COUNTIES MANUKAU DISTRICT HEALTH BOARD

COUNTIES MANUKAU HEALTH

Annual Report 2015

Our Values

Care & Respect

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

Teamwork

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

Professionalism

Acting with integrity and embracing the highest ethical standards.

Innovation

Constantly seeking and striving for new ideas and solutions.

Responsibility

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

Partnership

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

COUNTIES
MANUKAU
HEALTH

Contents

Chair and Chief Executive's Review

Counties Manukau Health continues to build upon the foundations to transform our healthcare system and bring about better health outcomes for our communities. Our strategic goal has been to achieve a balance between excellence and sustainability to be the best healthcare system in Australasia by December 2015.

In 2014/15 we continued to deliver on five major health targets, with sustained performance in most individual targets and strong progress made towards achieving the new Faster Cancer Treatment target, all of which impacts directly on our community's health. This was done while delivering high standards of quality and safety of service and a breakeven financial position. Our Quality Accounts reflect the detail of how both quality and safety is embedded across hospital and community services. We are very proud of achieving a Health Excellence Bronze award, the second DHB in New Zealand to have achieved this.

Our whole of system integration of primary care, community and hospital services continue to bring services closer to where communities live, with an increased use of multidisciplinary based services within our localities, as well as continued expansion of our At Risk Individuals (ARI) programme within primary care, providing comprehensive care for people with long term conditions, benefiting our Maaori and Pacific whaanau.

Achieving "Healthy Futures for Maaori" or Paeora is a priority, where we aim to see Maaori living longer and healthier lives with whaanau in their communities. This is first year we have integrated our Maaori heath indicators into our Annual Report as part of our commitment to make performance reporting more visible and to track the health gain of Maaori, Pacific and Asian groups in Counties Manukau in support of our wider goal of achieving health equity for our community.

Finally we would like to thank the ongoing commitment of staff across the hospital and community, as well as our PHO partners who work together to deliver excellent care to every patient and whaanau.

Dr Lee Mathias
Chairman

Geraint A Martin
Chief Executive

Note -

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

Snapshot of Counties Manukau Health

In 2014/15, CM Health[1] provided health and disability services to an estimated 524,500 people who reside in the local authorities of Auckland, Waikato District and Hauraki District.

We employ around 7,400[2] (5,550 FTE) people in a number of different locations across the district and manage a budget of more than $1.5 billion a year.

Our population is growing at a rate of 1-2 percent per year, the second fastest growing population (after Waitemata DHB) when compared with other DHBs. Overall, the Counties Manukau population is expected to grow by approximately 8,000-8,500 residents each year for the next 10 years. From 2015/16 to 2025/26 the number of new residents in Counties Manukau is projected to be just under 83,000.

The key demographic features that inform our planning assumptions are:

- There are a diverse range of needs that can be further distinguished by four geographical locality areas that have been defined covering the Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin. Each locality is diverse in terms of its population demographics and health needs.
- The Counties Manukau district has an ethnically diverse population: 16 percent Maaori, 39 percent NZ European/Other groups, 24 percent Asian, and 21 percent Pacific. Twelve percent of all New Zealand's Maaori population, 38 percent of New Zealand's Pacific people and 21 percent of New Zealand's Asian population live in Counties Manukau.
- Compared with other DHBs, Counties Manukau has the second highest number of Maaori (after Waikato DHB), the highest number of Pacific peoples, and the second highest number of people (after Auckland DHB) who identify as Asian ethnicities.
- If current population projections remain appropriate, the Asian population of CM Health will continue to increase the fastest of our ethnic groups, followed by Pacific, then Maaori, while our NZ European/Other population will show little growth.
- We are a relatively young population with 23 percent of our population aged 14 years and younger. Thirteen percent of New Zealand's child population lives in Counties Manukau, and we have the highest number of 0-14 year olds of all the DHBs. The Mangere/Otara and Manukau localities are particularly youthful.
- The population aged 65 and over in Counties Manukau is projected to increase by an average of just over 4 percent each year from 58,700 in 2015/16 to 86,850 by 2025/26, the fastest relative growth in this age group of all the DHBs. It is this group who will place the highest demands on health services in the years to come and is particularly significant for the Franklin and Eastern localities.
- Overall, life expectancy (2011-2013 average) at birth in Counties Manukau is similar to that of the New Zealand average at 81 years. While Maaori and Pacific life expectancy have been improving at a similar absolute rate compared with non-Maaori/non-Pacific population, the life expectancy gap between Maaori and non-Maaori/non-Pacific was just under 10 years while the gap between Pacific and non-Maaori/non-Pacific was just over 8 years for 2011-2013.
- At the time of the 2013 Census 36 percent of the Counties Manukau population lived in areas classified as being the most socio-economically deprived in New Zealand. Fifty-eight percent of Maaori, 76 percent of Pacific and 45 percent of 0-14 year olds in Counties Manukau lived in areas with a deprivation index of 9 or 10 at the time of the 2013 Census.
- On the basis of the NZDep2013[3] measure, Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau district.
- For health service planning purposes, the rural adjustor used in the Population Based Funding Formula gives an indication of the proportion of the population identified as living in rural areas which are seen to require additional resources to deliver health services. In the DHB funding allocation for the 2015/16 financial year, CM Health was the only DHB that did not receive any 'rural adjustor' funding.

[1] To reflect a system approach to health service planning, the collective health resources and associated infrastructures to deliver services for our resident population is referred to as Counties Manukau Health (CM Health).
[2] This figure includes employees on casual contracts (0 FTE).
[3] The New Zealand Deprivation Index is a measure of the level of socioeconomic deprivation in small geographic areas of New Zealand (meshblocks). It combines nine variables from the 2013 census which reflect eight dimensions of deprivation.

Board Members

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

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

Executive Leadership

Executive Leadership Team	
Geraint Martin	Chief Executive
Ron Pearson	Deputy Chief Executive & Director of Corporate and Business Services
Dr Gloria Johnson	Chief Medical Officer
Dr Campbell Brebner	Chief Medical Advisor, Primary & Integrated Care
Karyn Sangster	Chief Nursing Advisor, Primary & Integrated Care
Phillip Balmer	Director of Hospital Services
Benedict Hefford	Director Primary Health & Community Services
Denise Kivell	Director of Nursing
Margie Apa	Director of Strategic Development
Martin Chadwick	Director of Allied Health
Professor Jonathon Gray	Director of Ko Awatea[4]
Beth Bundy[5]	General Manager Human Resources

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

[5] Beth Bundy was appointed to ELT on 12 May 2015.

Key Achievements in 2014/15

Better Health Outcomes for All

- Achievement of 5 National Health Targets, and strong progress made towards achieving the new Faster Cancer Treatment target
- 26% increase in referrals to Living Smokefree Triage Service compared 2013/14 (FY14/15 2,785 referrals)
- The quit bus team have provided smokefree brief engagements to 5,581 people, provided one off smokefree support to 839 people and supported 417 people received ongoing behavioural support to stop smoking
- 342 pregnant women and their whaanau were referred to the Smokefree pregnancy incentives programme, 142 set a quit date, with a 53 percent success rate for pregnant women at 3 months
- Improved access to quality housing with over 1,000 homes insulated through Warm-Up Counties Manukau
- 95% of infants fully immunised by 8 months of age
- 350 safe sleep devices given to families/whaanau with newborns in unsafe sleeping environments by the Safe Sleep Team and community health workers

Before School Check target exceeded, with 8,700 children receiving a comprehensive health and developmental check

- 61 Mana Kidz clinics in schools, with 12,981 children and family members treated for Group A Streptococcus sore throats, and 15,894 skin infections treated
- Over 26,700 adolescents accessed free community oral health services

Patient and Whaanau Centred Care

- Extended visiting hours for immediate family/whaanau
- Increased family/whaanau involvement in decision-making and support for patients through the implementation of 'Partners in Care'. On average, 50 'Partners in Care' are staying overnight to support partner patients.
- 25,000 patients invited to complete the new CM Health online Patient Experience Survey. To date more than 2000 patients have completed the survey. Survey results show:
  - Overall care rating: 80% rate CM Health as Excellent or Very Good
  - Treated with compassion, dignity and respect: 80% Excellent or Very Good
  - Feel confident about quality of care and treatment: 79% Excellent or Very Good
- Continued emphasis on capability building to improve face to face communication with AI2DET training package providing regular training to staff
- Improved information flow to patients with copies of clinic letters now being sent to patients.
- Improved leadership safety rounds which gather information from patients, staff and ward environment.
- Established a Consumer Council to facilitate consumer engagement with services

System Integration

- Completed transition to the At Risk Individuals (ARI) Programme to provide more proactive, patient centred care for patients with multiple long term conditions. 99 practices across Counties Manukau are now utilising this model of care and accessing associated flexible funding for complex patients
- Over 14,000 patients are now enrolled in the ARI programme – benefitting from goal based care plans shared electronically between care team members
- Implementation of Shared Care solution to 435 clinicians across 27 teams, enabling the sharing of patient information between primary, secondary and community clinicians involved in a patients care
- 128 patients with shared care patient portal access, enabling increased patient involvement in and visibility of their care plan
- 54 regional pathways have been developed and disseminated, providing a comprehensive road map for the local management of patients with common conditions. 200 clinicians are actively using pathways
- Initiation of a Community Health Integration Programme of work to increase the capability and capacity of community services, facilitating integration with primary, NGO and speciality services
- Development of a reablement service within Community Health Teams to support patients to regain physical functioning following an acute exacerbation of an existing health condition or a significant hospital event

- Led by Ko Awatea, 23 general practice teams took part in an inaugural Safety in Practice programme – using a care bundle approach to enhance safer care for patients in the primary care setting who are at higher risk of experiencing avoidable harm
- Completion of a 6 month Proof of Concept for enhancing the general practice model of care encompassing: lean process reengineering; improved consumer engagement, utilisation of eHealth services to improve patient access and improved integration with pharmacy
- Development of a regional data sharing agreement, providing a consistent and coordinated approach to data sharing which will support the planning and development of healthcare services across the wider Auckland region as well as supporting connected healthcare services for high risk patient

First Do No Harm[6]

- Implementation and expansion of the Safety in Practice collaborative with a focus on warfarin management, test results handling, medications reconciliation and opioids management
- Achievement of the Health Quality & Safety Commission (HQSC Quality) and Safety Marker with all 3 parts of the checklist used in 90 percent of procedures
- Ongoing steady improvement in hand hygiene performance

Enabling High Performing People

- Development and launch of the Ko Awatea built 'Improving Together' website, a collaboration between Ko Awatea, the Ministry of Social Development, the Ministry of Education, the Ministry of Health, and the Health Quality & Safety Commission, focuses on empowering staff involved in education, social services and health services across New Zealand. The resource delivers a consistent approach to quality improvement.
- Ko Awatea delivered their third APAC Forum in Melbourne, Australia, creating sharing and learning experiences on quality, patient safety and health system improvement in the Asia Pacific region. 1,476 delegates attended (an increase of 42% on previous year) from 30 countries, including 163 from 15 NZ DHBs.
- Ko Awatea, in partnership with the Ministry of Education Early Learning Taskforce worked closely with seven Early Learning Centres from Clendon and Weymouth, and a further 23 Auckland centres, to look at improving attendance and enrolment in quality early childhood education. Data has shown an increase from 80% to 89% in enrolments for the first seven Early Learning Centres from 7th January 2015 - 17th June 2015.
- Expansion of Health Science Academies and pacific mentoring programme
- Sixteen emerging leaders graduated from the Ko Awatea Leadership Academy with post graduate certificates in public sector leadership (University of Waikato)
- Establishment of workforce and education committee to ensure strong alignment of activity with the organisations strategic priorities
- Ko Awatea LEARN – e-learning platform grew to 10,000+ users across 8 DHBs with an average of 480 people per day accessing development programmes
- Mental Health First Aid programme delivered by Ko Awatea free to over 200 people from the Counties Manukau community
- Ko Awatea's Mindfulness Based Resilience programmes developed and delivered to 200+ staff

Practicing Sustainable Healthcare

- Achieved breakeven financial position
- Achieved Practising Sustainable Healthcare savings targets of $13 million of one-off savings, and $22.1 million of sustainable savings achieved through applying a quality focus on process design, procurement, contract negotiation and our environment

[6] Refer to the 2014/15 Quality Account for full details of the First, Do No Harm work and achievements.

Performance Against National Health Targets

CM Health's strong performance against the national health target expectations in 2014/15 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with primary health care and Primary Health Care Organisations (PHOs), and their commitment and leadership to focus resources towards improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

Health Targets	Quarter			
	1	2	3	4
Shorter stays in Emergency Departments 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours[7]	95% ✓	96% ✓	96% ✓	97% ✓
Improved access to Elective Surgery The volume of elective surgery will be increased by at least 4,000 discharges per year[8]	111% ✓	112% ✓	108% ✓	108% ✓
Shorter waits for Cancer Treatment All patients, ready-for-treatment, will wait less than four weeks for radiotherapy or chemotherapy[7]	100%[9] ✓	-	-	-
Faster Cancer Treatment 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016[10]	-	52%	59%	63%[11]
Increased Immunisation 95% of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2015[7]	94%	94%	93%	95% ✓
More Heart and Diabetes Checks 90% of the eligible population will have had their cardiovascular risk assessed in the last five years[8]	91% ✓	91% ✓	91% ✓	92% ✓
Better help for Smokers to Quit Secondary Care 95% of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking[7]	96% ✓	95% ✓	95% ✓	95% ✓
Primary Care 90% of patients who smoke and are seen by a health practitioner in primary care are offered advice and support to quit smoking[8]	98% ✓	96% ✓	95% ✓	96% ✓

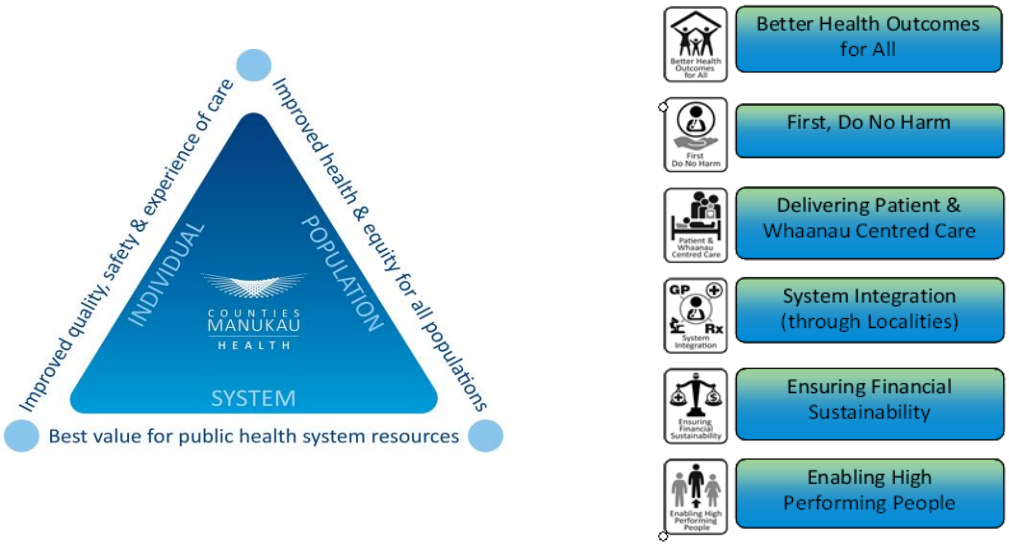
[7] Results reflect performance in each discrete quarter throughout the 2014/15 year.
[8] Results reflect the cumulative total during the 12 month period 1 July 2014 to 30 June 2015.
[9] This is the last time the 'Shorter waits for cancer treatment' results were reported as a health target. From 1 October 2014 (quarter two) the new 'Faster cancer treatment' target came into effect.
[10] From 1 October 2014 (quarter two) the cancer target changed to 'Faster cancer treatment'. The results reflect the cumulative total during the 9 month period 1 October 2014 to 30 June 2015.
[11] Result of 63% reflects our achievement towards the 85% target by 1 July 2016. The MOH have given an 'achieved' rating for the quarter 4 result.

What are we trying to achieve

In realising our vision, our strategic goal is to be the best health care system in Australasia by December 2015 – delivering excellent healthcare services to our communities in a manner that is sustainable and provides best value for public resources.

We will achieve our goal through implementation of our Triple Aim strategic objectives as outlined in Figure 1 below.

Figure 1: Triple Aim and executable strategies



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

CM Health has to ensure that strategic planning translates into healthcare delivery that will make a difference to the lives of people in contact with our health system. For us, being the best healthcare system in Australasia will only be truly meaningful if it brings about a change in the health outcomes for the people of Counties Manukau. CM Health is committed to ensuring that we are able to measure and publicly report on how the multiple initiatives and strategies make an impact on health improvement in our district.

From our experience, feedback from patients and whaanau, interaction with the wider community, knowledge through our campaigns and health needs assessments, we know that non communicable diseases like diabetes, lung disease and cardiovascular disease are key contributors to our mortality rates. Our hospitalisation rate for children and young people is above the national average and is largely for preventable conditions like sudden unexpected death in infants, lower respiratory infections, rheumatic fever, skin conditions and meningococcal disease.

We know that our Maaori and Pacific people are disproportionately affected by these conditions and that the determinants of poor health for our community are affected by lifestyle choices. For example, smoking is one of the largest contributors to the five main causes of death that contribute to inequity in life expectancy between Maaori and Pacific and non-Maaori and non-Pacific. In response to this particular challenge, we continue to progress a number of actions from community through to hospital settings to increase access to advice and help to quit smoking.

We understand that greater gains in the improvement of health outcomes can be achieved by becoming more patient and whaanau centred through:

- Continued efforts in making our health system and services safer and of better quality, i.e., care is safe, timely, efficient, effective, equitable and patient centred
- A cultural shift to involve our patient and families in the management of their own care and care planning, and greater engagement in the redesign of services; and
- Improved integration of services across the health system to deliver more accessible services and continuity of care

To enable us to articulate more clearly the linkages between the performance of our healthcare system to the impacts above, Ko Awatea have developed system level measures (SLMs). These 'big dot' measures are outlined in our Performance Measurement Framework (refer Figure 3) and provide a useful context for interpreting performance of contributory or 'little dot' measures of key healthcare system priority areas and signalling areas where focus may be needed to improve or maintain performance.

Figure 2: Intervention Logic

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

Figure 3: CM Health performance measurement framework

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

How will we know if our population is living longer, healthier and more independent lives?

Our Performance Measurement Framework (refer Figure 3) sets out how we will measure the effectiveness of our healthcare system through our System Level Measures. The framework also sets out a cross section of key contributory measures which span the spectrum of our services and which collectively tell us if we are on track to meet our strategic goals and the organisational Triple Aim. Embedded within the framework are measures which will give us an indication over time whether our strategies are contributing toward the positive change we seek for our population. These measures are proxy measures which best reflect the health priorities and challenges faced by our population and are amenable to being tracked overtime to provide a good indication of whether our communities are indeed living longer, healthier and more independent lives. This section gives an overview of how well we are performing across a selection of key outcome and service delivery indicators.

Outcome Key Performance Indicators

Continued improvement in overall life expectancy and narrowing of ethnic disparity

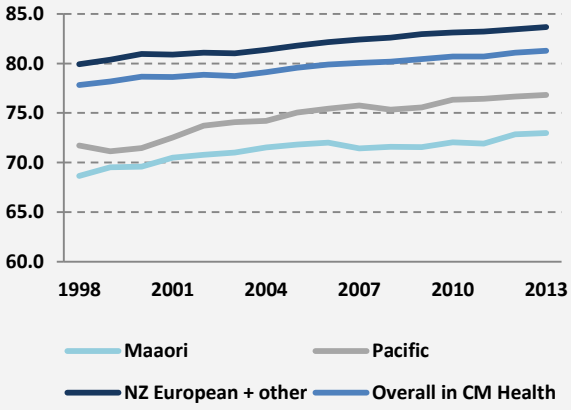
Life expectancy at birth is a key long term measure of health. Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern.

However, despite an overall increase in life expectancy, there continue to be large gaps between life expectancy at birth for Maaori and Pacific, and non-Maaori and non-Pacific groups. In addition Maaori in Counties Manukau have fallen behind Maaori nationally. The gap for Pacific, although smaller, is also of ongoing concern.

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

The life expectancy gap of Maaori and Pacific in Counties Manukau compared to non-Maaori, non-Pacific[12]

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



A reduction in the incidence of rheumatic fever

Acute rheumatic fever (ARF) is a preventable, life-limiting illness that continues to be diagnosed in children across New Zealand and reduction in hospitalisations for rheumatic fever is one of the government's Better Public Service goals.

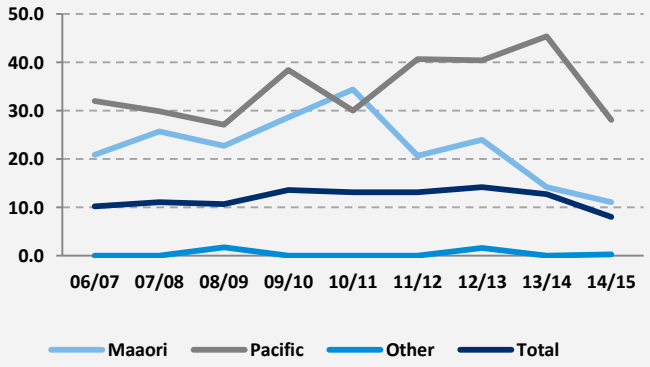
Rheumatic heart disease (RHD) and ARF are potentially preventable conditions if Group A streptococcal throat infections are prevented and/or identified and treated appropriately. ARF occurs most commonly in children aged 5-14 years and disproportionately affects Maaori and Pacific children and communities.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

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

We are committed to reducing the burden of Rheumatic Fever in our communities and acknowledge the complexity of preventing this disease as well as the wide range of activities and investment needed if a significant reduction in cases is to be achieved. A range of initiatives are being implemented targeting those most at risk. This includes school-based

Acute rheumatic fever first hospitalisations per 100,000 population

	13/14 Baseline	14/15 Result	14/15 Target
Maaori	14.2	11.1	16.1
Pacific	45.4	28.1	-
Total	12.7	8.0	8.2[13]



[12] Data sourced from Mortality Collection, Ministry of Health; Estimated populations by DHB, Statistics New Zealand.
[13] The MOH updated the target to 8.2% based on the updated denominators following the Census.

throat swabbing programmes in 61 schools; providing access to sore throat management in primary and community care through 48 Sore Throat Clinics; and systematically identifying children who are at risk of developing rheumatic fever and offering a package of housing-related interventions to reduce their risks.

Improved Control of Long Term Conditions

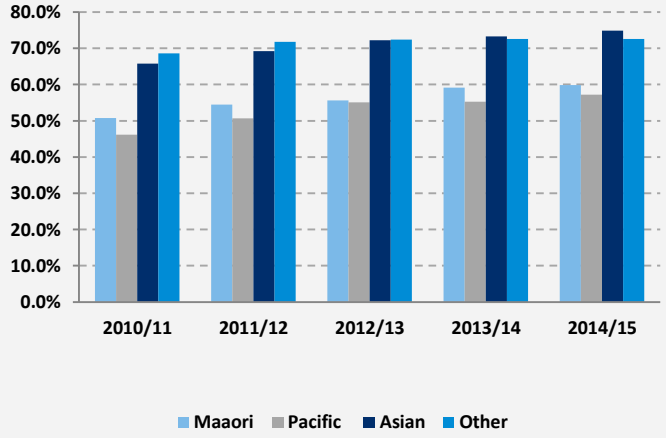
Long term conditions affect a substantial number of New Zealanders every year, reducing both quality of life and life expectancy.

In 2011, approximately 54,290 (14 percent of the adult population people aged 15 years and over) were identified with one or more long term conditions. Volumes for each condition and the degree of overlap (people with more than one of the conditions) varied by ethnicity. The largest number of people was recorded as having diabetes (33,140) and cardiovascular disease (11,780). These diseases have a disproportionate effect on Maaori and Pacific people in the Counties Manukau community.

There is consistent evidence that good management of these conditions will improve morbidity and mortality – resulting in better health for the individual and reduced needs for acute hospital services.

For diabetes, better glucose control will reduce the progression of related conditions that cause complications, e.g. blood vessel blockages in the legs, chronic kidney disease and others.

The percentage of people in Counties Manukau who have good control of their type 2 diabetes (Hb1Ac <=64mmol/mol)	13/14[14] Baseline	14/15[15] Result	14/15 Target
Maaori	59%	60%	66%
Pacific	55%	57%	
Asian	73%	75%	
Other	73%	73%	



Alongside continuing to improve our heart and diabetes risk assessments for our population, we are therefore increasing our attention on how well these diseases are being controlled in our community, through Ko Awatea led Manaaki Hauora Supporting Wellness campaigns.

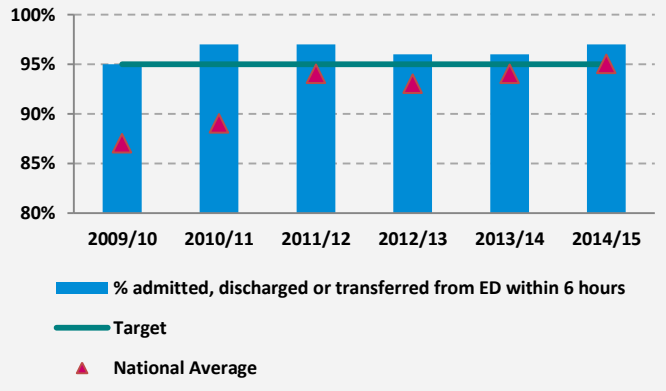
Service Delivery Key Performance Indicators

Shorter stays in emergency departments (Health Target)

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

Despite a 5 percent growth in acute presentations and an increase in self-referrals, CM Health has consistently achieved the national target throughout 2014/15, with at least 95% of people presenting to the CM Health emergency department being admitted, discharged or transferred within 6 hours of arrival in every quarter of 2014/15. A number of improvements to facilities, including the opening of a surgical assessment unit to complement the existing medical assessment unit and the continued utilisation of the designated hospital discharge lounge have helped maintain the efficient flow of patients through the department and have contributed to the achievement of this target. We have a robust quality programme in the Emergency Department and we are committed to maintaining the shorter stays in emergency department target in 2015/16 and improving the quality and timeliness of emergency care.

The percentage of people presenting to CM Health emergency department who were admitted, discharged or transferred within 6 hours	13/14[14] Baseline	14/15[15] Result	14/15 Target
	96%	97%	95%



[14] Result as at 30 June 2014
[15] Result as at 30 June 2015

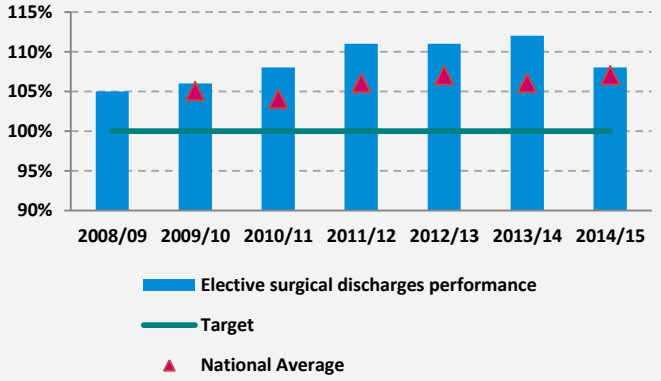
Improved access to elective surgery (Health Target)

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

CM Health has continued to perform above the national target to increase the volume of elective surgery by at least 4,000 discharges each year. The 2014/15 target was to have performed 16,200 discharges; CM Health exceeded this target by 1,333 discharges.

