COUNTIES MANUKAU HEALTH

Annual Report

30 June 2012

Counties Manukau District Health Board Annual Report 2012

CONTENTS

Chair and Chief Executive's Review	2
Board Members	4
Executive Leadership Team	4
What we have achieved this year	5
District Annual Plan	11
Good Employer	14
Financial Statements	16
Statement of Service Performance	62
Board Committee Membership	91
Board Members' Disclosures of Interest	93
Directory & Key Abbreviations	96

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

VISION

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

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

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

VALUES

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

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

Professionalism: Acting with integrity and embracing the highest ethical standards.

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

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

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

CHAIR AND CHIEF EXECUTIVE'S REVIEW

Welcome to the Counties Manukau District Health Board Annual Report. We are an organisation that has its foundations firmly rooted in its values, expertise and experience and this report will take you through our journey of achievement during the past year.

We have made some significant gains in 2011/12 by putting the patient and their whanau/family first, emphasising the importance of improving population health gains and not losing sight of our duty to optimise Vote Health revenue.

Our response to the challenging and dynamic environment in which we deliver health, health care and services to our community has been to galvanize our resolve and meet the challenges by continuing to change what is not working, build on past successes and where possible out-do our performance of previous years.

Achievement of the National Health Targets in the 2011/12 year is one example:

- 94% of our inpatient smokers are now being given advice and help to quit smoking by a health practitioner in our hospitals.
- 95% of all our two year old children are now fully immunised.
- We have continued to meet the target for ensuring that 95% or more patients in Emergency Care are admitted, transferred or discharged within six hours. This is the third year consecutive year that we have reached this target.
- Our population continues to enjoy timely access to elective surgery. 16,257 elective procedures were performed in the year and we maintained full compliance with the Ministry of Health's Elective Services Patient Flow Indicators.
- For the second consecutive year, all patients requiring radiotherapy treatment were treated within four weeks from decision to treat.

We have delivered further gains for our patients as well contributing towards a break even financial year-end position through our First, Do No Harm and Thriving in Difficult Times programmes:

- The Quality Improvement team have made a substantial contribution through their central line acquired bacteraemia, pressure injury and falls initiatives saving our patients 1,700 unnecessary bed days and totalling $3.0 million
- Thriving in Difficult Times Phase 2, realised a saving of $26.5 million. Combining this with the $23.0 million in the previous fiscal year we have a total saving of $49.5 million with just over half of this being a sustainable saving, $30.0 million. This means our total cost base for the equivalent activity, has been permanently reduced by this amount.

Initiatives such as these are supported by Ko Awatea, Centre for Health System Innovation and Improvement, which opened in June 2011. Ko Awatea plays a key role in mentoring, harnessing and supporting innovative ideas and research through four Centres of Excellence: Research, Knowledge and Information Management; Workforce & Leadership Capability; Quality Improvement; and Health System Improvement.

Ko Awatea's strategic and close working relationship and partnership with the Institute of Healthcare Improvement (IHI) means that healthcare professionals from around the country now have the opportunity to develop new skills to drive healthcare initiatives, thanks to training in IHI's quality improvement methodology.

Our Saving 20,000 Days and Aiming for Zero Patient Harm campaigns are examples of the innovative quality programmes developed through Ko Awatea.

Drawing your attention to these gains would not be complete without thanking the people who have made it possible - our talented and committed staff, volunteers, supporters and partners - for their belief in what we are seeking to achieve, the considerable skills they bring to the challenge, their dedication and hard work. Thank you.

We are also grateful for the continued support of the Middlemore Foundation for Health Innovation (previously known as the South Auckland Health Foundation) who has been a key partner over the years in helping us fundraise for equipment or services which enhance our existing work.

In the last year, the Middlemore Foundation raised over $2 million for various projects including:

- a new CT Scanner for Middlemore Hospital's Radiology Department;
- a purpose-built 12-metre long dental surgery truck for children's oral health care services;
- retrofitting of insulation to the houses of low income homes under our WarmUp Counties Manukau project;
- paediatric equipment for the Kidz First neonatal unit.

The first Northern Region Health Plan was successfully implemented in the 2011/12 year with seven out of the Top 10 commitments for the year achieved, with good progress being made in the other three. The Northern Region DHBs and primary care partners, Greater Auckland Integrated Health Network (GAIHN), Alliance Health+ and the National Hauora Coalition were congratulated by the Ministry of Health for this achievement.

Our focus as a District Health Board with a whole of system approach has also seen us reach agreement with our primary care partners and define our Locality Clinical Partnership model. The model builds on our need to change the way healthcare is delivered in Counties Manukau and puts healthcare professionals and services together in the locality in which the patient lives to receive their care and treatment, rather than at one central location such as Middlemore Hospital. A Locality Clinical Partnership was formed in Franklin in July 2012, and the following partnerships are being established:

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

Counties Manukau District Health Board is now one of four foundation partners (along with Waitemata, Canterbury and Auckland District Health Boards) in the New Zealand Health Innovation Hub which commenced operations in June 2012. The Hub will provide a mechanism to engage industry and translate health technologies and service improvement into service delivery for the health and economic benefit of all New Zealanders.

With our culture of quality and quality improvement to the fore we launched our Achieving a Balance strategic direction in February 2012. The 2012/13 fiscal year marks the first of a four year journey to transform the way we deliver health, healthcare and health services to our people in a manner which balances financial and resource sustainability with a healthcare system which delivers excellent services for our population.

Despite the extraordinary environment in which we work and the multiple challenges that it brings, it is an exciting time to be proactively participating in the health sector and drawing out the very best of care and services for our people. It is the commitment of everyone who works with us that together we are able to produce the results we have and we look forward to another year of achievement for Counties Manukau.

Professor Gregor Coster, CNZM
Chair

Geraint Martin
Chief Executive

BOARD MEMBERS

Board Members as at 30 June 2012

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

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

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

Executive Leadership Team as at 30 June 2012	
Geraint Martin	Chief Executive Officer
Ron Pearson	Deputy CEO/Director Corporate & Business Services
Margie Apa	Director, Strategic Development
Dr Campbell Brebner	Chief Medical Advisor Primary
Martin Chadwick	Director, Allied Health
Jenni Coles	Director, Hospital Services
Professor Jonathan Gray	Director, Centre for Health Services Innovation
Martin Hefford	Director, Primary Health & Community
Dr Gloria Johnson	Chief Medical Officer
Denise Kivell	Director of Nursing

WHAT WE HAVE ACHIEVED THIS YEAR

In this section annual report, we highlight some of the successes, key achievements and milestones reached by the DHB in the last year.

We have used the Institute of Healthcare Improvement's Triple Aim as the foundation of our organisational strategic direction and our 2011/12 strategic objectives were to:

- Improve the health of the population and reduce inequalities;
- Improve our patients and their families' experience of care; and
- Make the best use of our population-based funding.

We are very proud of the innovation, effort and the commitment of our staff in delivering a high quality healthcare service to our population and some of the best performances in the region and country for their target areas. This was achieved in the face of significant challenges and growth pressures.

We ended the year on a favourable note with a $2.9mil budget surplus. Our Thriving in Difficult Times programme has continued to deliver impressive savings to our bottomline through a structured programme of quality improvement and waste reduction initiatives including:

- Reduction of cases of serious harm caused by hospital stays;
- Improved contracting and reporting processes with our neighbouring DHBs for Inter District Flows;
- Improved procurement processes at healthAlliance;
- Improved revenue management processes for ACC payments and non-residents.

We remain committed to the Triple Aim objectives which have been translated into our 2012 – 2015 Achieving a Balance strategy to deliver healthcare excellence and build a healthcare system that will be sustainable and able to meet the healthcare needs of our growing community.

More detailed information on the performance of the DHB on health targets and key measures of service delivery and organisational priorities is found in the Statement of Service Performance on pages 62-90.

Health Targets

- More than 94 percent of inpatient smokers are now being given advice and help to quit by health practitioners in our secondary care facilities. This is an outstanding achievement for all staff involved in promoting and championing the Smokefree ABCs since the introduction of this target in 2008/09.
- We reached the national health target for child immunisations with 95 percent of our two year olds now fully immunised (97 percent Pacific, 92 percent Maaori). This is an important public health milestone for our communities as it means that there is a general level of immunity in the population which will decrease the likelihood of the spread of infectious diseases like measles and whooping cough.
- This is the third consecutive year that we achieved the target for ensuring that 95 percent or more patients in Emergency Care (EC) are admitted, transferred or discharged from EC within 6 hours.
- 16,257 elective surgical discharges were provided and we maintained full compliance with the Ministry of Health's Elective Services Patient Flow Indicators.
- For the second consecutive year, all patients requiring radiotherapy treatment were treated within 4 weeks from decision to treat.

Smokefree

- In the year ended 30 June 2012, 520 staff completed Smokefree Best Practice training and 101 staff completed the Nicotine Replacement Therapy Standing Orders training.

Healthy Housing and housing insulation programmes

- 367 joint health and housing assessments were carried out in the community and more than 1,300 homes were insulated through our home insulation programmes, Snug Home and Warm Up Counties Manukau.

Violence Intervention Programme (VIP)

- We received an audit score of 183/200 in the follow up AUT audit of hospital responsiveness to family violence and child abuse. This score places the CMDHB VIP in the Ministry of Health's "Outstanding" performance category.
- CMDHB led a national Elder Abuse and Neglect Service Development Project. Recommendations from the project are currently under consideration by the Ministry of Health.
- The DHB's Emergency Care now routinely screens for domestic violence and child abuse.

Child Health

- The Child Health Alliance Forum, Counties Manukau, of which we are a partner, won a four year contract with the Ministry of Health to provide sore throat swabbing services, awareness of rheumatic fever and service coordination in Counties Manukau via a nurse led school based model of service delivery in areas of high need.
- Our rate of babies exclusively and fully breastfed at 6 weeks improved from 55 percent to 69 percent this year. Middlemore Campus achieved Baby Friendly Hospital Initiative (BFHI)[1] accreditation in November 2011 and all our community maternity units maintained their Baby Friendly Hospital status.
- 66 percent of our eligible preschoolers were enrolled with the oral health service. We continue to work towards achieving 85 percent by June 2013. This enables delivery of oral health education and dental care to families at an early stage to prevent premature childhood tooth decay.
- Our Preschool Oral Health Education & 'Brush-in' Programme operates in 58 preschool centres across the district. We aim to have the programme in 150 preschool centres by July 2013.
- Adolescent utilisation of free oral health services increased from 68 percent to 71 percent and we now have 73 adolescent dental contracts with dental providers in our district. Mobile dental services enabled us to reach out-of-school youth; adolescents from alternative education centres, youth justice and those in Child, Youth and Family Services care residences.
- A total of 7,111 B4 School Checks were completed against a year end target of 7,076, exceeding targets for all quintile areas for the second consecutive year running.

Youth Health

- We partnered Youthline in the development of a Youth and Community Development Centre sited at the former Papatoetoe fire station. This provides a permanent location for youth to socialise with their peers and also receive healthcare services which impact on their health and wellbeing.
- Our school health services had 150,000 health contacts with students this year. Evaluations demonstrate improved health outcomes particularly around access to appropriate healthcare and health seeking behaviours.
- Centre for Youth Health, Kidz First continues to provide excellent support and health care services to the 500 young people in Alternative Education and the young parents and their babies in the two Teen Parent Units. These more intensive services reflect the greater needs of the young people in the services.
- Te Pou Herenga Waka the multi-agency centre for family violence and sexual abuse which opened in June 2011 provides a comprehensive intersectoral assessment to the 500 children/ young people entering Child, Youth and Family care and referrals onto appropriate health services.
- 100 Pacific youth leaders from 10 LotuMoui churches attended the annual LotuMoui youth leadership camp in November 2011. We are empowering our youth leaders to lead, drive and implement health focussed youth initiatives focusing on personal growth and healthy lifestyles with the support of the DHB.

[1] The Baby Friendly Hospital Initiative (BFHI) is a global campaign developed by the World Health Organisation and UNICEF, and administered in New Zealand by the New Zealand Breastfeeding Authority (NZBA). Achieving accreditation means that all our maternity units offer all birthing women an environment which supports breastfeeding and will have trained advocates, lactation consultants, midwives and nurses on hand to encourage and give advice if required.

Integrated Primary Care

- Formation of localities in the Counties Manukau district to organise healthcare delivery using a locality clinical partnership model[2]. These are:
  - Mangere and Otara (including Northern Papatoetoe);
  - Manukau (Including Southern Papatoetoe, Manurewa, Takanini and Papakura);
  - Eastern (including Howick, Beachlands/ Maraetai, Clevedon and Kawakawa/Orere);
  - Franklin.
- Development of the first Locality Clinical Partnership in Franklin was completed in July 2012. Development of LCPs in other localities is underway and all are expected to be fully operational by December 2013.

Saving 20,000 Days

- We launched our Saving 20,000 Days campaign in November 2011 which aims to ensure that over the next two years our people will spend the equivalent of 20,000 of these acute event hospital days – about 5 percent of our total – at home or in the community. This will reduce hospital bed days by 20,000 days and 5,000 unnecessary hospital admissions.[3]

Management of Long Term Conditions and Acute Demand

- We increased the volume of enrolments to all our long term management and integrated programmes to reduce acute demand:
  - Within Counties Manukau, Primary Health Organisations (PHOs) carried out a record 21,698 Diabetes Get Checked reviews this year;
  - 9,788 people enrolled in the Primary Options for Acute Care (POAC) programme in 2011/12 and 8,942 POAC patient admissions were avoided at Emergency Care (compared to 7,126 last year);
  - The Very High Intensive User (VHIU) programme had 1,929 referrals to the programme of which 607 were accepted.

After Hours Primary Care

- We have worked with our DHB partners, PHOs, and Accident & Medical (A&M) clinics to ensure Aucklanders have improved access to after hours care. There are now 11 A&M clinics open until at least 10PM and four of these are open 24 hours including one in South Auckland. The cost of after hours care is subsidised for eligible adults and already more than 90 percent of under sixes who live in Counties Manukau have access to a free face-to-face after hours medical consultation within 60 minutes of their home. We aim to get this to 98 percent by June 2013.

[2] A locality clinical partnership (LCP) is a partnership between Counties Manukau District Health Board and its Primary Care partners (Primary Health Organisations and General Practitioners/family doctors) to change the way healthcare is delivered so that a greater number of health professionals work together to treat patients in their localities rather than at one central location like Middlemore Hospital.

[3] More information on the Saving 20,000 Days campaign can be found here: http://koawateablog.co.nz

Services Closer to Home and Health of Older People

- Our Adult Rehabilitation and Health of Older People services has had a focus on community/locality initiatives to provide better, sooner, more convenient services in the community including:
    - Increasing the AT&R beds at Pukekohe Hospital from 2 to 10 which allows more patients in Franklin to be treated closer to home;
    - Launching an Integrated Care Cluster Pilot in the Eastern Locality Development which will facilitate the identification and management of patients at risk of hospital admission in the community;
    - Rapid response in the community and supported discharge team initiatives which focus on reducing hospital presentations and facilitating earlier discharge post admission.
- Phase 1 and 2 of the Dementia Care Pathway Project was completed and Phase 3 commenced in April 2012. Completion of this project will improve access to multidisciplinary expertise and a consistent approach to management for people with dementia.
- A fourth AT&R ward opened at the Middlemore site, bringing the AT&R bed capacity to 108 beds at Middlemore.
- Our Auckland Spinal Rehabilitation Unit developed a draft standardised inpatient spinal pathway utilising the IHI improvement science methodology. The pathway is currently being trialled with a review planned at the end of 2012.
- Advance Care Planning (ACP) is now being implemented in specific service areas within AT&R, VHIU programme, Pukekohe and Franklin Memorial Hospitals. Staff training continues and the process of recording a conversation and developing an ACP plan has been developed and rolled out.
- Vitamin D prescription in CMDHB Aged Related Residential Care facilities is the highest in the country, thanks to the Community Geriatric Service Educational Programme.

Hospital and Clinical Services

- Our breast screening services achieved a great result of getting 69 percent of our eligible women screened. Rates for Maaori women in particular saw the biggest increase from 60 percent in the previous year to 69 percent this year.
- Overall mental health access rate for year to end 31 March 2012 was 3.32 percent. This is above the New Zealand average of 3.20 percent. We achieved our access targets for the 20 plus age groups.
- The number of unique mental health clients seen over the time period was 16,693, which is a marked increase from the previous year of 15,636.
- Middlemore Central (MMC) our centralised information and action hub started operations in September 2011. MMC brings together workforce and resource utilisation activity giving a helicopter view of daily operations and enabling improved capacity planning. It is also responsible for emergency and disaster planning and response.
- A CMDHB initiative which transfers after hours heart attack patients requiring PCI from our ED to Auckland City Hospital within 90 minutes won the Improvement Project of the Year Award at the 2012 annual Continuous Improvement Forum.
- The insertion and maintenance bundle for central lines first introduced into the Intensive Care Unit has now been rolled out across other clinical areas and wards including radiology. Our inpatient Central Line Acquired Bacteraemia (CLAB) went from an average of 4 per month for the year July 2010 to June 2011 to an average of 2.3 per month for the year July 2011 to June 2012. This is a savings of 338 fewer bed days.
- Our Centre for Quality Improvement is the national lead for the National Central Line Acquired Bacteraemia (CLAB) Prevention Collaborative and also supports the regional First, Do No Harm CLAB project.

- An electronic medicines reconciliation and assessment of risk tool was successfully trialled in Plastics, the National Burns Centre and Assessment, Treatment & Rehabilitation. As a result of this work, on average 99 percent of "high risk" patients now have their medicines reconciled on admission and 64 percent of these within 48 hours of admission. Roll out of the programme is scheduled to begin in October 2012.
- Before the start of our falls prevention project, the average rate of patients with falls resulting in major harm (SAC1-3) was 0.3 per 1,000 bed days. This rate has since halved and has been sustained across the organisation for more than 30 months. The Centre for Quality Improvement also contributes to the regional First, Do No Harm fall prevention programme and is exploring ways of extending this from the secondary care setting out to aged-related residential care settings in the community.
- Prior to the Lung Cancer working group, only 30 percent of lung cancer patients were waiting less than 14 days for their first special assessment (FSA). Since September 2011, 95 percent of FSAs for lung cancer patients are within the 14 days target.
- Patient focussed booking was successfully trialled in the Endocrinology specialty with a 7 percent reduction in their average DNA rate pre and post implementation of the new process.
- Patient focussed booking was rolled out to all specialities within medicine. The new system is expected to help specialties with no capacity issues in reducing the high numbers of overdue appointments.
- Prior to the establishment of the pressure injury working group, the rate of pressure injuries averaged more than 10 percent per 100 patients. In the July 2011 to June 2012 period, the rate averaged just over 4.4 percent. Our goal is to achieve an average rate of 3.5 percent by June 2013.
- MoH innovation funding has allowed CMDHB to explore the use of other workforces to further support and unburden the medical workforce. This has been realised with Allied Health Practitioners (Physiotherapists) screening First Specialist Assessments for low back pain allowing for improved utilisation of the orthopaedic consultants, and more appropriate care of the patients.

Workforce & Leadership Capability

- Our Health Science Academies initiatives won the Tomorrow's Workforce Award and the overall Supreme Award in the 2012 ANZ Equal Employment Opportunities Trust Work and Life Awards. There are currently 137 students enrolled in the three health science academies with 75 Year 11 students and 62 Year 12s. 80 percent of Year 11 students in the first cohort achieved NCEA Level 1 in the 2011 academic year. The retention rate of students in the academies is at an impressive 85 percent.
- A total of 9 Dedicated Education Units have been established to support nursing students.
- Our Clinical Training & Education Centre provided training to 1,167 participants who attended a total of 1,622 simulation learning training sessions.
- Our e-Campus e-learning system now offers 38 interactional e-learning courses. In the last year we had 4,590 users with over 2,000 staff registering course completions for online learning. Hutt Valley DHB is now a user group accessing the shared resources, highlighting our strategic national approach.
- Our Learning & Development service ran a total of 232 workshops which were delivered to 3,488 participants across the spectrum of nursing, medicine, mental health, midwifery, non-clinical staff and students.
- In partnership with the Institute of Healthcare Improvement (IHI) we run the following courses: Executive Quality Academy, Improvement Science in Action and Breakthrough Series, available to both external candidates and our own staff.
- Health Could B 4 U was delivered in 8 schools across South Auckland and supported selected Maaori and Pacific students to health career pathways. There are currently over 500 students in the pipeline.
- Our Earn and Learn Pacific Nursing Pilot Programme which we run with our Ko Awatea partner, Manukau Institute of Technology, is supporting 13 local Pacific students to complete the MIT Bachelor of Nursing – Pacific. This project won the Workforce Development Category of the 2012 CMDHB Health Excellence Awards.
- Allied Health ran a well attended expo showcasing the many workforces that fall under this umbrella grouping and the many professions that are options to progress into after high school for Health Could B 4 U and Health Science Academy nominees.

Regional Collaboration

- The Northern region DHBs and primary care partners, Greater Auckland Integrated Health Network (GAIHN), Alliance Health+ and the National Hauora Coalition, were congratulated by the Ministry of Health on the achievement of the first year implementation plans for the Northern Region Health Plan[4]. The Northern region achieved seven out of ten of its Top 10 commitments for the year, with good progress being made in the other three.

Innovation and Research at the DHB

- We are one of four foundation partners (along with Waitemata, Canterbury and Auckland) in the New Zealand Health Innovation Hub which started operations in June 2012. The Innovation Hub will engage with industry to develop, validate and commercialise health technologies and service improvement initiatives that will deliver health and economic benefits to New Zealand.
- We are a study site and major collaborator in the SHIVERS project (Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance), a five year ESR-led collaborative study funded by the Centre for Disease Control (CDC). The SHIVERS study is investigating the possible causes of severe acute respiratory infections in patients admitted to hospitals in Auckland and will help us understand how different viruses, especially influenza and bacteria, contribute to severe respiratory illness in New Zealand. It will also help New Zealand prepare for any future influenza outbreaks.

Towards 20/20 – Facilities Modernisation

- We completed Phase 1 of our Clinical Services Building and Phase 2 is underway. Upon completion of Phase 2 of the CSB in late 2013, we will have 14 operating theatres, Theatre Admission and Discharge Unit (TADU), a sterile supply unit, High Dependency Unit (HDU), Assessment and Planning Unit, Spiritual Centre and facilities for support services.
- Our histopathology lab moved to new facilities in April 2012.
- We completed the Manukau Health Park[5] master plan in January 2012 and have been developing a strategic assessment which aligns the Manukau Health Park business case with Treasury's Better, Business Case guidelines. This will be presented to the Ministry of Health in August 2012.

[4] The Northern Region Health Plan (NRHP) s is a core strategic document setting out a common set of objectives for the region which aims to improve health outcomes, reduce disparities and deliver services which are better, sooner and more convenient given the resources available.

[5] The Manukau Health Park is a development on Browns Road which will house numerous health related but wellness orientated services as well as the current clinics and hospital services which make up the Manukau Surgical Centre and the Manukau Super Clinic.

OUR ANNUAL PLAN 2012/13

Our district annual plan

This district annual plan for CMDHB marks an important milestone for us as a DHB and us as a community. This year we begin the second year on a four year journey... to be the best healthcare system in Australasia by 2015. We are changing the way we plan and deliver health services across the whole health system - from primary and community services to the hospital - so that our communities receive better, sooner, more convenient services whilst we build a health system which is affordable and of good value. **This strategy is called Achieving a Balance: delivering sustainability and excellence in health.**

The gains we have made through better regional services planning have translated into improved quality and safer hospital services as well as improved hospital productivity. Our relationships with our primary care partners are better than ever as we work together to develop localities for the provision of all types of health services that will be in the community which we serve.

Our key focus is on continuing to build closer integration between the hospital, primary care and community services. The intention is for primary care to play a key role upon which new and integrated services can better manage unplanned, urgent care, long-term conditions and services for older people.

75%
of eligible people will have had their cardiovascular risk assessed in the last five years by June 2013

1000
homes insulated through Warm Up Counties Manukau in 2012-13

308
we aim to complete 308 cardiac surgeries by June 2013

Giving back
20,000
days of health and wellness for our community through reducing unnecessary hospital admissions in 2012-13

150
preschool centres will be trained and resourced to run oral health education and brush-in programmes in 2012-13

2012-13 cataract removals
1,739

75%
of referrals to child and adolescent mental health services are seen within three weeks this year

full immunisation by 2 years
95%
and we aim to fully immunise 85% of babies at 8 months in 2012-13

754 Hip and knee replacements in 2010-11
833
in 2012-13

90%
of smokers who are seen by a primary care health practitioner will be offered advice to quit smoking in 2012-13

Every day

everybody every day

23	babies are born, 5 by Caesarean section, one is low birth weight (under 2,500g), two will have mothers under the age of 20
5	of the 23 babies will be re-admitted acutely to hospital in their first year of life
7	people die
3	people die under the age of 75, two from potentially preventable conditions
330	people are admitted to a public hospital
47	of these are aged 0-74 and have a potentially preventable condition (excluding injury)
247	presentations to an Emergency Care facility
735	people have contact with mental health services
7,600	hours of home based support care visits occur
6,240	An estimated 6,240 people consult their general practitioner (4,700 adults and 1,540 children)
7,980	people have prescriptions dispensed, with 24,220 items costing $420,000
2,520	people have 11,020 laboratory tests costing approximately $108,000
340	free influenza vaccines are administered to people aged 65+ (March to June)
123	immunisation visits occur for children under two (as per Immunisation Schedule)
573	young people are seen through secondary school based health services (during term time)

We need to now progress at a more rapid pace. Our strategic direction over the next four years will be directed by balancing the triple aims of:

- **Keeping our population well**
- **Improving the experience of patients and their families/whanau**
- **Delivering healthcare services which are affordable and good value.**

We need to be both providing a service that has sustainability and excellence at its centre.

Achieving a Balance will mean the following for our population:

- People live healthier, longer, more productive, disease free lives - we will support people to live healthier lifestyles through population health education and programmes to reduce the incidence and delay the onset of preventable conditions.
- People are at the centre of our health system – we will ensure that patients are engaged as partners in their own care and their families are seen as a part of the care team. Patients and families will also be engaged in decisions around models of care and service improvement so that they receive the right care, at the right time and place, delivered by the right person.
- People stay well in the community – we will develop services in primary care and in the community to ensure that people who need long term care are supported to stay well and manage their conditions in community based settings.

What you can expect

Fewer than **20** in-hospital falls causing harm by June 2013

70% of women aged 45-69 years will have had a breast screen in the last 2 years

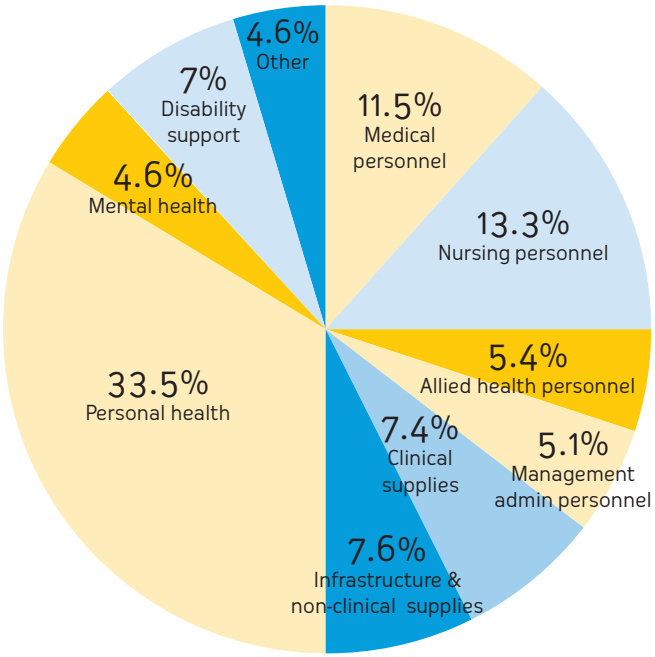
85% of accepted referrals for coronary angiograms will receive their procedure within 3 months

100% of patients needing radiation or chemotherapy will start treatment within four weeks of decision to treat

539 people in the health workforce development pipeline in 2012

240 advanced care conversations with patients and their whanau

How our funding is spent



GOOD EMPLOYER

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

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

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

Good Employer principles in practice
Provisions which reflect the General Principles include:

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

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

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

Equal Employment Opportunities (EEO):
Principles:
CMDHB believes that by ensuring our workplaces reflect and value the differences within our workforce, we will be able to deliver quality health services more efficiently, effectively, and appropriately.

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

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

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

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

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

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

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

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

Benefits:
EEO will help CMDHB develop a more united and diverse workforce which is responsive to change, is more flexible and has a richer workplace culture. EEO is a way of honouring our obligations under the Treaty of Waitangi.

EEO will assist CMDHB to:
- deliver improved customer service by better matching our services with our clients
- improve its productivity through valuing its employees and treating them fairly

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

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

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

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

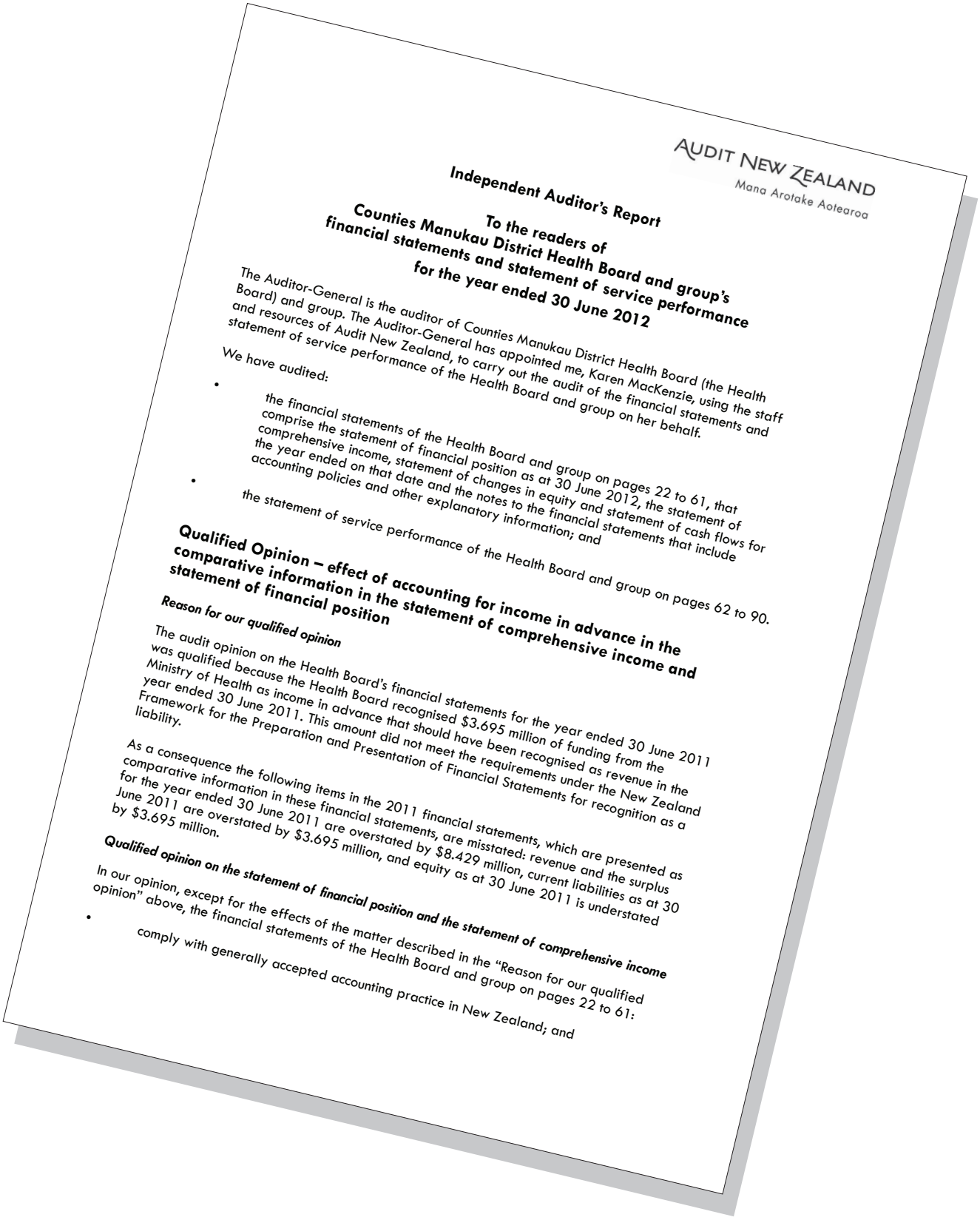
	Females		Males	
Employee Group	Number	Average Salary	Number	Average Salary
Senior Medical Officers	164	211,666	276	236,315
Registered Medical Officers	188	105,339	171	112,547
Individual Employment Agreements	232	97,323	76	113,836
Clerical	615	47,591	14	48,224
Cleaners & Orderlies	231	35,178	107	35,566
Medical Laboratory	124	54,122	32	59,314
Radiology	84	69,652	14	64,770
Allied Health	787	60,331	162	60,283
Security & Trades	6	42,811	60	50,989
Mental Health Nursing & Health care Assistants	261	62,136	83	58,786
Midwives	135	65,401	_	_
Nursing & Health care Assistants	2,117	61,376	207	58,730
Interpreters	14	46,722	6	47,554

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

FINANCIAL STATEMENTS

	Page
Report of the audit office	17
Statement of responsibility	21
Statement of comprehensive income	22
Statement of changes in equity	23
Statement of financial position	24
Statement of cash flows	25
Notes to the financial statements	26

REPORT OF THE AUDIT OFFICE



AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Counties Manukau District Health Board and group's
financial statements and statement of service performance
for the year ended 30 June 2012

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

We have audited:

- the financial statements of the Health Board and group on pages 22 to 61, that comprise the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 62 to 90.

Qualified Opinion – effect of accounting for income in advance in the comparative information in the statement of comprehensive income and statement of financial position

Reason for our qualified opinion

The audit opinion on the Health Board's financial statements for the year ended 30 June 2011 was qualified because the Health Board recognised $3.695 million of funding from the Ministry of Health as income in advance that should have been recognised as revenue in the year ended 30 June 2011. This amount did not meet the requirements under the New Zealand Framework for the Preparation and Presentation of Financial Statements for recognition as a liability.

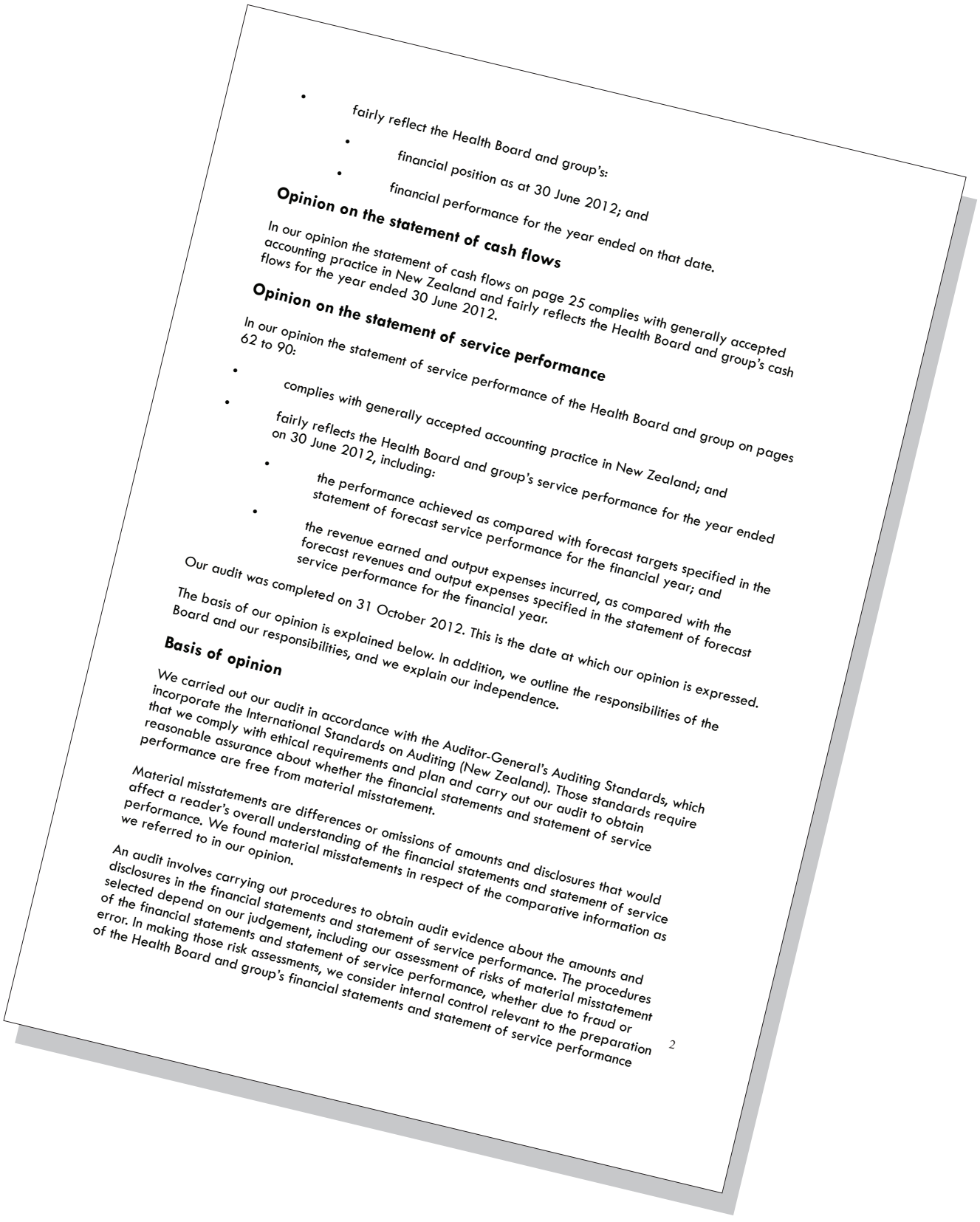
As a consequence the following items in the 2011 financial statements, which are presented as comparative information in these financial statements, are misstated: revenue and the surplus for the year ended 30 June 2011 are overstated by $8.429 million, current liabilities as at 30 June 2011 are overstated by $3.695 million, and equity as at 30 June 2011 is understated by $3.695 million.

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

In our opinion, except for the effects of the matter described in the "Reason for our qualified opinion" above, the financial statements of the Health Board and group on pages 22 to 61:

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

REPORT OF THE AUDIT OFFICE



- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2012; and
  - financial performance for the year ended on that date.

Opinion on the statement of cash flows

In our opinion the statement of cash flows on page 25 complies with generally accepted accounting practice in New Zealand and fairly reflects the Health Board and group's cash flows for the year ended 30 June 2012.

Opinion on the statement of service performance

In our opinion the statement of service performance of the Health Board and group on pages 62 to 90:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance for the year ended on 30 June 2012, including:
  - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
  - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 31 October 2012. This is the date at which our opinion is expressed.

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

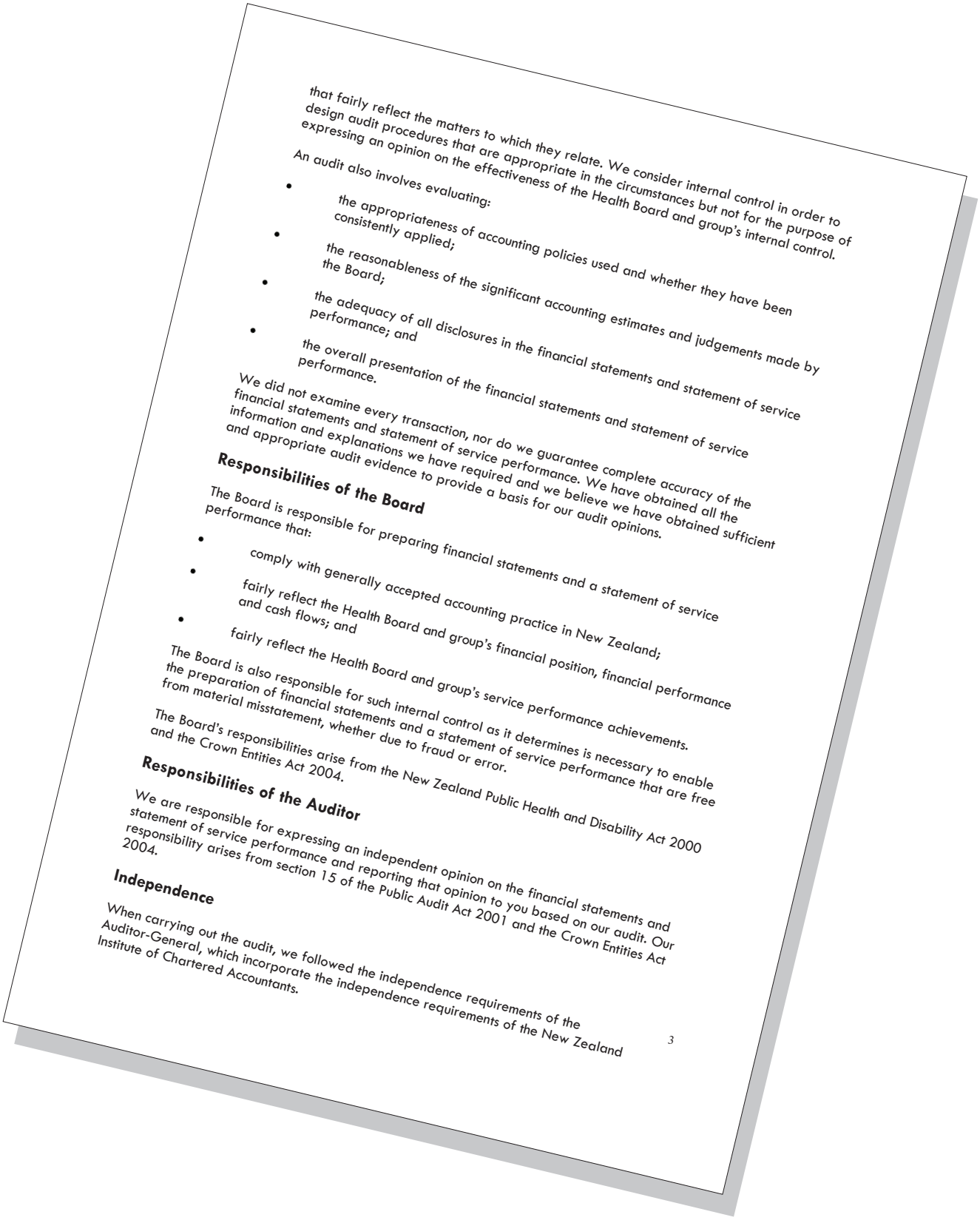
Basis of opinion

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

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. We found material misstatements in respect of the comparative information 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 statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and statement of service performance

2



that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

An audit also involves evaluating:

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

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and 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 a statement of service performance that:

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

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

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

Responsibilities of the Auditor

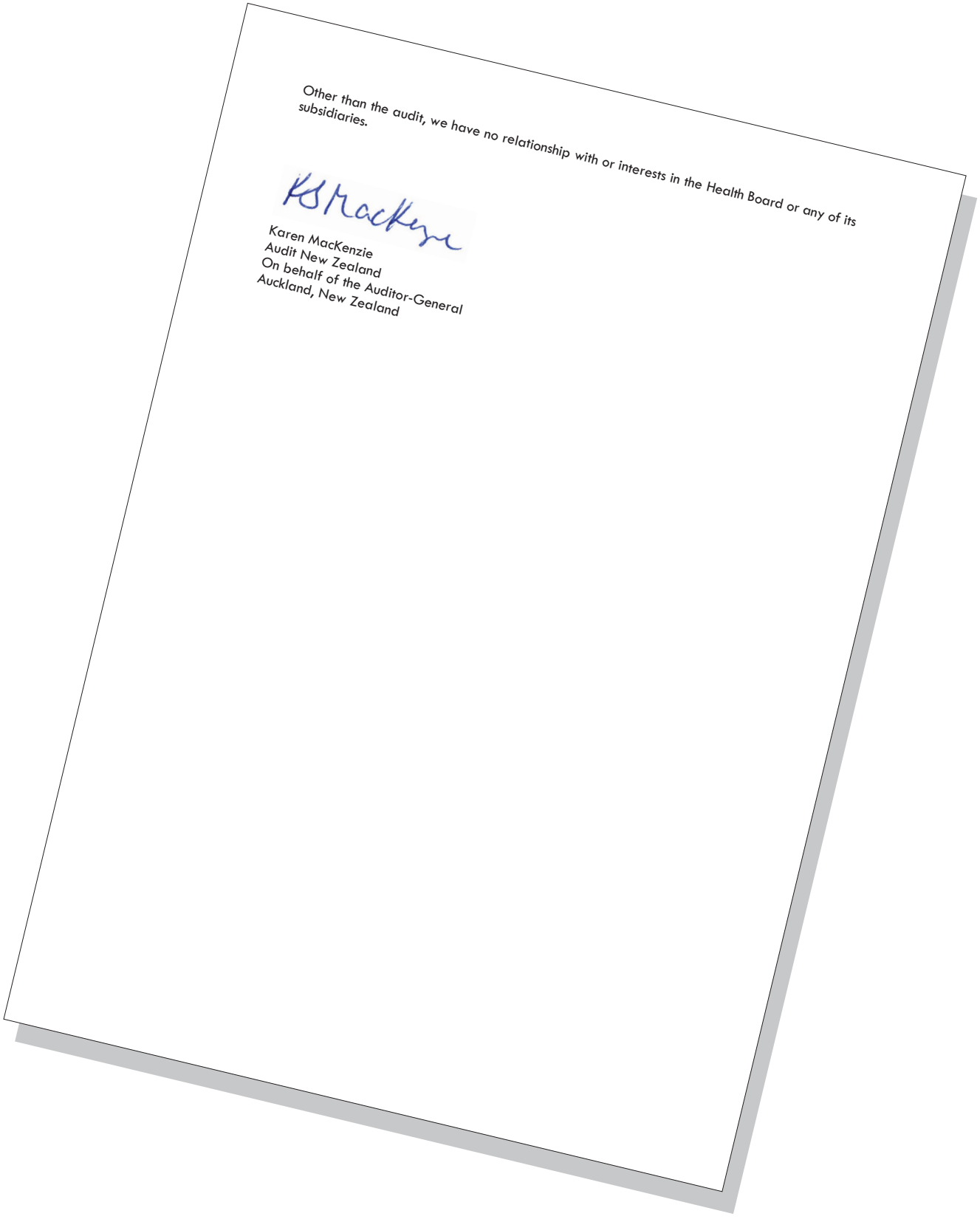
We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

3

REPORT OF THE AUDIT OFFICE



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

STATEMENT OF RESPONSIBILITY

STATEMENT OF RESPONSIBILITY

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

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

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2012.

Signed on behalf of the Board:

Professor Gregor Coster CNZM
Chair

Jan Dawson
Chair Audit, Risk and Finance

Geraint Martin
Chief Executive Officer

Ron Pearson
Deputy CEO/
Director Corporate & Business Services

31 October 2012

STATEMENT OF COMPREHENSIVE INCOME

(Parent and Group)

For the year ended 30 June 2012

	Notes	Parent and Group 2012 Actual $000	2012 Budget $000	2011 Actual $000
Income				
Patient Care Revenue	2	1,325,522	1,303,380	1,276,291
Interest Income		890	1,000	1,172
Other Income	3	26,081	24,577	18,710
Total income		**1,352,493**	**1,328,957**	**1,296,173**
Expenditure				
Personnel costs	4	481,244	479,325	453,525
Depreciation and amortisation expense	13	22,732	23,831	25,454
Outsourced services		57,361	50,028	54,436
Clinical supplies		99,352	90,475	93,355
Infrastructure and non-clinical expenses		53,359	56,434	55,316
Other District Health boards		273,613	275,109	255,236
Non-health board provider expenses		327,446	324,780	324,750
Capital Charge	5	12,441	12,000	12,108
Interest expenses		9,626	12,500	9,457
Other expenses	6	9,910	4,432	7,674
Total expenditure		**1,347,084**	**1,328,914**	**1,291,311**
Surplus/(deficit)		**5,409**	**43**	**4,862**
Other comprehensive income				
Impairment of buildings and plant	13	(2,500)		
Other comprehensive income		**(2,500)**	**-**	
Total comprehensive income for the year		**2,909**	**43**	**4,862**

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

STATEMENT OF CHANGES IN EQUITY

(Parent and Group)

For the year ended 30 June 2012

	Parent and Group		
	2012 Actual $000	2012 Budget $000	2011 Actual $000
Balance 1 July	**161,708**	**160,023**	**154,200**
Comprehensive income			
Surplus for the year	5,409	43	4,862
Other comprehensive income	(2,500)	-	-
Total comprehensive income	**2,909**	**43**	**4,862**
Capital contributions from the Crown	2,148	3,009	3,070
Repayment of capital to the Crown	(416)	(420)	(419)
Interest on restricted funds	5	12	(5)
Balance at 30 June	**166,354**	**162,667**	**161,708**

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

STATEMENT OF FINANCIAL POSITION

(Parent and Group)

As at 30 June 2012

	Notes	Parent and Group 2012 Actual $000	2012 Budget $000	2011 Actual $000
Assets				
Current Assets				
Cash and cash equivalents	7	6,166	1,878	(2,235)
Debtors and other receivables	8	32,366	49,998	37,685
Inventories	10	835	613	868
Prepayments		190	560	431
Non-current assets held for sale	11	-	-	8,676
Total current assets		**39,557**	**53,049**	**45,425**
Non-current assets				
Investments	12	10,081	-	-
Property, plant and equipment	13	522,535	506,438	473,884
Intangible assets	14	-	4,993	-
Other Non-Current Assets	9	1,199	-	1,126
Total non-current assets		**533,815**	**511,431**	**475,010**
Total assets		**573,372**	**564,480**	**520,435**
Liabilities				
Current liabilities				
Creditors and other payables	15	94,530	88,000	94,549
Borrowings	16	30,005	33,600	6,594
Employee entitlements	17	98,320	88,077	92,990
Total current liabilities		**222,855**	**209,677**	**194,133**
Non-current liabilities				
Borrowings	16	167,600	177,514	150,005
Employee entitlements	17	15,351	13,614	13,577
Provisions	18	1,212	1,008	1,013
Total non-current liabilities		**184,163**	**192,136**	**164,595**
Total liabilities		**407,018**	**401,813**	**358,728**
Net assets		**166,354**	**162,667**	**161,707**
Equity				
Crown equity	19	109,383	110,500	107,654
Accumulated deficits	19	(51,675)	(58,997)	(57,084)
Revaluation reserves	19	107,798	110,298	110,298
Trust funds	19	848	866	839
Total Equity		**166,354**	**162,667**	**161,707**

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

STATEMENT OF CASH FLOWS

(Parent and Group)

For the year ended 30 June 2012

	Notes	Parent and Group 2012 Actual $000	2012 Budget $000	2011 Actual $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,214,828	1,164,067	1,263,238
Other		166,460	127,148	27,977
Interest received		895	1,000	1,172
Payments to suppliers		(853,639)	(805,772)	(775,631)
Payments to employees		(474,140)	(475,713)	(441,283)
Capital charge		(12,441)	(12,011)	(11,911)
Interest payments		(9,559)	(12,500)	(9,457)
Goods and services tax (net)		974	(96)	(968)
Net cash flow from operating activities	**20**	**33,378**	**21,285**	**53,137**
Cash flows from investing activities				
Purchase of property, plant, equipment and intangible assets		(67,715)	(52,647)	(58,182)
Net cash flow from investing activities		**(67,715)**	**(52,647)**	**(58,182)**
Cash flows from financing activities				
Capital contributions from the Crown		2,148	3,009	3,070
Repayment of capital to the Crown		(416)	(420)	(419)
Repayment of loans		(6,594)	-	(1,000)
Proceeds from borrowings		47,600	28,773	-
Repayment of Finance Leases				(413)
Net Appropriation from Trust Funds		9	12	(5)
Net cash flow from financing activities		**42,738**	**31,374**	**1,233**
Net increase in cash and cash equivalents		**8,401**	**12**	**(3,812)**
Cash and cash equivalents at the start of the year		(2,235)	1,866	1,577
Cash and cash equivalents at the end of the year		**6,166**	**1,878**	**(2,235)**

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

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

Financial statements for the Company and consolidated financial statements are presented. The consolidated financial statements of CMDHB as at and for the year ended 30 June 2012 comprise the Company 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 the DHB are for the year ended 30 June 2012, and were approved by the Board on 31 October 2012.

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.

Use of estimates and judgements

The preparation of the financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets, liabilities, income and expenses. Actual results may differ from these estimates.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimates are revised and in any future periods affected. Information about critical judgements in applying accounting policies that have the most significant effect on the amounts recognised in the financial statements is included in the following notes:

- Note 9 – Other Non-Current Assets
- Note 12 – Investments in Associates & Jointly Controlled Entities

Information about assumptions and estimation uncertainties that have a significant risk of resulting in a material adjustment within the next financial year are included in the following notes:

- Note 17 – measurement of leave obligations
- Notes 18 – provisions
- Note 22 – Contingences

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.

SIGNIFICANT ACCOUNTING POLICIES

Subsidiaries

Subsidiaries are entities controlled by the Group. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Loss of Control

On the loss of control, the Group derecognises the assets and liabilities of the subsidiary, any non-controlling interests and the other components of equity related to the subsidiary. Any surplus or deficit arising on the loss of control is recognised in profit or loss. If the Group retains any interest in the previous subsidiary, then such interest is measured at fair value at the date that control is lost. Subsequently it is accounted for as an equity-accounted investee or as an available-for-sale financial asset depending on the level of influence retained.

Investments in associates and jointly controlled entities (equity accounted investees)

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

Jointly controlled operations

A jointly controlled operation is a joint venture carried on by each venturer using its own assets in pursuit of the joint operations. The consolidated financial statements include the assets that the Group controls and the liabilities that it incurs in the course of pursuing the joint operation and the expenses that the Group incurs and its share of the income that it earns from the joint operation.

Transactions eliminated on consolidation

Intra-group balances and transactions, and any unrealised income and expenses arising from intra-group transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with equity accounted investees are eliminated against the investment to the extent of the Group's interest in the investee.3 Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Revenue

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

Crown funding

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 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.

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Staff training costs are recognised as an expense when incurred.

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

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

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

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

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

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

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

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

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

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

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

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

Borrowings
Borrowings are initially recognised at their fair value. 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.

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

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

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

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

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

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

Provisions are not recognised for future operating losses.

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

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

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

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

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 uses the following.

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

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

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

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

Use of estimates and Judgements
The preparation of the financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets, liabilities, income and expenses. Actual results may differ from these estimates.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimates are revised and in any future periods affected.

Information about critical judgements in applying accounting policies that have the most significant effect on the amounts recognised in the financial statements is included in the following notes:
- Note 9 – business combinations, acquisition of subsidiary
- Note 10 – commission revenue, determination of whether the Group acts as an agent in the transaction rather than as the principal
- Note 19 – classification of investment property
- Note 28 – accounting for an arrangement containing a lease
- Note 35 – lease classification.

Information about assumptions and estimation uncertainties that have a significant risk of resulting in a material adjustment within the next financial year are included in the following notes:
- Note 17 – key assumptions used in discounted cash flow projections
- Note 17 – measurement of defined benefit obligations
- Notes 32 and 37 – provisions and contingencies.

Property ,plant and equipment
Recognition and measurement1
Items of plant and equipment are measured at cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are measured at fair value, less accumulated depreciation on buildings and accumulated impairment losses recognised after the date of the revaluation. Valuations are performed with sufficient frequency to ensure that the fair value of a revalued asset does not differ materially from its carrying amount.

Cost includes expenditure that is directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the following:
- the cost of materials and direct labour;
- any other costs directly attributable to bringing the assets to a working condition for their intended use;
- when the group has an obligation to remove the asset or restore the site, an estimate of the costs of dismantling and removing the items and restoring the site on which they are located; and
- capitalised borrowing costs.

Cost also includes transfers from equity of any gain or loss on qualifying cash flow hedges of foreign currency purchases of property, plant and equipment. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

Any gain or loss on disposal of an item of property, plant and equipment (calculated as the difference between the net proceeds from disposal and the carrying amount of the item) is recognised in profit or loss.

Reclassification to investment property
When the use of a property changes from owner-occupied to investment property, the property is remeasured to fair value and reclassified as investment property. Any gain arising on remeasurement is recognised in profit or loss to the extent that it reverses a previous impairment loss on the specific property, with any remaining gain recognised in other comprehensive income and presented in the revaluation reserve in equity. Any loss is recognised immediately in profit or loss.

Subsequent costs
Subsequent expenditure is capitalised only when it is probable that the future economic benefits associated with the expenditure will flow to the Group. Ongoing repairs and maintenance is expensed as incurred.

Depreciation
For plant and equipment, depreciation is based on the cost of an asset less its residual value,

CMDHB has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

- Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item. The DHB has decided to present this analysis in note 19

- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on the DHB is that certain information about property valuations is no longer required to be disclosed. Note 13 has been updated for these changes.

  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 are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

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

2 Patient care revenue

	Actual 2012 $000	Actual 2011 $000
Health and disability services (MoH contracted revenue)	1,206,614	1,167,712
ACC contract revenue	17,318	9,523
Revenue from other district health boards	88,543	83,308
Other patient care related revenue	13,047	15,748
Total patient care revenue	**1,325,522**	**1,276,291**

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.

3 Other income

	Actual 2012 $000	Actual 2011 $000
Donations and bequests received	2,492	1,940
Rental income	1,792	889
Gain on Disposal of Assets	1,608	-
Other income	20,189	15,881
Total other income	**26,081**	**18,710**

4 Personnel costs

	Actual 2012 $000	Actual 2011 $000
Salaries and wages	464,222	431,151
Contributions to defined contribution schemes	9,917	8,960
Increase in liability for employee entitlements	7,104	13,414
Total personnel costs	**481,244**	**453,525**

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 2012 was 8% (2011: 8%).

6 Other expenses

	Actual 2012 $000	Actual 2011 $000
Other expenses include:	$000	$000
Audit fees	172	156
Operating leases expense	6,071	2,499
Impairment of debtors	3,221	4,577
Board and committee members fees and expenses	446	442
Total Other Expenses	**9,910**	**7,674**

7 Cash and cash equivalents

	Actual 2012 $000	Actual 2011 $000
Cash at bank and on hand (overdraft)	318	(3,074)
Trust / Special purpose Funds note 19	848	839
Call deposits	5,000	-
Total cash at bank and on hand	6,166	(2,235)
Cash and cash equivalents for the purposes of the statement of cash flows	**6,166**	**(2,235)**

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 2012 $000	Actual 2011 $000
Ministry of Health receivables	11,806	27,162
Other receivables	11,762	9,534
Other accrued revenue	11,895	6,967
Less: provision for impairment	(3,097)	(5,979)
Total Debtors and other receivables	**32,366**	**37,685**

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:

	2012 Gross $000	2012 Impairment $000	2012 Net $000	2011 Gross $000	2011 Impairment $000	2011 Net $000
Not past due	22,309	-	22,309	34,432	-	34,432
Past due 1-30 days	4,869	(634)	4,235	1,296	(812)	484
Past due 31-60 days	465	(186)	279	996	(648)	348
Past due 61-90 days	1,042	(532)	510	412	(232)	180
Past due > 90 days	6,778	(1,745)	5,033	6,528	(4,287)	2,241
Total	**35,463**	**(3,097)**	**32,366**	**43,664**	**(5,979)**	**37,685**

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 2012 $000	Actual 2011 $000
Balance at 1 July	5,979	4,413
Charged to 'Other Expenses'	3,221	4,577
Receivables written off	(6,103)	(3,011)
Total Debtors and other receivables	**3,097**	**5,979**

9 Other Non-Current Assets

	Actual 2012 $000	Actual 2011 $000
Reversionary interest in car park building	1,199	1,126
Total Investments	**1,199**	**1,126**

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

10 Inventories

	Actual 2012 $000	Actual 2011 $000
Pharmaceuticals	727	751
Other Supplies net of provision for obsolete stock	108	117
Total inventories	**835**	**868**

Some inventories are subject to retention of title clauses.
The amount of inventories recognised as an expense during the year was $20.637 m which is included in the Clinical supplies line item for the Statement of Comprehensive Income.

11 Non-current assets held for sale

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

	Notes	Actual 2012 $000	Actual 2011 $000
IT Assets	13	-	4,779
Software	14	-	3,897
Total Non-current assets held for sale		**-**	**8,676**

12 Investments in Associates

Investments in associates
CMDHB has the following investments in associates

a) General information

Name of entity	Principal activities	Interest held at 30 June 2012	Balance date
Northern Regional Training Hub Ltd	Provision of health training services	33.0%	30 June-12
Northern DHB Support Agency Ltd	Provision of health support services	33.3%	30 June-12
healthAlliance NZ Ltd	Provision of shared services	20.0%	30 June-12
NZ Health Innovation Hub Management Ltd	Provision of services to grow NZ's health innovation sector	25.0%	30 June-12

b) Summary of financial information (unaudited) of associate

Year end 30 June 2012 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Training Hub Ltd	2,414	2,365	49	3,033	47
Northern DHB Support Agency Ltd	6,059	5,387	672	8,253	38
healthAlliance NZ Ltd	61,453	19,629	61,453	90,485	-
NZ Health Innovation Hub Management Ltd	0	0	0	0	0

Year end 30 June 2011 $000	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
Northern Regional Training Hub Ltd	2,238	2,236	2	2,880	-
Northern DHB Support Agency Ltd	5,929	5,295	634	9,870	5
healthAlliance NZ Ltd	14,446	14,446	-	42,252	-

c) Share of profit of associate entities

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Share of profit/(loss)	**28**	**2**

Investment in Associate	Actual 2012 $000	Actual 2011 $000
Investment in healthAlliance NZ Ltd	10,081	-
Total Investments	**10,081**	**-**

On 1 March 2011 the finance, procurement and supply chain and information services activities of Northland and Auckland District Health Boards and regional internal audit function of the Northern DHB Support Agency were merged into healthAlliance NZ Ltd thereby reducing CMDHB share to 25% (50%). healthAlliance NZ Ltd received approval from the Minister of Health to alter the shareholder structure in August 2011 and consequently CMDHB's shareholding in healthAlliance NZ Ltd changed from 25% to 20%. There was no gain or loss on this change in shareholding. The investment in healthAlliance is carried at the fair value of assets contributed to the company.
There are two classes of shares
"A Shares" held by the DHB 80% have voting and the right to share in any surpluses or deficits.
"B shares" held by HBL taking a 20% shareholding, have voting rights only and no share in any surpluses or deficits.

NZ Health Innovation Hub

The four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) have established a national Health Innovation Hub. The Hub will engage with the DHBs, clinicians and Industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in NZ and internationally.

The Hub has been structured as a limited partnership, with the four foundation DHBS each having a 25% shareholding in the limited partnership and the general partner, NZ Health Innovation Hub Management Limited. which was incorporated on 26 June 2012.

13 Property, plant and equipment

Cost or valuation	Land $000	Buildings & Plant $000	Clinical Equipment, IT & Motor Vehicles $000	Other Equipment $000	Work in progress $000	Total $000
Balance at 1 July 2010	**72,753**	**332,844**	**134,621**	**14,732**	**17,686**	**572,636**
Additions	-	-	-	-	58,034	58,034
Work in Progress	-	14,849	10,208	757	(27,583)	(1,769)
Transferred to Assets held for Resale (see note 11)	-	-	(34,141)	-	-	(34,141)
Disposals/transfers	-	(218)	(457)	(2)	-	(677)
Balance at 30 June 2011	**72,753**	**347,475**	**110,231**	**15,487**	**48,137**	**594,083**
Balance at 1 July 2011	**72,753**	**347,475**	**110,231**	**15,487**	**48,137**	**594,083**
Additions	-	-	-	-	75,909	75,909
Work In Progress capitalised	-	28,144	7,403	88	(35,635)	-
Impairrment of Assets		(2,500)				(2,500)
Disposals/transfers	-	(6)	(929)	(10)	-	(945)
Balance at 30 June 2012	**72,753**	**373,113**	**116,705**	**15,565**	**88,411**	**666,547**
Accumulated depreciation and impairment losses						
Balance at 1 July 2010	**-**	**11,706**	**102,717**	**12,319**	**-**	**126,742**
Depreciation expense	-	12,002	10,840	676	-	23,518
Elimination on disposal/transfer	-	(241)	(457)	(1)	-	(699)
Transferred to Assets held for Resale (see note 11)	-	-	(29,362)	-	-	(29,362)
Balance at 30 June 2011	**-**	**23,467**	**83,738**	**12,994**	**-**	**120,199**
Balance at 1 July 2011	**-**	**23,467**	**83,738**	**12,994**	**-**	**120,199**
Depreciation expense	-	13,495	8,584	654	-	22,732
Elimination on disposal/transfer		(14)	1,104	(10)		1,081
Balance at 30 June 2012	**-**	**36,948**	**93,426**	**13,638**	**-**	**144,012**
Carrying amounts						
At 1 July 2010	72,753	321,138	31,904	2,413	17,686	445,894
At 30 June and 1 July 2011	72,753	324,008	26,493	2,493	48,137	473,884
At 30 June 2012	**72,753**	**336,165**	**23,279**	**1,927**	**88,411**	**522,535**

The total amount of property, plant, and equipment in the course of construction is $88.4m (2011 $48.14m).

Valuation

Land

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

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

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

Buildings

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

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

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

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

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

CMDHB advises that there is a problem with the exterior cladding of the Adult Medical Centre building, and in respect of this, there has been an impairment of the Net Book Value of the building. This has been brought in as part of a potentially larger claim as the full outcome is unable to be quantified at this stage.

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:

	Acquired software $000
Balance at 1 July 2010	29,403
Additions	871
Work in Progress Capitalised	1,769
Transferred to assets held for sale (See Note 11)	(32,043)
Balance at 30 June 2011 / 1 July 2011	-
Additions	-
Balance at 30 June 2012	-
Accumulated amortisation and impairment losses	
Balance at 1 July 2010	26,211
Amortisation expense	1,935
Transferred to assets held for sale (See Note 11)	(28,146)
Balance at 30 June 2011/1 July 2011	-
Amortisation expense	
Balance at 30 June 2012	-
Carrying amounts	
At 1 July 2010	3,192
At 30 June and 1 July 2011	-
At 30 June 2012	-

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

15 Creditors and other payables

	Actual 2012 $000	Actual 2011 $000
Creditors and accrued expenses	85,926	82,277
GST payable	5,266	5,148
Capital charge payable	20	3,298
Income in advance	3,318	3,826
Total creditors and other payables	**94,530**	**94,549**

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

16 Borrowings

	Actual 2012 $000	Actual 2011 $000
Current portion		
Unsecured bank loan	-	6,500
Finance leases	5	94
Crown Health Financing Agency loans – fixed interest	30,000	-
Total current portion	**30,005**	**6,594**
Non-current portion		
Finance leases	-	5
Crown Health Financing Agency loans – fixed interest	167,600	150,000
Total non-current portion	**167,600**	**150,005**
Total borrowings	**197,605**	**156,599**
Borrowing facility limits		
Crown Health Financing Agency loan facility limit	297,600	297,600
Overdraft facility	50,000	50,000
Total borrowing facility limits	**347,600**	**347,600**

Crown Health Financing Agency loans
The Crown Health Financing Agency (CHFA) loans are secured by a negative pledge.
The DHB must also meet the following covenants:

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

The fair value of CHFA borrowings is $216.724m (2011 $159.493m). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.32% to 6.51% (2011 3.75% to 6.51%)

CHFA ceased to operate on 30 June 2012 and loans from CHFA are now managed by the NZ Debt Management Office, as part of the Treasury

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

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

Finance leases
Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default.

The net carrying amount of assets held under finance lease is $5k.

The fair value of finance leases is $5k (2011 $99k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 8.59% to 8.66% (2011 8.59% to 8.66%).

Analysis of finance leases

	Actual 2012 $000	Actual 2011 $000
Minimum lease payments payable:		
No later than one year	5	102
Later than one year and not later than five	-	5
Later than five years	-	-
Total minimum lease payments	5	107
Future finance charges	-	(8)
Present value of minimum lease payments	5	99
Present value of minimum lease payments payable:		
No later than one year	5	94
Later than one year and not later than five years	-	5
Later than five years	-	-
Total present value of minimum lease payments	5	99

17 Employee entitlements

	Actual 2012 $000	Actual 2011 $000
Current portion		
Accrued salaries and wages	34,638	35,159
Annual leave	45,283	41,712
Sabbatical leave	1,479	1,234
Continuing medical education leave	16,920	14,848
Total current portion	**98,320**	**92,990**
Non-current portion		
Long service leave	5,710	5,008
Retirement gratuities	8,139	7,566
Sick leave	1,502	1,003
Total non-current portion	**15,351**	**13,577**
Total employee entitlements	**113,671**	**106,567**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 2.43% - 4.29% (2011 2.84% - 6.24%) and an inflation factor of 1.5% (2011 2.0%) were used.

18 Provisions

	Actual 2012 $000	Actual 2011 $000
Non-current portion		
ACC Partnership Programme	1,212	1,013
Total provisions	**1,212**	**1,013**

Movements for each class of provision are as follows:

	ACC Partnership Programme 2012 $000	ACC Partnership Programme 2011 $000
Balance at 1 July	1,013	959
Additional provisions made	199	54
Balance at 30 June	**1,212**	**1,013**

ACC Partnership Programme

Liability valuation

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

Risk margin

A risk margin of 20% (2010 20%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

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

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

Key assumptions

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

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

Insurance risk

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

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

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

19 Equity

	Actual 2012 $000	Actual 2011 $000
Crown equity		
Balance at 1 July	107,654	105,004
Capital contributions from the Crown	2,148	3,069
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**109,383**	**107,654**
Accumulated surpluses/(deficits)		
Balance at 1 July	(57,084)	(61,946)
Surplus/(deficit) for the year	5,409	4,862
Balance at 30 June	**(51,675)**	**(57,084)**
Revaluation reserves		
Balance at 1 July	110,298	110,298
Revaluations	(2,500)	
Balance at 30 June	**107,798**	**110,298**
Revaluation reserves consist of:		
Land	69,149	69,149
Buildings	38,649	41,149
Total revaluation reserves	**107,798**	**110,298**
Trust funds		
Balance at 1 July	839	844
Transfer from/(to) accumulated surpluses	9	(5)
Balance at 30 June	**848**	**839**

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.

The income and expenditure items presented above are included in the Income Statement and are presented above for information purposes.

Total equity	**166,354**	**161,707**

Included in accumulated surpluses/deficits are $15.453m (2011 $8.101m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established.

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

	Actual 2012 $000	Actual 2011 $000
Net surplus/(deficit	**5,409**	**4,862**
Add/(less) non-cash items		
Donated property, plant, and equipment	-	(1,872)
Depreciation and amortisation expense	22,732	25,454
Total non-cash items	22,732	23,582
Add/(less) items classified as investing or financing activities		
Gain on disposal of assets	(1,608)	-
Total items classified as investing or financing activities	(1,608)	-
Add/(less) movements in statement of financial position items		
Debtors and other receivables	5,560	(1,912)
Inventories	33	(255)
Creditors and other payables	(5,857)	13,447
Employee entitlements	7,104	13,414
Net movements in working capital items	6,840	24,694
Net cash flow from operating activities	**33,378**	**53,137**

21 Non-cancellable Contractual Commitments including Capital commitments and Operating leases

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

	Actual 2012 $000	Actual 2011 $000
Not later than one year	117,025	92,439
Later than one year and not later than five years	113,828	108,941
Later than five years	8,231	35,776
Total non-cancellable contractual commitments	**239,084**	**237,156**

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

Capital commitments

	Actual 2012 $000	Actual 2011 $000
Property , plant and equipment	68,565	29,844
Total capital commitments	**68,565**	**29,844**

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

Non-cancellable operating lease commitments

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

	Actual 2012 $000	Actual 2011 $000
Not later than one year	2,857	3,556
Later than one year and not later than five years	6,326	6,830
Later than five years	2,538	3,248
Total other non-cancellable contractual operating commitments	**11,721**	**13,634**

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

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

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.

Contingent assets
The DHB has no contingent assets (2011 $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 DHB's of $1,337m (2011 $1,261m) to provide health services in the Counties Manukau area for the year ended 30 June 2012 (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 2012 totalled $11.8m (2011 $10.8m). These purchases included the purchase of electricity from Meridian, air travel from Air New Zealand, and postal services from New Zealand Post, blood from NZ Blood Service and training from University of Auckland.

Transactions with key management personnel
Key management personnel compensation

	Actual 2012 FTE	Actual 2011 FTE	Actual 2012 $000	Actual 2011 $000
Executive management team *	10	13	2,476	3,322
Board	11	11	379	357
Committee	33	28	43	45
Total key management personnel compensation	**54**	**52**	**2,898**	**3,724**

* The actual expense above for the Executive Management team includes Other long-term benefits amounting to $58k (2011 $47k)

Key management personnel include all Board members, the Chief Executive, and nine 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 $49k (2011 $16k) and was incurred on normal commercial terms. There is a balance of $nil (2011 $nil) outstanding for unpaid invoices at year end.

Related party transactions with the DHB's subsidiaries and associates

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

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

CMDHB has determined 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 Foundationfunds.

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.

The Manukau Health Trust

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

CMDHB has historically had one nominees 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 2012

Statement of Financial Performance $000

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Income	1,354	1,296
Surplus (Deficit)	(98)	22
Statement of Financial Position		
Total Equity	**711**	**809**
Non-Current Assets	3	1
Current Assets	878	955
Total Assets	**881**	**956**
Current Liabilities	170	147
Net Assets	**711**	**809**

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $4.3m ($4.5)m and a surplus of $0.2m ($0.6m) which may be subject to restrictions on distribution as at 30 June 2012. The financial statements of the Foundation for 2012 are not publicly available as they have not yet been approved by the Foundation's trustees.

Sales to related parties

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Northern Region Training Hub	-	27
healthAlliance NZ Ltd	187	3
Northern DHB Support Agency Ltd	902	839
Air New Zealand	1	6
Dept of Building & Housing	-	1
District Health Boards of NZ	-	10
Health Quality & Safety Commission	987	-
Manukau Institute of Technology	-	479
Physiotherapy NZ	-	2
ProCare Health Ltd	8	-
Taikura Trust	-	7
University of Auckland	2,142	1,584
Total	**4,227**	**2,958**

Purchases from related parties

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Northern Region Training Hub	3,958	3,786
healthAlliance NZ Ltd	24,614	22,112
Northern DHB Support Agency Ltd	3,295	3,170
Auckland Council	560	199
Bob Wichman Ltd	49	18
District Health Boards of NZ	-	1
Manukau City Council	-	115
Manukau Institute of Technology	-	239
Manukau Water	-	239
Raukura Hauora O Tainui Iwi Advisory	-	14
Sapere Research Group	109	-
University of Auckland	1,533	2,213
Total	**34,118**	**32,106**

Outstanding balances of Sales to related parties

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Northern Region Training Hub	1	-
healthAlliance NZ Ltd	3	1
Northern DHB Support Agency Ltd	54	-
Auckland Council	-	2
District Health Boards of NZ	-	12
Manukau Institute of Technology	-	1
ProCare Health Ltd	7	-
University of Auckland	611	13
Total	**676**	**29**

Outstanding balances of Purchases from related parties

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Northern Region Training Hub	-	7
healthAlliance NZ Ltd	71	3
Northern DHB Support Agency Ltd	452	70
Air NZ	-	3
Auckland Council	14	2
University of Auckland	5	23
Total	**542**	**108**

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

24 Board member remuneration

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

	Actual 2012	Actual 2011
Professor Gregor Coster	59,969	55,000
Mrs Jan Dawson	35,781	20,354
Mr Anae Arthur Anae	33,500	27,083
Mr David Collings	21,500	16,125
Mr Donald Barker	36,375	30,635
Mr Paul Cressey	32,750	32,646
Mr Robert Wichman	30,250	27,250
Mrs Colleen Brown	37,375	31,969
Mrs Lyn Murphy	33,000	16,292
Mrs Sandra Alofivae	29,750	16,167
Mr Frank Solomon	27,250	16,583
Mrs Anne Candy	-	11,917
Mr Michael Williams	-	12,167
Mrs Ruth De Souza	-	13,833
Mrs Penelope Ginnen	-	13,094
Ms Miria Andrews	-	15,896
Total board member remuneration	**379,500**	**357,011**

Committee Members

	Award $ 2012
Ms Wendy Bremner	208
Dr Andrew Chan Mow	1,042
Mr Bob Clark	2,083
Mr Robert Clark	1,667
Ms Elizabeth Farrell	2,292
Mr Jonathan Frith	1,458
Ms Heather Grace	1,458
Ms Malia Hamani	1,250
Mr Sefita Hao'uli	3,542
Ms Susan Haynes	1,758
Dr Gary Jackson	1,667
Ms Louisa Lavakula	3,750
Mrs Roine Lealaiauloto	833

	Award $ 2012
Mr Philip Beilby	1,875
Ms Joanna Katipa	833
Ms Joy Simpson	1,250
Ms Alma Wilson	1,250
Ms Te Aomarama Wilson	1,458
Ms Nganeko Minhinnick	1,667
Ms Bernadette Pereira	1,250
Mr Nuku Rapana	3,333
Mr Ezekiel Robson	1,667
Dr Gerhard Sunborn	1,458
Rev Uea Tuleia	2,198
Mr Josaia Maka	1,667
Total	**42,914**

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 (2011 $nil).

25 Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

Total remuneration paid or payable	Actual 2012 $000	Actual 2011 $000
$100,000 – 109,999	109	102
$110,000 – 119,999	78	75
$120,000 – 129,999	46	44
$130,000 – 139,999	28	29
$140,000 – 149,999	27	27
$150,000 – 159,999	24	29
$160,000 – 169,999	25	21
$170,000 – 179,999	24	23
$180,000 – 189,999	17	30
$190,000 – 199,999	20	16
$200,000 – 209,999	27	26
$210,000 – 219,999	28	28
$220,000 – 229,999	25	25
$230,000 – 239,999	28	13
$240,000 – 249,999	20	22
$250,000 – 259,999	12	16
$260,000 – 269,999	18	13
$270,000 – 279,999	14	7
$280,000 – 289,999	14	8
$290,000 – 299,999	11	6
$300,000 – 309,999	8	10
$310,000 – 319,999	4	5
$320,000 – 329,999	5	3
$330,000 – 339,999	2	9
$340,000 – 349,999	6	-
$350,000 – 359,999	2	2
$360,000 – 369,999	4	2
$370,000 – 379,999	3	1
$380,000 – 389,999	-	3
$390,000 – 399,999	6	-
$400,000 – 409,999	-	2
$410,000 – 419,999	1	-
$420,000 – 429,999	-	-
$430,000 – 439,999	-	1
$440,000 – 449,999	1	-
$450,000 – 459,999	-	-
$460,000 – 469,999	1	-
$470,000 – 479,999	-	2
$480,000 – 489,999	-	-
$490,000 – 499,999	-	-
$500,000 – 509,999*	1	-

* Note: - paid includes a payment relating to the prior period.
During the year ended 30 June 2012, 7 (2011: 41) employees received compensation and other benefits in relation to cessation totalling $255,598 (2011 $394,821).

During the Year Ended 30 June 2012, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 545 (2011 - 529) are Medical Staff and 94 (2011 - 71) are Management.

26 Events after the balance date

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

There is a proposal to establish an unincorporated joint venture with three tertiary education organisations – University of Auckland, AUT University and Manukau Institute of Technology- to jointly operate and develop the centre and grow a future workforce that meets the needs of our community.

This proposal is currently with the Minister of Health but at 30 Jun 2012 had not been given final approval.

27 Financial instruments

Financial instruments categories
The carrying amounts of financial assets and liabilities are as follows

	Actual 2012 $000	Actual 2011 $000
Loans and receivables		
Cash and cash equivalents	6,166	(2,235)
Debtors and other receivables	32,366	37,685
Total loans and receivables	**38,532**	**35,450**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	85,946	85,574
Borrowings – CHFA loans and Unsecured Bank Loans	197,600	156,500
Total financial liabilities measured at amortised cost	**283,546**	**242,074**

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 2012, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have been $85.2k lower/higher (2011 $36.3k).

Credit risk
Credit risk is the risk that a third party will default on it's obligations to the DHB, causing it to incur a loss.

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

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

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

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

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

	Actual 2012 $000	Actual 2011 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	848	-
AA	-	839
Total cash and cash equivalents and investments	848	839
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total debtors and other receivables	32,366	37,685

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
2011						
Creditors and other payables	85,574	85,574	85,574	-	-	-
Finance leases	99	99	94	5	-	-
CHFA loans	150,000	187,912	5,070	44,396	49,601	88,845
Unsecured Bank Loans	6,500	6,500	6,500	-	-	-
Total	**242,173**	**280,085**	**97,238**	**44,401**	**49,601**	**88,845**
2012						
Creditors and other payables	85,946	85,946	85,946	-	-	-
Finance leases	5	5	5	-	-	-
CHFA loans	197,600	249,179	36,556	5,437	47,072	160,114
Unsecured Bank Loans	-	-	-	-	-	-
Total	**283,551**	**335,130**	**122,507**	**5,437**	**47,072**	**160,114**

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

Trust/Special funds

	Parent and Group 2012 Actual	Parent and Group 2011 Actual
Balance at beginning of year	839	844
Funds expended	(3)	(10)
Interest received on Restricted Funds	12	5
Balance at end of year	**848**	**839**

30 Explanation of major variances against budget

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

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

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

Statement of comprehensive income

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

- Total Income for the year (excluding donations) was $46.9m greater than budget due to additional funding received for services from the Crown after the finalisation of the budget and a change in the methodology around PHO payments with different DHB's taking the lead in certain areas. CMDHB is the lead on the National Hauora Coalition PHO merger.
- Expenditure for the year was $41.6m greater than budget which reflects additional volumes and services purchased by the Crown as stated in the point above and a change in the methodology around PHO payments with different DHB's taking the lead in certain areas. CMDHB is the lead on the National Hauora Coalition PHO merger.

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

- Drawing down funding facilities
- Improved collection of Trade receivables
- Catch-up on spending on property, plant and equipment due to timing of construction
- Transfer of IT assets to healthAlliance

The major variances in the Statement of Cashflow are attributed to

- Improved operating cashflow of $10.5m due to
  - Increased collection from the Crown
  - Increased revenue (purchases) from Crown
  - higher payments to suppliers to match increased purchases from Crown
  - lower interest payments
- higher investing led to higher financing requirements for the year.

31 Performance by Output Classes

	Prevention	Early Detection	Intensive	Rehabilitation	Total
Revenue	**17,847**	**211,439**	**1,021,635**	**101,572**	**1,352,493**
Budget	*18,801*	*177,150*	*1,036,348*	*96,658*	*1,328,957*
Personnel costs	3,177	-	478,066	-	481,243
Outsourced Services	1,343	-	56,018	-	57,361
Clinical Supplies	603	-	105,857	-	106,460
Infrastructure & Non-Clinical Supplies	1,027	-	102,434	-	103,461
Other	11,697	211,439	276,351	101,572	601,059
Total costs	**17,847**	**211,439**	**1,018,726**	**101,572**	**1,349,584**
	18,801	*177,150*	*1,036,305*	*96,658*	*1,328,914*
Surplus (Deficit)	**-**	**-**	**2,909**	**-**	**2,909**
Budget	-	-	*43*	-	*43*

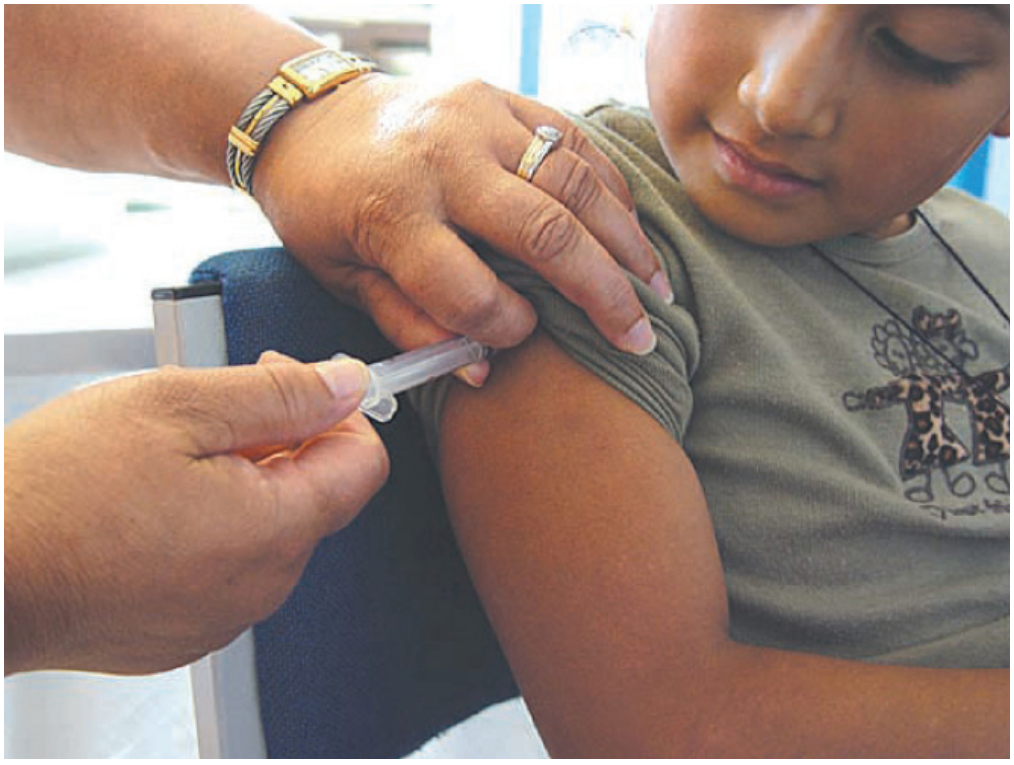
STATEMENT OF OBJECTIVES & SERVICE PERFORMANCE

This Statement of Service Performance sets out our performance for the period 1 July 2011 to 30 June 2012 on the things we said we would deliver - as described in our Statement of Intent, 2011/12 – 2013/14.

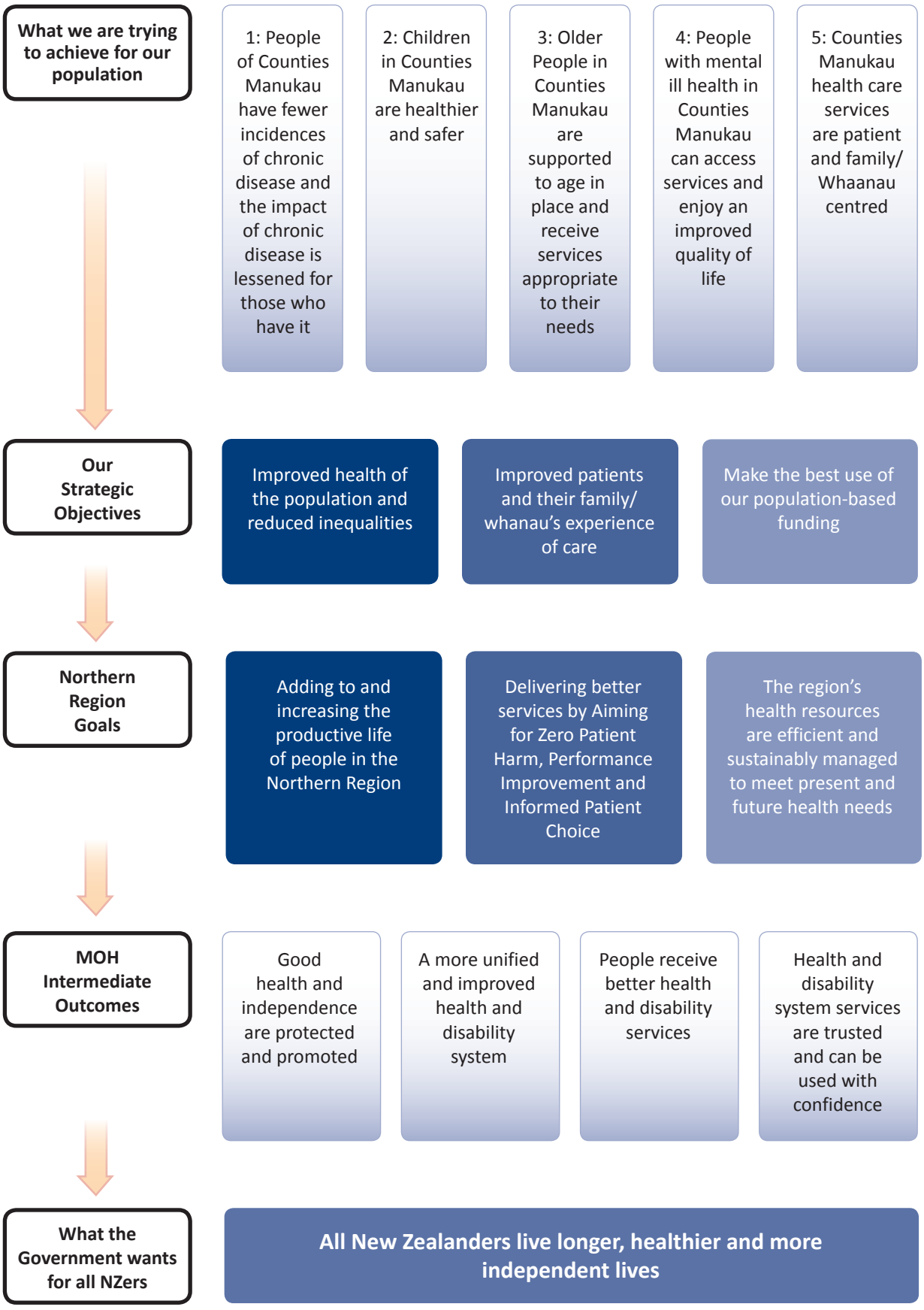
At the start of 2011/12, we outlined in our Statement of Intent our strategic direction and how we were organising our activities and outputs in order that we will be able to achieve the following intermediate outcomes for our population, leading to outcomes which were in line with our Triple Aim objectives, regional strategic direction, national policy priorities and the Minister of Health's expectations for the sector.

- People of Counties Manukau have fewer incidences of chronic disease and the impact of chronic disease is lessened for those who are affected;
- Children in Counties Manukau are healthier and safer;
- Older people in Counties Manukau are supported to age in place and receive services appropriate to their needs;
- People with mental ill health in Counties Manukau can access services and enjoy an improved quality of life;
- Counties Manukau healthcare services are patient and family/whaanau centred.

Our intervention logic is illustrated on the next page.



Our Intervention Logic – What we are trying to achieve for our population



At a Glance: Our 2011/12 Performance

A Achieved N Not Achieved Not Applicable

Performance Indicators: Health Targets	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Shorter stays in emergency departments *95 percent of patients were admitted, transferred or discharged from the Emergency Department within 6 hours*	96%	97%	97%	97%
Improved access to elective surgery *14, 704 elective discharges were delivered for 2011/12*	109%	108%	111%	111%
Shorter waits for cancer treatment *All patients needing radiotherapy treatment received this within 4 weeks from decision to treat*	100%	100%	100%	100%
Increased immunisation *95 percent of two years olds were fully vaccinated*	89%	91%	93%	95%
Better help for smokers to quit: hospital inpatients *95 percent of smokers seen by a health practitioner in a public hospital were offered brief advice and support to quit smoking*	89%	92%	94%	94%
Better help for smokers to quit: primary care patients *90 percent of smokers seen by a health practitioner in primary care were offered brief advice and support to quit smoking*	17%	19%	19%	20%
Better diabetes and cardiovascular services: diabetes annual checks *82 percent of diabetics had an annual check*	81%	80%	79%	82%
Better diabetes and cardiovascular services: diabetes management *60 percent of diabetics had satisfactory or better diabetes management (Average blood sugar level of equal to or less than 64mmol/mol)*	56%	59%	60%	62%
Better diabetes and cardiovascular services: cardiovascular risk assessments[1] *90 percent of the eligible population had their cardiovascular risk assessed in the last five years*	83%	84%		
More heart and diabetes checks: cardiovascular risk assessments[2] *60 percent of the eligible population had their cardiovascular risk assessed in the last five years*			50%	52%

* *Where applicable numbers in the table have been rounded to the nearest unit*

[1] This health target was replaced with a new cardiovascular risk assessment measure (see More heart and diabetes checks) from 1 January 2012.

[2] New cardiovascular risk assessment measure introduced from 1 January 2012. The target was changed from 90% to 60% due to the change from using National Labs Warehouse data to PHO Performance Programme data for reporting.

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

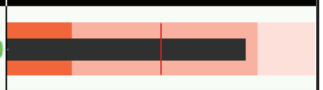
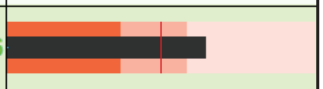
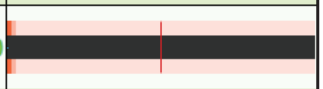
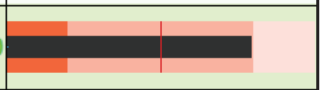
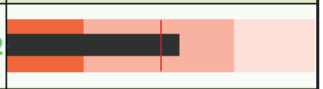
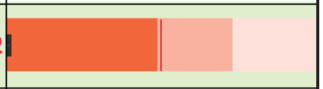
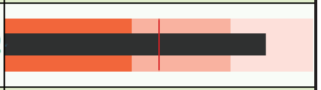
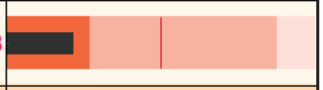
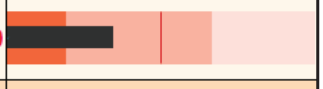
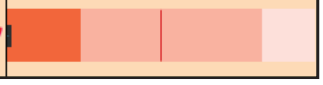
In our 2010/11 Annual Report we introduced benchmarking information from our annual *Health Profile*[3] to give some comparison of where the DHB's performance on the national health targets and some of the hospital quality and productivity measures are in relation to the national average and to other DHBs. We have continued the use of this information for this year's report.

The following will be presented where:

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

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

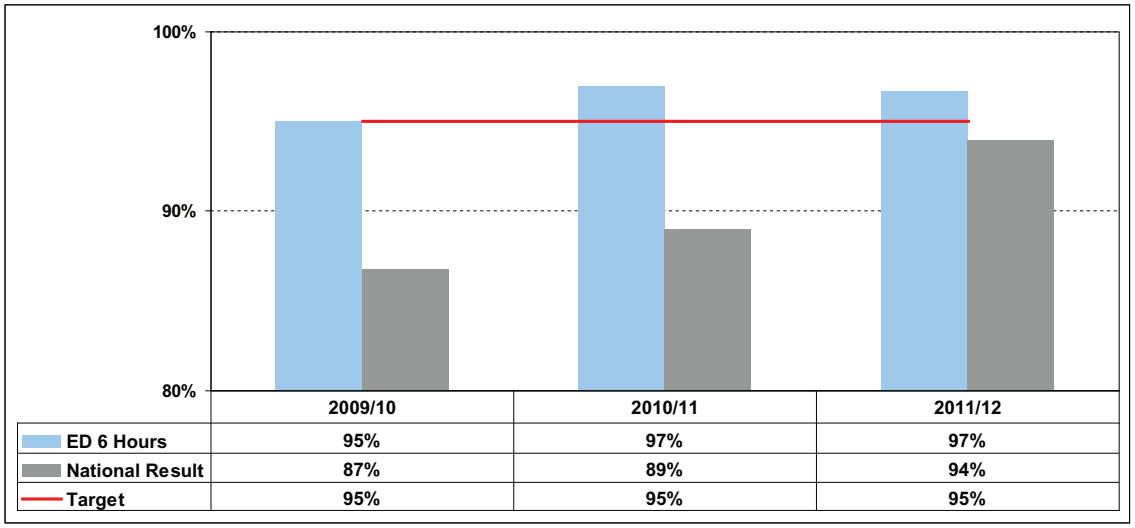
[3] Health Profile is the intellectual property of the South East Public Health Observatory, Oxford, England, used by CMDHB with permission.

Indicator	NZ Bottom	NZ Top	NZ Average	CMDHB	NZ Range
1. Shorter stays in emergency departments (% of attendance < 6 hours)	87.4	99.6	93.8	97.0	
2. Improved access to elective surgery (%)	100.3	121.2	106.2	110.6	
3. Shorter waits (< 6 weeks) for cancer treatment radiotherapy (%)	100.0	100.0	100.0	100.0	
4. Two-year olds fully immunised (%)	78.4	96.4	93.1	95.0	
5. Better help for smokers to quit (% hospital patient smokers advised)	89.4	98.9	93.6	94.2	
6. Better diabetes management (%)	62.2	80.7	72.0	62.2	
7. Diabetes free check (%)	50.6	87.8	70.0	82.2	
8. Eligible adults cardiovascular disease assessed (%)	19.8	66.2	48.7	52.1	
9. Average length of stay for acute (days)	4.7	3.5	4.0	4.0	
10. Average length of stay for elective surgery (days)	4.4	3.4	4.0	4.3	
11. Acute readmissions to hospitals (%)	11.5	8.0	10.1	9.4	
12. Day surgery without an overnight stay (%)	52.8	64.8	57.8	55.9	
13. Surgery admission on the same day surgery takes place (excluding day surgery) (%)	65.1	98.1	82.3	87.4	
14. In-hospital patient mortality (%)	1.9	1.2	1.5	1.3	
15. Potentially preventable hospital admission by primary care for age 0-74 years old (%) (Maaori)	127.6	66.7	100.0	106.0	
16. Potentially preventable hospital admission by primary care for age 0-74 years old (%) (Pacific)	118.5	66.0	100.0	106.0	
17. Potentially preventable hospital admission by primary care for age 0-74 years old (%) (Other)	119.8	78.5	100.0	104.4	
18. Elective surgery discharge rate (per 1,000 pop)	27	54	33	36	
19. Acute medical bed days (per 1,000 pop)	247	131	205	247	

Our 2011/12 Performance in Focus: National Health Targets

Shorter stays in Emergency Departments

Proportion of patients presenting at the Counties Manukau DHB Emergency Department admitted, discharged or transferred within 6 hours



	2009/10	2010/11	2011/12
ED 6 Hours	95%	97%	97%
National Result	87%	89%	94%
Target	95%	95%	95%

* *Numbers in the table have been rounded to the nearest unit*

CMDHB continued to perform above the national target of 95 percent in the last 12 months to the end of June 2012. This despite a 3 percent increase in ED attendances[4] from the previous financial year.

In the 2011/12 year, there were 91, 270 attendances at ED with 88,233 of these patients being admitted, transferred or discharged within 6 hours.

Our 15-bed Assessment and Observation Unit which opened in April 2010 has played an important part in reducing the number of acute medical patients presenting in ED as have joint initiatives with primary care which ensure people who are high users of secondary care or people with chronic conditions are able to be managed and treated in primary care like the *Very High Intensive User* (VHIU) programme and the *Primary Options for Acute Care* (POAC) programme. Both programmes were expanded in 2011/12 enabling more people to be enrolled.

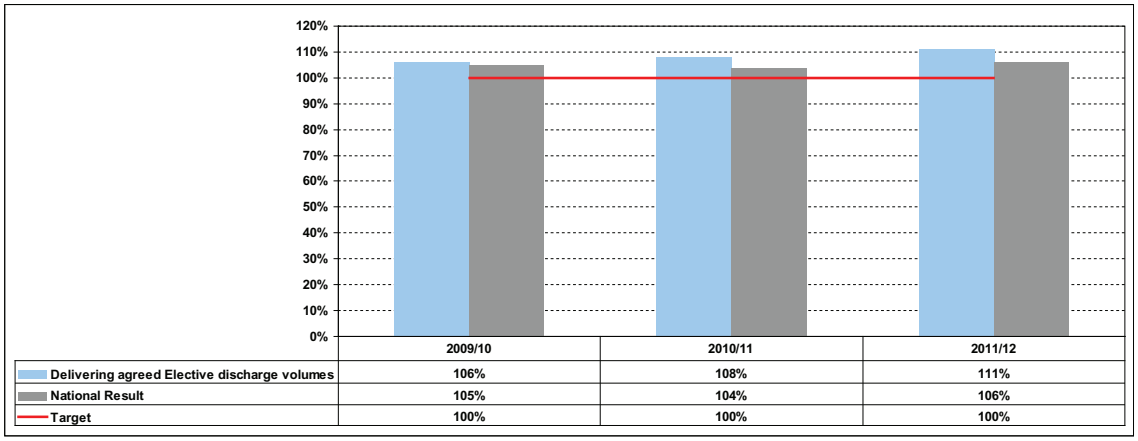
We continue to improve our processes and will be implementing care pathways for conditions like cellulitis which will improve patient flow through the system from primary care through to the emergency department and inpatient specialities. Our after hours network, the localities work streams planned for 2012/13, particularly our *Saving 20,000 Days* campaign initiatives, and the Greater Auckland Integrated Health Network (GAIHN) primary care initiatives like the extension of POAC, improving access to diagnostics and the implementation of clinical pathways will help us to better understand our pressure points and how we can reduce acute demand.

The alignment of our *Safe Staffing, Healthy Workplaces* initiative with improved capacity demand management through Middlemore Central our centralised information and action hub, will also contribute to maintenance of performance on this target.

[4] Counting only 'Eligible' ED patients, that is, those who did not self-discharge and those who did not go to the Assessment and Observation Unit as their first location in emergency care.

Improved access to Elective Surgery

Counties Manukau elective discharges delivered



	2009/10	2010/11	2011/12
Delivering agreed Elective discharge volumes	106%	108%	111%
National Result	105%	104%	106%
Target	100%	100%	100%

* *Numbers in the table have been rounded to the nearest unit*

DHB performance in the delivery of elective services is measured in our Statement of Intent in two ways.

- The number of patients we treated and discharged which is measured against our Electives health target, and;
- How well we managed our patients as they moved through the Electives system as monitored by the Elective Services Patient Flow Indicators (ESPIs)

The DHB delivered 16,257 elective surgical discharges in 2011/12 and achieved full compliance with the Ministry of Health ESPIs which demonstrate that our systems are managing patients in an appropriate manner and within accepted referral and treatment timeframes.

CMDHB Elective Services Patient Flow Indicators for the year ended 30 June 2011, presented as a range from lowest to highest

ESPI	Description	Target 2011/12	Result 2011/12
1	DHB services that appropriately acknowledge and process all patient referrals within ten days	> 90%	100%
2	Patients waiting longer than six months for their first specialist assessment (FSA)	<1.5%	0 – 0.1%
3	Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold	< 5%	0.1 – 0.3%
4	Clarity of treatment status	< 5%	0%
5	Patients given a commitment to treatment but not treated within six months.	< 4%	0 – 0.6%
6	Proportion of patients who have been placed on active review who have not received a clinical assessment within the last 6 months	< 15%	0%
7	Patients who have not been managed according to their assigned status and who should have received treatment.	< 5%	0 - 0.6%
8	The proportion of patients treated who were prioritised using nationally recognised processes or tools	> 90%	100%

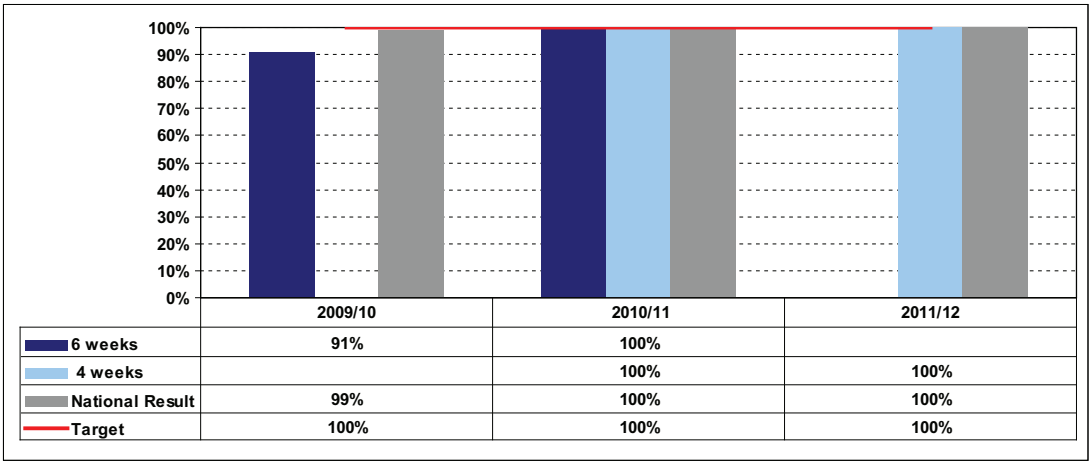
Our standardised intervention rates for elective surgical services which measures the level of service delivery to our standardised population shows we are delivering good levels of service for key conditions.
See page 88 for other elective surgery efficiency measures.

Standardised discharge rates per 10,000, year ended 31 March 2012

	National target discharge rate per 10,000	CMDHB standardised discharge rate per 10,000
Cardiac	6.5	6.34
Cataracts	27	38.68
Major Joints	21	19.78

Shorter waits for cancer treatment

Proportion of Counties Manukau cancer patients who received radiation therapy within 4 weeks from decision to treat



	2009/10	2010/11	2011/12
6 weeks	91%	100%	
4 weeks		100%	100%
National Result	99%	100%	100%
Target	100%	100%	100%

* *Numbers in the table have been rounded to the nearest unit*

From December 2010, the waiting time for radiation therapy cancer treatment was changed from 6 weeks to 4 weeks from decision to treat. In 2011/12 another quality measure for cancer services was introduced as a policy priority to track DHBs' delivery of chemotherapy services to patients within 4 weeks from decision to treat.

We achieved the national health target of 100 percent of our patients who required radiotherapy were treated by 4 weeks from decision to treat. 93.4 percent of these patients received their first specialist assessment within 4 weeks from their date of referral.

Working collaboratively with our Northern Region DHB counterparts through the Northern Region Cancer Network to implement the regional Radiation Therapy Strategic Plan has been instrumental to sustainable service delivery for improved access to timely radiation therapy and maintenance of our target performance.

We did not meet the target for delivering chemotherapy treatment to patients within 4 weeks from decision to treat due to capacity constraints. All chemotherapy treatment except that for our haematology patients are delivered through our regional cancer centre based at Auckland DHB.

In the last year, we have worked with our regional colleagues to:

- improve access to timely chemotherapy treatment through the use of medical oncology prioritisation criteria;
- improve cancer wait times through the lung tumour stream; and
- develop a haematology clinical network.

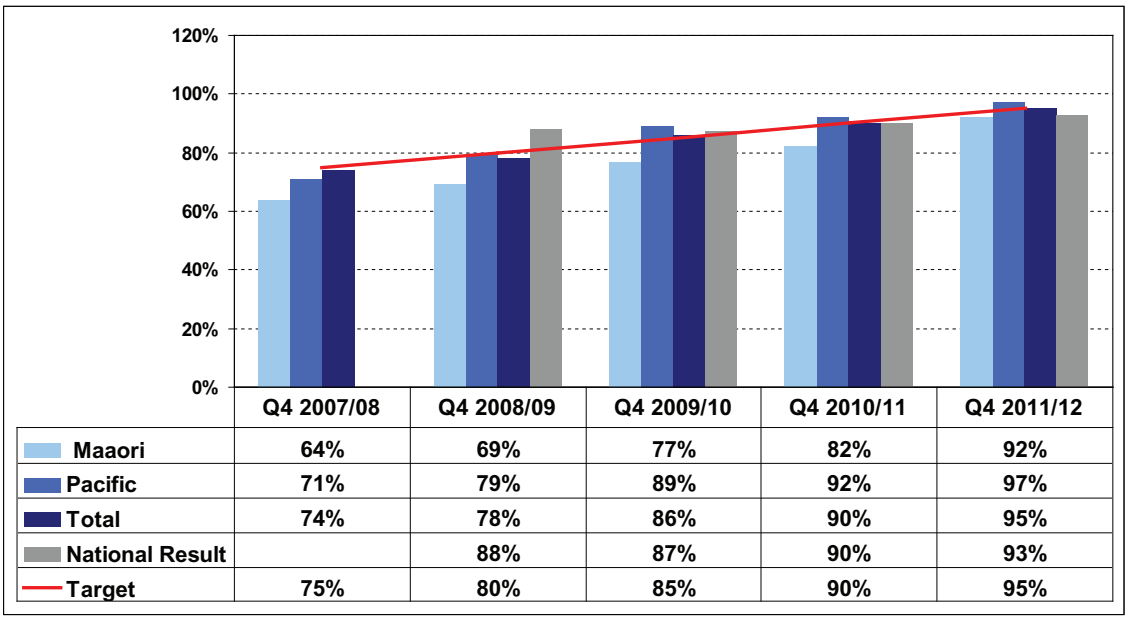
Prior to the Lung Cancer working group, only 30 percent of lung cancer patients were waiting less than 14 days for their first special assessment (FSA). Since September 2011, 95 percent of FSAs for lung cancer patients are within the 14 days target. Work is now underway to ensure that this happens for all cancers.

98 percent (381 out of 390) of Counties Manukau chemotherapy patients seen at Auckland DHB were treated within 4 weeks from decision to treat and 97 percent (65 out of 67) of haematology patients were treated at Counties Manukau DHB within 4 weeks from decision to treat.

The chemotherapy target will be reported as a part of the national health target for Shorter waits for cancer treatment from 1 July 2012. We are working with our Northern region DHB counterparts through the Northern Region Cancer Network to support faster cancer treatment for patients using a patient pathway approach.

Increased immunisations

Proportion of Counties Manukau two year olds fully immunised



	Q4 2007/08	Q4 2008/09	Q4 2009/10	Q4 2010/11	Q4 2011/12
Maaori	64%	69%	77%	82%	92%
Pacific	71%	79%	89%	92%	97%
Total	74%	78%	86%	90%	95%
National Result		88%	87%	90%	93%
Target	75%	80%	85%	90%	95%

* *Numbers in the table have been rounded to the nearest unit*

Our childhood immunisation service and our partners in primary care and community health services reached a very important public health milestone for the Counties Manukau population this year by achieving the target of having fully immunised 95 percent of our two year old population. Reaching this target is important for various reasons.

First, it is an extremely important aspect of public health care in terms of providing 'herd immunity', that is, a general level of immunity in the population which will help decrease the likelihood of the spread of infectious disease.

Second, our rates for Maaori and Pacific have shown the greatest improvement with a 28 percent and 26 percent increase over the last four years respectively. This is a testament of the diligence, focus, innovation and collaboration between our childhood immunisation service and their partners in primary care and the community who have worked to ensure that the model for immunisation services are responsive to Maaori and Pacific families.

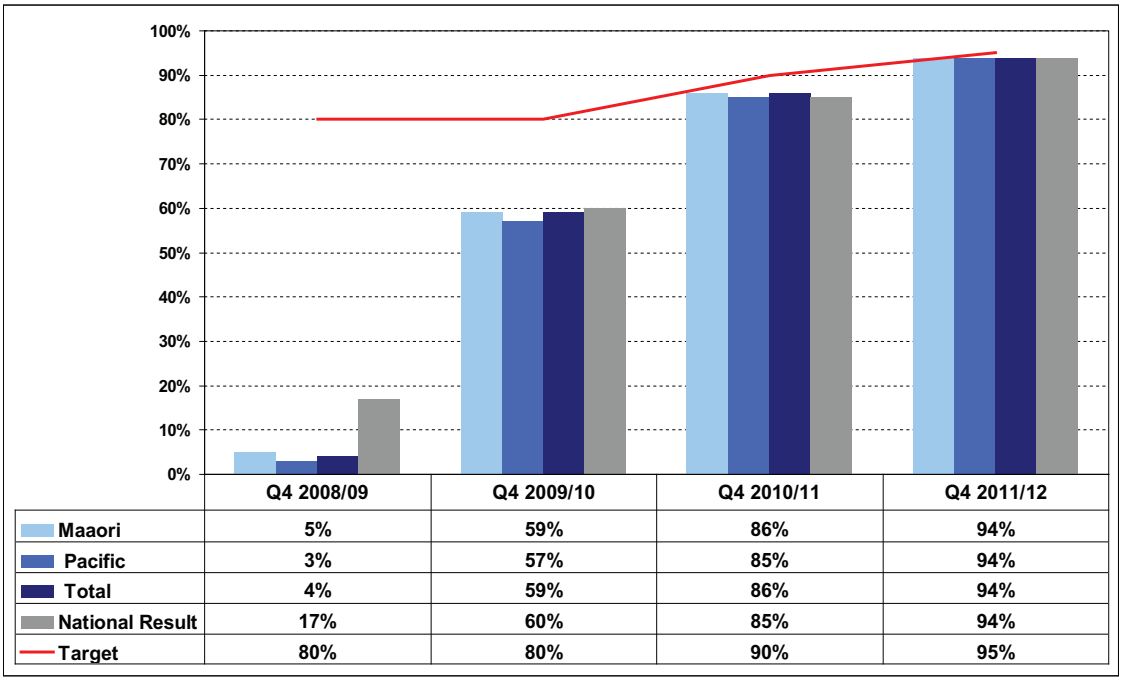
Our challenge going forward will be to continue to maintain these high rates for our population.

As of 1 July 2012, the national health target for Increased Immunisations has changed to: 85 percent of eight month olds will have their primary course of immunisation on time by July 2013.

The target for two year olds to be fully immunised will remain a policy priority for the district health board and Ministry of Health.

Better help for smokers to quit – Secondary facilities

Proportion of smokers who are inpatients at Counties Manukau DHB secondary facilities given brief advice and help to quit smoking



	Q4 2008/09	Q4 2009/10	Q4 2010/11	Q4 2011/12
Maaori	5%	59%	86%	94%
Pacific	3%	57%	85%	94%
Total	4%	59%	86%	94%
National Result	17%	60%	85%	94%
Target	80%	80%	90%	95%

* *Numbers in the table have been rounded to the nearest unit*

In Quarter 4 of 2011/12, we achieved a result of 94.2 percent of our inpatient smokers being given advice and help to quit from health practitioners in our secondary care facilities. Whilst we missed the national health target by 0.8 percent, the improvement we have made on this target is an outstanding achievement.

This has been made possible through the ongoing commitment by hospital leadership – both management and clinicians - and our Smokefree Services to promote and champion the Smokefree ABCs as a routine part of patient care. In the last year, we have implemented initiatives including daily reporting for high demand areas such as in our Emergency Care department, weekly progress updates to hospital management, and the ongoing coordination of an active Smokefree Champions network. We have also made Smokefree training mandatory for all nurses as a part of their annual update.

The Smokefree service continues to provide Smokefree best practice and Nicotine Replacement Therapy (NRT) standing orders training, including refreshers, and will undertake a training recertification process during the next period. Several staff have opted to undertake the STEPS (Sustainable Trainer Education to Promote Smokefree)[5] training, providing an additional mechanism for staff training.

In the year ended 30 June 2012, 520 staff completed Smokefree Best Practice training and 101 completed the Nicotine Replacement Therapy Standing Orders training.

The reduction of tobacco use is a priority for the DHB as is it a leading preventable cause of death, disease and disability for all ethnicities, particularly Maaori. Children who are smoke exposed or whose parents smoke are also more likely to be hospitalised for respiratory infections, asthma and dental conditions.

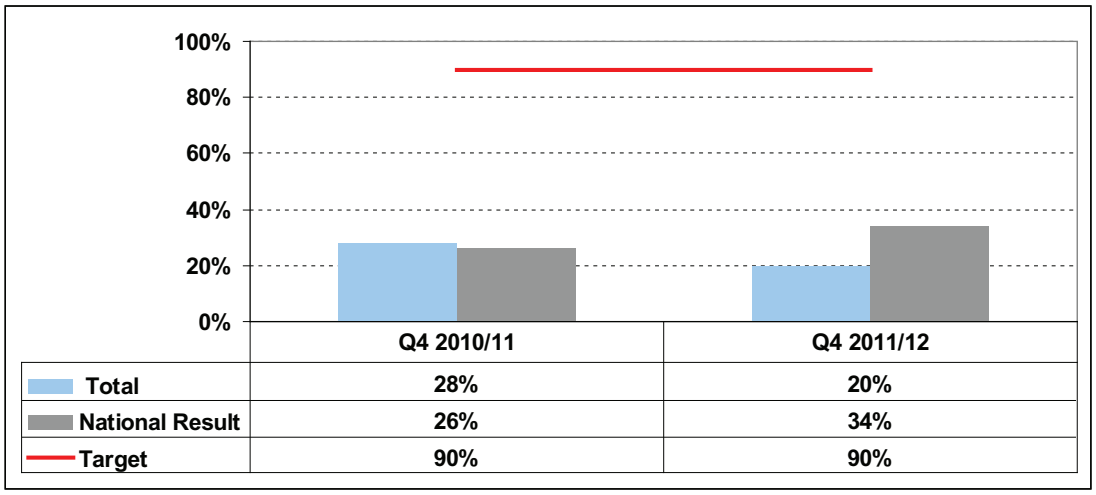
Our adult inpatient smoking prevalence rate recorded for the year ended June 2012 is 19 percent (Maaori 43 percent, Pacific 19 percent) compared to the 2006 Census results which recorded 22 percent of adults as regular smokers. The latest national survey on youth smoking rates[6] shows that the proportion of Year 10 students in Counties Manukau who have never smoked increased about five percent from last year, from 63.3 percent to 68.4 percent.

[5] STEPS is a national programme funded by the Ministry of Health and delivered by Counties Manukau DHB in partnership with Hawkes Bay DHB.

[6] Survey by Action on Smoking and Health (ASH) non-governmental organisation.

Better help for smokers to quit – Primary Care

Proportion of smokers who are seen by their health practitioner in primary care are given brief advice and help to quit smoking



	Q4 2010/11	Q4 2011/12
Total	28%	20%
National Result	26%	34%
Target	90%	90%

* *Numbers in the table have been rounded to the nearest unit*

Our year end result for 2011/12 show that our performance has dropped in relation to our 2010/ 11 year end result. Whilst performance has not improved, the quality of the data from which results are derived is much better than what it was 12 months ago due to the introduction of validation processes initiated at various points of the data collection and reporting systems.

We have continued to support the work Auckland DHB is undertaking with DHBNZ to resolve the issue around disaggregating cross-boundary PHO data for individual DHBs which we believe continue to affect the accuracy of the results reported this financial year. PHO Smokefree results for PHOs operating in more than one DHB catchment area have been reported as an Auckland metro result as we were unable to extract the PHO data by DHB catchment areas.

We also continue to work with our PHOs to improve their understanding of the data collection and reporting processes including understanding of smoker definitions, different Patient Management Systems and the importance of consistency of data coding across individual practices and PHOs.

For 2012/13, CMDHB is committed to resourcing a Smokefree coordinator who will work with PHOs and practices to undertake a current state assessment, complete a gap analysis, and recommend corrective actions and assist with implementation.

Better diabetes and cardiovascular services

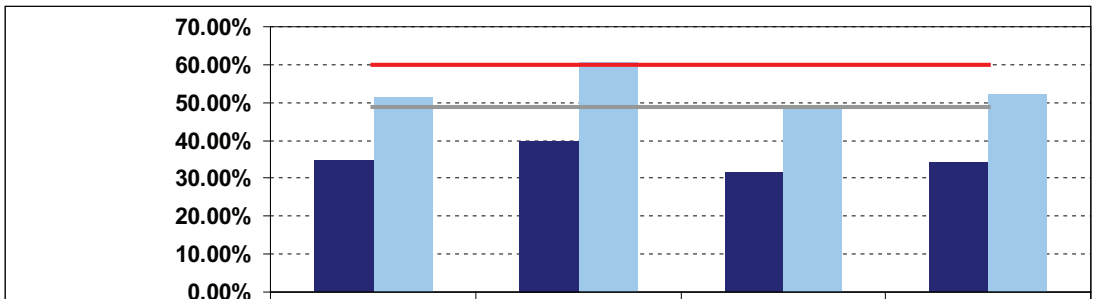
A new national health target - More Heart and Diabetes Checks - was introduced in January 2012 to reflect the Minister's expectation that DHBs carry out more cardiovascular disease risk assessments (CVDRA). This target replaces the Better Diabetes and Cardiovascular Services health target which was a composite measure made up of three targets: diabetes annual review, diabetes management and cardiovascular risk assessment for eligible people.

This new health target will measure the proportion of eligible population who will have had their cardiovascular risk assessed in the last five years, with the expectation that DHBs will achieve 60 percent by July 2012, 75 percent by July 2013 and 90 percent by July 2014.

The data source for this measure has been changed from the National Labs Warehouse data to the PHO Performance Programme data, necessitating a change in the CVDRA target from the 90 percent as agreed in our 2011/12 Annual Plan to 60 percent by July 2012. Our result at the end of Quarter 2, based on the National Labs Warehouse data, was 84 percent against the target of 90 percent.

For the year ended 30 June 2012, we achieved the CVD risk assessment target for our Pacific population but did not achieve for Maaori and Other groups.

Proportion of eligible CMDHB population who have had their cardiovascular risk assessed in the last five years



	Maaori	Pacific	Other	Total
Baseline	34.70%	39.80%	31.50%	34.00%
Q4 2011/12	51.20%	60.80%	48.10%	52.10%
Target	60%	60%	60%	60%
National Result	49%	49%	49%	49%

* *Baseline figures from PHO Performance Programme, as at 30 June 2012*

Cardiovascular disease and diabetes are good examples of chronic disease which could lead to premature mortality if early intervention and management is not received. Reducing the impact of cardiovascular disease and diabetes requires an integrated response from both primary and secondary care. In the last year, we have been working with our Northern Region DHB colleagues and primary care partners to design better health systems and improve clinical quality and practice for managing long term conditions such as diabetes and cardiovascular disease.

In order to reach the target in 2012/13 a number of initiatives have been developed both regionally (Northern Region CVD and Diabetes Networks) and locally. PHOs within CMDHB have developed plans that detail the specific practice and reporting processes, IT tools and workforce development opportunities that are now being implemented. Several of these plans have been linked into a wider framework around the management of long term conditions and all of them have a quality focus.

The diabetes annual review and management measures are no longer national health targets but they will continue to be tracked under the Ministry of Health accountability performance framework.

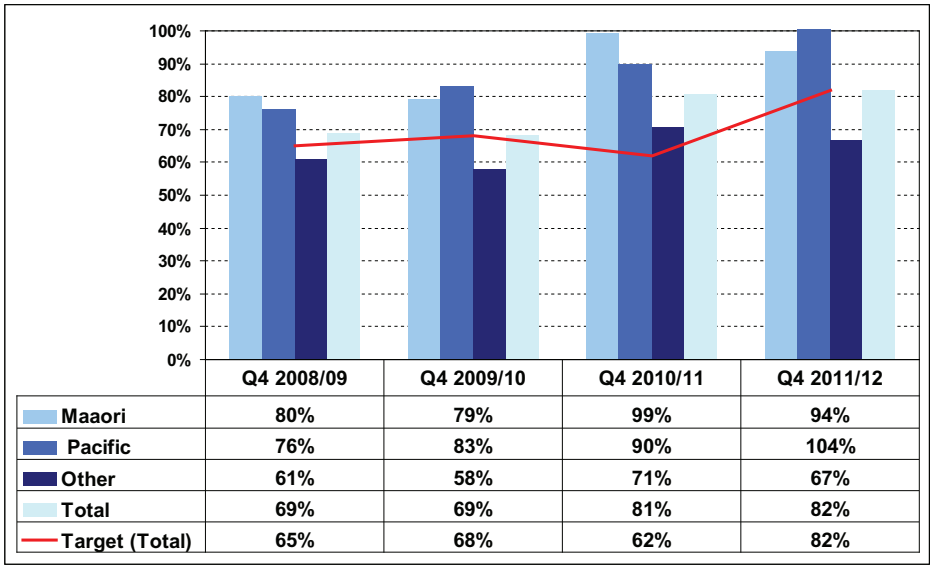
For the 2011/12 year, we achieved a diabetes annual review result of 104 percent for Pacific and 94 percent for Maaori. The improvement in screening coverage has led to an increase in the number of people identified as having diabetes in the DHB. The latest Ministry of Health figures estimate the Counties Manukau diabetes prevalence at 31 December 2011 as approximately 31,023 people.[7] This is an 11.8 percent growth from the previous year at 27,362.

We achieved the overall diabetes management target of 61 percent and our Maaori and Pacific populations achieved their respective year end targets of 54 percent and 49 percent but it remains a challenge for the DHB and our primary care partners for the next few years to ensure that diabetes management for Maaori and Pacific is as good as that for non-Maaori and non-Pacific.

CMDHB is supporting the development of Locality Clinical Partnerships which will result in increased primary and secondary collaboration, improved data management as well as audit and feedback to practices, development of workforce capacity and redesigning the Chronic Care Management programme. We are also a part of the Northern Region Diabetes and Cardiovascular Disease Clinical Networks and will be implementing regional initiatives supporting better clinical management for diabetes and cardiovascular disease through our Diabetes Care Improvement Plan.

All PHOs in CMDHB will be using reporting and auditing tools such as Dr Info to ensure that they are able to send regular feedback to the practices with regard to their progress against the health targets and patient health outcomes. Also practices will have direct access to information on patients who are eligible for CVD/Diabetes screening, who have not been screened in the past 5 years.

Proportion of CMDHB diabetics who have had an annual review

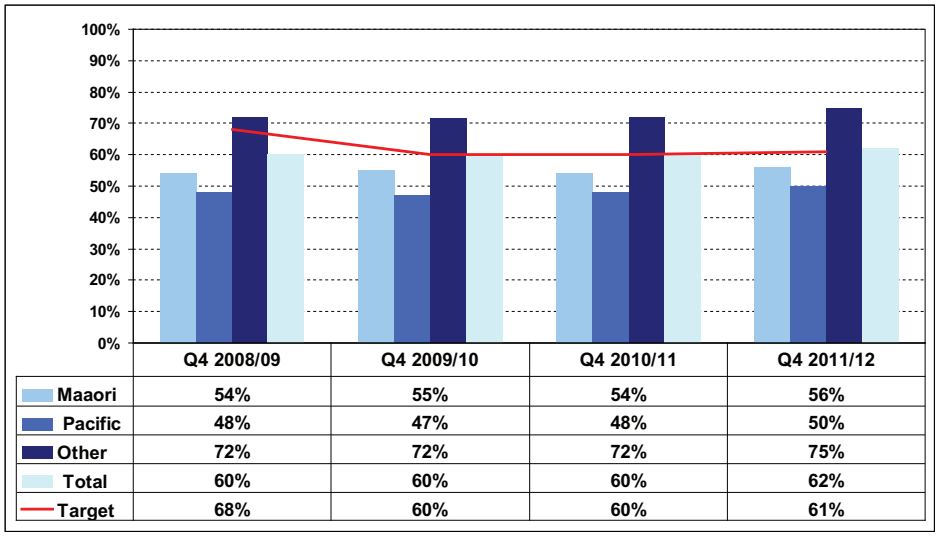


	Q4 2008/09	Q4 2009/10	Q4 2010/11	Q4 2011/12
Maaori	80%	79%	99%	94%
Pacific	76%	83%	90%	104%
Other	61%	58%	71%	67%
Total	69%	69%	81%	82%
Target (Total)	65%	68%	62%	82%

Note: The 2011/12 target was re-negotiated after the publication of the 2011/12 Statement of Intent and changed from 78 percent to 82 percent.

[7] Ministry of Health Virtual Diabetes Register, version 6.82. Numbers refer to PHO registered patients only.

Proportion of CMDHB diabetics who have satisfactory or better diabetes management



	Q4 2008/09	Q4 2009/10	Q4 2010/11	Q4 2011/12
Maaori	54%	55%	54%	56%
Pacific	48%	47%	48%	50%
Other	72%	72%	72%	75%
Total	60%	60%	60%	62%
Target	68%	60%	60%	61%

Note: The 2011/12 diabetes management target was re-negotiated after the publication of the 2011/12 Statement of Intent and changed from 60 percent to 61 percent.

Our 2011/12 Performance in Focus: What we said you could expect

People have fewer incidences of chronic disease and the impact of chronic disease is lessened for those who have it

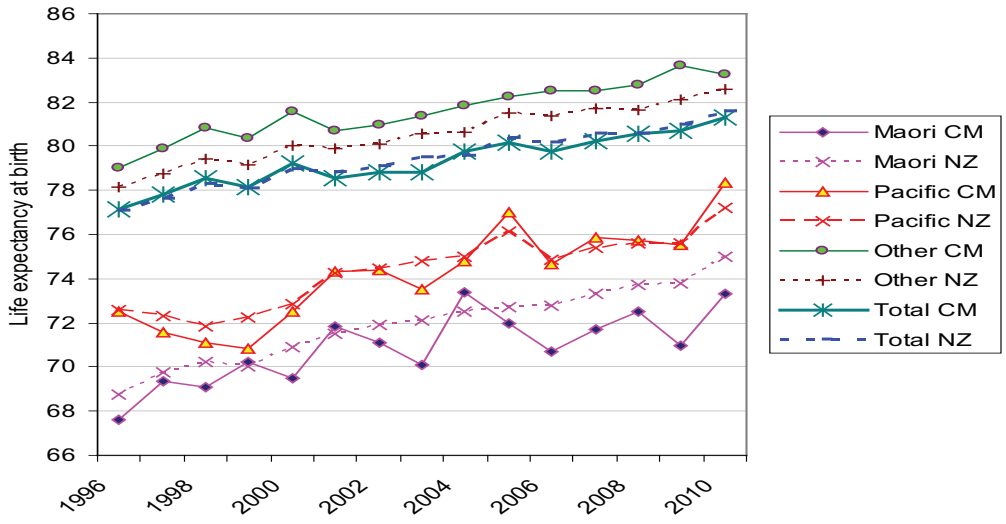
Ensuring that fewer people experience chronic disease and that those who do have it stay well is a top priority for the DHB as our population gets older. In order to do this well we need to have good quality integrated services across the continuum of care from when people first start requiring services in the community and in primary care to our secondary care services.

Life expectancy at birth

The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific is an important marker for the DHB of the impact we are making in lifting the health outcomes of Maaori and Pacific and reducing health inequalities.

Whilst overall life expectancy at birth has increased, the gap between Maaori and Pacific and non-Maaori and non-Pacific has not decreased.

The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific, Counties Manukau versus New Zealand [8]



[8] Jackson, G., & Papa, D (2011) Life expectancy update to 2010 for Counties Manukau

Potentially preventable hospital admissions by primary care

Potentially preventable hospital admissions measured through Ambulatory Sensitive Hospitalisations (ASH) is a good indicator of the efficacy of our primary care and community based services in keeping people well in the community and out of hospital.

Adult ASH rates have increased marginally in the last 12 months compared to the previous year but looking back over the previous five years, there has been no substantial change in overall ASH rates for any ethnic group although rates do remain above the national average and an ethnic disparity persists. ASH rates for children aged 0 to 4 years however has decreased in the last year and the trend in the last five years shows an overall reduction for this age group.

It is interesting to note that there has been reduced growth for conditions such as cellulitis across all ethnic groups and ages and reduced volumes of smoking related illness (pneumonia and asthma, myocardial infarction) in Maaori. As we develop more integrated care pathways and extend our primary care programmes such as Primary Options for Acute Care, Self Management Education and Chronic Care Management, we expect to see more improvement for these conditions in the future.

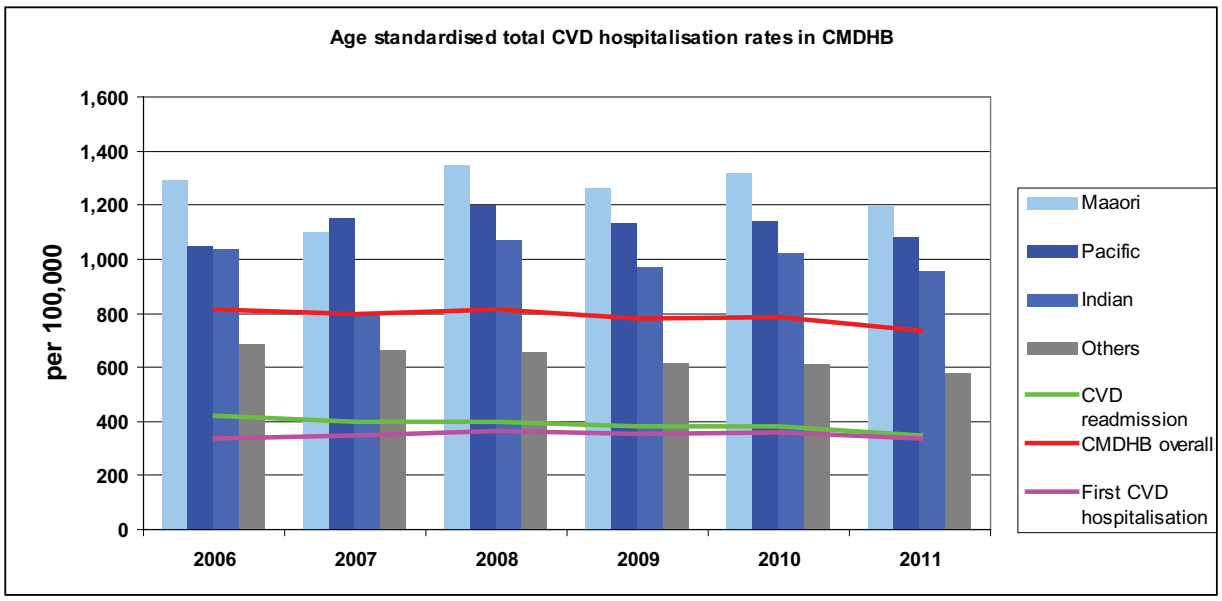
Hospitalisation rates for cardiovascular disease and diabetes

Total hospitalisation rates for cardiovascular disease are starting to level out and overall appear to be reducing. Decreasing readmission rates may indicate that our investment in cardiac interventions such as CVD risk screening and management, increased cardiac procedures, improved medication prescription upon discharge with increased number of people in the community on CVD medication, may be contributing to this.

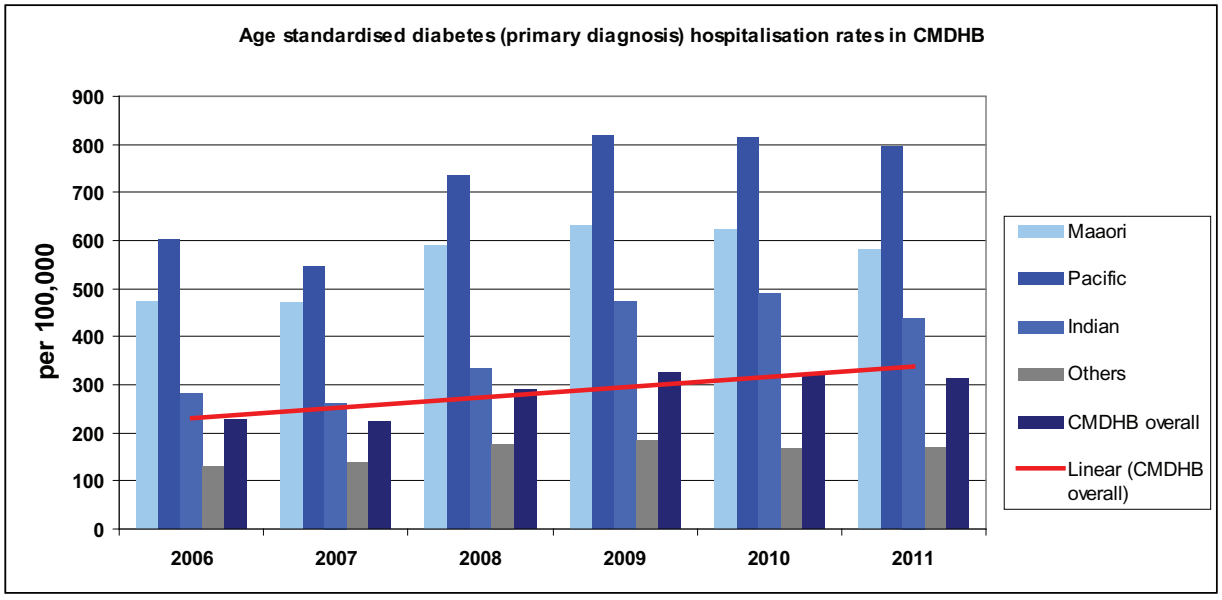
The overall first CVD hospitalisation rate which can be a proxy indicator for new cases has also been flat and is falling for the Other group. However, this is not the case for our Maaori, Pacific and Indian populations due to the continuing unfavourable trends in diabetes for these ethnicities.

Hospitalisation rates for diabetes continue to show an upward trend particularly for our Maaori, Pacific and Indian populations.

Age standardised total CVD hospitalisation rates per 100,000 in CMDHB by ethnicity [9]



Age standardised diabetes (primary diagnosis) hospitalisation rates per 100,000 in CMDHB by ethnicity [10]



Population based screening

Our breast screening service achieved a great performance this year and was only 1 percent short of reaching the 70 percent target for the year. The screening rate for Maaori women has seen the largest improvement from 56 percent in the previous year to 69.3 percent.

[9] Analysis by CMDHB. Hospitalisation figures from the National Minimum Dataset and population projections from Statistics New Zealand.

[10] As above

Supporting Measures

What we said you could expect	2010/11	2011/12
Expected number of years of life from birth[11]		
• Maaori	73.3	72.3
• Pacific	78.4	76.1
• Other	83.3%	83.2
Community-based and Primary Care Services		
60 percent of eligible young women completed the full Human Papillomavirus (HPV) vaccination course (3 doses)	**45%[12]**	**60.7%[13]**
70 percent of women aged 45 to 69 years had a breast screen in the last 24 months		
• Maaori	60%	69%
• Pacific	67%	67%
• Total	67%	69%
75 percent or more women aged 20 to 70 years had a cervical smear in the last three years	**67%**	**63.8%**
82 percent of diabetics had an annual check	**81%**	**82%**
• 99 percent Maaori	99%	94%
• 90 percent Pacific	90%	104%
• 73 percent Other	71%	67%
60 percent of diabetics had satisfactory or better diabetes management (Average blood sugar level of equal to or less than 64mmol/mol)	**60%**	**62%**
• 54 percent Maaori	54%	56%
• 49 percent Pacific	48%	50%
• 71 percent Other	72%	75%
Potentially preventable hospital admission by primary care (ambulatory sensitive hospitalisations): 0 to 74 years		
• Maaori	131	106
• Pacific	134	106
• Other	115	104
Potentially preventable hospital admission by primary care (ambulatory sensitive hospitalisations): 0 – 4 years		
• Maaori	85	72
• Pacific	95	97
• Other	72	75
Potentially preventable hospital admission by primary care: 45 to 64 years		
• Maaori	175	133
• Pacific	156	113
• Other	133	120
Increased GP consultations for Counties Manukau high needs patients compared to non high need patients[14]	**1.03**	**1.02[15]**
80 percent of primary care patients screened for smoking status across all PHOs	**52%**	**78%**
850 additional patients enrolled in Self Management[16] programmes	**873**	**551**
More than 19,500 people with chronic conditions enrolled in all Chronic Care Management (CCM) programmes[17]	**18,465**	**19,910**
9,000 people enrolled in Primary Options for Acute Care (POAC) programme[18]	**7,500**	**9,788**
7,650 POAC patient admissions avoided at Emergency Care	**7,126**	**8,942**
800 enrolments to the Very High Intensive User (VHIU) programme[19]	**829**	**607[20]**

[11] Analysis by CMDHB from national mortality data
[12] Academic year Feb 2010 - Dec 2010. in the 2010/11 Annual Report, this result was reported by financial year
[13] Academic year Feb 2011 – Dec 2011
[14] A rate greater than 1 indicates that GP services for high need populations are matched to the level of health need providing equal opportunity of health outcomes.
[15] Quarter ended 31 March 2012. Data is collated a quarter in arrears for completeness.
[16] Self Management Education programmes are open to people with chronic conditions through referral via their GP. These chronic care group courses teach people with chronic conditions to live as well as possible with their chronic conditions.
[17] Chronic Care Management (CCM) is a structured programme supporting patients with chronic conditions in the community where they can be followed up on a regular basis throughout the year.
[18] Primary Options for Acute Care (POAC) is a service allowing doctors to access investigations, care or treatment for their patient, as an alternative to an acute hospital admission.
[19] The Very High Intensive User (VHIU) programme is an integrated care model designed to improve the care of frequent presenters (that is, people aged15 years or over presenting at Middlemore ED on five or more occasions in the preceding 12 months) through establishing or re-establishing a programme of care in the community and general practice.
[20] Whilst the total number of referrals to the programme was 1,929 only 607 referrals were accepted. Frequent presenters are identified and then a triage tool is used to assess suitability for acceptance to the programme.

Children in Counties Manukau are healthier and safer

Improving the health and wellbeing of children and young people living in Counties Manukau is a priority for us as we have a young population - 40 percent of our population is under the age of 25 years - and our children deserve the best possible start in life.

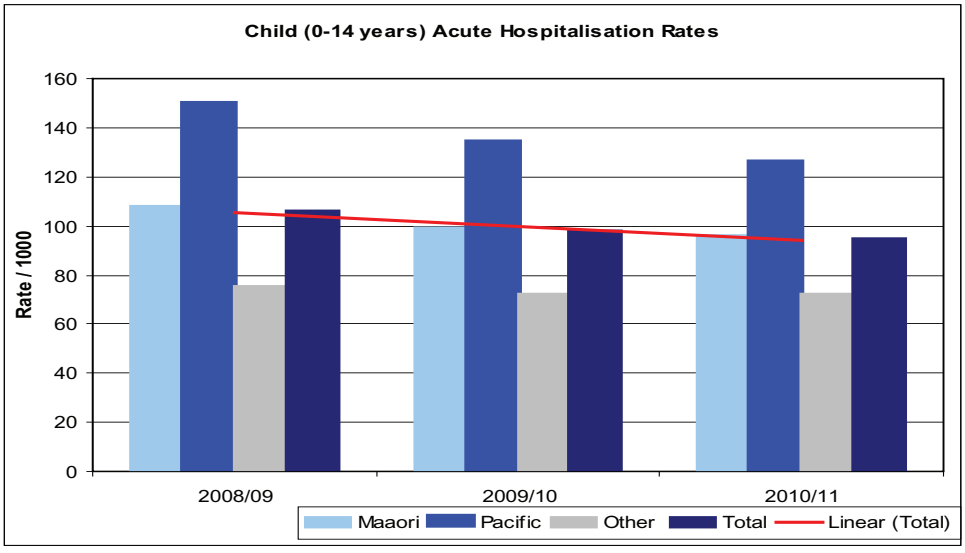
Hospitalisation rates are a good indicator for whether our child health initiatives and programmes including primary care, intersectoral and population health initiatives are making an impact on improving child health and reducing the number of children being admitted to hospital for preventable conditions such as skin infections, respiratory disease and rheumatic fever.

The trend over the last few years seems to indicate that we are making incremental improvements in our children and young people acute hospitalisation rates but our overall hospitalisation rates for children and young people residing in CMDHB remain above the national average for medical conditions, such as lower respiratory infections, rheumatic fever and skin infections. Maintaining our high rate of immunisation and improving the quality of housing and increasing smokefree living environments are central to decreasing the risk of these infectious diseases. See page 71, for the DHB's performance on childhood immunisation.

As outlined on page 78, the trend for ambulatory sensitive hospitalisations for children aged 0 to 4 is also showing overall reductions in the last five years.

In the coming year, we are looking to align our community based services to a locality approach where services are delivered to the preference of the community in the respective areas. We adapted our B4 School Check delivery model this year to reflect the locality approach. CMDHB is the only DHB offering home based vision and hearing checks. Home visiting has replaced community clinics which have traditionally attracted high DNA rates. Home based vision and hearing checks are offered to all children who live in a quintile 5[21] area and do not attend an Early Childhood Centre.

CMDHB Children's Acute Hospitalisation Rates [22]



[21] An area rated New Zealand Deprivation Index Quintile 5 indicates that the area is in the most deprived 20% of areas in New Zealand

[22] Hospitalisations data from Ministry of Health National Minimum Data Set

Supporting Measures

What we said you could expect	2010/11	2011/12
Healthy Environments		
Increase proportion of Year 10 students who have never smoked	**63.3%**	**68.4%**
Proportion of women identified as smokers giving birth at CMDHB birthing facilities (baseline measure)		**19%**
320 healthy housing assessments completed	**540**	**367**
1,500 homes insulated in the home insulation programme		
• 500 through Snug Homes		252
• 1,000 through Warm Up Counties Manukau		1,116
Health Screening		
7,076 children have had their B4 School Check	**3,035**	**7,111**
Health Promotion and Education Services		
Three community providers participating in the Baby Friendly Community Initiative accreditation	**0**	**3**
67 percent of infants are fully and exclusively breastfed at 6 weeks of age[23]	**55%**	**69%**
• 62 percent Maaori	53%	63%
• 67 percent Pacific	52%	60%
• 70 percent Other	59%	72%
55 percent of infants are fully and exclusively breastfed at 3 months of age	**43%**	**60%**
• 46 percent Maaori	35%	51%
• 51 percent Pacific	43%	50%
• 59 percent Other	48%	63%
26 percent of infants are fully and exclusively breastfed at 6 months of age	**17%**	**29%**
• 18 percent Maaori	11%	19%
• 22 percent Pacific	16%	19%
• 29 percent Other	21%	33%
150 preschool centres in the district are engaged in oral health education and tooth brushing programmes by June 2013	**0**	**58**
65 percent of children under 5 years enrolled in DHB-funded oral health services	**61%**	**66%**
Fewer than 10% of enrolled preschool children did not receive an examination within the 30 day recall period	**42%**	**12%**
52 percent or more five year olds are caries free	**45%**	**48%**
• 43 percent Maaori	38%	38%
• 35 percent Pacific	38%	32%
• 65 percent Other	62%	64%
Year 8 children had an average of 1.2 or less Decayed, Missing, Filled Teeth (DMFT)	**1.29**	**1.44**
• 1.50 Maaori	1.59	1.65
• 1.63 Pacific	1.72	1.99
• 0.88 Other	0.90	1.04
100 percent of Year 8 children had their treatment completed and were transferred to the Adolescent Dental Service	**100%**	**100%**
80 percent of adolescents utilised free oral health services	**68%**	**71.4%**

[23] Only Plunket data

Supporting Measures

What we said you could expect	2010/11	2011/12
Family Violence Intervention Programme		
Audit score of 140/200 for hospital responsiveness to family violence and child abuse[24]	**173/200**	**183/200**
All women presenting in Emergency Care, Women's Health and Kidz First are screened for family violence and child/partner abuse		
• Emergency Care – Adults		5%
• Emergency Care - Kidz First		2%
• Kidz First Medical Services		0%
• Kidz First Surgical Services		6%
• Community Midwives and Satellite Units		39.39%
Rate of positive disclosures as a result of screening		
• Emergency Care – Adults		50%
• Emergency Care - Kidz First		0%
• Kidz First Medical Services		0%
• Kidz First Surgical Services		0%
• Community Midwives and Satellite Units		8.33%

[24] Auckland University of Technology (AUT) audit

Older People are supported and receive services appropriate to their needs

We want to ensure that older people are supported to remain living in their own homes where it is appropriate and to have access to aged residential care when they need it.

To date, CMDHB has seen steady growth in people using home based support services over the last few years while residential care numbers are stable. We want to increase the ratio of the number of older people receiving home based support services to the number of older people receiving age related residential care in the coming years, and will be looking at ways of improving and expanding the range of community and home-based services available, whilst also ensuring that we have enough beds for fragile older people who need to be in long term residential care.

Our Adult Rehabilitation and Health of Older People services has had a focus on community/locality initiatives to provide better, sooner, more convenient services in the community including:

- Increasing the AT&R beds at Pukekohe Hospital from 2 to 10 which allows more patients in Franklin to be treated closer to home
- Launching an Integrated Care Cluster Pilot in the Eastern Locality Development which will facilitate the identification and management of patients at risk of hospital admission in the community
- Rapid response in the community and supported discharge team initiatives which focus on reducing hospital presentations and facilitating earlier discharge post admission

Supporting Measures

What we said you could expect	2010/11	2011/12
Assessment, Treatment & Rehabilitation		
Fewer than 15 in-hospital falls a month in Assessment, Treatment & Rehabilitation	23	27
Barthel Score[25] for inpatients to be at 60 percent or higher prior to discharge	74%	69%
More than 15 percent of people aged 65 years plus referred to Assessment, Treatment and Rehabilitation (AT&R) from Emergency Care	26%	21%
Average length of stay of less than 15 days in Assessment, Treatment & Rehabilitation	23.6	15.9
Proportion of people over 75 years who are hospitalised due to falls[26]	14%	
Aged Residential Care Services		
More than 1,043 subsidised aged residential care bed days provided	1,043	1,690
100 percent of residential care service providers meet the required certification standards	100%	100%
Fewer than 10 complaints received regarding aged residential care provision	10	16
Decrease the proportion of Counties Manukau elderly received aged residential care services (< 29 percent)	29%	30%
Home Based Support Services		
More than 484,146 home based support hours provided	484,146	491,660
80 percent of cases received home based support services within 10 days from completion of initial needs assessment		100%
20 percent of cases received home based support services within 20 days from completion of initial needs assessment		100%
Zero complaints received regarding home based support services	0	6
More than 332 people supported in their own homes with complex packages of home based care[27]	332	2,180
Proportion of 65+ year olds presenting at Emergency Care to be no more than 18 percent	18%	18%
Increase the proportion of Counties Manukau elderly receiving home based support services (> 71 percent)	71%	69%
Number of discharges linked to Home Health Care follow-up services[28]		
Palliative Care		
Number of people with advance care plans in the community[29]		31

[25] The Barthel score is used to measure performance in basic activities in daily living. A higher number is associated with a greater likelihood of being able to live at home with a degree of independence following discharge from hospital.

[26] This measure was introduced in 2011/12 as a placeholder measure in anticipation of developing a health target for falls prevention for 2012/13. It was removed from the MOH accountability performance framework in December 2011 further to advice from MOH.

[27] Coordinated through CMDHB's Needs Assessment and Service Coordination

[28] This measure was dropped from the suite of performance measures for ARHOP in 2011/12

[29] This project is now aligned with the regional advance care planning initiative and staff are being trained to record advance care "conversations" which will then be developed into plans. The performance indicator for 2012/13 is to have 240 conversations recorded.

People with mental illness have access to services and enjoy an improved quality of life

Access to the appropriate support for our mental health clients when it is needed is important for ensuring that people with mental illness have fewer acute episodes of mental ill health and have an improved quality of life.

Access to mental health services

We exceeded all access targets in the different ethnicity groups for both the 20 to 64 and 65+ age groups but did not reach the target for the 0 to 19 age group.

The overall access rate for the reporting period ending March 2012 is 3.32 percent, which is an increase from our access rate for the corresponding period ending September 2011 which was 3.28 percent. This is above the New Zealand average of 3.20 percent.

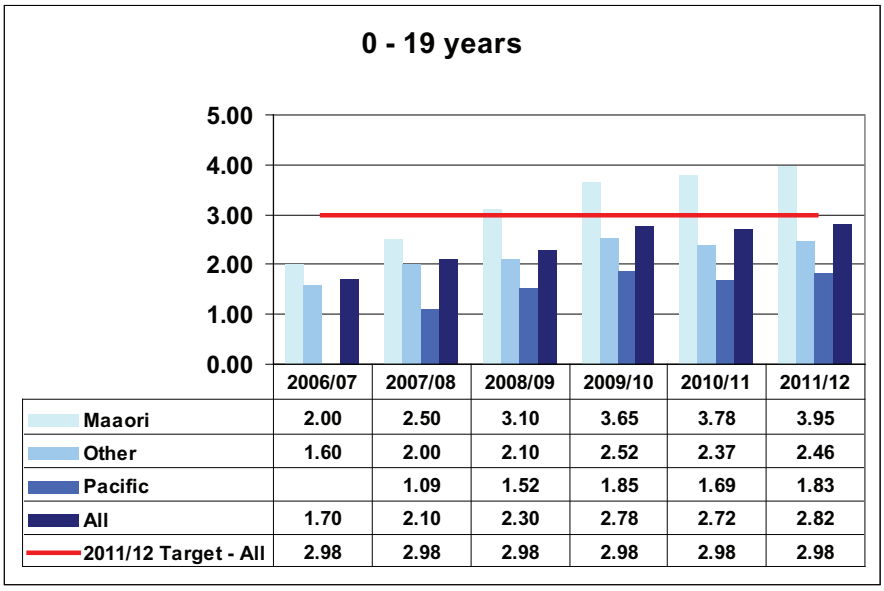
The actual number of unique clients seen in the year to March 2012 increased to 16,693, from 16,357, for the corresponding period ending September 2011. This is an increase of 336 clients seen or a percentage increase of 2.1 percent. This is also a marked increase from our March 2011 result where we saw 15,636 unique clients.

We did not reach the target for the 0 to 19 age group as the actual unique number of clients seen in the year to March 2012 decreased marginally from 4,671 to 4,652. The Child and Youth Service plans to meet access targets in 2012/13 by repositioning its access relationships so that they align and integrate with Special Education Services, Child, Youth and Family Services and PHOs. The service will also be looking at the implementation of Choice and Partnership Approach (CAPA)[30].

Relapse prevention plans for long term clients

We made progress this year on ensuring that more of our long term mental health clients had relapse prevention plans and met the 95 percent target for long term clients in the 20+ age group. Although we improved on our previous year's performance for our child and youth mental health clients we did not meet the 95 percent target. Our Child and Adolescent Mental Health teams will continue to track performance towards meeting this target and maintaining resiliency plans for all clients.

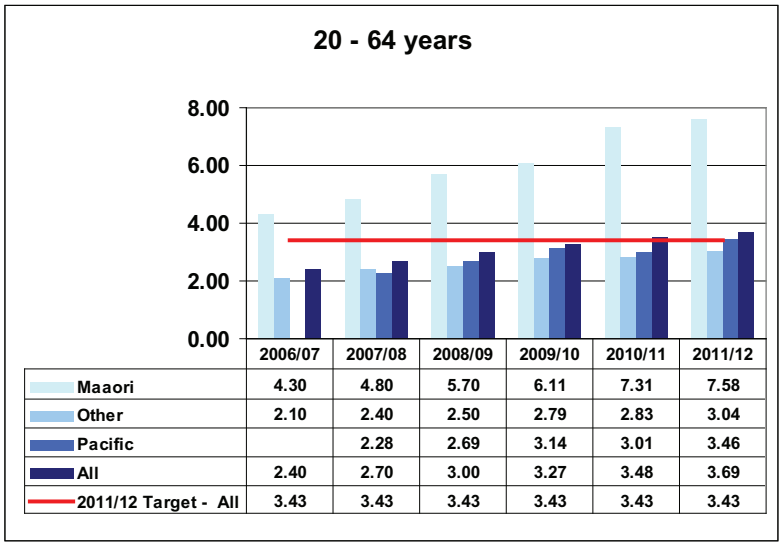
CMDHB Mental Health Access Rates: 0 – 19 years, year ended 31 March 2012



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Maaori	2.00	2.50	3.10	3.65	3.78	3.95
Other	1.60	2.00	2.10	2.52	2.37	2.46
Pacific		1.09	1.52	1.85	1.69	1.83
All	1.70	2.10	2.30	2.78	2.72	2.82
2011/12 Target - All	2.98	2.98	2.98	2.98	2.98	2.98

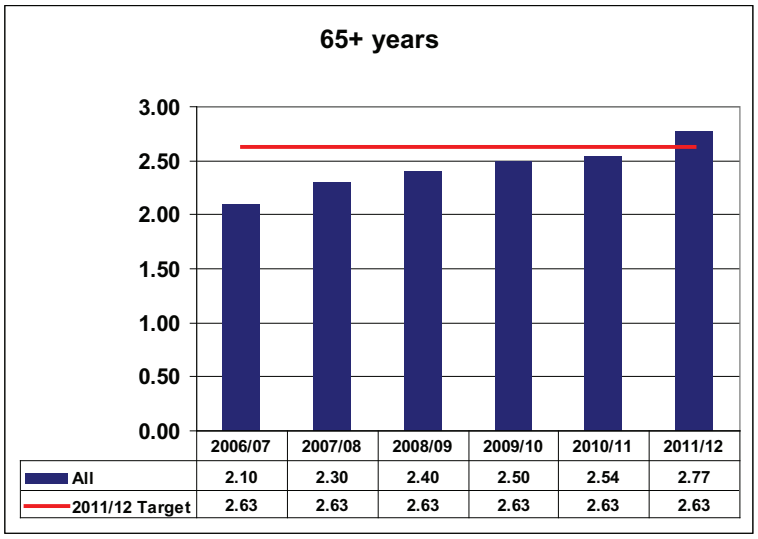
[30] Choice & Partnership Approach (CAPA) is a system flow management tool developed in the UK for Child and Adolescent Mental Health Services (CAMHS) to reduce long waiting lists and provide a quicker more responsive service.

CMDHB Mental Health Access Rates: 0 – 19 years, year ended 31 March 2012



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Maaori	4.30	4.80	5.70	6.11	7.31	7.58
Other	2.10	2.40	2.50	2.79	2.83	3.04
Pacific		2.28	2.69	3.14	3.01	3.46
All	2.40	2.70	3.00	3.27	3.48	3.69
2011/12 Target - All	3.43	3.43	3.43	3.43	3.43	3.43

CMDHB Mental Health Access Rates: 0 – 19 years, year ended 31 March 2012



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
All	2.10	2.30	2.40	2.50	2.54	2.77
2011/12 Target	2.63	2.63	2.63	2.63	2.63	2.63

Please note that there is only one Access target for the overall 65+ age group; there is no specified target in the different ethnicity groups

Supporting Measures

What we said you could expect	2010/11	2011/12
95 percent of long term mental health service child and youth clients had current relapse prevention plans	**68%**	**86%**
• Maaori	58%	90%
• Pacific	70%	94%
95 percent of long term mental health service clients aged 20+ years had current relapse prevention plans	**68%**	**95%**
• Maaori	61%	94%
• Pacific	75%	95%
Alcohol and other Drug waiting times[31]		

[31] This was introduced as a developmental output measure by the Ministry of Health for 2011/12. We are working regionally to ensure that there is a consistent measurement and reporting framework around wait times for NGO mental health providers and will start reporting on this in 2012/13.

Counties Manukau healthcare services are patient and family/whaanau centred

Ensuring that our healthcare services are patient and family/ Whaanau centred is in line with our Triple Aim objective of ensuring that we improve our patients and their family/ whaanau's experience of care. Patient experience of care is shaped by whether the care received meets their physical needs as well as emotional needs.

Patient Satisfaction

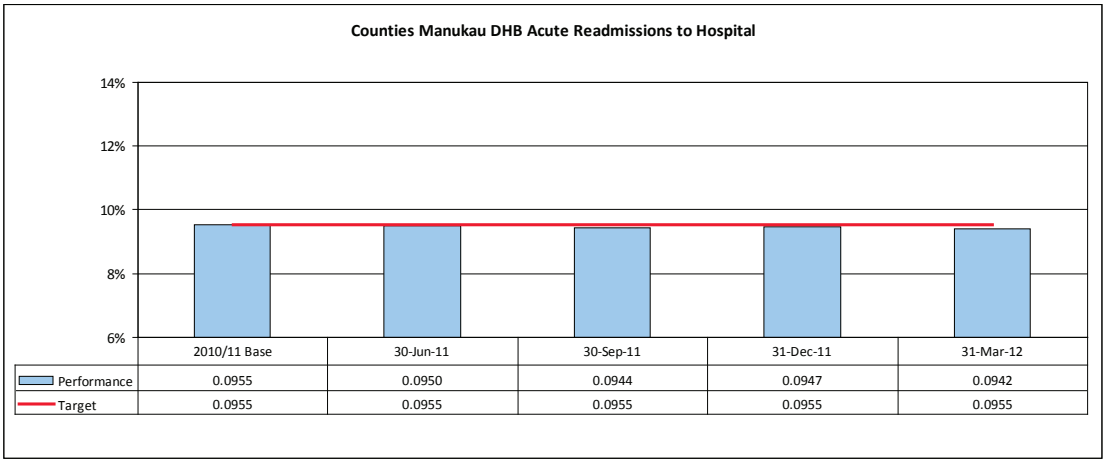
We are unable to provide an update on our patient satisfaction measure for this Annual Report as the patient satisfaction survey process is being reviewed nationally. The Ministry of Health has suspended the requirement to report on this while the review is underway.

In 2012/13 we will be implementing the new processes built off the recommendations from the national review.

Rate of Acute Readmissions and Average Length of Stay

Our rate of acute readmissions has remained relatively stable and within the target range of 9.55 percent for readmissions due to unforeseen medical circumstances. Unplanned acute readmissions above the target range may indicate short comings in quality of care provided by the DHB such as early discharge, inadequate home support and inefficient hospital care.

We have an acute readmission rate better than the national average and have the lowest rate of the three large DHBs who achieved this target.[32]



	2010/11 Base	30-Jun-11	30-Sep-11	31-Dec-11	31-Mar-12
Performance	0.0955	0.0950	0.0944	0.0947	0.0942
Target	0.0955	0.0955	0.0955	0.0955	0.0955

Elective surgery efficiency

Being able to access treatment when it is required can be a proxy measure for patient centred care. Elective services are an important component of the health care system for the diagnosis, treatment and management of health problems. Timely access to a first specialist assessment or elective surgery will improve quality of life for our patients by ensuring early diagnosis, intervention or treatment.

CMDHB achieved full compliance with the Ministry of Health Elective Service Patient Indicators in the 12 months to April 2012.

In 2012/13, we will continue to work towards improving patient flow so that all elective patients who are waiting for a first specialist assessment and those who have been given a commitment to treatment are seen and treated within five months.

The drive in the last six months to ensure that all patients given a commitment to treatment are treated within six months has meant an increase in higher complexity patients being treated, most of whom require an inpatient stay. This has affected our performance on our elective day surgery rates.

[32] The other two large DHBs being Canterbury DHB and Capital and Coast DHB.

We have however made incremental increases throughout the year and we expect to build on initiatives we have developed this last year, such as the surgical preadmission project which is expected to minimize inappropriate admissions prior to surgery.

Patient Safety and Quality Improvement

We have a robust quality and safety programme through our Centre for Quality Improvement which has seen marked improvement in key areas such as the reduction in Central Line Acquired Bacteraemia (CLAB) infections, pressure injuries, and minimising harm from falls and medication errors.

CLAB

Through the piloting of bundles of care developed for central venous line insertion and maintenance, we were able to reduce our average number of CLAB rates from 5.6 to 4.8 hospital wide and from 4.0 to 2.3 for inpatients, from the previous year. This is a great achievement and as a result of our success, the DHB was asked to lead a national programme, Target CLAB Zero, aimed at preventing CLAB in hospitals throughout the country. The benefit of this collaboration is already becoming clear with no incidents of CLAB reported in New Zealand during April and May this year.

Pressure Injuries

Prior to the establishment of the pressure injury working group, the rate of pressure injuries averaged more than 10 percent per 100 patients. In the July 2011 to June 2012 period, the rate has averaged just over 4.4 percent (2011, 3.4 percent). Our goal is to achieve an average rate of 3.5 percent by June 2013.

Electronic medicines reconciliation

An electronic medicines reconciliation and assessment of risk tool was successfully trialled in Plastics, the National Burns Centre and Assessment, Treatment & Rehabilitation. As a result of this work, on average 99 percent of patients identified as “high risk” in these areas now have their medicines reconciled on admission and 64 percent of these within 48 hours of admission. Roll out of the programme is scheduled to begin in October 2012.

Falls prevention

Before the start of our falls prevention project, the average rate of patients with falls resulting in major harm (SAC1-3) was 0.3 per 1,000 bed days. This rate has since halved and has been sustained across the organisation for more than 30 months.

Through our Achieving a Balance, First, Do No Harm executable strategy[33], we will be looking to extend our quality and safety programme out to the community so that similar issues such as minimising harm from medications, pressure injuries, serious falls causing harm, miscommunication during transfers of care and misidentification of patients are addressed wherever care is delivered be that in hospital, at home, in an age-related residential care facility or in a general practice setting.

Outpatient Did Not Attend (DNA) rates

Patient focussed booking - where appointments are scheduled no more than six weeks in advance and the date/time is negotiated with the patient as opposed to the DHB setting this for the patient - was first trialled in the Endocrinology specialty and achieved a 7 percent reduction in their average DNA rate pre and post implementation of the new process. Patient focussed booking has now been rolled out to all specialities within medicine.

The overall DNA rate is at its lowest since data was collected however the DNA rates for Maaori and Pacific outpatients at the Manukau Surgery Centre remain unacceptably high despite adopting best practice utilising Patient Focused Booking. Ongoing work to review the appropriateness of service delivery for Maaori and Pacific will be a part of our 2012/13 Achieving a Balance, Patient and Family Centred Care executable strategy.

[33] See Counties Manukau DHB Annual Plan 2012/13

Supporting Measures

What we said you could expect	2010/11	2011/12
More than 90 percent of patients surveryed report DHB services as "Good" or "Very Good"	90%	
9.55 percent or lower rate of acute readmissions to hospital	10%	9%
Average length of stay of 3.92 days for elective and arranged inpatients	4.18[34]	4.26[35]
Average length of stay of 3.96 days for acute inpatients	3.96[36]	3.96[37]
60 percent of elective and arranged surgery to be day surgery discharges[38]	55%	56%
90 percent of elective and arranged surgery where patients are admitted on the day of surgery	82%	87%
Theatre utilisation is at 85 percent or better	85%	87%
100 percent compliance with Elective Services Patient Indicators (ESPI) for elective surgical and medicine specialities	100%	100%
More than 80 percent of First Specialist Assessment medical patients are seen within their designated priority timeframe[39]		
Zero Central Line Acquired Bacteraemia (CLAB) cases per month hospital wide[40]	5.6	4.8
Zero adverse drug events	49%	36%
Outpatient Did Not Attend (DNA) rate		
• 10 percent or lower for All	9.7%	9.0%
• 10 percent or lower for Maaori	19%	19%
• 15 percent or lower for Pacific	16%	18%

[34] Result at 31 March 2011

[35] Result at 31 March 2012

[36] Result at 31 March 2011

[37] Result at 31 March 2012

[38] Day surgery discharges are where the patient did not have an overnight stay. Advantages of day surgery include increased throughput of patients, improved scheduling of patient, decreased staff and hospital costs and a consequent decrease in waiting lists.

[39] We are developing a system to measure this more accurately and will implement reporting in 2012/13

[40] This measure was changed from measuring CLAB rates per 1,000 line days to cases per month.

BOARD AND COMMITTEE MEMBERSHIP

Board and Committee Membership as at 30 June 2012

Board		No. of meetings	11
Professor Gregor Coster CNZM	Chair		11
Mrs Jan Dawson	Deputy Chair		9
Mrs Sandra Alofivae			9
Mr Anae Arthur Anae			9
Mr Donald Barker JP			11
Mrs Colleen Brown MNZM, JP			11
Mr David Collings			8
Mr Paul Cressey ONZM			11
Mrs Lyn Murphy			10
Mr Frank Solomon			11
Mr Robert Wichman			8

Hospital Advisory Committee		No. of meetings	11
Mr Paul Cressey ONZM	Chair		9
Professor Gregor Coster CNZM			11
Mrs Jan Dawson			7
Mrs Sandra Alofivae			8
Mr Anae Arthur Anae			9
Mr Donald Barker JP			11
Mrs Colleen Brown MNZM, JP			9
Mr David Collings			4
Mrs Lyn Murphy			9
Mr Frank Solomon			9
Mr Robert Wichman			6
Mr Bob Clark			11
Mr Nuku Rapana			9
Mr Robert Clark			9

Community and Public Health Advisory Board		No. of meetings	11
Professor Gregor Coster CNZM	Chair		11
Mrs Jan Dawson			5
Mrs Sandra Alofivae			10
Mr Anae Arthur Anae			10
Mr Donald Barker JP			11
Mrs Colleen Brown MNZM, JP			9
Mr David Collings			6
Mr Paul Cressey ONZM			11
Mrs Lyn Murphy			9
Mr Frank Solomon			10
Mr Robert Wichman			8
Ms Nganeko Minhinnick			9
Mr Sefita Alofi Haouli			10
Mrs Elizabeth Farrell			11
Ms Donna Richards	Resigned August		1
Dr Gary Phillip Jackson			9
Mr Phil Beilby	Resigned November		4
Ms Cindy Kiro	Started February		4
Mr Jonathan Frith			7

Disability Support Advisory Committee		No. of meetings	10
Mrs Colleen Brown MNZM, JP	Chair		10
Mr Donald Barker JP			10
Mrs Lyn Murphy			10
Mr Robert Wichman			6
Ms Heather Grace			7
Mrs Susan Haynes			8
Mrs Wendy Bremmer	Appointed May		2
Mr Ezekiel Penton Robson			10
Ms Joanna Katipa	Resigned December		4
Ms Te Aomarama Wilson			8
Ms Alma Wilson	Resigned February		6
Ms Joy Simpson	Resigned April		6
Ms Louisa Lavakula			10

Pacific Health Advisory Committee		No. of meetings	10
Mr Anae Arthur Anae	Chair		8
Mrs Sandra Alofivae			7
Mr David Collings			4
Mr Frank Solomon			1
Ms Roine Lealaiauloto			3
Mrs Bernadette Pereira			7
Mr Sefita Alofi Haouli			8
Rev Uea Etene Tuleia			7
Mrs Heather Grace			9
Ms Malia Hamani			6
Dr Andrew Chan Mow			6
Dr Gerhard Sunborn			7
Ms Louisa Lavakula			9
Mr Phil Beilby	Resigned November		4
Mr Josaia Maka			7

Audit, Risk and Finance		No. of meetings	5
Mrs Jan Dawson	Chair		5
Professor Gregor Coster CNZM			5
Mr Donald Barker JP			4
Mrs Colleen Brown MNZM, JP			2
Mr Paul Cressey ONZM			5
Mrs Lyn Murphy			3

Facilities Management and Planning (non-statutory committee, non-paid)	
Mr Donald Barker JP	Chair
Professor Gregor Coster CNZM	
Mr Paul Cressey ONZM	
Mrs Lyn Murphy	
Mr Robert Wichman	

BOARD MEMBERS' DISCLOSURE OF INTEREST

Member	Disclosure of interest
Professor Gregor Coster CNZM Chairman	• Health Workforce New Zealand, (Deputy Chair) • Fellow Royal New Zealand College of General Practitioners (Dist) • Better Value Healthcare Asia-Pacific, (Director) • UNICEF New Zealand, (Board Member) • Marama Global Ltd (Director) • Bevan Commission, Wales (Member) • School of Government, Victoria University of Wellington (Visiting Professor) • Ceased during the year o Chairman, DHBNZ
Jan Dawson, Deputy Chair	• Erua Ltd (Director) • Yachting New Zealand Inc (President/Director) • Disciplinary Tribunal of the Institute of Chartered Accountants (Member) • Capital Investment Committee – NHB (Member) • Air New Zealand (Director), • Westpac New Zealand (Director) • The University of Auckland (Council Member) • Jan Dawson Ltd • Voyager Museum (Trustee) • Ceased during the year o KPMG Finance Trustee Ltd (Director) o KPMG Transaction Services Ltd (Director) o KPMG Funding Trustee Ltd (Director) o KPMG Peat Marwick Ltd (Director) o KPMG Peat Marwick Audit Ltd (Director) o KPMG Ltd (Director) o KPMG Nominee Company Ltd (Director) o KPMG Property (Christchurch) Ltd (Director) o KPMG Services Ltd (Director) o Peat Marwick Services Ltd (Director) o KPMG Property (Wellington) Ltd (Director) o KPMG Trustee Ltd (Director) o Viaduct Leasing Ltd (Director) o KPMG (Chief Executive)
Sandra Alofivae	• Auckland South Community Response Forum (MSD appointment) (Member) • Tausa'afia Trust (Aoga Amata PIC Mangere) (Secretary) • Auckland Social Policy Forum, Auckland Council (MSD Member) • Pacific Advisory Group to Counties Manukau Police Headquarters (Member)
Arthur Anae	• Auckland Council (Councillor) • Phobic Trust (Board member) • The John Walker 'Find Your Field of Dreams' (Member) • NZ Good Samaritan Heart Mission to Samoa Trust (Chairman)
Don Barker JP	Nil

Member	Disclosure of interest
Colleen Brown MNZM, JP	• Local Board (Member) • Parent and Family Resource Centre Board (Auckland Metropolitan Area) (Chair) • Advisory Committee for Disability Programme Manukau Institute of Technology (Member) • NZ Down Syndrome Association (Member) • Husband –Determination Referee for Department of Building and Housing • Early Childhood Education Taskforce for COMET (Chair) • Manurewa Advisory Group (Member) • Child Advocacy Group - Manukau (Member) • Auckland Social Policy Forum, Auckland Council (MSD Member) • Auckland City Council Disability Strategic Advisory Group (Deputy Chair) • ECE Implementation Team Auckland South (Chair) • Ceased during the year o Parent and Family Resource Centre Board (Auckland Metropolitan Area) (Chair) o Maori Women's Welfare League (Manukau) (Member) o South Auckland Computers in Homes Steering Committee (Chair) o Auckland Council Disability Leaders Group (Member)
David Collings	• Howick, Local Board of Auckland Council (Member)
Paul Cressey ONZM	• South East Auckland Life Education Trust (Chairman) • GS1 New Zealand (Board Member) • Plunket Plus Steering Group (Member) • Medication Safety Programme Steering Group (Chairman) • Cressey Pharmacy Ltd, Personal Administration (Director) • CLA Enterprises Ltd, Non Trading (Director) • Ceased during the year o Interim E-Medicines Steering Group (Chairman)
Lyn Murphy	• Undertaking a PhD through the University of Tasmania. CCRep and CMDHB provide the location for this research • International Society for Pharmacoeconomics and Outcomes Research (ISPOR). (Member) • ACT NZ. (Member previously Board Secretary) • New Zealand Association of Clinical Research (NZACRez). (Member) • Recipient of an ISPOR student travel grant to present research at the ISPOR international convention in Prague Nov 2010 • Actively involved in the establishment of an ISPOR chapter in New Zealand • Manukau Institute of Technology (Senior lecturer in management and leadership) • Northern Region Ethics Y Committee (Member) • Bizness Synergy Training Ltd (Director) • Synergex Holdings Ltd (Director)

Member	Disclosure of interest
Frank Solomon	• Solomon Group Education and Training Academy – Ngātiporou, Ngāti Kahu ki Whangaroa, funded by TEC and MSD. The level 3 Foundation course is MIT (Managing Director) • Counties Manukau DHB 'Grow Your Own Workforce' Project (Member) • 'Panmure Transformation' Project (Member) • Manurewa Marae 'Te Rau Korowai' Advisory Komiti (Member) • Waikato Tainui Whanau Ora Project – 'Te Ope Koiora' (Member) • 'Te Ringa Awhina/Helping Hand Charitable Trust', has applied to The Tindall Foundation re: School Leavers Support for the Mangere Youth Initiative (Chair) • Te Manuka – Tamakimakaurau Maori PTEs • MIT Runanga, Executive and Board member (Ex-Chair) • Youth Mentoring Network (Trustee) • Ceased during the year o Tamakimakaurau Maori Party (Co-Chair)
Bob Wichman	• Bob Wichman Papatoetoe Ltd (Director) (Appliance servicing arrangement with CMDHB through healthAlliance)

Directory

REGISTERED OFFICE
Counties Manukau District Health Board
19 Lambie Drive
Manukau City
Postal Address: Private Bag 94052
South Auckland Mail Centre
Telephone: 09 262 9500
Facsimile: 09 262 9501

AUDITORS
Audit New Zealand on behalf
of the Auditor General

SOLICITORS
Buddle Finlay
Chapman Tripp
Meredith Connell
Russell McVeah
Simpson Grierson

BANKERS
ASB Bank Limited
Commonwealth Bank
Westpac Banking Corp

Key Abbreviations

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