



Auckland District Health Board

Board Meeting

Wednesday 2 March 2011

2:00pm

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

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

1

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
Lester LEVY (Chair)	1. University of Auckland Business School 2. New Zealand Leadership Institute 3. Health Benefits Limited 4. Tonkin & Taylor 5. Waitemata District Health Board	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman			1 February 2011
Jo AGNEW	1. Senior Lecturer Nursing, Auckland University 2. Casual Staff Nurse ADHB		Salary Salary		21 April 2010
Peter AITKEN	1. Pharmacist 2. Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	1. Nil				9 December 2010

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 Starship Trauma Service 3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School 4. Associate, Epsom Anaesthetic Group 5. Member, ASMS 6. Shareholder, Ormiston Surgical 7. Surveyor Quality Healthcare NZ 				12 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	2. James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	3. Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	4. National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	5. Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
Lee MATHIAS	1. Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	1 February 2011
	2. Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	3. Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	4. Pictor Limited	Shareholder, Director Director	Fee No fee	Biotech start-up focussing on diagnostic products Estate of late husband	
	5. John Seabrook Holdings Limited	Governance Advisor	Fee	Provider of early childhood education services contracted to	

	6. AuPairlink Limited			the MoE.	
	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Robyn NORTHEY	1. Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	2. Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
	3. Northern Region Ethics Committee	Member			
Gwen TEPANIA-PALMER	1. Waitemata District Health Board	Board member	Fee		2 February 2011
	2. Manaia PHO	Board member	Fee paid to NHHT		
	3. Ngati Hine Health Trust	Chair	Fee		
	4. Awanmarangi Waonangi	Committee member			
	5. Te TAitokerau Whanau Ora	Committee member			
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	

CONFIRMATION OF MINUTES

- 2 FEBRUARY 2011

MEETING DETAILS											
Time and Date	2:00 pm, Wednesday, 2 February 2011										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
1	MIHI WHAKATAU										
	The meeting commenced at 2:02pm with a Mihi from the ADHB Kaumatua with responses by the Chair and the CEO.										
2	ATTENDANCE AND APOLOGIES										
	<p>Board Members</p> <table> <tr> <td>Dr Lester Levy (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director Performance & Innovation Ngaire Buchanan - General Manager Operations Taima Campbell – Executive Director Nursing Hilda Fa’asalele – General Manager Pacific Health Mark Fenwick – Communications Manager Naida Glavish – Chief Advisor Tikanga, GM Maori Health Paul Green – Manager Materials Management Aroha Haggie – Maori Health Gains Manager Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>An apology had been received from Rob Cooper.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Chris Chambers	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lester Levy (Chair)	Jo Agnew										
Peter Aitken	Judith Bassett										
Susan Buckland	Dr Chris Chambers										
Dr Lee Mathias	Robyn Northey										
Gwen Tepania-Palmer	Ian Ward										
3	CONFLICTS OF INTEREST										
	There were no notifications of conflicts of interest for any item on the agenda. Updates to the register had been noted at previous meetings for the Chair being Chair of Waitemata District Health Board and for Gwen Tepania-Palmer including being on the Board of the Waitemata DHB.										

4	CONFIRMATION OF MINUTES 2 DECEMBER 2010
	<p><u>Moved Jo Agnew; seconded Chris Chambers</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 2 December 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 2 DECEMBER 2010
	There were no actions or matters arising from the minutes.
7	CHAIRMAN'S REPORT
	<p>The Letter of Expectation had been received from the Minister and the Board and places a continued and renewed focus on improving services and reducing waiting times. The six health targets remain critical and the Board identified that these would also form a pivotal part of the Board's own key priorities for the organisation.. Health of older people has been introduced as a new priority and there is confirmation that financial performance needs to be within allocated budgets with no deficits. In terms of the targets the Board noted that the ADHB had, other than radiation therapy waiting times, relatively underperformed. The Chairman noted that the aim was now to get Auckland near the top of the league table for each target. The Board's view was to have a culture focused on patient care as well as clinical care.</p> <p>There would be more collaboration with Waitemata DHB in addition to the regional work with an early example being funding and planning for primary care exploring consolidation and joint appointments. Shared Services were also being addressed regionally to seek further savings.</p>
8.1	Chief Executive's Summary
	<p>The Chief Executive advised that his summary was at a high level with the points having been discussed in Committees.</p> <p>Elective surgery was a critical target and performance year to date was very concerning and mitigations were being set in place. In addition to the three staff recognised for services in the New Years Honours being Naida Glavish, Associate Professor Ed Gane and Associate Professor John Ormiston, Professor Leslie McGowan had been recognised.</p> <p>There was pressure in the diabetes service which management was addressing as a high priority. Kay Hyman had worked for ADHB for twenty years and her contribution was acknowledged.</p> <p>From a financial perspective costs were unacceptably high with savings not being realised. There is a need to have greater clinical engagement.</p>

8.2	Minister's Six Health Priorities 2010/11
	<p>A number of the targets had been discussed at the Hospital Advisory Committee. Diabetes Get Checked was an ongoing challenge for primary care and the appropriateness of the target had been discussed at the National Health Board as while it captured those with diabetes it did not address the 10% of the population that were likely to develop diabetes, particularly the disadvantaged, Maori and Pacific. The target could be more focussed on that population and how a difference could be made. This was critical and a high priority in regional planning. The same comments applied to cardiovascular risk assessment.</p> <p>Immunisation had a shared regional target of which ADHB's was 91%. It was noted that Maori intervention rates had not improved and while similar to Counties Manukau and Waitemata would be a major focus through a thirteen agency inter-sectorial approach. Overall the target was close to the level expected in the population.</p>
8.3	Quarter One 2010/11 Performance – MoH Report
	<p>The new reporting in a visual chart had been developed by the MoH and would be issued quarterly.</p>
8.4	Better Sooner More Convenient
	<p>This was a high priority for the region and would have more visibility with a focus on the eight DAP projects which would be included in regional services planning for the future. There had been insufficient clinical involvement in access to diagnostics. ED was considering providing after hours services from midnight to 8:00am which was supported by the Clinical Director as being cheaper than the external provider. There had been some delays in the pharmaceutical project in getting staff to interact with GPs. Clinical pathways had been developed, including discussions with Canterbury, being a useful tool as a means of prioritising at patient level. Overall there was positive regional work.</p>
8.5	Greenlane Surgical Unit
	<p>The approval of the Minister was noted and there would be a full briefing at a future meeting.</p>
10.1	DAP Projects Report
	<p>This was the overall summary for the organisation of progress against the District Annual Plan. It was considered that elective surgery volumes should be noted as it was an area of serious concern. Management were undertaking walkarounds with a focus on patient and staff safety with issues varying from area to area.</p>
11.1	Finance Committee Recommendations
	<p><u>Moved Lee Mathias; seconded Robyn Northey</u></p> <p>Relocation of Contact Centre and Referrals</p> <p><i>That the ADHB approves the capex of \$586,614 to fit-out vacant space in Building 11 on the Greenlane site for the Contact Centre and Referrals Service to enable these services to vacate Building 10 at Greenlane in accordance with the Exit Plan for that building approved by the Board in December 2007; and that the tender from Teak Construction Ltd to undertake the fit-out works in Building 11 be accepted and the CEO be delegated authority to execute the contract once finalised</i></p> <p>CT Scanner, Ultrasounds and Mobile Image Intensifier</p> <p><i>That the ADHB endorses and approves the procurement process for the purchase of the CT Scanner for Auckland at \$1,247,230; the 7 Ultrasound machines for Cardiology and Radiology at \$812,786 and the Mobile Intensifier for Auckland at \$141,717 and associated building work.</i></p>

Orthopaedic Trauma Implants and Instrumentation

That the ADHB approves the Supply Agreements for Orthopaedic Trauma Implants and Instrumentation between Counties Manukau DHB, Waitemata DHB and Auckland DHB and a panel of supplier; Biomet Ltd. Johnson & Johnson, LMT, Medartis, Medtronic, Smith & Nephew, Stryker, Zimmer, Synthes; with the contracts being for 3 years plus 2 year right of renewal with fixed pricing.

Retinal Screening

That the ADHB approves the ADHB Optimize Retinal Screening Project of \$529,032 noting the regional processes and waiting list priority but subject to the Regional Capital Committee approval and that of the MoH.

Mental Health Child and Family Unit Upgrade

That the ADHB approves the release of \$75,000 seed money to develop a final business case to upgrade the Mental Health Child and Family Unit and approves in principle total capital expenditure of approximately \$1,500,000 subject to that business case.

Carried

11.2 Finance Report

The variance for the month was favourable which had increased the favourable variance year to date. January would be important in terms of annual leave charge which would be against the accrual in the balance sheet. Main variances were favourable revenue and unfavourable direct treatment costs and payroll. Looking forward there was a risk of not meeting the elective surgery volume targets . The balance sheet reflected the early payment of January revenue by the Ministry. The expectation of the Board was for no deficit budgets and for a coherent cost reduction programme.

15 PUBLIC EXCLUSION

Moved Robyn Northey; seconded Gwen Tepania-Palmer

That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 15.

The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
15.1 Confidential Board Minutes 2 December 2010 15.2 Northern Region Shared Services Organisation	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.

Carried

The items discussed in public exclusion were the confidential minutes 2 December 2010 and the Northern Region Shared Services Organisation.

Moved Gwen Tepania-Palmer; seconded Robyn Northey

That the meeting resume in public.

Carried

NEXT MEETING

The meeting closed at 3:58 pm

The next scheduled meeting is :
2:00pm, Wednesday 2 March 2011
Pohutukawa Room, Sorrento in the Park
One Tree Hill Domain
Epsom

CONFIRMED

CHAIR:

DATE:

ACTION POINTS

- 2 FEBRUARY 2011

Board
Action Points from the meeting on Wednesday 2 February 2011

Item	Detail	Designated	Action
8.3	Dashboard diagramme to be provided to Members	Ian Bell	Actioned 4 February 2011

CHAIRMAN'S REPORT

CHIEF EXECUTIVE'S REPORT

+.1 Chief Executive's Summary

Chief Executive Officer's Summary

	Traffic Light	Comment	Mitigation
Goal 1 Lift the Health of the People of Auckland			
Elective Surgery	Red	Compliance risk for ESPI 5 mitigated. Still have compliance risk for ESPI 2. Elective production plan has a 500 discharge gap.	Work out plan for each service for ESPI 2 compliance being developed. Actions being developed to close the discharges gap. Daily monitoring of actions put in place including outsourcing. (Refer to KPI report for specifics.)
Annual Planning Process	Green	The high level intervention logic being used in the Regional Plan was discussed along with the ADHB draft annual plan at the February CPHAC. The Annual Plan will be on the March CPHAC Agenda for review and approval and the Regional Plan on the April Board Agenda.	
Better help for Smokers	Orange	Below target.	New initiatives have been implemented to lift the result to target.
Goal 2 Improve Performance			
Diabetes	Red	Service under extreme demand pressure.	Service Excellence process commenced with Performance Improvement Team to complete end to end process review.
Acute flow (6 hr)	Orange	Below target.	New targeted interventions are being implemented to lift the result to the target in the short term while sustainable longer term solutions continue to be implemented.
Goal 3 Live Within Our Means			
January Result	Green	Positive result for January. Pressures for the year end result are resourcing acute growth and short term health target improvement for Acute flow (6hr) and electives.	Focussed forecast management
Regional Shared Services	Green	Continued good progress in the established regional shared services agency.	

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BRIEFING PAPER TO THE BOARD

Date: 2 March 2011

To: **Auckland District Health Board – Board Meeting**

From: Aroha Haggie, Health Gain Manager, He Kamaka Oranga
Phone: 630 9943 ext 4262

Subject: **Whanau Ora Framework**

ADHB are working with Te Runanga o Ngati Whatua (TRoNW) to develop a Whanau Ora framework and Whanau Ora outcome measures. This framework and measures are distinct to health opposed to the broader cross sectoral activities in Whanau Ora (which for future purposes we will call Whanau Oranga as it takes on the focus of wellbeing).

The intent of the framework is whanau ora - Māori families supported to achieve their maximum health and wellbeing¹. For the health and disability sector He Korowai Oranga guides us to recognise the interdependence of people, that health and wellbeing are influenced and affected by the 'collective' as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms.