CM Health's strong performance against this target reflects the importance placed on optimising wellbeing for the community demonstrated by commitment of staff to provide timely care; strong focus on productivity and theatre utilisation in newly enhanced facilities; continuing use Ko Awatea's Enhanced Recovery After Surgery (ERAS) approach to care in General Surgery, Orthopaedic and ORL services to promote early discharge.

	13/14[14] Baseline	14/15[15] Result	14/15 Target
The elective surgical services discharge performance of CM Health	112%	108%	100%
	17,457 Discharges	17,533 Discharges	16,200 Discharges



We remain committed to delivering efficient and effective elective surgery productivity in 2015/16 and maintaining achievement of this target.

More heart and diabetes checks (Health Target)

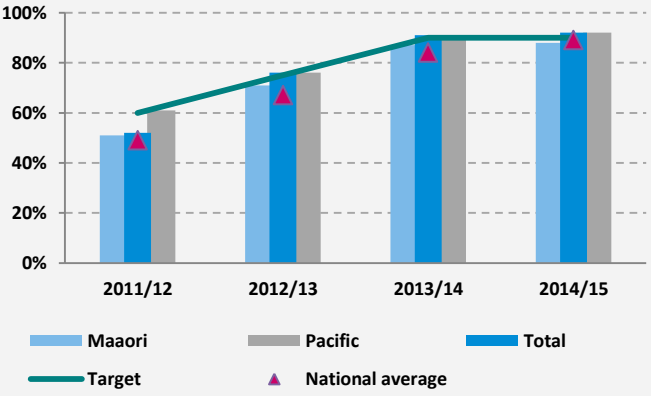
Diabetes and cardiovascular disease affect a substantial number of New Zealanders every year, reducing both quality of life and life expectancy. These diseases have a disproportionate effect on Maaori and Pacific people in the Counties Manukau community.

Early detection and management of diabetes and cardiovascular disease can improve health outcomes and contribute to people living longer, healthier, more independent lives.

CM Health has consistently achieved the national target throughout 2014/15, with at least 90% of eligible people in Counties Manukau having had their cardiovascular risk assessed in the last 5 years in every quarter of 2014/15.

CM Health's strong performance against this target reflect Clinical Champion leadership and support; reporting and audit tools enabling eligible patients to be identified and proactively contacted for a cardiovascular risk assessment and diabetes check; access to phlebotomy and Point of Care testing; PHOs and practices participating in quality improvement forums to share success stories; and monthly monitoring and analysis of performance.

		13/14[14] Baseline	14/15[15] Result	14/15 Target
The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessed in the last 5 years	Total	91%	92%	90%



Shorter waits for cancer treatment & Faster cancer treatment (Health Target)

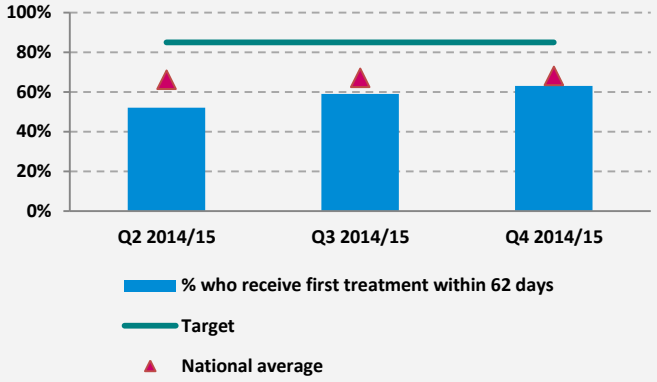
Cancer is a leading cause of morbidity and mortality in New Zealand, accounting for nearly one third of all deaths.

From 1 October 2014, the 'Faster cancer treatment' target replaced the 'Shorter waits for cancer treatment' target. The new target aims to support improvements in access and patient experience through the cancer pathway, including the period of investigations before treatment begins. It supports DHBs to monitor the whole cancer pathway from referral to first treatment to identify any bottlenecks in the system and opportunities for improvement that will benefit all cancer patients. The 62-day timeframe is an internationally accepted timeframe for cancer treatment to begin and in many cases patients will start treatment sooner.

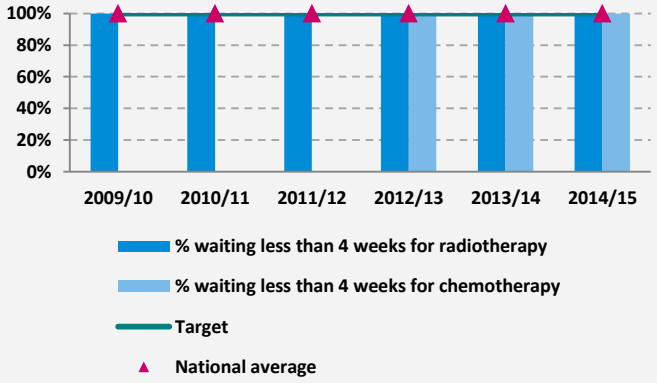
Since the new target has come been in place, CMDHB has made steady progress towards the target.. Actions to date include mapping the cancer pathway for the 6 largest tumour streams to identify key areas for improvement; improvement of patient tracking and reporting quality to ensure best-possible information is available to report and act from; engagement of the tumour stream clinical staff in the FCT development process; and implementation of 'quick wins' such as prospective patient tracking and improved access to timely radiology investigations. Ko Awatea also formed a Rapid Improvement team identifying early improvements.

Planned actions in 2015/16 to support achievement of the target include utilising faster cancer treatment data through monthly reports to services to identify and improve patient flow and timely assessment and treatment; developing expedited pathways for urgent high suspicion of cancer patients by improving diagnostic turn-around times, optimising referral handling processes and maintaining proactive oversight of patients throughout the pathway; standardising processes to reduce wait-times between process steps and ensure timely diagnosis and treatment.

The percentage of CM Health patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	13/14[16] Baseline	14/15[15] Result	14/15 Target
	-	63%	85%



The percentage of CM Health patients[17] who receive radiotherapy or chemotherapy within 4 weeks of first specialist appointment	13/14[14] Baseline	14/15[18] Result	14/15 Target
	100%	100%	100%



In quarter 1, CM Health achieved the 'Shorter waits for cancer treatment' target with 100 percent of patients, ready-for-treatment, receiving treatment within 4 weeks from the decision to treat.

[16] Baseline results not available as this is a new target.
[17] Patients ready-for-treatment.
[18] Result as at 30 September 2014. From 1 October 2014, the 'Faster cancer treatment' target replaced the 'Shorter waits for cancer treatment' target.

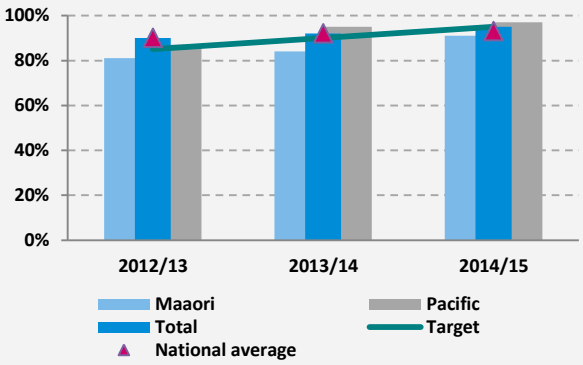
Increased immunisation (Health Target)

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

CM Health achieved the immunisation target in quarter 4, with 95 percent of eight-month-old babies in Counties Manukau completing their primary course of immunisations on time. For Pacific and Asian eight-month-olds, Counties Manukau exceeded the target achieving 97 percent coverage, and 99 percent coverage respectively

We have continued to make progress increasing Maaori immunisation rates – the coverage rates for Maaori eight-month-olds has increased from 84 percent in quarter 4 2013/14 to 91 percent in quarter 4 2014/15.

	13/14[14] Baseline	14/15[15] Result	14/15 Target
The percentage of Counties Manukau eight-month-olds who are fully immunised	92%	95%	95%



Targeted actions to increase immunisation rates in 2014/15 has included active follow up on declines to ensure parents and whaanau have made an informed decision; outreach immunisation services, opportunistic immunisations of siblings at outreach B4SC (before school check) check clinics on Saturdays; and continuing to work closely with primary care.

Better help for smokers to quit (Health Target)

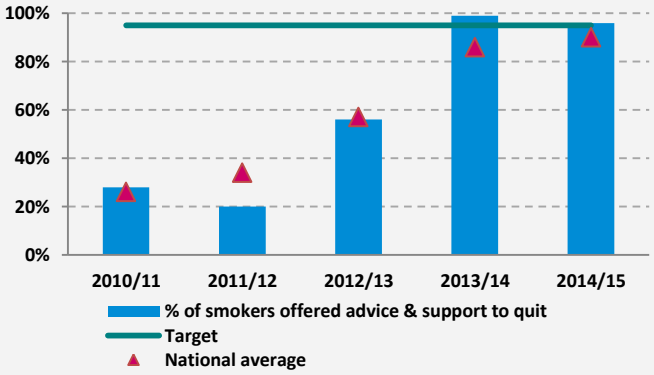
Smoking is a leading cause of death in New Zealand, killing around 5,000 people every year and reducing the quality of life for thousands more. Smoking increases the risk of developing heart disease, respiratory infections and lung diseases, including cancer; all of which contribute to the differences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

At the 2013 Census, 15.9 percent of Counties Manukau residents reported that they were smoking regularly – a 6.2 percent decrease since the 2006 Census. Over the same period, Counties Manukau Maaori smoking prevalence fall from 46.8 percent in 2006 to 36% in 2013, and Pacific from 30.3% to 23.2%.

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

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

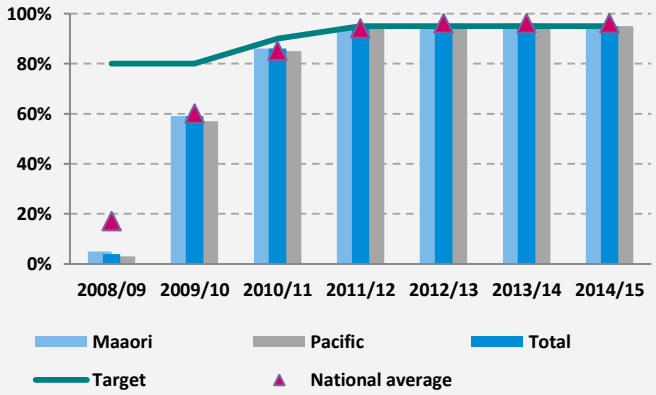
	13/14[14] Baseline	14/15[15] Result	14/15 Target
Percentage of enrolled Counties Manukau smokers seen by a health practitioner in primary care and offered brief advice and support to quit	99%	96%	90%



In 2014/15 CM Health has exceeded the primary care target in every quarter. This result reflects concerted effort by primary care across the region and has included clinical champion support and leadership, and appointment of a dedicated primary care Smokefree Advisor. Actions to support achievement of the target have included sustainable quality improvement plans and activity within practices and PHOs; on-going continuing medical education (CME) and continuing nursing education (CNE) opportunities for primary care staff on the ABC approach19; call centre activity including offering smokers brief advice and cessation support and IT systems such as practice management system (PMS) prompts, reporting and audit tools, text to remind and electronic referral forms to cessation providers; ongoing monthly monitoring of performance and quality improvement forums to share success.

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

	13/14[14] Baseline	14/15[15] Result	14/15 Target
The percentage of CM Health hospitalised smokers offered brief advice and support to quit	96%	95%	95%



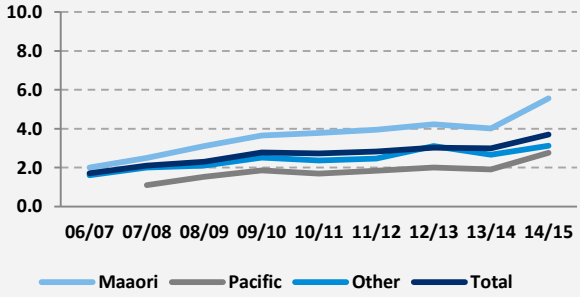
Improved Access to Mental Health and Addiction Services

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

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

Mental health access rates are a useful indicator for determining the impact of Counties Manukau (CM) Health mental health service delivery on improving the quality of life for those who are suffering from mental illness or with alcohol or drug addiction.

		13/14[14] Baseline	14/15[15] Result	14/15 Target
The mental health access rates for 0-19 year olds in Counties Manukau	Maaori	4.01	5.55	4.45
	Pacific	1.90	2.76	-
	Other	2.66	3.13	-
	Total	2.99	3.69	3.15



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

It is believed that acute mental health episodes will decrease with an increase in access to specialist Mental Health (MH) and Addiction services.

The access rates reported include all CM residents who access any of the following services: CM provider arm specialist MH services, regional specialist MH and/or Addiction services (e.g. specialist Alcohol and Other Drugs, Forensics) and NGO services (both MH and Addictions). Increasing access to these services is evident for the overall CM population; and in particular the CM Maaori population.

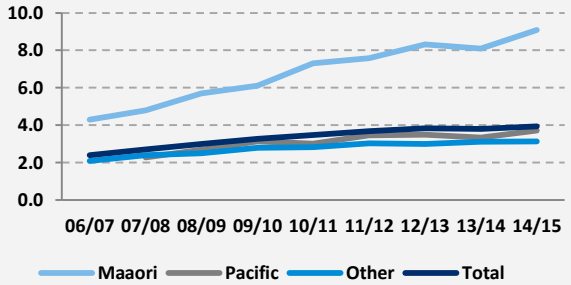
Implementation of cultural engagement at key points of access to the services has enabled better responsiveness and improved access for Maaori. Specific initiatives have included the Child and Youth KPI National Benchmarking initiative for the 0-19 year olds which resulted in a number of improvements, including better engagement of Maaori whaanau at point of Triage point and improved triage pathways for Maaori whaanau.

Nearly 1 in 10 adult Maaori residents in Counties Manukau are now accessing a specialist or NGO MH and Addiction service. The current challenge is to ensure adequate access to specialist services while enabling and supporting specialist services to enhance the capability and capacity of the primary care level services to provide MH and Addiction services. This is being undertaken through integration initiatives, IT developments and the work on enabling specialist clinicians and services to report on non-NHI defined clinical consultation to other providers.

The Mental Health Service for Older People (MHSOP) community team undertake consultation liaison meetings within rest homes and private hospitals. Staff from each facility or the GP allocated to the facility refer clients for consultation with the MHSOP Psychiatrists. These sessions provide sufficient advice to mean a formal referral is not necessary.

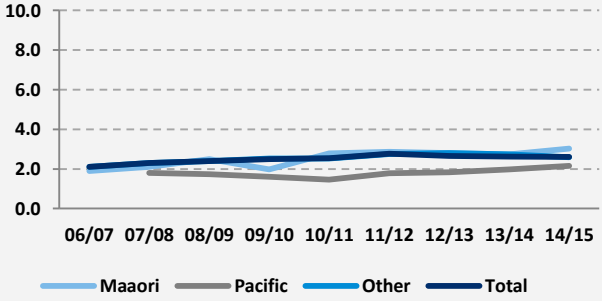
The mental health access rates for 20-64 year olds in Counties Manukau

	13/14[14] Baseline	14/15[15] Result	14/15 Target
Maaori	8.09	9.08	7.75
Pacific	3.34	3.72	-
Other	3.11	3.14	-
Total	3.80	3.94	3.15



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

	13/14[14] Baseline	14/15[15] Result	14/15 Target
Maaori	2.73	3.02	-
Pacific	1.98	2.16	-
Other	2.73	2.59	-
Total	2.62	2.61	2.7



Statement of Service Performance

As part of our annual planning cycle, we provide an annual forecast of the services we plan to deliver. In developing the annual forecast, we consider the health needs of our population and select those 'measures' or activities and services that have the greatest potential to contribute to improving the health and wellbeing of our community and those which are markers of broader system-level change, or those where we expect to see a significant change in activity level. Against each measure we set performance targets. This section presents CM Health's actual performance against the forecast outputs presented in our 2014/15 Statement of Intent. The services or 'outputs' we measure are grouped into four 'output classes' that reflect the nature of the services provided: Prevention Services, Early Detection and Management, Intensive Assessment and Treatment, and Rehabilitation and Support.

Prevention Services

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

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

		2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Health Promotion and Education Services					
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking		96%	95%	95%	Achieved
Proportion of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit		99%	90%	96%	Achieved
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer who are offered brief advice and support to quit smoking		91%[23]	90%	96%	Achieved
Percentage of infants exclusively or fully breastfed at 6 weeks[24]	Total	57%	68%	57%	Not Achieved[25]
	Maaori	54%		52%	
	Pacific	54%		51%	
Percentage of infants exclusively or fully breastfed at 3 months[24]	Total	47%	54%	46%	Not Achieved[25]
	Maaori	39%		38%	
	Pacific	41%		44%	
Percentage of infants receiving breastmilk at 6 months[24]	Total	59%	59%	61%	Not Achieved[25]
	Maaori	47%		46%	
	Pacific	56%		58%	

[20] Result as 30 June 2014 (Q4) unless otherwise stated.
[21] Target to be achieved by 30 June 2015 (Q4) unless otherwise stated.
[22] Result as at 30 June 2015 (Q4) unless otherwise stated.
[23] This data is provided by the MOH and accounts for around 80 percent of pregnancies.
[24] The performance measure description and targets for breastfeeding in 2014/15 Annual Plan was inaccurate and have been amended in this document to reflect the correct definition and targets. Baseline as at 31 December 2013. Targets are to be achieved by 31 December 2014. Results as at 31 December 2014.
[25] CM Health undertook a needs assessment in 2014 to further understand the barriers and enablers to breastfeeding in Counties Manukau. In response to the findings a programme of work is being undertaken to improve breastfeeding rates, this includes workforce development, community breastfeeding support services and supporting implementation of Baby Friendly Community Initiative (BFCI).

		2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score (self audit using AUT tool)[26]	Partner Abuse	98/100	=> 140 combined score	98/100[27]	Achieved
	Child Abuse and Neglect	99/100		97/100[27] Combined score = 195	
Immunisation Services					
Proportion of 8 month olds who have had their primary course of immunisation (six weeks, three months and five months immunisation events) on time (National Health Target)	Maaori	84%	95%	91%	Not Achieved[28]
	Pacific	95%		97%	Achieved
	Total	92%		95%	Achieved
Proportion of older people (65+) who have had their flu vaccinations		69%[29]	75%[30]	67%[31]	Not Achieved[32]
Health Screening					
Proportion of women aged 50 – 69 years who have had a breastscreen in the last 2 years	Maaori	67%	70%	66%	Not Achieved[33]
	Pacific	72%		77%	Achieved
	Total	69%		70%	Achieved
Proportion of women aged 25-69[34] years who have had a cervical smear in the last three years	Maaori	59%	80%	61%	Not Achieved[35]
	Pacific	65%		73%	Not Achieved[35]
	Total	70		71%	Not Achieved[35]
Proportion of the eligible population who have had their B4 School Checks	Vision & Hearing[36]	90% (including 3,612 of high deprivation population)	90% (8,026 of which 3,532 will be High Dep, Q5)[37]	101% (8,070 including 3,534 High Dep Q5)	Achieved
	Nurse[38]				
Proportion of newborns born at CM Health maternity facilities screened before discharge from hospital		81%	90%	82%	Not Achieved[39]

[26] The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training method.
[27] This is a preliminary result as at May 2015; final result due November 2015.
[28] Refer to p.18 for a summary of the work being undertaken to improve immunisation rates for Maaori tamariki.
[29] Baseline as at December 2013.
[30] Target to be achieved by December 2014.
[31] Result as at December 2014.
[32] This year we focussed on those patients eligible for funded flu vaccines this included pregnant women and children the response has not been what we had hoped and understand this is due to the high workload in practices meeting health targets. In some local areas there was a focus on older adults to reduce admissions, they report a good response to the flu vaccination programme.
[33] Ongoing work in being undertaken with PHOs and Practices to improve Maaori breastscreening rates.
[34] The performance measure description in 2014/15 Annual Plan was inaccurate and has been amended in this document amended to reflect correct definition. While the National Cervical Screening Programme recommends screening for women aged between 20-70 years, coverage data provided by the National Screening Unit is reported for women aged 25-69 years.
[35] Work is being undertaken with the PHOs, Auckland Regional Cervical Screening Service and other key stakeholders to improve screening coverage. A number of local initiatives are being implemented and a Cervical Screening High Needs Coordinator has been employed by the DHB.
[36] Vision and hearing – 2 components.
[37] The target in the 2014/15 Annual Plan was a preliminary target. The target included in this document is the final target provided by the MOH in May 2014 after the Annual Plan was approved.
[38] Nurse – 8 components.
[39] There are a number of factors that impact on this target not being achieved: infants born and leaving hospital the same day, or born and leaving hospital outside the hours screening is available, infants born and discharged from ALBU, and the requirement for the infant to be asleep and the room silent to carry out the screen.

	2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Proportion of newborns born at CM Health maternity facilities screened by 12 weeks	97%	95%	95%	Achieved
Hospitalisation rates for acute rheumatic fever per 100,000	12.7 per 100,000	8.2 per 100,000[40]	8 per 100,000	Achieved
Statutory and Regulatory Services				
Enforcement of alcohol legislation: Number of licensed premises (on, off club and special) risk assessed	N/A[41]	4,000 est.	4,354	Achieved
Enforcement of the Smokefree Environments Act 1990: Number of retailer compliance checks conducted	457	300	284	Not Achieved[42]
Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted	498[43]	300	284	Not Achieved[44]

Early Detection and Management Services

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

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

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

		2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Primary Health Care Services					
Eligible people receiving CVD risk assessment in the last 5 years	Maaori	87%	90%	88%	Not Achieved[45]
	Pacific	90%		92%	Achieved
	Total	91%		92%	Achieved
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)	Maaori	59%	66%	60%	Not Achieved[46]
	Pacific	55%		57%	Not Achieved
	Asian	73%		75%	Achieved
	Other	73%		73%	Achieved
	Total	64%		65%	Not Achieved[46]
Number of additional patients enrolled in self-management (SM) programmes		1134	700	1,230	Achieved

[40] The MOH updated the target to 8.2 per 100,000 based on the updated denominators following the Census.
[41] Due to legislative changes (implementation of the Sale and Supply of Alcohol Act 2012), accurate baseline data is not available.
[42] The result achieved was just short of target due to a position being vacant.
[43] Baseline is for 2012/13.
[44] Controlled purchase operations (CPOs) are demand driven as requested by the Police (leading Agency).
[45] Refer to p.16 for a summary of work being undertaken to improve CVD risk assessment rates for Maaori.
[46] Refer to p.15 for further information on CM Health's approach to improving Improved Control of Long Term Conditions.

		2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Percentage of all At Risk Individuals (ARI)[47] who have a: ▪ Care Plan ▪ Electronic Summary Record ▪ Self-Management Assessment ▪ Named Care Coordinator		-	80%	80%	Achieved
Oral Health Services					
Proportion of children under 5 years enrolled in DHB-funded oral health services		76%[48]	85%[30]	70%[49]	Not Achieved[50]
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)		8.1%[48]	≤7%[30]	8.5%[49]	Not Achieved[51]
Proportion of Year 8 children who have their treatment completed and are transferred to the adolescent dental service		100%[48]	100%[30]	100%[49]	Achieved
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		77%[48]	85%[30]	74%[49]	Not Achieved[52]
Diagnostics					
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	75.5%	90%	69.7%	Not Achieved[53]
	MRI	73.6%	80%	52.6%[54]	Not Achieved[55]
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		63.6%	75%	80.9%	Achieved
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		31.2%	60%	31.5%	Not Achieved
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		76.8%	60%	82.2%	Achieved

[47] The ARI Programme allows for those with Chronic Conditions and complex health needs to actively manage their health in primary care in the community. This in turn leads to decreased acute admissions and avoidable mortality; this is a new measure so no baseline data available.
[48] Result as at December 2013.
[49] Result as at December 2014.
[50] Target missed due to prior focus on children enrolled from 9 months and focussed to high needs children examined in dental clinics from 2 years. In addition lack of capacity in Auckland Regional Dental Services (ARDS) constrained focus on enrolling preschool children aged 0-2 years. A new target to enrol infants earlier by Well Child Tamariki Ora (WCTO) providers and to be examined in dental clinic by 12 months of age has been implemented to support achievement of this target.
[51] Target missed due to a large number of vacancies not filled in South team of Auckland Regional Dental Services (ARDS) which constrained capacity for appointments.
[52] Prior growth in Adolescent utilisation is from providing mobile dental services on-site at secondary schools where prior utilisation has been as low as 50% due to students unlikely to visit a dentist independently. The last secondary schools still to allow on-site dental services and achieve target are Howick College and the private schools. Achievement is consistent with national results.
[53] An additional acute CT scanner is providing additional capacity required to meet this indicator.
[54] Modelling of demand and capacity resulted in more FTE recruited, additional lists undertaken, as well as outsourcing to local private providers.
[55] MRI scanners running 12 hours per day with outsourcing to local private radiology providers.

Intensive Treatment and Assessment Services

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

They include:

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

			2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Mental Health						
Proportion of child and youth clients discharged with a transition (discharge) plan[56]			-[57]	95%	75%	Not Achieved[58]
Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years	Mental Health (Provider Arm)	3 weeks	69.7%	80%	77.2%	Not Achieved[59]
		8 weeks	94.6%	95%	93.6%	Not Achieved[59]
	Addictions (NGO)	3 weeks	81.3%	80%	81.6%	Achieved
		8 weeks	92.1%	95%	85 %	Not Achieved[60]
Elective Services						
ESPI 2: Proportion of patients who wait longer than four months for their first specialist assessment (FSA)			0%	0%[30]	0%	Achieved
ESPI 5: Proportion of patients given a commitment to treatment but not treated within four months			0.1%	0%[30]	0.1%	Not Achieved
Number Elective Surgical Discharges			112% 17,457	100% 16,200	108% 17,533	Achieved
Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population		Major joints	22.7[61]	21	23[62]	Achieved
		Cardiac Surgery	5.6[61]	6.5	6.69[62]	Achieved
		Cataracts	42[61]	27	38.2[62]	Achieved
Outpatient Did Not Attend (DNA) rates		Maaori	12%	<10%	11%	Not Achieved
		Pacific	10%	<10%	8%	Achieved

[56] The performance measure description in 2014/15 Annual Plan was inaccurate and has been amended in this document amended to reflect correct definition.
[57] New measure, baseline data not available.
[58] Whirinaki has been engaged in the development, piloting and implementation of the national transition planning (discharged) guidelines, and are confident that target will be achieved by the end of 2015.
[59] Acuity at point of entry delaying routine appointments – an acute response team implemented; youth teams aligned to localities.
[60] As a result of data issues at a Provider level this target was not achieved. These data issues have since been resolved.
[61] Baseline as at March 2014.
[62] Result as at March 2015.

			2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Acute Services[63]						
Acute readmissions to hospital[64]		Total	7.7%[61]	≤7.4% standardised	7.6%[62]	Not Achieved
		75+	11.52%[61]	≤10.1% standardised	10.1%[62]	Achieved
Acute Inpatient Average Length of Stay[65]			3.88 days[61]	3.88 days	3.84%[62]	Achieved
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours (National Health Target)			96%	95%	97%	Achieved
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment (and are ready to start treatment) who receive treatment within four weeks from decision to treat (National Health Target)	Chemo-therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	
	Radio-therapy	Maaori	100%	100%	100%	Achieved
		Pacific	100%		100%	
		Total	100%		100%	
Proportion of patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks			-[66]	85% by July 2016	63%[67]	Not Achieved[67]
Proportion of patients referred urgently with high suspicion of Lung cancer to first cancer treatment (62 days)			71.3%	85%	75%[68]	Not Achieved[69]
Cardiac Services						
Proportion of all outpatients triaged to chest pain clinics who are seen within 6 weeks for cardiology assessment and stress test			99.5%	80%	99%	Achieved
Proportion of outpatient coronary angiograms with a waiting time of <3 months			100%[70]	90%	99.5%	Achieved
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission			78%	70%	80%	Achieved

[63] Cancer treatment services for patients in Counties Manukau are provided through the Auckland DHB Regional Cancer and Blood Centre and CM Health Haematology.
[64] Unplanned acute readmissions to hospital can occur as a result of the care provided by the health system, related to inadequate length of stay, and puts pressure on hospital resources. Reducing unplanned hospital readmissions can be interpreted as an indication of improving quality of acute care in the hospital and/or the community.
[65] Inadequate length of stay can lead to increased readmission. Optimal inpatient LOS ensures patients receive sufficient care to avoid readmission.
[66] New measure, no baseline.
[67] Result of 63% reflects our achievement towards the 85% target by 1 July 2016. The MOH have given an achieved rating for the quarter 4 result.
[68] The lung cancer work is part of the wider organisation FCT improvement work, and a new lung cancer pathway is to be implemented from August 2015 designed to increase the performance level.
[69] Lung cancer work is part of the wider organisation FCT improvement work, a new Lung Cancer Pathway is to be implemented from August 2015 designed to increase performance level.
[70] Result directly from MOH (this differs from the 97.7 percent reported in the Annual Report 30 June 2014).

	2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins	89%	80%	81%	Achieved
Quality and Patient Safety				
Average rate of Central Line Associated Bacteraemia (CLAB) in the Intensive Care Unit per 1,000 line days[71]	0.7	0	0.8	Not Achieved[72]
Rate of falls causing major harm per 1000 bed days	0.08/1,000 bed days	0.07/1,000 bed days	0.10/1,000 bed days	Not Achieved[73]
Proportion of pressure injuries hospital wide per 100 patients	3.3%	<3.5%[74]	2.8%	Achieved
Hand hygiene compliance (based on Gold Audit)	74%	80%	78%	Not Achieved[75]

Rehabilitation and Support Services

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

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

	2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Needs Assessment and Service Coordination (NASC)				
Proportion of CM Health NASC staff who have participated in interRAI training and can deliver appropriate assessments in the community and allocate support using CM Health contracted HBSS[76]	100%	100%	100%	Achieved
Assessment, Treatment and Rehabilitation Services				
Community Services: Provision of AT & R services for the Franklin locality through Pukekohe hospital	88%	100%	80%	Not Achieved[77]
Hospital Services: Average length of stay in AT & R (Pukekohe hospital beds)	16.75 days	<15 days	15.6 days	Not Achieved[77]
Average length of stay for patients included in the acute geriatric pilot at Middlemore Hospital	8.3 days	7 days	7.6 days	Not Achieved[78]

[71] The CLAB programme, which developed a standard process ("bundles") for the insertion and maintenance of central lines to prevent the occurrence of CLAB, was successfully implemented in ICU and the insertion bundle in now used in all areas. As a result of this programme, there are now inpatient areas that have had over 400 days without a CLAB; one area has been CLAB free for over 1,000 days.
[72] This result reflects a single CLAB staph aureus in June as was the only one for this colander in the year.
[73] We are possibly not seeing a great shift in these rates due to the increasing complexity of our ageing patient population and the increase in demand on our resources. Initiatives planned for next year to impact on these rates are mostly around patient education.
[74] Monthly average of less than 3.5 percent prevalence of inpatients developing pressure injuries at CM Health.
[75] A 1% improvement represents changing >600 behaviours per day every day at CM Health, a 4% increase from last year is significant.
[76] This measures the percentage of staff that are competent to administer the Home Care or Contact Assessment InterRAI tool to older people and determine their Home and Community Support Service's needs.
[77] Occupancy of 10 AT&R beds at Pukekohe Hospital – based on the 10 beds, one patient is taking longer to rehabilitate which is impacting on LOS percentage.
[78] The ACE model has met and exceeded three of the four target areas for the project with the acute length of stay at an average of 7.6 days still being slightly higher than the target time of 7 days. The model has been shown to reduce length of stay by over a week for patients requiring an acute and rehabilitation stay. There is no more ongoing work as part of the ACE project as it is now complete and will become business as usual in the 2015-2016 financial year.

	2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Age Related Residential Care (ARRC)				
Proportion of residential facilities in the CMDHB area using or training their nurses to use the interRAI Long Term Care Facility assessment tool[79]	86%	100%	100%	Achieved
Number of potentially avoidable EC presentations from ARRC per month[80]	15	≤ 20 per month	18 per month[81]	Achieved
Home Based Support				
Proportion of CM Health NASC clients receiving Home Base Support Services who have a comprehensive interRAI assessment completed in the last 12 months	69.7%	95%	82.7%[82]	Not Achieved[83]

Maaori Health Plan Indicators

As part of the Annual Planning cycle, DHBs are required to develop a Maaori Health Plan. The Maaori Health Plan provides a comprehensive collection of evidenced based activities with performance indicators designed to reduce health inequities, accelerate Maaori health gain and progress the principles of the Treaty of Waitangi. The plan has a number of prescribed national indicators that link to the leading causes of mortality and morbidity for Maaori. DHBs also have the flexibility to develop their own local indicator set which reflects the specific needs of the Maaori population in the district. This section gives an overview of our performance against the indicators in the 2014/15 Maaori Health Plan.

			2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
National Indicators						
Ethnicity Data						
Percentage of PHO enrollees with ethnicity 'not stated'		Total	0.2%	<0.2%	0.2%	Not Achieved[84]
Access to Care						
Percentage of Maaori enrolled in a PHO[85]		Maaori	90%	98%	90%	Not Achieved[86]
		Total	97%		97%	Not Achieved[86]
Ambulatory Sensitive Hospitalisation (ASH) rates	Age 0-74 years	Maaori	199	≤ 191	190	Achieved
		Total	120	≤ 114	119	Not Achieved
	Age 0-4 years	Maaori	119	≤ 118	113	Achieved
		Total	103	≤ 101	102	Not Achieved
	Age 45-64 years	Maaori	272	≤ 266	265	Achieved
		Total	143	≤ 124	141	Not Achieved

[79] This measures the percentage of residential facilities in CM Health using or training to use the interRAI Long Term Care Facility InterRAI tool as their primary clinical assessment tool in Age Related Residential Care (ARRC). The DHB is required to support the use of this tool in ARRC per national contract from 01 July 2015.

[80] Fewer EC presentations from Aged Residential Care should result from effective services put in place to support Aged Related Residential Care (ARRC) like specialist input into ARRC, enhanced access to assessment and intervention within ARRC, including diagnostics and point of care testing, and consistent access to in and after hours acute assessment and treatment.

[81] Throughout the 2015-16 year, this data will be utilised to identify reasons for admissions. This analysis will enable the Community Geriatric Services team to develop a support plan for identified Aged Residential Care Facilities.

[82] Result as at March 2015.

[83] In mid-2014 it was identified that regional reporting of this measure through NRA would provide consistency in reporting within the Northern Region and this new regional reporting was implemented in Q1 2014/15.

[84] In partnership with the PHOs, in 2015/16 CM Health will implement the Primary Care Ethnicity Data Audit Tool (EDAT) to enable assessment and improvement of ethnicity data collection in primary health care settings.

[85] Enrolled in any PHO in NZ.

[86] CM Health is continuing to work with primary care and community stakeholders to raise awareness about the benefits of enrolment with Primary Health Organisations, with a focus on increasing newborn enrolment rates.

			2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Child Health						
Percentage of infants exclusively or fully breastfed	Age 6 weeks	Maaori	54%	68%	52%	Not Achieved[87]
		Total	57%		57%	Not Achieved[87]
	Age 3 months	Maaori	39%	54%	38%	Not Achieved[87]
		Total	47%		46%	Not Achieved[87]
Percentage of infants being fed breast milk	Age 6 months	Maaori	47%	59%	46%	Not Achieved[87]
		Total	59%		61%	Achieved
Cardiovascular						
Percentage of eligible population who have had their cardiovascular risk assessed in the last 5 years		Maaori	87%	90%	88%	Not Achieved[45]
		Total	91%		92%	Achieved
Percentage of patients presenting with an acute coronary syndrome (ACS) who were referred for angiography and received it within 3 days of admission (day of admission being day 0)		Maaori	83%	70%	90%	Achieved
		Total	78%		80%	Achieved
Percentage of patients presenting with acute coronary syndrome (ACS) who undergo coronary angiography have completion of ANZACS QI[88] ACS and Cath/PCI registry data collection within 30 days		Maaori	97%	95%	96%	Achieved
		Total	96%		96%	Achieved
Cancer						
Percentage of eligible women who received a three yearly cervical screen		Maaori	59%	80%	62%	Not Achieved[35]
		Total	70%		72%	Not Achieved[35]
Percentage of eligible women who received a breast screen 50-69 within past 24 months		Maaori	67%	70%	66%	Not Achieved[33]
		Total	69%		70%	Achieved
Smoking						
Percentage of hospitalised patients who smoke and were seen by a health practitioner in public hospitals and were offered brief advice and support to quit smoking		Maaori	96%	95%	95%	Achieved
		Total	96%		95%	Achieved
Percentage of enrolled patients who smoke and were seen by a health practitioner in general practice and were offered brief advice and support to quit smoking		Maaori	61%[89]	90%	78%[89]	Not Achieved[90]
		Total	99%		96%	Achieved
Immunisation						
Percentage of eight months olds who have had their primary course of immunisation on time		Maaori	84%	95%	91%	Not Achieved[28]
		Total	92%		95%	Achieved

[87] CM Health undertook a needs assessment in 2014 to further understand the barriers and enablers to breastfeeding in Counties Manukau. In response to the findings a programme of work is being undertaking to improve breastfeeding rates, this includes workforce development, community breastfeeding support services and supporting implementation of Baby Friendly Community Initiative (BFCI).

[88] All New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS QI).

[89] The Ministry of Health does not provide the official primary care smoking cessation data at an ethnicity breakdown – this is an unadjusted figure.

[90] Refer to p.18 for a summary of the work being undertaken to improve performance against the primary care smokefree target.

		2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Percentage of seasonal influenza immunisation in eligible population >65 years	Maaori	67%[91]	75%	66%[92]	Not Achieved[32]
	Total	69%[91]		67%[92]	Not Achieved[32]
Rheumatic Fever					
Acute rheumatic fever first hospitalisation rate per 100,000 population	Maaori	14.2 per 100,000	16.1 per 100,000	11.1 per 100,000	Achieved
	Total	12.7 per 100,000	8.2 per 100,000[13]	8 per 100,000	Achieved
Oral Health					
Percentage of preschool children 0-4 years enrolled in DHB funded oral health service	Maaori	65%	85%	61%	Not Achieved[50]
	Total	76%		70%	Not Achieved[50]
Mental Health					
Mental health Act: section 29 community treatment order indefinites rate per 100,000	Maaori	299	-[93]	204	-
	Total	-		81	
SUDI					
Sudden Unexpected Death in Infancy (SUDI) rate per 1,000 live births	Maaori	1.83[94]	0.5	2.48[95]	Not Achieved[96]
	Total	-		1.00[95]	Not Achieved[96]
Local Indicators					
Workforce Development					
Percentage of CM Health employees who are Maaori	Whole organisation	5.4%	7%	6%	Not Achieved[97]
	Hospital directorate	-[98]		7.2	Achieved
Youth Mental Health					
Access to Primary Mental Health Coordinator Services – Number of Brief Interventions for 12-19 years olds	Maaori	[98]	Same level as non-Maaori/non Pacific	45 per 100,000	Not Achieved
	Total	[98]		49 per 100,000	-
Access to extended consultations 18-19 year olds	Maaori	[98]	Same level as non-Maaori/non Pacific	225 per 100,000	Not Achieved[99]
	Total	[98]		334 per 100,000	-

[91] Baseline result at December 2013.
[92] Result at December 2014.
[93] The MOH did not set a target for this measure.
[94] As at 30 June 2012. 2012 mortality data was the most recent data available due to the delay in receiving coded mortality data.
[95] 2010 mortality data was the most recent data available due to the delay in receiving coded mortality data
[96] A programme of work is being undertaken in Counties Manukau to reduce SUDI risk factors. This includes early engagement in maternity services, smoking cessation in pregnancy, safe sleeping environment for baby, increasing breastfeeding rates and duration, earlier engagement with Well-child/Tamariki Ora providers, and earlier enrolment of babies in all key health support services. A significant part of the uptake and implementation of the SUDI / Safe Sleep messaging is through the Safe Sleep / SUDI Coordinator. This role is dedicated to facilitating and progressing the SUDI Action Plan across Counties Manukau Health and maintaining strong relationships regionally, and with Whakawhetu and TAHA.
[97] A number of initiatives are underway to increase the CM Health Maaori workforce, these include developing our future workforce, increasing Maaori nursing workforce, having accurate workforce data and retaining our current Maaori workforce.
[98] New measure, baseline data not available.
[99] PHOs have been promoting the CCM Depression programme and providing additional GP and Practice Nurse training sessions in order to encourage a larger number of clinicians to access and utilise the programme. Several updated resources were released including a patient engagement flowchart.

		2013/14 Baseline[20]	2014/15 Target[21]	2014/15 Result[22]	Achievement
Access to cognitive behavioural therapy (CBT) for 18-19 year olds	Maaori	98	Same level as non-Maaori/non Pacific	244 per 100,000	Not Achieved[100]
	Total	98		486 per 100,000	-

Performance by Output Classes (Includes agency costs)

Output Classes $000	Prevention	Early Detection	Intensive	Rehabilitation	Total
Revenue *(includes agency revenue)*	**19,148**	**213,552**	**1,157,644**	**113,700**	**1,504,044**
Budget (includes agency revenue)	16,621	211,828	1,145,250	118,665	1,492,364
Personnel costs	5,293	-	543,682	-	548,975
Outsourced Services	2,889	-	66,425	-	69,314
Clinical Supplies	3,353	-	115,877	-	119,230
Infrastructure & Non-Clinical Supplies	308	-	116,478	-	116,786
Other*(includes agency costs)*	7,305	213,552	312,165	113,700	646,722
Total costs	**19,148**	**213,552**	**1,154,627**	**113,700**	**1,501,027**
Budget(includes agency costs)	16,621	211,828	1,142243	118,665	1,489,357
Surplus (Deficit)	-	-	**3,017**	**-**	**3,017**
Budget	-	-	3,007	-	3,007

Agency revenue and costs for the year amounts to $18,078k.

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

[100] The CBT criteria have recently been reviewed and updated in order to improve access. This change better reflects current guidelines and research that moderate depression is managed by medication or CBT.

Good Employer

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

Principle

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

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

Good Employer principles in practice

Provisions which reflect the General Principles include:

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

Standards

CMDHB shall ensure that employees maintain proper standards of integrity and conduct, in keeping with the "Vision and Values" of CMDHB. Unacceptable behaviour will not be tolerated; this is supported by the organisations human resources policies, procedures and guidelines.

Complaints and appeals

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

Equal Employment Opportunities (EEO)

Principles

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

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

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

Policy

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

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

CMDHB is a member of the Equal Employment Opportunity (EEO) trust. This assists the organisation to champion our EEO goals which are aligned with the seven key "Good Employer" elements of:

- Leadership, accountability and culture
- Recruitment, selection and induction
- Employee development, promotion and exit
- Flexibility and work design
- Remuneration, recognition and conditions
- Harassment and bullying prevention
- Safe and Healthy Environment

Over the next year EEO initiatives will continue to engage and consult with our employees regarding the development of EEO initiatives as we grow and celebrate our diverse workforce.

Discrimination

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

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

Benefits

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

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

EEO will assist CMDHB to:

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

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

Policies, Procedures and Guidelines

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

These policies, procedures and guidelines are reviewed and updated on a scheduled and as required basis to reflect changing needs of legislation, demographics and workforce trends. This process includes consulting and engaging with key stakeholders, including employees, as appropriate.

CMDHB Workforce

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

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

	Females		Males	
Employee Group	Number	Average salary	Number	Average salary
Administration & Management	978	$60,753	145	$78,192
Allied Health & Technical	1,086	$63,062	253	$62,153
Medical				
Specialist Medical Officer	193	$223,207	295	$246,843
Registrars	147	$100,919	124	$104,793
Medical Officer of Specialist Scale	8	$174,551	13	$156,936
House Officers	65	$91,604	64	$89,189
Non-Clinical Support	432	$39,193	279	$43,147
Nursing/Midwifery/HCA				
Mental Health Nursing	219	$65,697	83	$59,907
Midwifery	181	$61,966	0	$0
General Nursing	2,538	$62,667	287	$58,958

Number of ethnic groups employed?

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

Ethnicity	FTE	FTE Percentage	Headcount	Headcount Percentage
Asian	1,606	29%	2,009	27%
Maaori	308	6%	415	6%
NZ European + Other	2,787	49%	3,712	50%
Pasifika	592	11%	823	11%
Not Disclosed	257	5%	431	6%
Grand Total	5,550	100%	7,390	100%

Financial Statements

Statement of Responsibility

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

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

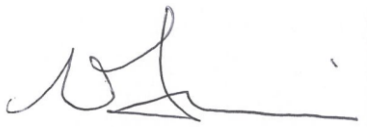
The Board of the Counties Manukau District Health Board has the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Counties Manukau District Health Board for the year ended 30 June 2015.

Signed on behalf of the Board:

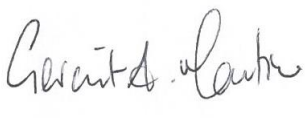
Dr Lee Mathias

Chairman



Wendy Lai

Chair, Finance & Audit Committee



Geraint Martin

Chief Executive Officer

Ron Pearson

Deputy CEO/Director Corporate & Business Services

2 November 2015

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2015

	Notes	Parent and Group		
		Actual 2015 $000	Budget 2015 $000	Actual 2014 $000
Revenue				
Patient Care Revenue	2	1,458,702	1,455,667	1,417,479
Interest Revenue		3,042	1,200	2,239
Gain on Sale of Land		-	3,007	-
Other Revenue	3	24,222	32,490	20,304
Total Revenue		**1,485,966**	**1,492,364**	**1,440,022**
Expenditure				
Personnel costs	4	548,674	547,728	526,817
Depreciation and amortisation expense	13/14	28,435	34,156	29,923
Outsourced services		68,931	56,217	65,082
Clinical supplies		110,901	97,040	101,198
Infrastructure and non-clinical expenses		55,518	55,446	53,714
Other District Health boards		209,294	278,040	199,829
Non-health board provider expenses		420,032	380,206	422,024
Capital Charge	5	15,273	13,140	15,257
Interest expense		12,506	15,360	8,822
Other expenses	6	13,385	12,024	14,302
Total expenditure		**1,482,949**	**1,489,357**	**1,436,968**
Surplus		**3,017**	**3,007**	**3,054**
Other comprehensive revenue and expense				
Revaluation of Land	13	34,662	-	47,590
Revaluation of Buildings	13	2,195	-	(40,659)
Total Other comprehensive revenue and expense		**36,857**	**-**	**6,931**
Total comprehensive revenue and expense		**39,874**	**3,007**	**9,985**

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

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

For the year ended 30 June 2015

	Notes	Parent and Group		
		Actual 2015 $000	Budget 2015 $000	Actual 2014 $000
Balance 1 July		**198,173**	**191,216**	**188,598**
Comprehensive revenue and expense		-	-	-
Surplus for the year		3,017	3,007	3,054
Other comprehensive revenue and expense		36,857	-	6,931
Total comprehensive revenue and expense		**39,874**	**3,007**	**9,985**
Capital contributions from the Crown		-	-	-
Repayment of capital to the Crown		(420)	(419)	(420)
Interest on restricted funds		18	-	10
Balance at 30 June		**237,644**	**193,804**	**198,173**

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

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2015

	Notes	Parent and Group		
		Actual 2015 $000	Budget 2015 $000	Actual 2014 $000
Assets				
Current Assets				
Cash and cash equivalents	7	56,138	23,216	21,580
Debtors and other receivables	8	45,075	42,000	32,887
Inventories	10	1,320	4,490	1,434
Prepayments		945	500	1,196
Non-Current Assets held for Sale	11	12,503	-	12,503
Total current assets		**115,981**	**70,206**	**69,600**
Non-current assets				
Investments in Associates and Jointly Controlled Entities	12	23,611	29,750	21,618
Property, plant and equipment	13	629,079	589,267	594,681
Intangible assets	14	10,580	884	9,803
Other Non-Current Assets	9	1,449	1,449	1,360
Total non-current assets		**664,719**	**621,350**	**627,462**
Total assets		**780,700**	**691,556**	**697,062**
Liabilities				
Current liabilities				
Creditors and other payables	15	109,686	65,779	105,390
Borrowings	16	-	-	40,000
Employee entitlements	17	122,645	116,753	110,432
Total current liabilities		**232,331**	**182,532**	**255,822**
Non-current liabilities				
Borrowings	16	292,500	297,600	227,600
Employee entitlements	17	16,888	16,200	14,130
Provisions	18	1,337	1,420	1,337
Total non-current liabilities		**310,725**	**315,220**	**243,067**
Total liabilities		**543,056**	**497,752**	**498,889**
Net assets		**237,644**	**193,804**	**198,173**
Equity				
Crown equity	19	108,126	124,079	108,545
Accumulated deficits	19	(45,093)	(58,578)	(48,110)
Revaluation reserves	19	173,729	127,443	136,874
Trust funds	19	882	860	864
Total Equity		**237,644**	**193,804**	**198,173**

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

The accompanying notes form part of these financial statements.

Statement of Cash Flow

For the year ended 30 June 2015

	Notes	Parent and Group		
		Actual 2015 $000	Budget 2015 $000	Actual 2014 $000
Cash flows from operating activities				
Receipts from patient care:				
MOH		1,341,443	1,451,863	1,319,466
Other		129,612	29,315	141,971
Interest received		3,043	1,200	2,239
Payments to suppliers		(871,048)	(876,793)	(871,343)
Payments to employees		(533,592)	(535,520)	(522,541)
Capital charge		(15,273)	(12,188)	(14,680)
Interest payments		(12,506)	(15,364)	(8,521)
Goods and services tax (net)		(2,784)	-	1,279
Net cash flow from operating activities	20	**38,895**	**42,513**	**47,870**
Cash flows from investing activities				
Purchase of property, plant, equipment and intangible assets		(26,572)	(10,156)	(43,687)
Acquisition/roll over of investments		(2,263)	(5,265)	(5,872)
Net cash flow from investing activities		**(28,835)**	**(15,421)**	**(49,559)**
Cash flows from financing activities				
Capital contributions from the Crown		-	-	-
Repayment of capital to the Crown		(419)	(419)	(419)
Repayment of loans		(40,000)	-	(5,000)
Proceeds from borrowings		64,900	-	35,000
Repayment of Finance Leases		-	-	-
Net Appropriation from Trust Funds		18	-	10
Net cash flow from financing activities		**24,499**	**(419)**	**29,591**
Net increase in cash and cash equivalents		**34,558**	**26,674**	**27,902**
Cash and cash equivalents at the start of the year		21,580	(3,458)	(6,322)
Cash and cash equivalents at the end of the year		**56,138**	**(23,216)**	**21,580**

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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

Statement of Accounting Policies

Reporting Entity

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

The consolidated financial statements of CMDHB as at and for the year ended 30 June 2015 comprise CMDHB and its subsidiaries (together referred to as the "Group" and individually as "Group entities") and the Group's interest in associates and jointly controlled entities.

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

The financial statements for CMDHB are for the year ended 30 June 2015, and were approved by the Board on 2 November 2015.

Basis of Preparation

Statement of compliance

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

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

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. The material adjustments arising on transition to the new PBE accounting standards are explained in Note 31.

Measurement base

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

Functional and presentation currency

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

Standards issued and not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on and after 1 Jul 2014. The DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting statements was updated to incorporate requirements and guidance for the not-for-profit sector. These updated statements apply to PBEs with reporting periods beginning on or after 1 April 2015. The DHB will apply these updated standards in preparing its 30 June 2016 financial statements. The DHB expects there will be minimal or no change in applying these updated accounting standards

Significant Accounting Policies

Subsidiaries

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

Investments in Associates and Jointly Ventures

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

Revenue

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

MOH Revenue

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

ACC Contract Revenues

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

Rental revenue

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

Revenue relating to service contracts

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

Revenue from other DHBs

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Donations and bequests

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

Capital charge

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

Interest expense

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

Leases

Finance leases

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

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

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

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

Operating leases

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

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

Cash and cash equivalents

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

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

Debtors and other receivables

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

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

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

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

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

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

Inventories

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

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

Non-Current assets held for sale

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

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

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

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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

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

Intangible assets

Software acquisition and development

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

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

Staff training costs are recognised as an expense when incurred.

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

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

FPSC Rights

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

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

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

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

Amortisation

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

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

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

Impairment of Property, Plant & Equipment and Intangible Assets

CMDHB does not hold any cash generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.

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

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

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

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

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

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

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

Creditors and other payables

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

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term entitlements

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

• likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and

• the present value of the estimated future cash flows.

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

Employer contributions to Kiwi Saver, the Government Superannuation Fund, and the State Sector Retirement

Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Provisions

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

Provisions are not recognised for future operating losses.

Restructuring

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

ACC Partnership Programme

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

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

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

Revaluation reserves

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost Allocation

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

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

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

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

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

Critical accounting estimates and assumptions

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

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

Land and buildings revaluations

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

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

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

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

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

• Physical inspection of assets;

• Asset replacement programs;

• Review of second-hand market prices for similar assets; and

• Analysis of prior asset sales.

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

Retirement and long service leave

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

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

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

Agency relationship

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

For a number of contracts CMDHB makes payments to the service providers on behalf of the DHBs receiving services and these DHBs will then reimburse CMDHB for the costs of the services provided in their districts. Where Counties Manukau has assessed that it has acted as an agent for the other DHBs, payments and receipts in relation to the other DHBs are not recognised in the Counties Manukau's financial statements.

2. Patient care revenue

	Actual 2015 $000	Actual 2014 $000
Health and disability services (MoH contracted revenue)	1,343,252	1,300,756
ACC contract revenue	18,362	17,579
Revenue from other district health boards	80,036	80,220
Other patient care related revenue	17,052	18,924
Total patient care revenue	**1,458,702**	**1,417,479**

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 from other District Health Boards for agency contracts has been offset against the cost of those contracts. $18.1m (2014 $20.9m).

3. Other revenue

	Actual 2015 $000	Actual 2014 $000
Donations and bequests received	1,592	1,968
Other revenue	20,972	16,691
Rental revenue	1,628	1,602
Gain on Disposal of Assets	30	43
Total other revenue	**24,222**	**20,304**

4. Personnel costs

	Actual 2015 $000	Actual 2014 $000
Salaries and wages	517,566	507,483
Contributions to defined contribution schemes	15,937	14,798
Increase in liability for employee entitlements	14,971	4,276
Restructuring provision for employee exit costs	200	260
Total personnel costs	**548,674**	**526,817**

5. Capital Charge

The DHB pays a quarterly capital charge to the Crown. The charge is based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2015 was 8% (2014: 8%).

6. Other expenses

Other expenses include:	Actual 2015 $000	Actual 2014 $000
Audit fees – audit of financial statements	197	189
Operating leases expense	7,180	6,838
Impairment of debtors	5,603	6,913
Board and committee members fees and expenses	405	362
Total Other Expenses	**13,385**	**14,302**

7. Cash and cash equivalents

	Notes	Actual 2015 $000	Actual 2014 $000
Cash at bank and on hand		47	10
Health Benefits Ltd		55,209	20,705
Trust / Special purpose Funds	19	882	865
Cash and cash equivalents for the purposes of the statement of cash flows		**56,138**	**21,580**

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

CMDHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and all District Health Boards dated 12 November 2012. This Agreement enables HBL to "sweep' DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement allows individual DHBs to borrow funds from HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of month's Provider Arm funding plus GST. For CMDHB, that equates to $69.9m (2014: $69.9m).

8. Debtors and other receivables

	Actual 2015 $000	Actual 2014 $000
Ministry of Health receivables	5,289	4,671
Other receivables	15,837	9,768
Other accrued revenue	28,486	21,838
Less: provision for impairment	(4,537)	(3,390)
Total Debtors and other receivables	**45,075**	**32,887**

Fair value

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

Impairment

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

	2015			2014		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	35,270		35,270	28,573		28,573
Past due 1-30 days	6,489		6,489	2,120		2,120
Past due 31-60 days	2,196	(722)	1,474	1,245	(605)	640
Past due 61-90 days	1,311	(726)	585	1,650	(663)	987
Past due > 90 days	4,346	(3,089)	1,257	2,689	(2,122)	567
Total	**49,612**	**(4,537)**	**45,075**	**36,277**	**3,390**	**32,887**

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

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

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

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

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

	Actual 2015 $000	Actual 2014 $000
Balance at 1 July	3,390	2,384
Charged to 'Other Expenses' (additional provisions made)	5,603	6,969
Receivables written off	(4,456)	(5,963)
Balance at 30 June	**4,537**	**3,390**

9. Other Non-Current Assets

	Actual 2015 $000	Actual 2014 $000
Reversionary interest in car park building	1,449	1,360
Total Other Non-Current Assets	**1,449**	**1,360**

CMDHB has entitlement to a car parking building currently not owned or operated by CMDHB, but which will revert to them in 14 years' time. This is a notional value at this point in time, based on the discounted NPV of the expected value of the car-park at the date of acquisition. A discount rate of 6.5% was used.

10. Inventories

	Actual 2015 $000	Actual 2014 $000
Pharmaceuticals	619	708
Other Supplies net of provision for obsolete stock	701	726
Total inventories	**1,320**	**1,434**

Some inventories are subject to retention of title clauses.

The amount of inventories recognised as an expense during the year was $18.2m (2014 $19.3m) which is included in the Clinical supplies line item in the Statement of Comprehensive Revenue and Expense.

11. Non-Current Assets held for Sale

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

	Actual 2015 $000	Actual 2014 $000
Land	10,323	10,323
Buildings	2,180	2,180
Total Non-current assets held for sale	**12,503**	**12,503**

12. Investments in Associates and Jointly Controlled Entities

General information

Name of entity	Principal activities	Status	Interest held at 30 June 2015	Balance date
Northern Regional Alliance Ltd	Provision of health support services	Associate	33.3%	30 June-15
healthAlliance NZ Ltd	Provision of shared services	JV	20.0%	30 June-15
NZ Health Innovation Hub Limited Partnership	Provision of services to grow NZ's health innovation sector	JV	25.0%	30 June-15

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

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

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

Share of profit of associate entities and Jointly Controlled Entities

	Parent and Group	
	Actual 2015 $000	Actual 2014 $000
Share of profit/(loss)	**(63)**	**482**

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

Investments in Associates and Jointly Controlled Entities

	Actual 2015 $000	Actual 2014 $000
healthAlliance NZ Ltd	**23,611**	**21,618**

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

13. Property, plant and equipment

	Land	Buildings, Plant & Infrastructure	Clinical Equipment, IT & Motor Vehicles	Other Equipment	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost or valuation						
Balance at 1 July 2013	72,753	407,829	127,667	16,305	130,236	754,790
Additions	-	-	505	-	41,511	42,016
Work In Progress capitalised	-	138,420	29,082	2,396	(169,898)	0
Revaluation of Assets	47,590	(108,545)	-	-	-	(60,955)
Disposals/transfers	-	-	(505)	(1)	-	(506)
Transferred to Assets held for Resale (see note 11)	(10,323)	(2,653)	-	-	-	(12,976)
Balance at 30 June 2014	110,020	435,051	156,749	18,700	1,849	722,369
Balance at 1 July 2014	110,020	435,051	156,749	18,698	1,851	722,369
Additions	-	-	-	-	25,897	25,897
Work In Progress capitalised	-	15,234	3,288	3,366	(21,888)	-
Revaluation of Assets	34,662	2,195	-	-	-	36,857
Disposals/transfers	-	-	(559)	(4)	-	(563)
Transferred to Assets held for Resale (see note 11)	-	-	-	-	-	-
Balance at 30 June 2015	144,682	452,480	159,478	22,060	5,860	784,560
Accumulated depreciation and impairment losses						
Balance at 1 July 2013		50,632	101,731	14,274	-	166,637
Depreciation expense		17,727	11,219	923	-	29,869
Elimination on disposal/transfer		(67,886)	(457)	-	-	(68,343)
Transferred to Assets held for Resale (see note 11)		(473)	-	-	-	(473)
Balance at 30 June 2014	0	0	112,493	15,195	-	127,690
Balance at 1 July 2014			112,493	15,195	-	127,690
Depreciation expense		21,465	5,668	1,192	-	28,325
Elimination on disposal/transfer		-	(533)	-	-	(533)
Elimination on revaluation		-				0
Balance at 30 June 2015	0	21,465	117,628	16,389	-	155,482
Carrying amounts						
At 1 July 2013	72,753	357,197	25,936	2,031	130,236	588,153
At 30 June and 1 July 2014	110,020	435,051	44,256	3,503	1,851	594,681
At 30 June 2015	144,682	431,015	41,850	5,672	5,860	629,079

Valuation

Land

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

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

The most recent valuation of land was performed by a registered independent valuer, Darroch, and the valuation is effective as at 30 June 2015 and amounted to $144.6m.

Buildings

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

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

The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.

The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.

The remaining useful life of assets is estimated.

Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

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

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

Restrictions on title

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

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

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

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

All titles are subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act (which restricts disposal, including leasing of the land).

Values have not been adjusted to reflect the imposition of Section 148 of The Act. Restrictions on CMDHB’s ability to sell land would normally not impair the value of the land because CMDHB has operational use of the land for the foreseeable future and will substantially receive the full benefits of outright ownership.

14. Intangible assets

Movements for each class of intangible assets are as follows:

	FPSC Rights $000	Software $000	Work in Progress $000	Total $000
Balance at 1 July 2013	3,791	4,391	-	8,182
Additions	1,718	-	-	1,718
Work in Progress Capitalised	-	-	-	-
Balance at 30 June 2014 / 1 July 2014	5,509	4,391	-	9,900
Additions	270	143	4,686	5,099
Work in Progress Capitalised	-	192	(192)	-
Disposals/Transfers	-	(4,212)	-	(4,212)
Balance at 30 June 2015	5,779	514	4,494	10,787
Accumulated amortisation and impairment losses				
Balance at 1 July 2013	-	43	-	43
Amortisation expense	-	54	-	54
Balance at 30 June 2014/1 July 2014	-	97	-	97
Amortisation expense	-	109	-	109
Balance at 30 June 2015	-	206	-	206
Carrying amounts				
At 1 July 2013	3,791	4,348	-	8,139
At 30 June and 1 July 2014	5,509	4,294	-	9,803
At 30 June 2015	**5,779**	**308**	**4,494**	**10,580**

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

At 30 June 2015, the DHB had made payments totalling $5,779k (2014:$5,509k) to HBL in relation to the Finance Procurement Supply Chain (FPSC) Programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

In 2014 the government agreed to a proposal from DHBs to move the implementation of the shared services programmes from HBL to a DHB owned vehicle. This was agreed to be completed by 30 June 2015. DHB FPSC rights in HBL are expected to transfer into the new DHB owned vehicle.

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

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

15. Creditors and other payables

	Actual 2015 $000	Actual 2014 $000
Payables under exchange transactions		
Creditors and accrued expenses	101,930	95,047
Revenue in advance	1,920	3,192
Total payables under exchange transactions	103,850	98,239
Payables under non- exchange transactions		
GST payable	5,446	6,761
Capital charge payable	390	390
Total payables under non-exchange transactions	5,836	7,151
Total creditors and other payables	**109,686**	**105,390**

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

16. Borrowings

	Actual 2015 $000	Actual 2014 $000
Current portion		
Crown loans – fixed interest	-	40,000
Total current portion	**-**	40,000
Non-current portion		
Crown loans – fixed interest	292,500	227,600
Total non-current portion	**292,500**	**227,600**
Total borrowings	**292,500**	**267,600**
Borrowing facility limits		
Crown loan facility limit	297,600	297,600
Overdraft facility	69,939	67,145
Total borrowing facility limits	**367,539**	**364,745**

Crown loans

The fair value of Crown loans is $305.4m (2014 $270.2m). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3.30% to 6.36% (2014 3.32% to 6.36%).

Overdraft facility

CMDHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue. This is used in determining working capital limits, being defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST, for CMDHB that equates to $69.9m (2014 $67.1m).

17. Employee entitlements

	Actual 2015 $000	Actual 2014 $000
Current portion		
Accrued salaries and wages	50,602	40,386
Annual leave	53,131	51,322
Sick Leave	531	277
Long Service Leave	803	1,382
Retirement Gratuities	2,061	1,873
Sabbatical leave	1,039	704
Continuing medical education	14,478	14,488
Total current portion	**122,645**	**110,432**
Non-current portion		
Long service leave	6,183	5,454
Retirement gratuities	8,443	7,262
Sick leave	2,262	1,414
Total non-current portion	**16,888**	**14,130**
Total employee entitlements	**139,533**	**124,562**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Discount rate of 2.93% - 5.50% (2014 3.70% - 5.20%) and an inflation factor of 1.5% (2014 0.6%) were used.

18. Provisions

	Actual 2015 $000	Actual 2014 $000
Non-current portion		
ACC Partnership Programme	1,337	1,337
Total provisions	**1,337**	**1,337**

Movements for each class of provision are as follows:	ACC Partnership Programme 2015 $000	ACC Partnership Programme 2014 $000
Balance at 1 July	1,337	1,337
Balance at 30 June	**1,337**	**1,337**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON Hewitt, has calculated the liability as at 30 June 2015. The actuary has attested they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 20% (2014 20%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

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

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

Key assumptions

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

- an average assumed rate of inflation of 2.1% for 30 June 2015 and 2014;
- a weighted average discount factor of 3.0% for 30 June 2015 and for 30 June 2014 (3.5%) that has been applied to future payment streams; and
- claim inception rates based on analysis of historical claim experience of the DHB. It has been assumed that 11% of claims will result in no payment, 86% will result in medical claims, and 21% will result in an element of time off work

Insurance risk

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

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

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

19. Equity

	Actual 2015 $000	Actual 2014 $000
Crown equity		
Balance at 1 July	108,545	108,964
Capital contributions from the Crown		
Repayment of capital to the Crown	(419)	(419)
Balance at 30 June	**108,126**	**108,545**
Accumulated surpluses/(deficits)		
Balance at 1 July	(48,110)	(51,164)
Surplus/(deficit) for the year	3,017	3,054
Balance at 30 June	**(45,093)**	**(48,110)**
Revaluation reserves		
Balance at 1 July	136,874	129,943
Revaluations	36,855	6,931
Balance at 30 June	**173,729**	**136,874**
Revaluation reserves consist of:		
Land	151,401	116,739
Buildings and Infrastructure	22,328	20,135
Total revaluation reserves	**173,729**	**136,874**
Trust funds		
Balance at 1 July	864	854
Transfer to/(from) accumulated surpluses	18	10
Balance at 30 June	**882**	**864**

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

Total equity	**237,644**	**198,173**

Included in accumulated surpluses/deficits are $32.467m (2014 $26.589m) of unspent Mental Health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established.

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

	Actual 2015 $000	Actual 2014 $000
Net surplus/(deficit	3,017	3,054
Interest on Restricted Funds	18	10
Add/(less) non-cash items		
Depreciation and amortisation expense	28,435	29,923
Total non-cash items	28,435	29,923
Add/(less) items classified as investing or financing activities		
Gain on disposal of assets	30	43
Total items classified as investing or financing activities	**30**	43
Add/(less) movements in statement of financial position items		
Debtors and other receivables	(12,187)	2,555
Inventories	114	(488)
Creditors and other payables	4,386	8,497
Employee entitlements	15,082	4,276
Net movements in working capital items	**7,395**	**14,840**
Net cash flow from operating activities	**38,895**	**47,870**

21. Capital Commitments and Operating Leases

Capital Commitments

	Actual 2015 $000	Actual 2014 $000
Property , plant and equipment	3,772	2,584
Total capital commitments	**3,772**	**2,584**

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

Non-cancellable operating lease commitments

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

	Actual 2015 $000	Actual 2014 $000
Not later than one year	3,473	2,778
Later than one year and not later than five years	5,832	2,604
Later than five years	1,020	-
Total Non-Cancellable Operating Leases	**10,325**	**5,382**

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

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

22. Contingencies

Contingent liabilities

Asbestos

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

Kingseat

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

Superannuation schemes

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

Contingent assets

The DHB has no contingent assets (2014 $nil).

23. Related Party Transactions

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

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

Significant transactions with government-related entities

The DHB has received funding from the Crown, ACC and other DHBs (including Agency Revenue) of $1,468m (2014 $1,438m) to provide health services in the Counties Manukau area for the year ended 30 June 2015 (note 2).

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

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

The DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2015 totalled $8.5m (2014 $7.7m). These purchases included the purchase of air travel from Air New Zealand, postal services from New Zealand Post, and blood from NZ Blood Service.

Transactions with key management personnel

Key management personnel compensation

	Actual 2015 FTE	Actual 2014 FTE	Actual 2015 $000	Actual 2014 $000
Executive management team	12	11	3,397	3,441
Board	11	11	363	313
Committee	8	14	11	14
Total key management personnel compensation	31	36	3,771	3,768

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

The actual expense for the Executive Management team includes other long-term benefits (KiwiSaver) amounting to $92k (2014 $83k).

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

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

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

The Manukau Health Trust

The MHT was formed to conduct health screening and other health activities to promote and provide for the health, wellbeing and benefit of a health nature to South Auckland Communities. The operation of the Trust ceased at 8 November 2013 and the Trust has been wound-up.

Statement of Financial Performance	Parent and Group	
	Actual 2015 $000	Actual 2014 $000
Revenue	-	363
Surplus (Deficit)	-	(113)

Middlemore Foundation for Health Innovation

The Middlemore Foundation for Health Innovation is a registered charitable trust that raises funds for a number of charitable purposes and general advancement of CMDHB. The Board has received independent professional advice that the Foundation is a separate legal entity, is not under the control of CMDHB and determines its own financial and operating policies with the power to distribute funds to parties other than the DHB. Accordingly the Board is of the view that it should not consolidate the Foundation, as to do so would overstate the financial position of the DHB and may give the misleading impression that the Foundation is in some way controlled by the DHB. While CMDHB has been the major beneficiary of the Trust, it must meet all normal Charitable Trust requirements in terms of applications for funding. The DHB has not calculated the financial effect of a consolidation. The latest published financial position of the Foundation shows that it had net assets of $5.1m (2014 $5.0m) and a surplus of $0.1m (2014 $0.2m) which may be subject to restrictions on distribution as at 30 June 2015. The financial statements of the Foundation for 2015 are not publicly available as they have not yet been approved by the Foundation's trustees.

24. Board member remuneration

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

	Actual 2015 $	Actual 2014 $
Dr. Lee Mathias[2]	61,000	24,875
Ms Wendy Lai	25,333	15,521
Mrs Sandra Alofivae	30,313	26,812
Mr Arthur Anae	27,500	25,375
Mr Reece Autagavaia[2]	31,000	12,375
Mrs Colleen Brown	31,313	26,125
Mr David Collings	32,500	26,875
Mrs Dianne Glenn[2]	31,250	12,625
Mrs Lyn Murphy	30,563	27,625
Mrs Kathryn Maxwell[2]	30,250	12,625
Mr George Ngatai[2]	31,500	13,375
Professor Gregor Coster[1]	-	27,500
Mrs Jan Dawson[1]	-	18,375
Mr Donald Barker[1]	-	14,500
Mr Paul Cressey[1]	-	14,312
Mr Robert Wichman[1]	-	13,750
Total board member remuneration	**362,522**	**312,645**

[1] Board member resigned December 2013

[2] Board member taking office December 2013

Committee Members	Award $ 2015
Ms Margaret Abercrombie	1,000
Ms Wendy Bremner	1,667
Mr Sefita Hao'uli	2,292
Ms Hine Joyce-Tahere	625
Ms Angela Lim	200
Mr Nicholas Main	1,458
Ms Tangihaere MacFarlane	833
Mr Ezekiel Robson	2,708
Total	**10,783**

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

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

No Board members received compensation or other benefits in relation to cessation (2014 $nil).

25. Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:	Actual 2015	Actual 2014
Total remuneration paid or payable:		
$100,000 – 109,999	146	170
$110,000 – 119,999	112	110
$120,000 – 129,999	65	56
$130,000 – 139,999	53	50
$140,000 – 149,999	31	27
$150,000 – 159,999	29	34
$160,000 – 169,999	16	26
$170,000 – 179,999	25	29
$180,000 – 189,999	24	21
$190,000 – 199,999	19	21
$200,000 – 209,999	25	-
$210,000 – 219,999	19	52
$220,000 – 229,999	33	32
$230,000 – 239,999	34	37
$240,000 – 249,999	27	25
$250,000 – 259,999	29	25
$260,000 – 269,999	18	19
$270,000 – 279,999	16	8
$280,000 – 289,999	15	14
$290,000 – 299,999	11	18
$300,000 – 309,999	13	8
$310,000 – 319,999	7	11
$320,000 – 329,999	7	4
$330,000 – 339,999	8	9
$340,000 – 349,999	7	5
$350,000 – 359,999	7	2
$360,000 – 369,999	4	2
$370,000 – 379,999	7	6
$380,000 – 389,999	-	3
$390,000 – 399,999	2	1
$400,000 – 409,999	3	1
$410,000 – 419,999	1	2
$420,000 – 429,999	1	2
$430,000 – 439,999	2	-
$440,000 – 449,999	1	1
$450,000 – 459,999	1	-
$460,000 – 469,999	1	-
$470,000 – 479,999	-	-
$480,000 – 489,999	-	-
$490,000 – 499,999	-	-
$500,000 – 509,999	-	-
$510,000 – 519,999	-	-
$520,000 – 529,999	1	1

During the Year Ended 30 June 2015, the above numbers of employees received remuneration of at least $100,000 on an annualised basis – of these employees, 707 (2014 - 703) are Medical Staff and 113 (2014 - 129) are Management.

During the year ended 30 June 2015, 7 (2014: 4) employees received compensation and other benefits in relation to cessation totalling $144,679 (2014 $230,124).

26. Events after the balance date

There were no significant events after the balance date.

27. Financial instruments

Financial instrument categories

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

	Actual 2015 $000	Actual 2014 $000
Loans and receivables		
Cash and cash equivalents	56,138	21,580
Debtors and other receivables	45,075	32,887
Total loans and receivables	**101,213**	**54,467**
Financial liabilities measured at amortised cost		
Creditors and other payables (excluding income in advance and GST)	101,927	95,047
Borrowings	292,500	267,600
Total financial liabilities measured at amortised cost	**394,427**	**362,647**

Financial instrument risks

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

Market risk

Price risk

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

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

Cash flow interest rate risk

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

Sensitivity analysis

As at 30 June 2015, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the deficit for the year would have no impact as all loans are fixed (2014 $0.0k).

Credit risk

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

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 25 per cent of trade debtors). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

Credit quality of financial assets

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

	Actual 2015 $000	Actual 2014 $000
COUNTERPARTIES WITH CREDIT RATINGS		
Cash and cash equivalents and investments		
AA-	882	864
COUNTERPARTIES WITHOUT CREDIT RATINGS		
Total cash and cash equivalents and investments	55,256	20,715
Total debtors and other receivables	45,075	32,887

Liquidity risk

Management of liquidity risk

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

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

Contractual maturity analysis of financial liabilities.

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

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2014						
Creditors and other payables	**105,390**	**105,390**	**105,390**	**-**	**-**	**-**
Crown Loans	**267,600**	**331,622**	**52,221**	**10,216**	**101,609**	**167,576**
Total	**372,990**	**437,012**	**157,611**	**10,216**	**101,609**	**167,576**
2015						
Creditors and other payables	109,684	109,684	109,684	-	-	-
Crown loans	292,500	364,593	12,470	17,435	119,179	215,510
Total	**402,184**	**474,277**	**122,154**	**17,435**	**119,179**	**215,510**

28. Capital management

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

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. The DHB has complied with these provisions in the 2014-15 financial year.

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

29. Trust & Special Purpose Funds

	Parent and Group	
	Actual 2015 $000	Actual 2014 $000
Trust/Special funds		
Balance at beginning of year	864	854
Funds expended	-	-
Interest received on Restricted Funds	18	10
Balance at end of year	**882**	**864**

30. Explanation of major variances against budget

Statement of comprehensive revenue and expense

The major variances in the Statement of Comprehensive Revenue and Expense are due to:

- Total revenue for the year (excluding donations and including revenue from agency contracts) was $12.8m higher than budget - this was due to variations in contacts for work undertaken with MOH, fluctuations in Private Patient revenue and Higher interest revenue, offset by sale of land still under negotiation at year end.
- Expenditure for the year (Including expenditure on agency contracts) was $11.7m higher than budget caused by the flow-on effect of the revenue variations, and clinical mix of work undertaken.

Donations were lower by $1.1m due to timing of receiving donations.

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

- Stronger Cash position from drawing down funding in June 2015
- Increase in Trade receivables
- Lower Inventories
- Non sale of assets held for sale
- Revaluation in land
- Investment in Project Swift and healthAlliance
- Creditor under estimation

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

- Lower operating cashflow of $2.0m due to:
  - higher payments to suppliers to match increased outputs
  - lower interest payments
  - higher capital charge payment due to revaluation at June 14
- Higher investing in Property, plant and Equipment.
- Higher financing due to planned draw-down of funds not occurring in 2014 and the subsequent need to draw down funds in 2015.

31. Adjustments Arising on Transition to the New PBE Accounting Standards

Reclassifications adjustments

There have no reclassifications on the face of the financial statements in adopting the new PBE accounting standards.

Recognition and measurement adjustments

The table below explains the recognition and measurement adjustments to the 30 June 2014 comparative information resulting from the transition to the new PBE accounting standards.

	Parent		
	NZ IFRS (PBE)	Adjustment	PBE Accounting Standards
	2014 $000	2014 $000	2014 $000
Balance as at 1 July			
Statement of financial position			
Assets	69,600	-	69,600
Current Assets	627,462	-	627,462
Non-current assets			
Liabilities	255,822	-	255,822
Current Liabilities	243,067	-	243,067
Non-current liabilities	198,173	-	198,173
Equity	69,600	-	69,600
Statement of comprehensive revenue and expense			
Surplus/deficit	3,054	-	3,054
Other comprehensive revenue	6,931	-	6,931
Statement of changes in equity			
Balance 1 July	188,598	-	188,598
Total comprehensive revenue and expense	9,995	-	9,995
Capital contribution	(420)	-	(420)
Balance at 30 June	198,173	-	198,173

Board and Committee Membership Attendances

Number of meetings	Board[101]	HAC[101]	CPHAC[101]	F&AC[101]	DiSAC[102]	MHAC[102]
Dr Lee Mathias (Chair)	10	10	10	8	6	2
Wendy Lai (Deputy Chair)	8	9	-	7	-	-
Colleen Brown	8	8	9	-	7	2
Lyn Murphy	9	9	-	7	-	2
Sandra Alofivae	10	10	7	-	2	-
Kathy Maxwell	10	10	-	8	-	-
Dianne Glenn	10	10	9	-	6	3
Arthur Anae	8	7	-	-	-	-
Reece Autagavaia	10	10	10	-	6	-
George Ngatai	8	9	5	5	3	3
David Collings	8	9	10	6	4	-

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

[101] Board, HAC, CPHAC & F&AC met six weekly from January 2015.
[102] DiSAC & MHAC met twelve weekly from January 2015.

Board Members' Disclosure of Interests

As at June 2015

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

Dr Lyn Murphy	▪ Senior lecturer in Management and Leadership at Manukau Institute of Technology ▪ Member, ACT NZ ▪ Director, Bizness Synergy Training Ltd ▪ Director, Synergex Holdings Ltd ▪ Associate Editor NZ Journal of Applied Business Research ▪ Member Franklin Local Board
Sandra Alofivae	▪ Member, Fonua Ola Board ▪ Board Member, Pasefika Futures ▪ Board Member, Housing New Zealand
David Collings	▪ Chair, Howick Local Board of Auckland Council ▪ Member Auckland Council Southern Initiative
Kathy Maxwell	▪ Director, Kathy the Chemist Ltd ▪ Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd) ▪ Editorial Advisory Board, New Zealand Formulary ▪ Member Pharmaceutical Society of NZ ▪ Trustee, Maxwell Family Trust ▪ Member Manukau Locality Leadership Group, CMDHB ▪ Board Member, Pharmacy Guild of New Zealand
Dianne Glenn	▪ Member – NZ Institute of Directors ▪ Member – District Licensing Committee of Auckland Council ▪ Life Member – Business and Professional Women Franklin ▪ Member – UN Women Aotearoa/NZ ▪ Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust ▪ Life Member – Ambury Park Centre for Riding Therapy Inc. ▪ CMDHB Representative - Franklin Health Forum/Franklin Locality Clinical Partnership ▪ Vice President, National Council of Women of New Zealand ▪ Justice of the Peace ▪ Member, Pacific Women's Watch (NZ) ▪ Member, Auckland Disabled Women's Group

George Ngatai	▪ Arthritis NZ – Kaiwhakahaere ▪ Chair Safer Aotearoa Family Violence Prevention Network ▪ Director Transitioning Out Aotearoa ▪ Director BDO Marketing ▪ Board Member, Manurewa Marae ▪ Conservation Volunteers New Zealand ▪ Maori Gout Action Group ▪ Nga Ngaru Rautahi o Aotearoa Board
Apulu Reece Autagavaia	▪ Member, Pacific Lawyers' Association ▪ Member, Labour Party ▪ Member, Auckland Council Pacific People's Advisory Panel ▪ Member, Tangata o le Moana Steering Group ▪ Employed by Tamaki Legal ▪ Board Member, Governance Board, Fatugatiti Aoga Amata Preschool

Report of the Audit Office

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Counties Manukau District Health Board group's financial statements and performance information for the year ended 30 June 2015

The Auditor-General is the auditor of Counties Manukau District Health Board and its New Zealand domiciled subsidiaries and other controlled entities. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the group consisting of Counties Manukau District Health Board and its subsidiaries and other controlled entities (collectively referred to as "the Group"), on her behalf.

We have audited:

- the financial statements of the Group on pages 36 to 72 that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 14 to 31.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Group:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2015; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Accounting Standards.

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

Some significant performance measures of the Group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations and general practices. The Group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the

primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on performance information of the Group for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Group on pages 14 to 31:

- presents fairly, in all material respects, the Health Board and group's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 2 November 2015. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the

Group's financial statements and performance information in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.

An audit also involves evaluating:

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

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

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

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand;
- present fairly the Group's financial position, financial performance and cash flows; and
- present fairly the Group's performance.

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

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

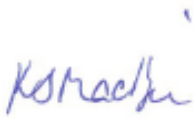
Responsibilities of the Auditor

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

Independence

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

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



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

Directory

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Auditor

Audit New Zealand on

behalf of the Auditor General

Solicitors

Buddle Finlay

Chapman Tripp

Meredith Connell

Simpson Grierson

Bankers

Westpac Banking Corp

ASB Bank Limited

Commonwealth Bank

Care & Respect

Teamwork

Professionalism

Innovation

Responsibility

Partnership

COUNTIES
MANUKAU
HEALTH