



Auckland District Health Board

Board Meeting

Wednesday 3 August 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*

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 A+ Trust	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman Trustee			31 May 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	31 May 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 Tamaki Transformation Transitional Board	Council member Chair	Fee 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 Ngati Hine Health Trust	Board member Chair			
	Te Taitokerau Whanau Ora	Committee member	Fee		
Ian WARD	Principal/Director C -4 Consulting Limited				4 May 2011

CONFIRMATION OF MINUTES
- WEDNESDAY 6 JULY 2011

Auckland District Health Board Minutes



MEETING DETAILS									
Time and Date	2:00 pm, Wednesday, 6 July, 2011								
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton								
1	KARAKIA								
	The Chair declared the meeting open at 2:10pm. Naida Glavish led the meeting with the karakia and it was noted that it was Maori Language Week.								
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>Susan Buckland</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>Dr Denis Jury – Acting Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director Performance and Innovation Taima Campbell – Executive Director Nursing Aroha Haggie – Health Gain Manager Maori Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager, Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Judith Bassett, Chris Chambers, Rob Cooper and Garry Smith.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lester Levy (Chair)	Jo Agnew								
Peter Aitken	Susan Buckland								
Dr Lee Mathias	Robyn Northey								
Gwen Tepania-Palmer	Ian Ward								
3	CONFLICTS OF INTEREST								
	There were no declarations of conflicts of interest for any item on the agenda.								
4.1	CONFIRMATION OF MINUTES 1 JUNE 2011								
	<p><u>Moved Robyn Northey; seconded Gwen Tepania-Palmer</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 1 June 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>								

6	CHAIRMAN'S REPORT
	<p>It was the start of a new financial year. Studies indicated that 25% of staff were under performing so it was important to have staff engagement and while the financial year had ended it was important to motivate and keep the momentum into the new year.</p> <p>There was a need for visibility at Board level of exercise of delegated authorities. While they allow actions to be undertaken, the Board did need to know what was done for more visibility and transparency.</p> <p>The Board was also keen to get regular snapshots i.e. at the HAC around elective surgery and surgery with a view on volumes, clients and issues. There also needed to be more visibility around SMOs starting with HR on how paid, rate etc so that the Board got a view on what was happening. This was not interference but in the interest of good governance. Two topics would be addressed each month.</p> <p>The new combined committees would commence in August. Work was being done on trying to get operational alignment of Maori Health across ADHB and WDHB as one which was supported by the Chief Executive. Having a combined committee was the first step with then focus on Tikanga and facilitating cooperation.</p> <p>There were some concerns at the progress of regionalisation that needed to be resolved. While Waitemata had approved the Regional Health Plan they had not expected the proposed extra cost around After Hours services so there needed to be a framework for these issues to be resolved.</p>
7.1	Chief Executive's Report
	<p>A number of the Senior Leadership Team had denoted time to serve meals at the Auckland City Mission on 30 June and had seen the new health clinic and adjoining pharmacy and were briefed on other facilities including the detox facility. The Health Quality and Safety Commission supported the northern region's "Do No Harm" with a view to spreading this out to other DHBs.</p> <p>Planning for the Rugby World Cup was going well but there was some concern at the number of people that would be in central Auckland. St Johns were trialling a station in Wellington's Courtney Place with a view to these being established at "party central" on the Auckland waterfront and Victoria Park during the Cup. While Auckland had more visitors at other times the concern was the concentration of visitors. People will present acutely and while this would impose more costs there was no extra funding. There was good work being done by the Incident Management Team in collaboration with Police and St Johns.</p> <p>The Electives Production Plan for 2011 - 2012 was to deliver 11,149 discharges. There was good planning but still work to be done on the mix and putting ESPI into the plan. This was divided to each service determining resources, capacity and throughput planning.</p> <p>The improvement in immunisation was noted and there was a need to analyse what coordinators had done, what had been done differently and where there were successes. Coordinators had assisted improving data with primary care and getting families to enrol with primary care. The coordinators do go around and spread best practice to other practices.</p> <p>The initiatives on new models of care appeared to be system changes rather than step changes. There would be a primary care paper going to the CPHAC with how to align the two DHBs and the way that primary care was wanted to change. With children the focus had been on immunisation and for the new year the higher target may be difficult to achieve. There were conversations between clinical leaders at ADHB and WDHB on how to provide services across both DHBs.</p> <p>There were many processes within hospital services for older people. The InterRIA rollout had been completed to Home Based Support Services and would then be rolled out to residential care. Older people is also a regional project with Waitemata taking a leadership role. There was</p>

	development of a dementia care pathway which included a process for non residential care. ADHB does contract for dementia care but has strict criteria and there had been a number of debates with providers that do not meet those criteria.
5	ACTION POINTS 1 JUNE 2011
	<p>Primary Care</p> <p>A summary of initiatives in primary care was tabled with some phased over years. From this inventory there is a lot of Better Sooner More Convenient already in place but this gave a sense of what is going on. The Board requested that they be categorised, their status provided and expected completion date.</p> <p>Regional After Hours Services</p> <p>There was a proposal and this would be discussed with PHOs. It did take an A&M approach and requested funding of \$5m more than present, split between DHBs and PHOs, with the bulk going to lowering co-payments. There was some disagreement across the region which was a learning process. The timeline was 1 September implementation which was considered not possible and while there may be agreement by that date it would not be possible to be implemented with a need for an implementation plan. There was a meeting to get focus and the Deputy Chair is to be kept informed. There was concern at dominance of A&M and their location in relation to the ADHB locality strategy so there needed to be provision for exit from the contract, performance measures and a reserving of the right to alter the model. While open book was proposed there was nothing novel in the proposal and extra money had not been budgeted. The existing White Cross contract expired at the end of June and had been extended for a year with 9 months expiry if necessary, being 6 months and 3 months notice but it could be varied with agreement earlier.</p> <p>Smoking</p> <p>There had been a meeting with the complainant about smoking on site and he had been provided a copy of the paper presented to the Hospital Advisory Committee. There had been a briefing to Communications and there would be a press release and staff communication.</p> <p>Quarterly 2010 - 2011 Performance</p> <p>While the report from the Ministry was good the layout of the overview was not very useful.</p>
7.2	Minister's Six Health Priorities
	All these had been reviewed.
8.1	Hospital Advisory Committee Recommendations
	<p><u>Moved Gwen Tepania-Palmer; seconded Peter Aitken</u></p> <p><i>That the Auckland District Health Board instructs management to take every step possible to be a smoke free environment as soon as possible starting with Starship Hospital and precincts and enforcement of non-smoking with staff.</i></p> <p><u>Carried</u></p>
9.1	DAP Projects Report
	The report was noted.

10.1	Finance Committee Recommendations
	<p>Electrophysiology Catheters</p> <p>The question of reuse had been through the Clinical Board with a preference not to reuse being supported by the Board.</p> <p><u>Moved Ian Ward; seconded Robyn Northey</u></p> <p><i>That ADHB enter into the following contracts with Johnson & Johnson New Zealand Ltd & Medtel New Zealand Ltd for the supply of Electro Physiology Catheters (EP Catheters) and associated consumables at an estimated annual value of \$2.145 million for a period of 4 years:</i></p> <p><i>Johnson & Johnson - \$1.46 million p.a. for an initial 2 year term plus a Right of Renewal of 2 years.</i></p> <p><i>Medtel - \$687,000 p.a. for an initial 3 year term plus a Right of Renewal of 1 year.</i></p> <p><i>This is a proposed total spend of \$8.6 million across 4 years.</i></p> <p><u>Carried</u></p> <p>Insurance</p> <p>The insurances had all expired and been renewed on 30 June. Previously there had been a proposal to reduce the cover from \$320m to \$100m but the Crown had not wished to absorb additional risk. The brokers had provided good service. The increase in material damage for ADHB was \$700k.</p> <p><u>Moved Robyn Northey; seconded Peter Aitken</u></p> <p><i>That the ADHB Board notes and approves the insurance renewal for 20011 – 2012.</i></p> <p><u>Carried</u></p>
10.2	Finance Report
	<p>There had been a favourable variance for the month with a year to date result of a \$4.2m surplus. The electives result was confirmed and other year end positions were being finalised. The actuarial rate was awaited from Treasury and the expected Pharmac rebate had reduced by \$2m. The indicative result would be available Monday with the final in mid August.</p>
12	GENERAL BUSINESS
	<p>Relationships with the Private Sector</p> <p>There was discussion on relationships and contracting with the private sector with the need, where they are going to be used for a longer term, to put longevity into the contract to achieve better pricing in such areas as PET scans, heart surgery and maternity. It was important to deliver to the DAP, be neutral about ideology and agnostic around boundaries and budgets. Management were looking at speeding up the move to centres of excellence and to take strategic and long term relationships with the private sector. The approach to contracting was with public and private cooperating together through prudent sound relationships. It was suggested that the maternity model at Waikato be considered.</p>

14	PUBLIC EXCLUSION						
	<p><u>Moved Lee Mathias; seconded Jo Agnew</u></p> <p><i>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.</i></p> <p><i>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:</i></p> <table border="1" data-bbox="204 517 1358 949"> <thead> <tr> <th data-bbox="204 517 616 636">General subject of each matter to be considered:</th> <th data-bbox="616 517 979 636">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="979 517 1358 636">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="204 663 616 887"> 12.1 Confidential Board Minutes 4 May 2011 12.2 Confidential Board Minutes 18 May 2011 12.3 Committee Structure Finalisation of Membership 12.4 Te Whetu Tawera 12.5 Remuneration Strategy </td> <td data-bbox="616 663 979 831"> 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="979 663 1358 887"> 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> </tbody> </table> <hr/> <p><u>Carried</u></p> <p>Matters discussed in public exclusion were Confidential Board Minutes 4 May 2011, Confidential Board Minutes 18 May 2011, Committee Structure Finalisation of Membership, Te Whetu Tawera and Remuneration Strategy.</p> <p><u>Moved Robyn Northey; seconded Gwen Tepania-Palmer</u></p> <p><i>That the ADHB Board 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 4 May 2011 12.2 Confidential Board Minutes 18 May 2011 12.3 Committee Structure Finalisation of Membership 12.4 Te Whetu Tawera 12.5 Remuneration Strategy	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.
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	NEXT MEETING						
	<p>The meeting closed at 4:00 pm</p> <p>The next scheduled meeting is: 2:00pm, Wednesday, 3 August 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>						
	<p>CONFIRMED</p> <p>CHAIR: _____ DATE: _____</p>						

ACTION POINTS

- WEDNESDAY 6 JULY 2011

Board**Action Points from the meeting on Wednesday 6 July 2011**

Item	Detail	Designated	Action
Carried forward	Audit of practice recording of HbA1c management	Denis Jury	To CPHAC July
5	Primary Care summary of initiatives categorise, status (where at), expected completion date	Denis Jury	
5	Regional After Hours project keep Chair informed and update monthly to Board	Denis Jury	
	Delegated Authorities look at combining across ADHB/WDHB	Ian Bell	

CHAIRMAN'S REPORT

CHIEF EXECUTIVE'S REPORT

- 7.1 Chief Executive's Report**
- 7.2 Minister's Six Health Priorities**
- 7.3 Towards Excellence**
- 7.4 Northern Region Health Plan Budget**

7.1 Chief Executive's Summary

CHIEF EXECUTIVE'S REPORT

1	EVENTS AND NEWS IN JUNE
2	EVENTS AND NEWS IN JULY
3	MANAGING THE WIDER HEALTH SYSTEM
4	BOARD PERFORMANCE PRIORITIES
APP	DETAILED PROJECT REPORTS

Introduction

This report covers the month of June. It includes a brief summary of events of note in June and July, an update of management of the wider health system and a summary of progress against the Board's priorities and regional projects to confirm these matters are being appropriately addressed.

1 Events and news in June

1.1 Events

During June the following events took place:

- The face of Red Nose Day, Eva Mitchell, featured again in fundraising. Red Nose Day was linked with a charity hitch-hiking journey by two Fairfax reporters from Queenstown to Auckland to raise money for Cure Kids.
- 60 Minutes began filming Onehunga blast survivor Ian Winsom at Auckland City Hospital, where he is an inpatient.
- The Smokefree proposal generated favourable national publicity.
- There was a complaint from a former staff member about conditions at Te Whetu Tawera which generated concern among staff, a letter of complaint to Health and Disability Commissioner and some media coverage. This has been managed with an invitation to meet with the Commissioner and discuss the matters raised.
- There were extensive media requests for interviews and information on the impact of synthetic cannabis use on clinical and emergency services. Clinical Director of ED, Dr Tim Parke, responded to describe the impact on emergency services. Beyond the Sunday Star Times and NZ Herald, further requests were declined on the grounds that Dr Parke needed to move back to running the department and further comment would need to be based on appropriate research.
- In the previous month's report we highlighted other June events such as the father who donated part of his liver to his son, the opening of a dental clinic by Associate Minister of Health Peter Dunne and a number of people who were honoured in the Queen's birthday honours. Mention was made of MP Jackie Blue attending the Rugby World Cup emergency management exercise and the participation of members of the ADHB management team in Auckland Homeless Steering Group initiatives.

2 Events and news in July

2.1 Events

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

Web

- The Statement of Intent has been loaded to ADHB website.
- The Annual Plan will be loaded to ADHB website.

- The CEO's disclosure of expenditure has been made available on the ADHB website.
- National Women's Health has launched a new website:
<http://nationalwomenshealth.adhb.govt.nz/>

Media

- Publicity around Chace Topperwien, who has acute myeloid leukaemia and is in need of a stem cell transplant, sparked a nationwide fundraising appeal. Chace is a patient on Starship's Oncology Ward.
- A hospital grandparent volunteer, Starship's Northern Health School volunteer and Radio Lollipop's volunteer will feature on a TV One programme called "Unsung Heroes."
- A Coroner's inquest and attendant publicity regarding the death of medical student Zachary Gravatt at Auckland City Hospital.

Internal

- Healthcare Excellence awards have been opened for nominations.
- The refurbished ADHB Contact Centre and Central Referrals new offices have been officially opened.
- Auckland City Hospital doctor Divya Dhar was filmed in early July in a promotion of her role as New Zealand ambassador for the 2012 Olympics campaign.
- The August edition of Nova was published in late July, providing a full report of ADHB's achievement against the six health targets.
- Auckland Central MP Nikki Kaye spent an evening and morning on a shift in ACH's ED.
- There was a soft launch of the Health Fraud Awareness campaign early in July.

3 Managing the wider health system

3.1 System performance

June is the final month of the financial year and as such there is a keen focus on ensuring that targets for the current year are met and plans for the next year are approved. There has been good performance towards meeting all key goals and a number have been exceeded, such as immunisation levels, which is an excellent achievement not only by DHB staff but the many providers and networks involved.

The planning round for 2011/12 is well advanced and, as noted in the events section of this report, the Statement of Intent has been published on the web site. The Annual Plan has also been approved by the Minister following some changes requested by the Ministry of Health to clarify wording and process around the primary care initiatives at local and regional level.

The breakeven financial target was achieved for the year and the total FTE returned to the budgeted level for June. The Auditors have commenced their end of year audit work with a similar timetable to last year. This will enable audit clearance for the filing of the financial templates with the Crown on 19 August.

NGO providers continued to perform to plan and, as noted further on in the report the transition of targeted surgical services to primary care is working well. Capacity planning and patient flow management for medical services has been tested during the winter months with the high levels of demand resulting in high levels of ward utilisation.

The work on amalgamation of the PHOs is now complete and Auckland has seven PHOs, with four in the ADHB catchment. A more detailed commentary is included in a later part of this report together with a summary of key primary care initiatives. Further detail is also available in the CPHAC papers.

The close working collaboration with Waitemata DHB is progressing with several meetings occurring during the last month to agree the basis for integrating Board meeting processes. This is in addition to the funding and clinical initiatives already in place.

3.2 Clinical quality and professional governance

Clinical Leadership Group

The Clinical Leadership Group (previously known as the Clinical Board) has been established to provide patient safety and clinical governance assurance to the Board. The Clinical Leadership Group includes all Level 1 & 2 Health Service Group Clinical Leaders and Medical Advisors for Quality and I.T; Nurse Advisor – Quality and the Quality Group Manager. The Clinical Leadership Group standard work includes the following areas:

Standard work	Expected outcomes
Risk Register (including moderate risks)	<ul style="list-style-type: none"> Confirmation of the adequacy of controls/ mitigation strategies and actions. Identification of emerging risks.
Complaints (critical & major) Complaints resolution	<ul style="list-style-type: none"> Identification of trends / themes and appropriate actions. Delays in complaint resolution are identified and actions confirmed.
Adverse Events	<ul style="list-style-type: none"> Feedback on trends / themes and appropriate actions confirmed. Sharing of event learning.
Scorecards and KPIs	<ul style="list-style-type: none"> Variations / exceptions in clinical performance are identified and actions to improve confirmed. The Safety Scorecard is under development and will align with the Northern Regional Health Plan 'Do No Harm' indicator suite. Clinical KPIs are being considered alongside the Health

Standard work	Expected outcomes
	Round Table data set.
Standing Committee reports and KPIs	<ul style="list-style-type: none"> • Variations / exceptions in clinical performance are identified and actions to improve confirmed. • Annual reports tabled e.g. Clinical Practice Committee.
Quality Improvement	<ul style="list-style-type: none"> • Presentations and updates on quality improvement initiatives e.g. Early Warning System implementation.

Early Warning System (EWS)

The EWS includes a new clinical form to replace the existing 20 observational records. The new form is based on a human factors approach that generates a score and agreed response including an increased level of observation or an emergency code (code red). Implementation of the EWS in adult services has been in progress for the last few months and will continue to the end of December. The number of Code Red calls has increased post-implementation, as expected. The EWS is not applicable to maternity services and Starship will participate in an international study to test a paediatric early warning system (PEWS).

3.3 Hospital services

The continued improvement in patient flow management has been rewarded by achieving the targets for adult and child emergency services. Whilst the high winter acute volumes created a challenge for the achievement of elective targets, the target was nevertheless met.

The provider arm recorded an unfavourable variance for the year and, as forecast, the corrective measures were not able to achieve a return to the budgeted net result for this part of the organisation. FTE management and direct treatment costs were a continued focus for the team and will continue to be in the 2011/12 year. As reported in previous months, an important component of these additional costs related to outsourcing elective procedures to ensure that targets were met. Outsourcing is monitored on a daily basis to minimise the number of procedures outsourced.

There is an equal emphasis on both surgical and medical specialties in terms of the management of patient flow. It was pleasing to see the radiation therapy team continue to meet their 100% target for the month, and the diabetes management target was met for annual checks after operating below target for Q3.