For ADHB whanau ora is a strategic tool for the health and disability sector to assist in working together with iwi, Māori and non-Maori providers and Māori communities and whānau to increase the life span of Māori, improve the health and quality of life, and reduce disparities with other New Zealanders.

Below is a brief outline of the 4 key components of the framework, these are outcomes, leadership, support and delivery².

Outcomes

An outcomes focus for whanau ora services provides both the direction and destination for service delivery, and we will know quickly whether or not whanau are experiencing improvements to their situation. Increased whanau capacity to self-manage their journey towards whanau ora is the planned result.

Leadership

Joint Iwi and DHB leadership to guide whanau ora outcomes, particularly engaging, discussing and agreeing on outcomes, strategies and measures with whanau, Maori providers and government agencies.

¹ MOH He Korowai Oranga 2002

² Te Runanga o Ngati Whatua draft Whanau Ora framework 2011

Support

This is support for building and consolidating an effective infrastructure across ADHB that supports achieving whanau ora outcomes.

Delivery

This is about supporting whanau ora networks and their workforce and the delivery of whanau ora services across ADHB. For us, this means building capacity of high performing provider networks so that they can deliver good quality whanau ora services that empower and engage whanau.

Our next steps are to finalise the framework and outcome measures and establish the monitoring of whanau ora outcome measures (the measures are expected to be completed by 30 June 2011) the priority areas for rolling out the measures will be for child health and long term conditions across the patient journey.

7.3 Board Briefing Paper Better Sooner More Convenient Meeting



BRIEFING PAPER TO THE BOARD

Date: 2 March 2011

To: Auckland District Health Board – Board Meeting

From: Denis Jury, Chief Planning & Funding Officer
Phone: 630 9943 ext 8071

Subject: Better Sooner More Convenient (BSMC)

1.0 Information

As an Organisational Priority BSMC will be a regular Report.

2.0 Regional Progress to Date:

The Metro Auckland DHBs collectively continue to make progress with implementation of the regional components of Governments Better Sooner More Convenient Primary Health Care (BSMC).

- **Contracting Framework**

Payments have continued to PHOs under the contracting arrangements as planned.

- **Business Cases**

Active involvement continues to support the three Business Cases in development and rollout of their respective Implementation Plans. There is however, a perception amongst some PHOs that the DHBs are not supporting GAIHN. This relates to issues around funding, and is currently being worked through with the GAIHN ALT.

- **Progress with PHO Consolidation**

The National Maori Coalition has advised that they wish to form into a single PHO. This will need to be carefully worked through, particularly from WDHBS perspective where there is a clear policy of contracting with two PHOs only.

- **Progress with ADHB Primary Care Plan**

Work has continued with forming the ADHB District Alliance with the active support of PHOs.

3.0 Improve Primary – Secondary System Efficiency: The Regional Annual Plan projects

Access to Diagnostics-Radiology

As noted previously this project is behind target on the basis of increases in primary accessed radiology procedures year to date but remedial activity is being put in place and we have a degree of confidence that the targets will now be met with the contribution of increasing volumes from CMDHB and WDHB.

Agreement has been reached regarding the inclusion of radiology in the regional e-referrals and in the meantime ProCare is customizing some aspects of ProExtra to meet CMDHB requirements as an interim solution until the proposed e-referrals “radiology” is completed for implementation in primary care. WDHB is taking part in the analysis but has reserved its decision regarding the use of ProExtra. However increased volumes through their present system of triage for radiology can be validly counted as part of the target.

Minor Surgery - Skin Lesions

Provider selection across the region has now been completed and contracts are currently being prepared for the successful respondents. This project is now proceeding to plan and there is confidence that the target will be met.

Regional Clinical Pathways

All five pathways will be fully developed and implementable by 30.06.11 as required by the Annual Plan target. However, there was an additional target that there would be a reduction in FSA for Dyspepsia of 30% which is unlikely to be met but there will be a reduction of FSA of 20% across all of the pathways being developed.

Acute Demand / POAC

This project is tracking to plan and there is confidence that the target will be met. There are however some risks, particularly associated with a tender process and the likely number of respondents and the ability to achieve efficiencies compared to the present price. These are being mitigated through the design of the RFP process

After Hours

Project is currently tracking to plan but there are a number of risks which need to be managed. In particular the design of the process to manage the conflicts of the various parties who have been involved in this project and the public law requirements will be critical. In addition, the provision of out of hour's services has a high public profile.

Pharmaceuticals CMDHB & ADHB Project

Delays occurred due to the inability to recruit suitable staff -these have now been resolved. Given these delays it was previously thought that this initiative would at best cover its establishment costs (\$600k) but further analysis has shown that the return will be greater than this and may well approach the original target of \$1.5m.

Maori Service Development

These projects have progressed more slowly than anticipated and while the original target of 31.12.10 will not be met CDHB and WDHB are working toward completion by financial year end.

Health Targets

Progressing as expected.

Business Cases Implementation

Alliance Health+

Alliance Health+ establishment date was 1 October 2010; its Alliance Leadership Team (ALT) is operational. The established Clinical Network model used by its member Ta Pasifika is being established across its other two member providers, with a strong focus on consolidation of common understanding of contractual and organisational expectations by front-line workers and business owners so they can deliver consistent quality care to their patients.

GAIHN

GAIHN business case membership includes seven PHOs that operate on a day-to-day basis as separate entities but collectively collaborate and co-operate to implement better sooner more convenient primary care for their collective enrolled populations.

- The GAIHN Alliance Agreement has been finalised and is now with the PHOs for signing. Once the Alliance Agreement has been signed by all parties the variation to the PHO Head Agreement will be executed. The GAIHN implementation plan has been signed off by the MoH. ADHB as lead DHB is currently working with GAIHN and the Ministry on a contract to fund the implementation plan
- GAIHN has established three Clinical Alliance Teams (CATs) who respectively focus on: reducing acute demand; long term conditions; reducing inequalities. The GAIHN CAT projects will be part of the DHB 2011-12 District Annual Plans, however the budget for these is yet to be confirmed,
- The funding GMs are currently pursuing with GAIHN detail within their proposed budgets to identify what relates to current DHB spend, what could correctly be funded from Flexible Funding Pool (FFP), and what prioritisation may be required to release funds for yet to be agreed 'new work'

National Maori Coalition

National Maori PHO Coalition (NMPC) – soon to be renamed National Hauora Coalition is in the process of establishing its ALT and had its first joint Auckland/Midland ALT meeting on 25 January 2011. It is currently proposing to become a single PHO.

The NMPC is focusing on getting it right for their patients/whanau. They are in the process of developing a Whanau Ora Outcomes Framework (based on the Freidman model) to drive a Business Case wide culture that constantly questions throughout implementation and service provision 'is this making a positive difference for whanau, and how can this be shown/measured'

DHBs Annual Plan 2011-12 Primary Care Content

- The ADHB Planning & Funding Primary Care team has taken the lead to draft the Regional Primary Care narrative content for inclusion in the three DHBs' Annual Plans, which will be completed for DHB and other approval processes during March.
- The funding GMs are currently determining the 'regional' budget for primary care regional Annual Plan content. All financial material has to be with the NHB by 4 March; a copy of the Annual Plan by 25 March and the Regional Plan is due by 11 April.

7.4 Board Briefing Paper Regional Service Planning Progress Summary Meeting



BRIEFING PAPER TO THE BOARD

Date: 2 March 2011

To: **Auckland District Health Board – Board Meeting**

From: Margaret Wilsher, Chief Medical Officer
Phone: 307 4949 ext 23936

Subject: **Regional Service Planning Progress Summary**

The Northern Region Health Services Plan is well developed with a final challenge workshop including key clinicians, planners and managers scheduled for February 21. The plan incorporates sound intervention logic, encompasses the triple aim of population health, cost/productivity and patient experience and targets critical health challenges for the northern region. Three big dot interventions with campaign approach were chosen after a multidisciplinary, whole system workshop and are; 'first do no harm', 'life and years', and 'the informed patient'. Within the 'life and years' big dot there are three major programmes of work; diabetes, cardiovascular disease, and health of older people. There are also pieces of work on child health, radiology (forming a clinical network), elective surgery and emergency care. Cancer is already established with a network and will be developed further with a clinical network to guide the implementation of agreed regional strategies.

The plan incorporates activity from the region's primary care business cases (GHAIN, Alliance Health and Maori coalition) and has been clinically led with participation from hospital and community clinicians across the region. All four DAPs incorporate the plan's key objectives and those of the business cases. It is shaped so that deliverables for the first year are clearly articulated, with deliverables for the outer years (2-5 and >5) indicated. The clinical deliverables match those in the business cases and implementation detail will be developed further in the local DAPs. The big dot 'first do no harm' will focus on patient safety and aligns with key messages coming from the Health Safety and Quality Commission. The 'informed patient' campaign will focus on advanced care planning in the first year and then focus on knowledge and self management.

Following the challenge workshop the NRHSP will be further refined with more specificity and absolute clarity about the deliverables; what, when, who and will be submitted to the NHBBU on time in early April.

There have been separate meetings between CIOs and CMOs to ensure regional IT approach to supporting the plan whilst also delivering the NHIT board strategy and implementing local IT priorities. Vulnerable services are identified in the plan and key service configuration changes (notably between WDHB and ADHB) will be also be noted although the service reviews will form part of local DHB activity.

The NRHSP plan has been successfully developed to this point with the goodwill and time of many clinical and planning staff from both hospital and primary care sectors with excellent level of support from NDSA. The steering group comprising 3 individuals from each DHB plus primary care representation has been greatly encouraged by the spirit of collaboration and the enthusiasm for a whole of system whole of region campaign approach. The biggest risk is the sheer volume of activity that the plan signals and our ability to constrain the clinical enthusiasm such that we can deliver all that is promised.

7.5 Board Briefing Paper Northern Regional Shared Service Summary Meeting



BRIEFING PAPER TO THE BOARD

Date: 2 March 2011

To: **Auckland District Health Board – Board Meeting**

From: Brent Wiseman, Chief Financial Officer
Phone: 630 9943 ext 3608

Subject: **Northern Regional Shared Service Summary**

Completed for February:

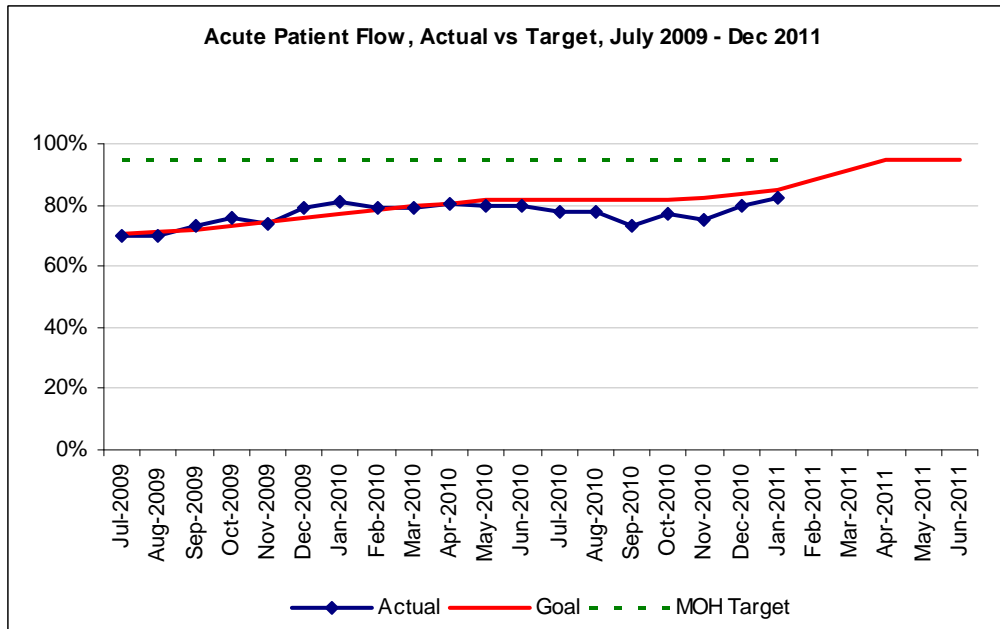
- Main consultation completed and decision to proceed presented to impacted staff.
- Name of Health Alliance NZ Ltd advised to staff.
- Interim Operations Manager and Chief Executive Appointments completed with start dates of 1 March and 14 March respectively.
- Letters to impacted staff to be sent 22 February 2011 for 1 March transfer date subject to all approvals being received.
- Papers to be considered by Regional Governance Group 25 February 2011, including signing of regulatory documents under delegated authority.

