



Auckland District Health Board

Board Meeting

Wednesday 1 June 2011

2:00pm

**A+ Trust Room
Clinical Education Centre
Level 5
Auckland City Hospital
Grafton**

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

1

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	Writing, editing and public relations services Medical Council of NZ Occupational Therapy Board	Self-employed Professional Conduct Committee member Professional Conduct Committee member	Fees Hourly fee Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
Dr Chris CHAMBERS	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

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

	Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education services contracted to the MoE. Statutory Authority	
	John Seabrook Holdings Limited	Director	No fee		
	AuPairlink Limited	Governance Advisor	Fee		
	NZ Council of Midwives	Council member	Fee		
Robyn NORTHEY	Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
	Hope Foundation Northern Region	Board member	Nil		
	Ethics Committee	Member	Fee		
Gwen TEPANIA-PALMER	Waitemata District Health Board	Board member	Fee		18 May 2011
	Manaia PHO	Board member			
	Ngati Hine Health Trust	Chair			
	Te Taitokerau Whanau Ora	Committee member	Fee		
Ian WARD	Principal/Director C -4 Consulting Limited				4 May 2011

CONFIRMATION OF MINUTES

4.1 4 May 2011

4.2 18 May 2011

Auckland District Health Board Minutes



MEETING DETAILS											
Time and Date	2:00 pm, Wednesday, 4 May 2011										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
1	KARAKIA										
	The Chair declared the meeting open at 2:22pm. Naida Glavish led the meeting with the karakia.										
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 and Innovation Taima Campbell – Executive Director Nursing Naida Glavish – Chief Advisor Tikanga, GM Maori Health Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Rob Cooper had been granted leave of absence.</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										
	Ian Ward advised an amendment to his interest register having resigned from Health Vision Limited. Lester Levy had provided a declaration of conflicts of interest dated 3 May 2011 and had a conflict in connection to item 12.5 in public exclusion as Deputy Chair of Health Benefits Limited. There were no other declarations of conflicts of interest for any item on the agenda.										
4	CONFIRMATION OF MINUTES 6 APRIL 2011										
	<p><u>Moved Ian Ward; seconded Gwen Tepania-Palmer</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 6 April 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

5	ACTION POINTS 6 APRIL 2011
	<p>All actions were completed with Bernard Te Paa attending the CPHAC meeting and the Annual Plan, as sent to Wellington, being distributed to Board members.</p> <p>Northern Region's Health Plan</p> <p>Feedback on the Plan had only just been received and work on the implementation plan would proceed next week.</p>
6.1	CHAIRMAN'S REPORT
	Feedback on the Northern Region's Health Plan was favourable.
6.2	Chairman's Recommendations
	<p>Starship Foundation</p> <p><u>Moved Ian Ward; seconded Robyn Northey</u></p> <p><i>That the Auckland District Health Board appoints Susan Buckland as the ADHB representative on the Starship Foundation.</i></p> <p><u>Carried</u></p> <p>Susan Buckland did not participate in the discussion or voting.</p> <p>A+ Charitable Trust</p> <p>Lee Mathias assumed the Chair.</p> <p><u>Moved Lee Mathias; seconded Ian Ward</u></p> <p><i>That in terms of the deed of the A+ Trust Charitable Trust, which provides for the Chair of ADHB to be a trustee ex officio, the Chair Lester Levy will be a trustee.</i></p> <p><u>Carried</u></p> <p>Lester Levy did not participate in the discussion or vote on the resolution.</p> <p>Lester Levy resumed the Chair.</p>
7.1	Chief Executive's Summary
	<p>Feedback on the Annual Plan had been received with this being more about presentation and wording as well as alignment with the other DHBs Annual Plans and the regional setting. The 20 May deadline for resubmission would be achieved and it was agreed that the Board would convene in a special meeting following the CPHAC meeting on 18 May 2011 to confirm the Annual Plan.</p> <p>There are to be discussions next week with the National Health Board on the elective surgical base number for 2011 – 2012 (with the extra 600 requested at the beginning of this year having now been put into the base which would mean a 26% increase over 2 years). It was noted that in the Ministry's Operational Policy Framework there was an expectation that the growth of services would not be more than 7% annually.</p> <p>The GAIHN primary care business case is now becoming more focussed and specific, particularly about localities. While there is a focus on the 3 business cases they are not the only primary care initiatives related to clinical services i.e. radiology that Auckland DHB is involved in. This may be about services being more accessible to primary care rather than shifting services to primary care although some, such as follow-up on specialist appointments, could be easily transferred.</p> <p>Work was being undertaken on dementia care capacity for Aged Care. Criteria for assessment</p>

	<p>for Aged Care services were clear.</p> <p>The National Health Board's questions relating to financials in the Annual Plan had been responded to, including FTE numbers. There is frustration from CFOs with the MoH advise that items not approved should not be in the capital plan with the CFOs considering that the Plan is what you intend to get approvals for. This approach was supported by the Board, but is unlikely to change. There was a commitment to have clinical leadership regional training hubs from 1 July in the Northern Region.</p> <p>The growth in Health of Older People care was exactly as planned and was noted as being a priority in the Letter of Expectation from the Minister. The bed blockages for those under 65 were being resolved.</p> <p>ESPI were compliant but there was a focus on those waiting longer than 12 months. Johan Vendrig's appointment as General Manager Information Services for healthAlliance was noted. National employment relations were focused around SMOs and it was important to get that settled. Other negotiations were on track. The Nurses collective agreement is to be negotiated and Service and Food Workers had an interim settlement.</p>
7.2	Minister's Six Health Priorities 2010 - 2011
	<p>Better Help for Smokers to Quit had improved to 75% in April and the Steering Group was being reconvened. Work was being done in high volume areas of ED, Ophthalmology and Women's Assessments as well as looking at what other DHBs do. League tables by speciality were being produced as a competitive incentive but there were still some data capture issues. There was more engagement with Allied Health i.e. Pharmacists working in APU. Coders would also be included in the Steering Group.</p> <p>Immunisation was at 88% in March and 89% in April with an increase for Maori. There was confidence that the target of 91% by year end would be reached noting that the additional numbers were small, for example for Maori, 40 people.</p> <p>Diabetes Control of HbA1c had been flat for 3 years with no significant changes which was a similar issue across the region and country with a focus on self management plans. Compliance was recorded through GP practices. It was suggested that there be random audits of reporting in practices noting the CVD reporting is by GPs and this is good. It was noted that Maori were improving with "Get Checked" but not control. Previous self management programmes had been patchy and with these improving there was an expectation of gains over time. The Board noted that diabetes was a critical area and requested that management totally rethink the approach and present the Board with a new pathway towards this target.</p>
8.1	Lift the Health of People in Auckland City
	There were no recommendations.

9.1	DAP Projects Report
	<p>An overview of the progress was given with exceptions being mainly about timing which was getting management's attention. There was confidence that Skin Lesions and Pharmaceuticals would reach target and the palliative care redesign concerned shifting funding. Access to community diabetic eye screening was within clinical guidelines with no addition to the backlog. The Eye Network was expected to be functioning by the end of July following modification of English software, from the UK grading to the different NZ grading. The Pharmaceutical target should be about utilisation rather than dollars and the calculation of dollars was wrong as it did not take into account the Pharmac rebates. Utilisation was a better measure.</p> <p>The Board raised concerns that the comments were casual and did not reach the standard required. Responses need to be far more specific.</p>
10.1	Finance Committee Recommendations
	<p>Fluoroscopy Room Radiology <u>Moved Gwen Tepania-Palmer; seconded Robyn Northey</u></p> <p><i>That the Auckland District Health Board approves the budget based business case for the replacement of fluoroscopy equipment with associated installation costs at a cost of \$1m subject to tender for the equipment.</i></p> <p><u>Carried</u></p> <p>Replacement 2 Angiography/DSA Rooms <u>Moved Robyn Northey; seconded Lee Mathias</u></p> <p><i>That the Auckland District Health Board approves the budget based business case for the replacement of a bi-plane and single plane DSA/Angiography equipment with associated installation costs and approves the purchase of pendants for carrying anaesthetic gases as specified by Anaesthetic clinical staff, subject to tender for the equipment, with the project not to exceed \$3.5m.</i></p> <p><u>Carried</u></p> <p>Clinical Records Scanning Solution <u>Moved Ian Ward; seconded Robyn Northey</u></p> <p><i>That the Auckland District Health Board approves the purchase and implementation of the 3M Health Information Systems (3M) solution for a clinical record scanning system at a capital cost of \$3,348,427 and ongoing annual operating costs of \$180,000 subject to a further budget of \$1.3m being found through reprioritisation of the capital budget and subject to regional and national IT approval processes.</i></p> <p><u>Carried</u></p> <p>It was noted that the scanning volumes had not reduced. The project was a move to voice recognition technology.</p>

10.2	Finance Committee Recommendations											
	The Financial Report had been reviewed in detail at the Finance Committee. The results were slightly favourable for the month and year to date \$4.26m favourable to budget with a surplus of \$2.7m. The focus was on achieving the elective surgery target. The forecast was still to break even but would require tight management to achieve. It was noted that the Car Park Building at ACH was progressing well. IDF inflows as well as outflows were monitored, these being plastic surgery and forensic mental health as well as the Otahuhu natural boundary for people preferring to go to Counties Manukau.											
11	GENERAL BUSINESS											
	There were no items of general business.											
12	PUBLIC EXCLUSION											
	<p><u>Moved Lee Mathias; seconded Robyn Northey</u></p> <p>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 12.</p> <p>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:</p> <table border="1" data-bbox="199 1030 1356 1523"> <thead> <tr> <th data-bbox="199 1030 582 1153">General subject of each matter to be considered:</th> <th data-bbox="582 1030 981 1153">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="981 1030 1356 1153">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="199 1153 582 1232">12.1 Confidential Board Minutes 6 April 2011</td> <td data-bbox="582 1153 981 1232" rowspan="5">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)</td> <td data-bbox="981 1153 1356 1523" rowspan="5">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.</td> </tr> <tr> <td data-bbox="199 1232 582 1310">12.2 Governance Committee Structure and Meeting Cycle</td> </tr> <tr> <td data-bbox="199 1310 582 1388">12.3 Committee Structure Quality, Risk and Audit Committee</td> </tr> <tr> <td data-bbox="199 1388 582 1467">12.4 Appointment to the Audit and Finance Committee</td> </tr> <tr> <td data-bbox="199 1467 582 1523">12.5 Northern Region Shared Services Organisation</td> </tr> </tbody> </table> <p>The items discussed in public exclusion were the Confidential Board minutes 6 April 2011, Governance Committee Structure and Meeting Cycle, Committee Structure Quality Risk and Audit Committee, appointment to the Audit and Finance Committee and Northern Region Shared Services Organisation.</p> <p><u>Moved Robyn Northey; seconded Lee Mathias</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>		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:	12.1 Confidential Board Minutes 6 April 2011	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.	12.2 Governance Committee Structure and Meeting Cycle	12.3 Committee Structure Quality, Risk and Audit Committee	12.4 Appointment to the Audit and Finance Committee	12.5 Northern Region Shared Services Organisation
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12.3 Committee Structure Quality, Risk and Audit Committee												
12.4 Appointment to the Audit and Finance Committee												
12.5 Northern Region Shared Services Organisation												

	NEXT MEETING
	The meeting closed at 4:46 pm The next scheduled meeting is: 2:00pm, Wednesday, 1 June 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton
CONFIRMED CHAIR: DATE:	

Auckland District Health Board Minutes



MEETING DETAILS									
Time and Date	2:00 pm, Wednesday, 18 May 2011								
Venue	Marie Hosking Room, Level 7, Building 14, Greenlane Clinical Centre, Epsom								
1	ATTENDANCE AND APOLOGIES								
	<p>Committee Members</p> <table> <tr> <td>Dr Lee Mathias (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p>Management in Attendance</p> <p>Dr Denis Jury – Chief Planning & Funding Officer Brent Wiseman – Chief Financial Officer Taima Campbell – Executive Director Nursing Hilda Fa’asalele – General Manager Pacific Health Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health Aroha Haggie – Maori Health Gain Manager Janice Mueller – Director Allied Health Ian Bell – Board Administrator</p> <p>Apologies</p> <p>Rob Cooper had been granted leave of absence. Apologies had been received from Dr Lester Levy, Dr Chris Chambers and Garry Smith.</p>	Dr Lee Mathias (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lee Mathias (Chair)	Jo Agnew								
Peter Aitken	Judith Bassett								
Susan Buckland	Robyn Northey								
Gwen Tepania-Palmer	Ian Ward								
2	ADHB 2011 - 2012 ANNUAL PLAN, NORTHERN REGION HEALTH PLAN, MAORI HEALTH PLAN								
	<p>Tony O’Connor, Consultation Manager was in attendance.</p> <p>Maori Health Plan</p> <p>This aligned with the Northern Region Health Plan and the Annual Plan and was developed as it a requirement of the MoH, with particular priorities. The Waitemata template had been used and it aligns with regional priorities. There had been limited consultation with the Senior Leadership Team and work with Planning and Funding with approval of the plan sought subject to updating before submission on Friday. The style of the plan was endorsed. Work was being done with primary care to be responsive to Maori needs. It was suggested that there be one target for general services, with performance measures, for the organisation to get a step forward and removal of blockages. The Maori Health Plan belonged to the organisation, not separate, but was needed so that Maori health did not get lost in bigger plans and would be incorporated into operational plans.</p> <p><u>Moved Lee Mathias; seconded Gwen Tepania-Palmer</u></p> <p><i>That the Board approves the Maori Health Plan for submission to the National Health Board as final draft on 20 May; and agrees the signatures to the Maori Health Plan, including sign off from our Treaty partners.</i></p> <p><u>Carried</u></p> <p>The plan sent to the MoH would be distributed to members.</p>								

PUBLIC EXCLUSION

Moved Lee Mathias; seconded Jo Agnew

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 12.

