



Auckland District Health Board

Board Meeting

Wednesday 3 March 2010

2:00pm

**Pohutukawa Room
Sorrento in the Park
One Tree Hill Domain
Royal Oak**

*Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare*

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full nature of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legislation.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Pat SNEDDEN (Chair)	1. Ngati Whatua o Orakei Maori Trust Board	Consultant	Hourly consulting rate	Member of Treaty Negotiation Team in respect of Claim 388 register with Waitangi Tribunal Wholesale supplier of water and waste water services to the Auckland region Has a joint multi-million Healthy Housing programme with Health Board Investigating a comprehensive cross agency intervention related to the Tamaki area including ADHB Oversees implementation of quality programmes in DHB nationwide Crown Negotiator Ngati Kahu Treaty of Waitangi Claim Crown Negotiator Muriwhenua Treat of Waitangi Claim	3 September 2008
	2. Watercare Services Limited	Director	Fee		
	3. Housing New Zealand	Chair	Fee		
	4. Tamaki Establishment Board	Chair	Fee via HNZC		
	5. Quality Improvement Committee	Chair	Fee		
	6. Chief Crown Negotiator Ngati Kahu Claim	Consultant	Fee		
	7. Chief Crown Negotiator Muriwhenua Forum	Consultant	Fee		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Replas Ltd	Owner/Managing Director.	Salary	Plastics Manufacturing Company	6 August 2009
	2. Matta Products Ltd	Owner/Director.		Plastics Manufacturing Company	
	3. Remat Group Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	4. Burkhardt Investments Ltd	Shareholder/Director			
	5. Burris Ltd	Shareholder/Director			
	6. Reco Ltd	Director	Fee		
	7. ADHB Charitable Trust	Trustee		Government owned Maori Tourist operation	
	8. New Zealand Maori Arts and Craft Institute	Chairman		Plastics Manufacturing Holding Company	
	9. Matt I Ltd	Shareholder/Director		Plastics Distribution Company USA	
	10. Matta LLC	Trustee		Negotiator for Ngati Kuri o te Iwi Treaty of Waitangi claim	
	11. Deputy Chair and Negotiator Ngati Kuri o te Iwi	Consultant	Fee		
	12. Packaging Council of New Zealand	Executive Board Member			
Jo AGNEW	1. Senior Lecturer Nursing, Auckland University		Salary		4 February 2009

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Credentialing Committee for Ormiston private hospital 7. Surveyor Quality Healthcare NZ 				3 February 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust 2. New Zealand Research Centre for Growth and Development 3. James Henare Research Centre, University of Auckland 4. Manaia PHO, Whangarei 5. Whanau Ora Task Force 6. National Health Board	Chief Executive Board Member Advisory Board Member Shareholder Member Member	Salary Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee Fee	Management of a Health, Disabilities, Social & Education Services Trust Governs a leading health sciences research centre Advises U o A on Maori research in Northland Governs a Whangarei based PHO Assists in the development of Government's Whanau Ora policy	17 February 2010
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				15 July 2009
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO 2. Locum GP 3. Waiheke "Integrated Family Health Centre" Steering Group	Chair Member	Meeting fee Contract rate		27 January 2010
Bob TIZARD	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Seiuli Dr Juliet WALKER	<ol style="list-style-type: none"> 1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure 2. Member, National Breast Screening Advisory Committee 3. Facilitator, RNZCGP General Practice Education Programme Stage II 4. ADHB Employee: contracted roster Doctor for Pohutukawa 	<p>Self employed contractor</p> <p>Member</p> <p>Contractor</p> <p>Contractor</p>	<p>Contract hourly rate</p> <p>Fee</p> <p>Contracted monthly fee</p> <p>Hourly rate</p>	<p>General practitioner services</p> <p>Consultant Pacific Advisor</p> <p>Educational Support and Training</p> <p>Forensic sexual assault examinations</p>	1 November 2009
Ian WARD	<ol style="list-style-type: none"> 1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C -4 Consulting Limited 		Fee	Tender to National Shared Services	3 February 2010

CONFIRMATION OF MINUTES

- 3 FEBRUARY 2010



Auckland District Health Board Minutes

MEETING DETAILS													
Time and Date	2:00 pm, Wednesday, 3 February 2010												
Venue	A+ Trust Room Clinical Education Centre, Level 5, Auckland City Hospital Grafton.												
1	<p>KARAKIA</p> <p>The Chair declared the meeting open at 2:10pm and Rob Cooper led the meeting with the karakia.</p>												
2	<p>ATTENDANCE AND APOLOGIES</p> <p>Board Members</p> <table> <tbody> <tr> <td>Pat Snedden (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td></td> </tr> </tbody> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning and Funding Officer Dr David Sage – Chief Medical Officer Dr Margaret Wilsher – Deputy Chief Medical Officer Brent Wiseman - Chief Financial Officer Greg Balla - Director Performance and Innovation Taima Campbell - Executive Director Nursing Hilda Fa'asalele – General Manager Pacific Janice Mueller - Director Allied Health Vivian Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p>	Pat Snedden (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	Dr Chris Chambers	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	
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Susan Buckland	Harry Burkhardt												
Dr Chris Chambers	Rob Cooper												
Dr Brian Fergus	Dr Ian Scott												
Rt Hon Bob Tizard	Seiuli Dr Juliet Walker												
Ian Ward													
3	<p>CONFLICTS OF INTEREST</p> <p>There were no notifications of conflicts of interest for any item on the agenda.</p> <p>Chris Chambers, Ian Scott and Ian Ward had advised some changes to the interest register at previous meetings.</p>												
4	<p>CONFIRMATION OF MINUTES 2 DECEMBER 2009</p> <p><u>Moved Chris Chambers; seconded Bob Tizard.</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 2 December 2009 be confirmed as a true and correct record with an alteration to reference to the Auckland Sexual Abuse Help Foundation.</i></p> <p><u>Carried.</u></p>												

5	ACTION POINTS 2 DECEMBER 2009
	<p>City Mission</p> <p>It was proposed that the presentation by the City Mission be in the second quarter, April to June 2010.</p> <p>Hospital Advisory Committee</p> <p>Professor Iain Martin had been asked to present strategic issues for the provider at the next Hospital Advisory Committee.</p>
6	RESEARCH
	<p>Margaret Wilsher supported by Samantha Jones presented on research at ADHB.</p> <p>Research added an academic dimension to working at ADHB and was greatly valued. Examples of the research at ADHB was given including investigative initiated research and pharmaceutical funded clinical trials which tended to be phase 3 studies. The number of research projects had grown with 257 in 2009. Pharmaceutical studies assisted in bringing in considerable funds, there was a balance of funds in the A+ Charitable Trust and over \$1m in overheads had been recovered during 2009. Approvals included Maori Research Review Committee, Research Revenue Committee, Research Grants Committee and legal signoff. External research approvals included the National Ethics Committee.</p> <p>Research was supported by the Research Office which was a coordination point and provided administrative support to the approval committees. It acted as a liaison between stakeholders and ensured all the necessary approvals were in place throughout the duration of studies. There was a research strategy to promote high quality research by strengthening governance, increasing research outputs, improving internal support and growing capability, the latter through training.</p> <p>The ADHB Annual Research Report 2008 was distributed.</p> <p>The Board thanked the presenters.</p>
7	CHAIRMAN'S REPORT
	<p>The Prime Minister and Minister of Health had visited and had expressed their appreciation.</p>
8	CHIEF EXECUTIVE OFFICER'S SUMMARY
	<p>Primary care initiatives EOIs had been presented to the CPHAC and it was noted that family healthcare centres needed to be in the areas of need. The Regional Public Health Service funding had been presented to the CPHAC. The summer plan it had assisted but improvements were still possible. While AED flows had improved there was a need to make them sustainable. With production there had been a presentation on Releasing Time to Care which was fully supported and production overs and unders.</p> <p>Paediatric Oncology funding required national engagement with the distribution of services from Capital and Coast with a need for the money to follow the change to service configurations. With shared services the national strategies were a strong opportunity for ADHB with the Auckland regional population being 40% of New Zealand.</p> <p>It was noted that in the presentation of Releasing Time for Care the tools were providing permission and empowering people to make change with a model providing leadership but letting staff make the necessary changes. It was nurses leading nurses making quick early wins and giving the time to undertake the project. The 5s were aimed at getting sustainability.</p> <p>The Minister's Six Health Priorities were tabled.</p>

	<p><u>Moved Bob Tizard; seconded Jo Agnew</u></p> <p><i>That the Chief Executive Officer's report be noted.</i></p> <p><u>Carried</u></p>
11.1	Finance Committee
	<p>Harry Burkhardt reported that the Finance Committee had received the research overview which was a highly transparent process of managing risks, received a report on the funding envelope, been updated on the surgical centre which was a good opportunity and been briefed on the national procurement model managed by the Ministry of Economic Development. Other information was on the Shared Services Establishment Board and where DHBs were sitting financially this year with ADHB being one of four rated good noting that the sector deficit was \$130m.</p> <p><u>Moved Pat Snedden; seconded Ian Ward</u></p> <p><i>That the report from the Finance Committee be received.</i></p> <p><u>Carried</u></p>
10.1	Performance Improvement Committee Reports
	<p>Ian Scott advised that the Quality Committee had received a presentation on Releasing Time to Care and reports on sabbatical taken by Chief Medical Officer David Sage and Deputy Chair Medical Officer Margaret Wilsher.</p> <p>Harry Burkhardt and Ian Scott left the meeting at 3:00pm.</p>
9	LIFTING THE HEALTH OF PEOPLE IN AUCKLAND
9.1	Committee Recommendations
	<p>Community and Public Health Advisory Committee</p> <p>The CPHAC had received the EOI presentations and were making a recommendation of a formal process for signoff of the EOIs to go to the MoH on 1 March 2010 under delegation to the Chair and CEO. There was some uncertainty as to whether the EOIs were addressing inequalities and there was substantive concern by the Board that integrated family health centres needed to be in areas of need.</p> <p><u>Moved Brian Fergus; seconded Ian Ward</u></p> <p><i>That the Auckland District Health Board:</i></p> <p>Notes the emerging themes from the three primary care consortiums selected to submit business cases to the Ministry of Health:</p> <ul style="list-style-type: none"> • The Greater Auckland Integrated Health Network (GAIHN) covering over one million enrolled people across 10 PHOs (including over 90% of the CMDHB population) • The Alliance Health+ - a coalition of the three Pacific led PHOs in Auckland across CMDHB and ADHB • The National Maori PHO Coalition – a north island consortium of PHO with a focus on Whanau Ora. <p>Notes the next steps and DHB signoff process:</p> <ul style="list-style-type: none"> • Near final business cases to be submitted to the 17 February CPHAC meeting • ADHB signoff through delegated authority and CPHAC advice • Submission to the Ministry of Health due 1 March <p>Delegates authority to the Board Chairman and CEO to approve submission for each EOI Business Case to the Ministry of Health on 1 March 2010.</p> <p><u>Carried</u></p>

	<p>Hospital Advisory Committee</p> <p>The question of the role of the Hospital Advisory Committee had been raised which was an interesting challenge. There had been a presentation on oncology networks and cancer control and the interaction between public and private service provision. Other issues raised were workforce stress and burnout which was for a future discussion, networks with the evolving need to understand them and an update on plastic services to the region with concern at the breast reconstruction services.</p> <p><u>Moved Pat Snedden; seconded Susan Buckland</u></p> <p><i>That the Committee reports be received.</i></p> <p><u>Carried</u></p>
10.2	<p>DAP Projects Report</p>
	<p>This was a high level report.</p> <p><u>Moved Bob Tizard; seconded Juliet Walker</u></p> <p><i>That the DAP projects report be noted.</i></p> <p><u>Carried</u></p>
11.2	<p>Finance Report</p>
	<p>Operating was on budget but it would be challenging as this included one offs with prior year revenue and interest swap gains. The targeted savings gains needed to increase from \$2m to \$3m per month so it would be more challenging with a lot of activity to identify initiatives. Management FTE reviews had been completed and discretionary savings trending down with the imposition of travel guidelines. There was focus on break even. The other longer term initiatives would deliver beyond this financial year. The balance sheet was affected by the early payment of January funding increasing cash resources and income in advance.</p> <p>The Board had an overall impression that finances were being managed.</p>
13	<p>GENERAL BUSINESS</p>
	<p>Community Laboratories</p> <p>The Chair, Pat Snedden, updated the Board on the Community Laboratories with the 18 December 2009 governance group meeting giving clear direction to close off the audit report. Points that had been done were the Australasian Pathologists review had been completed, the numbers of complaints were down and an immunologist and haematologist had been employed. Performance had now been cleared to proceed with the IANZ March 2010 accreditation and the quality systems were now ably led.</p> <p>Conversation with stakeholders, Procure and midwives had shown improvements. There remained the question of sustainability and building confidence with the GP and physician community as it would take time for that clinical intimacy to be established. Contact is also being kept with DML with a question of viability however they were holders of a cervical smear contract which was presently being tendered. Communication was open with all parties and all were reporting to KPIs although the KPIs may need to be refined. Concern was, with Labtests, the lower volumes over Christmas and whether it is sustainable at higher volumes as previous experience had seen improvements and then a deterioration and there was a need for a Chief Operating Officer recruited in New Zealand and likewise a Quality Manager to replace the present secondment from Southern Laboratories. It was noted that DML had decided to let staff go. There would be a further meeting of the governance group on 8 February 2010.</p> <p><u>Moved Pat Snedden; seconded Jo Agnew</u></p> <p><i>That the report on Community Laboratories be received.</i></p> <p><u>Carried</u></p>

	Strategic Planning The question of a Strategic Planning day for the Board would be considered by the Chair and Chief Executive.
	NEXT MEETING
	The meeting closed at 3:40pm The next scheduled meeting is : 2:00pm, Wednesday, 3 March 2010 Pohutukawa Room Sorrento in the Park One Tree Hill Domain Auckland
CONFIRMED CHAIR: DATE:	

ACTION POINTS

- 3 FEBRUARY 2010

Action Points from the meeting on Wednesday 3 February 2010

Item	Detail	Designated	Action
Carried forward	Presentation by City Mission in new year	Garry Smith	
	Suggested Strategic Planning Day for the Board	Pat Snedden Garry Smith	

PRESENTATIONS

No Presentations this Month

CHAIRMAN'S REPORT

CHIEF EXECUTIVE'S REPORT

8.1 Chief Executive's Summary

Chief Executive Officer's Summary

	Traffic Light	Comment	Mitigation
Goal 1 Lift the Health of the People of Auckland			
Immunisation Rates	Green	Latest data indicates 85% achieved.	N/A
Radiation Oncology	Orange	Wait time in January < 6 weeks	Outsourcing patients, new Linac commissioned 25 January. Back within target by the end of March
Health of Older People Residential Care / Home Support	Orange	Expenditure YTD in excess of budget.	New Contracts and NASC processes have seen improvement in last 2 months.
Primary Care EOI	Orange	Process for business cases requiring major input and engagement.	Strong DHB input and commitment to meet requirements.
Goal 2 Improve Performance			
Emergency Department 6 hour rule	Orange	6% Improvement for quarter.	Strong commitment to improvement programme "across the whole system".
Number of Performance Indicators	Green	The number of indicators included in Board and Committee Agendas have been reduced to those escalated because of their anniversary to report or abnormal trend.	Trial to see if this is more effective use of Board input and perfecting the management process.
Goal 3 Live Within Our Means			
Result 2009/10	Red	Drive to reach breakeven forecast.	Weekly meetings to drive savings programme and FTE Management.
Electives	Orange	Throughput was lower this quarter but YTD result within range.	Production Planning.
Paediatric Oncology	Orange	Funding for new National Configuration still to be resolved.	National Engagement.
Shared Services	Green	Number of regional discussions. Discussions and engagement with Shared Services Establishment Board.	Proactive Engagement.