7.6 Minister's Six Health Priorities 2010-11 Meeting

Project:

Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours

Date of Delivery: 30 June 2011



Project Risks / Comments:

While we have made good progress to off set the volume increases we are still off target. Discussions have been held with both the Adult and Childrens project teams to indentify immediate actions to improve performance to target. These actions are noted in summary form on the following separate Adults and Childrens Acute flow pages. **A more detailed action plan will be presented at the Hospital advisory committee.**

Project: Adult Acute Patient Flow

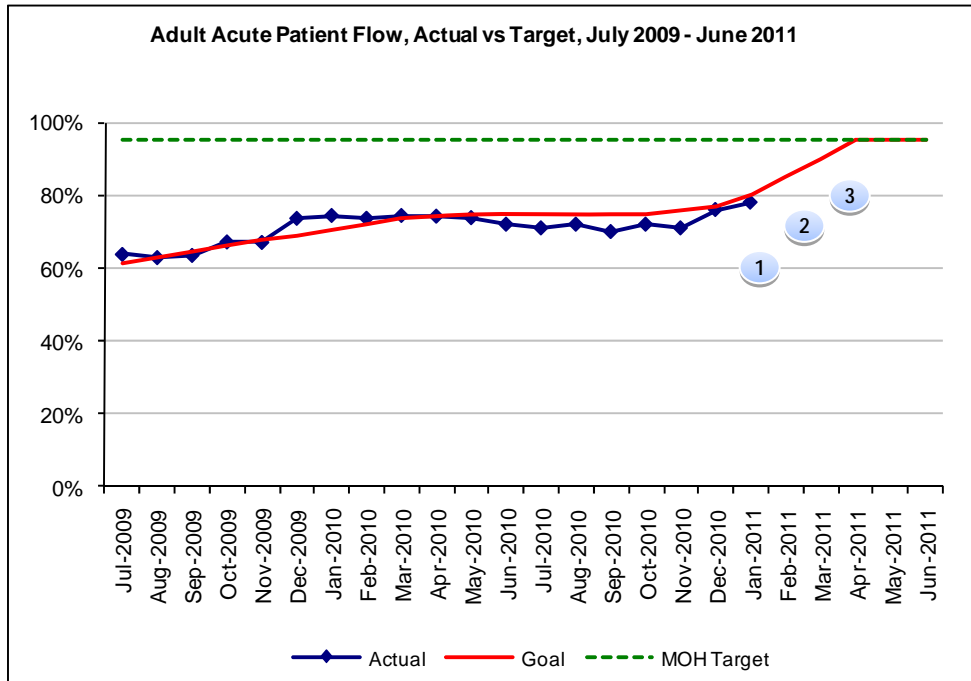
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

Steering Group: Nurse Director Margaret Dotchin, General Manager Ngaire Buchanan, Dr Tim Parke, Dr Art Nahill, Dr Wayne Jones, Dr Andrew Old, Nurse Advisor Mark Entwistle.



Project Risks / Comments:

Record numbers were experienced in the early part of January 2010.

Improvement noted in January and February (quarter to date) to 80%.

A number of activities are underway to boost performance immediately.

A 5 day Rapid Improvement event is planned for April to accelerate identification and implementation of solutions. This will ensure short term solutions become sustainable.

Daily results are now being posted in the Level 5 Admin area, with a similar display in place in AED.

Daily review of patients who stay longer than six hours in AED in place.

A team recently visited CMDHB and WDHB with several strategies to be considered.

Main risks to ongoing improvement includes General Medicine continuing to be under considerable pressure due to workload, team cohesion and RMO vacancies. Mitigation includes medical subspecialty support. Also need to increase improvement focus in most medical and surgical specialties from time to referral from ED to time to be seen to reduce delays in decision to admit or discharge from ED.

A more detailed action plan on immediate actions to improve performance will be tabled at the HAC meeting.

Improvements to date:

Streamlined AED processes and measurement and manage the challenge of growing demand

Reviewed Medical / Nursing requirements for AED and approved business case for resource increase to match increased workload.

Charge nurse patient flow coordinator introduced

Improved access to Radiology

Streamlined documentation required for safe transfer

Improved triage processes.

Managing bed block with additional resources

58 Additional beds opened 2009 2010

Winter Ward 31 General Medicine 10 additional beds August – October 2010

Managing bed block & reducing the time patients wait through improved processes and teamwork

Daily Rapid Rounds introduced in General Medicine (Feb 2010) and Orthopaedics (July 2010)

Nurse Facilitated Discharging in General Medicine (April 2010)

Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.

Daily breach review meetings to understand root causes and implement short term solutions.

Immediate actions to improve performance:

1. Increased engagement of Senior Leadership Team to support improvement activities and reduce road blocks to improvement.
Increase communication and engagement of Clinical Directors, SMO's, RMO's
Increase communication and engagement of Charge Nurses and RN's after hours to further reduce wait times for patient transfer from Emergency Department
Engage with SMO's, RMO's and nurses one to one, by CD, Nurse Advisor or Level 2 clinical leader where resistance to required behaviour is demonstrated.
Valuing patient time poster campaign
2. Establish ED short stay unit
Implement APU flex beds
Improve measurement of Ready to Go patients in ED
Complete recruitment of remaining ED resource to improve weekend coverage
Support General Medicine by diversion of patients to subspecialties
Implement general surgery acute flow team initiatives to improve response time
CMO to attend Orthopaedic SMO meeting to increase engagement.
Relocate bed manager to ED after hours
Implement ED discharge nurse on weekend
Hands on support of ED flow Charge Nurse to reduce roadblocks to timely review and transfer of patients
Commence physiotherapy facilitated discharge in Orthopaedics.
Establish discharge co ordination responsibility in Gen Med ward nursing team.
Further increase timely overnight transfers from ED to inpatient wards once bed allocated.
3. Five day rapid improvement event planned for April to focus on improvement of process from decision to admit to patient transfer complete.
Improve elective scheduling.

Project: Children's Acute Patient Flow

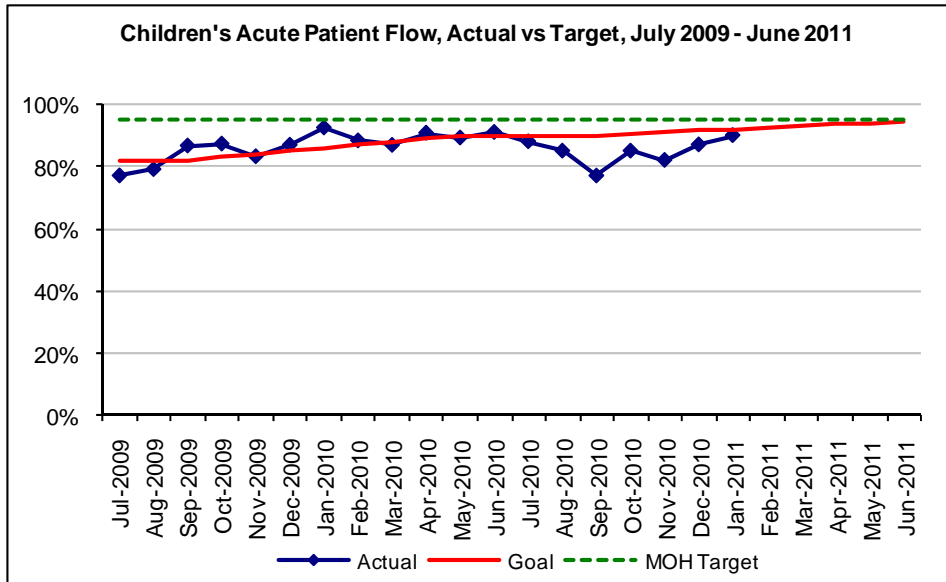
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan, Kay Hyman, Richard Aickin, Michael Shepherd, Janet Campbell, Stuart Dalziel



Project Risks / Comments:

Starship's admissions decreased in January as expected, however acute average monthly occupancy for was the highest January for 6 years – on average an extra 19 inpatients per day. This did impact on inpatient transfers, due to planned reduction in beds in the first 2-3 weeks in January, though no red alerts occurred.

There are a number of Process Improvement projects focussed on improving access to inpatient beds underway which will continue to deliver improvements over the next months.

Improvements to date:

- Business Case to develop CED Nurse Practitioners – 2x Nurse Specialist (in training for NP) appointed in January
- Improved Measurement systems to better identify clinical short stay patients
- Development of weekly dashboard reporting for CED to better track performance
- Daily reviews to identify specific reasons for delays on a case by case basis and to communicate findings with relevant teams
- Weekly communications of performance to ward level
- Development of 'full hospital plan' to improve responsiveness when indicators of 'bed block' developing
- Enhancement of electronic tracking systems for acute patient flow – going live in March

Immediate Actions to Lift Performance

- Opening of 4 additional beds to accommodate the mid week peaks – Tuesday, Wednesday, Thursday
- Increase use of transition lounge to improve bed availability
- Additional CNA to assist wards receiving patients to stop delays on patient transfer.
- Two nurse specialists to immediately take case load in CED
- Greater Starship CD engagement, Enhance communications to Charge nurses

Longer term projects

- Lean Six Sigma Green Belt projects in progress:
- Patient Transfers from CED to a ward where a bed is available
 - Bed turnaround time in ward 24B – time to discharge from Doctor's clearance
 - Inter hospital Paediatric transfers
 - Estimated Discharge Date accuracy in Paediatric

Project: Improved access to elective surgery

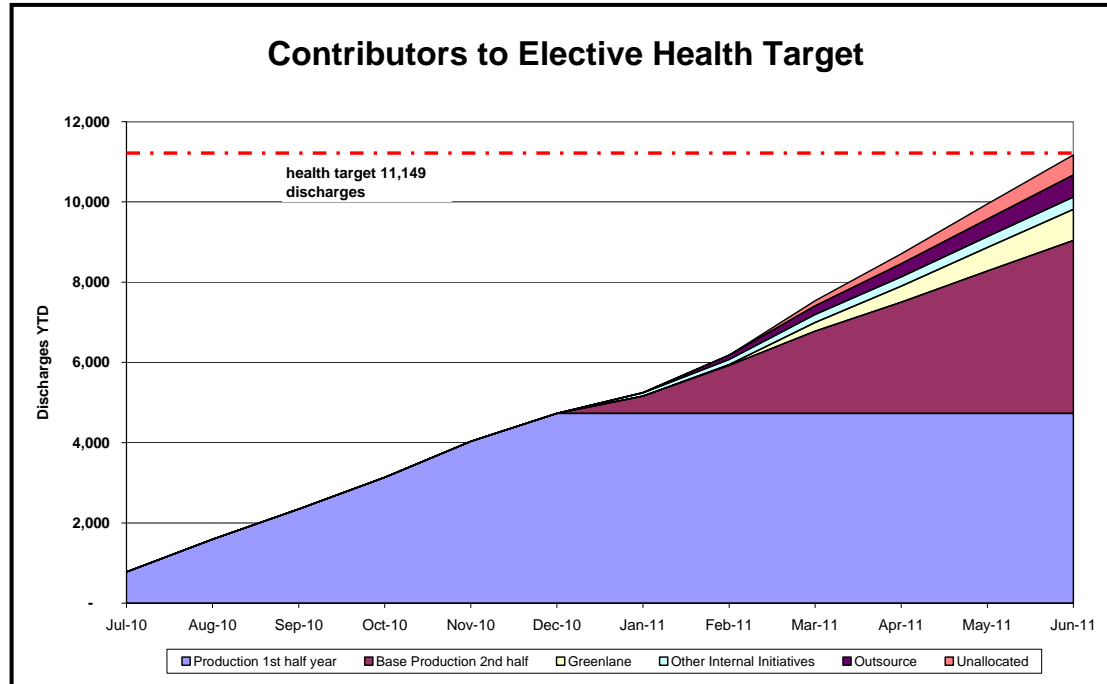
Primary Objective: Increase ADHB Elective Surgical Discharges from 10189 to 11149

Date of Delivery: 30 June 2011

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

Steering Group: Ngaire Buchanan, Dr Vanessa Beavis, Margaret Dotchin, Fionnagh Dougan, Ian Civil.



Planned activities:

1. Operationalising 2 new OR at Greenlane Surgical Centre during March and April. Additional 777 discharges
2. Other internal includes weekend ophthalmology lists at GSU in February and March and longer days at ACH & GSU, Additional 305 discharges.
3. Outsourcing across a range of specialties, Additional 550 discharges
4. As services confirm the production options we will allocate the 500 unallocated discharges to services.
5. We are also reviewing some data issues eg review of patient discharge data for electives coded as acutes & surgical discharges allocated to a medical specialty and not counted as an elective discharge,

Risks / Comments: (Amber)

Last month we indicated we had an ESPI 5 risk (patients waiting greater than 6 months for surgery) . ESPI non compliance would have a financial penalty of approximately \$3.7m however this risk has been mitigated by additional lists on weekends and outsourcing, improving scheduling and regular service meetings. We still have an ESPI 2 risk (patients waiting longer than 6 months for a first specialist assessment) we have actions in place to mitigate this risk by the end of March, providing the service and avoiding the penalty. Actions include prioritisation in existing clinics, extended clinic hrs during march, confirming requirements with patients and GP's. A more detailed plan for elective surgery will be provided at the Hospital Advisory Committee.

Project: Better help for smokers to quit

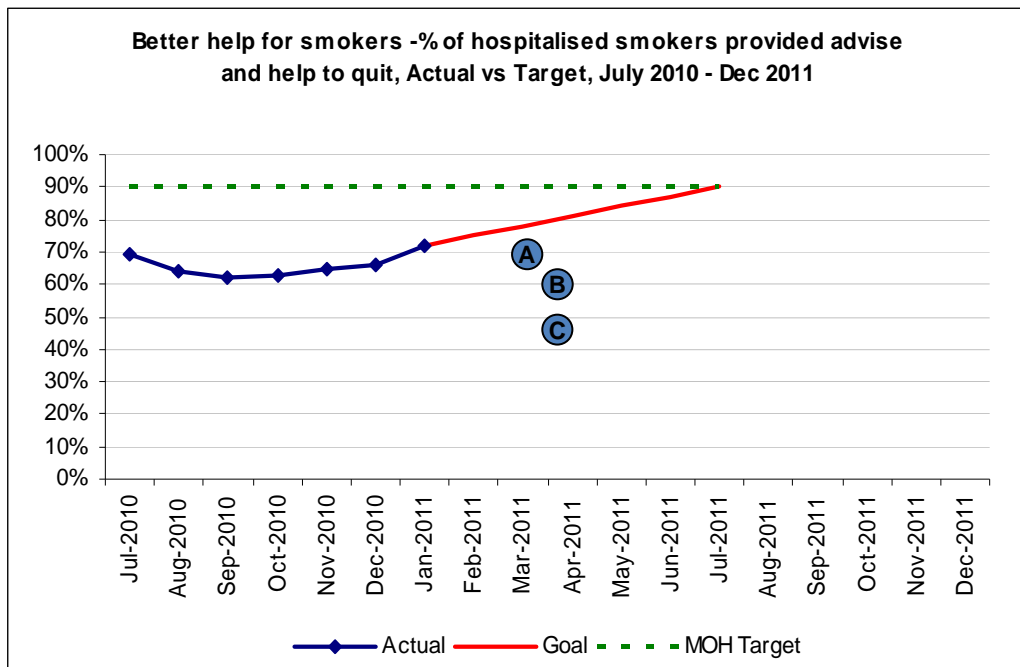
Primary Objective : % of hospitalised smokers provided advice and help to quit

Date of Delivery: 90% by 1/07/2011, 95% by 1/07/2012

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

Steering Group: Membership under review



Project Risks and Comments

Of the 7960 events coded in January, 1064 (13.4%) patients were identified as smokers and 762 (72%) of the smokers were documented as receiving advice or support to quit. Data suggests a positive trend in terms of inpatient nicotine withdrawal management. NRT dispensed to all services doubled in 2010 with a total of 66,818 NRT units dispensed compared to 31,092 in 2009.

Analysis of data by length of stay suggests that services with high volume and short length of stay (under 6 hrs) are less likely to be offered help to quit. To improve this a programme of ABC coaching and training updates are planned for February in Adult Emergency Department, APU, General Surgery and General Medicine. To improve clinical engagement and leadership of programme activities, membership of the Steering Group is under review.

Improvements to date:

- Direct follow up with wards/services underperforming in ward audits.
- ABC Training and coaching of staff in AED & APU.
- ABC chart reminders placed all in AED & APU folders
- Better Help for Smokers to Quit included in Releasing Time to Care KPIs.
- Recognition of wards/ services meeting target and sharing of learning

Immediate Actions to improve performance:

A. Focus on short stay and high volume areas:

- Smokefree team member to be based in AED and APU to coach staff on documenting the ABC.
- 1:1 ABC staff coaching to commence in General Medicine and General Surgery.
- Negotiation with Women's Health to identify best options to improve target performance using funded resources.

B. Improve engagement with clinical workforce:

- New intake of House Officers on 28th February to be trained on documentation of ABC.
- Campaign for a Call to Action to Senior Medical staff to encourage Registrars and House Officers to routinely assess smoking with patients and document the ABC.
- Monthly publication of results of Senior Medical Officer's Better Help for Smokers to Quit performance.
- Details of all Quit Card Providers to be included in monthly reports to services.
- Better Help for Smokers to Quit Steering group Terms of Reference and membership revised.
- Clinical research strategy under development

C. Data collection systems and processes:

- Meet with Clinical Coding team to review coding practise and identify areas for improvement.
- Monthly reports and data analysis to identify areas of improvement and address areas of underperformance with services.
- Electronic Discharge Summary data to be audited for consistency and accuracy against patient clinical records

Project: Shorter waits for Radiation Therapy

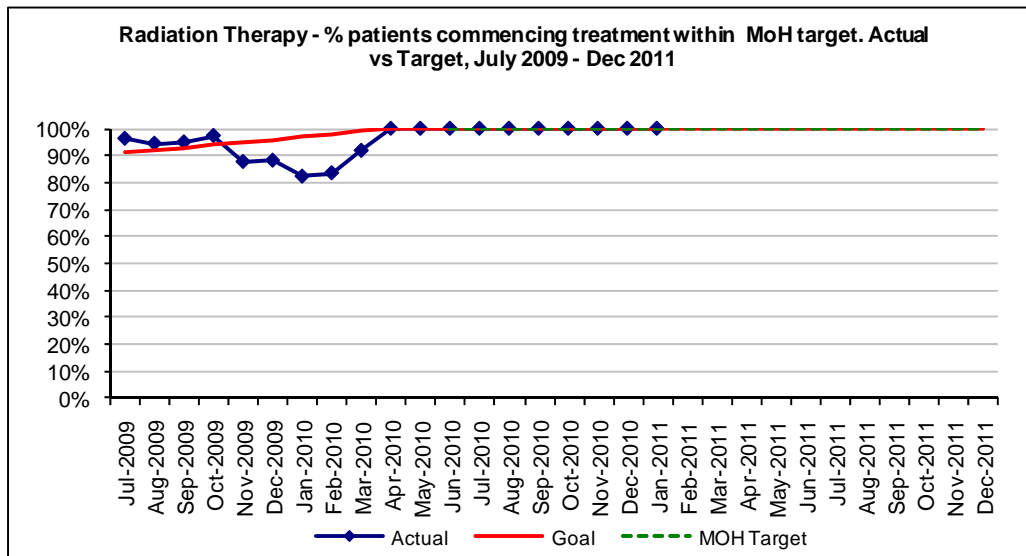
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

Steering Group: Fionnagh Dougan, Andrew Macann, Margaret White, Robyn Dunningham



Risks / Comments:

The service expects to be 100% compliant to the 4 week target for Quarter 3.

Key risks which may impact capacity:

- Linear Accelerator breakdown – the service experienced loss of capacity in January as a result of a series of small Linear Accelerator breakdowns. Strategies to sustain the target included rescheduling patients onto other machines, working through lunchtimes, outsourcing patients, and RT's working extended hours and evening shifts.
- The CT Simulator is down to one unit due to staff training requirements. This is being monitored daily to ensure any bottleneck is appropriately managed.
- RT staff vacancies – 3 resignations were received in December/ January. The service has secured two senior RT's from Toowoomba to work in the department on fixed term contracts from mid February to April to ensure production is sustained.

Radiation Oncology Wait times – January 2011

In January 100% of eligible patients were treated within the 4 week target for patients in priority categories A,B & C.

Improvements to date:

- MV5 Linear Accelerator is now fully operational. Extended hours: Extended hours have been implemented for RT staff where this is an option within the terms of their contract.
- **Outsourcing:** A short term agreement has been agreed with ARO for provision of public capacity.
- Model of service delivery has been developed which would underpin a long term partnership has been agreed.
- **Aria project:** A project is underway to develop a full electronic record within the LINAC machine's operating system. This will better match demand to capacity.
- **A weekly capacity modelling tool** has been developed and is now being used for future LINAC capacity planning, improved forecasting capability and management of workload.
- An "Operational team" has been established whose key accountability is to measure KPI's to prioritise the waitlist and analyse performance on a weekly basis.
- A daily Waitlist report has been developed for daily monitoring and immediate remedial action if required.
- Flexible working hours for Radiation Therapists were introduced in June 2010 and are ongoing.
- A comprehensive and ongoing recruitment plan to attract RT staff to the service.

Project: Cardiac Bypass Surgery

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 80.

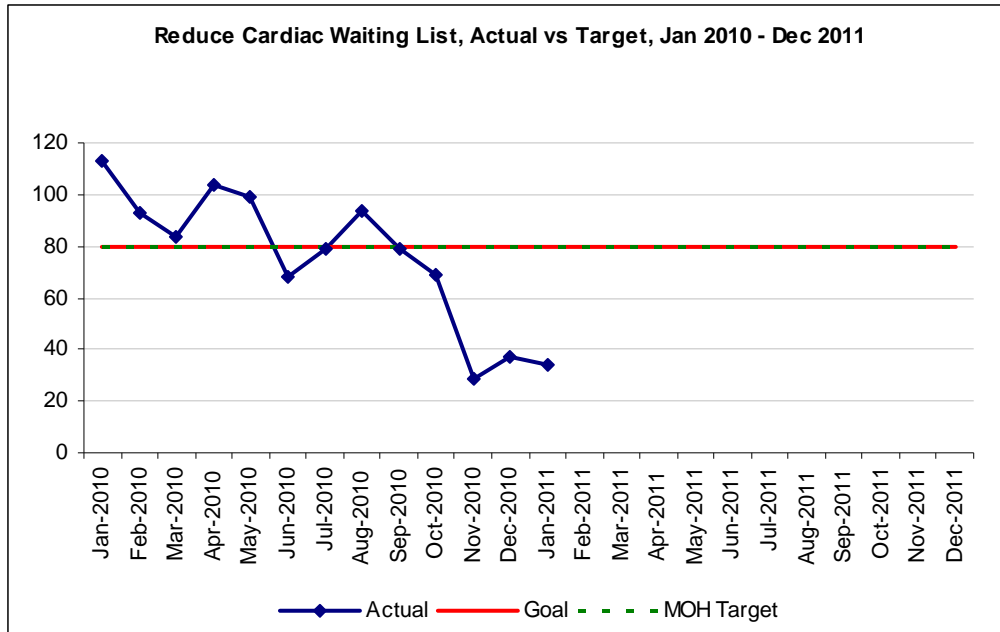
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2011

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Fionnagh Dougan

Steering Group: Marian Hussey, Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam McCormack, Greg Balla, Gordon Davies



Project Risks / Comments:

There are 45 patients on the waiting list as at the end of January 2011. YTD throughput is 15 (3%) patients less than planned as at end January 2011. Opportunities for additional capacity have been built into the production plan however catch up on the throughput target of 916 is constrained by a shortfall of additions to the waiting list. Work continues on improving the reliability and productivity of the service. The service is projected to complete 153 more bypass procedures (through the ACH facility) than last year (19% improvement)

Completed Improvement Activities:

- Developed and implemented electronic scheduling system
- Initiated pre admit process
- Developed detailed operational reporting
- Set up development production process
- Approved business case for CVICU bed capacity
- Built capacity planning model for CVICU and Ward 42
- Developed patient load planning tool
- Initiated daily bed management meeting

Further improvements in progress:

- Standard theatre roster
 - Provide greater weekly standardisation in supply of theatre resource, to improve planning and co ordination
- 3 in a row bypass (productive list)
 - Optimise the theatre schedule by planning a productive list
- ECMO – Resource planning process
 - To improve resource planning and day to day processes to reduce the impact of high ECMO demand
- The Productive Operating Room (NHS Programme)
 - To increase productivity and improve safety in theatre through better co ordination and removal of waste and frustrations
- CVICU/HDU Merge
 - To increase the overall skill mix so that staff can work in both units, adding flexibility and reducing cancellations
- Enhanced recovery initiative
 - To provide a pathway for suitable patients, reducing average LOS and cancellations
- Delay to discharge – ward 42
 - To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Delay to discharge CVICU
 - To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations

Project: Diabetes

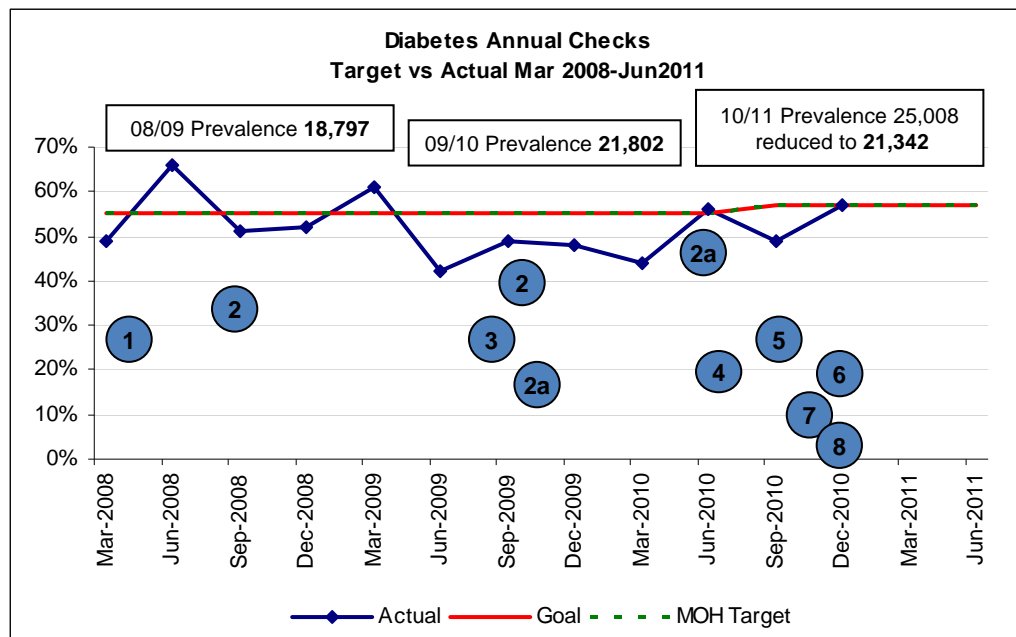
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 2) Practise based data (results) feedback
- 2a) Increase other feedback options
- 3) Improved understanding of IT linkages in Practice systems
- 4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
- 5) Routine reports to clinical advisory leadership meetings
- 6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
- 7) Regional shared care pathway work
- 8) Regional shared target setting and service outcomes

Project Risks / Comments:

Q2 shows we are now meeting target for DGC, however this is primarily due to the MOH decreasing the denominator for the expected number of people with diabetes. The number of Diabetes Annual Reviews for the Pacific and Indian populations are performing over 20% above target, with reviews for Maori now also above target under the revised prevalence. However, the performance for the Other group continues to underperform against target (42% against a target of 58%). In order to improve performance, the DHB is working with primary care to implement a comprehensive range of activities to improve DGC numbers and initiate an overall quality improvement framework. One initiative is a contract with the PHO's (through Auckland PHO) to employ long term condition quality improvement coordinators to work with all our priority practices to improve get checked performance. The first two coordinators start in February 2011. Another initiative is the funding of a Population audit tool for each practice to enable them to better interrogate their practice management system to identify and manage their population with long term conditions. This contract will be signed shortly. [Please note that the activity from Tongan Health Society has been estimated due to their data not being received in time for this report].

Project: Diabetes

Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

Date of Delivery: 79% of people with diabetes will have a HbA1c <8%

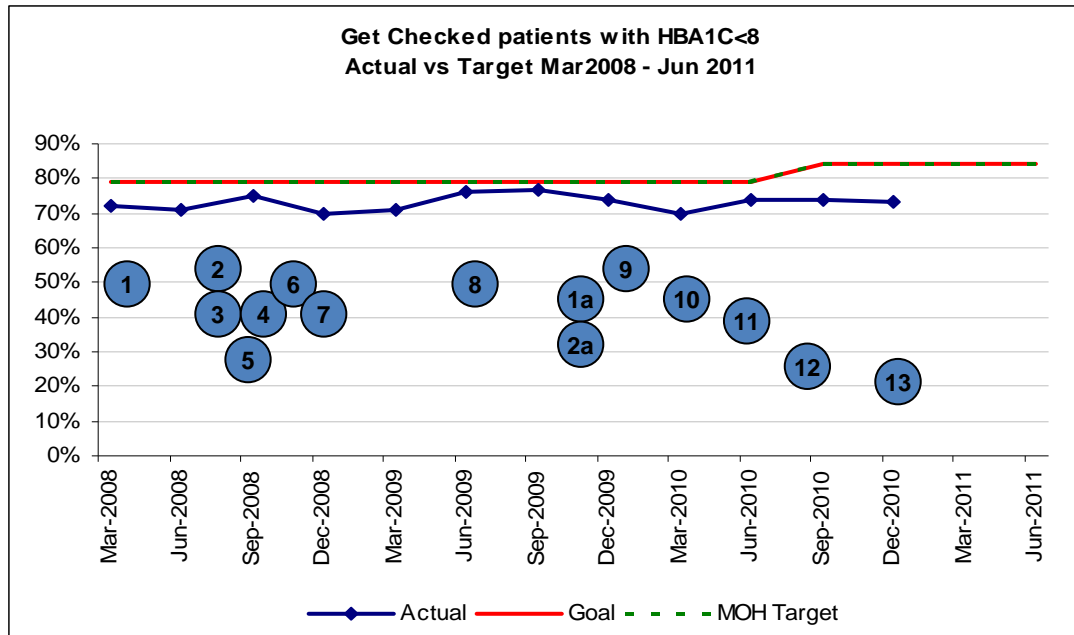
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team

Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 1a) reinforce awareness
- 2) Practise based data (results) feedback via various mediums including Health point
- 2a) increase feedback processes
- 3) Direct Secondary Service phone support for GPs
- 4) Increased community shared clinics with secondary care
- 5) Increased SEAsian Nurse Specialist access
- 6) Widened opportunity for self management to include greater than 2 year or less diagnosed people with diabetes
- 7) Improved culturally appropriate self management courses
- 8) Improved understanding of IT linkages in Practice systems (linking PPP)
- 9) Auckland Diabetes Advisory Team – structured agreed district plan of action
- 10) Redesign the supported self management to meet needs of population
- 11) Developing shared care pathway for Diabetes
- 12) Regional shared care pathway work including clinical workshop
- 13) Implementation plan being developed for diabetes coordinators (quality improvement roles) and population audit tools for each practice.



Project Risks / Comments:

Q2 of 2010/11 performance continues in the same trend as the previous quarter, and we have only achieved 73% against a target of 84% of people having an HbA1C <8. The main areas of underperformance are in our diabetic management of Maori and Pacific populations. As noted in the DGC report, the activities currently being put in place to improve the DGC targets should impact on management in the long term. Additionally a new contract is being signed with Te Hononga O Tamaki Me Hoturoa to provide Diabetes Self Management Education for the ADHB region. With their focus on providing to our high needs populations, we look to see improvement in the self management capacity of our high needs populations with diabetes.

Project: Cardiovascular Risk Assessment

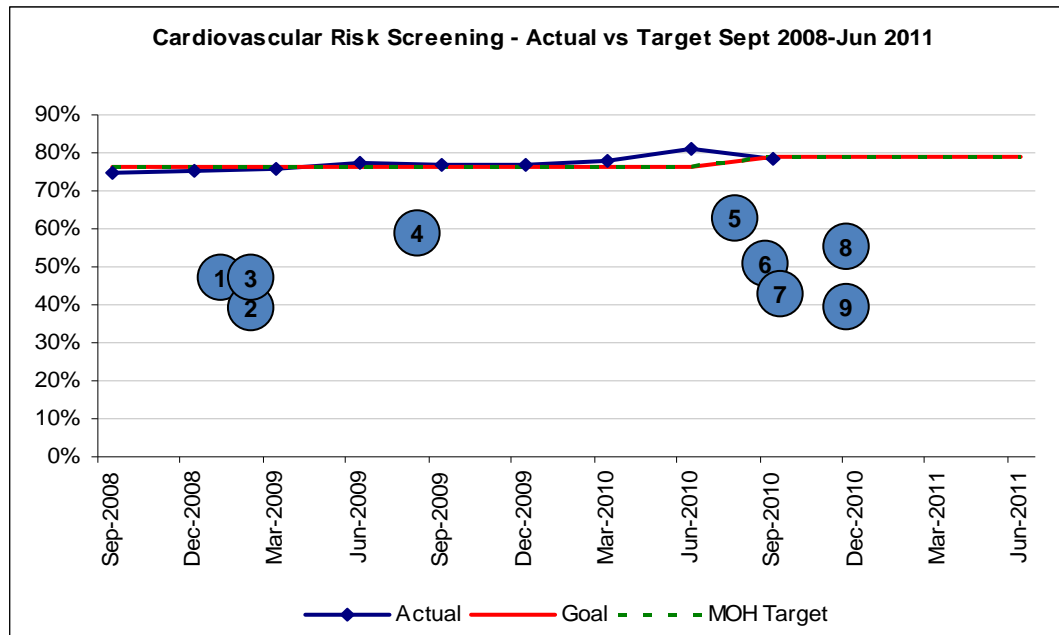
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

Date of Delivery: Overall goal is to have 80% of eligible population CVD risk assessed every five years.

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



Project Risks / Comments:

Q2 CVD data is not available from the MOH until February 2011. However the previous quarter showed that we are very close to reaching our overall target (78.5% against a target of 79%).

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract.

Recent and Current activities:

- 1) Support the uptake of an electronic CVD tool
- 2) Training and information system support for electronic tool
- 3) IT help line for GPs for risk assessment tool
- 4) Increase the cumulative incentive payments for achieving both good assessment and good management together
- 5) Review and reshape incentives to link with PPP targets
- 6) Enhance links to Green Rx and maximise primary care uptake
- 7) Continue to work in various workplaces to enhance CVD risk assessment for men
- 8) Link in with research looking at ways to optimise Pacific males participation in health self management
- 9) Work regionally to have similar focus on incentive goals

Project: Increased Immunisation

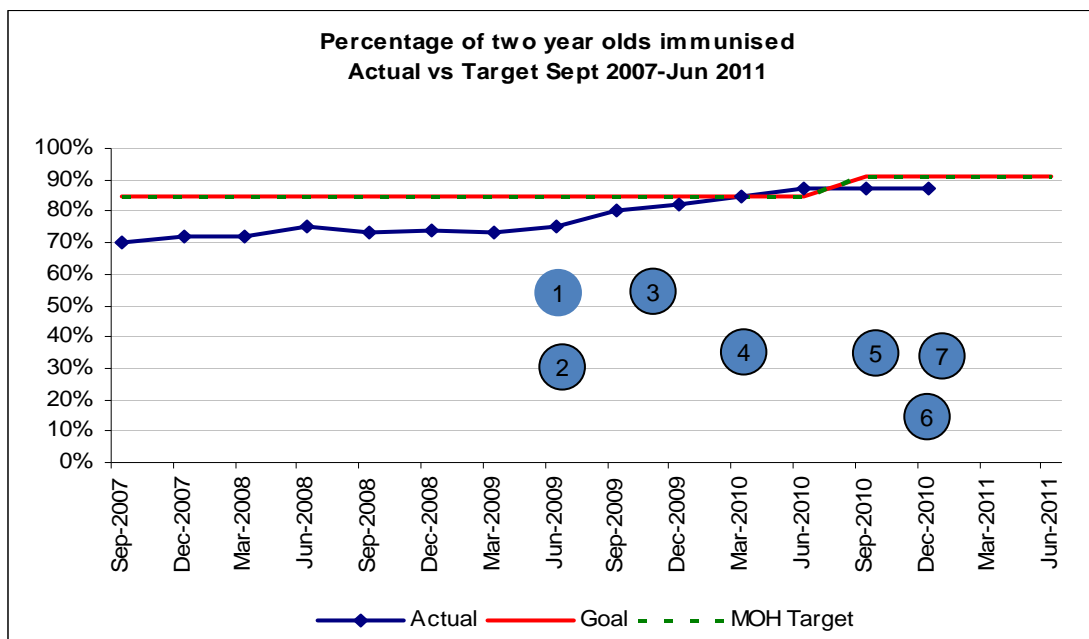
Primary goal: That 85% of two year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

Date of Delivery: 1 July 2010, 1 July 2011 and 1 July 2012

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

Steering Group: Richard Aickin, Carol Stott, Aroha Haggie, Hilda Faasalele, Ruth Bijl, Alison Leversha, IMAC, Auckland PHO, Public Health, Plunket, Commissioner for Children Office, Ministry of Health



Current activities

1. Practice level reporting available
2. Primary care Immunisation Coordinators funded ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.

Project Risks / Comments:

Coverage for Quarter 2, 2010/11 (2 years olds full immunised all ethnicities) remains at 87%. The data quality and practice nurse education project targeting systems issues has just began and is expected to result in increased coverage. Maori coverage at all milestone ages remains a challenge as does timeliness, in particular at 6 and 18 months. Opportunities to further engage high needs families through initiatives in MSD, MoE, Corrections and other agencies may help facilitate access for those highest needs children and their families/whanau.

7.7 Election 2010 Report



2010 TRIENNIAL ELECTION

REPORT TO THE AUCKLAND DISTRICT HEALTH BOARD

From the Electoral Officer

21 February 2011

Outline

The 2010 Auckland District Health Board's triennial election occurred on Saturday 9 October 2010 and was undertaken on behalf of the Board by the Auckland Transition Agency, on behalf of the Auckland Council. The election was conducted satisfactorily, on time and on budget and met all legislative and practical requirements.

This report summaries the electoral process.

1. INTRODUCTION

Local government elections are required to be held every three years, with the 2010 election occurring on Saturday 9 October 2010. The conduct of these elections is prescribed by legislation and regulation (New Zealand Public Health & Disabilities Act 2000, Local Electoral Act 2001 and Local Electoral Regulations 2001) to ensure public confidence and electoral integrity are maintained.

Two electoral systems (first past the post and single transferable voting) were again used together for most local authorities in New Zealand. All district health board elections are required to use the single transferable voting system (a requirement under the New Zealand Public Health & Disability Act 2000).

The 2010 Auckland District Health Board election was required to be undertaken by the Auckland Transition Agency on behalf of the Auckland Council, the territorial authority which the Board's district is within.

Dale Ofsoske was appointed electoral officer for the Auckland Council to undertake the 2010 elections.

With the elections now complete, this report details the various electoral processes undertaken, together with election statistics for the information of the Board.

2. NARRATIVE

2.1 Elections Required

Elections were undertaken for:

Auckland Council	-	Mayor, 20 Councillors, 149 Local Board Members
Waitemata District Health Board	-	7 Members
Auckland District Health Board	-	7 Members
Counties Manukau District Health Board	-	7 Members
Parakai Licensing Trust	-	6 Members
Birkenhead Licensing Trust	-	6 Members
Waitakere Licensing Trust	-	7 Members
Portage Licensing Trust	-	10 Members
Mt Wellington Licensing Trust	-	6 Members
Wiri Licensing Trust	-	6 Members

2.2 Election Timetable

Key election functions and dates were:

- Nomination period 23 July - 20 August 2010
- Inspection of Preliminary Electoral Roll 23 July - 20 August 2010
- Delivery of voting mailers 17-22 September 2010
- Special voting / early processing 17 September - 9 October 2010
- Election day/preliminary count 9 October 2010
- Official count 9-13 October 2010
- Return of Electoral Expenses & Donations Form by 10 December 2010

2.3 Electoral Roll

Only resident electors are eligible to vote for the district health board election.

The Residential Electoral Roll is formed from parliamentary electors, the register of this being maintained and supplied by the Electoral Enrolment Centre (a division of NZ Post).

2.4 Preliminary and Final Electoral Rolls

The Preliminary and Final Electoral Rolls were compiled for the new Auckland Council and associated other organisations (including the Board) and was divided into separate rolls for each Auckland Council local board area.

The Preliminary Electoral Roll was available for public inspection at all libraries and council offices region-wide between 23 July 2010 and 20 August 2010.

The total number of resident electors on the Final Electoral Roll was 957,490, of which 299,410 were eligible to vote in the Board's election.

2.5 Nominations

The nomination period was 23 July 2010 to 20 August 2010.

Nomination papers and candidate information booklets were available during this time:

- (i) by phoning a respective electoral office to have the material posted out;
- (ii) by visiting one of a number of locations to uplift the material;
- (iii) by downloading the material from the Board's website.

A total of 18 nominations were received for the seven vacancies. This compares to 27 nominations received for the seven vacancies at the 2007 election.

2.6 Voting Mailers

Voting mailers consisting of an outward envelope, return prepaid envelope, a revised 'new look' voting document and a candidate profile booklet (which included instructions in twelve different languages) were dispatched to electors from Friday 17 September 2010.

The voting mailers were produced by Datam (printer/mailhouse) in Auckland and were consistent in design layout to all other local authorities in the country.

2.7 Elector Turnout

Of the 959,120 resident and non-resident ratepayer electors whose details appeared on the Final Electoral Roll for the Auckland Council, 489,059 electors returned their voting document. This represents a 51.0% return and compares to a 37.3% return (an average of the seven territorial authorities now comprising the new Auckland Council) in 2007.

Of the 299,410 eligible electors in the Auckland District Health Board area, 154,656 (or 51.7%) returned their voting documents, a significant improvement over a return of 39.6% in 2007.

A schedule of the number of daily returned voting documents for the Auckland Council election is attached (**Appendix 1**).

The 2010 average nationwide elector turnout is 49.1% which is a substantial improvement on the 43.6% average achieved at the 2007 election.

2.8 Results

The preliminary results were released at 11:30am on Sunday 10 October 2010 and the final results (Declaration of Results of Election – see **Appendix 2**) were made on Friday 15 October 2010.

Under the STV electoral system, no progress results were released – the preliminary results are released only when all votes/preferences have been included, excluding special votes requiring clarification.

For the Auckland District Health Board issue, there was quite a high number of 'informal' and 'blank' voting documents returned. Of the 154,656 returned voting documents, 26,710 (or 17.3%) were returned 'blank' (not voted on) and 11,265 (or 7.3%) were deemed 'informal'.

'Blank' votes simply mean the elector did not wish to vote for a particular issue, and apart from greater public education/promotion, there is little that can be done to encourage a voter to complete all sections of the voting document.

'Informal' votes are where the voter has marked the voting document incorrectly (eg ticked as for first past the post rather than a number ranking) or the voter's intention is not clear.

A copy of the STV "iteration report" is available on request.

Those elected were Jo AGNEW, Chris CHAMBERS, Lee MATHIAS, Judith BASSETT, Peter AITKEN, Susan BUCKLAND and Robyn NORTHEY.

2.9 Election Costs

The cost to the Auckland District Health Board for its 2010 election is \$335,000 + GST, or for 299,410 electors, \$1.19 + GST per elector.

This compares to the estimated budgeted cost of \$365,000 + GST and to the 2007 cost of \$316,119 + GST (or \$1.11 + GST per elector).

2.10 Role of Electoral Officer

The New Zealand Public Health & Disabilities Act 2000 requires a district health board to appoint the Electoral Officer of one of its constituent territorial authorities as its Electoral Officer. In the case of the Auckland District Health Board, this must be the Electoral Officer of the Auckland Council.

The Auckland Council has decided to bring the role of the Electoral Officer 'in-house' and has accordingly appointed a staff member (Bruce Thomas) as the Electoral Officer for Auckland Council.

3. SUMMARY and CONCLUSIONS

The Auckland District Health Board's 2010 triennial election was conducted successfully and met all legislative and practical requirements. No issues or concerns of significance arose from these elections and all tasks were completed satisfactorily, on time and on budget.

Author:



Dale Ofsoske
Electoral Officer
Independent Election Services Ltd
for Auckland District Health Board

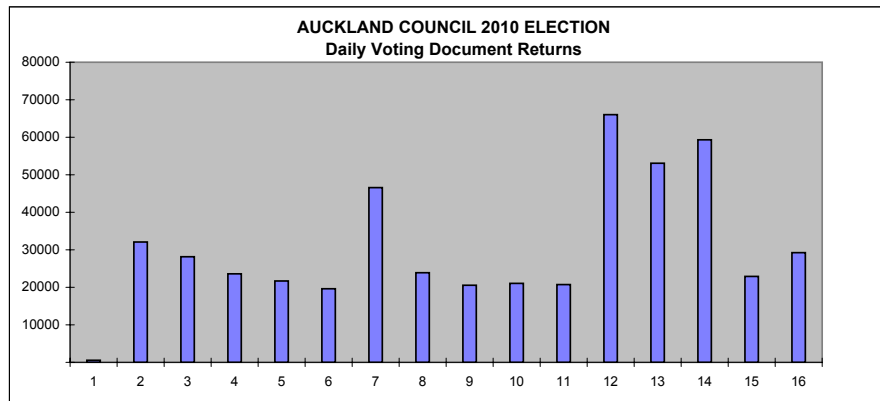
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VOTING DOCUMENT RETURNS - 2010 ELECTIONS

ELECTION DAY*

LB(SUB)/ELECTORS	20-Sep	21-Sep	22-Sep	23-Sep	24-Sep	27-Sep	28-Sep	29-Sep	30-Sep	1-Oct	4-Oct	5-Oct	6-Oct	7-Oct	8-Oct	9-Oct
ALBERT-EDEN (MAUNGAWHAU)	19	1069	795	666	635	601	1680	776	678	760	719	2538	2095	2387	832	1233
33953	19	1088	1883	2549	3184	3785	5465	6241	6919	7679	8398	10936	13031	15418	16250	17483
	0.1%	3.2%	5.5%	7.5%	9.4%	11.1%	16.1%	18.4%	20.4%	22.6%	24.7%	32.2%	38.4%	45.4%	47.9%	51.5%
ALBERT-EDEN (OWAIRAKA)	6	659	893	807	717	614	1673	886	758	663	770	2385	1754	2228	865	1041
32741	6	665	1558	2365	3082	3696	5369	6255	7013	7676	8446	10831	12585	14813	15678	16719
	0.0%	2.0%	4.8%	7.2%	9.4%	11.3%	16.4%	19.1%	21.4%	23.4%	25.8%	33.1%	38.4%	45.2%	47.9%	51.1%
DEVONPORT-TAKAPUNA	23	1495	1002	788	789	648	2163	997	863	915	987	3408	2650	3271	1104	1582
41144	23	1518	2520	3308	4097	4745	6908	7905	8768	9683	10670	14078	16728	19999	21103	22685
	0.1%	3.7%	6.1%	8.0%	10.0%	11.5%	16.8%	19.2%	21.3%	23.5%	25.9%	34.2%	40.7%	48.6%	51.3%	55.1%
FRANKLIN (PUKEKOHE)	20	796	657	576	507	454	914	555	406	498	493	1171	1097	1153	502	624
20310	20	816	1473	2049	2556	3010	3924	4479	4885	5383	5876	7047	8144	9297	9799	10423
	0.1%	4.0%	7.3%	10.1%	12.6%	14.8%	19.3%	22.1%	24.1%	26.5%	28.9%	34.7%	40.1%	45.8%	48.2%	51.3%
FRANKLIN (WAIROA)	17	731	467	355	300	334	613	366	333	324	370	957	850	1106	463	400
14085	17	748	1215	1570	1870	2204	2817	3183	3516	3840	4210	5167	6017	7123	7586	7986
	0.1%	5.3%	8.6%	11.1%	13.3%	15.6%	20.0%	22.6%	25.0%	27.3%	29.9%	36.7%	42.7%	50.6%	53.9%	56.7%
FRANKLIN (WAIUKU)	2	405	10	534	139	198	383	224	170	217	225	28	918	687	232	297
9330	2	407	417	951	1090	1288	1671	1895	2065	2282	2507	2535	3453	4140	4372	4669
	0.0%	4.4%	4.5%	10.2%	11.7%	13.8%	17.9%	20.3%	22.1%	24.5%	26.9%	27.2%	37.0%	44.4%	46.9%	50.0%
GREAT BARRIER	3	74	36	0	53	27	45	29	15	8	42	52	47	53	15	54
705	3	77	113	113	166	193	238	267	282	290	332	384	431	484	499	553
	0.4%	10.9%	16.0%	16.0%	23.5%	27.4%	33.8%	37.9%	40.0%	41.1%	47.1%	54.5%	61.1%	68.7%	70.8%	78.4%
HENDERSON-MASSEY	35	2174	1696	1332	1260	1256	2829	1524	1392	1283	1344	4093	3523	4098	1809	1778
69150	35	2209	3905	5237	6497	7753	10582	12106	13498	14781	16125	20218	23741	27839	29648	31426
	0.1%	3.2%	5.6%	7.6%	9.4%	11.2%	15.3%	17.5%	19.5%	21.4%	23.3%	29.2%	34.3%	40.3%	42.9%	45.4%
HIBISCUS & BAYS (EAST COAST BAYS)	6	748	645	525	590	508	1578	756	712	667	687	3023	2346	2895	948	1126
33117	6	754	1399	1924	2514	3022	4600	5356	6068	6735	7422	10445	12791	15686	16634	17760
	0.0%	2.3%	4.2%	5.8%	7.6%	9.1%	13.9%	16.2%	18.3%	20.3%	22.4%	31.5%	38.6%	47.4%	50.2%	53.8%
HIBISCUS & BAYS (HIBISCUS COAST)	10	1190	784	823	787	660	1612	793	679	717	774	2401	1745	2050	674	1000
30801	10	1200	1984	2807	3594	4254	5866	6659	7338	8055	8829	11230	12975	15025	15699	16699
	0.0%	3.9%	6.4%	9.1%	11.7%	13.8%	19.0%	21.6%	23.8%	26.2%	28.7%	36.5%	42.1%	48.8%	51.0%	54.2%
HOWICK (BOTANY)	15	604	933	845	791	701	1735	810	718	718	740	2406	1527	1642	671	616
29431	15	619	1552	2397	3188	3889	5624	6434	7152	7870	8610	11016	12543	14185	14856	15472
	0.1%	2.1%	5.3%	8.1%	10.8%	13.2%	19.1%	21.9%	24.3%	26.7%	29.3%	37.4%	42.6%	48.2%	50.5%	52.8%
HOWICK (HOWICK)	6	338	1105	997	821	813	1902	920	777	892	902	2744	1867	1968	721	836
30715	6	344	1449	2446	3267	4080	5982	6902	7679	8571	9473	12217	14084	16052	16773	17609
	0.0%	1.1%	4.7%	8.0%	10.6%	13.3%	19.5%	22.5%	25.0%	27.9%	30.8%	39.8%	45.9%	52.3%	54.6%	57.3%
HOWICK (PAKURANGA)	13	206	875	841	856	779	1794	858	741	781	757	2451	1870	1821	684	763
29192	13	219	1094	1935	2791	3570	5364	6222	6963	7744	8501	10952	12822	14643	15327	16090
	0.0%	0.8%	3.7%	6.6%	9.6%	12.2%	18.4%	21.3%	23.9%	26.5%	29.1%	37.5%	43.9%	50.2%	52.5%	55.1%
KAIPATIKI	29	1721	1198	903	897	888	2360	1176	1080	1153	1182	4061	3285	4442	1505	1891
57938	29	1750	2948	3851	4748	5636	7996	9172	10252	11405	12587	16648	19933	24375	25880	27771
	0.1%	3.0%	5.1%	6.6%	8.2%	9.7%	13.8%	15.8%	17.7%	19.7%	21.7%	28.7%	34.4%	42.1%	44.7%	47.9%
MANGERE-OTAHUHU	25	1815	1929	1544	1300	1185	1983	1007	982	877	801	2047	1605	1768	705	1179
44681	25	1840	3769	5313	6613	7798	9781	10788	11770	12647	13448	15495	17100	18868	19573	20752
	0.1%	4.1%	8.4%	11.9%	14.8%	17.5%	21.9%	24.1%	26.3%	28.3%	30.1%	34.7%	38.3%	42.2%	43.8%	46.4%
MANUREWA	13	2048	1773	1461	1258	1161	2432	1208	1150	1094	1002	3056	2298	2373	948	1363
51481	13	2061	3834	5295	6553	7714	10146	11354	12504	13598	14600	17656	19954	22327	23275	24638
	0.0%	4.0%	7.4%	10.3%	12.7%	15.0%	19.7%	22.1%	24.3%	26.4%	28.4%	34.3%	38.8%	43.4%	45.2%	47.9%
MAUNGAKIEKIE-TAMAKI (MAUNGAKIEKIE)	19	756	663	471	400	367	984	461	417	479	410	1340	1060	1170	478	573
19396	19	775	1438	1909	2309	2676	3660	4121	4538	5017	5427	6767	7827	8997	9475	10048
	0.1%	4.0%	7.4%	9.8%	11.9%	13.8%	18.9%	21.2%	23.4%	25.9%	28.0%	34.9%	40.4%	46.4%	48.9%	51.8%
MAUNGAKIEKIE-TAMAKI (TAMAKI)	19	924	1010	675	748	580	1306	709	580	548	441	1519	1219	1388	467	638
27902	19	943	1953	2628	3376	3956	5262	5971	6551	7099	7540	9059	10278	11666	12133	12771
	0.1%	3.4%	7.0%	9.4%	12.1%	14.2%	18.9%	21.4%	23.5%	25.4%	27.0%	32.5%	36.8%	41.8%	43.5%	45.8%
ORAKEI	46	2423	2053	1623	1480	1358	3749	1801	1402	1505	1472	4840	3777	4250	1536	2138
60369	46	2469	4522	6145	7625	8983	12732	14533	15935	17440	18912	23752	27529	31779	33315	35453
	0.1%	4.1%	7.5%	10.2%	12.6%	14.9%	21.1%	24.1%	26.4%	28.9%	31.3%	39.3%	45.6%	52.6%	55.2%	58.7%
OTARA-PAPATOETOE (OTARA)	19	936	1032	781	718	553	785	464	454	432	356	726	555	605	332	434
20162	19	955	1987	2768	3486	4039	4824	5288	5742	6174	6530	7256	7811	8416	8748	9182
	0.1%	4.7%	9.9%	13.7%	17.3%	20.0%	23.9%	26.2%	28.5%	30.6%	32.4%	36.0%	38.7%	41.7%	43.4%	45.5%

OTARA-PAPATOETOE (PAPATOETOE)	12	1274	1194	931	847	672	1514	741	604	632	539	1842	1238	1222	560	675
28462	12	1286	2480	3411	4258	4930	6444	7185	7789	8421	8960	10802	12040	13262	13822	14497
	0.0%	4.5%	8.7%	12.0%	15.0%	17.3%	22.6%	25.2%	27.4%	29.6%	31.5%	38.0%	42.3%	46.6%	48.6%	50.9%
PAPAKURA	17	1682	1058	668	700	580	1232	674	573	554	508	1776	1318	1338	526	678
29234	17	1699	2757	3425	4125	4705	5937	6611	7184	7738	8246	10022	11340	12678	13204	13882
	0.1%	5.8%	9.4%	11.7%	14.1%	16.1%	20.3%	22.6%	24.6%	26.5%	28.2%	34.3%	38.8%	43.4%	45.2%	47.5%
PUKETAPAPA	19	1090	1100	980	754	739	1896	981	849	869	863	2728	2097	2348	863	1067
38078	19	1109	2209	3189	3943	4682	6578	7559	8408	9277	10140	12868	14965	17313	18176	19243
	0.0%	2.9%	5.6%	8.4%	10.4%	12.3%	17.3%	19.9%	22.1%	24.4%	26.6%	33.8%	39.3%	45.5%	47.7%	50.5%
RODNEY (DAIRY FLAT)	3	155	130	73	96	80	189	99	91	95	129	346	300	376	133	159
4481	3	158	288	361	457	537	726	825	916	1011	1140	1486	1786	2162	2295	2454
	0.1%	3.5%	6.4%	8.1%	10.2%	12.0%	16.2%	18.4%	20.4%	22.6%	25.4%	33.2%	39.9%	48.2%	51.2%	54.8%
RODNEY (KUMEU)	14	684	473	246	322	302	592	432	295	363	382	1180	891	1228	489	658
16776	14	698	1171	1417	1739	2041	2633	3065	3360	3723	4105	5285	6176	7404	7893	8551
	0.1%	4.2%	7.0%	8.4%	10.4%	12.2%	15.7%	18.3%	20.0%	22.2%	24.5%	31.5%	36.8%	44.1%	47.0%	51.0%
RODNEY (WARKWORTH)	21	820	459	364	372	352	616	345	276	314	321	945	702	755	350	388
12400	21	841	1300	1664	2036	2388	3004	3349	3625	3939	4260	5205	5907	6662	7012	7400
	0.2%	6.8%	10.5%	13.4%	16.4%	19.3%	24.2%	27.0%	29.2%	31.8%	34.4%	42.0%	47.6%	53.7%	56.5%	59.7%
RODNEY (WELLSFORD)	9	227	114	84	101	90	183	106	53	90	81	192	200	204	86	73
3702	9	236	350	434	535	625	808	914	967	1057	1138	1330	1530	1734	1820	1893
	0.2%	6.4%	9.5%	11.7%	14.5%	16.9%	21.8%	24.7%	26.1%	28.6%	30.7%	35.9%	41.3%	46.8%	49.2%	51.1%
UPPER HARBOUR	13	1149	760	556	565	568	1436	731	657	694	687	2728	2097	2535	881	967
34412	13	1162	1922	2478	3043	3611	5047	5778	6435	7129	7816	10544	12641	15176	16057	17024
	0.0%	3.4%	5.6%	7.2%	8.8%	10.5%	14.7%	16.8%	18.7%	20.7%	22.7%	30.6%	36.7%	44.1%	46.7%	49.5%
WAIHEKE	6	355	263	243	196	155	344	209	123	184	189	447	323	295	206	374
5979	6	361	624	867	1063	1218	1562	1771	1894	2078	2267	2714	3037	3332	3538	3912
	0.1%	6.0%	10.4%	14.5%	17.8%	20.4%	26.1%	29.6%	31.7%	34.8%	37.9%	45.4%	50.8%	55.7%	59.2%	65.4%
WAITAKERE RANGES	17	1043	647	629	650	563	1413	767	697	654	696	2207	1990	2542	1077	1379
32953	17	1060	1707	2336	2986	3549	4962	5729	6426	7080	7776	9983	11973	14515	15592	16971
	0.1%	3.2%	5.2%	7.1%	9.1%	10.8%	15.1%	17.4%	19.5%	21.5%	23.6%	30.3%	36.3%	44.0%	47.3%	51.5%
WAITEMATA	62	1360	1132	1024	854	814	2237	1244	892	939	881	2950	2471	2868	1045	1798
46004	62	1422	2554	3578	4432	5246	7483	8727	9619	10558	11439	14389	16860	19728	20773	22571
	0.1%	3.1%	5.6%	7.8%	9.6%	11.4%	16.3%	19.0%	20.9%	23.0%	24.9%	31.3%	36.6%	42.9%	45.2%	49.1%
WHAU	16	1122	1261	1251	1180	1020	2402	1244	1138	1134	983	3444	3364	2253	1201	1459
50036	16	1138	2399	3650	4830	5850	8252	9496	10634	11768	12751	16195	19559	21812	23013	24472
	0.0%	2.3%	4.8%	7.3%	9.7%	11.7%	16.5%	19.0%	21.3%	23.5%	25.5%	32.4%	39.1%	43.6%	46.0%	48.9%
TOTAL	554	32073	28147	23596	21683	19620	46574	23893	20555	21053	20733	66031	53079	59319	22908	29241
959120	554	32627	60774	84370	106053	125673	172247	196140	216695	237748	258481	324512	377591	436910	459818	489059
	0.06%	3.40%	6.34%	8.80%	11.06%	13.10%	17.96%	20.45%	22.59%	24.79%	26.95%	33.83%	39.37%	45.55%	47.94%	50.99%
DAILY %	0.08%	3.34%	2.93%	2.46%	2.26%	2.05%	4.86%	2.49%	2.14%	2.20%	2.16%	6.88%	5.53%	6.18%	2.33%	3.05%
2007 Average for Auckland	0.8%	3.2%	5.3%	7.9%	9.4%	11.9%	13.5%	15.5%	17.3%	19.2%	22.2%	24.3%	27.2%	31.0%	34.7%	37.3%