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:
2 Northern Region Health Plan 2.2 ADHB 2011-12 Annual Plan	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 Northern Region Health Plan and ADHB 2011 - 2012 Annual Plan which had yet to be submitted to the Minister.

Moved Lee Mathias; seconded Susan Buckland

That the meeting resume in public.

Carried

The meeting closed at 4:29 pm

CONFIRMED

CHAIR: DATE:

ACTION POINTS

- WEDNESDAY 4 MAY 2011

Board**Action Points from the meeting on Wednesday 4 May 2011**

Item	Detail	Designated	Action
7.1	Board to be convened in special meeting after CPHAC meeting 18 May 2011 to approve the Annual Plan 2011 - 2012	Denis Jury Ian Bell	See Minutes 4.2
7.2	Audit of practice recording of HbA1c management	Denis Jury	Noted
	What Services do mortality reviews and which don't	Margaret Wilsher	Under Action

CHAIRMAN'S REPORT

6.1 Re port

6.2 Chairman's Recommendations

61. Report

6.2 Chair man's Recommendations

ADHB Board**Author:** Ian Bell (8077)**Subject:** Committee Membership – Community and Public Health Advisory
Committee (CPHAC)

Recommendation

That the Auckland District Health Board appoints the following as members of its Community and Public Health Advisory Committee (CPHAC):

Chair: Lee Mathias (ADHB)

Deputy Chair: Warren Flaunty (WDHB)

Ex Officio: Lester Levy (ADHB/WDHB)

Representing both Boards: Rob Cooper (WDHB/ADHB)

Members ADHB: Jo Agnew, Peter Aitken, Susan Buckland, Chris Chambers, Robyn Northey

Members WDHB: Max Abbott, Pat Booth, Sandra Coney, Christine Rankin, Allison Roe

Background

The ADHB Board resolved to reconstitute a number of committees at its meeting on 4 May 2011 to have greater sub-regional collaboration after getting approval of the Minister. The reconstitution provides for cross membership from ADHB and WDHB on each of its CPHAC and that their two committees meet and act as one committee. This resolution appoints members to the ADHB CPHAC which will be mirrored for WDHB CPHAC and gives effect to the sub-regional collaboration.

There is provision for up to 3 external members to be recommended by the Chair and Deputy Chair with the suggestion of one clinician, one member from the Pacific community and one member from the Asian community.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Committee Membership – Disability Support Advisory Committee (DSAC)

Recommendation

That the Auckland District Health Board appoints the following as members of its Disability Support Advisory Committee (CPHAC):

Chair: Sandra Coney (WDHB)

Deputy Chair: Jo Agnew (ADHB)

Ex Officio: Lester Levy (ADHB/WDHB)

Members ADHB: Susan Buckland, Robyn Northey

Members WDHB: Max Abbott, Pat Booth

Background

The ADHB Board resolved to reconstitute a number of committees at its meeting on 4 May 2011 to have greater sub-regional collaboration after getting approval of the Minister. The reconstitution provides for cross membership from ADHB and WDHB on each of its DSAC/DiSAC and that their two committees meet and act as one committee. This resolution appoints members to the ADHB DSAC which will be mirrored for WDHB DiSAC and gives effect to the sub-regional collaboration.

There is provision for up to 4 external members to be recommended by the Chair and Deputy Chair.

ADHB Board**Author: Ian Bell (8077)****Subject: Committee Membership – Maori Health Gain Advisory Committee
(M HGAC)**

Recommendation

That the Auckland District Health Board appoints the following as members of its Maori Health Gain Advisory Committee (MHGAC):

Chair: Rob Cooper (ADHB/WDHB)

Deputy Chair: Gwen Tepania-Palmer (WDHB/ADHB)

Ex Officio: Lester Levy (ADHB/WDHB)

Members ADHB: Chris Chambers, Robyn Northey

Members WDHB: Wendy Lai, James Le Fevre

Background

The ADHB Board resolved to reconstitute a number of committees at its meeting on 4 May 2011 to have greater sub-regional collaboration after getting approval of the Minister. The reconstitution provides for cross membership from ADHB and WDHB on each of its MHGAC/MaGAC and that their two committees meet and act as one committee. This resolution appoints members to the ADHB MHGAC which will be mirrored for WDHB MaGAC and gives effect to the sub-regional collaboration.

There is provision for 3 external appointments nominated by Manawhenua and 1 external member nominated by Maataawaka

ADHB Board

Author: Ian Bell (8077)

Subject: Finance Committee

Recommendation

That the Auckland District Health Board rename its Finance Committee as the Audit and Finance Committee.

Background

The purpose of this resolution is to rename the existing Finance Committee as the Audit and Finance Committee to align the naming of committees with WDHB in terms of sub-regional collaboration.

CHIEF EXECUTIVE'S REPORT

7.1 Chief Executive's Summary

7.2 Minister's Six Health Priorities 2009/10

7.3 Eligibility

7.1 Chief Executive's Report

CHIEF EXECUTIVE'S REPORT

6.1	EVENTS AND NEWS IN APRIL
6.2	EVENTS AND NEWS IN MAY
6.3	PERFORMANCE PRIORITIES
APP	PROJECT INDICATOR REPORTS

Introduction

This report covers the month of April. It includes a brief summary of events of note in April and May and a top level summary for the Board's priorities to confirm all matters are being appropriately addressed.

6.1 Events and news in April

6.1.1 Events

During April there was two Ministerial visits celebrating success:

- Minister Ryall opened the Greenlane Clinical Centre on 27 April.
- Minister Ryall visited Greenlane Clinical Centre to congratulate diabetes nurses on achieving prescribing authority on 7 April.

6.2 Events and news in May

6.2.1 Budget

Budget 2011 announced an extra \$2.2 billion to public health services over the next four years. The Minister of Finance has also announced that in the next financial year there will be \$585 million for health initiatives. This comprises up of \$420 million of new money, plus around \$165 million from savings going back into healthcare. District Health Boards will receive around \$400 million - \$350 million in population-based funding plus over \$50 million for service contracts from the Ministry of Health.

The \$2.2 billion extra over four years will fund new initiatives including:

- \$18 million for 40 extra medical training places – part of the Government's promise to boost the number of medical training places by 200 over five years.
- A further \$54.5 million for maternity initiatives to improve safety and quality and provide extra WellChild visits, with a particular focus on first time mothers.
- \$80 million for widened access to medicines. It is expected around 32,000 patients in the first year will benefit from this extra funding.
- \$68 million for more elective surgery, continuing the increase of 4,000 extra operations a year, and reduce waiting times.
- An additional \$40 million for dementia care, which is expected to provide almost 200 extra beds over the next two years and extra respite care. \$40 million for mental health, including \$4 million for dementia-related respite care.
- An extra \$130 million for disability support services to meet rising needs and costs.
- \$80 million extra from DHBs for GP visit subsidies and \$14 million for more people qualifying in programmes such as very low cost access and free under sixes.

For 2011/12 these funding changes will translate into the following increases to the funding envelope (all DHBs):

Category	Funding \$m	Expectation
<u>Funding envelope</u>		
Demographics (1.74%)	176.0	2,000 more elective procedures
Price (1.72%)	174.0	
Community pharmaceutical budget	20.0	
Maternity services	6.4	
<u>New initiative funding</u>		
Elective	24.0	2,000 more elective procedures
Health of older people - residential	10.0	
Health of older people - respite	1.0	
Health Benefits Ltd funding	5.0	
Primary care initiatives	3.6	
Total	420.0	

In addition to these measures the changes to the Kiwisaver regime will have an adverse impact as a result of the removal of State Services Commission funding for the employer's contribution with effect from 1 July 2012. In addition the employer's contribution will increase to 3% with effect from 1 April 2013. There will also be some administrative costs associated with the changes.

The Kiwisaver subsidy is approximately \$5m for 2010/11 year. With wage inflation and step and base increases it is estimated that this cost will increase to approximately \$5.3m by the 2012/13 financial year. Further uptake of Kiwisaver could potentially increase this estimate to \$5.5m reflecting the value of lost funding from the State Services Commission. The increase in the employer contribution rate from 2% to 3% with effect from 1 April 2013 will be additional to this \$5.5m. The Minister expects these costs to be managed within existing funding.

6.2.2 Events

During May the following events either have or will take place:

- Minister Bennett visited Starship 20 May to meet Dr Patrick Kelly and staff of Te Puaruruhau. As a result of a journalist being present from the Listener the event gained more significance than usual. It provided an opportunity for senior clinicians to present their view in terms of screening young children presenting to the hospital with evidence of non accidental injuries and other forms of abuse.




- Northland, Waitemata, Auckland, Counties District Health Boards will publish their District Annual Plans to their websites.
- ADHB dietitian Nadia Lim won the Masterchef competition. This was a fantastic achievement for Nadia.

6.3 Performance Priorities

The Board has set 10 priority areas. These have been mapped to the Regional and DAP goals and the key result areas specified by the MOH as follows:

Regional goal	Auckland DHB Goal	Auckland DHB Key Result Areas	Board Priorities
Improved population health	Lift the health of people living in the ADHB area	Improved health status	New models of care Chronic disease management Health of older people
Improved patient experience	Performance improvement	Better quality care Increased patient safety Staff engagement	Emergency care Elective surgery Shorter waiting times for cancer treatment Clinical leadership Culture
Cost and productivity management	Live within our means	Economic sustainability	Regionalisation through collaboration Living within our means




Progress in each area is summarised in the remainder of this report under three headings:




- Scope of the work programme Proceeding to plan 
- Current status Issues being addressed 
- Expected outcome for the year Target unlikely to be met 

For the 2010/11 year good progress is being made in every area although the risk factors are greatest where programmes are reliant on patient or NGO provider compliance, such as diabetes management. In those cases the level of engagement has been increased in the areas where the impediments to progress are greatest. Some Board priorities will be implemented in the 2011/12 year and this has been noted where appropriate.

Where a full indicator report is available for an area it has been included as an appendix. These reports are also provided to the Board as part of the CPHAC and HAC papers depending on the subject matter.

3.1 Lift the health of people living in the ADHB area

New models of care	New models of care for fast stream elective surgery, readmission prevention, Whanau Ora, health promotion, children and young persons and older people
Scope	This is a 2011/2 priority to use performance improvement projects to increase the effectiveness and efficiency of services across the organisation thereby improving services and increasing capacity by releasing resources. This will involve lean improvement techniques, awareness programmes and
Status 	A summary of projects is included in the 2011/12 DAP. This reflects the continuation of some existing projects, such as the work with primary care cases and Maori providers to develop Integrated Family Health Centres/Whanau Ora Centres, and new projects such as improving ward utilisation and theatre usage.
Outcome	Work is expected to continue with a formal project framework being established during the next financial year.
Chronic disease management	Better assessment of cardiovascular risk, enhanced treatment for heart disease and diabetes, reduced waiting times for elective cardiac surgery and clinical pathways to be across the care continuum
Scope – cardio screening	Increase the number of CVD screenings for at risk populations in accordance with agreed targets.
Status – cardio screening 	The full DAP project indicator report is attached, which explains the initiative to introduce an electronic tool together with training and information systems support. This has been combined with an incentive payments plan and communication strategy.
Outcome	Third quarter performance was 79.9% against a target of 79%. Individual targets for each ethnicity were also met, and this is expected to continue.
Scope - diabetes	Increase access and capacity for community diabetic eye screening in accordance with agreed targets.
Status – diabetes 	The full DAP project indicator report is attached as covers the work to increase awareness and work with PHOs to improve information sharing. There are also quality improvement coordinators, a population audit tool and work is in hand to develop a regional shared care pathway.
Outcome - diabetes	Q3 activity was below target for the quarter although the number of reviews for Pacific and Indian populations continues to perform above target. Discussions with PHO CEO's and the Primary Care Clinical Advisory Group are taking place to address underperformance for the remaining quarter of this year. It is anticipated that improvements will be achieved but that targets will not be met.