8.2 Minister's Six Health Priorities 2009/10

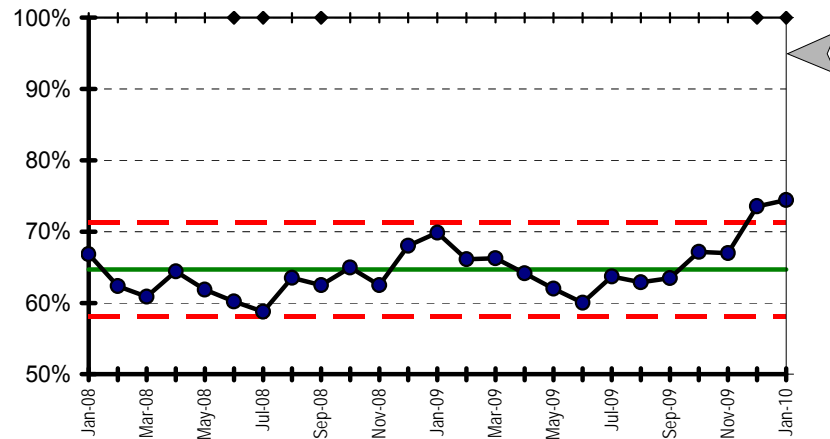
Minister's Six Health Priorities 2009/10

†	MOH top 6
‡	IDP
Ω	SOI
Π	HBI
Φ	Mental Health KPI set

January 2010

	Frequency		report page ref #
A48. MOH-01% AED patients with ED stay <6hrs	M	†	1
A51. MOH-01% CED patients with ED stay <6hrs	M	†	1
B59. Number of Elective Discharges ADHB Population ADHB Provider (subset of MOH-02)	M		2
B53. MOH03. % of A, B & C category radiation oncology patients receiving treatment within 6 weeks of FSA	M	†	3
B60. (MOH-05) Percentage of hospitalised smokers offered advice and support to quit	M	†	3
L14 (MOH-04) % of 2 year olds fully immunised - Total	Q	†,Ω	4
L19. (MOH-06) Diabetes Annual Check - Total	Q	Ω,†	4
L20. (MOH-06) Get Checked Patients with an HbA1c<8 Total	Q	Ω,†	5
L22 (MOH-06) % of the eligible adult population having CVD Risk assessed in the last five years - Total	Q	Ω,†	5

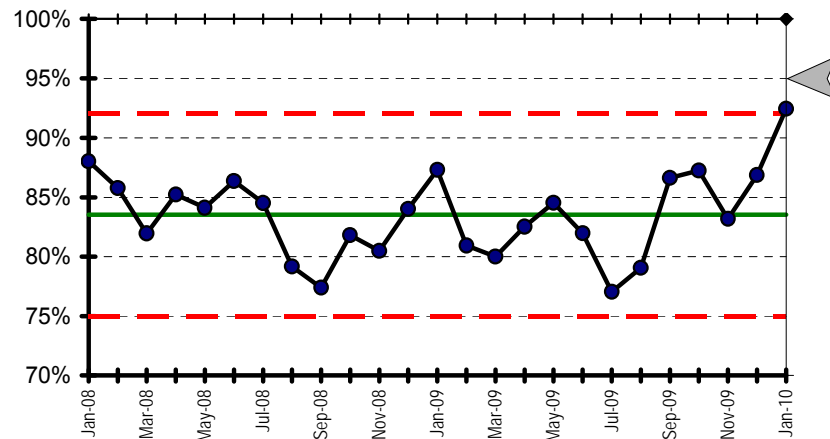
A48. (MOH-01) % AED patients with ED stay <6hrs



MOH-01: By Jan 2010, 95% of AED patients are admitted discharged or transferred within 6 hours .

Performance has continued to improve in January 2010.

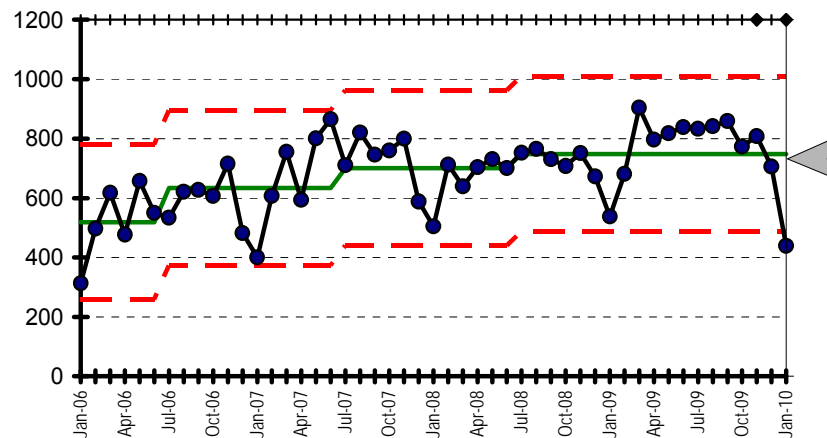
A51. (MOH-01) % CED patients with ED stay <6hrs



MOH-01: By Jan 2010, 95% of CED patients are admitted discharged or transferred within 6 hours

This has been achieved despite highest January attendances for six years. There has been no significant change in triage, casemix or percentage of patients referred for admission.

B59. Number of Elective Discharges, ADHB Population, ADHB Provider (Subset of MOH-02)



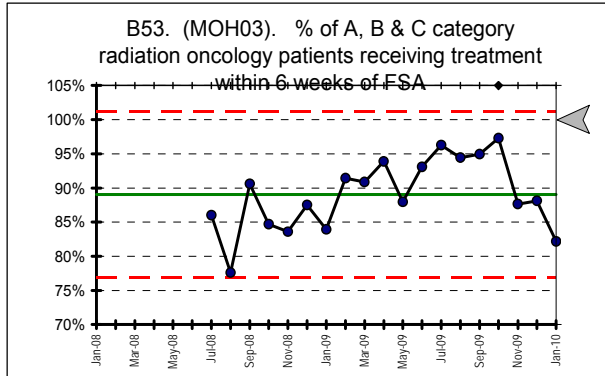
MOH-02. 9425 Elective Surgical Discharges for ADHB population for 2009/10 year. (The indicator measured monthly is the subset of the Target treated by the ADHB provider and comprises 93% of total: Target: 8790 or 733 per month)

Elective outputs reduced due to a combination of: -

- greatly reduced outsourcing (with saving in direct treatment costs) due to closure of private hospitals,
- the application of the excess annual leave programme and
- in some services the impact of higher than anticipated acute volumes.

YTD position - target = 5,131 discharges

actual = 5,259 discharges



MOH-03. By July 2010, 100% of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).

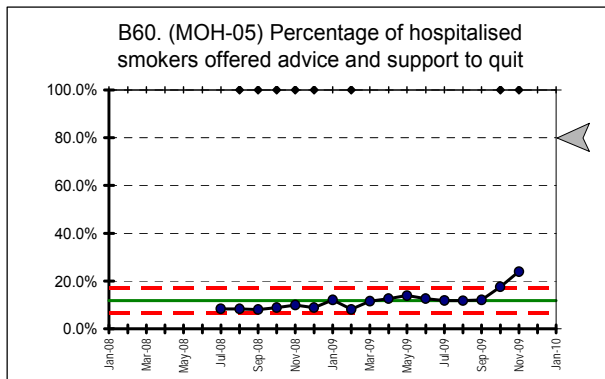
The service is aiming to meet the 6 week average waiting time target which is effective from 1 July 2010. The current average wait time for "C" Radical breast is currently greater than this. Compliance for the first and second quarters was 86% and 84% respectively (six month average compliance 85%). The average wait time in January is 6.3 weeks. The >6 week wait time is related to Linac capacity, increased demand and high acuity.

The service has developed a tool to forecast demand for treatment capacity, reflecting trends by tumour type as well as linear accelerator technological capability. This model demonstrates a need to increase treatment capacity by 5 hours per day in order to meet the 6 week target by 1 July.

Outsourcing simple breast and prostate patients to Waikato Hospital (2 per week) commenced in mid January with 3 patients commencing treatment. A communications plan has been released to all stakeholders and the MOH notified.

