COUNTIES MANUKAU DISTRICT HEALTH BOARD

Annual Report 2016

COUNTIES MANUKAU HEALTH




Healthy Together




Kind
Care for other people's wellbeing

Excellent
Safe, Professional, always improving.

Valuing everyone
Make everyone feel welcome and valued.

Together
Include everyone as part of the team.

Front Cover: A collage of photos reflecting Counties Manukau's Whaanau & Families, Community and Services.

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Counties Manukau District Health Board 2015/16 Annual Report

Published November 2016.

Chairman and Chief Executive Foreword

CM Health is delivering more care and a broader range of healthcare services than ever before. Our population is growing faster than the rate of funding and available resources to meet those needs. To meet these challenges we have made strategic decisions. Over the past eight years we have charted a course for transformation and system integration as the way that we will best respond to those needs.

In 2015/16 we evaluated the performance of 2012-2015 Achieving a Balance strategy "to be the best healthcare system in Australasia by December 2015". This independent review highlighted our strong performance against national and international benchmarks in a number of indicators. We have achieved these great results in the face of huge service demand pressures, while achieving a breakeven operational financial performance. This result has been made possible through the shared commitment and hard work of our primary care Alliance and many teams across hospital and community based services in our district.

We now have a strong platform to launch the next phase of our journey to really accelerate integration and achieve health equity for our community. We were excited to launch the next phase of our strategy through "Healthy Together" and supported by our refreshed values.

The range of services and care provided closer to where our people live in the community continued to grow in 2015/16 – supported by over 20,000 people with e-shared health care plans. Our integrated care achievements tell a story of our primary care Alliance commitment to community based teams working together with patients, whaanau and with broader intersectoral partners. Through our free ManaKidz and other programmes in schools our community has seen a 50 percent reduction in rates of rheumatic fever since 2014. We also continued our investment in modernisation of our hospital services with Ministerial approval to build a state of the art acute mental health inpatient unit on the Middlemore site.

We strengthened our focus on actions that will improve the health of our Maaori, Pacific and Asian communities. To further support this, we continued to build our workforce capacity and capability to reflect the diversity of the community we serve and better meet the needs of our people in Counties Manukau.

We would like to thank our local community for their advice and contribution to service co-design and keeping our focus on what matters for patients, whaanau and families. As well, our primary care Alliance partners have been pivotal through their leadership towards our vision of health equity. We cannot achieve our goals without the dedication and hard work of our staff and providers across the district. Being truly healthy together relies on everyone coming together who will collectively transform our health system to enable people to live well in the community.

Dr Lee Mathias
Chairman

Geraint A Martin
Chief Executive

Note -

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

Snapshot of Counties Manukau Health

In 2015/16, CM Health provided health and disability services to an estimated 528,340 people who reside in Counties Manukau. Our population is growing at a rate of 1- 2 percent per year; one of the fastest growing DHB populations in New Zealand. From 2015/16 to 2025/26 the number of new residents in Counties Manukau is projected to increase by just over 84,000.

The key demographic features that inform our planning assumptions are:

- There are a diverse range of needs that can be further distinguished by four geographical locality areas that have been defined covering the Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin
- The Counties Manukau district has an ethnically diverse population: 16 percent Maaori, 39 percent NZ European/Other groups, 24 percent Asian, and 21 percent Pacific. Twelve percent of all New Zealand's Maaori population, 37 percent of New Zealand's Pacific people and 21 percent of New Zealand's Asian population live in Counties Manukau
- Compared with other DHBs, Counties Manukau has the second highest number of Maaori [after Waikato], the highest number of Pacific peoples, and the second highest number of people [after Auckland DHB] who identify as Asian ethnicities
- If current population projections remain appropriate, the Asian population of CM Health will continue to increase the fastest of our ethnic groups, followed by Pacific, then Maaori, while our NZ European/Other population will show little growth
- We are a relatively young population with 23 percent of our population aged 14 years and younger. Thirteen percent of New Zealand's child population lives in Counties Manukau, and we have the highest number of 0-14 year olds of all the DHBs. The Mangere/Otara and Manukau localities are particularly youthful
- The population aged 65 and over in Counties Manukau is projected to increase on average almost five percent each year from 59,140 in 2015/16 to 88,380 by 2025/26. It is this group who will place the highest demands on health services in the years to come and is particularly significant for the Franklin and Eastern localities
- Overall, life expectancy at birth in Counties Manukau is similar to that of the New Zealand average at 81 years in 2014. While there is modest narrowing of the long-standing ethnic inequalities in life expectancy between Maaori and Non-Maaori, Non-Pacific groups in Counties Manukau, there is still a gap of over 9 years in life expectancy at birth. The gap between Pacific and Non-Maaori, Non Pacific groups was 6 years in 2014; this is similar to previous years
- At the time of the 2013 Census 36 percent of the Counties Manukau population lived in areas classified as being the most socio-economically deprived in New Zealand. Fifty-eight percent of Maaori, 76 percent of Pacific and 45 percent of 0-14 year olds in Counties Manukau lived in areas with a deprivation index of 9 or 10 at the time of the 2013 Census
- On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau district
- For health service planning purposes, the rural adjustor used in the Population Based Funding Formula gives an indication of the proportion of the population identified as living in rural areas which are seen to require additional resources to deliver health services. In the DHB funding allocation for the 2015/16 financial year, CM Health was the only DHB that did not receive any 'rural adjustor' funding

Board Members

Back row: Mrs Dianne Glenn ONZM JP, Apulu Reece Autagavaia, Mr George Ngatai, Anae Arthur Anae, Mrs Colleen Brown MNZM JP, Mrs Kathy Maxwell, Mr David Collings

Front row: Mrs Sandra Alofivae MNZM, Mrs Wendy Lai [Deputy Chair], Dr Lee Mathias ONZM [Chairman], Mr Geraint Martin [Chief Executive], Dr Lyn Murphy

Executive Leadership Team

Executive Leadership Team	
Geraint Martin	Chief Executive
Ron Pearson	Deputy Chief Executive & Director of Corporate and Business Services
Dr Gloria Johnson	Chief Medical Officer
Dr Campbell Brebner	Chief Medical Advisor, Primary & Integrated Care
Karyn Sangster	Chief Nursing Advisor, Primary & Integrated Care
Phillip Balmer	Director of Hospital Services
Benedict Hefford	Director of Primary Health & Community Services
Denise Kivell	Director of Nursing
Margie Apa	Director of Strategic Development
Martin Chadwick	Director of Allied Health
Professor Jonathon Gray	Director of Ko Awatea[1]
Beth Bundy	Director of Human Resources
David Lenihan	Director Healthy Together 2020[2]

[1] Embedded within CM Health, Ko Awatea is a centre for innovation and system improvement. Focussing on transformation and integration, through a unique partnership of improvement, innovation, education, research, knowledge management and decision support, Ko Awatea deliver system wide improvement for the benefit of the Counties Manukau community, the population of New Zealand and the Asia Pacific region.

[2] Mr Lenihan was appointed to ELT in June 2016

Key Achievements in 2015/16

Better Health Outcomes for All

- Achievement of five National Health Targets, and strong progress made towards achieving the Faster Cancer Treatment target.
- Health equity was achieved in all three of the Tobacco Health Targets and CM Health was ranked first nationally for Primary Tobacco Health Target. This meant that of the people who smoke and were seen by a health practitioner across primary care and hospital services; 96 percent in hospital, 92 percent in primary care and 100 percent of pregnant women were offered brief advice and support to quit smoking.
- PHO commitment to achieving Smokefree NZ 2025 was reflected in the 800 percent increase in primary care referrals to the Living Smokefree Service [1,234 referrals in 2015/16 compared to 127 in 2014/15].
- National Health target for Childhood Immunisations [eight months and 24 months] have been achieved for the fifth consecutive year.
- Improved rates of cervical screening service usage across all ethnicities, and in particular a seven percent increase in Maaori and Pacific women compared with 2014/2015.
- Reduction in rheumatic fever rates was supported through 25,000 children in high risk areas accessing throat swabbing services in free school based programmes [ManaKidz]. Through this programme and other initiatives, CM Health achieved an almost 50 percent reduction in rheumatic fever rates between March 2014 and March 2016.
- Improved the efficiency and increased number of CT and MRI services through better planning and operational management resulting in 92 percent of patients with an accepted referral receiving a CT scan within six weeks .
- Achievement of all gastroenterology procedure targets [and reduced number provided externally] through better planning and coordination, use of staff and facilities.
- Since its commencement in January 2016, the Fracture Liaison Service [FLS] rapidly exceeded interim targets set for the identification and implementation of treatment for the target population. The FLS will extend support and treatment for 800 patients per year at risk of subsequent fragility fractures.
- Surgical and Ambulatory Care services demonstrated strong performance through the delivery of 785 acute and 390 elective discharges above the 2014/15 volumes [without an increase in outsourcing].
- As part of Ko Awatea's 'Handle the Jandal' programme, 12 youth leaders trained 24 young people in the practice of community organising. They in turn mobilised, organised and engaged 492 young people to develop solutions and take charge of the own mental health and wellbeing.
- Service improvements have resulted in 33 percent percent fewer suspected suicide deaths of people known to mental health services during the 2015/16 year compared to two years previously; and a 50 percent reduction in suspected suicide deaths of people who had an open referral to CM Health specialist mental health services at the time of their death.

Patient and Whaanau Centred Care

- Ko Awatea's focus for Patient Experience Week 2016 was consumer and whaanau engagement and the correlation between patient experience and staff experience. A film was developed based on patients' positive and negative communication experiences aligned to CM Health's values. In the four months since its launch in March 2016, the film has been viewed over 1,000 times within New Zealand and internationally.
- The Fanau Ola team worked with 1,909 primary Pacific clients and 5,833 fanau members very complex health and psycho-social support needs
- The Whaanau Ora Safety Assessment Management [SAM] triage process has enabled increased [intersectoral] focus on each reported case of family violence to inform future [frontline service] improvements
- The Tiaho Mai team worked closely with service users and their families to codesign the design principles for a new acute mental health facility at Middlemore Hospital. This resulted in shared design principles such as creating a welcoming sanctuary, a place for healing and recovery with lots of natural light and fresh air.
- The School Health Awareness Raising Project [SHARP] team released the completed 'Guide to Employing a Registered Nurse within a Secondary School Setting'. This provides schools and nurses with practical advice

regarding employing a registered nurse to provide safe youth appropriate care in a school setting.

- With the support of a Patient and Whaanau Centred Care Consumer Council, there has been an increased number of consumer representatives working across CM Health services.
- Roll out of Real-Time Feedback collection using iPads enabling online collection of service user feedback across adult services.

System Integration

- Through our primary care Alliance, over 20,000 patients have now been through the At Risk Programme and 781 of these patients have graduated to self-management. This result was supported by 18 community multi-disciplinary team meetings each month, 602 secondary clinicians using shared care and 20,776 e-Shared Care Plans completed.
- The Toto Ora Renal Service opened the first public/private haemodialysis unit in Mangere in February 2016. The unit provides haemodialysis to patients in the community [where they live] and allows patients to be seen by other services at the same time, e.g. community podiatry. The number of patients dialysing at the unit grew steadily to reach a total of 96 patients receiving care and over 6,700 dialysis sessions performed to July 2016.
- Ongoing development of clinical pathways saw 10,000 hits on the Clinical Pathways site. Development continued with the Enhanced Primary Care and Diabetes collaboratives launched along with ongoing development of regional clinical pathways led by CM Health.
- Significant increase in the number of people accessing allied health services under the Diabetes Care Improvement Package and an increase in the number of people participating in group Self-Management Education.
- Ko Awatea, in partnership with the Ministry of Education Early Learning Taskforce worked closely with their second cohort of 23 Early Learning Centres in the Auckland region to improve attendance and enrolment in quality early childhood education. Data has shown an increase from 76 to 84 percent in enrolments from participating centres.
- Approaches to integrate Mental Health and Addictions services into physical health services resulted in the establishment of new hospital-wide Department of Psychological Medicine and three successful integration pilots between mental health and primary care in the Franklin, Otara and Mangere localities.

First Do No Harm[3]

- The APAC Forum is the largest healthcare improvement conference in the Asia Pacific region and is the third largest in the world. This Forum provided a unique platform for sharing knowledge and learning from experiences on quality, patient safety and health system improvement in the Asia Pacific region. Ko Awatea delivered their fourth APAC Forum in Auckland where 1,508 delegates attended [20 percent greater than in 2015].
- Development of a new integrated model of care for the mental health and addictions with the support of over 500 people in 47 co-design workshops.
- Successful pilot of Awake Overnight Mental Health Nurse in the Emergency Department to provide 24 hours a day/7 days a week acute assessment and interventions.
- Achieved the highest performance rating in 'Continuous Improvement' from the MOH for our significantly improved performance against Health and Disability Sector Standards. The superb work at Tamaki Oranga was recognised in stopping their use of seclusion in a challenging population.
- Continued use of 'Our Open Book' that encouraged services to examine their own systems or practice in light of each [adverse event] review.
- Our point of care survey instrument 'Care Compass' was launched in July 2015. Care Compass aids in identifying safety concerns while the patient is in the ward. This provides an opportunity for staff to intervene quickly and make improvements to improve patient safety and experience.
- Supported by Ko Awatea, 32 general practice teams took part in the second year of the Safety in Practice programme. They used a care bundle approach to enhance safer care for patients at higher risk of experiencing avoidable harm in the primary care setting.

[3] Refer to the 2015/16 Quality Account for full details of the First, Do No Harm work and achievements.

Enabling High Performing People

- In December 2015 three Maaori and two Pacific year 13 students were selected as the first cohort of cadets at CM Health. These cadetships are practical opportunities for rangitahi to gain a wider understanding of the health sector as part of a paid work experience programme.
- CM Health has been approved by the Nursing Council New Zealand to lead the first phase of the roll out of registered nurse prescribers in community health. This will include nurses working in schools, public health nursing, district nursing and primary care to increase access to medicines for treatment of skin, sore throat and other minor infections in a normally well population.
- First New Zealand Nurse Practitioner [in Child and Adolescent Mental Health and Addictions at CM Health] was endorsed by the New Zealand Nursing Council.
- In April 2016, CM Health's People Strategy was launched to support our Healthy Together strategic objectives. This is the first time that the development needs of the workforce have been brought together in one place and it recognises that our organisation's strength is our people.
- Successful launch of a series of Master Classes aimed at managers who want to update and improve their Human Resource knowledge and practices.
- Launch of values based recruitment with Talent Acquisition Team support for managers to implement.
- CM Health successfully maintained Tertiary Status of Injury Management under the ACC Partnership Program as per Audit in October 2015.
- The second cohort of 25 Emerging Leaders graduated from a 10 month postgraduate and experiential development programme. All successful participants received a Ko Awatea Leadership Academy Award in Healthcare Leadership and an accredited Post Graduate Certificate in Public Sector Leadership from the University of Waikato.
- Ko Awatea Leadership Academy launched 'Doctors as Leaders' with 25 senior doctors from both primary and secondary care. This programme aimed to cultivate their leadership capability and confidence to think innovatively about how patients are cared for, where care will be delivered and the impact of the increasing involvement of patient and whaanau in their care.
- Ko Awatea Learn, a national health professional e-learning platform, grew to over 21,000 across 11 New Zealand DHBs with an average of 720 people per day accessing healthcare development programmes.

Practicing Sustainable Healthcare

- The launch of KoLab [koawatea.co.nz/improvement-map] a collaborative, interactive atlas of system improvement activities designed to collect international knowledge and experience and connect experts nationally and internationally who have already identified solutions to common problems. This now displays 512 improvement initiatives across 37 countries and comprises projects focused on patient safety, co-design, transformational change and leadership.
- Implemented an on demand cloud based project/programme management tool [Daptiv™] across CM Health for more than 100 users to enable greater visibility of projects and more efficient project reporting and tracking of benefits.

Financial Performance

- Achieved an operating breakeven financial performance in the face of huge clinical pressures, demands and extremely tight fiscal conditions.
- Continued to implement and achieve further savings targets of $5.0m – one off savings and $7.3m permanent savings, including almost $3m procurement benefits.
- Progressed the Ministerial approval to completely rebuild the Mental Health unit Taiho Mai, on the Middlemore site, with demolition and construction already commenced.
- Successful completion of Treasury requirement of all public sector entities of an ICR (Investor Confidence Rating). This reflects all aspects of asset planning and management, with CMDHB receiving an initial A Rating – one of only two public entities to date to have achieved such.
- Within the ICR, CM Health has developed a Long Term Investment Plan detailing the strategic direction of CM health over at least the next ten years incorporating capital requirements and consequences of such.

National Health Target Performance

CM Health's performance against the national health target expectations in 2015/16 reflects our district wide collaborative approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnership with the many people and services supporting the diverse people living in Counties Manukau. The results link to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

It was the hard work and commitment of our clinical and managerial staff across primary, community and hospital health care supported by Primary Health Care Organisations [PHOs] and CM Health executives that enabled our success. This commitment to innovate and work together was exemplified in 2015/16 in our achievement of health equity for Maaori and Pacific peoples in all three tobacco [better help for smokers to quit] health targets.

Health Targets	Quarter			
	1 [Jul-Sep]	2 [Oct-Dec]	3 [Jan-Mar]	4 [Apr-Jun]
Shorter stays in Emergency Departments: 95% of patients will be admitted, discharged, or transferred from an Emergency Department [ED] within six hours[4]	95% ✓	95% ✓	95% ✓	96% ✓
Improved access to Elective Surgery: The volume of elective surgery will be increased by at least 4,000 discharges per year[5]	99% ✓	103% ✓	105% ✓	109% ✓
Faster Cancer Treatment: 85% of patients receive their first cancer treatment [or other management] within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks[5]	69%	71%	70%	76%[6]
Increased Immunisation: 95% of eight-month-olds will have their primary course of immunisation [six weeks, three months and five months immunisation events] on time[4]	95% ✓	95% ✓	94%	95% ✓
More Heart and Diabetes Checks: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years[4]	92% ✓	92% ✓	92% ✓	92% ✓
Better help for Smokers to Quit: **Secondary Care** 95% of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking[4]	95% ✓	95% ✓	95% ✓	96% ✓
Primary Care 90% of patients who smoke and are seen by a health practitioner in primary care are offered advice and support to quit smoking[7]	87%	88%	89%	92% ✓
Maternity Care 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer [LMC] offered brief advice and support to quit smoking[4]	96% ✓	94% ✓	100% ✓	100% ✓

[4] Results reflect performance in each discrete quarter throughout the 2015/16 year.
[5] Results reflect the cumulative total during the 12 month period 1 July 2015 to 30 June 2016.
[6] Final result based on report run for period 1 January 2016 to 30 June 2016. Difference of 2% from preliminary result of 74% reported by MOH is due to minor retrospective adjustments caused by further information becoming available, such as histology results or operation notes.
[7] The removal of the adjustor by MOH in Quarter 1 resulted in a decrease of 9%. Results reflect performance in each discrete quarter throughout the 2015/16 year.

Improving Health Outcomes for our Population

Our strategic intentions

We launched our refreshed values in July 2015 as the foundation of our future strategic actions.

Our current values served us well for the last decade. However, given that CM Health has experienced tremendous growth, the community and our environment has changed, it was timely to step back and refresh those values to make them current.

We launched 'Living our values, together' project in February 2015. We started engaging with staff, patients and their whaanau/family and carers to gather their insights and input about what mattered to them.[8]

The refreshed value statements were considered and approved by the Counties Manukau District Health Board in July 2015. Our focus in 2015/16 was to embed the values into the everyday behaviours of staff across CM Health.

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

- **Valuing everyone** - make everyone feel welcome and valued
- **Kind** - care for other people's wellbeing
- **Together** - include everyone as part of the team
- **Excellent** - safe, professional, always improving

Shared commitment to achieving national performance expectations

The 2015/16 government's Better Public Health Services and six national health targets set the context for our priority setting. We have a particular focus on the integration of health services across the [Auckland] region and between community and hospital health service providers. CM Health cannot succeed in meeting these challenges without aligning key initiatives with strategic partners. This includes other Northern Region District Health Boards, Counties Manukau based PHO Alliance and related service providers and social sector agencies.

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

Working together with our regional DHBs and community partners.

Regional planning focuses on where regional health system collaboration will make a real difference [tangible benefits] and addresses important health issues for the population.

2015/16 was year four of the Northern Region Health Plan [http://www.ndsa.co.nz] implementation. Work plans are developed each year with regional DHBs [Auckland, Waitemata, Northland and Counties Manukau] and their community care partners. In 2015/16, this built on the region's previous three plans with an emphasis on longer term planning, care closer to home and the provision of better integration of healthcare for patients and communities within constrained funding increases. There was a focus on demonstrative collaboration and more detailed planning to deliver against priority regional goals and delivering on regional workforce, IT and capital objectives and more detailed planning across regional priorities. This included ongoing changes to our business support systems, and in particular the regional focus around information systems, procurement and the supply chain.

[8] The first part of ''Living our values, together'' engagement was an interactive week to listen to patients, family/whaanau and each other, and several weeks of engaging staff and patients to complete surveys online and around the hospital. This developed tangible behaviours that show what our values look like in day-to-day interactions as we go about delivering the care we all aspire to.

Regional informatics was a major focus for 2015/16 that included aligning the local Information Systems plan with regional direction and working with regional partners towards achieving an Electronic Health Record. CM Health's Annual Plan priorities aligned to the Northern Region goals as shown in the high level Intervention Logic outlined in Figure 2.

2015/16 saw the conclusion of our "Best health care system in Australasia by December 2015" strategic goal.

Over the last four years we have been working towards the strategic goal of being the "Best health care system in Australasia by December 2015". This strategy aimed to make a difference to the health of our communities and make CM Health into one of the best places to work.

Our 2015/16 strategic priorities included some of the programmes outlined below [refer to the 'Key Achievements in 2015/16' section for further information]:

Improved health and equity for all populations	Our ***Better Health Outcomes for All*** programme aimed to improve population health. Initiatives aimed to specifically work with our communities to address the barriers to good health to improve life expectancy, reduce inequalities in health, and support individuals and whaanau to lead healthy lives. Key programmes included reducing smoking prevalence to less than 12 percent by 2018 and 5 percent by 2025 [Smokefree 2025], improved care and services for mums and babies in their first 2000 days of life [successful approaches were transitioned in to business as usual in 2016], reduced hospital admissions due to poor quality housing and improved health literacy. These continue to be our Healthy Together focus in addition to reduced harm from alcohol as part of our **Healthy Communities** strategic objective.
Improved quality, safety and experience	Our ***First Do No Harm*** programme implemented the national, regional and local quality and safety initiatives in hospital and primary care. Many initiatives have been implemented as part of everyday quality improvement. Collaborative approaches and development of national quality and safety priorities continue in 2016/17 and as part of our **Healthy Services** strategic objective.
	The second programme ***Patient and Whaanau Centred Care*** implemented tools and approaches to improve service design and delivery throughout the care continuum. Codesign was a cornerstone approach to ensure that patient and whaanau experiences actively contributed to service redesign. A Patient and Whaanau Centred Care Consumer Council was established in early 2015 and continues to facilitate patient/service user and their whaanau input into service improvement. The Council provided advice and active support for the strategy and values refresh projects in 2016. Collaborative approaches continue in 2016/17 as part of our **Healthy Services** and **Healthy People, Whaanau and Families** strategic objectives.
Best value for public health system resources	***System Integration*** [including localities and community health integration]. With Alliance partner support, this programme drove model of care enhancement in general practice and development of integrated community health services. Work continues through the Healthy Together Integrated Care programme.
	Ensuring Financial Sustainability. This programme aimed to deliver on savings programmes and alignment of long term financial planning with the service changes delivered through 'System Integration' and targeted efficiency gains. Work continues each year as part of our annual business planning processes. Collaborative approaches continue in 2016/17 as part of our **Healthy Services** strategic objective.
	Enabling High Performing People. This programme focused on how we managed our workforce resources to deliver quality healthcare services in a manner that is sustainable and high performing. We formalised this programme into a Workforce and Education Committee responsible for integrated workforce development planning with a whole of system [and district] focus. Work continues in 2016/17 as part of our **Healthy Services** strategic objective.

We refreshed our strategy to prepare for our future priorities.

Strategic planning must translate into healthcare delivery that will make a difference to the lives of people in contact with our health system. We have learnt from patients and whaanau feedback, interaction with the wider community,

knowledge through our campaigns and health needs assessments. We know that our Maaori and Pacific peoples are disproportionately affected by these conditions and that the determinants of poor health for our community are affected by lifestyle choices. We have persistent health inequalities for Maaori and Pacific peoples.

To better understand our future strategic priorities we:

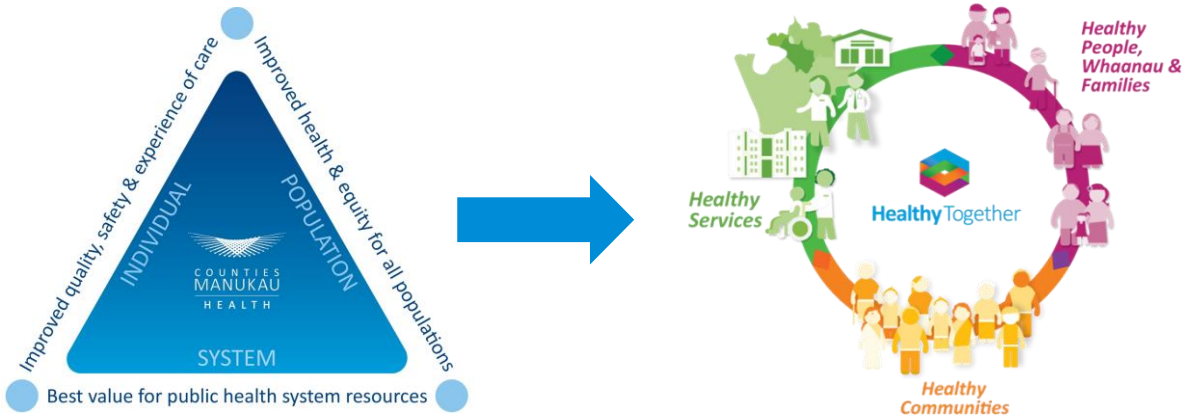
- commissioned independent evaluation[9] of our current strategy [against comparable national and international system level measures] to learn what worked and where we could best continue to build on our achievements, and
- engaged with over 1,500 people across our district to seek their views on future strategic priorities.

This resulted in development of our *Healthy Together strategy* and three objectives. The resounding message from our community and staff, was that they cared about achieving health equity for our diverse community. Our Healthy Together strategic goal reflects this ambition:

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

Healthy Together is a continuation of our previous strategy's foundation achievements in quality and safety improvement, establishment of four localities and system integration – an "evolution" of the Triple Aim [Figure 1].

Figure 1: Triple Aim evolution to Healthy Together



We measured our performance through system level measures in addition to government health targets.

To clearly show the linkages between the performance of our healthcare system and our strategic objectives, we implemented a suite of system level measures [SLMs]. This was the basis for evaluation of our "Best health care system in Australasia by December 2015" strategic goal.

These 'big dot' measures are outlined in our Performance Measurement Framework [Figure 3]. These provide a useful context for interpreting performance of contributory or 'little dot' measures of key healthcare system priority areas. They also signal areas where focus may be needed to improve or maintain performance.

Embedded within the framework are measures which give us an indication over time whether our strategies are contributing toward the positive change we seek for our population. In areas where disparities are being faced by our Maaori, Pacific and Asian populations, results were disaggregated by ethnicity. This gave us a better picture of health gain for these communities and others facing similar poor health outcomes. Work continued in 2015/16 to improve the scope and accuracy of our ethnicity data coding so that we can more reliably understand actual and emerging health disparities.

Both big dot and little dot measures are reported on a regular basis to the Executive Leadership Team, Board and Board Committees. This enables visibility of areas of strong performance as well as those needing more focus. These measures evolved in 2016 to reflect the national SLMs [http://www.health.govt.nz] supported by local and Northern regional improvement plans.

[9] Doolan-Noble, F; Barson,S; Cullinane, F; Lyndon, M; Stokes, T; Gauld, R. Quality Improvement at Counties Manukau Health: A case study evaluation. Dunedin: Centre for Health Systems, University of Otago; 2016 [Available online from http://www.otago.ac.nz/healthsystems]

Figure 2: Intervention Logic

We will contribute to the national health goal for ...	**All New Zealanders live longer, healthier and more independent lives**		
We support and align with the northern region vision to ...	Improve health outcomes and reduce disparities by delivering, better, sooner more convenient services; and doing this in a way that meets future demand whilst living within our means		
By contributing to regional priorities ...	Life and years	First, do no harm	The informed patient
To reach our vision for the people of Counties Manukau ...	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		
So that our community can ...	**Live longer, healthier and more independent lives**		
We commit our skills and resources to reaching our goal of ...	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
By delivering our triple aim strategic objectives for	Improved health and equity for all populations	Improved quality, safety and experience of care	Better value for public health system resources
By organising and delivering our actions through six executable strategies	Better Health Outcomes for All First Do No Harm System Integration Ensuring Financial Sustainability Enabling High Performing People Delivering Patient and Whaanau Centred Care		
That work together with health service delivery by supporting our community throughout their life course with	**Prevention** Health Promotion & Education, Immunisation, Health Screening, Statutory and Regulatory	**Early Detection and Management** Primary Health Care, Long Term Conditions, Oral Health Diagnostics, Pharmacy	**Treatment** Mental Health, Elective, Acute, Maternity, Additional Patient Safety	**Rehabilitation and Support** NASC, Assessment Treatment & Rehabilitation, Palliative Care, ARRC, Home Based Support
So that all people living in Counties Manukau ... 	✓ Will be smokefree by 2025 ✓ Children will have the best start in life ✓ Will have good levels of health literacy ✓ Will experience better transitions of care ✓ Are active participants in their own health care ✓ Participate and collaborate in decision making ✓ See better value from health care funding ✓ Will have better access to services based in the community ✓ See a health care workforce that looks more like their own community		

Figure 3: CM Health performance measurement framework

To progress towards our goal of:	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
We will measure our achievements through our Triple Aim …	Improved health and equity for all populations	Improved quality, safety and experience of care	Better value for public health system resources
Our collective executable strategic initiatives and service delivery performance across the whole of our health system will be monitored through 'big dot' System Level Measures [SLMs] ….	• Life expectancy at birth • Childhood immunisation status • Un-enrolled health service utilisation • Ambulatory sensitive hospitalisations • Long term conditions risk assessment [CVD/ Diabetes risk assessment] • Long term condition management • Patient experience of care • Rate of adverse events • Hospital standardised mortality rate • Acute hospital readmissions • Hospital days in the last 6 months of life • Emergency Department length of stay • Healthcare cost per capita • Timely access to diagnostics • Waitlist to elective surgery • Workforce retention		
	There are complex interactions between measures of activity and impact that collectively contribute to our Triple Aim objectives and strategic goal, so we will monitor these across the spectrum of services provided by the CM Health system.		
By protecting longer term population health through early detection and improved prevention support …	• Proportion of 8-month olds who have their primary course of immunisation on time [Maaori, Pacific, Total] • Proportion of enrolled preschool and school children who have not been examined by the Oral Health Service [within 30 days of their recall date] • Proportion of the eligible population who have had their B4 School Checks • Hospitalisation rates for acute rheumatic fever per 100,000 population [Maaori, Pacific, Total] • Proportion of enrolled patients who smoke and are seen in General Practice that are offered brief advice and support to quit smoking [High Needs, Total] • Prevalence of regular smoking for those aged 15 years and over by total responses [Maaori, Pacific, Total]		
Improving population health equity and individual health through early detection and management of common conditions …	• Proportion of women aged 50-69 years who have had a breast screen in the last 24 months • Proportion of eligible people receiving cardiovascular disease [CVD] risk assessment in the last 5 years [Maaori, Pacific, Asian, Other] • Proportion of Counties Manukau residents who have had a previous CVD event who are on triple therapy [Maaori, Pacific, Asian, Other] • Total number of general practice enrolled patients with diabetes who do not have satisfactory or better diabetes management - HbA1c of greater than 64mmol/mol [Maaori, Pacific, Asian, Other]		
Improve support for people and families with mental health and addictions issues …	• Access rates to specialist mental health and addictions services across the life course [0-19 years], 20-64 years and 65+ years with greater access for Maaori [Maaori, Pacific, Other] • Proportion of people aged 0-19 years referred for non-urgent mental health of addictions services seen within 3 weeks and 8 weeks respectively [Counties Manukau DHB Hospital Care and NGOs] • Percentage of people seen within 7 days of discharge from an adult inpatient mental health unit		
Providing the best value for health funding through efficient and effective service delivery …	• Percentage of surveyed patients that were 'very satisfied' with communication and coordination of experience [of care/services] • Proportion of patients referred with a high suspicion of cancer and a need to be seen within two weeks to first cancer treatment within 62 days • Patients waiting longer than 4-months for their first specialist assessment • Acute readmissions to hospital within 28 days • Improved workforce diversity as a percentage by ethnicity compared to population percentage by ethnicity [Maaori, Pacific, Asian, Other] • Number of patients having advance care planning discussions		

Performance Measurement

Our Performance Measurement Framework [Figure 3] sets out how we measured the effectiveness of our healthcare system through our System Level Measures. The framework also sets out a cross section of key contributory measures which span the spectrum of our services and which collectively tell us if we are on track to meet our strategic goals and the organisational Triple Aim.

Embedded within the framework are measures which will give us an indication over time whether our strategies are contributing toward the positive change we seek for our population. These measures are proxy measures which best reflect the health priorities and challenges faced by our population. They are amenable to being tracked overtime to provide a good indication of whether our communities are indeed living longer, healthier and more independent lives.

This section gives an overview of how well we are performing across a selection of key outcome and service delivery indicators.

Outcome Key Performance Indicators

Continued improvement in overall life expectancy and narrowing of ethnic disparity

Life expectancy at birth is a key long term measure of health. The overall life expectancy at birth in Counties Manukau in 2015 was 81.7 years.

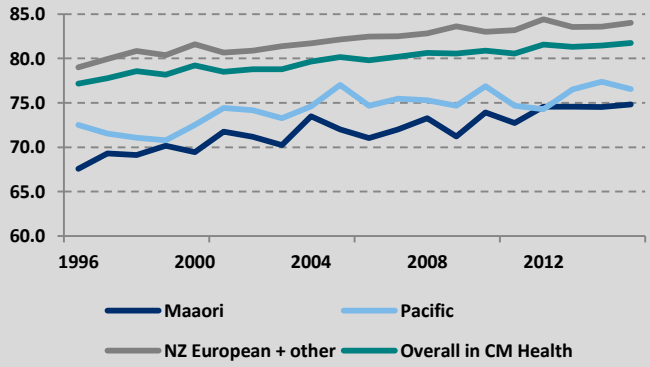
Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern; increasing by 1.9 years from 2006 to 2015.

While there is modest narrowing of the long-standing ethnic inequities in life expectancy between Maaori and Non-Maaori, Non-Pacific groups in 2015 living in Counties Manukau, there is still a gap of over 9 years in life expectancy at birth.

The gap between Pacific and Non-Maaori, Non Pacific groups was 7 years in 2015. We remain committed to reducing these inequities, working with our communities to address the broader social determinants of the health gaps, and ensure that the highest quality health care is accessible and provided to our Maaori, Pacific and other communities with health disparities.

The life expectancy gap of Maaori and Pacific in Counties Manukau compared to non-Maaori, non-Pacific[10]

	2008 Baseline	2015 Result	Target
Maaori	10.4 yrs	9.2 yrs	Reduce baseline rates
Pacific	7.1 yrs	7.4 yrs	



A reduction in the incidence of rheumatic fever

Acute rheumatic fever [ARF] is a potentially preventable, life-limiting illness. Reduction in hospitalisations for rheumatic fever is one of the government's Better Public Service goals.

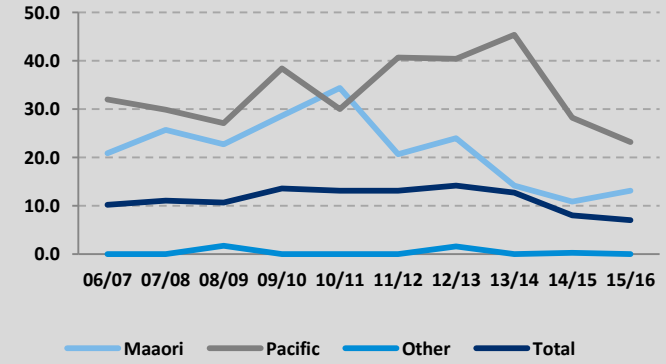
Rheumatic heart disease [RHD] and ARF are potentially preventable conditions if Group A streptococcal throat infections are prevented and/or identified and treated appropriately. ARF occurs most commonly in children aged 5-14 years and disproportionately affects Maaori and Pacific children and communities. The long term sequelae of RHD also result in a considerable burden of disease in the adult population.

CM Health has the highest number of rheumatic fever cases and overall rheumatic fever rate of any DHB nationally.[11] Although considerable improvement has been achieved in the past 4 years, we have more work to do to reduce rates in our Maaori and Pacific children.

We are committed to reducing the burden of Rheumatic

Acute rheumatic fever first hospitalisations per 100,000 population[12]

	14/15 Baseline	15/16 Result	15/16 Target
Maaori	10.9	13.1	-
Pacific	28.2	23.2	-
Total	8.0	7.0	5.9



[10] Data sourced from Mortality Collection, Ministry of Health; Estimated populations by DHB, Statistics New Zealand.
[11] The Ministry of Health website reports national progress by individual DHB. This is accessible from: http://www.health.govt.nz
[12] Source of baseline data: MOH incidence of first episode acute rheumatic fever cases as defined by MOH algorithm for the 1 July 2014 to 30 June 2015. Rate per 100,000 population based on Statistics NZ estimated resident population projections.

Fever in our communities and acknowledge the complexity of preventing this disease as well as the wide range of activities and investment needed if a significant reduction in cases is to be achieved.

In 2015/16 we continued to implement and offer a range of initiatives targeting those most at risk. These included school-based throat swabbing programmes in 61 schools; providing access to sore throat management in primary and community care; and systematically identifying children who are at risk of developing rheumatic fever and offering a package of housing-related interventions to reduce their risks.

Service Delivery Key Performance Indicators

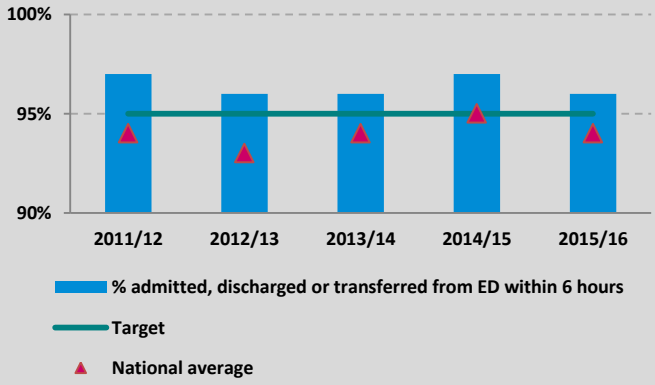
Shorter stays in emergency departments [Health Target]

Shorter stays in emergency departments can improve both patient experience and clinical outcomes. Long waits in emergency departments are inconvenient, often uncomfortable for patients and are linked to overcrowding, poorer clinical outcomes and reduced privacy and dignity. This target seeks to address this by aiming for 95% of people presenting to the CM Health emergency department being admitted, discharged or transferred within 6 hours of arrival.

The growth in Middlemore Hospital "average ED presentations per day per month" from 2013/14 to 2015/16 of 12.5 percent is high relative to other Auckland regional DHBs. Despite this high growth rate, CM Health has consistently achieved this national health target in each quarter of the 2015/16, year.

We have achieved this by substantial collaboration to work together across hospital and community teams.

The percentage of people presenting to CM Health emergency department who were admitted, discharged or transferred within 6 hours	14/15 Baseline	15/16 Result	15/16 Target
	97%	96%	95%



Our "Front Door" approaches to connect up our end to end processes and acute hospital journey efficiency gains. We have a robust quality programme in the Emergency Department and we are committed to maintaining the shorter stays in emergency department target in 2015/16 and improving the quality and timeliness of emergency care.

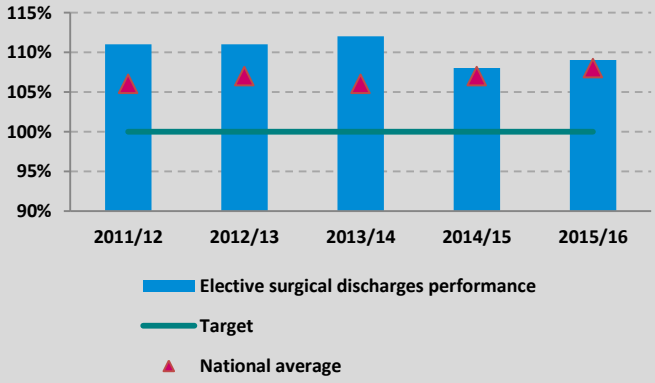
Improved access to elective surgery [Health Target]

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

CM Health has continued to perform above the national target to increase the volume of elective surgery by at least 4,000 discharges each year. The 2015/16 target was to have performed 19,883 discharges; CM Health exceeded this target by 1,767 discharges.

CM Health's strong performance against this target reflects commitment of staff to provide timely care; strong focus on productivity and theatre utilisation in newly enhanced facilities and on maintaining our Enhanced Recovery After Surgery [ERAS] approaches to promote early discharge.

The elective surgical services discharge performance of CM Health	14/15 Baseline	15/16 Result	15/16 Target
	108%	109%	100%
	17,533	21,650	19,883



Improved Control of Long Term Conditions

Long term conditions affect a substantial number of New Zealanders every year, reducing both quality of life and life expectancy. Two such conditions, diabetes and cardiovascular disease [CVD], have a disproportionate effect on Maaori and Pacific peoples in the Counties Manukau community. Cardiovascular disease and diabetes are two of the leading causes of death in Counties Manukau. CM Health has the largest population of people with diabetes and is a growing public health issue.

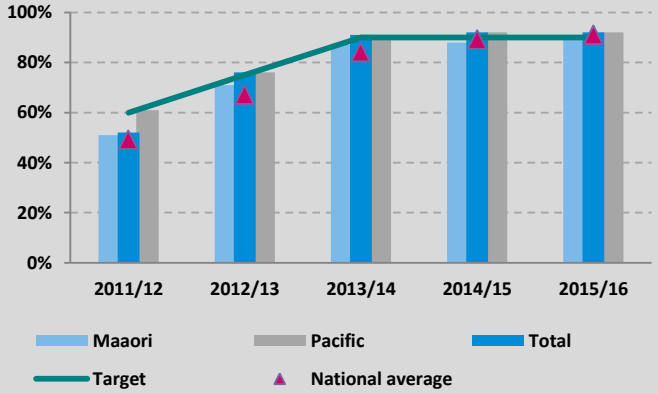
More heart and diabetes checks [Health Target]

Cardiovascular risk assessment is an important step in identifying those who have modifiable risk factors of cardiovascular events. Management of CVD risk is the goal of CVD risk assessment. CM Health has consistently achieved the national target throughout 2015/16, with at least 90% of eligible people in Counties Manukau having had their cardiovascular risk assessed in the last 5 years in every quarter of 2015/16.

Now that we have achieved this health target, our focus in on measures of effective management of CVD and diabetes. Appropriate management of these conditions has been shown to reduce morbidity and mortality – resulting in better health for the individual and reduced needs for acute hospital services.

In 2015/16, we are also increased our attention on how well these diseases and risk factors are being managed in our community, through regular meetings with our Primary Health Organisations.

The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessed in the last 5 years		14/15 Baseline	15/16 Result	15/16 Target
	Maaori	88%	89%	90%
	Pacific	92%	92%	
	Total	92%	92%	



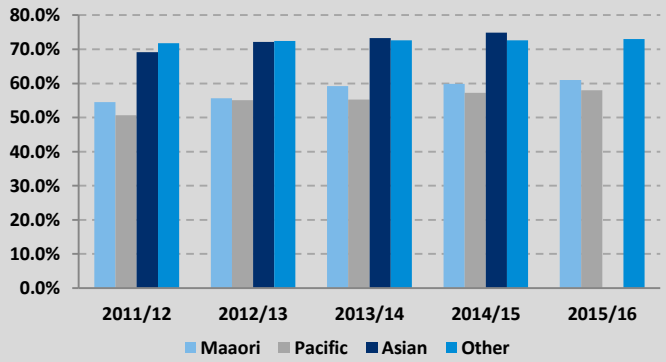
More people with good control of their diabetes

Better glucose control will reduce the progression of micro-vascular complications, e.g. blood vessel blockages in the legs, chronic kidney disease and others.

A modified DCIP Programme has been introduced to a small number of selected practices to enable them to focus on people with inadequate diabetes control. The overall objective is to provide optimal clinical management for all people with diabetes, which includes good glycaemic control, appropriate cardiovascular risk management, prevention and management of diabetes related complications such as albuminuria, neuropathy and retinopathy.

We are actively working with ourPHOs to continue to improve data coverage and quality in relation to care delivered to the people with diabetes.

The percentage of people in Counties Manukau who have good control of their type 2 diabetes [Hb1Ac <=64mmol/mol]		14/15[13] Baseline	15/16 Result	15/16 Target
	Maaori	60%	61%	66%
	Pacific	57%	58%	
	Asian	75%	-	
	Other	73%	73%	



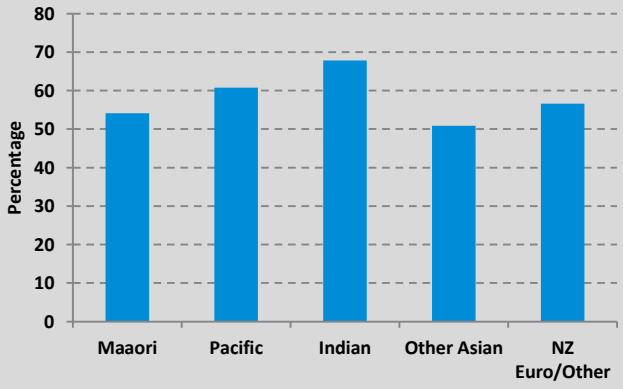
Better management of CVD

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

While the current percentage of people who have had a previous CVD event who are receiving triple therapy for the CM Health population is at the upper end of results for the Northern Region DHBs, there is considerable room for improvement for people of all ethnicities.

In 2015/16, we worked with our Primary Health Organisations to ensure that practices are supported to manage patients with previous CVD events. This included using forums to share successful strategies, and providing funding for electronic systems and workforce development.

Cardiovascular disease [CVD] management as measured by the percentage of Counties Manukau residents aged 30 to 80 who have had a previous CVD event who are on triple therapy, for the 12 months ended 31 March 2016[14]



[13] Result as at 30 June 2015

[14] Data sourced from the Regional Cardiac KPIs CVD Prevention Medication report for the Northern Region, July 2016. Triple therapy as defined as statins, antiplatelet/coagulants, BP lowering dispensed in at least 3 quarters in the year

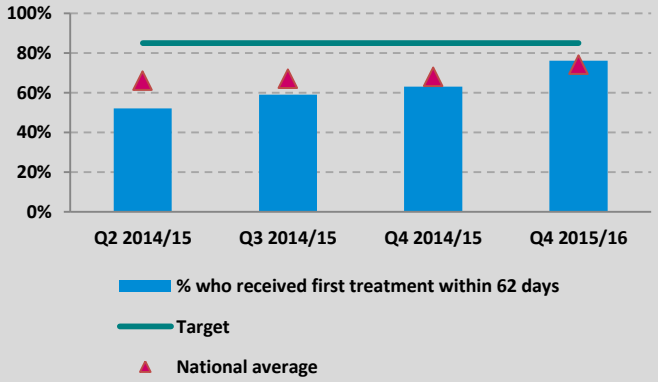
Shorter waits for cancer treatment & Faster cancer treatment [Health Target]

Cancer is one of the leading causes of morbidity and mortality in CM Health, accounting for about 30% of all deaths.

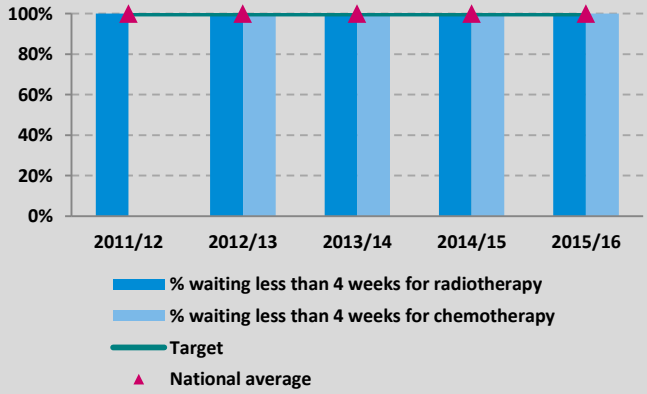
The Faster Cancer Treatment Health Target provides measures of system performance to ensure the time from referral to treatment start is optimised at 62 days or less and the time from decision-to-treat to treatment is within 31 days. This health target is being used to drive system improvements across the cancer care pathway, ensuring timely treatment for patients with urgent cancer needs. In many cases patients will start treatment sooner than the 62 day timeframe.

Since the new target has come been in place, CM Health has made steady progress towards the target. Actions in 2015/16 to support achievement of the target include utilising faster cancer treatment data through monthly reports to identify and improve patient flow and timely assessment and treatment; developing expedited pathways for urgent high suspicion of cancer patients by improving diagnostic turn-around times, optimising referral handling processes and maintaining proactive oversight of patients throughout the pathway; standardising processes to reduce wait-times between process steps and ensure timely diagnosis and treatment.

The percentage of CM Health patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	14/15 Baseline	15/16 Result	15/16 Target
	63%	76%[15]	85%



The percentage of CM Health patients[16] who receive radiotherapy or chemotherapy within 4 weeks of first specialist appointment	14/15[17] Baseline	15/16 Result	15/16 Target
	100%	100%	100%

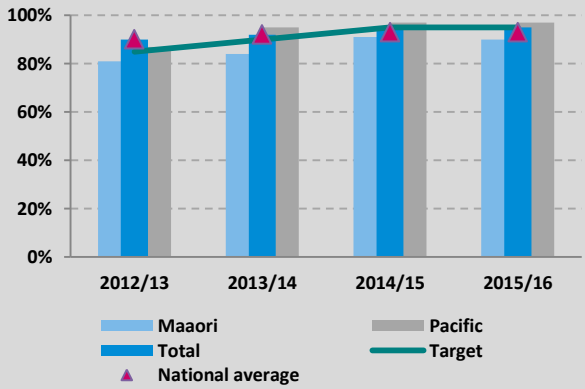


Increased immunisation [Health Target]

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

CM Health achieved the immunisation target in quarters 1, 2 and 4, with 95 percent of eight-month-old babies in Counties Manukau completing their primary course of immunisations on time [a result of 94% was achieved in quarter 3]. For Pacific and Asian eight-month-olds, Counties Manukau exceeded the target achieving 97 percent coverage, and 99 percent coverage respectively.

The percentage of Counties Manukau eight-month-olds who are fully immunised		14/15 Baseline	15/16 Result	15/16 Target
	Maaori	91%	90%	-
	Pacific	97%	97%	-
	Total	95%	95%	95%



[15] Final result based on report run for period 1 January 2016 to 30 June 2016. Difference of 2% from preliminary result of 74% reported by MOH is due to minor retrospective adjustments caused by further information becoming available, such as histology results or operation notes.

[16] Patients ready-for-treatment.

[17] Result as at 30 September 2014. From 1 October 2014, the 'Faster cancer treatment' target replaced the 'Shorter waits for cancer treatment' target.

Our Maaori immunisation rates have remained steady at 90% for most of the year. We implemented a range of approaches to increase our Maaori immunisation coverage rates including sending overdue reports of all milestone immunisations to general practices. This resulted in a faster turnaround from practices to complete, decline or refer to outreach.

Other initiatives included making use of outreach immunisations for home visits and also offering a drop in Saturday outreach clinic in order to better meet the needs of families. We will continue this work throughout 2016/17.

Better help for smokers to quit [Health Target]

Based on 2013 Census data, it is currently estimated there are 62,000 people that smoke in the Counties Manukau district. Maaori and Pacific comprise almost one-third each of the smoking population [at an estimated 18,900 and 17,900 respectively], with NZ European/Other groups comprising almost one-third [estimated 20,500], and one-tenth identified as people of Asian ethnicities [estimated 6,000]. There remain clear inequities in smoking prevalence in the Counties Manukau population, with Maaori in Counties Manukau still more than twice as likely to smoke [36%] as the total population [15.9%]. Pacific communities as a whole are also more likely to smoke than the total population [23.2%], with some groups such as Cook Island Maaori [30.3%], and Tongan men [30.7%], considerably more likely.

Smoking increases the risk of developing heart disease, respiratory infections and many types of cancer; all of which contribute to the differences in life expectancy between Maaori and Pacific and non-Maaori/non-Pacific in Counties Manukau. The Ministry's 'Health Loss in New Zealand 1990-2013', states that tobacco smoking accounts for 8.7% of all health lost in New Zealand. Most people who smoke want to quit, and there are simple, effective and evidence based interventions that should be routinely provided in the health system, including primary, community, secondary and maternity care.

Brief advice can be effective at prompting quit attempts and long-term quit success. This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer cessation support to people who currently smoke.

In 2015/16 CM Health met all three 'Better Help for Smokers to Quit' health targets – primary, secondary and maternity – with equity achived across all ethnicities. [18] This result reflects CM Health's commitment not only to achieving the health targets but also working towards achieving equity for our communities and Smokefree NZ 2025.

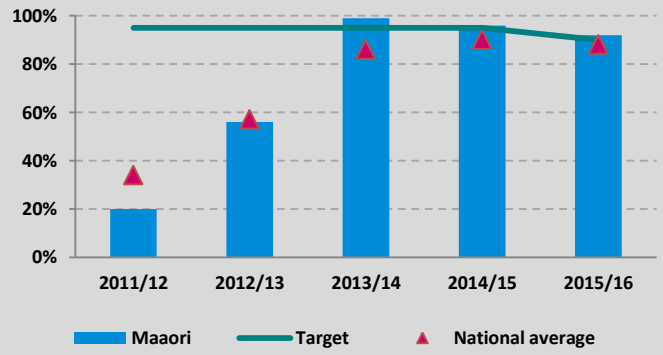
The maternity target continues to exceed the 95% brief intervention goal. Maaori pregnant women remain the target population for interventions during pregnancy to enable decreasing the rate postnatally.

Primary Care Target

This primary care result reflects concerted effort by primary care across the region and has included clinical champion support, leadership, and the appointment of a dedicated primary care Smokefree Advisor. Actions to support achievement of the target have included; sustainable quality improvement plans and activity within practices and PHOs; on-going continuing education for primary care staff on the ABC approach[19]; call centre activity offering brief advice and cessation support; electronic referral forms to a central triage point and ongoing monthly monitoring of performance and quality improvement forums to share success.

The difference in result from 14/15 baseline to 15/16 is due to the change in indicator definition and the removal of the Ministry of Health's applied adjustor. The original indicator was defined as all people who smoke and are seen in General practice are provided brief advice and offered cessation support however after the change, General Practice are now responsible to ensuring that all enrolled people who smoke are provided brief advice and cessation support.

Percentage of enrolled Counties Manukau smokers seen by a health practitioner in primary care and offered brief advice and support to quit	14/15 Baseline	15/16 Result	15/16 Target
	96%	92%	90%



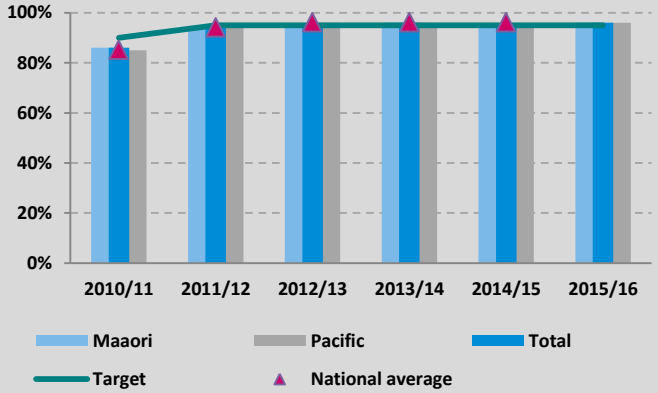
[18] Pacific maternity result based on internal data

[19] The ABC approach is a brief intervention model which includes key steps to helping people who smoke. These include **a**sking about smoking status, providing **b**rief advice and offering **c**essation support.

Hospital Target

CM Health has consistently met the secondary care smokefree target since June 2012, with at least 95 percent of hospitalised smokers provided brief advice and offered support to quit. This has been achieved through identifying and supporting Smokefree Champions on an ongoing basis; delivering best practice and refresher training; monthly monitoring of smoking referrals, coded smokers and missed interventions; undertaking internal audits to find missed interventions and coding errors; and a strong commitment from all level of leadership.

The percentage of CM Health hospitalised smokers offered brief advice and support to quit	14/15 Baseline	15/16 Result	15/16 Target
	95%	96%	95%

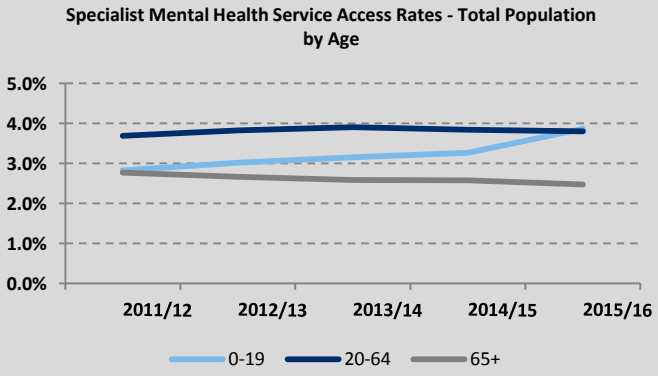


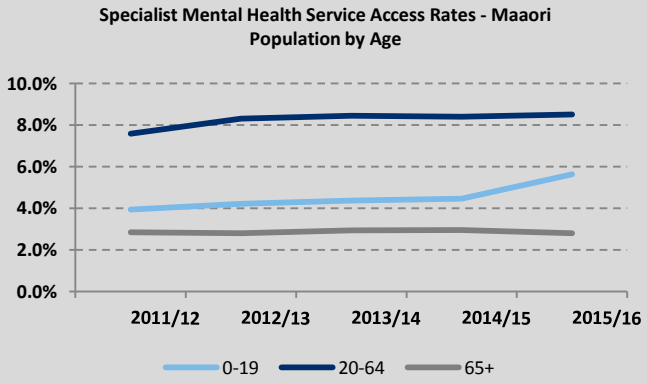
Improved Access to Mental Health and Addiction Services

Mental health disorders are common in New Zealand and worldwide. Many New Zealanders will experience a mental illness and/or an addiction at some time in their lives, with an estimated one in five people affected every year. Overall, Maaori and Pacific peoples experience higher rates of mental illness than non-Maaori, non-Pacific.

Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes. Mental health access rates are a useful indicator for determining the impact of CM Health mental health service delivery on improving the quality of life for those who are suffering from mental illness or with alcohol or drug addiction.

While access rates [20] to specialist mental health and addiction services [service access and timely first specialist assessment appointments] over the last decade have significantly increased as a result of investment in a number of community-based support options, they are now plateauing. The current emphasis is on responsiveness and effectiveness of the specialist interventions, reducing inequities and earlier intervention through service integration between mental health and addictions services and primary and community care.

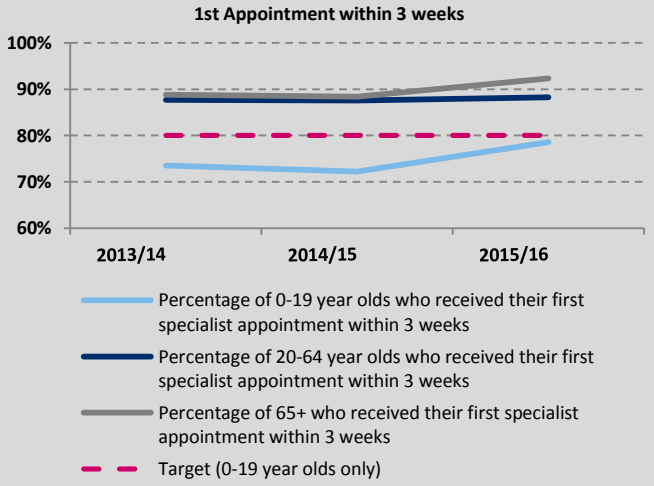


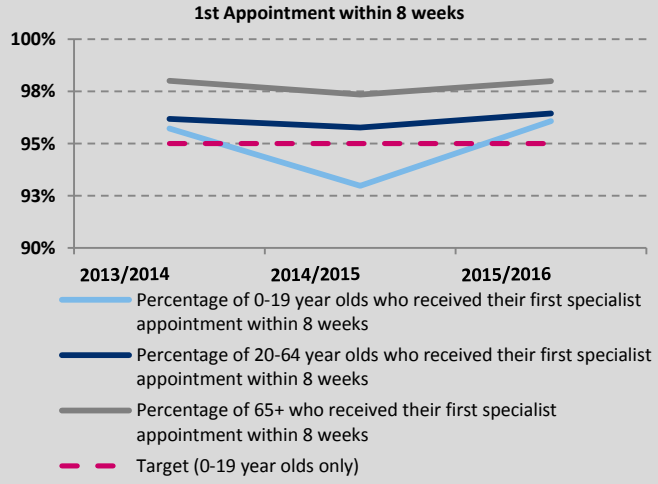


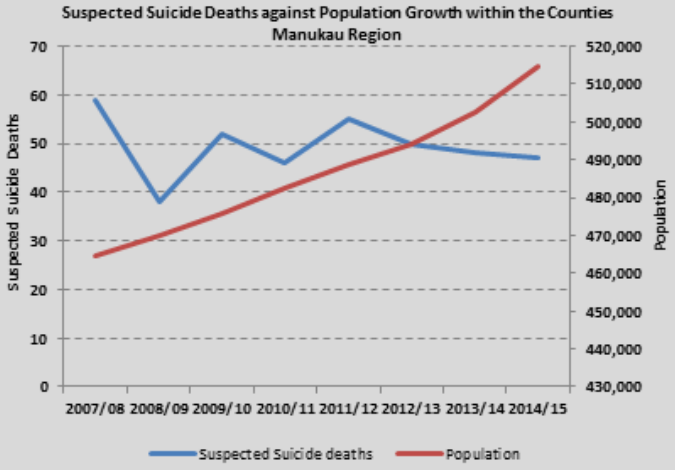
[20] *The access rates reported include all Counties Manukau residents who access any of the following services: CM Health hospital specialist Mental Health services, regional specialist Mental Health and/or Addiction services [e.g. specialist Alcohol and Other Drugs, Forensics] and NGO services [both Mental Health and Addictions].*

The rate of suspected suicides in the Counties Manukau district[21] continues to decrease. However, this is an area where we should strive to do better. The suicide rate for Counties Manukau Maaori is higher than the average suicide rate for Maaori across New Zealand. The rate of youth suicide in the Counties Manukau region is also higher than the national average.

Our aim over time will be to have zero preventable suicides within the Counties Manukau region. This year saw the development and drafting of the CM Health Suicide Prevention and Postvention Plan 2016-2020 which with be published during 2016. The actions outlined in this prevention plan, which will be implemented over the coming years, are focused on the following key themes: supporting mentally healthy families, whaanau and communities, enabling easy access and ensuring a high quality service.







[21] http://www.justice.govt.nz/courts/coroners-court/suicide-in-new-zealand/suicide-statistics-1/2013-2014-provisional-suicide-figures

Statement of Service Performance

This section presents CM Health's actual performance against the forecast outputs presented in our 2015/16 Statement of Intent. The services or 'outputs' we measure are grouped into four 'output classes' that reflect the nature of the services provided.

Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations. They comprise of services that enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. On a continuum of care these services are public wide preventative services and include:

- health promotion to ensure that illness is prevented and unequal outcomes are reduced;
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and,
- population health protection services such as immunisation and screening services.

		2014/15 Baseline[22]	2015/16 Target[23]	2015/16 Result[24]	Achievement
Health Promotion and Education Services					
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking		95%	95%	96%	Achieved
Proportion of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit		96%	90%	92%	Achieved[25]
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer [LMC] who are offered brief advice and support to quit smoking		96%	90%	100%	Achieved
Percentage of infants exclusively or fully breastfed at discharge from birthing facility[26]	Total	84%	75%	88%	Achieved
	Maaori	84%		88%	
	Pacific	81%		86%	
Percentage of infants exclusively or fully breastfed at LMC discharge 4-6 weeks[27]	Total	57%	75%	58%	Not Achieved[28]
	Maaori	52%		52%	
	Pacific	51%		53%	
Percentage of infants exclusively or fully breastfed at 3 months	Total	46%	60%	46%	Not Achieved[28]
	Maaori	38%		37%	
	Pacific	44%		39%	
Percentage of infants receiving breastmilk at 6 months	Total	61%	65%	62%	Not Achieved[28]
	Maaori	46%		48%	
	Pacific	58%		59%	
Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score [self-audit using AUT tool][29]	Partner Abuse	98/100	=> 180 combined score	98/100	Achieved
	Child Abuse & Neglect	97/100		99/100	

[22] Result as 30 June 2015 [Q4] unless otherwise stated.
[23] Target to be achieved by 30 June 2016 [Q4] unless otherwise stated.
[24] Result as at 30 June 2016 [Q4] unless otherwise stated.
[25] This target was met in Q4 (previous quarter results were as follows: Q1:87%, Q2:88%, Q3:89%).
[26] Middlemore data only, excludes Primary Units and babies admitted to neonatal care. This was a new measure included in 2015/16 Annual Plan therefore baseline data is unaudited.
[27] Baseline as at 31 December 2014; Results as at 31 December 2015; Data sourced directly from Plunket.
[28] Significant work is underway to improve breastfeeding rates in Counties Manukau, including strengthening and aligning community breastfeeding support services, development of a Counties Manukau Breastfeeding Action Plan and workforce development.
[29] The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training method.

		2014/15 Baseline[22]	2015/16 Target[23]	2015/16 Result[24]	Achievement
Immunisation Services					
Proportion of 8 month olds who have had their primary course of immunisation [six weeks, three months and five months immunisation events] on time [National Health Target]	Maaori	91%	95%	90%	Not Achieved[30]
	Pacific	97%		97%	Achieved
	Total	95%		95%	Achieved[31]
Proportion of two year olds who are fully immunised[32]	Maaori	90%	95%	92%	Not Achieved[30]
	Pacific	98%		98%	Achieved
	Total	94%		95%	Achieved[33]
Proportion of older people [65+] who have had their flu vaccinations		67%	75%	47%	Not Achieved[34]
Health Screening					
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Maaori	66%	70%	65%	Not Achieved[35]
	Pacific	77%		76%	Achieved
	Total	70%		69%	Not Achieved
Proportion of women aged 25-69 years who have had a cervical smear in the last three years[36]	Maaori	62%	80%	69%	Not Achieved[37]
	Pacific	75%		82%	Achieved
	Total	73%		75%	Not Achieved
Proportion four year olds who have had their B4 School Checks	Vision & Hearing[38]	101% [including 3,532 of high deprivation population]	90% [8,026 of which 3,532 will be High Dep, Q5]	101% [8085 of which 3373 were high Dep, Q5]	Achieved
	Nurse[39]				
Proportion of newborns enrolled by 3 months[40]		72%[41]	98%	75%	Not Achieved[42]

[30] While the total population health target was achieved, we did not achieve this equitably for Maaori tamariki. We implemented a range of approaches to address this. Overdue reports of all milestone immunisations were sent to General Practices and this resulted in a faster turnaround from practices to complete, decline or refer to outreach. By making use of outreach immunisations for home visits and also offering a drop in Saturday outreach clinic we hoped to better meet the needs of families. When a family declines an immunisation they are still invited for the next milestone target in case of change of mind.

[31] Note that this target was achieved in quarters 1,2 and 4 (Q3: 94%).

[32] This was a new measure included in 2015/16 Annual Plan therefore baseline data is unaudited.

[33] Note that this target was achieved in quarters 2,3 and 4 (Q1: 94%).

[34] The performance result for 2015/16 has been sourced from the National Immunisation Register [NIR] at birth report for the first time. As this is the first year that primary care have entered this data for older people [65+] there is a gap between the number entered in the NIR and the number of flu vaccinations that were administered to older people [65+] as per PHO data.

[35] Breast Screening volumes have been lower than target this year due to MRT shortages and Mangere sub-site closure to upgrade equipment. Screening coverage is expected to increase once the Mangere site is reopened and staff vacancies filled. The service has worked with the Maaori Health Development Team to run focus groups with Maaori women to determine the best ways to promote breast screening. A report from the focus groups has been completed and a media campaign is in development.

[36] Note that baseline data has been updated to adjust for increased numerator figures that were received in July 2015 (previous baseline data as follows: Maaori 61%, Pacific 73% and total 71%).

[37] While we did not achieve the target for Maaori women, there has been an upwards trend in coverage rates for Maaori women over 2015/16 [Q1: 62% to Q4: 69%]. There has been considerable resource invested in this including a high needs cervical screening co-ordinator, investigation of barriers for Maaori women, provision of community based smear clinics, working with PHOs to improve screening recall systems and cultural appropriateness of screening in general practices, encouraging women to use alternative screening providers and working to improve health literacy related to screening.

[38] Vision and hearing - 2 components.

[39] Nurse – 8 components.

[40] Births are only Counties Manukau domiciled but patients can be enrolled in any PHO

[41] Note that Q4 2014/15 result of 95% that was recorded in the 2014/15 Annual Report was incorrect. This figure has now been corrected to reflect the final MOH data.

[42] The newborn enrolment target of 98% has not been met. A newborn enrolment working group has been established to help better understand the current problems / issues with regard to newborn enrolments. This will enable solutions to be identified and a shared action plan to be developed which outlines actions, milestones and accountability from each stakeholder to address the problems. A number of initiatives, such as keeping a pregnancy register in general practices, are currently being trialled.

Early Detection and Management Services

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

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

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

		2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Primary Health Care Services					
Eligible people receiving cardiovascular [CVD] risk assessment in the last 5 years	Maaori	88%	90%	89%	Not Achieved
	Pacific	92%		92%	Achieved
	Total	92%		92%	Achieved
Proportion of people with diabetes who have satisfactory or better diabetes management [HbA1c of equal to or less than 64 mmol/mol]	Maaori	60%	66%	61%	Not Achieved[43]
	Pacific	57%		58%	Not Achieved
	Asian	75%		-	-
	Other	73%		73%	Achieved[44]
	Total	65%		65%	Not Achieved
Proportion of PHO enrolled population enrolled within At Risk programme[45]		3%	5%	5%	Achieved[46]
Percentage of all At Risk who have a: ▪ Care Plan ▪ Electronic Summary Record ▪ Self-Management Assessment ▪ Named Care Coordinator		80%	80%	94%	Achieved
Average Length of Stay for patients within ReACH [Locality reablement] service[47]		-	4 weeks	26 Days	Achieved[48]
Increased clinical care time for community health resources		0%[49]	10%	0%	Not Achieved[50]
Oral Health Services					
Proportion of children [0-4 years] enrolled in DHB-funded oral health services[51]		76%[52]	95%[53]	74%	Not Achieved[54]

[43] Prevalence, morbidity and mortality rates from diabetes are higher for Pacific than other groups in the Counties Manukau district. Therefore, targeted initiatives are required to reduce the prevalence of risk factors for the development of diabetes and to improve identification, screening and management of diabetes, particularly to achieve good glycaemic control. The Modified Diabetes Care Improvement Package focuses on people with poor glycaemic control and facilitates primary care access to specialist Senior Medical Officer advice through virtual reviews, as well as planned proactive care for the patient and self-management support. This improvement focus, which is enabled through improvement methodology is our focus for the 2016/17 year.

[44] Measure reported 6 monthly. Note that measure was achieved in quarter 4 (Q2: 52%).

[45] The AR Programme allows for those with Chronic Conditions and complex health needs to actively manage their health in primary care in the community. This in turn leads to decreased acute admissions and avoidable mortality. This was a new measure included in 2015/16 Annual Plan therefore baseline data is unaudited.

[46] Note that this target was achieved in quarter 4 (Q1:3.2%, Q2:3.7% and Q3:4.1%).

[47] New measure, baseline data not available. This is a developing programme as part of CM Health's Integrated Care programme

[48] Average length of stay calculated as the time between referral to the service and the date of the last clinical contact [rather than referral end date].

[49] Baseline as at March 2015. This was a new measure included in 2015/16 Annual Plan therefore baseline data is unaudited.

[50] This measure is continuing to be defined in the 2015/16 financial year.

[51] This measure description in the 2015/16 Annual Plan was inaccurate and has been amended to reflect correct definition. Note that baseline data has been updated to adjust for amended eligible population figures supplied by ARDS (previous eligible population figure of 28,573 updated to 31,220. Previously reported result for December 2014 was 70%).

[52] Baselines for all 4 oral health measures are as at December 2014.

[53] Targets for all 4 oral health measures are to be achieved by December 2016.

[54] There is currently a regional service review underway to identify opportunities for service improvements for 0-4 year olds. This work is ongoing and initial recommendations are expected by 30 September 2016.

		2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Proportion of enrolled preschool and primary school children who have not been examined (within 30 days of their recall date)[55]		8.3%	7%	15%	Not Achieved[56]
Proportion of Year 8 children who have their treatment completed and are transferred to the adolescent dental service		100%	100%	100%	Achieved
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		74%	85%	73.3%	Not Achieved[57]
Diagnostics[58]					
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks[59]	CT	70%	95%	92%	Achieved[60]
	MRI	53%	85%	62%	Not Achieved[61]
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks [14 days]		81%	75%	90%	Achieved
Proportion of patients accepted as non-diagnostic colonoscopy who receive their procedure within 6 weeks [42 days]		32%	65%	44%	Not Achieved[62]
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks [84 days] beyond the planned date		82%	65%[63]	82%	Achieved

Intensive Treatment and Assessment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are generally complex are require integrated team work and location to enable co-location of clinical expertise and specialised equipment such as a hospital.

They include:

- Ambulatory services [including outpatient, district nursing and day services] across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services [acute and elective streams] including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services
- On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

[55] Note that baseline data has been updated to adjust for amended eligible population figures supplied by ARDS (previous eligible population figure of 28,573 updated to 31,220. Previously reported result for December 2014 was 8.5%).
[56] Our approach to improving this result has been to enrol infants at 5 months and follow up at 1 year of age [instead of 2 years]. We have found this to be a more effective approach that we will continue to advance in 2016/17.
[57] Improvements in 2015/16 have focused on engagement with secondary schools to enable on-site mobile dental clinic visits. Increased coverage will be achieved through on-site dental services at more secondary schools and accessing adolescents out of the school system in workforce, training or alternate education services.
[58] All diagnostic baselines and results provided for period 1 July 2015 to 30 June 2016.
[59] Baseline as at June 2015. Result as at June 2016.
[60] Note that this target was achieved in quarters 3 and 4 (Q1:90%, Q2:93%).
[61] We employed production modelling methods to improve efficiency and test the impact of different approaches to reach this target. One approach is to outsource services which significantly reduced the number of patients over 42 days. Quality improvement and outsourcing approaches continue.
[62] Note that quarterly results illustrate that measures taken during the course of 2015/16 have resulted in a marked improvement in the number of patients receiving non-diagnostic colonoscopies within six weeks (Q1:43%, Q2:39%, Q3:39% and Q4:80%). Over 2015/16 there was significant work done in order to increase capacity and develop and deliver a robust production plan in order to achieve the target of 65% by June 2016. Measures taken include the addition of a new procedure room and the employment of two additional SMOs.
[63] Note that target has been corrected (the 2015/16 Annual Plan included a target of 60% in error).

			2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Mental Health						
Proportion of child and youth clients with a transition discharge plan			75%	95%	92%	Not Achieved[64]
Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years	Mental Health [Hospital Care Arm]	3 weeks	77%	80%	76%	Not Achieved[65]
		8 weeks	94%	95%	96%	Achieved
	Addictions [Hospital Care Arm and NGO]	3 weeks	82%	80%	96%	Achieved
		8 weeks	85%	95%	98%	Achieved[66]
Elective Services						
ESPI 2: Proportion of patients who wait longer than four months for their first specialist assessment [FSA]			zero	zero	zero	Achieved
ESPI 5: Proportion of patients given a commitment to treatment but not treated within four months			zero	zero	0.1%	Not Achieved[67]
Number Elective Surgical Discharges			108% 17,533	100% 19,883	109% 21,650	Achieved
Elective Services Standardised Intervention Rates [SIRs] per 10,000 of population		Major joints	23	21	22.39	Achieved
		Cardiac Surgery	6.69	6.5	6.04	Not Achieved[68]
		Cataracts	38.19	27	33.25	Achieved
Outpatient Did Not Attend [DNA] rates		Maaori	11%	10%	18%	Not Achieved[69]
		Pacific	8%	10%	16%	Not Achieved
Acute Services[70]						
Acute readmissions to hospital[71]		Total	7.6%	Commitment to improve on baseline target	7.7%	-
		75+	10.1%		9.7%	-
Acute Inpatient Average Length of Stay[72]			3.84 days	2.63 days	2.57 days	Achieved
Proportion of patients admitted, discharged or transferred from the ED within six hours [National Health Target]			97%	95%	96%	Achieved
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment [and are ready to	Chemo-therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	
	Radio-	Maaori	100%	100%	100%	Achieved

[64] Steady progress against the 95% stretch target has occurred and a number of challenges have been identified which require further improvement in order to reach target; namely, consistent data entry and collection, and improved quality of internal transfers of care. Focus on achieving this target remains a quality improvement priority.

[65] The number of unique Counties Manukau DHB domiciled clients aged 0-19 seen during the year ended 31 March 2016 was 6292, an increase of 6% from those seen in the corresponding period last year. This increase has meant delays for some young people with non-urgent presentations being seen within 3 weeks but all being seen within 8 weeks. A whole of system approach including the development of school-based mental health services and the alignment of NGO and primary care at intake are amongst initiatives to be continued in 2016/17.

[66] Note that this target was achieved in quarters 1 and 4 (Q2: 87% and Q3: 91%).

[67] For some specialties, the results were partially impacted by SMO and anaesthetic technician vacancies and atypically high referral numbers. This lead to reduced capacity due to cancellation of elective theatre lists. We continue to work in improvement in these services.

[68] Cardiac surgery is provided by Auckland District Health Board for Counties Manukau residents.

[69] A number of quality improvement initiatives has been undertaken to improve results. Examples of initiatives to reduce DNA rates include processes such as allowing patients to select their appointment time, an appointment reminder process that includes numerous text messages, telephone reminders and an appointment confirmation letter, clinic transportation support and others. We continue to codesign improvement approaches and are assessing the effectiveness of such processes on a locality by locality basis.

[70] Cancer treatment services for patients in Counties Manukau are provided through the Auckland DHB Regional Cancer and Blood Centre and CM Health Haematology.

[71] The MOH were reviewing this measure and data was provided for information only. DHBs were not measured/assessed against any targets.

[72] Inadequate length of stay can lead to increased readmission. Optimal inpatient LOS ensures patients receive sufficient care to avoid readmission.

			2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
start treatment] who receive treatment within four weeks from decision to treat	therapy	Pacific	100%		100%	
		Total	100%		100%	
Proportion of patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks			63%	85%	76%[73]	Not Achieved[74]
Cardiac Services						
Proportion of all outpatients triaged to chest pain clinics who are seen within 4 weeks for cardiology assessment and stress test[75]			99%	80%	92%	Achieved
Proportion of outpatient coronary angiograms with a waiting time of <3 months			99.5%	95%	99%	Achieved
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission			80%	70%	81%	Achieved
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions [PCI] who receive this within 120 mins			82%[76]	80%	93%	Achieved

Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services will provide support for individuals.

	2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Needs Assessment and Service Coordination [NASC]				
Percentage of current clients receiving long term HBSS that have an interRAI clinical assessment within the previous 24 months[77]	-	65%	65.4%[78]	Achieved
Assessment, Treatment and Rehabilitation Services				
Percentage of identified fragility patients will be investigated and offered interventions to prevent second fragility fractures[79]	-	70%	71%[80]	Achieved
Age Related Residential Care [ARRC]				
Number of potentially avoidable EC presentations from ARRC per month	18 per month	<15 per month	Average of 12 per month	Achieved
Home Based Support				
Proportion of CM Health NASC clients receiving Home Base Support Services who have a comprehensive interRAI assessment completed in the last 3 months	-	To be established	95.3%[81]	NA

[73] Final result based on report run for period 1 January 2016 to 30 June 2016. Difference of 2% from preliminary result reported by MOH is due to minor retrospective adjustments caused by further information becoming available, such as histology results or operation notes.
[74] While the target of 85% has not been met, performance has been improved over the 2015/16 year. A stock take of current activity compared with NHS best practice guidelines and national DHB approaches has been completed. Overall we have implemented the majority of suggested actions. Further opportunities for development in 2016/17 include structured escalation plans for patients that may breach, engagement with primary care around a whole of system approach, ongoing implementation and auditing the use of radiology imaging protocols and investigating the gap between expected and actual cancer registrations.
[75] The 4 week target is for CM Health whilst the Regional target is 6 weeks.
[76] Note that baseline has been corrected (the 2014/15 Annual Report included a result of 81% in error).
[77] New measure, baseline data not available.
[78] Result as at 1 July 2016.
[79] New measure, baseline data not available.
[80] The Fracture Liaison Service officially commenced in February 2016. Result for period February 2016 to June 2016.
[81] Result for period April to June 2016.

Maaori Health Plan Indicators

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

The plan has a number of prescribed national indicators that link to the leading causes of mortality and morbidity for Maaori. DHBs also have the flexibility to develop their own local indicator set which reflects the specific needs of the Maaori population in the district. This section gives an overview of our performance against the indicators in the 2015/16 Maaori Health Plan.

			2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
National Indicators						
Ethnicity Data						
Percentage of general practices in 2 CM Health PHOs who have completed the 3 stages of EDAT			zero	50%	99%	Achieved
Access to Care						
Percentage of Maaori enrolled in a PHO[82]		Maaori	90%	100%	93%	Not Achieved[83]
		Total	97%	-	98%	NA
Ambulatory Sensitive Hospitalisation [ASH] rates[84]	Age 0-4 years	Maaori	All baselines to be established	All targets to be established	100%	NA
		Total			108%	NA
	Age 45-64 years	Maaori			228%	NA
		Total			122%	NA
Child Health[85]						
Percentage of infants exclusively or fully breastfed	LMC discharge 4-6 weeks	Maaori	52%	75%	52%	Not Achieved
		Total	57%		58%	
	Age 3 months	Maaori	38%	60%	37%	Not Achieved
		Total	46%		46%	
Percentage of infants being fed breast milk	Age 6 months	Maaori	46%	65%	48%	Not Achieved
		Total	61%		62%	
Cardiovascular						
Percentage of eligible population who have had their cardiovascular risk assessed in the last 5 years		Maaori	88%	90%	89%	Not Achieved
		Total	92%		92%	Achieved
Percentage of eligible Maaori tane aged 35-44 years who have had their cardiovascular risk assessed in the last 5 years[86]		Maaori	70%[87]	90%	73%	Not Achieved[88]
Percentage of high-risk patients who receive an angiogram within 3 days of admission ['Day of Admission' being 'Day 0']		Maaori	90%	>70%	73%	Achieved
		Total[89]	79%		81%	Achieved
Percentage of patients presenting with acute coronary syndrome [ACS] who undergo coronary angiography have completion of ANZACS QI[90] ACS and Cath/PCI registry data collection within 30 days		Maaori	96%	>95%	94%	Not Achieved[91]
		Total	97%[92]		92%	Not Achieved

[82] Enrolled in any PHO in NZ.
[83] We need to understand the initiatives and improvements to PHO data accuracy achieved to date.
[84] Work underway with the MOH to develop new measures therefore no targets have been set.
[85] Significant work is underway to improve breastfeeding rates in Counties Manukau, including strengthening and aligning community breastfeeding support services, development of a Counties Manukau Breastfeeding Action Plan and workforce development.
[86] This was a new measure included in 2015/16 Maaori Health Plan therefore baseline data is unaudited.
[87] Baselines as at March 2015.
[88] Initiatives outlined in the Maaori Health Plan continue.
[89] Note that baseline data has been updated to reflect minor retrospective adjustments made by ANZACS-QI (previous Q4 2014/15 result was reported as 80%).
[90] All New Zealand Acute Coronary Syndrome Quality Improvement [ANZACS QI].

		2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Cancer					
Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 36 months	Maaori	62%	80%	69%	Not Achieved[93]
	Total	73%[94]		75%	Not Achieved
Percentage of eligible women who received a breast screen 50-69 within past 24 months	Maaori	66%	70%	65%	Not Achieved[95]
	Total	70%		69%	Not Achieved
Smoking					
Percentage of pregnant Maaori wahine who are smokefree at 2 weeks postnatal[96]	Maaori	73%	86%	72%[97]	Not Achieved[98]
	Total	90%		91%[99]	Achieved
Immunisation					
Percentage of eight months olds who have had their primary course of immunisation on time	Maaori	91%	95%	90%	Not Achieved[100]
	Total	95%		95%	Achieved
Percentage of seasonal influenza immunisation in eligible population >65 yrs	Maaori	66%	75%	44%	Not Achieved[101]
	Total	67%		47%	Not Achieved
Rheumatic Fever					
Acute rheumatic fever first hospitalisation rate per 100,000 population[102]	Maaori	10.9 per 100,000	5.9 per 100,000	13.1 per 100,000[103]	Not Achieved[104]
	Total	8.0 per 100,000		7.0 per 100,000[105]	Not Achieved

[91] The cause for this slight decline is being investigated and remedial action will be taken as required. With the target set at 95% the margin of error is small.
[92] Note that baseline data has been updated to reflect minor retrospective adjustments made by ANZACS-QI (previous Q4 2014/15 result was reported as 96%).
[93] While we did not achieve the target for Maaori women, there has been an upwards trend in coverage rates for Maaori women over 2015/16 [Q1: 62% to Q4: 69%]. There has been considerable resource invested in this including a high needs cervical screening co-ordinator, investigation of barriers for Maaori women, provision of community based smear clinics, working with PHOs to improve screening recall systems and cultural appropriateness of screening in general practices, encouraging women to use alternative screening providers and working to improve health literacy related to screening.
[94] Note that baseline data has been updated to adjust for increased numerator figures that were received in July 2015 (previous Q4 2014/15 result was reported as 72%).
[95] Breast Screening volumes have been lower than target this year due to MRT shortages and Mangere sub-site closure to upgrade equipment. Screening coverage is expected to increase once the Mangere site is reopened and staff vacancies filled. The service has worked with the Maaori Health Development Team to run focus groups with Maaori women to determine the best ways to promote breast screening. A report from the focus groups has been completed and a media campaign is in development.
[96] This was a new measure included in 2015/16 Maaori Health Plan therefore baseline data is unaudited.
[97] Results as at March 2016.
[98] The results show that there are a higher proportion of Maaori women smoking 2 weeks postnatal compared to non Maaori women. Maaori pregnant women remain the target population for interventions during pregnancy to enable decreasing the rate postnatally. The Smokefree pregnancy incentives programme has been extended to all South Auckland to enable wide reaching access to it and we are continually working with midwives to increase their 'accepted support' rates with a schedule of refresher training. The maternity target continues to exceed the 95% brief intervention goal. Unfortunately, relapse rate following birth can be extremely high but we have been working with maternity staff on the birthing units as well as post-natal midwives to send through referrals for the purpose of maintaining abstinence.
[99] Result as at March 2016.
[100] While the total population health target was achieved, we did not achieve this equitably for Maaori tamariki. We implemented a range of approaches to address this. Overdue reports of all milestone immunisations were sent to General Practices and this resulted in a faster turnaround from practices to complete, decline or refer to outreach. By making use of outreach immunisations for home visits and also offering a drop in Saturday outreach clinic we hoped to better meet the needs of families. When a family declines an immunisation they are still invited for the next milestone target in case of change of mind.
[101] The performance data for 2015/16 has come from the National Immunisation Register for the first time. As this is the first year that primary care have entered this data for older people [65+] there is a gap between the number entered in the NIR and the number of flu vaccinations that were administered to older people [65+] as per PHO data.
[102] Data sourced from MOH incidence of first episode of rheumatic fever cases as defined by MOH algorithms for 1 July 2014 to 30 June 2015. Rate per 100,000 population based on Statistics NZ estimated resident population projections. Note that baseline data has been updated to reflect new numerator figure sourced from the 2014/15 (2015 update) population projections (previously reported baselines used numerator figure sourced from 2014/15 (2014 update) population projections. Q4 2014/15 result was previously reported as Maaori 11.1 per 100,000 and total 8.0 per 100,000).
[103] Results as at June 2016. Data sourced from MOH incidence of first episode of rheumatic fever cases as defined by MOH algorithms for 1 July 2015 to 30 June 2016. Rate per 100,000 population based on Statistics NZ estimated resident population projections. Note that the increase in the rate of rheumatic fever for Maaori from 2014/15 was a result of two additional cases for the 2015/16 year (9 cases in 2014/15 against 11 cases in 2015/16).
[104] MOH has recorded the 2015/16 results as having been partially achieved.

		2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Oral Health[106]					
Percentage of preschool children 0-4 years enrolled in DHB funded oral health service[107]	Maaori	70%	85% by Dec 2015; 95% by June 2016	67%	Not Achieved
	Total	76%		74%	Not Achieved
Mental Health[108]					
Mental Health Act: section 29 community treatment order indefinites rate per 100,000[109]	Maaori	148	No target set	131	NA
	Non-Maaori	35.5		33.7	
Average time spent in seclusion[110]	Maaori	23	Reduce by 50%	12	Not Achieved[111]
	Total	14.9	-	8	NA
Percentage of 2-hourly reviews of use of seclusion that include Kaumatua, Kuia or culturally trained Maaori staff member		-	100%	0%	Not Achieved[112]
Percentage of clients admitted to the acute unit who have a consultation with Kaumatua, Kuia or culturally trained Maaori staff member within 24 hours		-	100%	0%	Not Achieved[113]
SUDI[114]					
Sudden Unexpected Death in Infancy [SUDI] rate per 1,000 live births	Maaori	2.48[115]	0.5	2.13[116]	Not Achieved
	Total	1.00		0.96	Not Achieved
Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1[117]	Maaori	45%	100% of the WCTO enrolled population	73%	Not Achieved
	Total	55%		80%	Not Achieved

[105] Result as at March 2016.
[106] There is currently a regional service review underway to identify opportunities for service improvements for 0-4 year olds. This work is ongoing and initial recommendations are expected by 30 September 2016.
[107] Note that baseline data has been updated to adjust for amended eligible population figures supplied by ARDS (previous eligible population figure of 28,573 updated to 31,220. Previously reported results for December 2014 were Maaori 61% and total 70%).
[108] Access to kaumatua and kuia for Maaori patients admitted to acute mental health services, or placed in seclusion, has not been recorded consistently throughout the last financial year. For quarter 4, a narrative was provided that summarised performance. 12 Maaori service users experienced seclusion events. Of these, one service user refused cultural input, but of the remaining 11, 9 were assessed by Kaumatua, Kuia or other culturally trained person.
[109] Note that the way this measure is calculated has changed. Measure is now based on Maaori and non-Maaori (rather than total) population (per 100,000).
[110] Baselines as at March 2014; results as at March 2016. This was a new measure included in 2015/16 Maaori Health Plan therefore baseline data is unaudited.
[111] The target was almost achieved and reflects the strenuous efforts to reduce seclusion within the whole acute mental health pathway. Improvements made in 2015/16 should continue to decrease time spent in seclusion.
[112] The reporting in HCC for this deliverable has been difficult with regard to extracting information about how and when cultural assessments are undertaken and by whom. We can see from HCC clinical note that service users are well engaged with Kaumatua and Kuia, however specific reporting on engagement during the seclusion reviews is not yet available.
[113] Measures for this target remain in development and accurate data was not able to be extracted
[114] Both indicators for this condition have improved over the year with higher proportions of caregivers given SUDI prevention advice and the condition showing a commensurate reduction in incident for Maaori. CM Health's SUDI strategy is aligned to the Northern Regional Alliance SUDI 5 year Action Plan. Actions planned for 2016/17 specifically targeted to reduce SUDI rates for Maaori include facilitating community and intersectoral linkages through monthly Safe Sleep Champion meetings and annual Community Network hui, facilitating access to safe sleep devices for babies in unsafe sleep environments and promotion of pregnancy and parenting education opportunities with Maaori whaanau incorporating key SUDI messages and support services.
[115] 2010 mortality data was the most recent data available due to the delay in receiving coded mortality data.
[116] 2010 mortality data was the most recent data available due to the delay in receiving coded mortality data.
[117] This was a new measure included in 2015/16 Maaori Health Plan therefore baseline data is unaudited.

		2014/15 Baseline	2015/16 Target	2015/16 Result	Achievement
Local Indicators					
Workforce Development[118]					
Percentage of CM Health employees who are Maaori	Whole organisation	6%	8%	7.1%	Not Achieved
Youth Mental Health					
Number of rangatahi accessing Alcohol Brief Interventions[119]	Maaori	10	Increase 30% from established baseline	61	Achieved
	Total	99	-	270	NA
Number of rangatahi accessing Mental Health Brief Interventions[120]	Maaori	6	Increase 30% from established baseline	15	Achieved
	Total	31	-	41	NA

Performance by Output Classes [Includes agency costs]

Output Classes [$000]	Prevention	Early Detection	Intensive	Rehabilitation	Total
Revenue [includes agency revenue]	**48,810**	**208,144**	**1,165,155**	**117,354**	**1,539,463**
Budget [includes agency revenue]	*35,390*	*216,096*	*1,155,425*	*114,487*	*1,521,398*
Personnel costs	28,233	-	536,435	-	564,668
Outsourced Services	2,740	-	69,528	-	72,268
Clinical Supplies	3,572	-	119,642	-	123,214
Infrastructure & Non-Clinical Supplies	(597)	-	118,068	-	117,471
Other [includes agency costs]	14,862	208,144	318,612	117,354	658,972
Total costs	**48,810**	**208,144**	**1,162,285**	**117,354**	**1,536,593**
Budget [includes agency costs]	*35,390*	*216,096*	*1,152,723*	*114,487*	*1,518,696*
Surplus [Deficit]	**-**	**-**	**2,870**	**-**	**2,870**
Budget	-	-	2,702	-	2,702

Agency revenue and costs for the year amounts to $18.8m.

[118] There has been no significant improvement in the Maaori workforce indicators. The Maaori Workforce team continues to working closely with the Recruitment Centre to improve the collection of ethnicity data and to improve the recruitment and selection processes for Maaori applicants.
[119] This was a new measure included in 2015/16 Maaori Health Plan therefore baseline data is unaudited.
[120] This was a new measure included in 2015/16 Maaori Health Plan therefore baseline data is unaudited.

Information on Appropriations

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

An assessment of what has been achieved with Counties Manukau DHB's 2015/16 appropriations is detailed below:

Appropriations allocated and scope

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

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

What is intended to be achieved with this appropriation

The DHB provides services that aligns with:

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

How performance will be assessed and end of year reporting

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

Amount of Vote Health Appropriations

	2014/15		2015/16		
	Budgeted $000	Estimated Actual $000	Estimates $000	Supplementary estimates[121] $000	Total $000
Total appropriations	1,246,364	1,246,364	1,268,476	5,873	1,274,349

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

[121] Reasons for change in appropriation can be found in Vote Health – Supplementary Estimates of Appropriations 2015/16.

Good Employer

Counties Manukau DHB is committed to being an Equal Employment Opportunities [EEO] employer and adhere to the good employer requirements in Section 118 of the crown Entities Act 2004. Counties Manukau DHB has a wide variety of programmes available to fulfil our good employer commitment and demonstrate our strength as an equal opportunity employer.

The aims of our Good Employer policy are to provide:

- Good and safe working conditions
- An equal opportunities programme
- 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, women and person with disabilities
- Opportunities for the enhancement of the abilities of individual employees

As a Good Employer, Counties Manukau DHB is committed to the equal employment of all employees:

- 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
- Removing seen and unseen barriers which prevent people from reaching their full potential, we can deliver top performance at every level of the organisation
- Being an organisation where patient safety comes first

The Seven Key Elements

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

1. Leadership, accountability and culture

Organisational culture and values

We know that values-led approaches drive positive staff, patient, whaanau and family experience. It is important to work with people about what matters to better understand how we can work together to make a real difference.

The '*Living our values, together*' project in 2015 facilitated the refresh of our decade old values. Engagement with staff, patients, whaanau and families focused on:

- Identifying how we can be at our best consistently for patients, family/whaanau and each other
- As we grow it's about keeping the essence of what makes Counties Manukau DHB's patient care special
- Bringing together our staff, patients and people who provide services on our behalf to – exemplify what Counties Manukau DHB is about
- Allowing us to deliver a high quality patient and staff experience

In September 2015 Counties Manukau DHB launched the refreshed values. These words are supported by a behavioural framework of detailed descriptors and examples of behaviour "we want to see" and "we don't want to see".

Change leadership

The health system faces an ongoing challenge to achieve the balance of the delivery of excellent health care and sustainability. In order to meet this challenge we need good leadership and consumer participation to continually improve and redesign services.

Counties Manukau DHB continues to deliver capacity for change leadership at all levels of the organisation. This includes improvement and leadership development programmes lead by Ko Awatea, e.g.:

- Leadership Academy aimed at developing emerging leaders

- Clinical staff involvement in improvement initiatives, campaigns, innovation and improvement intensives
- Pipeline initiatives such as the Health Science Academy

Ko Awatea supports ongoing organisational resilience and capability development to proactively respond to changing [health care] demands. This is supported by mindfulness, system innovation and improvement, and patient centred care workshops and master classes and service codesign with patients and whaanau.

2. Recruitment, selection and induction

To enable values led behaviour, it is important that we recruit new talent who embody them. In 2015 we launched a comprehensive Values Based Recruitment programme. This guides the recruitment process, from attraction, screening, interviewing and employment.

Counties Manukau DHB wants new talent coming into the organisation to identify with these values and join us in our goal of making Counties Manukau DHB a great place to receive healthcare and to work.This programme supports hiring managers with training, tools and techniques to select staff who will reflect our values in their daily work.

3. Employee, development, promotion and exit

Employee development

Part of Counties Manukau DHB's strategy is to establish a performance development culture. This can be viewed as one in which staff are encouraged to continuously learn and to convert that learning into action to bring about positive and sustained change.

To achieve this kind of culture requires far more than having an annual or six-monthly staff review with one's manager. Commitment by leadership and staff to a culture of performance development needs to focus on a process of regular and ongoing constructive feedback designed to improve performance. Individual performance must be linked to group, service and organisational performance to enable the organisation to move forward and grow.

The following three principles underpin Counties Manukau DHB's approach to performance development:

- A continuous process requiring the engagement and active participation of all parties involved
- Aligned with the strategic requirements of Counties Manukau Health, with a focus on excellence in all outcomes
- Learning needs and opportunities shall be planned and agreed based on the discussions and agreements reached during the performance development process

Exit interviews

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

4. Flexibility and work design

Workplace flexibility

As a health care provider we are a 24/7 roster environment. Many staff work in a rostered and rotated arrangement which is included in the multi-employer arrangements [MECA].

Counties Manukau DHB also offers flexible hours and is reflected in our large part time workforce and requires roster flexibility that meets organisational and personal needs. Staff may undertake part of their work away from their normal place of work at Counties Manukau DHB premises for a number of reasons. Whilst it is expected that normally staff will be in the workplace, it is accepted that there will be circumstances where an individual and the relevant General Manager and/or Director decide that it is mutually beneficial for that individual to work from home. The DHB has written a guideline to provide clarity and consistency to these arrangements. This guideline is currently under review.

Flexible return to work for parents

The flexible return to work for parents provisions specifically relate to employees who are returning from parental leave and require support to ensure they can continue to breastfeed their infant. The employer obligations are to

ensure that employees are able to either breastfeed their child or express and store breast milk while at work. As well as our obligations for infant feeding, employees returning from parental leave can request flexible work arrangements if they need it; as parental leave can be shared between partners.

5. Remuneration, recognition and conditions

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

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

6. Harassment and bullying prevention

Organisational Commitment

Counties Manukau DHB is committed to providing a healthy and safe working environment and organisational culture based on our shared values. Counties Manukau DHB has a zero-tolerance for all forms of harassment and bullying. We strive to ensure that the best practice policies, procedures and processes are in place for all employees to maintain proper standards of integrity and conduct at all times.

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

The role of a contact person

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

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

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

7. Safe and healthy environment

Employee Assistance Programme at work

Counties Manukau DHB works to promote positive wellbeing in the workplace and understands the specific issues affecting people working in the health sector. The Employee Assistance Programme [EAP] is a contracted service provided by Occupational Health and Safety Services.

This is a confidential service and participation will not adversely affect an employee's work at Counties Manukau DHB. All counsellors are qualified, registered EAP professionals with expertise in the wide range of areas affecting people. Up to three sessions are available for each staff member and no details are placed on an employee's record. The programme is supportive, confidential, and available to all Counties Manukau DHB staff and offers assistance with a wide range of problems:

- Work issues
- Grief and loss
- Relationship issues
- Drug and alcohol issues
- Anger / conflict management / domestic violence
- Stress – work or personal

- Parenting / family issues
- Life transition / direction
- Health and wellbeing
- Mentoring and coaching
- Career planning
- Budgeting

Quarterly newsletter

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

Complaints and appeals

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

Policies, procedures and guidelines

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

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

Counties Manukau DHB Workforce

What our workforce looked like by age and ethnicity

Of the total workforce in 2015/16, women comprised 79% [5,949] and men 21% [1,572]. The average age for women was 43 years and 41 years for men. The younger workforce less than 40 years of age represented almost 44% of the total workforce. Our employee data also highlights an ethnically diverse workforce.[122]

Employee Age Distribution	Percentage of All Employees
Under 20	0.4
20-29	18.4
30-39	24.9
40-49	23.0
50-59	22.1
60-69	9.7
70+	1.6

Ethnicity	FTE	FTE Percentage	Headcount	Headcount Percentage
Asian	1,740	30%	2,168	29%
Maaori	320	6%	419	6%
NZ European and Other	2,852	49%	3,758	50%
Pasifika	640	11%	851	11%
Not Disclosed	235	4%	328	4%
Grand Total	**5,787**	**100%**	**7,524**	**100%**

[122] Ethnic data is collected through the Leader Payroll system with 94% of employees disclosing ethnicity. This allows for greater access to valuable planning data for services who are working to meet the organisations' objective of having a workforce which more accurately reflects the population we serve.

What our workforce looked like by employee group

The table below breaks down the Counties Manukau DHB workforce profile [head count] into selected groups.

Employee Group[123]	Females		Males	
	Number	Average salary	Number	Average salary
Administration & Management				
Individual Employee Agreements	321	100,149.13	135	107,970.24
Clerical	677	50,684.25	26	50,140.96
Allied Health & Technical				
Allied Health	859	61,798.96	189	61,213.13
Laboratory	135	58,419.31	33	61,482.21
Radiology	125	69,016.78	28	68,067.25
Medical				
Specialist Medical Officer	212	220,722.48	316	243,414.28
Resident Medical Officer	265	103,992.05	226	110,426.25
Non-Clinical Support				
Cleaners & Orderlies	281	37,077.19	156	36,562.33
Security & Trades	5	40,727.00	52	48,064.37
Interpreters	98	47,828.51	27	48,100.89
Nursing/Midwifery/Health Care Assistant				
Mental Health Nursing	248	65,030.96	107	56,641.61
Midwifery	185	64,055.65		
General Nursing	2,538	63,423.14	277	61,342.95

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

Financial Statements

Statement of Responsibility

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

The Board is responsible for any end-of-year performance information provided by Counties Manukau District Health Board under section 19A of the Public Finance Act 1989.

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

In the Board's opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2016.

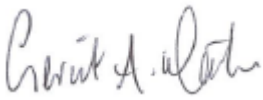
Signed on behalf of the Board:

Dr Lee Mathias

Chairman

Sandra Alofivae

Board Member



Geraint Martin

Chief Executive Officer

Ron Pearson

Deputy CEO/Director Corporate & Business Services

28 October 2016

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2016

	Notes	Actual 2016 $000	Budget 2016 $000	Actual 2015 $000
Income				
Patient Care Revenue	2	1,498,670	1,495,497	1,465,403
Interest Income		3,355	1,700	3,042
Other Income	3	18,614	24,201	17,521
Total Income		**1,520,639**	**1,521,398**	**1,485,966**
Expenditure				
Personnel costs	4	564,668	560,813	548,674
Depreciation and amortisation expense	13/14	30,637	35,856	28,435
Outsourced services		72,268	63,113	68,931
Clinical supplies		113,285	106,408	110,901
Infrastructure and non-clinical expenses		51,914	48,324	55,518
Other District Health boards		218,688	281,101	209,294
Non-health board provider expenses		421,470	379,543	420,032
Capital Charge	5	18,510	14,136	15,273
Interest expense		12,470	14,712	12,506
Other expenses	6	13,859	14,690	13,385
Total expenditure		**1,517,769**	**1,518,696**	**1,482,949**
Surplus		**2,870**	**2,702**	**3,017**
Other comprehensive income				
Revaluation of Land	13	21,524	-	34,662
Revaluation of Buildings	13	23,876	-	2,195
Total Other comprehensive income (expense)		**45,400**	**-**	**36,857**
Total comprehensive income (expense) for the year		**48,270**	**2,702**	**39,874**

Statement of Changes in Equity

For the year ended 30 June 2016

	Notes	Actual 2016 $000	Budget 2016 $000	Actual 2015 $000
Balance 1 July		**237,644**	**237,660**	**198,172**
Comprehensive income				
Surplus for the year		2,870	2,702	3,017
Other comprehensive income		45,400	-	36,857
Total comprehensive income		**48,270**	**2,702**	**39,874**
Capital contributions from the Crown		-	-	-
Repayment of capital to the Crown		(419)	(419)	(420)
Movement in restricted funds		(9)	-	18
Balance at 30 June		**285,486**	**239,943**	**237,644**

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

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2016

	Notes	Actual 2016 $000	Budget 2016 $000	Actual 2015 $000
Assets				
Current Assets				
Cash and cash equivalents	7	32,676	38,397	56,138
Debtors and other receivables	8	50,045	50,628	45,075
Inventories	10	1,468	1,320	1,320
Prepayments		292	450	945
Non-Current Assets held for Sale	11	-	-	12,503
Total current assets		**84,481**	**90,795**	**115,981**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	31,925	24,481	23,611
Property, plant and equipment	13	685,091	652,614	629,079
Intangible assets	14	13,007	5,509	10,580
Other Non-Current Assets	9	1,527	1,300	1,449
Total Non-Current assets		**731,550**	**683,904**	**664,719**
Total assets		**816,031**	**774,699**	**780,700**
Liabilities				
Current liabilities				
Creditors and other payables	15	103,680	94,550	109,686
Borrowings and overdraft	16	5,000	5,000	-
Employee entitlements	17	116,293	126,086	122,645
Total current liabilities		**224,973**	**225,636**	**232,331**
Non-current liabilities				
Borrowings and overdraft	16	287,500	287,500	292,500
Employee entitlements	17	17,141	20,283	16,888
Provisions	18	931	1,337	1,337
Total non-current liabilities		**305,572**	**309,120**	**310,725**
Total liabilities		**530,545**	**534,756**	**543,056**
Net assets		**285,486**	**239,943**	**237,644**
Equity				
Crown equity	19	107,707	107,707	108,126
Accumulated deficits	19	(42,223)	(42,391)	(45,093)
Revaluation reserves	19	219,129	173,729	173,729
Trust funds	19	873	898	882
Total Equity		**285,486**	**239,943**	**237,644**

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

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2016

	Notes	Actual 2016 $000	Budget 2016 $000	Actual 2015 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,370,147	1,475,816	1,341,443
Other		136,704	36,963	129,612
Interest received		3,277	1,699	3,043
Payments to suppliers		(890,464)	(893,248)	(871,048)
Payments to employees		(570,531)	(566,803)	(533,592)
Capital charge		(19,225)	(14,526)	(15,273)
Interest payments		(12,325)	(14,712)	(12,506)
Goods and services tax (net)		722	-	(2,784)
Net cash flow from operating activities	20	**18,305**	**25,189**	**38,895**
Cash flows from investing activities				
Purchase of property, plant, equipment and intangible assets		(33,025)	(30,737)	(26,572)
Acquisition/roll over of investments		(8,314)	(11,787)	(2,263)
Net cash flow from investing activities		**(41,339)**	**(42,524)**	**(28,835)**
Cash flows from financing activities				
Capital contributions from the Crown		-	-	-
Repayment of capital to the Crown		(419)	(419)	(419)
Repayment of loans		-	-	(40,000)
Proceeds from borrowings		-	-	64,900
Net Appropriation to/from Trust Funds		(9)	-	18
Net cash flow from financing activities		**(428)**	**(419)**	**24,499**
Net increase/(decrease) in cash and cash equivalents		**(23,462)**	**(17,754)**	**34,558**
Cash and cash equivalents at the start of the year		56,138	56,148	21,580
Cash and cash equivalents at the end of the year		**32,676**	**38,394**	**56,138**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Statement of Accounting Policies

Reporting Entity

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

The financial statements of CMDHB as at and for the year ended 30 June 2016 comprise CMDHB and its interest in associates and jointly controlled entities.

CMDHB is a public benefit entity for financial reporting purposes.

The financial statements for CMDHB are for the year ended 30 June 2016.

The Board approved signing delegation on 7 September 2016 for the Chairman and a Board member together with the CEO and Deputy CEO, to sign on 28 October 2016.

Basis of Preparation

Statement of compliance

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

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

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

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

Significant Accounting Policies

Investments in Associates and Joint Ventures

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

Revenue

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

MOH revenue

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

The revenue recognition approach for MOH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantially linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as CMDHB provides the service.
Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied.

ACC Contract revenues

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

Rental income

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

Borrowing costs are capitalised on qualifying assets in accordance with CMDHB's policy. All other borrowing costs are treated as an expense in the financial year in which they are incurred.

Leases

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

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.
The finance charge is charged to the surplus or deficit prior to other comprehensive income over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

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

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits
Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	10 - 100 years	1% - 10%
Electrical Services	10 - 15 years	6% - 10%
Other Services	15 - 25 years	4% - 6%
Fit out	5 - 10 years	10% - 20%
Infrastructure	20-100 years	1% - 5%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	3 - 25 years	4% - 33%
Information Technology	3 - 5 years	20% - 33%
Vehicles	3 - 6 years	16% - 33%
Other Equipment	3 - 25 years	4% - 33%

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

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

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

Staff training costs are recognised as an expense when incurred.

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

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

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by NZ Health Partnerships Ltd, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZ Health Partnerships Ltd through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

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

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

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

Impairment of Property, Plant and Equipment and Intangible Assets

CMDHB does not hold any cash generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.
Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.
The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

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

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, sabbatical leave and sick leave.
A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.
A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past, practice that has created a constructive "obligation".

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

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

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

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

Superannuation schemes

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

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

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit in the plan will affect future contributions by individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme. Further information on this scheme is disclosed in Note 22.

Provisions

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

Provisions are not recognised for future operating losses.

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

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

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

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

Critical accounting estimates and assumptions

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

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

Estimating useful lives and residual values of property, plant, and equipment
At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.
An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit prior to other comprehensive income and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

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

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

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

Critical judgements in applying accounting policies

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

Leases classification
Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.
Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments.
Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.
The DHB has exercised its judgement on the appropriate classification of leases, and has recognised no leases as finance leases.

Agency relationship
Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.
For a number of contracts CMDHB makes payments to the service providers on behalf of the DHBs receiving services and these DHBs will then reimburse CMDHB for the costs of the services provided in their districts. Where CMDHB has assessed that it has acted as an agent for the other DHBs, payments and receipts in relation to the other DHBs are not recognised in CMDHB's financial statements.

Standards issued and not yet effective and not early adopted

In 2015, the External Reporting Board issued *Disclosure Initiative (Amendments to PBE IPSAS 1)*, *2015 Omnibus Amendments to PBE Standards*, and *Amendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments*. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. CMDHB will apply these amendments in preparing its 30 June 2017 financial statements. CMDHB expects there will be no effect in applying these amendments.

2. Patient care revenue

	Actual 2016 $000	Actual 2015 $000
Health and disability services (MOH contracted revenue)	1,369,296	1,343,252
ACC contract revenue	24,460	18,362
Revenue from other district health boards	79,402	80,036
Other patient care related revenue	25,512	23,753
Total patient care revenue	**1,498,670**	**1,465,403**

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. An adjustment of $6,701k has been made to the 2014/15 values for Other Patient Care revenue, being revenue misclassified as Other Income in that year.

Income received from other District Health Boards for agency contracts has been offset against the cost of those contracts. $18.8m (2015 $18.1m).

3. Other income

	Actual 2016 $000	Actual 2015 $000
Donations and bequests received	2,146	1,592
Other income	14,604	14,271
Rental income	1,864	1,628
Gain on Disposal of Assets	-	30
Total other income	**18,614**	**17,521**

An adjustment of $(6,701k) has been made to the 2014/15 values for Other Income, being Other Patient Care revenue misclassified as Other Income in that year.

4. Personnel costs

	Actual 2016 $000	Actual 2015 $000
Salaries and wages	553,741	517,566
Contributions to defined contribution schemes	17,026	15,937
Increase/(Decrease) in liability for employee entitlements	(6,099)	14,971
Restructuring provision for employee exit costs	-	200
Total personnel costs	**564,668**	**548,674**

5. Capital Charge

The DHB pays a quarterly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2016 was 8% (2015: 8%).

6. Other expenses

Other expenses include:	Actual 2016 $000	Actual 2015 $000
Audit fees – audit of financial statements	204	197
Operating leases expense	8,184	7,180
Impairment of debtors	5,104	5,603
Board and committee members fees and expenses	367	405
Total other expenses	**13,859**	**13,385**

7. Cash and cash equivalents

	Notes	Actual 2016 $000	Actual 2015 $000
Cash at bank and on hand		77	47
NZ Health Partnerships Limited (formerly Health Benefits Ltd)		31,726	55,209
Trust / Special purpose Funds	19	873	882
Cash and cash equivalents for the purposes of the statement of cash flows		**32,676**	**56,138**

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

CMDHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHP) and all District Health Boards dated 12 November 2012. This Agreement enables NZHP to "sweep' DHB bank accounts and invest surplus funds on their behalf.

8. Debtors and other receivables

	Actual 2016 $000	Actual 2015 $000
Ministry of Health receivables	4,307	5,289
Other receivables	14,091	15,837
Other accrued revenue	36,151	28,486
Less: provision for impairment	(4,504)	(4,537)
Total debtors and other receivables	**50,045**	**45,075**

Fair value

The carrying value of debtors and other receivables approximates their fair value.

Impairment

The ageing profile of receivables at year end is detailed below:

	2016			2015		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	42,790	-	42,790	35,270	-	35,270
Past due 1-30 days	2,315	-	2,315	6,489	-	6,489
Past due 31-60 days	2,723	(416)	2,307	2,196	(722)	1,474
Past due 61-90 days	727	(395)	332	1,311	(726)	585
Past due > 90 days	5,994	(3,693)	2,301	4,346	(3,089)	1,257
Total	**54,549**	**(4,504)**	**50,045**	**49,612**	**(4,537)**	**45,075**

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

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

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

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

9. Other non-current assets

	Actual 2016 $000	Actual 2015 $000
Reversionary interest in car park building	1,527	1,449
Total other non-current Assets	**1,527**	**1,449**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to them in 13 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 6.5% was used.

10. Inventories

	Actual 2016 $000	Actual 2015 $000
Pharmaceuticals	766	619
Other supplies net of provision for obsolete stock	702	701
Total inventories	**1,468**	**1,320**

No inventories are pledged as security for liabilities (2015 $0), however, some inventories are subject to retention of title clauses.

The amount of inventories recognised as an expense during the year was $17.0m (2015 $18.2m) which is included in the clinical supplies line item in the Statement of Comprehensive Income.

11. Non-Current Assets held for sale

The DHB owns Land and Buildings assets which had been classified as held for sale following the Board's approval of their sale. Subsequently, despite protracted negotiations, a suitable sale was unable to proceed and the assets have now been brought back into the DHB's asset ledger.

	Actual 2016 $000	Actual 2015 $000
Land	-	10,323
Buildings	-	2,180
Total non-current assets held for sale	**-**	**12,503**

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2016	Balance date
Northern Regional Alliance Ltd	Provision of health support services	Associate	33.3%	30 June-16
healthAlliance NZ Ltd	Provision of shared services	JV	25.0%	30 June-16
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	JV	25.0%	30 June-16

CMDHB holds both Class A and Class C shares in healthAlliance NZ Ltd – only the Class A shares carry voting rights and thus they determine the extent of the interest CMDHB has in healthAlliance NZ Ltd.

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

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

Year end 30 June 2015 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	11,627	10,117	1,510	14,969	124
healthAlliance NZ Ltd	125,389	23,492	101,897	123,276	(37)
NZ Health Innovation Hub Limited Partnership	1,157	186	971	698	(389)

Share of profit of associate entities and Jointly Controlled Entities

	Actual 2016 $000	Actual 2015 $000
Share of profit/(loss)	**(304)**	**(63)**

Associates and Joint Ventures are not accounted for using the equity method or proportionate method, as they are not material.

Investments in Associates and Jointly Controlled Entities

	Actual 2016 $000	Actual 2015 $000
healthAlliance NZ Ltd	**31,925**	**23,611**

The increase represents the issue of additional Class C shares – these shares are non-voting and have no impact on the calculation of share of profit/(loss).

13. Property, plant and equipment

	Land	Buildings, Plant & Infrastructure	Clinical Equipment, IT & Motor Vehicles	Other Equipment	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance at 1 July 2014	110,020	435,051	156,749	18,698	1,851	722,369
Additions	-	-	-	-	25,897	25,897
Work In Progress capitalised	-	15,234	3,288	3,366	(21,888)	-
Revaluation of Assets	34,662	2,195	-	-	-	36,857
Disposals/transfers	-	-	(559)	(4)	-	(563)
Transferred to Assets held for Resale (see note 11)	-	-	-	-	-	-
Balance at 30 June 2015	**144,682**	**452,480**	**159,478**	**22,060**	**5,860**	**784,560**
Balance at 1 July 2015	144,682	452,480	159,478	22,060	5,860	784,560
Additions	-	-	-	-	28,936	28,936
Work In Progress capitalised		14,244	11,671	390	(26,305)	-
WIP Misclassified in 2015	-	(3,593)	(4,284)	(1,941)	9,818	-
Revaluation of Assets**	21,524	(17,322)	-	-	-	4,202
Disposals/transfers	-	-	(892)	(8)	-	(900)
Transferred from Assets held for Resale (see note 11)	10,323	2,180	-	-	-	12,503
Balance at 30 June 2016	**176,530**	**447,989**	**165,973**	**20,501**	**18,309**	**829,301**
Accumulated depreciation and impairment losses						
Balance at 1 July 2014	-	-	112,493	15,197	-	127,690
Depreciation expense	-	21,465	5,668	1,192	-	28,325
Elimination on disposal/transfer	-	-	(533)	-	-	(533)
Elimination on revaluation	-	-		-		-
Balance at 30 June 2015	**-**	**21,465**	**117,628**	**16,389**	**-**	**155,482**
Balance at 1 July 2015	-	21,465	117,628	16,389	-	155,482
Depreciation expense	-	19,732	9,808	987	-	30,526
Elimination on disposal/transfer	-	-	(593)	(8)	-	(601)
Elimination on revaluation	-	(41,197)	-	-	-	(41,197)
Balance at 30 June 2016	**-**	**-**	**126,843**	**17,368**	**-**	**144,210**
Carrying amounts						
At 1 July 2014	110,020	435,051	44,256	3,501	1,851	594,679
At 30 June and 1 July 2015	144,682	431,015	41,850	5,671	5,860	629,079
At 30 June 2016	**176,530**	**447,989**	**39,130**	**3,133**	**18,309**	**685,091**

** Note that Revaluation of Buildings $(17,322) is made up of Building revaluation $23,876 less Accumulated depreciation written back $(41,197).

Valuation

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

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

The most recent valuation of land was performed by a registered independent valuer, Darroch, as at 30 June 2016. The total asset valuation amounted to $176.5m, resulting in a 2015/16 revaluation adjustment of $21.524m.

Buildings
Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.
Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- The remaining useful life of assets is estimated.
- Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

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

The most recent valuation of buildings was performed by a registered independent valuer, Darroch, as at 30 June 2016. The total asset valuation amounted to $447.9m, resulting in a 2015/16 revaluation adjustment of $23.876m.

Restrictions on title

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

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

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

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

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

14. Intangible assets

Movements for each class of intangible assets are as follows:

	FPSC Rights $000	Software $000	Work in Progress $000	Total $000
Balance at 1 July 2014	5,509	4,391	-	9,900
Additions	270	143	4,686	5,099
Work in Progress Capitalised	-	192	(192)	-
Disposals/Transfers	-	(4,212)	-	(4,212)
Balance at 30 June 2015/1 July 2015	**5,779**	**514**	**4,494**	**10,787**
Additions	-	239	4,798	5,037
Work in Progress Capitalised	-	-	-	-
Impairment	-	-	(1,553)	(1,553)
Transfers/Adjustments	-	(192)	(756)	(948)
Balance at 30 June 2016	**5,779**	**561**	**6,983**	**13,323**
Accumulated amortisation and impairment losses				
Balance at 1 July 2014	-	97	-	97
Amortisation expense	-	109	-	109
Balance at 30 June 2015/1 July 2015	**-**	**206**	**-**	**206**
Amortisation expense	-	110	-	110
Balance at 30 June 2016	**-**	**316**	**-**	**316**
Carrying amounts				
At 1 July 2014	5,509	4,294	-	9,803
At 30 June and 1 July 2015	5,779	308	4,494	10,580
At 30 June 2016	**5,779**	**245**	**6,983**	**13,007**

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

During the year ended 30 June 2016, the DHB had made no payments (2015: $5,779k) to NZ Health Partnerships Ltd (formerly Health Benefits Ltd) in relation to the Finance Procurement Supply Chain (FPSC) Programme, which was in progress at year end. This is a national initiative facilitated by NZHP. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of NZHP, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

A revised FPSC programme business case was approved by all DHBs by 30 June 2015 and all DHBs have committed to providing funding required to complete the FPSC program. The program will be implemented by a DHB owned vehicle (NZ Health Partnerships Limited), in which all DHBs own equal "A" class voting shareholding of 5%. The investment in the FPSC asset transferred into the new company on 1 July 2015 with no change to the "B" class shareholding as there was no economic event giving rise to a change in the asset. The revised business case demonstrates that the investment generates a positive Net Present Value for CMDHB. On this basis, the Depreciated Replacement Cost of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired.

15. Creditors and other payables

	Actual 2016 $000	Actual 2015 $000
Payables under exchange transactions		
Creditors and accrued expenses	95,392	101,930
Income in advance	1,917	1,920
Total payables under exchange transactions	**97,309**	**103,850**
Payables under non-exchange transactions		
GST payable	6,696	5,446
Capital charge payable	(325)	390
Total payables under non-exchange transactions	**6,371**	**5,836**
Total creditors and other payables	**103,680**	**109,686**

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

16. Borrowings and overdraft

	Actual 2016 $000	Actual 2015 $000
Current portion		
Crown loans – fixed interest	5,000	-
Total current portion	**5,000**	**-**
Non-current portion		
Crown loans – fixed interest	287,500	292,500
Total non-current portion	**287,500**	**292,500**
Total borrowings	**292,500**	**292,500**
Borrowing facility limits		
Crown loan facility limit	297,600	297,600
Overdraft facility	69,939	69,939
Total borrowing facility limits	**367,539**	**367,539**

Crown Loans

The fair value of Crown loans is $319.4m (2015 $305.4m). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.30% to 6.36% (2015 3.30% to 6.36%).

Overdraft Facility

CMDHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Ltd (NZHP) and the participating DHBs. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at the credit interest rate received by NZHP plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue. This is used in determining working capital limits, being defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST, for CMDHB that equates to $69.9m (2015 $69.9m).

17. Employee entitlements

	Actual 2016 $000	Actual 2015 $000
Current portion		
Accrued salaries and wages	40,098	50,602
Annual leave	54,937	53,131
Sick Leave	375	531
Long Service Leave	1,557	803
Retirement Gratuities	2,148	2,061
Sabbatical leave	1,550	1,039
Continuing medical education	15,628	14,478
Total current portion	**116,293**	**122,645**
Non-current portion		
Long service leave	6,056	6,183
Retirement gratuities	9,253	8,443
Sick leave	1,832	2,262
Total non-current portion	**17,141**	**16,888**
Total employee entitlements	**133,434**	**139,533**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 1.93% - 3.00% (2015 2.93% - 5.50%) and an inflation factor of 1.0% (2015 1.5%) were used.

18. Provisions

	Actual 2016 $000	Actual 2015 $000
Non-current portion		
ACC Partnership Programme	931	1,337
Total provisions	**931**	**1,337**

Movements for each class of provision are as follows:

	ACC Partnership Programme 2016 $000	ACC Partnership Programme 2015 $000
Balance at 1 July	1,337	1,337
Actuarial valuation movement	(406)	-
Balance at 30 June	**931**	**1,337**

ACC Partnership Programme

Liability valuation
An external independent actuarial valuer, AON Hewitt, has calculated the liability as at 30 June 2016. The actuary has attested they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin
A risk margin of 20% (2015 20%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

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

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

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

- an average assumed rate of inflation of 1.7% for 30 June 2016 (2015 2.1%);
- a weighted average discount factor of 4.2% for 30 June 2016 and for 30 June 2015 (3.0%) that has been applied to future payment streams; and
- claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 11% of claims will result in no payment, 86% will result in medical claims, and 21% will result in an element of time off work

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

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

A stop loss limit of 183% of the industry premium is used. The stop loss limit means the DHB will carry the total cost of all claims only up to a total of $4.417m per annum.

19. Equity

	Actual 2016 $000	Actual 2015 $000
Crown equity		
Balance at 1 July	108,126	108,545
Capital contributions from the Crown	-	-
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**107,707**	**108,126**
Accumulated surpluses/(deficits)		
Balance at 1 July	(45,093)	(48,110)
Surplus/(deficit) for the year	2,870	3,017
Balance at 30 June	**(42,223)**	**(45,093)**
Revaluation reserves		
Balance at 1 July	173,729	136,872
Revaluations	45,400	36,857
Balance at 30 June	**219,129**	**173,729**
Revaluation reserves consist of:		
Land	172,925	151,401
Buildings and Infrastructure	46,204	22,328
Total revaluation reserves	**219,129**	**173,729**
Trust funds		
Balance at 1 July	882	864
Transfer to/(from) accumulated surpluses	(9)	18
Balance at 30 June	**873**	**882**

CMDHB has established Trust and Special Funds for specific purposes. The conditions for use of these funds are imposed by deed of gift or by the terms of endowments and bequests.

Total equity	**285,486**	**237,644**

Included in accumulated surpluses/deficits are $43.74m (2015 $32.467m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established, with $33.396m authorised and committed to be used for partial funding of the new Mental Health facility on the Middlemore site. The balance of the funding required has been approved by the Crown.

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

	Actual 2016 $000	Actual 2015 $000
Net surplus/(deficit)	**2,870**	**3,017**
Add/(less) non-cash items		
Impairment of Intangibles	1,553	-
Depreciation and amortisation expense	30,637	28,435
Total non-cash items	**32,190**	**28,435**
Add/(less) items classified as investing or financing activities		
Gain on disposal of assets	12	30
Interest on Restricted Funds	(9)	18
Total items classified as investing or financing activities	**3**	**48**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(4,395)	(12,187)
Inventories	(148)	114
Creditors and other payables	(6,352)	4,386
Employee entitlements	(5,863)	15,082
Net movements in working capital items	**(16,758)**	**7,395**
Net cash flow from operating activities	**18,305**	**38,895**

21. Capital commitments and operating leases

Capital commitments

	Actual 2016 $000	Actual 2015 $000
Property , plant and equipment	4,604	3,772
Total capital commitments	**4,604**	**3,772**

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

Non-cancellable operating lease commitments

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

	Actual 2016 $000	Actual 2015 $000
Not later than one year	2,906	3,473
Later than one year and not later than five years	4,248	5,832
Later than five years	434	1,020
Total Non-Cancellable Operating Leases	**7,588**	**10,325**

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

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

22. Contingencies

Contingent liabilities

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

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

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

As at 31 March 2016, the Scheme had a past service surplus of $11.7m (7.4% of the liabilities) - this amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS25.

The Actuary to the Scheme recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended employer contributions remain suspended.

Contingent Assets

The DHB has no contingent assets (2015 $nil).

23. Related party transactions

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

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

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $1,499m (2015 $1,465m) to provide health services in the Counties Manukau area for the year ended 30 June 2016 (note 2).

Collectively, but not individually, significant transactions with government-related entities

In conducting its activities, the DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2016 totalled $9.5m (2015 $8.5m). These purchases included the purchase of air travel from Air New Zealand, postal services from New Zealand Post, and blood from NZ Blood Service.

Transactions with key management personnel

Key management personnel compensation

	Actual 2016 FTE	Actual 2015 FTE	Actual 2016 $000	Actual 2015 $000
Executive management team	12	12	3,632	3,397
Board	11	11	347	363
Committee	7	8	12	11
Total key management personnel compensation	**30**	**31**	**3,991**	**3,771**

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board Members.

The actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $84.9k (2015 $92k).

Key management personnel include all Board members, the Chief Executive, and eleven members of the management team. One member of the Executive Management team commenced 1 May 2015.

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

CMDHB is required under the Crown Entities Act, to consolidate into its statutory Accounts those entities "deemed" subsidiaries under this Act. The definition of subsidiaries extends to those entities, whose sole or primary purpose gives "benefit", in this case to CMDHB. This is irrespective of legal ownership.

CMDHB does not have any subsidiaries.

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. While CMDHB has been the major beneficiary of the Trust, it must meet all normal Charitable Trust requirements in terms of applications for funding. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $5.6m (2015 $5.1m) and a surplus of $0.4m (2015 $0.1m) which may be subject to restrictions on distribution as at 30 June 2016. The financial statements of the Foundation for 2016 are not publicly available as they have not yet been approved by the Foundation's trustees.

24. Board member remuneration

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

	Actual 2016 $	Actual 2015 $
Dr. Lee Mathias	59,750	61,000
Wendy Lai	19,563	25,333
Sandra Alofivae	29,438	30,313
Arthur Anae	27,500	27,500
Reece Autagavaia	29,250	31,000
Colleen Brown	29,625	31,313
David Collings	31,500	32,500
Dianne Glenn	30,500	31,250
Dr Lyn Murphy	29,813	30,563
Kathy Maxwell	28,750	30,250
George Ngatai	30,500	31,500
Total board member remuneration	**346,189**	**362,522**

Committee members	Award $ 2016
Wendy Bremner	2,292
Sefita Hao'uli	1,875
Hine Joyce-Tahere	417
Nicholas Main	1,250
Tangihaere MacFarlane	417
Ezekiel Robson	2,917
John Wong	2,500
Total	**11,668**

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

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

No board members received compensation or other benefits in relation to cessation (2015 $nil).

25. Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:	Actual 2016	Actual 2015
Total remuneration paid or payable:		
$100,000 – 109,999	179	146
$110,000 – 119,999	123	112
$120,000 – 129,999	73	65
$130,000 – 139,999	51	53
$140,000 – 149,999	40	31
$150,000 – 159,999	32	29
$160,000 – 169,999	19	16
$170,000 – 179,999	18	25
$180,000 – 189,999	24	24
$190,000 – 199,999	23	19
$200,000 – 209,999	26	25
$210,000 – 219,999	21	19
$220,000 – 229,999	20	33
$230,000 – 239,999	37	34
$240,000 – 249,999	30	27
$250,000 – 259,999	19	29
$260,000 – 269,999	38	18
$270,000 – 279,999	20	16
$280,000 – 289,999	22	15
$290,000 – 299,999	11	11
$300,000 – 309,999	12	13
$310,000 – 319,999	13	7
$320,000 – 329,999	2	7
$330,000 – 339,999	10	8
$340,000 – 349,999	6	7
$350,000 – 359,999	9	7
$360,000 – 369,999	3	4
$370,000 – 379,999	-	7
$380,000 – 389,999	2	-
$390,000 – 399,999	2	2
$400,000 – 409,999	1	3
$410,000 – 419,999	2	1
$420,000 – 429,999	2	1
$430,000 – 439,999	-	2
$440,000 – 449,999	2	1
$450,000 – 459,999	2	1
$460,000 – 469,999	1	1
$470,000 – 479,999	-	-
$480,000 – 489,999	-	-
$490,000 – 499,999	-	-
$500,000 – 509,999	-	-
$510,000 – 519,999	1	-
$520,000 – 529,999	-	1
$530,000 – 539,999	1	-
Grand total	**897**	**820**

During the Year Ended 30 June 2016, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 735 (2015 - 707) are Medical Staff and 162 (2015 - 113) are Management.

During the year ended 30 June 2016, 12 (2015: 7) employees received compensation and other benefits in relation to cessation totalling $157,868 (2015 $144,679).

26. Events after the balance date

The Board of Counties Manukau District Health Board, at a Special Board Meeting on 17 August 2016, determined that a parcel of land comprising approximately 13.1 hectares on the Manukau site bordered by Great South Road and Kerrs Road was surplus to requirements. Subsequently the land has been offered to the Crown and accepted subject to commercial negotiations.

Any proceeds will be used for the purchase of improvements to, or extension of, publically owned facilities for health purposes.

On 27th July 2016, the Board of CMDHB approved the letting of a construction contract relating to the new Mental Health facility on the Middlemore site. This approval was subsequent to Ministerial approval for the project having been granted on 13th April 2015.

27. Financial instruments

Financial instrument categories

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

	Actual 2016 $000	Actual 2015 $000
Loans and receivables		
Cash and cash equivalents	32,676	56,138
Debtors and other receivables	50,045	45,075
Total loans and receivables	**82,721**	**101,213**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	95,156	101,927
Borrowings and overdraft	292,500	292,500
Total financial liabilities measured at amortised cost	**387,656**	**394,427**

Financial instrument risks

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Price risk
Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. The DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits and bank loans that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the DHB as investments and borrowings are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

Sensitivity analysis
As at 30 June 2016, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have no impact as all loans are fixed (2015 $0.0k).

Credit risk

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

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

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

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

	Actual 2016 $000	Actual 2015 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	940	882
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	31,736	55,256
Total debtors and other receivables	50,045	45,075

Liquidity risk

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

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

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

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2015						
Creditors and other payables	109,686	109,686	109,686	-	-	-
Crown Loans	292,500	364,593	12,470	17,435	119,179	215,510
Total	**402,186**	**474,279**	**122,156**	**17,435**	**119,179**	**215,510**
2016						
Creditors and other payables	103,680	103,680	103,680	-	-	-
Crown loans	292,500	353,883	17,435	46,279	147,839	142,330
Total	**396,180**	**457,563**	**121,115**	**46,279**	**147,839**	**142,330**

28. Capital management

The DHB's capital is its equity, which comprises Crown equity, accumulated surpluses, revaluation reserves, and trust funds. Equity is represented by net assets.

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. The DHB has complied with these provisions in the 2015-16 financial year.

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

29. Trust and Special Purpose Funds

	Actual 2016 $000	Actual 2015 $000
Trust/Special funds		
Balance at beginning of year	882	864
Funds expended	(19)	-
Interest received on Restricted Funds	10	18
Balance at end of year	**873**	**882**

30. Explanation of major variances against budget

Statement of Comprehensive Revenue and Expenditure:

- Overall income and expenditure variances (including expenditure on agency contracts) are minimal. Actual results reflect normal variation in demand and clinical mix of work undertaken together with timing of capital investment
- Actual Non Health Board Provider expenditure includes an adjustment for payments to and funding of PHOs and Labs where Auckland DHB acts as agent for Counties Manukau DHB. This adjustment was not included in the budget which reflects the gross amount of the funding and payments. This adjustment has an offset appearing in Other District Health Board expense.

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

- Timing of operational payments and capital investment. Operating cash remains positive
- Revaluation in land and buildings
- Investment in Healthy Together 2020 and healthAlliance

The major variances in the Statement of Cash flow are attributed to:

- Lower operating cash flow due to:
    - lower net interest
    - net higher capital charge payment directly attributable to due declared surplus
- Balance sheet movements in debtors and creditors
- Higher investing in Property, plant and Equipment
- Acquisition of additional Class C shares in healthAlliance NZ Ltd reflecting additional investment in IT capacity and capability

Board and Committee Membership Attendances

Number of meetings	Board[124]	HAC[124]	CPHAC[124]	AR&F[124]	DiSAC[125]	MHAC[125]
Dr Lee Mathias [Chairman]	8	8	9	9	4	4
Wendy Lai [Deputy Chair]	7	7	-	7	-	-
Colleen Brown	7	7	7	-	3	2
Dr Lyn Murphy	7	7	-	7	-	2
Sandra Alofivae	8	7	7	-	-	-
Kathy Maxwell	6	6	-	7	-	-
Dianne Glenn	8	8	9	-	4	3
Arthur Anae	6	7	1	-	2	-
Reece Autagavaia	7	7	5	-	3	-
George Ngatai	6	6	6	8	-	4
David Collings	6	5	8	8	3	-

HAC	Hospital Advisory Committee
CPHAC	Community and Public Health Advisory Board
AR&F	Audit Risk and Finance Committee
DiSAC	Disability Support Advisory Committee
MHAC	Maaori Health Advisory Committee

[124] Board, HAC, CPHAC & AR&F meet six weekly.
[125] DiSAC & MHAC meet twelve weekly.

Board Members' Disclosure of Interests

As at June 2016

Dr Lee Mathias [Chairman]	▪ Chairman, Health Promotion Agency ▪ Chairman, Unitec ▪ Deputy Chair, Auckland District Health Board ▪ Acting Chair, New Zealand Health Innovation Hub ▪ Director, healthAlliance NZ Ltd ▪ Director, New Zealand Health Partners Ltd ▪ External Advisor, National Health Committee ▪ Director, Pictor Limited ▪ Director, John Seabrook Holdings Limited ▪ MD, Lee Mathias Limited ▪ Trustee, Lee Mathias Family Trust ▪ Trustee, Awamoana Family Trust ▪ Trustee, Mathias Martin Family Trust
Wendy Lai [Deputy Chair]	▪ Partner, Deloitte ▪ Board Member Te Papa Tongarewa, the Museum of New Zealand ▪ Chair, Ziera Shoes ▪ Board Member, Avanti Finance
Anae Arthur Anae	▪ Councillor, Auckland Council ▪ Member, The John Walker 'Find Your Field of Dreams'
Colleen Brown	▪ Chair, Disability Connect [Auckland Metropolitan Area] ▪ Member, Advisory Committee for Disability Programme Manukau Institute of Technology ▪ Member, NZ Down Syndrome Association ▪ Husband, Determination Referee for Department of Building and Housing ▪ Chair IIMuch Trust ▪ Director, Charlie Starling Production Ltd ▪ Member, Auckland Council Disability Advisory Panel ▪ Member, NZ Disability Strategy Reference Group

Dr Lyn Murphy	▪ Member, ACT NZ ▪ Director, Bizness Synergy Training Ltd ▪ Director, Synergex Holdings Ltd ▪ Trustee, Synergex Trust ▪ Member, International Society of Pharmacoeconomics and Outcome Research [ISPOR NZ] ▪ Member, New Zealand Association of Clinical Research [NZACRes] ▪ Member Franklin Local Board ▪ Senior lecturer, AUT University School of Inter professional Health Studies ▪ Member, Public Health Association of New Zealand
Sandra Alofivae	▪ Member, Fonua Ola Board ▪ Director, Housing New Zealand ▪ Member, Ministerial Advisory Council for Pacific Island Affairs ▪ Member, Social Housing Reference Group
David Collings	▪ Chair, Howick Local Board of Auckland Council ▪ Member Auckland Council Southern Initiative
Kathy Maxwell	▪ Director, Kathy the Chemist Ltd ▪ Regional Pharmacy Advisory Group, Propharma [Pharmacy Retailing [NZ] Ltd] ▪ Editorial Advisory Board, New Zealand Formulary ▪ Member, Pharmaceutical Society of NZ ▪ Trustee, Maxwell Family Trust ▪ Member, Manukau Locality Leadership Group, Counties Manukau DHB ▪ Board Member, Pharmacy Guild of New Zealand
Dianne Glenn	▪ Member, NZ Institute of Directors ▪ Member, District Licensing Committee of Auckland Council ▪ Life Member, Business and Professional Women Franklin ▪ Member, UN Women Aotearoa/NZ ▪ President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust ▪ Life Member, Ambury Park Centre for Riding Therapy Inc. ▪ Vice President, National Council of Women of New Zealand ▪ Justice of the Peace ▪ Member, Pacific Women's Watch [NZ] ▪ Member, Auckland Disabled Women's Group

George Ngatai	▪ Chair, Safer Aotearoa Family Violence Prevention Network ▪ Director, Transitioning Out Aotearoa ▪ Transitioning out Aotearoa provides services and back office support to Huakina Development Trust and also provide GP services to their people ▪ Director, BDO Marketing ▪ Board Member, Manurewa Marae ▪ Conservation Volunteers New Zealand ▪ Maori Gout Action Group ▪ Nga Ngaru Rautahi o Aotearoa Board ▪ Chair, Restorative Practices NZ
Apulu Reece Autagavaia	▪ Member, Pacific Lawyers' Association ▪ Member, Labour Party ▪ Member, Auckland Council Pacific People's Advisory Panel ▪ Member, Tangata o le Moana Steering Group ▪ Employed by Tamaki Legal ▪ Board Member, Governance Board, Fatugatiti Aoga Amata Preschool ▪ Trustee, Epiphany Pacific Trust

Independent Auditor's Report

To the readers of Counties Manukau District Health Board's financial statements and performance information for the year ended 30 June 2016

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

We have audited:

- the financial statements of the Health Board on pages 42 to 74, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flow for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 15 to 35.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 42 to 74:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

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

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there

are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 15 to 35:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 31 October 2016. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board's financial statements and performance information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Standards;
- present fairly the Health Board's financial position, financial performance and cash flows; and
- present fairly the Health Board's performance.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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

Responsibilities of the Auditor

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

Independence

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

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

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

Directory

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Manukau 2241

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South Auckland Mail Centre

Auditor

Audit New Zealand on

behalf of the Auditor General

Solicitors

Buddle Findlay

Chapman Tripp

Meredith Connell

Simpson Grierson

Chen Palmer

Bankers

Westpac Banking Corp

ASB Bank Limited

Commonwealth Bank

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Kind
Manaakitanga

Excellent
Rangatiratanga

Valuing everyone
Whakawhanaungatanga

Together
Kotahitanga

COUNTIES
MANUKAU
HEALTH