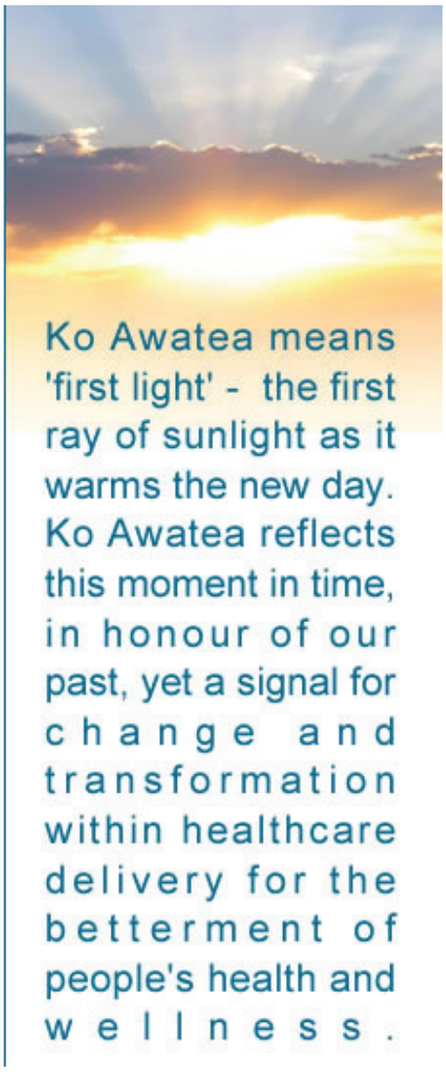
Counties Manukau District Health Board
Annual Report
as at
30 June 2011

"Taawhiti rawa toou haerenga te kore haere tonu.
Nui rawa oou mahi te kore mahi nui tonu."

"We have come too far not to go further.
We have done too much, not to do more."

Sir James Henare

COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership



KO AWATEA

APPLIED HEALTHCARE INNOVATION

Vision

Ko Awatea is not just a building or an empty space waiting to be filled. This new and exciting innovation centre is about people and supporting them to provide the best care they can for their patients and community.

What makes Ko Awatea special is that it will help people to not only reach their full potential in regard to careers and training but it will encourage people to think outside the square and come up with innovative ideas and initiatives. Ideas that with the proper support, guidance and expertise can take us from providing good care to one of providing outstanding care.

CENTRES OF EXCELLENCE

Ko Awatea is looking at setting up several centres of excellence. These centres will operate from the Centre, allowing for multi-disciplinary and innovative solutions for health systems improvement to be developed.

The centres will focus on:

Research, Knowledge & Information Management

The purpose of the *Research, Knowledge & Information Management Centre* is the discovery of new knowledge and, the capture and effective use of information.

It is focussed on specific needs of the organisation and coordinated knowledge to solve system challenges and issues.

Workforce Capability & Leadership

The purpose of the *Workforce Capability & Leadership Centre* is to foster development of a workforce skilled in both their care skill set and able and willing to improve the quality, safety and value of patient care.

Quality Improvement

The purpose of the *Quality Improvement Centre* is to provide a focus on both the quality improvement knowledge and technical skills needed to ensure healthcare is reliable in practice; and the knowledge and skills needed to appraise and evaluate scientific evidence, the development of proven healthcare interventions, leading to improvements in patient care.

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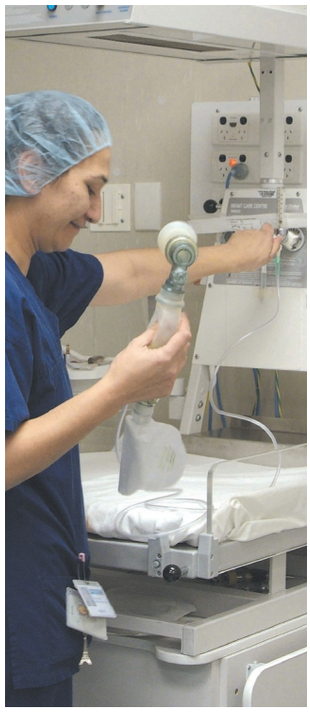


Vision & Values

Vision

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

We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated.

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

Values

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

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

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

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

Innovation: Constantly seeking and striving for new ideas and solutions.

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

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

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

Chair and Chief Executive's Review

Ko te ohonga ake o aku moemoea, ko te puaawaitaga o ngaa whakaaro

The awakening of dreams and aspirations comes from the blossoming of ideas, thoughts and innovation

Te Puea Herangi

It is with great pleasure that we present the 2010/11 annual report for Counties Manukau District Health Board (CMDHB).

CMDHB has had a very challenging past year with higher than usual demand for acute services and earlier disruption to services from industrial action. Despite the challenges and the extremely tight fiscal conditions that DHBs have had to operate within, CMDHB continued to deliver significantly improved healthcare to our community - both within primary and secondary care areas, including record elective surgery levels - and has once again been able to end the year with a financial surplus against a budgeted breakeven position.

The DHB continues to deliver improved performance in all six national health target areas, achieving five of the six national health targets.

- We continue to lead (amongst hospitals of similar size and complexity to ours) for shorter stays in emergency departments, and reached and exceeded the 95% national target for patients seen in Emergency Care within six hours for all four quarters this year. This is a great achievement not only because of the efforts of our EC team but it is also a reflection of the wider contribution and team work of Middlemore Hospital staff.
- The delivery of over 900 more elective surgery procedures than the previous year to the Counties Manukau community.
- The achievement of the 90% immunisation target for two year olds with an impressive result of 92% for the children of our Pacific communities. The Pacific rate has increased by 24% over the last five years. Whilst the Maaori immunisation rate was at 82% this still represented a 6% increase from last year and a 31% increase over the last five years.
- All our patients who required radiotherapy treatment received treatment within the accepted timeframe of four weeks from referral.
- The achievement of our Diabetes Get Checked and Diabetes Management targets. A record 19,229 Diabetes Get Checked reviews were delivered by our PHOs – which is 2,932 more checks than were delivered in the previous year.
- The continued progress made by our inpatient facilities in providing our inpatients who are smokers with advice and help to become smokefree. This is a 27% improvement from the same time last year.

These significant improvements in healthcare have been achieved while also successfully managing record Emergency Department (ED) attendances (the highest single location, ED volumes in New Zealand or Australia), continuing higher birth numbers in New Zealand, while being the only DHB operating within a "capped" funding environment.

We would like to take this opportunity to acknowledge the hard work, skills and the commitment of our staff and partners who have contributed to these great results.

The DHB will continue to strive for better performance and quality healthcare services and, in this regard, the launch of *Ko Awatea* - our *Institute for Healthcare Improvement* - places us in a very good position to achieve our goal of becoming the leader for healthcare in Australasia by 2015. This Centre has four key strategic partnerships:

- Coordination of tertiary training with three major institutions – Auckland University of Technology, Manukau Institute of Technology and the University of Auckland.
- Creation of *Centres of Excellence* which allow for multidisciplinary working and innovation of health systems improvement.
- Establishment of an Advisory Board which combines New Zealand leaders with international expertise from Australia, the UK and the USA.
- Establishment of an *Innovation Hub* which will drive research and development culture and capacity.

Ko Awatea is a very exciting development for the DHB and provides the DHB with significant strategic capacity to design the changes needed in the New Zealand healthcare system to deliver high quality, safe and cost effective care.

In the last year, we have supported our primary care partners in the Greater Auckland Integrated Health Network (GAIHN), National Hauora Coalition and Alliance Health+ in the implementation of the national *Better, Sooner, More Convenient* primary health care Year One initiatives to deliver care in a more integrated way and in more community-based settings. There remains much work to be done with our partners but we are already starting to see some incremental gains including:

- ➢ A 26% increase in referrals to the Primary Options for Acute Care programme for managing acute demand and avoidable hospitalisations.
- ➢ Undertaking work with our regional partners to address the long standing issue of the provision of after hours care in Auckland, with emergent solutions for our community coming into fruition in early 2011/12.
- ➢ The establishment of an integrated nurse-led clinic in Mangere which enables nursing and allied health practitioners in the community to provide local practices with access to shared consultations and patients with the ability to access community nursing or allied health practitioners when they are scheduled to be in clinic.

There will be many more exciting developments in primary health care in the years to come as we seek to re-think how we connect with our communities and the role of primary care as a driver for health and healthcare.

The DHB's *Grow Our Own Workforce* Programme aimed at encouraging more Maaori and Pacific people into the health workforce continues to gain momentum further to securing funding from the Tindall Foundation. Three local high schools - James Cook High, Tangaroa College and Otahuhu College – became Health and Science Academies in February 2011 and through various initiatives, including the South Auckland Health Foundation and the Tindall Foundation, over 90 scholarships

were awarded to people living in the community to support their journey towards becoming healthcare workers and health professionals.

We are extremely grateful to the South Auckland Health Foundation and its supporters who continue to contribute generously to our work and the community through various fundraising initiatives. In the last year, major contributions totalling almost $2m from the Foundation (over $30m since formation) included:

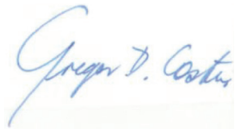
- Securing funding for Ko Awatea and the setting up of the Stevenson Chair of Applied Healthcare Research and Effective Practice.
- Purchasing a cystoscope system, an operating microscope and a V-beam perfecta laser machine for Surgical Services.
- Purchasing a cardiac ultrasound machine and two AccuScreen infant hearing systems for Kidz First Children's Hospital.
- Purchasing an ultrasound machine for Emergency Care.

At the end of the past financial year the DHB resolved to expand the role of healthAlliance NZ Limited, our very successful shared service agency jointly owned with Waitemata DHB, to include Auckland DHB, Northland DHB, as well as Health Benefits Limited (HBL) the national shared services initiative. This collaboration will provide significant opportunities for further cost savings and improved efficiencies, all of which will directly contribute to increased clinical or 'frontline' investment.

The outlook for this coming year remains extraordinarily challenging on all fronts as we continue to operate under naturally constrained funding reflecting the difficult world economy whilst at the same time health demands and expectations continue to grow almost unchecked. We are taking many innovative steps both within CMDHB and with our many partners to develop solutions that will meet these challenges in a sustainable and affordable manner.

In particular we are committed to taking proactive steps to develop strong and effective clinical partnerships between our hospital and community care clinicians. We see this as essential to maintaining the delivery of quality healthcare to our population.

Finally, we would like to thank everybody – staff, volunteers, our supporters and partners in the sector and in the community - who have contributed to the exciting achievements of the past year, and we continue to look forward to the challenges and opportunities to come. We would also like to acknowledge the Board, which has provided strategic leadership for the organisation during the past year and we look forward to another successful year with many challenges.



Professor Gregor Coster, CNZM
Chair

Geraint Martin
Chief Executive

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.

Margaret Mead

Significant problems faced cannot be solved by the same thinking that caused them

Einstein

Executive Management Team as at 30 June 2011

Geraint Martin	Chief Executive Officer
Sam Bartrum	General Manager, Human Resources
Martin Chadwick	Director, Allied Health
Jenni Coles	Chief Operating Officer
Professor Jonathon Gray	Director, Ko Awatea
Denise Kivell	Director, Nursing
Dr Donald Mackie	Chief Medical Officer
Tina McCafferty	Director, Service Integration (acting)
Dr Allan Moffitt	Clinical Director, Primary Care
Ron Pearson	Finance Director
Dr Mary Seddon	Director, Quality Improvement
Bernard Te Paa	General Manager, Maaori Health

Board Committee Membership

as at 30 June 2011

Board Member	Committee
Professor Gregor Coster	Board (Chair), CPHAC, HAC, DiSAC, PHAC, ARF, FMP
Mrs Jan Dawson took office 6 Dec 10	Board (Deputy Chair from 6 Dec 2010), CPHAC, HAC, ARF (Chair)
Mrs Sandra Alofivae took office 6 Dec 10	Board, CPHAC, HAC, PHAC
Mr Anae Arthur Anae	Board, CPHAC, HAC, PHAC (Chair)
Mr Donald Barker	Board, CPHAC, HAC, DiSAC, ARF, FMP (Chair)
Mrs Colleen Brown	Board, CPHAC, DiSAC (Chair), ARF, HAC, PHAC
Mr David Collings took office 6 Dec 10	Board, CPHAC, HAC, PHAC
Mr Paul Cressey	Board (Deputy Chair to 5 Dec 2010), CPHAC, HAC (Chair), ARF, FMP
Mrs Lyn Murphy took office 6 Dec 10	Board, CPHAC, DiSAC, ARF, HAC, FMP
Mr Frank Solomon took office 6 Dec 10	Board, CPHAC, HAC, PHAC
Mr Robert Wichman	Board, CPHAC, HAC, PHAC, FMP, DiSAC

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

A mind stretched by a new idea, never returns to its original dimensions

Joye Rowlands
Clinical Quality and Risk Manager

Member	Committee	Member	Committee
Nganeko Minhinnick	CPHAC	Ezekiel Penton Robson	DiSAC
Roine Lealaiauloto	PHAC	Stephanie Uini Erick-Peleti	PHAC
Bernadette Pereira	PHAC	Gary Phillip Jackson	CPHAC
Christine Bolton	DiSAC	Joanna Katipa	DiSAC
Heather Grace	DiSAC	Te Aomarama Wilson	DiSAC
Sefita Alofi Haouli	CPHAC, PHAC	Timi Maipi	PHAC
Uea Etene Tuleia	PHAC	Alma Wilson	DiSAC
Bob Clark	HAC	Andrew Chan Mow	PHAC
Nuku Rapana	HAC,PHAC	Joy Simpson	DiSAC
Malia Hamani	DiSAC, PHAC	Michael Lamont	CPHAC
Elizabeth Farrell	CPHAC	Gerhard Sunborn	PHAC
Etuate Saafi	PHAC	Louisa Lavakula	PHAC
Peter Skelton	PHAC		

Board Members' Disclosure of Interest

Back Row:
Mr Robert Wichman, Mr Anae Arthur Anae, Mr Donald Barker

Middle Row:
Mr Frank Solomon, Mrs Sandra Alofivae, Mrs Lyn Murphy, Mrs Colleen Brown, Mr David Collings

Seated:
Mr Paul Cressey, Professor Gregor Coster (Chair), Mrs Jan Dawson (Deputy Chair), Mr Geraint Martin (CEO)

Professor Gregor Coster CNZM Chair July 2010 - present	• Wife works with AC Research Associates New Zealand (ceased Nov 10) • Chairman, DHBNZ • Joint Chair Ministry/DHBNZ Productivity Working Group (ceased July 10) • Deputy Chair, Health Workforce New Zealand • Fellow Royal New Zealand College of General Practitioners (Dist) • Director, Better Value Healthcare Asia-Pacific (started Apr 11) • Board Member, UNICEF New Zealand (Jun 11) • Director, Marama Global Ltd (Jun 11)
Jan Dawson Deputy Chair December 2010 - present	• KPMG Finance Trustee Ltd (Director) • KPMG Transaction Services Ltd (Director) • KPMG Funding Trustee Ltd (Director) • KPMG Peat Marwick Ltd (Director) • KPMG Peat Marwick Audit Ltd (Director) • KPMG Ltd (Director) • KPMG Nominee Company Ltd (Director) • KPMG Property (Christchurch) Ltd (Director) • KPMG Services Ltd (Director) • Peat Marwick Services Ltd (Director) • Erua Ltd (Director) • KPMG Property (Wellington) Ltd (Director) • KPMG Trustee Ltd (Director) • Viaduct Leasing Ltd (Director) • KPMG (Chief Executive) • Yachting New Zealand Inc (President/Director) • Disciplinary Tribunal of the Institute of Chartered Accountants (Member) • Capital Investment Committee – NHB (Member) • Director, Air New Zealand (started May 11)
Sandra Alofivae December 2010 - present	• Member of the Auckland South Community Response Forum (MSD appointment) • Secretary for the Tausa'afia Trust (Aoga Amata PIC Mangere) • MSD Member, Auckland Social Policy Forum, Auckland Council • Member, Pacific Advisory Group to Counties Manukau Police Headquarters
Arthur Anae July 2010 - present	• Manukau City Councillor (ceased Oct 10) • Councillor, Auckland Council (started Oct 10) • Board member Phobic Trust • Board member Counties Manukau Sport (ceased Nov 10) • Member of the John Walker 'Find Your Field of Dreams' • Chairman, NZ Good Samaritan Heart Mission to Samoa Trust

We must always aim for the impossible. If we lower our goal we also diminish our effort.

Dorothy Day

If I have seen further than others, it is because I have stood on the shoulders of giants

Sir Isaac Newton

Board Members' Disclosure of Interest

Don Barker July 2010 - present	• Trustee, West Franklin Community Trust (ceased Sept 10)
Colleen Brown July 2010 - present	• Manukau City Councillor (ceased Oct 10) • Local Board Member (started Oct 10) • Member SRG Watercare(ceased Oct 10) • Chair Parent and Family Resource Centre Board (Auckland Metropolitan Area) • Member of Advisory Committee for Disability Programme Manukau Institute of Technology • Member NZ Down Syndrome Association • Member Maori Women's Welfare League (Manukau) • Husband – Barry Brown – Director Fraser Thomas Ltd Consulting Engineers and Determination Referee for Department of Building and Housing • Member Advisory Board for Paradigm (disability service) (ceased Oct 10) • Chair, Early Childhood Education Taskforce for COMET • Member, Manurewa Advisory Group • Chair for the South Auckland Computers in Homes Steering Committee • Member, Child Advocacy Group - Manukau • MSD Member, Auckland Social Policy Forum, Auckland Council • Member, Auckland Council Disability Leaders Group • Deputy Chair, Auckland City Council Disability Strategic Advisory Group
David Collings December 2010 - Present	• None advised
Paul Cressey July 2010 - present	• Chairman, South East Auckland Life Education Trust • Board Member, GS1 New Zealand • Chairman, Safe Medication Management Programme Sector Stakeholders Group (ceased Feb 11) • Member, Safe Medication Management Steering Group (ceased Feb 11) • Member Plunket Plus Steering Group • Chairman, NZ Universal List of Medicines Steering Group (ceased March 11) • Chairman, National E-Medicines Programme Steering Group
Lyn Murphy December 2010 - Present	• Undertaking a PhD through the University of Tasmania. CCRep and CMDHB provide the location for this research • Member of the International Society for Pharmacoeconomics and Outcomes Research (ISPOR). • ACT candidate in the Botany Bi-election which took place on 5 March 2011 • Member of the New Zealand Association of Clinical Research (NZACRez) • Recipient of an ISPOR student travel grant to present research at the ISPOR international convention in Prague Nov 2010 • Actively involved in the establishment of an ISPOR chapter in New Zealand • Senior lecturer in management and leadership at Manukau Institute of Technology • Board Secretary, ACT NZ
Frank Solomon December 2010	• Managing Director, Solomon Group Education and Training Academy – Ngaatiporou, Ngaati Kahu ki Whangaroa, funded by TEC and MSD. - Present The level 3 Foundation course at MIT • Member, Counties Manukau DHB 'Grow Your Own Workforce' Project • Member, 'Panmure Transformation' Project • Member, Manurewa Marae 'Te Rau Korowai' Advisory Komiti • Member, Waikato Tainui Whanau Ora Project – 'Te Ope Koiora' • Co-Chair Tamakimakaurau Maori Party • Chair 'Te Ringa Awhina/Helping Hand Charitable Trust', has applied to The Tindall Foundation re: School Leavers Support for the Mangere Youth Initiative • Te Manuka – Tamakimakaurau Maori PTEs • Ex-Chair MIT Runanga, Executive and Board member • Trustee, Youth Mentoring Network
Bob Wichman July 2010 - present	• Director Bob Wichman Papatoetoe Ltd (Appliance servicing arrangement with CMDHB through healthAlliance Ltd) • Manukau City Councillor (ceased Oct 10)

It's kind of fun to do the impossible

Walt Disney

For success, attitude is equally as important as ability

Harry F Banks

Outgoing Board Members

Miria Andrews July 2010 – December 2010	• Chief Executive Tainui MAPO • Board member Taikura Trust • Member, Regional Cancer Collaboration Group • Board member, Bright Mortar Trust • Board representative, LBD Partnership Steering Group • Chair – Raukura Hauora O Tainui Iwi Advisory for Breast and Cervical Screening Programme • Chair, Maori Leadership Group, Northern Regional Cancer Network
Anne Candy July 2010 – December 2010	• Member Tainui Beneficiary Register • Member Iwi Register, Ngaiterangi • Manukau City Councillor, Manurewa Ward Chair, Environmental Hearings Committee Member, Te Tiriti o Waitangi Committee (ceased Oct 10) • Life Member, Maaori Women's Welfare League • (Nga Wahine Atawhai o Matukutureia Branch holds current and potential contracts with CMDHB) • Patron, Manurewa RSA • Trustee, Taonga Education Centre (current and potential contracts with CMDHB) • Patron, Manukau National Council of Women • Member 28th Maaori Battalion Association • Ex officio member Toi o Manukau Maaori Arts and Culture Trust (ceased Oct 11) • Member, Liaison Committee, Auckland Region Women's Corrections Facility (ceased Oct 11) • Member, MIT Advisory Committee • Trust Board Member, Te Whare Ruruhau o Meri • Chair, Manukau Pan Pacific South East Asia Women's Association (PPSEAWA) • Member of the Quality Council for Presbyterian Support Northern • Tamaki Makaurau elected representative on the Maori Advisory Committee to LGNZ National Council (ceased Oct 11)
Ruth DeSouza July 2010 – December 2010	• Board Member Asia New Zealand Foundation • Member, Refugee Council NZ (ceased July10) • Member of the Lottery Community Sector Research Committee • Councillor of the New Zealand Asian Studies Society • Co-ordinator of the Aotearoa Ethnic Network (AEN) and edits the AEN Journal • Editorial Board member of the journals Diversity in Health and Social Care and Transcultural Nursing • Staff Member, Auckland University of Technology • Reference Group, Weight Management Implementation Guidelines (started August 10) • Maaori, Pacific and Asian Advisory Committee on ARCOS IV (Auckland Regional Community Stroke Study 2010-2015)
Penelope Ginnen July 2010 – December 2010	• Barrister, regularly appointed by the Family Court to represent children who reside in the Counties Manukau area, some of whom have health issues • Chair, Brainwave Trust • Director and Shareholder of Ginnen Alarms Ltd • Sister-in-law of Naumati Heath, ClU nurse, currently employed by Auckland District Health Board • Member Housing New Zealand Corporation Board
Michael Williams July 2010 – December 2010	• Manukau City Councillor (ceased Oct 10) • Howick Local Board Member (started Oct 10) • CFO, Treescape Ltd (associated with Vector Ltd) • Elder, St Columba Church, Botany

The best way to predict the future is to invent it

Alan Kay

Innovation is the creation of the new or the re-arranging of the old in a new way

Michael Vance

What We Have Achieved This Year

Here are some of the DHB's key achievements in the last year presented under the headings of our District Strategic Plan 2006 – 2011 Outcome Areas. These achievements represent only a fraction of the planning and work that is undertaken by the DHB to deliver health services that better serve the community.