Scope – cardiac waiting list	Establish and implement a plan that meets the MOH goal of increasing the national intervention rate by 20%.
Status – cardiac waiting list 	The full DAP project indicator report is attached and summarises the strategies for scheduling systems, pre-admit processes, capacity and load planning, and daily activity management. Despite these measures and success in increasing throughput, the waiting list has risen by 60% during April. This is due to acute related events and extra thoracic volumes for acute thoracic cancers.
Outcome – cardiac waiting list	The availability of capacity in the private sector has been confirmed to bring the wait list back down to target levels within the time remaining this year.
Scope – clinical pathways	This is a 2011/2 priority to establish a regional project to agree clinical pathways for specific conditions to improve patient experience and provider efficiency across primary and secondary care.
Status – clinical pathways 	This project is at the conceptual stage at present and a team will be formed to consider the scope of the work. The project is likely to be led from a primary care perspective and care will be taken to ensure that the work is meaningful without attempting too broad focus at one time. This is important to ensure the scale of the undertaking does not dilute the impact of the project.
Outcome – clinical pathways	Outcomes will be determined once the project scoping has been completed.
Health of older people	Integrate and streamline services, one point of entry to specialists, specialised inpatient areas for stroke, dementia and delirium, co-ordination of discharge planning, improve respite care and ensure effective outreach programmes (primary and community)
Scope	This is a 2011/2 priority to understand the drivers and improve home based care to enable ageing in place and minimise acute admissions
Status 	There is a large body of work to be completed but early gains have been achieved with the establishment of: <ul style="list-style-type: none"> • A specialised inpatient area for stroke patients • an access centre for single point of contact for home based referrals • closer working relationships with 4 home based providers to provide flexible care packages to support older people in their homes; and • assessment tools (Interai) • better understanding of how a casemix approach to purchasing services would operate.
Outcome	Work is expected to continue with a formal project framework being established during the next financial year.

Regional projects

Life and years	We will improve life expectancy and the quality of life for our population, particularly those with high health needs.
Scope	Improve quality of life and life expectancy in four specific areas: diabetes, CVD, cancer and health of older people.
Status	<p>The framework for this project has been established as:</p> <ul style="list-style-type: none"> • grow the clinical networks to enable clinician engagement and leadership and enable consumer involvement • develop regional implementation plans which specify consistent key performance indicators and targets (including national health targets) • fill the gaps in information, establishing clear population health views so we understand the impact our initiatives are having on the high risk populations • detail the roadmap of quality improvement activities which are action focussed and have tangible benefits
Outcome	Work is expected to continue with a formal project framework being established during the next financial year.



3.2 Performance improvement

Emergency care	95% of patients are admitted, discharged or transferred from adult and children's EDs within 6 hours
Scope	As above
Status	The full DAP project indicator reports for adult and child services are attached. The goal has been met by adopting a wide range of measures focusing on patient flow management, right sizing bed numbers, and ensuring the right skill mix and number of staff with training where required.
Outcome	It is expected that the current level of performance will be maintained through to year end and beyond.
Elective surgery	Achieve the number of elective procedures specified in the DAP
Scope	Increase elective surgical discharges from 9,425 to 11,149
Status	The full DAP project indicator report is attached and confirms an improvement in elective volumes has been achieved. This included opening two new operating rooms at Greenlane Surgical Centre, the use of weekend lists in ophthalmology and longer days in others and outsourcing enabling 550 discharges.
Outcome	Daily monitoring of elective production is continuing and as at 1 May the plan was 300 discharges short of target. The plan is to rectify this position by year end.



Shorter waiting times for cancer treatment	Radiation treatment within four weeks of first specialist assessment and medical oncology within agreed DAP timelines
Scope	As above.
Status 	The full DAP project indicator report is attached and confirms that close management of the waiting list and weekly capacity planning has been successful. The use of new techniques and technology has also assisted the process and further gains are planned with a reduction in treatment times providing increased capacity. There are some concerns regarding equipment breakdowns and increased referral levels. Service levels are being closely monitored.
Outcome	Current gains are sustainable and further improvements are anticipated but not yet quantified.
Clinical leadership	Leadership from bedside to boardroom, clinicians involved in all strategic and operational decisions, leadership development for clinicians and development, management and monitoring of clinical networks
Scope	The clinical leadership framework for ADHB needs to be agreed, documented and implemented for medicine, nursing & midwifery, allied health, scientific & technical professional groups. This will support the organisational realignment project and the creation of Health Care Service Groups (HSGs) as part of the ADHB Integrated Governance Framework. The programme will include appropriate organisational; development and leadership training.
Status 	Recruitment processes are currently being completed to appoint the Level 2 clinical leadership roles which form a critical part of the programme.
Outcome	It is expected that these appointments will be completed by year end. In 2011/12 the ADHB will actively participate in the 'In good hands' measurement and evaluation processes with the aim of being in the top 10% of DHB performance
Culture	Professionalism, clinical excellence coupled with patient service and improved communication with patients
Scope	This is a 2011/2 priority to develop a culture of patient safety, open disclosure, timely and empathetic communication with respect for patients and families at all times.
Status 	A formal project framework is being established for 2011/12 to develop our clinical leaders to be more effective at developing culture and taking appropriate action as well as implementing a: <ul style="list-style-type: none"> • coaching framework • leadership walk around programme • open disclosure training for level 2 and 3 leaders

Outcome	Preliminary planning is under way and it is expected that the programme will be put in place progressively over the next 12 months.
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Regional projects

First, do no harm	Develop a patient safety culture across the region
Scope	This is a 2011/2 campaign designed to lead and be accountable for the identification, development and benefits tracking of initiatives to improve quality and patient safety across the region's health system.
Status 	The framework for this project has been established as: <ul style="list-style-type: none"> • quality improvement through the use of improved measures and tools • a stock take of current initiatives to identify lessons and avoid duplication • standard methodology for patient safety/quality improvement • a review of the 50 most recent deaths • a safe medicines management programme
Outcome	Work is expected to continue with a formal project framework being established during the next financial year.
The informed patient	Engage patients and their families in decisions about care
Scope	This is a 2011/2 campaign designed to lead and be accountable for the identification, development and benefits tracking of initiatives to improve quality and patient safety across the region's health system.
Status 	This project is designed to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum: <ul style="list-style-type: none"> • reduction of unplanned care and avoidance of acute presentations at hospital emergency departments • increased patient compliance with treatments and care plans NRHP 16 May 2011 36 • involvement of patients in decisions about care options • increased awareness and knowledge among our population to ensure early decisions to seek diagnosis and care <p>Improving the flow of information to patients is too wide an objective for the short and medium term, so the initiatives target we are targeting two specific areas for action - Whānau Ora Assessments and Advance Care Planning.</p>
Outcome	Work is expected to continue with a formal project framework being established during the next financial year.

3.3 Live within our means

Regionalisation through collaboration	Collaboration as an overriding principle undertaken with studious intent and with a special focus on Waitemata DHB
Scope	This is a 2011/2 priority to focus on regional strategies to better integrate and manage the delivery and costs of healthcare services for the people of the Auckland region.
Status 	A plan has been developed with three focus areas: <ul style="list-style-type: none"> • improving patient safety, using regional targets for key services, improving patient communication and developing advanced care planning • healthAlliance to reduce back-office costs • Waitemata DHB to optimise service planning and deliver across the two organisations
Outcome	It is expected that the programme will be successfully put in place over the next 12 months.
Living within our means	Financial deficits are not acceptable under any circumstances
Scope	Achieve a break even position by year end.
Status 	The YTD April result is \$4.6m favourable.
Outcome	We forecast break even for the year.

Appendix 1 DAP Project Indicator Reports

The following indicator reports are included in this appendix:

1. Cardiovascular risk assessment
2. Cardiac Bypass Surgery
3. Diabetes management (two reports)
4. Acute adult and child patient flow (three reports)
5. Improved access to elective surgery
6. Shorter waits for radiation therapy

7.2 Minister's Six Health Priorities 2009/10

Project: Cardiovascular Risk Assessment

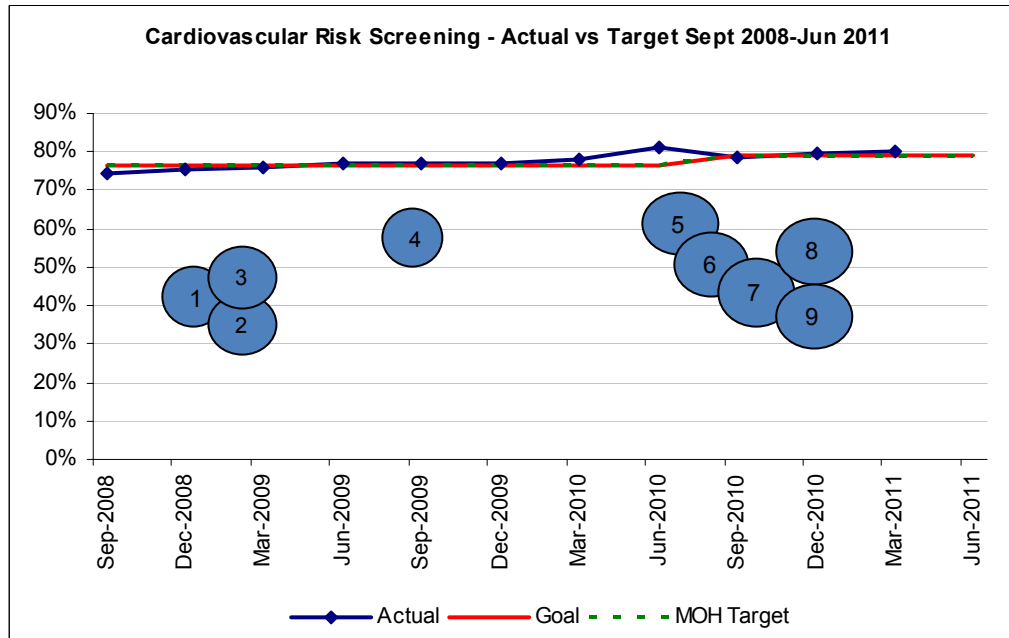
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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



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 Risks / Comments:

The Q3 CVD data from the MOH shows a small but steady improvement on this target with an increase of 0.5% from the last quarter, giving us a 79.9% performance against a target of 79%. Individual targets for each ethnicity have also been met.

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract, which we will be reviewing in the coming months to ensure that incentives are properly aligned.

Project: Cardiac Bypass Surgery

62

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

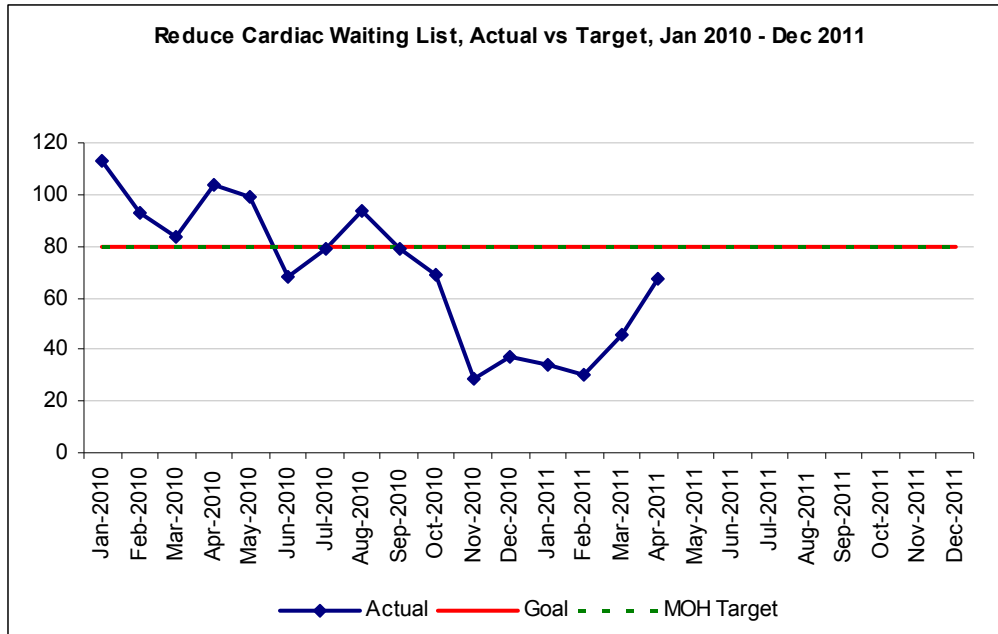
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

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 72 patients on the waiting list as at the end of April 2011. The service has currently completed 96 more bypass procedures (through the ACH facility) than last year (17% improvement). The waiting list has risen by 60% during April. This is despite delivering 66 procedures against a plan of 72 procedures (91%). The rise in the waiting list has been caused by a number of our completed procedures being for acute related events as well as having to deliver over and above our planned thoracic volumes to deal with acute thoracic cancers. We have confirmed the availability of capacity in the private sector to bring the wait list back down to target levels within the time remaining this year.

