



# **Auckland District Health Board**

## **Board Meeting**

**Wednesday 6 April 2011**

**2:00pm**

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

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



1

***1***

**KARAKIA**



## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

## **Creator and Spirit of life.**

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.



**ATTENDANCE AND APOLOGIES**



**Auckland District Health Board  
Board Member Attendance Schedule 2011**

NAME	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV
Dr Lester Levy (Chair)		✓	✓								
Jo Agnew		✓	✓								
Peter Aitken		✓	✓								
Judith Bassett		✓	✓								
Susan Buckland		✓	✓								
Chris Chambers		✓	✓								
Rob Cooper		x	x								
Lee Mathias (Deputy Chair)		✓	✓								
Robyn Northey		✓	✓								
Gwen Tepania-Palmer		✓	✓								
Ian Ward		✓	✓								

*\* attended part of the meeting only*



**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](http://www.legislation.govt.nz)) and “Managing Conflicts of Interest – Guidance for Public Entities” ([www.oag.govt.nz](http://www.oag.govt.nz)).



## ADHB BOARD INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Susan BUCKLAND</b>	<ol style="list-style-type: none"> <li>1. Writing, editing and public relations services</li> <li>2. Medical Council of NZ</li> <li>3. Occupational Therapy Board</li> </ol>	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
<b>Dr Chris CHAMBERS</b>	<ol style="list-style-type: none"> <li>1. Employee, Auckland District Health Board</li> <li>2. Wife employed by Starship Trauma Service</li> <li>3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School</li> <li>4. Associate, Epsom Anaesthetic Group</li> <li>5. Member, ASMS</li> <li>6. Shareholder, Ormiston Surgical</li> <li>7. Surveyor Quality Healthcare NZ</li> </ol>				12 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Rob COOPER</b>	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	2. James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	3. Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	4. National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	5. Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Lee MATHIAS</b>	1. Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	1 February 2011
	2. Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	3. Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	4. Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products	
	5. John Seabrook Holdings Limited	Director	No fee	Estate of late husband	
	6. AuPairlink Limited	Governance Advisor	Fee	Provider of early childhood education services contracted to the MoE.	
	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
<b>Robyn NORTHEY</b>	1. Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	2. Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
	3. Northern Region Ethics Committee	Member			

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Gwen TEPANIA-PALMER</b>	1. Waitemata District Health Board 2. Manaia PHO 3. Ngati Hine Health Trust 4. Awanmarangi Waonangi 5. Te TAitokerau Whanau Ora	Board member  Board member Chair Committee member  Committee member	Fee  Fee paid to NHHT Fee		2 February 2011
<b>Ian WARD</b>	1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C -4 Consulting Limited		Fee	Tender to National Shared Services	3 February 2010



**CONFIRMATION OF MINUTES**  
**- WEDNESDAY 2 MARCH 2011**



# Auckland District Health Board Minutes



<b>MEETING DETAILS</b>											
Time and Date	2:00 pm, Wednesday, 2 March 2011										
Venue	Sorrento in the Park, One Tree Hill Domain, Epsom, Auckland										
<b>1</b>	<b>KARAKIA</b>										
	Naida Glavish led the meeting with the Karakia. The Chair acknowledged the support being given to the people of Christchurch by ADHB and individuals. Individual acknowledgements of those staff that had gone to Christchurch to assist would be made on behalf the Board. There would also be a special edition of NOVA.										
<b>2</b>	<b>ATTENDANCE AND APOLOGIES</b>										
	<p><b>Board Members</b></p> <table> <tr> <td>Dr Lester Levy (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith – Chief Executive  Dr Denis Jury – Chief Planning &amp; Funding Officer  Dr Margaret Wilsher – Chief Medical Officer  Brent Wiseman - Chief Financial Officer  Greg Balla – Director Performance &amp; Innovation  Taima Campbell – Executive Director Nursing  Naida Glavish – Chief Advisor Tikanga, GM Maori Health  Aroha Haggie – Maori Health Gains Manager  Janice Mueller – Director Allied Health  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>An apology had been received from Rob Cooper.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Chris Chambers	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lester Levy (Chair)	Jo Agnew										
Peter Aitken	Judith Bassett										
Susan Buckland	Dr Chris Chambers										
Dr Lee Mathias	Robyn Northey										
Gwen Tepania-Palmer	Ian Ward										
<b>3</b>	<b>CONFLICTS OF INTEREST</b>										
	Ian Ward advised his interest in the energy sector concerning item 10.1 Electricity Tender. There were no other declarations of interest for any other item on the agenda.										
<b>4</b>	<b>CONFIRMATION OF MINUTES 2 FEBRUARY 2011</b>										
	<p><u>Moved Gwen Tepania-Palmer; seconded Chris Chambers</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 2 February 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

<b>5</b>	<b>ACTION POINTS 2 FEBRUARY 2011</b>
	The DHB performance dashboard had been distributed.
<b>6</b>	<b>CHAIRMAN'S REPORT</b>
	The Chair emphasised the importance of the health targets.
<b>7.1</b>	<b>Chief Executive's Summary</b>
	<p>The regional shared services commenced on 1 March as healthAlliance NZ Limited with a new CEO who was presently meeting staff. Formal transfers of shareholdings and assets would be undertaken on 1 July 2011.</p> <p>There was to be a meeting of DHB chairs on Monday, 8<sup>th</sup> March 2011 with a recommendation that DHBNZ be liquidated by 30 June 2011. The Chair was unable to attend due to University teaching commitments and Dr Lee Mathias would attend on his behalf with ADHB's Waitemata's proxy vote for the liquidation which was supported by the Board. Three DHBNZ functions would be retained by DHBs collectively, being national services contracts, employment relations and a small secretariat to support collaboration and Chair/CEO meetings. These would be run by the central shared services agency.</p> <p>Diabetes services were at risk and the service improvement approach was being used, first to stabilise the service and then to implement improvements through the longer term. However, initial rapid improvement processes were required through several short term actions.</p>
<b>7.2</b>	<b>Whanau Ora Framework</b>
	<p>Measures were being developed and would be completed by 30 June 2011 and will be updated to the Board. There will be a section on Whanau Ora in the Board agenda on a monthly basis. .</p> <p>The Tamaki Makarau leadership group would oversee the six providers with the philosophy to make integration work. Whanau Ora is in the establishment stage at present and there would be research and evaluation of the whanau driven initiative.</p>
<b>7.3</b>	<b>Better Sooner More Convenient</b>
	<p>This would also be a regular item in the Board papers but would be discussed more fully in CPHAC. The pharmaceutical costs were incorrect as they had not taken into account the Pharmac rebates and are expected to recover costs. A number of projects would require RFP processes which raised questions of probity and conflicts of interest.(with probity paramount). The DAP deliverables were critical.</p> <p>POAC had been going for 10 years and was funded at \$2m across the region and it was planned to move to a single provider. The delays in the Maori service development were due to difficulties in unpicking funding lines. PHOs did not think that after hours were part of their responsibility.</p>
<b>7.4</b>	<b>Regional Services Planning Progress Summary</b>
	The full plan would be presented to the Board in April 2011 for review. It was focused on what DHBs controlled and was aligned to the national plan based on reducing disparities and achieving financial breakeven. It was suggested that there would be only one Maori Health Plan between Waitemata and Auckland DHBs.

<b>7.5</b>	<b>Northern Regional Shared Services Summary</b>
	While the target was to have the Northern Regional Shared Services operational by 1 March 2011 the shareholders agreement and constitution needed the Minister's approval as did delegated authorities, so on legal advice from Simpson Grierson, who provided an independent review, the transfer of assets would occur on 1 July 2011. There would be an independent Chair and directors appointed by each DHB and Health Benefits Limited.. The work of Brent Wiseman and Vivienne Rawlings on behalf of the organisation was acknowledged in delivering a vision but protecting the interests of staff.
<b>7.6</b>	<b>Minister's Six Health Priorities 2010/2011</b>
	The KPIs and targets had been discussed at both the Hospital Advisory Committee and the Community and Public Health Advisory Committee, but the Board requested that they remain as an item on the Board agenda. Cardiac bypass surgery was experiencing reduced demand, partially attributed to the use of aspirin and Lipex in the population. Access rates for Maori and Pacific are appropriate as they have a different type of disease which may not be suitable for surgery i.e., as a result of diabetes. It was expected in the future that there would be lower intervention rates.
<b>7.7</b>	<b>Election 2010 Report</b>
	This was the formal report by the Electoral Officer on the election and it was noted that the STV and First Pass Post voting systems created confusion.
<b>8.1</b>	<b>Committee Recommendations</b>
	<p>The recommendation was from the Disability Support Advisory Committee.</p> <p><u>Moved Jo Agnew; seconded Robyn Northey</u></p> <p><i>That the ADHB adopts the Accessibility Report in principle with a request to Management to develop an implementation plan.</i></p> <p><u>Carried</u></p>
<b>9.1</b>	<b>DAP Projects Report</b>
	The Tamaki P2HC project was being translated into an ADHB own workforce project to lift the percentage of the workforce to more closely reflect our population. While there is processes to prioritise Maori and Pacific normal employment criteria by hiring managers applied although affirmative action was the philosophy.
<b>10.1</b>	<b>Finance Committee Recommendations</b>
	<p>Ian Ward's conflict of interest in the energy sector was declared. Electricity costs were increasing by 20% and there was a 15% risk factor using the spot market.</p> <p><u>Moved Gwen Tepania-Palmer; seconded Chris Chambers</u></p> <ol style="list-style-type: none"> <li>1. <i>That ADHB enter an Electricity Supply Agreement with Meridian Energy for the Auckland City Hospital, Greenlane Clinical Centre and the Point Chevalier sites for two years from April 1st 2011. The estimated value of the contract is approximately \$1.9million p.a. The contract will also have the effect of setting the price for electricity purchased from Energy for Industry who operate the cogeneration facility at Auckland City Hospital. The estimated cost of this electricity will now be approximately \$3.0million pa.</i></li> <li>2. <i>That the CEO be delegated authority to execute the contract once the final terms and conditions have been reviewed by the ADHB legal team.</i></li> </ol> <p><u>Carried</u></p> <p>Ian Ward did not participate in the discussion and abstained.</p>

<b>10.2</b>	<b>Finance Report</b>						
	The Finance Committee had reviewed the financial reports thoroughly and had been assured by Management of a breakeven for year end. For the DHB sector as a whole it was \$71.7m ahead of plan with only four under budget and a roughly half in surplus.						
<b>11</b>	<b>GENERAL BUSINESS</b>						
	There were no items of general business.						
<b>12</b>	<b>PUBLIC EXCLUSION</b>						
	<p><u>Moved Gwen Tepania-Palmer; seconded Robyn Northey</u></p> <p>That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 12.</p> <p>The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:</p> <table border="0" data-bbox="193 779 1497 1122"> <thead> <tr> <th data-bbox="193 779 587 869">General subject of each matter to be considered:</th> <th data-bbox="592 779 986 869">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="991 779 1497 869">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="193 920 587 1077">           12.1 Confidential Board Minutes 2 February 2011            12.2 Supporting Primary Care Across ADHB and WDHB            12.3 Budget 2011 - 2012         </td> <td data-bbox="592 920 986 1077">           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="991 920 1497 1077">           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> <p><u>Carried</u></p> <p>The items discussed in public exclusion were the Confidential Minutes 2 February 2011, Supporting Primary Care across ADHB and WDHB and the Budget 2011/2012.</p> <p><u>Moved Chris Chambers, seconded Susan Buckland</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>	General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:	12.1 Confidential Board Minutes 2 February 2011 12.2 Supporting Primary Care Across ADHB and WDHB 12.3 Budget 2011 - 2012	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.
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 2 February 2011 12.2 Supporting Primary Care Across ADHB and WDHB 12.3 Budget 2011 - 2012	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.					
	<b>NEXT MEETING</b>						
	<p>The meeting closed at 4:17 pm</p> <p>The next scheduled meeting is : 2:00pm, Wednesday 6 April 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>						
<p><b>CONFIRMED</b></p> <p><b>CHAIR: DATE:</b></p>							

**ACTION POINTS**

- **WEDNESDAY 2 MARCH 2011**



Action Points from the meeting on Wednesday 2 March 2011

Item	Detail	Designated	Action
	Budget 2011 – 2012 risks, with risk assessment, and challenges to be advised together with the detailed saving plan for the Board to monitor	Brent Wiseman	Item 12 Public Exclusion



**CHAIRMAN'S REPORT**



## **CHIEF EXECUTIVE'S REPORT**

- 7.1 Chief Executive Summary**
- 7.2 Better Sooner More Convenient**
- 7.3 Regional Service Planning Progress Summary**
- 7.4 Minister's Six Health Priorities 2009/10**



**7.1 Chief Executive's Summary**

---



## Chief Executive Officer's Summary

	Traffic Light	Comment	Mitigation
<b>Goal 1 Lift the Health of the People of Auckland</b>			
Annual Plan	Green	Plan delivered to National Health Board on time.	Ongoing formatting and enhancement, tightening.
National Hauora Coalition (National Maori PHO Coalition)	Green	Meeting to establish this key relationship and PHO development.	Continue resource allocated for development and inter-relationship with Ngati Whatua, Whanau Ora and our locality approach.
Primary Care Planning – Waitemata and Auckland DHBs	Green	Implementation of new way of working under way.	Innovative improvements.
<b>Goal 2 Improve Performance</b>			
Step change noted in ED 6 hour target.	Green	Much improved results since mid February 2011.	Daily monitoring.
Elective Surgery	Orange	Good months result and innovative service responses.	Daily monitoring.
Continuous Power Supply	Green	Regular testing exposed switching problem.	Increase frequency of full switch-over testing.
<b>Goal 3 Live Within Our Means</b>			
Regional Shared Services	Green	Staff successfully transferred 1 March 2011. CEO interviewing for Level 2 roles.	Regular reporting.
Forecast 2010 / 11	Orange	YTD favourable but very close scrutiny required for balance of year.	Regular monitoring meetings. Management correction in labour and direct treatment costs.
Budget 2011 / 12	Orange	Pressure of Elective and Acute growth together with cost inflation to be managed.	Full cost saving and productivity improvement implementation plans in development so effective by 1 July 2011.



## **7.2 Better Sooner More Convenient**

---





## BRIEFING PAPER TO THE BOARD

**Date:** 6 April 2011

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

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

**Subject:** **Better Sooner More Convenient (BSMC)**

---

### Primary Care

#### **Regional Progress to Date**

The Metro Auckland DHBs collectively continue to make progress with implementation of the regional components of Government's Better Sooner More Convenient Primary Health Care (BSMC). Discussions on locality service planning and delivery frameworks and how these fit within a regional approach are being progressed within DHBs and escalated through primary care business cases and GAIHN activity.

- **Contracting Framework**

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

- **Business Cases**

Active involvement continues to support the three Business Cases in development and rollout of their respective Implementation Plans. GAIHN ALT continues to develop, taking accountability for a range of projects and outcomes. A GAIHN ALT retreat was held on for 31 March & 1 April.

- **Progress with PHO Consolidation**

The National Maori Coalition is working through a process to become a single national PHO. DHBs are supporting this development and have agreed that CMDHB will be the host DHB of the new entity. It is likely that the metro-Auckland DHB collaborative arrangements will be utilised.

- **Progress with the ADHB Primary Care Plan**

ADHB continues to work with its four PHOs in developing a District Alliance.

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

#### ***Access to Diagnostics-Radiology***

By 20 March, 110 general practices across ADHB and 3 in CMDHB (who are trialling the ADHB version) have the ProExtra Radiology tool installed.

The current focus across ADHB is encouraging GPs to use ProExtra Radiology; of those not using it the rate of inappropriate referrals to ADHB Radiology is around 35% of total GP referrals, which is creating waste in the system and causing patients to experience unnecessary waiting times. Two of the ADHB GP Liaisons are manually triaging all GP

referrals on 'old forms' and sending a rejection letter to the respective referring GPs. This peer review process is resulting in GPs increased use of ProExtra Radiology.

During early March 2011 Waitemata DHB confirmed it will not rollout the ProExtra Radiology interim solution across its practices, instead it will wait for the long-term solution. However, WDHB Radiology have been manually triaging all GP referrals against the Clinical Triage Criteria for several months, and contacting GPs to discuss inappropriate referrals; they anecdotally report a progressively decreasing volume of inappropriate GP referrals.

CMDHB has elected to rollout ProExtra across 100 of its practices and during March 2011 ProCare have been customising ProExtra Radiology to achieve this.

### ***Minor Surgery - Skin Lesions***

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

### ***Regional Clinical Pathways***

The Dyspepsia and Iron Deficiency Anaemia (IDA) pathways have been signed off and are now being utilised. The pathways are accessible to primary and secondary care via Health Point. Progress is being made on other clinical pathways and the Annual Plan target of having five pathways fully developed and implementable by the end of June is on track to be achieved.

A request-for-proposals process is underway to establish/develop an electronic platform for this work.

### ***Acute Demand / POAC***

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

### ***After Hours***

The issues relating to this project have been previously reported, and are being actively managed. A consultation document on the provision of an Auckland Regional After-Hours Network has been prepared and is currently out with interested parties. Feedback is due 12 April 2011.

### ***Pharmaceuticals CMDHB & ADHB Project***

Although delayed there is confidence that the establishment costs will be recovered (\$600k) and further analysis is being undertaken to determine the return above this. There has been a shift in the focus of this project from financial returns to making changes and improvements in pharmaceutical utilisation.

### ***Maori Service Development***

As previously reported these projects have progressed more slowly than anticipated and did not meet the original target of 31 December 2011. Metro-Auckland DHBs are meeting regularly to manage the slippage issues and get the project back on track and completion by the financial year end.

Initiative		Regional Volumes		Target to end June 2011
		Month (February )	YTD	
<b>Acute Demand / POAC (Cases)</b>		1,322	10,541	15,000
<b>Access to Diagnostics / Radiology</b>	<b>DAP Target 1</b> <i>Measures elective plain x-ray and ultrasound referrals by GPs for diagnostic radiology to Non DHB Providers (N.B. GP's cannot refer CT Scans and MRI to Private Radiology Providers)</i>	61	1,139	4,500 With CMDHB rollout commencing from March 2011, and acceptance by Ministry of Health that WDHB manual triage of all GP radiology referrals can be included, has enabled regional volumes to be added to the previous ADHB only volumes
	<b>DAP Target 2</b> <i>Measures elective referrals by GPs to DHB Radiology Services for diagnostic radiology</i>	474 (referred via Clinical Triage Criteria) 1,284 (referred via "old" forms)	14,585	16,000+ With CMDHB rollout commencing from March 2011, and acceptance by Ministry of Health that WDHB manual triage of all GP radiology referrals can be included, has enabled regional volumes to be added to the previous ADHB only volumes
<b>Skin Lesions</b> <i>(Community based procedures)</i>		65	374	1,200
<b>National Targets</b>				
•Immunisation		•87%		•90%
•Diabetes Detection		•56%		•55%
•Diabetes Management		•65%		•70%
•CVD Risk Assessment		•80%		•80%



## **7.3 Regional Service Planning Progress Summary**

---





## BRIEFING PAPER TO THE BOARD

**Date:** 6 April 2011

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

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

**Subject:** **Regional Service Planning Progress Summary**

---

Accompanying the Auckland DHB Board agenda is a copy of the Northern Region's Health Plan.

The project team and Northern Region Health Plan Steering Group have benefited significantly from the active participation and leadership of Margaret Wilsher as Regional Clinical Sponsor of the Plan along with other key members of the executive and clinical teams of Auckland DHB along with their regional colleagues.

Further feedback is welcome from the Auckland DHB Board up until Friday 8 April 2011.

Three big dot interventions with campaign approach were chosen after a multidisciplinary, whole system workshop and are; 'first do no harm', 'life and years', and 'the informed patient'. Within the 'life and years' big dot there are three major programmes of work; diabetes, cardiovascular disease, and health of older people. There are also pieces of work on child health, radiology (forming a clinical network), elective surgery and emergency care. Cancer is already established with a network and will be developed further with a clinical network to guide the implementation of agreed regional strategies.

The plan incorporates activity from the region's primary care business cases (GHAIN, Alliance Health and Maori coalition) and has been clinically led with participation from hospital and community clinicians across the region. All four DAPs incorporate the plan's key objectives and those of the business cases. It is shaped so that deliverables for the first year are clearly articulated, with deliverables for the outer years (2-5 and >5) indicated.

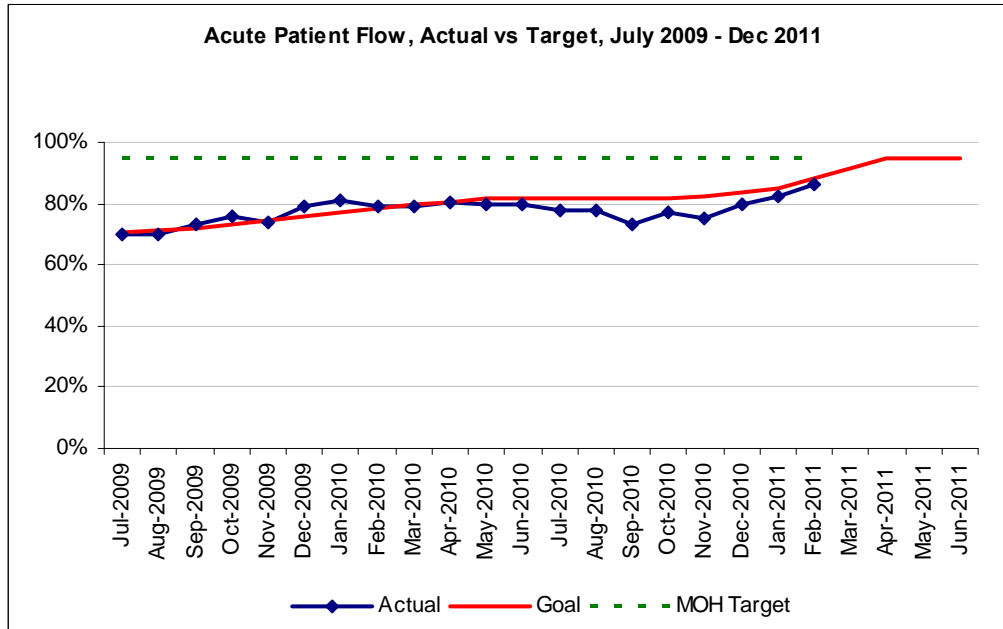


**7.4 Minister's Six Health Priorities 2010/11**

---



**Project:**  
 Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours  
 Date of Delivery: 30 June 2011



**Project Risks / Comments:**

Performance to achieve Shorter Stays in ED for both Adults and Children’s services continues to demonstrate improvement . Overall performance for month of February was 86%. This has further improved in March ( 1 March to 25 March) to 94.2% of patients admitted, discharged or transferred within 6 hours.

## Project: Adult Acute Patient Flow

50

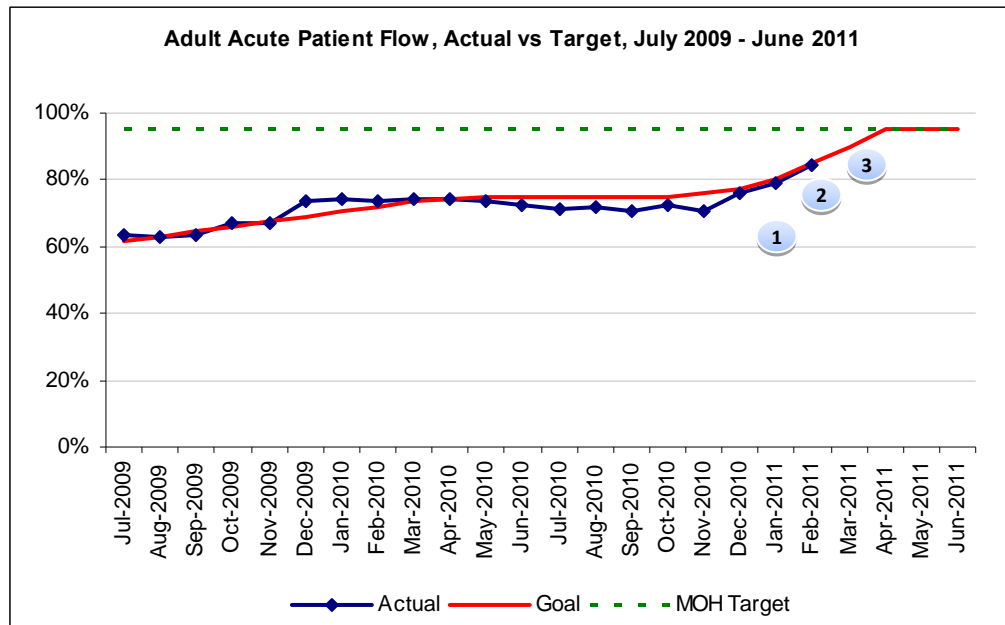
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



### Project Risks / Comments:

Significant improvement noted in February with 84% of patient discharged or transferred from ED within 6 hours.

Achieved 96% of patients discharged or transferred from ED within 6 hours on February 16<sup>th</sup>.

Detailed action plan being implemented.

A 5-day Rapid Improvement event is planned for April to identify and implement further solutions from decision to admit to leaving ED. Further work is also underway on weekend resourcing to meet variable demand.

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

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

Further performance improvement is noted from 1 March to 25<sup>th</sup> March with 94.7% of patients admitted, discharged or transferred within 6 hours.

### Improvements to date:

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

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

Charge nurse patient flow coordinator introduced

Improved access to Radiology

Streamlined documentation required for safe transfer

Improved triage processes.

### Managing bed block with additional resources

58 Additional beds opened 2009-2010

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

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

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

Nurse Facilitated Discharging in General Medicine (April 2010)

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

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

### Immediate actions to improve performance:

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

## Project: Children's Acute Patient Flow

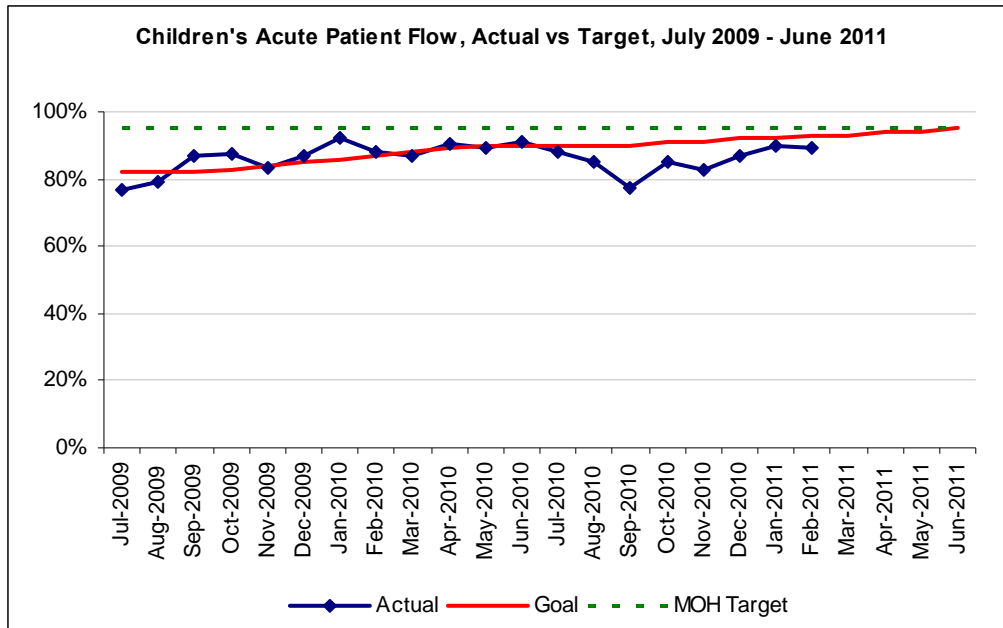
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



### Project Risks / Comments:

*Starship's performance remained below the expected goal for February. In part this was due to higher than forecast acute presentation. To address this aspect additional beds were opened mid week and extended to 24/7. This did assist with inpatient transfers. The Medical Director, Acting GM Starship and GM Operations & Clinical Support service instigated think tank workshop with combined with the Adult services to cross pollinate the number of solutions that could be adapted to Starship acute flow. The Process Improvement projects have been identified into three areas of focus; capacity, process improvement and models of practice. A number of initiatives that were quick to implement have begun which includes launch of the bed board and visibility or patient movements through Chips have begun.*

### Improvements to date:

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

### Immediate Actions to Lift Performance

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

### Longer term projects

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

## Project: Improved access to elective surgery

52

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

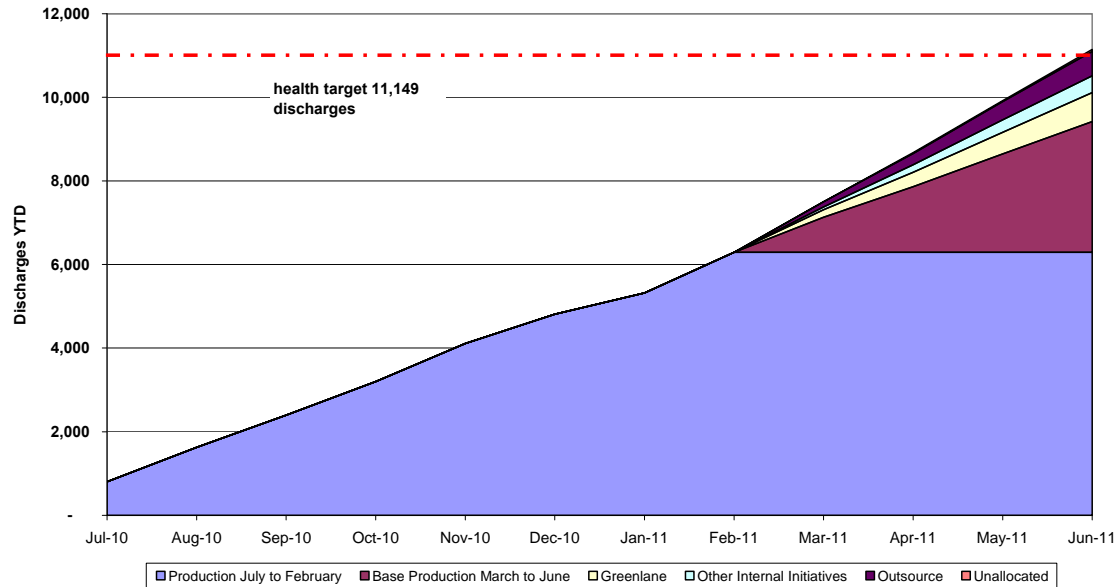
Date of Delivery: 30 June 2011

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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

### Contributors to Elective Health Target



#### Planned activities:

1. Operationalising 2 new OR at Greenlane Surgical Centre during March and April. Additional 777 discharges
2. Other internal includes weekend ophthalmology lists at GSU in March and longer days at ACH & GSU, additional 305 discharges.
3. Outsourcing across a range of specialties, Additional 550 discharges
4. As services confirm the production options we will allocate the 100 - 200 unallocated discharges to services.
5. We are also reviewing some data issues e.g.  
review of patient discharge data for electives coded as acutes & surgical discharges allocated to a medical specialty and not counted as an elective discharge,

#### Risks / Comments: (Amber)

The risk for ESPI 2 (FSAs) and ESPI 5 (surgery) has been mitigated. Weekly meetings between the Director of Elective Services and service managers are focussing on ESPI compliance and elective production. Actions have included prioritisation in existing clinics, extended clinic hrs during march, confirming requirements with patients and GP's.

The ADHB elective production plan is monitored on a daily basis. The cumulative year to date position as at February met the replaced target submitted to the MoH 10 February 2011.

## Project: Shorter waits for Radiation Therapy

53

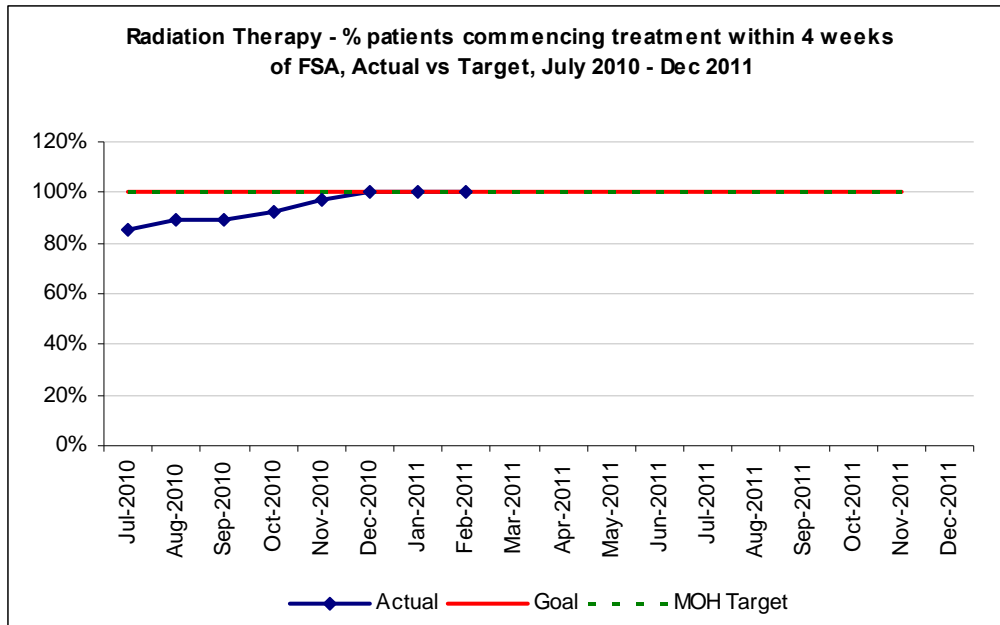
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

Date of Delivery: 31 December 2010 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



### Risks / Comments: *The service expects to be 100% compliant to the 4 week target for Quarter 3.*

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

- Linear Accelerator breakdown – the service experienced loss of capacity in January & February as a result of a series of Linear Accelerator breakdowns. Strategies to sustain delivery to the target are in place.
- Sustained demand – the service on average is receiving 5 more referrals pw as compared to the same period last year.
- The CT Simulator is down to 1.2 operable machines due to staff training requirements. This is being monitored daily to ensure any bottleneck is appropriately managed.
- RT staff vacancies and skill mix – ongoing issues supported by a recruitment strategy.
- Highly complex cases requiring specific SMO expertise.
- Introduction of new technology transiently reduces capacity

### Radiation Oncology Wait times – February 2011

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

#### Improvements to date:

- **MV5 Linear Accelerator** is now fully operational.
- **Extended hours:** Have been implemented for RT staff where this is an option within the terms of their contract.
- **A public/private Model of care** has been developed for our clinicians to treat public patients at ARO. Effective from March 2011.
- **Breast hypo-fractionation:** Emerging clinical evidence supports the use of reduced fractions in a higher % of breast patients. This has reduced treatment time and frees up capacity on the linear accelerators.
- **Aria project:** A project is underway to develop a full electronic record within the LINAC machine's operating system.
- **A weekly capacity modelling tool** has been developed and is now being used for future LINAC capacity planning, improved forecasting capability and management of workload.
- An **"Operational team"** has been established whose key accountability is to measure KPI's to prioritise the waitlist and analyse performance on a weekly basis.
- A **daily Waitlist report** has been developed to enable daily monitoring and immediate remedial action if required.
- **Flexible working hours** for Radiation Therapists were introduced in June 2010 and are ongoing.
- **A comprehensive and ongoing recruitment plan** to attract RT staff to the service.

## Project: Better help for smokers to quit

54

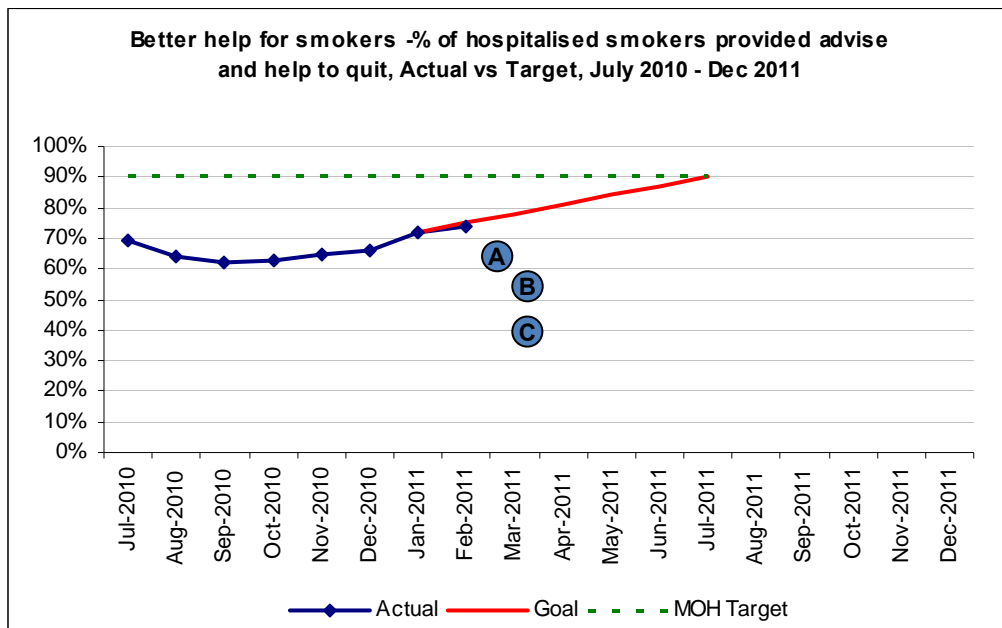
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

Steering Group: Membership - under review



### Project Risks and Comments

Of the 8556 events coded in February, 1127 (13.2%) of patients were identified as smokers and 831 (74%) of the smokers were documented as receiving advice or support to quit.

National Women's Health are working with the clinical coding team to enable them to more easily identify smokers and brief advice given. Daily audits and staff coaching commenced in the General Medical and General Surgical wards in late February to increase the target results. Additional Coaching and auditing is now focussed all underperforming wards. Clinical Directors have been sent Departmental results of the Better Help for Smokers to Quit and advised the results are to be sent out by clinician next month. An audit of the Electronic Discharge Summary (EDS) showed that only 10% of patients were identified as smokers in the EDS 3% lower than the ADHB patient average. The option - "This patient was not asked and/or smoking status was not documented" was selected in 28% of the EDS. Actions will be put in place to reduce this figure to under 10% which will result in a more accurate prevalence rate.

### Improvements to date:

- Direct follow up with wards/services underperforming in ward audits.
- ABC Training and coaching of staff in AED & APU.
- ABC chart reminders placed all in AED & APU folders
- Better Help for Smokers to Quit included in Releasing Time to Care KPIs.
- Recognition of wards/ services meeting target and sharing of learning
- New intake of House Officers on 28th February trained on documentation of ABC.

### Immediate Actions to improve performance:

#### A. Focus on short stay and high volume areas:

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

#### B. Improve engagement with clinical workforce:

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

#### C. Data collection systems and processes:

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

# Project: Cardiac Bypass Surgery

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

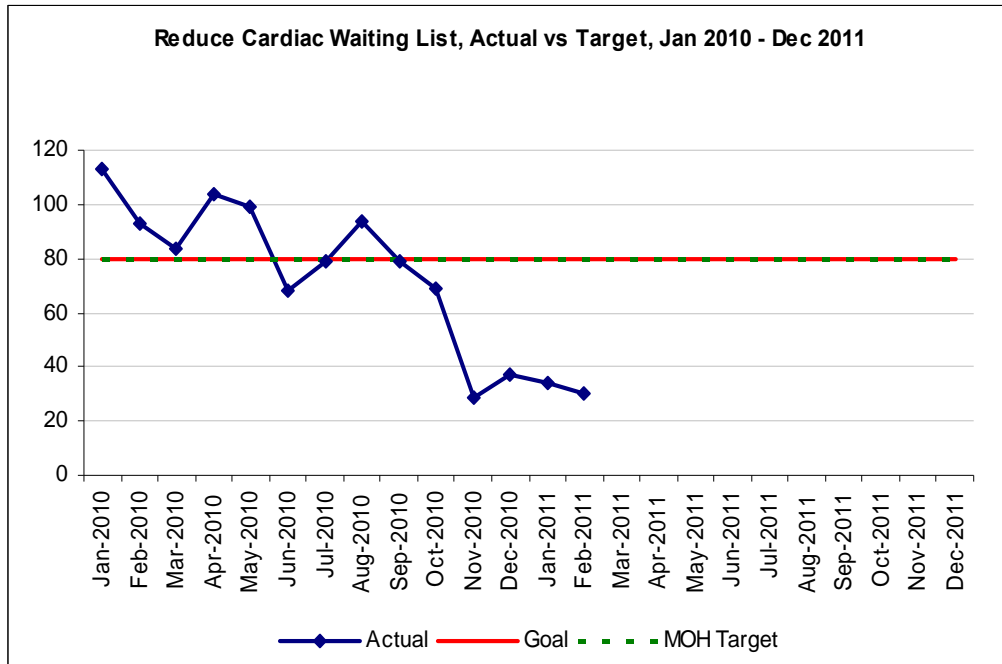
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2011

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Fionnagh Dougan

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



## Project Risks / Comments:

There are 32 patients on the waiting list as at the end of February 2011. YTD throughput is 23 patients less than planned as at end January 2011. Opportunities for additional capacity have been built into the production plan however catch up on the throughput target of 916 is constrained by a shortfall of additions to the waiting list. Work continues on improving the reliability and productivity of the service. The service is projected to complete 140 more bypass procedures (through the ACH facility) than last year (19% improvement)

## Completed Improvement Activities:

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

## Further improvements in progress:

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

## Project: Diabetes

56

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

Date of Delivery: 55% June 2011

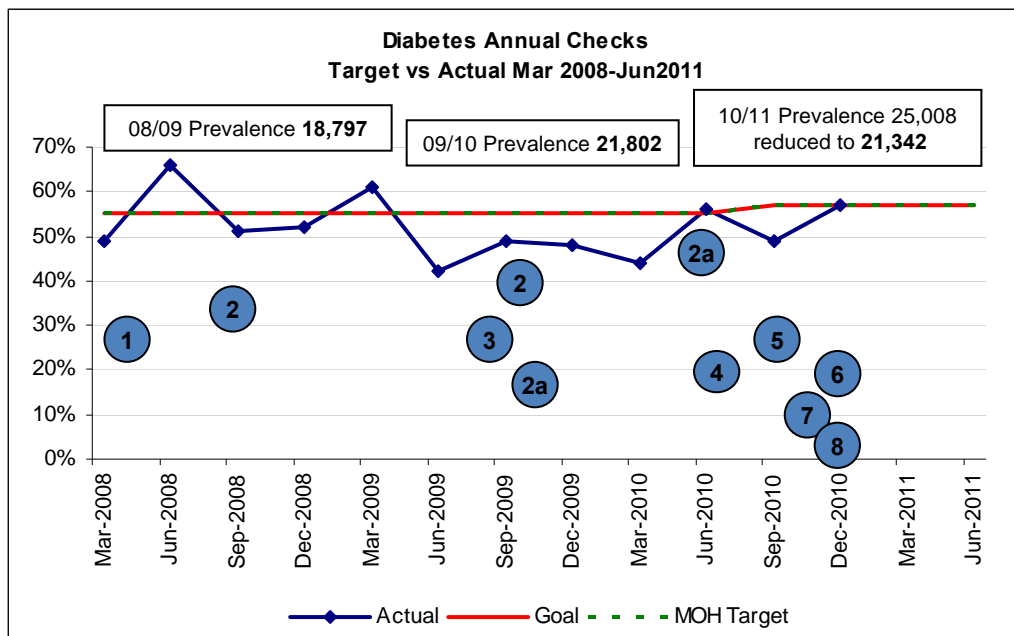
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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

### Recent and Current activities:

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



### Project Risks / Comments:

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

## Project: Diabetes

57

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%

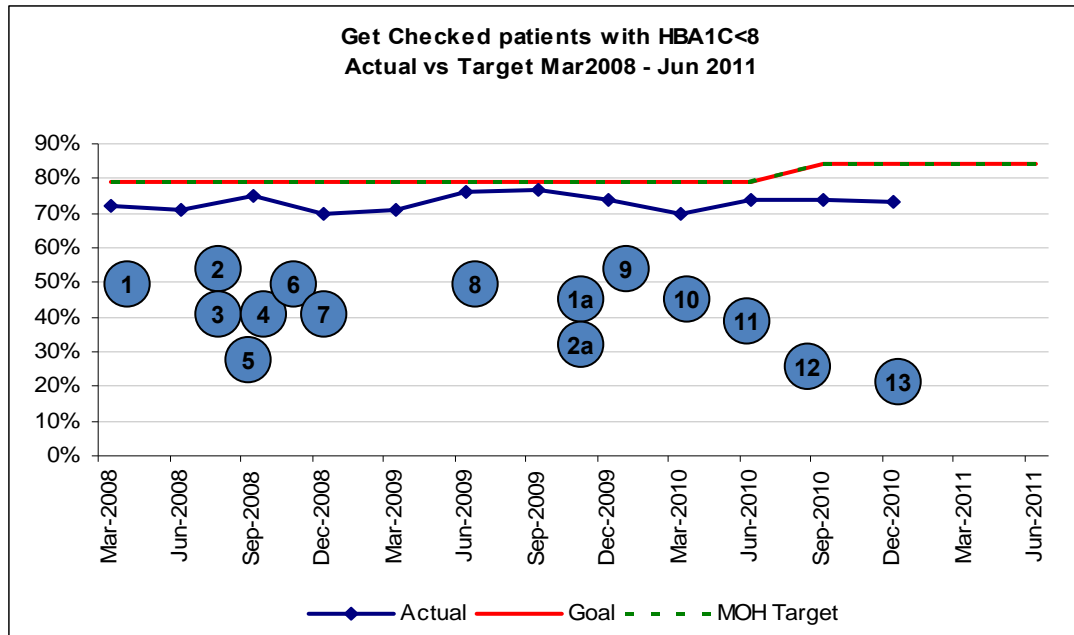
Clinical Lead: Gayl Humphrey

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:

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

## Project: Cardiovascular Risk Assessment

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

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

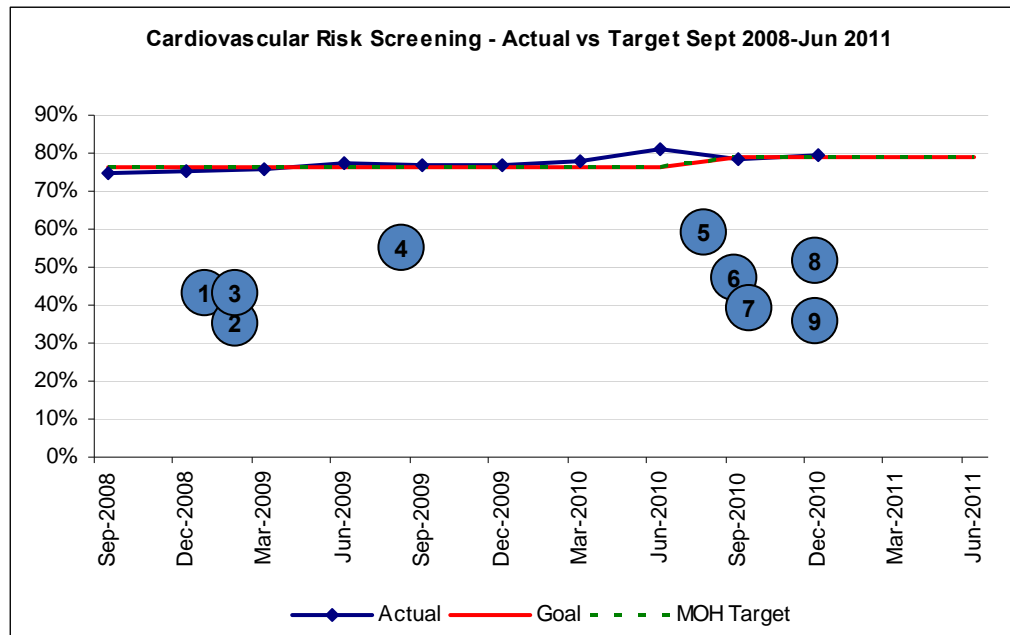
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team

### 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 Q2 CVD data from the MOH shows that we have now meet this target (79.4% against a target of 79%). Individual targets for each ethnicity have also been meet.

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: Increased Immunisation**

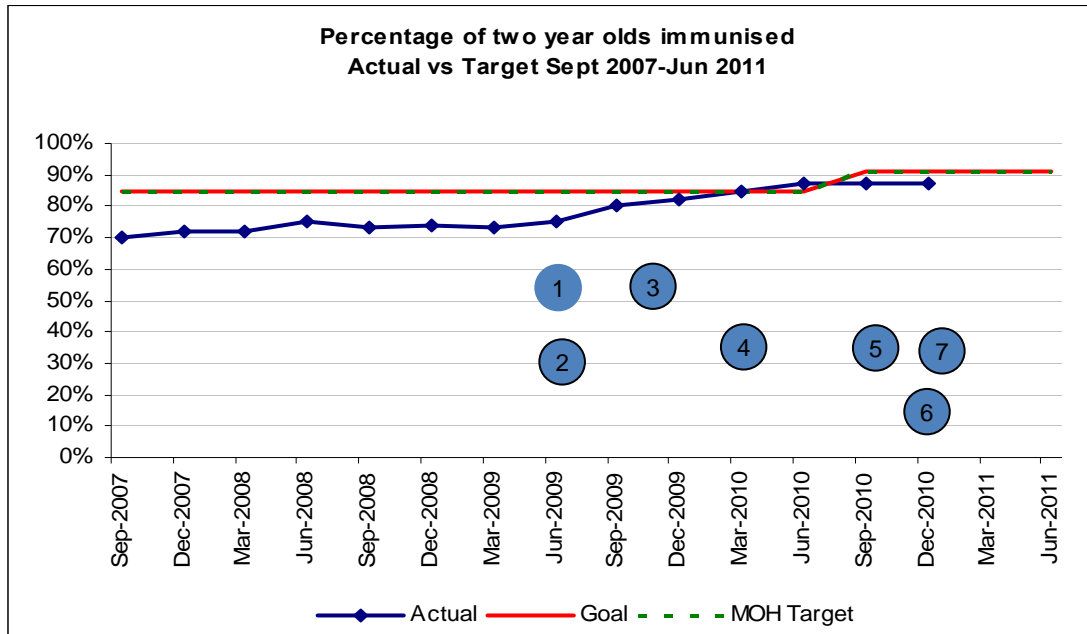
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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.

## Project Risks / Comments:

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



# **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**



# **PERFORMANCE IMPROVEMENT**

## **9.1 DAP Projects Report**



# Group Pack Report

Group/Committee: Board



## Goal Level Summary

DAP Projects - total projects: 107

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Define	Plan Measure	Analyse	Do/Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
1 Lift the Health of the people in Auckland City	40	40	11	9	3	13	3	0	34	4	1	38	0	1	37	1	1	1	1	0	0
2 Performance improvement	56	54	9	7	8	25	3	0	40	13	1	50	3	1	49	4	1	2	2	0	0
3 Live within our means	11	10	2	1	3	2	1	0	8	2	0	10	0	0	10	0	0	1	1	0	0
<b>Total #</b>	<b>107</b>	<b>104</b>	<b>22</b>	<b>17</b>	<b>14</b>	<b>40</b>	<b>7</b>	<b>0</b>	<b>82</b>	<b>19</b>	<b>2</b>	<b>98</b>	<b>3</b>	<b>2</b>	<b>96</b>	<b>5</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>97%</b>	<b>21%</b>	<b>16%</b>	<b>13%</b>	<b>37%</b>	<b>7%</b>	<b>0%</b>	<b>77%</b>	<b>18%</b>	<b>2%</b>	<b>92%</b>	<b>3%</b>	<b>2%</b>	<b>90%</b>	<b>5%</b>	<b>2%</b>	<b>4%</b>	<b>4%</b>	<b>0%</b>	<b>0%</b>

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

### Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	Committee
Develop Care Pathways for people with Long Term Conditions	National	Define	▲	●	●	Good to hear about other discussions on alternate mechanisms for improving information sharing and role integration . The regional clinical advisory teams will also add value to this work and many of the team are part of those groups which is laudable. It will be good to see some of the outputs from these groups soon.	CPHAC
Increase access and capacity to community diabetic eye screening	National	Analyse	▲	●	●	It is a concern that teh CAPEX sign off is yet to be approved. this will have implications on the timelines for the addition of the community provider. I note all strategies to complete this process are being done.	CPHAC
Māori Service Development	Regional	Define	▲	●	●	Merger activity to date has been complex and time consuming. Progress has been made although slow. A project framework is under consideration. Additional activity is planned to get the project back on track.	CPHAC
Palliative Care Redesign	ADHB	Analyse	▲	●	●	Delays - clarity around the way forward expected from steering group meeting scheduled for the end of March.	CPHAC

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

## Goal: 2 Performance improvement

### Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	Committee
Adult 6-hour project	National	Improve				Significant improvement noted in February with 84% of patient discharged or transferred from ED within 6 hours. Achieved 96% of patients discharged or transferred from ED within 6 hours on February 16th. Detailed action plan being implemented to accelerate improvement. A 5-day Rapid Improvement event is planned for April to identify and implement of solutions from decision to admit to leaving ED planned for 11th April. Daily results are now being posted in the Level 5 Admin area, with a similar display in place in AED. Daily review of patients who stay longer than six hours in AED in place. Further performance improvement is noted from 1 March to 25th March with 94.7% of patients admitted, discharged or transferred within 6 hours.	HAC
After Hours	Regional	Improve				Good sector engagement to date. A future state strawman has been developed and costing / pricing activity has been completed. An RFP process is currently under development.	CPHAC
Better help for smokers to quit	National	Improve				A range of improvement strategies are in the process of being implemented including Smokefree team members and additional staff being based in services with high volumes of patients to improve service performance. A new steering group has been established to support the implementation of the improvement plan. Confirmation of funding for Smokefree services for the 11/12 year has not been confirmed. Funding expires 30 June.	HAC
Skin Lesions	Regional	Improve				Project is now back on track. Contracting arrangements are currently being worked through.	CPHAC
Pharmaceuticals	Regional	Measure				Project is now underway although a little behind schedule. Original benefits identified may not be delivered although work is underway to forecast benefits likely for the end of the financial year.	CPHAC
Starship 6 hour project	National	Improve				Starship's admissions decreased in January as expected, however acute average monthly occupancy for was the highest January for 6 years – on average an extra 19 inpatients per day. This did impact on inpatient transfers, due to planned reduction in beds in the first 2-3 weeks in January, though no red alerts occurred. There are a number of Process Improvement projects focussed on improving access to inpatient beds underway which will continue to deliver improvements over the next months.	HAC
Tamaki P2HC project	Regional	Analyse				A workshop with Tamaki Transformation representatives, community representatives and other stakeholders was held in March to review the revised programme design. The reduced scale of the programme and revision of the offer to Tamaki residents was considered congruent with the original intent. Learnings from the experiences of the 9 early start participants has also been included in the redesign. A final proposal for funding is due to be tabled at the May Board mtg.	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:** Crown Health Financing Agency

---

**Recommendation**

*That the Auckland District Health Board agrees that the proposed repayment of \$10.5m to CHFA due in March 2011, as contained in the District Annual Plan 2010 – 2011, be suspended and that that amount be lodged in an amortisation fund.*

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Supply of Standard Catalogue Office Furniture

---

**Recommendation**

*That the ADHB approves Gregory Commercial Furniture NZ Ltd (GCF) as the preferred supplier for purchase of all standard catalogue office furniture.*

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.

**ADHB Board****Author: Ian Bell (8077)****Subject: Direct Negotiations Outsourced Surgical Procedures**

---

**Recommendation**

*That the ADHB grants a dispensation to enter into direct negotiation with MercyAscot, Southern Cross, Gillies Hospital, St Marks Hospital, Laparoscopy Auckland and Auckland City Surgical Services, for the provision of outsourced surgical procedures.*

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.

**ADHB Board****Author:** Ian Bell (8077)**Subject:** Auckland Region DHB Electronic Referrals - Phase 1

---

**Recommendation**

*That the ADHB endorses that the Auckland DHB, Counties Manukau DHB and Waitemata DHB Boards approve additional capital funding of \$165K to ensure full implementation of the Auckland Regional Electronic Referrals solution. This additional funding is required to cover a forecasted shortfall in the current capital budget of \$1,380K.*

*ADHB's share of the additional capital funding is \$55K and it is suggested that this is funded from the IMTS capital budget through substitution of capital funds assigned to projects that have been or will be delayed.*

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.

**ADHB Board****Author: Ian Bell (8077)****Subject: Duel Energy Linear Accelerator**

---

**Recommendation**

*That the ADHB approves the dispensation from RFP for the purchase of a linear accelerator from Varian Medical Systems. The estimated price is \$2.9m (dependent on US\$ exchange rate). \$463,000 is budgeted in 2010/11 for the deposit, with the remainder budgeted in 2011/12.*

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Lease 99 Grafton Road

---

**Recommendation**

*That the ADHB approves the Variation of Lease and Rent Review for the property at 99 Grafton Road, Grafton for an initial 6 year period with 2 Rights of Renewal of 3 years each and delegates authority to the Chief Executive Officer to execute the Deed.*

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.

**ADHB Board****Author:** Ian Bell (8077)**Subject:** Implementing a Metro Auckland Regional After-Hours Network

---

**Recommendation**

*That the Finance Committee recommends that the ADHB Board:*

1. **Approves** the issuing of an regional request for proposals (RFP) for the development of the Auckland Regional After-hours Network;
2. **Notes** that the overall objective of this RFP is to implement an affordable, sustainable, integrated After-hours network for the Auckland region that reflect locality needs;
3. **Notes** that Counties Manukau District Health Board will manage the RFP process on behalf of the Metro Auckland DHBs;
4. **Notes** Ministerial support for the RFP approach and timeframes committed to through our District Annual Plan;
5. **Approves** delegation of the final decision on the model to be funded to the Chair and Chief Executive Officer to enable timeframes to be met.

**Background**

This will be discussed by the Finance Committee at their meeting on 5 April 2011.



## 10.2 Finance Report

---

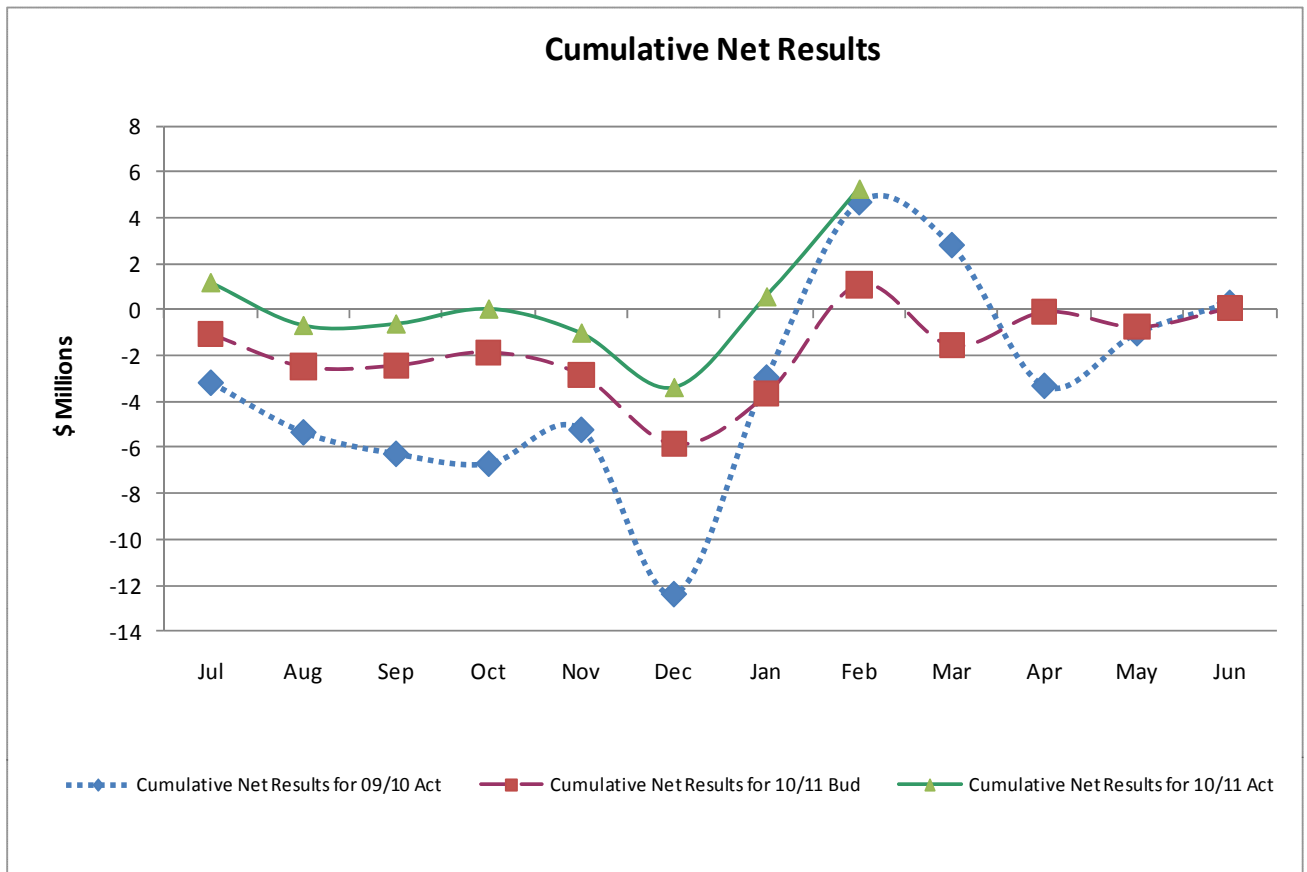
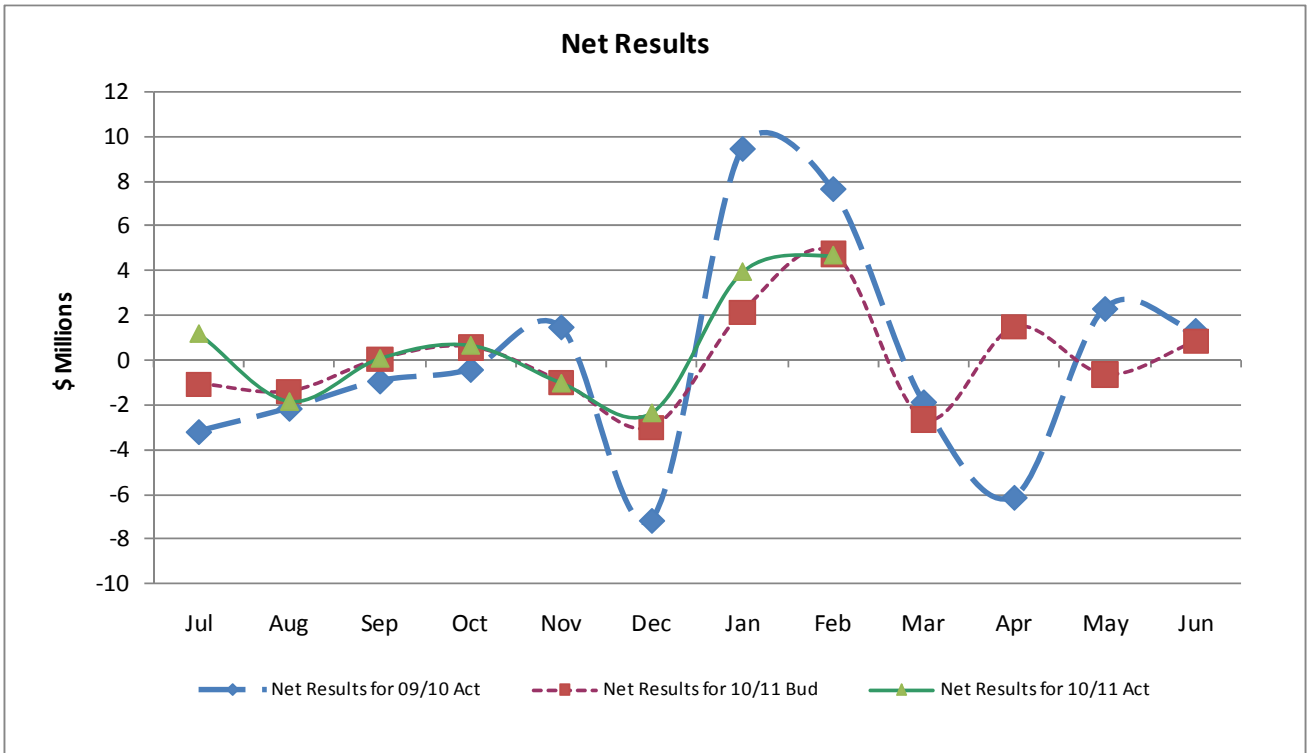


# Auckland District Health Board

## **Board Financial Report**

February 2011

Performance Graphs by Month & YTD



Auckland District Health Board  
Summary Result  
Month of Feb-11

\$000s	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
<b>Income</b>						
PBF - AKL Population	79,946	79,701	245 F	640,898	637,610	3,288 F
Inter District Inflows	54,071	47,891	6,180 F	400,870	383,125	17,745 F
	134,017	127,592	6,425 F	1,041,768	1,020,735	21,034 F
MOH Sub-contracts	8,808	7,242	1,566 F	57,525	59,504	1,979 U
Other Patient Care	2,779	2,677	101 F	23,535	21,537	1,998 F
Services & Products	4,103	4,380	278 U	35,863	35,624	239 F
CTA	1,715	1,757	42 U	12,862	13,276	415 U
Trust & Donation Income	293	427	134 U	4,033	3,460	573 F
Financial Income	559	316	244 F	5,604	2,944	2,660 F
Other Income	655	500	155 F	4,573	4,195	378 F
	152,929	144,891	8,038 F	1,185,763	1,161,275	24,488 F
<b>Expenditure</b>						
Employee Costs						
Medical	18,880	18,065	814 U	155,151	154,542	609 U
Nursing	19,293	18,201	1,092 U	159,135	156,663	2,472 U
Technical	9,547	9,393	154 U	79,485	80,982	1,497 F
Hotel Services	817	735	82 U	6,664	6,367	296 U
Administration	7,304	7,152	152 U	61,638	61,760	122 F
Other	3,981	3,313	668 U	28,020	27,744	275 U
Total Employee Costs	59,822	56,860	2,962 U	490,092	488,059	2,033 U
Direct Treatment Costs	19,059	16,973	2,086 U	151,117	139,476	11,640 U
Indirect Treatment Costs	3,194	3,210	16 F	28,553	26,108	2,445 U
Funder Payments	43,525	39,465	4,060 U	326,562	315,605	10,957 U
Inter District Outflows	8,426	8,372	54 U	65,825	66,978	1,153 F
Prop. Equip. & Transport	3,829	3,987	157 F	32,321	33,269	949 F
Maintenance	196	133	62 U	1,276	1,067	209 U
Building Compliance	0	0	0 F	0	0	0 F
Loss on Sale of Fixed Assets	14	1	13 U	372	11	361 U
Administration Costs	1,661	2,049	389 F	14,908	15,948	1,039 F
<b>Total Operating Expenditure</b>	139,730	131,052	8,678 U	1,111,027	1,086,522	24,505 U
<b>Operating Contribution</b>	13,200	13,839	639 U	74,736	74,753	18 U
Depreciation	4,215	4,436	222 F	34,422	36,025	1,603 F
Finance Costs	1,394	1,582	188 F	12,225	13,386	1,161 F
Capital Charge	2,921	3,062	141 F	22,861	24,256	1,395 F
<b>Total Non Operating Costs</b>	8,530	9,081	551 F	69,508	73,668	4,160 F
<b>Net Surplus / (Deficit)</b>	4,670	4,759	89 U	5,228	1,086	4,142 F

<b>Auckland District Health Board</b>				
<b>Statement of Financial Position</b>				
<b>As at Feb 2011</b>				
	<b>Feb-11</b>	<b>Feb-11</b>	<b>Jan-11</b>	<b>Jun-10</b>
	<b>Actual B</b>	<b>udget</b>	<b>Actual A</b>	<b>ctual</b>
	<b>\$ 000s</b>	<b>\$ 000s</b>	<b>\$ 000s</b>	<b>\$ 000s</b>
<b>Crown Equity</b>				
Opening Balance	569,409	569,304	569,409	566,089
Equity Injections/(Repayments)	1,144	2,029	1,144	3,320
Closing Balance	570,553	571,333	570,553	569,409
<b>Revaluation reserve</b>				
Opening Balance	353,538	381,278	353,538	381,278
Revaluation Adjustments	(0)	-	(0)	(27,740)
Closing Balance	353,537	381,278	353,537	353,538
<b>Retained Earnings</b>				
Opening Balance	(468,367)	(468,437)	(468,367)	(468,645)
Surplus/(Deficit) Current Year	5,229	1,085	558	279
Closing Balance	(463,138)	(467,352)	(467,808)	(468,367)
<b>Total Crown Equity</b>	<b>460,953</b>	<b>485,259</b>	<b>456,283</b>	<b>454,578</b>
<b>Represented by:</b>				
<b>Fixed Assets</b>				
Land	181,497	201,337	181,497	181,497
Buildings	574,862	584,007	574,782	586,094
Clinical, Other Equipment & Motor Vehicles	81,207	120,384	77,296	79,856
Work in Progress	29,745	26,887	35,174	23,166
<b>Total Fixed Assets</b>	<b>867,311</b>	<b>932,616</b>	<b>868,750</b>	<b>870,612</b>
<b>Derivative Financial Instruments</b>	<b>5,321</b>	<b>4,399</b>	<b>5,321</b>	<b>7,061</b>
<b>Investments</b>				
Associated Company Investments	95	386	95	470
Trust Deposits	6,326	8,000	4,526	10,078
<b>Total Investments</b>	<b>6,421</b>	<b>8,386</b>	<b>4,621</b>	<b>10,547</b>
<b>Current Assets</b>				
Cash & Short Term Deposits	77,246	33,374	63,807	56,815
Trust Deposits	15,564	11,508	17,174	11,747
Debtors	19,132	24,435	15,749	25,691
Accrued Income	32,567	24,894	27,838	31,221
Prepayments	3,912	2,320	3,123	2,245
Inventory	12,286	12,106	12,718	11,220
<b>Total Current Assets</b>	<b>160,706</b>	<b>108,638</b>	<b>140,409</b>	<b>138,938</b>
<b>Current Liabilities</b>				
Borrowings	26,086	28,917	24,708	75,027
Trade & Other Creditors, Provisions	222,646	206,935	216,564	222,910
Income Received in Advance	24,523	18,685	25,818	20,087
Taxes Payable	18,640	19,183	8,865	18,040
Funds Held in Trust	1,088	1,102	1,088	1,067
<b>Total Current Liabilities</b>	<b>292,984</b>	<b>274,822</b>	<b>277,042</b>	<b>337,132</b>
<b>Working Capital</b>	<b>(132,278)</b>	<b>(166,185)</b>	<b>(136,634)</b>	<b>(198,193)</b>
<b>Non Current Liabilities</b>				
Borrowings	263,078	273,078	263,070	213,014
Employee Entitlements	22,744	20,880	22,705	22,435
<b>Total Non Current Liabilities</b>	<b>285,822</b>	<b>293,957</b>	<b>285,775</b>	<b>235,449</b>
<b>NET ASSETS</b>	<b>460,952</b>	<b>485,259</b>	<b>456,282</b>	<b>454,578</b>

Statement of Cashflows for the Year ended 30 June 2011						
	Feb-11			Year to Date		
	Actual B	udget	Variance	Actual	Budget	Variance
<b>Operations</b>						
Revenue Received	142,964	142,787	177	1,189,857	1,170,580	19,277
Payments	(127,140)	(119,836)	(7,304)	(1,145,501)	(1,131,999)	(13,502)
<b>Net Operating Cashflows</b>	<b>15,824</b>	<b>22,951</b>	<b>(7,127)</b>	<b>44,356</b>	<b>38,581</b>	<b>5,775</b>
<b>Investing</b>						
Income	559	369	190	4,627	2,957	1,670
Capital						
Sale of Assets	16	2	14	17	11	6
Purchase Fixed Assets	(2,776)	(6,462)	3,686	(31,733)	(51,686)	19,953
<b>Net Investing Cashflows</b>	<b>(2,201)</b>	<b>(6,091)</b>	<b>3,890</b>	<b>(27,089)</b>	<b>(48,718)</b>	<b>21,629</b>
<b>Financing</b>						
Equity Injections	0	0	0	1,145	2,029	(884)
New Loans	0	21,000	(21,000)	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
<b>Net Financing Cashflows</b>	<b>0</b>	<b>21,000</b>	<b>(21,000)</b>	<b>1,145</b>	<b>23,404</b>	<b>(22,259)</b>
<b>Total Net Cashflows</b>	<b>13,623</b>	<b>37,860</b>	<b>(24,237)</b>	<b>18,412</b>	<b>13,267</b>	<b>5,145</b>
<b>Opening Cash</b>	34,818	5,436	29,382	30,029	30,029	0
<b>Closing Cash</b>	48,441	43,296	5,145	48,441	43,296	5,145

## Financial Performance

The result for February was a surplus of \$4.7m compared to a budgeted surplus of \$4.7m. The result year to date is a surplus of \$5.2m compared to a budgeted surplus of \$1.1m, a favourable variance to budget of \$4.1m. The result year to date, is driven by higher revenue \$24.5m compared with higher expenditure of \$(20.4)m.

Year to date revenue was higher than budget by \$24.5m. This was the result of:-

- a) Favourable Base Revenue \$21.0m is driven by higher base contract variations, which are primarily for additional Herceptin funding no longer in subcontract revenue \$5.7m, PHO realignment funding \$9.4m, Oral Health funding \$1.0m and provision for 2010/11 IDF Washups \$4.0m.
- b) Lower MoH Subcontract revenue \$(2.0)m, is driven by lower Herceptin funding (now in base revenue) \$(5.5)m, lower Additional Elective revenue \$(5.1)m as a result of lower volume delivery. There is higher SCI funding \$2.2m, Mental Health (Eating Disorder) funding \$2.4m and other MoH Subcontract revenue \$4.0m.
- c) Higher volumes of non resident activity \$2.8m
- d) Higher External Sales volumes \$0.5m
- e) The timing of donations \$0.6m
- f) Higher interest received on term deposits \$1.7m.
- g) A realised gain on Interest Rate Swap Instruments \$0.9m

Year to date expenditure was higher than budgeted by \$(20.4)m.

- The unfavourable variance in employee costs of \$(2.0)m was driven by vacancies and annual leave taken in Mental Health \$2.4m, Adult Health \$1.8m, Operations \$2.2m and Cancer \$0.9m. There are increased employee costs in Child Health (\$2.1)m, Cardiac \$(1.6)m, Operating Theatres \$(1.4)m and Ambulatory \$(0.4)m, driven by increased volume and complexity. In addition provision has been made for potential MECA settlements \$(2.8)m and long service and gratuity payments \$(0.9)m.
- Direct Treatment costs are \$(11.6)m unfavourable to budget in the following services – Adult Health \$(1.0)m, Child Health \$(3.5)m, Cardiac Services \$(4.7 m, OR & Anaesthesia \$(1.5)m, Laboratories \$(2.4)m, Imaging \$(1.3)m and Ambulatory \$(0.5)m. The increase is due to increases in Drugs \$(0.8)m driven by high usage in immunology and paediatric oncology, Chemicals & Media \$(1.9) m driven by higher test volumes and higher reagent prices, Clinical Supplies & Implants \$(5.7) m driven by higher volumes in OR & A, Cardiac and Child Health and Outsourcing \$(3.1) m primarily to cover operational vacancies and manage Cardiac waiting lists. There were also various initiatives that have not delivered the treatment cost savings to the planned levels.
- Funder Payments (excluding IDF Outflows) are over budget \$(10.9)m due to PHO realignment where additional IDF revenue is being received for the payments that are now processed on behalf of the other DHBs. There are also unfavourable variances in Laboratory costs following revised contracts with LTA and DML \$(1.6)m, costs arising from settlement of prior year's pharmaceutical claims \$(1.7)m, additional Mental Health (Eating Disorder) expenditure \$(1.5)m, for which additional revenue has been received as noted above.
- Indirect Treatment Costs are \$(2.4)m unfavourable primarily due to provisioning for doubtful non resident debts in relation to the increased revenue described above \$(2.0)m and the higher cost of sales for retail pharmacies for which additional revenue has been received \$(0.3)m.

- Property costs are favourable to budget \$0.9m driven by lower utilities, lower property and vehicle maintenance costs and lower computer maintenance costs.
- Administration Costs are lower than budget \$1.0m following lower consulting fees for efficiency improvement projects \$0.9m.
- Loss on Sale of Fixed Assets is higher than budget \$(0.4)m following review of the fixed asset register.
- Depreciation is lower than budget \$1.6m driven by the timing of capitalisation of capital projects.
- Finance Costs are lower than budget \$1.2m driven by lower than planned interest rates and CHFA loans not having to be drawn down.
- The Capital Charge is lower than budget \$1.4m driven by the revaluation of Land & Buildings downwards at balance date.

### **Financial Position**

- The opening balance of fixed assets was \$(39.5)m below budget principally due to the downward revaluation of land & buildings \$(27.8)m as at 30 June 2010 and FY10 full year capital spending being \$(28.7)m lower than forecast.
- YTD Capital spending is \$31.4m, under budget by \$(20.3)m. Baseline and Facilities projects are behind budget by \$(10.7)m driven by slower spending on the Greenlane Surgical Unit \$(6.0)m, Oral Heath Clinics \$(2.8)m and a reduction in spending through reprioritisation \$(4.8)m. Information Systems projects are behind budget by \$(9.6)m driven by the pace at which business cases are completed, approved and implemented.
- At month end there is an unused overdraft facility of \$51.1m.



# *11*

## **GENERAL BUSINESS**



*12*

**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 12.

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

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
12.1 Confidential Board Minutes 2 March 2011 12.2 Shared Services Steering Group Update 12.3 Budget 2011 - 2012	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.

<b>MEETING DETAILS</b>	
Time and Date	2:00pm, Wednesday 6 April 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
Members	Dr Lester Levy (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Paul Green, Janice Mueller, Vivienne Rawlings, Ian Bell.

	<b>Item</b>	<b>Page No</b>
<b>1</b> 2m to 2:02pm	<b>Karakia</b>	<b>001</b>
<b>2</b> 3m to 2:05pm	<b>Attendance and Apologies</b>	<b>005</b>
<b>3</b> 2m to 2:07pm	<b>Conflicts of Interest</b>	<b>009</b>
<b>4</b> 5m to 2:12pm	<b>Confirmation of Minutes Wednesday 2 March 2011</b>	<b>019</b>
<b>5</b> 3m to 2:15pm	<b>Action Points Wednesday 2 March 2011</b>	<b>025</b>
<b>6</b> 5m to 2:20pm	<b>Chairman's Report - Verbal</b>	<b>029</b>
<b>7</b> 10m 3m 2m 15m to 2:50pm	<b>Chief Executive's Report</b> 7.1 Chief Executive's Summary 7.2 Better Sooner More Convenient 7.3 Regional Service Planning Progress Summary 7.4 Minister's Six Health Priorities 2010 - 2011	<b>031</b>
<b>8</b> 5m to 3:00pm	<b>Lift the Health of People in Auckland City</b> 8.1 Committee Recommendations	<b>061</b>

	Item	Page No
<b>9</b> 5m to 3:05pm	<b>Performance Improvement</b> 9.1 DAP Projects Report	<b>065</b>
<b>10</b> 5m 10m to 3:15pm	<b>Live Within Our Means</b> 10.1 Finance Committee Recommendations 10.2 Finance Report	<b>069</b>
<b>11</b> 5m to 3:20pm	<b>General Business</b>	<b>091</b>
<b>12</b> 30m to 3:50pm	<b>PUBLIC EXCLUSION</b>	<b>093</b>
<b>NEXT MEETING</b>		
	<b>Time and Date:</b> 2:00pm, Wednesday 4 May 2011 <b>Venue:</b> 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