* including special votes

DECLARATION OF RESULT OF ELECTION

for the 2010 elections of three district health boards in the Auckland region

I hereby declare the results of the elections held on 9 October 2010 for the following offices:



Auckland District Health Board (seven vacancies)

Votes Received		Votes Received		Votes Received	
AGNEW, Jo (City Vision Health)	Elected	NORTHEY, Robyn (City Vision Health)	Elected	FERGUS, Brian (Citizens & Ratepayers)	Excluded
CHAMBERS, Chris (Citizens & Ratepayers)	Elected	TIZARD, Bob (City Vision Health)	Excluded	SHARMA, Vinod	Excluded
MATHIAS, Lee (Citizens & Ratepayers)	Elected	WARD, Ian (Citizens & Ratepayers)	Excluded	GAETA, Helen	Excluded
BASSETT, Judith (Citizens & Ratepayers)	Elected	ELLEY, Jeanette (City Vision Health)	Excluded	SUIN, Tanya (Independent)	Excluded
AITKEN, Peter (Citizens & Ratepayers)	Elected	SAAFI, Edward (Citizens & Ratepayers)	Excluded	RUSSELL, Gary (Independent)	Excluded
BUCKLAND, Susan (Independent)	Elected	FRASER, David (Independent)	Excluded	MACNAB, Moira	Excluded

Informal votes received: 11265

Blank votes received: 26710

I therefore declare Jo AGNEW, Chris CHAMBERS, Lee MATHIAS, Judith BASSETT, Peter AITKEN, Susan BUCKLAND and Robyn NORTHEY to be elected.

The final quota as determined at the last iteration was 13671.05371.

Full details of the official results of the election are available on request from the electoral officer (Phone (09) 973 5212)



Counties Manukau District Health Board (seven vacancies)

ANAE, Arthur (Independent)	Elected	STEVENS, Hamish (Citizens & Ratepayers)	Excluded	PADFIELD, Mike (Community Voice)	Excluded
BROWN, Colleen (Team Healthy Counties Manukau)	Elected	MANAPORI, Tupou Tamata (ABC - A Better Choice)	Excluded	DAVIS, Sally (Independent)	Excluded
WICHMAN, Bob (Citizens & Ratepayers)	Elected	WONG-TUNG, David (Citizens & Ratepayers)	Excluded	MISA-TUPOU, Fia (Citizens & Ratepayers)	Excluded
CRESSEY, Paul (Independent)	Elected	CATCHPOLE, Brent (Independent)	Excluded	MACKERETH, Gayleen (Independent)	Excluded
COLLINGS, David (Residents and Ratepayers Team)	Elected	SINGH, Ajit (Citizens & Ratepayers)	Excluded	DARIER, Rene (Independent)	Excluded
BARKER, Don (Independent)	Elected	LUXTON, Therese (Team Healthy Counties Manukau)	Excluded	PHARE, Janet	Excluded
MURPHY, Lyn (Citizens & Ratepayers)	Elected	NGATAI, George (Citizens & Ratepayers)	Excluded	JONES, David Jenkins	Excluded
DALTON, Angela (Manurewa Action Team)	Excluded	MORRISSEY, Brent	Excluded	SCHULZE, Alison	Excluded

Informal votes received: 9674

Blank votes received: 19714

I therefore declare Arthur ANAE, Colleen BROWN, Bob WICHMAN, Paul CRESSEY, David COLLINGS, Don BARKER and Lyn MURPHY to be elected.

The final quota as determined at the last iteration was 14055.14258.

Full details of the official results of the election are available on request from the electoral officer (Phone (09) 973 5212)



Waitemata District Health Board (seven vacancies)

ABBOTT, Max (Health Board Action)	Elected	WILLIAMS, Andrew (Independent Progressive Leadership)	Excluded	KEARNEY, June (Citizens & Ratepayers)	Excluded
BOOTH, Pat (Independent)	Elected	HOADLEY, Wyn (Independent)	Excluded	REID, Ngaroimata (Tu Wahine Trust)	Excluded
RANKIN, Christine (North Now)	Elected	LUJ, David (CAP - Communities Advancing Prosperity)	Excluded	DUNN, Ivan	Excluded
CONEY, Sandra (Independent)	Elected	ADAMS, Tracey	Excluded	THORNTON, David (Independent)	Excluded
FLAUNTY, Warren William (Health Board Action)	Elected	BRADLEY, Ian	Excluded	MILLER, Neil	Excluded
ROE, Allison	Elected	ASHBY, Steve (Independent)	Excluded	SIDDALL, Anne (North Now)	Excluded
LE FEVRE, James	Elected	BAU, Russell	Excluded	LYTHE, Mary	Excluded
BENSON-COOPER, Mary-Anne (Independent)	Excluded	LAWLEY, Judy (Totally Independent)	Excluded	EDINBOROUGH, Sharon (Independent)	Excluded
COOPER, Linda (Citizens & Ratepayers)	Excluded	NOBILO, Leo Frank (Te Atatu Senior Citizens)	Excluded	WHITEHEAD, Max (North Now)	Excluded
COLEMAN, Lynne (Independent)	Excluded	WILLIAMS, Mike	Excluded		
NEESON, Brian (Independent)	Excluded	SULLIVAN, Paddy	Excluded		

Informal votes received: 11628

Blank votes received: 21450

I therefore declare Max ABBOTT, Pat BOOTH, Christine RANKIN, Sandra CONEY, Warren William FLAUNTY, Allison ROE and James LE FEVRE to be elected.

The final quota as determined at the last iteration was 16506.07617.

Full details of the official results of the election are available on request from the electoral officer (Phone (09) 973 5212)

Dated at Auckland, 15 October 2010

Dale Ofoske

Electoral Officer

phone (09) 973 5212 or 0800 922 822

Level 8, 92 Albert Street, Auckland.

Local Elections 2010
**YOUR VOTE
YOUR COMMUNITY**

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

, .1 Committee Recommendations

, .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

ADHB Board

Author: Ian Bell (8077)

Subject: Disability Access Review

Recommendation

That the Disability Support Advisory Committee recommends the Accessibility Report to the Board for adoption in principle, and a request to Management to develop an implementation of plan.

Background

The Disability Support Advisory Committee received the disability access review final report at its meeting on 16 February 2011 and recommends that the Board adopts it in principle with Management to prioritise the recommendations and develop an implementation plan.

PERFORMANCE IMPROVEMENT

- .1 DAP Projects Report

Group Pack Report

Group/Committee: Board



Goal Level Summary

DAP Projects - total projects: 107

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Define	Measure	Analyse	Do/Check/Improve	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
1 Lift the Health of the people in Auckland City	40	40	11	9	3	13	3	0	36	3	0	39	0	0	38	1	0	1	1	0	0
2 Performance improvement	56	54	9	7	8	25	3	0	39	14	1	49	4	1	49	4	1	2	2	0	0
3 Live within our means	11	10	2	1	3	2	1	0	8	2	0	10	0	0	10	0	0	1	1	0	0
Total #	107	104	22	17	14	40	7	0	83	19	1	98	4	1	97	5	1	4	4	0	0
Total %	100%	97%	21%	16%	13%	37%	7%	0%	78%	18%	1%	92%	4%	1%	91%	5%	1%	4%	4%	0%	0%

Goal: 1 Lift the Health of the people in Auckland City

Exceptions













Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	Committee
Increase access and capacity to community diabetic eye screening	National	Analyse				Good to see the two parts of the approach are coalescing with vendors and solutions coming to finalisation. The discussion document process is good to see. It is good to see that activity of the community provider to undertake screening for some of our patients has started.	CPHAC




Legend: Red - , Orange - , Green -

Goal: 2 Performance improvement

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	Committee
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Adult 6-hour project	National	Improve				Record numbers were experienced in the early part of January 2010. Improvement noted in January and February (quarter to date) to 80%. A number of activities are underway to boost performance immediately. A five day rapid improvement event is planned for April to accelerate identification and implementation of solutions. Daily results are now being posted in AED. Daily breach review meetings underway. Visits to CMDHB and WDHb completed with several successful strategies being implemented at ACH. Main risks ongoing include General Medicine continuing to be under considerable pressure due to workload, vacancies and team cohesion. Mitigation includes use of subspecialty teams to support. Further work also required in most medical and surgical specialities to improve time from referral from ED to time to decision to admit / discharge.	HAC
Better help for smokers to quit	National	Improve				Of the 7960 events coded in January, 1064 (13.4%) patients were identified as smokers and 762 (72%) of the smokers were documented as receiving advice or support to quit. Data suggests a positive trend in terms of inpatient nicotine withdrawal management. NRT dispensed to all services doubled in 2010 with a total of 66,818 NRT units dispensed compared to 31,092 in 2009. Analysis of data by length of stay suggests that services with high volume and short length of stay (under 6 hrs) are less likely to be offered help to quit. To improve this a programme of ABC coaching and training updates are planned for February in Adult Emergency Department, APU, General Surgery and General Medicine. To improve clinical engagement and leadership of programme activities, membership of the Steering Group is under review.	HAC
Starship 6 hour project	National	Improve				Starship's admissions decreased in January as expected, however acute average monthly occupancy for was the highest January for 6 years – on average an extra 19 inpatients per day. This did impact on inpatient transfers, due to planned reduction in beds in the first 2-3 weeks in January, though no red alerts occurred. There are a number of Process Improvement projects focussed on improving access to inpatient beds underway which will continue to deliver improvements over the next months.	HAC
Tamaki P2HC project	Regional	Analyse				In December 2010 the Auckland DHB Board agreed to the continuation of the current 'early start' component of the Pathways Programme to maintain momentum and goodwill and as an important learning opportunity to inform a review of overall Programme design. Subject to completion of a detailed programme design and costings review to be tabled in April, funding to a maximum of 2.7m over the next 3 years (\$660,000 in 2011/12) to train and graduate 300 new Maori and Pacific health care workers is proposed. This revised proposal is significantly reduced from the original proposal to train 900 participants over seven years but still aligns to the original ADHB objective of increasing the number of Maori and Pacific in the ADHB health care workforce.	BOARD

Legend: Red - , Orange - , Green - 

Goal: 3 Live within our means

Exceptions

There are no projects that have been marked as an exception

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LIVE WITHIN OUR MEANS

1\$.1 Finance Committee Recommendations

1\$.2 Finance Report

1\$.1 Finance Committee Recommendations

ADHB Board

Author: Ian Bell (8077)

Subject: Electricity Tender

Recommendation

1. *That ADHB enter an Electricity Supply Agreement with Meridian Energy for the Auckland City Hospital, Greenlane Clinical Centre and the Point Chevalier sites for two years from April 1st 2011. The estimated value of the contract is approximately \$1.9million p.a.*

The contract will also have the effect of setting the price for electricity purchased from Energy for Industry who operate the cogeneration facility at Auckland City Hospital. The estimated cost of this electricity will now be approximately \$3.0million pa.

2. *That the CEO be delegated authority to execute the contract once the final terms and conditions have been reviewed by the ADHB legal team.*

Background

This will be discussed by the Finance Committee at their meeting on 1 March 2011.

11.2 Finance Report

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GENERAL BUSINESS