3.4 Primary care and community services

The reporting focus this month includes an update on the PHO amalgamation process which is now complete, the work to reposition GAIHN, surgical referrals and POAC. As noted in the opening comments, the achievement of the immunisation and diabetes check targets were good achievements, particularly for the Maori and Pacific population groups.

Greater Auckland Integrated Health Network (GAIHN)

As previously reported, GAIHN is refocusing on a single goal of reducing acute demand and unplanned hospital admissions across Auckland. This positions the group as a change agent in the primary care sector for acute demand management and prevention. A work programme has been developed at a high level and is being translated into detailed work plans to identify the project detail, timeframes and resource requirements.

A paper will be presented to PHO and DHB Boards in July 2011 seeking endorsement of the direction and approval of funding and DHB staff resources. The paper will include achievements to date, the change of direction and intentions from the agreed business case, an overview of projects and initiatives planned over the next 1-3 years to address acute demand with specific detail for the 2011/12 year, and the detail of funding and resource requirements.

Primary care – PHO amalgamation

The PHO amalgamation process is largely complete with a substantial reduction in the number of PHOs in the Auckland region. The coverage of the seven PHOs varies with ProCare operating across the entire metro region, Alliance Health + and National Hauora Coalition operating across Auckland and Counties Manukau DHB. The remaining PHOs comprise Auckland PHO, East Health Trust and Waitemata PHO. This coverage results in Counties Manukau DHB having five PHOs in its district; Waitemata DHB has two; and Auckland DHB has four.

The collaboration with primary care providers is further extended by the Locality Planning process. A steering group reflecting localities, primary care and long term conditions has been formed and members will meet fortnightly. Implementation plans for the Locality Model and a Health Needs Assessment are being developed. This will be run in conjunction with processes designed to increase the skills and capacity of the participants. It is being piloted with two ADHB localities and Auckland Council.

Papers describing the alignment of the approach to primary care and localities at both ADHB and WDHB will be presented for discussion at the August and September meetings of the new combined CPHAC of the two DHBs.

Primary care – surgical referrals

The number of minor surgery referrals sent to Accredited GPs is steadily increasing across the region, and an improvement plan has been implemented during June. Clinical trust is a key issue and this is being addressed through a robust process for accrediting providers. The new arrangements have been advertised across the region with information on the skin surgery scheme, the path to follow and frequently asked questions. A list of contracted GPs is available on Health point. This is supported by a central triage point at each DHB to manage skin cancer referrals and forward appropriate referrals to the accredited GPs.

Primary care – POAC

Regional monthly targets have been consistently met for managing primary options for acute care (POAC). There has been a metro-regional average of 1,370 referrals per month (target 1,250) and a provisional annual figure of 16,435 referrals against a

target of 15,000. As a result of this strategy 87% of all referrals were managed in primary care without admission to hospital with an average cost per referral across all DHBs of \$197. This is below budget although the additional volumes resulted in a higher total cost.

Primary care – After Hours

As previously reported an after hours service provision has been received from an alliance of four PHOs in the Auckland metro region. This proposal uses existing A and M Centres, but with significant additional funding lowers co-pays for many service users. There has been ongoing work by the DHBs and the PHO Alliance to develop the detail of this proposal and further work is required regarding service model, governance and funding.

Primary care – Community Pharmacy

There has been considerable work at a national level to develop an alternative to the current transactional based community pharmacy contract on expiry of the current contract in September 2011. As discussed at July CPHAC, while good progress has been made the Auckland metro-region's view was that the new contract framework was not in a sufficiently developed form for September implementation. This view was endorsed by CPHAC and it is pleasing to note that subsequently all DHBs nationally have agreed to an eight month extension of the contractible development of the alternative approach continues.

3.5 National services

ADHB has participated in a project led by the National Health Board (NHB) to scope the current services that will transition to NHB planning & funding management. As part of this process new service specifications and purchase unit codes have been approved for the four national paediatric services:

- Clinical genetics
- Paediatric and congenital cardiac services
- Paediatric and perinatal pathology
- Paediatric and adult metabolic service.

The new governance and operating structure will be communicated to DHBs shortly and a work programme to implement the new arrangements will be established over the next few months with the involvement of the clinical network.

3.6 Intersectoral relationships

Intersectoral relationships relate to the achievement of health gain for vulnerable and hard to reach groups especially women, children, older people, Maori and Pacific people, people living with mental illness and addictions, people living with disability, people living in poverty, refugees and people who are homeless. Each month this part of the report will focus on topical intersectoral initiatives and projects.

In many cases the intersectoral processes are part of business as usual. However, there are a number of special initiatives such as Snug Homes (insulation of homes with children with respiratory disease), Strengthening Families programme (a formal

intersectoral programme with the aim of coordinating services provided to families) and the Tamaki Transformation project (establishing health career pathways) that are undertaken in conjunction other agencies and communities. In comparison, the protection of children from violence through the protocols in place in Starship and collaboration with CYF and Police on that issue and drug related problems are examples of business as usual processes.

Other areas where the participation is more in the nature of consultation, informal partnerships and working relationships, and exchange of information are in general achieving good outcomes. Examples are the ADHB Immunisation Governance Group which has members from a wide range of other sectors, primary care and community organisations, and the initiative related to homeless people where the targets are clear and the action plan has a wide base of support from the various agencies involved.

Budget 2011 allocated more than \$15.3 million over four years for the provision of Gateway Assessments, a programme of comprehensive health assessments for children and young people in the care of CYF. Based on an estimated 257 referrals annually ADHB will receive approximately \$231,000 per annum. This programme builds on an earlier initiative that ADHB developed and funded in 2008. This was adopted and funded by the Ministry of Health as one of four national pilots. It is now being rolled out across the country.

Under this programme children and young people who come into the care of CYF with high unmet health needs are referred to DHBs for an assessment by a paediatrician or specialist nurse. An education profile is sought from their school and a coordinator employed by the DHB consolidates the health information relating to the child. Following the health assessment a plan is agreed between the health assessor, the coordinator and the CYF social worker to ensure that any identified needs are followed up. This collaboration ensures that a complete picture of the needs of each child or young person is established with access to the right services.

3.7 Employee Relations Update

3.7.1 National Bargaining update

Managed Bargaining

Continued engagement with the unions on 13 / 14 July for day 3 and day 4 of managed bargaining and the process continues to go well. The majority of the time was spent in groups and the issues raised by all parties were further canvassed and prioritised in an agreed template. The team is now working to consolidate the issues into a single document which will be confirmed with the unions.

The National Health Board has been briefed on progress and no concerns were raised by them.

Ongoing bargaining and related activities

RDA – Nothing new to report.

ASMS SMOs – Formal negotiations are effectively on hold until the end of July while the ASMS advocate is out of the country.

APEX Clinical Physiologists – Bargaining initiated in July 2010. The Union is part of the Contract Negotiation Services Group (CNS) that was earlier offered NToS type settlement, which was rejected. Workforces included under this MECA are clinical Physiologists, clinical physiology technicians and electrocardiograph technicians. The MECA expired 31 August 2010. Bargaining proceeded from December 2010 to March 2011. The parties attended Mediation on 10 May 2011 but did not make significant progress. Further Mediation has been set for 25 July.

APEX Medical Physicists – The National Health Board has reviewed and endorsed the bargaining strategy.

APEX Medical Radiation Technologists – This document expires on 30 September 2011. Bargaining strategy is being developed. APEX is able to initiate on 2 August 2011.

SFWU – Included in managed bargaining.

NZNO Nursing and Midwifery – Included in Managing Bargaining.

3.7.2 Local Bargaining (ADHB) update




Clinical Perfusionists SECA (APEX) – Bargaining resumes 24 August 2011.

4 Board 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 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 

The status descriptions provide an immediate comparison with last month with – status improved – status unchanged – status reduced. For this month no areas have reported a reduction in status and one reported an improvement. Where a full report is available for an area this has been noted.

4.1 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	These Board priorities anticipate a mix of improved service delivery, prevention and promotion measures. The existing statistics for each area are understood and the scope is to seek measurable improvement against current performance in each area.
Status 	Status unchanged. The work is contained in two parts. The Board's priorities reflect initiatives at a local and regional level and the current status is summarised in Appendix 1. The focus for 2011/12 is set out in the DAP and will be reported against over the next financial year.
Outcome	Active work programmes have been defined in each area and improvements are expected to be achieved. They are not short term initiatives and will continue in 2011/12.
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 	Status unchanged. The detailed report for cardiovascular screening and treatment is included in Section 7.2. Cardiovascular risk assessment was at target levels for Q3 and the Q4 report is not yet available from the MOH.
Outcome	Fourth quarter performance for cardiovascular risk assessment is not yet available.
Scope - diabetes	Enhanced treatment for diabetes. This is achieved through better disease management practices and improved access to services.
Status – diabetes 	Status improved. The detailed report is included in Section 7.2 and covers the work to increase awareness and work with PHOs. This is also a priority area in the regional health plan. The Q4 report indicates that there has been a substantial improvement in the level of checks and that the target was met. Whilst there has been an improvement in diabetes management levels the performance for Q4 remained below target.
Outcome - diabetes	It is anticipated that improvements will continue to be achieved.
Scope – cardiac waiting list	Establish and implement a plan that meets the MoH goal of increasing the national intervention rate by 20%.
Status – cardiac	Status unchanged. The detailed report is included in Section 7.2 and summarises




waiting list 	the strategies for scheduling systems, pre-admit processes, capacity and load planning, and daily activity management. 77 patients were on the waiting list at the end of June and this was within the target level of performance. Treatment rates were substantially improved with 109 procedures completed against a plan of 90 with 20 cases outsourced to other providers.
Outcome – cardiac waiting list	Subject to the continuing need to outsource some volumes, the current service levels are sustainable.
Scope – clinical pathways	This is a 2011/12 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 	Status unchanged. Whilst this project is largely at a conceptual stage progress is being made with pathways for dyspepsia and transient ischemic attack. A real time IT system to support pathways for care of congestive cardiac failure is being developed.
Outcome – clinical pathways	Outcomes will be progressively achieved through a focus on selected areas that offer the maximum potential gain.
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 2011/12 priority to understand the drivers and improve home based care to enable ageing in place and minimise acute admissions.
Status 	Status unchanged. A large body of work is in planning but early gains have been made 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 (InterRAI) • better understanding of how a casemix approach to purchasing services would operate.
Outcome	Work will continue with a formal project framework 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>Status unchanged. 2011/12 projects have been established to:</p> <ul style="list-style-type: none"> • Ensure 50% of patients with lung cancer have first surgical treatment within 14 days of multi disciplinary meeting • 70% of patients admitted with acute coronary syndrome go from 'door to catheter laboratory' within 72 hours • Increase to 80% the number of high needs diabetes patients with microalbuminuria / proteinuria on who are taking ACE / ARB • Undertake retinal screening on 4,500 additional people in the region. • For each DHB train 2 more specialist nurses and 3 diabetes nurse specialists as prescribers.
Outcome	Achieve and maintain the Minister's Health Targets.

4.2 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	<p>Status improved. The detailed report for adult and child services is included in Section 7.2. Continued improvements in performance resulted in the target being met for both adult and child services.</p>
Outcome	Performance levels are sustainable and ongoing project work to further streamline the processes will continue to maintain and enhance performance.
Elective surgery	Achieve the number of elective procedures specified in the DAP
Scope	Increase elective surgical discharges from 9,425 to 11,149
Status	<p>Status unchanged. The detailed report is included in Section 7.2. Services were impacted by a lack of beds due to high acute winter demand, but active management and careful planning ensured that the target was met.</p>
Outcome	Target met.
Shorter waiting times for cancer	Radiation treatment within four weeks of first specialist assessment and medical


treatment	oncology within agreed DAP timelines
Scope	As above.
Status 	Status unchanged. The detailed report is included in Section 7.2 and confirms that in June 100% of eligible patients were treated within the four week timeline. A continued focus on capacity planning, equipment management and upgrade has enabled this achievement to be sustained for more than 430 consecutive days.
Outcome	Current performance levels are sustainable subject to managing some loss of capacity during the equipment upgrade from August to December.
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 organisational realignment project and the creation of Health Care Service Groups (HSGs) is part of the ADHB Integrated Governance Framework. The programme includes appropriate development including leadership training and coaching.
Status 	Status unchanged. The last two appointments to Level 2 clinical leadership roles remain in hand with likely completion in Q1 of the 2011/12 financial year. A paper explaining the operational detail of the new structure is at an advanced stage of preparation and will assist in ensuring all ADHB personnel are fully informed. Data and reporting systems are being amended to ensure that reporting is in accordance with the revised structure.
Outcome	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 	Status unchanged. 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.

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 	Status unchanged. The 2011/12 regional project framework has been established and work has begun on: <ul style="list-style-type: none"> • Reducing the number of harmful falls in our hospitals by 20%. • Reducing the number of patients who have pressure injuries in hospital or aged residential care by 20%.
Outcome	Achieve and maintain the Minister's Health Targets.
The informed patient	Engage patients and their families in decisions about care
Scope	This is a 2011/12 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 	Status unchanged. This work stream is designed to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum. The 2011/12 regional projects have been established and work has begun on: <ul style="list-style-type: none"> • Completing Whānau Ora Assessments for the targeted population. • Holding Advance Care Plans discussions with 500 patients.
Outcome	Achieve and maintain the Minister's Health Targets.

4.3 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 	Status unchanged. The status remains unchanged from last month's report. 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

	<ul style="list-style-type: none"> • Waitemata DHB to optimise service planning and deliver across the two organisations
Outcome	The programme will be 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 	<p>Status unchanged. The unaudited financial result for the year to June 2011 records break even with a \$0.14m surplus.</p> <p>Further narrative on the financial results is included in the finance papers.</p>
Outcome	We have achieved the break even budget target for the year.

Appendices Detailed reports

These detailed reports are included here:

1. New models of care

These detailed reports are referred to in the narrative above and are contained in Section 7.2 which covers the Minister's Six Health Priorities:

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

Appendix 1 New models of care

Initiatives to introduce new models of care are included in the regional health plan, the 2011/12 DAP and the Board priorities. There is some cross over and this analysis restricts its focus to the Board priorities. From a broad perspective the work falls into five categories:

- Become better informed about needs and service requirements of key population groups – Maori, children and young persons, and older people.
- Understand the drivers and circumstances for areas where improvements are required.
- Establish and improve clinical networks to ensure a common view of priorities and enable action plans to be established.
- Change the care pathways to improve access and lower cost whilst maintaining/improving quality.
- Develop new facilities and services to match the identified needs of the basis of established priorities.

Focus area	Comment	Status
Fast stream elective surgery	Improve the capacity to manage elective surgery by better management of patient flows, reducing dependency on inpatient beds and releasing resources through initiatives to increase performance efficiency.	<p>As noted in the main part of this report there has been progressive improvement in the level of referrals for surgical procedures to accredited primary care providers for simple procedures such as skin lesions.</p> <p>The improvements in patient flow and production planning have continued to be augmented by selective outsourcing to ensure volume performance at target levels. This has been successful and assisted in managing June volumes which were impacted by lower bed availability.</p>
Readmission prevention	This is connected to the do no harm goal of the regional health plan. There is a focus on the 13% of discharges leading to readmissions as a result of harm caused by medical treatment. A third of these readmissions are considered avoidable. This clinically led campaign identifies, develops and tracks benefits of initiatives to improve quality and patient safety.	These regional projects will become fully operational in the 2011/12 financial year. The ADHB is currently implementing initiatives to minimise readmissions in relation to pressure sores, falls and infections.

Focus area	Comment	Status
Whanau Ora Centres	<p>There are two key work streams:</p> <p>Work with the primary care and Maori providers to develop Integrated Family Health Centres/Whanau Ora Centres. This includes indicator measures for Whanau Ora and developing a Whanau Ora approach for all services devolved.</p> <p>Implement the year one activities of the cross DHB: MAPO Whanau Ora framework for 2010 – 2015 by developing indicator measures, completing the Ho Hou i te Rongo project and fostering closer working relationship with iwi.</p>	<p>The establishment project has been completed with development of the business case and whanau ora programmes for the next three years. Work has also begun on modelling service impacts. The next stage of work forms part of the Maori Health Plan 2011/12 (RP5.3).</p> <p>The 2010/11 project work on the three elements of this project has been completed and the next stage of work on indicator measures for Whanau Ora continues under a new project for 2011/12. The Ho Hou i te Rongo work has been completed and is now a MOH funded contract under Te Auahatanga funding and the iwi and DHB relationship development processes has transferred to business as usual.</p>
Primary care	<p>Better-sooner-more convenient focused initiatives cover a broad range of work from the GAIHN focus on reducing demand and unplanned hospital admissions to PHO amalgamation and the Whanau Ora initiatives above. Primary care initiatives are reported in detail to CPHAC each month and a further commentary is included in the 'Management of the wider health system' section of this report. The comments here are limited to areas where the model of care is changing.</p>	<p>The GAIHN initiative was reported to the ADHB CPHAC Committee on 20 July seeking endorsement of the direction and approval of funding and resources.</p> <p>The last of the PHO alliance workshops are scheduled for late July/early August. These target immunisation and diabetes and reduction of 951 first specialist assessments (FSA) as a result of GP referred diagnostic radiology. The work to enhance the progress towards achieving the 30% reduction in FSAs continues to develop options to raise the likely 20% outcome to target levels.</p>
Health promotion	<p>Health promotion is led by the regional Public Health team and local involvement is aligned with those initiatives. In particular there are initiatives around the high priority areas of cardiac, diabetes and smoking which form part of the regular ADHB planning cycle and are included in MOH targets.</p>	<p>The areas of smoking, diabetes management and cardiac are covered in other parts of this report with further detail in the project status summaries included in these appendices.</p>
Children and young	<p>The focus for children and young persons has been placed on the Well Child</p>	<p>This will be part of the operational focus in</p>











Focus area	Comment	Status
persons	framework, increased screening to identify unmet need and improved access to dental care and immunisation.	the 2011/12 financial year.
Older people	<p>The growth of this segment of the population and constraints on funding indicate that current models of care are not sustainable. There is a need to work with a greater focus on ageing in place and preventing avoidable admissions to hospital. The initiatives are as follows:</p> <p>Promote Ageing in Place with increased capacity in respite care; use improved tools (InterRAI), multidisciplinary support services in the home; better access to aged residential care.</p>	<p>These regional projects will become fully operational in the 2011/12 financial year.</p> <p>As reported last month the InterRAI rollout is complete. Respite funding has been devolved to community providers as well as specialist services to increase population health gain through increased access.</p>
	<p>Reduce avoidable hospital admissions from aged residential care through a study of causes of avoidable admissions from aged residential care undertaken.</p> <p>Focus on cognitive decline through better clinical pathways for delirium, dementia and depression.</p>	<p>Not yet started – awaiting WDHB research trial to be concluded.</p> <p>Not yet started</p>
	<p>Workforce modelling and development to identify workforce shortages, increase the number of support workers achieving the Level 3 national qualification and developing the nursing workforce in the community.</p>	<p>Not yet started</p>

7.2 Minister's Six Health Priorities


7.2 Health Target Updates

The information set out on the attached pages covers the six health target reports that are reported to the MOH each month. They comprise:


- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services

	Status	Comment
Adult acute patient flow		95% requirement achieved.
Child acute patient flow		95% requirement achieved.
Improved access to elective surgery		Target met.
Shorter waits for radiation therapy		100% of eligible patients treated.
Increased immunisation		92% performance exceeded 91% target.
Better help for smokers to quit		Below target but improved identification and number of smokers given brief advice.
Diabetes checks		Target met with significant improvement in Q4.
Diabetes management		ADHB performance high compared to other DHBs, but the high target of 79% not met by 74% actual performance.
Cardiovascular risk assessment		Q4 data not yet available from the MOH. Q3 performance was above target levels.
Cardiac bypass surgery		Waiting times met. Volumes being compiled to assess performance to target.

Key to symbols:

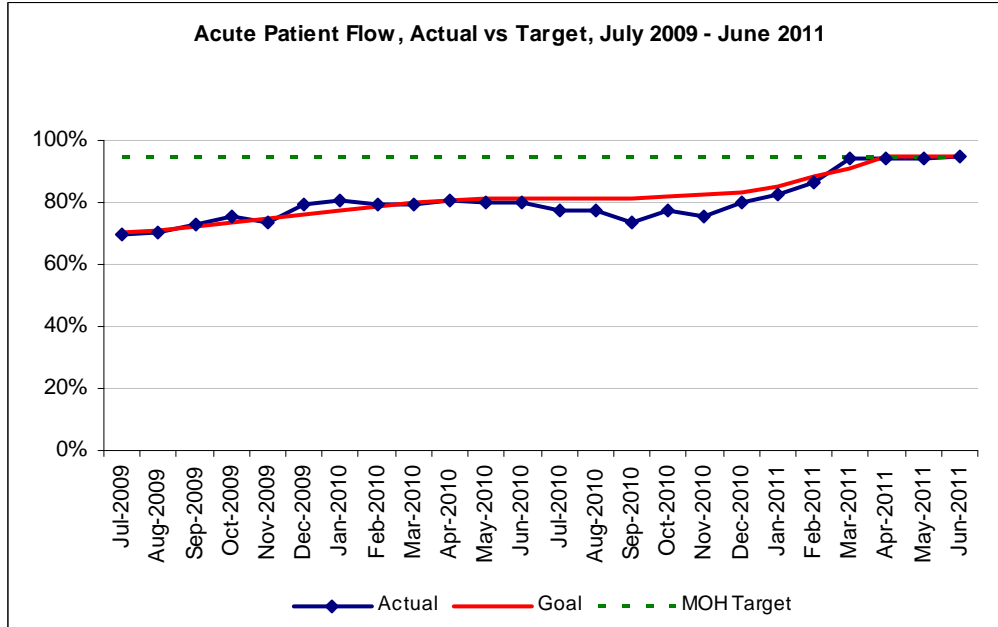
Proceeding to plan 

Issues being addressed 

Target unlikely to be met 

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



TARGET MET

Project Risks / Comments:

Performance to achieve Shorter Stays in ED for both Adults and Children’s services continues to demonstrate improvement . 95% of patients admitted, discharged or transferred from AED and CED for the 4th quarter.

Project: Adult Acute Patient Flow

57

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

Improvements to date:

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

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

Charge nurse patient flow coordinator introduced

Improved access to Radiology

Streamlined documentation required for safe transfer

Improved triage processes.

Managing bed block with additional resources

58 Additional beds opened 2009-2010

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

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

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

Nurse Facilitated Discharging in General Medicine (April 2010)

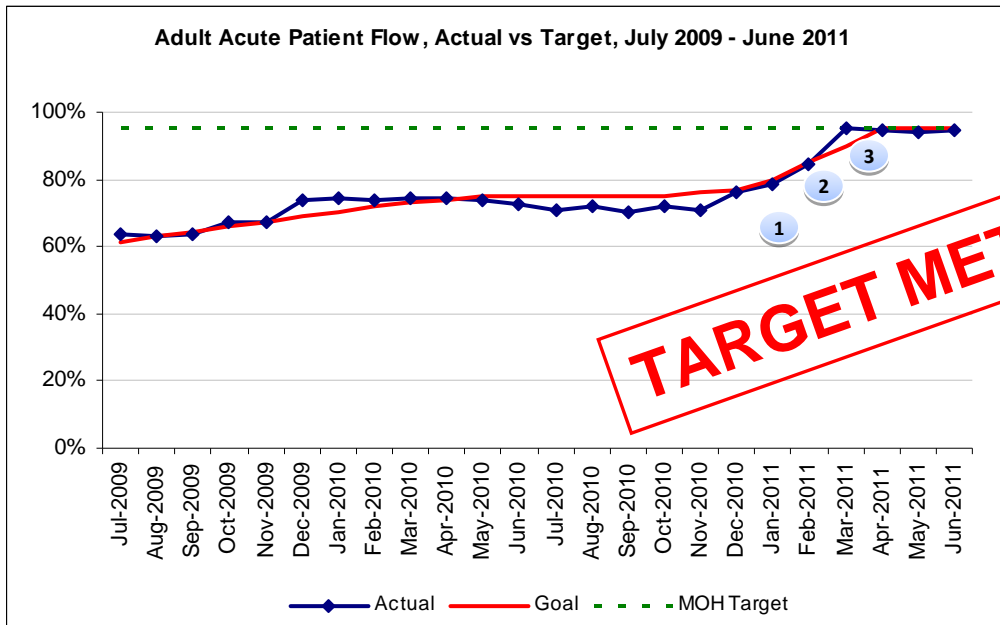
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.

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

Immediate actions to improve performance:

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

Adult Acute Patient Flow, Actual vs Target, July 2009 - June 2011



Project Risks / Comments:

95% of patient discharged or transferred from ED within 6 hours in June. AED and inpatient services escalation plans under discussion and to be incorporated into standard work for team to respond to surges in demand. Capacity alerts updated to lower triggers to lead to an earlier response to pending access block. Rapid Improvement Event solutions being implemented to improve process for patient transfer from ED when inpatient bed is available. Daily breach meeting transferred to ED floor and incorporated into daily standard work. A daily rapid review process for balancing acute and elective admissions to match available service capacity under development. Close monitoring of performance through winter required to maintain performance and respond to early signals of deterioration. Rugby World Cup impact and response plans underway

Project: Children's Acute Patient Flow

58

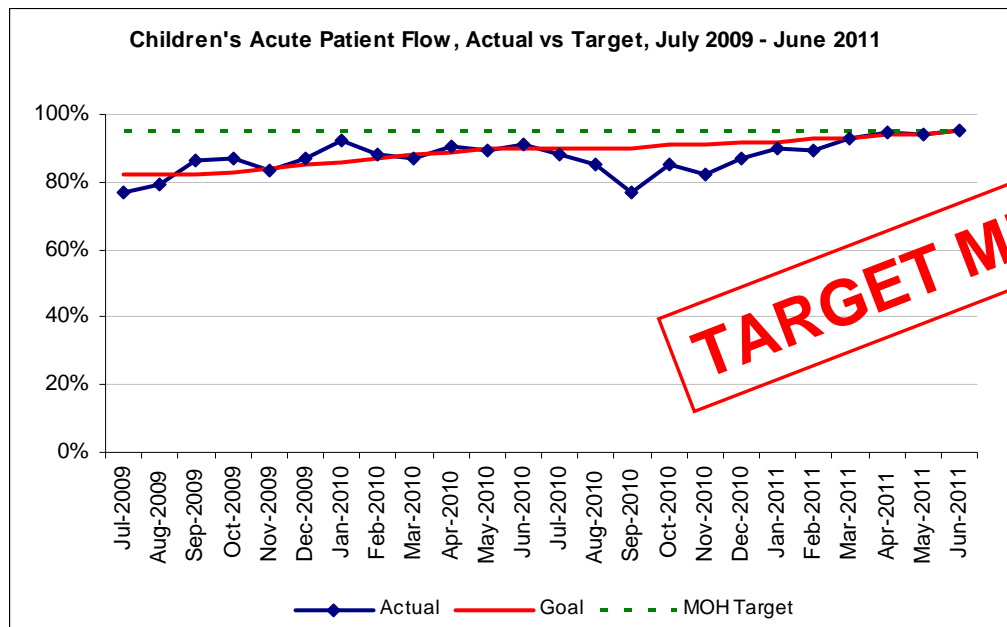
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

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



TARGET MET

Project Risks /Comments: The improved performance of prior months continued into June where Starship achieved 95% of patients being processed within the six hour target. There were 13 days where greater than 95% was achieved.

Services continue to focus on the '2 component of the 3-2-1. Strategies are being developed to assist Registrars to review CED patients deemed needing of admission. Some of these strategies are, review of ward work loads, rosters - in particular the call back roster and the role of the House Officer. Services are also reviewing documentation duplication. There continues to be a positive commitment from staff to improve flow through Children's Emergency Department. Wards are also focusing on bed turn over by reviewing and improving ward rounds, introducing rapid ward rounds, and becoming more accurate with Estimated Dates of Discharge.

The senior team is also improving data management, with the aim to have an overview of current inpatients, know expected patients and estimated acute volumes for the coming week in order to manage peak days and implement strategies that will reduce elective cancellations, extended waits in CED and staff resource issues, with the first formal weekly meeting to start on the 1st July.

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

Project: Improved access to elective surgery

59

Primary Objective: Increase ADHB Elective Surgical Discharges from 9,425 to 11,149

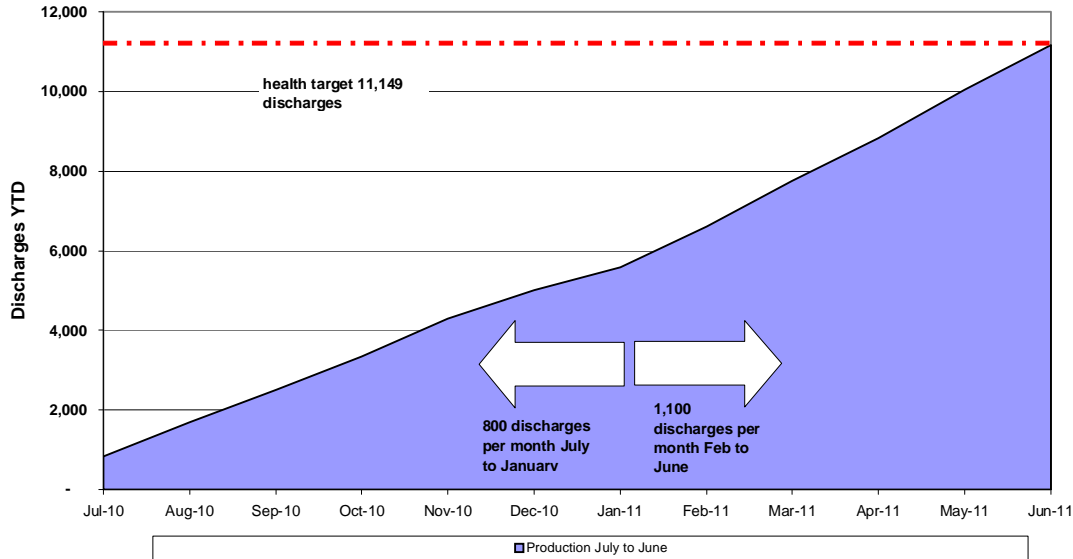
Date of Delivery: 30 June 2011

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. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Fortnightly meetings between the Director of Elective Services and service managers focussing on ESPI compliance and elective production.
3. Continuing to review the production plan at a daily level

Risks / Comments: (Amber)

1. June electives were adversely affected by bed availability resulting in elective cancellations and production shifting to non-ADHB patients waiting greater than 6 months
2. February was a record month for ADHB population access to surgical procedures at ADHB. This was exceeded by 11% in March. March was exceeded by 9% in May
3. Surgical waitlist reduced since January by 17%. Clinic waitlist reduced by 12%
4. People waiting greater than 6 months for clinic and surgery has more than halved since January
5. Over the last 6 months an extra 55 Auckland people are getting elective surgery each week compared to first 6 months.
6. Second 6 months production will be 37% above the reported first 6 months (23% after recodes).

Notable services by volume are

1. Ophthalmology, +353 discharges, +45%
2. General Surgery, +243 discharges, +24%
3. Paed ENT, +218 discharges, +61%
4. Adult ENT, +124 discharges, +34%

Project: Shorter waits for Radiation Therapy

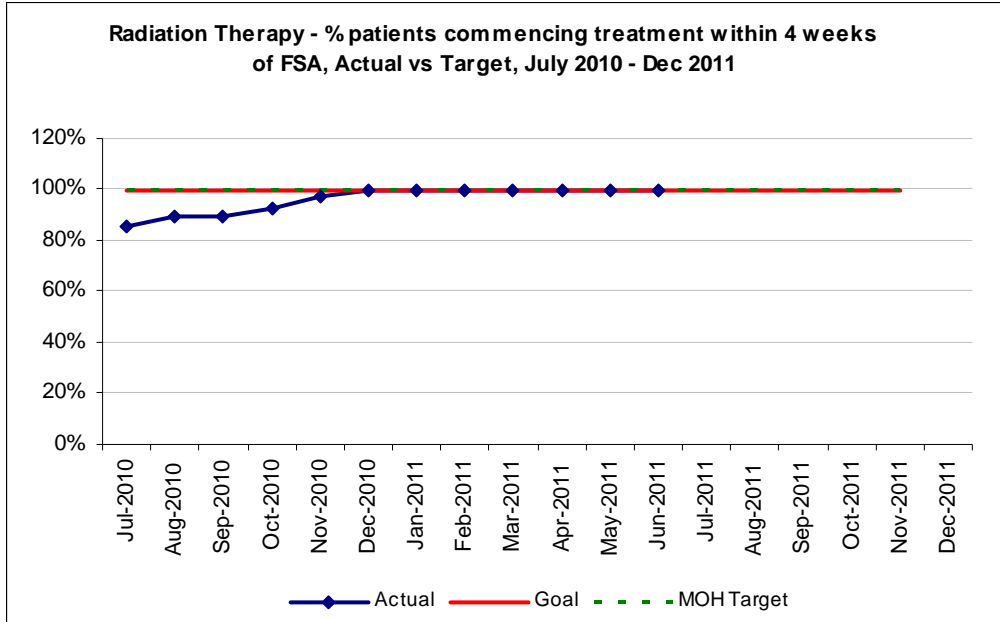
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



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

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 August - December 2011.

An increase in Head & Neck Cases (Complex IMRT treatment).

RT staff vacancies and skill mix – There is an improvement in RT staffing levels in July with re-introduction of flexishifts.

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

An ongoing international RT recruitment campaign is underway to attract overseas staff – Radiation therapists and Physicists.

Radiation Oncology Wait times – June 2011

In June 100% of eligible patients were treated within the 4 week target timeline. As at 30 June Radiation Oncology has achieved more than 430 consecutive days of meeting the target.

Further improvements in progress to sustain delivery:

Pantak replacement is underway and commissioning expected to be complete in July 2011

Replacement of MV6: Decommissioning commences early August until late December 2011. Evening shifts will be reinstated during this period to mitigate lost capacity

Introduction of HDR for Gynaecological patients is currently being rolled out with a small number of patients receiving treatment in MV2.

A public/private Model of care has been developed to enable our clinicians to treat public patients at ARO. Noting the variability in our referral flows, ARO have agreed to operate a 4 week rolling average of approx 4 patients per week from July 2011.

Introduction of new technology: The introduction of V-Mat treatment has the potential to reduce treatment times by up to 50% when fully implemented. A project team has been identified and will start work in July.

Aria project: A project is underway to develop a full electronic record within the LINAC machine's operating system. The project has been reviewed recently by Varian with excellent incremental improvements noted month on month. Project end expected Dec 2011.

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”** measures 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.

Project: Increased Immunisation

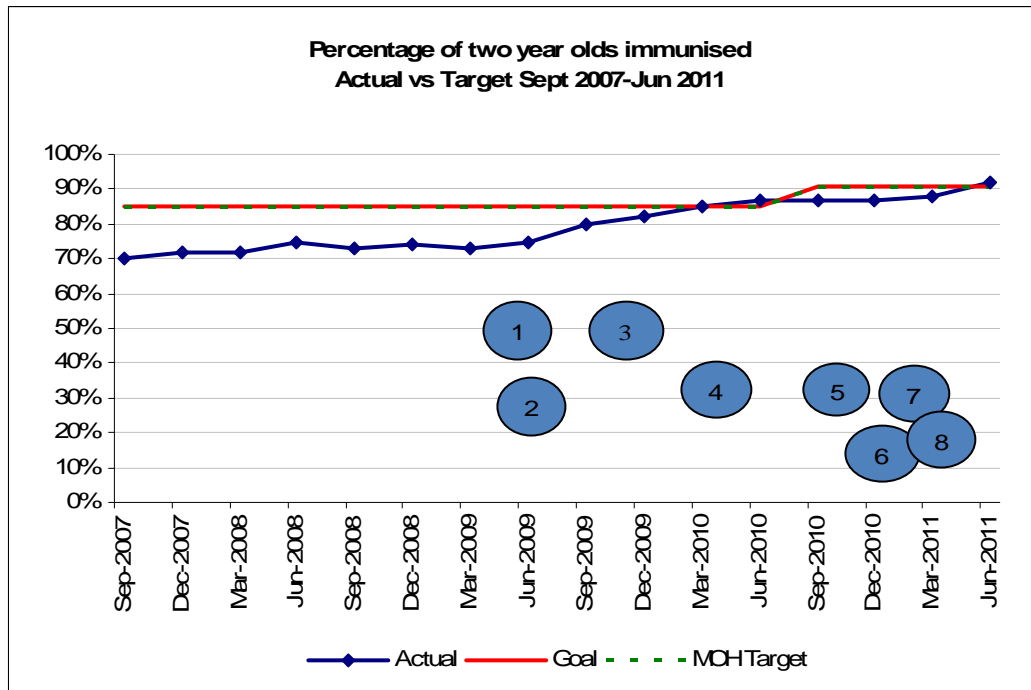
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

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

**Current activities**

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct.

Project Risks / Comments:

As at 30 June 2011, ADHB's immunisation coverage (2 year olds full immunised all ethnicities) was 92% (regional target 90%, ADHB target 91%). On 30 June 2009 ADHB's immunisation coverage rate for Maori children aged 2 years was 68% (total coverage 75%). Maori coverage has now reached 88%, a 20 percentage points increase in two years. Pacific coverage was 78% and is now 95%. This achievement was the result of a huge effort by all providers, particularly general practices. It was also the result of more systematic and targeted approaches driven from ADHB Planning and Funding and the National Immunisation Register team. They were strongly supported by PHO based Immunisation Coordinators and more systematised outreach work by the Immunisation Advisory Centre based outreach team. Referrals to the outreach team nearly doubled earlier this year as the focus shifted to referring children overdue for scheduled immunisations much more quickly. This made the task of connecting with often mobile families easier. The relationship with PHO based Immunisation Coordinators has also been critical as has a district wide data analysis and improvement project. ADHB is committed to achieving the lowest possible incidence of vaccine preventable disease and to reducing inequalities by achieving the highest possible immunisation coverage across the whole population.

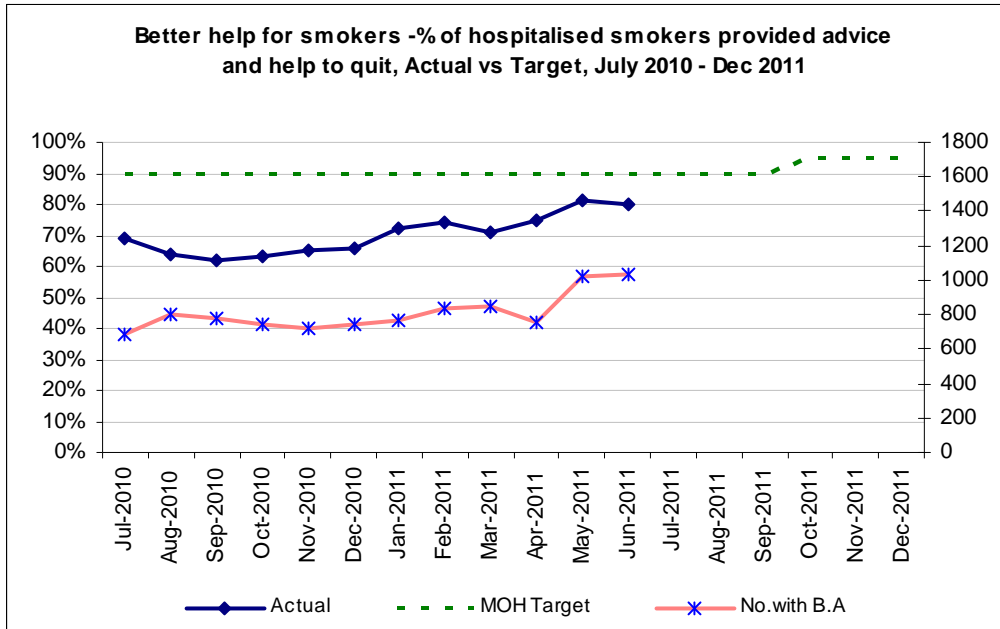
Project: Better help for smokers to quit

Primary Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

Steering Group: Di Roud, Anna Schofield, Maggie O'Brien, Stephen Child, George Laking, Jim Kriechbaum, Paul Bohmer, Arun Kulkarni, Michelle Stevens, Kristine Nicol, Bernadette Rehman, Paul Birch, Anne-Marie Pickering, Victoria Child, Jan Marshall, Kara Hamilton, Steven Stewart



Improvements to date:

- AED - Brief advice handout developed for Nurse Specialists to give to all short stay smokers.
- ABC chart reminders placed in Adult Health charts.
- Increased communication on Smokefree environments and smoking on hospital grounds.

Immediate Actions to improve performance by 15%:

- A. Continued focus on short stay and high volume areas to achieve 5%:**
- Continued auditing and 1:1 coaching in AED and APU
 - Women’s Health checking all smokers coding and requesting recoding to ensure target results are accurate. Brief Advice Brochure to be developed for Women’s Assessment Unit.
- B. Improve engagement of clinical workforce to achieve 5-8%:**
- Campaign for a Call to Action to Senior Medical staff: Smokefree Clinical Champion presentation to House Officer training and Medical Grand Round in May .
 - Monthly publication of results of Senior Medical Officer’s Better Help for Smokers to Quit performance commenced
 - Steering Group meeting monthly to guide and monitor Health Target progress.
 - Clinical research strategy under development
- C. Data collection systems and processes to achieve 5%:**
- Weekly results to be circulated to services from 1 May
 - Weekly audit of smokers records with no brief advice to identify any miscoding to be recoded before month’s end
 - Analysis of Short Stay Surgical Unit recording of ABC and initiate a process to improve SSSU results
 - Monthly reports and data analysis to identify and address areas of underperformance with services.
 - Electronic Discharge Summary data to be audited for consistency and accuracy against patient clinical records

Project Risks and Comments

Of the 8614 events coded in June 1296 smokers (15%) were identified as smokers. 80% all smokers were given brief advice to stop smoking. While the DHB did not reach the 90% target in the last quarter there was a notable increase in the numbers of smokers identified (+296) and the number of smokers given brief advice (+444).

Significant gains have been made in AED and APU however due to the high volumes and short stays these services still represent 40% of the smokers not given brief advice. The remainder is spread across all services in small numbers with the exception of the Short Stay Surgical Unit. We are working with this service to capture Brief Advice on the day of surgery so this can be counted in the Health target figures as the pre-admission documentation can not be coded. Work is underway to standardise the capture of smoking status, brief advice and documentation on ward electronic whiteboards. Exploration of further enhancements to the smoking section of the Electronic Discharge Summary are under way.

Project: Diabetes

63

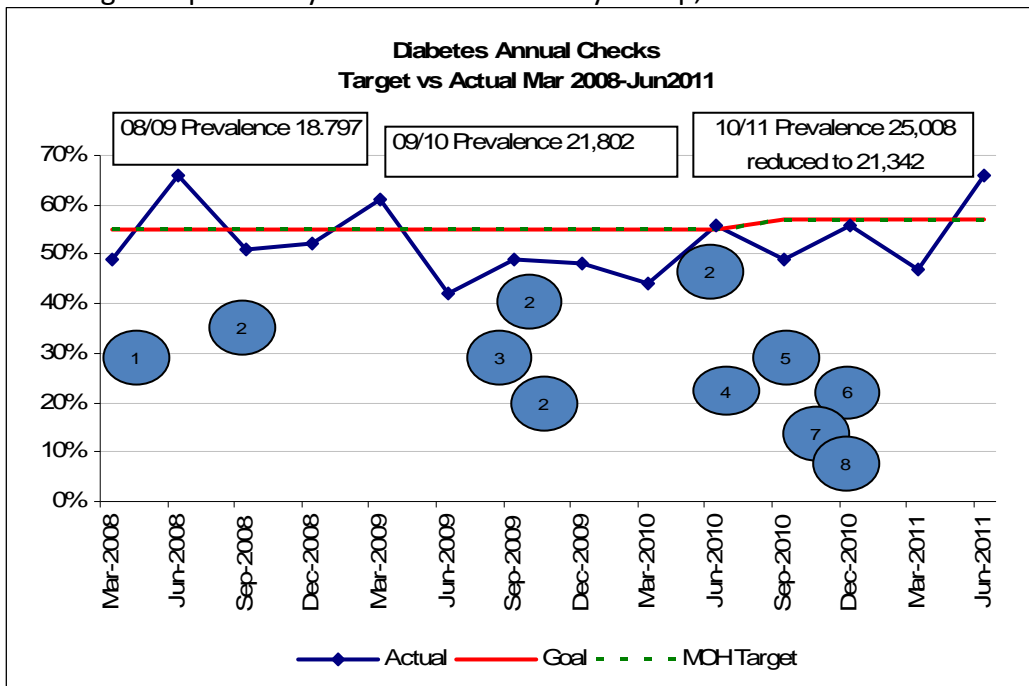
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

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:

Q4 shows a significant increase in the number of Diabetes Annual Reviews (DAR's) from the previous quarter, reaching 66% (9 % above target). Performance has been increasing steadily over the months with DAR's at 59% in April, 65% in May and 73% in June. The performance for "Other", which is where all of the underperformance has fallen, has shown a steady increase from 47% in March, to 50% in April, 53% in May and 67% in June, contributing to an overall Quarter 4 performance for Other of 57% (1% under target of 58%). Performance against target for Maori and Pacific continues to be strong, with Q4 performance for Pacific at 79% and for Maori 63% (against a target of 55%).

The Long Term Condition Quality Improvement Coordinators have visited a significant number of practices in ADHB and have gained a good understanding of systems and management of diabetes in Primary Care. They have supported and assisted practices to establish an accurate register of patients with diabetes, establish recall systems and utilise IT systems, such as Dr Info, to better manage their patients with Long Term Conditions. They have also met with a considerable number of stakeholders, including the Auckland Diabetes Centre, as part of their work to improve coordination of care between primary and secondary services.

Project: Diabetes

64

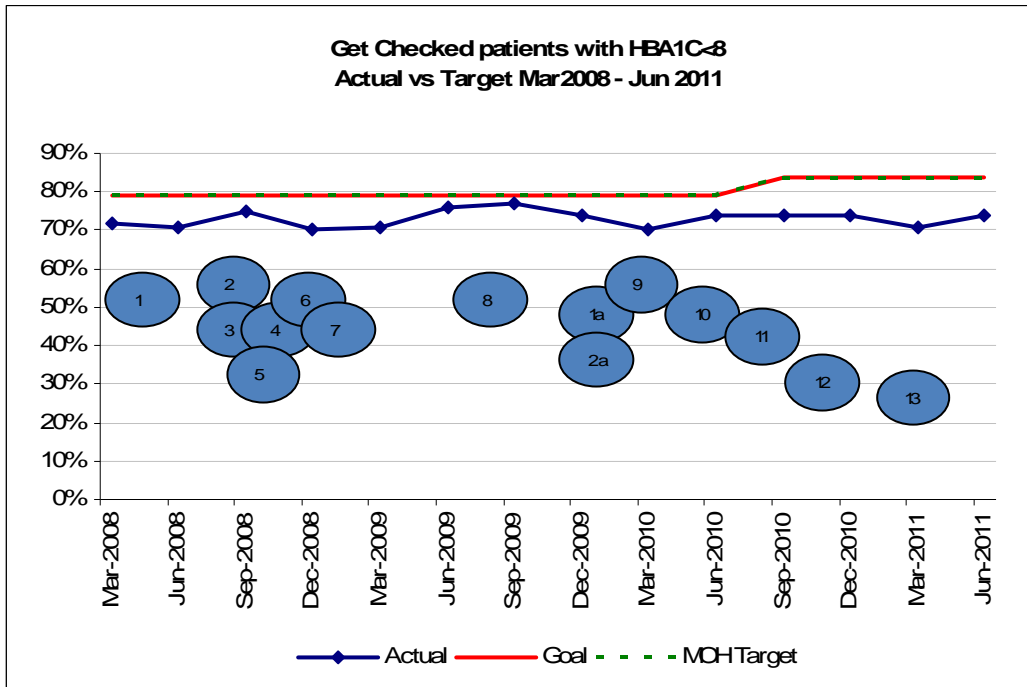
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

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:

Q4 data shows an increase from the previous quarter of 71% to 74%. Diabetes management for Maori and Pacific has also improved. In Q3 this was 60% for Maori and 55% for Pacific, while in Q4 this increased to 67% for Maori and 60% Pacific.

There are a number of activities to support this component of the target, including long term condition quality improvement initiative, who will be working with practices and secondary services to improve this performance. The Diabetes Self Management Education service provider has run 15 courses between February and May, with a focus on 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 two courses having been completed as at the end of June and 4 community based staff having been trained as Master Trainers at the end of June.

Project: Cardiovascular Risk Assessment

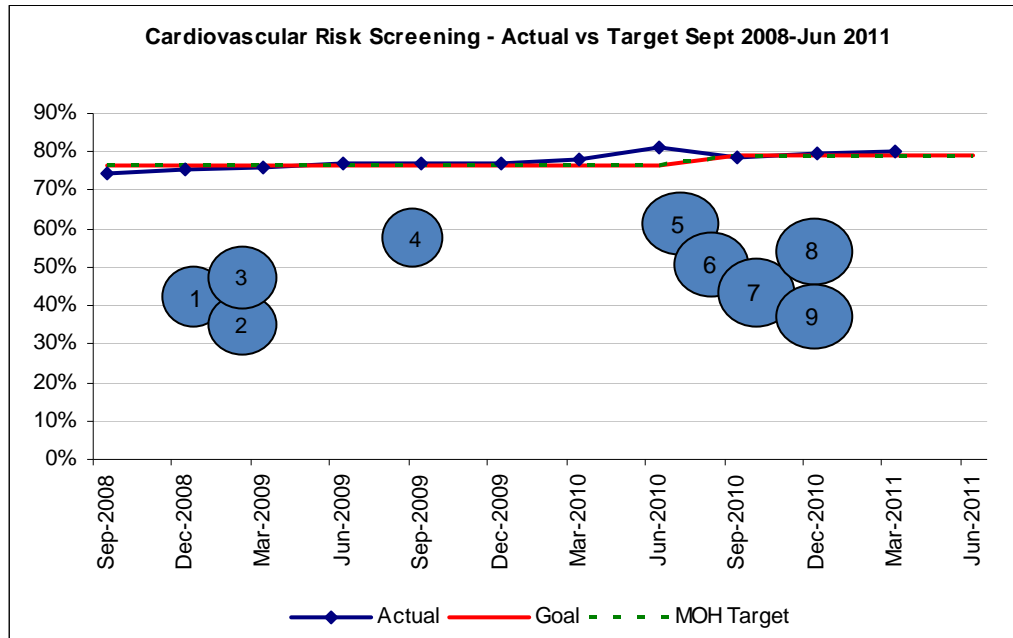
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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 Q4 CVD data from the MOH is not yet available. However Q3 data showed a steady improvement on this target, giving us a 79.9% performance against a target of 79%. Individual targets for each ethnicity were also 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

66

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 81.

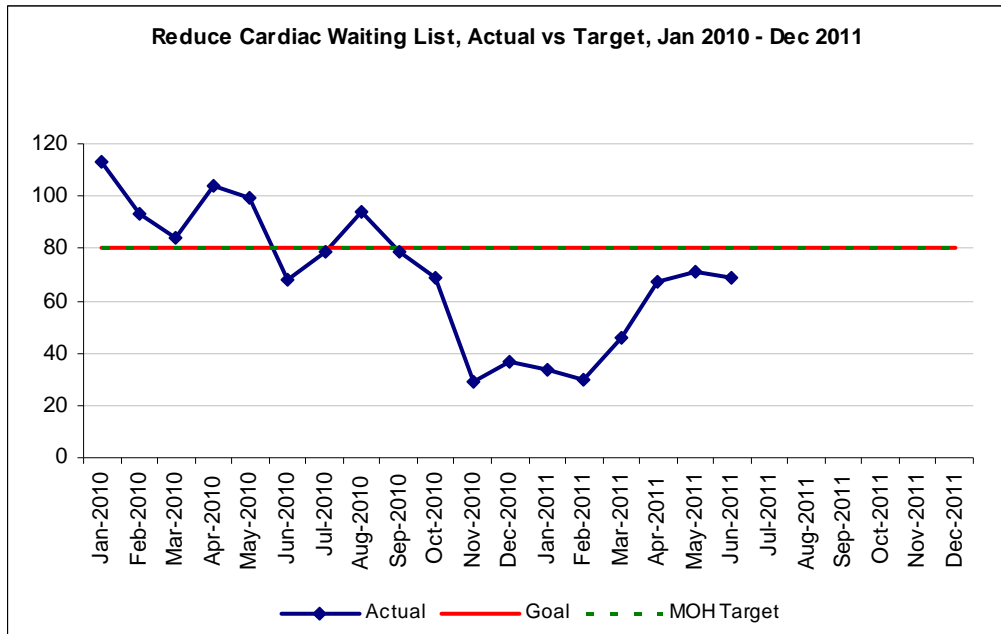
To support the national cardiac bypass intervention target, 916 bypasses should be completed in 2010/2011

Date of Delivery: 31 December 2011

Clinical Lead: Paget Milsom

Project Sponsors: Garry Smith, Fionnagh Dougan

Steering Group: Marian Hussey, Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam Freeman



Project Risks / Comments:

There are 77 patients on the waiting list as at the end of June 2011. June was a productive month delivering 109 procedures against a plan of 90. An outsourcing strategy has assisted in achieving these figures with 20 cases being done privately in June. A reduction in acute demand has relieved the bed blocking issues in CVICU and as such the cancellation rate for surgery has dropped significantly. In addition to this the case load for urgent thoracic cases has also dropped off. Allowing more bypass procedures to be completed. The enhanced recovery pathway has been used throughout June in CVICU and over the coming months the results will be measured to determine the significance of the change. Ward 42 and CVICU have completed their collective proposal for a new discharge process. The last of the training is currently taking place and we are planning on starting the new process in the coming weeks. Our production plan shows 899 eligible bypass procedures have been completed by the service according to the figures in our production plan (against the MoH target of 920). In the coming weeks the coding for the year will be completed and we will know our actual production number against this target. The aim for the service in July is to ensure all wait list patients are treated within their specified waiting times. We are also working to finalise our production model for 2011/2012. This will determine where capacity can be delivered.

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
 - Enhanced recovery pathway in ICU
 - Scheduling workshop for productive theatres
 - Releasing time to care foundation modules
- CVICU\HDU merger

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 on bypass cases
- The Productive Operating Room (NHS Programme)
 - To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- 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
- Elective patient focused team project
 - To maintain elective throughput in the service during periods of constrained production

7.3 Towards Excellence



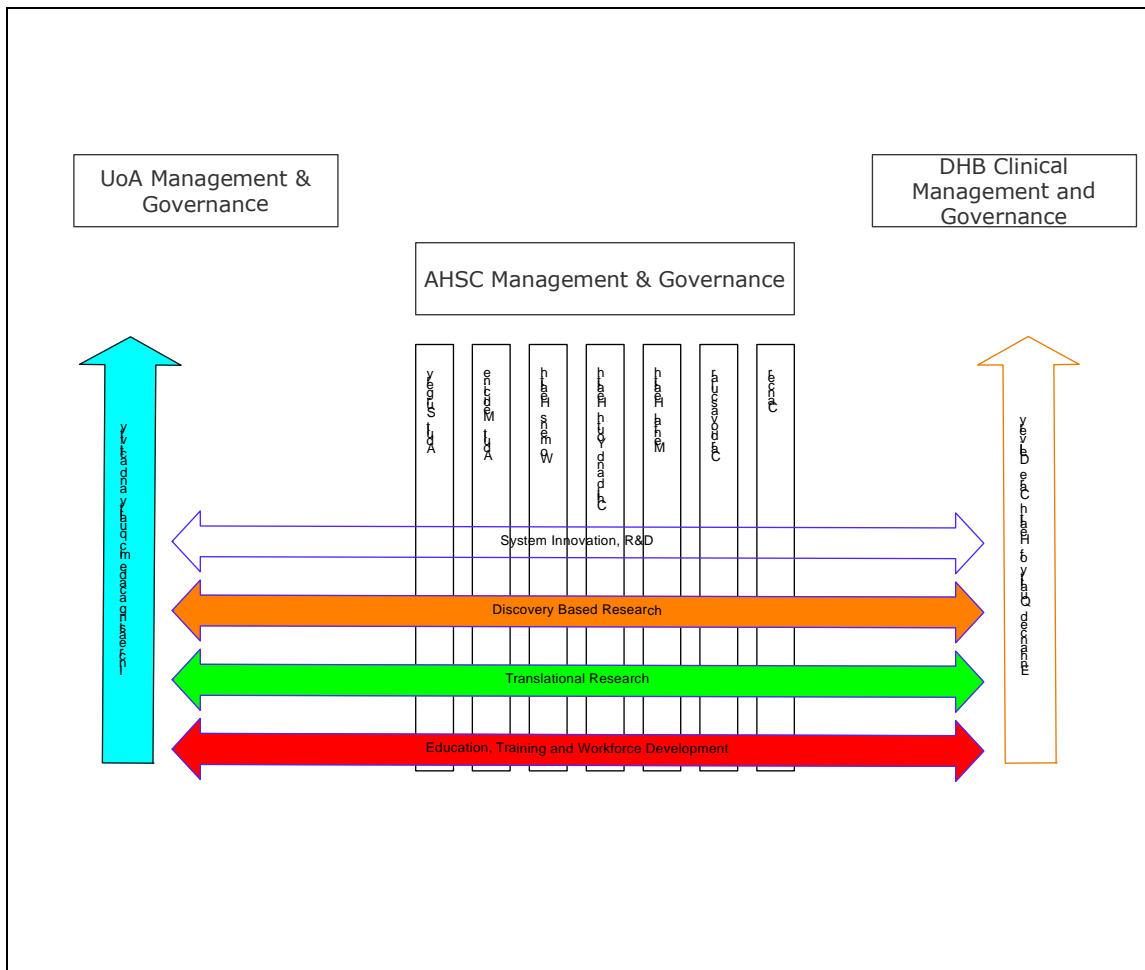
Auckland District Health Board Decision Paper

Date	Wednesday 3 August 2011
To	Auckland District Health Board
From	Margaret Wilsher, Chief Medical Officer Admin, Level 5, Auckland City Hospital 021 326326 mwilsher@adhb.govt.nz and Iain Martin Faculty of Medical and Health Sciences, University of Auckland i.martin@auckland.ac.nz
Author	As above
Functional Group	Planning and Funding
Subject	Towards Excellence
1	<p>Recommendations</p> <p>That the Board:</p> <p>Notes the contents of this paper, and</p> <p>Considers the decision to support the concept of an Academic Health Alliance with the Faculty of Medical and Health Sciences, University of Auckland</p>
2	<p>Summary</p> <p>ADHB and the Faculty of Medical and Health Sciences, University of Auckland have enjoyed a close relationship for nearly forty years but there are there are opportunities for both organisations if the relationship is developed further along the lines of an Academic Health Science Campus, or, as proposed in this document, a formal Academic Health Alliance. Such an alliance would deliver greater research and teaching opportunities, strengthen our workforces and enable Healthcare Excellence through improved organizational performance. The alliance could expand to include faculties such as Engineering and Business, and would cover the whole of health system through inclusion of the School of Population Health.</p>
3	<p>Background</p> <p>The ADHB and University of Auckland already share academic activities, a common academic library and shared academic/clinical appointments. The co-location of a Medical School and the largest tertiary hospital has allowed for a unique teaching and research environment in the New Zealand context. It has been considered that there are opportunities for both organisations if the</p>

	<p>relationship is developed further along the lines of an Academic Health Science Campus.</p> <p>The concept 'Academic Health Sciences Campus (AHSC)' is best understood in the UK translation of such following Lord Darzi's review of the NHS and subsequent recommendation of the AHSC model as a national policy. As a consequence, the Department of Health launched a competitive process which resulted in 5 AHSC established through partnerships of hospital trusts and universities (applicable to England only). The Department of Health also commissioned a National Health Research Strategy from Dame Sally Davies and subsequently, through the National Institute of Health Research, channelled health research funding into a range of competitive schemes most notably the Biomedical Research Centres (BRCs). The goal of this exercise was to ensure high quality research productivity with rapid translation of research findings from bench to bedside. The Kings Health Partners, one of the 5 AHSCs, is seeking to go further with vertical integration of research across primary to tertiary (the Primary Care Trusts are separate from the hospitals) and improved Public Health research addressing major health problems with targeted interventions and working collaboratively with other agencies such as Lambeth Council.</p> <p>The key components of an AHSC include clinical academic partnerships realized through integrated governance of academic activities with internationally recognized excellence in research and clinical practice, integrated research funding, joint research programmes and shared commercial expertise to enable translation of research findings. Internationally AHSCs share these features although the terminology and governance arrangements vary. In essence all integrate research with patient care and teaching/education, and all aspire to excellence. These benefits extend beyond the hospital setting into the full continuum of health as well described in the Association of Academic Health Centres' Value Proposition)</p>
4	<p>The local context</p> <p>Both ADHB and the University of Auckland (UoA) are legal entities and there is as yet no national health research strategy nor is there any prescribed framework to allow shared governance of health sciences research, teaching and patient care. There is however a great willingness on the part of each organisations' professional and executive leadership, and the academic clinicians, to strengthen the relationship in order to benefit not only the respective organisations, but to improve patient care through translation of research findings and improved education and teaching.</p> <p>ADHB has committed to the Baldrige Health Excellence framework, a lengthy improvement journey with the aim of improving organizational performance, improved health status of its population and safer clinical care, and with that improved patient, family, and staff satisfaction. ADHB has also committed to the Northern Region Health Plan with key work streams on patient safety, long term conditions and informed patient choices. Innovative and novel approaches will be required to successfully deliver to this plan, and capturing the benefits will require research across the health services continuum. Research is integral to all components of the Baldrige framework including management and leadership.</p>

	<p>Between our ADHB and the UoA we have expertise in population health research, clinical and biomedical sciences research, management and leadership research all of which is supported by research governance and administration infrastructure, and commercialization expertise. The establishment of the Innovation Hub, of which ADHB is a founding partner, enables greater opportunity for translation of new clinical research ideas into commercial reality.</p> <p>The benefit of harnessing the collective power of both organisations was recognized in the recent external review of cancer research at FMHS. Following the release of the reviewers' report, a series of meetings, with researchers from the biomedical, clinical and population research groups involved in local cancer research, indicated a very strong desire to share research activities, work more closely together and learn about and celebrate each others' successes with the intent to enhance and grow the workforce and improve patient outcomes</p>
5	<p>Realising the vision towards health excellence</p> <p>ADHB has recently restructured its core services into Health Services Groups with the intent to plan and deliver health care across the continuum of community to hospital service delivery, and with the aim of improving health status of the population and in particular reducing inequities. The brand 'excellence' cannot be self applied – it must be earned and so the path to health excellence means recognition through superior population health status, reduced health status disparities, improved access to services and improved organisational performance both financially and in terms of productivity. In strengthening the relationship with the UoA, initially through the FMHS, both organisations can work towards increasing research outputs, strengthening research quality and complementing this with similar activities in respect of teaching and training.</p>
6	<p>Starting with small steps</p> <p>In line with the notion that 'excellence' is a moniker to be earned, so the journey must begin slowly and carefully. This is not the place for large branding announcements but rather a careful laying of foundations and the consolidation of what we already have now. From both organisations' perspectives there are two ADHB Health Services Groups (HSGs) that are clearly productive in terms of academic outputs and with strong links to biomedical and population health researchers in the FMHS. Those HSGs are Cancer and Blood, and Cardiovascular. Both have related Chairs in the FMHS and both have cohesive groups of clinician researchers with strong track records in collaboration and research productivity. It makes sense to explore a stronger relationship through both HSGs, including the opportunity to engage with primary health care organisations and the School of Population Health in FMHS. There are many other large and small service groups in the DHB that could rightly claim excellence in research and or clinical service delivery but developing a model that is enduring will take time and piloting the concept with a smaller number seems sensible from both parties perspective.</p>
7	<p>Alliance rather than Centre?</p> <p>Neither organisation has the mandate to change its status, nor is it prudent to consider a 'centre' appropriate when the DHB is responsible for a health system.</p>

	<p>Health science excellence, and the translation of such into clinical practice, does not require bricks and mortar but it does require strong relationships, hence the notion of an alliance as a framework to move forward. The pillars of such an alliance will be those that form the foundation of the English AHSCs, namely research, education and training, and patient care. In the Auckland context it is suggested that the term Academic Health Alliance be used as the inclusion of 'science' implies that the translation of research findings is restricted to science when in effect management, engineering and legal research may well be of considerable value in this setting.</p>
<p>8</p>	<p>An example of how this might work</p> <p>Taking cancer as an example, an academic health alliance might require shared governance of research activity including review and approvals, grant applications and activities, dissemination, promotion and translation of research findings. Such research activities would include new drug development, clinical trials, population health surveys and health system improvements. In concert with this, shared approaches to teaching and training of under and post graduate students from relevant schools within the faculty, and shared interest in, and commitment to improve clinical and population health outcomes. That would mean that teaching about cancer might occur in the hospital or the university, and by hospital or university staff with a shared commitment to delivering a pre-agreed curriculum. In time the ADHB/FMHS Cancer Health Alliance may become recognised as a university/health system partnership of excellence in training, research and patient care.</p> <p>Much detail will need to be worked through including a clear understanding of the governance arrangements and limits, current and possible financial planning and monitoring, identification of measures of quality, productivity and success, stock-take of current and future facilities, infrastructure and workforce. Key stakeholders will need to be identified and consulted and key liaisons with primary care established through existing or new networks. A multi and interdisciplinary approach across the health system and across the university campus is essential. The existing Joint Relations Committee would enable governance of the Alliance and the operational management could occur with the HSG leadership partnering with the relevant faculty Chair.</p>
<p>9</p>	<p>Model of the governance arrangement</p> <p>Originally conceived with the concept of an AHSC in mind, this model could be adapted further to incorporate performance improvement and organizational excellence.</p>



10 Benefits

A flourishing culture of enquiry and research will lead to innovation, which in turn will potentially translate into clinical improvements and health system efficiency. Improved teaching and academic rigor will enhance student and staff satisfaction and potentially create magnet facilities. Both will potentially result in improved patient outcomes and population health status. Recognition of such benefits will ensure the notion of excellence. Complimenting this, research and enquiry as an organizational principle in the broadest sense – in management, leadership, operational activity – will enable the aspiration of Healthcare Excellence to be achieved. For the UoA, the capture of research and other academic outputs adds value in terms of reputation and with that enhanced staff recruitment and retention, and subsequently, enrolments.

11 Next steps

It is proposed that ADHB and the FMHS instruct the Medical Directors of the Cardiac and Cancer and Blood HSGs and their partner FMHS Chairs to form academic health leadership teams, and begin the work of developing working alliances that enable joint promotion and support of research activities, and shared transmission of results with translation into clinical practice or commercialization as appropriate. Oversight of this will be via the existing JRE and for the DHB, reporting of KPI via the Clinical Leadership Group and onto the Board reports.

12	<p>Expanding the concept</p> <p>In the UK, the AHSCs are largely linked with the BRCs and as such their research mandate is largely restricted to the translation of bench research to bedside benefits. However, there are potentially greater opportunities for ADHB with a strong population health campus as part of the FMHS and a whole of health system approach to planning healthcare delivery and population health benefits. Moreover, the Health Excellence Alliance could be expanded to include other University of Auckland Faculties such as Engineering, Law and the Business School. Already ADHB researchers collaborate with the Bioengineering Institute and there are further opportunities particularly in respect of commercialization of research findings. The Business School offers opportunities for an expanding research programme in healthcare services delivery, transformational change and clinical leadership. Ultimately further alliances might occur with other providers such as national and international universities.</p>
13	<p>Acknowledgement; Dr Divya Dhar for research and background preparation.</p> <p>Recommended reading Iain Martin, Dean FMHS, paper to the ADHB Board Meeting, 2010 Cardiology Annual Report 2010 Klasen EC et al. Academic Health Centres in research –intensive settings in Europe The Kings Health Partners; www.kingshealthpartners.org Association of Academic Health Centres: Value Proposition (http://www.aahcdc.org/)</p> <p>Dame Sally Davies, National Health Research Strategy, UK NZ Parliamentary Select Committee report on clinical trials</p>

7.4 Northern Region Health Plan Budget



Auckland District Health Board Decision Paper

Date	Wednesday 3 August 2011
To	Auckland District Health Board
From	Margaret Wilsher, Chief Medical Officer Admin, Level 5, Auckland City Hospital Private Bag 92024 Auckland PH:(09) 3074921 ext. 23936 FAX: (09) 307 2810 int. 24690 MOB: 021 326 326 mwilsher@adhb.govt.nz
Author	Sarah Prentice General Manager NDSA (Northern DHB Support Agency Ltd Mob 021 353 167 sarah.prentice@ndsa.co.nz
Functional Group	Planning and Funding
Subject	Northern Region Health Plan Budget
1.	<p>Recommendations</p> <p>That the Board:</p> <p>Note the previously approved ADHB share (population based funding share) of the core \$1.2m budget for implementation of the Northern Region Health Plan in 2011/12 and in addition,</p> <p>Approve its population based share of the additional \$955,000 budget for the First Do No Harm Campaign element of the Northern Region Health Plan for the 2011/12 year</p>
2.	<p>Glossary</p> <p>ACE Angiotensin-Converting Enzyme Inhibitors ARB Angiotensin-Receptor Blockers CEO Chief Executive Officer CMO Chief Medical Officer DHB District Health Board FTE Full Time Equivalent (staff resource) HWNZ HealthWorkforce New Zealand IHI Institute for Healthcare Improvement NDSA Northern DHB Support Agency</p>
3.	<p>Executive Summary</p> <p>This decision paper details the Budget required for 2011/12 to fund the Northern Region Health Plan implementation along with the associated</p>

	<p>justification, risks and benefits. The budget totalling \$2,135,000 is presented to the Auckland District Health Board for approval.</p> <table border="1" data-bbox="308 286 1353 539"> <thead> <tr> <th></th> <th>Full Time Equivalents</th> <th>Other Costs</th> <th>TOTAL COSTS</th> </tr> </thead> <tbody> <tr> <td>Core Budget</td> <td>450,000</td> <td>400,000</td> <td>850,000</td> </tr> <tr> <td>First, Do No Harm</td> <td>730,000</td> <td>555,000</td> <td>1,285,000</td> </tr> <tr> <td></td> <td><u>1,180,000</u></td> <td><u>955,000</u></td> <td><u>2,135,000</u></td> </tr> </tbody> </table> <p>This budget has been built and endorsed by the Northern Region Health Plan Steering Group, mindful of the financial constraints all District Health Boards are working to and relies on substantive <i>in kind</i> resources in each workstream area.</p> <p>The Auckland District Health Board has previously approved its population based share (\$313,320) of the initial core \$1.2m budget signalled for the Northern Region Health Plan. This paper is requesting approval from Auckland DHB for its population based share (\$244,000) of the additional funding required to support the balance of activity associated with the First, Do No Harm campaign.</p> <p>In total Auckland DHB's contribution in 2011/12 to the implementation of the Northern Region Health Plan amounts to \$557,400.</p>		Full Time Equivalents	Other Costs	TOTAL COSTS	Core Budget	450,000	400,000	850,000	First, Do No Harm	730,000	555,000	1,285,000		<u>1,180,000</u>	<u>955,000</u>	<u>2,135,000</u>
	Full Time Equivalents	Other Costs	TOTAL COSTS														
Core Budget	450,000	400,000	850,000														
First, Do No Harm	730,000	555,000	1,285,000														
	<u>1,180,000</u>	<u>955,000</u>	<u>2,135,000</u>														
4.	<p><i>Introduction/Background</i></p> <p>In this first year of regional health planning, the Northern Region Health Plan was developed in a parallel time frame with the DHB Annual Plan. This made alignment of the budget required for the Northern Region Health Plan implementation and the DHB budgets problematic. At the Northern Region CEO/CMO Group meeting in February 2011 an early budget signal of \$1.2 million for the <u>Northern Region Health Plan</u> implementation in Year One (1 July 2011 to 30 June 2012). This included an initial provision of \$350,000 for First, Do No Harm but it was acknowledged that further work needed to be undertaken to fully cost the campaign activity.</p> <p>Net of the First, Do No Harm activity the core budget is \$850,000 in 2011/12</p> <p>The core and First, Do Harm budgets are discussed further below.</p> <p>4.1. Core Budget Composition</p> <p>4.1.1. FTE Costs</p> <p>In 2011/12 ongoing work will be required to develop the Northern Region Health Plan further and to support the resourcing of the 2011/12 work plan. The core resource estimated to be required to achieve this is outlined below.</p>																

Core Budget	Core FTE	FTE	Total FTE
Diabetes Network	1.0		1.0
Cardiac Network	1.0	0.25	1.25
Health of Older People Network	0.5	0.25	0.75
Radiology Network	0.5		0.5
Overall Planning	1.0		1.0
Decision Support	1.0		1.0
TOTAL	5.00	0.5	5.50

Approximately 2.0 FTE had previously been budgeted within NDSA for regional health planning. The additional budget required to support this higher level of resourcing (\$450,000) has taken this into account.

4.1.2. Consulting and Project Support Costs

In addition to the FTE budget above, initial estimates have been developed for consulting and project support during 2011/12 in the following areas:

Initiative	Funding	Comment
Regional Spatial and Asset Management Plan	\$150,000	This work has not yet been scoped but it is envisaged external project support and spatial planning expertise will be required to work alongside our asset management and health planning teams to complete this work.
Information systems-population health workstream	\$100,000	DHBs have each made a contribution of \$200,000 of each of the other four foundation workstreams, but this fifth workstream was identified after the DHB budgeting process. It is therefore proposed that some initial funding is provided for regionally in 2011/11. If additional funding is required then reprioritisation within existing IS spend would be required.
Advance care planning training	\$150,000	This represents around half the estimated training costs for advance care planning. An application has been made to HWNZ to support this training nationally, but early indications are that this may be a lengthy approval process. Should the balance of funding not be available from HWNZ the region will need to either look at how it can scale the training differently (eg spread over two years), or alternatively reprioritise within existing funding.

Total	\$400,000	
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These costs are estimates and will require approval from the Northern Region Health Plan Steering Group before committing expenditure against them.

4.2 First, Do No Harm Budget

The First, Do No Harm budget has been subject to a detailed review by Dr Gloria Johnson, Chief Medical Officer, Northland DHB who led development of the First, Do No Harm Plan, Professor Jonathon Gray, Counties Manukau DHB, who advised composition of the budget and Rosalie Percival, Chief Financial Officer, Waitemata DHB, who reviewed the budget on behalf of the region.

The final budget sum of \$1,285,000 for First, Do No Harm is required for this activity. \$350,000 was provided for in the initial budgeting for the Northern Region Implementation, and therefore, in total an additional \$935,000 is required to fund the costs associated with the First Do No Harm campaign. The composition of the First Do No Harm budget is as outlined below:

FTE	Core FTE	Clinical Lead FTE	TOTAL FTE	Costs \$
Clinical Leader		0.5	0.5	
Campaign Manager	1.0			
Communications	1.0			
Data Analyst	1.0			
Administrator	1.0			
Implementation Managers	2.0			
TOTAL FTE	6.0	0.5	6.5	
FTE COSTS	590,000	140,000		\$ 730,000
Other Costs				
Event Management (3-4 events)				\$100,000
Accommodation				\$20,000
Travel Budget Central Team				\$30,000
Printing and Communications				\$80,000
Communications Materials				
Website				\$25,000
IHI (<i>please see detail below 2.3</i>)				\$300,000
TOTAL OTHER COSTS				\$555,000
TOTAL FIRST, DO NO HARM				\$1,285,000

Spending against the other cost items will be subject to approval from the Northern Region Health Plan Steering Group.

The FTE costs account for the majority of costs and reflect the level of seniority

and experience that will be required to successfully delivery the campaign. Of the other costs the most significant cost is for Institute for Healthcare Improvement training. This cost does not include any licensing costs for Institute for Healthcare Improvement but rather relates directly to costs associated with training as detailed below in 4.2.1.

4.2.1 Institute for Healthcare Improvement

It is proposed that the Institute of Healthcare Improvement provide training for First, Do No Harm. This programme contracted to Counties Manukau DHB will be delivered in Auckland by the Massachusetts-based Institute for Healthcare Improvement.

The Institute for Healthcare Improvement is one of the world's leading proponents of quality improvement, with a proven track record spanning 20 years. IHI is a non-profit organisation and provides programmes and strategic advice to many health systems in the US and internationally including Kaiser Permanente, the Scottish National Health Service, and Jonkoping in Sweden. It also works in Africa in partnership with the Gates Foundation.

The costs contributing to the \$300,000 are listed below.

Offering	Participants	Cost	Total (excluding GST)
Breakthrough Series	20 people	\$6,500	\$130,000
Improvement Adviser Program	12 people	\$7,500	\$90,000
Intensive Coaching Support			\$80,000
			\$300,000

4.2.1.1. The Breakthrough Series College

The Breakthrough Series programme brings together healthcare service units and organisations to collaboratively develop and implement a 'breakthrough' quality improvement initiative. The intention is that the first series, which will be held in Auckland in October 2011, will be focussed around the regional First, Do No Harm project

4.2.1.2. Improvement Science Professional Development Program

Currently, individuals with the necessary skills are rare. Many health care organisations turn to external resources for improvement leadership, but often there is no one who has the required training, expertise, and support to fully succeed in the role. To effectively meet the demands of the job, these people need more than just experience and interest in improvement work. They need a solid foundation, advanced knowledge and skills in the art and science of improvement, and the ability to work with and coach front-line teams in achieving and maintaining successful changes.

The Institute for Healthcare Improvement has designed a professional

	<p>development and support program to help health care professionals involved in improvement further develop and enhance their skills. The goal of this program is for participants to become highly effective leaders in helping their organisations accomplish strategic improvement plans.</p> <p>It is proposed that selected people from throughout the region who are tasked with leading aspects of First Do Not Harm participate in the Improvement Science Development Program which will be held in Auckland in October. This is a six-month program targeted at teams of two to four people per team</p> <p>4.2.1.3. Other</p> <p>In addition to the above, the Institute for Healthcare Improvement in association with New Zealand based clinical quality improvement experts will provide intensive coaching to First, Do No Harm project teams over a six month period as they begin implementing their initiatives.</p>
5.	<p>Risks and Issues</p> <p>The Northern Region Health Plan is an ambitious but achievable work programme with a strong commitment to achieving its goals from clinical and executive leaders across the region. Approximately sixty percent of this budget will fund recruitment of human resources/skills in 2011/12 and if not approved, the following consequences are likely:</p> <ul style="list-style-type: none"> • Implementation will be delayed: The 2011/12 deliverables have been agreed to by the region's four District Health Boards and three <i>Better, Sooner, More Convenient</i> business case collaborations. The Northern Region Health Plan has also been submitted and approved by the National Health Board but will not be achieved if approval is not received for the budget. Inability to deliver the Plan as designed will also cause loss of momentum at the region, and with it clinical and managerial support. • Clinical Leaders will not be able to implement their vision: The Northern Region Health Plan has been clinically led and designed to address the very real issues we face at the region. However the Clinical Leaders of Health of Older People, Diabetes and Cardiac clinical networks have only 0.3 FTE of their time devoted to the regional role and therefore need active support from Programme Managers to achieve implementation. This will not occur if Programme Managers are not appointed. • Transformation will not occur if the clinical networks are not fully supported by Programme Managers the critical communication and coordination functions will not occur. The clinical networks are the integrating mechanism through which strategic development, implementation oversight, monitoring as well as communication will occur. Robust support for each network will be integral to the achievement of the Northern Region Health Plan. Success will be enabled by the Programme Managers. • The opportunity given to the Region to ensure long term sustainability will be lost. From the analysis provided in the Northern Region Health

	<p>Plan, failure to address the future sustainability of the Northern Region health system is not an option.</p> <ul style="list-style-type: none"> • We will continue to harm our patients. We have clearly identified that we harm patients who interact with our services and facilities. This statistic has to change and we have scoped a lean campaign to deliver reduction in harm with specific measures to demonstrate the benefits of the investment
6.	<p>Approach/Methodology/Analysis</p> <p>6.1 Methodology</p> <p>Where possible, the cost of this investment will be made by shifting resources internally. This has occurred within the NDSA where some resources have been re-allocated to Northern Region Health Plan. However the core business of the NDSA remains so there is a mix of existing resource allocated to the Plan's implementation as well as new resource</p> <p>6.2 Options considered: Re-assign DHB employed resource to support</p> <p>6.3 Implementation of the Plan</p> <p>As a region we need to free up money where additional resource is required to detail the next phase of the Plan and ongoing implementation. Whilst some resources have already been re-allocated within the NDSA, this has not occurred within the DHBs.</p> <p>Reassignment of DHB employed resource is an option. This is not a quick solution for 2011/12 but will be a requirement for 2012/13 and beyond. The process to do this is identified in the Plan and each network is to prepare a full stock-take of core activity and associated resource in the four DHBs.</p> <p>There was insufficient time to do this adequately in preparing the Plan and it is intended that the information from the stock-takes will clearly demonstrate where duplication is occurring across the region. It is expected that some employee resource will be re-directed to the region's priorities as a result of this process.</p> <p>The stock-takes will take until December 2011 and be conducted by the Programme Managers. A human resource management process will then be required to manage changes to roles. These opportunities will be built into the Plan's implementation schedule from 2012/13 onward.</p> <p>6.4 Benefits of Investment</p> <p>The Northern Region Health Plan intentionally does not attempt to address every challenge related to service delivery across our region. The intent has been to identify a few priority areas to address sustainability (clinical and financial) and inequalities.</p> <p>The focus is on:</p> <ul style="list-style-type: none"> • First Do No Harm – where it is estimated that around 13% of hospital discharges have an adverse event of which around a third were significantly

avoidable. Previous analysis at a New Zealand level suggests that preventable adverse events are estimated to cost around \$573 million annually. The Northern Region share of this on a population basis would be around \$230 million. Reducing this by 1% would result in a payback of around 180% on the \$1.29 million budget in 2011/12. A number of the targets set for this year are for 10% or 20% reduction in adverse events so a 1% overall reduction should be achievable

- **Life and Years** – it is estimated that annually our four DHBs spend around \$900 million on diabetes, cardiovascular disease and cancer and \$428 million on older people in aged residential care and in community settings. These are key focus of the Plan in 2011/12 as growth in expenditure in these areas is not sustainable. An investment of \$850,000 against this budget is considered critical to slowing this unsustainable trend.

Within the Northern Region Health Plan there is a strong emphasis on defining tangible benefits, however there is some variance to the extent we are able to do this. Areas where there are established networks and other mechanisms in place have defined very clear benefits. The focus for other areas is to build these networks and baselines up, with the intent that the networks will define and deliver the benefits in the future.

In the short term we will also put in place the foundations to achieve benefits over the medium and long term. This will include:

- Implementing and tracking benefits in areas where there are already good structures in place, such as cancer and cardiovascular disease.
- Implementing the 'quick win' initiatives
- Supporting the new diabetes, radiology and health of older people networks
- Establishing clinical leadership teams to support the First, Do No Harm and The Informed Patient campaign
- Refining the expected benefits for each of the initiatives so we stay focussed on our targets and our targets are feasible to achieve
- Building for the future by designing new interventions and being at the forefront of innovation and research.

The Top Ten key deliverables for 2011/12 are listed below will *directly benefit patients*

All Interventions 2011/12

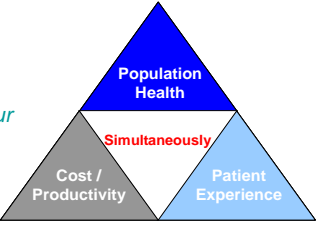
1. Achieve and maintain the Minister's Health Targets

First, Do No Harm

2. Reduce the number of harmful falls in our hospitals by 20%
3. Reduce the number of patients who have pressure injuries in hospital or aged Residential care by 20%

Life and Years

4. Ensure 50% of patients with lung cancer will have first surgical treatment within 14 days of multi disciplinary meeting
5. 70% of patients admitted with acute coronary syndrome will go from

	<p>'door to catheter laboratory' within 72 hours</p> <p>6. Increase to 80% the number of high needs diabetes patients with microalbuminuria/proteniuria who are taking ACE/ARB</p> <p>7. Undertake retinal screening on 4,500 additional people in our region</p> <p>8. For each DHB train two more specialist nurses and three diabetes nurse specialists as prescribers at Auckland DHB</p> <p>The Informed Patient</p> <p>9. Complete Whānau Ora Assessments for targeted population</p> <p>10. 500 patients will have discussions regarding Advance Care Plans</p>												
7.	<p>Linkages/Impact</p> <p>7.1 Strategic Context</p> <p>The development of the Northern Region Health Plan has been as well linked as possible given the timeframe for delivery to the National Health Board. The next phase of strategic development will be more widely communicated and more inclusive of a wider range of stakeholders as the clinical networks will be established and more time will be allowed.</p> <p>7.2 Impact on reducing inequalities and Maori Health Gain.</p> <p>As per the Mission statement below, the Northern Region Health Plan takes a focussed approach, with a clear intention to reduce disparities among the 1.6 million residents of the Northern Region.</p> <div data-bbox="456 1137 1310 1637" style="border: 1px solid black; padding: 10px;"> <p>Our Mission:</p> <p><i>"To improve health outcomes and reduce disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means."</i></p> <p style="text-align: right;">Triple Aim Methodology</p>  <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 33%;">First, Do No Harm</td> <td style="width: 33%;">Life and Years</td> <td style="width: 33%;">Informed Patient</td> </tr> <tr> <td colspan="3">National Health Targets</td> </tr> <tr> <td colspan="3">Service Changes</td> </tr> <tr> <td>Information Systems</td> <td>Workforce</td> <td>Facilities</td> </tr> </table> </div>	First, Do No Harm	Life and Years	Informed Patient	National Health Targets			Service Changes			Information Systems	Workforce	Facilities
First, Do No Harm	Life and Years	Informed Patient											
National Health Targets													
Service Changes													
Information Systems	Workforce	Facilities											
8.	<p>Costs/Resources/Funding</p> <p>In total \$2.135m funding is required for implementation of the Northern Region Health Plan in 2011/12. Of this \$1.20 million has previously been approved by the four DHBs and all have endorsed the activity proposed in the plan, including the First, Do Harm activity. An additional <u>\$935,000 is required to fund this activity.</u></p> <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="width: 15%;">NHRP Implementation</td> <td style="width: 15%;">All DHBs</td> <td style="width: 15%;">Northland</td> <td style="width: 15%;">Waitemata</td> <td style="width: 15%;">Auckland</td> <td style="width: 15%;">Counties Manukau</td> </tr> <tr> <td>Previously</td> <td>1,200,000</td> <td>12.20% 146,400</td> <td>31.10% 373,200</td> <td>26.11% 313,320</td> <td>30.59% 367,080</td> </tr> </table>	NHRP Implementation	All DHBs	Northland	Waitemata	Auckland	Counties Manukau	Previously	1,200,000	12.20% 146,400	31.10% 373,200	26.11% 313,320	30.59% 367,080
NHRP Implementation	All DHBs	Northland	Waitemata	Auckland	Counties Manukau								
Previously	1,200,000	12.20% 146,400	31.10% 373,200	26.11% 313,320	30.59% 367,080								

	Approved Additional Funding	935,000	114,070	290,785	244,129	286,017
	Total Budget	2,135,000	260,470	663,985	557,449	653,097
	<p>The Auckland DHB investment in 2011/12 is \$557,450 with \$313,320 of this having been approved and included in the DHB's 2011/12 budget. Approval is now being sought for unbudgeted expenditure of \$244,000.</p> <p>This expenditure will be included in the NDSA budget. Reporting will be to both the Northern Region Health Plan Steering Group and the NDSA Management Committee. Approvals will be sought from the Steering Group for key elements of costs where there is currently some uncertainty regarding budgets (for example, Advance Care Planning, training).</p>					
9.	<p>Consultation/Engagement</p> <p>9.1 Consultation already undertaken</p> <p>This budget has been consulted with and endorsed by the Northern Region Health Plan Steering Group and the Northern Region CEO/CMO Group.</p> <p>Validation of the budget was also provided by Rosalie Percival, Chief Financial Officer, Waitemata DHB</p> <p>9.2 Planned consultation</p> <p>No further consultation is proposed in respect to the budget for this plan</p>					
10.	<p>Implementation</p> <p>Approval of this budget is urgent as we have completed the first month of the financial year and not been able to commence the activities detailed in the implementation plan.</p>					
11.	<p>Conclusion</p> <p>The core budget outlined above and some elements of the First, Do No Harm budget have been included in NDSA's budget and the costs will be shared by the four Northern DHBs on a Population Based Funding Formula basis. Now that the First, Do No Harm budget has been finalised the NDSA will work with the DHBs to determine the best way to manage and report on the balance of the expenditure. Expenditure against budget will be reported on as part of the NDSA's standard reporting to the Management Committee. It will also be reported to the Northern Region Health Plan Steering Group.</p>					

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

Disabled Support Advisory Committee Recommendations

ADHB Board

Author: Ian Bell (8077)

Subject: Community and Public Health Advisory Committee – After Hours Proposal for Auckland Metro Region

Recommendation

That the Auckland DHB Board:

1. **Receives** the Auckland Region After Hours Proposal to Metro Auckland DHBs June 2011 prepared by the After-Hours Alliance, noting that the Proposal is currently being updated to include further operational detail and specificity
2. **Endorses** the redesign of after-hours services in the Auckland region over the next year in line with the After-Hours Alliance Proposal, subject to sufficient funding being approved by Metro Auckland DHBs and PHOs
3. **Notes** that indicative funding for the total Proposal is \$10M; approximately \$5M of which is already committed by DHBs in existing services and the remaining funding of \$5M is proposed to be shared by DHBs and PHOs
4. **Endorses** that the DHB contribution across the region is on a population based funding equivalent basis
5. **Approves** that management proceed to work through the required implementation detail with the After-Hours Alliance, and provide a report by the end of August 2011 that includes specific funding recommendations
6. **Notes** that a phased implementation approach is proposed, and a review of overnight service options will be completed in phase two and prior to 31 December 2011, in order to inform service arrangements and funding from 1 April 2012
7. **Notes** the current rural after hours services will continue as now and be unaffected by the changes proposed in Phase 1 and 2 (to March 2012)

Background

This is a recommendation from the CPHAC meeting held on 20 July 2011.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Community and Public Health Advisory Committee – Community Pharmacy Contract Renewal

Recommendation*That the Auckland DHB Board:*

1. *endorses the general direction of the Pharmacy agreement proposal.*
2. *endorses the proposal's aims to cap close control which should equate to \$500k of savings for ADHB, against the 2011-12 budget.*
3. *notes the risks of a 1 September 2011 implementation date.*
4. *endorses the approach of a contract roll over and a later implementation start.*
5. *endorses a 1 September 2011 start date should the majority of DHBs vote in its favour to align ADHB with the national process; and*
6. *endorses the need for well defined long term conditions criteria.*

Background

This is a recommendation from the CPHAC meeting held on 20 July 2011.

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 106 improvement activities ADHB committed to in the 2010/11 District Annual plan.

All 106 projects have been started with 20% in the planning stage, 42% in implementation and 38% completed. One project has been cancelled. There are 39 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.

With the advent of year end a review of project status has been undertaken. The review has led to a substantial change in phasing and status as shown below.

	This month	Last month	Change
Planning	20	36	-16
Implementation	45	59	-14
Cancelled	1	0	1
Completed	40	11	29
Total	106	106	0

This significant change from last month is reflective of project timing and the arrival of year end. This reflects the nature of the projects which fall into three categories:

- Health and performance annual targets – these projects end on 30 June and are renewed with new projects for the next financial year
- Specific tasks or issues for resolution – these have defined scope and timeframes at the outset and are held to account on those initial expectations.
- Wider initiatives – these usually require further definition and often result in the initial assessment of a one year horizon being insufficient to complete all aspects of the project.

The project review involved contacting sponsors of all projects with end dates on or before 30 June 2011 and confirming the current project phase, status for timing, budget and outcomes and assessing any changes required to the end dates to reflect ongoing work. Where the project is behind but otherwise proceeding to plan the end date has not been changed. The results of the review are set out on the next page.

	This month
Projects previously reported as complete (see June Board report)	11
Projects assessed as complete by the end of June	29
Total projects completed in the 2010/211 financial year	40
Projects still running with mitigation strategies to address issues	10
Projects cancelled	1
Projects with an amended future end date	22
Projects previously reported as due by 30 June 2011	73
Projects already having a later completion date than 30 June 2011	33
Total projects	106

Subsequent to the review the systems shows that 71% of projects still being completed are on time, 95% on budget and 89% will deliver expected outcomes.

Status	This month	Last month	Change
On time	71%	71%	0%
On budget	95%	87%	8%
Expected outcome	89%	82%	7%



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	39	39	2	4	3	11	3	0	18	4	1	23	0	0	22	1	0	16	16	0	0
2 Performance improvement	56	56	3	3	4	24	6	1	26	12	2	37	2	1	34	5	1	15	14	1	0
3 Live within our means	11	11	0	0	1	1	0	0	2	0	0	2	0	0	2	0	0	9	9	0	0
Total #	106	106	5	7	8	36	9	1	46	16	3	62	2	1	58	6	1	40	39	1	0
Total %	100%	100%	8%	11%	12%	55%	14%	1%	71%	25%	4%	95%	3%	2%	89%	9%	2%	37%	98%	1%	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 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 and meets the regional needs. The support from the community provider to enable the volumes to continue to be screened is operating well and the additional capacity offered is helpful while the sustainable solution is being constructed.	CPHAC

Goal: 2 Performance improvement

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	Committee
eReferrals Phase 1	Regional	Improve				The IT standards have taken a longer time to implement. This has put the timelines at risk but planning has addressed this concern with timelines remaining unchanged. The red flag relates to perceived supplier delivery and GP acceptance risks rather than issues with the project processes.	
Tamaki project	P2HC Regional	Analyse				Paper being developed for August Finance Committee. Early Start Group have completed level 3 programmes and are enrolled in foundation programmes with MiT and AUT. Cost of unsubsidised training to ADHB for semester 2 is 10k	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: University Steam Agreement Extension

Recommendation

1. *That, upon expiry of the current steam agreement, ADHB enter a new agreement to supply steam to the University of Auckland's School of Medicine campus for a further ten years. The new agreement will commence on November 1st 2012 and have an estimated annual value of approximately \$340,000 p.a.*
2. *That the CEO be delegated authority to execute the contract.*

Background

This will be discussed by the Finance Committee at their meeting on 2 August 2011.

ADHB Board

Author: Ian Bell (8077)

Subject: Roster & Timesheet Automation Project (RiTA)

Recommendation

That the Board approves and seeks National IT approval to the commitment of \$2M of capital and opex of \$543K pa for the implementation by ADHB of a regional Roster and Timesheet Automation project.

Background

This will be discussed by the Finance Committee at their meeting on 2 August 2011.

ADHB Board

Author: Ian Bell (8077)

Subject: 2011 Year-end CFIS Financial Information

Recommendation

That the Board delegate authority to sign the required CFIS documents on behalf of the Auckland District Health Board as follows:

(a) Joint Statement of Representation to Audit NZ and Ministry of Health – Chair, Board Member, Chief Executive and Chief Financial Officer.

(b) Audited CFIS template – Chief Financial Officer

Background

This will be discussed by the Finance Committee at their meeting on 2 August 2011.

ADHB Board

Author: Ian Bell (8077)

Subject: Crown Funding Agreement – Extension of Term until 30 June 2012

Recommendation

That the ADHB Board:

- *notes the proposal of the Minister of Health to extend the term of the existing Crown Funding Agreement (CFA) until 30 June 2012, and*
- *agrees to the Minister's proposal to make the following substitutions in the CFA:*
- *substitute all references in the CFA to 'District Annual Plan' or 'DAP' with 'Annual Plan' or 'AP'. This is to reflect changes made by the New Zealand Public Health and Disability Amendment Act 2010.*
- *approves the extension of term of the CFA for the period 1 July 2011 to 30 June 2012, estimated amount \$987M (GST excl).*

Background

This will be discussed by the Finance Committee at their meeting on 2 August 2011.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Tamaki 300: Pathways to Health Careers Programme

Recommendation

That the Board approves funding for the Tamaki 300: Pathways to Health Careers Programme for the next three (out of seven) financial years up to a maximum of \$2.6 million (GST excluded) as follows:

- 2011/12 – \$384,000
- 2012/13 – \$1 million
- 2013/14 – \$1.2 million
- *Estimated total investment is \$6.7 million over the full 7 year life of the Pathways Programme.*

Background

This will be discussed by the Finance Committee at their meeting on 2 August 2011.

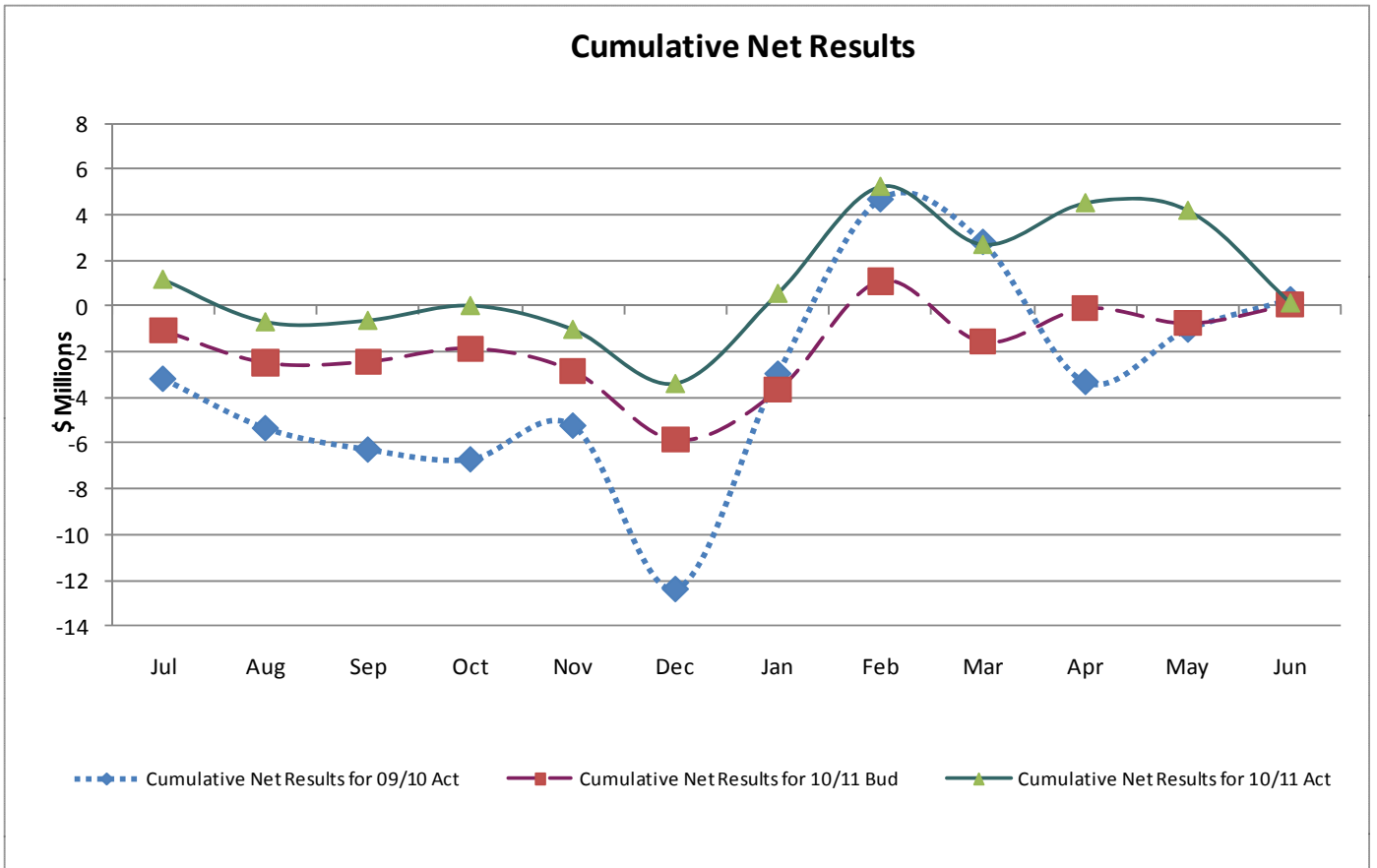
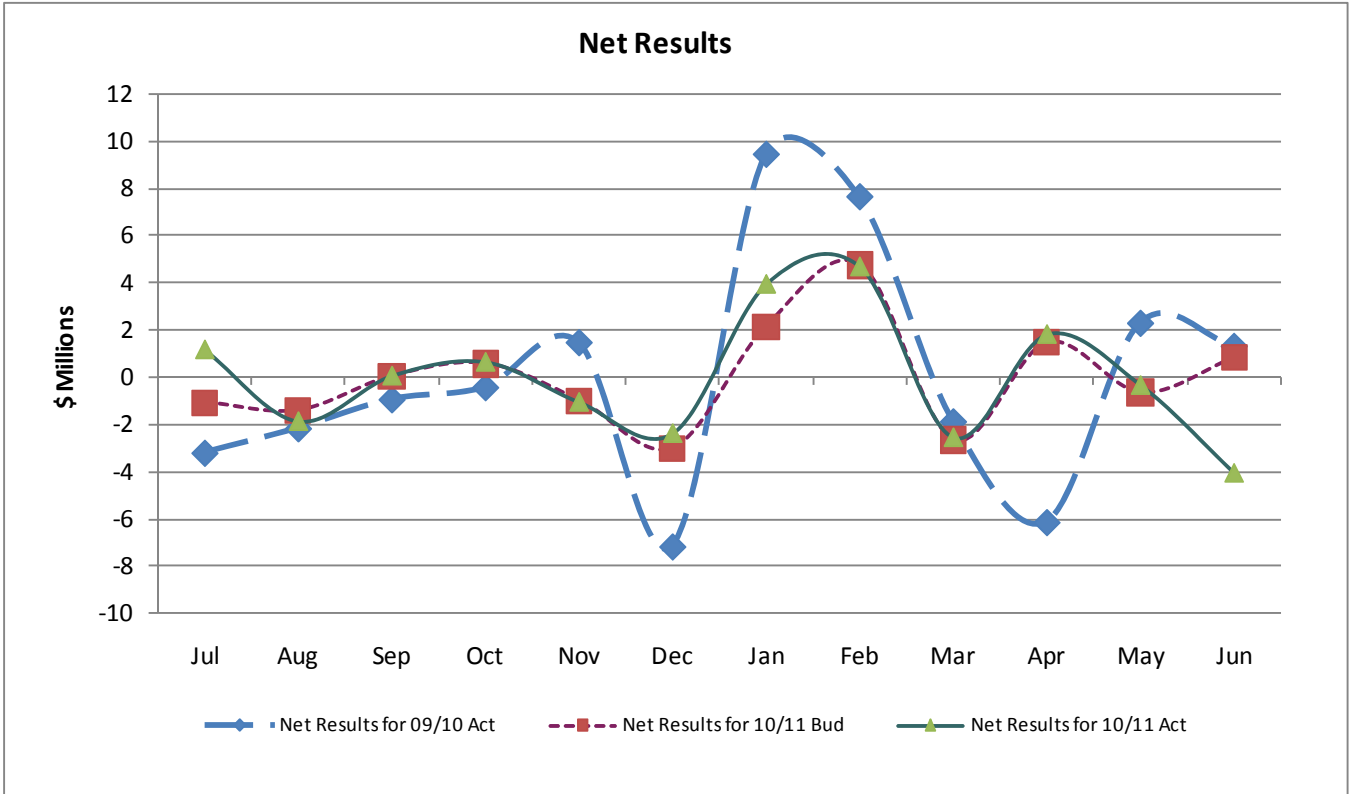
10.2 Finance Report

Auckland District Health Board

Board Financial Report

June 2011

Performance Graphs by Month & YTD



Statement of Financial Performance
Month & YTD - Jun 2011

	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
	\$000s					
Income						
PBF - AKL Population	80,359	79,701	657 F	961,595	956,414	5,180 F
Inter District Inflows	52,327	47,891	4,436 F	610,327	574,688	35,639 F
	132,686	127,592	5,094 F	1,571,922	1,531,102	40,820 F
MOH Sub-contracts	13,192	7,435	5,756 F	106,818	89,217	17,601 F
Other Patient Care	6,811	3,691	3,119 F	54,715	43,131	11,584 F
Services & Products	3,902	3,675	227 F	46,549	45,762	787 F
CTA	2,112	1,924	188 F	20,102	20,254	151 U
Trust & Donation Income	610	428	183 F	6,358	6,170	188 F
Financial Income	1,143	246	897 F	9,285	4,653	4,633 F
Other Income	895	411	484 F	5,415	3,332	2,082 F
	161,350	145,403	15,947 F	1,821,163	1,743,620	77,543 F
Expenditure						
Employee Costs						
Medical	18,747	19,103	356 F	227,594	226,035	1,560 U
Nursing	22,189	19,390	2,799 U	240,375	233,885	6,490 U
Technical	10,520	10,255	265 U	120,399	121,894	1,495 F
Hotel Services	953	808	145 U	10,194	9,590	605 U
Administration	6,533	7,718	1,185 F	84,768	91,535	6,767 F
Other	5,331	1,890	3,441 U	44,519	39,929	4,590 U
Total Employee Costs	64,273	59,164	5,109 U	727,850	722,866	4,983 U
Outsourced Services	7,472	2,857	4,616 U	54,006	34,188	19,818 U
Direct Treatment Costs	16,598	15,651	947 U	202,757	187,251	15,506 U
Indirect Treatment Costs	4,556	3,257	1,300 U	43,833	39,176	4,657 U
Funder Payments	49,040	39,465	9,575 U	515,719	473,466	42,253 U
Inter District Outflows	8,429	8,372	57 U	99,532	100,468	936 F
Prop, Equip, & Maintenance	4,996	4,085	911 U	50,766	50,839	74 F
Administration Costs	1,638	2,100	462 F	22,703	24,225	1,522 F
Total Operating Expenditure	157,004	134,951	22,053 U	1,717,165	1,632,480	84,685 U
Operating Contribution	4,346	10,452	6,105 U	103,998	111,140	7,142 U
Depreciation	3,950	4,767	818 F	51,146	54,310	3,164 F
Finance Costs	1,481	1,670	189 F	18,219	20,154	1,934 F
Capital Charge	2,953	3,193	240 F	34,491	36,617	2,126 F
Total Non Operating Costs	8,383	9,630	1,247 F	103,857	111,081	7,224 F
Net Surplus / (Deficit)	(4,037)	822	4,858 U	141	60	82 F

Statement of Financial Position

as at 30 June 2011

	30-Jun-11			31-May-11	30-Jun-10
	Actual	Budget	Variance	Actual	Actual
	\$'000				
Public Equity	573,103	573,362	259U	571,058	569,409
Reserves					
Revaluation Reserve	331,989	381,278	49,288U	353,537	353,538
Accumulated Deficits from Prior Year's	(468,367)	(468,437)	70F	(468,367)	(468,648)
Current Deficit	143	58	85F	4,512	281
	(136,235)	(87,102)	49,133U	(110,317)	(114,829)
Total Equity	436,869	486,260	49,391U	460,741	454,579
Non Current Assets					
Fixed Assets					
Land	163,331	201,337	38,006U	181,497	181,497
Buildings	573,160	597,265	24,105U	571,508	586,095
Plant & Equipment	75,452	126,381	50,929U	81,251	79,856
Work in Progress	17,699	15,190	2,509F	32,245	23,166
	829,642	940,173	110,531U	866,502	870,613
Derivative Financial Instruments	5,669	4,399	1,270F	4,772	7,061
Investments					
Associate Company Investments	502	386	116F	95	95
Trust Funds	3,898	8,000	4,102U	6,326	10,078
	4,400	8,386	3,986U	6,421	10,172
Total Non Current Assets	839,711	952,958	113,247U	877,694	887,846
Current Assets					
Cash & Short Term Deposits	83,325	34,293	49,032F	83,284	56,815
Trust Deposits	19,160	11,508	7,652F	15,763	11,747
Debtors	27,532	24,435	3,097F	20,761	25,691
Accrued Income	28,673	31,680	3,007U	31,939	31,220
Prepayments	3,025	2,320	705F	3,088	2,245
Inventory	12,021	12,106	85U	12,161	11,220
Property Intended for Resale	20,041	-	20,041F	-	-
Total Current Assets	193,778	116,342	77,435F	166,996	138,938
Current Liabilities					
Borrowing	(23,249)	(25,836)	2,586F	(2,804)	(74,652)
Trade & Other Creditors, Provisions	(105,338)	(99,492)	5,846U	(99,770)	(97,714)
Income Received in Advance	(23,445)	(18,533)	4,912U	(26,134)	(20,087)
GST & PAYE Payable	(20,931)	(19,169)	1,762U	(16,154)	(18,040)
Employee Benefits	(136,320)	(124,896)	11,424U	(132,079)	(125,196)
Funds Held in Trust	(1,093)	(1,126)	32F	(1,093)	(1,067)
Loan from Associates	(1,386)	-	1,386U	-	-
Total Current Liabilities	(311,762)	(289,051)	22,711U	(278,034)	(336,757)
Working Capital	(117,984)	(172,708)	54,724F	(111,038)	(197,818)
Non Current Liabilities					
Borrowings	(263,110)	(273,110)	10,000F	(283,094)	(213,014)
Employee Entitlements	(21,748)	(20,880)	868U	(22,821)	(22,435)
Total Non Current Liabilities	(284,858)	(293,990)	9,132F	(305,915)	(235,449)
Net Assets	436,869	486,260	49,391U	460,741	454,579

Statement of Cashflows for the Year ended 30 June 2011						
	Jun-11			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	161,964	143,298	18,666	1,815,817	1,744,507	71,310
Payments	(155,314)	(129,183)	(26,131)	(1,749,103)	(1,682,692)	(66,411)
Net Operating Cashflows	6,650	14,115	(7,465)	66,714	61,815	4,899
Investing						
Income	657	370	287	7,155	4,436	2,719
Capital						
Sale of Assets	331	1	330	648	16	632
Purchase Fixed Assets	(3,758)	(6,460)	2,702	(51,929)	(77,527)	25,598
Net Investing Cashflows	(2,770)	(6,089)	3,319	(44,126)	(73,075)	28,949
Financing						
Equity Injections	2,046	1,015	1,031	3,696	4,058	(362)
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	2,046	1,015	1,031	3,696	25,433	(21,737)
Total Net Cashflows	5,926	9,041	(3,115)	26,284	14,173	12,111
Opening Cash	50,387	35,161	15,226	30,029	30,029	0
Closing Cash	56,313	44,202	12,111	56,313	44,202	12,111

Financial Performance

- The net result for the year was \$0.14m, a favourable variance to the budgeted net result of \$0.06m.
- The average WIES per discharge is 1.1% higher than last year. Discharges are up by 0.6% compared to last year.
- The result for June is driven by higher revenue of \$15.9m compared with higher expenditure of \$(20.8)m. The result for the full year is driven by higher revenue of \$77.5m compared with higher expenditure of \$(77.4)m.
- Year to date revenue was higher than budget by \$77.5m. This was the result of:-
 - a) Favourable Base Revenue \$40.8m is driven by higher base contract variations, which are primarily for additional Herceptin funding \$8.5m, PHO realignment funding \$26.1m, Oral Health funding \$1.6m and IDF revenue \$5.2m.
 - b) Higher MoH Subcontract revenue \$17.6m, is driven by higher SCI funding \$7.9m, Mental Health (Eating Disorder) funding and other MoH Subcontract revenue \$15.8m, lower Herceptin funding (now in base revenue above) \$(8.5)m and higher Additional Elective revenue \$2.4m as a result of achieving required targets
 - c) Higher volumes of non resident & ACC activity \$4.6m
 - a. Higher levels of inter DHB side contracts \$6.4m to meet additional PHO costs
 - d) Higher interest received on term deposits \$2.7m.
 - e) A realised gain on Interest Rate Swap Instruments \$1.9m
- Year to date expenditure was higher than budgeted by \$(77.4)m.
 - a) The unfavourable variance in employee costs of \$(5.0)m was driven by vacancies and annual leave taken in Mental Health \$3.7m, Adult Health \$0.6m, Operations \$2.0m and Cancer \$0.6m but increased employee costs in Child Health (\$5.7)m, Cardiac \$(2.9)m, Operating Theatres \$(3.0)m, Ambulatory \$(0.9)m, driven by increased volume and complexity. Administration staff costs are favourable to budget \$6.8m, 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 \$(19.8)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 \$(6.8)m and by additional outsourcing \$(10.9)m primarily to cover operational vacancies, manage cardiac waiting lists and increase electives volumes during the year.

Direct & Indirect Treatment costs are \$(20.2)m unfavourable to budget in the following services – Adult Health \$(1.1)m, Child Health \$(4.8)m, Cardiac Services \$(4.5)m, OR & Anaesthesia \$(4.0)m, Laboratories \$(2.8)m, Imaging \$(1.1)m and Ambulatory \$(0.6)m. The increase is due to increased Chemicals & Media \$(3.0)m driven by higher test volumes and higher reagent costs, Clinical Supplies & Implants \$(12.5)m driven by higher volumes in OR&A, Cardiac and Child Health. In addition there has been higher provisioning for non resident bad debts \$(3.3)m given the higher revenue noted above. Lower demand for blood and drug usage in Cancer has resulted in a favourable variance of \$3.0m. There were also various initiatives that have not delivered the treatment cost savings to the planned levels. Further analysis is provided within the Hospital Advisory Committee agenda.

- c) Funder Payments (including IDF Outflows) are over budget \$(41.3)m due to increased PHO expenditure following a process of realigning PHO's \$(36.9)m where additional IDF revenue is being received to cover the additional expenditure incurred on behalf of the regional DHBs. There are also unfavourable variances in Laboratory costs following revised contracts with LTA and DML \$(2.6)m, costs arising from settlement of prior year's pharmaceutical claims and costs for additional Mental Health (Eating Disorder) expenditure \$(0.9)m, for which additional revenue has been received as described above. Inter District Outflows are favourable to budget \$1.1m.
- d) Depreciation is lower than budget \$3.2m driven by lower levels of capital expenditure.
- e) Finance Costs are lower than budget \$1.9 m driven by lower than planned interest rates and CHFA loans not having to be drawn down.
- f) The Capital Charge is lower than budget \$2.1m driven by the revaluation of Land & Buildings downwards at 30 June 2010 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.
- There was a further downwards revaluation of Land and Buildings as at 30 June 2011 \$(21.5)m
- FY11 YTD Capital spending under budget by \$(25.4)m. Baseline and Facilities projects are below budget by \$(23.3)m driven by slower spending on Grafton Car park \$(3.9)m, Greenlane Surgical Unit \$(9.4)m, Oral Health Clinics \$(0.6)m and a reduction in spending through reprioritisation \$(9.4)m. Information Systems projects are below budget by \$(2.1)m driven by the pace at which business cases are developed, approved and implemented.
- At month end there is an unused overdraft facility of \$41.8m.

11

PAPERS

Nil

12

GENERAL BUSINESS

APPENDICES

13.1 Academic Health Alliance – Value Proposition

13.1 Academic Health Alliance – Value Proposition

The Compelling Value Proposition of Academic Health Centers

Steven A. Wartman, MD, PhD, MACP

The strength of academic health centers results from the intertwining of their three central activities — education, research, and patient care



Association of Academic Health Centers®
Leading institutions that serve society

Academic health centers represent a unique combination of teaching, research, and patient care. This blend of academe and clinical care creates a perspective in which these multiple roles are *not* disparate, but rather contribute to a whole that is truly greater than the sum of its parts. But is this idea, which is commonly shared, a form of wishful thinking or naïveté? Or, is it something tangible that can be expressed and codified? In other words, what is the compelling value of academic health centers?

When asked to articulate their value, whether it be with government leaders, policymakers, professional organizations, patient groups, communities, or even their own faculty and staff, academic health center leaders often offer the commonly held view that an academic environment with research and teaching contributes to patient care and vice versa. But this can sound more like a statement of a belief than a concrete set of verifiable achievements. As self-evident as it may appear to those working in leadership positions at these institutions, the significance of this complex, integrated mission is not often clearly apparent to others.

This was noted in a recent report which pointed out that the complex mission and multifaceted relationships that academic health centers maintain “can make the [academic health science centre] value proposition difficult to articulate.”¹

Yet, at a time when the contribution of academic health centers is more important than ever, it is ironic that they may struggle to articulate what makes them such important pillars of society. How *does* one effectively communicate the *value proposition* of the academic health center?

THE DEFINING ACADEMIC HEALTH CENTER VALUE PROPOSITION

What is meant by a value proposition? Looking through the lens of the academic health center,

the value proposition may be characterized as a concise expression as to why individuals and organizations — be they public or private — should support and/or use its services. For instance, the tag line on the AAHC's stationery and web page reads: Leading institutions that serve society. Perhaps this is a bit vague as a value proposition.

The strength of academic health centers results from the intertwining of their three central activities — education, research, and patient care — working in concert to improve health and well-being as they expand the boundaries of knowledge. This combination is doubly powerful: as a vital contributor to health security and as a significant engine of economic growth.

Every day the results of the efforts of academic health centers are apparent, be it the healing of one individual, the education of one health professions student, or the discovery of one bit of new knowledge. Taken together, these core activities improve the lives of many and lead to better health and prosperity for a community and a nation.

Thus, academic health centers are the anchor around which patient care, health professions education, research, and technology support economic success and a healthy population. They are crucial local and regional institutions that are also indispensable as a collective global enterprise. Perhaps the value proposition of academic health centers can be expressed as: *Advancing and Applying Knowledge to Improve Health™*.

DELINEATING THE VALUE PROPOSITION

Advancing and Applying Knowledge to Improve Health™ describes the critical values that academic health centers bring to the table in a manner that no other health-related institution or industry can

“[Academic health centers] are crucial local and regional institutions that are also indispensable as a collective global enterprise.”

offer or address as comprehensively. While many health-related institutions can claim that they advance knowledge, and others that they apply it, it is only the academic health center that does both in such a synergistic and substantive fashion. The combination of building the knowledge economy through education and research and delivering comprehensive health care provides the foundation for economic growth and health and well-being.

Global Health and Well-Being

A healthy population is essential to a flourishing civilization; without it, progress is limited by daily life struggles. By delivering comprehensive care, from the basic to the most advanced, and by serving as a community's health safety net, academic health centers are often able to return individuals productively to the workforce. The academic health center is there every day for the community. And, in times of disaster and need, whether in Haiti, Chile, New Orleans, or elsewhere, the global academic health center community is there to aid, organize, deliver care, and help re-establish the health infrastructure.

Public Trust

Academic health centers have the great responsibility of earning and keeping the deep connection and trust that so many individuals and organizations have given them. This is, above all, an emotional connection that is clearly implied in the suggested value proposition.

Economic Benefits

The economic growth stimulated by academic health centers is remarkable. During the current recession, jobs in the U.S. health care sector actually *increased*,² demonstrating the sector's robustness. The academic health center creates much of this workforce through its schools, including medicine, nursing, dentistry, public health, graduate studies, pharmacy, veterinary medicine, and other health-related professions. Through research, the academic health center makes ideas and products available for commercialization, catalyzing industrial growth,

including the creation of spin-off companies, business incubators, and research parks. This is in addition to the training of highly qualified researchers who go on to jobs in academe, government, and the private sector.

Social Revitalization

The overall picture is that of a robust organization that constantly renovates and revitalizes the region that it serves. Thus, the academic health center exerts a threefold impact: its delivery of needed and high quality health care improves *health status*; its research addresses pressing *health care problems*; and its educational programs *produce health professionals who serve the community*.

This impact makes a strong case for the value proposition of academic health centers being *Advancing and Applying Knowledge to Improve Health™*.

COLLABORATING TO PROMOTE THE VALUE PROPOSITION

If this value proposition is indeed appropriate, what can be done to promote its wide understanding and acceptance? The process begins with enhancing the public and political perception and knowledge of academic health centers. In doing so, academic health center leaders can move from the reactive side of the equation to the proactive side, and change the dynamic from defending their costs to promoting their value.

Although academic health centers are large, complex institutions by any standard, they are often perceived as local entities, belonging to a city or particular region. As a result of this perception, they do not have the kind of clout or influence on a national or international scale that should be commensurate with their magnitude and impact. In comparison with corporations of similar size, their lack of broader unification results in a diminution of political influence. This is partly the result of decades of localism, the (now fading) ivory tower mentality, and the keen sense of inter-institutional competition.

It is now past time for academic health centers to open up their architecture and realize

that “collaboration is the new competition”³ by rallying around their value proposition and communicating a unified message.

RECALIBRATING INSTITUTIONS TO ONE MISSION

Implicit in the proposed value proposition is a call for institutional recalibration. It is no longer enough to say, as is commonly done, that the academic health center missions are to:

- Educate the next generation of health professionals;
- Conduct cutting edge research; and
- Deliver a broad spectrum of comprehensive care.

Rather, these “missions” must be viewed as *functions* — the *means* by which the true mission is accomplished: improved health and well-being.

By focusing the mission sharply on improved health and well-being, the entire enterprise is given enhanced meaning and direction, not to mention markedly improved political viability. In its most tangible form, this implies that an academic health center takes responsibility for the health and well-being of the community in which it plays a central role. In some instances, this community may be a specific part of a city; in others, it may be a larger region. But instead of simply co-existing, the academic health center and the community develop a viable partnership that brings direction and value to both entities.

This is particularly important in light of studies that have shown that an individual’s health prospects are shaped by five broad factors:

- Genetic and gestational endowments;
- Social circumstances;
- Environmental conditions;
- Behavioral choice; and
- Medical care.⁴

There is, of course, a rather complex interplay amongst these domains, but it is generally estimated that medical care accounts for less than 25% of a population’s health status.⁵ It is essential, therefore, for academic health centers to take a broader view of health.

“...instead of simply co-existing, the academic health center and the community develop a viable partnership.”

Emphasizing the Social Determinants of Health

We know that health is powerfully influenced by education, employment, poverty, housing, crime, income disparities, and social cohesion.⁶ Traditionally, the academic health center has focused — understandably — on the medical care domain, the rationale being that this is what it knows best and that there is little it can do about these other factors. This is in part a reflection of the siloed nature of many of our health professions schools within the academic health center. For example, schools of public health have long recognized the need to put more emphasis on the social determinants of health, but the lack of emphasis on interprofessional education and training has limited their impact on the programs of other schools.

Mounting evidence suggests that health cannot be addressed in isolation, that improvement in health status requires a broader approach. Enhanced alignment and communication between the disciplines at academic health centers can serve to better integrate how an institution approaches the mission of improving health and well-being locally, nationally, and globally. If academic health centers are to be leading organizations of the future, they must be demonstrably effective in achieving this mission and, thereby, fulfilling their value proposition. This suggests that their education, research, and patient care functions must be focused more directly on the communities they serve. As noted in a recent report, “Scrutiny of the community benefit offered by academic health centers is growing. Helping to address the social determinants of health is one way centers can demonstrate their value and sustainability and stay relevant to the communities they serve.”⁷

FULLFILLING THE VALUE PROPOSITION

What are the implications of this *recalibration* for the education, research, patient care, and leadership activities of academic health centers?

Recalibrating Education to Societal needs

In the education realm, there is increasing recognition of the need for substantive curricular change. For example, the new “Genes to Society” curriculum at The Johns Hopkins University School of Medicine has as one of its cardinal tenets that: “[The] basic structure of medical curricula is not suited to the nature and pace of scientific and societal changes.”⁸

This new curriculum includes a special “societal component” that emphasizes how individual patient phenotypes may affect the family or community. Similarly, the increasing emphasis on interprofessional health education speaks to the development of a new paradigm for care delivery. Academic health centers must take the lead in recalibrating their educational programs to target evolving societal and patient needs.

Linking Research to Health

In research, the recalibration of the academic health center will assist the transition from the current very highly leveraged model to one which is more broadly based in scope and function. Indeed, the link between research and improved health needs development and support, including new research tools and infrastructure.⁹ Another important area for recalibration in the research arena is the relationship between academe and industry. A positive, mutually productive relationship will likely prove vital in the years ahead, not only to sustain quality research, but, more importantly, to enhance the commercialization of needed health breakthroughs.

“...health cannot be addressed in isolation, that improvement in health status requires a broader approach.”

Transforming Patient Care

Patient care will also undergo transformation and redesign. As noted in a recent paper, academic health centers “need to transcend traditional academic and geographic borders and engage in global public-private partnerships, not only to fill gaps in research domains, but also to build the final essential component of the discovery-care continuum.”¹⁰ The authors envision the evolution of the academic health center into a full-fledged academic health system.

Challenging Leadership to be Visionary

Given the recalibration of teaching, research, and patient care, there is the additional — and perhaps pivotal — administrative challenge of overseeing the overarching alignment of these efforts, for without alignment much of the synergy is lost.¹¹ This effort is ultimately a test of leadership, for the challenge is not easy. There are numerous difficulties and barriers at virtually every level, including leadership, faculty, staff, governance, economics, and political considerations. As one academic health center leader has pointed out, academic health centers are finely tuned to the current environment and therefore not easily changeable. They depend on growth in specific areas to sustain their momentum and allow the needed subsidization of various core aspects of the enterprise. The model that has been embraced to date is so highly leveraged with specific funding streams — streams that are likely to diminish in purchasing power — that its sustainability is in question. It is likely that this delicate ecology will be upset in the future, and strong, visionary leadership will be necessary to move the enterprise ahead successfully.

SUSTAINING THE VALUE PROPOSITION GLOBALLY

As academic health centers adapt and change to the new environment, it is critical that they look outward as well, for the global health environment is increasingly interconnected as diseases, patients, students, and professionals cross international

“...academic health centers are finely tuned to the current environment and therefore not easily changeable.”

borders with greater ease and frequency.

The Association of Academic Health Centers International™ (AAHCI) was established to facilitate academic health centers to become agents of change embodying the ideals of enhancing health and well-being worldwide, through the promotion of best practices and international networking and collaboration.¹²

The AAHCI serves to mobilize and speak on behalf of the collective strengths and resources of academic health centers, to ensure that these institutions have a voice in international matters affecting health, research, and the economy. As an organized group, academic health centers can address pressing needs in public health, patient care, health professions education, and biomedical and clinical research. In addition, AAHCI can work with institutions to develop the organizational and management expertise that captures the power of the combined functions of the academic health center. It can also provide support to leaders needing to demonstrate the value proposition in their own regions.

Building upon the success and momentum generated from meetings in Asia and Europe, as well as from the International Forums held in Washington, AAHCI recently convened an *International Working Group* to address the successful development and sustainability of the academic health center. Participants representing Europe, Asia, Latin America, North America, and Australia discussed the primary issues facing their institutions and common challenges facing academic health centers worldwide. The group suggested some major thematic areas to pursue:

- **Enhancing Strategic Planning and Governance Models**

This stems from the recognition that each academic health center faces unique circumstances, including political and economic contexts. The group stressed the importance of studying organizational,

management, and leadership strategies to create a profile of models and develop guidelines that can be tailored to individual academic health center needs;

- **Adapting to the Changing Research Environment**
As international research and business opportunities continue to expand, academic health centers and AAHCI should look for new ways to reduce and/or eliminate barriers to international collaboration and to facilitate cooperation through international networks;
- **Communicating the Academic Health Center Value Proposition**
Given the continuously changing political environments, academic health centers must remain diligent in communicating their value message, so governments and stakeholders understand and appreciate their educational, economic, and healthcare value;
- **Addressing Population Health**
As leaders in healthcare, academic health centers can set the standard for the provision of care. Their efforts directly enhance the health and well-being of their communities, while also playing an important role in the improvement of population health and health systems; and,
- **Evaluating the Healthcare Workforce**
The unpredictability of healthcare, including new diseases, changing models of care, and shifting demographics within the workforce, make it challenging to evaluate and predict future workforce demands. Academic health centers and the AAHCI are well positioned to evaluate and provide guidelines on health workforce planning.

“...the value proposition can be clearly demonstrated.”

CONCLUSION

Despite significant economic, cultural, and historical differences, the international academic health community has much in common. By working collaboratively, they can make a difference in striving toward the common goal of improving health and well-being around the world for the 21st century.

As academic health centers begin the careful *recalibration* of the enterprise, there are three guiding principles to follow:

- Alignment of the functions of teaching, research, and patient care, so that they work synergistically with each other;
- Tangible commitment to a partnership with the communities they serve that demonstrably improves health and well-being for both individuals and populations; and,
- Collaborative engagement with other academic health centers on a national and international scale to create an open framework for mutual improvement and problem-solving.

By realigning the academic health center enterprise around these principles, the value proposition can be clearly demonstrated. With strong leadership, the academic health center community can work together in *Advancing and Applying Knowledge to Improve Health™*.

Adapted from the presidential address at the 2010 AAHC International Forum.

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Association of Academic Health Centers[®]
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VISION

To advance health and well-being through the vigorous leadership of academic health centers.

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To mobilize and enhance the strengths and resources of the academic health center enterprise in health professions education, patient care, and research.

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14

PUBLIC EXCLUSION

AUCKLAND DISTRICT HEALTH BOARD**RESOLUTION TO EXCLUDE THE PUBLIC
FROM A MEETING OF THE BOARD****Clauses 32 and 33, Schedule 3,
New Zealand Public Health and Disability Act 2000 (“Act”)**

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 14

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:
14.1 Confidential Board Minutes 6 July 2011 14.2 Human Resources 14.3 Criteria Leased ADHB Premises 14.4 Ministerial Consent to NRSSO	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.