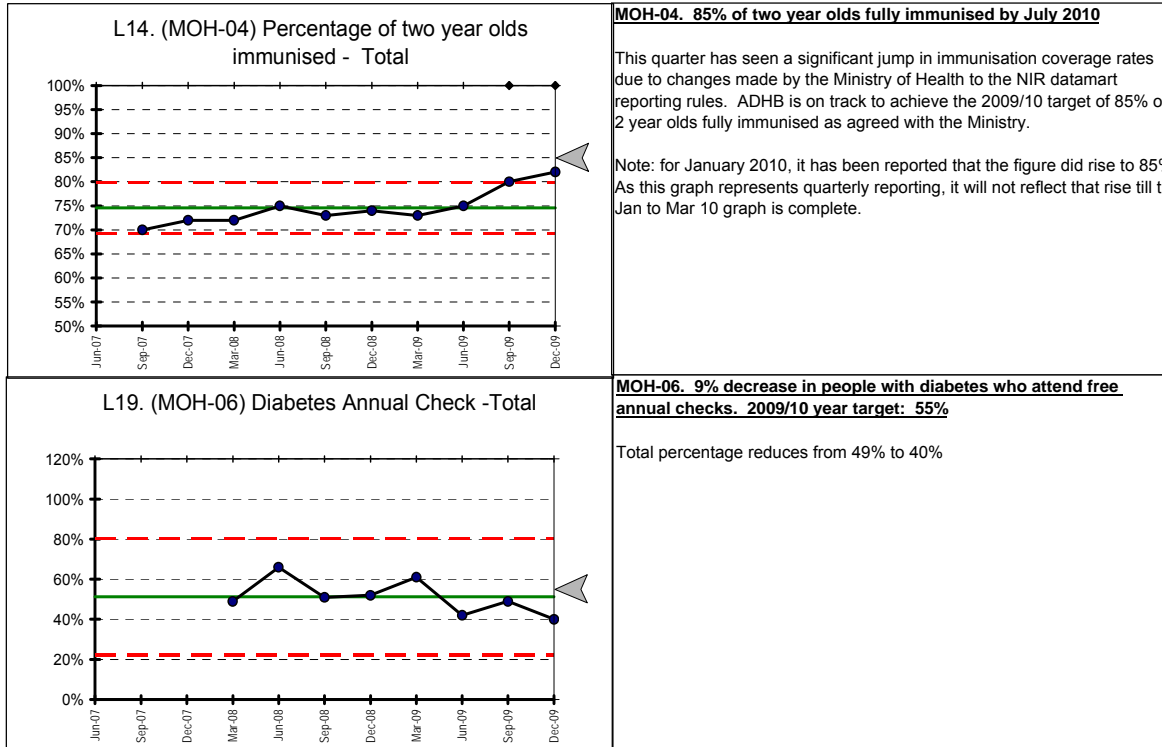
The replacement linac (MV4) was commissioned on the 25th January and increases capacity of the fleet. The service has an evening shift commencing in March to extend treatment capacity by 4 hours per day. The service expects to see a gradual improvement in wait times over the next quarter.

Additional evening shift hours are required to compensate for the obsolescence of the oldest Linear accelerator (13 years vs. 10 year useful life and running only 2 hours per day). The business case for this replacement is being prepared and will be presented to Regional Capital during April, in line with the Strategic Plan for delivery of Radiation Oncology for the Northern Region to 2019.

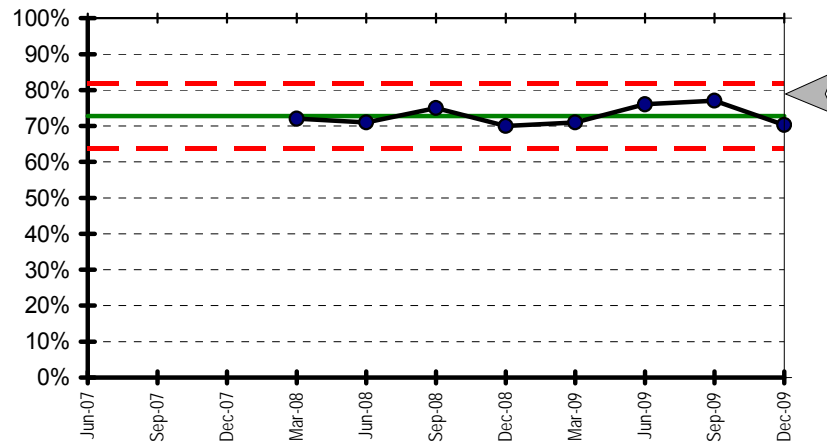


MOH-05. 80% of hospitalised smokers are provided with advice and help to quit by July 2010

This Quarter has seen an increase in the brief advice and support for smokers being recorded as a result of intensive training. Standing Orders for NRT was also introduced. While it is early days the amount of NRT being dispensed to provider arm services is steadily increasing.



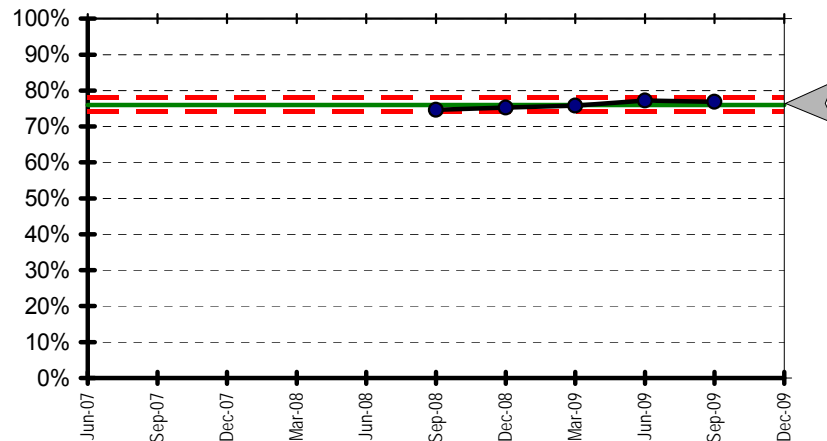
L20. (MOH-06) Get Checked Patients with an HbA1c<8 -Total



MOH-06. 7% decrease in people with diabetes who have satisfactory or better Diabetes management. 2009/10 year. target 79%

The percentage dropped from 77% to 70% between quarters.

L22. (MOH-06) Cardiovascular risk screening - Total



MOH-06. No increase or decrease in the eligible adult population who have had their CVD risk assessed in the last five years. 2009/10 target 76.5%

The percentage is 77% which is the same as the last quarter.

8.3 2010-2011 District Annual Plan & Statement of Intent



Board Paper

Date	24 February 2010			
To	Auckland District Health Board			
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz			
Author	Julie Helean Ext 4390 jhelean@adhb.govt.nz			
Functional Group	Planning and Funding Functional Group			
Subject	2010-2011 District Annual Plan and Statement of Intent			
1	Purpose To present the District Annual Plan for 2010-11 for approval and to update on progress re the Statement of Intent			
2	Recommendations			
		DAP	DSP	Budget
	That Board members give their attention to the document and note any areas where changes may be required			
	That the Board approve that the District Annual Plan, following any changes arising at this meeting, be presented on Thursday 11 March for Ministry of Health review			
	Note that Treaty partners to the Auckland DHB have an interest in the District Annual Plan and are co-signatories to it			
	The Committee note the timeframes for submitting the Statement of Intent			
	That the Community and Public Health Advisory Committee be given the authority to approve the Statement of Intent as a draft for Ministry review when they meet on 17 th March			
3	District Annual Plan 2010-11 This document is attached for review. Previous versions of this work have been discussed at our advisory groups, by the senior leadership team, and by our Treaty partners --Tihi Ora MaPO. The work is presented for consideration and discussion. Changes recommended and agreed at the Board can be made prior to the submission to the Ministry of Health on 11 March. Our Treaty partners (Tihi Ora MaPO acting on behalf of Te Runanga O Ngati Whatua) are also considering the Annual Plan and have previously provided feedback on draft versions. As in past years we expect to make all the changes advised through this process and to receive Iwi approval before the date of submission to the Ministry of Health.			
4	Statement of Intent The Statement of Intent is due with the Ministry of Health on 19 th March. The document is still in early stages of development. The Community and Public Health Advisory Committee will be asked to review draft material at their 17 March meeting. The Committee will also be asked (on behalf of the Board) to approve that version in its draft form.			
5	Appendices available on request The District Annual Plan is being circulated to Board members under a separate cover on Monday 1 March.			

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

9.1 Committee Recommendations

9.1 Committee Recommendations

Community and Public Health Advisory Committee Recommendations

Maori Health Advisory Committee Recommendations

Pacific Health Advisory Committee Recommendations

Disabled Support Advisory Committee Recommendations

10

PERFORMANCE IMPROVEMENT

10.1 Committee Recommendations

10.2 DAP Projects Report

10.1 Committee Recommendations

Hospital Advisory Committee Recommendations

Verbal by Committee Chair

Quality, Risk and Audit Advisory Committee Recommendations

Verbal by Committee Chair

10.2 DAP Projects Report

Goal 1: Lift the health of people living in Auckland city

High Level Strategy	Objective	Strategies to achieve objectives	
Reduce inequities in health status	Maori	<ol style="list-style-type: none"> 1. Reduce Maori DNA rates. 2. Increase enrolment of Maori in PHOs 3. Rangatiratanga - Maori Health Equity Framework 	
	Pacific	<ol style="list-style-type: none"> 1. Healthy Village Action Zone (HVAZ) evaluation 2. Implement and monitor revised KPIs for HVAZ Parish Community Nurses 3. Healthy Village Action Zone leadership and coordination 	
Improve outcomes in priority areas	Children & young people	<ol style="list-style-type: none"> 1. Achieve agreed Ministry of Health immunisation targets (focus Maori & Pacific) 2. Increase PHO/primary care involvement in managing immunisation 3. Practice level reporting 3. Practice nurse NIR training 4. Maori immunisation initiative 	
		<ol style="list-style-type: none"> 1. Improve oral health outcomes for children 2. Auckland DHB wide oral health promotion 2. Implement new service model 	
	Older People	<ol style="list-style-type: none"> 1. Streamline access to older people's services 2. Create a single point of entry to services 2. Develop clinical triage according to need (direct referral to community support) 3. Establish new Home Based Support Services 4. Increase packages of care available 5. Restorative care process implemented 	
	Mental Health	<ol style="list-style-type: none"> 1. Increase effectiveness across primary, secondary & tertiary services 2. Eating Disorder Services 2. Reconfigure Maori Mental Health Services 3. Reconfigure current level 3 & 4 residential rehab services 4. Implement share care project (PROGRESS+) Primary /secondary integration 	
	Palliative Care	<ol style="list-style-type: none"> 1. Implement revised service model to align with client need 2. Unbundle current resources 2. Restructure programs to achieve effective use of general and specialist services 3. Increase the input of primary care teams in palliative care services 	
	Prevent & manage long term conditions	Strengthen community participation and action	<ol style="list-style-type: none"> 1. Work with Healthy Village Action Zones initiative to spread lessons 2. Plan the approach to maximise community engagement 3. Achieve target for cardiovascular risk screening
		Support whanau and self resilience	<ol style="list-style-type: none"> 1. Increase efficiency, capacity and options of self-management approaches
		Proactive planned coordinated care	<ol style="list-style-type: none"> 1. Run a GP clinical network for long term conditions that develops planned care 2. Increase retinal screening capacity 3. Develop care pathways for people with long term conditions
Intensive support for people with high needs		<ol style="list-style-type: none"> 1. Pilot case management 2. Increase the percentage of people utilising cardiac rehabilitation 3. Develop workforce for Kaupapa Maori cardiac rehabilitation 	

Goal 2: Performance Improvement (Better, Sooner, More Convenient)

High Level Strategy	Objective	Strategies to achieve Objective
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Improve the effectiveness & efficiency of Healthcare System</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Primary healthcare</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Improve Primary Secondary system efficiency -decrease total system cost</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Improve hospital efficiency / throughput</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Reduce waiting times for elective services</p>	Implementation of PHO-DHB primary healthcare plan	1. Implement approach to providing efficient & effective coordinated care in the neighbourhood
	Improve access to after hours primary care	1. Develop after-hours services including palliative and residential care
	Improve information availability across system	1. e-referrals, health event summaries and electronic outpatient letters 2. Increase access to diagnostic tests in primary care 3. Transfer some services to primary/community
	Improve access & efficiency of service delivery	1. Projects to improve performance against 6 hr benchmark (OPJ) 2. Increase the use of and capacity of primary options
	Improve the performance of ED	1. OPJ Starship theatre project 2. Adult inpatient capacity step (beds and workforce)
	Improve the acute capacity management	1. OPJ Cardiac surgery project
	Improve Cardiac Surgery Throughput	1. Increase Greenlane capability to a full elective services centre (feasibility)
	Increase elective services to National Intervention rates	1. Improve service scheduling process & utilisation of day stay 2. Tumour specific model implementation 3. Optimising the patient journey projects
	Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation & medical oncology	1. Patient centred scheduling and communication 2. Accurate waiting time information. Reduced Waiting time 3. Increased input from GP's
	Improve Outpatient Management for Surgical Patients while improving patient satisfaction	1. Establish a new elective services centre
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Improve Leadership Capability</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Improve clinical quality & professional governance</p>	Reduce unmet need for elective services	1 Leadership development, mentoring and engagement process 2 Integrated governance reporting implemented 3. Define baldrige roll out plan and complete base line
	Clinical leadership model: implement, monitor and evaluate	1. Develop GP network (collaborative) with primary care
	Improve senior leadership team performance	1. Implement NQIP Medication Safety, Infection Prevention & Control, Mortality Review, Incident Management 2. Increase the number of GP practices with Cornerstone accreditation
	Implement sector wide clinical networks	1. Targeted recruitment ICU, Midwives, RMOs, OR staff 2. Define, train and implement new workforce roles 3. Review performance based incentive programs 4. Improve the ease of application and entry
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Strengthen the health workforces</p>	Improve safety and quality of care	1. Implement the resilience improvement plan
	Improve clinical staff retention	1. Regional Strategic Plan development in alignment with NZ HIS 2009
	Healthy workplace	1. Implement dynamic planning process (right beds, staff, facilities)
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Information management</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Planning</p>	Develop response to Long Term Services Plan	1. National 2. Regional 3. Local
	Improve resilience and availability of core IT systems	
Regional Strategic Plan		
Improve Capacity Management		
Long Term Services Planning		

Goal 3: Live Within Our Means (Improve Value for Money)

High Level Strategy	Objective	Strategies to achieve Objective
Manage Revenue	Ensure revenue received for services provided	<ol style="list-style-type: none"> 1. IDF annual agreements ensure we are paid for what we do. 2. Participate in National pricing process
	Reduce Administration Cost	<ol style="list-style-type: none"> 1. Improve HR payroll processing and leave management 2. Reduce back office cost (regional shared services) 3. Manage administration of M&A FTE cap
Improve Productivity	Improve Clinical Effectiveness	<ol style="list-style-type: none"> 1. Improve clinical resource utilisation 2. Reduce variation in Clinical Practice
	Health Service Process Improvement	<ol style="list-style-type: none"> 1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.
	Achieve procurement savings	<ol style="list-style-type: none"> 1. Leverage national/regional procurement initiatives 2. Refine procurement strategy 3. Deliver direct treatment cost savings 4. Deliver indirect treatment cost savings 5. Monitor and collect rebates within contracts for supplies and services
	Optimise stock holding	<ol style="list-style-type: none"> 1. Revisit replenishment parameters 2. Improve supply chain systems and processes
Manage Cash	Sustainable Cash Management Plan	<ol style="list-style-type: none"> 1. Asset Management Plan alignment with the Long Term Services Plan 2. Improve prioritisation process for new capital 3. Long term financial modelling process is implemented

Goal Level Summary Report (Board) 65

Total Projects: 81

DAP GOAL	Number (#)	Started (#)	Current Phase						On Time			On Budget			Expected Outcome		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver
			Define	Measure	Analyse	Improve	Control										
1) Lifting the Health of the people in Auckland City	25	25	7	2	4	7	2	0	23	2	0	25	0	0	24	0	1
2) Performance Improvement	45	43	14	7	10	9	2	0	36	8	1	45	0	0	41	4	0
3) Living within our Means	11	10	3	1	2	2	1	0	8	3	0	11	0	0	11	0	0
Totals #	81	78	24	10	16	18	5	0	67	13	1	81	0	0	76	4	1
Totals %	100%	96%	30%	12%	20%	22%	6%	0%	83%	16%	1%	100%	0%	0%	94%	5%	1%

Goal 1

Review

Overall good progress across a range of projects. In particular the approach to long term condition management is taking shape with the implementation plan developed from the ADHB Primary Care plan almost completed. Also, the GP collaborative is progressing well with good participation by all members and a focus on CVD / diabetes, registers and care pathways. While the EoI processes have impacted on the timeline for some of this work it is nevertheless being completed and will be transferable whatever the future environment for primary care. Similarly, good progress with a number of mental health services initiatives supporting a responsive continuum of care is noted.

Goal 2

Review

Overall projects in goal 2 are as plan. The project that is running very late is the regional long term service planning project. Key improve activities are underway in the Acute flow projects, concord and cardiac surgery projects. Ongoing significant DHB support of the primary care EoI process. Processes are in place for Board review and sign-off for the 1 March deadline. Board requirements regarding responsiveness to high need populations has been conveyed to respective EoI Groups. Original plans regarding service devolution and secondary / primary interface changes have largely become part of the EoI processes with consequent impact on deliverables and timelines.