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

63

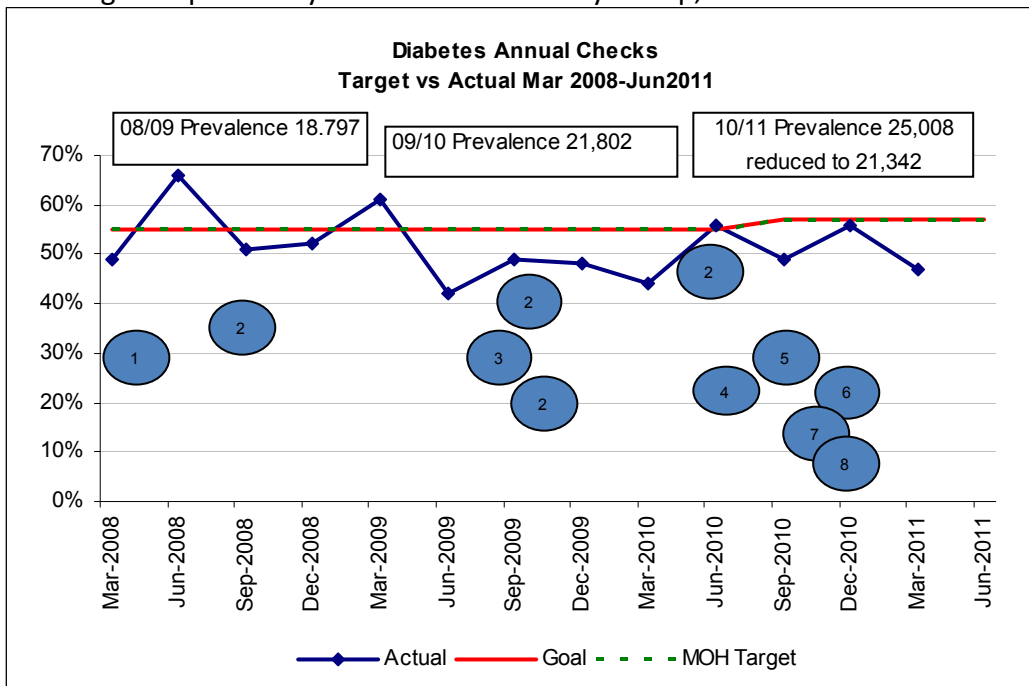
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

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:

Q3 activity shows we have dipped significantly below target to 47% for the quarter, which was due to the low number of diabetes annual reviews during the holiday period (January). The number of reviews for Pacific and Indian populations continues to perform above target but activity for "Other" is significantly underperforming this quarter (35%). 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. The contract for the long term condition quality improvement coordinators is underway with the coordinators starting work with priority practices to improve Diabetes Annual Check numbers. Performance against this target is also being raised with the PHO CEO's and Primary Care Clinical Advisory Group this month, and we are working with our largest PHO (where most of the underperformance lies) to devise and implement strategies, in addition to those we have put in place, to improve performance for the remaining quarter of this year.

[Note: Q2 data has been updated to reflect actual activity from Tongan Health Society – this was estimated in last quarter's report, changing Q2 performance from 57% to 56%]

Project: Diabetes

64

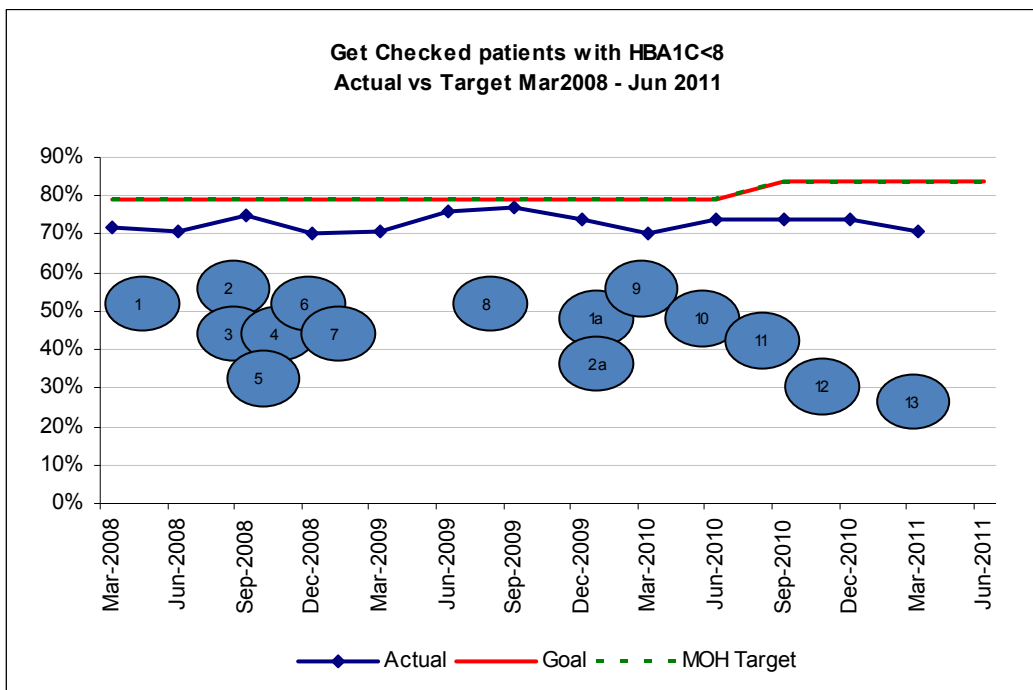
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

Date of Delivery: 79% of people with diabetes will have a HbA1c \leq 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:

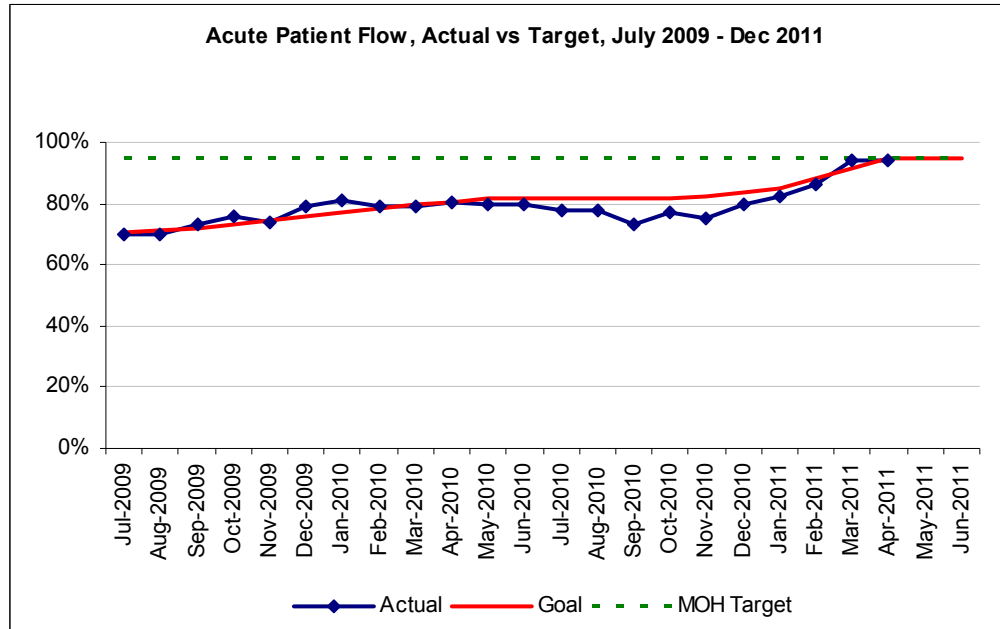
Q3 performance shows a decrease in management from the previous two quarters, achieving 71% against a target of 84% of people having an HbA1C <8. The target for Other has been achieved (83%) however the target for both Maori and Pacific has not been met (60% and 55% respectively). The long term condition quality improvement coordinators will be working with practices to improve this target as part of their overall approach. The contract for Diabetes Self Management Education services has started, with four courses (of 4 sessions each) being run in February and March. This contract delivers to all of ADHB and aims to ensure accessibility (in terms of access and cultural competency) to our high needs populations. Additionally a generic self management course for long term conditions (based on the Stanford model) is being implemented for our Pacific populations through the HVAZ framework, with the first courses due to start this month.

[Note: Q2 data has been updated to reflect actual activity from Tongan Health Society – this was estimated in last quarter's report, changing Q2 performance from 73% to 74%]

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:

Performance to achieve Shorter Stays in ED for both Adults and Children's services continues to demonstrate improvement .

Project: Adult Acute Patient Flow

66

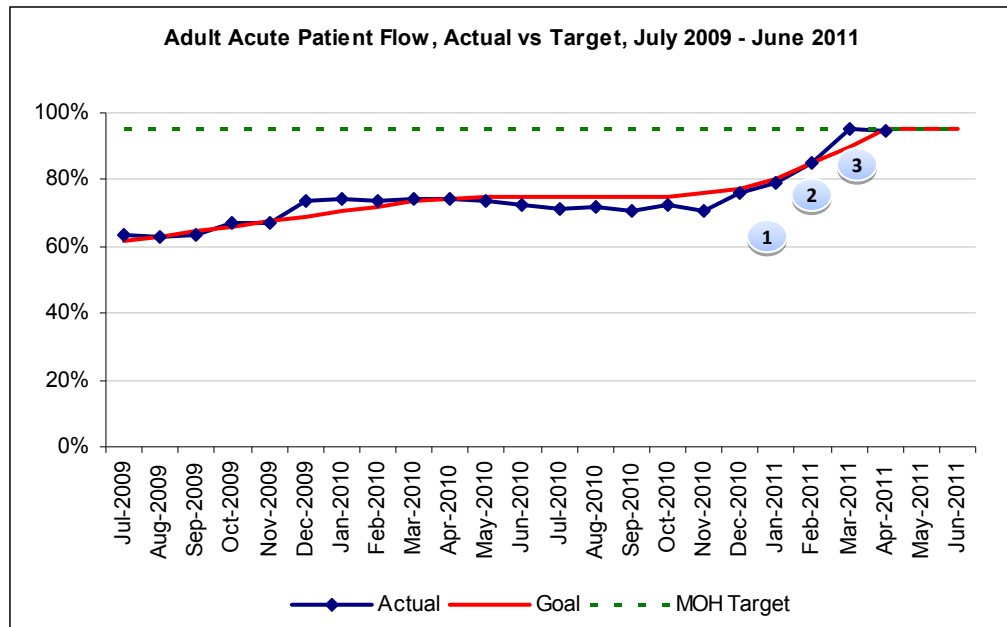
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

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:

A 5-day Rapid Improvement event was held on 11-15 April to identify and implement further solutions from decision to admit to leaving ED. Improvement solutions from this event will be implemented from early May 2011.

ED Short Stay ward capital request approved and planning for refurbishment now underway.

Triggers for implementing APU / Medical bed flex beds to accommodate increased admissions over winter is in place.

To maintain improved performance as we enter winter months a review of ED weekend resourcing to meet variable demand, and escalation process to accommodate increasing presentations to ED is underway.

Further work is also required to improve elective scheduling and to establish daily operational triggers with response plans to maintain flow in times of high hospital occupancy, and increased acute or elective surgical demand.

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:

- 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
- 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.
- 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

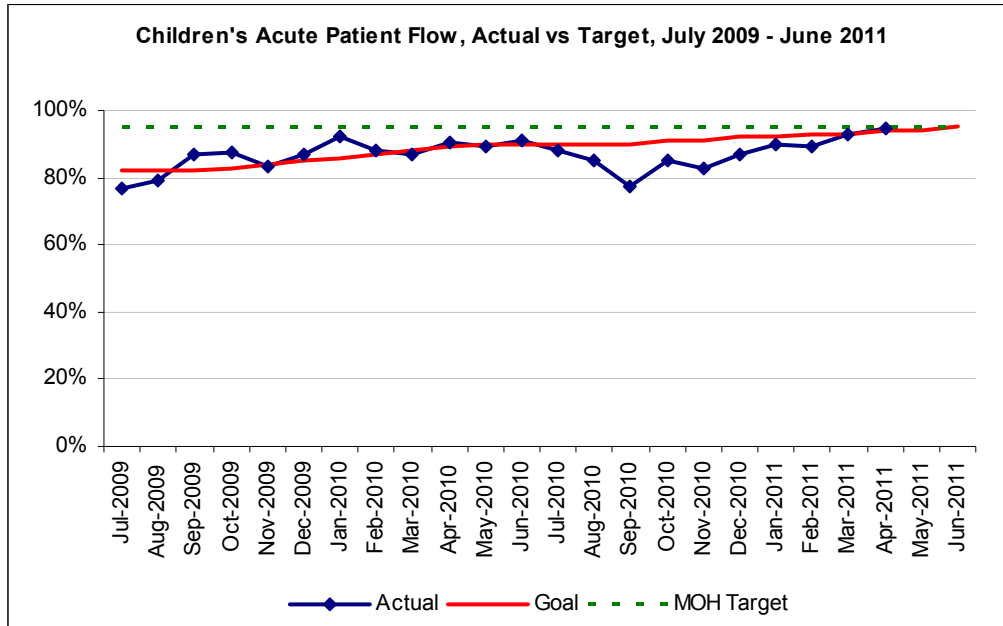
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Project Risks / Comments: Starship continues to show pleasing improvements in the time taken to process patients through the Children's Emergency Department. The April result of 94% of patients under the 6 hour target was the best ever recorded month for Starship. This represented a 1% improvement over March and 3% improvement on April 2010. Significantly there were 17 days during April 2011 where Starship achieved 95% or better compared to only 6 days in the equivalent month last year.

The improved performance can be attributed to a number of factors including:

Further improvements in the mean time to transfer patients from the Emergency Department to Wards.
Improved processes relating to triaging and diagnosis within the Emergency Department.

A strong focus by the management team on breaches to establishing root causes and appropriate remedial actions.

New data processed in the past months has provided the Starship Team with a more comprehensive and deeper understanding of current performance relative to the 3-2-1 guideline. Following a meeting of key stakeholders a new project focused on the '2 component' has been undertaken. Starship expects this to yield improvements in advance of the winter months.

Aside from the above project, a number of other ward based initiatives focused on improving discharging processes and timely discharging are being initiated. A number of projects are also centered on improving the visibility of patient data at both a detailed level, aiding day to day management, to a high level that facilitates improved resource planning and flow of elective surgery.

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
- 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:

- a) Patient Transfers from CED to a ward where a bed is available
- b) Bed turnaround time in ward 24B - time to discharge from Doctor's clearance
- c) Inter-hospital Paediatric transfers
- d) Estimated Discharge Date accuracy in Paediatric Orthopaedics:

Project: Improved access to elective surgery

68

Primary Objective: Increase ADHB Elective Surgical Discharges from 9,425 to 11149

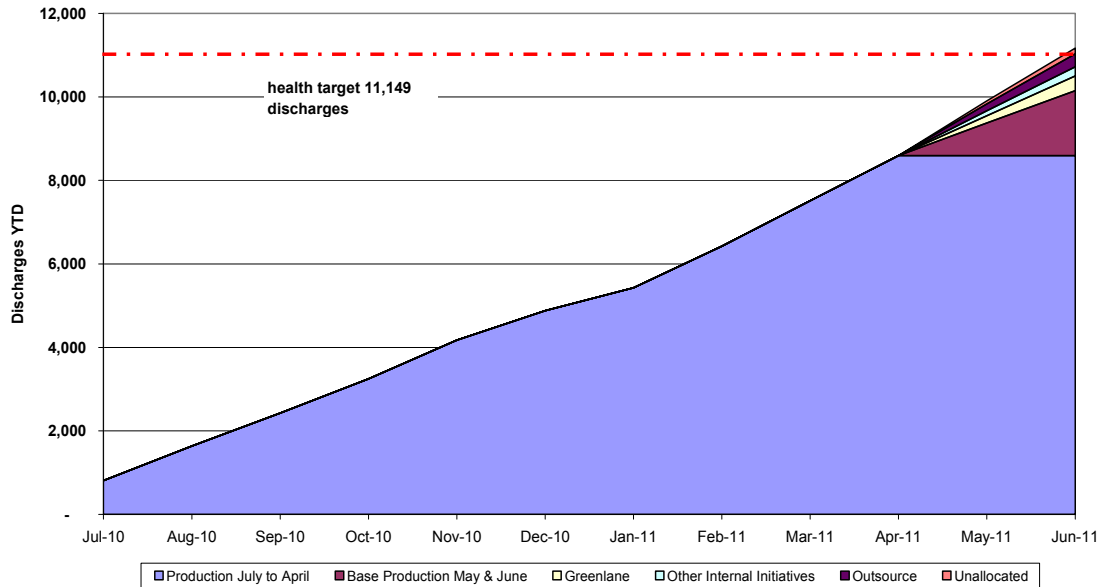
Date of Delivery: 30 June 2011

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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

Contributors to Elective Health Target



Planned activities:

1. Operationalising 2 new ORs at Greenlane Surgical Centre during March and April.
2. Other internal includes weekend ophthalmology lists at GSU in 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 unallocated discharges to services.
5. We are also reviewing some data issues e.g. ongoing 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)

Weekly meetings between the Director of Elective Services and service managers are focussing on ESPI compliance and elective production.

Actions have included prioritisation in existing clinics, extended clinic hrs, confirming requirements with patients and GP's.

The ADHB elective production plan is monitored on a daily basis.

Project: Shorter waits for Radiation Therapy

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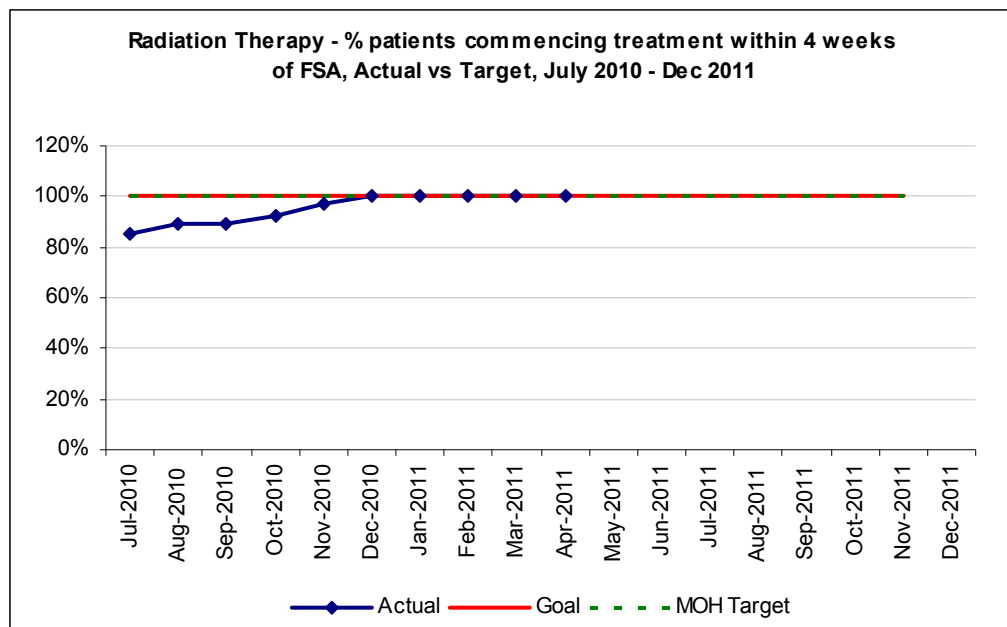
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

Date of Delivery: 31 December 2010 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



Risks / Comments: The service is 100% compliant to the 4 week target for Quarter 3.

Key risks which may impact capacity to deliver to the target:

MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement July – November 2011.

Sustained demand – the culmination of short weeks following Easter is likely to drive a demand surge in mid-May

RT staff vacancies and skill mix – pending resignations will impact staffing ratios during May and flexi shifts cannot operate due to contractual constraints.

From June MV2 will not be utilised (except for HDR gynae) due to RT vacancies

Introduction of new technology during this time also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment, QA testing of new technology.

A new international RT recruitment campaign is underway to attract overseas staff.

Radiation Oncology Wait times – April 2011

In April 100% of eligible patients were treated within the 4 week target timeline.

Further improvements in progress to sustain delivery:

Pantak replacement is planned from early May to July 2011

Replacement of MV6: Decommissioning commences mid-July until late November 2011. Evening shifts will be reinstated during this period to mitigate lost capacity

Introduction of HDR for Gynaecological patients is scheduled and on track to be implemented in May 2011.

A public/private Model of care has been developed to enable our clinicians to treat public patients at ARO. Effective from March 2011 and progressing well. 2 patients per week are outsourced to ARO.

Breast hypo-fractionation implemented: This has reduced treatment time and freed up capacity on the linear accelerators.

Introduction of new technology: The introduction of V-Mat treatment has the potential to reduce treatment times by up to 50% when fully implemented. Capacity modelling to analyse potential efficiency gains is underway for Brain, Gynae and H&N.

Aria project: A project is underway to develop a full electronic record within the LINAC machine's operating system.

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** enables daily monitoring and immediate remedial action if required.

7.3 Eligibility

Memorandum

TO: The Chair and Board
FROM: General Counsel
DATE: 18 May 2011
SUBJECT: **2011 ELIGIBILITY DIRECTION**

Recommendation

That the ADHB Board:

- Endorse the pursuit of a single regional approach and policy on the determination of eligibility and the recovery of costs from ineligible patients.
- Require a recommendation from management as to which clinical services, if any, should be excluded from the requirement to make determinations as to eligibility and recovery of costs.
- Note the initiatives being pursued by the National Health Board and Health Benefits Limited in regard to eligibility.
- Direct ADHB to become a party to an agreement with the Department of Labour to allow access to data on the visa status of individual non-residents.

The first recommendation will assist consumers, especially those who are referred to another DHB or directly access the services of more than one DHB.

The second recommendation is required because ADHB's policy currently excludes public health services and patients accessing sexual health services and some infectious diseases from eligibility determinations. The 2011 Eligibility Direction has not adopted ADHB's approach, thus where current services are not given exemption under the 2011 Direction their exclusion should only continue once endorsed by the ADHB Board, with advice to the Ministry of Health.

Background - 2011 Eligibility Direction

The Ministry of Health (**the Ministry**) wrote to the Chief Executives of all DHBs on 15 April 2011, providing a copy of a new eligibility direction under s32 of the New Zealand Public Health and Disability Act 2000 (**the 2011 Direction**). Consistent with the Minister of Health's limited scope for the review of eligibility for publicly

funded healthcare, the Ministry has endeavoured not to make any fundamental changes to the criteria or principles inherent in the 2003 Direction. To some extent, this limited scope was a consequence of s32 and the NZPHD Act.

DHBs are directed to provide publicly funded services without cost to anyone who can show they meet one or more of 27 different criteria defined in the 2011 Direction. These criteria fall into two broad categories. First, criteria that make a consumer eligible for all publicly funded services, e.g. New Zealand citizenship, and second, criteria that make a consumer eligible for certain procedures or services, e.g. maternity related services (partners of eligible people) and acute care (UK and Australian visitors). The latter categories generally have a requirement for a clinical assessment, for example 'services that relate to infectious diseases to the extent appropriate in the circumstances to address risks to other persons' and, for Australian visitors, 'conditions requiring immediately necessary treatment'.

However, while DHBs have a document which sets out criteria for determining those consumers they may **not** charge when providing publicly funded services, there is no guidance as to how to deal with those who fall outside those criteria and seek services. Whether or not a health provider should endeavour to determine the eligibility of any or all consumers and/or recover costs of services provided to ineligible consumers remains at the discretion of each provider, with the legal caveat to that discretion being that a failure of a provider to highlight to a patient the possibility that they may be liable for costs if they are ineligible for publicly funded healthcare at the earliest practicable point, ideally on presentation if acute and always before commencing treatment, will prevent that health provider from retrospectively seeking to recover the costs of services from those consumers later found to be ineligible.

In deciding on a policy in respect to eligibility determination and recovery DHBs will also need to consider if alignment in operational practices and policies is a desirable objective. Failure to align regionally will mean continuing issues for consumers who may be asked by every DHB for the same information or find that one DHB requires payment for services where another does not.

HealthAlliance has expressed a commitment to a common approach. This is however subject to alignment of all four DHBs in respect to their policy on determination of eligibility and recovery of costs. ADHB would be the logical lead DHB in developing the approach and policy for the region, to be consistent with expectations of the Ministry, National Health Board and Health Benefits Limited.

Issues for ADHB

Changes inherent in the 2011 Direction will have only minor impact on current ADHB practice, as many of the new provisions are intended to confirm what had become the status quo, e.g. infectious diseases (B23), pregnant women (B21) and pregnant women with HIV (B22); while others, e.g. emergency services (B24) and WellChild services (B17), are limited in scope. ADHB will however need to address its current policy and practices to align with the detail of the 2011 Direction and determine if any current exceptions should continue. In particular:

- ADHB's current formal eligibility policy states that public health services and sexual health services are excluded from eligibility determination. This means that providers of public health initiatives which are undertaken in the workplace or church, e.g. smoking cessation and healthy eating, need not endeavour to proactively exclude ineligible participants from their sessions.

Auckland Regional Public Health Service and others have in the past provided a robust policy argument for this position, so while the Ministry declined to adopt submissions on this point there remain good reasons for ADHB to maintain the status quo.

- Infectious diseases. While the Ministry may have intended this new criteria to confirm current practice, 'infectious diseases' is given a very particular definition in the 2011 Direction, including linkage with 'notifiable' diseases under the Health Act 1956. ADHB will need to address this new definition to ensure the services for 'infectious diseases' as defined to ineligible consumers are only "to the extent appropriate in the circumstances to address risks to other persons".

It will also be necessary to determine if current practice to deem universal eligibility for treatment of certain diseases which are not included by the Ministry within this criteria should continue. The best example is HIV, where ADHB currently treats without recovery of costs and which is notified anonymously, but is not been included in the Health Act. Treatment and other actions to address risks to other persons from the index patient are comparable with those followed when a person is diagnosed with diseases that are in the Health Act as notifiable diseases e.g. typhoid fever, giardia, legionella, hepatitis C. That is, every effort is made after diagnosis to identify contacts who might have been infected with HIV from the index patient, or from whom the index patient may have acquired infection. The index patient,

and all infected contacts are advised clearly and repeatedly about measures to avoid transmission, and uninfected regular contacts are given similar advice. Treatment of HIV infection to reduce the level of risk of transmission, and to restore or maintain the person's health is given and monitored.

The inconsistency within the 'infectious diseases' criteria in respect to HIV is highlighted by there being another criteria which requires DHBs treat all pregnant women with HIV infection to prevent the transmission of HIV infection to their infants.

- Tuberculosis is now defined as an 'infectious disease'. This means that s9 and 10 letters under the TB Act need only be issued where there is genuine concern that the patient will not accept treatment, despite it being free.
- Subject to clarification by the Ministry of the breadth of B25 (compulsory services), there may be a need to revisit policies for provision of mental health services for ineligible voluntary consumers.
- Recognition of the new regime in respect to residency introduced by the Immigration Act. For example, evidence of short-term eligibility will be via a visa and there is a new interim visa while applications are processed.

Work in Progress

Ongoing work in respect to the 2011 Direction falls into two categories:

1. Internally within DHBs to determine changes to policies to align with the 2011 Direction and to formalise their position on determining the eligibility of consumers and recovery of costs of services provided to ineligible consumers.
2. Work within the Ministry to provide support to DHBs.

Work within in the Ministry includes:

- Maintaining a website as a 'single source of truth' for eligibility. This will be undertaken by the National Health Board (**NHB**).
- Providing 'best practice' templates and guidance for DHBs who choose to implement a process for determining eligibility and recovery of costs from ineligible consumers. This will be undertaken by Health Benefits Ltd (**HBL**).

HBL will be asking all DHBs to include cost recoveries achieved from ineligible consumers when reporting on cost savings. How this will apply to ADHB who already includes forecast recoveries in its Annual Plans is unclear.

- Resolving disputes as to eligibility. This will remain a responsibility of the Ministry. The Ministry has also run workshops on the 2011 Direction and will integrate questions and issues raised in those workshops in the website and HBL outputs.
- Negotiating an agreement under s301 of the Immigration Act to formalise DHB access to data the Department of Labour (**DOL**) holds on the visa status of individual non-residents. This is a joint effort between the Ministry, NHB and DOL, with some DHB input. The current draft provides for a lead DHB to sign the agreement with DOL. Subject to any comments from the Joint Oversight group NHB would propose that ADHB be that lead DHB.

There is also an agreement under s300 of the Immigration Act being established between the Ministry and DOL to allow data matching between information held by the Ministry and Immigration information as to entry and exits from New Zealand. Advice from Audit and Compliance at the Ministry is that the first practical application of this agreement will be to undertake quarterly data matching in respect to PHO registers. If that does eventuate DHBs and/or PHOs will be requested to purge PHO registers of visitors and those no longer in New Zealand based on the outputs from this process.

- Negotiation with Internal Affairs, who hold citizenship information, on provision of all New Zealand birth data from the early 20th century until 2006. This is subject to there being an acknowledgement from DHBs as to how this information would assist DHBs in practice to confirm eligibility based on New Zealand citizenship arising from birth.

ADHB and healthAlliance management are involved in all the above initiatives.

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

8.1 Committee Recommendations

8.1 Committee Recommendations

Community and Public Health Advisory Committee Recommendations

Maori Health Advisory Committee Recommendations

Pacific Health Advisory Committee Recommendations

ADHB Board

Author: Ian Bell (8077)

Subject: Pacific Health Advisory Committee

Recommendation

That the Pacific Health Advisory Committee recommends to the Board that the PHAC remain and; that in recognising the current vision of the DHB to move to regionalisation that it is an opportunity for the current PHAC to broaden its focus and area of coverage and; that a PHAC representative be appointed to CPHAC and; that the Committee supports consideration of a Pacific representative being appointed as a Board member and; That the PHAC continue with the same Terms of Reference but meet quarterly.

Background

The future of the PHac was discuss at the meeting on 18 May and the Chair summarized the discussion:

It was agreed and carried that PHAC remains and there be no reason for it to be disestablished even with current changes across the region.

It was agreed and supported that PHAC recognises the current vision of DHB to move to regionalisation, and that it is an opportunity for the current PHAC to broaden its focus regarding area of coverage. This does not apply to actual membership of PHAC. (What this means, is that current community representative would need to consider Waitemata community area as well in their input and involvement in PHAC.)

It was agreed and supported that a recommendation be put forward for a permanent representation from PHAC to represent the Pacific perspective to CPHAC.

It was also agreed and supported that the same recommendation be put forward for a Pacific representative to be seconded onto the DHB in order to ensure that the voice of Pacific and issues concerning Pacific are being heard at the right level. There was a point being raised about the legislative number of people allowed on DHBs, (11), and whether there is any room at the moment to accommodate this request for a Pacific representative secondment. This needs to be explored when the recommendation is put forward by those who attend both CPHAC and DHB.

Disabled Support Advisory Committee Recommendation

PERFORMANCE IMPROVEMENT

9.1 DAP Projects Report

9.1 District Annual Plan Progress Report

The information set out on the attached pages covers progress for the 107 improvement activities ADHB committed to in the 2010/11 District Annual plan.

All 107 projects have been started with 39% in the planning stage, 52% in implementation and 9% completed. No projects have been cancelled. There are 40 projects which focus on lifting the health of the people in Auckland city, 56 for performance improvement and 11 to address the need to live within our means.

A higher percentage of projects are in the implementation phase this month and four projects have been completed being the projects to increase delivery of radiation therapy and cardiac surgery services, improve clinical resource utilisation and efficiency and consolidate and continue to implement the NQIP projects. The latter project is the subject of a Board presentation this month on 'Concord'.

	This month	Last month	Change
Planning	42	48	-6
Implementation	55	53	2
Completed	10	6	4
Total	107	107	0

Three projects are running behind their implementation schedule with a further 17 projects addressing potential issues with mitigation strategies in place. The exception reports cover these matters in more detail.

In terms of overall project status 72% of projects are on time, 88% on budget and 85% are expected to deliver expected outcomes. This is slightly lower than last month but reflects the completion of four projects during the month and is not regarded as a concern. The changes are summarised below.

Status	This month	Last month	Change
On time	72%	77%	-5%
On budget	88%	91%	-3%
Expected outcome	85%	89%	-4%



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			Finished	Post Implementation Benefits		
			Plan	Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green	Orange		Red		
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	40	40	7	9	3	16	3	0	34	3	1	38	0	0	37	1	0	2	2	0	0
2 Performance improvement	56	56	6	5	6	29	3	0	35	12	2	46	2	1	44	4	1	7	6	0	0
3 Live within our means	11	11	1	2	3	1	3	0	8	2	0	10	0	0	10	0	0	1	1	0	0
Total #	107	107	14	16	12	46	9	0	77	17	3	94	2	1	91	5	1	10	9	0	0
Total %	100%	100%	13%	15%	11%	43%	8%	0%	72%	16%	3%	88%	2%	1%	85%	5%	1%	9%	8%	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	Improve	🔴	🟢	🟢	The focus of the work programme is on increasing retinal screening from current levels to meet the increases in diagnosed people with diabetes. Currently screening is being delivered at GCC and augmented by a contract for 1000 by Mangere Health Care Trust. It is therefore good to see that MCHT are now successfully working through the assigned volumes and this has relieved pressure on the GCC retinal service. The work to enable the wider community screening programme to be operationalised is continuing with clinical and project teams working closely together to ensure that the system meets the work flow, data requirements and new structure. Customisation discussions with the vendor for the software component of the project is in progress as is the regional alignment for the solution to ensure that a regional system is developed. Overall, the desired outcomes are expected to be achieved, but not within the original timeframes.	CPHAC

Māori Service Development	Regional	Define	▲	●	●	The original project intention was to devolve \$600k of services (largely health promotion and public health) from metro-Auckland DHBs and the Ministry of Health (MoH) to Iwi and Maori providers by 30.12.10. This target date was too ambitious and was revised to 28/02/2011 for the identification of services across the DHBs to be devolved and construct a devolution framework. A number of services from CMDHB and WDHB were tagged for devolution and these are so far; • CMDHB: Smokefree RFP has been awarded to Raukura Hauora o Tainui. Total contract price is \$240k PA • WDHB: CAYAD contract has been let, value \$176PA. Well Child contract awaiting MoH decision, therefore RFP process on hold The draft devolution framework was due to CMDHB by 06/05/11. The original timeframes have already passed but the tools for future devolution work are in place and \$416K worth of services should be devolved before the financial year end.	CPHAC
Pacific Indicators	Regional	Finished	▲	▲	▲	Work in progress	PHAC

Legend: Red - ◆, Orange - ▲, Green - ●

Goal: 2 Performance improvement

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	Committee
Better help for smokers to quit	National	Improve	▲	●	▲	Of the 7813 events coded in April, 1105 (12.9%) of patients were identified as smokers and 751 (75%) of the smokers were documented as receiving advice to quit. The improvement plan has been updated and a number of initiatives will commence in May including weekly reporting of the Target results and weekly checks of all the smoker events coded with no brief advice. Where recoding is necessary this will be done prior to the end of the month so that no smokers recorded with brief advice will be missed. In services where documentation is identified as an issue the Service Mangers, Nurse Advisors and Charge Nurse will be advised. Work continues with the Medical Staff to improve the documentation of ABC. The Smokefree Clinical Champion Stephen Child will be presenting to medical forums in May and sending out updates to Clinical Directors. The AED focus on systems changes toward meeting the 6 hour Target may challenge this service's ability meet the Better Help for Smokers to Quit target. AED and APU have made great progress and it is crucial that they continue to improve in order to assist ADHB meet the target. Smokefree service contract will be renewed.	HAC
Pharmaceuticals	Regional	Measure	▲	●	▲	Optimal prescribing – to improve medicines safety for patients and to improve prescribing quality of providers through a multi-faceted approach which utilises bulletins, analysis and prescriber level data through GP cell groups to encourage peer review and pressure to inform 'best practice' prescribing. By adopting 'best practice' prescribing efficiencies can be made through the quantity and type of medications prescribed and the reduction in polypharmacy in the elderly. The project was originally envisioned to save at least \$1.5million of pharmaceutical expenditure in the 2010 / 2011 financial year which would be divided equally with the project. This was a joint project with CMDHB and involves Procure and East Health Trust. The project's programme of interventions is progressing well and is gaining traction with GPs. There has been difficulty in agreeing on a methodology for calculating savings as it is a complex process which involves pharmaceutical rebates which are unknown and there are so many external factors that can impact on pharmaceutical spend. The project is on budget, ADHB has contributed \$300K to the project which is expected to be covered by the pharmaceutical savings made (once a methodology is agreed). However the target of \$1.5 million in savings may have been too ambitious as highlighted above external factors can impact and plans for reduced costs or additions to the schedule which have fallen through will have impacted on the original savings estimated. Regardless of the savings the project is improving the quality of prescribing and so is improving clinical practice and optimising community pharmacy budget.	CPHAC
Starship 6 hour project	National	Improve	▲	●	●	Starship continues to show pleasing improvements in the time taken to process patients through the Children's Emergency Department. The April result of 94% of patients under the 6 hour target was the best ever recorded month for Starship. This represented a 1% improvement over March and 3% improvement on April 2010. Significantly there were 17 days during April 2011 where Starship achieved 95% or better compared to only 6 days in the equivalent month last year. The improved performance can be attributed to a number of factors including: • Further improvements in the mean time to transfer patients	HAC

					from the Emergency Department to Wards. • Improved processes relating to triaging and diagnosis within the Emergency Department. • A strong focus by the management team on breaches to establishing root causes and appropriate remedial actions. New data processed in the past months has provided the Starship Team with a more comprehensive and deeper understanding of current performance relative to the 3-2-1 guideline. Following a meeting of key stakeholders a new project focused on the '2 component' has been undertaken. Starship expects this to yield improvements in advance of the winter months. Aside from the above project, a number of other ward based initiatives focused on improving discharging processes and timely discharging are being initiated. A number of projects are also centered on improving the visibility of patient data at both a detailed level, aiding day to day management, to a high level that facilitates improved resource planning and flow of elective surgery.		
Tamaki P2HC project	Regional	Analyse	◆	◆	◆	The Tamaki Pathways to Health Careers Programme (P2HC) is one of the Tamaki Transformation Projects providing an opportunity for Tāmaki residents (in particular Māori and Pacific) to complete a transformational journey towards higher qualifications and work in a health and disability career. An early start cohort, comprising 3 Pacific and 5 Māori adults, commenced their 2011 studies and will continue with ADHB funding support over the next 3 years. Further implementation of Pathways Programme is dependent on securing sufficient funding for the Programme so no further recruitment is currently in progress. The project should provide the required deliverables provided funding is received to enable implementation of the final design and this is currently under negotiation with Te Puni Kokiri and the Ministry of Health.	BOARD

Legend: Red - ◆, Orange - ▲, Green - ●

Goal: 3 Live within our means

Exceptions

There are no projects that have been marked as an exception

10

LIVE WITHIN OUR MEANS

10.1 Finance Committee Recommendations

10.2 Finance Report

10.1 Finance Committee Recommendations

ADHB Board**Author:** Ian Bell (8077)**Subject:** Cardiac Investigative Unit (CIU) and Cath Lab (CL) Consumables

Recommendation

That ADHB enter into joint contracts with CMDHB, WDHB and Canterbury DHB for the provision of Cardiac Investigative Unit (CIU) and Cath Lab (CL) Consumables with 10 companies for a period of 3 years with a 2 year right of renewal.

Background

This will be discussed by the Finance Committee at their meeting on 31 May 2011.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Linear Accelerator Maintenance Contract

Recommendation

That ADHB endorses the purchase of a Linear Accelerator Maintenance Contract with Varian Medical Systems to cover the 6 accelerators in the Radiation Oncology Department at ADHB for 3 years with a 2 year right of renewal.

Background

This will be discussed by the Finance Committee at their meeting on 31 May 2011.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Request for Dispensation to Tender Ophthalmology Clinic

Recommendation

That the Auckland District Health Board approves dispensation for a closed tender limited to Fletchers, Mainzeal, Hawkins, Watts and Hughes, Kalmar Construction and Canam rather than an open tender and delegates authority for the CEO and CFO to approve an acceptable tender for the new Ophthalmology Clinic Greenlane Surgical Centre.

Background

This will be discussed by the Finance Committee at their meeting on 31 May 2011.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Starship Theatre Project

Recommendation

That the Auckland District Health Board approves up to \$300k to develop the design sufficiently to enable a robust business case For the Starship Theatre Business Case to be completed before submitting to the Audit and Finance Committee and ADHB Board.

Background

This will be discussed by the Finance Committee at their meeting on 31 May 2011. The completed business case is anticipated to be available in November 2011.

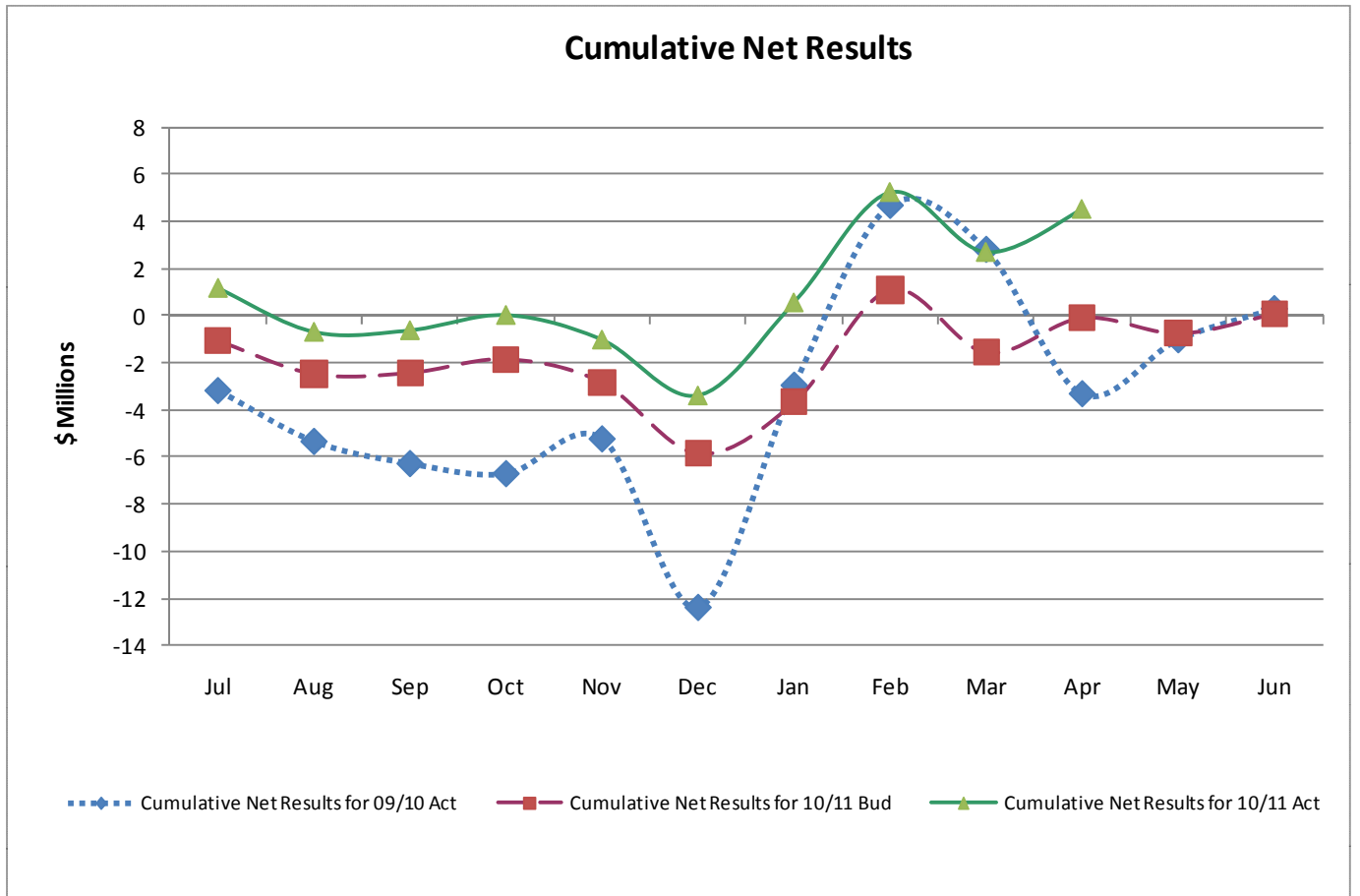
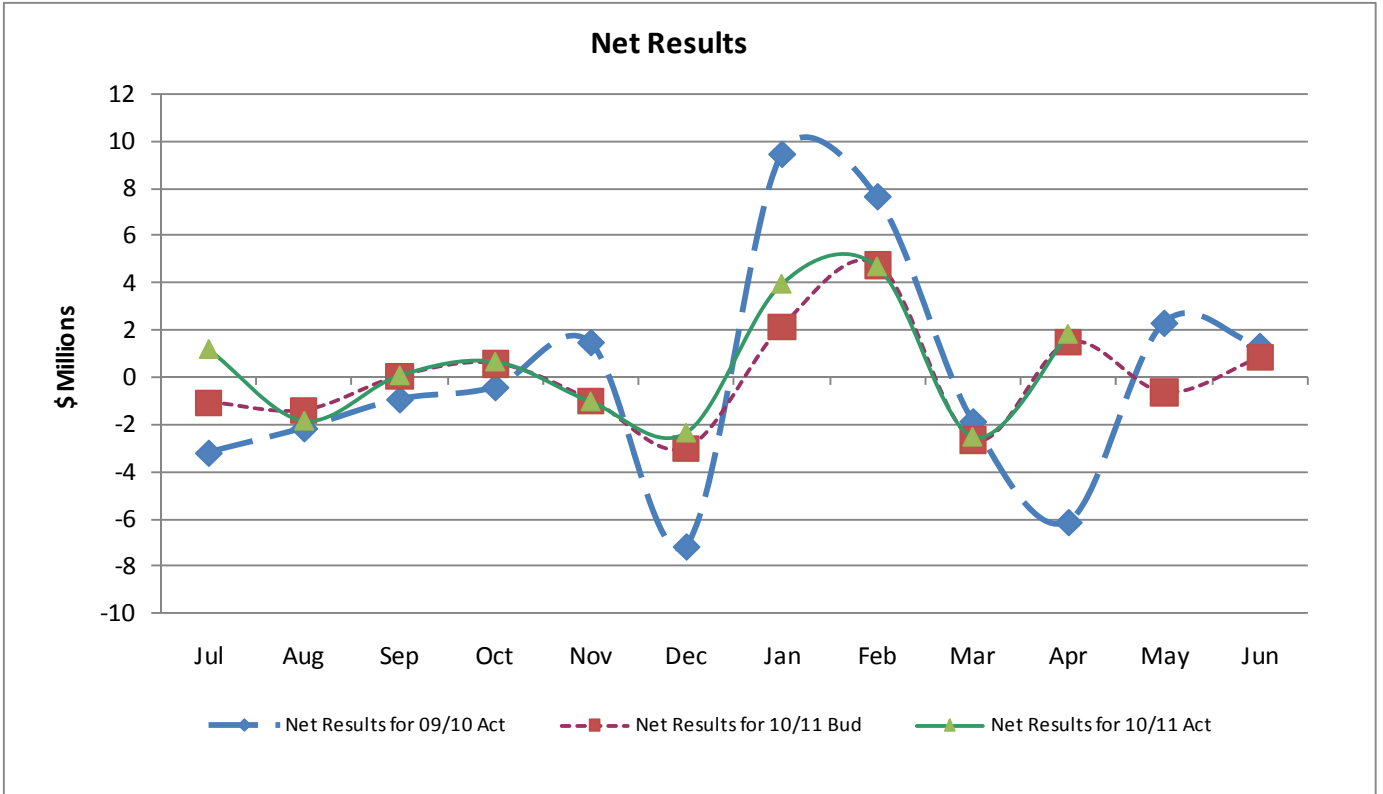
10.2 Finance Report

Auckland District Health Board

Board Financial Report

April 2011

Performance Graphs by Month & YTD



Auckland District Health Board
Summary Result
Month of Apr-11

\$000s	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
Income						
PBF - AKL Population	80,107	79,701	406 F	801,129	797,012	4,117 F
Inter District Inflows	54,790	47,891	6,899 F	508,286	478,906	29,380 F
	134,897	127,592	7,305 F	1,309,415	1,275,918	33,497 F
MOH Sub-contracts	9,497	7,346	2,152 F	76,953	74,364	2,589 F
Other Patient Care	12,704	9,273	3,431 F	41,294	33,480	7,813 F
Services & Products	(1,981)	(1,292)	689 U	38,325	38,881	556 U
CTA	1,934	1,684	250 F	16,414	16,645	232 U
Trust & Donation Income	398	927	529 U	5,004	4,815	189 F
Financial Income	584	316	268 F	7,563	4,090	3,473 F
Other Income	(427)	(392)	36 U	4,560	4,371	189 F
	157,606	145,454	12,151 F	1,499,528	1,452,566	46,962 F
Expenditure						
Employee Costs						
Medical	20,031	19,073	958 U	195,356	194,170	1,186 U
Nursing	19,787	19,593	194 U	199,575	196,360	3,215 U
Technical	10,087	9,929	158 U	100,413	101,626	1,213 F
Hotel Services	859	785	74 U	8,366	7,986	380 U
Administration	6,694	7,547	853 F	75,698	77,521	1,824 F
Other	3,724	3,344	380 U	35,556	34,591	964 U
Total Employee Costs	61,182	60,271	911 U	614,963	612,253	2,710 U
Outsourced Services	1,101	0	1,101 U	2,101	0	2,101 U
Direct Treatment Costs	19,976	16,949	3,027 U	192,828	174,558	18,269 U
Indirect Treatment Costs	3,398	3,254	144 U	35,459	32,642	2,817 U
Funder Payments	46,924	39,465	7,459 U	419,201	394,536	24,665 U
Inter District Outflows	8,426	8,372	54 U	82,677	83,723	1,046 F
Prop, Equip. & Transport	4,107	4,074	33 U	40,281	41,273	992 F
Maintenance	131	133	2 F	1,515	1,333	181 U
Loss on Sale of Fixed Assets	(225)	1	226 F	68	14	54 U
Administration Costs	2,073	2,053	20 U	19,096	20,065	969 F
Total Operating Expenditure	147,095	134,575	12,521 U	1,408,203	1,360,400	47,803 U
Operating Contribution	10,511	10,880	369 U	91,325	92,165	840 U
Depreciation	4,323	4,684	361 F	42,960	45,132	2,171 F
Finance Costs	1,476	1,670	194 F	15,215	16,770	1,555 F
Capital Charge	2,894	3,062	168 F	28,637	30,369	1,732 F
Total Non Operating Costs	8,693	9,416	723 F	86,813	92,271	5,457 F
Net Surplus / (Deficit)	1,818	1,464	354 F	4,511	(105)	4,617 F

Auckland District Health Board				
Statement of Financial Position				
As at Apr 2011				
	Apr-11	Apr-11	Mar-11	Jun-10
	Actual B	udget	Actual A	ctual
	\$ 000s	\$ 000s	\$ 000s	\$ 000s
Crown Equity				
Opening Balance	570,553	569,304	569,409	566,089
Equity Injections/(Repayments)	505	3,044	1,144	3,320
Closing Balance	571,058	572,348	570,553	569,409
Revaluation reserve				
Opening Balance	353,538	381,278	353,538	381,278
Revaluation Adjustments	(0)	-	(0)	(27,740)
Closing Balance	353,537	381,278	353,537	353,538
Retained Earnings				
Opening Balance	(468,367)	(468,437)	(468,367)	(468,645)
Surplus/(Deficit) Current Year	4,512	(107)	2,693	279
Closing Balance	(463,854)	(468,544)	(465,673)	(468,367)
Total Crown Equity	460,741	485,081	458,418	454,578
Represented by:				
Fixed Assets				
Land	181,497	201,337	181,497	181,497
Buildings	571,508	598,283	573,241	586,094
Clinical, Other Equipment & Motor Vehicles	81,251	122,904	81,373	79,856
Work in Progress	32,245	13,906	32,938	23,166
Total Fixed Assets	866,502	936,430	869,048	870,612
Derivative Financial Instruments	4,772	4,399	4,772	7,061
Investments				
Associated Company Investments	95	386	95	470
Trust Deposits	6,326	8,000	6,326	10,078
Total Investments	6,421	8,386	6,421	10,547
Current Assets				
Cash & Short Term Deposits	83,284	28,848	80,787	56,815
Trust Deposits	15,763	11,508	15,679	11,747
Debtors	20,761	24,435	30,181	25,691
Accrued Income	31,939	28,287	25,538	31,221
Prepayments	3,088	2,320	3,454	2,245
Inventory	12,161	12,106	12,202	11,220
Total Current Assets	166,996	107,504	167,842	138,938
Current Liabilities				
Borrowings	2,804	23,207	25,640	75,027
Trade & Other Creditors, Provisions	231,849	215,495	226,004	222,910
Income Received in Advance	26,134	18,609	27,939	20,087
Taxes Payable	16,154	19,240	23,128	18,040
Funds Held in Trust	1,093	1,114	1,086	1,067
Total Current Liabilities	278,034	277,665	303,796	337,132
Working Capital	(111,038)	(170,161)	(135,954)	(198,193)
Non Current Liabilities				
Borrowings	283,094	273,094	263,086	213,014
Employee Entitlements	22,821	20,880	22,782	22,435
Total Non Current Liabilities	305,915	293,973	285,868	235,449
NET ASSETS	460,741	485,081	458,418	454,578

Statement of Cashflows for the Year ended 30 June 2011							
	Apr-11			Year to Date			
	Actual B	udget	Variance	Actual	Budget	Variance	
Operations							
Revenue Received	158,446	143,350	15,096	1,503,197	1,457,662	45,535	
Payments	(155,401)	(144,611)	(10,790)	(1,446,846)	(1,412,449)	(34,397)	
Net Operating Cashflows	3,045	(1,261)	4,306	56,351	45,213	11,138	
Investing							
Income	584	370	214	5,871	3,697	2,174	
Capital							
Sale of Assets	218	1	217	235	13	222	
Purchase Fixed Assets	(1,777)	(6,460)	4,683	(39,461)	(64,606)	25,145	
Net Investing Cashflows	(975)	(6,089)	5,114	(33,355)	(60,896)	27,541	
Financing							
Equity Injections	505	0	505	1,650	3,043	(1,393)	
New Loans	0	0	0	70,000	91,000	(21,000)	
Loans Repaid	0	0	0	0	375	(375)	
Equity Repayment	0	0	0	0	0	0	
Loans Repaid	0	0	0	(70,000)	(70,000)	0	
Net Financing Cashflows	505	0	505	1,650	24,418	(22,768)	
Total Net Cashflows	2,575	(7,350)	9,925	24,646	8,735	15,911	
Opening Cash	52,100	46,114	5,986	30,029	30,029	0	
Closing Cash	54,675	38,764	15,911	54,675	38,764	15,911	

Financial Performance

- The result for April was a surplus of \$1.8m compared to a budgeted surplus of \$1.5m, a favourable variance to budget of \$0.3m. The result year to date is a surplus of \$4.5m compared to a budgeted deficit of \$0.1m, a favourable variance to budget of \$4.6m.
- The average WIES per discharge is 1.34% higher than last year. Discharges are up by 0.27% compared to last year.
- The result year to date, is driven by higher revenue \$47.0m offset by higher expenditure of \$(42.3)m.
- Year to date revenue was higher than budget by \$47.0m. This was the result of:-
 - a) Favourable Base Revenue \$33.5m is driven by higher base contract variations, which are primarily for additional Herceptin funding \$7.1m, PHO realignment funding \$17.8m, Oral Health funding \$1.3m and a provision for FY11 IDF wash up's \$5.1m.
 - b) Higher MoH Subcontract revenue \$2.6m, is driven by higher SCI funding \$4.5m, Mental Health (Eating Disorder) funding and other MoH Subcontract revenue \$8.0m, lower Herceptin funding (now in base revenue above) \$(6.2)m and lower Additional Elective revenue \$(3.7)m as a result of lower year to date volume delivery
 - c) Higher volumes of non resident activity \$3.6m
 - d) Higher levels of inter DHB side contracts \$3.7m to meet additional PHO costs
 - e) Higher interest received on term deposits \$2.2m.
 - f) A realised gain on Interest Rate Swap Instruments \$1.3m
- Year to date expenditure was higher than budgeted by \$(42.3)m.
 - a) The unfavourable variance in employee costs of \$(2.7)m was driven by vacancies and annual leave taken in Mental Health \$2.9m, Adult Health \$2.0m, Operations \$2.0m and Cancer \$0.5m but increased employee costs in Child Health (\$3.7)m, Cardiac \$(1.9)m, Operating Theatres \$(2.6)m, Ambulatory \$(1.0)m, driven by increased volume and complexity. In addition, provision has been made for potential MECA settlements \$(2.0)m and long service and gratuity payments \$(1.0)m. Administration staff costs are favourable to budget \$1.6m, primarily as a result of the transfer of Finance, Procurement and IS staff to Health Alliance with effect from 1 March as noted below.
 - b) The unfavourable variance in Outsourced Services \$(2.1)m is driven by the transfer of Finance, Procurement and IS staff to Health Alliance with effect from 1 March with payroll costs decreasing by the same amount.
 - c) Direct Treatment costs are \$(18.2)m unfavourable to budget in the following services – Adult Health \$(2.7)m, Child Health \$(5.6)m, Cardiac Services \$(6.0)m, OR & Anaesthesia \$(2.8)m, Laboratories \$(3.1)m, Imaging \$(1.8)m and Ambulatory \$(0.7)m. The increase is due to increases in Drugs \$(0.9)m driven by high usage in immunology and paediatric oncology, Chemicals & Media \$(2.4)m driven by higher test volumes and higher reagent costs, Clinical Supplies & Implants \$(8.7)m driven by higher volumes in OR & A, Cardiac and Child Health and Outsourcing \$(6.3)m primarily to cover operational vacancies, manage cardiac waiting lists and increase electives volumes during the balance of the year. There were also various initiatives that have not delivered the treatment cost savings to the planned levels. Further analysis is also provided within the Hospital Advisory Committee agenda.

- d) Funder Payments (excluding IDF Outflows) are over budget \$(24.7)m due to increased PHO costs following a process of realigning PHO's \$(23.6)m where additional IDF revenue is being received to cover the additional costs incurred on behalf of the regional DHBs. There are also unfavourable variances in Laboratory costs following revised contracts with LTA and DML \$(1.6)m, costs arising from settlement of prior year's pharmaceutical claims \$(0.7) m and additional Mental Health (Eating Disorder) expenditure \$(1.0) m, for which additional revenue has been received as described above.
- e) Inter District Outflows are favourable to budget \$1.1m driven by the finalisation of the FY 2010 outflows provision.
- f) Indirect Treatment Costs are \$(2.8)m unfavourable primarily due to the provisioning for doubtful non resident debts in relation to the increased non resident revenue described above (\$2.2)m and the higher cost of sales for retail pharmacies for which additional revenue has been received \$(0.5)m.
- g) Property costs are favourable to budget \$1.0m driven by lower utility, property, vehicle and computer maintenance costs.
- h) Administration Costs are lower than budget \$1.0m due to lower consulting fees for improvement projects \$0.8m.
- i) Depreciation is lower than budget \$2.2m driven by lower levels of capital expenditure.
- j) Finance Costs are lower than budget \$1.6 m driven by lower than planned interest rates and CHFA loans not having to be drawn down.
- k) The Capital Charge is lower than budget \$1.7m driven by the revaluation of Land & Buildings downwards at balance date.

Financial Position

- The opening balance of fixed assets was \$(39.5)m below budget principally due to the downward revaluation of land & buildings \$(27.8) m as at 30 June 2010 and FY10 full year capital spending being \$(28.7) m lower than forecast.
- FY11 YTD Capital spending is \$39.2m, under budget by \$(25.4)m. Baseline and Facilities projects are behind budget by \$(13.2)m driven by slower spending on the Greenlane Surgical Unit \$(6.0)m, Oral Health Clinics \$(2.8)m and a reduction in spending through reprioritisation \$(4.8)m. Information Systems projects are behind budget by \$(12.2)m driven by the pace at which business cases are completed, approved and implemented.
- At month end there is an unused overdraft facility of \$45.0m.

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GENERAL BUSINESS

MEETING DETAILS	
Time and Date	2:00pm, Wednesday, 1 June 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
Members	Dr Lester Levy (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	Rob Cooper (Leave of Absence)
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Janice Mueller, Vivienne Rawlings, Ian Bell.

	Item	Page No
1 2m to 2:02pm	Karakia	001
2 3m to 2:05pm	Attendance and Apologies	005
3 2m to 2:07pm	Conflicts of Interest	007
4 5m to 2:12pm	Confirmation of Minutes 4.1 4 May 2011 4.2 18 May 2011	015 017 025
5 3m to 2:15	Action Points 4 May 2011	029
6 5m 5m to 2:25pm	Chairman's Report 6.1 Report 6.2 Chairman's Recommendations	033 035 037
7 10m 15m to 2:50pm	Chief Executive's Report 7.1 Chief Executive's Report 7.2 Minister's Six Health Priorities 2009/10 7.3 Eligibility	043 045 059 071
8 5m to 2:55pm	Lift the Health of People in Auckland City 8.1 Committee Recommendations	079 081

	Item	Page No
9 5m to 3:00pm	Performance Improvement 9.1 DAP Projects Report	083 085
10 5m 10m to 3:15pm	Live Within Our Means 10.1 Finance Committee Recommendations 10.2 Finance Report	091 093 099
11 5m to 3:20pm	General Business	109
NEXT MEETING		
	Time and Date: 2:00pm, Wednesday, 6 July 2011 Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton	