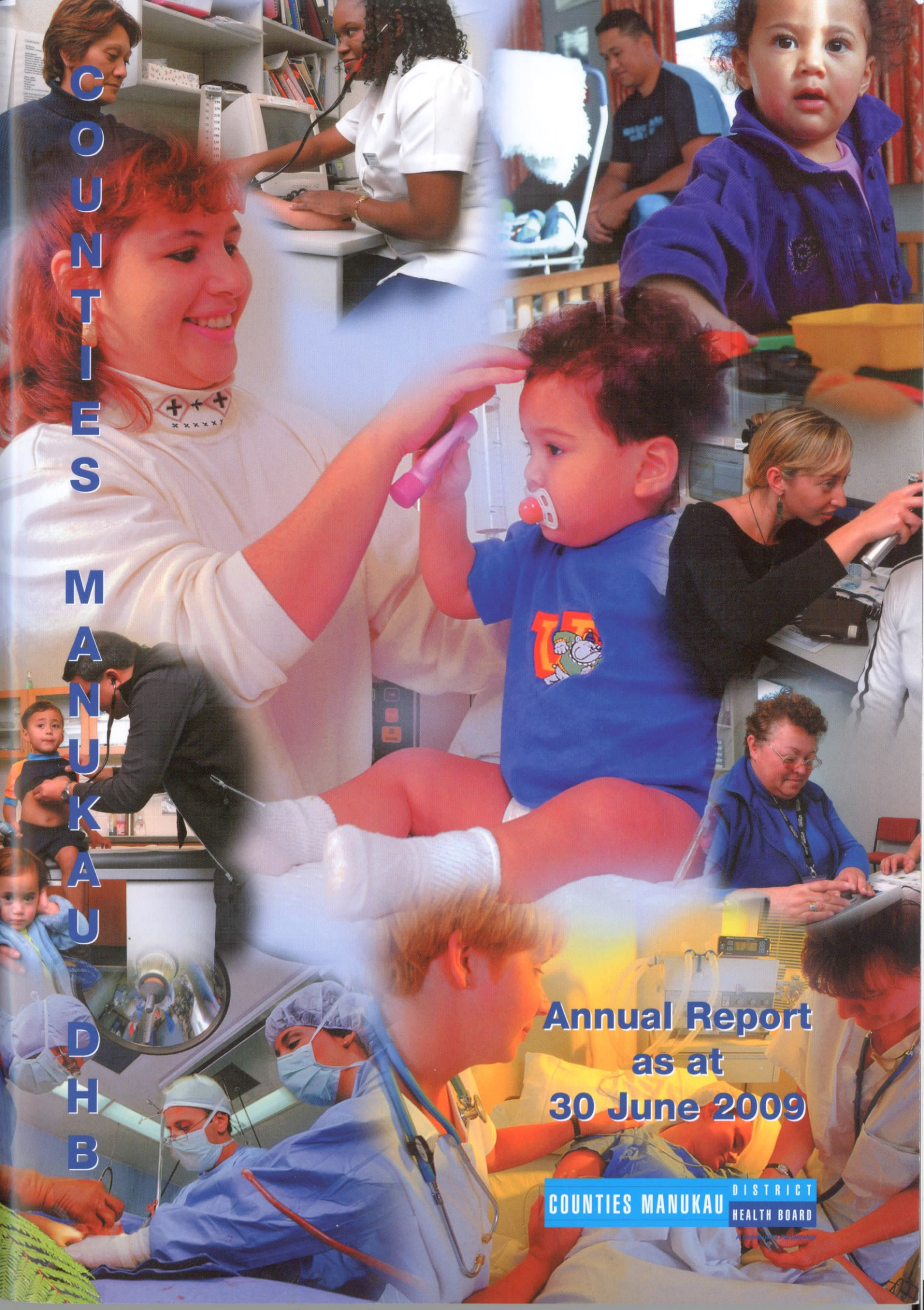

Annual Report as at 30 June 2009

COUNTIES MANUKAU DISTRICT HEALTH BOARD

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Vision & Values

Vision

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

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

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

Values

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

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

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

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

Innovation: Constantly seeking and striving for new ideas and solutions

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

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

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

Chairman's and Chief Executive's Review

Over the past year, Counties Manukau District Health Board has worked hard to deliver accessible, safe and high quality health and disability services to the people of Counties Manukau. Following the creation of the Quality Improvement Unit and the development of the Quality Improvement Strategy in 2007/08, 2008/09 was the year when the DHB rolled up its collective sleeves and got on with the business of implementing the various national and local quality improvement initiatives throughout the Middlemore Hospital and Manukau SuperClinic campuses and other satellite DHB sites.

CMDHB is an active participant in all six National Quality Improvement Committee (NQIC) workstreams, and the fact that we are the national lead for the Optimising Patients' Journey (OPJ) workstream, which focuses on improving patient experience within secondary care services, is testament to the high regard in which the DHB's management and clinical leadership is held at the national level.

While improving on how we deliver health and disability services to meet the needs of our population remains a key priority, the DHB has also been looking at various ways of 'working smarter' to create efficiencies in staff time and DHB resources so that these savings can be focused on delivering better patient care and safety at the same time as achieving value for money. Examples include:

- The implementation of Whai Manaaki (More Time, Better Care) has shown that improved work processes and environments can free up staff time for better patient care and enhanced patient safety.

- The pilot implementation of the drug dispensing Pyxis machines to reduce medication errors has shown that the impact of focusing on patient safety has also generated savings in our pharmaceutical costs.

- The reduction of Central Line Bacteraemia Infections in the Intensive Care Unit from 8 cases in the first half of the year to 1 case in the second half of the year. These infections are expensive to treat and pose a danger to vulnerable patients.

Much remains to be done in the area of quality improvement; however, we look forward to building on the work that has been done already and to continue improving on delivering safe and high quality health and disability services that meet our population's expectations.

Whilst the year has been marked by a major focus on quality improvement, there are also many other noteworthy items we would like to mention such as the outstanding performance of our Surgical Services in exceeding our elective contract volumes; the opening of new healthcare facilities to accommodate our rapid population growth; the continued strengthening of our relationships with our Primary Care partners in preparation for the next phase of primary sector development; our continued development of the health workforce; and our excellent financial performance.

We have seen a great performance from the Surgical Services team with elective surgery volumes being 9% above the same volumes for the previous year, at the same time as the acute volumes ran at 6%. Whilst this has been a considerable pressure on our hospital services, it has meant that an additional 3,706 patients received an elective procedure in 2008/09 compared to the previous year.

We have also been working to improve the culture and performance of our Emergency Department and are already seeing a big impact on the numbers of patients waiting for Emergency Care and waiting in corridors. Over the course of the year, the percentage of patients waiting in corridors reduced from nearly 20% to less than 4%, and the percentage of patients seen and discharged from EC in less than 6 hours is up to 85%. The "6 Hours Can be Ours" project launched in August 2009 will give added impetus to this work in the new financial year.

Other highlights include the work we have been doing with our primary care partners and local community stakeholders to identify areas of focus required to further reduce the health inequality gap within the District; this work has served us very well and will provide a sound platform for planning and implementing the next phase of primary sector development.

A comprehensive list of our results and achievements in the last year are outlined in the section "What we have achieved" of the annual report.

We are very proud of the skills and enthusiasm that all our staff collectively contribute towards these successes and acknowledge their continued commitment to deliver their best work for the benefit of the people of Counties Manukau.

Despite the pressures of achieving all of the above improvements, we have been able to maintain very strong financial controls and consequently have achieved our budgeted target of a zero operating deficit. Regrettably our Accounts have been qualified as we are not fully compliant with an accounting requirement. This is a deliberate decision by the Board and Management as the amount in question relates to revenue received in this financial year for contracts which will not be delivered until the 2009/10 year or later. Had we not taken this decision then we believe the true operating performance would have been misleading in the eyes of the reader.

The coming financial year will be one of significant challenge as well as opportunity as we anticipate the changes for the health sector arising from the Ministerial Review. The DHB is taking an active part in the development of a proposal for taking these challenges forward and is excited about the opportunity to develop sustainable models of healthcare and governance.

The current economic climate and the requirement for DHBs to deliver a zero deficit position in the face of above average demographic growth, complex clinical challenges and stretched facilities means that there will be challenges to CMDHB's ability to invest and expand services in essential areas in the short to medium term. However, we will continue to focus on the outcomes articulated in our District Strategic Plan, and through innovation and "working smarter", will continue to ensure that the DHB grows and improves its service.

It is at this point that we would like to acknowledge the continued commitment and hard work of the Chair and the staff of the South Auckland Health Foundation who have tirelessly fundraised to support major projects like the extensive rebuild of the Buckland Road Community Oral Health Clinic which was able to re-open for the community in November 2008.

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

Professor Gregor Coster
Chair

Geraint Martin
Chief Executive

Executive Management Team as at 30 June 2009

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

Board Committee Membership

as at 30 June 2009

Board Member	Award	Committee
Professor Gregor Coster	55,485	Board (Chair), CPHAC, HAC, DiSAC, PHAC, ARF, POU, FMP
Mr Paul Cressey	29,948	Board, CPHAC, HAC (Chair), ARF, POU, FMP
Mr Donald Barker	32,293	Board, CPHAC, HAC, DiSAC, ARF, FMP (Chair)
Anae Arthur Anae	29,375	Board, CPHAC, HAC, PHAC (Chair), ARF, POU
Mr Robert Wichman	26,250	Board, HAC, PHAC, FMP
Ms Mira Andrews	29,639	Board, CPHAC, HAC, DiSAC, , POU
Mrs Colleen Brown	31,242	Board, CPHAC, HAC, DiSAC (Chair), ARF
Mrs Anne Candy	28,906	Board, CPHAC (Chair), HAC, DiSAC, PHAC, POU (Chair)
Mrs Penelope Ginnen	30,591	Board, CPHAC, HAC, PHAC, ARF
Mr Michael Williams	29,792	Board, CPHAC, HAC, ARF (Chair), ARF, FMP
Mrs Ruth Desouza	27,708	Board, CPHAC, HAC, PHAC, ARF, POU

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

Committee Member	Award	Committee	Committee Member	Award	Committee
Ms Elizabeth Farrell	1,667	CPHAC	Te Aomarama Wilson	1,250	DiSAC
Mr Sefita Haouli	6,865	CPHAC, PHAC	Ms Alma Wilson	833	DiSAC
Ms Malia Hamani	2,500	CPHAC, PHAC	Mrs Roine Lealaiauloto	1,042	PHAC
Ms Donna Richards	-	CPHAC, POU	Ms Bernadette Pereira	1,667	PHAC
Ms Nganeko Minhinnick	4,167	CPHAC, POU	Ms Stephanie Erick-Peleti	1,250	PHAC
Mr Jonathan Frith	2,083	CPHAC	Ms Louisa Lavakula	2,292	PHAC
Dr Gary Jackson	1,667	CPHAC	Leau Peter Skelton	1,667	PHAC
Mr Bob Clarke	2,292	HAC	Dr Etuate Lui Saafi	1,667	PHAC
Nuku Rapana	2,500	HAC, Phac	Rev Uea Tuleia	888	PHAC
Rereokeroa Shaw	1,250	HAC	Dr Andrew Chan Mow	-	PHAC
Ms Heather Grace	833	DiSAC	Mr Martin Cooper	1,875	POU
Ms Chris Ellis	1,042	DiSAC	Mr Timi Maipi	5,851	POU
Mr Ezekiel Robson	3,717	DiSAC	Ms Te Pare Meihana	-	POU
Ms Joy Simpson	-	DiSAC	Ms Tania Kingi	-	POU
Mr Philip Beilby	1,875	DiSAC, PHAC	Ms Georgina Kupa	-	POU
Ms Joanna Katipa	1,042	DiSAC			

Board Members Disclosure of Interest

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

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

Front Row from left:
Anne Candy, Gregor Coster, Paul Cressey

Professor Gregor Coster (Chair)

- Dean of Graduate Studies – University of Auckland
- Wife works with AC Research Associates New Zealand
- Deputy Chair, DHBNZ
- Deputy Chair, PHARMAC

Mr Paul Cressey (Deputy Chair)

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

Mr Arthur Anae

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

Ms Mira Andrews

- Chief Executive, Tainui MAPO
- Board member, Taikura Trust
- Member, Regional Cancer Collaboration Group

Mr Donald Barker

- Trustee, West Franklin Community Trust

Mrs Colleen Brown

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

Mrs Penelope Ginnen

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

Mrs Anne Candy

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

Mrs Ruth DeSouza

- Member of the ARMS Trustee Appointment Committee (appointee of Auckland City Council)
- Board Member Asia New Zealand Foundation
- Member, Refugee Council NZ
- Member of the Lottery Community Sector Research Committee
- Councillor of the New Zealand Asian Studies Society
- Co-ordinates the Aotearoa Ethnic Network (AEN) and edits the AEN Journal
- Editorial Board member of the journals Diversity in Health and Social Care and Transcultural Nursing
- Guidelines Technical Advisory Group (GTAG) for the development of evidence based guidelines for the management and treatment of overweight and obesity for children/youth and adults in New Zealand
- Staff Member, Auckland University of Technology
- Reference Group attached to the Mental Health Literacy Programme of the Ministry of Health
- Member, Steering Group for Plunket Breast Feeding Support
- Nationwide Services Framework Project for the Mental Health and Addictions (Asian and Refugee) Technical group

Mr Robert Wichman

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

Mr Michael Williams

- Manukau City Councillor
- Finance Manager, Property for Industry Limited (associated with AMP Capital Investors Limited)
- Elder, St Columba Church, Botany

What we have achieved

Improve community wellbeing

- The Mangere Integrated Community and Health (MICH) group, Roopu Whakahaere, developed a 'Community Statement of Aspirations for Health and Wellness in Mangere' to inform the future development of primary and community services in Mangere. MICH is encouraging the Mangere community to "Own its own health" and are working on the Mangere Bridge Clinic development and the Ihumatoa community needs assessment.

- Nutrition Grants of $189,000 were delivered to 29 schools and 43 Early Childhood Education Centres, enabling the schools and centres to put in veggie gardens, water fountains, and access educational toys and materials for teaching children about nutrition.

- A multi-agency initiative led by Let's Beat Diabetes has seen 12 Community Gardens set up around Manukau linked to neighbourhood clusters in Otara, Manurewa, Mangere, Papakura and Franklin through to Manukau Parks. The Growing for Health and Sustainability projects aim to educate and train 2000 households in fruit and vegetable gardening and establish more than 60 linked community gardens throughout Counties Manukau by 2012.

- Community Action Fund grants of $55,697 were distributed to organisations for healthy lifestyle initiatives such as the Monte Cecilia 'garden to plate' concept project. Other recipients include the Franklin Integration Project, Edmund Hillary School, Tamaki Ki Raro Trust, Anand Isher Educational and Community Trust, ISSO Swaminarayan Hindu Temple, Hindu Elders Foundation and AROGYA (Divisions of the Hindu Council of New Zealand), Mangere Refugee Resettlement Centre.

- Phase 1 of the Let's Beat Diabetes SWAP2WIN campaign was rolled out and survey results of the campaign has shown exceptional changes in people's awareness of the causes of diabetes and what they can do to reduce the risk.

- The school-based Human Papillama Virus (HPV) immunisation programme rolled out successfully with an over 88% consent form return rate for Maaori, of which 79% consented to being immunised.

- The CMDHB Community Panel continues to bring a community perspective to organisational plans and service development. Plans they have provided input to in the last year include the Whai Manaaki Communication Strategy, Community Pharmacy Services, Locality Planning, the Human Papillamo Virus (HPV) immunisation programme and the Towards 20/20 Manukau Site proposal.

- CMDHB is working with Fonterra, Goodman Fielder, Foodstuffs and Progressive Enterprises on a milk initiative to support people changing from full fat to lower fat milk. The DHB will be launching a milk campaign in late 2009.

- CMDHB developed the Takiwa Ora locality planning concept to support the development of primary and community services. The approach has been agreed to by the PHOs and will provide a local framework for developing future primary care services.

- Tiaho Mai, the Acute Mental Health Inpatient Unit became a smokefree facility this year. There are now four cessation and co-ordination roles working across hospital inpatient settings, outpatient and ambulatory care, KidzFirst, Mental Health and pregnancy services.

- Two Maaori community leadership models for encouraging smoking cessation were developed, one working with youth and the other with Marae. The youth leadership model was piloted across two settings with over 30 participants thinking of their smoking status and 12 actively working towards being smokefree. Kaiwhakahaere (facilitators) from 4 Franklin marae are trained Quit Card providers.

- Over 1,130 people from Lotu Moui churches and other ethnic specific groups attended 20 Kai Lelei ("Good Food") workshops on nutrition and healthy eating. Sixteen Lotu Moui members from nine Pacific churches completed the Pacific Nutrition Certificate and will be sharing learning with their congregations.

- More than 2,500 people from 27 churches participated in the Lotu Moui games in October 2008, to celebrate their journey on the Lotu Moui programme since it began two years ago.

- CMDHB played a key role in the national response to the H1N1 pandemic including support for primary care, coordination of communications, and attendance at the Auckland International Airport border controls and managing the quarantine facility for travellers in transit.

Improving child and youth health

- Immunisation rates have improved in Counties Manukau; Maaori and non-Maaori immunisation rates have narrowed, and for the first time, the Pacific rates are higher than non-Pacific rates.
- Ambulatory sensitive hospitalisations for children aged 0 to 4 years old are below the national health target thresholds for all ethnicities.
- Middlemore Hospital is actively working towards Baby Friendly Hospital Initiative (BFHI) accreditation. The last year has seen 50% of the nursing and midwifery staff complete the BFHI required education. Doctors and support staff will also undertake this training in 2009/10.
- Paediatric Medicine Outpatients introduced virtual first specialist assessment and increased first specialist assessment volumes, improving the timeliness of patient access to first clinical assessments.
- Secured Health Research Council (HRC) partnership funding grant to continue the prospective epidemiology study of severe lower respiratory disease in young children.
- Specialist youth health services extended to two more additional Alternative Education providers, bringing the total number to 6.
- StandUp! CMDHB's school-based initiative for youth experiencing alcohol and other drug issues is now in 11 low decile schools. The pilot initiative was evaluated to be effective in addressing not only alcohol and drug issues but educational outcomes as well.
- The Hoki ki te Rito parenting programme pilot for families experiencing significant relationship problems with their infants and young children showed very positive outcomes including demonstrated improvements in parent-child interactions, maternal well being and child behaviour. A further 6 groups have been funded in 2009/10.
- The Pacific Youth Mental Health Team (Vaka Toa) was launched in October 2008.

Reducing health inequalities

- Eighteen formalised Counties Manukau Marae-based health programmes were put in place last year, 14 of which are Hauora Marae programmes and 4 are Whare Oranga Marae programmes.
- Over 600 staff have received Tikanga best practice training across Tiaho Mai, Women's Health, Spinal Unit and Breast Screening. The Tikanga in Practice programme aims to develop ward/ service areas which have adopted the Tikanga responsiveness approach to working with Maaori.
- CMDHB secured funding for the establishment of an interpreting service for use by primary care in high needs areas.

Reduce the incidence and impact of priority conditions

- 865 patients enrolled in 44 Self Management Education programmes in the year. 49 Course Leaders trained in the Stanford Chronic Disease Self Management Programme. The DHB is anticipating greater numbers of voluntary lay leaders coming onboard as Course Leaders in 2009. The Stanford programme is being adapted and translated for Samoan and Maaori.
- 2,781 new enrolees in Chronic Care Management programmes this year bringing the total to 16,068 people in Counties Manukau. Seven out of nine PHOs reached their enrolment targets.
- More than 16,000 Get Checked annual reviews took place for people with diabetes, exceeding the national health target for diabetes detection and followup for all ethnicities, with a significant gain for Maaori.
- Multidisciplinary clinical networks have been set up with the support of the Primary Health Care Innovation Fund and ProCare Network, Manukau to improve the outcomes for people with chronic conditions.
- Access to CMDHB mental health services for all age groups and ethnicities increased by 14.2% in the last year. The DHB's overall access rate of 2.7% has exceeded the Ministry of Health target of 2.6%, with particular improvement with Maaori Child and Youth access.

Reduce the number of people admitted to hospital who could have been cared for in the community

- 86% of referrals to Primary Options for Acute Care (POAC) were able to be managed out of hospital, which means 4,501 avoided presentations to hospital.
- Overall ASH rates improved despite significant population growth. The implementation of the Very High Intensive Users programme, which was delayed in 2008, will support ongoing work towards reducing ASH rates.
- A successful tender was completed for After Hours primary care access. Residents in the highest needs localities across Counties Manukau will have lower cost access until 10PM at night.
- The Aged Related Residential Care (ARRC) Medication Review Support was extended to 4 large residential facilities. Advanced Nursing Support is gradually being introduced to the facilities. Advance care planning was successfully implemented as a pilot in one rest home and will be gradually introduced in ARRC facilities over the next 2 to 3 years.
- Mental Health First Aid for Whaanau piloted in the district with 200 families.
- General Practitioners with Special Interest (GPwSI) continues to develop in the district, with 281 cases on the Plastic Surgical waiting list managed by credentialed GPwSI and 597 ORL referrals handled as First Specialist Assessments.
- CMDHB continues to have, amongst DHBs, the lowest levels of acute inpatient care relative to its population in New Zealand. This is being achieved through a number of successful initiatives including integration of clinical care across community and inpatient settings, effective community based crisis resolution and community based alternatives to inpatient admission including crisis respite.
- The introduction of the Tiaho Mai integrated model of care which uses new therapeutic approaches and multidisciplinary teams to facilitate continuity of care in the community for acute mental health service users has resulted in a significant reduction in the number of seclusion incidents from more than 40 at the start of the year to less than 5 in June 2009.

Improve the capacity of the health sector to deliver quality services

- CMDHB successfully achieved and exceeded our contracted elective surgery volumes including additional volumes contracted in June 2009. This effort equated to a 9% increase for the year compared to previous year, despite a 6% increase in acute discharges.
- The Auckland Regional Mental Health Information Technology (ARMHIT) project successfully went live across the metro Auckland DHBs. This major new clinical information system provides a single electronic patient record (EPR), clinical workflow and care plan for mental health clients that is shared by all three DHB mental health care providers contributing to improved quality of care.
- Implementation of the NHI Medical Warnings display in patient records provide clinical staff with easy access to warning information which was previously only available on the EC Whiteboard while the patient was in EC.
- Introduction of Medicine Nurses forums for nursing staff to discuss topical issues and improve communication across the division.
- Forms on Line system to support Needs Assessment and Service Coordination for the Elderly went live in October 2008. The system collects patient assessment information, and staff use the system to develop support plans and scheduled services for delivery by DHB and non-DHB providers.
- New Risk Management software inline with the Australia New Zealand Risk Management standards has been installed and migration of the DHB's paper based risk registers to the new system is underway.

Developing our workforce to meet the community's need for services

- Continued support of the South Auckland Health Foundation (SAHF) Health Scholarship Programme which has cumulatively funded over 241 scholarships. Forty-eight students were funded over a broad variety of disciplines in 2008/09, with the help of local sponsors, Manukau Institute of Technology, The Mad Butcher, Suburban Newspapers Community Trust and Meredith Connell.
- The second year of the MIT Community Health Worker Course saw 24 students graduate with the level 4 qualification.

- Introduction of the Medication Safety Coordinator role has improved education around medication safety. The role also supports the roll out of the Pyxis medication dispensing system.

- 10 Let's Beat Diabetes Nutrition Scholarships were awarded to young Maaori doing courses in nutrition and dietician training at Massey University.

- 75 students enrolled in the Pu Ora Matatini Bachelor of Nursing programme.

- Primary Health Care Nursing worked in conjunction with Manukau Institute of Technology and PHOs to establish a Dedicated Education Unit to support undergraduates and post graduate placements.

- Establishment of nursing leader positions in the Adult Community, Adult Inpatient, Mental Health Services - Older Persons, Pacific Mental Health Service and Maaori Mental Health Service. Nurse Specialists were successfully introduced in the following areas – Bariatric, Wound Care and Ambulatory Paediatrics.

- Improved retention of nurses in Emergency Care and Surgical Services with Emergency Care nursing vacancies going from 22 FTE vacancies to zero in the last year. There are also zero vacancies in Surgical Services. CMDHB also had the highest ever Nursing Professional Development and Recognition Programme (PDRP) compliance rate with some areas achieving 100% compliance.

- CMDHB continues to target young Maaori and Pacific students through the HEALTH COULD B 4 U and Taioahi Towards Health programmes which promote pathways towards health careers and provide scholarships for those facing financial barriers. A hundred students are currently enrolled in CMDHB's Incubator programme, which is running in five schools across South Auckland.

- CMDHB successfully tendered for and is now leading the development of the National Maaori Workforce Coordination Centre – "Kia Ora Hauora' workforce initiative.

- CMDHB is in the early stages of writing a business case for the development of a Centre for Health Services Innovation facility which will provide Counties Manukau with an educational and learning facility that will enable the district to grow, develop and support our current and future workforce and to build skills and knowledge for the enhancement of service delivery. It will also provide a focus for research, evaluation, innovation and quality improvement activities at Counties Manukau.

- Sixteen practice nurses are being supported to complete their Long Term Conditions Management postgraduate certificate at the University of Auckland. CMDHB will have a total of 41 nurses with this qualification when they complete their course.

- The Nurse Entry to Practice Expansion Programme was accredited by the New Zealand Nursing Council and 6 placements have been made in Primary Care.

- KidzFirst increased the number of new graduate nurses from 8 in the previous year to 15 last year and made 10 student nurse placements.

Implement quality improvement initiatives to ensure patient safety

- CMDHB was made the national lead for the Optimising Patients' Journey (OPJ) programme initiated by the Quality Improvement Committee. The programme has looked at improving the patient journey within secondary care, including outpatient processes, emergency care, diagnostics, theatres and supporting the implementation of Whai Manaaki. As national leader, the DHB also led on a series of collaborative learning events focusing on process blockages.

- CMDHB was chosen as the preferred DHB for the national demonstration site for Safe Staffing Healthy Workplaces.

- Introduction of the Whai Manaaki programme, based on the Toyota Production Systems Lean Thinking methodology, into wards and the Emergency Department has seen ward processes and environments improve and more staff time freed up for patient care. The programme will be continuing in 2009 with a move to integrating into the divisional structure.

- Associated with Whai Manaaki are also patient-safety-on-the-ward initiatives which the DHB has introduced in the last year: reducing pressure injuries and patient falls, restraint procedures, ward cleaning and hand hygiene.

- The Pyxis pilot in Wards 4, 9 and Intensive Care showed a successful result in reducing drug costs of up to $176,000 across the areas. Pyxis is now being rolled-out across all hospital wards.

- Work to improve the culture and performance of the Emergency Department has made an impact on reducing the number of patients cared for in EC and waiting in corridors. Over the course of the

year, the percentage of patients waiting in corridors reduced from nearly 20% to less than 4%, and the percentage of patients seen and discharged from EC in less than 6 hours is up to 85%. The '6 Hours Can be Ours' project launched in August 2009 will give added impetus to this work in the new financial year.

- The Intensive Care Unit has been able to reduce the number of central line bacteraemia infections from 8 cases in the first half of the year to just 1 in the second half of the year. These infections are expensive to treat and pose a danger to vulnerable patients. This programme will be extended to the rest of the hospital in 2009.

- Implementation of the Frequent Presenter Flag on the EC Whiteboard is helping the EC Care Coordinator identify patients who have had more than 4 presentations in the last 12 months, enabling clinicians to establish patients' needs in a timely manner.

- Residential care providers who received training have been successful in responding to and effectively managing norovirus outbreaks in residential care facilities, minimising the overall impact of the disease.

Continued facility planning to meet the needs of our communities

- The Buckland Road Community Oral Health Clinic by the Southern Cross Campus opened in November 2008. This is the first of a series of community-based oral health clinics for Counties Manukau. The Buckland Road clinic also has training chairs for the training and development of the local dental therapy workforce.

- A new Renal Unit (Rito Unit) opened in February 2009 at the Manukau Surgery Centre. The 28-station dialysis unit increases the capacity of stations by 14, providing care for up to 120 patients, and replaces an old and unsuitable unit on the western campus.

- A new 6-bed High Dependency Unit opened in April 2009 as a part of the Critical Care Complex project. This unit provides a level of care for patients who are between the general ward and the intensive care unit.

- CMDHB unveiled the first stage of the Edmund Hillary Block in June 2009, with the opening of Levels 1 (cardiac investigation), 3 (medical) and 4 (surgical). Stage 2 has commenced and is expected to be completed in mid-2010. An additional 240 inpatient beds will be provided upon completion.

- Buildings A and B opened in June 2009 at the Manukau SuperClinic increasing the number of clinic rooms for consultations and treatments for Ophthalmology, Women's Health and Urology. This facility improves access for local patients, particularly those who need Urology services who would otherwise travel to Auckland Hospital to be seen or treated.

- Whai Manaaki exercise at the AT & R wards identified minor refurbishments to improve the use of space and functioning of the treatment areas. The AT & R ward refurbishments were completed recently in July 2009.

- The Tui ward at Tiaho Mai (Acute Mental Health Unit) was upgraded to provide users with a therapeutic environment and more privacy and dignity. All users now have individual bedrooms and ensuites and access to a dedicated sensory room supported by Te Pou (National Centre for Mental Health Research, Information and Workforce Development).

Good Employer

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

Principle:

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

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

Good employer principles in practice

Provisions which reflect the General Principles include:

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

Standards:

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

Complaints and appeals:

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

Equal Employment Opportunities (EEO):

Principles:

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

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

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

Policy:

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

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

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

Discrimination:

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

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

In CMDHB, EEO is:

- fairness at work
- based on merit
- a cost-effective tool
- essential for active employee involvement
- a good way to plan for CMDHB's business
- concerned with all aspects of employment
- a solution, not a problem.

In CMDHB, EEO is not:

- about quotas
- about tokenism
- reverse discrimination
- charity.

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 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.

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

Employee Group	Females		Males	
	Number	Average Salary	Number	Average Salary
SMO	121	191,340	246	212,041
RMO	143	101,539	154	107,289
IEA's	265	85,706	114	89,280
Clerical	637	43,935	21	45,539
Cleaners & Orderlies	158	31,219	77	32,863
Home aids	12	30,748	–	–
Medical Laboratory	106	48,350	30	51,979
Radiology	73	67,812	15	60,430
Allied Health	586	54,256	135	53,690
Security	5	34,.201	22	33,475
Mental Health Nursing & Health care Assistants	298	60,771	86	56,119
Midwives	59	64,131	–	–
Nursing & Health care Assistants	1,965	58,060	144	55,040
Interpreters	128	48,262	74	47,116

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

Number of ethnic groups employed:

It is not mandatory for employees of CMDHB to disclose their ethnic group as a number of employees have a mixture of ethnic background, and they believe that it is not respectful to name one ethnic group over another.

Of those that have disclosed, there are approximately 95 different ethnic backgrounds.

Overview of CMDHB Population, Health Issues

A snapshot of health in Counties Manukau

Every week for the people of Counties Manukau:

43	people die
7	of the deaths are tobacco-related
21	people die under the age of 75, 14 of them from potentially preventable conditions
166	babies are born, 32 by Caesarean section, 10 are low birth weight (<2,500g), 17 have teenage mothers
32	of the 166 babies will be re-admitted acutely to hospital in their first year of life
700	women have cervical smears performed
1,250	people are admitted to a CMDHB hospital
320	of these are aged 0-74 and have a potentially preventable condition (excluding injury)
12	are admitted for mental health conditions
181	adults are admitted electively for surgery
59	children are admitted electively for surgery
130	people are admitted to private hospitals for surgical procedures
3,400	people received 8,000 home based support care visits
680	people are in DHB-supported residential care
600	people are in private hospital care
70	people are in dementia services care
20,900	adults consult their general practitioner
5,600	children visit their general practitioner
34,400	people have prescriptions dispensed, with 97,600 items costing $2m
11,700	people have 52,500 laboratory tests costing $0.51m
1,360	free influenza vaccines are administered to people aged 65+ (March to June)
970	vaccinations are given to children (as per Immunisation Schedule)
700	people have a free diabetes check
230	people with diabetes are admitted to hospital
169	people are admitted to hospital due to injury
106	people are admitted to hospital due to cardiovascular disease
150	people are admitted to hospital due to respiratory conditions
26	people are admitted to hospital due to asthma
260	children are admitted to hospital (excluding newborns)
500	theatre procedures are performed (excluding maternity)
7,290	people are seen in Outpatients
1,520	people are seen in Emergency Care
155	births occur
1,900	people are visited by Home Health community workers

People of Counties Manukau DHB

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

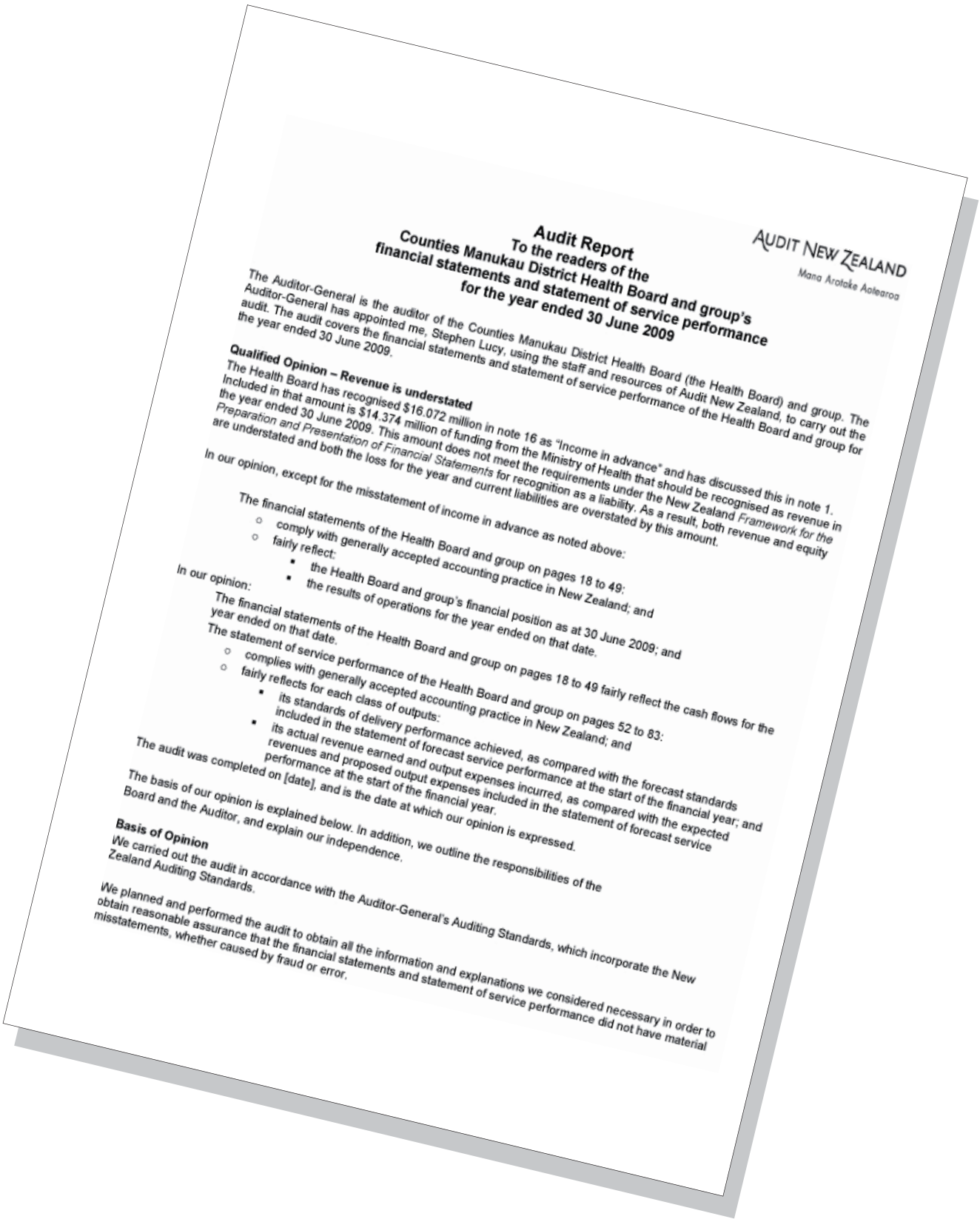
- a high proportion of Maaori
- a high proportion of Pacific people
- a high proportion of Asian people
- the relative youthfulness of these populations, and the population as a whole
- the fast growth of this population
- the high proportion of the population who are socio-economically deprived.

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

- CMDHB residents' health is improving. For example life expectancy at birth is similar to the New Zealand average despite the material socio-economic disadvantage in Counties Manukau
- Despite this improvement, health disparities remain undiminished. Males, Maaori and Pacific people and those socio-economically deprived all do worse than their counterparts
- Hospitalisation volumes growth has slowed, and is now similar to population growth at around 3% per year. Of all hospitalisations, 34% would be considered potentially avoidable, much of the scope for prevention of these lies in the primary healthcare sector
- Infectious disease rates for Counties Manukau people, particularly children, remain high. Meningococcal meningitis disease rates halved in 2004/05 with the vaccination campaign to the fore
- Diabetes prevalence (type II diabetes) is likely to double in Counties Manukau by 2020
- Primary care is under-resourced in Counties Manukau compared with the rest of New Zealand. The implementation of the Primary Care Strategy, including the establishment of Primary Health Organisations (PHOs), is providing additional resourcing for primary care in Counties Manukau to ease this situation
- Teenage pregnancy rates are very high for Maaori and Pacific young people
- Elective surgery utilisation has steadily being increasing over the last 7 years in Counties Manukau. There has been a distinct improvement in access
- Total birth numbers continue to increase due to the relative youthfulness and cultural makeup of the Counties Manukau population, and counter to trends elsewhere in New Zealand
- Mental health care is under-resourced in Counties Manukau compared with the rest of New Zealand. The additional Blueprint funding allocated to CMDHB is assisting to move Counties Manukau closer to national averages for access to mental health services.

Financial Statements

Report of the Audit Office



AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Audit Report
To the readers of the
Counties Manukau District Health Board and group's
financial statements and statement of service performance
for the year ended 30 June 2009

The Auditor-General is the auditor of the Counties Manukau District Health Board (the Health Board) and group. The Auditor-General has appointed me, Stephen Lucy, using the staff and resources of Audit New Zealand, to carry out the audit. The audit covers the financial statements and statement of service performance of the Health Board and group for the year ended 30 June 2009.

Qualified Opinion – Revenue is understated

The Health Board has recognised $16.072 million in note 16 as "Income in advance" and has discussed this in note 1. Included in that amount is $14.374 million of funding from the Ministry of Health that should be recognised as revenue in the year ended 30 June 2009. This amount does not meet the requirements under the New Zealand *Framework for the Preparation and Presentation of Financial Statements* for recognition as a liability. As a result, both revenue and equity are understated and both the loss for the year and current liabilities are overstated by this amount.

In our opinion, except for the misstatement of income in advance as noted above:

The financial statements of the Health Board and group on pages 18 to 49:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health Board and group's financial position as at 30 June 2009; and
  - the results of operations for the year ended on that date.

In our opinion:

The financial statements of the Health Board and group on pages 18 to 49 fairly reflect the cash flows for the year ended on that date.

The statement of service performance of the Health Board and group on pages 52 to 83:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects for each class of outputs:
  - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
  - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on [date], and is the date at which our opinion is expressed.

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

Basis of Opinion

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

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

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

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

Audit procedures generally include:

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

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

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

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2009 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

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

Independence

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

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

S B Lucy
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Statement of Responsibility

STATEMENT OF RESPONSIBILITY FOR THE YEAR ENDED 30 JUNE 2009

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

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

3. In the opinion of the Board and Management of Counties Manukau District Health Board, the annual Group Financial Statements, Statement of Service Performance for the year ended 30 June 2009, fairly reflect the financial position and operations of the Counties Manukau District Health Board.

Professor Gregor Coster
Chair

Geraint Martin
Chief Executive Officer

Michael Williams
Chair Finance and Audit

30 October 2009

Statement of Financial Performance

(Parent and Group)

For the year ending 30 June 2009
in thousands of New Zealand Dollars

	Note	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Revenue	1	1,112,554	1,074,465	1,037,376
Other operating income	2	24,202	21,636	20,110
Finance income	5a	1,771	2,196	3,092
Total income		**1,138,527**	**1,098,297**	**1,060,578**
Employee benefit costs	4	393,775	376,059	345 ,657
Depreciation and amortisation expense	7,8	23,346	22,212	23,294
Outsourced services		49,495	46,531	46,706
Clinical supplies		79,950	72,957	71,137
Infrastructure and non-clinical expenses		54,887	57,936	55,256
Payments to non-health board providers		509,961	497,129	482,508
Other operating expenses	3	7,960	5,000	6,918
Finance costs	5b	7,831	9,564	8,187
Capital charge	6	14,316	14,004	13,722
Total expenses		**1,141,521**	**1,101,392**	**1,053,385**
Surplus/(Loss)	**13**	**(2,994)**	**(3,095)**	**7,193**
Consisting of:				
Operating Surplus/(Loss)		6	(95)	8,693
Application of Prior Year's Surpluses		(3,000)	(3,000)	(1,500)
Surplus/(Loss)		**(2,994)**	**(3,095)**	**7,193**

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

Statement of Movement of Equity

(Parent and Group)

For the year ending 30 June 2009
in thousands of New Zealand Dollars

	Note	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Total Equity at Beginning of Period	**13**	**181,484**	**180,104**	**171,274**
Surplus/(Loss) for the period		(2,994)	(3,095)	7,193
Interest received on Restricted Funds	13	24	(48)	48
Crown Equity injection	13	1,037		
Crown Equity withdrawal	13	(419)	-	(420)
Revaluation of Fixed Assets	13	(18,645)	20,611	3,389
Total Equity at End of Period		**160,487**	**197,572**	**181,484**

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

Statement of Financial Position

(Parent and Group)

As at 30 June 2009
in thousands of New Zealand Dollars

	Note	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Assets				
Property, plant and equipment	7	433,531	480,338	413,509
Intangible assets	8	1,196	1,183	1,107
Total non-current assets		**434,727**	**481,521**	**414,616**
Inventories	9	493	1,090	619
Trade and other receivables	11	51,063	32,578	34,028
Cash and cash equivalents	12	1,128	1,013	1,423
Trust/special fund assets	12	834	–	810
Total current assets		**53,518**	**34,681**	**36,880**
Total assets		**488,245**	**516,202**	**451,496**
Equity				
Crown equity	13	102,414	118,170	101,796
Revaluation reserves	13	119,073	158,329	137,718
Retained earnings/(losses)	13	(61,834)	(79,689)	(58,840)
Trust/Special funds	13	834	762	810
Total equity		**160,487**	**197,572**	**181,484**
Liabilities				
Interest-bearing loans and borrowings	14	120,000	120,000	70,000
Employee benefits	15	12,982	8,536	9,879
Total non-current liabilities		**132,982**	**128,536**	**79,879**
Interest-bearing loans and borrowings	14	18,500	30,300	29,000
Trade and other payables	16	98,305	98,794	93,641
Employee benefits	15	77,971	61,000	67,492
Total current liabilities		**194,776**	**190,094**	**190,133**
Total liabilities		**327,758**	**318,630**	**270,012**
Total equity and liabilities		**488,245**	**516,202**	**451,496**

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

Statement of Cash Flows

(Parent and Group)

For the year ending 30 June 2009
in thousands of New Zealand Dollars

	Note	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and patients		1,129,586	1,093,114	1,054,330
Cash paid to suppliers		(707,983)	(673,529)	(664,974)
Cash paid to employees		(381,689)	(376,059)	(330,893)
Cash generated from operations		**39,914**	**43,526**	**58,463**
Interest received		1,771	2,244	3,092
Interest paid		(7,598)	(9,564)	(6,498)
Net taxes refunded/(paid) (goods and services tax)		(767)	19,211	190
Capital charge paid		(11,883)	(37,189)	(20,912)
Net cash flows from operating activities	**12**	**21,437**	**18,228**	**34,335**
Cash flows from investing activities				
Acquisition of property, plant and equipment		(61,850)	(64,456)	(48,285)
Net appropriation from trust funds	13	24	(48)	48
Net cash flows from investing activities		**(61,826)**	**(64,504)**	**(48,237)**
Cash flows from financing activities				
Proceeds from/(Repayment of) equity injection		618	-	(420)
Borrowings raised		50,000	50,000	85,000
Repayment of borrowings		(10,500)	(8,609)	(70,074)
Net cash flows from financing activities		**40,118**	**41,391**	**14,506**
Net increase in cash and cash equivalents		(271)	(4,885)	604
Cash and cash equivalents at beginning of year		2,233	5,898	1,629
Cash and cash equivalents at end of year	**12**	**1,962**	**1,013**	**2,233**

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

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

Statement of Contingent Liabilities

(Parent and Group)

As at 30 June 2009
in thousands of New Zealand Dollars

The Board is aware of a number of possible claims involving employment and medical issues, which may ultimately, result in legal action. However, the potential liability to the Board is not considered material.
The position for this year is unchanged from the 2007/08 year.

Asbestos

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

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

Statement of Commitments

(Parent and Group)

As at 30 June 2009
in thousands of New Zealand Dollars

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Capital commitments		
Capital Commitments approved and contracted	**12,280**	**39,400**
Operating Commitments		
To the Crown, SOEs or other Crown entities	411	411
To third parties	179,982	196,749
	180,393	**197,160**
Total Commitments	**192,673**	**236,560**
Non-cancellable commitments – Total		
Not more than one year	48,818	72,960
One to two years	31,397	27,484
Two to three years	27,855	27,107
Three to four yeas	27,259	26,385
Four to five years	27,176	26,967
Over five years	30,168	55,657
	192,673	**236,560**

Non-cancellable commitments – operating lease commitments

	Leased Properties	Leased Vehicles	Total 2009	Leased Properties	Leased Vehicles	Total 2008
Not more than one year	2,334	861	**3,195**	2,037	851	**2,888**
One to two years	2,268	585	**2,853**	2,010	1,090	**3,100**
Two to three years	2,251	205	**2,456**	1,972	1,132	**3,104**
Three to four years	2,108	28	**2,136**	1,972	89	**2,061**
Four to five years	1,386	-	**1,386**	1,867	6	**1,873**
Over five years	3,571	-	**3,571**	3,354	-	**3,354**
	13,918	**1,679**	**15,597**	**13,212**	**3,168**	**16,380**

The Board's Funder Arm has a number of open ended or evergreen contracts at the end of the financial year. These contracts are Bed Day contracts for Aged Residential Care. Funder Arm operating commitments as at 30 June 2009 in respect of the 2009/10 financial year total is estimated to range from $103.1m to $115.4m. However, in light of the unprecedented growth that is being experienced in the area of Aged Care, it is impossible to predict the value of commitments for other future periods.

The operating commitments disclosed in this note include committed obligations for health purchasing expenditure with various external parties. The DHB is also obligated to funding significant streams of 'demand driven' health purchasing expenditure. Commitments of this nature are in place for the purchase of pharmacy, laboratory and GP services. Because this expenditure is 'demand driven' it is not possible to quantify the obligation in this note. Expenditure of this nature in the 2008/09 year totalled $187.9m (2007/08 $176.3m).

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

Notes to the Financial Statements

(Parent and Group)
Significant accounting policies

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

The CMDHB group consists of the ultimate parent, Counties Manukau District Health Board and its "deemed" subsidiaries, Manukau Health Trust (0% owned), and South Auckland Health Foundation (0% owned) - these are not considered to be material and have not been consolidated into the accounts. Its associate companies are healthAlliance Ltd (50%), Auckland Regional RMO Services Ltd (33%) and the Northern DHB Support Agency (33.3%) – these entities are not equity accounted as they are not considered material to CMDHB. All CMDHB subsidiaries and associates are incorporated and domiciled in New Zealand. Counties Manukau DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Public Finance Act 1989 and the Crown Entities Act 2004.

Counties Manukau DHB is a public benefit entity, as defined under NZIAS 1.

Counties Manukau DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

The financial statements were authorised for issue by the Board on 30/10/09.

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

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted
Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to CMDHB include:
NZ IAS 1 *Presentation of Financial Statements (revised 2007)* replaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009.
The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The revised standard gives CMDHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). CMDHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.
NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009.
The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. In October 2008, the mandatory adoption of NZI AS 23 (revised 2007) by public benefit entities was deferred pending the completion of the Financial Reporting Standards Board's research project into the application of NZ IAS 23 (revised 2007) by public benefit entities. CMDHB has elected to defer the adoption of the revised NZ IAS 23. Accordingly, all borrowing costs that are directly attributable to the acquisition, construction or production of a qualifying asset continue to be recognised as an expense.

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

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

Critical accounting estimates and assumptions
In preparing these financial statements the DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Refer to note 1 for the treatment of income in-advance.

Management discussed with the Audit Risk & Finance Committee, the development, selection and disclosure of CMDHB's critical accounting policies and estimates and the application of these policies and estimates.

Basis for consolidation
Subsidiaries
Counties Manukau District Health Board is required under the Crown Entities Act, to consolidate into its statutory Accounts those entities "deemed" subsidiaries under this Act. The definition of subsidiaries extends to those entities,

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

Associates
The Board holds share holdings in associate companies. The interests in these associates are not accounted for as they are not material to Counties Manukau District Health Board.

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

Financial instruments
Non-derivative financial instruments
Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.
Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.
A financial instrument is recognised if CMDHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if CMDHB's contractual rights to the cash flows from the financial assets expire or if CMDHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset.
Cash and cash equivalents
Cash and cash equivalents includes cash on hand, deposits held at call with the banks, other short term highly liquid investments with original maturities of three months or less, and bank overdrafts.
Bank overdrafts are shown within borrowings as a current liability in the statement of financial position.

Instruments at fair value through profit or loss
An instrument is classified as at fair value through profit or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments (interest rate swaps) are designated at fair value through profit or loss if CMDHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in profit or loss when incurred. Subsequent to initial recognition, financial instruments at fair value through profit or loss are measured at fair value, and changes therein are recognised in profit or loss.
Other
Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.
Trade and other receivables
Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.
Interest-bearing loans and borrowings
Interest-bearing loans and borrowings are classified as other non-derivative financial instruments.
Trade and other payables
Trade and other payables are initially measured at fair value and subsequently at amortised cost using the effective interest rate

Derivative financial instruments
CMDHB uses foreign exchange and interest rate swap contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities.
Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments that do not qualify for hedge accounting are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the statement of financial performance. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount that CMDHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Hedging
Cash flow hedges
The Board has no financial instruments by way of interest rate options or foreign currency hedges, although it has entered into these in prior years.

Hedge of monetary assets and liabilities
Where a derivative financial instrument is used to hedge economically the foreign exchange exposure of a recognised monetary asset or liability, no hedge accounting is applied and any gain or loss on the hedging instrument is recognised in the statement of financial performance.

Property, plant and equipment
Classes of property, plant and equipment
The major classes of property, plant and equipment are as follows:
- freehold land
- freehold buildings

- plant and equipment
- clinical equipment
- motor vehicles
- other equipment

Owned assets
Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance.

Additions to property, plant and equipment between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

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

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

Leased assets
Leases where CMDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Operating Leases
An operating lease is a lease that does not transfer substantially all 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 statement of financial performance over the lease term as an integral part of the total lease expense.

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

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

Class of asset	Estimated life	Depreciation rate
• - 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	4 years	25%
• Other Equipment	3 - 25 years	4% - 33%

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

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

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

Amortisation
Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

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

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

Inventories held for distribution
Inventories held for distribution are stated at the lower of cost and current replacement cost.

Impairment
The carrying amounts of CMDHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

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

Reversals of impairment
Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest-bearing borrowings
Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

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

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

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

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

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

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

Goods and services tax
All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated

inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Crown funding

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

Goods sold and services rendered

Revenue from goods sold is recognised when CMDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and CMDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to CMDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by CMDHB.

Rental income

Rental income is recognised in the statement of financial performance on a straight-line basis over the term of the lease.

Revenue relating to service contracts

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

Mental Health Ring Fenced Revenue

In accordance with Generally Accepted Accounting Practice and NZIFRS, surpluses of Income over expenditure are reported through the Statement of Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods. As at 30 June 2009, there was an amount of $1.892m unspent revenue in respect of Mental Health Ring Fenced Revenue (as at 30 June 2008 - nil). The $1.892m has been applied to expenses incurred after balance date.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Interest Expense

The interest expense component of finance lease payments is recognised in the statement of financial performance using the effective interest rate method.

Cost of Service (Statement of Service Performance)

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of CMDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

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

Cost Drivers for Allocation of Indirect Costs

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

Notes to the Financial Statements

(Parent and Group)

in thousands of New Zealand Dollars

1 Revenue

	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Health and disability services (MOH contracted revenue)	1,011,316	978,411	941,378
ACC contract	25,123	17,550	16,820
Inter District Patient Inflows	73,114	73,264	78,640
Other revenue	3,001	5,240	538
	1,112,554	**1,074,465**	**1,037,376**

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

Revenue received for Service contracts still to commence has been treated as Income in Advance, as has Revenue for the uncompleted portion of partially completed Service contracts. While this is not strictly in compliance with GAAP, the Board considers that this is the appropriate treatment in order to ensure that the readers of the Accounts have a true and fair view of the performance of the organisation. Recognition of this unearned (unspent) income would distort both this year's and next year's Accounts by an amount of approximately $14.3m, favourably overstating the operating financial performance in the year ending June 2009 and negatively impacting the year ending June 2010 result. The matching principles have been applied, despite GAAP requirements, to ensure that Expenses are matched against associated Revenue. While this treatment is contrary to IPSAS 23, it is believed to be appropriate under NZIAS 18, relating to Service contracts.

2 Other operating income

	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Donations and bequests received	2,835	4,020	2,361
Rental income	986	790	965
Other	20,381	16,826	16,784
	24,202	**21,636**	**20,110**

3 Other operating expenses

	Note	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Impairment of trade receivables (bad and doubtful debts)	11	3,361	(103)	3,357
Audit fees (for the audit of the financial statements)		136	336	136
Audit related fees (IFRS)		12	-	21
Board fees and expenses	21	458	471	464
Operating lease expenses		955	1,261	4,169
Increase/(decrease) in provisions		3,022	3,024	(1,231)
Koha		16	11	2
		7,960	**5,000**	**6,918**

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

4 Employee benefit costs

	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Wages and salaries	380,193	376,059	334,235
Changes in Employee Benefits	13,582	-	11,422
	393,775	376,059	345,657

5a Finance income

	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Interest income	1,771	2,196	3,092

5b Finance costs

	Parent and Group 2009 Actual	Parent and Group 2009 Budget	Parent and Group 2008 Actual
Interest expense	7,831	9,564	8,187

6 Capital charge

COUNTIES MANUKAU DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2009 was 8 per cent (2008: 8 per cent).

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

7 Property, plant and equipment

	Freehold land (at valuation)	Buildings & Plant (at valuation)	Clinical equipment, IT and vehicles	Leased assets- buildings	Other equipment	Work in progress	Total
Cost							
Balance at 1 July 2007	84,066	260,817	101,712	1,419	13,484	15,351	476,849
Additions	-	30,867	12,171	-	238	3,765	47,041
Disposals	-	-	(807)	-	-	-	(807)
Revaluations	-	3,389	-	-	-	-	3,389
Balance at 30 June 2008	84,066	295,073	113,076	1,419	13,722	19,116	526,472
Balance at 1 July 2008	84,066	295,073	113,076	1,419	13,722	19,116	526,472
Additions	-	54,812	7,921	-	397	(2,030)	61,100
Disposals	-	-	-	-	-	-	-
Revaluations	(2,538)	(16,107)	-	-	-	-	(18,645)
Balance at 30 June 2009	81,528	333,778	120,997	1,419	14,119	17,086	568,927
Depreciation and impairment losses							
Balance at 1 July 2007	-	8,648	72,646	313	9,966	-	91,573
Depreciation charge for year	-	9,918	11,113	67	1,100	-	22,198
Disposals	-	-	(806)	-	-	-	(806)
Balance at 30 June 2008	-	18,566	82,953	380	11,066	-	112,965
Balance at 1 July 2008	-	18,566	82,953	380	11,066	-	112,965
Depreciation charge for year	-	11,965	9,536	127	804	-	22,432
Balance at 30 June 2009	-	30,531	92,489	507	11,870	-	135,397
Carrying amounts							
At 1 July 2007	84,066	252,169	29,065	1,106	3,518	15,351	385,275
At 30 June 2008	84,066	276,507	30,125	1,039	2,656	19,116	413,509
At 1 July 2008	84,066	276,507	30,125	1,039	2,656	19,116	413,509
At 30 June 2009	81,528	303,245	28,508	912	2,249	17,086	433,531

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

Buildings & Plant $7,032k, Clinical Equipment, IT & Motor Vehicles $9,975k, Other Equip $79k

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment.

Current valuation standards and guidance notes have been developed in association with the Treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings was carried out as at 30 June 2009 by Telfer Young Ltd, an independent registered Valuer and a member of the New Zealand Institute of Valuers. The valuation conforms to International Valuation Standards and was based on an optimised depreciation replacement cost methodology. The Valuer was contracted as an independent Valuer. The next valuation will be completed by 30 June 2010.

The revaluation of the Land & Buildings resulted in a write-down to Buildings and Land of $18,645k.

Restrictions

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

Titles to land transferred from the Crown to CMDHB are subject to a the terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

Leased assets

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

Property, plant and equipment under construction

During the year ended 30 June 2009, CMDHB continued with construction of a new hospital building on the Middlemore site.

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

8 Intangible assets (Software)

	Total
Cost	
Balance at 1 July 2007	24,875
Additions	327
Balance at 30 June 2008	25,202
Balance at 1 July 2008	25,202
Additions	1003
Balance at 30 June 2009	26,205
Amortisation and impairment losses	
Balance at 1 July 2007	22,999
Amortisation charge for the year	1,096
Balance at 30 June 2008	24,095
Balance at 1 July 2008	24,095
Amortisation charge for the year	914
Balance at 30 June 2009	25,009
Carrying amounts	
At 1 July 2007	1,876
At 30 June 2008	1,107
At 1 July 2008	1,107
At 30 June 2009	1,196

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

9 Inventories

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Central stores	154	112
Pharmaceuticals	339	507
	493	619

Write-down of inventories amounted to NIL for 2008 (2007: NIL).
The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2009 was $493k (2008: $619k).

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

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

10 Investments in associates

CMDHB has the following investments in associates:

a) General information

Name of entity	Principal activities	Interest held at 30 June 2009	Balance date
Auckland Regional RMO Services Ltd	Provision of health training services	33.0%	30 June
Northern DHB Support Agency Ltd	Provision of health support services	33.3%	30 June
healthAlliance Ltd	Provision of shared services	50.0%	30 June

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

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

2008 Actual	Assets	Liabilities	Equity	Revenues	Profit/(loss)
Auckland Regional RMO Services Ltd	2,490	2,489	1	2,005	-
Northern DHB Support Agency Ltd	5,455	5,173	282	6,156	60
healthAlliance Ltd	7,703	7,703	-	32,112	-

c) Share of profit of associate entities

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Share of profit/(loss)	83	20

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

11 Trade and other receivables

	Note	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Trade receivables due from associates	21	634	1,057
Trade receivables from non-related parties		5,015	7,277
Ministry of Health receivables		7,742	5,903
Accrued income		35,856	18,172
Prepayments		1,816	864
Fair value interest rate swaps		-	755
		51,063	34,028

Trade receivables are shown net of provision for doubtful debts amounting to $3,211k (2008: $3,072k) recognised in the current year and arising mainly from unrecoverable Non-Resident debt.

Movements in the provision for impairment of receivables are as follows

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Balance of provision I July	3,072	4,303
Additional provision made during the year	3,499	2,126
Receivables written off during the year	(3,360)	(3,357)
Closing Balance 30 June	3,211	3,072

12 Cash and cash equivalents

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Bank balances	1,116	1,410
Cash and cash equivalents	12	13
Trusts & Special Funds	834	810
Cash and cash equivalents in the statement of cash flows	1,962	2,233

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

Working capital facility

CMDHB has a working capital facility supplied by Commonwealth Bank (limit of $45m), which was established in December 2003. The facility consists of a revolving cash advances facility.

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

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

Reconciliation of surplus for the period with net cash flows from operating activities:

	Note	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Surplus for the period	13	(2,994)	7,193
Add back non-cash items:			
Depreciation and assets written off		23,346	23,294
Other non-cash items (movement in non-current staff entitlements)		3,013	181
Add back items classified as financing activity:			
Movements in working capital:			
(Increase)/decrease in trade and other receivables		(17,174)	64
(Increase)/decrease in inventories		126	1,875
Increase/(decrease) in trade and other payables		4,412	(10,777)
Increase/(decrease) in employee benefits		10,569	13,736
Increase/(decrease) in provision for doubtful debts		139	(1,231)
Net movement in working capital		(1,928)	3,667
Net cash inflow/(outflow) from operating activities		21,437	34,335

13 Capital and reserves

Reconciliation of movement in capital and reserves

	Crown equity	Land revaluation reserve	Buildings revaluation reserve	Trust/ Special funds	Retained earnings	Total equity
Balance at 1 July 2007	102,216	80,462	53,867	762	(66,033)	171,274
Total recognised income and expense				48	7,193	7,241
Repayment to the Crown	(420)					(420)
Revaluation			3,389			3,389
Balance at 30 June 2008	101,796	80,462	57,256	810	(58,840)	181,484
Balance at 1 July 2008	101,796	80,462	57,256	810	(58,840)	181,484
Total recognised income and expense				24	(2,994)	(2,970)
Contribution from the Crown	1,037					1,037
Repayment to the Crown	(419)					(419)
Revaluation		(2,538)	(16,107)			(18,645)
Balance at 30 June 2009	102,414	77,924	41,149	834	(61,834)	160,487

Revaluation reserve

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

Trust/ Special funds

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

Trust/ Special funds	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Balance at beginning of year	810	762
Interest received on Restricted Funds	24	48
Balance at end of year	834	810

14 Interest-bearing loans and borrowings

	Note	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Non-current			
Crown Health Financing Agency	19	120,000	70,000
Current			
Unsecured bank facility		18,500	29,000

Unsecured Crown Health Financing Agency loans

CMDHB has an unsecured bank loan with the Crown Health Financing Agency. The details of terms and conditions are as follows:

Interest rate summary	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Crown Health Financing Agency	3.75% - 6.51%	6.35% - 6.5%

Repayable as follows:	Parent and Group 2009 Actual	Parent and Group 2008 Actual
One to five years	45,000	-
Later than five years	75,000	70,000

Term loan facility limits	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Crown Health Financing Agency	197,600	197,600
Term loan & standby cash facility	45,000	45,000

Security and terms

The term loan is unsecured.

CMDHB has used interest rate swaps in order to manage interest rate risk. The notional principal or contract amount of interest rate swaps outstanding at 30 June 2009 was $0.0m (2008: $40.0m).

The loan facility is provided by the Crown Health Financing Agency - CHFA term liabilities are by a negative pledge.

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

The Government of New Zealand does not guarantee term loans.

Unsecured bank loans

CMDHB has an unsecured bank loan denominated in NZD with Commonwealth Bank with the maximum facility of $45.0m. Of this $18.5m (2008: $29.0m) has been drawn down at balance date, leaving an available balance of $26.5m. Interest is charged based on market rate (2.45%).

15 Employee benefits

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Non-current liabilities		
Liability for Accident Insurance (ACC)	455	365
Liability for long-service leave	4,722	3,662
Liability for sick leave	543	190
Liability for retirement gratuities	7,262	5,662
	12,982	9,879

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Current liabilities		
Liability for sabbatical leave	390	500
Liability for annual leave	35,111	29,477
Liability for sick leave	421	–
Liability for continuing medical education leave	1,744	1,744
Salary and wages accrual	40,305	35,771
	77,971	67,492

16 Trade and other payables

	Note	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Trade payables due to associates	21	1,633	946
Trade payables to non-related parties		11,696	8,671
ACC levy payable		3,542	2,281
GST and PAYE payable		9,875	9,252
Income in advance		16,072	8,115
Capital charge due to the Crown		3,918	1,485
Other non-trade payables and accrued expenses		51,569	62,891
		98,305	93,641

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

17 Operating leases

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Less than one year	3,195	2,888
Between one and five years	12,402	13,493
	15,597	16,380

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

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

18 Non-current assets held for sale

As at 30 June 2009, CMDHB held no non-current assets for sale. (2008: nil).

19 Financial instruments

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

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 58 per cent of trade debtors). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

	Gross Receivable 2009	Impairment 2009	Gross Receivable 2008	Impairment 2008
Trade receivables				
Current	9,695	(154)	9,026	-
Past due 0-30 days	1,301	(474)	2,281	(307)
Past due 31-180 days	3,069	(977)	3,680	(922)
Past due 181-360 days	927	(496)	866	(614)
Past due more than 1 year	1,610	(1,110)	1,456	(1,229)
Total	16,602	(3,211)	17,309	(3,072)

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

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Trade receivables		
Gross trade receivables	16,602	17,309
Individual impairment	(3,211)	(3,072)
Net total trade receivables	13,391	14,237

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

Liquidity risk

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

19 Financial instruments (continued)

Liquidity risk

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

	Note	Balance sheet	Contractual cash flow	Less than 1 year	1 – 5 years	More than 5 years
2009						
CHFA loans	14	120,000	161,530	-	77,923	83,607
Unsecured bank loans	14	18,500	18,500	18,500	-	-
Trade and other payables	16	98,305	98,305	98,305	-	-
Total		148,330	278,335	116,805	77,923	83,607

	Note	Balance sheet	Contractual cash flow	Less than 1 year	1 – 5 years	More than 5 years
2008						
CHFA loans	14	70,000	96,555	-	22,018	74,537
Unsecured bank loans	14	29,000	29,000	29,000	-	-
Trade and other payables	16	93,641	93,641	93,641	-	-
Total		192,641	219,196	122,641	22,018	74,537

Market risk

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

Interest rate risk

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

CMDHB adopts a policy of ensuring that between 40 and 100 per cent of its exposure to changes in interest rates on borrowings is on a fixed rate basis. Interest rate swaps, denominated in NZD, have been entered into in the past to achieve an appropriate mix of fixed and floating rate exposure within CMDHB's policy. At 30 June 2009, CMDHB had no interest rate swaps (2008: notional contract amount $40m).

The net fair value of swaps at 30 June 2009 was $0k; (2008: $755k, comprising assets of $755k and liabilities of $0k). These amounts were recognised as fair value derivatives.

Effective interest rates and repricing analysis

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

	Group and Parent 2009 Actual					Group and Parent 2008 Actual				
	Effective interest rate %	Total	Less than 1 year	1 to 5 years	More than 5 years	Effective interest rate %	Total	Less than 1 year	1 to 5 years	More than 5 years
Cash and cash equivalents	**2.5 – 3.0%**	1,962	1,962	-	-	**6.0 -7.0%**	2,233	2,233	-	-
CHFA loans:	**3.75 – 6.51%**	120,000	-	45,000	75,000	**6.3-6.5%**	70,000	-	-	70,000
Bank facility	**2.45%**	18,500	18,500	-	-	**6.5 – 7.5%**	29,000	29,000	-	-

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

19 Financial instruments (continued)

Foreign currency risk

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

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

As at year end CMDHB had no exposure to foreign currency risk (2008 nil).

Capital management

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

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

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

Sensitivity analysis

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

At 30 June 2009, it is estimated that a general movement of one percentage point in interest rates would either increase or decrease CMDHB DHB's surplus before tax by approximately $1.188m (2007: $0.914m). Interest rate swaps have been included in this calculation.

Classification and fair values

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

2009	Note	Designated at fair value through profit & loss	Designated at fair value at Amortised Cost	Loans and receivables	Carrying amount 2009 Actual	Fair value 2009 Actual
Trade and other receivables	11			51,063	51,063	51,063
Cash and cash equivalents	12	1,962			1,962	1,962
Secured bank loans	14		(120,000)		(120,000)	(122,654)
Unsecured bank liabilities	14		(18,500)		(18,500)	(18,500)
Trade and other payables	16	(98,305)			(98,305)	(98,305)

19 Financial instruments (continued)

Classification and fair values

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

2008	Note	Held for trading	Designated at fair value through profit & loss	Designated at fair value at Amortised Cost	Loans and receivables	Carrying amount 2008 Actual	Fair value 2008 Actual
Trade and other receivables	11				33,273	33,273	33,273
Cash and cash equivalents	12		2,233			2,233	2,233
Interest rate swaps:							
Assets	11	755				755	755
Secured bank loans	14			(70,000)		(70,000)	(70,000)
Unsecured bank liabilities	14			(29,000)		(29,000)	(29,000)
Trade and other payables	16		(93,641)			(93,641)	(93,641)

Estimation of fair values analysis

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

Securities

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

Derivatives

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

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

Interest-bearing loans and borrowings

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

Trade and other receivables / payables

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

Interest rates used for determining fair value

The entity uses the government yield curve as of 30 June 2009 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Loans and borrowings	3.75 – 6.51%	6.30 - 7.50%

20 Performance by Output Classes

	Funding	Elimination	DHB Hospital Provider	Governance and Funding Administration	Total DHB
Revenue					
• Crown	1,042,135	(533,698)	594,047	10,070	1,112,554
• Other	1,473		24,500		25,973
Total Revenue	1,043,608	(533,698)	618,547	10,070	1,138,527
Budget Revenue	*1,034,829*	*(524,074)*	*578,969*	*8,573*	*1,098,297*
Expenditure					
• Personnel			386,917	6,858	393,775
• Depreciation			23,346		23,346
• Capital Charge			14,316		14,316
• Other	1,043,659	(533,698)	194,347	5,776	710,084
Total expenditure	1,043,659	(533,698)	618,926	12,634	1,141,521
Budget Expenditure	*1,034,776*	*(524,074)*	*579,377*	*11,313*	*1,101,392*
Net surplus/(deficit)	(51)	-	(379)	(2,564)	(2,994)
Budget Surplus/(Deficit)	53	-	(408)	(2,740)	(3,095)
Reconciliation to retained earnings					
Opening retained earnings	3,657	-	(49,779)	(12,718)	(58,840)
Plus/(less) surplus/ (deficit) for year	(51)	-	(379)	(2,564)	(2,994)
Closing retained earnings	3,606	-	(50,158)	(15,282)	(61,834)
Budget	(2,712)	-	(66,276)	(10,701)	(79,689)

The **loss** for the year of **$2,994k** is **$101k** lesser than the budgeted loss of **$3,095k**. Refer note **24** for an explanation of this variance

Elimination relates to the transfer of funds between Funding and both the Hospital Provider and the Governance Arms

21 Related parties

Identity of related parties

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

Compensations

The Executive Management Team compensations are as follows:

Remuneration

Total remuneration is included in "wages and salaries" (see note 4)

	FTE 2009	FTE 2008	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Board members	36	39	458	464
Key Management personnel	11	17	2,874	3,991
	47	**56**	**3,332**	**4,455**

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

21 Related parties (continued)

Termination Payments
During the year ended 30 June 2009, 9 Employees (2008: 3) received a total of $195,192 (2008: $20,756) in compensation and other benefits in relation to cessations.

During the Year Ended 30 June 2009, the following numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 441 (375) are Medical Staff and 76 (62) are Management.

Total Remuneration Banding	Number of Employees 2009	Number of Employees 2008
$100,000 – 109,999	80	71
$110,000 – 119,999	47	58
$120,000 – 129,999	50	29
$130,000 – 139,999	30	26
$140,000 – 149,999	24	19
$150,000 – 159,999	35	22
$160,000 – 169,999	18	27
$170,000 – 179,999	22	19
$180,000 – 189,999	24	25
$190,000 – 199,999	19	23
$200,000 – 209,999	23	25
$210,000 – 219,999	15	13
$220,000 – 229,999	18	13
$230,000 – 239,999	24	15
$240,000 – 249,999	14	10
$250,000 – 259,999	11	12
$260,000 – 269,999	9	5
$270,000 – 279,999	8	2
$280,000 – 289,999	9	4
$290,000 – 299,999	9	3
$300,000 – 309,999	7	4
$310,000 – 319,999	7	3
$320,000 – 329,999	1	4
$330,000 – 339,999	4	-
$340,000 – 349,999	1	1
$350,000 – 359,999	2	2
$360,000 – 369,999	1	1
$380,000 – 390,999	1	-
$420,000 – 429,999	1	1
$430,000 – 439,999	1	-
$440,000 – 449,999	1	-
$470,000 – 480,999	1	-
	517	**437**

21 Related parties (continued)

Sales to related parties

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Auckland Regional RMO Services Ltd	-	24
Northern DHB Support Agency Ltd	503	290
healthAlliance Ltd	-	245
Manukau Health Trust	1,689	1,622
	2,192	2,181

Purchases from related parties

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Auckland Regional RMO Services Ltd	2,554	3,005
Northern DHB Support Agency Ltd	1,807	2,660
healthAlliance Ltd	15,426	15,179
	19,787	20,844

Outstanding balances to related parties

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Auckland Regional RMO Services Ltd	252	13
Northern DHB Support Agency Ltd	420	931
healthAlliance Ltd	961	2
	1,633	946

Outstanding balances from related parties

	Parent and Group 2009 Actual	Parent and Group 2008 Actual
Auckland Regional RMO Services Ltd	458	-
Northern DHB Support Agency Ltd	39	-
healthAlliance Ltd	22	22
Manukau Health Trust	115	1,035
	634	1,057

Ownership

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

21 Related parties (continued)

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

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

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

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

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

CMDHB has historically had two nominees on the five person MHT Board of Trustees, with the external Trustees having control under the Constitution.

In the interests of full disclosure and transparency, CMDHB is with the consent of MHT, disclosing through this Note, the unaudited financial position of MHT for the period ending 30 June 2009

	2009	2008
Statement of Financial Performance		
Net Income	1,807	2,132
Net Surplus (Deficit)	**235**	**392**
Statement of Financial Position		
Total Equity	**906**	**687**
Non-Current Assets	125	38
Current Assets	957	2,002
Total Assets	**1,082**	**2,040**
Current Liabilities	176	1,353
Net Assets	**906**	**687**

21 Related parties (continued)

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

In the interests of full disclosure and transparency, CMDHB is with the consent of SAHF , disclosing through this Note, the unaudited financial position of SAHF for the period ending 30 June 2009

	2009	2008
Statement of Financial Performance		
Net Income	3,456	3,397
Operating Surplus	3,016	3,045
Distributions	3,623	3,089
Net Surplus (Deficit)	**(607)**	**(44)**
Statement of Financial Position		
Total Equity	**3,988**	**4,595**
Non-Current Assets	6	10
Current Assets	4,986	4,669
Total Assets	**4,992**	**4,679**
Current Liabilities	1,004	84
Net Assets	**3,988**	**4,595**

22 Subsequent events

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

23 Explanation of financial variances from budget

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

The major variances in the Statement of Performance are due to

- Revenue for the year (excluding Donations) was $41.4m greater than budget, while expenditure for the year was $40.2m greater than budget. These increases reflect additional volumes and services purchased by the Crown during the year, as well as specific programmes.

The major variances in the Statement of Position are due to

- Under spending on property, plant and equipment due to timing of construction as well as Land & Buildings not being revalued to the extent as anticipated in the 2007/08 year and revalued downwards in 2008/09.
- trade receivables due to timing of collections
- Crown Equity affect by the valuation of Land and Buildings.

Major variances in Statement of Cashflow are attributed to

- Improved operating cash flows $3m due to increased revenue from the Crown
- Delayed spending on property, plant , equipment $3m
- Greater operating cash and lower investing lead to lower financing requirements for the year

Governance & Accountability Statement

Role of the Board

The Board's governance responsibilities include:

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

Structure of the DHB

DHB operations

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

Quality Assurance

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

Governance Philosophy

Board membership

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

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

Division of responsibility between the Board and Management

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

Accountability

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

Disclosure of interest

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

Internal audit

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

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

Risk management

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

Legislative compliance

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

Directions issued by Ministers

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

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

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

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

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

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

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

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

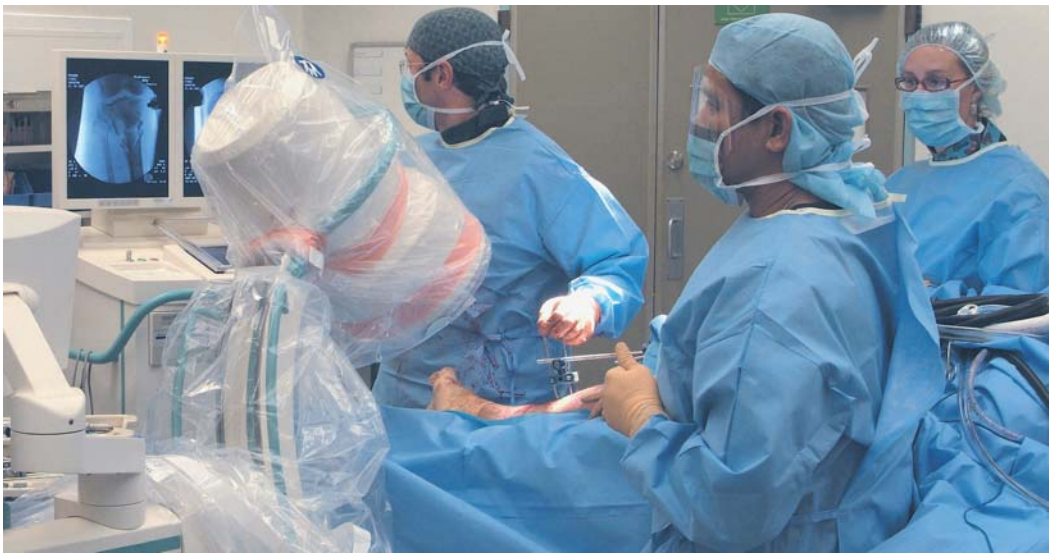
- Comply with generally accepted accounting practice.

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

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

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

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



Statement of Objectives and Service Performance

The Statement of Objectives and Service Performance sets out Counties Manukau DHB's achievement of the performance measures and objectives as described in the Statement of Intent for the period 1 July 2008 to 30 June 2009.

The 2008/09-2010/11 Statement of Intent was based on the revised District Strategic Plan which provided an increased focus on longer term health outcomes. The structure of this section is based on the District Strategic Plan's six medium term outcomes to achieve the DHB's strategic vision and 2008/09 annual objectives that sit within these six outcomes. Only those performance measures from the District Strategic Plan which can be measured frequently (at least every three years), or where there is an expectation that the measure will change within a year were included in the Statement of Intent.

Due to the availability of data at different times, some measures can only be reported by calendar year (rather than financial year). For example, some data may be reported for the year ended 31 December 2008, rather than for the year ended 30 June 2009. Where reporting has been based on calendar year, this is noted below the table or graph. Additionally, calendar year is reported using only the year (e.g. 2008), whereas financial data is reported with reference to both years (e.g. 2008/09).

National Health Targets

As described in the Minister of Health's 2008/09 'Letter of Expectations', the 2008/09 year sees the introduction of ten health targets aligned to national strategic priorities. One target is to reduce the percentage of the health budget spent on the Ministry of Health and DHBs are not expected to provide direct contribution to achieving this. Two further targets improving HEHA, and improving tobacco control are health sector targets, but it is expected that DHB activity will support achievement of each target. DHBs are expected to directly contribute to the achievement of the remaining seven targets. All targets, except the final target related to Ministry of Health expenditure, are summarised with results for 2008/09 in the following section.

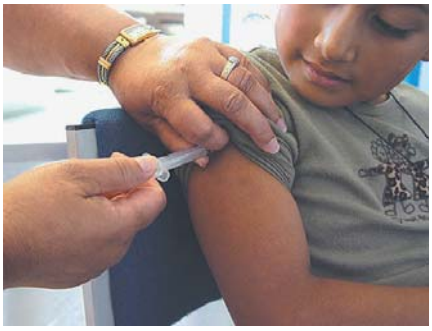
Improving immunisation coverage

Health Target	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
95% of two year olds are fully immunised with at least 4 to 6 percent point increase on 2005 national immunisation coverage survey baseline	80%	78%	✘

Overall, 2008/09 coverage for children who have fully completed age-appropriate immunisations by the age of two years in CMDHB was 78%. Although the target was not met, this is a 3% improvement on the previous year's figure. CMDHB has further narrowed the gap between Maaori and overall, and, completely closed the gap for Pacific coverage rates which are 1% above the overall figure.

Immunisation coverage for children who have fully completed age-appropriate immunisations by the age of two years in CMDHB, 2008/09

	Immunisation coverage at two years of age
NZ European	84%
Maaori	69%
Pacific	79%
Asian	86%
Other	76%
Total	78%



Source: National Immunisation Register

Improving oral health

Health Target	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Progress is made towards 85% adolescent oral health utilisation	57%	56.1%	✘

In 2008/09, CMDHB improved on the previous year's result by increasing utilisation by 2.3%.

Improving elective services

Health Target	CMDHB Target 2008/09			
Indicator 1: Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs).	Indicator 1: ESPI 1 – 97% ESPI 2 – <1.6% ESPI 3 – <4% ESPI 4 – NA ESPI 5 – <3% ESPI 6 – <10% ESPI 7 – <3.0% ESPI 8 – 97%			
Indicator 2: Each DHB will set an agreed increase in the number of elective service discharges, and will provide the amount of service agreed	Indicator 2:	Base	Add.	Total
	Planned elective discharges	13052	1305	14357

In 2008/09, CMDHB had an outstanding result in the delivery of elective services, all the indicator 1 ESPI targets were met and all elective services contracts were exceeded meaning that the DHB was able to deliver more elective procedures to the community.

Elective Service Annual Report Indicators 2008/09

	Planned			Actual Result	Variance
	Base	Add.	Total	Total	Total
Total elective discharges	13052	1305	14357	✔ 15544	1187

CMDHB achieved an outstanding rating from the Ministry of Health for maintaining compliance on all Elective Services Patient Flow Indicators (ESPI's). Of particular note, the DHB did not have any patients in active review who had not received a clinical assessment in the last six months.

Reducing cancer waiting times

Health Target	CMDHB Target 2008/09
All patients wait less than 6 weeks* between first specialist assessment and the start of radiation oncology treatment (excluding category D)	The DHB acknowledges that the Health Target that all patients (100%) to wait less than 6 weeks between first specialist assessment and the start of radiation oncology treatment and will work with the provider DHB towards achieving this target. The Auckland region has a very strong relationship with the ADHB provider with regular operational meetings held with issues discussed. Where the target is in danger of not being met, the DHB will discuss this with the provider as soon as possible with a view to looking at feasible solutions.

In 2008/09, the national health target measure for reducing cancer waiting times was changed from a patient waiting time of less than 8 weeks between first specialist assessment and the start of radiation oncology treatment to a waiting time of less than 6 weeks.

539 CMDHB patients received courses of radiotherapy treatment at ADHB in the 2008/09 financial year, of which 470 (87%) met the target criteria for receiving radiotherapy treatment within six weeks. Ninety-two percent of CMDHB patients were seen within eight weeks, which is an improvement from last year's result of 76%. Ongoing regional collaboration on tumour streams and multidisciplinary meetings will contribute to achieving consistent diagnosis and improved treatment times.

Radiotherapy waiting times for cancer patients who met the criteria for treatment in 2008/09

	Proportion of cancer patients started treatments in each time category
Wait < 24 hours	12%
Wait 0 to 2 weeks	34%
Wait 2 to 4 weeks	23%
Wait 4 to 6 weeks	17%
Wait 6 to 8 weeks	6%
Waited > 8 weeks	7%

Source: Oncology and Haematology, ADHB

Reducing ambulatory sensitive hospital (ASH) admissions

Health Target	CMDHB Target 2008/09
There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0 - 74 years across all population groups	CMDHB ASH admissions (as a percentage above or below national ASH rates)

Age group	Maaori	Pacific	Other
0 – 4	< 95	<= 107.9	< 95
45 – 64	<= 122.1	<= 104.5	<= 109.3
0 -74	<= 111.4	<= 105.4	<= 101.4

Percentage above (+) or below (-) target ambulatory sensitive hospitalisation numbers in CMDHB for 2007

	Maaori	Pacific	Other
0 to 4 years	✔ - 1%	✔ (-6.2%)	✔ - 5%
45 to 64 years	✘ + 12.4%	✘ + 6.7%	✔ - 4.7%
0 to 74 years	✘ + 0.6%	✘ + 4.9%	✘ + 4.5%

Source: NMDS (12 months ending 30 September 2008 rather than 30 June 2009)

All ambulatory sensitive hospitalisations targets for children aged 0 to 4 years were met in 2008. It is encouraging to note that, though we are above target in key areas particularly relating to the 45 to 64 year old age groups, the actual volumes have decreased across all age groups on the last figures for year to date September 2008. This is despite significant population growth.

In addition to the Chronic Care Management programme, other targeted programmes like Primary Options for Acute Care (introduced to specific practices with the highest Maaori admission volumes) and the Very High Intensive User/ Frequent Adult Medical Admissions programme (targeted at preventing readmissions of people with high presentation rates) have also been introduced to manage the rate of preventable hospitalisations. CMDHB is expecting to see improvements in readmission rates in 2009, particularly in the 45 to 64 age group, when these programmes bed in. The work CMDHB is planning with the primary sector around the devolution of services and integrated care models will also address incentives for better demand management including reduction in ASH rates.

Reducing Diabetes and CVD Risk

Health Target	CMDHB Target 2008/09
There will be an increase in the percentage of people in all population groups • Estimated to have diabetes accessing free annual checks • On the diabetes register who have good diabetes management • Who have had their CVD risk assessed in the last five years	

	Total	Maaori	Pacific	Other
Detection & Follow-up volumes	15,041	2,124	5,121	7,795
Diabetes Follow-up %	65%	63%	65%	65%
Diabetes Management %	68%	60%	52%	80%
CVD Risk Management	76.4%	70.3%	69.9%	79.6%

Note (1): The MOH updated the prevalence rates in 2008/09 resulting in a 75% increase for CMDHB.
Note (2): The MOH did not have a baseline for 2008/09 so both the volumes and percentage have been included for detection and follow-up.
Note (3): The CVD indicator was introduced in 2008/09 and replaced retinal screening.

CMDHB has met the 2008/09 Detection & Followup targets for all ethnicities except for Others, which missed by only 2%. By comparison, the detection rates for Maaori and Pacific exceeded targets by almost 10%.

None of the case management targets by ethnicity were achieved; only 60% - against a target of 65% - of people receiving an annual review have recorded an HBA1c of equal to or less than 8, which is an indicator of good diabetes management.

CVD risk management targets for all ethnicities were met in 2008/09.

CMDHB Get Checked and CVD risk management results for 2008/09

	Total	Maaori	Pacific	Other
Detection & Follow-up volumes	16,054	2,669	5,992	7,393
Detection & Follow-up % (based on 6 months)	✔ 69%	✔ 80%	✔ 76%	✘ 61%
Diabetes Management %	✘ 60%	✘ 54%	✘ 48%	✘ 72%
CVD Risk Management %	✔ 76.7%	✔ 71.1%	✔ 71.4%	✔ 79.5%

Improve mental health services

Health Target	CMDHB Target 2008/09
At least 90% of long-term clients have up-to-date relapse prevention plans (NMHSS criteria 16.4)	90% of long-term clients (children, adults and older people) have up-to-date relapse prevention plans

More than 1,500 people – children and adults - within CMDHB have been in contact with mental health services for two years or more in 2008/09. In the most recent quarterly audit of 234 client files in June 2009, 92% of the files were found to have up-to-date relapse prevention plans. However, the target has not been achieved for children and youth under 20 years of age where the overall rate was only 68.4%. This will improve with the use of the newly implemented electronic clinical information system which enables the capture of relapse prevention plans outlined in clients' notes.

Results for percentage of people in contact with mental health services in CMDHB for more than two years with relapse prevention plans in 2008/09

Ethnicity	Total	Maaori	Pacific
20 years plus (excluding those with addictions only)	✔ 95.8%	✔ 96.6%	✔ 100%
Child & Youth	✘ 68.4%	✘ 80%	✘ 50%
Total	✔ 91.9%	✔ 94.1%	✔ 91.2%

Source: CMDHB service data, using a stratified random sample file audit method

Improve nutrition, increase physical activity and reduce obesity

Health Target	CMDHB Target 2008/09	Achieved
Proportion (percent) of infants exclusively and fully breastfed - 74% at six weeks - 57% at three months - 27% at six months	Specific objectives aimed at improving breastfeeding rates, nutrition, increasing physical activity and reducing obesity are in Outcome 1 – *Improving community wellbeing* and Outcome 2 – *Improve child and youth health*	
Proportion (percent) of adults (15+ years) consuming at least three servings of vegetables per day, and proportion (percent) of adults (15+ years) consuming at least two servings fruit per day: - 70% for vegetable consumption - 62% for fruit consumption		There were no results for 2008/09. The LBD benchmark survey is carried out every 3 years and will be repeated in 2009/10.

Proportion of infants exclusively and fully breastfed at:	National Health Target	CMDHB Results 2008/09	Achieved
6 weeks	74%	51.6%	✘
3 months	57%	42.7%	✘
6 months	27%	18.2%	✘

Source: Plunket (July to December 2008). This data is not a true representation of breastfeeding in CMDHB as it only looks at one Well Child provider. Plunket enrols about 90% of the newborn population and Maaori and Pacific infants may be under-represented in enrolments. Additionally, the timing of the data collection does not always fit the ages quoted.

Key initiatives in the Breastfeeding Action Plan include the implementation of the Baby Friendly Hospital Initiative (BFHI) and the Baby Friendly Community Initiative (BFCI). CMDHB has completed the first year of a two-year project of working towards achieving Baby Friendly Hospital Initiative (BFHI) accreditation at Middlemore Hospital. About fifty percent of the nursing and midwifery staff have completed the BFHI required education and the rest, along with the doctors and support staff, are scheduled to complete training this year.

Reduce the harm caused by tobacco

Health Target	CMDHB Target 2008/09	Achieved
Year 10 'never smoker' target - To increase the proportion of "never smokers" among Year 10 students by at least 3% over 2007/08 - An increase for both Maaori Year 10 'never smokers' and Pacific Year 10 'never smokers' that is greater than European Year 10 'never smokers' ***Smokefree homes target*** - To reduce the prevalence of exposure of non-smokers to secondhand smoke inside the home to less than 5% - A reduction in the prevalence of exposure of non-smokers to second-hand smoke inside the home for Maaori and Pacific that is greater than for European	According to the 2008 national Action on Smoking and Health (ASH) survey results: - The proportion of Year 10 students who were "never smokers" in CMDHB increased by 4% on the 2007 result from 56% to 60% - European never smokers was greater than Maaori (which had a slight decrease) and Pacific. European never smokers increased 5.2% from 59.9% to 65.1%. Maaori never smokers decreased .6% from 31.3% to 30.7%. Pacific never smokers slightly increased from 50.2% to 52.1%. The smokefree homes target is similar to the ASH survey smokefree environments indicator which measures the proportion of Year 10 students who live in houses where smoking is permitted in the home. Please see Outcome 1 - Improving Community Wellbeing for CMDHB's 2008 results.	✔ Year 10 never smoker target

Outcome 1 – Improve Community Wellbeing

Health outcomes for the Counties Manukau population can be significantly improved only by a 'whole society' approach. CMDHB works with our communities (in particular Maaori and Pacific communities) and other agencies (in particular Manukau City Council through Tomorrow's Manukau, and Franklin and Papakura district councils; the Ministry of Social Development; and Housing New Zealand) to encourage healthy behaviours, and to improve the environments in which people live, work and play. CMDHB also works closely with the Ministry of Health, a major funder of services in this area, through the regional Public Health Service Alignment Group to ensure alignment of CMDHB and Ministry of Health priorities and outcomes.

Increase smokefree environments

Objective	Performance Measure
Reduce the proportion of Year 10 students where smoking is allowed in the house	*Numerator* Number of Year 10 students where smoking is allowed within the house *Denominator* Number of Year 10 students surveyed in CMDHB schools

This smokefree target is similar to the *smokefree environments* indicator measured annually by national non-governmental organisation Action on Smoking and Health (ASH) New Zealand which asks Year 10 students the question, "Do people smoke inside your house?" The results from the 2008 ASH survey are presented here.

Year 10 students who live in houses where there is smoking in the home

	2002	2003	2004	2005	2006	2007	2008	Target
Maaori	46%	54%	42%	43%	41%	37%	36%	39% ✔
Pacific	28%	35%	19%	27%	26%	21%	22%	21% ✘
Asian	20%	18%	20%	19%	15%	13%	15%	18% ✔
Other	22%	18%	13%	25%	33%	27%	17%	20% ✔
Total	25%	24%	24%	23%	25%	22%	21%	

Source: ASH Survey 2008

Increase the proportion of adults who are regularly physically active

Objective	Performance Measure
Increase the proportion of adults who are regularly physically active (LBD Survey)	*Numerator* Number of adults who do at least 2.5 hours of physical activity per week *Denominator* Number of adults surveyed in CMDHB

The proportion of CMDHB adults who do at least 2.5 hours physical activity per week

	Baseline (SPARC Survey)	LBD Survey 2006/07	CMDHB Target 2006/07	Achieved 2006/07	Target 2008/2009
Total	65%	67%	67%	✔	No survey
Maaori	62%	73%	65%	✔	
Pacific	63%	70%	65%	✔	
Asian	NA	60%	NA	NA	
Other	43%	69%	48%	✔	

Source: LBD Baseline Survey

The 2006/07 Let's Beat Diabetes Baseline Survey was used to report on this measure as it provides a relatively recent representation of physical activity in CMDHB. The survey will be repeated in the 2009/10 financial year and no new data is available for this indicator in 2008/09. No target has therefore been set for 2008/09 and the results have been left unchanged from the 2006/07 annual report.

Increase healthy school environments

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Increase the proportion of schools that are health promoting schools *Numerator* The number of health promoting schools *Denominator* The total number of schools eligible and appropriate for being enrolled in the health promoting schools programme within the DHB*	120/202 *	98/199*	✘

Source: Health Promoting Schools

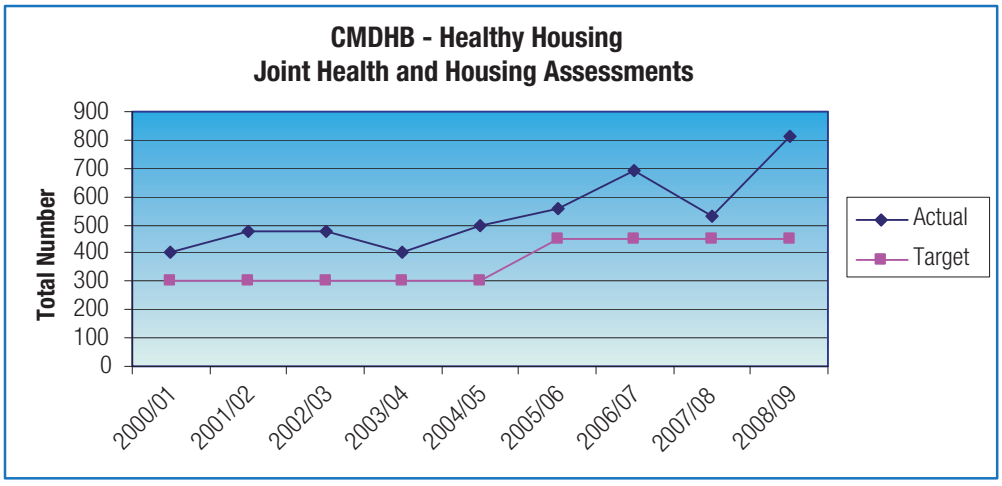
** The number of eligible schools changes yearly, due to the opening and closing of schools, amalgamations and emergence of alternative education providers. In 2008/09, the total number of eligible schools was 202 (based on Ministry of Education school rolls) when this target was set but this has since been reduced to 199 in the latest MoE roll.*

Comment

The Health Promoting Schools Service aims to get at least 65% of all Deciles 1 to 3 schools in Counties Manukau to be Health Promoting Schools. About 70% of all schools in the district are Deciles 1 to 3. The service had 98 schools in the Health Promoting Schools programme in 2008/09. Additionally, there were 23 more schools in the Fruit in Schools programme which now has a total of 65 schools in Counties Manukau.

Develop healthy communities

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Complete the target number of joint health and housing assessments done for the Healthy Housing Programme *Absolute number of health and housing assessments completed in financial year, compared with target number*	480	812	✔



Source: Healthy Housing Project

Comment

The Healthy Housing programme achieved a record number of joint assessments in 2008/09 of 812 completed assessments against a target of 480. More than 550 households in Counties Manukau were assisted with a housing solution in 2008/09.

2008/09 Annual Objectives

Objective	Deliverable	Timeframe	Achieved	Comment
Reduce smoking in Counties Manukau, particularly amongst Maaori and Pacific families with children	CMDHB Tobacco Control Strategy and implementation plan completed. Tobacco Control Strategy implemented	1 Jul 08 30 Jun 09	✔ ✔	Implementation of the Tobacco Control Strategy has begun; implementation is planned to take place over 3 years.
Promote behaviour change through social marketing	The next phase of SWAP2WIN	30 Jun 09	✔	
Align the implementation of national strategies, programmes and priorities such as Healthy Eating Healthy Action, Mission On, Fruit in Schools, breakfast clubs and Smokefree with the local initiatives of the Let's Beat Diabetes (LBD) project and existing Health Promoting School (HPS) programmes and initiatives	Fruit in Schools initiative within the Tipu Ka Rea model implemented for HPS in 40 Schools	30 Jun 09	✔	
Development of Family Violence Prevention (FVP) role and FVP initiatives to improve identification and access to assault services within health services	Evaluation of current service and gaps. FVP screening is implemented within provider arm services	30 Jun 09	✔ ✔	
Improving the health, social and housing outcomes for families residing in the suburb of Wiri	'Lifting the Game in Counties Manukau', an intersectoral initiative to address the needs of Wiri residents, is scoped and developed in collaboration with Manukau City Council, Housing New Zealand, Ministry of Social Development and other NGOs	30 Jun 09	✔	The Wiri Improvement Project (Lifting the Game) scope is completed and CMDHB, MCC, HNZC, MSD and NGOs, have started delivering on the workplan. The DHB has recruited staff to improve access to health services.

Outcome 2 – Improve Child and Youth Health

The population of Counties Manukau has a high proportion of children and young people, a significant number of whom live in areas of high deprivation. CMDHB will meet the health needs of children and young people through improving their access to health care services and by developing and implementing policies, programmes and initiatives which improve their health status.

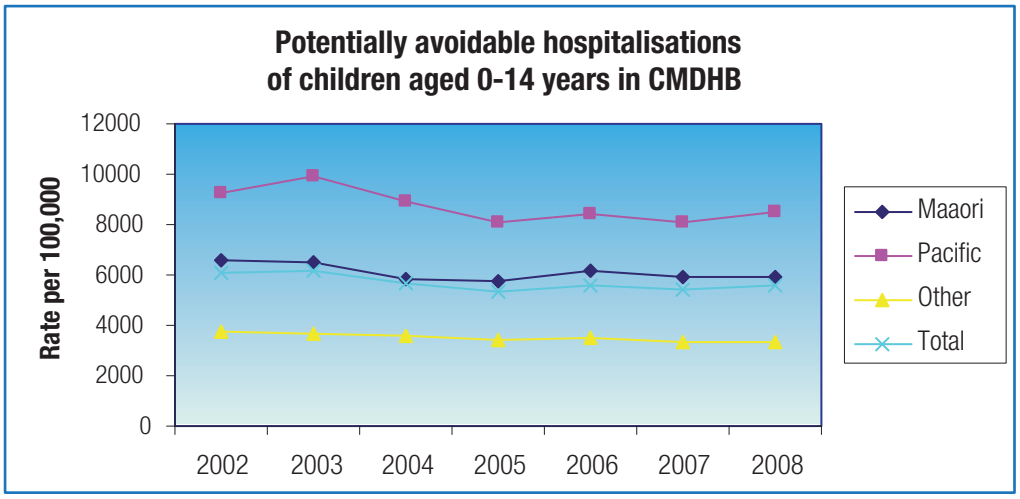
Decrease the number of preventable hospitalisations of children aged 0-14 years

Objective	Performance Measure
Reduce the rate of potentially avoidable hospitalisations for children	*Numerator* Total number of hospital discharges considered potentially avoidable, in children aged 0-14 years *Denominator* Total number of CMDHB residents aged 0-14 years

This measure is reported as a rate per 100,000 people

	2002	2003	2004	2005	2006	2007	2008	Target
Maaori	6613	6496	5825	5757	6148	5954	5933	5857 ✘
Pacific	9274	9889	8951	8059	8428	8083	8473	8134 ✘
Other	3768	3690	3577	3416	3499	3331	3358	3709 ✔

Source: NMDS, age-standardised (calendar years to 31 December 2008 rather than 30 June 2009)



Source: NMDS, age-standardised (calendar years)

Comment

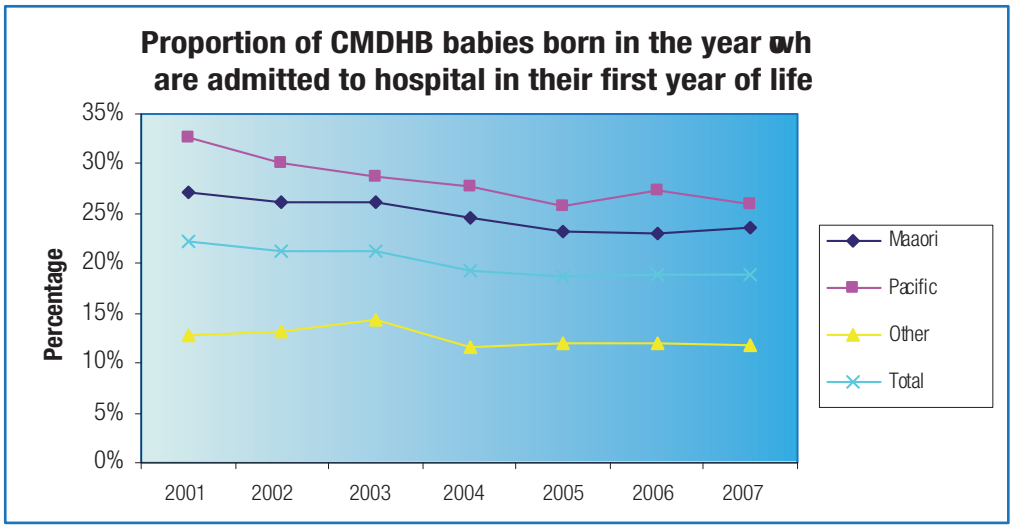
Potentially avoidable hospitalisation (PAH) is a sensitive measure of health inequalities. This measure is an indication of access to, and the effectiveness of, primary care as well as accident prevention and other public health interventions to keep people out of hospital. A downward trend in childhood PAH has been observed for those of Pacific and Other ethnicities over the past five years although the Pacific rates exceeded the target in 2008.

Decrease the proportion of CMDHB children admitted in the first year of life (excluding birth)

Objective	Performance Measure
Decrease the admission and readmission rate for infants	*Numerator* Number of these babies who are admitted to hospital in their first year of life (other than at delivery) *Denominator* Total number of Counties Manukau babies born in one year *Note: Readmissions for children born in 2007 are measured for one year following birth, meaning that readmissions data is available through to the end of calendar year 2008. Readmissions for children born in 2007 are compared against targets for 2008/09 set in the 2008/09 SOI.*

	2001	2002	2003	2004	2005	2006	2007	Target
Maaori	27.1%	26.1%	26.1%	24.5%	23.2%	23.0%	23.6%	21% ✘
Pacific	32.6%	30.1%	28.7%	27.8%	25.8%	27.4%	25.9%	26% ✔
Other	12.8%	13.1%	14.3%	11.6%	11.9%	11.9%	11.7%	14% ✔
Total	22.2%	21.3%	21.3%	19.2%	18.7%	18.8%	18.9%	20% ✔

Source: NMDS (calendar years to 31 December 2008)



Source: NMDS, age-standardised (calendar year)

Comment

A combination of health services and social economic interventions are central to improving on this indicator. Initiatives in Counties Manukau like Well Child checks and immunisation, Baby Friendly Community Initiatives, Healthy Housing will contribute to improvement on this indicator in future years.

Decrease the mean number of DMFT (decayed, missing, or filled teeth) in five year-olds

Health Objective	Performance Measure
Decrease the mean number of Decayed, Missing or Filled (DMF) teeth in 5 year olds	*Numerator* Total number of DMF teeth *Denominator* Total number of children enrolled with the Dental Service in CMDHB

Mean DMFT in enrolled CMDHB five year-olds

	2006	2007	2008	Target
Other	1.36	1.51	1.57	1.5 ✘
Maaori	3.4	3.10	5.33	3.0 ✘
Pacific	3.71	3.75	3.49	3.1 ✘
Total	2.27	2.41	3.01	2.1 ✘

Source: Auckland Regional Dental Service (calendar years to 31 December 2008 rather than 30 June 2009)

Comment

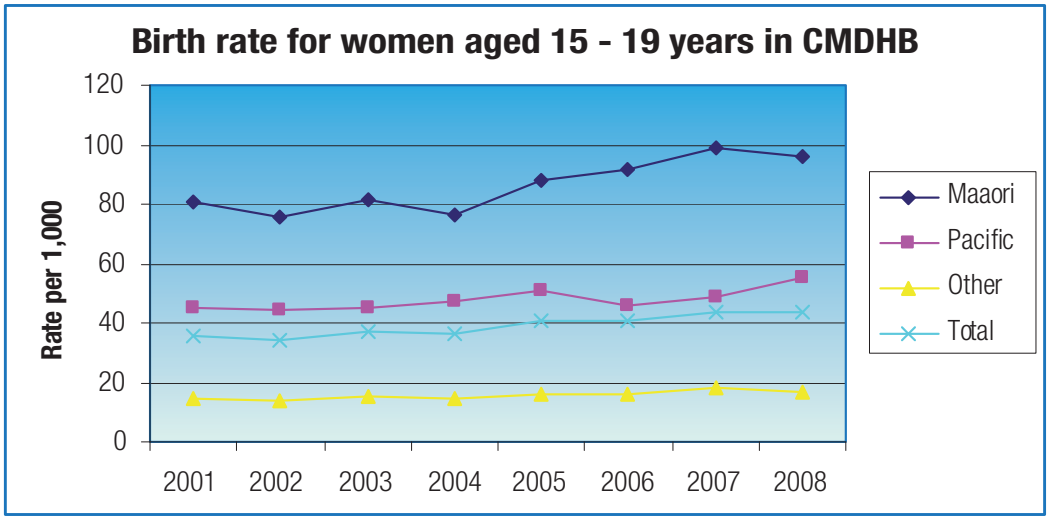
There has been significant worsening of oral health status for five year-olds over the last few years. This is a national decline which is not limited to CMDHB. Much of the deterioration has been seen in Maaori and Pacific children, with marked inequity in oral health status between those of Maaori and Pacific ethnicities and those of European ethnicity. Further oral health inequity exists between children of Asian ethnicities and European children. Five year-old children in CMDHB have the highest average DMFT in the region.

Decrease the incidence and impact of risk taking by young people

Health Objective	Performance Measure
Reduce the number of births to teenage mothers (15-19 years)	*Numerator* Total number of babies born to women 15-19 years old who reside in CMDHB *Denominator* Total number of women aged 15-19 years in CMDHB

	2001	2002	2003	2004	2005	2006	2007	2008	Target
Maaori	80.5	75.4	81.2	76.4	87.9	91.8	98.6	95.9	87 ✘
Pacific	45.4	44.3	45.4	47.4	51.1	45.6	48.8	55.6	50 ✘
Other	14.5	14.1	15.4	14.8	16.2	15.9	18.4	16.5	16 ✘
Total	35.9	34.5	37	36.3	40.6	40.5	43.8	43.7	40 ✘

Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)



Source: NMDS (calendar year)

Comment

The teenage birth rate has been steadily increasing in CMDHB with rates being particularly high for Maaori. None of the targets were met in 2008.

2008/09 Annual Objectives

Objective	Deliverable	Timeframe	Achieved	Comment
Reduce readmissions of high risk Maaori newborns	Improved provision of information and referral access to community health services and delivery of clinical information for patients and their whaanau	30 Jun 09	✘	
Improve breastfeeding rates for fully breastfed at 6 months	First stage of the CMDHB Community Breastfeeding Plan implemented	30 Jun 09	✔	
Improve early detection and hearing loss in children	Implementation of the national newborn hearing programme in accordance with the regional agreement commenced	30 Jun 09	✘	Implementation is planned for 2009/10 subject to confirmation of funding.
Review the current outreach strategies to improve coverage for Maaori and Pacific children under 5 years	New models of care implemented, following review, in conjunction with outreach providers, PHOs and public health nursing service	30 Jun 09	✔	A local review of CMDHB's opportunistic immunisation service pilot at the SuperClinic and a regional review of immunisation (including outreach) were completed. Implementation of new models of care to take place in 2009/10.
Implement preschool oral health model and child and adolescent oral health business plan	Protocols agreed and in place with well child providers and community dental services	30 Jun 09	✘	The planned changes to Titanium (ARDS IT system) to accommodate a pre-school risk assessment carried out by Well Child Providers has been delayed.
	Consultation and local oral health plans for Papatoetoe, Manukau-Manurewa and Papakura areas completed	30 Jun 09	✔	Community consultation completed for CMDHB child and adolescent oral health business plan. Implementation planning is underway.
Implement recommendations from Teen Parenting Evaluation Review to ensure best practice delivery of Teen Parent Unit services	Gaps identified by review implemented	30 Jun 09	✔	Recommendations identified by the review are being implemented.

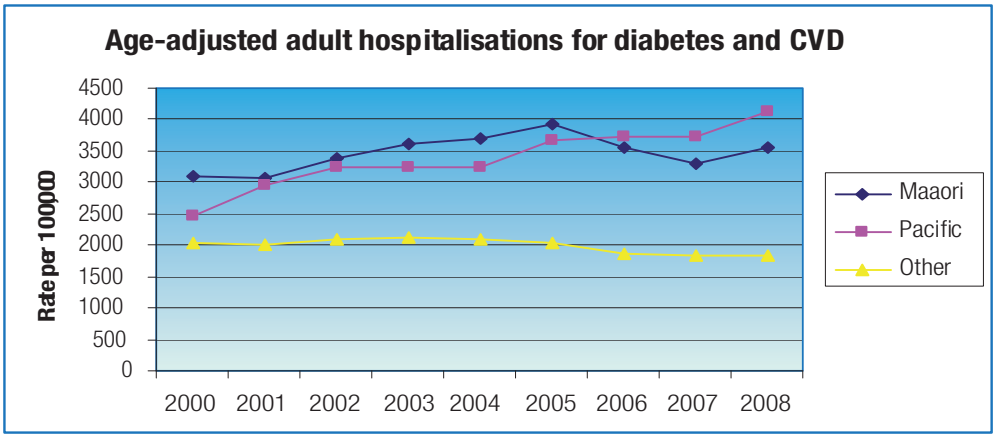
Outcome 3 – Reduce the Incidence and Impact of Priority Conditions

Reduce the impact of diabetes and cardiovascular disease

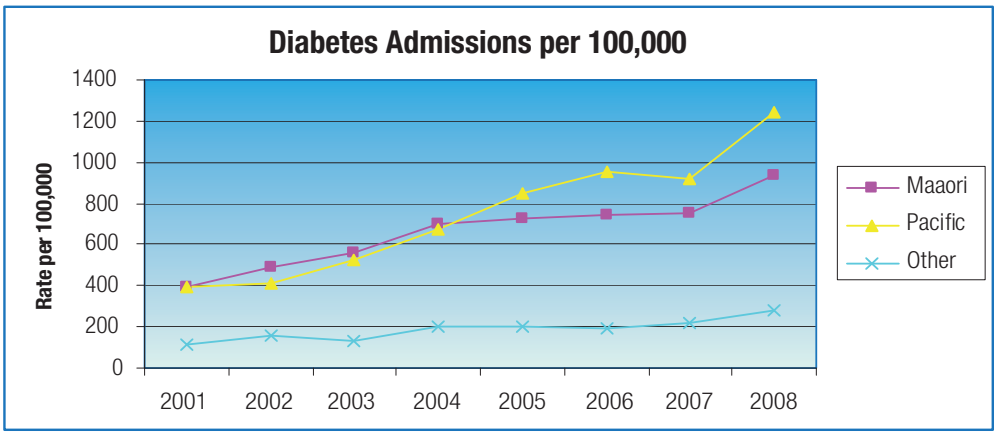
Objective	Performance Measure
Decrease the hospital admission rate for cardiovascular disease and diabetes in adults	Age-adjusted hospitalisation rate for hospital discharges with principal diagnosis codes for diabetes and cardiovascular disease *This measure is reported as rate per 100,000 people*

	2000	2001	2002	2003	2004	2005	2006	2007	2008	Target
Maaori	3107	3060	3391	3608	3683	3932	3560	3300	3549	3300 ✘
Pacific	2460	2961	3243	3250	3237	3665	3737	3735	4129	3600 ✘
Other	2038	2001	2103	2110	2103	2036	1877	1841	1830	1800 ✘

Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)



Source: NMDS, age-adjusted (Calendar year)



Source: NMDS, age-adjusted (Calendar year)

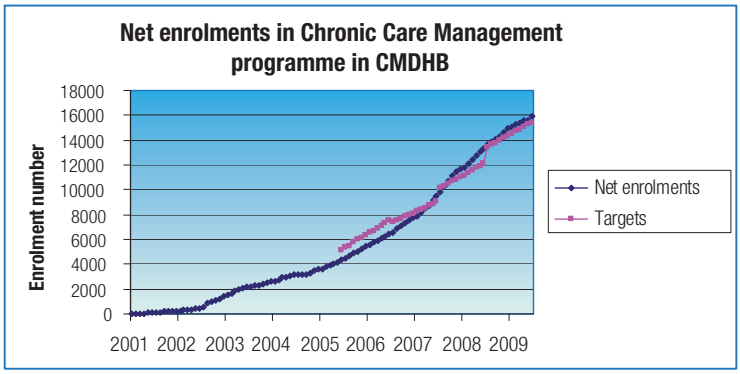
Comment

Acute coronary syndrome rates are constant (per head of population) with acute myocardial infarction trending downwards. Diabetes admissions are going up, and most markedly for those with the highest risk - our Pacific and Maaori populations. Some of this may be because of better diagnosis and or better coding; but, inescapably, the rates of diabetes admissions (direct or associated) are outstripping population growth – Pacific by 3 times, Maaori 2.5 times - despite preventative programs.

Increase access to structured programmes to reduce the impact of priority conditions

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Increase the numbers of Chronic Care Management (CCM) programme enrolments for all five modules *Total enrolments in CCM programme (All enrolments minus dis-enrolments)*	11,000	12,851	✔

Source: CMDHB Chronic Care Management programme



Source: CMDHB Chronic Care Management programme

Comment

The Chronic Care Management (CCM) programme has led the way nationally in the management of people with chronic diseases. People with chronic diseases work with their primary health care teams to optimise disease management and are followed up on a regular basis throughout the year. Total CCM enrolments for five modules were 12,851. This increases to 16,086 if the Depression module is added. Net enrolments in CCM (including the Depression module) exceeded targets in 2008/09 with a 21% increase from the previous year.

Reduce the incidence and impact of diabetes

Objective	Performance Measure
Increase the proportion of estimated number of people with diabetes who had an annual Get Checked free check	*Numerator* The number of individuals with diabetes who have a free annual check *Denominator* The estimated number of individuals with diabetes

Proportion of CMDHB people with diabetes who had an annual Get Checked

	Baseline number of free annual checks in 2006 (calendar)	Number of free annual checks in 2008/09	CMDHB Result 2008/09	Target
Total	10,710	16,054	68.9%	65% ✔
Maaori	1,585	2,669	79.8%	63% ✔
Pacific	4,036	5,992	75.9%	65% ✔
Other	5,090	7,393	61.3%	65% ✘

Source: Get Checked annual reports

Comment.

CMDHB's Get Checked targets were exceeded, with more than 16,000 checks completed on individuals. The Get Checked targets and results have been reported using the revised Ministry of Health prevalence estimate of around 23,000 people with diabetes in CMDHB.

Reduce the incidence and impact of cancer

Objective	Performance Measure
Increase the 2 year breast screening coverage for women aged 45-69	*Numerator* Number of women aged 45-69 years who have had a breast screen in the last 24 months *Denominator* Number of women aged 45-69 years living in Counties-Manukau

	2004/05 50-64 years	2005/06 50-64 years	2006/07 50-64 years	2007/08 50-64 years	2008/09 45-69 years*	Target 2008/09 45-69 years*
Maaori	51%	46%	43%	45%	40%	54% ✘
Pacific	46%	43%	41%	45%	44%	51% ✘
Other	54%	52%	51%	53%	48%	57% ✘
Total	52%	50%	49%	51%	48%	56% ✘

Source: Breastscreen Aotearoa

* *The screening coverage rates presented in this report for 2008/09 are for women aged 45-69 years over a 2 year period. Previous data related to women aged 50-64 year.*

Comment

Since July 2006, CMDHB has offered screening to 45-69 year old women as the eligibility criteria was changed. Coverage for this age group has increased from 36% in July 2006 to 48% in June 2009.

CMDHB has not met targets for women aged 45-69 years in 2008/09. This has mainly been due to a severe workforce shortage for radiographers that has affected CMDHB since January 2008. In early 2009 additional radiographers were recruited and the volume of women being screened has increased. However as this target related to the percentage of women screened over a two year period, several months of high screening volumes would be required to increase coverage significantly.

Improve outcomes for people severely affected by mental illness

Objective	Performance Measure
Increase the proportion of the Counties-Manukau population with severe mental illness accessing mental health services	*Numerator* Number of CMDHB domiciled unique clients seen in previous 12 months *Denominator* Number of CMDHB residents aged 20-64 years

Proportion of the population with severe mental illness accessing mental health services

	Year to 31 March 2008			Year to 31 March 2009			
	Maaori	Other	Total	Maaori	Other	Total	Target
0-19 years	2.5	2.0	2.1	3.1	2.1	2.3	2.2 ✔
20-64 years	4.8	2.4	2.7	5.7	2.5	3.0	2.8 ✔
65+ years	**2.1**	2.3	2.3	2.5	2.4	2.37	2.4 ✘

Source: Mental Health Information National Collection (MHINC)

Comment

CMDHB has exceeded the target of 12,194 clients to be seen in 2008/9, equating to an overall increase in clients seen of 14.2% from the previous year, which is well in excess of the 8.8% access target. The 0-19 and 20-64 age group targets were exceeded and the 65+ age group is only 0.03% below target. This group has benefited, and will continue to benefit, from the enhancement to the Needs Assessment and Service Co-ordination Service. The continued development of the He Kakano Service (Maaori Child and Youth Service) and Manaaki Ora (Maaori Adult Community Mental Health Centre) do appear to be enhancing access for Maaori.

2008/09 Annual Objectives

Objective	Deliverable	Timeframe	Achieved	Comment
Increase access to evidence based CVD risk management	>2850 patients who have a CVD risk >15% have received CVD management based on NZ guidelines	30 Jun 09	✔	More than 3000 patients had received CVD management at June 2009
Expand availability of diabetes self-management education programme	Capacity of formal enrolments in diabetes self management programmes increased to enable 650 participants per year	30 Jun 09	✔	
Continue implementation of the Cancer Control Strategy across CMDHB	Implementation of local chemotherapy service at CMDHB	30 Jun 09	✘	This was not able to be implemented in 2008 as originally planned
Implement recommendations for systems adaptation of CCM as part of phase two of CCM evaluation	Recommendations finalised and implementation plan completed and accepted by PHOs	30 Jun 09	✔	
Improve the quality of mental health clinical services through audits of the Provider Arm	Partnership in Evaluation towards Recovery audits completed and individual service recommendations implemented	30 Jun 09	✔	Planned audits by the Partnership Towards Recovery team [PER team] have been completed; action plans drawn up for implementing audit recommendations.

Outcome 4 – Reduce Health Inequalities

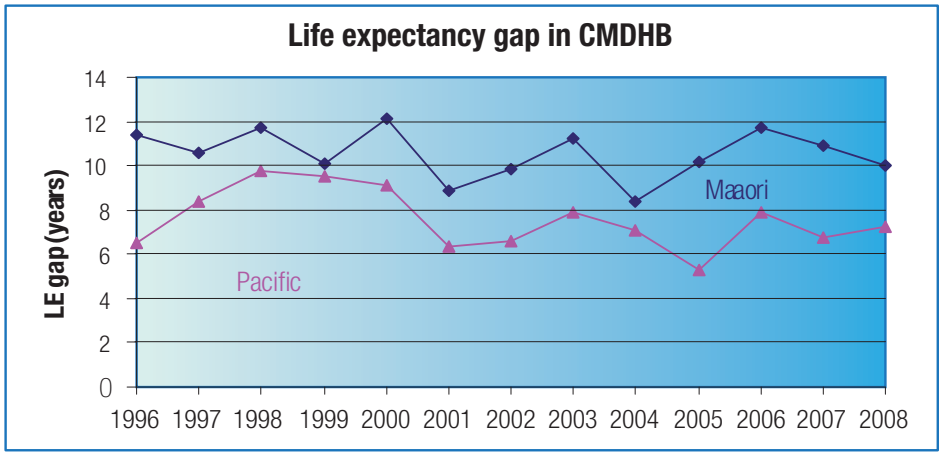
Decrease the life expectancy gap

Life expectancy at birth is often used as a summary measure of health status within populations. For CMDHB, the gap in life expectancy is a key indicator of health equity, although it is impacted upon by many factors outside the control of the health sector. It is used to measure health disparities between those of Maaori and Pacific ethnicities and those of Other ethnicities.

Objective	Performance Measure
Decrease the life expectancy gap between Maaori and Pacific and non-Maaori, non-Pacific	Difference in life expectancy (in years) between Maaori and non-Maaori, non-Pacific and between Pacific and non-Maaori, non-Pacific

	2003	2004	2005	2006	2007	2008	Target
Gap for Maaori (years)	11.3	8.4	10.2	10.2	10.8	10.0	9.8 ✘
Gap for Pacific (years)	7.9	7.1	5.3	7.9	6.7	7.3	6.4 ✘

Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)



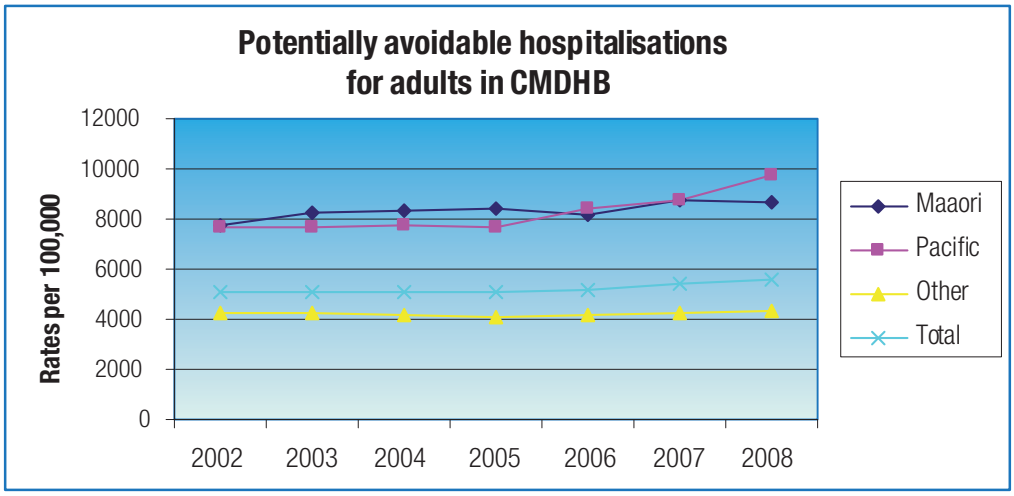
Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)

Comment

The general trend towards reducing life expectancy gaps for Maaori and Pacific in CMDHB appears to be slowing. The largest differences in mortality are from causes such as cardiovascular disease, smoking-related lung diseases and diabetes. An increase in emphasis on population-based initiatives directed at reducing the consumption of tobacco in CMDHB, reducing obesity, and reducing the prevalence and impact of diseases like diabetes will be needed if further reductions in the gaps in life expectancy are to continue.

Address the systematic origins of inequalities

Objective	Performance Measure
Reduce the rate of potentially avoidable hospitalisations for adults	*Numerator* The total number of hospital discharges considered potentially avoidable in adults aged 15+ years *Denominator* Total number of adult residents in CMDHB *This is reported as a rate per 100,000 people*



Source: NMDS, age-standardised (calendar years to 31 December 2008 rather than 30 June 2009)

Potentially avoidable hospitalisations in adults, CMDHB residents per 100,000

	2002	2003	2004	2005	2006	2007	2008	Target
Maaori	7774	8268	8345	8453	8138	8722	8704	8600 ✘
Pacific	7662	7641	7727	7682	8395	8716	9770	8722 ✘
Other	4240	4221	4186	4122	4129	4255	4333	4600 ✔
Total	5072	5106	5115	5072	5150	5414	5593	5640 ✔

Source: NMDS, age-standardised (calendar years to 31 December 2008 rather than 30 June 2009)

Comment

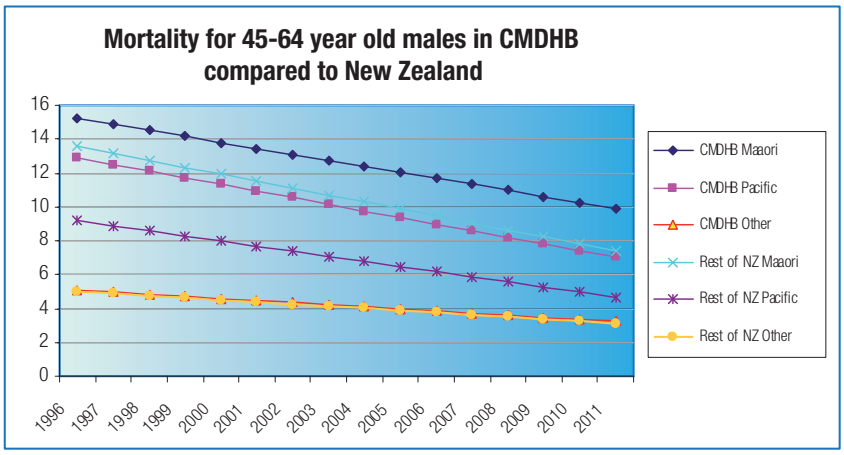
Potentially avoidable hospitalisation (PAH) is a sensitive measure of health inequalities. This measure is an indication of access to, and the effectiveness of, primary care as well as accident prevention and other public health interventions to keep people out of hospital. Rates of PAH for Maaori and Pacific in Counties Manukau remain considerably higher than for those of Other ethnicities. Many interventions have been introduced in CMDHB to reduce preventable admissions. These initiatives will take time to have an impact on PAH. This is particularly true for cardiovascular disease which makes up a significant proportion of PAH.

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

Objective	Performance Measure
Reduce the mortality rate for Maaori and Pacific men aged 45-64 years	*Numerator* Total number of deaths of male CMDHB residents aged 45-64 years *Denominator* Total number of men in CMDHB aged 45-64 years *This measure is reported as rate per 100,000 people*

	2001	2002	2003	2004	2005	2006	2007	2008	Target
Maaori	980	1540	1250	1110	1040	1550	1220	970	1200 ✔
Pacific	1080	880	1100	990	730	1000	810	910	900 ✘
Other	480	420	420	360	410	400	390	380	390 ✔
Total	610	600	600	530	520	600	540	520	520 ✔

Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)



Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)

Comment

The main contributor to the large premature mortality gap for Maaori and Pacific males is cardiovascular disease followed by smoking-related conditions and diabetes. Urgent attention is required to population-based programmes of tobacco reduction and obesity prevention to reverse these significant gaps.

Improve ethnicity data collection

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Ethnicity data is collected accurately and completely in secondary care *Numerator* Number of patients who have ethnicity recorded as Not stated or Not defined *Denominator* Number of patients seen as an inpatients	< 3% National target	1.35%	✔

Source: CMDHB Patient Information Services

Comment

Inpatient recording of ethnicity is good, has remained stable and has met the required national target of 3% since 2002/03, due to a concerted effort by staff to correctly record ethnicity information in patient records.

2008/09 Annual Objectives

Objective	Deliverable	Timeframe	Achieved	Comment
Implement Whaanau Ora Plan	Formalised health programmes in place in 15 Counties Manukau Marae, of which 2 are whare oranga pilots	30 Jun 09	✔	19 Counties Manukau Marae have formalised health programmes and 4 are Whare Oranga pilots
	At least 40 Maaori enrolled in the Manukau Institute of Technology bachelor of nursing programme	30 Jun 09	✔	75 Maaori are enrolled in the programme
Implement Tupu Ola Moui	Pacific Provider Development Plan completed	30 Jun 09	✔	
	Pacific Leadership Workshop for Ministers Group held	30 Jun 09	✘	This was not held due to the lack of resources
	At least 30 Pacific nurses to have completed the return to nursing course	30 Jun 09	✘	10 nurses have achieved their IELTS (English language competency test) and will be ready to commence their CAPS to attain NZNR registration.
Continue to implement the Maaori responsiveness programme within CMDHB	Tikanga in practice implemented in partnership with: - Tiaho Mai - Kidz First	30 Jun 09	✔ ✘	Tiaho Mai rollout of Tikanga in Practice has started. Kidz First rollout will commence when resources are confirmed.
Ensure the CMDHB workforce reflects the local community	Review the processes and systems to capture workforce ethnicity data	30 Jun 09	✔	Ethnicity data available
	Identify recommendations to improve data collection	30 Jun 09	✘	Strategies in place to resource this project from a personnel and infrastructure perspective
Develop formal processes to collect, analyse and monitor performance data appropriate for Counties Manukau	Develop and pilot Maaori quality measures/ tools and IT support that will measure effectiveness of change	30 Jun 09	✘	This did not take place

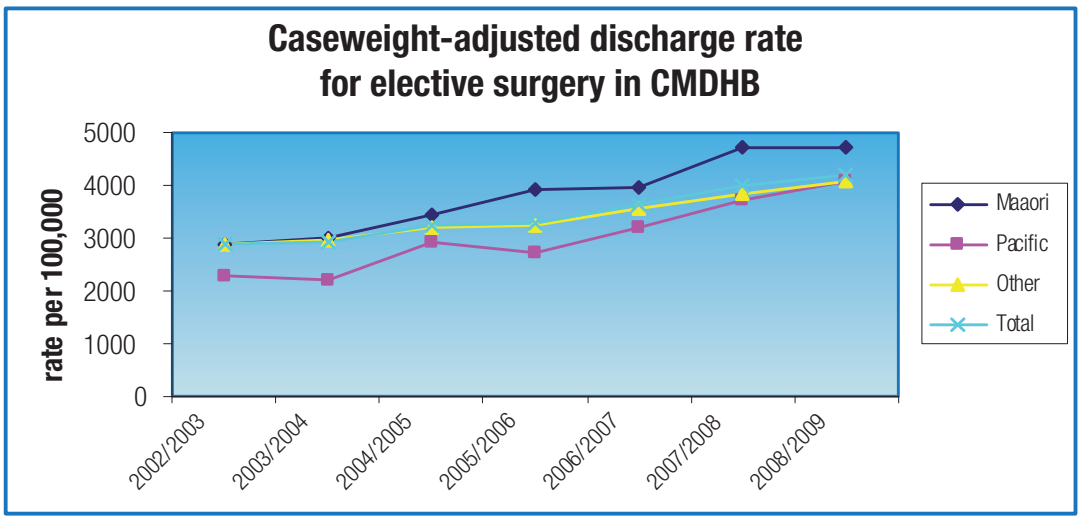
Outcome 5 – Improve Health Sector Responsiveness to Individual and Family/ Whaanau Need

Improve access to and management of elective services

Objective	Performance Measure
Increase the caseweight-adjusted utilisation for elective surgery	Caseweight-adjusted hospital discharge rate for elective surgical services - *Surgical electives, casemix only, excluding ACC.* - *This measure is reported as rate per 100,000 age standardised population*

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Target
Total	2870	2930	3260	3300	3630	4010	4220	3531 ✔
Maaori	2880	2990	3460	3930	3970	4740	4720	
Pacific	2270	2200	2920	2720	3190	3720	4100	
Other	2890	2950	3210	3250	3560	3860	4080	

Source: NMDS, age- and caseweight-adjusted (calendar years to 31 December 2008 rather than 30 June 2009)



Source: NMDS, age- and caseweight-adjusted (calendar years to 31 December 2008 rather than 30 June 2009)

Comment

The caseweight-adjusted hospital discharge rate for elective surgery in CMDHB has continued to rise since 2003 and all targets were achieved for 2008. This increase is representative of continued efforts in CMDHB to improve access to elective services.

Improve access to and management of elective services

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Decrease the number of patients who have not been managed according to their assigned status and who should have received treatment *Numerator* Those patients who have not received treatment within 6 months and those patients placed on active review who have not received a clinical assessment within the last 6 months *Denominator* Patients, irrespective of their assigned status, who have a priority score above the treatment threshold	< 3%	0.8% - 1.6%	✔

Source: Elective Services, Ministry of Health

Comment
This indicator, reported by MoH as ESPI7 on an individual monthly basis, has consistently exceeded the national target of 5% since June 2005.

Increase access to services so that they align with national levels

Objective	Performance Measure
Increase the proportion of elective services which are at or above national access levels	*Numerator* The number of service groups (e.g. orthopaedics) where CMDHB is below the NZ average *Denominator* The number of service groups analysed

	Services	Total standardised discharge ratio (SDR) for children and adults	Target (total)
1	Cardiothoracic	1.12	✔
2	Cardiac	0.96	✘
3	Dental	1.03	✔
4	Endoscopy	0.00	NA
5	ENT	0.94	✘
6	Eye	1.57	✔
7	General surgery	1.12	✔
8	Gynaecology	1.00	✔
9	Neurosurgery	1.11	✔
10	Orthopaedics	1.10	✔
11	Plastics	1.23	✔
12	Urology	1.01	✔
13	Vascular surgery	1.34	✔

Source: NMDS (year ending 31 December 2008)

Comment
The standardised discharge ratio (SDR) is the ratio between the number of operations completed by CMDHB and the number that would be expected if the DHB provided services at the national average rate. A rate higher than 1 indicates that the DHB is providing more than the average rate in New Zealand, and a rate lower than 1 indicates that the DHB is providing less than the average rate in New Zealand. CMDHB had 10 (out of 12) service groups with higher rates than the New Zealand average rate.

Increase primary care utilisation

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Increase rate of GP consultations for high needs (Maaori, Pacific, or living in decile 9 or 10 area) compared with non-high needs populations *Numerator* *The rate of GP consultations per high needs person* *Denominator* *The rate of GP consultations per non-high needs person*	>1	1.11	✔

Source: PHO Performance Management Programme

Comment

High needs patients (Maaori, Pacific, or living in decile 9 or 10 area) in CMDHB PHOs use general practitioners at higher rates than non-high needs patients, reflecting poorer levels of health in these communities. CMDHB continues to meet its targets in reducing barriers to primary care access.

Improve the continuum of care for services provided to older people

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Increase the expenditure on home based care to compared with expenditure on residential care *Ratio of number of people receiving home based support services (HBSS) to the number of people receiving Aged Residential Care (ARC)*	2.6	2.5	✘

Source: Counties Manukau District Health Board

Comment

This Health of Older People (HOP) indicator measures the success of the HOP initiatives to support older people to remain in their own homes and to maintain the highest health and fitness status. The target ratio of HBSS clients to ARC clients was reduced from 3 to a more realistic target of 2.6 in 2008/09, and, although the target was not met, the ARHOP team remains committed to the provision of services to support the national policy direction of ageing in place.

2008/09 Annual Objectives

Objective	Deliverable	Timeframe	Achieved	Comment
Increase internal capacity to achieve elective services provision at CMDHB	Internal capacity for the delivery of 1100 elective surgery WIES per month (including gynaecology) developed	31 Dec 08	✔	Internal capacity is available within facilities but variable constraints like staffing along with external factors, e.g. Swine Flu, can affect actual production
Ensure that modality of service provided is aligned with best practice	Eligible day of surgery rates >90% by service Day of surgery admission rates >95% by service	30 Jun 09	NA NA	Not measured for 2008/09 Data not collected for 2008/09
Deliver to base elective contract, orthopaedic and cataract initiative, and new elective surgery funding targets	Delivery against agreed contract schedule	Monthly ongoing	✔	CMDHB has continued to exceed targets set for this indicator. Base and additional volumes were both completed, together with 200 further wies.
Ensure all elective patients are seen and managed in a timely manner, consistent with Ministry of Health guidelines	Green ESPI compliance is maintained on a monthly basis, and where a service moves out of compliance it is returned within three months	Monthly ongoing	✔	CMDHB achieved an "Outstanding" rating for maintaining compliance with all ESPI targets, and all service goals were achieved
Implement the Counties Manukau Primary Health Care Plan	Extension of Primary Options to Acute Care programme (POAC) to rest homes piloted	30 Jun 09	✔	
	A clear direction for future PHO configuration confirmed including role of primary and community health centres and locality planning	30 Jun 09	✔	
Build opportunities for health promotion, disability prevention and rehabilitation through the expansion of community geriatric services and developing links with primary care	Proposal for co-location of PHO/GP, needs assessment and service co-ordination and home health care services developed. Community geriatric service with PHO and residential care providers extended as per implementation plan.	30 Jun 09	✔ ✔	

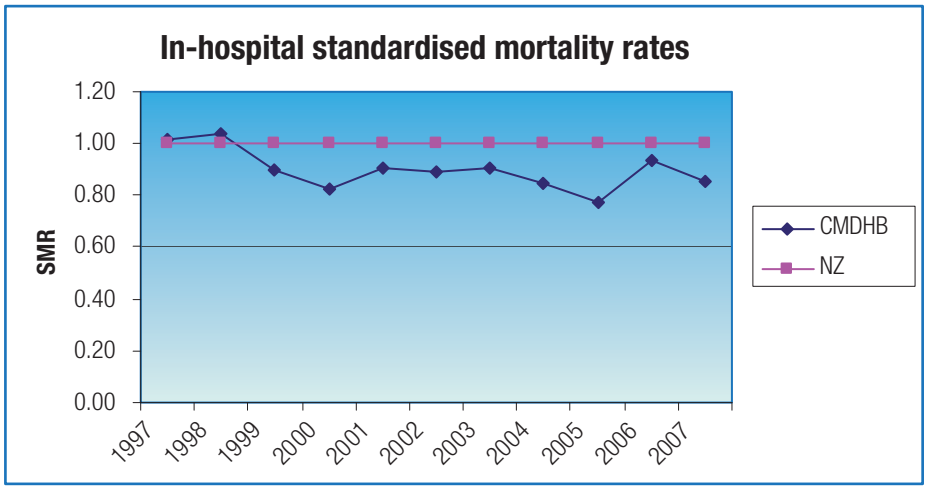
Outcome 6 – Improve the Capacity of Health Sector to Deliver Quality Services

Ensure the delivery of safe and effective hospital services

Objective	Performance Measure	Achieved
Maintain a low in-hospital standardised mortality rate	Ratio of the actual number of deaths occurring in hospital to the expected number (if national mortality rates were applied to CMDHB)	✔

	2002	2003	2004	2005	2006	2007	2008	Target
	0.91	0.88	0.84	0.76	0.95	0.87	0.87	≤ 0.9 ✔

Source: NMDS (calendar years to 31 December 2008 rather than 30 June 2009)



Source: NMDS (calendar years to 31 December 2007 rather than 30 June 2008) (31 December 2008 not available)

Comment

The standardised mortality ratio compares the number of deaths that have occurred in hospital in CMDHB with the number that would be expected if the DHB had performed in line with national averages. This allows comparison of in-hospital deaths in CMDHB with national data. CMDHB has had consistently lower in-hospital mortality than national figures since 1999.

Ensure the health workforce meets the community's need for services

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Reduce the percentage of employees who voluntarily resign (Staff turnover – FTE) *Numerator* *The number of employees who resign* *Denominator* *The total number of employees in the organisation*	<14%	9.6%	✔

Source: CMDHB Balanced Scorecard

Comment

Staff turnover rates has gradually declined since 2004. CMDHB met its target of less than 14% of employees resigning during the year.

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

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Reduce the ratio of communication patient complaints to the number of admissions *Numerator* *Number of communication complaints received* *Denominator* *Total number of admissions*	0.3%	0.3%	✔

Source: CMDHB Incident Reporting System

Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Increase the proportion of inpatients surveyed who are satisfied with service delivery *Percentage of inpatient satisfaction survey respondents who rate service satisfaction good/very good*	83%	84%	✔

Source: CMDHB Incident Reporting System

Comment

The number of complaints related to communication has increased above the target of 0.3% of hospital admissions over the last two years. It is likely that this increase is related to a change in the way complaints are recorded, rather than an actual increase in communication complaints. The Feedback Monitor complaints system was implemented in December 2006 and this allowed for selection of more than one complaint category, whereas in the former system, selection of only one category was possible. The target documented in the Statement of Intent did not take account of this change.

Ensure that services and facilities are planned to meet the future needs of the community

Health Objective and Performance Measure	CMDHB Target 2008/09	CMDHB Result 2008/09	Achieved
Reduce the number of days where medical and surgical services occupancy is greater than 90% in CMDHB facilities *Number of days in a financial year where occupancy of medical and surgical services is greater than 90% capacity*	30	14	✔

Source: CMDHB

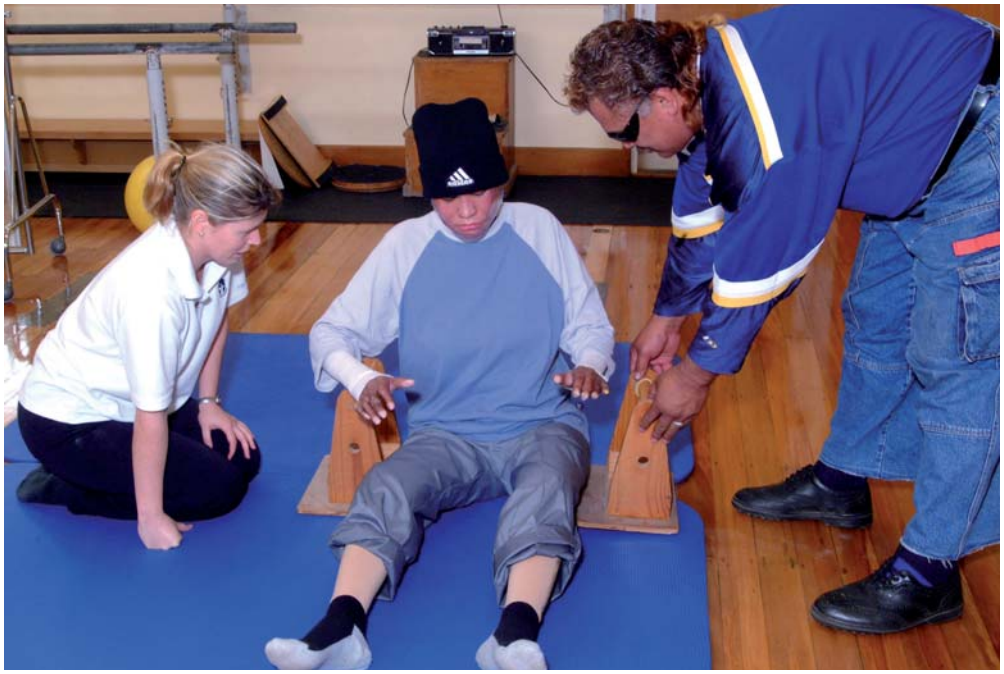
	2008	Target
Days with > 85% occupancy	170	135 ✘
Days with > 90% occupancy	14	30 ✔

Source: CMDHB

Comment

In 2007/08 this indicator was approximated by calculating bed days as a proportion of approximate capacity for medical, surgical and maternity acute beds in CMDHB. For 2008/09, this indicator does not include maternity acute beds in the calculation of bed capacity as these beds cannot be used for non-maternity patients and, hence, should not be considered an available pool of beds.

The number of days per year of high occupancy for medical and surgical services in CMDHB has dropped in 2008/09. There were 25 new beds for Medicine following the opening of the Edmund Hillary Block at the Middlemore Campus in June 2009, which may have contributed to this drop but occupancy rates remain high particularly in the area of medicine and surgical services on the Middlemore Campus.



Ensure the efficient use of resources

Objective	Performance Measure
The percentage of pharmaceutical transactions and laboratory test with a valid NHI	*Numerator* Pharmaceuticals: *The number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted.* Laboratory tests: *The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted.* Denominator Pharmaceuticals: *The total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district.* Laboratory: *The total number of tests carried out by community laboratories in the DHB district.*

The proportion of laboratory tests and pharmaceutical subsidy claims with valid NHI numbers in CMDHB

	2004/05	2005/06	2006/07	2007/08	2008/09	Target
Pharmaceuticals	77.8%	91.3%	93.4%	94.3%	95.5%	94% ✔
Laboratory	92.7%	93.3%	93.8%	95.1%	99.2%	94% ✔

Source: Northern DHB Support Agency

2008/09 Annual Objectives

Objective	Deliverable	Timeframe	Achieved	Comment
Improve Patient Safety	Physiologically Unstable Patient Programme implemented	31 Oct 08	✔	
	ICU bundles in place and used on all appropriate patients	30 Jun 09	✔	
Improve performance within the ward environment through the Releasing Time to Care programme	Programme completed for 4 wards each quarter until April 2009	30 Apr 09	✔	
Recruit and retain staff	Implement the CMDHB workforce development plan	30 Jun 09	✔	Workforce Development plan implemented as per agreed priorities to July 2009.
Enhance staff-patient communication	Coaching and mentoring programme reviewed and implemented.	30 Jun 09	✔	In place.
	Patient-focused communication modules to support building a culture of quality implemented		✔	A number of communication modules are in place through the L&D calendar and custom designed modules within services.
Improve utilisation of the Manukau Surgery Centre	Physical occupancy increased from 38% to 50%	30 Jun 09	✘	Utilisation over the year increased to 40.1% based on available bed days of 28,470 and inpatient utilisation of 11,519.
Increase bed capacity to meet increasing requirements	New Adult Medical Building available	30 Jun 09	✔	Stage One of the Edmund Hillary Block opened in June 2009. An additional 240 inpatient beds will be available upon completion of Stage two in mid-2010.
Integrate health information from secondary services to primary care	Primary care access to regional repository of health event summaries piloted	30 Jun 09	✔	This has been achieved and GPs have access to Testsafe (Regional Results Repository) and Regional Concerto.

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

Meredith Connell
Russell McVeagh

BANKERS

Commonwealth Bank
ASB Bank Limited
Westpac Banking Corp

Key Abbreviations

Acronyms Description

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