Goal 3

Review

Overall good progress is being made on the projects in Goal 3. The three projects that are running late are still expected to deliver the planned benefits.

LIVE WITHIN OUR MEANS

11.1 Finance Committee Recommendations

11.2 Finance Report

11.1 Finance Committee Recommendations

Recommendation 1**ADHB Board****Author: Ian Bell (8077)****Subject: Debt Repayment 2010**

Recommendation

That the Auckland District Health Board agrees that the proposed repayment of \$10.5m to CHFA due in March 2010 as contained in the District Annual Plan 2009 – 2010 be suspended and that amount be lodged in an amortisation fund and that the redraw of \$13.5m of loan from CHFA be on the debt maturity profile as approved by the Committee, namely, \$3.5m to mature in 2012 and \$10m in 2019..

Background

This is a recommendation from the Finance Committee which will have met on 2 March 2010.

11.2 Finance Report

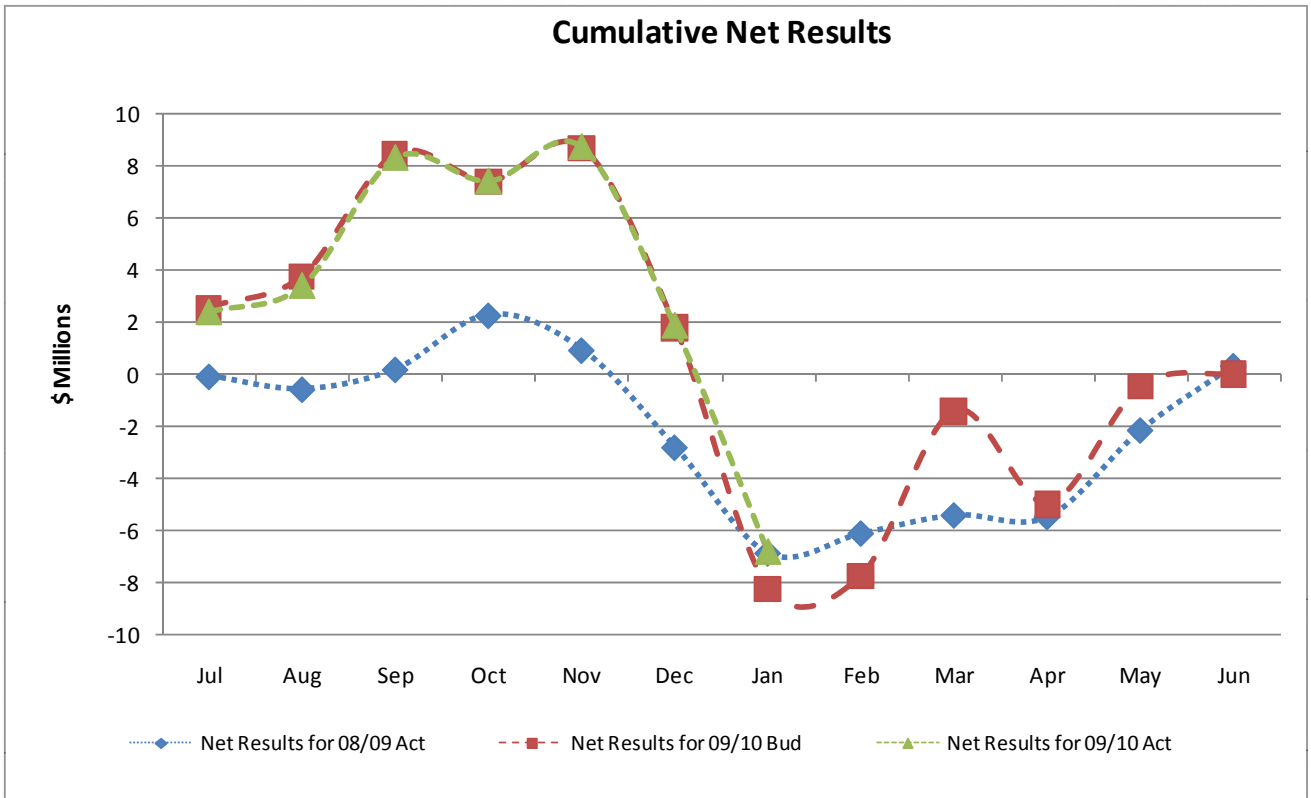
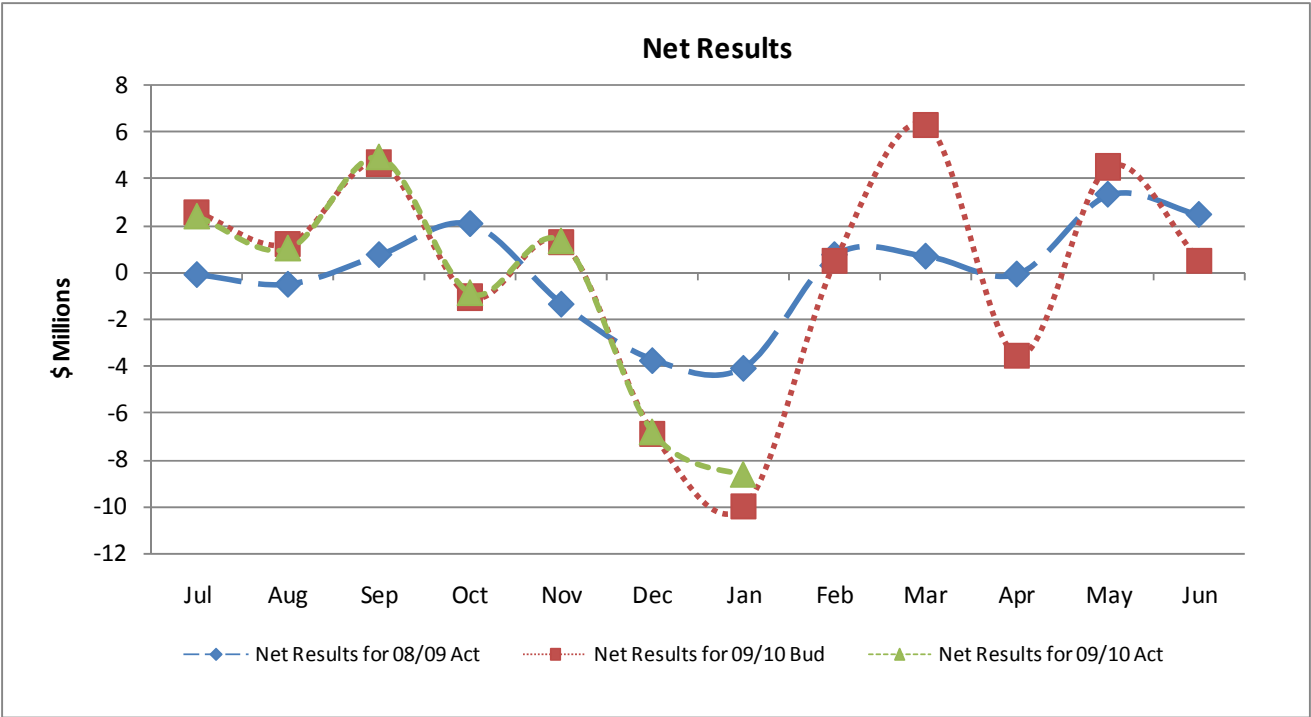
Auckland District Health Board

Board Financial Report

Prepared by Grant Barnett

January 2010

Performance Graphs by Month & YTD



Auckland District Health Board
 Summary Result
 Jan 2010 Month & Full Year Forecast

	\$000s			YTD		
	Month A	Month B	Month Var	A	B	Var
Income						
PBF - AKL Population	61,938	67,128	5,190 U	551,121	548,268	2,853 F
Inter District Inflows	46,078	46,989	911 U	325,237	328,924	3,686 U
	108,016	114,118	6,101 U	876,358	877,192	834 U
MOH Sub-contracts	5,457	5,533	75 U	40,978	39,697	1,281 F
Other Patient Care	2,809	2,996	187 U	19,400	21,003	1,603 U
Services & Products	3,531	3,372	159 F	25,361	25,028	333 F
CTA	1,389	1,526	137 U	12,295	11,396	899 F
Trust & Donation Income	87	846	759 U	2,593	6,098	3,505 U
Financial Income	147	206	59 U	3,202	(87)	3,290 F
Other Income	552	520	32 F	4,582	3,913	669 F
	121,989	129,116	7,127 U	984,770	984,241	529 F
Expenditure						
Employee Costs						
Medical	16,015	17,641	1,626 F	129,419	129,949	530 F
Nursing	19,808	19,971	163 F	139,252	139,064	188 U
Technical	8,445	9,587	1,142 F	68,066	70,539	2,473 F
Hotel Services	863	778	85 U	5,702	5,654	48 U
Administration	6,118	7,127	1,009 F	52,613	52,194	419 U
Other	3,632	4,038	406 F	24,959	26,314	1,356 F
Total Employee Costs	54,881	59,142	4,260 F	420,010	423,714	3,704 F
Direct Treatment Costs	15,334	16,919	1,586 F	130,349	123,986	6,364 U
Indirect Treatment Costs	3,128	3,203	76 F	23,053	22,464	588 U
Funder Payments	36,359	36,795	437 F	270,579	267,409	3,170 U
Inter District Outflows	7,784	8,093	309 F	47,543	48,557	1,014 F
Prop, Equip. & Transpt	3,244	4,107	862 F	27,908	30,183	2,275 F
Maintenance	15	133	118 F	1,231	933	298 U
Building Compliance	0	0	0 F	(400)	0	400 F
Loss on Sale of Fixed Assets	63	2	61 U	157	12	144 U
Administration Costs	1,192	1,512	319 F	10,810	10,991	181 F
Total Operating Expenditure	122,000	129,904	7,904 F	931,238	928,248	2,990 U
Operating Contribution	(11)	(787)	776 F	53,531	55,992	2,461 U
Depreciation	3,945	4,273	328 F	27,903	29,482	1,579 F
Finance Costs	1,699	1,709	10 F	11,848	11,815	32 U
Capital Charge	2,998	3,248	250 F	20,576	22,920	2,344 F
Total Non Operating Costs	8,643	9,230	588 F	60,327	64,217	3,890 F
Net Surplus / (Deficit)	(8,654)	(10,018)	1,364 F	(6,795)	(8,225)	1,429 F

**Auckland District Health Board
Statement of Financial Position
As at Jan 2010**

	Jan-10 Actual \$ 000s	Jan-10 Budget \$ 000s	Dec-09 Actual \$ 000s	Jun-09 Actual \$ 000s
Crown Equity				
Opening Balance	566,089	569,698	566,089	601,089
Equity Injections/(Repayments)	220	-	57	(35,000)
Closing Balance	566,309	569,698	566,146	566,089
Revaluation reserve				
Opening Balance	381,278	417,016	381,278	417,019
Revaluation Adjustments	-	-	-	(35,741)
Closing Balance	381,319	417,016	381,278	381,278
Retained Earnings				
Opening Balance	(468,647)	(468,975)	(468,647)	(468,972)
Surplus/(Deficit) Current Year	(6,796)	(8,225)	1,857	325
Closing Balance	(475,444)	(477,200)	(466,790)	(468,647)
Total Crown Equity	472,184	509,514	480,634	478,719
Represented by:				
Fixed Assets				
Land	201,337	245,814	201,337	201,337
Buildings	595,469	576,718	597,035	605,970
Clinical, Other Equipment & Motor Vehicles	81,696	101,515	83,082	85,971
Work in Progress	22,165	10,317	21,101	8,288
Total Fixed Assets	900,667	934,363	902,555	901,566
Derivative Financial Instruments	6,204	2,823	6,204	6,954
Investments				
Associated Company Investments	386	366	386	386
Trust Deposits	8,000	5,500	8,000	8,000
Total Investments	8,386	5,866	8,386	8,386
Current Assets				
Cash & Short Term Deposits	60,785	43,500	131,154	61,937
Trust Deposits	12,414	15,264	11,508	11,780
Debtors	32,435	19,571	24,655	24,176
Accrued Income	24,635	15,432	42,365	36,920
Prepayments	2,711	2,604	3,170	2,320
Inventory	11,839	11,348	12,148	11,717
Total Current Assets	144,819	107,719	225,000	148,850
Current Liabilities				
Bank Overdraft	42,200	26	-	26,650
Borrowings	90,266	90,051	88,593	18,372
Trade & Other Creditors, Provisions	195,696	183,205	222,258	216,416
Income Received in Advance	25,319	24,511	100,784	17,509
Taxes Payable	12,818	17,267	28,351	17,210
Funds Held in Trust	1,060	1,070	1,054	1,038
Total Current Liabilities	367,360	316,130	441,040	297,196
Working Capital	(222,540)	(208,412)	(216,040)	(148,346)
Non Current Liabilities				
Borrowings	199,477	199,308	199,469	269,168
Employee Entitlements	21,056	25,818	21,002	20,673
Total Non Current Liabilities	220,533	225,126	220,471	289,841
NET ASSETS	472,184	509,514	480,634	478,719

Statement of Cashflows for the Year ended 30 June 2010

	Dec-09			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	53,698	144,222	(90,524)	1,002,434	990,107	12,327
Payments	(164,822)	(155,928)	(8,894)	(997,740)	(982,300)	(15,440)
Net Operating Cashflows	(111,124)	(11,706)	(99,418)	4,694	7,807	(3,113)
Investing						
Income	422	151	271	2,897	2,558	339
Capital						
Sale of Assets	0	2	(2)	-	14	(14)
Purchase Fixed Assets	(2,058)	(5,658)	3,600	(27,004)	(32,706)	5,702
Net Investing Cashflows	(1,636)	(5,505)	3,869	(24,107)	(30,134)	6,027
Financing						
Equity Injections	153	0	153	210	3,609	(3,399)
New Loans	0	0	0	0	0	0
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
Net Financing Cashflows	153	0	153	210	3,609	(3,399)
Total Net Cashflows	(112,607)	(17,211)	(95,396)	(19,203)	(18,718)	(485)
Opening Cash	128,691	33,780	94,911	35,287	35,287	0
Closing Cash	16,084	16,569	(485)	16,084	16,569	(485)

Financial Performance

The result for January was a deficit of \$8.6m a favourable variance to budget of \$1.4m. On a year to date basis there is a deficit of \$(6.8)m a favourable variance to budget of \$1.4m.

Year to date revenue is higher than budget by \$0.5m at \$984.8m.

- Higher revenue variance was driven by the release of IDF wash-up revenue over and above 0809 year end balances \$2.0m, higher volume delivery \$1.1m (net of over delivery), higher MoH subcontract revenue \$1.3m predominantly for PHO performance management and higher CTA Income \$0.8m driven by additional volumes and payment of arrears and higher volumes of retail pharmacy sales \$1.1m.
- Interest Rate Swap Instruments are recording a gain of \$0.3m driven by a decrease in long term market interest rates, this being a favourable variance to budget of \$3.0m.
- These favourable variances have been offset by lower donation income associated with the timing of Starship funded projects \$(3.5)m and lower ACC and Non resident fee volumes \$(1.6)m.

Year to date expenditure is lower than budget by \$0.9m at \$991.6m.

- Labour Costs are \$3.7m favourable to budget year to date mainly driven by
 - a) a favourable timing variance as a result of the budget phasing of the NZNO, RDA and PACT Meca's \$1.3m
 - b) Annual leave reduction over budget in January \$5.6m
 - c) Medical & Technical staff vacancies \$6.5m
 - d) Savings in administrative staff 72 FTE \$3.6m
 - e) Superannuation contributions being below budget \$2.1m.
 - f) Redundancy Costs \$(0.7)m
 - g) Nursing 107 FTE over budget \$(2.0)m
 - h) Savings targets \$(12.5)m
- Direct Treatment costs are \$(6.4)m unfavourable to budget due to higher third party treatment costs \$(3.3)m, principally for Cardiac Services \$(2.9)m, driven by the waitlist reduction initiative, General Surgery \$(0.6)m, Orthopaedics \$(0.3)m and Child Health \$(0.9)m for other outsourcing. In addition Clinical Supplies costs were \$(4.8)m unfavourable to budget largely due to increased surgical volumes and savings targets to be delivered \$(2.2)m.
- Funder Payments are \$(2.1)m unfavourable to budget driven by higher PHO expenditure \$(3.6)m as a result of the payment of PHO performance management, with the partial offset referred to in the revenue above, higher Laboratory expenditure \$(1.9)m driven by budget phasing and the introduction of a further contract, higher Health Of Older people expenditure \$(2.1)m driven by increased cost of residential and hospital care and high Public Health expenditure \$(0.8)m. These unfavourable variances are offset by the timing of Mental Health expenditure \$1.0m, underspends in personal health \$2.3m and Medical/ Surgical \$3.0m.
- Property Costs were favourable to budget \$2.3m mainly driven by lower costs for computer maintenance \$0.5m and lower property and clinical equipment maintenance \$1.3m.
- There has been a partial release of the provision for asbestos removal credited to Building Compliance Costs \$0.4m.

- The Capital Charge is lower than budget \$2.3m driven by the Ministry washup for FY09 \$1.0m and downward revaluation of Land & Buildings at balance date. This downward revaluation credit will be ongoing for the balance of the year.
- Depreciation costs are below budget by \$1.6m as a result of the reassessment of IS Software lives and the depreciation adjustment for property revaluation.

Financial Position

- The opening balance of fixed assets was \$(29.6)m below budget principally due to the downward revaluation of land & buildings \$(35.7)m as at 30 June 2008.
- YTD Capital spending is \$27.0m, under budget by \$5.7m. Baseline and Facilities projects are under budget by \$2.3m and Information Systems projects are behind budget by \$3.4m driven by the Christmas/New Year holiday period and the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$60.8m (excluding Trust deposits) reflecting the higher income in advance. There is an overdraft of \$(42.2)m at month end and an unused overdraft facility of \$22.8m.

12

PAPERS

12.1 2010 Triennial Election

12.1 2010 Triennial Election



AUCKLAND DISTRICT HEALTH BOARD: 2010 TRIENNIAL ELECTION

REPORT TO THE BOARD

From the Electoral Officer

23 February 2010

Outline

The 2010 Auckland District Health Board triennial election will occur on Saturday 9 October 2010, and several issues require Board consideration – (i) confirmation of the Board’s electoral officer, (ii) the order of candidate names to appear on the voting document (iii) the adoption of early processing of returned voting documents, and (iv) authorisation for the CEO to sign the Memorandum of Understanding between the Board and the Auckland Council.

1. INTRODUCTION

1.1 Background

The 2010 triennial election is due to occur on Saturday 9 October 2010, and must be undertaken according to the Local Electoral Act 2001, the Local Electoral Regulations 2001 and the New Zealand Public Health & Disability Act 2000.

The above legislation sets out certain pre-election requirements and choices for a local authority (which includes a district health board) to determine. Two such requirements are the order of candidate names on the voting document and the adoption of early processing of returned voting documents.

In addition, although not a legal requirement, the confirmation of the Board’s electoral officer, Dale Ofsoske (electoral officer for the new Auckland Council), should be made for the 2010 triennial election. Authorisation by the Board for the chief executive to approve the Memorandum of Understanding between the Board and the Auckland Council for the conduct of the 2010 triennial election, is also sought.

2. NARRATIVE

2.1 2010 Election Timetable

With an election date of **Saturday 9 October 2010**, the following key functions and dates will apply:

Roll open for inspection/nominations open:	Friday 23 July 2010
Roll closes/nominations close (12 noon):	Friday 20 August 2010
Delivery of voting mailers:	from Friday 17 September 2010
Close of voting:	12 noon Saturday 9 October 2010
Members come into office:	6 December 2010

A more detailed timetable is attached ([Appendix 1](#)).

2.2 Fact Sheet

A fact sheet summarising aspects of the 2010 triennial election is attached ([Appendix 2](#)) and should be made available to any interested person.

2.3 Confirmation of Electoral Officer

The electoral officer appointed by the Auckland District Health Board for the 2007 triennial election was Dale Ofoske, electoral officer for the Auckland City Council.

Under the Local Electoral Act 2001, an electoral officer remains in office unless he or she dies, resigns, is dismissed from office, or becomes incapable of acting. Accordingly, Dale Ofoske still remains the electoral officer for the Auckland District Health Board for the 2010 triennial election (but as electoral officer for the new Auckland Council), although the Board may wish to confirm this appointment.

2.4 Order of Candidate Names

The Local Electoral Regulations 2001 provides the opportunity for the Board to choose the order of candidate names appearing on the voting documents from three options – alphabetical (status quo), pseudo-random (names drawn out of a hat in random with all voting documents printed in this order) or random order (names randomly drawn by computer with each voting document different).

The Board may determine which order the names of candidates are to appear on the voting documents, but if no decision is made, the order of names defaults to alphabetical order.

The Board resolved to adopt the alphabetical order for the 2007 triennial elections.

2.4.1 Alphabetical Order

Alphabetical order is simply listing candidate surnames alphabetically and is the order traditionally used in local authority and parliamentary elections.

The issues for alphabetical order are:

- voters easily able to find candidate names for whom they wish to vote for. Some candidates and voters over the years have argued that alphabetical order of candidate names may tend to favour those candidates with names in the first part of the alphabet, but in practice this is generally not the case – most voters tend to look for name recognition, regardless of where in the alphabet the surname lies;
- the voting documents can be pre-printed in bulk rather than individually laser printed (as required for random order).

2.4.2 Pseudo-Random Order

Pseudo-random order is where candidate surnames are randomly selected and the order selected is the order appearing on all voting documents relevant to that issue. The names are randomly selected by a method such as drawing names out of a hat.

The issues for pseudo-random order are:

- the candidate names appear in mixed order on the voting document;
- possible voter criticism/confusion as specific candidate names are not easily found, particularly where there are a large number of candidates;
- the voting documents can be pre-printed in bulk rather than individually laser printed (as required for random order).

2.4.3 Random Order

Random order is where all candidate surnames are randomly selected and the order of surnames is different on every voting document. The names are randomly selected by computer so that the order of surnames is different on each voting document.

The random order enables names to be placed on each issue in a completely unique order on each voting document.

The issues for random order are:

- the candidate names appear in mixed order on the voting document;
- possible voter criticism/confusion as specific candidate names are not easily found, particularly where there are a large number of candidates;
- the voting documents can be partially pre-printed but must be individually laser printed which is more expensive than pre-printing the full voting document.

2.5 Early Processing Resolution

The early processing of returned voting documents is permitted under section 79 of the Local Electoral Act 2001. The early processing enables returned voting documents, once the Roll Scrutiny process has been completed, to open, extract, check validity and twice capture individual votes electronically. No totalling of votes is permitted prior to the close of voting. These early processing functions are undertaken in a secure environment and under the supervision of a Justice of the Peace.

Early processing enables timely and accurate preliminary results to be released as soon as they are available after the close of voting.

The Board had resolved to allow the early processing of returned voting documents for the 2007 triennial elections, and approval from the Board is again sought for this to occur for the 2010 triennial elections.

2.6 Memorandum of Understanding

A Memorandum of Understanding (MOU) for the conduct of the 2010 triennial election should again be exchanged between the Auckland District Health Board and its constituent territorial authority, the Auckland Council.

A 2010 MOU is currently being finalised by the SOLGM Electoral Working Party (of which the Ministry of Health and the District Health Boards Association are members) and is shortly to be released.

Approval is sought from the Board for the chief executive to approve and sign this document on behalf of the Auckland District Health Board.

3. Recommendations

It is recommended that:

1. The Board confirms the appointment of Dale Ofsoske, electoral officer for the Auckland Council, as the electoral officer for the Auckland District Health Board for the conduct of the 2010 triennial election.
2. The Board resolves for the 2010 Auckland District Health Board triennial election, to adopt **either**:
 - (i) the alphabetical order of candidate names; **or**
 - (ii) the pseudo-random order of candidate names; **or**
 - (iii) the random order of candidate namesas permitted under regulation 31 of the Local Electoral Regulations 2001.
3. The Board resolves for the 2010 Auckland District Health Board triennial election to adopt the early processing of returned voting documents, as permitted under section 79 of the Local Electoral Act 2001.
4. The Board authorises the chief executive to approve and sign the Memorandum of Understanding on behalf of the Auckland District Health Board with the Auckland Council, for the conduct of the 2010 triennial Board election.

Author:



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Electoral Officer
Independent Election Services Ltd
for Auckland District Health Board

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GENERAL BUSINESS

APPENDICES

No Appendices this Month

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NEXT MEETING		
	Time and Date: 2:00pm, Wednesday 7 April 2010	
	Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital	

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare