clients.

2009-12 Statement of Intent
CMDHB 2009-12 Statement of Intent did not fully comply with the requirements of the Crown Entities Act 2004. Sections 142 (2) (b) and (c) of the Crown Entities Act 2004 require for each output class adopted, that the Statement of Intent:

- Identify the expected revenue to be earned, and proposed expenses to be incurred, for each class of outputs; and

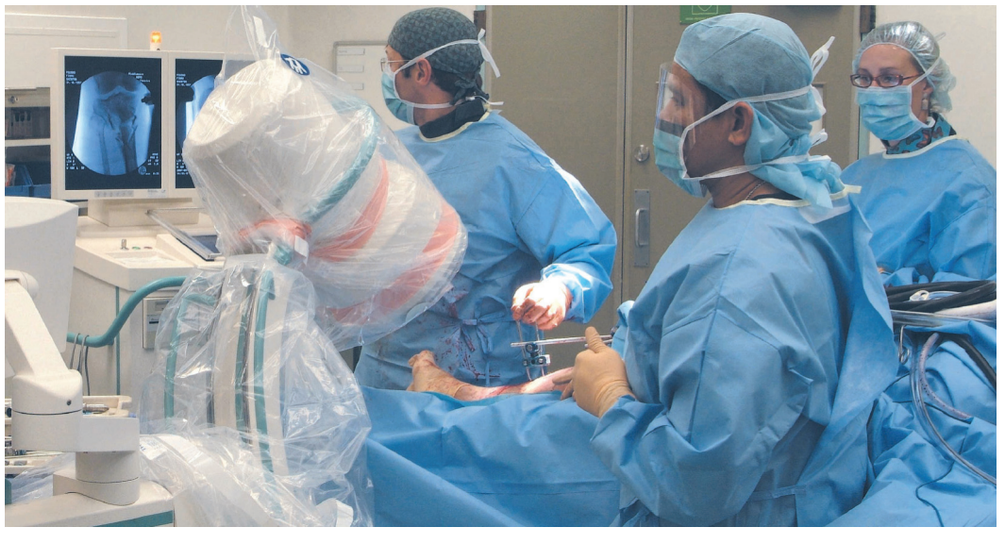
- Comply with generally accepted accounting practice.

At the time the 2009-12 Statement of Intent was adopted, CMDHB was unable to reliably identify the expected revenue and proposed expenses for each class of outputs. As a result, CMDHB breached sections 142 (2) (b) and (c) of the Crown Entities Act 2004.

The breaches occurred because CMDHB decided to adopt more relevant output classes, but they were not able to allocate the underlying budget information to the new output classes. The allocation process requires a substantial amount of work and there was insufficient time for it to be carried out between the time new output classes were adopted and the time the Statement of Intent was adopted.

The new output classes will enable CMDHB to more meaningfully report service performance for the year ending 30 June 2010.

The CMDHB is yet to identify the expected revenue to be earned and proposed expenses to be incurred for each output class. A mapping process is underway to categorise revenue and expenditure into output classes. This process should be completed by 30 June 2010.



Statement of Objectives and Service Performance

The Statement of Objectives and Service Performance sets out Counties Manukau DHB's achievement of the performance measures and objectives as described in the 2009/10 - 2011/12 Statement of Intent for the period 1 July 2009 to 30 June 2010.

For the first time, the Statement of Service Performance is structured along the lines of the four output classes of:

- Public Health Services;
- Primary & Community Services;
- Hospital Services; and
- Support Services.

However, the reader should note that the performance measures contained within each of the four outputs are still very much linked to the achievement of the DHB's strategic outcomes as articulated in the *Counties Manukau 2006 – 2011 District Strategic Plan* and the annual objectives in the *Counties Manukau 2009/10 District Annual Plan*.

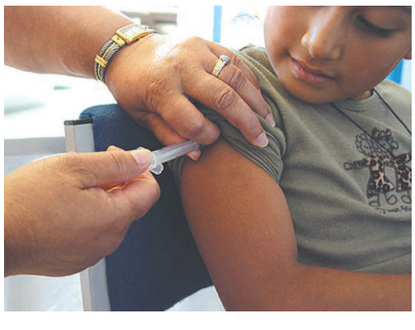
Due to the availability of data at different times, some measures can only be reported by calendar year (rather than financial year). For example, some data may be reported for the year ended 31 December 2009, rather than for the year ended 30 June 2010. Where reporting has been based on calendar year, this is noted below the table or graph. Additionally, calendar year is reported using only the year (e.g. 2009), whereas financial data is reported with reference to both years (e.g. 2009/10).

A note to the reader about the 2009/10 national health targets

In 2009/10, the number of national health targets was reduced from ten to six. This is a reflection of the change of focus in the Minister of Health's priorities following the change of Government in late 2008.

National Health Targets

Indicator	Health Target
Shorter stays in emergency departments	*95% of patients admitted, discharged, or transferred from an emergency department within 6 hours*
Improved access to elective surgery	*Increase of elective surgery volumes by an average of 4000 discharges per year*
Shorter waits for cancer treatment radiotherapy	*100% of patients in category A, B, and C wait less than 6 weeks between first specialist assessment and the start of radiation oncology treatment*
Increased immunisation	*85% of two year olds are fully immunised by July 2010*
Better help for smokers to quit	*80% of hospitalised smokers are provided with advice and help to quit by July 2010*
Better diabetes and cardiovascular services	*Measure 1: Proportion of people with diabetes who have had an annual check* *Measure 2: Proportion of people with diabetes who have satisfactory or better diabetes management* *Measure 3: Proportion of the eligible adult population who have had their CVD risk assessed in the last 5 years*



Statement of Service Performance for the Public Services Output Class

Output Class	Definition
Public Health Services	Public health services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from the curative services which repair / support health and disability dysfunction. Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and individual health protection services such as immunisation and screening services

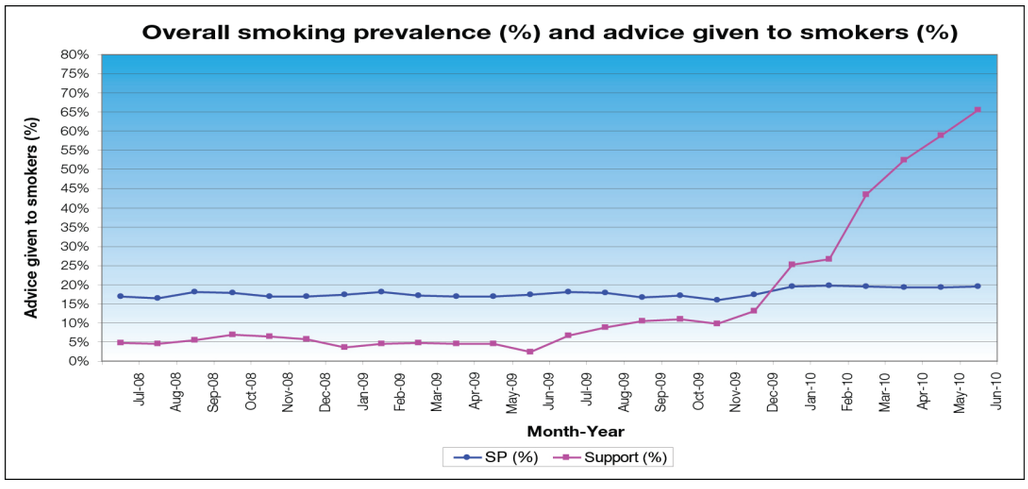
National Health Target: Better help for smokers to quit

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10		Achieved
80% of hospitalised smokers can access advice and help to quit by July 2010	n/a	80%	**Quarter 1**	10%	✘
			Quarter 2	11%	✘
			Quarter 3	31%	✘
			Quarter 4	59%	✘

Comment

The DHB's performance in supporting hospitalised smokers with advice and help to quit has continued to improve quarter on quarter since the measure was first introduced in July 2009. Although the target has not been met, the DHB has managed to improve performance from 10% in the first quarter result to 59% in the fourth quarter. The DHB continues to work on long term sustainable outcomes with a focus on building good systems and increasing the importance and confidence in addressing smoking with patients amongst health professionals. There are now seven clinicians who have undergone training to be Smokefree Trainers within the hospital and who contribute to ensuring nurses understand smokefree best practice procedures. CMDHB is committed to progressing this target each year so that by 2013 the DHB will reach the 95% target as currently stipulated in the national health targets framework.

Smoking prevalence and advice given to Counties Manukau DHB hospitalised smokers, 2008/09 – 2009/10



Source: Counties Manukau DHB Decision Support Services from Patient Information Management System data

National Health Target: Increase immunisation

Performance Measure	CMDHB Performance				
85% of two year olds are fully immunised by 2010		Result 2008/09	Target 2009/10	Result 2009/10	Achieved
	Total	78%	85%	86%	✔
	Maaori	69%	85%	77%	✘
	Pacific	79%	85%	89%	✔
	Source: National Immunisation Register				

Comment

For the first time, CMDHB has achieved and exceeded the national immunisation target to reach 86% at the end of the financial year. The rate for Maaori increased by 4% over the year to 77% but the biggest increase was from Pacific which rose from 80% to 89%. This is a great collective result for the DHB and its immunisation stakeholders but much work remains to be done to reach the national target of 95% by 2012. Regional collaboration will continue in the new financial year as the DHB works with other northern DHBs toward achievement of the immunisation target. For the first time all northern DHBs will be working towards a regional target of 90% for 2010/11.

Improve nutrition

Performance Measure	CMDHB Performance			
➢ At least 70% of adults eat three or more servings of vegetables per day by 2014 ➢ At least 62% of adults eat two or more servings of fruit per day by 2014	**Average number of vegetable and fruit servings consumed by Counties Manukau residents**			
		2006	2009	Achieved
	Total	4.6	4.4	✘
	Maaori	4.8	4.4	✘
	Pacific	4.3	4.0	✘
	South Asian	n/a	3.8	n/a
	Source: Counties Manukau DHB Let's Beat Diabetes Survey 2009			

Comment

A proxy measure – which measures the mean or average number of vegetable and fruit servings consumed by Counties Manukau residents - has been used to capture information for this performance measure. This measure is a part of the Counties Manukau DHB's 'Let's Beat Diabetes' survey and is only carried out every 3 years. The results of the latest survey carried out in 2009 is compared to the results of the benchmark survey in 2006 and shows a drop in the number of vegetable and fruit servings consumed. This may in part be due to the timing of the surveys. The original survey was conducted during the summer months but due to unexpected circumstances the 2009 survey was conducted in winter when fruit and vegetables are more expensive. Much work remains to be done to reach the national target of 95% by 2012.

Improve infant health

Performance Measure	CMDHB Performance				
Proportion of infants exclusively and fully breastfed at 6 weeks		Result 2008/09	Target 2009/10	Result 2009/10	Achieved
	Total	52%	53.6%	52%	✘
	Maaori	45%	47.2%	50%	✔
	Pacific	48%	49.9%	47%	✘
	Source: Plunket				

Comment

The breastfeeding result is based on Counties Manukau Plunket enrolment data. The reader should note that Plunket is only one of many Well Child providers operating in the district and enrols about 95% of all newborns in the district. The Ministry of Health and DHBs are looking at how breastfeeding information from other Well Child providers can be included in this performance indicator for future years. The Plunket results for the year ended December 2009 shows a modest increase for Maaori but overall, the breastfeeding target was not met. The DHB will be working with community partners to deliver additional community-based services in the coming year and the maternity unit at Middlemore Hospital will continue to work towards achieving Baby Friendly Hospital Initiative (BFHI) accreditation. The DHB will be embarking on year 3 of the 3-4 year BFHI work project in 2010/11. The combination of these efforts is expected to result in a greater improvement in breastfeeding rates over the coming year.

Increase breast screening to reduce the incidence and impact of cancer

Performance Measure	CMDHB Performance				
Proportion of women 45-69 years who have had a breast screen in the last 24 months		Result 2008/09	Target 2009/10	Result 2009/10	Achieved
	Total	48%	58%	59%	✔
	Maaori	40%	56%	50%	✘
	Pacific	44%	52%	57%	✔
	Other	48%	51%	61%	✔
	Source: Breastscreen Aotearoa				

Comment

BreastScreen Counties Manukau has exceeded the targets for total coverage and Pacific coverage. Although the target was not reached for Maaori coverage, there has been an increase of 10% since the previous year. Increased coverage has been possible due to expanded capacity in the service. In particular, the recruitment of additional Medical Radiation Technologists, the purchase of an additional digital screening machine in March 2010, and the co - location of services at Manukau SuperClinic has helped improve service efficiency and effectiveness.

Develop Healthy Environments

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Number of eligible schools that are health promoting schools A *health promoting school* is one defined by its commitment to supporting and enhancing the development of healthy environments for living, learning and working (World Health Organisation) An eligible school is a school in the Counties Manukau district that is registered with the Ministry of Education as an education provider. *Source: Kidz First Community Health*	98	100	99	✘

Comment
The Counties Manukau DHB Health Promoting Schools (HPS) programme was one school short of meeting the target number of health promoting schools. The feedback from schools is that HPS has been less of a priority for them since the introduction and the implementation of the new curriculum standard assessments. Those schools already engaged are continuing in the programme but engagement of new schools into HPS has been more difficult. The HPS team continues to work with schools supported by their public health nursing colleagues

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Number of joint health and housing assessments for the Healthy Housing Programme *Source: Healthy Housing Project*	812	480	1170	✔

Comment
The Healthy Housing Programme once again achieved a record number of joint assessments in 2009/10 with 1170 completed assessments against a target of 480. A recent study of the hospitalisation rates of residents from households participating in the Counties Manukau Healthy Housing Programme from September 2001 to December 2007 found that improvements in housing conditions can have a strong effect on health, even to the extent of reducing their acute hospitalisation rates[1].

1 Jackson, G., Thornley, S., Woolston, J., Papa, D,. Bernacchi, A., & Moore, T. (2010). Reduced Acute Hospitalisation with the Healthy Housing Programme. *In press*

Develop Healthy Environments

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
DHB progress towards taking a systematic approach towards the identification and intervention of child and partner abuse. Progress is measured using an audit tool developed by the Auckland University of Technology (AUT). It assesses programmes against criteria for an "ideal programme". Higher scores indicate greater levels of programme development, with programmes assessed according to the number of years they have been in operation. AUT researchers and the Ministry of Health have agreed that a score of 70 for each programme is a feasible target for New Zealand hospitals. *Source: Auckland University of Technology Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit Score*	n/a	Family violence prevention: 70/100 Child protection: 70/100 Total: 140/200	Family violence prevention: 85/100 Child protection: 52/100 Total: 137/200	Family violence prevention: ✔ Child protection: ✘

Comment

Since the DHB was audited in October 2009, work is now underway to integrate the Family Violence and Child Protection programmes. The DHB has a separate clinical service-based Child Protection service for children identified with abuse and is piloting an Assessment for Children in Care programme.

Statement of Service Performance for the Primary & Community Services Output Class

Output Class	Definition
Primary and Community Services	Primary and community healthcare services comprise services that are delivered by a range of health professionals in various private, not-for-profit and government service settings. These include general practice, community and Maaori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

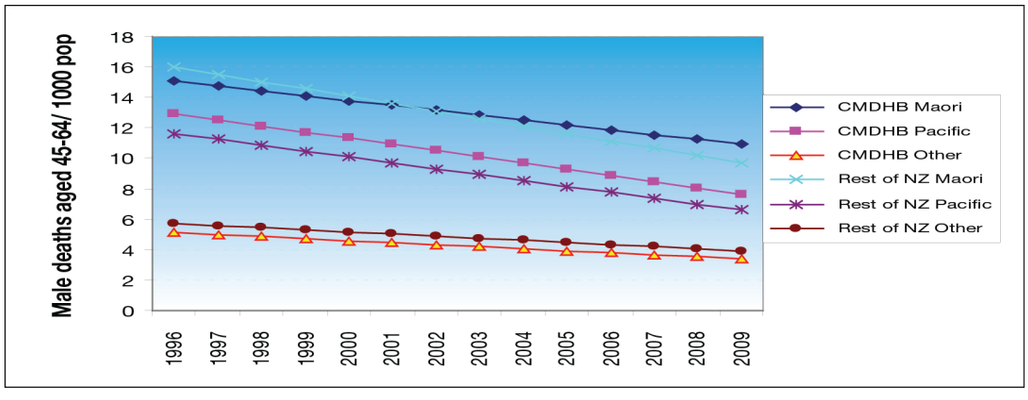
Reduce the mortality rates for Maaori and Pacific men aged 45-64

Performance Measure	CMDHB Performance			
Mortality rate for Maaori and Pacific men aged 45-64 years	**Mortality rate (per 1000) for men 45 – 64 years - 2009 calendar year**			
		Target 2009	**Result 2009**	**Achieved**
	Total	< 5.2	4.7	✔
	Maaori	< 12.0	11.9	✔
	Pacific	< 9.0	7.1	✔
	Other	< 3.9	3.2	✔
	Source: Counties Manukau DHB Health Intelligence Unit, from National Mortality Dataset (provisional)			

Comment

Male premature mortality rates continue to drop for residents in the district but the gap between Maaori and Pacific males compared with other ethnicities remains stark, with Maaori rates decreasing at a slower rate than the rest. It should be noted that the rates for Counties Manukau Maaori and Pacific males are also higher than Maaori and Pacific males in the rest of the country. Cardiovascular disease, diabetes and smoking-related conditions are main contributors to this gap. More population-based interventions targeting smoking, diet, physical activity and alcohol intake will be required to close these gaps. The DHB has rolled out a long term strategy called 'Creating a Better Future' which builds upon the 'Let's Beat Diabetes' programme to reduce the risk factors of non-communicable diseases.

Male death rate/1000, Counties Manukau residents compared to the rest of New Zealand, ages 45 – 64 years , 1996 - 2009



Source: CMDHB HIU, from National Mortality Dataset, linear trends, 2008 & 2009 provisional.

National Health Target: Better Diabetes and Cardiovascular Services

Performance Measure	CMDHB Performance			
Proportion of people with diabetes who have had an annual check	**Results from year end to March 2010**			
		Target 2009/10	**Result 2009/10**	**Achieved**
	Total	68%	69%	✔
	Maaori	67%	79%	✔
	Pacific	75%	83%	✔
	Other	65%	58%	✘
	Source: PHO Performance Programme with diabetes prevalence rates determined by the Ministry of Health			
Proportion of people with diabetes who have satisfactory or better diabetes management (HBA1c = 8% or less)	**Results from year end to March 2010**			
		Target 2009/10	**Result 2009/10**	**Achieved**
	Total	60%	60%	✔
	Maaori	54%	55%	✔
	Pacific	48%	47%	✘
	Other	71%	72%	✔
	Source: PHO Performance Programme with diabetes prevalence rates determined by the Ministry of Health			
Proportion of the eligible adult population who have had their CVD risk assessed in the last 5 years	**Results from year end to March 2010**			
		Target 2009/10	**Result 2009/10**	**Achieved**
	Total	78%	79%	✔
	Maaori	72%	74%	✔
	Pacific	73%	75%	✔
	Other	81%	81%	✔
	Source: PHO Performance Programme with diabetes prevalence rates determined by the Ministry of Health			

Comment

The diabetes detection and follow-up targets for Maaori, Pacific and the district as a whole were achieved but not for non-Maaori and non-Pacific ("Other"). Whilst the DHB will need to improve on performance for the latter, the DHB remains focused on Maaori & Pacific detection rates as prevalence rates, particularly for Pacific, are still on the increase.

The DHB met the overall target rate of 60% for diabetics who had good diabetes management. For 2010/11, the Diabetes and Cardiovascular Disease Clinical Governance Group will be considering the use of quality improvement frameworks to support Primary Health Organisations and general practice in order to meet or exceed these targets.

The targets for all ethnicities were met for CVD lipid tests for 2009/10. To ensure performance is sustained in 2010/11, the DHB and Primary Health Organisations are committed to the continuation of initiatives such as:

- the provision of opportunistic screening as per the Counties Manukau CVD Strategy,
- using the Patient Management System to identify eligible people who have yet had a CVD Risk Assessment, and
- the recalling of patients who were screened in the last 5 years.

Reduce admissions to hospital that are preventable

Performance Measure	CMDHB Performance
Rate of Ambulatory Sensitive Hospitalisations (ASH) expressed as a percentage above or below national ASH rates where 100 is the national average. *Ambulatory Sensitive Hospitalisations* (ASH) are hospital admissions that could have been potentially avoided through community based or primary health care services	**CMDHB ASH admissions for ages 0 – 4, year end to March 2010**

	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Maaori	94.0	96.3	90.9	✔
Pacific	101.7	106.8	107.3	✘
Other	90.0	97.0	74.8	✔

CMDHB ASH admissions for ages 45-64, year end to March 2010

	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Maaori	134.5	116.9	150.2	✘
Pacific	111.2	108.0	150.9	✘
Other	104.6	113.2	124.9	✘

CMDHB ASH admissions for ages 0-74, year end to March 2010

	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Maaori	112.0	108.5	122.0	✘
Pacific	110.3	107.0	129.9	✘
Other	105.9	106.0	106.8	✘

Source: NMDS public hospital data, maintained by the NZ Health Information Service (NZHIS).
**Please note that 2008/09 data is for the year end to September 2008*

Comment

Except for the 0 to 4 age group for Maaori and Other, there has been an overall deterioration in the DHB's ASH rate across all ethnicities. Several factors have contributed to this. The implementation of planned initiatives in tackling this issue has been slow due to the diversion of staff time toward developing the regional primary care Better, Sooner, More Convenient business case. Many of these initiatives will be picked up in the new financial year as a part of the Greater Auckland Integrated Healthcare Network business case implementation. The DHB will also be actively working to address the factors which are within the DHB's sphere of influence. The DHB's high ASH rates are also a reflection of the poverty in the district and the impact the downturn in the economy has had on vulnerable communities' health and wellbeing.

Deliver affordable primary care services

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Lower or reduced cost access to primary care services *Source: PHO Performance Management Programme*	100%	100%	100%	✔

Comment

Counties Manukau DHB continues to achieve 100% compliance with the passing on of fees to PHOs so that residents in the district are able to access cheaper primary care services. The DHB has also been able to come to an agreement with some Primary Health Organisations to deliver low cost after hours services for three of its highest needs areas and one of its remote rural areas. The DHB continues to publish information about Primary Health Organisation fee structures on the DHB website so that fee information for all general practices in the district is publicly available.

Increase primary care utilisation and structured programmes

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Rate of GP consultations for high needs populations (Maaori, Pacific, or living in decile 9 or 10 area) compared with non-high needs populations *Source: PHO Performance Management Programme*	1.11	> 1	1.05	✔
Care Plus enrolled population Care Plus funding is given to PHOs to develop additional services to improve care for individuals with known high health needs. High enrolment levels are indicative of people with long term conditions accessing appropriate primary care. The target is the national goal that PHOs will have 70% of expected Care Plus population enrolled in Care Plus by July 2009. *Source: Counties Manukau DHB (Primary Care)*	92.3%	70%	92.0%	✔

Improve community pharmaceutical and laboratory expenditure

The recording of National Health Index (NHI) numbers on prescriptions and laboratory tests is important for the DHB as this provides information on patterns of prescribing and what health needs are being presented. This information is used for the planning for the effective use of the DHB's pharmaceutical and laboratory expenditure.

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
The percentage of laboratory tests with a valid NHI *Source: PHO Performance Management Programme*	99.2%	95%	99.1%	✔
The percentage of pharmaceutical transactions with a valid NHI *Source: PHO Performance Management Programme*	95.5%	95%	96.0%	✔

Improve the oral health of children

Performance Measure	CMDHB Performance				
Proportion of children caries- free at five years of age This is an outcome indicator of oral health status of children aged five years old. It measures the total number of caries free children at the first examination after the child has turned five years, but before they turn six years old. A higher number denotes better oral health status	**Proportion of 5 year olds who are caries-free - 2009 calendar year**				
		Result 2008	**Target 2009**	**Result 2009**	**Achieved**
	Total	46%	52%	44%	✘
	Maaori	34%	35%	34%	✘
	Pacific	30%	35%	27%	✘
	Other	63%	65%	61%	✘
	Source: Auckland Regional Dental Service				
Mean Decayed, Missing or Filled Teeth (DMFT) score for Year 8 children[2] This is an outcome indicator of oral health status of children who are in Year 8 and measures the number of permanent teeth decayed, missing (due to caries), or filled at the last dental examination, before the child leaves the DHB school-based community oral health service. A lower number denotes better oral health status.	**Mean DMFT score in enrolled CMDHB Year 8 children – 2009 calendar year**				
		Result 2008	**Target 2009**	**Result 2009**	**Achieved**
	Total	1.15	1.10	1.19	✘
	Maaori	1.51	1.5	1.47	✔
	Pacific	1.35	1.30	1.61	✘
	Other	0.94	0.90	0.88	✔
	Source: Auckland Regional Dental Service				

Improve adolescent utilisation of oral health services

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Utilisation of oral health services by adolescents from Year 9 up to and including the age of 17 years *Source: Auckland Regional Dental Service from HealthPac data*	56%	57%	62%	✔

Comment

The DHB achieved an outstanding result for increasing the number of adolescents accessing oral health services from 56% to 62%. This has been due to increased activity of the mobile adolescent oral health services, the increase in numbers of contracted dentists, and the more efficient transfer of Year 8 children from the School Dental Service to adolescent services with the implementation of the Titanium patient information management system.

2 This is the correct definition of the measure, Indicator of District Health Board Performance or IDP POP-04 (as referenced by the Ministry of Health), which was erroneously described in the 2009/10 Statement of Intent as the mean decayed, missing or filled teeth (DMFT) score for five year olds

Statement of Service Performance for the Hospital Services Output Class

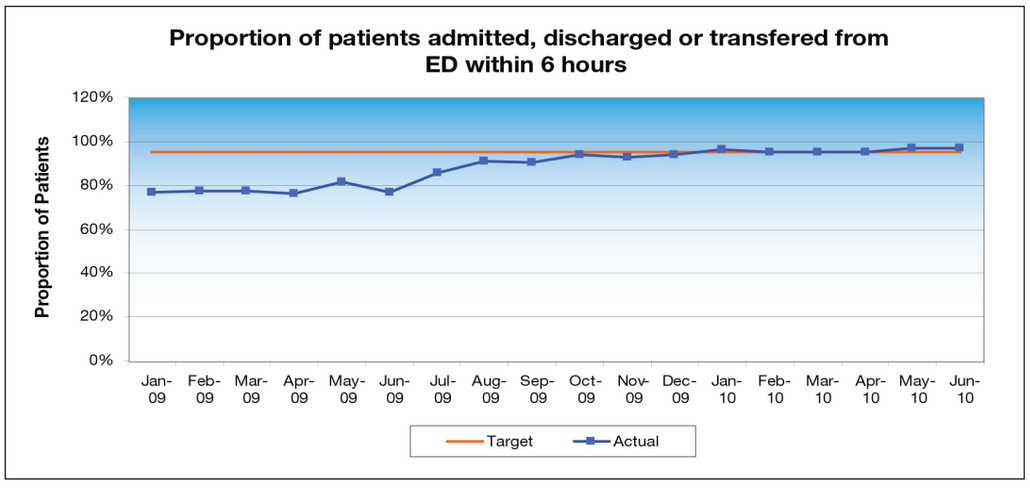
Output Class	Definition
Hospital Services	Hospital services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include: • Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services. • Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services. • Emergency Department services including triage, diagnostic, therapeutic and disposition services.

National Health Target: Shorter stays in emergency departments

Performance Measure	CMDHB Performance			
95% of patients to be admitted discharged or transferred from the emergency department within six hours		Target 2009/10	Result 2009/10	Achieved
	Quarter 1	95%	89%	✘
	Quarter 2		94%	✘
	Quarter 3		95%	✔
	Quarter 4		96%	✔
	Source: Decision Support Services from the Patient Information Management System			

Comment

Counties Manukau DHB achieved the ED target of 95% in the third quarter and has continued to perform above the 95% mark. The achievement of this target is credited to the DHB's '6 Hours Can Be Ours' initiative which used problem solving methods to look at patient flow through ED and other service areas within the hospital that patients from ED are transferred to. The initiative has improved patient flow which in turn reduced overcrowding, and has led to improved clinical care. The DHB was awarded the 2010 Institute of Public Administration New Zealand Treasury Award for improving public value through business transformation.



National Health Target: Improve access to elective (non-urgent) services

Performance Measure	Target 2009/10	Result 2009/10	Achieved
Increased volume of elective surgery delivered, by an average of 4000 discharges per year *Source: Ministry of Health Elective Services*	13,964	14,753	✔

Comment

As in previous years, the DHB has continued to exceed the target on elective surgery volume. In 2009/10, the DHB delivered an extra 789 elective surgery procedures to the district than was agreed.

	Planned			Actual Result	Variance
	Base	Additional	Total	Total	Total
Total Elective Discharges	11,051	2,913	13,964	14,753	789

2009/10 Counties Manukau DHB Patient Flow Indicators (Elective Services Patient Indicators)

The DHB received an outstanding rating from the Ministry of Health for maintaining compliance with all eight national elective service patient flow indicators throughout 2009/10. These indicators monitor how patients are managed while awaiting an elective (non-urgent) service and show the extent to which the DHB is meeting the Government's targets in respect of patients receiving the right care within acceptable timeframes.

Counties Manukau DHB Patient Flow Indicator results 2009/10, displayed as a range from the lowest result to the highest result for the year

ESPI	Definition	Target 2009/10	Result 2009	Achieved
1	DHB services that appropriately acknowledge and process all patient referrals within ten days.	97%	100% -100%	✔
2	Patients waiting longer than six months for their first specialist appointment (FSA).	1.6%	0% -0.2%	✔
3	Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)	4%	0.5% - 0.7%	✔
4	Clarity of treatment status	N/A	N/A	N/A
5	Patients given a commitment to treatment but not treated within six months	3%	1.4% - 2.0%	✔
6	Proportion of patients who have been placed on active review who have not received a clinical assessment within the last 6 months	10%	0% - 0%	✔
7	Proportion of patients with a priority score above the treatment threshold who have not received treatment within 6 months	3%	1.3% - 1.7%	✔
8	The proportion of patients treated who were prioritised using nationally recognised processes or tools	97%	100% - 100%	✔

Source: Ministry of Health Elective Services

National Health Target: Shorter waits for cancer treatment (radiotherapy)

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10		Achieved
All patients wait less than 6 weeks* between their first specialist assessment and the start of radiation oncology treatment (excluding category D) *Source: Auckland District Health Board (Oncology and Haematology Service)*	87%	100%	91%		✘
			Quarter 1	100%	
			Quarter 2	92%	
			Quarter 3	92%	
			Quarter 4	100%	

Comment

The DHB works closely with service provider, Auckland DHB, to ensure that patients are to wait less than 6 weeks between their first specialist assessment and the start of radiation oncology treatment.

436 Counties Manukau cancer patients received courses of radiotherapy treatment in Auckland DHB in 2009/10, of which 395 (91%) met the target criteria for receiving radiotherapy treatment within 6 weeks.

In 2010/11, the national health target measure for reducing cancer waiting times will be changed from a patient waiting time of less than 6 weeks between first specialist assessment and the start of radiation oncology treatment to a waiting time of less than 4 weeks.

Ongoing regional collaboration on tumour streams and multidisciplinary meetings will contribute to achieving consistent diagnosis and improved treatment times.

Proportion of cancer patients who started treatment in each time category, 2008/09 - 2009/10

	2008/09	2009/10
Wait < 24 hours	**12%**	**0%**
Wait 0 to 2 weeks	**34%**	**46%**
Wait 2 to 4 weeks	**23%**	**31%**
Wait 4 to 6 weeks	**17%**	**13%**
Wait 6 to 8 weeks	**6%**	**4%**
Waited > 8 weeks	**7%**	**5%**

Improve access to mental health services for people with severe mental illness

Performance Measure	CMDHB Performance
Increase the proportion of the Counties Manukau population with severe mental illness accessing mental health services	**N.B. All results are at 12 months to the end of March 2010**

Average number of CMDHB residents with severe mental illness accessing mental health services as a proportion of the DHB population, 0-19 years

	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Total	2.30	2.20	2.78	✔
Maaori	3.10	3.00	3.65	✔
Other	2.10	1.95	2.52	✔

Average number of CMDHB residents with severe mental illness accessing mental health services as a proportion of the DHB population, 20-64 years

	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Total	3.00	2.81	3.27	✔
Maaori	5.70	5.20	6.11	✔
Other	2.50	2.40	2.79	✔

Average number of CMDHB residents with severe mental illness accessing mental health services as a proportion of the DHB population, 65+ years

	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Total	2.37	2.40	2.50	✔
Maaori	2.50	2.40	1.98	✘
Other	2.40	2.40	2.53	✔

Source: Programme for the Integration of Mental Health Data (PRIMHD)

Comment

The DHB's Mental Health Service has met and exceeded the access target for all ethnicities and age groups with the exception of the 65+ age group for Maaori clients. Dedicated Maaori staff have been working with the Older Adults' Service to assist with improving access for this client group since the second quarter of the financial year.

The access rate across all age groups for the DHB's Mental Health Services was 3.04% for the reporting period ending 31 March 2010. The New Zealand average for the same time period was 2.46%. The actual number of clients seen by the DHB increased by 15% from 12,803, for the 12 month period ending March 2009 to 14,720, representing a 13% increase in access rates over the time period.

