



Auckland District Health Board

Hospital Advisory Committee Meeting

Wednesday 6 October 2010

10.45am

**A+ Trust Room
Clinical Education Centre
Auckland City Hospital**

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



HAC Meeting Date:		
Feedback By:		
DAP		
RECOMMENDATIONS		
1.		
2.		
NOTING		
1.		
2.		
KPIs		
RECOMMENDATIONS		
1.		
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NOTING		
1.		
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RISKS		
RECOMMENDATIONS		
1.		
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NOTING		
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Hospital Advisory Committee Action Points

MEETING DETAILS	
Date and Time	

Item	Detail	Responsibility	Action
XX			
XX			
XX			
XX			

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Replas Ltd	Managing Director and shareholder	Salary	Plastics Manufacturing Company	6 April 2010
	2. Matta Products Ltd	Director and shareholder.		Plastics Manufacturing Company	
	3. Remat Ltd	Director and shareholder		Plastics Manufacturing Holding Company	
	4. Matt I Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	5. Matta LLC	Trustee		Plastics Distribution Company USA	
	6. New Zealand Maori Arts and Craft Institute	Chairman	Honorarium	Government owned Maori Tourist operation	
	7. Auckland District Health Board	Deputy Chair, Chair Finance Committee			
	8. ADHB Charitable Trust	Trustee			
	9. Ngati Kuri Trust Board	Deputy Chairman and Treaty Negotiator			
	10. Packaging Council of New Zealand	Executive Member			
	11. Ngati Whatua o Orakei Health Clinic Ltd	Chairman			
Jo AGNEW	1. Senior Lecturer Nursing Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	1. Writing, editing and public relations services 2. Medical Council of NZ 3. 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	1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Surveyor Quality Healthcare NZ				7 July 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust 2. New Zealand Research Centre for Growth and Development 3. James Henare Research Centre, University of Auckland 4. Manaia PHO, Whangarei 5. Whanau Ora Task Force 6. National Health Board 7. Chair Whanau Ora Governance Group	Chief Executive Board Member Advisory Board Member Shareholder Member Member	Salary Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee	Management of a Health, Disabilities, Social & Education Services Trust Governs a leading health sciences research centre Advises U o A on Maori research in Northland Governs a Whangarei based PHO Assists in the development of Government's Whanau Ora policy	21 April 2010
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland 2. Northern (AK) Regional Ethics Committee	 Chair	 Fee		29 June 2010
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		1 September 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Bob TIZARD	1. Nil				27 February 2008
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure	Self employed contractor	Contract hourly rate	General practitioner services	16 August 2010
	2. Member, National Breast Screening Advisory Committee	Member	Fee	Consultant Pacific Advisor	
	3. Facilitator, RNZCGP General Practice Education Programme Stage II	Contractor	Contracted monthly fee	Educational Support and Training	
	4. ADHB Employee: contracted roster Doctor for Pohutukawa	Contractor	Hourly rate	Forensic sexual assault examinations	
	5. Panel Member, Medical Appeal Board, Work and Income		Fee		
	6. Bader Drive Healthcare	Programme Facilitator	Fee	Clinical Training Support	
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rev Alfred NGARO	1. 4pm Group Ltd	Consultant	Salary	Community Development Pacific Advisory for ADHB PHAC representative Representative from Family and Community Services national advisory group Development and implementation of a comprehensive social intervention logic for supporting families nationally Development of Auckland Safer City plans Chair management committee for cluster of 13 schools in management improvement initiative Disciplinary and property Committee NGO delivering social services within the Tamaki area	11 May 2009
	2. Pacific Advisory Committee, PHAC CPHAC member	Chair	Fee		
	3. National Task Force for Family Violence MSD	Member	Fee		
	4. Family and Community Services national advisory group	Task Force member	Fee		
	5. Auckland Safer Communities	Advisory Member			
	6. Tamaki Achievement Pathways Schooling improvement	Executive member	Voluntary		
	7. Tamaki College Board of Trustees	Chair	Voluntary		
	8. Tamaki Community Development Trust	Elected Trustee	Fee		
Farida SULTANA	1. Nil	Member	Voluntary		6 August 2008

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	1. Maternity Services Consumer Council 2. Auckland Women's Health Council 3. Member National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee	Employee Employee	Salary Salary		4 August 2008
Iain MARTIN	1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	1. Private Paediatric Surgical Practice	Director	Joint Owner		4 August 2010
	2. Employee Communitio NZ	Senior Consultant	Contractor		
	3. Siggins Miller, Australia	Senior Consultant	Contractor		
	4. Head, Auckland Clinical School, School of Medicine, University of Auckland	Employee	Salary		
	5. Husband: Employee University of Auckland		Fee		
	6. Risk and Audit Committee Whanganui District Health Board	Member			
	7. Pharmac Board	Member	Fee		
	8. South Island Neurosurgical Services Expert Panel	Chair	Fee		

CONFIRMATION OF MINUTES
WEDNESDAY 1 SEPTEMBER 2010

Hospital Advisory Committee Minutes



MEETING DETAILS													
Time and Date	10:45am, Wednesday, 1 September 2010												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
1	ATTENDANCE AND APOLOGIES												
	<p>The Chair declared the meeting open at 10:50 am.</p> <p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Pat Snedden</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Dr Juliet Walker</td> <td>Ian Ward</td> </tr> <tr> <td>Professor Iain Martin</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Dr Richard Aickin – Director Child Health Greg Balla – Director Performance & Innovation Ngairé Buchanan – General Manager Operations Fionnagh Dougan - GM Mental Health, Ambulatory, Cancer & Blood Services Kay Hyman – General Manager Women’s and Children’s Services’ Paul Green – Manager Materials Management Janice Mueller – Director Allied Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Harry Burkhardt, Anne Kolbe, Taima Campbell and Vivienne Rawlings.</p>	Dr Chris Chambers (Chair)	Jo Agnew	Susan Buckland	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Professor Iain Martin	Lynda Williams
Dr Chris Chambers (Chair)	Jo Agnew												
Susan Buckland	Rob Cooper												
Dr Brian Fergus	Dr Ian Scott												
Pat Snedden	Rt Hon Bob Tizard												
Seiuli Dr Juliet Walker	Ian Ward												
Professor Iain Martin	Lynda Williams												
2	CONFLICTS OF INTEREST												
	<p>There were no declarations of conflicts of interest for any item on the agenda. Juliet Walker advised that she was programme facilitator for Pacific General Practice and Ian Scott advised some amendments to his register.</p>												
3	CONFIRMATION OF MINUTES 4 AUGUST 2010												
	<p><u>Moved Juliet Walker, seconded Lynda Williams</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 4 August 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The annual National Women’s Clinical Report day had been excellent with very good feedback from the Ministry of Health and should be a model that other DHBs should follow.</p> <p>The ongoing industrial action had been raised at the Quality, Risk and Audit Committee and</p>												