More detailed information on the performance of the DHB on significant measures of service delivery and key priorities as planned in the 2010/11 Statement of Intent is found in the Statement of Service Performance on pages 63-88.

Taawhiti rawa toou haerenga te kore haere tonu
Nui rawa oou mahi te kore mahi nui tonu

We have come too far not to go further
We have done too much, not to do more

Sir James Henare

Improve Community Wellbeing

Smokefree

- **86% of all hospitalised smokers are now offered advice and help to quit. This is a 27% increase from the same quarter last year.**
- New Smokefree services started for pregnant women and their families and for Maaori. A similar service will commence for Pacific in 2011/12.
- A pilot Smokefree service commenced through the Manukau Community Link Office (A Ministry of Social Development initiative).

LotuMoui

- LotuMoui 'Train the Trainer' programme saw 60 people become Active Training physical trainers and 30 people as healthy eating trainers. A further 15 people received AUT-certified training in Pacific Nutrition.
- **All LotuMoui churches now offer a variety of physical activities.**

Healthy Lifestyles

- Three Counties Manukau rugby league clubs signed up to the League 4 Life programme which promotes smokefree grounds, child protection and responsible drinking.

Intersectoral Collaboration

- **More than 480 joint health and housing assessments were carried out in the community.**
- 187 people were enrolled onto the Providing Access to Health Solutions (PATHS) programme which helps people with health conditions or disabilities return to work whilst managing their health needs.

Violence Intervention Programme

- Emergency Care now screens for domestic violence and child abuse as part of routine processes.
- **The DHB's Violence Intervention Programme trained over 300 Emergency Care, Kidz First, Medical and Surgical staff to improve identification of child and/or partner abuse and referral processes.**

Further highlights for this outcome can be found in our *Creating a Better Future* programme report for 2010/11 which can be found at: www.betterfuture.co.nz.

Improve Child and Youth Health

Child Health

- **90% of our two year olds were fully immunised (92% Pacific, 82% Maaori).**
- Improved on our rate of babies exclusively and fully breastfed at 6 weeks.
- Our community maternity units maintained their Baby Friendly Hospital status. Middlemore Hospital is making significant progress towards BFHI accreditation with more than 80% of staff required to be trained for accreditation having received training.
- Breastfeeding advocacy service launched in Middlemore Hospital and three community organisations were selected to undertake the Baby Friendly Community Initiative accreditation which includes promoting and supporting breastfeeding in their communities.
- **Approximately 9,000 preschoolers (0-4 years) are now enrolled with oral health services**, an increase of 2,000 overall enrolments from last year. This enables delivery of oral health education and dental care to families at an early stage to prevent premature childhood tooth decay.
- A Newborn Hearing Screening service commenced in July 2010 at Middlemore Maternity's Assessment and Labour Birthing Unit (ALBU) and the Neonatal Unit. The service was progressively rolled out to the three community maternity units. The service has screened 6,381 babies which is 81% of the total births.
- **A total of 5,531 B4 School Checks were completed against a year end target of 5,404**. Over 90% of the checks were delivered within a home setting.
- Established an assessment service for children under the care of Child, Youth and Family requiring a comprehensive health assessment. All assessments for Child Protection and Gateway are provided at the Multi Agency Centre in Manukau.
- Virtual First Specialist Assessments (VFSAs) were introduced as a way of providing timelier specialist advice to GPs for certain groups of patients. This model of care is proving to be efficient, cost effective and with very low rates of re-referrals following the VFSA.

Youth Health

- Continued enhancements to School Based Health Services (SBHS) including:
  - School Health Nursing Specialists appointed to support nurses working in Counties Manukau secondary schools.
  - A new Mental Health initiative was established to build links between school health services, guidance counsellors and primary care.

- Improved regional networking and collaboration amongst senior nurses in School Health and/or Alternative Education.

- Adolescent utilisation of free dental health services achieved 68% due to the addition of 20 dentist contracts in the past few years, increased mobile dentists and promotion of oral health services to out-of-school adolescents.
- The HPV immunisation catch up campaign was very successful and the DHB met all its targets for delivering the three doses of the vaccine. A new service delivery model using Whanau Support Workers working with Public Health Nurses to facilitate consent is currently working very well.

Reduce the incidence and the impact of priority conditions

Management of Long Term Conditions and Acute Demand

- **PHOs carried out a record 19,229 Diabetes Get Checked reviews (2,932 more than the previous year) in Counties Manukau.**
- 80% of our eligible adult population had their cardiovascular disease risk assessed.
- An additional 800 people with long term conditions received self management education over the 2010/11 financial year. Over a dozen people have now completed a Self Management Education course and will now be trained as course leaders in order to deliver education within their own communities. In addition, six Master Trainers have been trained within Counties Manukau.
- A pilot programme to raise awareness of gout and how to prevent recurrences was successfully established in collaboration with the NZ Pharmacy Guild and will now form the basis for a regional programme.
- **8,004 referrals were made to the Primary Options for Acute Care (POAC) programme during 2010/11 – a 26% increase from the previous year.**
- 829 enrolments to the Very High Intensive User (VHIU) programme with 786 patients referred in 2010/11. VHIU actively manages people with complex medical and social/psychological needs in primary care.

Cancer Control

- **Breast screening volumes achieved with coverage for eligible women increasing by over 6% for Maaori and 9% for Pacific women.**

Reduce health inequalities

Provider Support and Development

- 95 Maaori, 125 Pacific and 25 South Asian community members participated in Community Coach classes through the Counties Manukau Active Programme to become community physical activity leaders.
- 7 Maaori community organisations received Maaori Community Action funding.
- 30 Pacific organisations received Fonua Mou'ui community action funding and 29 LotuMoui churches received grants.
- The Pacific Cardiac Rehabilitation Programme was successfully piloted.

Maaori and Pacific Workforce Development

- **Over 2,600 Maaori registered onto the national Kia Ora Hauora workforce development programme which is led by Counties Manukau DHB** with links to the Northern, Central, Midland and Southern DHBs. Te Rau Matatini – a national Maaori Mental Health Workforce Development organisation is a programme partner.
- Established a national Kia Ora Hauora mentoring programme to provide support to year 12, 13 and tertiary students.
- Established Maaori and Pacific Nursing Leadership groups.
- CMDHB collaboration with MIT has established a Bachelor of Nursing: Pacific.
- **The first cohort of the Aspiring Leaders programme started this year. The focus is to identify and prepare talented Maaori, Pacific and Asian staff for future management positions.**

Improve Health Sector responsiveness to individual and family/ whaanau need

Hospital and Clinical Services

- **97% of patients seen in Emergency Care were admitted, transferred or discharged from EC within 6 hours.**
- 477 patients received radiotherapy treatment and all were treated within 4 weeks of their first specialist assessment.
- **Provided 15,670 elective surgical discharges and exceeding our target by 1,181 extra discharges and also achieved a 5% increase in acute WIES for the year.**
- Maintained full compliance with the Ministry of Health's Elective Patient Flow Indicators.
- The World Health Organisation Surgical Safety checklist is now used in all theatres.

Go well as you seek and gain new knowledge and wisdom through a journey of discover, learning and achievement

Karen Clarke
Nurse Educator, Maternity

Knowing is not enough; we must apply. Willing is not enough; we must do

Johan Wolfgang von Goethe

- Mental health access targets for all age groups have been achieved, with services delivered to 3.14% of the population. **The number of unique clients seen over the 2010/11 year has increased by 6.2% to 15,636.**
- There are now over 50 Full Time Equivalent funded Peer Support Specialist (PSS) staff across the DHB and NGO providing Mental Health and Addictions services in Counties Manukau.
- Roll out of the Shared Care Primary Maternity Information System which enables GPs and their practice nurses to share up to date clinical information with the Community Midwifery team and vice versa.
- A Nurse Specialist led Early Pregnancy Assessment Service was successfully introduced.

Services Closer to Home

- Local Chronic Pain Service launched to give patients and their families access to services closer to home.
- Launch of the first integrated nurse clinic in Mangere through the Mangere Community Health Trust. Mental Health, Midwifery and Continence services have commenced through the clinic.
- **10 Primary Mental Health outreach clinics were established across Counties Manukau to improve the interface between Secondary Mental Health services and Primary Care.**
- Launch of "Walking On" – a community based programme which utilises support workers to provide exercise to community clients under the supervision of a physiotherapist.
- Lymphodema and Continence services were launched to provide care closer to home for older patients.
- Needs Assessment and Service Coordination team commenced training in the interRAI tool. All NASC assessments will use interRAI by July 2012.
- The Community Long Term Support Service was set up with former Interim Funding Pool funding devolved from Taikura Trust. This service supports people under 65 years with one or more chronic health conditions lasting longer than 6 months and who have very high support needs.
- **ARHOP moved to new facilities which added 26 more AT&R beds.**
- Reduced EC presentations from residential care due to the Community Geriatric Services Team and the Community Based Rehabilitation Teams working together to provide assessment and rehabilitation in the community.

Patient Safety

- **The number of in-hospital falls causing harm decreased from 24 falls per month to 18 falls per month.**
- **Proportion of inpatients with pressure injuries decreased from 10% to 3.4%.**
- **ICU reduced their Central Line Associated Bacteraemia (CLAB) rates from 4.5 days per 1000 line days to 0.9 days per 1000 line days.** CLAB is a primary catheter-associated bloodstream infection which is very costly to treat.
- Pyxis medication system implemented in 70% of Middlemore Hospital clinical areas.
- Launch of a new Patient Safety Training Programme incorporating e-learning, face to face assessments, simulation training and team based learning.
- Establishment of the Institute for Healthcare Improvement (IHI) Adverse Drug Event (ADE) Trigger Tool process, along with a collaborative project with CDHB and CCDHB to share our learning. This work has lead to the development of a 'Triggers Tools' database to facilitate audit workflow and reporting.

Improvement of any system requires will, ideas, and execution.

Thomas Nolan PHD

Improve the Capacity of the Health Sector to Deliver Quality Services

Facilities Modernisation

- **Ko Awatea, the DHB's Institute for Healthcare Improvement, was opened in June 2011.**
- The Edmund Hillary Block was officially opened by the Prime Minister in July 2010 and is now fully occupied.
- **Construction of the first phase of the Clinical Services Block commenced in November 2010 and will include 14 new operating theatres, a new commercial kitchen and facilities for support services when completed.**
- An extra 202 staff car parks were created on the Western Campus, creating more car parks on the Middlemore Campus for visitor parking.
- Progress continues on the planning and implementation of 12 new school dental clinics, including 2 on DHB sites at Botany Downs and Manukau Super Clinics. In addition, 5 existing school dental clinics will be refurbished.
- **2 Mobile Diagnostic Vans are now in service. These will reach up to 107 schools and 6 Marae to screen children and provide preventative treatments for oral health.**

I have not failed, I've just found 10,000 ways that won't work

Thomas A Edison

Workforce development

- **The Grow Our Own Workforce programme received another $1.25m from the Tindall Foundation.**
- A total of 80 Doctors were recruited this year.
- New nursing graduates were supported into eight placements with another six to start in September.
- 84 Primary Care Nurses are undertaking post-graduate education with funding through Health Workforce New Zealand.
- 98% of enrolled nurses successfully met the new scope of practice criteria.

- The Delivering Futures Midwifery campaign was launched and 50 Midwives were recruited from New Zealand and United Kingdom and 17 Midwifery graduates were selected in the largest intake to date. 6 "Return to Midwifery" midwives also joined the service.
- Over 90% of the DHB's eligible social workers are registered with the Social Work Registration Board.

Learning & Development

- Over 490 frontline staff were involved in CALM Communication training to help them manage relationships with patients, their families and colleagues.
- **The e-Learning project at CMDHB has reached the end of phase 2 and there are currently over 2900 users accessing learning materials from within and external to the DHB.**

Information Systems

- All Auckland GPs are now set up to receive CMDHB clinic letters electronically, saving the DHB around $1,500 per week on postage.
- Implemented Phase 2, Part 1 of the Electronic Medications Reconciliation (e-MR) project. Completion of this project in 2012 will improve the communication of medication information between primary and secondary care.
- Developed an electronic Medication Reconciliation prioritisation tool (At Risk Tool – ART) to establish a real time 'virtual ward' of patients at high risk of experiencing adverse medication outcomes. These patients are prioritised to undergo the medication reconciliation process and pharmacist clinical review which is documented in the Clinical Reporter module of the system.
- TestSafe Pharmacy was added to the TestSafe regional clinical data repository. Secondary clinicians, GPs and community pharmacists in the Auckland metro region are now able to view medicines dispensing from community pharmacies for patients whose care they share.
- **The DHB ran an Emergency Operations Centre to assist with the Canterbury earthquake in February which involved different parts of the organisation and staff assisting.**

Regional Collaboration

- A new Northern Region Shared Services organisation, healthAlliance NZ, was formed in March 2011 for Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau DHB and Health Benefits Ltd.

Research at the DHB

- The Middlemore Tissue Bank was established. The bank will enable the storage of human tumour-related specimens, bone marrow and blood for research purposes.
- **The Kidz First respiratory research team received a Health Research Council of New Zealand (HRC) project grant of $1.2m for the 'Healthy Lungs' study which aims to reduce the development of chronic respiratory infections.**
- Speech and Language Therapy is a lead site for a national research project looking at cough reflex testing to assist in swallowing assessments.
- Spinal Unit physiotherapy is a research centre involved in the SCIPA (Spinal cord injury and physical activity programme) "Hands-on" research examining early intensive hand rehabilitation to address loss of hand use in tetraplegia.

Great discoveries and improvements invariably involve the cooperation of many minds

Alexander Graham Bell

Every system is perfectly designed to get the results that it does

Paul Batalden

Good Employer

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

Principle:

CMDHB operates a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment.

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

Creativity is thinking up new things. Innovation is doing new things

Theodore Levitt

Good Employer principles in practice

Provisions which reflect the general principles include:

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

The very first requirements in a hospital is that it should do the sick no harm

Florence Nightingale

Standards:

CMDHB shall ensure that employees maintain proper standards of integrity and conduct, in keeping with the vision and values of CMDHB.

Complaints and appeals:

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

Equal Employment Opportunities (EEO):

Principles:

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

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

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

Policy:

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

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

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

Discrimination:

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

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

Benefits:

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

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

EEO assists CMDHB to:

- deliver improved customer service by better matching our services with our clients;
- improve its productivity through valuing its employees and treating them fairly.

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

Policies, Procedures and Guidelines:

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

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

	Females		Males	
Employee Group	**Number**	**Average Salary**	**Number**	**Average Salary**
Senior Medical Officers	144	202,732	269	225,217
Registered Medical Officers	188	104,337	151	110,950
Individual Employment Agreements	254	92,005	105	102,104
Clerical	658	46,347	23	46,730
Cleaners & Orderlies	172	33,593	93	34,680
Home aids	10	33,630	–	–
Medical Laboratory	101	52,010	27	53,889
Radiology	84	70,234	13	63,778
Allied Health	720	58,204	159	56,836
Security & Trades	5	39,073	38	40,703
Mental Health Nursing & Health care Assistants	250	61,765	82	57,668
Midwives	97	64,215	–	–
Nursing & Health care Assistants	2,018	60,175	174	57,330
Interpreters	14	45,954	6	46,928

Kootahi te koohao o te ngira, e kuhuna
Te miro maa, te miro whero me te miro pango e

A needle has only one eye but it can take white, red or black thread

King Taahiao

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

Number of ethnic groups employed;

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

Overview of CMDHB Population, Health Issues

A snapshot of health in Counties Manukau

Every week for the people of Counties Manukau: *(based on 2010 data)*

Demographics

150	births occur
162	babies are born, 30 by Caesarean section, 10 are low birth weight (<2,500g), 15 have teenage mothers
33	of the 162 babies will be re-admitted acutely to hospital in their first year of life
700	women have cervical smears performed
2,240	people are admitted to a public hospital
340	of these are aged 0-74 and have a potentially preventable condition (excluding injury)
44	people die
7	of the deaths are tobacco-related
23	people die under the age of 75, 14 of them from potentially preventable conditions

Hospital

1,900	people are admitted to hospital
240	children are admitted to hospital (excluding newborns)
170	people are admitted to hospital due to injury
110	people are admitted to hospital due to cardiovascular disease
160	people are admitted to hospital due to respiratory conditions
30	people are admitted to hospital due to asthma
250	people with diabetes are admitted to hospital
12	are admitted for mental health conditions
130	people are admitted to private hospitals for surgical procedures
830	people are in private hospital care
580	people are in DHB-supported residential care
113	people are in dementia services care
500	theatre procedures are performed (excluding maternity)
372	people are admitted electively
209	adults are admitted electively for surgery
63	children are admitted electively for surgery
6,400	people are seen in outpatients
1,700	people are seen in Emergency Care

Primary

3,440	people received 51,600 hours of home based support care visits
23,700	adults consult their general practitioner
7,900	children visit their general practitioner
37,600	people have prescriptions dispensed, with 110,200 items costing $1.9m
12,200	people have 54,300 laboratory tests costing $0.5m
1,360	free influenza vaccines are administered to people aged 65+ (March to June)
610	vaccinations are given to children under 2 (as per Immunisation Schedule)
860	people have a free diabetes check

With great learning comes great opportunity

Tony McBride
healthAlliance
Information Services

People of Counties Manukau DHB

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

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

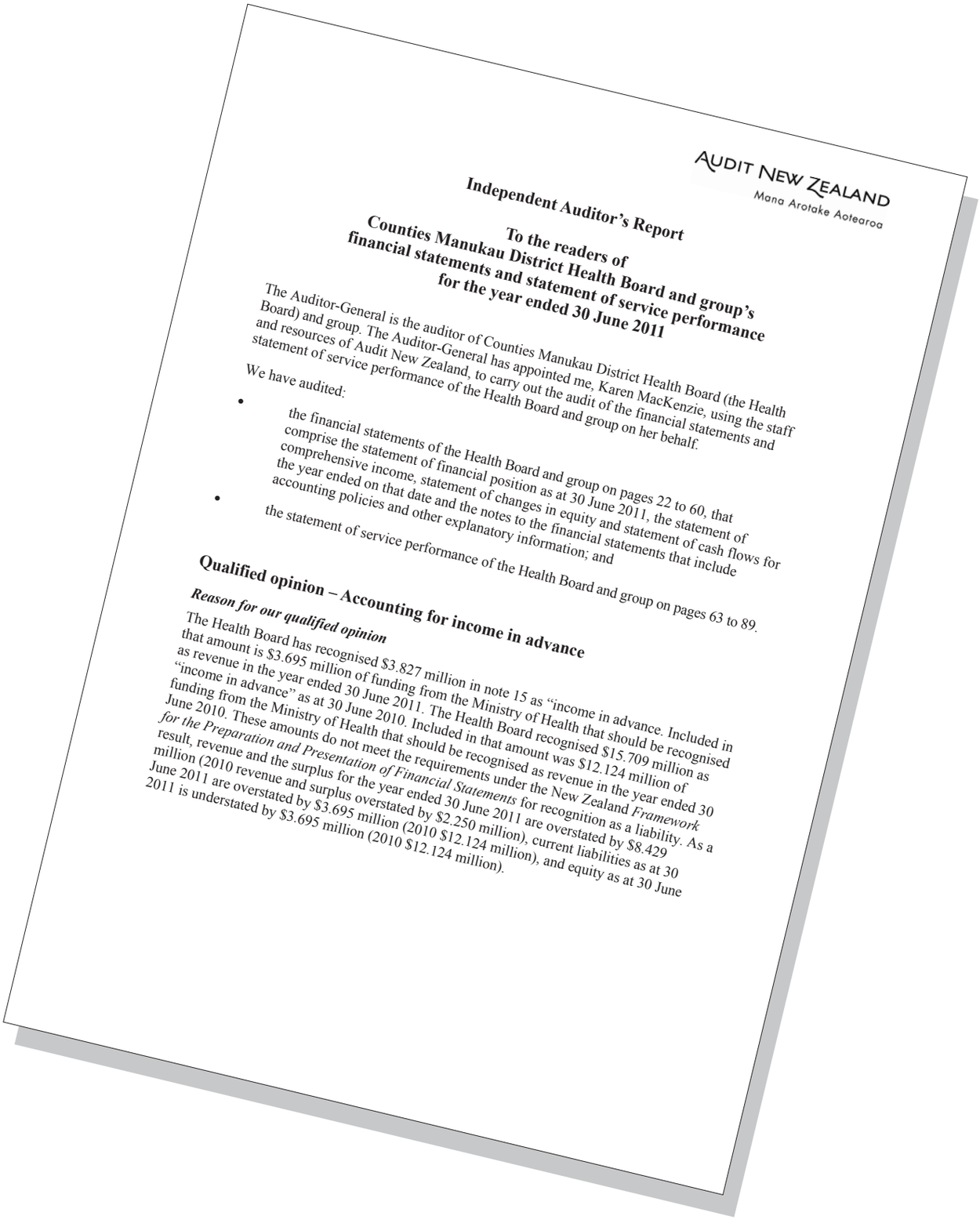
The Counties Manukau Population Health Indicators 2006 document (available on www.cmdhb.org.nz) provides a detailed analysis of the health of Counties Manukau residents.

Key themes in this report, along with other work show:

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

Financial Statements

Report of the Audit Office



AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Counties Manukau District Health Board and group's
financial statements and statement of service performance
for the year ended 30 June 2011

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

We have audited:

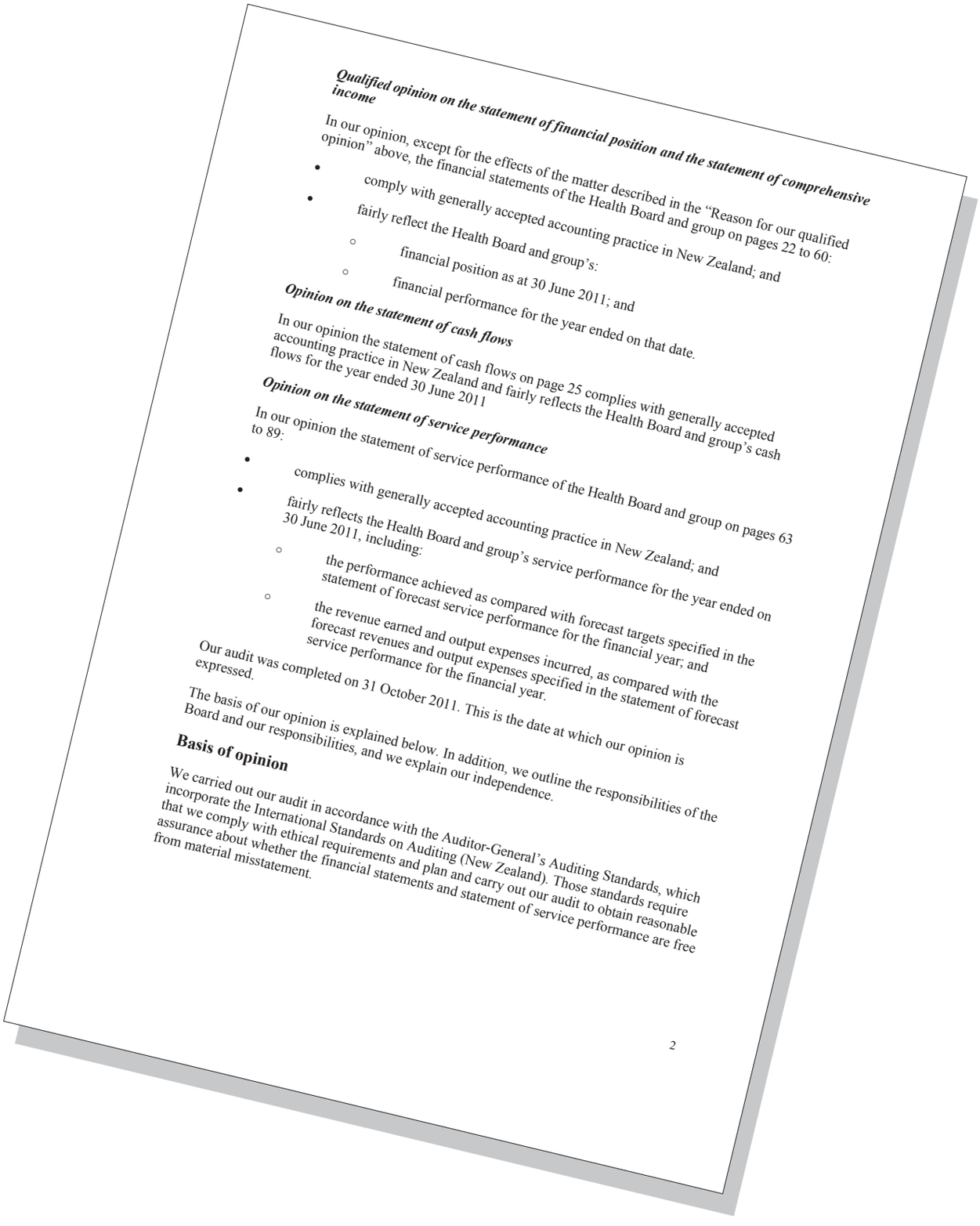
- the financial statements of the Health Board and group on pages 22 to 60, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 63 to 89.

Qualified opinion – Accounting for income in advance

Reason for our qualified opinion

The Health Board has recognised $3.827 million in note 15 as "income in advance. Included in that amount is $3.695 million of funding from the Ministry of Health that should be recognised as revenue in the year ended 30 June 2011. The Health Board recognised $15.709 million as "income in advance" as at 30 June 2010. Included in that amount was $12.124 million of funding from the Ministry of Health that should be recognised as revenue in the year ended 30 June 2010. These amounts do not meet the requirements under the New Zealand *Framework for the Preparation and Presentation of Financial Statements* for recognition as a liability. As a result, revenue and the surplus for the year ended 30 June 2011 are overstated by $8.429 million (2010 revenue and surplus overstated by $2.250 million), current liabilities as at 30 June 2011 are overstated by $3.695 million (2010 $12.124 million), and equity as at 30 June 2011 is understated by $3.695 million (2010 $12.124 million).

Report of the Audit Office



Qualified opinion on the statement of financial position and the statement of comprehensive income

In our opinion, except for the effects of the matter described in the "Reason for our qualified opinion" above, the financial statements of the Health Board and group on pages 22 to 60:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2011; and
  - financial performance for the year ended on that date.

Opinion on the statement of cash flows

In our opinion the statement of cash flows on page 25 complies with generally accepted accounting practice in New Zealand and fairly reflects the Health Board and group's cash flows for the year ended 30 June 2011

Opinion on the statement of service performance

In our opinion the statement of service performance of the Health Board and group on pages 63 to 89:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance for the year ended on 30 June 2011, including:
  - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
  - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

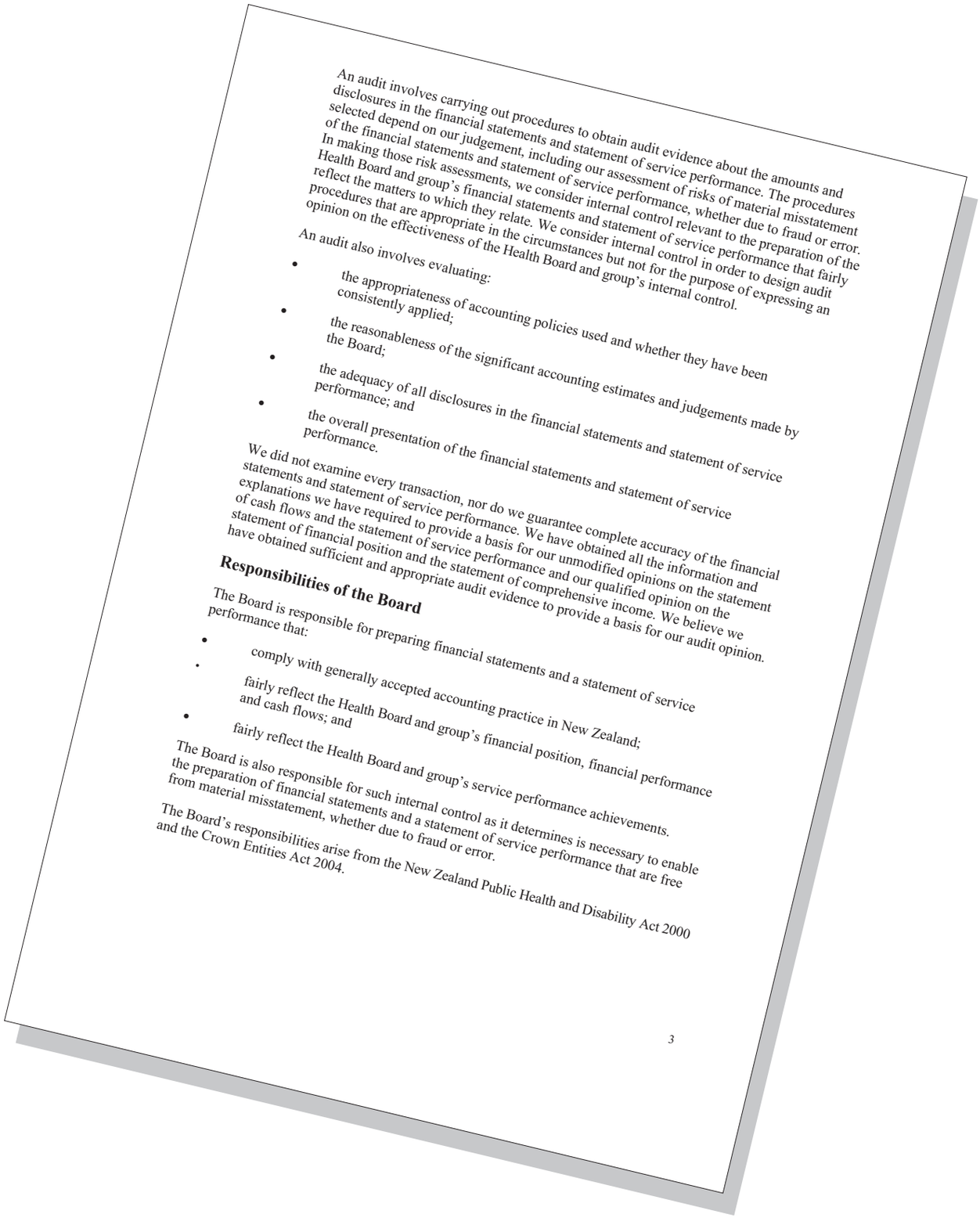
Our audit was completed on 31 October 2011. This is the date at which our opinion is expressed.

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

Basis of opinion

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

2



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

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 adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required to provide a basis for our unmodified opinions on the statement of cash flows and the statement of service performance and our qualified opinion on the statement of financial position and the statement of comprehensive income. 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 a statement of service performance that:

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

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

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

3

Report of the Audit Office

Responsibilities of the Auditor

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

Independence

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

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

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

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Statement of Responsibility

STATEMENT OF RESPONSIBILITY

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

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

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2011.

Signed on behalf of the Board:

Professor Gregor Coster CNZM
Chairperson

Jan Dawson
Chair Audit, Risk and Finance

Geraint Martin
Chief Executive Officer

Ron Pearson
Finance Director

31 October 2011

Statement of Comprehensive Income

(Parent and Group)

For the year ending 30 June 2011

	Notes	Parent and Group 2011 Actual $000	2011 Budget $000	2010 Actual $000
Income				
Patient Care Revenue	2	1,265,152	1,242,566	1,188,154
Interest Income		1,172	1,000	647
Other Income	3	29,849	11,083	27,555
Total income		**1,296,173**	**1,254,649**	**1,216,356**
Expenditure				
Personnel costs	4	453,525	445,471	427,485
Depreciation and amortisation expense		25,454	27,081	23,283
Outsourced services		54,436	44,250	50,169
Clinical supplies		93,355	85,398	86,894
Infrastructure and non-clinical expenses		55,316	53,449	48,581
Other District Health boards		255,236	228,685	218,535
Non-health board provider expenses		324,750	344,159	330,512
Capital Charge	5	12,108	14,004	12,586
Interest expenses		9,457	8,520	8,436
Other expenses	6	7,674	3,604	9,712
Total expenditure		**1,291,311**	**1,254,621**	**1,216,193**
Surplus/(deficit)		**4,862**	**28**	**163**
Other comprehensive income				
Revaluation of land and buildings		–	–	(8,775)
Total other comprehensive income/(expense)		**–**	**–**	**(8,775)**
Total comprehensive income /(expense)		**4,862**	**28**	**(8,612)**

Explanations of major variances against budget are provided in note 30.
The accompanying notes form part of these financial statements

Statement of Changes in Equity

(Parent and Group)

For the year ending 30 June 2011

	Notes	Parent and Group		
		2011 Actual $000	2011 Budget $000	2010 Actual $000
Balance 1 July		**154,200**	**158,143**	**160,212**
Comprehensive income/(expense)				
Surplus / (deficit) for the year		4,862	28	163
Other comprehensive income /(expense)		–	–	(8,775)
Total comprehensive income /(expense)		**4,862**	**28**	**(8,612)**
Capital contributions from the Crown		3,070	1,037	3,009
Repayment of capital to the Crown		(419)	(420)	(419)
Interest on restricted funds		(5)	-	10
Balance at 30 June		**161,708**	**158,788**	**154,200**

Explanations of major variances against budget are provided in note 30.
The accompanying notes form part of these financial statements

Statement of Financial Position

(Parent and Group)

As at 30 June 2011

	Notes	Parent and Group 2011 Actual $000	2011 Budget $000	2010 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	(2,235)	1,894	1,577
Debtors and other receivables	8	37,685	71,650	46,393
Inventories	10	868	493	613
Prepayments		431	2,000	344
Non-current assets held for sale	11	8,676	–	–
Total current assets		**45,425**	**76,037**	**48,927**
Non-current assets				
Other Non-Current Assets	9	1,126	–	–
Property, plant and equipment	13	473,884	486,808	445,894
Intangible assets	14	–	1,562	3,192
Total non-current assets		**475,010**	**488,370**	**449,086**
Total assets		**520,435**	**564,407**	**498,013**
Liabilities				
Current liabilities				
Creditors and other payables	15	94,549	85,296	91,689
Borrowings	16	6,594	39,396	7,913
Employee entitlements	17	92,990	84,538	80,613
Total current liabilities		**194,133**	**209,230**	**180,215**
Non-current liabilities				
Borrowings	16	150,005	144,000	150,099
Employee entitlements	17	13,577	51,934	12,540
Provisions	18	1,013	455	959
Total non-current liabilities		**164,595**	**196,389**	**163,598**
Total liabilities		**358,728**	**405,619**	**343,813**
Net assets		**161,707**	**158,788**	**154,200**
Equity				
Crown equity	19	107,654	119,602	105,004
Accumulated surpluses/(deficits)	19	(57,084)	(80,721)	(61,946)
Revaluation reserves	19	110,298	119,073	110,298
Trust funds	19	839	834	844
Total Equity		**161,707**	**158,788**	**154,200**

The accompanying notes form part of these financial statements

Statement of Cash Flows

(Parent and Group)

For the year ending 30 June 2011

	Notes	Parent and Group 2011 Actual $000	2011 Budget $000	2010 Actual $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,263,238	1,242,565	1,219,689
Other		27,977	12,083	–
Interest received		1,172	996	647
Payments to suppliers		(775,631)	(751,749)	(749,353)
Payments to employees		(441,283)	(445,471)	(424,327)
Capital charge		(11,911)	(14,000)	(13,404)
Interest payments		(9,457)	(8,520)	(8,737)
Goods and services tax (net)		(968)	(9,600)	(317)
Net cash flow from operating activities	**20**	**53,137**	**26,304**	**24,198**
Cash flows from investing activities				
Purchase of property, plant, equipment and intangible assets		(58,182)	(57,027)	(45,770)
Net cash flow from investing activities		**(58,182)**	**(57,027)**	**(45,770)**
Cash flows from financing activities				
Capital contributions from the Crown		3,070	1,038	3,009
Repayment of capital to the Crown		(419)	(420)	(419)
Repayment of loans		(1,000)	–	–
Proceeds from borrowings		–	30,128	19,000
Repayment of Finance Leases		(413)	–	(413)
Net Appropriation from Trust Funds		(5)	–	10
Net cash flow from financing activities		**1,233**	**30,746**	**21,187**
Net (decrease)/increase in cash and cash equivalents		**(3,812)**	**23**	**(385)**
Cash and cash equivalents at the start of the year		1,577	1,871	1,962
Cash and cash equivalents at the end of the year		**(2,235)**	**1,894**	**1,577**

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

The accompanying notes form part of these financial statements

Notes to the Financial Statements

(Parent and Group)
Significant accounting policies

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

The CMDHB group consists of the ultimate parent, Counties Manukau District Health Board and its "deemed" subsidiaries, Manukau Health Trust and South Auckland Health Foundation - these are not considered to be material and have not been consolidated into the accounts. Its associate companies, Auckland Regional RMO Services Ltd (33%) and the Northern DHB Support Agency Ltd (33.3%), and its jointly controlled entity, healthAlliance NZ Ltd, are not equity accounted as they are not considered material to CMDHB. All CMDHB subsidiaries, associates and jointly controlled entities are incorporated and domiciled in New Zealand.

Counties Manukau DHB and Group is a public benefit entity for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements for the DHB are for the year ended 30 June 2011, and were approved by the Board on 31 October 2011.

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

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

Measurement base
The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings at fair value.

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

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

Early adopted amendments to standards
The following amendments to standards have been early adopted:

- NZ IFRS 7 *Financial Instruments: Disclosures* – The effect of early adopting these amendments is the following information is no longer disclosed:
  - the carrying amount of financial assets that would otherwise be past due or impaired whose terms have been renegotiated; and
  - the maximum exposure to credit risk by class of financial instrument if the maximum credit risk exposure is best represented by their carrying amount in the statement of financial position.
- NZ IAS 24 *Related Party Disclosures (Revised 2009)* – The effect of early adopting the revised NZ IAS 24 is:
  - more information is required to be disclosed about transactions between the DHB and entities controlled, jointly controlled, or significantly influenced by the Crown;
  - commitments with related parties require disclosure; and

  information is required to be disclosed about any related party transactions with Ministers of the Crown.

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

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following three main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus or deficit. The new standard is required to be adopted for the year ended 30 June 2014. The DHB has not yet assessed the effect of the new standard and expects it will not be early adopted.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. The DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

SIGNIFICANT ACCOUNTING POLICIES

Subsidiaries

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

The Manukau Health Trust Board which is operated by a group of trustees includes a nominee from Counties Manukau District Health Board. This entity is not consolidated as it is not material to Counties Manukau District Health Board.

The South Auckland Health Foundation operates as a registered Charitable Trust controlled by a group of trustees and includes three nominees from Counties Manukau District Health Board. Counties Manukau District Health Board has no legal right or equally, obligation in respect of SAHF. This entity is not consolidated as it is not material to Counties Manukau District Health Board.

Associates and jointly controlled entities

The DHB's associates (Auckland Regional RMO Services Ltd, 33% and Northern DHB Support Agency Ltd , 33.3%) are not equity accounted as they are not considered material to CMDHB. The DHB's jointly controlled entity (healthAlliance NZ Ltd , 50%) is not equity accounted or accounted for using the proportionate method as it is not considered material to CMDHB.

Revenue

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

Crown funding

The majority of revenue is provided by the MoH through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

ACC contract revenue is recognised as revenue when eligible services are provided and any 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 Service Contracts to provide specific services or outcomes is recognised in proportion to those services completed at balance date. Where revenue has been received in advance of the provision of services, a liability is recognised for the obligation to provide the specific services or outflow of resources in the future.

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

The DHB has elected to defer the adoption of the revised NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities.

Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Finance leases

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

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit 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 as to whether 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 straightline basis over the lease term.

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

Cash and cash equivalents

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

Bank overdrafts are shown within 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 any 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 plus transaction costs.

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 current replacement cost at the date of acquisition.

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

Non-Current assets held for sale

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

Any impairment losses for write-downs of Non-Current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

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

Property, plant, and equipment

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

- land;
- buildings and plant;
- clinical equipment, IT and motor vehicles;
- other equipment.

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

Additions

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

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

In most instances, an item of property, plant, and equipment is initially recognised at its cost. 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 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 - 50 years	2% - 10%
- Electrical Services	10 - 15 years	6% - 10%
- Other Services	15 - 25 years	4% - 6%
- Fit out	5 - 10 years	10% - 20%
• Plant and equipment	5 - 10 years	10% - 20%
• Clinical Equipment	3 - 25 years	4% - 33%
• Information Technology	3 - 5 years	20% - 33%
• Vehicles	3 - 5 years	20% - 33%
• Other Equipment	3 - 25 years	4% - 33%

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

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

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

Staff training costs are recognised as an expense when incurred.

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

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

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life.

Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

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

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

Impairment of Property, Plant & Equipment and Intangible Assets
Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For 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 a 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 plus transaction costs. 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. Borrowings where the DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

Employee entitlements
Short-term employee entitlements
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave. A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is 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.

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

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; 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
Sick leave, continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities 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 KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

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

Provisions are not recognised for future operating losses.

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

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

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

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

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

- Crown equity;
- accumulated surpluses;
- revaluation reserves; and
- trust funds.

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

Trust funds
This reserve records the unspent amount of 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 net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

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

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

Criteria for Direct and Indirect Costs
Direct costs are those costs directly attributable to an output class.

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

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

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
Note 13 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Estimating useful lives and residual values of property, plant & equipment and intangible assets
The useful lives and residual values of property, plant, and equipment and intangible assets are reviewed at each balance date.

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 depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:
- physical inspection of assets;
- asset replacement programs;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

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

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

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

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

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

Revenue recognition
Note 2 provides information about the DHB's judgment on the recognition of revenue received for service contracts.

2 Patient care revenue

	Actual 2011 $000	Actual 2010 $000
Health and disability services (MoH contracted revenue)	1,167,712	1,079,620
ACC contract revenue	9,523	24,760
Revenue from other district health boards	82,990	80,413
Other patient care related revenue	4,927	3,361
Total patient care revenue	**1,265,152**	**1,188,154**

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.

As at 30 June, the DHB has reviewed each service contract for specific services, programmes or outcomes and has recognized deferred revenue of $3.7m (2010 - $12.124m). This represents the fair value of that portion of the revenue received on service contracts for which there is an liability to provide future services or resources in future periods.

Mental Health Ring Fenced Revenue
As at 30 June 2011 there was $8.101m unspent in respect of Mental Health Ring Fenced Revenue (as at 30 June 2010 $3.602m).

3 Other income

	Actual 2011 $000	Actual 2010 $000
Donated property, plant, and equipment	1,872	–
Donations and bequests received	68	3,098
Rental income	889	1,016
Other income	27,020	23,441
Total other income	**29,849**	**27,555**

4 Personnel costs

	Actual 2011 $000	Actual 2010 $000
Salaries and wages	431,151	417,038
Contributions to defined contribution schemes	8,960	7,293
Increase/(decrease) in liability for employee entitlements	13,414	3,154
Total personnel costs	**453,525**	**427,485**

Employer contributions to defined contribution schemes include contributions to KiwiSaver, State Sector Retirement Savings Scheme, the Government Superannuation Fund

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 2011 was 8% (2010: 8%).

6 Other expenses

Other expenses include:	Actual 2011 $000	Actual 2010 $000
Audit fees for financial statement audit	156	140
Operating leases expense	2,499	4,912
Impairment of debtors	4,577	4,214
Board and committee members fees and expenses	442	446
Total Other Expenses	**7,674**	**9,712**

7 Cash and cash equivalents

	Actual 2011 $000	Actual 2010 $000
Cash at bank and on hand (overdraft)	(3,074)	733
Trust Funds	839	844
Cash and cash equivalents for the purposes of the statement of cash flows	**(2,235)**	**1,577**

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value. Cash and cash equivalents include funds of $839k (2010 $844k) donated or bequeathed for a specific purpose. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds are recognised in the surplus or deficit, and is transferred from/to general funds to/from trust funds in equity.

The temporary overdraft position occurred owing to a delay in funds being drawn down from the loan.

8 Debtors and other receivables

	Actual 2011 $000	Actual 2010 $000
Ministry of Health receivables	27,162	35,520
Other receivables	9,535	9,966
Other accrued revenue	6,967	5,320
Less: provision for impairment	(5,979)	(4,413)
Total Debtors and other receivables	**37,685**	**46,393**

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:

	2011 Gross $000	2011 Impairment $000	2011 Net $000	2010 Gross $000	2010 Impairment $000	2010 Net $000
Not past due	34,432	–	34,432	41,150	–	41,150
Past due 1-30 days	1,296	(812)	484	3,568	(228)	3,340
Past due 31-60 days	996	(648)	348	3,620	(2,088)	1,532
Past due 61-90 days	412	(232)	180	807	(605)	202
Past due > 90 days	6,528	(4,287)	2,241	1,661	(1,492)	169
Total	**43,664**	**(5,979)**	**37,685**	**50,806**	**(4,413)**	**46,393**

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

The provision for impairment has been calculated based on a review of significant debtor balances and a collective assessment of all debtors (other than those determined to be individually impaired) for impairment.
The collective impairment assessment is based on an analysis of past collection history and write-offs.

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

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

	Actual 2011 $000	Actual 2010 $000
Balance at 1 July	4,413	3,211
Additional provisions made	4,577	4,214
Receivables written off	(3,011)	(3,012)
Total Debtors and other receivables	**5,979**	**4,413**

9 Other Non-Current Assets

	Actual 2011 $000	Actual 2010 $000
Reversionary interest in car park building	1,126	–

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

10 Inventories

	Actual 2011 $000	Actual 2010 $000
Pharmaceuticals	751	505
Other Supplies net of provision for obsolete stock	117	108
Total inventories	**868**	**613**

The write-down of inventories held for distribution amounted to nil (2010 nil). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities (2010 $nil). However, some inventories are subject to retention of title clauses.

11 Non-current assets held for sale

The DHB owns IT and software assets which have been classified as held for sale following the Board's approval of the sale to healthAlliance NZ Ltd. Ownership of the assets transferred to healthAlliance NZ Ltd in July 2011.

	Notes	Actual 2011 $000	Actual 2010 $000
IT Assets	13	4,779	–
Software	14	3,897	–
Total Non-current assets held for sale		**8,676**	**–**

12 Investments in Associates and Jointly Controlled Entities

Investments in associates & jointly controlled entities

CMDHB has the following investments in associates & jointly controlled entities

a) General information

Name of entity	Principal activities	Interest held at 30 June 2011	Balance date
Auckland Regional RMO Services Ltd	Provision of health training services	33.00%	30 June-11
Northern DHB Support Agency Ltd	Provision of health support services	33.30%	30 June-11
healthAlliance NZ Ltd (JV)	Provision of shared services	50.00%	30 June-11

b) Summary of financial information (unaudited) of associate and jointly controlled entities

Year end 2011	Assets	Liabilities	Equity	Revenues	Profit/(loss)
Auckland Regional RMO Services Ltd	2,238	2,236	2	2,880	–
Northern DHB Support Agency Ltd	5,929	5,295	634	9,870	5
healthAlliance NZ Ltd (JV)	14,446	14,446	–	42,252	–

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

c) Share of profit of associate entities

	Parent and Group 2011 Actual	Parent and Group 2010 Actual
Share of profit/(loss)	2	32

Joint Ventures

On 1 March 2011 the finance, procurement and supply chain and information services activities of Northland and Auckland District Health Boards and regional internal audit function of the Northern DHB Support Agency were merged into healthAlliance NZ Ltd. healthAlliance NZ Ltd received approval from the Minister of Health to alter the shareholder structure in August 2011 and consequently CMDHB's shareholding in healthAlliance NZ Ltd changed from 50% to 20%.

13 Property, plant and equipment

	Land $000	Buildings & Plant $000	Clinical Equipment, $000	Other Equipment IT & Motor Vehicles $000	Work in progress $000	Total $000
Cost or valuation						
Balance at 1 July 2009	81,528	304,666	120,997	13,919	17,086	538,196
Additions		28,178	13,624	813	600	43,214
Revaluation increase/(decrease)	(8,775)					(8,775)
Balance at 30 June 2010	**72,753**	**332,844**	**134,621**	**14,732**	**17,686**	**572,635**
Balance at 1 July 2010	**72,753**	**332,844**	**134,621**	**14,732**	**17,686**	**572,635**
Additions					58,034	58,034
Work In Progress capitalised		14,850	10,208	757	(27,582)	(1,769)
Transferred to Assets held for Resale (See Note 11)			(34,141)			(34,141)
Disposals/transfers		(218)	(457)	(2)		(677)
Balance at 30 June 2011	**72,753**	**347,476**	**110,231**	**15,487**	**48,138**	**594,082**
Accumulated depreciation and impairment losses						
Balance at 1 July 2009		507	92,487	11,670		104,664
Depreciation expense		11,199	10,234	649		22,082
Elimination on disposal/transfer			(4)			(4)
Balance at 30 June 2010		**11,706**	**102,717**	**12,319**		**126,742**
Balance at 1 July 2010		11,706	102,717	12,319		126,742
Depreciation expense		12,002	10,840	676		23,518
Elimination on disposal/transfer		(241)	(457)	(1)		(699)
Transferred to Assets held for Resale (See Note 11)			(29,362)			(29,362)
Balance at 30 June 2011		**23,467**	**83,738**	**12,994**		**120,199**
Carrying amounts						
At 1 July 2009	**81,528**	**304,159**	**28,510**	**2,249**	**17,086**	**433,532**
At 30 June and 1 July 2010	**72,753**	**321,138**	**31,904**	**2,413**	**17,686**	**445,894**
At 30 June 2011	**72,753**	**324,009**	**26,493**	**2,493**	**48,138**	**473,884**

The total amount of property, plant, and equipment in the course of construction is $48.14m (2010 $17.69m).

Valuation

Land

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

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

The most recent valuation of land was performed by a registered independent valuer, Telfer Young Limited, and the valuation is effective as at 30 June 2010 and amounted to $72.75m.

Buildings

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

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

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

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

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

Restrictions on title

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

Some of the DHB's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

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.

14 Intangible assets

	Acquired software $000
Balance at 1 July 2009	26,205
Additions	3,198
Balance at 30 June 2010 / 1 July 2010	29,403
Additions	871
Work in Progress Capitalised	1,769
Transferred to assets held for sale (See Note 11)	(32,043)
Balance at 30 June 2011	–
Accumulated amortisation and impairment losses	
Balance at 1 July 2009	25,009
Amortisation expense	1,202
Balance at 30 June 2010/1 July 2010	26,211
Amortisation expense	1,935
Transferred to assets held for sale (See Note 11)	(28,146)
Balance at 30 June 2011	–
Carrying amounts	
At 1 July 2009	1,196
At 30 June and 1 July 2010	3,192
At 30 June 2011	–

There are no restrictions over the title of the DHB's intangible assets; nor are any intangible assets pledged as security for liabilities. The DHB owns IT and software assets which have been classified as held for sale following the Board's approval of the sale to healthAlliance NZ Ltd. Ownership of the assets transferred to healthAlliance NZ Ltd in July 2011. (See Note 11)

15 Creditors and other payables

	Actual 2011 $000	Actual 2010 $000
Creditors and accrued expenses	82,276	68,535
GST payable	5,148	4,345
Capital charge payable	3,298	3,100
Income in advance	3,827	15,709
Total creditors and other payables	**94,549**	**91,689**

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

	Actual 2011 $000	Actual 2010 $000
Current portion		
Unsecured bank loan	6,500	7,500
Finance leases	94	413
Total current portion	**6,594**	**7,913**
Non-current portion		
Finance leases	5	99
Crown Health Financing Agency loans – fixed interest	150,000	150,000
Total non-current portion	150,005	150,099
Total borrowings	**156,599**	**158,012**
Borrowing facility limits		
Crown Health Financing Agency loan facility limit	297,600	297,600
Overdraft facility	50,000	50,000
Total borrowing facility limits	**347,600**	**347,600**

Crown Health Financing Agency loans
The Crown Health Financing Agency (CHFA) loans are secured by a negative pledge.

The fair value of CHFA borrowings is $159.493m (2010 $157.355m). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.75% to 6.51% (2010 3.75% to 6.51%).

Unsecured bank loans
The DHB must meet the following covenants for loans with the Commonwealth Bank

- a cash flow covenant, under which the accumulated annual operating cash flow must be greater than zero.

Overdraft facility
The DHB has an overdraft facility with the ASB Bank. The facility is secured by a negative pledge. Without the ASB's prior written approval, the DHB cannot perform the following actions:

- create any security over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of its business as presently conducted; or
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value.

Finance leases
Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance lease is $99k.

The fair value of finance leases is $99k (2010 $512k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 8.59% to 8.66% (2010 8.59% to 8.66%).

Analysis of finance leases

	Actual 2011 $000	Actual 2010 $000
Minimum lease payments payable:		
No later than one year	102	452
Later than one year and not later than five	5	108
Total minimum lease payments	107	560
Future finance charges	(8)	(48)
Present value of minimum lease payments	99	512
Present value of minimum lease payments payable:		
No later than one year	94	413
Later than one year and not later than five years	5	99
Total present value of minimum lease payments	99	512

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

17 Employee entitlements

	Actual 2011 $000	Actual 2010 $000
Current portion		
Accrued salaries and wages	22,277	20,356
Annual leave	41,712	39,205
Sick leave	0	156
Sabbatical leave	1,234	209
Continuing medical education leave	14,848	12,642
Unsettled CEAs	12,919	8,045
Total current portion	92,990	80,613
Non-current portion		
Long service leave	5,008	5,140
Retirement gratuities	7,566	6,875
Sick leave	1,003	525
Total non-current portion	13,577	12,540
Total employee entitlements	**106,567**	**93,153**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 2.84% - 6.24% (2010 3.48% - 6.21%) and an inflation factor of 2.0% (2010 2.0%) were used.

18 Provisions

	Actual 2011 $000	Actual 2010 $000
Non-current portion		
ACC Partnership Programme	1,013	959
Total provisions	**1,013**	**959**

Movements for each class of provision are as follows:

	ACC Partnership Programme 2011 $000	ACC Partnership Programme 2010 $000
Non-current portion		
Balance at 1 July	959	455
Additional provisions made	54	504
Balance at 30 June	**1,013**	**959**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON Hewitt, has calculated the liability as at 30 June 2011. 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% (2010 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 2.5% for 30 June 2012 and 2013;
- a weighted average discount factor of 2.84% for 30 June 2012 and 3.81% for 30 June 2013 that has been applied to future payment streams; and
- claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 5% of claims will result in no payment, 80% will result in medical claims, and 15% will result in an element of time off work.

Insurance risk

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

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

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

19 Equity

	Actual 2011 $000	Actual 2010 $000
Crown equity		
Balance at 1 July	105,004	102,414
Capital contributions from the Crown	3,069	3,009
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**107,654**	**105,004**
Accumulated surpluses/(deficits)		
Balance at 1 July	(61,946)	(62,109)
Surplus/(deficit) for the year	4,862	163
Balance at 30 June	**(57,084)**	**(61,946)**
Revaluation reserves		
Balance at 1 July	110,298	119,073
Revaluations	–	(8,775)
Balance at 30 June	**110,298**	**110,298**
Revaluation reserves consist of:		
Land	69,149	69,149
Buildings	41,149	41,149
Total revaluation reserves	**110,298**	**110,298**
Trust funds		
Balance at 1 July	844	834
Transfer from/(to) accumulated surpluses/(deficits)	(5)	10
Balance at 30 June	**839**	**844**
Total equity	**161,707**	**154,200**

Included in accumulated surpluses/deficits are $8.101m (2010 $3.602m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established.

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

	Actual 2011 $000	Actual 2010 $000
Net surplus/(deficit	4,862	163
Add/(less) non-cash items		
Increase in provisions	–	517
Donated property, plant and equipment	(1,872)	–
Depreciation and amortisation expense	25,453	23,283
Total non-cash items	**28,443**	**23,963**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(1,912)	2,778
Inventories	(255)	(120)
Creditors and other payables	13,447	(6,266)
Employee entitlements	13,414	2,641
Provision for doubtful debts	–	1,202
Net movements in working capital items	24,694	235
Net cash flow from operating activities	**53,137**	**24,198**

21 Capital commitments and operating leases

	Actual 2011 $000	Actual 2010 $000
Capital Commitments		
Property , plant and equipment	29,844	18,706
Total capital commitments	**29,844**	**18,706**

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 2011 $000	Actual 2010 $000
Not later than one year	3,556	4,003
Later than one year and not later than five years	6,830	7,762
Later than five years	3,248	2,515
Total other non-cancellable contractual operating commitments	**13,634**	**14,280**

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

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

Non-cancellable contractual commitments

The future aggregate payments to be paid under non-cancellable contractual commitments are as follows:

	Actual 2011 $000	Actual 2010 $000
Not later than one year	92,439	83,590
Later than one year and not later than five years	108,941	139,004
Later than five years	35,776	2,515
Total non-cancellable contractual commitments	**237,156**	**225,109**

The majority of these commitments relate to the purchase of health services to be provided by other health service providers

22 Contingencies

Contingent liabilities

Asbestos

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

Kingseat

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

Contingent assets

The DHB has no contingent assets (2010 $nil).

23 Related Party Transactions

All related party transactions have been entered into on an arms' length basis.
The DHB is a wholly-owned entity of the Crown.

Significant transactions with government-related entities

The DHB has received funding from the Crown and ACC of $1,177m (2010 $1,104m) to provide health services in the Counties Manukau area for the year ended 30 June 2011.
Revenue earned from other DHBs for the care of patients outside the DHB's district amounted to $83.0m (2010 $80.4m) for the year ended 30 June 2011. Expenditure to other DHBs for their care of patients from the DHB's district amounted to $255.2m (2010 $219.2m) for the year ended 30 June 2011.

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 2011 totalled $10.8m (2010 $10.6m). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post, blood from NZ Blood Service and training from University of Auckland.

Transactions with key management personnel

Key management personnel compensation

	Actual 2011 FTE	Actual 2010 FTE	Actual 2011 $000	Actual 2010 $000
Executive management team	13	12	3,322	3,101
Board & committee	39	40	349	410
Total key management personnel compensation	52	52	3,671	3,511

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

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

During the year, the DHB transacted with Bob Wichman Limited in which Board member R Wichman is a Director and shareholder. The value of the expenditure totalled $16k (2010 $40k) and was incurred on normal commercial terms. There is a balance of nil (2010 $nil) outstanding for unpaid invoices at year end.

23 Related Party Transactions (continued)

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

Under this technical definition CMDHB would be required to consolidate The Manukau Health Trust (MHT) and the South Auckland Health Foundation (SAHF) accounts into its final statutory accounts. CMDHB has determined not to follow this requirement as both the MHT and SAHF are registered Charitable Trusts and as such are independent legal entities and are not under the control of CMDHB. In the Board's view to consolidate these accounts into those of CMDHB would overstate the financial position of CMDHB as well as give a misleading picture of CMDHB's legal right or ability to access MHT and SAHF funds.

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

The Manukau Health Trust
The Manukau Health Trust was formed to conduct health screening and other health activities to promote and provide for the health, wellbeing and benefit of a health nature to South Auckland communities. CMDHB has historically had two nominees on the six person MHT Board of Trustees.

In the interests of full disclosure and transparency, CMDHB is, with the consent of MHT, disclosing through this Note, the unaudited financial position of MHT for the year ending 30 June 2011.

	Parent and Group 2011 Actual $000	Parent and Group 2010 Actual $000
Statement of Financial Performance		
Income	1,296	1,153
Surplus (Deficit)	22	(128)
Statement of Financial Position		
Total Equity	**809**	**781**
Non-Current Assets	–	1
Current Assets	956	1,149
Total Assets	**956**	**1,150**
Current Liabilities	147	369
Net Assets	**809**	**781**

23 Related Party Transactions (continued)

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

In the interests of full disclosure and transparency, CMDHB is, with the consent of SAHF , disclosing through this Note, the unaudited financial position of SAHF for the year ending 30 June 2011

	Parent and Group 2011 Actual $000	Parent and Group 2010 Actual $000
Statement of Financial Performance		
Income	3,542	3,691
Operating Surplus	3,065	2,989
Distributions	(2,473)	(3,059)
Surplus (Deficit)	**592**	**(70)**
Statement of Financial Position		
Total Equity	**4,510**	**3,918**
Non-Current Assets	8	742
Current Assets	4,569	3,216
Total Assets	**4,577**	**3,958**
Current Liabilities	67	40
Net Assets	**4,510**	**3,918**

	Parent and Group 2011 Actual $000	Parent and Group 2010 Actual $000
Sales to related parties		
Auckland Regional RMO Services Ltd	27	–
healthAlliance NZ Ltd	3	–
Manukau Health Trust	1,651	1,194
Northern DHB Support Agency Ltd	839	506
South Auckland Health Foundation	10	–
Air New Zealand	6	–
Dept of Building & Housing	1	6
District Health Boards of NZ	10	–
Manukau City Council	–	1
Manukau Institute of Technology	479	334
Physiotherapy NZ	2	–
Taikura Trust	7	5
University of Auckland	1,584	1,353
Total	**4,619**	**3,399**

23 Related Party Transactions (continued)

Purchases from related parties	Parent and Group 2011 Actual $000	Parent and Group 2010 Actual $000
Auckland Regional RMO Services Ltd	3,786	3,075
healthAlliance NZ Ltd	22,112	15,480
Manukau Health Trust	12	–
Northern DHB Support Agency Ltd	3,170	1,559
South Auckland Health Foundation	280	–
Auckland Council	199	–
Bob Wichman Ltd	18	40
Counties Manukau Sport	–	97
District Health Boards of NZ	1	–
Manukau City Council	115	145
Manukau Institute of Technology	239	250
Manukau Water	239	788
PHARMAC	–	325
Raukura Hauora O Tainui Iwi Advisory	14	104
University of Auckland	2,213	–
Total	**32,398**	**21,863**

Outstanding balances to related parties	Parent and Group 2011 Actual $000	Parent and Group 2010 Actual $000
Auckland Regional RMO Services Ltd	–	261
healthAlliance NZ Ltd	1	448
Northern DHB Support Agency Ltd	–	308
Auckland Council	2	–
District Health Boards of NZ	12	–
Manukau Institute of Technology	1	47
Manukau Water	–	66
University of Auckland	13	–
Total	**29**	**1,130**

23 Related Party Transactions (continued)

Outstanding balances from related parties	Parent and Group 2011 Actual $000	Parent and Group 2010 Actual $000
Auckland Regional RMO Services Ltd	7	465
healthAlliance NZ Ltd	3	59
Manukau Health Trust	–	323
Northern DHB Support Agency Ltd	70	–
South Auckland Health Foundation	10	–
Air NZ	3	–
Taikura Trust	2	2
University of Auckland	23	–
Total	**118**	**849**

24 Board member remuneration

	2011 Actual $	2010 Actual $
Professor Gregor Coster	55,000	54,167
Mrs Jan Dawson took office 6 Dec 10	20,354	–
Mr Anae Arthur Anae	27,083	29,791
Mr David Collings took office 6 Dec 10	16,125	-
Mr Donald Barker	30,635	31,042
Mr Paul Cressey	32,646	34,062
Mr Robert Wichman	27,250	26,875
Mrs Colleen Brown	31,969	29,844
Mrs Lyn Murphy took office 6 Dec 10	16,292	–
Mrs Sandra Alofivae took office 6 Dec 10	16,167	–
Mr Frank Solomon took office 6 Dec 10	16,583	–
Mrs Anne Candy Resigned 5 Dec 10	11,917	30,208
Mr Michael Williams Resigned 5 Dec 10	12,167	30,625
Mrs Ruth DeSouza Resigned 5 Dec 10	13,833	28,333
Mrs Penelope Ginnen Resigned 5 Dec 10	13,094	30,417
Ms Miria Andrews Resigned 5 Dec 10	15,896	31,042
Total board member remuneration	**357,011**	**356,406**

24 Committee members

	Award $ 2011
Mr Philip Beilby	1,875
Ms Elizabeth Farrell	2,083
Mr Jonathan Frith	1,667
Mr Sefita Alofi Hao'uli	2,396
Dr Gary Jackson	1,458
Mr Michael Lamont	1,667
Ms Nganeko Minhinnick	2,083
Ms Christine Bolton	1,538
Ms Heather Grace	1,875
Ms Joanna Katipa	1,458
Mr Ezekiel P Robson	2,667
Ms Joy Simpson	1,667
Ms Alma Wilson	1,875
Te Aomarama Wilson	1,042
Ms Malia Hamani	1,042
Mr Robert Clark	2,083
Mr Nuku Rapana	2,917
Ms Stephanie Erick-Peleti	417
Ms Louisa Lavakula	2,083
Mrs Roine Lealaiauloto	1,042
Mr Timi Maipi	208
Dr Andrew Chan Mow	1,458
Ms Bernadette Pereira	1,250
Dr Etuate Saafi	1,458
Mr Peter Skelton	1,458
Dr Gerhard Sunborn	208
Rev Uea Tuleia	2,111
Mr Donovan Clark	833
Mr Martin Cooper	417
Ms Georgina Kupa	833
Total	**45,169**

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 (2010 $nil).

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

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:

Total Remuneration Paid or Payable	2011 Number of Employees	2010 Number of Employees
$100,000 – 109,999	102	98
$110,000 – 119,999	75	75
$120,000 – 129,999	44	52
$130,000 – 139,999	29	42
$140,000 – 149,999	27	24
$150,000 – 159,999	29	22
$160,000 – 169,999	21	14
$170,000 – 179,999	23	28
$180,000 – 189,999	30	16
$190,000 – 199,999	16	19
$200,000 – 209,999	26	25
$210,000 – 219,999	28	29
$220,000 – 229,999	25	22
$230,000 – 239,999	13	20
$240,000 – 249,999	22	17
$250,000 – 259,999	16	16
$260,000 – 269,999	13	12
$270,000 – 279,999	7	7
$280,000 – 289,999	8	5
$290,000 – 299,999	6	7
$300,000 – 309,999	10	3
$310,000 – 319,999	5	5
$320,000 – 329,999	3	2
$330,000 – 339,999	9	6
$340,000 – 349,999	–	3
$350,000 – 359,999	2	4
$360,000 – 369,999	2	–
$370,000 – 379,999	1	2
$380,000 – 389,999	3	1
$390,000 – 399,999	–	–
$400,000 – 409,999	2	–
$410,000 – 419,999	–	–
$420,000 – 429,999	–	–
$430,000 – 439,999	1	1
$440,000 – 449,999	–	–
$450,000 – 459,999	–	1
$460,000 – 469,999	–	–
$470,000 – 479,999	2	1

During the year ended 30 June 2011, 41 (2010: 10) employees received compensation and other benefits in relation to cessation totalling $394,821 (2010 $167,312).
During the Year Ended 30 June 2011, the following numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 529 (2010 - 509) are Medical Staff and 71 (2010 - 70) are Management.

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

26 Events after the balance date

On 1 March 2011 the finance, procurement and supply chain and information services activities of Northland and Auckland District Health Boards and regional internal audit function of the Northern DHB Support Agency were merged into healthAlliance NZ Ltd. healthAlliance NZ Ltd received approval from the Minister of Health to alter the shareholder structure in August 2011 and consequently CMDHB's shareholding in healthAlliance NZ Ltd changed from 50% to 20%

The Board of healthAlliance NZ Ltd and Boards of the shareholding District Health Boards agreed to transfer the Information Technology assets (hardware and software) held by the District Health Boards to healthAlliance NZ Ltd on 1 July 2011 .

27 Financial instruments

Financial instruments categories

The carrying amounts of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Actual 2011 $000	Actual 2010 $000
Loans and receivables		
Cash and cash equivalents	(2,235)	1,577
Debtors and other receivables	37,685	46,393
Total loans and receivables	35,450	47,970
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	85,574	71,635
Borrowings – CHFA loans and Unsecured Bank Loans	156,500	157,500
Total financial liabilities measured at amortised cost	242,074	229,135

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

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 2011, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have been $1.560m lower/higher (2010 $1.570m).

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

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

This exposure is not considered significant and is not actively managed.

As at year end CMDHB had no outstanding foreign denominated payables (2010 $0).

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers.

The Ministry of Health is the largest single debtor (approximately 58 per cent of trade debtors). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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 2011 $000	Actual 2010 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA	839	1,577
Total cash and cash equivalents and investments	839	1,577
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total debtors and other receivables	37,685	46,393

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 flow $000	Less than 1 year $000	1 – 2 years $000	2-5 years $000	More than 5 years $000
2010						
Creditors and other payables	71,635	71,635	71,635			
Finance leases	512	512	413	99		
CHFA loans	150,000	196,742	–	104,191	–	92,551
Unsecured Bank Loans	7,500	7,500	7,500			
Total	**229,647**	**276,389**	**79,548**	**104,290**	**–**	**92,551**
2011						
Creditors and other payables	85,574	85,574	85,574			
Finance leases	99	99	94	5		
CHFA loans	150000	187,912	5,070	44,396	49,601	88,845
Unsecured Bank Loans	6,500	6,500	6,500			
Total	**242,173**	**280,085**	**97,238**	**44,401**	**49,601**	**88,845**

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 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 Patient trust monies

Financial instruments categories

The carrying amounts of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

Trust/ Special funds	Parent and Group Actual 2011	Parent and Group Actual 2010
Balance at beginning of year	844	834
Interest received on Restricted Funds	5	10
Balance at end of year	**849**	**844**

The DHB administers funds on behalf of certain patients, which are held in bank accounts that are separate from the DHB's normal banking facilities. Interest earned on the funds is allocated to individual patients. Patient fund transactions and balances are not recognised in the DHB's financial statements.

30 Explanation of major variances against budget

The budget figures are those approved by the board at the beginning of the period in the initial Statement of Intent.

The budget figures have been prepared in accordance with Generally Accepted Accounting Practice and NZIFRS, and are consistent with the Accounting policies adopted by the Board for the preparation of the financial statements.

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

Statement of comprehensive income

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

- Total Income for the year (excluding donations) was $27.6m greater than budget due to additional funding received for services from the Crown after the finalisation of the budget.
- Expenditure for the year was $24.7m greater than budget which reflects additional volumes and services purchased by the Crown as stated in the point above.
- Additional volumes picked up from Christchurch after the February earthquake.

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

- Improved collection of Trade Receivables
- Under spending on property, plant and equipment due to timing of construction
- Borrowings lower than budget due to increased collections in Trade Receivables and to reduced (timing) Capital spending

The major variances in the Statement of Cashflow are attributed to

- Improved operating cashflow of $28m due to
  - Increased collection from the Crown of old debt
  - Increased revenue (purchases) from Crown
  - higher payments to suppliers to match increased purchases from Crown
  - lower payments to employees, lower interest payments offset by higher outsourced costs.
- Improved operating cash and lower investing lead to lower financing requirements for the year.

31 Performance by Output Classes

	Public Health	Primary & Community	Hospital	Support	Total
Revenue					
Crown	17,784	494,144	672,699	88,786	1,273,413
Other	641	1,078	20,846	195	22,760
Total Revenue	**18,425**	**495,222**	**693,545**	**88,981**	**1,296,173**
Budget	*10,379*	*485,143*	*666,832*	*92,295*	*1,254,649*
Expenditure					
Personnel	7,470	2,701	442,761	593	453,525
Depreciation			25,453		25,453
Capital Charge			12,108		12,108
Other	6,836	491,286	213,293	88,809	800,225
Total expenditure	**14,306**	**493,987**	**693,615**	**89,402**	**1,291,311**
Budget	*14,384*	*483,664*	*663,886*	*92,687*	*1,254,621*
Net surplus/(deficit)	**4,119**	**1,235**	**(70)**	**(421)**	**4,862**
Budget Surplus/(Deficit)	*(4,005)*	*1,479*	*2,946*	*(392)*	*28*

32 Compliance with Crown Entities Act 2004

Section 150(1) (b) of the Crown Entities Act 2004 requires CMDHB to provide its annual report to the Minister within 15 working days of receiving the Audit report. CMDHB did not meet this deadline in respect of the 2010/11 report.

Governance & Accountability Statement

Role of the Board

The Board's governance responsibilities include:

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

Structure of the DHB

DHB operations

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

Quality Assurance

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

Governance Philosophy

Board membership

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

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

Division of responsibility between the Board and Management

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

Accountability

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

Disclosure of interest

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

Internal audit

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

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

Risk management

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

Legislative compliance

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

Directions issued by Ministers

During the 2008-09 financial year, a "Whole of Government" direction was made jointly by the Ministers of Finance and State Services that affects CMDHB. The direction was that the DHB (and other Crown Agents) must consult with State Services Commission about online credential management or identify verification capability. If agreed, the DHB may proceed but, if after consultation, State Services Commission does not agree, the DHB must obtain Ministerial approval before proceeding. CMDHB made no such application during the year end 30 June 2009.

Statement of Governance and Accountability

Ethics

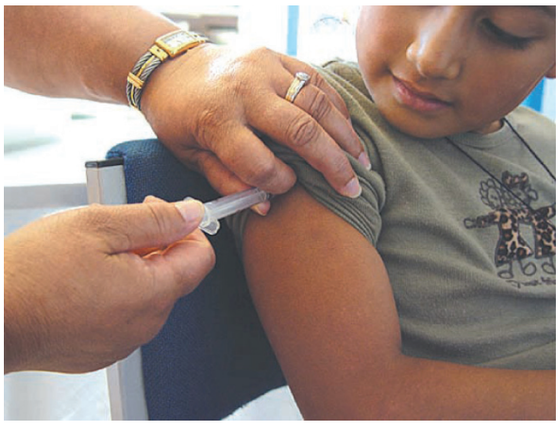
The Board has adopted a code of conduct and regularly monitors whether staff maintain high standards of ethical behaviour and practice the principles of "good corporate citizenship".

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

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

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

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



Statement of Service Performance 2010/11

The Statement of Service Performance sets out Counties Manukau DHB's achievement of the performance measures and objectives as described in the 2010/11 – 2012/13 Statement of Intent for the period 1 July 2010 to 30 June 2011.

The Statement of Service Performance is structured along the lines of the four output classes of:

Public Health Services

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

Primary & Community Services

Primary and community healthcare services comprise services that are delivered by a range of health professionals in various private, not-for-profit and government service settings. These include general practice, community and Maaori health services, pharmacy services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

Hospital Services

Hospital services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together.

Support Services

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

The performance measures and indicators contained within each of the four outputs are linked to the DHB's strategic priorities and have been selected to give a flavour of overall activity undertaken by the DHB and its impact on the community, articulated in the *Counties Manukau 2006 – 2011 District Strategic Plan* as the following high level outcomes:

Counties Manukau DHB's Outcomes

Improve Community Wellbeing	**Improve Child and Youth Health**	**Reduce the incidence and the impact of priority conditions**	**Reduce health inequalities**	**Improve Health Sector responsiveness to individual and family/ whaanau need**	**Improve the Capacity of the Health Sector to deliver Quality Services**

The relationship between the outputs in the Statement of Service Performance to the DHB's goals and the Government's priorities are illustrated in the diagram on page 65.

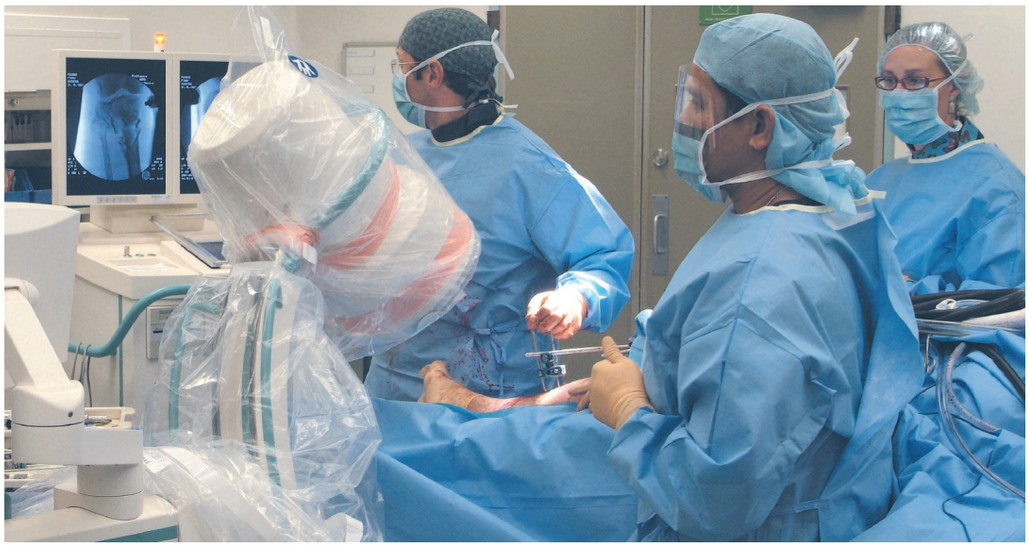
At a Glance: Our DHB's performance against the rest of the country

This year, we are introducing benchmarking information from our annual Health Profile to give some comparison of where the DHB's performance on the national health targets and some of the hospital quality and productivity measures are in relation to the national average and to other DHBs.

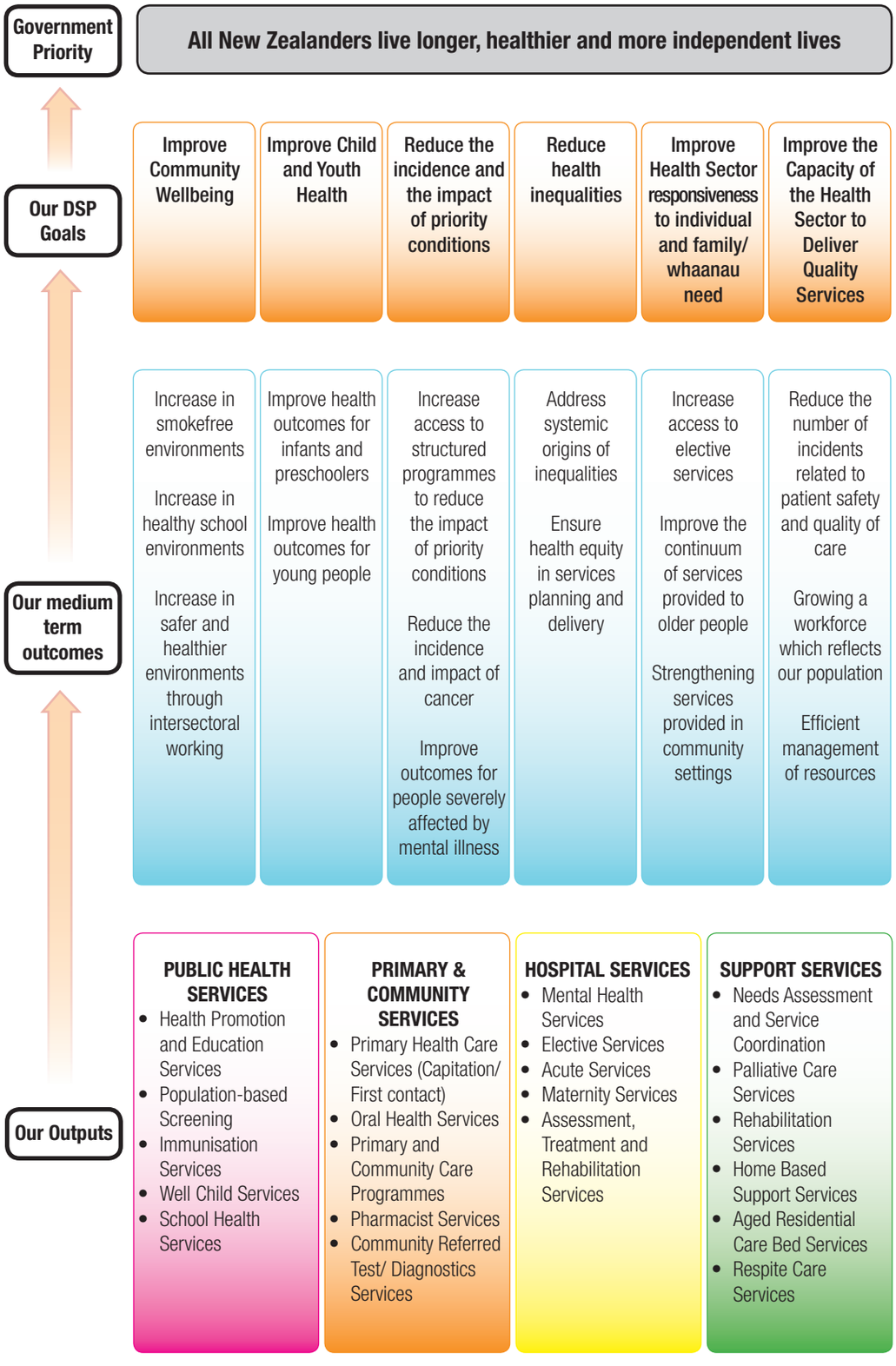
The following will be presented where:

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
67.7	81.9	75.0	80.0	

- The black bar is CMDHB's result.
- The red bar refers to other District Health Boards' results in NZ.
- The bottom value starts from the left side of the bar, with the dark red band indicating the 25% lowest DHBs and the light pink band indicating the 25% highest DHBs for that indicator.
- The New Zealand average is shown as a red line across the middle of the bar.
- A green number means that CMDHB's result is better than average and a red number means that the DHB is worse than the average.



2010/11 Output Class linkages to the DHB's medium term and long term outcomes



Output Class: Public Health Services

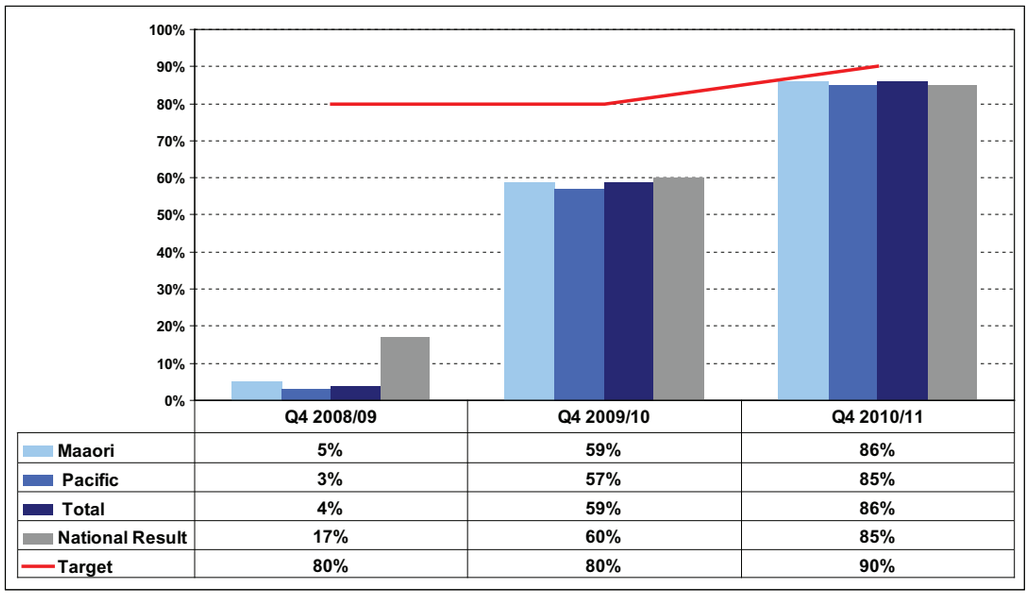
Improve Community Wellbeing - Better help for smokers to quit

Target 2010/11	Result 2010/11
1) 90% of hospitalised smokers will be provided with advice and help to quit	**(1) Hospital: Not Achieved**
(2) 50% of primary care patients who are smokers will be provided with advice and help to quit	**(2) Primary Care: Not Achieved**

Hospital inpatients who are smokers given advice and help to quit smoking

2010/11 Results, by Quarter

Q1	Q2	Q3	Q4
66%	67%	65%	86%

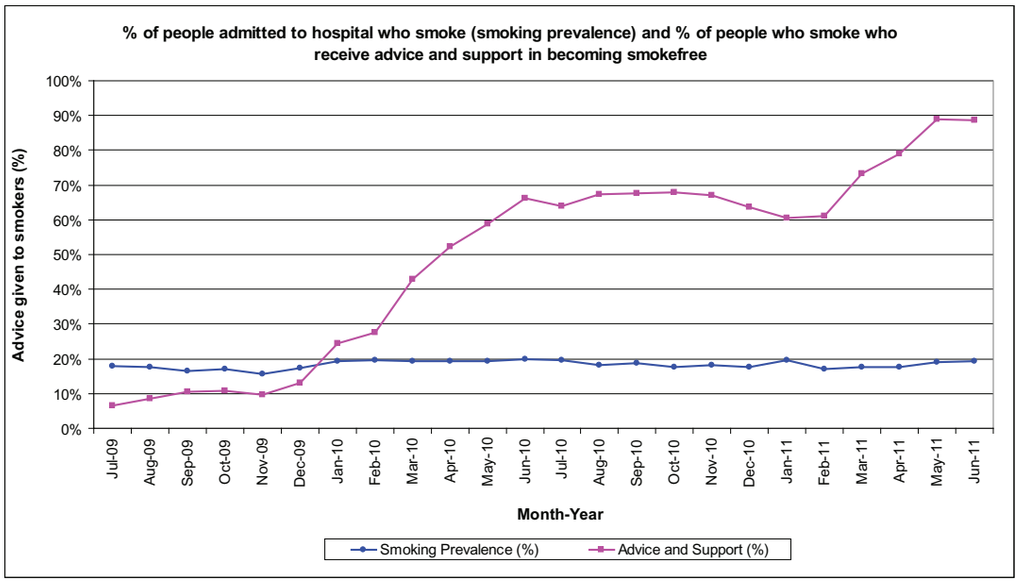


	Q4 2008/09	Q4 2009/10	Q4 2010/11
Maaori	5%	59%	86%
Pacific	3%	57%	85%
Total	4%	59%	86%
National Result	17%	60%	85%
Target	80%	80%	90%

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
71.2	100.0	84.6	85.8	

As of quarter four, 86% of all inpatient smokers were being offered advice and support to quit smoking. Strengthened commitment by hospital leadership has seen a renewed focus on the quality of advice and support provided to inpatients. All patients discharged from Emergency Care are now supplied with a quit card for subsidised Nicotine Replacement Therapy (NRT) and instructions on its use.

The following graph shows smoking prevalence and smokefree advice and support over the last two years and the progress that has been made particularly in the last quarter of 2010/11.



Primary Care patients

Data shows that currently 22% of primary care patients are being offered advice and support to quit smoking, which is above the national average of 17%. The data is obtained from DHBNZ as part of the PHO Performance Programme for smokefree. Work has been done over the past year to improve the systems for collecting and collating data which will enhance data reliability and reporting. In September 2011, a new PHO Smokefree steering group consisting of clinical and managerial representation from each PHO, will be formed to champion the smokefree target and develop initiatives aimed at improving performance from all General Practices.

Target 2010/11	Result 2010/11
100% of inpatients will have their current smoking status recorded within 6 hours of admission	**There is no result for this measure due to changes to the project *(see comment below)***

This is a quality improvement project that supports wards to undertake self-audits and then use the audit information to work on areas upon which they can improve. The nature of the audits is such that they are used as a management aid rather than a reporting tool. We are now seeing wards that have 100% of patients who smoke being offered help and support to quit with audits showing that the assessments are being done systematically and routinely for all patients.

Improve Community Wellbeing - Healthy Lifestyles

Target 2010/11	Result 2010/11
Tipu Ka Rea model for Health Promoting Schools implemented in 110 Schools	**107 Not Achieved**
90% of Lotu Moui churches will have a Smokefree policy	**81% Not Achieved**
90% of Lotu Moui churches will have a nutrition policy	**80% Not Achieved**

The DHB works at the grassroots level with communities and schools to promote better nutrition, smoking cessation and smokefree environments, and increased physical activity as a part of a healthy lifestyle.

A health promoting school is one defined by its commitment to supporting and enhancing the development of healthy environments for living, learning and working. The DHB's Health Promoting Schools (HPS) programme was three schools short of meeting the target number of health promoting schools this year. Of the 20 schools approached in the last six months of the financial year, 9 schools came onboard as HPS whilst 7 schools declined to participate and 4 are awaiting confirmation.

The DHB works with Pacific churches in the Lotu Moui programme to improve Pacific health by supporting the development of Pacific church environments which are protective and supportive of a healthy lifestyle. A total of 85 churches are currently in various stages of the Lotu Moui programme. Churches who do not have smokefree or nutrition policies are level 1 churches who have expressed an interest in promoting a healthier lifestyle to their congregations but do not yet have the tools and structures to enable them to do so. Level 4 churches – the highest level - are churches who have developed the structures and have completed the training which will enable them to be self-sustaining in their health promotion and education practices. This includes the ability to train up new leaders and becoming quit card providers.

Improve Community Wellbeing - Safer Environments

Target 2010/11	Result 2010/11
Combined audit score for hospital responsiveness to family violence, child and partner abuse of at least 140/ 200 or more	**Achieved**

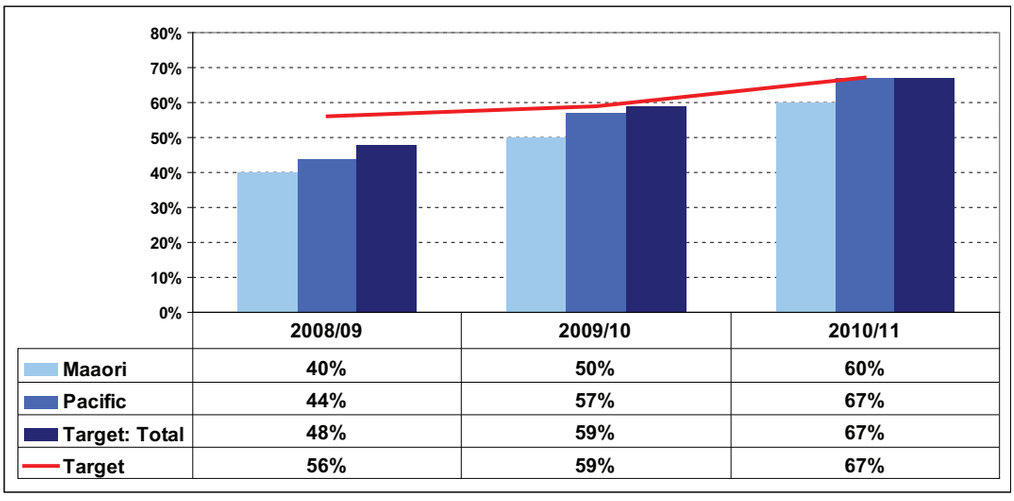
	2007/08	2008/09	2009/10	2010/11
Partner Abuse	65	73	85	89
Child Abuse and Neglect	-	-	52	84
Combined score (out of 200)	65	73	137	173

The Ministry of Health's Violence Intervention Programme (VIP) seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services.

The Counties Manukau DHB Violence Intervention Programme exceeded the minimal achievement target score for the first time and had the greatest increase in overall audit scores compared to other DHBs. The Ministry of Health has commended this result as an indication of the DHB developing a strong integrated Violence Intervention Programme.

Reduce the Incidence and Impact of Cancer - Population Screening and Health Protection

Target 2010/11	Result 2010/11
67% of women 45-69 years have had a breast screen in the last 24 months	**Achieved**



	2008/09	2009/10	2010/11
Maaori	40%	50%	60%
Pacific	44%	57%	67%
Target: Total	48%	59%	67%
Target	56%	59%	67%

Breast screening coverage in the CMDHB area continues to increase as BreastScreen Counties Manukau works toward achieving the national target of 70% women screened over 24 months in the 2011/12 year. Increased coverage is due to increased capacity from an additional digital screening machine and increased staffing levels. The service has also been working in partnership with primary care practices to increase enrolments in the programme and has implemented processes to ensure women who have enrolled in the programme but have not responded to invitations for screening are followed up in a more systematic manner.

Target 2010/11	Result 2010/11
Eligible young women who have completed the human papillomavirus vaccination course through the school based programme Dose 1 65% Dose 2 60% Dose 3 55%	**Dose 1: Achieved** **Dose 2: Achieved** **Dose 3: Achieved**

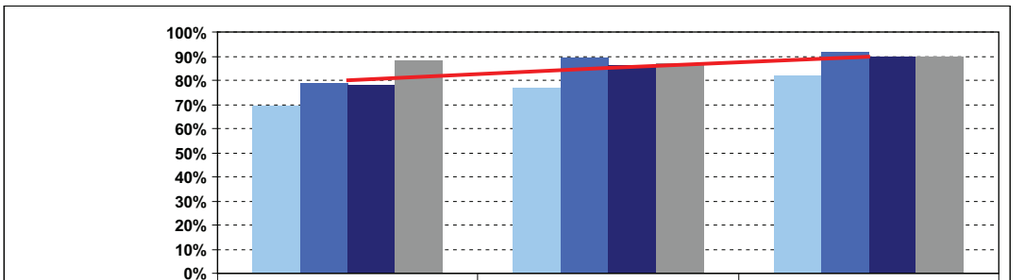
Cohort 1: 2010/11 Results

	2010/11		
	Dose 1	**Dose 2**	**Dose 3**
Maaori	77%	74%	68%
Pacific	86%	84%	80%
All	66%	60%	55%

A new cohort (Cohort 2) for an ongoing Year 8 programme began in March 2011. As of June 2011, 65% of the 3,548 eligible young women in Cohort 2 have received Dose 1 of the vaccine.

Improve Child Health - Childhood Immunisation

Target 2010/11	Result 2010/11
90% of two year olds are fully immunised	**Achieved**
50% of children referred to the outreach immunisation service are immunised	**35% Not Achieved**



	Q4 2008/09	Q4 2009/10	Q4 2010/11
Maaori	69%	77%	82%
Pacific	79%	89%	92%
Total	78%	86%	90%
National Result	88%	87%	90%
Target	80%	85%	90%

CMDHB closed the 2010/11 financial year with immunisation rates in Quarter 4 at a record high of 90%.

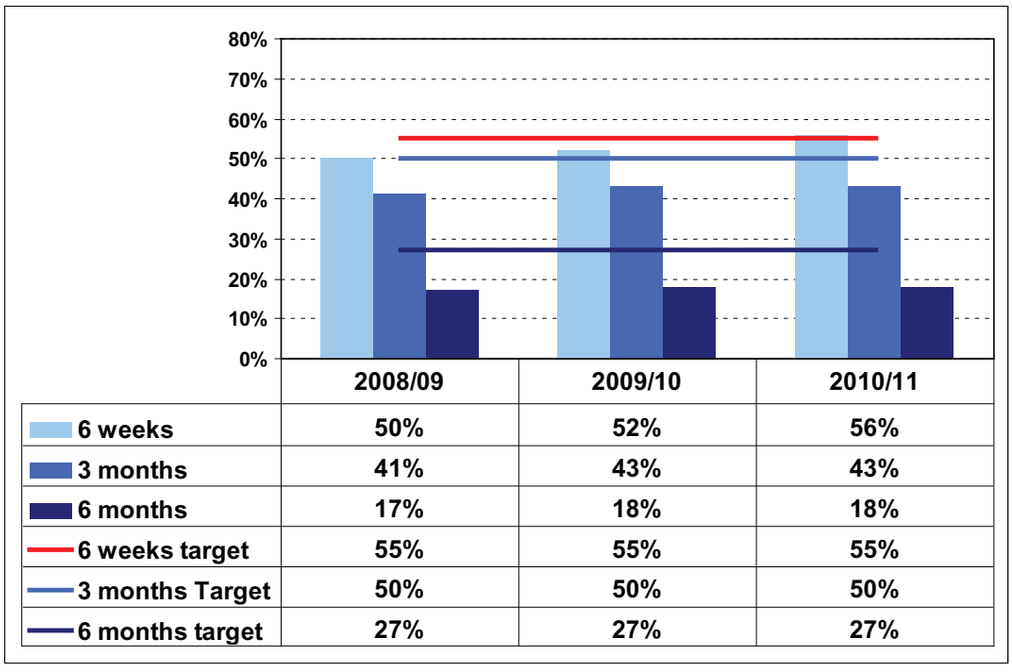
This has meant an increase in 29% over a five year period. For Maaori, the increase has been 31% (from 51% to 82%) and for Pacific a 24% increase (from 68% to 92%).

During 2010/ 11, a total number of 2,552 children were referred to outreach immunisation services. Of these, only 893 children were immunised.

To be more responsive to Maaori whaanau, the model for outreach immunisation services will be re-designed in 2011/12 to ensure the right balance between support and facilitation and the need for home based visits.

Improve Child Health – Breastfeeding rates

Target 2010/11					Result 2010/11
Infants exclusively and fully breastfed at:					**6 weeks: Achieved** **3 months: Not Achieved** **6 months: Not Achieved**
	Maaori	**Pacific**	**Other**	**Total**	
6 weeks	50%	50%	60%	55%	
3 months	48%	40%	57%	50%	
6 months	27%	27%	27%	27%	



	2008/09	2009/10	2010/11
6 weeks	50%	52%	56%
3 months	41%	43%	43%
6 months	17%	18%	18%
6 weeks target	55%	55%	55%
3 months Target	50%	50%	50%
6 months target	27%	27%	27%

Significant progress has been made with the 6 weeks' target where an increase of 6% has been achieved since 2008/09.

The DHB has been taking steps to increase breastfeeding rates at discharge from hospital through the Baby Friendly Hospital Initiative and providing community-based breastfeeding support services as well as training for practice nurses and community health workers.

Output Class: Primary & Community Services

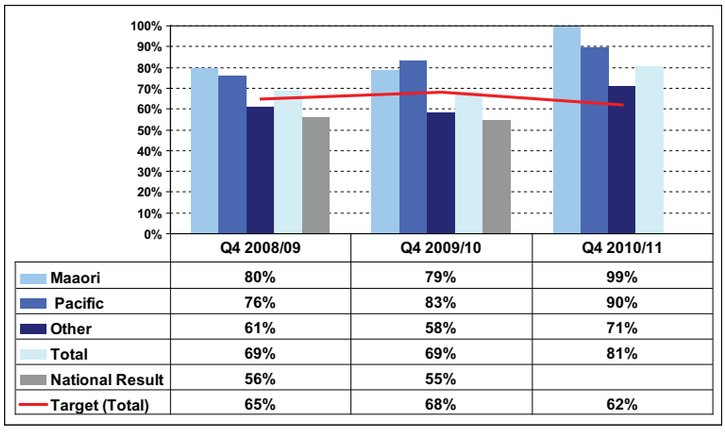
Management of Long Term Conditions - Better Diabetes Services

Target 2010/11	Result 2010/11
(1) Proportion of people with diabetes who have had an annual check	**(1) Diabetes Annual Check: Achieved**
(2) Proportion of people with diabetes have satisfactory or better diabetes management	**(2) Diabetes management: Achieved**

Maaori	Pacific	Other	Total
80%	69%	54%	> 62%

Maaori	Pacific	Other	Total
53%	48%	70%	> 60%

Diabetes Annual Checks



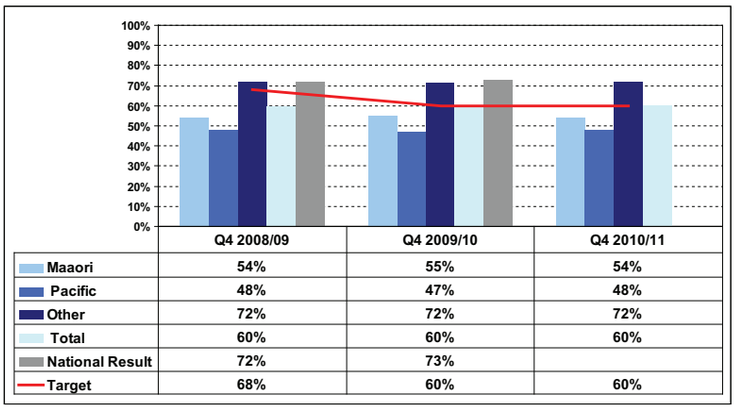
	Q4 2008/09	Q4 2009/10	Q4 2010/11
Maaori	80%	79%	99%
Pacific	76%	83%	90%
Other	61%	58%	71%
Total	69%	69%	81%
National Result	56%	55%	
Target (Total)	65%	68%	62%

Counties Manukau covers a population with a higher proportion of Maaori and Pacific people in comparison to other districts.

Rates of cardiovascular disease (CVD) and diabetes are high for these populations and therefore across Counties Manukau as a whole.

In 2010/11, 19,229 annual Diabetes Get Checked reviews were funded, which covers 81% of expected numbers of people with diagnosed diabetes based on the Ministry of Health prevalence of 23,818 in CMDHB.

People with good diabetes management (HbA1c greater or same as 8%)



	Q4 2008/09	Q4 2009/10	Q4 2010/11
Maaori	54%	55%	54%
Pacific	48%	47%	48%
Other	72%	72%	72%
Total	60%	60%	60%
National Result	72%	73%	
Target	68%	60%	60%

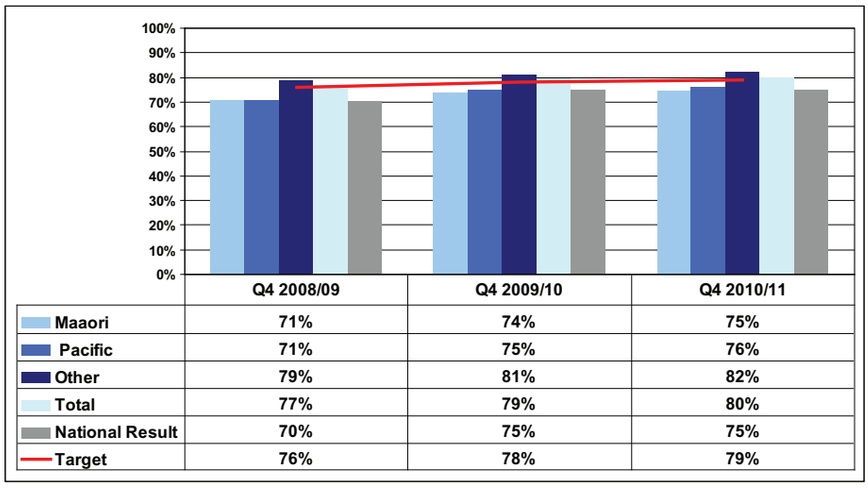
The table below shows the average of the two indicators (a) the percentage of people with diabetes who attended free annual checks and (b) the percentage of people with diabetes who had satisfactory or better diabetes management. The New Zealand average is based on Quarter 1, 2010 to Quarter 1, 2011 data.

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
63.9	86.2	64.0	71.7	

Management of Long Term Conditions - Better Cardiovascular Disease Services (CVD)

Target 2010/11	Result 2010/11
(3) Proportion of the eligible adult population who have had their CVD risk assessed in the last 5 years **Maaori** 74% | **Pacific** 75% | **Other** 82% | **Total** 79%	**(3) Achieved**

Eligible adult population who have had a CVD risk assessment in the last five years



	Q4 2008/09	Q4 2009/10	Q4 2010/11
Maaori	71%	74%	75%
Pacific	71%	75%	76%
Other	79%	81%	82%
Total	77%	79%	80%
National Result	70%	75%	75%
Target	76%	78%	79%

The DHB and Primary Health Organisations (PHOs) are committed to the continuation of initiatives such as:

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

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
67.7	81.9	75.0	80.0	

The New Zealand average is based on Quarter 1, 2010 to Quarter 1, 2011 data.

Management of Long Term Conditions –– Increasing Access to Structured Programmes

Target 2010/11	Result 2010/11
More than 17,500 enrolments in the Chronic Care Management (CCM) programme	**18,465** **Achieved**
Enrolments in the CCM Programme (excluding the depression module) by the following groups: **Maaori** 22% | **Pacific** 38% | **Asian** 11%	**Maaori** 20% | **Pacific** 38% | **Asian** 10% **Maaori: Not Achieved** **Pacific: Achieved** **Asian: Not Achieved**
More than 850 additional patients enrolled in self management education	**873** **Achieved**

Enrolments to structured programmes like Chronic Care Management and Self Management Education (SME) continue to be important strategies for the management of patients with long term conditions.

Management of Acute Demand – Ambulatory Sensitive Hospitalisations (ASH)

Target 2010/11	Result 2010/11
Ambulatory Sensitive (Avoidable) Hospitalisations	

Age	Maaori	Pacific	Other
0-4	95	113.0	95
45-64	139	132.7	113.4
0-74	117.0	125.2	103.0

Age	Maaori	Pacific	Other
0-4	85	95	72
45-64	175	156	133
0-74	131	134	115

0 – 4 years: Achieved
45 – 64 years: Not Achieved
0 – 74 years: Not Achieved

There has been a slight increase across the board in the 0 – 74 ASH volumes compared to March 2010.

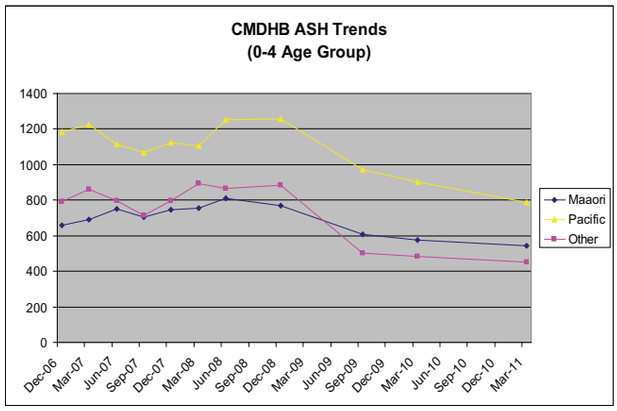
To some extent this will be related to population growth, and is driven largely by Cellulitis, Diabetes and Chest Pain admissions.

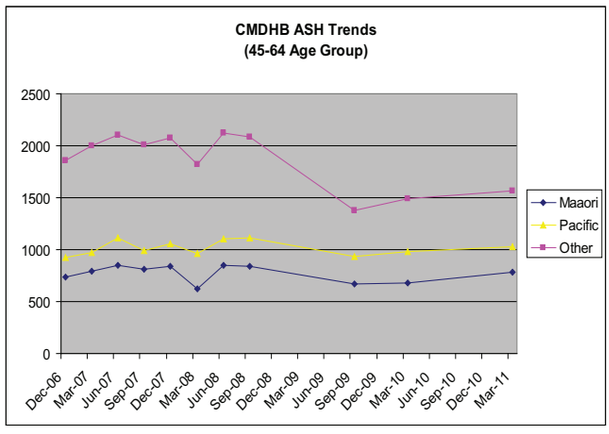
Cellulitis in particular has had substantial increases across all ethnic groups and age groups, despite this being a condition that is increasingly being managed under the Primary Options for Acute Care (POAC) scheme.

In comparison to last year's results there has been a reduction in ASH discharges for the 0 – 4 age group.

There has been a increase in overall ASH rates in the last 12 months for the 45-64 age group, most notably in Maaori.

Ischaemic heart disease admissions remain higher than expected for Maaori and Pacific in the 45-64 age group. A proportion of these higher volumes is likely to be related to population growth.

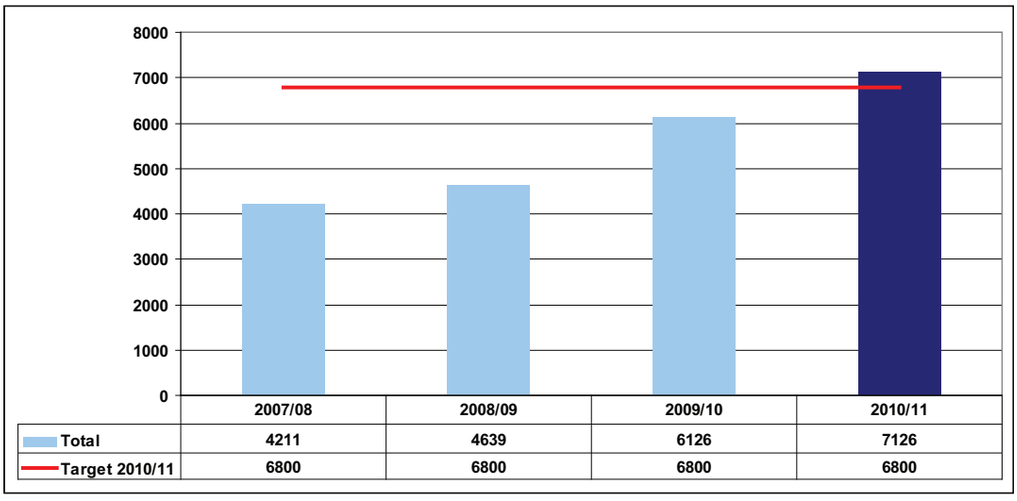




Any improvement in Myocardial Infarction admission rates will only be seen in the medium to longer term as strategies to increase CVD risk screening and management will take time to show an effect.

Management of Acute Demand – Increasing Access to Structured Programmes

Target 2010/11	Result 2010/11
More than 6,800 admissions avoided through using Primary Options for Acute Care (POAC)	**7,126 Achieved**
More than 400 enrolments in the Very High Intensive User (VHIU) programme	**829 Achieved**



	2007/08	2008/09	2009/10	2010/11
Total	4211	4639	6126	7126
Target 2010/11	6800	6800	6800	6800

For the 2010/11 year, a total of 7,126 POAC admissions were avoided. This total comprised of 1,063 Maaori and 2,061 Pacific admissions. POAC referrals have increased by 26% in the 2010/11 year, with 87% of patients being successfully managed in the community and therefore avoiding a hospital event.

The Very High Intensive User (VHIU) programme is a model of care for people who are high users of Emergency Care to reduce self-referrals to hospital and avoidable hospitalisations. This programme was rolled out in 2010/11 in conjunction with general practices in Manurewa, Otara, Mangere, and Howick/Pakuranga.

Improve Child Health - Improving access and utilisation of oral health services for preschool and primary school children

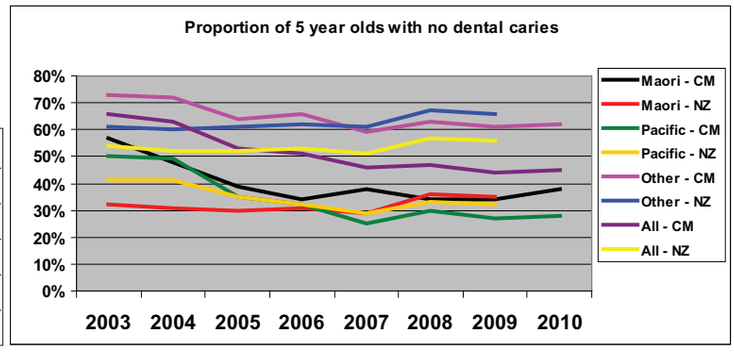
Target 2010/11	Result 2010/11
Proportion of children who are caries free at the age of 5:	Not Achieved

Maaori	Pacific	Other	Total
40%	35%	68%	52%

Fluoridated	Non Fluoridated
52%	60%

Results, Calendar Year 2010

Maaori	38%
Pacific	38%
Other	62%
Total	45%
Fluoridated	44%
Non Fluoridated	57%



The DHB did not achieve the caries free targets for children examined at the age of five. The trend shows that these rates have deteriorated compared to the national rates since the early 2000s but they may be levelling off with DHB investment in more targeted oral health promotion and programmes resulting in earlier enrolment and participation in oral health services for families with preschool children. Ministry of Health funding for new oral health facilities (including mobile dental services) and more clinical staff is also ensuring a better reach. However, the cohort is changing to include more children with high risk of tooth decay. Therefore, it will take 2 years to demonstrate significant improvement.

Target 2010/11	Result 2010/11
Children's average Decayed, Missing, Filled Teeth scores at Year 8 of school:	Not Achieved for all groups except Non-Fluoridated

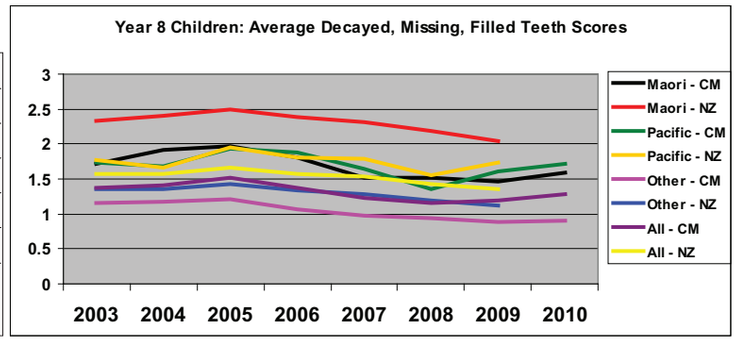
Maaori	Pacific	Other	Total
1.50	1.30	0.88	1.10

Fluoridated	Non Fluoridated
1.10	1.10

Results, Calendar Year 2010

Maaori	1.59
Pacific	1.72
Other	0.90
Total	1.29
Fluoridated	1.31
Non Fluoridated	0.87

* Note: Very small numbers for Non-Fluoridated children



The 2010 results for Year 8 DMFT show poorer oral health of the children examined.. The Auckland Regional Dental Service who provide services for the DHB believe the increase in DMFT rates may be due to increased use of x-rays (radiographs) which lead to higher detection of cavities. Ministry of Health funding for new oral health facilities (including mobile dental services), more clinical staff, earlier enrolment of preschool children, and increased preventative treatments are all ensuring a better reach for children in the preschool years and will result in better outcomes in future years.

<table>
<tr><th>Target 2010/11</th><th>Result 2010/11</th></tr>
<tr><td>Children under 5 years enrolled in DHB funded oral health services:
<table><tr><td>All Children</td><td>58%</td></tr><tr><td>0 – 2 years</td><td>50%</td></tr><tr><td>3 – 4 years</td><td>85%</td></tr></table></td><td>Results, calendar year 2010:
<table><tr><td>All Children</td><td>61%</td></tr><tr><td>0 – 2 years</td><td>46%</td></tr><tr><td>3 – 4 years</td><td>88%</td></tr></table>All Children: Achieved
0 – 2 years: Not Achieved
3 – 4 years: Achieved</td></tr>
<tr><td>Not more than 15% of enrolled children to miss receiving an annual examination</td><td>13%
Achieved</td></tr>
<tr><td>Ratio of 0.7 Dental Assistant to 1.0 Dental Therapists</td><td>0.6 Dental Assistant to 1 Dental Therapist
Not Achieved</td></tr>
</table>

The DHB did not meet the enrolment target for children under 5 years but was able to reduce the proportion of enrolled children overdue for their scheduled examinations. Over the last two years, the service has focused on resourcing the service to give it the capacity to deal with the reduction of arrears and to increase the enrolment of preschoolers. A Preschool Coordinator commenced in June 2010 and we have since seen a big increase in the number of preschoolers enrolled.

Workforce recruitment is being aligned to the commissioning of facilities. Additional staff is being recruited to align with clinic and mobile facilities being commissioned and opened. About 14 new Dental Assistants will be recruited over the next 9 months to align with new clinic openings.

Improve Youth Health - Improving access and utilisation of oral health services for adolescents

Target 2010/11	Result 2010/11
60% of adolescents are utilising DHB funded oral health services	**68% Achieved**
More than 95% of Year 8 students are transferred to the Adolescent Dental Service	**100% Achieved**

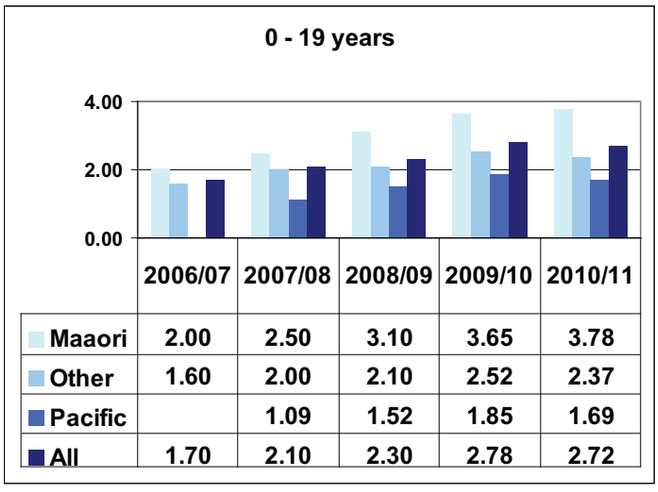
CMDHB has delivered an outstanding achievement in adolescent utilisation of free dental services. Over the last five years, the proportion of adolescents utilising DHB funded oral health services has risen from 45% to 68%. Improvements are due to:

- The introduction of additional dentist contacts (bringing the total to 63),
- An increase in the number of secondary schools with a mobile dentist provider on site,
- Further oral health promotion to out-of-school adolescents,
- Regional adolescent oral health co-ordination services.

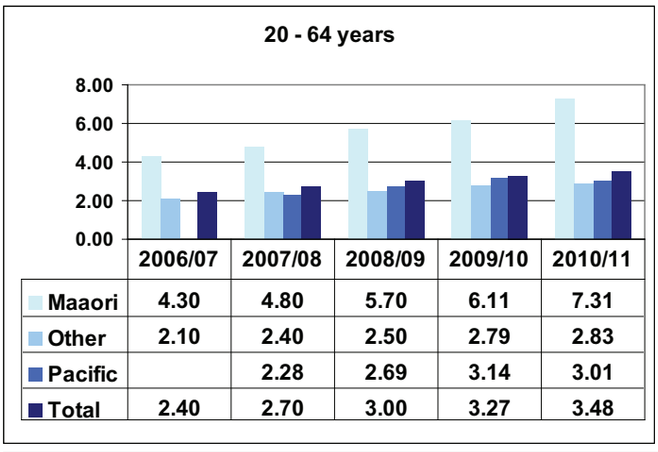
Management of Acute Demand – Mental Health

Target 2010/11	Result 2010/11
Proportion of the population with severe mental illness accessing mental health services	Achieved

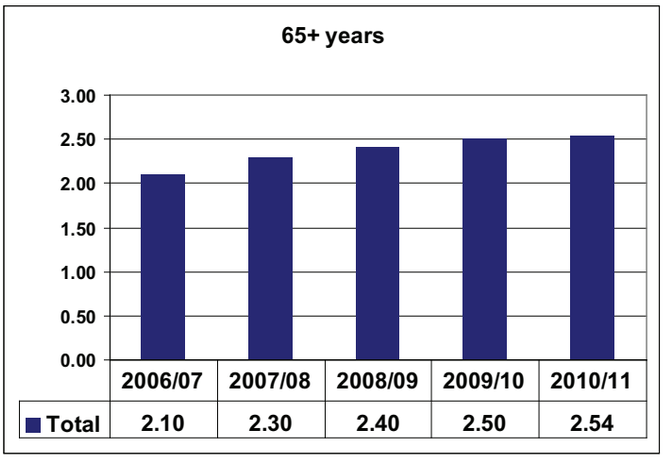
Ethnicity	Maaori	Other	Total
0 – 19 yrs	3.00%	1.99%	2.20%
20 – 64 yrs	5.58%	2.43%	2.88%
65+ yrs	1.98%		



	2006/07	2007/08	2008/09	2009/10	2010/11
Maaori	2.00	2.50	3.10	3.65	3.78
Other	1.60	2.00	2.10	2.52	2.37
Pacific		1.09	1.52	1.85	1.69
All	1.70	2.10	2.30	2.78	2.72



	2006/07	2007/08	2008/09	2009/10	2010/11
Maaori	4.30	4.80	5.70	6.11	7.31
Other	2.10	2.40	2.50	2.79	2.83
Pacific		2.28	2.69	3.14	3.01
Total	2.40	2.70	3.00	3.27	3.48



	2006/07	2007/08	2008/09	2009/10	2010/11
Total	2.10	2.30	2.40	2.50	2.54

Mental Health Access targets for all age groups are now being met, with an overall access rate of 3.14%.

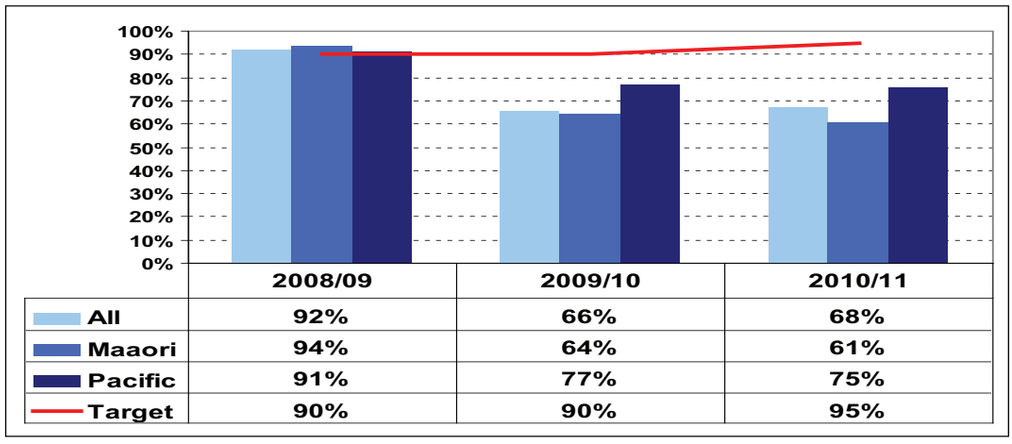
This is above the New Zealand average of 2.81% and a significant improvement from our March 2010 result of 3.04%.

The number of unique clients seen increased by 6.2% to 15,636 over the last year - a difference of 916 clients.

In comparison to March 2009, there has been a 22% increase in the number of unique clients.

Management of Acute Demand – Mental Health

Target 2010/11	Result 2010/11
95% of long term mental health service clients (those in contact for 2 years or more) will have current relapse prevention plans	**Not Achieved**



	2008/09	2009/10	2010/11
All	92%	66%	68%
Maaori	94%	64%	61%
Pacific	91%	77%	75%
Target	90%	90%	95%

CMDHB continues to manually audit 100% of patients who meet the eligibility criteria to determine whether they have a relapse prevention plan.

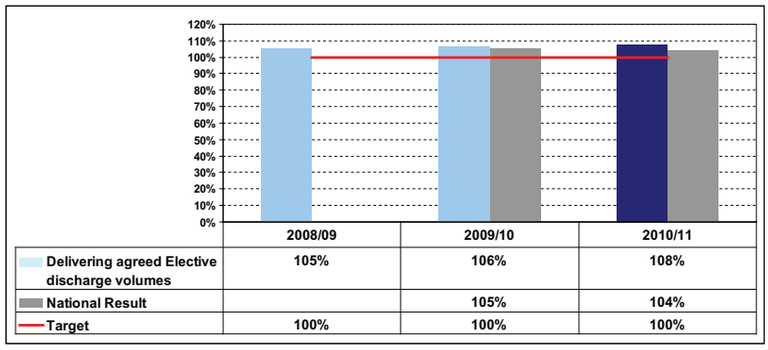
While we are currently under target, there has been considerable improvement in the number of clients with up to date plans. In the past six months, the total overall proportion has risen from 56.2% to 67.5%.

Since moving to a complete electronic clinical documentation record in 2009/10 it has been identified that a significant number of qualifying clients did not have properly documented resiliency plans. As of Quarter 4, 2010/11, this issue has been addressed with 99% of adult and 88% of Child and Youth qualifying clients having a documented resiliency plan.

Output Class: Hospital Services

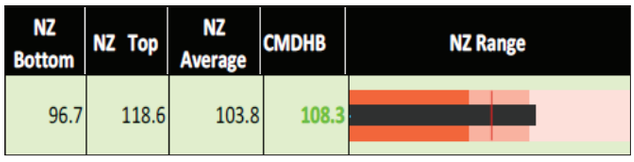
Improve our responsiveness to patients and their families – Increasing Access to Elective Services

Target 2010/11			Result 2010/11
Delivery of 14,174 elective surgical discharges			**Achieved**
Standardised Intervention Rates for Elective Surgical Services			**Achieved**
Cardiac Surgery	At least 6.5 per 10,000	273 procedures	**Cardiac Surgery** 283 procedures
Cataracts	At least 27 per 10,000	1,147 procedures	**Cataracts** 1,906 procedures
Major Joints	At least 21 per 10,000	812 procedures	**Major Joints** 812 procedures



The DHB had 15,670 elective surgical discharges in 2010/11.

This was achieved with full compliance of the Ministry of Health Patient Flow Indicators for elective services. These show that our systems are processing patients in an appropriate manner and within accepted referral and treatment timeframes.



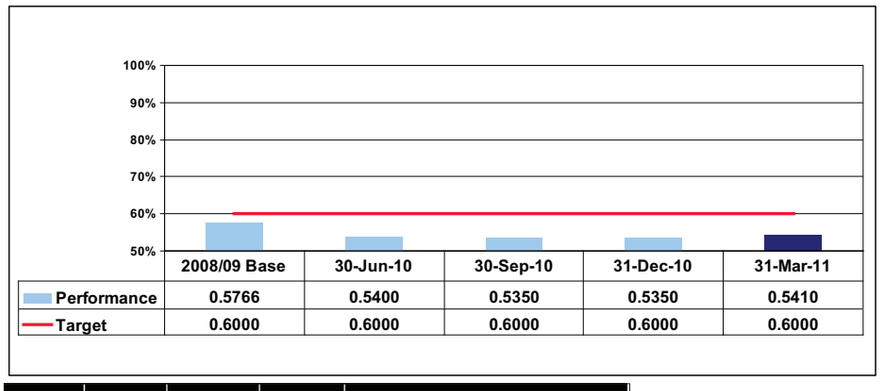
Elective Services Patient Flow Indicators
The DHB's compliance with Ministry of Health Patient Flow Indicators in the 12 months to April 2011, presented as a range from the lowest result to the highest result for the year

ESPI	Description	Target 2010/11	Result 2010/11
1	DHB services that appropriately acknowledge and process all patient referrals within ten days	> 90%	100%
2	Patients waiting longer than six months for their first specialist assessment (FSA)	< 1.5%	0.1 – 0.4%
3	Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold	< 5%	0.4 – 0.6%
4	Clarity of treatment status	< 5%	0%
5	Patients given a commitment to treatment but not treated within six months.	< 4%	1.5 – 3.1%
6	Proportion of patients who have been placed on active review who have not received a clinical assessment within the last 6 months	< 15%	0 – 2.6%
7	Patients who have not been managed according to their assigned status and who should have received treatment.	< 5%	1.0 – 2.9%
8	The proportion of patients treated who were prioritised using nationally recognised processes or tools	> 90%	100%

Improve our responsiveness to patients and their families – Elective Productivity

Target 2010/11	Result 2010/11
60% or more of elective and arranged surgery is undertaken on a day basis	**Achieved**
90% or more of elective and arranged surgery is done on a day of surgery admission (DOSA) basis	**Not Achieved**
Elective theatre utilisation rate of at least 82.5% or more	**Achieved**

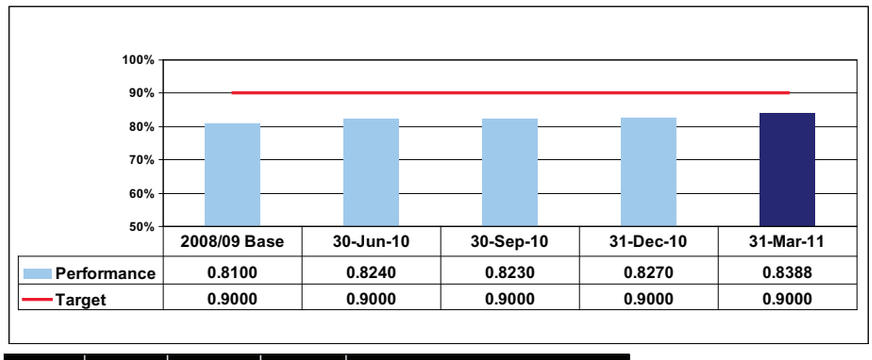
Elective and arranged surgery undertaken as day surgery



	2008/09 Base	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11
Performance	0.5766	0.5400	0.5350	0.5350	0.5410
Target	0.6000	0.6000	0.6000	0.6000	0.6000

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
51.7	62.8	56.4	54.1	

Elective and arranged surgery done on day of surgery admission



	2008/09 Base	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11
Performance	0.8100	0.8240	0.8230	0.8270	0.8388
Target	0.9000	0.9000	0.9000	0.9000	0.9000

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
63.6	98.3	80.9	83.9	

Over the 12 month period the rate of elective and arranged surgery undertaken as day surgery has remained static.

The way the day of surgery admission (DOSA) rate is being measured continues to be an issue for hospitals which provide tertiary services. Arranged acute admissions are not comparable to elective cases.

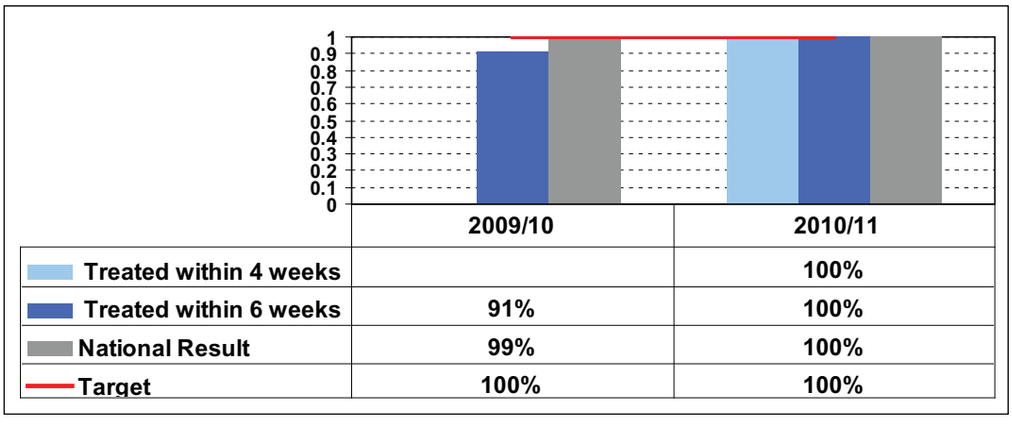
In Quarter 4, the DHB achieved an 88.6% DOSA rate for electives but only 58.2% for arranged acute admissions.

The DOSA rate for the Middlemore Hospital facility, which includes both electives and acute arranged admissions, achieved 69.5% whilst the Manukau SuperClinic, an electives only site, achieved 93.5%.

Improve our responsiveness to patients and their families - Shorter waits for cancer treatment

Target 2010/11	Result 2010/11
100% of patients in category A, B, and C wait less than 4 weeks* between first specialist assessment and the start of radiation oncology treatment. **From December 2010, the waiting time was changed from 6 weeks to less than 4 weeks*	**Achieved**

Patients waiting less than 4 weeks and 6 weeks for radiation oncology



	2009/10	2010/11
Treated within 4 weeks		100%
Treated within 6 weeks	91%	100%
National Result	99%	100%
Target	100%	100%

11 patients waited more than 6 weeks for chemotherapy treatment. These delays were due to clinical considerations and/ or patient request. All patients needing oncology were treated within 4 weeks.

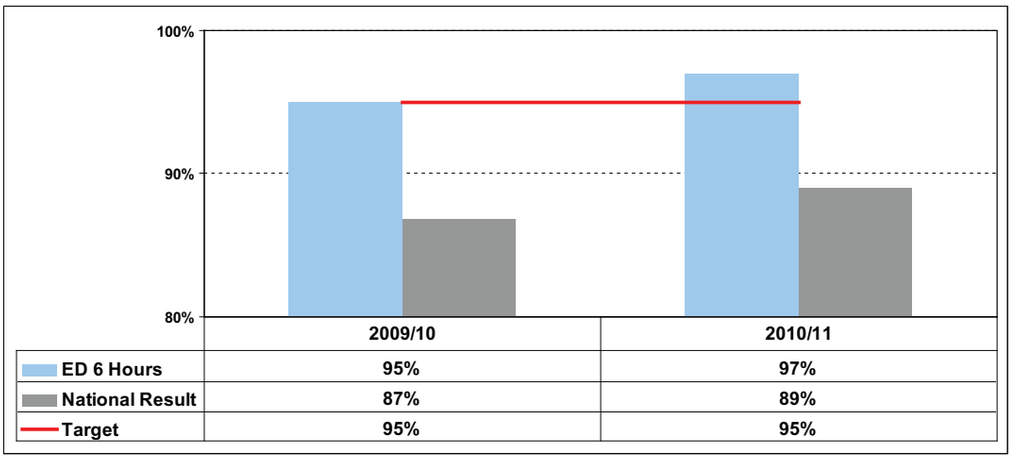
NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
99.5	100.0	99.9	100.0	

Target 2010/11	Result 2010/11
Proportion of patients waiting less than 6 weeks between FSA and the start of chemotherapy oncology treatment **Patients waiting less than 6 weeks for chemotherapy**	**Not Achieved**

	2008/09	2009/10	2010/11
Maaori	100%	100%	93%
Pacific	100%	100%	94.5%
All	96%	100%	97%

Improve our responsiveness to patients and their families – Shorter Stays in Emergency Departments

Target 2010/11	Result 2010/11
95% of patients will be admitted discharged or transferred from an emergency department (ED) within 6 hours **2010/11 Results, by Quarter** Q1: 96% Q2: 97% Q3: 97% Q4: 97%	**Achieved**



	2009/10	2010/11
ED 6 Hours	95%	97%
National Result	87%	89%
Target	95%	95%

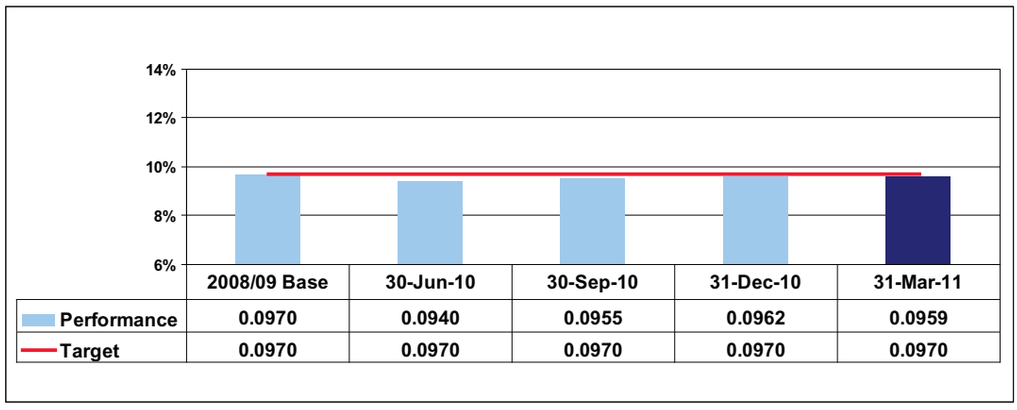
NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
73.8	99.8	91.6	96.8	

CMDHB has maintained achievement of the ED target since June, 2010. At present, 97% of patients are admitted, transferred or discharged from ED within 6 hours. For the 2010/11 year there was close to 88,000 ED attendances, with almost 85,000 of these patients being admitted, transferred or discharged within 6 hours.

Improve our responsiveness to patients and their families – Patient Experience and Quality Improvement

Target 2010/11	Result 2010/11
Rate of acute readmissions to hospital to be less than 9.70	**Achieved**
Average length of stay for acute inpatients of less than 4.01 bed days	**Achieved**
Average length of stay for elective and arranged inpatients of less than 3.92 bed days	**Not Achieved**

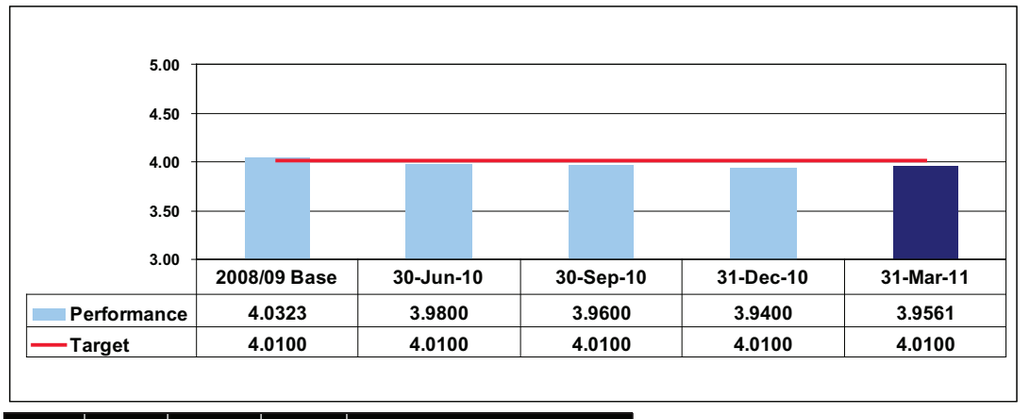
Rate of Acute Readmissions



	2008/09 Base	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11
Performance	0.0970	0.0940	0.0955	0.0962	0.0959
Target	0.0970	0.0970	0.0970	0.0970	0.0970

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
11.9	8.4	10.1	9.6	

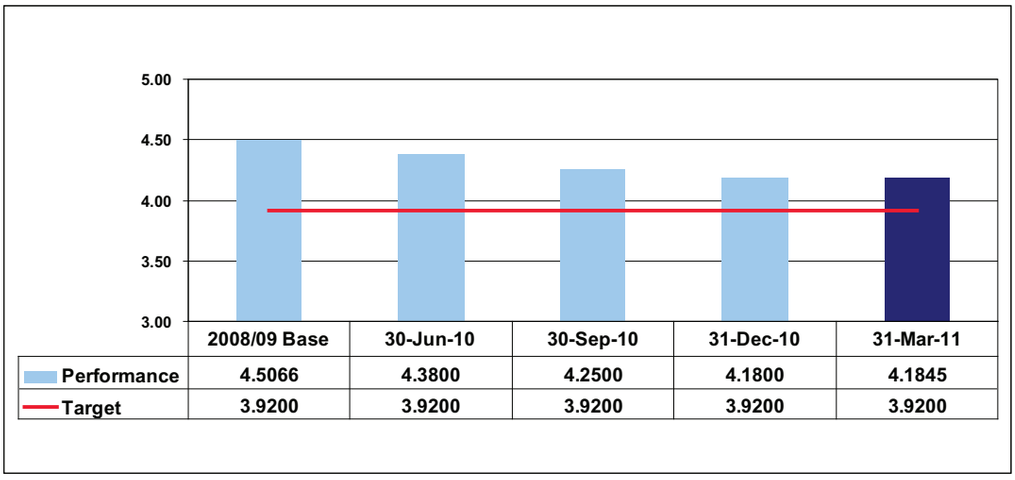
Average Length of Stay for Acute Inpatients



	2008/09 Base	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11
Performance	4.0323	3.9800	3.9600	3.9400	3.9561
Target	4.0100	4.0100	4.0100	4.0100	4.0100

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
4.4	3.5	4.0	4.0	

Average Length of Stay for Electives and Arranged Inpatients



	2008/09 Base	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11
Performance	4.5066	4.3800	4.2500	4.1800	4.1845
Target	3.9200	3.9200	3.9200	3.9200	3.9200

NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
4.7	3.3	4.1	4.2	

We were able to maintain our rate of acute admissions so that it remained below our target rate and also met the target for acute inpatients average length of stay. These two measures are monitored together to ensure that whilst ALOS is decreasing, the rate of acute readmissions is not increasing.

Over the 12 month period we have improved on our electives and arranged inpatient average length of stay by 0.20 days and will continue to challenge services for further incremental improvement.

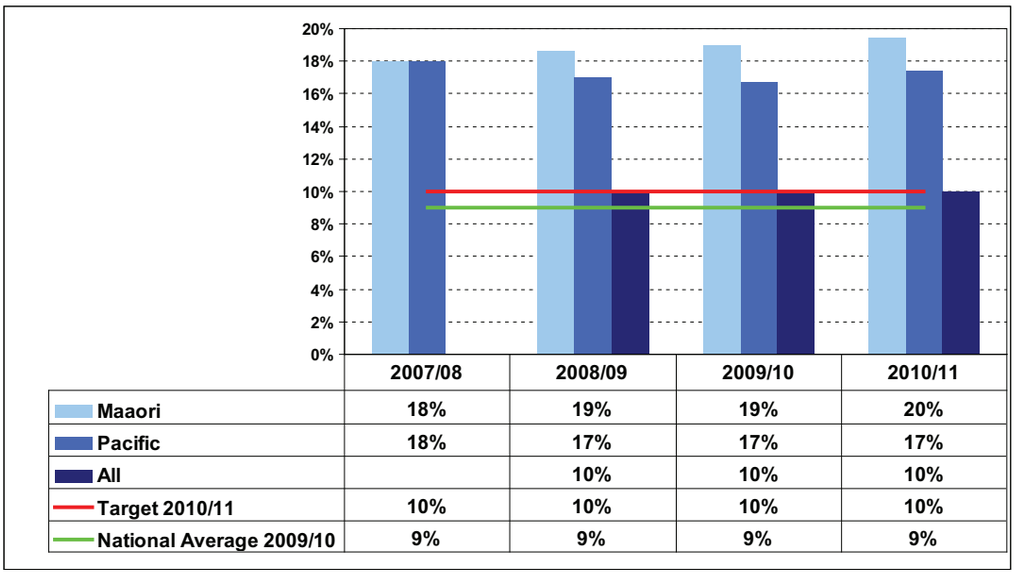
Improve our responsiveness to patients and their families – Patient Experience and Quality Improvement

Target 2010/11	Result 2010/11
At least 70% or more high needs Maaori patients are seen by a cultural support worker At least 80% or more high needs Pacific patients are seen by a cultural support worker	**Achieved** **Maaori: 72%** **Pacific: 82%**
Less than 10% Did Not Attend (DNA) rates for Maaori and Pacific outpatients	**Not Achieved** **Maaori: 20%** **Pacific: 17%**

The DHB has Maaori (Whaanau Support and Hauora Whaanau) and Pacific Cultural Support Units who provide cultural support and assistance to Maaori and Pacific patients and their families in inpatient care and those accessing outpatient services. This includes providing assistance to patients discharging from hospital to ensure they attend their follow up appointments and are transferred to their GP for ongoing care.

Both the Maaori and the Pacific Cultural Support Units achieved the targets set for providing support to high needs patients with 72.5% of Maaori high needs patients seen by Whaanau Support and Hauora Whaanau and 81.9% of Pacific high needs patients seen by the Pacific Cultural Support Unit.

Outpatient Did Not Attend rates



	2007/08	2008/09	2009/10	2010/11
Maaori	18%	19%	19%	20%
Pacific	18%	17%	17%	17%
All		10%	10%	10%
Target 2010/11	10%	10%	10%	10%
National Average 2009/10	9%	9%	9%	9%

This measure tracks all outpatient DNAs at our Manukau Superclinic facility and includes new patient and follow up appointments regardless of professional carer.

We are reviewing our outpatient service flow in 2011/12 which will look into ways of improving DNA rates for Maaori and Pacific.

Improve our responsiveness to patients and their families – Patient Experience and Quality Improvement

Target 2010/11	Result 2010/11
Less than 8% of inpatients to have hospital acquired pressure injuries	**Achieved 3.4%**
Less than 18 inpatient falls which cause harm per month	**Achieved 18**
Rate of Adverse Drug Events (ADEs) per 100 admissions to be less than 9%	**Not Achieved**
80% or greater compliance with World Health Organisation hand hygiene guidelines	**Not Achieved 56%**
Central Line Associated Bacteraemia (CLAB) of 4.5 per 1,000 line days or less	**Achieved 0.9**

The DHB launched the 'Aiming for Zero Patient Harm' campaign in the last year which focuses on embedding a culture of continuous quality improvement and patient safety in wards. Six areas identified as top causes of patient harm were picked as the DHB's key focus: Central Line Associated Bacteraemia (CLAB), Hand Hygiene, Falls, Pressure Injuries, Patient Identification and Venous Thromboembolism (VTE).

Introduction of the IHI Adverse Drug Event Trigger Tool in the last year - a methodology for detecting adverse drug events - has meant that we did not meet our 2010/11 target for reducing adverse drug events. The old system, upon which the 2010/11 target was set, depended on voluntary reporting of errors whereas the ADE TT is a more reliable measurement tool and will give us a reliable baseline from which to track future progress in improving medication safety.

The CLAB result is only for the Intensive Care Unit where the CLAB initiative has been running for the last three years. The initiative has since been rolled out to theatres, neonatal unit, surgical and renal wards but 2010/11 data is not available for those areas.

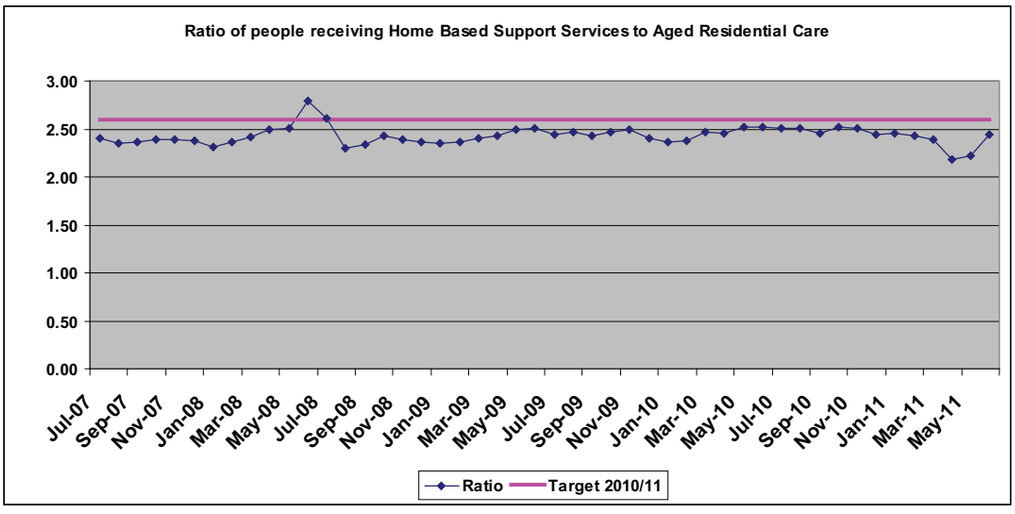
The Gold Audit [2] in February 2011 showed that DHB compliance with hand hygiene was at 58%. The DHB's self audit of in May 2011 had a result of 82% showing that improvements have already been made since February.

2 *Gold Auditors are auditors trained to undertake hand hygiene compliance monitoring as a part of the National Hand Hygiene Campaign. The National Hand Hygiene Campaign is one of three Infection Prevention and Control initiatives under the National Quality Improvement Programme.*

Output Class: Support Services

Improve the capacity of the DHB to deliver quality services - Improving the continuum of care for services provided to older people

Target 2010/11	Result 2010/11
Ratio of 2.6 people receiving home based support services (HBSS) to 1 person receiving Aged Residential Care (ARC)	**Not Achieved** **2.42**



CMDHB has seen steady growth in the number of people using home based support services over the last few years. In addition the ratio of spending on the two areas has been gradually shifting towards home based services. We expect current service development plans to enhance and strengthen these strategic directions.

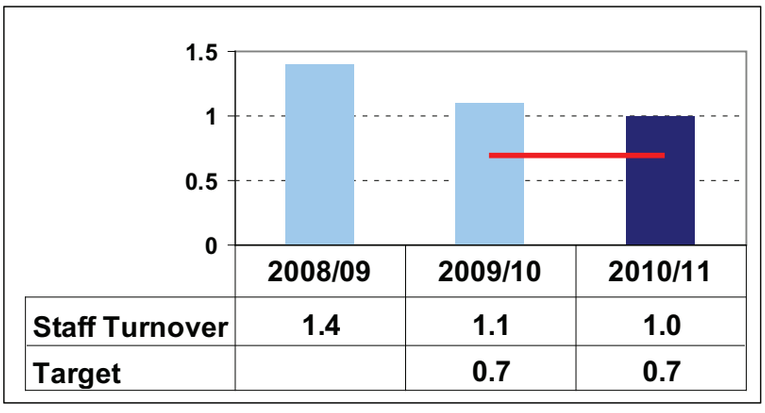
Target 2010/11	Result 2010/11
Total number of Community Respite bed days for 65+ year olds of at least 208 bed days per month	**367** **Achieved**

The DHB has had a significant increase in community respite bed days in 2010/11 through Ministry of Health funding for dedicated respite care beds; with additional beds made available in our Pukekohe and Franklin facilities. This has increased the uptake and the use of respite care in Counties Manukau.

Over the next year, the DHB plans to increase the scope of respite care in the district to include rest home and dementia level care.

Improve the capacity of the DHB to deliver quality services – Developing our workforce

Target 2010/11	Result 2010/11
Turnover of staff who resign within six months of their commencement date is less than 0.7%	**Not Achieved**



Source: CMDHB Human Resource from OneStaff data

The rate of employees voluntarily resigning in the period within six months of commencement is 0.3%.This is within the 2010/2011 target of 0.7%.

Over the past two years a more structured and robust management orientation and training programme has been implemented and there has been continued focus on proactive retention strategies across the organisation and within individual services. The Staff Satisfaction Survey and Exit Interview processes have provided both data and narrative to inform managers in developing pro-active and effective retention activities.

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Audit New Zealand on behalf
of the Auditor General

SOLICITORS
Buddle Finlay
Chapman Tripp
Meredith Connell
Russell McVeah
Simpson Grierson

BANKERS
ASB Bank Limited
Commonwealth Bank
Westpac Banking Corp

Key Abbreviations

Acronyms	Description
ACC	Accident Compensation Corporation
ADHB	Auckland District Health Board
CCM	Chronic Care Management programme
CFA	Crown Funding Agreement
CMDHB	Counties Manukau District Health Board
CPHAC	Community & Public Health Advisory Committee
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DiSAC	Disability Support Advisory Committee
DNA	Did not attend
EBIDT	Earnings Before Interest, Depreciation and Tax
EBIT	Earnings Before Interest and Tax
EMT	Executive Management Team
ESPI	Elective Services Performance Indicator
FMP II	Facilities Modernisation Program II
FTE	Full-time equivalent (Employees)
HAC	Hospital Advisory Committee
HR	Human Resources
IDF	Inter District Flows
IS	Information Systems or Services
ISP	Independent Service Providers
KPIs	Key Performance Indicators
MHINC	Mental Health Information National Collection
MMH	Middlemore Hospital
MoH	Ministry of Health
NDSA	Northern DHB Support Agency (DHB Shared Services)
NGO	Non-Governmental Organisation
PATHS	Providing access to health services
P&L	Profit and Loss
PBF	Population Based Funding
PBFF	Population Based Funding Formula
PHO	Primary Health Organisations
POAC	Primary Options to Acute Care
RISSP	Regional Information Services Strategic Plan
WAVE	Working to Add Value through E-information (Health information & Technology Plan)
WDHB	Waitemata District Health Board
WIES	Weighted Inlier Equivalent Separation = Weighted Relative Value Purchasing Unit for medical and surgical Inpatient services