Improve access to mental health services for people with severe mental illness

Performance Measure	CMDHB Performance				
At least 90% of long-term clients (more than two years) have up-to-date relapse prevention plans	**All Counties Manukau DHB long term clients with relapse prevention plans, 2009/10**				
		Result 2008/09	**Target 2009/10**	**Result 2009/10**	**Achieved**
	Total	92%	90%	66%	✘
	Maaori	94%	90%	64%	✘
	Pacific	91%	90%	77%	✘
	20 + year olds (excluding those with addictions only) with relapse prevention plans, 2009/10				
		Result 2008/09	**Target 2009/10**	**Result 2009/10**	**Achieved**
	Total	96%	90%	73%	✘
	Maaori	97%	90%	71%	✘
	Pacific	100%	90%	81%	✘
	Children and youth with relapse prevention plans, 2009/10				
		Result 2008/09	**Target 2009/10**	**Result 2009/10**	**Achieved**
	Total	68%	90%	39%	✘
	Maaori	80%	90%	37%	✘
	Pacific	50%	90%	40%	✘
	Source: Counties Manukau DHB from Programme for the Integration of Mental Health Data (PRIMHD) data				

Comment

Counties Manukau DHB is a partner DHB in the Auckland Regional Mental Health Information Technology (ARMHIT) project which is adapting a patient information management system for mental health services across the three DHBs so that clinicians are able to share clinical data and clients, their GPs and NGOs are able to participate in shared care.

The DHB's performance on this indicator has dropped from previous years as the DHB has spent the last year implementing the Health Care Community (HCC) electronic clinical record documentation system from ARMHIT. One aspect of this work is ensuring that long term clients have up to date relapse prevention/ resiliency plans in HCC. At the time of publication, almost 90% of all adults and older clients have plans in HCC but only about 50% of children and adolescents have current plans in HCC. More targeted approaches will be employed in the new financial year to ensure that at least 90% of all long term clients across all age groups have documented relapse prevention plans in HCC.

Foster workplaces which are marked by good staff management relationships and work environments that are supportive of effective service delivery

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Reduce the percentage of employees who voluntarily resign (Staff turnover – FTE) *Source: CMDHB Human Resource from OneStaff data*	9.6%	< 14.0%	<8.5%	✔

Improve health professionals' communication skills in their dealings with patients and their families/ whaanau

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Reduce the ratio of communication patient complaints to the number of admissions *Source: CMDHB Incident Reporting System*	0.3%	0.3%	0.4%	✘
Proportion of inpatients surveyed who rate service satisfaction as 'Good' – 'Very Good' *Source: CMDHB Incident Reporting System*	84%	83%	85%	✔

Statement of Service Performance for the Support Services Output Class

Output Class	Definition
Support Services	Support services comprise services that are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Support Coordination (NASC) Services for a range of services including palliative care services, home-based support services and residential care services

Improve the continuum of care for services provided to older people

Performance Measure	Result 2008/09	Target 2009/10	Result 2009/10	Achieved
Ratio of number of people receiving home based support services (HBSS) to the number of people receiving Aged Residential Care (ARC) *Source: Counties Manukau District Health Board from Northern District Health Board Support Agency data*	2.50	2.50	2.52	✔

Comment
This Health of Older People (HOP) indicator measures the levels of HOP initiatives funded by the DHB to support older people to remain in their own homes and to maintain the highest health and fitness. The target ratio of HBSS clients to ARC clients was met. The Adult Rehabilitation and Health of Older People team remains committed to the provision of services to support the national policy direction of ageing in place.

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Key Abbreviations

Acronyms Description
ACC Accident Compensation Corporation
ADHB Auckland District Health Board
ARC Aged residential care
CCM Chronic Care Management programme
CBAC Community based assessment centre
CFA Crown Funding Agreement
CIMS Co-ordinated incident management system
CMDHB Counties Manukau District Health Board
CPHAC Community & Public Health Advisory Committee
DHB District Health Board
DHBNZ District Health Boards New Zealand
DiSAC Disability Support Advisory Committee
DNA Did not attend
EBIDT Earnings Before Interest, Depreciation and Tax
EBIT Earnings Before Interest and Tax
EMT Executive Management Team
ESPI Elective Services Performance Indicator
FAC Finance & Audit Committee
FTE Full-time equivalent (Employees)
GP General practitioner
HAC Hospital Advisory Committee
HBSS Home based support services
HR Human Resources
IDF Inter District Flows
IS Information Systems or Services
ISP Independent Service Providers
KPIs Key Performance Indicators
LBD Let's Beat Diabetes
MECA Multi Employment Collective Agreement
MHINC Mental Health Information National Collection
MMH Middlemore Hospital
MoH Ministry of Health
NDSA Northern DHB Support Agency (DHB Shared Services)
NETP Nurse Entry to Practice programme
NGO Non-Governmental Organisation
NHI National Health Indicator
NIR National Immunisation Register
PATHS Providing access to health services
P&L Profit and Loss
PBF Population Based Funding
PBFF Population Based Funding Formula
PHAC Pacific Health Advisory Committee
PHO Primary Health Organisations
PMP PHO Performance management programme
POAC Primary Options to Acute Care
POU Previously the Maaori Health Advisory Committee
RISSP Regional Information Services Strategic Plan
SDR Standardised Discharge Ratio
SIA Services to Improve Access
SOI Statement of Intent
WDHB Waitemata District Health Board
WIES Weighted Inlier Equivalent Separation = Weighted Relative Value Purchasing Unit for medical and surgical Inpatient services