COUNTIES MANUKAU HEALTH

Annual Report

30 June 2014

2014

Counties Manukau District Health Board Annual Report 2014

Our Values

Care & Respect

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

Teamwork

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

Professionalism

Acting with integrity and embracing the highest ethical standards.

Innovation

Constantly seeking and striving for new ideas and solutions.

Responsibility

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

Partnership

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

COUNTIES
MANUKAU
HEALTH

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Counties Manukau District Health Board 2013/14 Annual Report

Published November 2014

Chair and Chief Executive's Review

Counties Manukau Health is well on to its way to achieving our ambition to be the best healthcare system in Australasia. It has been an exciting and challenging year where despite the growing demands on our time, resources and services, we continued to be a leading DHB nationally and actively contributed towards national sector improvements together with our regional DHB partners.

We are incredibly proud of the work that has been done, and is continuing to be done, through a variety of improvement work and innovation taking place across the health sector to ensure better care for our patients and families. The 2013/14 year included delivering all six major health targets for the second year running, while delivering high standards of quality and safety of service and a $3 million surplus. This is on top of opening the new Harley Gray Building – a major capital development to modernise Middlemore Hospital.

We have made significant progress on our strategic triple aim of improving population and individual health alongside ensuring the best value from available resources. We have seen significant progress in population health through a huge effort by general practice, PHO, hospital and community staff. Over 96 percent of people received advice and support to quit smoking, 91 percent of eligible people had cardiovascular disease risk assessments and 92 percent of 8-month olds were immunised.

Beyond our hospital services, we continued to expand the role of general practice and community based services, where our strong foundation of essential relationships and infrastructure enabled us to shift our home health care and district nurse services from Middlemore Hospital into the community. We developed an innovative At Risk Individual model to deliver planned, proactive, patient centred care in a more equitable way. As a result, we can now identify those at risk of multiple long term health problems earlier.

Keeping patients safe when in our care is one of our most important goals. We have achieved this through improved clinical communication, safety in primary care, reduced falls, hospital infections and hospital mortality rates. Our Quality Accounts outline in more detail how quality and safety is embedded across community and hospital services and our contributions to regional and national patient safety programmes. Within the Hospital experience programme we have listened to what patients and whaanau told us have made it easier for them to find their way through hospital. Our Partners in Care philosophy continues to emerge, with wards championing the approach that is now reflected in signage and the visitor policy. We continue to manage our resources effectively and balance our budget through wise investment in our current service needs, alongside looking ahead to embed changes for the future.

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

It goes without saying that a health system is only as strong as our local communities and the people who work in it across the health system. We also thank and acknowledge our outgoing Board and committee members in 2013, which provided strategic leadership that contributed to our successful outcomes in 2013/14

Thanks must go to our fantastic staff, who go the extra mile to deliver excellent care for every patient, every day.

Dr Lee Mathias
Chair

Geraint A Martin
Chief Executive

Snapshot of Counties Manukau Health

Counties Manukau Health (CM Health) provides health and disability services to an estimated 512,000 people who reside in the local authorities of Auckland, Waikato District and Hauraki District.

We employ around 6,300 people in a number of different locations across the district and manage a budget of more than $1.3 billion a year.

Our population is growing at a rate of approximately 1.5 percent per year, the second fastest growing population (after Waitemata) when compared with other DHBs. Overall, the Counties Manukau population is expected to grow by approximately 8,300 residents each year for the next 11 years. From 2014 to 2025 the number of new residents in Counties Manukau is projected to be 91,600.

The net impact is demand on health services above demographic growth and has significant system capacity implications. Key demographic features that inform our planning assumptions are:

- There are a diverse range of needs that can be further distinguished by four geographical locality areas have been defined covering Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin. Each locality is diverse in terms of its population demographics and health needs.
- The Counties Manukau district has a diverse population: 38 percent Pakeha and Other, 23 percent Pacific, 16 percent Maaori, 23 percent Asian. 12 percent of all New Zealand's Maaori, 40 percent of New Zealand's Pacific people and 22 percent of New Zealand's Asian population live in Counties Manukau.
- Compared with other DHBs, Counties Manukau has the highest number of Maaori, the highest number of Pacific peoples, and the second highest number of people (after Auckland DHB) who identify as Asian ethnicities.
- If current population projections remain appropriate, the Asian population of CM Health will continue to increase the fastest of our ethnic groups, followed by Pacific, then Maaori, while our Pakeha population will reduce in absolute numbers.
- We are a relatively young population with 24 percent of our population aged 14 years and younger. 14 percent of New Zealand's child population lives in Counties Manukau, and we have the highest number of 0-14 year olds of all the DHBs. This is particularly so for the Mangere/Otara and Manukau localities.
- The population aged 65 and over in Counties Manukau is projected to increase by an average of 4.1 percent each year from 55,860 in 2014 to 90,750 by 2026, the fastest growth of all the DHBs. It is this group who will place the highest demands on health services in the years to come and is particularly significant for the Franklin and Eastern localities.
- Overall, life expectancy (2010-2012 average) at birth in Counties Manukau is similar to that of the New Zealand average at 81 years. While Maaori and Pacific life expectancy have been improving at the same absolute rate compared with non-Maaori/non-Pacific population, the life expectancy gap between Maaori and non-Maaori/non-Pacific remains in excess of 10 years while the gap between Pacific and non-Maaori/non-Pacific is 6 to 8 years.
- At the time of the 2006 Census (2013 results awaited) 34 percent of the Counties Manukau population lived in areas classified as being the most socio-economically deprived in New Zealand. If the 2006 situation persists, 57 percent of Maaori, 79 percent of Pacific and 43 percent of 0-14 year olds in Counties Manukau live in areas with a deprivation index of 9 or 10.
- Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau district.
- At the time of the 2006 Census, 7 percent of the CM Health population were classified as living in rural areas; this was half the national average of 14 percent but more than our neighbouring DHBs (6 percent for Waitemata DHB and 0.3 percent for Auckland DHB). For health service planning purposes, the rural adjustor used in the Population Based Funding Formula gives an indication of the proportion of the population identified as living in rural areas which are seen to require additional resources to deliver health services. In the DHB funding allocation for the 2013/14 financial year, CM Health was the only DHB that did not receive any 'rural adjustor' funding.

Board Members

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

Front row: Mrs Sandra Alofivae, Ms Wendy Lai (Deputy Chair), Dr Lee Mathias ONZM (Chair), Mr Geraint Martain (Chief Executive), Dr Lyn Murphy

Executive Leadership

Executive Leadership Team	
Geraint Martin	Chief Executive
Ron Pearson	Deputy Chief Executive/ Director, Corporate & Business Services
Dr Gloria Johnson	Chief Medical Officer
Dr Campbell Brebner	Chief Medical Advisor, Primary & Integrated Care
Karyn Sangster	Chief Nursing Advisor, Primary & Integrated Care (Acting)
Jenni Coles[1]	Director Hospital Services
Phillip Balmer[2]	Director Hospital Services
Benedict Hefford	Director Primary Health & Community Services
Denise Kivell	Director Nursing Hospital Services
Margie Apa	Director Strategic Development
Martin Chadwick	Director Allied Health
Professor Jonathon Gray	Director Ko Awatea

[1] Jenni Coles resigned from Director Hospital Services on 4 October 2013
[2] Phillip Balmer was appointed as Director Hospital Services on 21 October 2013

Key Achievements in 2013/14

Better Health Outcomes for All

- Achievement of all six National Health Targets
- Before School Check target exceeded, with 3612 children receiving a comprehensive health and developmental check
- 115,657 throat swabs taken across 61 Mana Kidz clinics schools (8 new clinics opened in 2013/14) with 13,000 children and family members treated for Group A Streptococcus sore throats in their school and community
- 48 Sore Throat Clinics opened in secondary schools and primary care clinics to provide free treatment and assessment
- 125 pregnant women and their whaanau supported through the Smokefree Pregnancy Pilot to set a quit date, with a 60 percent success rate for pregnant women at 3 months
- 'Quit Bus' providing mobile quit smoking services established in Counties Manukau
- Increased access to contraception for over 250 women and 70 men through the Postnatal Contraception Pilot
- Improved availability of Lead Maternity Care (LMC) for pregnant women with 132 self-employed midwives available to provide LMCs services to women in Counties Manukau in addition to community midwives employed by the DHB
- 60 percent of pregnant women under the care of a self-employed midwife, an increase of 10 percent from 2012/13
- Fanau Ola outcomes and decreased admissions achieved for over 800 vulnerable Pacific patients and their fanau
- Improved access to quality housing with over 2,000 homes insulated through Warm-Up Counties Manukau

Patient and Whaanau Centred Care

- Improved way-finding for patients, whaanau and visitors through new hospital signage, using simplified terminology within the hospital and redesigning appointment letters with user friendly information
- Increased patient engagement in health and treatment decisions with 2000 advance care conversations completed
- Increased patient and whaanau involvement in the co-design of services through the Experience Based Design Programme – 226 patients and whaanau and 75 staff have been engaged as part of the programme this year

System Integration

- Initiated implementation of the district-wide At Risk Individuals (ARI) Programme to provide more proactive, patient centred care for patients with multiple long term conditions
- Implementation of eShared Care software to enable the sharing of patient information between primary, secondary and community clinicians involved in a patients care and to enable increased patient involvement through access to this information via the patient portal
- Development of the "NZ primary care trigger tool" that can be used to engage a wide range of Primary Care providers in activities to detect, respond to and reduce patient harm
- 45 clinical pathways live on Healthpoint, including the ARI pathway and 10 paediatric pathways
- Agreed process map for developing and implementing clinical pathways to embed across metro Auckland
- Clinical Pathway Enabler funding secured with proof of concept due to start 11 August 2014
- Rapid Response Service established in Franklin which is being well utilised by General Practices within Franklin, St John's Ambulance Service, the Emergency Nurses at Middlemore Hospital and the Discharge Lounge, and will connect with ARI once it is more embedded in the system
- Roll out of a district wide palliative care model in three general practices in the Eastern locality, under the ARI programme. This programme collaborates with the hospice, including a shared care plan, and has involved the participating general practices to undergo some specific education sessions and to have completed at least the Level 1 Advance Care Plan online sessions
- 47 comprehensive (clinical) medication reviews, and 86 residential care (clinical) medication reviews have taken place, in addition to a COPD care bundle audit for all people with COPD in the Eastern Locality
- Implementation of a child and maternal health and social service integration project
- The Manukau locality has completed a redesign process with the Papakura Home Health Care team to develop an integrated interdisciplinary model of care that is aligned with primary care teams

First Do No Harm[3]

- Commencement of Safety in Practice collaborative involving 23 General practices, 7 PHOs, and a core collaborative team of CM Health and Ko Awatea staff
- Adoption of national peri-operative surgical safety campaign to reduce peri-operative harm
- Hand Hygiene Gold Audit achieved, exceeding the national target of 70 percent for the fifth consecutive audit
- Reduction in healthcare related VTE events in patients having elective surgery

Enabling High Performing People

- Maaori and Pacific Recruitment and Retention Strategy developed
- Core Leadership Development programme launched as part of the Leadership Academy to build internal leadership capacity and capability
- Review, stocktake and re-design of Organisational Learning and Development

Practicing Sustainable Healthcare

- Achieved Practising Sustainable Healthcare savings targets of $24.0 million of one-off savings, and $28.0 million of sustainable savings achieved through applying a quality focus on process design, procurement, contract negotiation and our environment

[3] Refer to the 2013/14 Quality Account for full details of the First, Do No Harm work and achievements

Performance Against National Health Targets

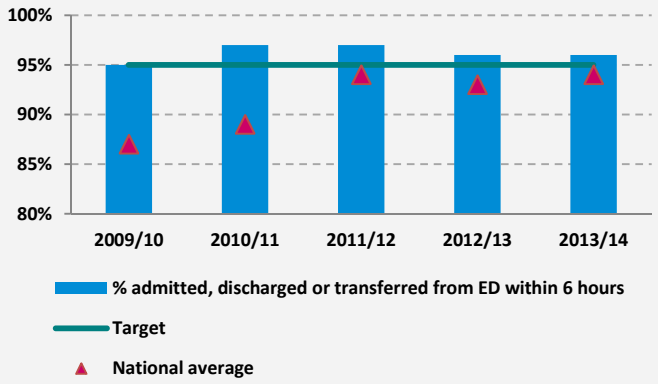
CM Health's strong performance against the national health target expectations in 2013/14 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with primary health care and PHOs, and their commitment and leadership to focus resources towards improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

Health Targets	Q1	Q2	Q3	Q4
Shorter stays in Emergency Departments — 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	96% ✓	96% ✓	95% ✓	96% ✓
Improved access to Elective Surgery — The national volume of elective surgery will be increased by at least 4,000 discharges per year	114% ✓	114% ✓	113% ✓	112% ✓
Shorter waits for Cancer Treatment — All patients, ready-for-treatment, will wait less than four weeks for radiotherapy or chemotherapy	100% ✓	100% ✓	100% ✓	100% ✓
Increased Immunisation — 90 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014	91% ✓	90% ✓	92% ✓	92% ✓
More Heart and Diabetes Checks — 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years	81%	83%	86%	91% ✓
Better help for Smokers to Quit — Secondary Care: 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking	96% ✓	95% ✓	95% ✓	96% ✓
Primary Care: 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered advice and support to quit smoking	59%	69%	77%	99% ✓

What difference have we made for our population?

Shorter stays in emergency departments

The percentage of people presenting to CM Health emergency department who were admitted, discharged or transferred within 6 hours	12/13 Baseline	13/14 Result	13/14 Target
	96%	96%	95%



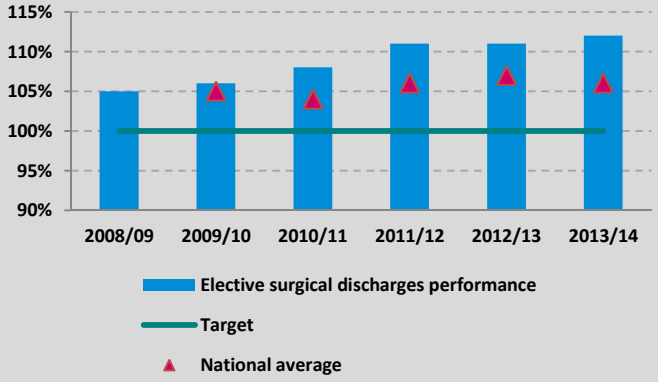
Shorter stays in emergency departments can improve both patient experience and clinical outcomes. Long waits in emergency departments are inconvenient, often uncomfortable for patients and are linked to overcrowding, poorer clinical outcomes and reduced privacy and dignity.

Despite a 4 percent increase in patient volumes, CM Health has continued to achieve the national target throughout 2013/14, with at least 95 percent of people presenting to the CM Health emergency department being admitted, discharged or transferred within 6 hours of arrival in every quarter.

CM Health's performance against this target is supported by strong leadership by senior management and clinicians, a whole-of-system approach and commitment across secondary and primary care to achieve the target. A number of improvements to facilities including the redesign of the emergency care floor space, the opening of the medical assessment unit and a designated hospital discharge lounge have helped sustain the flow of patients and contributed to the achievement of this target. We are committed to maintaining the shorter stays in emergency department target in 2014/15, and improving the quality and timeliness of emergency department care.

Improved access to elective surgery

The elective surgical services discharge performance of CM Health	12/13 Baseline	13/14 Result	13/14 Target
	111%	112%	100%
	17,085 discharges	17,457 discharges	15,635 discharges



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

CM Health has continued to perform above the national target to increase the volume of elective surgery by at least 4000 discharges each year. The 2013/14 target was to have performed 15,635 discharges; CM Health exceeded this target by 1822 discharges.

CM Health's strong performance against this target reflects the importance staff place on optimising wellbeing for the community, their commitment to provide timely care, and a strong focus on productivity and theatre utilisation. In 2013/14 we were the leading DHB in the introduction of the Enhanced Recovery After Surgery Programme, and expanded the programme into general surgery, orthopaedic, and ears, nose and throat services.

We remain committed to delivering efficient and effective elective surgery productivity in 2014/15 and maintaining achievement of this target.

Shorter waits for cancer treatment

The percentage of CM Health patients[4] who receive radiotherapy or chemotherapy within 4 weeks of first specialist appointment	12/13 Baseline	13/14 Result	13/14 Target
	100%	100%	100%

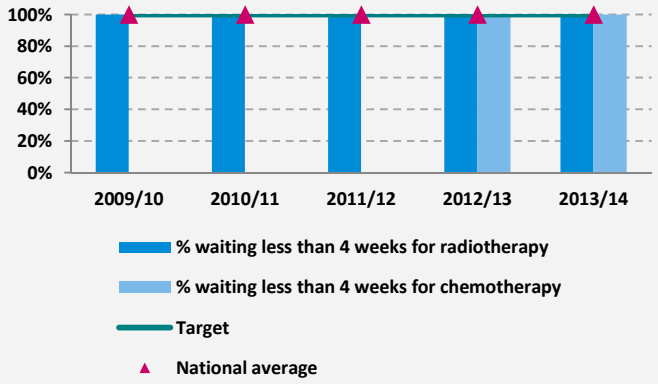
Cancer is a major health issue for New Zealand, and one of the country's leading causes of death. Timely access to specialist cancer treatment is essential in reducing the impact of cancer for patients, their whaanau and our communities.

CM Health has consistently met the radiotherapy

[4] Patients ready-for-treatment

and chemotherapy target throughout 2013/14 with 100 percent of patients, ready-for-treatment, receiving treatment within 4 weeks from the decision to treat. Cancer treatment services for patients in Counties Manukau are provided through the Auckland DHB Regional Cancer and Blood Centre as well as CM Health Haematology.

Reduction in wait time for cancer treatment is supported by regional collaboration through the Northern Cancer Network; implementation of multidisciplinary meetings to increase efficiency and timeliness of clinical decisions; and Cancer Nurse Coordinators to identify issues and facilitate pathway improvements.

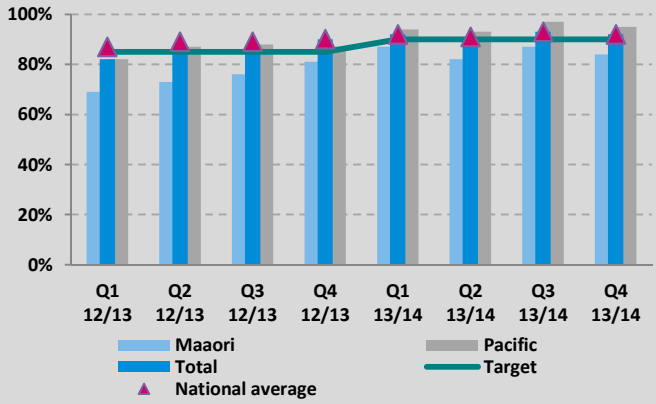


Increased immunisation

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

CM Health exceeded the national target for immunisation, with 92 percent of eight-month-old babies completing their primary course of immunisation on time. We have continued to make progress increasing Maaori and Pacific immunisation rates - the coverage rate for Maaori eight-month-olds has increased from 81 percent in quarter 4 2012/13 to 84 percent in quarter 4 2013/14, and in the same period Pacific coverage increased from 87 percent to 95 percent.

The percentage of Counties Manukau eight-month-olds who are fully immunised		12/13 Baseline	13/14 Result	13/14 Target
	Maaori	81%	84%	
	Pacific	87%	95%	90%
	Total	90%	92%	



Our performance against this target reflects strong Nurse Leadership across the DHB and PHOs; working closely with primary care, including the on-going immunisation working group forum; and continuous quality improvement work using the ECTO Quality Improvement Framework. Targeted actions to increase Maaori coverage has included the development of reports to identify Maaori children nearing overdue age to prompt earlier recall by primary care; and a pilot project which referred all overdue Maaori babies to outreach services.

Actions to support achievement of the December 2014 target of 95 percent include Clinical Champion to champion and support immunisation coverage; working closely with PHOs to develop protocols for outreach referrals; actively monitoring the introduction of the new immunisation schedule; maximising the use of available audit tools to manage recalling and encourage pre-calling; and engaging with LMCs and WCTO providers to develop a shared strategy for 6 week timely immunisation.

Better help for smokers to quit

Smoking is a leading cause of death in New Zealand, killing around 5,000 people every year and reducing the quality of life for thousands more. Smoking increases the risk of developing heart disease, respiratory infections and lung diseases, including cancer; all of which contribute to the differences in life expectancy between Maaori and Pacific and non-Maaori/non-Pacific in Counties Manukau.

At the 2013 Census, 15.9 percent of Counties

The percentage of enrolled Counties Manukau smokers seen by a health practitioner in primary care and offered brief advice and support to quit	12/13 Baseline	13/14 Result	13/14 Target
	56%	99%	95%

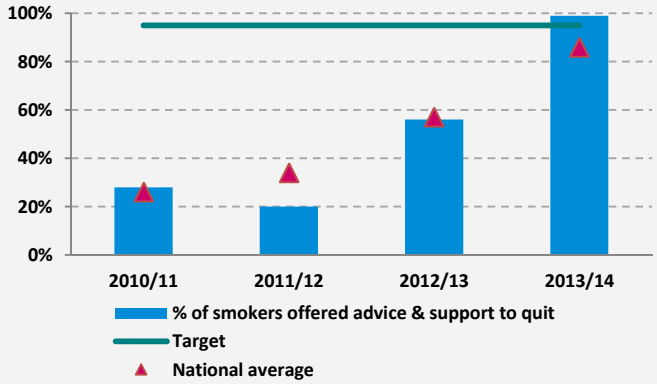
Manukau residents reported that they were smoking regularly – a 6.2 percent decrease since the 2006 Census. Over the same period, Counties Manukau Maaori smoking prevalence fell from 46.8 percent in 2006 to 36 percent in 2013, and Pacific from 30.3 percent to 23.2 percent.

Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

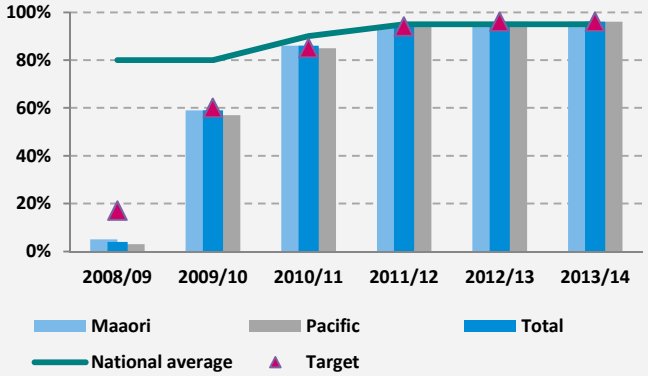
There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers.

Throughout 2013/14 CM Health has made strong progress towards the primary care target, achieving 99 percent in Quarter 4 – a 43 percent increase from Quarter 4 2012/13. This result reflects a concerted effort made by primary care across the region; active leadership by clinical champions; enhanced IT systems; support for increased nurse time from PHOs to assist practices to achieve their targets; regular meetings, reporting and monitoring; and identifying and supporting practices with high numbers of Maaori patients who require smoking cessation brief advice and support to quit.

CM Health has consistently met the secondary care smokefree target since 2012, with at least 95 percent of hospitalised smokers with at least 95 percent of hospitalised smokers offered brief advice and support to quit. This has been achieved through active hospital leadership; ongoing training and refreshers for staff; regular audit, feedback and reporting; and emphasising the impact of target activity on patient outcomes. The proportion of patients referred for ongoing support increased 87 percent in 2013/14, from 1,145 in 2012/13, to 2,142.



The percentage of CM Health hospitalised smokers offered brief advice and support to quit	12/13 Baseline	13/14 Result	13/14 Target
Maaori	95%	96%	95%
Pacific	96%	96%	95%
Total	95%	96%	95%



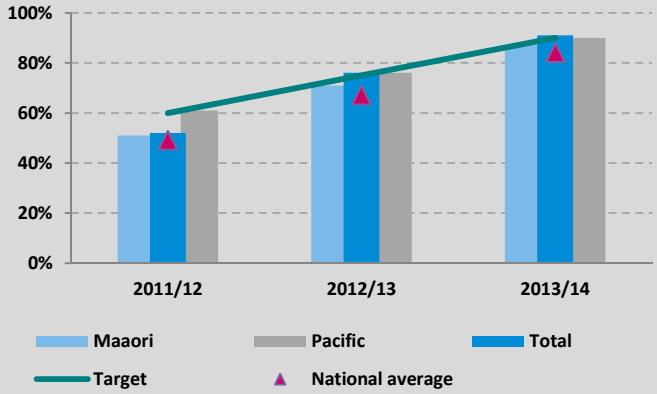
More heart and diabetes checks

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

CM Health made strong progress throughout 2013/14 towards the heart and diabetes target, and successfully achieved the target in quarter 4, with 91 percent of eligible adults having had their cardiovascular risk assessed in the last 5 years.

Significant work went into achieving this result which was made possible by a coordinated approach by PHOs, primary and secondary care providers across Counties Manukau. This work has been supported by a dedicated clinical champion for CVD and has included identification and targeting of eligible population who have not had an assessment within the last 5 years; after hours and nurse led clinics; text message reminders, staff CVDRA assessments; and funding to practices for phlebotomy services and CVDRA. Improvements in systems have resulted in improved data collection; and test safe data has also been used for completion of assessments and systems.

The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessed in the last 5 years	12/13 Baseline	13/14 Result	13/14 Target
Maaori	71%	87%	90%
Pacific	76%	90%	
Other	77%	93%	
Total	76%	91%	



What are we trying to achieve?

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

We have an organisational goal which is to be one of the best healthcare systems in Australasia by 2015, but ultimately, what we are here to do is to make a difference to the lives of our people - we want to see our communities living healthier, longer, more independent and productive lives.

To do this, we are working with our communities and our partners in the health system to address the barriers to good health through targeted population health improvement projects, improved access to services, improved management of chronic conditions and better patient/ service user experience of care.

The Triple Aim underpins all that we do at Counties Manukau Health. These three aims drive our strategic planning and are collectively considered and implemented in all our planning and funding decisions.

- Improved quality, safety and experience of care;
- Improved health and equity for all populations; and
- Best value for public health system resources.

Since 2012, we have implemented six strategic programmes of work to help us achieve our vision and goals.