	would be discussed at the Board.
4	ACTION POINTS 4 AUGUST 2010
	<p>The Chair welcomed Dr Teh, a guest from Penang in Malaysia.</p> <p>Elective Services Performance Indicators (ESPI) Reports</p> <p>Cathy Lewis of the Business Intelligence Team was in attendance and presented on the ESPI reports which were a relationship tool with DHBs showing contract volumes for acute and elective, waiting times for electives and out-patients and the reports could be run for each DHB and for specialities i.e., elective inpatient WEIS volumes, WEIS volumes by speciality, FSA out-patients volumes, out-patient volumes by speciality, surgical waiting lists and out-patient waiting time distributions. The reports were rich with information and meetings had been held with Northland and Waitemata and one arranged with Counties Manukau showing the previous twelve months data and the first month of this financial year seeking feedback. The reports would be reviewed in six months time. The information fed through to capacity planning and in December contract volumes for the ensuing year would be discussed. While the regional principle was equity of access to services this may not happen with different clinical thresholds. FSAs can be compared to contract and provide an alert if they were to exceed the contract.</p>
5.1	Operational Summary Report and Financials
	<p>The reporting had been changed with revenue reported collectively so that there was a concentration on operational costs and volumes to minimise costs and maximise volumes. While WEIS were 500 below the contract July was a slow month for coding due to the end of year.</p> <p>General Medicine was the most affected by the SMO/RMO shortage as was Children's. Training for RMOs was being improved as that was a reason they came to ADHB but there was a national shortage so there was more Consultant lead services. It was a balancing act to try and achieve 30% non-clinical time. The Committee was advised that while there was a glut in PGY1 overall there was a shortage with not enough graduates to fill all the positions in Australasia so the key solution would be to look at other roles. While 25 years ago General Medicine was aspired to there were now more sub specialities. SMO lead services with senior staff at the front door with patients was effective. Employment relations were a substantial barrier to changing the models.</p> <p>The variation to budget on blood products was a result of changes in case mix with more cardiac and more transplants with this being a volume variance. There was a table showing ethnicity of throughput which was a beginning to collect ethnicity data.</p>
7.1	Organisation Acute Flow
	<p>Ngairé Buchanan presented on the AED presentation trends with the increase being at a greater rate each year with, in 2010, a 10.2% increase while the population growth projection was 1.75%. While the number of admitted patients continued to rise the percentage of patients admitted had remained relatively constant. Weekend presentations had grown at a faster rate than week days with eight weekends in 2010 averaging over 160 presentations per day. There had been no changes in After Hours services in the community but there were significant cost barriers. Projections were being made to look at what resources will be needed with AED now looking for more resources as they became a bottleneck. CED had experienced a 7% increase with this year the usual peak in August and while Waitakere had opened, growth was still being experienced. There was a need for regional planning for CEDs. It was noted that children do get sick at night and also present late in primary care.</p> <p>Iain Martin left the meeting at 11:56am.</p>
7.2	Rugby World Cup (RWC)
	<p>Justin Rawiri, Manager, Emergency Management Services presented to the Committee advising that the Police were the lead agency but they were considering a broad spectrum of scenarios. While at national level there was scarcity of information there were well established emergency management relationships regionally and a RWC steering group had been established with good</p>

	<p>representation inclusive of St Johns and primary care. Events were being considered in categories of highly likely i.e., drugs, minor injuries etc. and of high consequence i.e. stadium collapse. There was an Emergotrain Exercise to be held in December which will be a challenging real time exercise. Controllers were Kay Hyman, Ngaire Buchanan and Margaret Dotchin with the Incidence Management Team (IMT) taking control with the Chair and CE notified. In reference to funding there were reciprocal agreements with UK and Australia and some overseas visitors would have insurance. In emergencies 0.1% of funding, if reach, gave avenues to access central funding.</p>
5.2	Operational Indicators Exception Report
	<p>The proportion of patients treated prioritised using the national recognised process had increased which was an improvement.</p>
6.1	DAP Projects Report
	<p>The Starship Theatres business case was in final draft and there would be a meeting held to determine the path forward to get the necessary approvals. The new model of care at Greenlane would be lead first by Ophthalmology. Industrial relations needed to be settled within terms of the major settlements and the Chair would talk to the Minister.</p>
9	General Business
	<p>Scott Macfarlane - Ronald McDonald House</p> <p>Scott Macfarlane, Paediatric Oncologist, had for 13 years been representative on the Ronald McDonald Trust. The Trust had started in 1994 and not only provided a roof but pastoral care for people with sick children. The Ronald McDonald House was built on the world wide organisation with ADHB generously supplying a site and initially \$1m was raised. Five years ago a further \$7m was raised for Stage III with now Ronald McDonald House having 48 rooms in-house, a family room at Starship at Level 3 and 13 rooms for people with a child in PICU. Demand continues to grow and in the last year 16 apartments in close proximity were leased and this year with the release of funding from the Alexandra Trust new premises acquired at 52-54 Grafton Road. Running costs are approximately \$3m with \$325k coming from Ronald McDonald charities, a substantial amount from transport subsidies and the rest donors. It is an effective and active trust with ADHB being active partners with their Trustees being John Paterson and Liz Segedin. There was strong support and patronage by ADHB management.</p> <p>Scott was congratulated for his leadership and dedication to the Trust and the tohunga on ADHBs premises was acknowledged. Scott was thanked for his contribution.</p>
	NEXT MEETING
	<p>The meeting closed at 12:52pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 6 October 2010 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
CONFIRMED	
CHAIR:	DATE:

ACTION POINTS

WEDNESDAY 1 SEPTEMBER 2010

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 1 September 2010**

Item	Detail	Designated	Action
	Nil		

OPERATIONAL PERFORMANCE

5.1 Operational Summary Report and Financials

5.2 Operational Indicators Exception Report

5.1 Summary Report

Overall Performance for the Month

Summary of Provider Results

\$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	(66,758)	(63,141)	3,617U	(128,894)	(126,267)	2,627U
Complementary	185	162	23F	(106)	234	340U
Functional	66,243	65,625	617F	129,674	131,652	1,978U
Ancilliary	66,427	65,787	640F	129,568	131,887	2,318U
Provider Net Surplus/(Deficit)	(330)	2,646	2,976U	674	5,620	4,946U

In the table above we have set out the summary results of various sections which make up the Provider. Under the Functional heading are included areas, such as Finance, HR and IS which support the operational areas. Under the complementary heading are included areas such as Public Health, A+ Trust, Research and Retail businesses.

Operational areas such as Adult Health, Cancer & Blood and Cardiac which are a subset of the total Provider are considered under the section headed 'Operational' below.

While the majority of variances at the total Provider Arm level are the same as at an operational level there are some key variances, such as the changes in the value of interest rate swap instruments and allowances for volume coding lag which are included in the 'Provider' section of the Finance Committee report as a result of including the support areas.

With effect from 1 July 2010, MOH base contract income (Price Volume Schedule income) for both the ADHB population and IDF Funders is now held under Functional, and is not reported within the Operational group of services.

5.1.1 PROVIDER OPERATING STATEMENT

Provider	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operating Statement - Aug 2010						
<i>Total Income</i>						
Internal Allocations - Ex Funder	85,783	87,685	1,902U	169,390	175,369	5,979U
MOH - Funding Subcontracts	2,777	2,908	132U	6,327	6,137	191F
Other Patient Care Revenue	2,920	2,714	206F	5,825	5,426	399F
Sales of Services & Products	4,495	4,438	56F	9,120	8,888	232F
Clinical Training & Education Income	1,572	1,625	53U	3,245	3,299	54U
Trust & Donation Income	325	473	148U	1,414	897	517F
Financial Income	554	316	238F	1,089	631	458F
Other Income	620	546	74F	1,024	1,096	72U
Profit on Disposal of Fixed Assets	8	0	8F	24	0	24F
Total Income	99,052	100,705	1,653U	197,459	201,743	4,284U
<i>Operating Expenditure</i>						
Employee Costs	60,271	61,388	1,117F	119,932	122,669	2,737F
Direct Treatment Costs	20,299	17,750	2,549U	39,414	35,678	3,736U
Indirect Treatment Costs	3,727	3,262	465U	7,229	6,516	713U
Property, Equipment & Transportation Costs	3,945	4,142	197F	7,979	8,213	234F
Administration Costs	1,305	1,618	313F	3,161	3,235	73F
Maintenance Programme	136	133	3U	269	267	3U
Indirect Service Billing	482	482	0F	964	964	0U
Loss on Sale of Fixed Assets	19	1	18U	29	3	26U
Total Operating Expenditure	90,185	88,777	1,408U	178,977	177,544	1,433U
Operating Surplus / (Deficit)	8,867	11,928	3,060U	18,482	24,199	5,717U
<i>Non-Operating Expenditure</i>						
Capital Charge	3,062	3,022	40U	5,778	6,058	280F
Depreciation	4,490	4,525	35F	8,741	9,053	311F
Finance Costs	1,645	1,734	89F	3,289	3,468	180F
Total :Non-Operating Expenditure	9,198	9,282	84F	17,808	18,579	771F
Total Surplus / (Deficit)	(330)	2,646	2,976U	674	5,620	4,946U

Key variances (> \$250,000) for August 2010 for the provider were:-

	Month	YTD
1 Internal Allocations	\$(1.902)m U	\$(5.979)m U
2 Employee Costs	\$1.117m F	\$2.737M F
3 Direct Treatment Costs	\$(2.549) m U	\$(3.736) m U
4 In-Direct Treatment Costs	\$(0.465) m U	\$(0.713) m U
5 Administration Costs	\$0.313m F	\$0.073m F

1 Internal Allocations

WIES Funded Services – 470 wies under contract - \$(2.0) m U

Non WIES funded services was virtually on contract \$0.1m F

2 Employee Costs

Provider arm employee costs were \$1.1m F to budget, a combination of FTEs and average cost per FTE under budget.

FTE Table 1 – FTEs for Month

FTEs	Budget FTE Month 2010- 11	Actual FTE Month 2010-11	Variance
Adult Health	1,737	1,725	12
Wom, Child, Card, OR&A	2,496	2,450	46
Operations	1,422	1,393	29
MH, Amb, Ophth, Cancer & Blood	1,295	1,280	15
Other Operational	1	5	-4
Ancillary	966	935	31
TOTAL	7,917	7,789	128

FTE Table 2 – Cost per FTE

Provider Services - Staffing Variance			
Month 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	61.4	60.3	1.82%
FTE Numbers	7,917.1	7,788.8	1.62%
Cost per FTE (Month)	7,754	7,738	0.20%
YTD 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	122.7	119.9	2.23%
FTE Numbers	7,921.3	7,788.4	1.68%
Cost per FTE (Year to Date)	15,486	15,399	0.56%

3 Direct Treatment Costs

The principal variances in direct treatment costs were as shown below:-

Cost	Variance Month \$M	Variance YTD \$M
Patient Appliances	(1.0)	(1.1)
3rd Party Treatment Costs	(0.3)	(0.3)
Clinical Supplies	(0.7)	(1.0)
Drugs	(0.4)	(1.0)
Chemicals & Media	(0.2)	(0.3)
Food	(0.0)	(0.0)
Contracted Services - Clinical	0.0	(0.1)
	(2.5)	(3.7)

Variances rounded to nearest \$100,000

Variances for patient appliances were as follows:-

Portfolio	Variance	Comments
Child Health	\$(0.1)m U	Two services contributed – paediatric surgery \$98k U, high cost hearing aids for which costs are recovered through sales plus purchase of high cost bones for tumour patients and transfer of implant charges from theatre; paediatric cardiac – high implant costs for ICDs.
Cardiac Services	\$(0.8)m U	Implantable devices (ICDs and pacemakers), catheter costs in cardiology and ECMO and LVAD costs in cardiothoracic were the main components of the adverse variance.

Variances for third party treatment costs were as follows:-

Portfolio	Variance	Comments
Cardiac Services	\$(0.2)m U	Resumption of cardiac outsourcing (9 patients to Mercy)
Imaging	\$(0.2)m U	Budget includes assumption of reduced outsourced volumes for the new Starship MRI and also a reduction in total demand (Concord project). The Starship MRI is now operational, resulting in fewer outsourced MRIs, but the MRT industrial action has resulted in additional outsourcing to offset reduced throughput in ACH.
Cancer Services	\$(0.4)m U	Costs associated with RT patients treated at other hospitals in excess of budget \$272k U, and payments related to Bone marrow Transplant cell collection \$89K U (timing).
Ancillary Services	\$0.4m F	Corporate provision for outsourcing (late DAP adjustment)

Offset by smaller favourable variances

Variances for clinical supplies were as follows:-

Portfolio	Variance	Comments
Child Health	\$(0.2)m U	Impact of winter volumes and catheter volumes in paediatric CIR.
Cardiac Services	\$(0.2)m U	Impact of catheter costs in EP lab and costs associated with ECMO and LVAD patients (noted above)
Operating Rooms	\$(0.2)m U	Actual theatre minutes for the month are 13% higher than budgeted resulting in the overspend.
Imaging	\$(0.1)m U	Numbers of interventional radiology cases higher than budgeted (14 procedures vs. 12 budgeted)

Variances for drug costs were as follows:-

Portfolio	Variance	Comments
Adult Health	\$(0.1)m U	Mainly in Emergency Dept & Critical Care \$116k U due to high acute volumes for the month.
Child Health	\$(0.2)m U	Higher than budgeted winter volumes.
Operating Rooms	\$(0.1)m U	See above comment re theatre activity (theatre minutes)

Variances for chemicals and media were as follows:-

Portfolio	Variance	Comments
Laboratories	\$(0.2)m	Budget is \$2.1M or 14% below 09/10 actuals. A combination of a reduction in test utilisation and/or price reductions for reagents is required to meet this budget target.

4 In-Direct Treatment Costs

Indirect treatment costs were unfavourable by \$465,000 for the month. Of this \$343,000 related to bad debts written off, offset by a movement in the provision for doubtful debts leaving a net adverse variance of \$267,000. Of the remaining adverse variance \$62,000 U was in respect of cleaning costs and \$100,000 U was in respect of the cost of sales in the retail pharmacies (offset by revenue).

5 Administration Costs

Administration costs were favourable by \$313,000 for the month. The performance improvement projects in CEO Functional were under budget for the month.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	Aug-10	Att per Day	Comparison to Last Month	Jul-10	Att per Day	Comparison to Last Year	Aug-09	Att per Day
APU	1,733	56	-0.5%	1,741	56	9.1%	1,589	51
AED	4,581	148	-0.4%	4,598	148	17.4%	3,902	126
CED	3,292	106	13.8%	2,892	93	4.4%	3,152	102

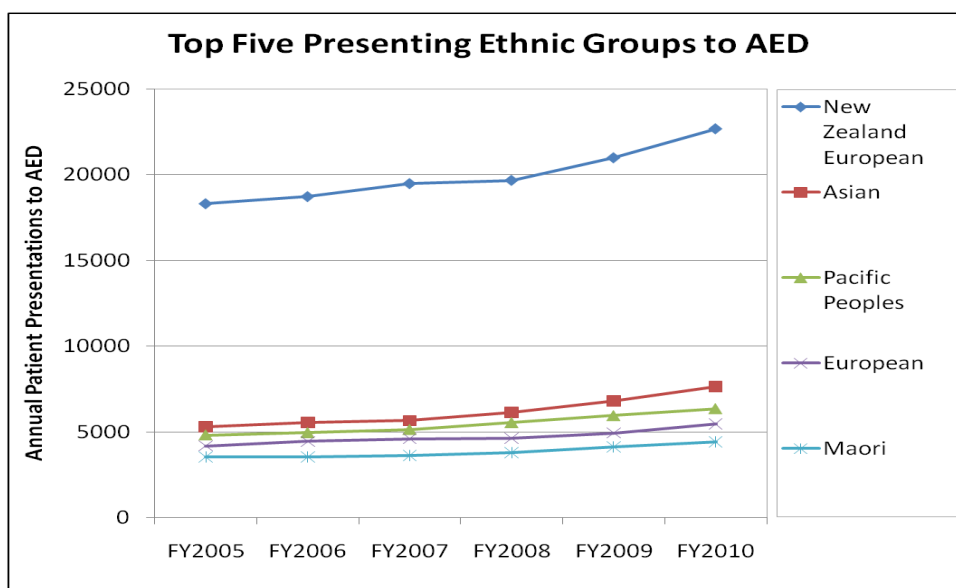
AED - A negligible drop in volumes from record levels last month and still much higher than last year. Nevertheless average LOS was managed back down, i.e. flow improved.

APU - Volumes very similar to AED (a negligible from the record last month) but big drops in LOS measures, i.e. very good flow into the wards and minimal longstayers. Excellent results for a month with such high volumes.

CED - Record month for CED, slightly higher than the previous record set August 2008. The volumes this August however contributed to overall flow problems with a high average LOS and a lift in the median LOS.

The chart below shows AED presentation data by ethnicity.

The table immediately below the chart shows the *rate of increase* in AED presentations by ethnic group.



New Zealand European Trends
Largest increase in presentations by volume

Asian Trends
Largest increase in presentations by percentage

Ethnic Group	Rate of Change (presentations/day)
Asian	0.0022 S.E. 0.0002
Pacific Island	0.0027 S.E. 0.0002
Indian	0.0018 S.E. 0.0001
Maori	0.0019 S.E. 0.0002
Cook Island Maori	0.0003 S.E. 0.0001
New Zealand European	0.0084 S.E. 0.0004

Throughput – by Admission Type

The table below shows the acute and elective wies positions for the first two months of the year for our own population and for Counties, Waitemata, Northland and all other DHBs combined.

Electives

DHB	Contract	Actual	Variance	% of completion
ADHB	2,644	2,023	-621	77%
CMDHB	943	833	-110	88%
WDHB	1,201	1,019	-182	85%
NLDHB	427	297	-130	70%
Other	678	674	-4	99%
	5,893	4,846	-1,047	82%

Acutes

DHB	Contract	Actual	Variance	% of completion
ADHB	8,848	9,200	352	104%
CMDHB	2,153	1,993	-160	93%
WDHB	3,125	3,218	93	103%
NLDHB	797	777	-20	97%
Other	1,256	1,072	-184	85%
	16,179	16,260	81	101%

Acute & Elective Combined

DHB	Contract	Actual	Variance	% of completion
ADHB	11,492	11,223	-269	98%
CMDHB	3,096	2,826	-270	91%
WDHB	4,326	4,237	-89	98%
NLDHB	1,224	1,074	-150	88%
Other	1,934	1,746	-188	90%
	22,072	21,106	-966	96%

Throughput – Contract Volumes

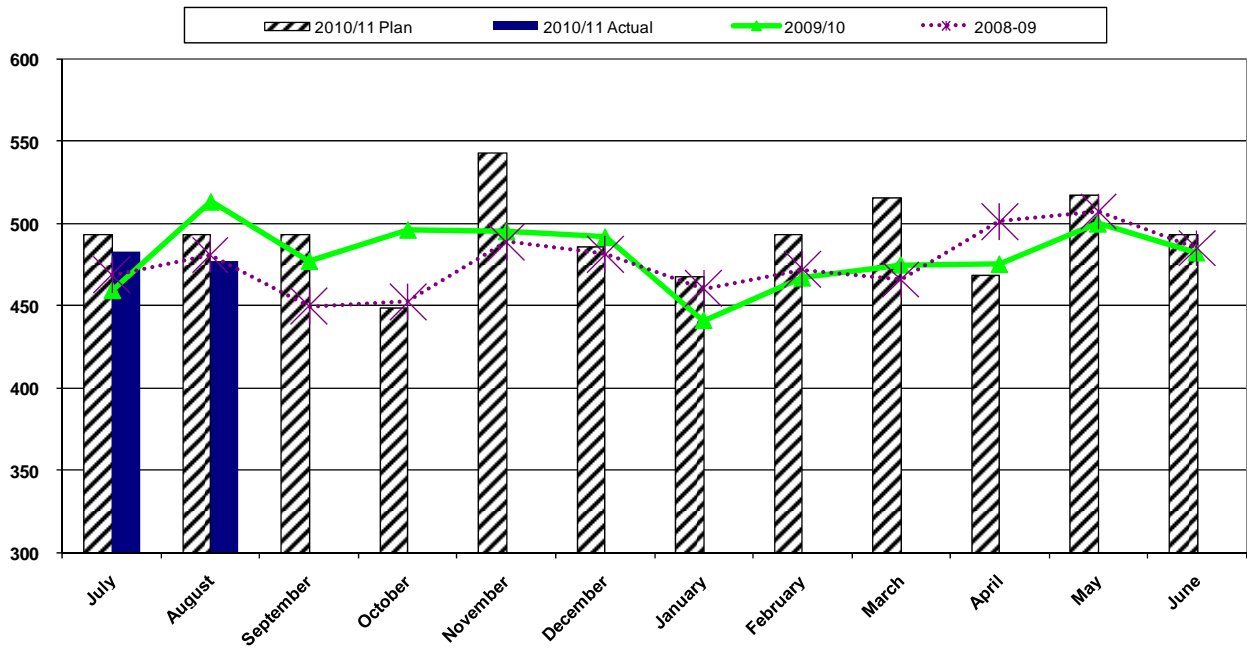
The chart below shows the production recorded to August 2010.

At the time the results were finalised, the coding was 52.1% complete with the average WIES per discharge being 1.2% lower than last year for the same period. Discharges are up by 0.5% from last year.

Inpatient delivery to the most current Price Volume Schedule (Jul 2010) was 95.5% for the month.

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	10,503	10,849	346U	21,132	21,698	566U
WIES Delivery per day	457	493	36U	480	493	13U

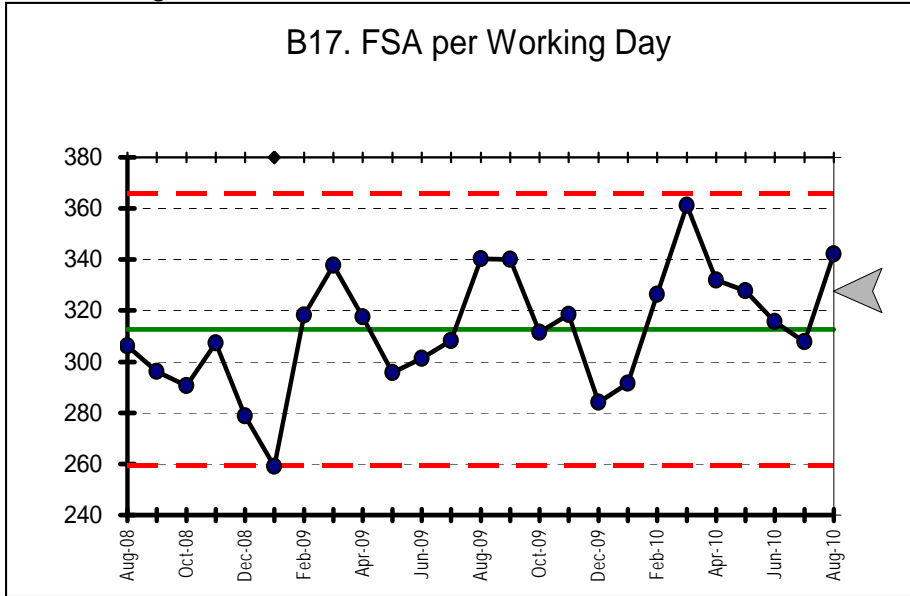
WIES per Working Day (excluding stat day - 1011 working year = 253 days)



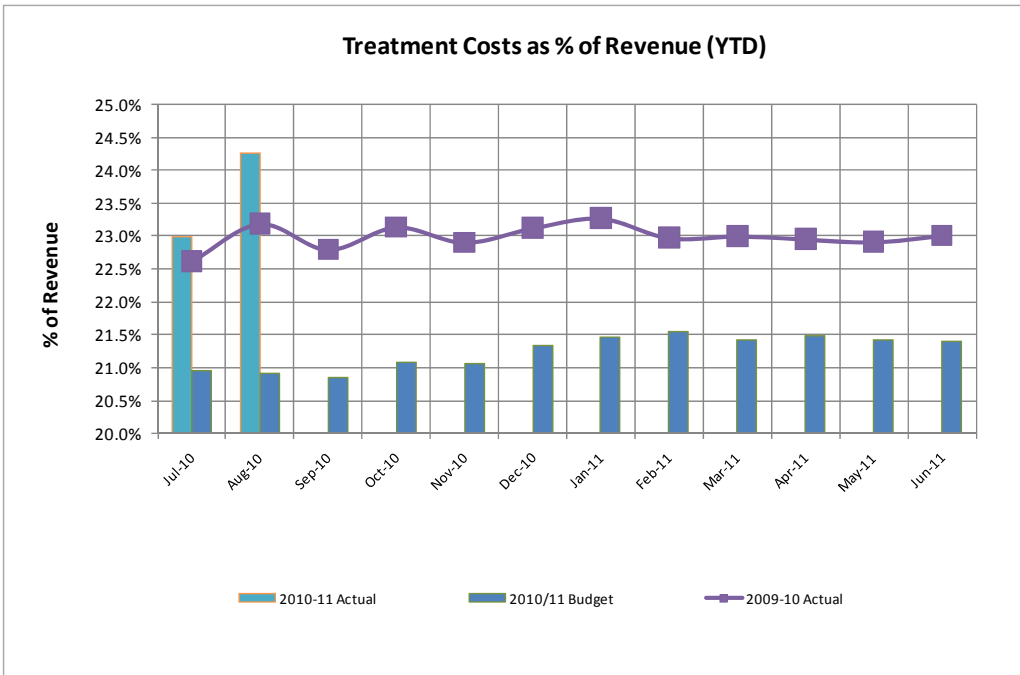
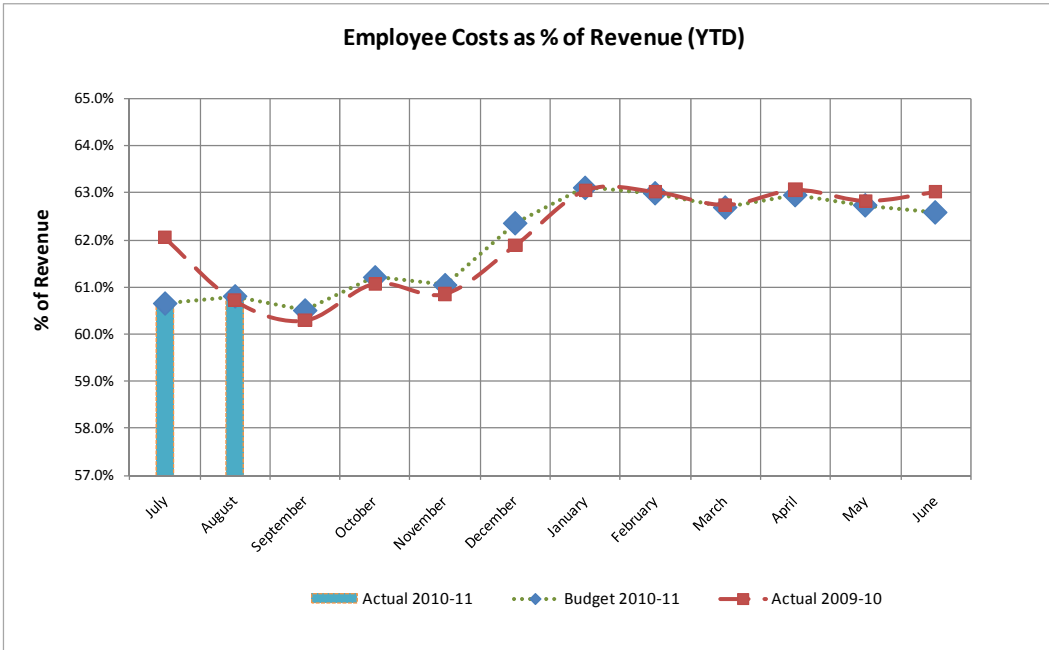
Outpatient Delivery

Below is a graph of outpatient activity in the same manner as for inpatient activity - output per working day. As well as being a useful indicator of productivity, outpatient activity is, in part, the 'feeder' activity for much of our elective 'production line'.

FSA= First Specialist Assessment
 Green Line= Average
 Arrow= Target



Cost Relationship Charts



The principal areas which differed from budget for Aug YTD are:-In \$,000's **37**

Health Service Portfolio	YTD - Net Cost of Service (\$ '000)			Comments
	Act	Bud	Var	
Adult Health	(33,620)	(33,783)	163F	The variance is primarily driven by favourable employee costs, reflecting a number of Medical vacancies, and low Staff Related Expenses due to CNME write-offs following new year entitlements effective in July.
Women, Child, Cardiac, ORA	(55,117)	(52,295)	2,822U	The key drivers are Employee costs \$733k UF (Medical \$392k UF and Nursing \$420k UF) and Direct Treatment costs \$2m UF (Drugs \$314k UF, Implants \$957k UF, Clinical supplies \$621k UF and Outsourcing \$194k UF). Medical variances were Cardiac SMO driven and related to additional payments for high workloads through the CTSU service. Nursing variances related to Child Health (phasing issues relating to contract finishing in December but budgets spread throughout the year) and ORA (theatre minutes up 13% on budgeted theatre minutes). Drugs (mainly Oncology, Cardiac - 5 ECMO patients in the month and Theatre related), Implants (mainly Cardiac ICDs and Pacemakers, one LVAD, 3 spinal cord procedures, 3 Melody valves for Paeds), Clinical Supplies (mainly Catheters) and Cardiac Outsourcing (due to blockages in CVICU)
Operations	(27,035)	(26,804)	231U	The variance is primarily driven by unfavourable Direct Treatment Costs, most significantly outsourcing of MRIs \$328k U (rate of variance should now reduce as new Starship MRI becomes fully operational), and Chemicals & Media in LabPlus \$302k U, for which the budget has a saving target requiring decreases in test utilisation and/or price for reagents. These unfavourable Direct Treatment Costs are partly offset by favourable Employee Costs achieved through vacancies.
Ambulatory & Ophthalmology	(5,273)	(4,697)	576U	The unfavourable variance is primarily driven by Pain Service ACC revenue \$101K unfavourable, employee costs \$183K unfavourable and treatment costs \$223K unfavourable. The employee cost variance of \$183K U is mainly due to the unachieved target saving assumption. The treatment cost variance is mainly Immunology blood products \$102K unfavourable which includes one patient who required treatment costing \$63K per month (YTD cost \$125K). Year to date volumes are close to budget overall with inpatients at 94% and outpatients at 104%.
Cancer & Blood	(9,096)	(9,433)	337F	Net cost \$337K favourable to budget is due to 1) Adult PCT washup adjustment \$251K fav, 2) medical, nursing and technical staff vacancies \$251k fav, offset by outsourcing costs (RT plus Bone Marrow Transplant (marrow retrieval)) in excess of budget \$381k unfav. 3) other costs largely favourable to budget.
ACH Others	(149)	(26)	123U	Variance reflects abnormal costs relating to MRT and MLWU strikes.
Mental Health	(14,214)	(14,927)	713F	The favourable variance is mainly due to staff vacancies \$495k favourable and lower staff related expenses \$127k favourable primarily caused by timing of expenses and vacancies.
Total Operational	(144,504)	(141,964)	2,540U	

Provider

Aug 2010

	YTD								
	Act 1011	% of Rev	Bud 1011	% of Rev	Act 0910	% of Rev	Var Budget	% Var to Bud	Var LY
Revenue									
MOH Base Funding	169,390		175,369		170,415		5,979 U	3.4%U	1,025 U
MoH Sub-contracts	6,327		6,137		5,792		191 F	3.1%F	536 F
Other Patient Care	5,825		5,426		5,088		399 F	7.4%F	737 F
	181,542		186,931		181,295		5,389 U	2.9%U	247 F
Services & Products	9,120		8,888		8,350		232 F	2.6%F	771 F
CTA	3,245		3,299		3,952		54 U	1.6%U	707 U
Trust & Donation Income	1,414		897		925		517 F	57.7%F	489 F
Other Income	2,138		1,728		2,633		410 F	23.7%F	495 U
	197,459		201,743		197,155		4,284 U	2.1%U	305 F
Expenditure									
Employee Costs									
Medical	37,936	19.2%	39,001	19.3%	37,861	19.2%	1,065 F	2.7%F	75 U
Nursing	39,305	19.9%	39,736	19.7%	39,189	19.9%	431 F	1.1%F	116 U
Technical	20,011	10.1%	20,578	10.2%	19,497	9.9%	567 F	2.8%F	514 U
Hotel Services	1,638	0.8%	1,598	0.8%	1,600	0.8%	40 U	2.5%U	38 U
Administration	14,440	7.3%	14,668	7.3%	14,477	7.3%	228 F	1.6%F	37 F
Other	6,601	3.3%	7,086	3.5%	7,077	3.6%	485 F	6.8%F	475 F
Total Employee Costs	119,932	60.7%	122,669	60.8%	119,702	60.7%	2,737 F	2.2%F	230 U
Direct Treatment Costs	39,414	20.0%	35,678	17.7%	39,326	19.9%	3,736 U	10.5%U	88 U
Indirect Treatment Costs	7,229	3.7%	6,516	3.2%	6,388	3.2%	713 U	10.9%U	842 U
Prop, Equip. & Transpt	7,979	4.0%	8,213	4.1%	8,372	4.2%	234 F	2.9%F	393 F
Administration Costs	3,161	1.6%	3,235	1.6%	2,151	1.1%	73 F	2.3%F	1,010 U
Maintenance Programme	269	0.1%	267	0.1%	300	0.2%	3 U	1.1%U	31 F
Indirect Service Billing	964	0.5%	964	0.5%	(22)	0.0%	0 U	0.0%U	986 U
Loss on Sale of Fixed Assets	29	0.0%	3	0.0%	-	0.0%	26 U	950.7%U	29 U
Total Operating Expenditure	178,977	90.6%	177,544	88.0%	176,217	89.4%	1,433 U	0.8%U	2,760 U
Operating Surplus/(Deficit)	18,482	9.4%	24,199	12.0%	20,937	10.6%	5,717 U	23.6%F	2,455 U
Capital Charge	5,778	2.9%	6,058	3.0%	6,069	3.1%	280 F	4.6%F	291 F
Depreciation	8,741	4.4%	9,053	4.5%	7,941	4.0%	311 F	3.4%F	801 U
Finance Costs	3,289	1.7%	3,468	1.7%	3,412	1.7%	180 F	5.2%F	123 F
Total Non Operating Costs	17,808	9.0%	18,579	9.2%	17,422	8.8%	771 F	4.1%F	386 U
Net Surplus / (Deficit)	674	0.3%	5,620	2.8%	3,515	1.8%	4,946 U	88.0%U	2,842 U

5.2 Operations Indicators Exception Report

ADHB HAC KPI Report

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

August 2010				
Indicator	Frequency	Review date	KPI report page ref	
Volume				
B3. Acute WIES Volume - Auckland	M	Aug-10	1	Ω
B4. Elective WIES Volume - Auckland	M	Jan-10	1	Ω
B5. Total WIES Volume - Auckland	M		1	Ω
B6. Non-DRG Revenue - Auckland	M	Mar-10	1	Ω
B7. Acute WIES Volume - IDF	M	Feb-09	2	Ω
B8. Elective WIES Volume -IDF	M		2	Ω
B9. Total WIES Volume -IDF	M	Jan-10	2	Ω
B10. Non-DRG Revenue - IDF	M	Jan-10	2	Ω
B11. Acute WIES Volume -All DHBs	M		3	Ω
B12. Elective WIES Volume -All DHBs	M	Jan-10	3	Ω
B13. Total WIES Volume - All DHBs	M	Jan-10	3	Ω
B14. Non-DRG Revenue - All DHBs	M	Jan-10	3	Ω
B30. Inpatient WIES Cumulative Variance to Contract - Acute/Elective by DHB	M	Apr-09	4	Ω
B31. Inpatient WIES Cumulative Variance to Contract - Total by DHB	M	Apr-09	4	Ω
B32. Inpatient WIES Cumulative Variance to Contract - Total all DHBs	M	Apr-09	4	Ω
B33. NON-DRG Revenue Cumulative Variance to Contract by DHB	M	Apr-09	4	Ω
B40. Mental Health Total Community Face-to-Face Appts.	M	Jan-10	6	
B41. Mental Health Total Access - Rate	M	Jan-10	6	
B42. Mental Health Community New Referrals	M		6	
Productivity				
B15. Acute WIES per Day	M		5	
B16. Elective WIES per Working Day	M	Jan-10	5	
B17. FSA per Working Day	M		5	
Length of Stay				
A22. Raw Average Length of Stay - WIES funded patients (days)	M		7	Ω
A61. Mental Health - Average Length of Stay (KPI Discharges) - Te Whetu Tawera	M	Aug-09	7	Φ
Elective Process and Waiting Times				
A03. Elective Day of Surgery Admission (DOSA) Rate	M		7	Π
B61. Raw Elective Surgical daycase rate	M		7	
B50. % of chemotherapy patients attending FSA within 6 weeks of referral	M		8	
B51. (POP-10) % of chemotherapy patients receiving treatment within 6 weeks of FSA	M		8	‡
B52. % of radiation oncology patients attending FSA within 6 weeks of referral	M		8	
B54. MOH-03 (from Dec 09). % of A, B & C category radiation oncology patients receiving treatment within 4 weeks of FSA	M		8	
B56. % of patients who commence bone marrow transplant within 6 weeks of decision to treat.	M		9	
B57. % of haematology patients attending FSA within 6 weeks of referral	M		9	
B58. % of haematology patients receiving treatment within 6 weeks of FSA	M		9	
A65. (ESPI 8). Proportion of patients treated prioritised using nationally recognised processes or tools	M	Aug-10	10	
Acute Process				
A56. % of stroke patients cared for within the stroke unit	Q	Jul-10		Ω
B63. Mental Health percentage of people with relapse prevention plans	M	Jan-10	6	
Cost				
B34. Cost and revenue for WIES funded inpatient events -all services	6 monthly			
B35. Cost and revenue for WIES funded inpatient events -child	6 monthly			
B36. Cost and revenue for WIES funded inpatient events -adult	6 monthly			
B37. Cost per WIES for WIES funded inpatients - all	6 monthly			
Human Resources				
F.12 % of Total Employee Turnover (Monthly)	M		11	
F.21 Lost Time Injury Frequency Rate	M		11	

HAC Exception Report

August 2010

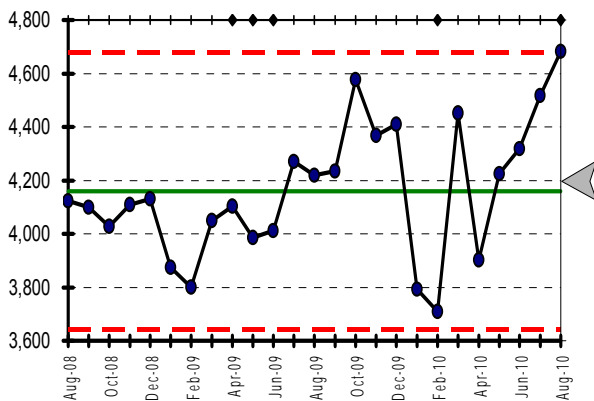
B3. Acute WIES Volume - Auckland

Overall wies volumes are 11% higher than last year, with large % increases in adult and paediatric respiratory volumes, obstetrics and general paediatrics. ADHB population acute volumes are approximately 250 wies above contract, representing work for which the DHB has no funding.

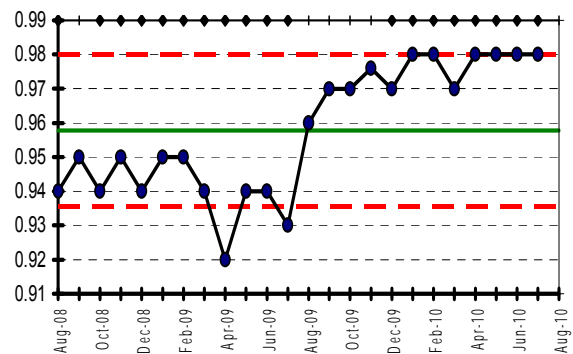
A65. (ESPI-8). Proportion of patients prioritised using nationally recognised processes or tools

98% of patients are prioritised using a nationally recognised tool. The exception is vascular surgery. However, a tool has been submitted to the Ministry for approval, but has not yet been agreed.

B3.Acute WIES Volume - Auckland



A65. (ESPI-8). Proportion of patients treated prioritised using nationally recognised processes or tools



IMPROVEMENT ACTIVITIES

6.1 DAP Projects Report



Auckland District Health Board

District Annual Plan *2010 - 2011*

22 June 2010

Priority and Developmental Work for 2010-11

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

High level strategy	Objective	Strategies to achieve objectives
1.1 Reduce inequities in health status	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: <ul style="list-style-type: none"> – develop Integrated Family Health Centres/Whanau Ora Centres – develop specific activities that achieve Whanau Ora – develop indicator measures for Whanau Ora – develop a Whanau Ora approach for all services devolved
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
		1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
		1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access to health care and support services	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture, employment and advocacy
		1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system

High level strategy	Objective	Strategies to achieve objectives
1.2 Improve outcomes in priority areas		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	<p>1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including:</p> <p>1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised</p> <p>1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised</p>
	1.2a.2 Improve the oral health of children	<p>1.2a.2.1 Increase school dental clinics to six by June 2011</p> <p>1.2a.2.2 Four new mobile clinics in total established by June 2011</p> <p>1.2a.2.3 Reduce inequalities in the use of school dental services:</p> <ul style="list-style-type: none"> - improving access by taking services to pre-schools - enhancing oral health education - increasing early enrolment with a focus on Maori and Pacific populations
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	<p>1.2b.1.1 Introduce the funding methodology for home-based services by July 2010</p> <p>1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services</p>
	1.2b.2 Quality improvement in residential care	<p>1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations</p> <p>1.2b.2.2 25% reduction in overall number of complaints from residential care</p>
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	<p>1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+)</p> <p>1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system</p> <p>1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures</p> <p>1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed</p> <p>1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches</p>

High level strategy	Objective	Strategies to achieve objectives
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes)
		1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed
1.2d.3.2 At least 2 cardiac rehabilitation courses are run in the community		
1.2d.3.3 At least 10% of retinal screening to be undertaken in the community		
1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base	
	1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities	
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce 1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome 1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011 1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme

More detail on some of these performance measures is included on page 36

Goal 2: Performance improvement: sooner, better, more convenient

High level strategy	Objective	Strategies to achieve objectives
2.1 Efficient and effective health care system		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters
		2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients
		2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year
	2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services	
	2.1b.1.5 Improve access to primary care for palliative care clients by 15%	
	2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m	
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes)
		2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10%
		2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children’s acute flow projects
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*
		2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		<p>and Mental Health services using Releasing Time to Care from 6 to 24</p> <p>2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery</p> <p>2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011</p> <p>2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in:</p> <ul style="list-style-type: none"> - General medicine - Orthopaedics - Radiology - Paediatrics general surgery - General surgery - Ophthalmology
	2.1c.2 Improve mainstream effectiveness	<p>2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches</p> <p>2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori</p> <p>2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11)</p> <p>2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider</p>
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	<p>2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011</p> <p>2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum</p>
	2.1c.5 Reduce waiting times for oncology	<p>2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010</p> <p>2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology</p> <p>2.1c.5.3 Implement lung and bowel tumour stream models by June 2011</p>
	2.1c.6 Increase elective surgical discharges to 10,227	<p>2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway</p> <ul style="list-style-type: none"> - Implement new model of care and workforce roles in the Greenlane Surgical

High level strategy	Objective	Strategies to achieve objectives
		Centre – Maintain past elective surgery improvement by including primary care in the referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against “In Good Hands” implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
2.3 Improve Clinical Quality and Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s 2.3.2.5 Implement Senior Leadership Team ‘Walk-around’ safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity

High level strategy	Objective	Strategies to achieve objectives
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time 2.5.1.2 KPI reporting for end-to-end application performance in place 2.5.1.3 IMTS user satisfaction increases by >10% against previous year 2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month 2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance 2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
2.6 Planning 2.6 Planning (cont)	2.6.1 Long term planning and change management	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines 2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: <ul style="list-style-type: none"> – description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases 2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

* Refer to appendix 8

Goal 3: Live within our means

High level strategy	Objective	Strategies to achieve objectives
3.1 Break-even position maintained		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and manage any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
3.2 Sustainable balance sheet		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans

Group Pack Report

Group/Committee: Hospital Advisory Committee



Goal Level Summary

DAP Projects - total projects: 23

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
1 Lift the Health of the people in Auckland City	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
2 Performance improvement	21	21	5	0	1	11	1	0	13	5	0	18	0	0	18	0	0	3	3	0	0	
3 Live within our means	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0
Total #	23	23	5	0	1	12	1	0	14	5	0	19	0	0	19	0	0	4	3	1	0	
Total %	100%	100%	22%	0%	4%	52%	4%	0%	61%	22%	0%	83%	0%	0%	83%	0%	0%	17%	13%	4%	0%	

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

High Level Summary - total projects: 1

High Level Strategy	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															
1.1 Reduce inequalities in health status	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2a Improve outcomes for children and young people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2c Improve outcomes for mental health and addictions	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
1.2d Improve outcomes for long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2e Improve outcomes for Palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Total %	100%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	100%	0%

Objectives

No Objectives have been entered for this committee or group against this goal.

Exceptions

There are no projects that have been marked as an exception

Goal: 2 Performance improvement

High Level Summary - total projects: 21

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan		Do/ Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green		Orange	Red	
			Define	Measure																	Analyse
2.1a Efficient and effective Primary health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	3	3	1	0	0	2	0	0	2	1	0	3	0	0	3	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	12	12	3	0	1	7	0	0	10	1	0	11	0	0	11	0	0	1	1	0	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	7	7	0	1	0	3	1	0	2	3	0	5	0	0	5	0	0	2	2	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	4	3	0	0	0	3	0	0	1	1	2	4	0	0	3	1	0	0	0	0	0
2.6 Planning	1	1	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0
Total #	21	21	5	0	1	11	1	0	13	5	0	18	0	0	18	0	0	3	3	0	0
Total %	100%	100%	24%	0%	5%	52%	5%	0%	62%	24%	0%	86%	0%	0%	86%	0%	0%	14%	14%	0%	0%

Objectives







Objective	Objective Owner	Comment
2.1c.1 Improve service throughput and productivity	Ngaire Buchanan (ADHB)	There are 8 projects associated with this objective all at different stages. Cardiac surgery throughput, Emergency six hour measure, releasing time to care, increasing Starship OR capacity and the Service improvement projects are all under way. Eliminating unnecessary outpatient follow ups will be within the service improvement programme. Improving operating rooms productivity will commence in late August with the TPOT programme.
2.1c.2 Improve mainstream effectiveness	Ngaire Buchanan (ADHB)	Maori DNA project has gone to BAU. The remaining 3 projects to commence.
2.1c.3 Improve relapse prevention planning in mental health	Fionnagh Dougan (ADHB)	27.09.10: The MOH have established a target which requires specific clients to have a relapse prevention plan in place. We have been formally reporting against this target during 09/10. As of August 2010 this project is included in the suite of DAP reports to ensure increased visibility. We are currently meeting the 95% target.
2.1c.4 Hospitalised smokers given assistance to stop smoking	Taima Campbell (ADHB)	There has been substantial movement in terms of numbers being given brief advice in the Admission and Planning Unit, Adult Emergency Dept. and Ophthalmology Services. A number of services are consistently meeting the 80% target. The current focus is to work with wards/services that have not yet met the target, to determine the cause and work on strategies to assist them meet and maintain it.
2.1c.5 Reduce waiting times for oncology	Fionnagh Dougan (ADHB)	The MOH target is that all patients requiring radiation therapy treatment receive this within 6 weeks. We are achieving this target although at times this is being delivered through outsourcing to Waikato and the private centre in Auckland.



2.1c.6 Increase elective surgical discharges to 10,227

[Ngaire Buchanan \(ADHB\)](#)

Surgical Steering group formed with Terms of Reference including a number of different pieces of work to come within this programme, including service improvement with TPOT, GSU, Capacity planning and MOH productivity

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Access to Diagnostics	Regional	Improve				Project is on track to deliver outcomes within an ammended timeframe. Key focus in the next period will be on scoping and commencing evaluation of the Project and on establishing cost effective connectivity to the ProExtra 'tool' for the non ProCare practices.
Skin Lesions	Regional	Improve				Project has had a major set back, with the EOI process run to identify suitable Primary Care providers having to be withdrawn due to a process issue. Project is now behind schedule. GAIHN ALT has sugested that ADHB divert away from the regional project and look to fund Primary Care direct for this via the ProXtra tool. A recent Clinicla Advisor Group has considered this request and recomendadted that ADHB stick with the regional project as originally described.

Legend: Red - , Orange - , Green - 

Goal: 3 Live within our means

High Level Summary - total projects: 1

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits			
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Finished	Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
3.1a Manage revenue to maintain break-even position	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
3.1b Cost management to maintain break-even position	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.2a Manage cash for sustainable balance sheet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
Total %	100%	100%	0%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	0%	0%	0%	0%

Objectives

No Objectives have been entered for this committee or group against this goal.

Exceptions

There are no projects that have been marked as an exception

PAPERS

**7.1 SURGICAL PERFORMANCE
– NGAIRE BUCHANAN**

Surgical Performance Programme Overview & The Productive Operating Room

HAC Presentation
October 2010

Overview

- Surgical Performance Steering Group
- Clinical Reference Group
- Current Workstreams
 - GSU development
 - **The Productive Operating Room**
 - Capacity Planning (surgical component)
 - ACH resource changes

Deliverables

- Elective surgical volumes
- Acute surgical volumes
- ESPI compliance
- Waiting list reduction
- GSU start up to plan
- 6% productivity improvement
- Successful introduction of TPOR
- Changes required to deliver capacity plan
- Implementation of ADHB's National Electives Productivity and Workforce Development Initiative

Key Performance Indicators

- Elective & Acute Surgical volumes to contract
- Medium acute time to OR (TBC)
- ESPI compliance
- ADHB Pop waiting list reduction
- GSU on plan

The Productive Operating Room

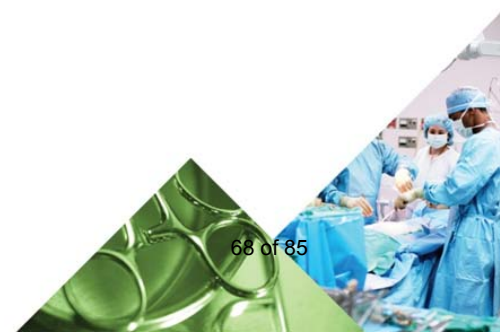
A better place to work, a safer place for care

23 Sep 2010



Why focus on ORs?

- ORs represent a significant ADHB investment. Their performance impacts a large number of patients, their families, and our staff
- Significant improvements have been made in changing and standardising OR operations in the past
 - This programme can identify new areas for improvement, or help augment existing processes



Why introduce this NHS programme?

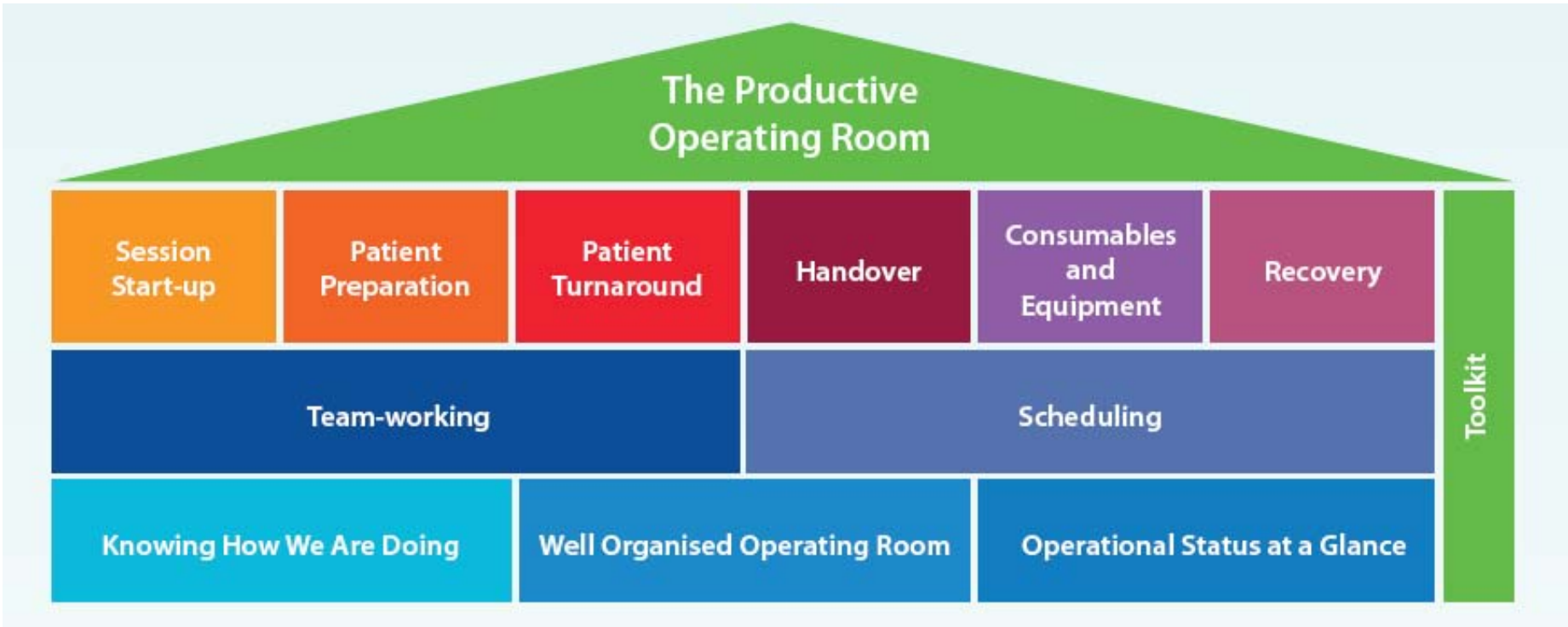
- Good fit with organisational goals of:
 - Putting patient experience and outcomes first
 - Clinician led approach to improvement
 - Embedding continuous improvement into business as usual
 - Supporting throughput goals to manage growing acute volumes and elective targets
- Positive experience with Releasing Time to Care
 - Lean thinking tried and tested in the healthcare environment



The Productive Operating Room

A better place to work, a safer place for care

70



**Team performance
and staff wellbeing**

**Patient's
experience
and outcomes**

**Safety
and reliability
of care**

**Value
and efficiency**



Releasing time to care & The productive Operating Room

Similarities

Developed and tested in NHS

Led by people that do the work:
not an outside-in approach to
improvement

Foundation modules are the same

Includes Process modules, as per
RTC, but relevant to Operating
Rooms

Differences

Enabler modules:

Scheduling and Teamwork

Recognising that these two drivers
of OR performance are critical to
developing a high performing OR



Timeline of key events and milestones



Benefits achieved in NHS

Safety & team working

Measurable increase in **job satisfaction, team working climate** and **safety climate**

Recovery: improved **pain scores** < 6 to 88%, **normothermia** to 98%

Consumables and equipment

£12K one off stock reduction per theatre

£9K annual saving per theatre on consumables

Session and list utilisation

Improved session utilisation from 90% to 99% with abolition of extra sessions

16% increase in touch time

Overall potential gain from full roll-out (estimated)

At least £3 million per annum

(for an *average* trust with 16 theatres)



How you can help us

- **Recognise that improvement requires investment**
 - **Ensure staff have time available for attending workshops and activities required**
 - **Help us find ways to manage throughput and ESPI compliance requirements for participating services so they can focus on improvement**
- **Visit the floor to see the environment and get an appreciation of the good work already done on level 4**
- **Support the team in their endeavours, they are the showcase suite and need your backing**



Staff quotes about this Programme...

“The Productive Operating Room programme allows theatre staff to make the changes they know need to be made to improve the efficiency of their own work environment”

Indran R – CT Surgeon

“It’s about empowering the staff to make changes, improve processes, improve the patient journey for theatres and making the OR a better place to work”

Wendy Ravelich – OR Manager

“This programme gives all staff involved in operating rooms the opportunity to change the working day to make it more enjoyable and efficient”

Rajan Patel – ORL Surgeon



FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

GENERAL BUSINESS

10

APPENDICES

10.1 Healthcare System Diagram

10.1 Healthcare System Diagram