- *Improved health and equity for all populations* is actioned through the 'Better Health Outcomes for All' suite of projects. These aim to improve population health by reducing smoking prevalence to less than 12 percent by 2018 and 5 percent by 2025 (Smokefree 2025), improve care and services for mums and babies in their First 2,000 days of life, reduce hospital admissions due to poor quality housing and improve health literacy. These population health improvement projects specifically work with our communities to address the barriers to good health to improve life expectancy, reduce inequalities in health and support individuals and whaanau to lead healthy lives.
- *Improved quality, safety and experience* is actioned through two programmes. 'First Do No Harm' implements the national, regional and local quality and safety initiatives in hospital and primary care. The second programme 'Patient and Whaanau Centred Care' implements tools and approaches to ensure that patient and whaanau experiences are used to improve service design and delivery throughout the care continuum.
- *Best value for public health system resources* is the most complex triple aim objective and is implemented through the 3 large executable strategies:
  - *'System Integration' that includes Localities* - this programme is the engine room for where system redesign and change is to be actioned. This programme has established and implements System Redesign projects, At Risk Individuals and the Quality and Safety programme for primary care. This programme also oversees the shifting and integration of primary and secondary services.
  - *'Ensuring Financial Sustainability'* - this programme oversees the savings programmes and aims to align long term financial planning with the service changes delivered through 'System Integration'.
  - *'Enabling High Performing People'* - this programme ensures we manage our workforce resources to deliver quality healthcare services in a manner that is sustainable, and gets the best from our people. This programme ensures that we are matching our service and healthcare needs with a workforce that is fit for purpose. This includes increasing the recruitment and retention of Maaori and Pacific people into healthcare roles.

Figure 1: Triple Aim

National and Regional			
National Goal	All New Zealanders live longer, healthier and more independent lives		
National Policy	Better sooner more convenient care		
Regional Vision	To improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services We will do this in a way that meets future demand whilst living within our means		
TRIPLE AIM	Population Health	Patient Experience	Cost/Productivity
National Priorities	Rheumatic Fever / Clinical Integration / Mental Health / Youth Mental Health / Vulnerable Children / Diagnostics / Cancer / Whaanau Ora / Living Within Our Means		
National Health Targets	Preventative health targets with a focus on: ▪ Increasing immunisation; reducing rheumatic fever ▪ Better help for smokers to quit ▪ More heart and diabetes checks	Improved access to: ▪ Emergency Departments (shorter stays) ▪ Elective services (surgical and outpatients) ▪ Cancer services	Living within our means by: ▪ Lifting productivity ▪ Keeping to budget
Regional Strategic Objectives	Adding to and increasing the productive life of people in the Northern Region	Delivering safe and good quality healthcare which is patient and family centred	The region's health resources are efficiently and sustainably managed to meet present and future health needs
Regional Priorities	Life and Years[5]	First Do No Harm[6] /The Informed Patient[7]	Life and Years[5]
Counties Manukau Health			
Goal	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
Strategy	Improved health and equity for all populations	Improved quality, safety and experience of care	Best value for health system resources
Priorities (3 year)	Better health outcomes for all programme targeting Housing, Smokefree by 2025 and First 2,000 Days Reducing the health impact of long term conditions	First Do No Harm programme Delivering Patient and Whaanau Centred Care programme	System integration (local and regional) programme Ensuring financial sustainability programme Enabling high performing people programme
Outcomes (10+ years)	People live healthier, longer more productive, disease free lives	People are at the centre of our health system with earlier access to quality health services	Health system clinical and financial sustainability
Key Impacts (5-10+ years)	▪ Continued improvement in overall life expectancy and narrowing of ethnic disparity ▪ Reduction in smoking related cancers and respiratory conditions ▪ Reduction in the differences in rates of housing related hospitalisations between ethnic groups and groups with different socioeconomic status	▪ Improved patient experience of care ▪ Increased proportion of whaanau as partners in care	▪ Reduced rate of annual health expenditure increase per capita ▪ Continued improvement in overall life expectancy and narrowing of ethnic disparity ▪ Increased workforce diversity and ethnicity ▪ Reduced labour cost growth
Key Impacts (1-5 years)	▪ Reduction in smoking prevalence ▪ Reduction in the incidence of rheumatic fever ▪ Improved diabetes control in our population	▪ Improved access to emergency care ▪ Improved access to mental health services ▪ Reduced hospital stays in the last 6-mths of life ▪ Improved access to elective services	▪ Increased percentage of total health service delivery/spend in primary and community care ▪ Improved reliability of care
Output Classes	Prevention Health Promotion & Education, Immunisation, Health Screening, Statutory and Regulatory	Early Detection and Management, Primary Health Care (GP), Long Term Conditions, Oral Health, Diagnostics, Pharmacy	Intensive Assessment and Treatment, Mental Health, Elective, Acute, Maternity, Additional Patient Safety	Rehabilitation and Support, NASC, Assessment Treatment & Rehabilitation, Palliative Care, ARRC, Home Based Support

[5] Reducing disparities and achieving longer, healthier and more productive lives
[6] Reducing harm and improving patient safety
[7] Ensuring patients and their whaanau get care, information and support appropriate to their context

How have we performed?

This section gives an overview of how well our population is doing across a selection of health indicators such as life expectancy at birth, smoking prevalence, incidence of rheumatic fever, diabetes management, access to emergency care, elective and mental health services. The list is not meant to be exhaustive but to reflect elements of our health system which are relevant to our population.

What difference have we made for our population?

Continued improvement in overall life expectancy and narrowing of ethnic disparity

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

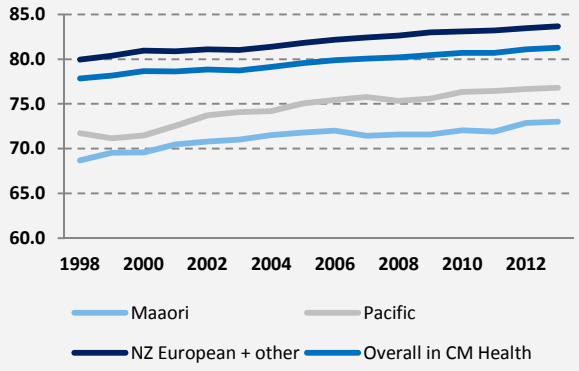
However, despite an overall increase in life expectancy, there continue to be large gaps between life expectancy at birth for Maaori and Pacific, and non-Maaori and non-Pacific groups.

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

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

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

	2008 Baseline	2013 Result	13/14 Target
Maaori	10.4 yrs	10.2 yrs	Reduce baseline rates
Pacific	7.1 yrs	5.1 yrs	



A reduction in smoking prevalence

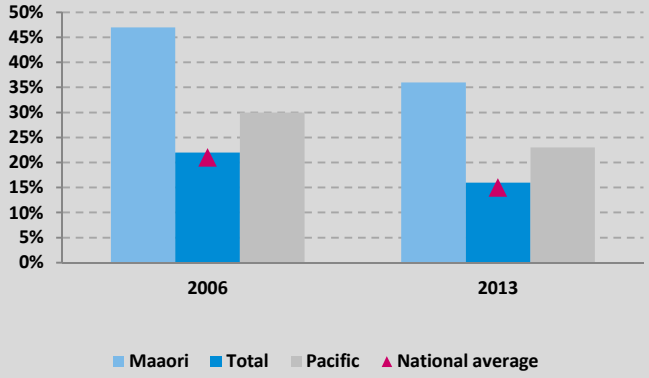
Smoking is a leading cause of death in New Zealand, killing around 5,000 people every year and reducing the quality of life for thousands more. Smoking increases the risk of developing heart disease, respiratory infections and lung diseases, including cancer, along with impacting the health of infants and children; all of which contribute to the differences in life expectancy between Maaori and Pacific and non-Maaori/non-Pacific in Counties Manukau.

At the 2013 Census, 16 percent of Counties Manukau residents reported that they were smoking regularly – a 6 percent decrease since the 2006 Census. Over the same period, Counties Manukau Maaori smoking prevalence fell from 47 percent in 2006 to 36 percent in 2013, and Pacific from 30 percent to 23 percent.

While ethnic differences in smoking prevalence have narrowed in absolute terms, there remains a significant equity gap with Maaori prevalence still more than double the overall CM Health population prevalence.

The percentage of Counties Manukau population 15+ years who smoke regularly

	2006 Baseline	2013 Result	13/14 Target
Maaori	47%	36%	Progress towards 12% prevalence by 2018
Pacific	30%	23%	
Total	22%	16%	



We are committed to achieving a Smokefree Counties Manukau by 2025 and will continue to implement strategies that focus on reducing smoking prevalence to 12% by 2018, and 18% for Maaori, as intermediate steps towards achieving <5% prevalence for all groups by 2025. Our three key priority workstreams for 2014/15 are to sustain and refine our core business, to continue implementing our innovation initiatives, and to gain deeper insight into our currently smoking population, with a focus on Maaori and Pacific, in order to inform effective future strategies.

A reduction in the incidence of rheumatic fever

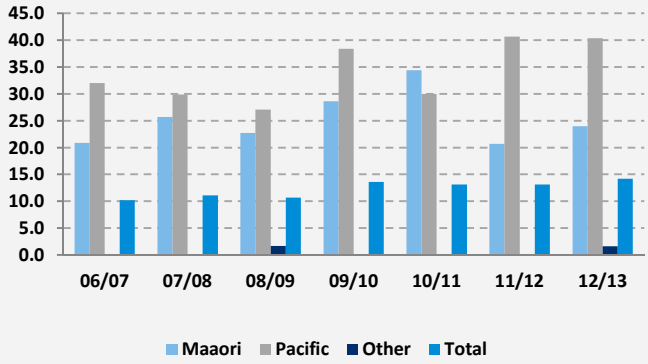
Acute rheumatic fever (ARF) is a preventable, life-limiting illness that continues to be diagnosed in children across New Zealand and reduction in hospitalisations for rheumatic fever is one of the

Acute rheumatic fever first hospitalisations rates per 100,000 population

	11/12 Baseline	12/13 Result	13/14 Target
Maaori	20.7	24	12.4
Pacific	40.7	40.4	
Total	13.1	14.2	

government's Better Public Service goals.

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



CM Health has the highest number of rheumatic fever cases of any DHB nationally, and has an overall rheumatic fever rate double the national average.

We are committed to reducing the burden of Rheumatic Fever in our communities and acknowledge the complexity of preventing this disease as well as the wide range of activities and investment needed if a significant reduction in cases is to be achieved. A range of initiatives are being implemented targeting those most at risk. This includes school-based throat swabbing programmes in 61 schools; providing access to sore throat management in primary and community care through 48 Sore Throat Clinics; and systematically identifying children who are at risk of developing rheumatic fever and offering a package of housing-related interventions to reduce their risks.

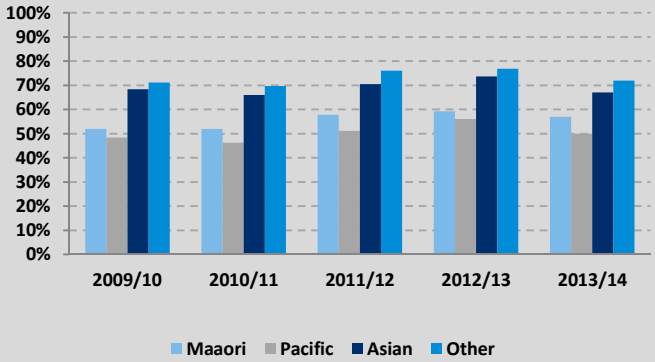
Improved diabetes control

Diabetes is an increasing cause of disability and premature death, and disproportionality affects Maaori and Pacific peoples. In 2012 there were approximately 34,000 adults identified as having diabetes living in Counties Manukau.

Good management of diabetes and associated risk factors is important in improving health for the individual and has potential in reducing long term health system costs.

Initiatives and measures to improve identification and management of diabetes include monthly DCIP reporting to the DHB by PHOs to monitor performance and provide support; improved data collection systems; performance audits; education; and linkages with the Regional Diabetes Network and Diabetes Auckland. Funding has been provided for insulin initiation, retinal screening, podiatry, health psychology, dietetics and Diabetes Nurse Specialists.

The percentage of people in Counties Manukau who have good control of their type 2 diabetes (Hb1Ac <=64mmol/mol)[8]		12/13 Baseline	13/14 Result	13/14 Target
	Maaori	59%	57%	Increase baseline rates
	Pacific	56%	50%	
	Asian	74%	74%	
	Other	77%	72%	



Improved patient experience of care

Understanding and improving patient experience of care is vital to improving patient safety and the quality of the service and care we deliver. Patient experience has been shown to be a sound indicator of the quality of health and disability services; and growing evidence indicates that improved patient experience, developing partnerships with patients, and patient and whaanau centred care are linked to improved health, clinical, financial, service and satisfactory outcomes.

From mid-2014 onward, CM Health will measure patient experience through two surveys. The web-based CM Health Patient Experience Survey was rolled out in April 2014 and measures patient experiences across 14 domains that are reflective of patient and whaanau centred care.

The National Patient Experience Survey, which is being led by the Health Quality and Safety Commission, is due to be implemented in August 2014 and will measure patient experience across four domains. Results from both surveys will be included in future Annual Reports.

The patient experience surveys are about improving the quality of health services and the care delivered by enabling patients to provide feedback that can be used to monitor and improve health service delivery.

[8] Data sourced from CM practice enrolled patients participating in the Chronic Care Management and Diabetes Care Improvement Package programmes. These data are therefore a subset of the total population.

Improved access to mental health services

Mental health disorders are common in New Zealand and worldwide. Many New Zealanders will experience a mental illness and/or an addiction at some time in their lives, with an estimated one in five people affected within one year. It is estimated that at any one time approximately 3 percent of the population are severely affected by mental illness and/or addiction. Overall, Maaori and Pacific peoples experience higher rates of mental illness than non-Maaori, non-Pacific.

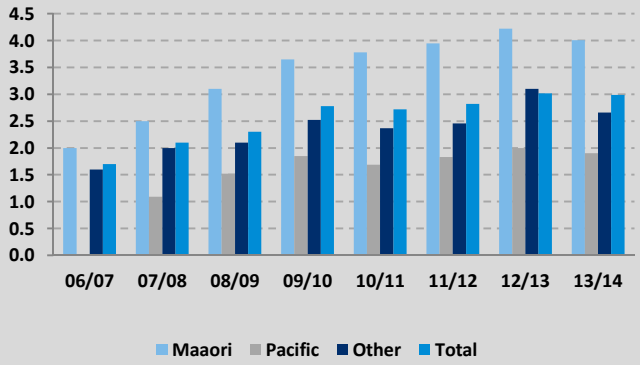
Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes.

Mental health service access rates are a proxy measure for determining the impact of CM Health mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction. There has been a substantial amount of work done since 2006 to increase mental health access for those with severe mental illness. Targets set at around 3 percent reflect the estimates of the population severely affected by mental illness and/or addiction.

CM Health has invested in a number of community based support options including community support, respite and acute alternatives and has experienced steady incremental growth the access rate for the population of recent years. While access rates now are at around similar levels to the previous year the trend appears to have plateaued. Increased productivity and efficiency is one area of improvement alongside understanding what other drivers there are for this result. Most notably this includes a new strategic focus that relates to enhancing access for a much larger group of the population with moderate to severe illness. This system wide approach to models of care builds on the gains made and further enhances the role of primary care and community based services. Specialist services are developing stronger partnerships with primary level care services and strengthening consultation and liaison activity while continuing to ensure high quality, accessible and responsive services for those with the most severe disorders. Detailed reporting on this shift in service delivery requires new (yet to be developed) activity based data collection in addition to the individual level service contact data captured by specialist services.

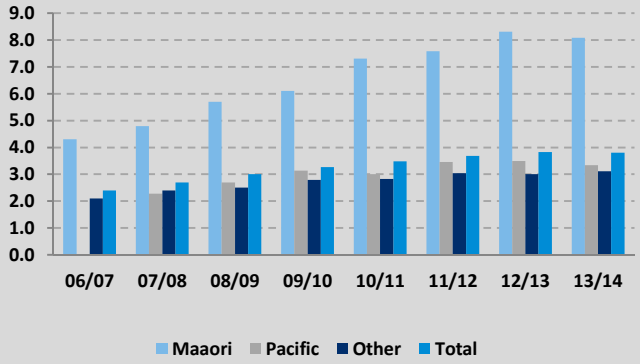
The mental health access rates for 0-19 year olds in Counties Manukau

	12/13 Baseline	13/14 Result	13/14 Target
Maaori	4.22	4.01	4.45
Pacific	2.00	1.90	-
Other	3.10	2.66	-
Total	3.02	2.99	3.07



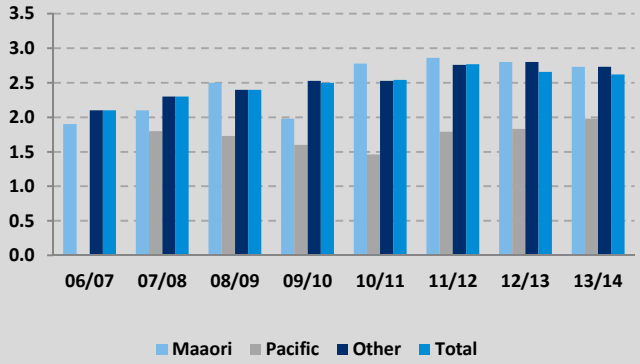
The mental health access rates for 20-64 year olds in Counties Manukau

	12/13 Baseline	13/14 Result	13/14 Target
Maaori	8.31	8.09	7.75
Pacific	3.49	3.34	-
Other	3.00	3.11	-
Total	3.83	3.80	3.07



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

	12/13 Baseline	13/14 Result	13/14 Target
Maaori	2.80	2.73	-
Pacific	1.83	1.98	-
Other	2.80	2.73	-
Total	2.66	2.62	2.80



Improved access to emergency care

Refer to Performance Against National Health Targets section.

The percentage of people presenting to CM Health emergency department who were admitted, discharged or transferred within 6 hours	12/13 Baseline	13/14 Result	13/14 Target
	96%	96%	95%

Reduced hospital stays in the last 6 months of life

End of life care commonly involves high use of hospital services, can be very costly and the experience of care for patients and their families may not be the best. It is also complicated by issues such as ageing population and chronic illnesses. Looking closer at information on how health services are used in the last months of life can offer helpful insights into how we can improve. Our focus is on better care for people who are in their last stages of life so this includes a health system and patient and whaanau perspective. Our key system level measure of improvement that we can measure now is "Hospital days in the last six months of life". This tells us about how well we organise our services and may also reflect a better balance between community and hospital based care. It is important to balance this measure with that of the patient and whaanau experience. This is in development as part of the Health Safety Quality Commission patient survey development.

The overall mean length of stay in hospital in the last 6 months of life in Counties Manukau	12/13 Baseline	13/14 Result	13/14 Target
	-	18 days	-[9]

Work on end of life care measures is currently under review by our Clinical Governance Group to ensure that we have the right set of contributory measures to inform our service improvement approaches.

In 2013/14 the overall mean length of stay in the last 6 months of life was 18 days. The Institute for Healthcare Improvement benchmark for this measure is a mean of 7 days. Discussions are currently taking place with CM Health leaders about what might be an appropriate target for our population given the sensitive nature of end of life care.

Improved access to elective services

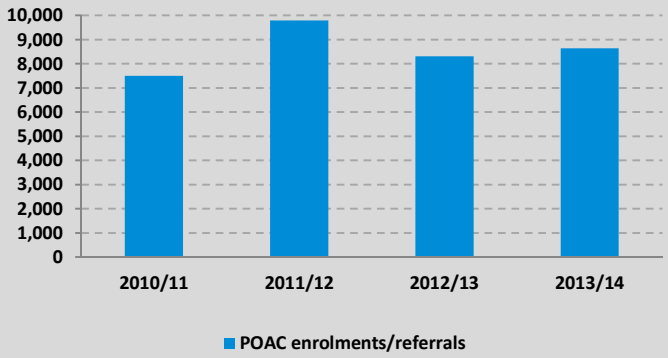
Refer to Performance Against National Health Targets section.

The elective surgical services discharge performance of CM Health	12/13 Baseline	13/14 Result	13/14 Target
	111%	112%	100%
	17,085 discharges	17,457 discharges	15,635 discharges

Increase percentage of total health service delivery/spend in primary and community care

A cornerstone strategic programme for CM Health is system integration, where we are expanding the range and scope of services (and resources) provided in the community so that more people can be better supported by the locality multidisciplinary team to stay well closer to where they live. To support this, CM Health has developed a whole of system commissioning framework to integrate secondary and primary and community care so that proactive, planned services are organised around the needs of an individual.

The number of enrolments/ referrals in Primary Options for Acute Care (POAC) in Counties Manukau	12/13 Baseline	13/14 Result	13/14 Target
	8309	8642	12,261



Our 2013/14 initiatives focused on those people that will have the most benefit from this approach, such as older people and those living with complex health and social needs. One of our objectives is to reduce the rates of unplanned hospital admissions.

Increasing the referrals to Primary Options for Acute Care (POAC) is the proxy measure we have chosen to demonstrate that we are increasing opportunities for our patients to engage with their primary healthcare provider so that they receive preventative care which will reduce the need for future hospital presentations.

Improved patient experience of care

Understanding and improving patient experience of care is vital to improving patient safety and the quality of the service and care we deliver. Patient experience has been shown to be a sound indicator of the quality of health and disability services; and growing evidence indicates that improved patient experience, developing partnerships with patients, and patient and whaanau centred care are linked to improved health, clinical, financial, service and satisfactory outcomes.

From mid-2014 onward, CM Health will measure patient experience through two surveys. The web-based CM Health Patient

[9] Target under development. The Institute for Healthcare Improvement benchmark for this measure is a mean of 7 days, with on-going discussions with CM Health leaders about what might be an appropriate target for our population given the sensitivity nature of end of life care.

Experience Survey was rolled out in April 2014 and measures patient experiences across 14 domains that are reflective of patient and whaanau centred care.

The National Patient Experience Survey, which is being led by the Health Quality and Safety Commission, is due to be implemented in August 2014 and will measure patient experience across four domains. Results from both surveys will be included in future Annual Reports.

The patient experience surveys are about improving the quality of health services and the care delivered by enabling patients to provide feedback that can be used to monitor and improve health service delivery.

Reduced rates of annual health expenditure increase per capita

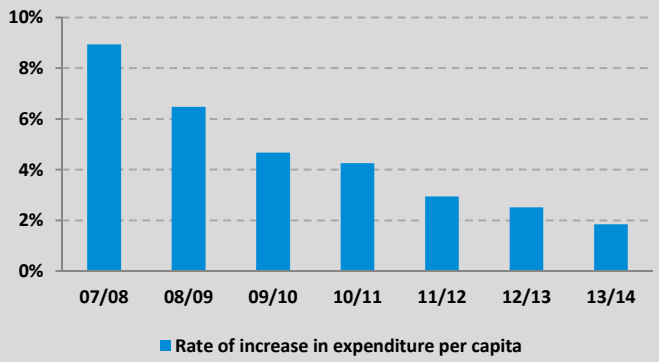
Achieving the best value for health system resources is vital for our long-term clinical and financial sustainability as we face an increasing demand for health services, at the same time the health sector is facing significant fiscal challenges. In order to achieve financial sustainability we must reduce the rate of annual cost increases.

We remain focused on continuous improvement and innovation in order to deliver high quality health services to meet the increasing demand in a manner that is sustainable and provides best value.

This includes developing sustainable clinical asset management strategies and plans; delivering long term cost savings through our Practising Sustainable Healthcare programme; and developing future financial models that will support our long term financial viability.

The rate of increase in CM Health expenditure per capita

12/13 Baseline	13/14 Result	13/14 Target
2.51%	1.85%	



CM Health Financial Outcome Trends 2006/07 to 2013/14

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Total Revenue $000's[10]	$949,226	$1,060,578	$1,138,527	$1,216,356	$1,296,173	$1,352,493	$1,405,654	$1,440,022
Total Expenditure $000's[10]	$948,101	$1,053,385	$1,141,521	$1,216,193	$1,291,311	$1,347,084	$1,402,642	$1,436,968
Population[11]	459,650	468,840	477,158	485,680	494,665	502,190	509,150	517,070
CM Health expenditure per capita[10, 12]	$2,063	$2,247	$2,392	$2,504	$2,610	$2,682	$2,755	$2,779
Rate of increase in CM Health expenditure per capita		8.92%	6.45%	4.68%	4.23%	2.76%	2.72%	0.87%

[10] Sourced from CMDHB Annual Reports 2007-2013

[11] 2013 projections for FYs from MOH/StatsNZ, based on 2006 Census

[12] Note that national services provided by CM Health are included in the total revenue and therefore includes services for people living outside our district, but this is a relatively small proportion of the total spend

Statement of Service Performance

As part of our annual planning cycle, we provide an annual forecast of the services we plan to deliver. In developing the annual forecast, we consider the health needs of our population and select those 'measures' or activities and services that have the greatest potential to contribute to improving the health and wellbeing of our community and those which are markers of broader system-level change, or those where we expect to see a significant change in activity level. Against each measure we set performance targets. This section presents CM Health's actual performance against the forecast outputs presented in our 2013/14 Statement of Intent.

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

Prevention Services

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

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

		2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Health Promotion and Education Services					
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking provided with advice and help to quit (National Health Target)		95%	95%	96%	Achieved
Proportion of enrolled patients who are smoke and are seen in General Practice are offered brief advice and help to quit (National Health Target)		56%	90%	99%	Achieved
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered brief advice and support to quit smoking[15]		-	Progress towards 90%	91.4% [16]	-
Number of completed health and housing assessments[17]		-	-	-	-
Number of homes insulated through Warm Up Counties Manukau programme		834	1000	2258	Achieved
Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score (self-audit using AUT tool)[18]	Partner Abuse	96/100	90/100	98/100[19]	Achieved
	Child Abuse and Neglect	98/100	90/100	98/100[19]	Achieved

[13] Baseline as at June 2013 (Q4) unless otherwise stated.
[14] Target to be achieved by June 2014 (Q4) unless otherwise stated.
[15] Developmental target.
[16] This data is provided by the MOH however only accounts for around 80 percent of pregnancies.
[17] This programme ceased operating in July 2013.
[18] The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training method.
[19] This is a preliminary result; final result due November 2014.

		2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Immunisation Services					
Proportion of 8 month olds who have had their primary course of immunisation (six weeks, three months and five months immunisation events) on time (National Health Target)	Maaori	81%	90%	84%[20]	Not achieved
	Pacific	92%		95%	Achieved
	Total	90%		92%	Achieved
Proportion of older people (65+) who have had their flu vaccinations		Dec 2012 61.9%	75%	64.8%[21]	Not achieved
Health Screening					
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Maaori	69.2%	70%	68.6%	Not achieved
	Pacific	71.9%		72.9%	Achieved
	Total	68.8%		69.2%	Not achieved
Proportion of women aged 25-69 years who have had a cervical smear in the last three years	Maaori	59.9%[22]	80%	59%[23]	Not achieved
	Pacific	63.3%[22]		64.9%[23]	
	Total	69.3%[22]		70%[23]	
Proportion of the eligible population who have had their B4 School Checks	Vision & Hearing[24]	80% (including 3,061 of high deprivation population)	90% (including 3,612 of high deprivation population)	90% (including 3,612 of high deprivation population)	Achieved
	Nurse[25]				
Statutory and Regulatory Services					
Number of licensed premises (on, off club and special) risk assessed by Auckland Regional Public Health Service		1,269[26]	1,200	1,226	Achieved
Number of licensed premises assessed as high risk		608[27]	400	134	Achieved
Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted		237	200	180[28]	Not achieved

[20] Refer to 'Performance Against National Health Targets' section.
[21] Hui are to be undertaken in Q1 2014/15 to discuss pathways and identify actions to increase access to seasonal flu vaccination for those aged 65+ years.
[22] Result at 31 March 2014.
[23] A number of targeted initiatives including data matching, pathway reviews, free screening and increasing community awareness are being implemented to increase cervical screening rates and reduce inequalities.
[24] Vision and hearing – 2 components.
[25] Nurse – 8 components.
[26] From October 2012, a new risk assessment tool was implemented. Before the tool was used, the risk of premises was not able to be systematically assessed. The number included here represents the number of license applications processed in the year 2011/12 as a base to estimate the number of licenses that may be risk assessed in the year 2013/14. 100 percent of license applications will be risk assessed.
[27] The number included here represents the number of premises that were considered of high risk according to the criteria used before the implementation of the new assessment tool and that received a compliance check. It is expected that the assessment tool will provide a better method for identification of high risk premises; the target for 2013/14 has been set accordingly.
[28] Controlled purchase operations (CPOs) are demand driven as requested by the Police (leading Agency).

Early Detection and Management Services

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

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

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

		2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Primary Health Care Services					
Number of bed days saved through our 'Saving 20,000 Day' campaign initiatives[29]		20,060	20,000 days	-	-
Long Term Conditions Management					
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)	Maaori	58%	66%	57%[30]	Not achieved
	Pacific	53%		50%[30]	Not achieved
	Total	64%		70%	Achieved
Proportion of eligible people who have had their cardiovascular risk assessed in the last 5 years (National Health Target)	Maaori	71%	90%	87%[31]	Not achieved
	Pacific	76%		90%	Achieved
	Total	76%		91%	Achieved
Number of additional patients enrolled in Self Management (SM) programmes		488	700	1134	Achieved
Proportion of primary care practices engaged in Chronic Care Management (CCM) programme		-	70%	88%	Achieved
Total number of new patients enrolled in the Very High Intensive User (VHIU) programme [32]		549, 113 primary care enrolled	411, 72 primary care enrolled	682, 217 primary care enrolled	Achieved
Provide VHIU community based care where possible to avoid hospital admissions		30% savings in bed days for VHIU (728 bed days saved)	25% saving in bed days for VHIU (438 bed days saved)	38% saving in bed days for VHIU (742 bed days saved)	Achieved
Number of enrolments/referrals in Primary Options for Acute Care (POAC)		8,309	12,261	8,642[33]	Not achieved
Oral Health Services					
Proportion of children under 5 years enrolled in DHB-funded oral health services		Dec 2012 71%	Dec 2013 75%	Dec 2013 77%	Achieved
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)		Dec 2012 19%	Dec 2013 12%	Dec 2013 8.6%	Achieved

[29] This has been discontinued with work distributed into individual collaborative teams and reported individually.
[30] Refer to 'Performance against National Health Targets' section.
[31] Refer to 'How have we Performed' section.
[32] With minimum 200 primary care enrolled.
[33] Lower POAC volumes in 2013/14 can be attributed to a combination of quality improvement processes, including the implementation of clinical pathways, development of policies to support safety and best practice; clinical quality improvement and education (e.g. changes to the way Cellulitis is managed) and changes in the criteria and funding options for accessing diagnostics. While the result of this activity has seen a reduction in referrals to POAC, this does not appear to have resulted in an increase in hospital referrals in the same areas.

		2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service		Dec 2012 100%	Dec 2013 100%	Dec 2013 100%	Achieved
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		Dec 2012 74.4%	Dec 2013 80%	Dec 2013 80%	Achieved
Diagnostics					
Proportion of accepted referrals for CT and MRI scans will receive their scan within 6 weeks	CT	Dec 2012 84%	Dec 2013 75%	Dec 2013 86%	Achieved
			June 2014 85%	June 2014 71%[34]	Not achieved
	MRI	Dec 2012 63%	Dec 2013 75%	Dec 2013 74%	Not achieved
			June 2014 85%	June 2014 69%[35]	Not achieved
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		Dec 2012 39%	Dec 2013 50%	Dec 2013 40%	Not achieved
			June 2014 50%	June 2014 67%	Achieved
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		Dec 2012 29%	Dec 2013 50%	Dec 2013 37%[36]	Not achieved
			June 2014 50%	June 2014 38%[36]	Not achieved
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		Dec 2012 73%	Dec 2013 50%	Dec 2013 75%	Achieved
			June 2014 50%	June 2014 85%	Achieved

Intensive Treatment and Assessment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.

They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

[34] A new CT scanner has since been purchased to increase capacity to meet demand.
[35] Peaks in demand coincided with FTE vacancies; these vacancies have now been filled.
[36] Insufficient capacity to meet increased demand, additional outsourcing has been put in place to meet demand and long term options to increase capacity are being investigated.

			2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Mental Health						
Proportion of long term clients with Relapse Prevention Plan (RPP)	Child and Youth	Maaori	97.6%	95%	95.7%	Achieved
		Total	95.2%		95.7%	
	Adult (20+)	Maaori	96.3%	95%	93.6%[37]	Not achieved
		Total	96.7%		91.7%[37]	
Proportion of people referred for non-urgent mental health or addiction services seen within 3 weeks and 8 weeks		3 weeks	60.5%	80%	81.2%	Achieved
		8 weeks	80.6%	95%	96%	Achieved
Elective Services						
ESPI 2: Patients waiting longer than four months for their first specialist assessment (FSA)			Dec 2012 26.9%	Dec 2014 0.0%	June 2014 0.0%	Achieved
ESPI 5: Patients given a commitment to treatment but not treated within four months			Dec 2012 0.1%	Dec 2014 0.0%	June 2014 0.1%[38]	Not achieved[38]
Number Elective Surgical Discharges			17,085	15,635	17,457	Achieved
Elective surgical services discharge performance (National Health Target)			111%	100%	112%	Achieved
Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population		Major joints	June 2013 22.27	21.0	March 2014 22.72	Achieved
		Cardiac	June 2013 6.48	6.5	March 2014 5.59	Not achieved
		Cataracts	June 2013 40.01	27.0	March 2014 41.98	Achieved
Outpatient Did Not Attend (DNA) rates		Maaori	19%	<10%	12%[39]	Not achieved
		Pacific	17%	<10%	10%[39]	Not achieved
Acute Services[40]						
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours (National Health Target)			96%	95%	96%	Achieved
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment (and are ready to start treatment) who receive treatment within four weeks from decision to treat (National Health Target)	Chemo-therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	
	Radiation therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	

[37] This is being addressed through refresher training for clinicians and weekly audits.
[38] Target is December 2014 whereas reported result is June 2014.
[39] Targeted strategies to reduce outpatient DNA rates have been implemented.
[40] Cancer treatment services for patients in Counties Manukau are provided through the Auckland DHB Regional Cancer and Blood Centre and CM Health Haematology

		2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Proportion of patients referred urgently with high suspicion of Lung cancer to first cancer treatment (62 days)		75%	60%	71.3%	Achieved
Proportion of patients referred urgently with high suspicion of lung cancer to first specialist appointment (all treatment types) within 14 days	Radiation oncology	62%	50%	91.5%	Achieved
	Medical oncology	62%	50%	91.5%	Achieved
Proportion of patients with confirmed lung cancer diagnosis who receive first cancer treatment within 31 days of decision of treat (all treatment types)		97%	60%	95.8%	Achieved
Cardiac Services					
Proportion of all outpatients triaged to chest pain clinics who are seen within 6 weeks for cardiology assessment and stress test		99%	80%	99.5%	Achieved
Proportion of outpatient coronary angiograms with a waiting time of < 3 months		93%	National 85% Regional 90%	97.7%	Achieved
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission		75%	70%	77.5%	Achieved
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins		86%	80%	89%	Achieved
Maternity Services					
Proportion of CM Health newborns screened within 12 weeks of birth		96%	90%	97%	Achieved
Quality and Patient Safety					
Acute readmissions to hospital	75+	11.85%	<=11.8%	11.52%	Achieved
	Total	7.99%	<=8.0%	7.7%	Achieved
Inpatient length of stay (elective)		3.49 days	3.21 days	3.22 days[41]	Not achieved
Wards (excluding Mental Health) that have electronic medication reconciliation systems in place		65% (implemented in 20 ward)	100%	82%[42] (implemented in 34 wards)	Not achieved
Average rate of Central Line Associated Bacteraemia (CLAB) in the Intensive Care Unit		1.2/1000 line days	0	0.7[43]	Not achieved
Number of in-hospital falls per bed-day		3.27/1000 bed days	Dec 2013 <3.5/1000 bed days	3.63/1000 bed days[44]	Not achieved

[41] Consistent and continual reductions in elective length of stay have been made each quarter in 2013/14. Continuing this trend will see CM Health meet the target in Q1 2014/15.

[42] Implementation of electronic medication reconciliation systems is in the process of being rolled out in the remaining clinical specialities: Gynaecology, Paediatrics and Mental Health.

[43] The CLAB programme, which developed a standard process ("bundles") for the insertion and maintenance of central lines to prevent the occurrence of CLAB, was successfully implemented in ICU and the insertion bundle in now used in all areas. As a result of this programme, there are now inpatient areas that have had over 400 days without a CLAB; one area has been CLAB free for over 1,000 days.

[44] Preventing falls is a key focus of the Falls Group which work with local champions to test and implement fall prevention interventions. This includes use of data to drive improvement, immediate post-fall learning and how reliably prevention interventions are in place falls. Regular auditing is used for monitoring that wards complete a risk assessment with patients who are most at risk of falling and that specific interventions are in place to prevent falls.

	2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
Number of pressure injuries hospital wide per 100 patients	3.3%	3.5%	3.3%	Achieved
Hand hygiene compliance rate (based on Gold Audit)	67%	80%	74%[45]	Not achieved

Rehabilitation and Support Services

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

On a continuum of care these services will provide support for individuals.

	2012/13 Baseline[13]	2013/14 Target[14]	2013/14 Result	Achievement
NASC				
Proportion of CM Health NASC staff who have participated in interRAI training and can deliver appropriate assessments in the community and allocate support using CM Health contracted HBSS	100%	100%	100%	Achieved
Assessment, Treatment and Rehabilitation Services				
Provision of AT & R services for the Franklin locality through Pukekohe hospital	67%	80% occupancy of 10 AT&R beds at Pukekohe Hospital	88%	Achieved
Average length of stay in AT & R (Pukekohe hospital beds)	18.35 days	<16 days	16.75 days[46]	Not achieved
Average length of stay for patients included in acute geriatric pilot at Middlemore Hospital	5 days	5 days	8.3 days[47]	Not achieved
Age Related Residential Care (ARRC)				
Proportion of residential care service providers who are trained in Long Term Care Facility interRAI	19%	32%	57%	Achieved
Number of avoidable EC presentations from ARRC	20	Decrease by 15%	15	Achieved
Number of emergency care presentations from retirement villages	33	Decrease by 5%	37.7[48]	Not achieved
Home Based Support				
Proportion of CM Health NASC clients receiving Home Base Support Services who have a comprehensive interRAI assessment completed in the last 12 months	34%	50%	69.7%	Achieved

[45] CM Health has exceeded the national target of 70 percent for the fifth consecutive audit and aims to achieve 80 percent by June 2015. Over the past year, we have continued implementation of the multi-modal strategy developed in 2012. Work on clinical engagement will continue, involving front-line staff in decision-making and increasing capability to audit and improve practice.

[46] This unit has 10 beds and a complex patient who took longer to rehabilitate had a significant impact on the average length of stay.

[47] The targeting of complex patients in 2013/14 resulted in higher length of stay (LOS).

[48] The Geriatric pilot concluded in early 2013/2014; a refocus on avoiding emergency care presentations from ARRC was prioritised.

Performance by Output Classes

(Includes agency costs)

$000	Prevention	Early Detection	Intensive	Rehabilitation	Total
Revenue (includes agency revenue)	**21,185**	**209,289**	**1,116,842**	**113,606**	**1,460,922**
Budget (includes agency revenue)	*20,127*	*208,287*	*1,101,079*	*113,441*	*1,442,934*
Personnel costs	6,443		520,374		526,817
Outsourced Services	1,257		63,825		65,052
Clinical Supplies	627		100,571		101,198
Infrastructure & Non-Clinical Supplies	960		52,764		53,714
Other(includes agency costs)	11,898	209,289	376,220	113,606	711,013
Total costs	**21,185**		**1,113,788**	**113,606**	**1,457,868**
Budget(includes agency costs)	*20,127*	*208,287*	*1,098,047*	*113,441*	*1,439,902*
Surplus (Deficit)	**-**	**-**	**3,054**	**-**	**3,054**
Budget	*-*	*-*	*3,032*	*-*	*3,032*

Agency revenue and costs for the year amounts to $20,856k.

Good Employer

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

Principle

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

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

Good Employer principles in practice

Provisions which reflect the General Principles include:

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

Standards

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

Complaints and appeals

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

Equal Employment Opportunities (EEO)

Principles

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

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

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

Policy

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

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

- Employment of EEO groups at all levels in the workplace

CMDHB is a member of the Equal Employment Opportunity (EEO) trust. This assists the organisation to champion our EEO goals.

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

Discrimination

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

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

Benefits

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

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

EEO will assist CMDHB to:

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

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

Policies, Procedures and Guidelines

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

Workforce

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

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

	Females		Males	
Employee Group	Number	Average salary	Number	Average salary
Administration & Management	835	$63,767	98	$101,449
Allied Health & Technical	984	$62,964	219	$62,113
Medical				
House Officers	63	$99,745	63	$98,299
Registrars	173	$114,496	147	$121,618
Medical Officer of Specialist Scale	9	$178,762	12	$166,802
Specialist Medical Officer	196	$215,838	274	$248,282
Non-Clinical Support	248	$38,502	169	$46,652
Nursing/Midwifery				
Mental Health Nursing	213	$64,756	86	$58,929
Midwifery	187	$66,226	0	-
General Nursing	2055	$63,261	227	$61,496

Number of ethnic groups employed?

Ethnic data is collected through the leader payroll system with 95 percent of employees disclosing ethnicity. This allows for greater access to valuable planning data for services who are working to meet the organisations' objective of having a workforce which more accurately reflects the population we serve.

Financial Statements

Statement of Responsibility

The Board are responsible for the preparation of the Counties Manukau District Health Board and group's financial statements, 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 2014.

Signed on behalf of the Board:

Dr Lee Mathias

Chair

Wendy Lai

Chair Audit, Risk and Finance

Geraint Martin

Chief Executive

Ron Pearson

Deputy Chief Executive / Director

Corporate & Business Services

31 October 2014

Statement of Comprehensive Income

For the year ended 30 June 2014

	Notes	Parent and Group		
		Actual 2014 $000	Budget 2014 $000	Actual 2013 $000
Income				
Patient Care Revenue	2	1,417,479	1,411,051	1,381,090
Interest Income		2,239	1,200	1,400
Other Income	3	20,304	29,149	23,164
Total income		**1,440,022**	**1,441,400**	**1,405,654**
Expenditure				
Personnel costs	4	526,817	529,125	511,413
Depreciation and amortisation expense	13/14	29,923	30,516	23,594
Outsourced services		65,082	55,267	62,506
Clinical supplies		101,198	94,249	101,448
Infrastructure and non-clinical expenses		53,714	55,739	46,979
Other District Health boards		199,829	272,267	200,560
Non-health board provider expenses		422,024	367,584	423,056
Capital Charge	5	15,257	12,996	12,738
Interest expense		8,822	13,450	8,134
Other expenses	6	14,302	7,176	12,215
Total expenditure		**1,436,968**	**1,438,369**	**1,402,642**
Surplus		**3,054**	**3,031**	**3,012**
Other comprehensive income				
Revaluation	13	6,931	-	19,645
Other comprehensive income		**6,931**	**-**	**19,645**
Total comprehensive income for the year		**9,985**	**3,031**	**22,657**

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

For the year ended 30 June 2014

	Notes	Parent and Group		
		Actual 2014 $000	Budget 2014 $000	Actual 2013 $000
Balance 1 July		**188,597**	**171,115**	**166,354**
Comprehensive income		-	-	-
Surplus for the year		3,054	3,031	3,012
Other comprehensive income		6,931	-	19,645
Total comprehensive income		**9,985**	**3,031**	**22,657**
Capital contributions from the Crown		-	2,148	-
Repayment of capital to the Crown		(419)	(419)	(419)
Interest on restricted funds		10	-	5
Balance at 30 June		**198,173**	**175,875**	**188,597**

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

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2014

	Notes	Parent and Group		
		Actual 2014 $000	Budget 2014 $000	Actual 2013 $000
Assets				
Current Assets				
Cash and cash equivalents	7	21,580	886	1,028
Debtors and other receivables	8	32,887	29,147	35,442
Inventories	10	1,434	3,990	946
Prepayments		1,196	450	321
Non-Current Assets held for Sale	11	12,503	-	-
Total current assets		**69,600**	**34,473**	**37,737**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	21,618	24,481	15,829
Property, plant and equipment	13	594,681	618,606	588,153
Intangible assets	14	9,803	5,509	8,139
Other Non-Current Assets	9	1,360	1,300	1,277
Total non-current assets		**627,462**	**649,896**	**613,398**
Total assets		**697,062**	**684,369**	**651,135**
Liabilities				
Current liabilities				
Overdraft	16	-	4,607	7,350
Creditors and other payables	15	105,390	85,273	95,965
Borrowings	16	40,000	5,000	5,000
Employee entitlements	17	110,432	126,414	106,691
Total current liabilities		**255,822**	**221,294**	**215,006**
Non-current liabilities				
Borrowings	16	227,600	270,600	232,600
Employee entitlements	17	14,130	15,300	13,595
Provisions	18	1,337	1,300	1,337
Total non-current liabilities		**243,067**	**287,200**	**247,532**
Total liabilities		**498,889**	**508,494**	**462,538**
Net assets		**198,173**	**175,875**	**188,597**
Equity				
Crown equity	19	108,545	93,208	108,964
Accumulated deficits	19	(45,610)	(45,632)	(48,664)
Revaluation reserves	19	134,374	127,443	127,443
Trust funds	19	864	856	854
Total Equity		**198,173**	**175,875**	**188,597**

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

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2014

	Notes	Parent and Group		
		Actual 2014 $000	Budget 2014 $000	Actual 2013 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,319,466	1,417,967	1,275,020
Other		141,971	30,349	148,632
Interest received		2,239	1,200	1,322
Payments to suppliers		(871,343)	(855,832)	(867,495)
Payments to employees		(522,541)	(521,015)	(504,673)
Capital charge		(14,680)	(12,996)	(12,925)
Interest payments		(8,521)	(13,450)	(8,134)
Goods and services tax (net)		1,279	757	(1,305)
Net cash flow from operating activities	**20**	**47,870**	**46,980**	**30,442**
Cash flows from investing activities				
Purchase of property, plant, equipment and intangible assets		(43,687)	(71,533)	(81,928)
Acquisition/roll over of investments		(5,827)	-	(584)
Net cash flow from investing activities		**(49,559)**	**(71,533)**	**(82,512)**
Cash flows from financing activities				
Capital contributions from the Crown		-	2,147	-
Repayment of capital to the Crown		(419)	(419)	(419)
Repayment of loans		(5,000)	(5,000)	(30,005)
Proceeds from borrowings		35,000	23,000	70,000
Net Appropriation from Trust Funds		10	-	6
Net cash flow from financing activities		**29,591**	**19,728**	**39,582**
Net increase in cash and cash equivalents		**27,902**	**(4,825)**	**(12,488**
Cash and cash equivalents at the start of the year		(6,322)	1,104	6,166
Cash and cash equivalents at the end of the year		**21,580**	**(3,721)**	**(6,322)**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Statement of Accounting Policies

Reporting Entity

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

Financial statements for CMDHB and consolidated financial statements are presented. The consolidated financial statements of CMDHB as at and for the year ended 30 June 2014 comprise CMDHB and its subsidiaries (together referred to as the "Group" and individually as "Group entities") and the Group's interest in associates and jointly controlled entities.

CMDHB 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 CMDHB are for the year ended 30 June 2014, and were approved by the Board on 31 October 2014

Basis of Preparation

Statement of compliance

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

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

Measurement base

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

Functional and presentation currency

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

Changes in accounting policies

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

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

Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by CMDHB. CMDHB does not consolidate its subsidiaries as they are not material.

Investments in Associates and Jointly Ventures

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

Revenue

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

MOH Revenue

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

ACC Contract Revenues

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

Rental income

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

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

Leases

Finance leases

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

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

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

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

- land
- buildings,plant and infrastructure
- 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 re valued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years.

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

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

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

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

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

Amortisation

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

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

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

Impairment of Property, Plant & Equipment and Intangible Assets

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as 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

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

Superannuation schemes

Defined contribution schemes

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

Provisions

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

Provisions are not recognised for future operating losses.

Restructuring

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

ACC Partnership Programme

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

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost Allocation

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

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

Critical accounting estimates and assumptions

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

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

Land and buildings revaluations

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

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

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

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

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit 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.

Retirement and long service leave

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

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

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

Agency relationship

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

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

Standards, amendments, and interpretations issued that are not yet effective and have not been early Adopted

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

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

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards have been developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is for the reporting periods beginning on or after 1 July 2014. This means the DHB will transition to the new standards in preparing its 30 June 2015 financial statements. The DHB has not assessed the implications of the new Accounting Standards Framework at this time.

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

2. Patient care revenue

	Actual 2014 $000	Actual 2013 $000
Health and disability services (MoH contracted revenue)	1,300,756	1,267,390
ACC contract revenue	17,579	16,516
Revenue from other district health boards	80,220	80,033
Other patient care related revenue	18,924	17,151
Total patient care revenue	**1,417,479**	**1,381,090**

Revenue for health services includes all revenue received from the Crown (via the Ministry of Health), Accident Rehabilitation and Compensation Insurance Corporation (ACC), and other sources.

Income received from other District Health Boards for agency contracts has been offset against the cost of those contracts. $20.9m (2013 $22.5m).

3. Other income

	Actual 2014 $000	Actual 2013 $000
Donations and bequests received	1,968	2,570
Rental income	1,602	1,473
Gain on Disposal of Assets	43	85
Other income	16,691	19,036
Total other income	**20,304**	**23,164**

4. Personnel costs

	Actual 2014 $000	Actual 2013 $000
Salaries and wages	507,483	492,572
Contributions to defined contribution schemes	14,798	11,916
Increase in liability for employee entitlements	4,276	6,615
Restructuring provision for employee exit costs	260	310
Total personnel costs	**526,817**	**511,413**

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 2014 was 8% (2013: 8%).

6. Other expenses

Other expenses include:	Actual 2014 $000	Actual 2013 $000
Audit fees – audit of financial statements	189	181
Operating leases expense	6,838	6,800
Impairment of debtors	6,913	4,819
Board and committee members fees and expenses	362	415
Total Other Expenses	**14,302**	**12,215**

7. Cash and cash equivalents

	Notes	Actual 2014 $000	Actual 2013 $000
Cash on hand		10	14
Trust / Special purpose Funds	19	865	854
Call deposits		-	160
Demand funds held with HBL		20,705	-
Cash and cash equivalents for the purposes of the statement of cash flows		**21,580**	**1,028**

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

8. Debtors and other receivables

	Actual 2014 $000	Actual 2013 $000
Ministry of Health receivables	4,671	4,176
Other receivables	9,768	11,995
Other accrued revenue	21,838	21,655
Less: provision for impairment	(3,390)	(2,384)
Total Debtors and other receivables	**32,887**	**35,442**

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:

	2014			2013		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	28,573		28,573	28,997		28,997
Past due 1-30 days	2,120		2,120	2,740		2,740
Past due 31-60 days	1,245	(605)	640	896	(438)	459
Past due 61-90 days	1,650	(663)	987	836	(446)	390
Past due > 90 days	2,689	(2,122)	567	4,356	(1,500)	2,856
Total	**36,277**	**(3,390)**	**32,887**	**37,825**	**(2,384)**	**35,442**

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 2014 $000	Actual 2013 $000
Balance at 1 July	2,384	3,097
Charged to 'Other Expenses' (additional provisions made)	6,969	4,819
Receivables written off	(5,963)	(5,532)
Balance at 30 June	**3,390**	**2,384**

9. Other Non-Current Assets

	Actual 2014 $000	Actual 2013 $000
Reversionary interest in car park building	1,360	1,277
Total Other Non-Current Assets	**1,360**	**1,277**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to them in 15 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 2014 $000	Actual 2013 $000
Pharmaceuticals	708	848
Other Supplies net of provision for obsolete stock	726	98
Total inventories	**1,434**	**946**

Some inventories are subject to retention of title clauses.

The amount of inventories recognised as an expense during the year was $19.3m (2013 $20.2m) which is included in the Clinical supplies line item for the Statement of Comprehensive Income.

11. Non-Current Assets held for Sale

The DHB owns Land and Buildings assets which have been classified as held for sale following the Board's approval of their sale.

	Notes	Actual 2014 $0	Actual 2013 $0
Land	13	10,323	-
Buildings	13	2,180	-
Total Non-current assets held for sale		**12,503**	**-**

12. Investments in Associates and Jointly Controlled Entities

a) General information

Name of entity	Principal activities	Interest held at 30 June 2014	Balance date
Northern Regional Alliance Ltd	Provision of health support services	33.3%	30 June-14
healthAlliance NZ Ltd	Provision of shared services	20.0%	30 June-14
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	25.0%	30 June-14

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

Year end 30 June 2014 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd	10,424	9,038	1,386	14,233	607
healthAlliance NZ Ltd	115,213	19,525	95,688	109,494	444
NZ Health Innovation Hub Limited Partnership	2,280	1,015	1,265	2,404	764

Year end 30 June 2013 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Alliance Ltd[49]	13,282	12,503	779	10,806	111
healthAlliance NZ Ltd	85,559	19,206	66,354	99,222	100
NZ Health Innovation Hub Limited Partnership	1,278	777	501	1,139	(299)

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

	Parent and Group	
	2014 Actual	2013 Actual
Share of profit/(loss)	482	56

d) Investments in Associates and Jointly Controlled Entities

	2014 Actual $000	2013 Actual $000
healthAlliance NZ Ltd	21,618	15,829
Total Investments	**21,618**	**15,829**

[49] The Northern DHB Support Agency Ltd changed its name during the 2012-13 year to Northern Regional Alliance Ltd (NRA). The Northern Regional Training Hub Ltd was incorporated into NRA during the 2012-13 year.

13. Property, plant and equipment

	Land	Buildings, Plant & Infrastructure	Clinical Equipment, IT & Motor Vehicles	Other Equipment	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance at 1 July 2012	**72,753**	**373,113**	**116,705**	**15,565**	**88,411**	**666,547**
Additions	-	-	-	-	73,393	73,393
Work in Progress	-	15,071	11,493	793	(31,568)	(4,211)
Revaluation of Assets	-	19,645	-	-	-	19,645
Disposals/transfers	-	-	(531)	(53)	-	(584)
Balance at 30 June 2013	**72,753**	**407,829**	**127,667**	**16,305**	**130,236**	**754,790**
Balance at 1 July 2013	**72,753**	**407,829**	**127,667**	**16,305**	**130,236**	**754,790**
Additions			505		41,511	42,016
Work In Progress capitalised	-	138,420	29,082	2,394	(169,896)	-
Revaluation of Assets	47,590	(108,545)				(60,955)
Disposals/transfers	-	-	(505)	(1)	-	(506)
Transferred to Assets held for Resale (see note 11)	(10,323)	(2,653)	-	-	-	(12,976)
Balance at 30 June 2014	**110,020**	**435,051**	**156,749**	**18,698**	**1,851**	**722,369**
Accumulated depreciation and impairment losses						
Balance at 1 July 2012	**-**	**36,948**	**93,426**	**13,638**	**-**	**144,012**
Depreciation expense	-	14,057	8,810	684	-	23,551
Elimination on disposal/transfer	-	(373)	(505)	(48)	-	(926)
Balance at 30 June 2013	**-**	**50,632**	**101,731**	**14,274**	**-**	**166,637**
Balance at 1 July 2013	**-**	**50,632**	**101,731**	**14,274**	**-**	**166,637**
Depreciation expense	-	17,727	11,219	923	-	29,869
Elimination on disposal/transfer	-	-	(457)	-	-	(457)
Elimination on revaluation		(67,886)				(67,886)
Transferred to Assets held for Resale (see note 11)	-	(473)	-	-	-	(473)
Balance at 30 June 2014	-	**-**	**112,493**	**15,195**	**-**	**127,890**
Carrying amounts						
At 1 July 2012	**72,753**	**336,165**	**23,279**	**1,927**	**88,411**	**522,535**
At 30 June and 1 July 2013	**72,753**	**357,197**	**25,936**	**2,031**	**130,236**	**588,153**
At 30 June 2014	**110,020**	**435,051**	**44,256**	**3,503**	**1,851**	**594,681**

Valuation

Land

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

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

The most recent valuation of land was performed by a registered independent valuer, Darroch, and the valuation is effective as at 30 June 2014 and amounted to $110.0m.

Buildings

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

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

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

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

The most recent valuation of buildings was performed by a registered independent valuer, Darroch, and the valuation is effective as at 30 June 2014 and amounted to $434.1m.

Restrictions on title

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

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

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

14. Intangible assets

Movements for each class of intangible assets are as follows:

	Notes	Shares HBL $000	Software $000	Total $000
Balance at 1 July 2012		-	-	-
Additions		3,791	4,391	8,182
Work in Progress Capitalised		-		-
Balance at 30 June 2013 / 1 July 2013		3,791	4,391	8,182
Additions		1,718		1,718
Balance at 30 June 2014		5,509	4,391	9,900
Accumulated amortisation and impairment losses				
Balance at 1 July 2012		-	-	-
Amortisation expense		-	43	43
Balance at 30 June 2013/1 July 2013		-	43	43
Amortisation expense		-	54	54
Balance at 30 June 2014		-	97	97
Carrying amounts				
At 1 July 2012		-	-	-
At 30 June and 1 July 2013		**3,791**	**4,348**	**8,139**
At 30 June 2014		**5,509**	**4,294**	**9,803**

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

At 30 June 2014, the DHB had made payments totalling $5,509k (2013: $3,791k) to HBL in relation to the Finance Procurement Supply Chain (FPSC) Programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

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

It is expected that the final costs of the FPSC Programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC Programme will proceed as originally planned. In this scenario, the DRC of the FPSC assets is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC Programme is uncertain and any future decision to re-scope or discontinue the FPSC Programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

15. Creditors and other payables

	2014 Actual $000	2013 Actual $000
Creditors and accrued expenses	95,047	88,133
GST payable	6,761	6,571
Capital charge payable (over payment)	390	(187)
Income in advance	3,192	1,448
Total creditors and other payables	**105,390**	**95,965**

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

	2014 Actual $000	2013 Actual $000
Current portion		
Overdraft facility (HBL)	-	7,350
Crown loans – fixed interest	40,000	5,000
Total current portion	**40,000**	**12,350**
Non-current portion		
Crown loans – fixed interest	227,600	232,600
Total non-current portion	**227,600**	**232,600**
Total borrowings	**267,600**	**237,600**
Borrowing facility limits		
Crown loan facility limit	297,600	297,600
Overdraft facility	67,145	64,428
Total borrowing facility limits	**364,745**	**362,028**

Crown loans

The fair value of Crown loans is $270.2m (2013 $245.1m)). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.30% to 6.36% (2013 3.32% to 6.36%)

Overdraft facility

CMDHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue. This is used in determining working capital limits, being defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST, for CMDHB that equates to $67.1m.

17. Employee entitlements

	2014 Actual $000	2013 Actual $000
Current portion		
Accrued salaries and wages	40,386	37,250
Annual leave	51,322	51,313
Sick Leave	277	300
Long Service Leave	1,382	661
Retirement Gratuities	1,873	1,820
Sabbatical leave	704	1,737
Continuing medical education leave	14,488	13,610
Total current portion	**110,432**	**106,691**
Non-current portion		
Long service leave	5,454	5,098
Retirement gratuities	7,262	7,106
Sick leave	1,414	1,391
Total non-current portion	**14,130**	**13,595**
Total employee entitlements	**124,562**	**120,286**

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 3.70% - 5.20% (2013 2.71% - 5.50%) and an inflation factor of 0.6% (2013 3.0%) were used.

18. Provisions

	2014 Actual $000	2013 Actual $000
Non-current portion		
ACC Partnership Programme	1,337	1,337
Total provisions	**1,337**	**1,337**

Movements for each class of provision are as follows:	ACC Partnership Programme 2014 $000	ACC Partnership Programme 2013 $000
Balance at 1 July	1,337	1,212
Additional provisions made	-	125
Balance at 30 June	**1,337**	**1,337**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON Hewitt, has calculated the liability as at 30 June 2014. 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% (2013 20%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

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

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

Key assumptions

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

- An average assumed rate of inflation of 3.0% for 30 June 2014 and 2013;
- A weighted average discount factor of 3.5% for 30 June 2014 and for 30 June 2013 that has been applied to future payment streams; and
- Claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 11% of claims will result in no payment, 86% will result in medical claims, and 21% will result in an element of time off work.

Insurance risk

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

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

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

19. Equity

	2014 Actual $000	2013 Actual $000
Crown equity		
Balance at 1 July	108,964	109,383
Capital contributions from the Crown		-
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**108,545**	**108,964**
Accumulated surpluses/(deficits)		
Balance at 1 July	(48,663)	(51,675)
Surplus/(deficit) for the year	3,054	3,012
Balance at 30 June	**(45,610)**	**(48,663)**
Revaluation reserves		
Balance at 1 July	127,443	107,798
Revaluations	6,931	19,645
Balance at 30 June	**134,374**	**127,443**
Revaluation reserves consist of:		
Land	116,739	69,149
Buildings and Infrastructure	17,635	58,294
Total revaluation reserves	**134,374**	**127,443**
Trust funds		
Balance at 1 July	854	848
Transfer from/(to) accumulated surpluses	10	6
Balance at 30 June	**864**	**854**

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

Total equity	**198,173**	**188,597**

Included in accumulated surpluses/deficits are $26.589m (2013 $21,908m) 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

	2014 Actual $000	2013 Actual $000
Net surplus/deficit	3,054	3,012
Interest on Restricted Funds	10	6
Add/(less) non-cash items		
Depreciation and amortisation expense	29,923	23,594
Total non-cash items	29,923	23,594
Add/(less) items classified as investing or financing activities		
Gain on disposal of assets	43	85
Total items classified as investing or financing activities	**43**	**85**
Add/(less) movements in statement of financial position items		
Debtors and other receivables	2,555	(3,076)
Inventories	(488)	(111)
Creditors and other payables	8,497	317
Employee entitlements	4,276	6,615
Net movements in working capital items	**14,757**	**3,745**
Net cash flow from operating activities	**47,870**	**30,442**

21. Capital Commitments and Operating Leases

Capital Commitments

	2014 Actual $000	2013 Actual $000
Property, plant and equipment	2,584	19,865
Total capital commitments	**2,584**	**19,865**

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:

	2014 Actual $000	2013 Actual $000
Not later than one year	2,778	2,879
Later than one year and not later than five years	2,604	4,689
Later than five years	-	247
Total Non-Cancellable Operating Leases	**5,382**	**7,815**

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 ten years.

22. Contingencies

Contingent liabilities

Asbestos

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

Kingseat

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

Superannuation schemes

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

Contingent assets

The DHB has no contingent assets (2013 $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, ACC and other DHBs (including Agency Revenue) of $1,438m (2013 $1,381m) to provide health services in the Counties Manukau area for the year ended 30 June 2014 (note 2).

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

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

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2014 totalled $7.7m (2013 $10.9m). These purchases included the purchase of electricity, air travel from Air New Zealand, and postal services from New Zealand Post, and blood from NZ Blood Service.

Transactions with key management personnel

Key management personnel compensation

	2014 Actual FTE	2013 Actual FTE	2014 Actual $000	2013 Actual $000
Executive management team	11	11	3,441	3,287
Board	11	10[50]	297	364
Committee	14	24	14	39
Total key management personnel compensation	36	45	3,752	3,690

The actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $83k (2013 $75k)Key management personnel include all Board members, the Chief Executive, and eleven members of the management team.

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

During the year, the DHB transacted with Bob Wichman Limited in which CMDHB Board member R Wichman, is a Director and shareholder. The value of the expenditure totalled $33k (2013 $17k) and was incurred on normal commercial terms. There is a balance of $nil (2013 $nil) outstanding for unpaid invoices at year end.

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

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

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

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

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

[50] Mr Frank Solomon resigned 26 Nov 2012

The Manukau Health Trust

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

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

In the interests of full disclosure and transparency, CMDHB is, with the consent of MHT, disclosing through this Note, the unaudited financial position of MHT for the year ending 30 June 2014.

Statement of Financial Performance $000	Parent and Group 2014 Actual $000	2013 Actual $000
Income	363	1,355
Surplus (Deficit)	(113)	(131)
Statement of Financial Position		
Total Equity	-	**581**
Non-Current Assets	-	2
Current Assets	-	876
Total Assets	-	**878**
Current Liabilities	-	297
Net Assets	-	**581**

The operation of the Trust ceased at 8 November 2013 and the Trust is in the process of being wound-up.

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $5.0m (2013 $4.1m) and a surplus of $0.2m (2013 $0.3m) which may be subject to restrictions on distribution as at 30 June 2013. The financial statements of the Foundation for 2014 are not publicly available as they have not yet been approved by the Foundation's trustees.

Revenue from Related Parties	Parent and Group 2014 Actual $000	2013 Actual $000
healthAlliance NZ Ltd	2,038	99
Northern Regional Alliance Ltd	1,647	1,178
Auckland University of Technology	691	-
Department of Building and Housing	2	-
Health Quality & Safety Commission	694	1,632
Manukau Institute of Technology	1,362	1,151
ProCare Health Ltd	5	13
Pharmaceutical Society of NZ	8	-
UNITEC	5	-
University of Auckland	1,892	1,705
Total	**8,344**	**5,778**

Purchases from Related Parties	Parent and Group 2014 Actual $000	2013 Actual $000
healthAlliance NZ Ltd	28,256	26,785
Health Benefits Ltd	2,239	2,077
Northern Regional Alliance Ltd	6,762	9,631
Auckland Council	401	132
Better Value Healthcare Asia-Pacific	37	-
Bob Wichman Ltd	29	17
Cressey Pharmacy	4	-
Goodman-Fielder Ltd	68	-
Manukau Institute of Technology	58	26
Meridian Energy	7	-
NZICA	6	-
Parent and Family Resource Centre Board	5	-
Raukura Hauora O Tainui Iwi Advisory	-	14
Pharmaceutical Society of NZ	14	-
ProCare Health Ltd	-	229
Sapere Research Group (no longer a related party)	-	58
University of Auckland	2,853	2
Total	**40,739**	**36,127**

Receivables from Related Parties	Parent and Group 2014 Actual $000	2013 Actual $000
Northern Regional Alliance Ltd	30	44
healthAlliance NZ Ltd	1,849	49
Health Quality & Safety Commission	5	23
Manukau Institute of Technology	406	2
ProCare Health Ltd	5	-
Pharmaceutical Society of New Zealand	6	-
University of Auckland	95	351
Total	**2396**	**469**

Payables to Related Parties	Parent and Group 2014 Actual $000	2013 Actual $000
healthAlliance NZ Ltd	553	1,504
Health Benefits Ltd	590	-
Northern Regional Alliance Ltd	1,314	2,144
Auckland University of Technology	10	-
Bob Wichman Ltd	6	-
University of Auckland	126	-
Total	**2,599**	**3,648**

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

24. Board member remuneration

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

	2014 Actual	2013 Actual
Professor Gregor Coster[51]	27,500	65,558
Dr. Lee Mathias ONZM[52]	24,875	-
Mrs Jan Dawson[51]	18,375	39,945
Ms Wendy Lai	15,521	-
Mr Arthur Anae	25,375	28,250
Mr David Collings	26,875	28,500
Mr Donald Barker[51]	14,500	34,574
Mr Paul Cressey[51]	14,312	32,000
Mr Robert Wichman[51]	13,750	29,000
Mrs Colleen Brown MNZM JP	26,125	30,937
Dr Lyn Murphy	27,625	33,878
Mrs Sandra Alofivae	26,812	29,500
Mr Frank Solomon[53]	-	11,417
Mrs Kathy Maxwell[52]	12,625	-
Mrs Dianne Glenn[52]	12,625	-
Mr George Ngatai[52]	13,375	-
Mr Reece Autagavaia[52]	12,375	-
Total board member remuneration	**297,125**	**363,559**

Committee Members	Award $ 2014
Ms Wendy Bremner	2,239
Dr Andrew Chan Mow	417
Ms Heather Grace	833
Ms Malia Hamani	417
Mr Sefita Hao'uli	1,458
Ms Raewyn Hodges	1,042
Mr Denise Ewe	240
Ms Louisa Lavakula	2,083
Mrs Roine Lealaiauloto	417
Mr Nuku Rapana	417
Mr Ezekiel Robson	1,875
Rev Uea Tuleia	417
Ms Te Aomarama Wilson	1,042
Mr Nicholas Main	625
Total	**13,522**

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 (2013 $nil).

[51] Board member resigned December 2013
[52] Board member taking office December 2013
[53] Resigned from the Board 26 November 2012

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:	2014 Actual $000	2013 Actual $000
Total remuneration paid or payable:		
$100,000 – 109,999	170	134
$110,000 – 119,999	110	84
$120,000 – 129,999	56	63
$130,000 – 139,999	50	52
$140,000 – 149,999	27	29
$150,000 – 159,999	34	20
$160,000 – 169,999	26	23
$170,000 – 179,999	29	15
$180,000 – 189,999	21	27
$190,000 – 199,999	21	20
$200,000 – 209,999	-	23
$210,000 – 219,999	52	21
$220,000 – 229,999	32	18
$230,000 – 239,999	37	29
$240,000 – 249,999	25	19
$250,000 – 259,999	25	31
$260,000 – 269,999	19	20
$270,000 – 279,999	8	17
$280,000 – 289,999	14	14
$290,000 – 299,999	18	11
$300,000 – 309,999	8	9
$310,000 – 319,999	11	9
$320,000 – 329,999	4	13
$330,000 – 339,999	9	6
$340,000 – 349,999	5	6
$350,000 – 359,999	2	4
$360,000 – 369,999	2	3
$370,000 – 379,999	6	2
$380,000 – 389,999	3	3
$390,000 – 399,999	1	4
$400,000 – 409,999	1	-
$410,000 – 419,999	2	6
$420,000 – 429,999	2	2
$430,000 – 439,999	-	2
$440,000 – 449,999	1	2
$450,000 – 459,999	-	-
$460,000 – 469,999	-	-
$470,000 – 479,999	-	1
$480,000 – 489,999	-	-
$490,000 – 499,999	-	-
$500,000 – 509,999 (*paid includes a payment relating to the prior period)	-	2*
$510,000 – 519,999	-	-
$520,000 – 529,999	1	-

During the Year Ended 30 June 2014, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 703 (2013 - 635) are Medical Staff and 129 (2013 - 109) are Management.

During the year ended 30 June 2014, 4 (2013: 4) employees received compensation and other benefits in relation to cessation totalling $230,124 (2013 $143,399).

26. Events after the balance date

There were no significant events after the balance date.

27. Financial instruments

Financial instrument categories

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

	2014 Actual $000	2013 Actual $000
Loans and receivables		
Cash and cash equivalents	21,580	1,028
Debtors and other receivables	32,887	35,442
Total loans and receivables	**54,467**	**36,470**
Financial liabilities measured at amortised cost		
Overdraft facility	-	7,350
Creditors and other payables (excluding income in advance and GST)	95,047	88,133
Borrowings	267,600	237,600
Total financial liabilities measured at amortised cost	**362,647**	**333,083**

Financial instrument risks

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

Market risk

Price risk

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

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

Cash flow interest rate risk

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

Sensitivity analysis

As at 30 June 2014, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have no impact as all loans are fixed (2013 $0.0k).

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 32% 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:

	2014 Actual $000	2013 Actual $000
Counterparties with credit ratings		
Cash and cash equivalents and investments	865	1,014
Counterparties without credit ratings		
Total cash and cash equivalents and investments	20,715	14
Total debtors and other receivables	32,887	35,442

Liquidity risk

Management of liquidity risk

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

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

Contractual maturity analysis of financial liabilities

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

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2013						
Creditors and other payables	95,965	95,965	95,965			
Borrowings (counterparties without credit rating)	7,350	7,350	7,350			
Crown loans	237,600	297,869	16,233	50,515	64,301	166,820
Total	**340,915**	**401,184**	**119,548**	**50,515**	**64,301**	**166,820**
2014						
Creditors and other payables	105,390	105,390	105,390			
Crown loans	267,600	331,622	52,221	10,216	101,609	167,576
Total	**372,990**	**437,012**	**157,611**	**10,216**	**101,609**	**167,576**

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. Trust & Special Purpose Funds

	2014 Actual $000	2013 Actual $000
Trust/Special funds		
Balance at beginning of year	854	848
Funds expended	-	-
Interest received on Restricted Funds	10	6
Balance at end of year	**864**	**854**

30. Explanation of major variances against budget

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

Statement of comprehensive income

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

- Total Income for the year (excluding donations) was $0.8m lower than budget this was due to variations in contacts for work undertaken with MOH and fluctuation in Private Patient revenue
- Expenditure for the year was $1.4m lower than budget caused by a flow effect of the revenue variations and clinical mix of work undertaken
- Donations were lower by $0.6m due to timing of receiving donations

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

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

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

- Improved operating cashflow of $0.8m due to:
  - Decreased collection from the Crown
  - Increased revenue (purchases) from Crown
  - higher payments to suppliers to match increased purchases from Crown
  - lower interest payments
- Lower investing led to lower financing requirements for the year

Board and Committee Membership

July 2013 – December 2013

	Board	CPHAC*	DiSAC*	FaAC	HAC*	CHAC*
Number of meetings	6	0	0	5	0	6
Professor Gregor Coster	5	N/A	N/A	2	N/A	3
Mrs Jan Dawson	6	N/A	N/A	3	N/A	6
Mr Don Barker	6	N/A	N/A	2	N/A	5
Mr Bob Wichman	6	N/A	N/A	-	N/A	4
Mrs Sandra Alofivae	6	N/A	N/A	-	N/A	6
Mrs Colleen Brown	6	N/A	N/A	-	N/A	4
Dr Lyn Murphy	6	N/A	N/A	2	N/A	5
Mr Paul Cressey	5	N/A	N/A	4	N/A	4
Mr Arthur Anae	5	N/A	N/A	-	N/A	5
Mr David Collings	5	N/A	N/A	-	N/A	5
Mr Frank Solomon[54]	-	N/A	N/A	-	N/A	-

January 2014 – June 2014[55]

	Board	CPHAC[56]	DiSAC[56]	FaAC	HAC[56]	CHAC
Number of meetings	5	5	5	5	5	0
Dr Lee Mathias	5	5	5	5	5	N/A
Ms Wendy Lai	5	-	-	3	5	N/A
Mrs Sandra Alofivae	5	3	4	-	3	N/A
Mrs Colleen Brown	5	5	5	-	3	N/A
Mr Arthur Anae	4	-	-	-	4	N/A
Mrs Dianne Glenn	5	5	5	-	5	N/A
Mrs Kathy Maxwell	5	-	-	5	5	N/A
Mr David Collings	3	4	-	4	4	N/A
Dr Lyn Murphy	4	-	-	4	5	N/A
Mr George Ngatai	4	3	4	5	4	N/A
Mr Reece Autagavaia	5	4	4	-	4	N/A

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

[54] Frank Soloman resigned from the Board on 26 November 2012. He did not attend any meetings in 2013.
[55] New Board came into office December 2013.
[56] In May 2013, CPHAC, DISAC and HAC were merged to form the Combined Health Advisory Committee (CHAC); in December 2013 CHAC ceased and separate Committees were re-instated.

Board Members' Disclosure of Interests

As at June 2014

Dr Lee Mathias (Chair)	▪ MD Lee Mathias Limited ▪ Trustee, Lee Mathias Family Trust ▪ Trustee, Awamoana Family Trust ▪ Chair Health Promotion Agency ▪ Deputy Chair Auckland District Health Board ▪ Director, Pictor Limited ▪ Director, iAC Limited ▪ Advisory Chair, Company of Women Limited ▪ Director, John Seabrook Holdings Limited ▪ Chairman, Unitec
Ms Wendy Lai (Deputy Chair)	▪ Board member and partner at Deloitte ▪ Board member Te Papa Tongarewa, the Museum of New Zealand
Mr Arthur Anae	▪ Councillor, Auckland Council ▪ Board Member Phobic Trust ▪ Member The John Walker 'Find Your Field of Dreams' ▪ Chairman, NZ Good Samaritan Heart Mission to Samoa Trust
Mrs Colleen Brown	▪ Chair Parent and Family Resource Centre Board (Auckland Metropolitan Area) ▪ Member of Advisory Committee for Disability Programme Manukau Institute of Technology ▪ Member NZ Down Syndrome Association ▪ Husband, Determination Referee for Department of Building and Housing ▪ Chair, Early Childhood Education Taskforce for COMET ▪ Member, Manurewa Advisory Group ▪ Member, Child Advocacy Group – Manukau ▪ MSD Member, Auckland Social Policy Forum, Auckland Council ▪ Deputy Chair, Auckland City Council Disability Strategic Advisory Group ▪ Chair ECE Implementation Team Auckland South ▪ Chair IIMuch Trust
Dr Lyn Murphy	▪ Member, International Society for Pharmacoeconomics and Outcomes Research (ISPOR). ▪ Member of the New Zealand Association of Clinical Research (NZACRes) ▪ Senior lecturer in management and leadership at Manukau Institute of Technology ▪ Member, ACT NZ ▪ Director, Bizness Synergy Training Ltd ▪ Director, Synergex Holdings Ltd ▪ Associate Editor NZ Journal of Applied Business Research ▪ Member Franklin Local Board
Mrs Sandra Alofivae	▪ Chair of the Auckland South Community Response Forum (MSD appointment) ▪ MSD Member, Auckland Social Policy Forum, Auckland Council ▪ Member, Fonua Ola Board ▪ Appointed to the Ministerial Forum on Alcohol Advertising & Sponsorship ▪ Board Member, Pacifica Futures

Mr David Collings	▪ Chair, Howick Local Board of Auckland Council ▪ Member Auckland Council Southern Initiative
Mrs Kathy Maxwell	▪ Director, Kathy the Chemist Ltd ▪ Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd) ▪ Editorial Advisory Board, New Zealand Formulary ▪ Member Pharmaceutical Society of NZ ▪ Trustee, Maxwell Family Trust ▪ Member Manukau Locality Leadership Group, CMDHB
Mrs Dianne Glenn	▪ Member – NZ Institute of Directors ▪ Member – District Licensing Committee of Auckland Council ▪ Life Member – Business and Professional Women Franklin ▪ President – National Council of Women Papakura/Franklin Branch ▪ Member – UN Women Aotearoa/NZ ▪ Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust ▪ Member – Friends of Regional Parks ▪ Life Member – Ambury Park Centre for Riding Therapy Inc. ▪ CMDHB Representative - Franklin Health Forum/Franklin Locality Clinical Partnership
Mr George Ngatai	▪ Arthritis NZ – Kaiwhakahaere ▪ Chair Safer Aotearoa Family Violence Prevention Network ▪ Director Transitioning Out Aotearoa ▪ Director BDO Marketing ▪ Board Member, Manurewa Marae
Mr Reece Autagavaia	▪ Member, Pacific Lawyers' Association ▪ Member, Labour Party ▪ Member, Auckland Council Pacific People's Advisory Panel ▪ Board Member, United Otara Market

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Counties Manukau District Health Board and group's financial statements and performance information for the year ended 30 June 2014

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

We have audited:

- the financial statements of the Health Board and group on pages 30 to 66, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board and group that comprises the statement of service performance on pages 18 to 25 and the report about outcomes on pages 13 to 17.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 30 to 66:

- comply with generally accepted accounting practice in New Zealand; and

- fairly reflect the Health Board and group's:

  - financial position as at 30 June 2014; and

  - financial performance and cash flows for the year ended on that date.

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

Reason for our qualified opinion

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

Our audit opinion on the performance information of the Health Board and group for the year ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 18 to 25 and 13 to 17:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

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

Our audit of the performance information involved evaluating:

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

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

Directory

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Auditor

Audit New Zealand on

behalf of the Auditor General

Solicitors

Buddle Finlay

Chapman Tripp

Meredith Connell

Russell McVeagh

Simpson Grierson

Bankers

ASB Bank Limited

Commonwealth Bank

Westpac Banking Corp

Care & Respect

Teamwork

Professionalism

Innovation

Responsibility

Partnership

COUNTIES
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