



Auckland District Health Board

Hospital Advisory Committee Meeting

Wednesday 6 April 2011

10.45am

A+ Trust Room

Clinical Education Centre

Level 5

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.		
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KPIs		
RECOMMENDATIONS		
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RISKS		
RECOMMENDATIONS		
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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).

CONFIRMATION OF MINUTES
- WEDNESDAY 2 MARCH 2011

MEETING DETAILS													
Time and Date	10:45am, Wednesday, 2 March 2011												
Venue	Sorrento in the Park, One Tree Hill Domain, Epsom												
1	ATTENDANCE AND APOLOGIES												
	<p>The Chair declared the meeting open at 10:47am.</p> <p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> <tr> <td>Associate Professor Anne Kolbe</td> <td>Professor Iain Martin</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith –Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Greg Balla – Director Performance and Innovation Taima Campbell – Executive Director Nursing Aroha Haggie –Maori Health Gains Manager Janice Mueller – Director Allied Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Rob Cooper and Ngaire Buchanan. An apology for lateness was recorded for Gwen Tepania-Palmer</p>	Dr Chris Chambers (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	Associate Professor Anne Kolbe	Professor Iain Martin
Dr Chris Chambers (Chair)	Jo Agnew												
Peter Aitken	Judith Bassett												
Susan Buckland	Dr Lester Levy												
Dr Lee Mathias	Robyn Northey												
Gwen Tepania-Palmer	Ian Ward												
Associate Professor Anne Kolbe	Professor Iain Martin												
2	CONFLICTS OF INTEREST												
	<p>There were no declarations of conflicts of interest for any item on the agenda.</p> <p>It was noted that Iain Martin was Chair of the Peri-Operative Mortality Review Committee and he undertook to talk on the operations of the committee in the third quarter of 2011.</p>												
3	CONFIRMATION OF MINUTES 2 FEBRUARY 2011												
	<p><u>Moved Jo Agnew, seconded Ann Kolbe</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 2 February 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The membership of committees will be finalised by the Chair in the next few weeks.</p>												

4	ACTION POINTS 2 FEBRUARY 2011
	<p>Financial Forecast</p> <p>This had been included in the Finance Committee papers.</p> <p>Capacity</p> <p>More work was being undertaken with Waitemata. Margaret Wilsher Chairs the regional planning of services and the regional service plan will come to the next meeting. It was noted that the University was going to increase their student numbers and so needed the regional service plan to plan their clinical education. The regional plan was based on “Do No Harm” addressing quality, having informed patients with advanced care planning, a focus on chronic care management of diabetes, CVD, cancer, and health of older people based on years to life, life to years and giving disadvantaged populations better access to care and treatment with specific deliverables in year one. This was an umbrella for ADHB’s DAP.</p>
7.1	Electives and Elective Targets 2011/2012
	<p>Peter Lowry, Director of Elective Performance was in attendance and presented to the Committee. The Government’s plan was to increase electives by 4,000 per annum which is an increase in excess of population growth. ADHB had been asked to increase their work the most with a projected 8% increase in 2011/2012. ADHB was at 94% and Waitemata at 92% of the equitable share so there is a need for considerable increase and this will be funded out of PBF. The drive for high targets and intervention rates were being discussed with the Ministry so that there is not an over investment which exceeds supply. ADHB undertook 40% of Waitemata’s electives and a combined view should be taken.</p> <p>There needs to be clarity on accounting as this was an issue with elective work being done out of theatres and not being counted and accounting was required to see that ADHB’s population had the right intervention rate at the national average: “if we fund it count it” no matter where it is done. ADHB did need to catch up from a historical low which raised the question of affordability and handling acute flows with funding through PBF. While the peak in 2010/2011 was being met in private there was planning and development of facilities now so that it did not occur in 2011/2012. This will involve the new plant at Greenlane, an investment in the productive operating theatre initiative and require a cultural shift to a big elective unit. The culture should be electives plus acutes rather than acutes plus electives.</p> <p>The Health Target Production Plan to 30 June 2011 showed that from the 500 unallocated volumes at 1 February this had been reduced to 116 at 1 March with planning service by service and would involve a 40% increase in production in the second six months compared with the first six months. The cultural change to move to Greenlane and the tension on the model that ADHB wished to run was not underestimated.</p> <p>The compliance risk to ESPI 5 had been addressed in February however it is non compliant for ESPI 2, patients waiting greater than 6 months for a first specialist appointment, which required a reduction of 250 patients. A number of strategies were being undertaken prioritising patients, looking at different pathways and daily and weekly monitoring. The responsibility was that of the clinical services and how information is presented was being reviewed to make it usable to assist decision making. The plan was to get to the elective target and be ESPI compliant.</p>
	Meeting the Health Targets
	<p>In ED there had been an analysis of activities to reach the six hour target with times to ED decision making having increased to 4 hours which was too long. More resources had been put into ED to lift performance i.e., bed management, nurse specialists and where there were breaches of times individuals were talked to. A dedicated acute surgical team for 7 days a week had been established. While there had been a step change in performance this had to be continuous and while there had been more resources the culture needed to change. It was noted that the new Director General was more engaged with health targets. It was suggested that the health target should be ADHB’s target and not have an ADHB interim target.</p>

5.1	Operational Report
	Financially there was a focus on managing of outsourcing, labour costs through leave management and direct treatment costs were subject to clinical scrutiny.
6.1	DAP Projects Report
	In relation to the strengthening clinical leadership model there was a question of building leadership across the region to lift clinical leadership and engagement with work being done with Health Workforce New Zealand and the Counties Manukau programme being very appealing. There was a question of how much to invest and priorities with a wide range of skill sets and engagement. It was noted that the annual review process can be negative.
	Networks
	The question of clinical practices and their impact on the bottom line was raised noting that clinical supplies are managed at the service level and that for changes of clinical practice there was the Clinical Practice Committee. ICD were driving costs through broadening their use. The Committee asked for a discussion on the impact of clinical networks, their governance, funding etc. both at the national and regional level. The regional cardiology network across the region was very powerful and the Northern Regional Health Plan was also an example of a living network.
	NEXT MEETING
	The meeting closed at 12:17pm The next meeting is scheduled for 10:45am, Wednesday, 6 April 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton
CONFIRMED	
CHAIR:	DATE:

4

ACTION POINTS

WEDNESDAY 2 MARCH 2011

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 2 March 2011**

Item	Detail	Designated	Action
5	Regional Service Plan to be advised to Medical School to assist in planning for increased enrolments	Margaret Wilsher	
6	Evaluation to Cancer Network	Greg Balla Fionnagh Dougan	

OPERATIONAL PERFORMANCE

5.1 OPERATIONAL SUMMARY REPORT

PROVIDER OPERATING STATEMENT

SIGNIFICANT VARIANCES

**THROUGHPUT, FRONT DOOR, ADMISSION TYPE, ESPI
PERFORMANCE, CONTRACT VOLUMES**

5.2 HEALTH TARGETS UPDATES

5.3 OPERATIONAL INDICATORS - EXCEPTION REPORT

5.1.1 PROVIDER (including support services) OPERATING STATEMENT

The ADHB Provider is made up of the clinical services (“Operational”) together with Ancillary Services - Finance, HR and IS, Public Health, A+ Trust, Research and our Retail businesses.

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.

Provider	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operating Statement - February 2011						
Profit & Loss						
<i>Total Income</i>						
Internal Allocations - Ex Funder	81,291	77,843	3,448F	665,439	662,783	2,656F
MOH - Funding Subcontracts	2,882	2,749	133F	20,424	23,555	3,131U
Other Patient Care Revenue	2,777	2,677	99F	23,473	21,537	1,936F
Sales of Services & Products	4,103	4,380	278U	35,863	35,624	239F
Clinical Training & Education Income	1,715	1,757	42U	12,862	13,276	415U
Trust & Donation Income	293	427	134U	4,033	3,460	573F
Financial Income	559	316	244F	5,604	2,944	2,660F
Other Income	577	500	77F	4,214	4,194	20F
Profit on Disposal of Fixed Assets	78	0	78F	208	1	207F
Total Income	94,274	90,648	3,626F	772,119	767,375	4,744F
<i>Operating Expenditure</i>						
Employee Costs	59,265	56,322	2,943U	485,383	483,367	2,016U
Direct Treatment Costs	19,061	16,971	2,090U	151,097	139,459	11,638U
Indirect Treatment Costs	3,177	3,186	9F	28,379	25,916	2,463U
Property, Equipment & Transportation Costs	3,759	3,919	160F	31,726	32,714	988F
Administration Costs	1,299	1,627	328F	11,661	12,550	889F
Maintenance Programme	196	133	62U	1,276	1,067	209U
Indirect Service Billing	482	482	0F	3,857	3,857	0U
Loss on Sale of Fixed Assets	14	1	13U	374	11	363U
Total Operating Expenditure	87,253	82,643	4,610U	713,754	698,942	14,812U
Operating Surplus/(Deficit)	7,021	8,005	984U	58,365	68,433	10,068U
<i>Non-Operating Expenditure</i>						
Capital Charge	2,921	3,062	141F	22,861	24,256	1,395F
Depreciation	4,190	4,435	245F	34,368	36,018	1,650F
Finance Costs	1,394	1,582	188F	12,225	13,386	1,161F
Total :Non-Operating Expenditure	8,505	9,080	574F	69,454	73,660	4,207F
Total Surplus/(Deficit)	(1,484)	(1,075)	410U	(11,088)	(5,227)	5,861U

Commentary on significant variances follows overleaf.

TOTAL INCOME

1 Patient Care Revenue (incorporating internal allocations from Funder, Ministry sub-contracts and Other Patient Care Revenue) – Year to Date \$1.5m Favourable

The Operational areas are 1,214 wies under plan YTD \$(5.3)m offset by \$6.8m overproduced in non DRG services.

The 1,214 wies under plan is (711) ADHB and (503) other DHBs.

Ministry sub-contracts are adverse by \$(3.1)m. There is a partial offset with the 'operational' result above in that Herceptin revenue is budgeted in Ministry sub-contracts but recognised in the base revenue above.

Other significant revenue variances are:-

Non resident income \$2.8m favourable year to date (NB under Expenditure – bad debt related costs are (1.9)m unfavourable year to date)

Accident Corporation income \$(1.1)m unfavourable year to date

2 Trust & Donation Income – Year to Date \$0.6m Favourable

Trust and donation income is favourable by \$0.6m YTD; the timing of such receipts is variable especially in respect of the fund raising efforts of the Starship Foundation.

3 Financial Income Year to Date \$2.7m Favourable

Higher interest received on term deposits \$1.7m F and a realised gain on Interest Rate Swap Instruments \$0.9m F.

OPERATIONAL COSTS

4 Employee Costs (Year to date \$2.0m Un-Favourable)

Significant employee cost variances in the month were:-

Adult Health \$(1.0)m U
CWORAC \$(1.1)m U
Financial Provisions \$(0.5m) U

Adult Health \$(1.0)m U

Medical – Medical FTE overall are 13 unfavourable, reflecting HOs that are 14 FTE over budget due to an agreed approach with ARRMOS to over allocate to Gen Med and Gen Surg in the February rotation on the basis there are normally a high number of withdrawals (which does not appear to have been the case for the December rotation). **\$(98)k U**

Nursing - 54 FTE over budget - predominantly due to approved unbudgeted additional positions in AED/APU to assist with acute flow and meeting the 6 hour target, and across the General Medicine wards where lower summer MOC has not been achieved due to high occupancy levels. In addition there has been a very high level of mental health watches during the month of February. **\$(544)k U**. A process for these services for all bureau usage to be signed off by Level 3 Nurse Advisor has been put in place. Watch usage is also being reported to Nurse Advisors daily for review and management with Duty Managers and Charge Nurses.

Staff Related Expenses – Largely timing differences for recharging from ARRMOS and payment of registration fees, year to date remains \$280k F). **\$(182)k U**

CWORAC \$(1.1)m U

CWORAC Management **\$0.2m F** - Employee costs are favourable due to a transfer in from Corporate to partially cover Employee Meca cost increases.

Women's Health **\$(0.2)m U** – variances mainly in obstetrics, Medical staffing \$(100)k U, - costs associated with job sizing and FTEs over budget; Nursing staffing \$(78)k U – bureau and resource nursing numbers over budget, higher unit cost offsetting the savings from the vacancies which they were filling..

Child Health **\$(0.4)m U** – the most significant variance was in Paediatric Cardiac and ICU - \$(399)k U, variances in other areas netted off. Low budget phasing impacted in February with budgets for Medical and Nursing phased significantly lower than the yearly average by \$195k. Although over budget, actual costs for the month were in fact lower than the average of the preceding 7 months. The balance of the UF variance related to the additional 2% salary increase \$50k; bureau nursing charges in NICU of \$62k and allowances and overtime related to the high activity levels in NICU, PICU and Ward 23B for the month. NICU, for example, is budgeted at 85% occupancy but averaged 93% with an excessive number of Level 3 (most complex) babies. PICU had very high numbers of transport hours (144). Ward 23B had occupancy of ~110% during the month with very complex patients needing an additional 4FTE to manage their care. Staff related expenses \$79k UF main variance was for SMO CPE including overseas travel.

OR & Anaesthesia & CSSD **\$(0.7)m U** - 2% increase for SMO's RMO's and Nursing. Medical \$158k U largely due to RMO 2% back pay. Nursing \$427k UF, 25.51 FTE UF. High Nursing costs largely driven by theatre minutes which are higher then budget combined with low budget cost per FTE in SSSU and SSH.

Financial Provisions \$(0.5m) U

Central accruals for wage awards and employee provisions in excess of budget.

FTE Table 1 – FTEs for Month and YTD (February 2011)

FTEs	Month			YTD		
	Budget FTE Month 2010-11	Actual FTE Month 2010-11	Total FTE Variance Month	Budget FTE YTD 2010-11	Actual FTE YTD 2010-11	Total FTE Variance YTD
Adult Health	1,717	1783	-66	1,725	1743	-18
Ambulatory	249	266	-17	249	263	-14
Women's & Children's	1,342	1344	-2	1349	1346	3
Operations	1436	1445	-9	1432	1414	18
Operating Rooms & Anaesthesia	689	723	-34	689	691	-2
Mental Health	746	728	18	747	718	28
Cancer & Blood Services	299	299	0	299	294	5
Cardiac Services	451	442	9	451	437	14
Other Operational	1	1	0	1	3	-2
Ancillary	972	987	-15	974	968	6
TOTAL	7,902	8,018	-116	7,916	7,877	38

The FTE numbers excluding Mental Health (which has a separate funding stream) is (134) FTE U for the month; and 10 FTE favourable YTD.

The unfavourable variances in Adult Health YTD relate to the accumulated impact over the year of (a) additional staff in AED/APU supporting shorter stays in ED, (b) additional staff in General Medicine due to higher occupancy than the budget assumption over the summer months as well as a high number of psych watches (13.5 FTE in the month of February), and (c) house officers over-appointed in the December run due to a change in practice agreed with ARMOSS to address the ongoing vacancies and gaps in run rosters.

The unfavourable variance in Operating Rooms & Anaesthesia relates to the additional staff who have been appointed to support the new initiatives relating to theatre throughput e.g. longer theatre hours at ACH, additional theatre capacity in the Short Stay Unit at Greenlane

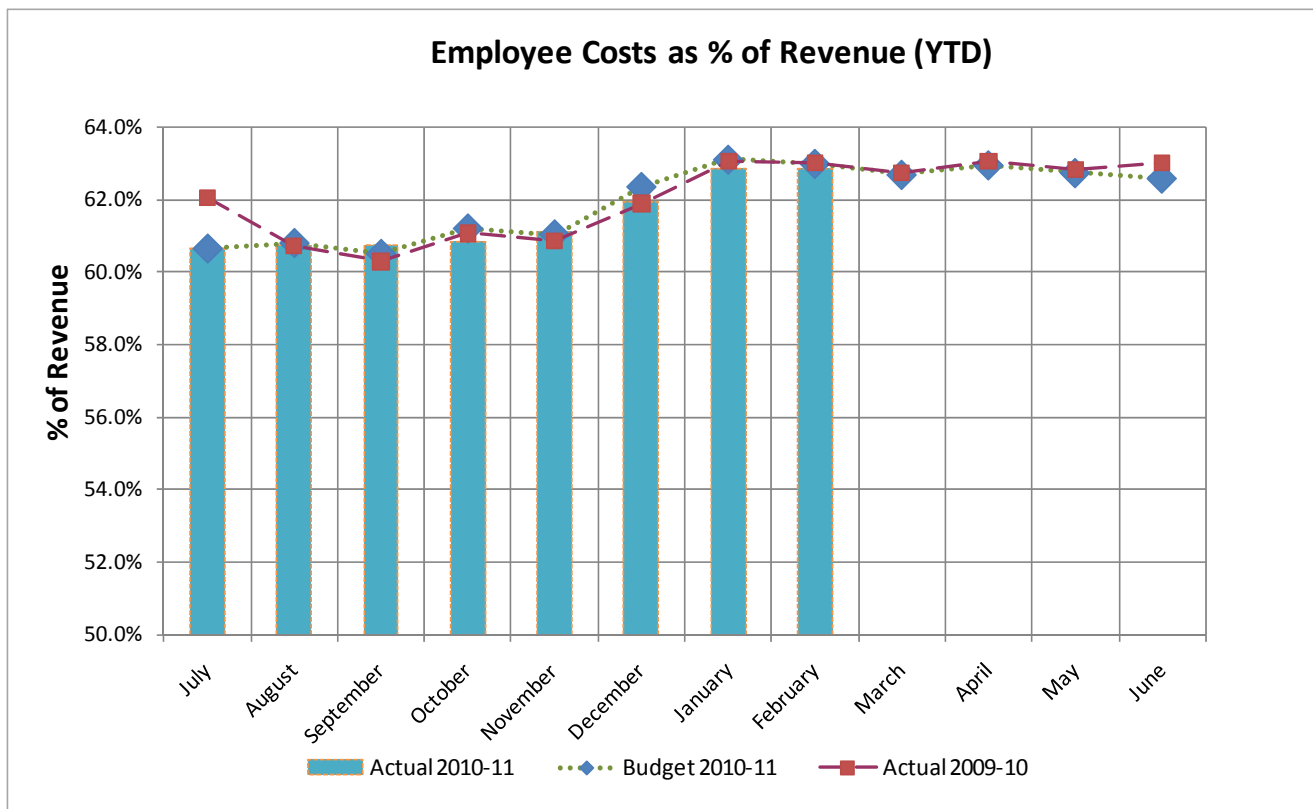
The unfavourable variance in Ambulatory Health Services YTD primarily relates to the target vacancy assumption not achieved and additional staffing costs in Ophthalmology for the Saturday theatre sessions to meet ESPI compliance.

FTE Table 2 – Cost per FTE

Provider Services – Staffing Variance			
Month 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	\$56.3	\$59.3	-5.23%
FTE Numbers	7,902	8,018	-1.47%
Cost per FTE (Month)	\$7,128	\$7,392	-3.70%
YTD 2010/11			
Budget	Actual	Variance %	
Employee Costs (\$M)	\$483.7	\$485.4	-0.35%
FTE Numbers	7,916	7,877	0.50%
Cost per FTE (Year to Date)	\$61,062	\$61,628	-0.93%

Within the unfavourable variance of \$(1.7)m UF YTD, there is an estimated figure of \$(6.7)m savings included in budgets of which \$1.7m is not achieved but \$4.68m has been achieved.

The chart below demonstrates the relationship between employee costs and revenue as a %, there has been a similar seasonal pattern in 2009-10 and 2010-11.



The year end forecast for staff costs for the provider arm is \$(3.3)m U to budget.

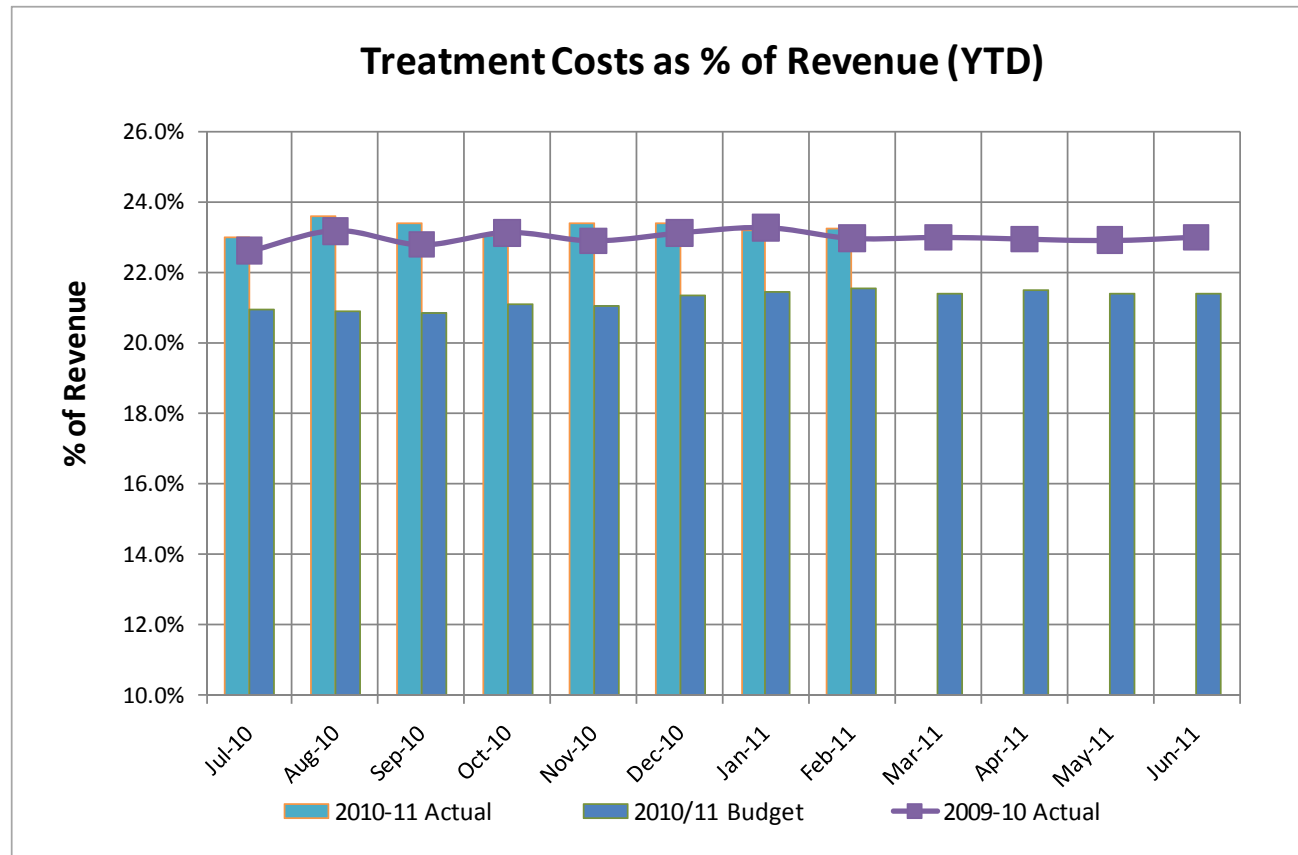
Significant Treatment Cost Variances and Actions

Direct and indirect treatment costs combined are \$(14.1)m adverse to budget year to date.

Direct Treatment Costs \$(11.6)m of which \$(9.8)m is savings targets not achieved.

Indirect Treatment Costs \$(2.5)m of which \$(1.9)m is non resident bad debts.

The chart below demonstrates the relationship between direct treatment costs and revenue. The budget for direct treatment costs as a proportion of revenue fell from 2009-10 levels but actuals have remained largely unchanged.



Cost Item	YTD Position	Commentary on Year to Date Position
	\$m var to budget	
Clinical Supplies	\$(3.2)	Significant volume related costs primarily in OR&A (related to greater operating time than assumed in budget).
3 rd Party Costs	\$(3.2)	Cardiac, Operations and Cancer services \$3.9m, offset by other areas where outsourcing has yet to commence.
Patient appliances	\$(2.5)	Actual volumes higher than budgeted assumption in Cardiac and Child Health e.g. Paed Orthopaedics, Paed Cardiac.
Chemicals & Media	\$(1.9)	Assumptions related to a reduction in laboratory test numbers and a reduction in reagent prices have not been achieved
Drugs	\$(0.8)	Very high cost drugs in Immunology and Paediatric Oncology (specific patients), offset by a favourable variance in Adult Oncology
Direct Treatment	\$(11.6)	Sub total of above
Indirect Treatment	\$(2.5)	\$(1.9)m relates to non resident bad debts; \$(294)k to cost of sales for retail business (offset by revenue)

As shown above, of the \$11.6m overspend in direct treatment costs YTD, the significant components (and % of overall variance) are:-

- Outsourcing in achieving health targets (cardiac and radiotherapy wait times) \$2.9m - 25%
- Cost savings in budgets not achieved in direct treatment costs (net of outsourcing savings) \$6.8m - 58%

Action Plans

- Targetted use of outsourcing to year end to enable health targets to be achieved and revenue which is currently unearned to be obtained.
- Careful review of use of high cost drugs in paediatric oncology and maintenance of the existing favourable mix variance in adult oncology.
- Ongoing review in conjunction with clinical partners the use of clinical supplies, patient appliances and other volume related variances, examples ongoing include : Radiology - Review of MRI usage; Laboratories - review of send-away tests and service delivery in Sexual Health; in addition there are service excellence projects in General Medicine, General Surgery, Orthopaedics and Radiology.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	Feb-11	Att per Day	Comparison to Last Month	Jan-11	Att per Day	Comparison to Last Year	Feb-10	Att per Day
APU	1,568	56	-4.3%	1,639	53	7.1%	1,464	52
AED	4,281	153	-8.1%	4,656	150	11.1%	3,852	138
CED	2,247	80	-3.2%	2,321	75	-3.8%	2,335	83

- **APU** - Small drop in volumes but their highest February. Average LOS dropped but median LOS increased slightly. Both were at least 1.5 hours longer than February last year. This may be due to high AED volumes and/or patients being transferred from AED to APU earlier.
- **AED** - Record high daily rate - 11% higher than February 2010. The admission rate (25%) was high for a February – February 2010 was 22%; February 2009 was 23%; February 2008 was 24%. However the average LOS was a record low and the median LOS stayed low, i.e. excellent flow. There is some evidence of a small increase in attendances from Canterbury based patients post earthquake.
- **CED** - Volumes have been dropping since November10 but it is unusual to have a drop in February. LOS measures increased as per previous years.

Throughput – by Admission Type

Year to Date inpatient volumes for the eight months to February 2011 are as follows in the table below. The table compares volumes firstly this years contract (% of completion) and then compared to last year.

Electives (wies)

DHB	Actual Last Year	Contract This Year	Actual This Year	Variance	% of completion	% compared to last year
ADHB	8,421	9,978	7,975	-2,003	79.9%	94.7%
CMDHB	3,214	3,556	3,154	-402	88.7%	98.1%
WDHB	4,153	4,531	3,860	-671	85.2%	92.9%
NLDHB	1,491	1,612	1,291	-321	80.1%	86.6%
Other DHBs	2,047	2,554	2,292	-262	89.8%	112.0%
	19,326	22,231	18,572	-3,659	83.5%	96.1%

Acutes (wies)

DHB	Actual Last Year	Contract This Year	Actual This Year	Variance	% of completion	% compared to last year
ADHB	33,577	33,271	34,563	1,292	103.9%	102.9%
CMDHB	7,961	8,104	8,087	-17	99.8%	101.6%
WDHB	11,978	11,765	12,494	729	106.2%	104.3%
NLDHB	2,757	3,007	3,142	135	104.5%	114.0%
Other DHBs	4,538	4,731	5,037	305	106.5%	111.0%
	60,811	60,878	63,323	2,445	104.0%	104.1%

Acute & Elective Combined (wies)

DHB	Actual Last Year	Contract This Year	Actual This Year	Variance	% of completion	% compared to last year
ADHB	41,998	43,249	42,537	-711	98.4%	101.3%
CMDHB	11,175	11,660	11,242	-419	96.4%	100.6%
WDHB	16,131	16,295	16,354	58	100.4%	101.4%
NLDHB	4,248	4,619	4,433	-186	96.0%	104.4%
Other	6,585	7,285	7,329	44	100.6%	111.3%
	80,137	83,109	81,895	-1,214	98.5%	102.2%

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

Throughput – Elective Service Performance Indicators

ESPI 2 – waiting for first specialist appointment

We were compliant at the end of February; the projection at the end of March is also for compliance.

ESPIs 2, 5 & 6 Status							
as at end of Feb-11		Total FSA Waitlist	ESPI 2: FSAs				
Health Service Group	Seen 12 Months		Level	Status	Limit	Imp. Req'd	
Adult Health Services	Cardiology	339	2231	1	0.0%	33	0
	Cardiothoracic	16	142	0	0.0%	2	0
	Gastroenterology	408	1766	1	0.1%	26	0
	General Medicine	39	280	0	0.0%	4	0
	General Surgery	1275	3516	41	1.2%	52	0
	Haematology	102	836	0	0.0%	12	0
	Infectious Diseases	38	336	0	0.0%	5	0
	Medical Oncology	97	1904	0	0.0%	28	0
	Neurology	595	4470	15	0.3%	67	0
	Neurosurgery	198	538	23	4.3%	8	-15
	ORL	1098	2574	140	5.4%	38	-102
	Orthopaedics	861	1686	36	2.1%	25	-11
	Radiation Oncology	96	2589	0	0.0%	39	0
	Renal Medicine	79	485	2	0.4%	7	0
	Respiratory Medicine	510	1863	114	6.1%	28	-86
Urology	234	1431	0	0.0%	21	0	
Vascular Surgery	335	1233	8	0.6%	18	0	
Total: Adult Health Services		6320	27880	381	1.4%	415	0
Ambulatory Health Services	Dermatology	365	1151	0	0.0%	17	0
	Diabetes	0					
	Endocrinology	398	1200	3	0.3%	18	0
	Immunology	361	937	8	0.9%	14	0
	Ophthalmology	1810	10248	100	1.0%	153	0
	Oral Health	0	0	0	0.0%	0	0
	Rheumatology	315	645	8	1.2%	10	0
	The Auckland Regional Pain Service	246	234	48	20.5%	3	-45
Total: Ambulatory Health Services		3495	14415	167	1.2%	215	0
Women & Childrens Health Services	Paediatric Endocrinology	63	308	0	0.0%	5	0
	Paediatric ORL	390	1532	9	0.6%	23	0
	Paediatric Gastroenterology	33	133	1	0.8%	2	0
	General Paediatrics	146	1616	0	0.0%	24	0
	Gynae Oncology	10	326	0	0.0%	5	0
	Gynaecology	761	3126	0	0.0%	47	0
	Paediatric Haem/Onc	0					
	Paediatric Immunology	108	278	7	2.5%	4	-3
	Paediatric Infectious Diseases	17	197	0	0.0%	3	0
	Paediatric Neurosurgery	14	87	0	0.0%	1	0
	Paediatric Neurology	91	501	0	0.0%	7	0
	Paediatric Orthopaedics	345	2012	87	4.3%	30	-57
	Paediatric Cardiac	107	620	1	0.2%	9	0
	Paediatric Renal Medicine	12	150	0	0.0%	2	0
	Paediatric Respiratory Medicine	46	153	4	2.6%	2	-2
	Paediatric Rheumatology	10	53	0	0.0%	1	0
Paediatric Surgery	485	1801	89	4.9%	27	-62	
Total: Women & Childrens Health Services		2638	12893	198	1.5%	192	-6
ALL HBO		12453	55188	746	1.4%	822	0

ESPI 5 – waiting for surgery (overleaf)

We have achieved compliance for February 2011 and we forecast that we will remain compliant for March 2011.

ESPI 5

Includes Data Entry up to end of 13/03/2011

		February-11				March-11est			
		ESPI 5 - Certainty				ESPI 5 - Certainty			
Health Service Group	Specialty	Level	Status	Limit	Imp. Req'd	Level	Status	Limit	Imp. Req'd
Adult Health	Cardiology	12	0.8%	58	0	14	0.9%	62	0
	Cardiothoracic	0	0.0%	36	0	0	0.0%	35	0
	General Surgery	55	2.3%	96	0	53	2.2%	96	0
	Neurosurgery	55	15.1%	15	-40	45	12.4%	15	-30
	ORL	11	2.4%	19	0	5	1.2%	17	0
	Orthopaedics	49	6.0%	33	-16	62	7.8%	32	-30
	Urology	41	3.9%	42	0	43	4.1%	42	-1
	Vascular Service	0	0.0%	10	0	0	0.0%	10	0
Adult Health Services Total		211	3.4%	251	0	208	3.4%	247	0
Ambulatory Health	Ophthalmology	142	4.0%	143	1	181	5.2%	140	-41
	Oral Health Greenlane	6	0.4%	59	0	4	0.3%	58	0
Ambulatory Health Services Total		148	2.9%	202	0	185	3.7%	199	0
Women & Children's	Adult Congenital Medical Heart (ACHD)	3	5.4%	2	-1	2	3.3%	2	0
	Adult Congenital Surgical	1	2.9%	1	0	1	2.6%	2	0
	ENT	5	0.4%	56	0	4	0.3%	55	0
	Gastroenterology Paediatric	0	0.0%	7	0	1	0.6%	7	0
	Gynaecology Inpatients	20	1.1%	74	0	19	1.0%	73	0
	Neuroservices	1	1.2%	3	0	1	1.1%	3	0
	Orthopaedics Paediatric	22	5.1%	17	-5	25	6.0%	17	-8
	Paed Cardiology	4	2.3%	7	0	15	8.1%	7	-8
	Paediatric CTSU	4	2.2%	7	0	6	3.5%	7	0
	Respiratory Paediatric	1	2.1%	2	0	1	3.0%	1	0
Surgery Paediatric	29	2.8%	41	0	32	3.2%	39	0	
Women & Children's Health Services Total		87	1.6%	215	0	105	2.0%	211	0
ADHB Total		446	2.7%	667	0	498	3.0%	657	0

Other Organisational Pressure Points

General Medicine

General Medicine currently faces a number of challenges; SMO and RMO roster gaps due to vacancies, seasonality of workload often combining with vacancies impacting on workload for medical teams, and current medical leadership structure find it challenging to be able to resolve service issues.

Mitigation:

To move the service forward, General Medicine is actively engaged in a Service Excellence programme including full redesign of SMO structure and rosters. An external review of current state and proposed solutions will also be completed by Dr Robyn Toomath (General Physician CCDHB) over the next couple of months.

Starship & Child Health current issues:

- Ongoing high occupancy rate despite opening additional beds
- Reliance on overtime/bureau nursing to allow us to staff the additional beds
- Particular pressure points:-
 - PICU
 - Paediatric Cardiac Services
 - Level 6 Starship (Subspeciality Paediatrics)
 - NICU
- These areas are characterised by high complexity, national provider status and very limited ability to manage demand for services or transfer work to other providers.
- Starship Operating Rooms/Anaesthesia/Perfusionist capacity is also a significant restraint for many services, especially paediatric cardiac services.

Mitigation:

- Starship OR development business case in development (led by Ngaire Buchanan)

- Formal review of Paediatric Cardiac Services systems with performance improvement team support to be undertaken (initial planning starting now, Richard Aickin)
- Review of contracted volumes for paediatric services vs. Starship Hospital resourced bed capacity/nursing model of care: underway (Danah Cadman)
- Hospital response to red alert has been revised and changes implemented (Cath Byrne)
- Review of hospital service configuration to spread workload more evenly across wards to relieve 26B pressure (Elizabeth Wood)

Throughput – Contract Volumes

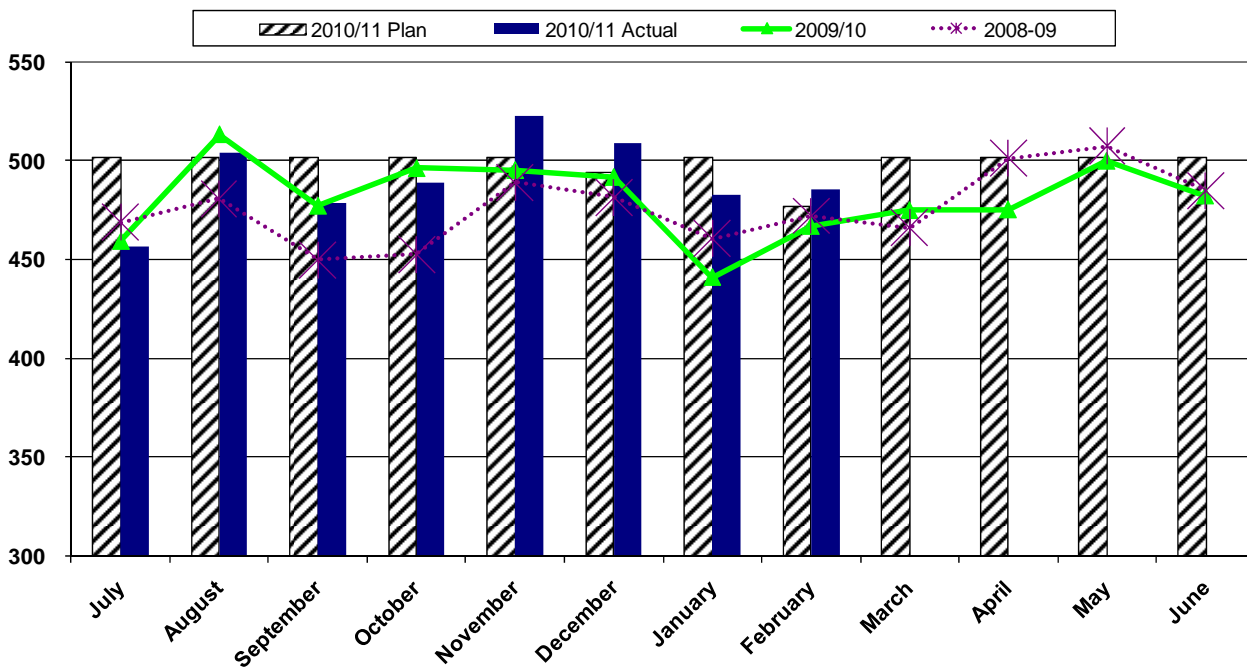
The chart below shows the production recorded to February 2011.

At the time the results were finalised, the coding was 72.7% complete with the average WIES per discharge being 1.3% higher than last year for the same period. Discharges are down by 0.3% from last year.

Inpatient delivery to the most current Price Volume Schedule was 101% for the month and 99% YTD.

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	9,715	9,370	345F	81,955	82,608	653U
WIES Delivery per day	486	469	17F	488	492	4U

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

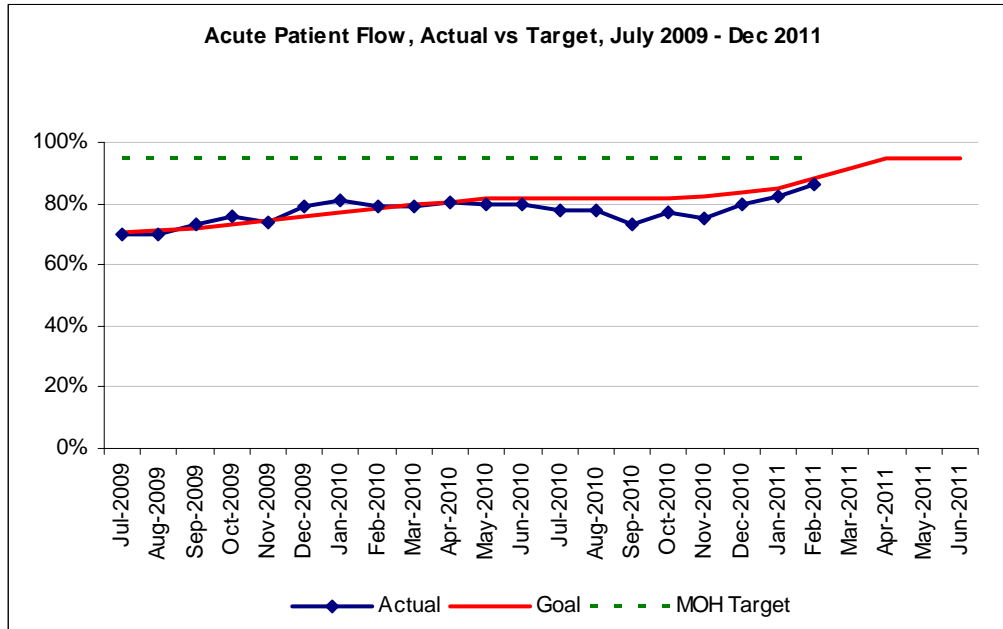


5.2 Health Targets Updates

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

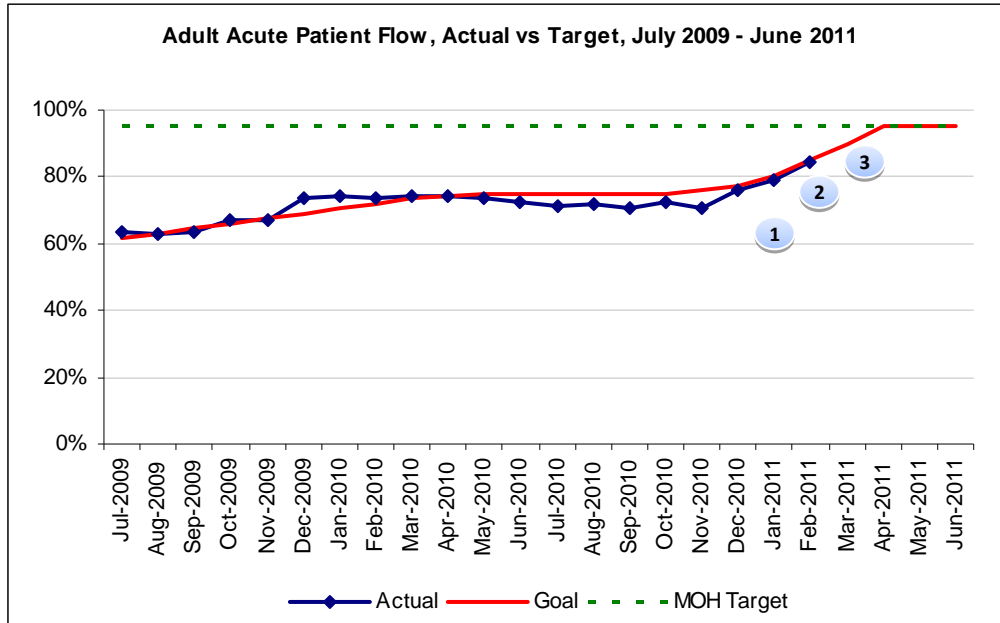
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

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 16th.

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 25th 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:

- Increased engagement of Senior Leadership Team to support improvement activities and reduce road blocks to improvement.

Increase communication and engagement of Clinical Directors, SMO's, RMO's

Increase communication and engagement of Charge Nurses and RN's after hours to further reduce wait times for patient transfer from Emergency Department

Engage with SMO's, RMO's and nurses one to one, by CD, Nurse Advisor or Level 2 clinical leader where resistance to required behaviour is demonstrated.

Valuing patient time poster campaign
- Establish ED short stay unit

Implement APU flex beds

Improve measurement of Ready to Go patients in ED

Complete recruitment of remaining ED resource to improve weekend coverage

Support General Medicine by diversion of patients to subspecialties

Implement general surgery acute flow team initiatives to improve response time

CMO to attend Orthopaedic SMO meeting to increase engagement.

Relocate bed manager to ED after hours

Implement ED discharge nurse on weekend

Hands on support of ED flow Charge Nurse to reduce roadblocks to timely review and transfer of patients

Commence physiotherapy facilitated discharge in Orthopaedics.

Establish discharge co-ordination responsibility in Gen Med ward nursing team.

Further increase timely overnight transfers from ED to inpatient wards once bed allocated.
- Five day rapid improvement event planned for April to focus on improvement of process from decision to admit to patient transfer complete.

Improve elective scheduling.

Project: Children's Acute Patient Flow

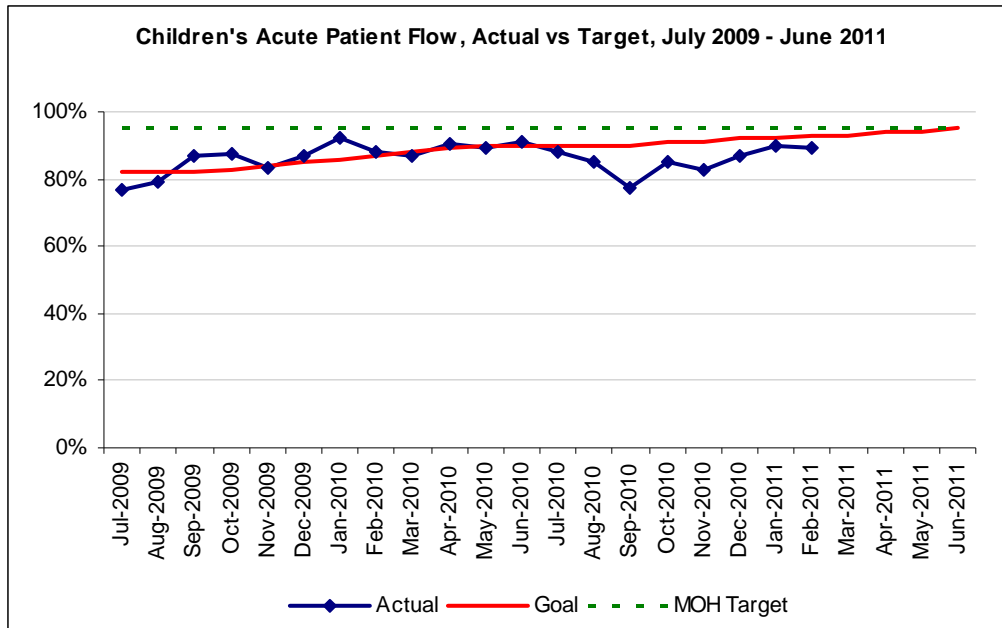
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan, 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.

Hospital Advisor Committee

Wednesday 6 April 2011

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

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

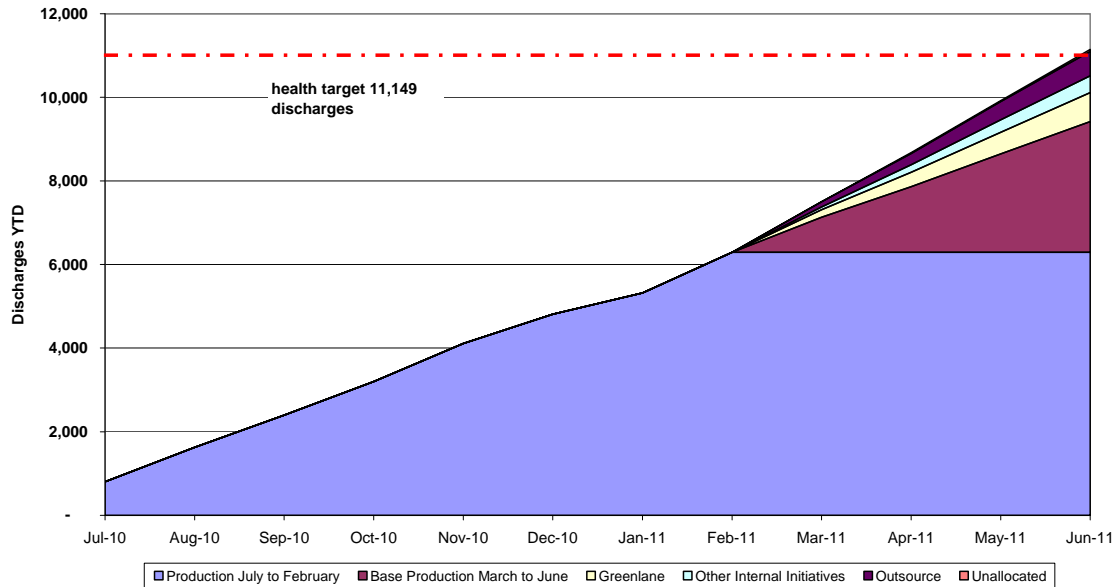
Date of Delivery: 30 June 2011

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

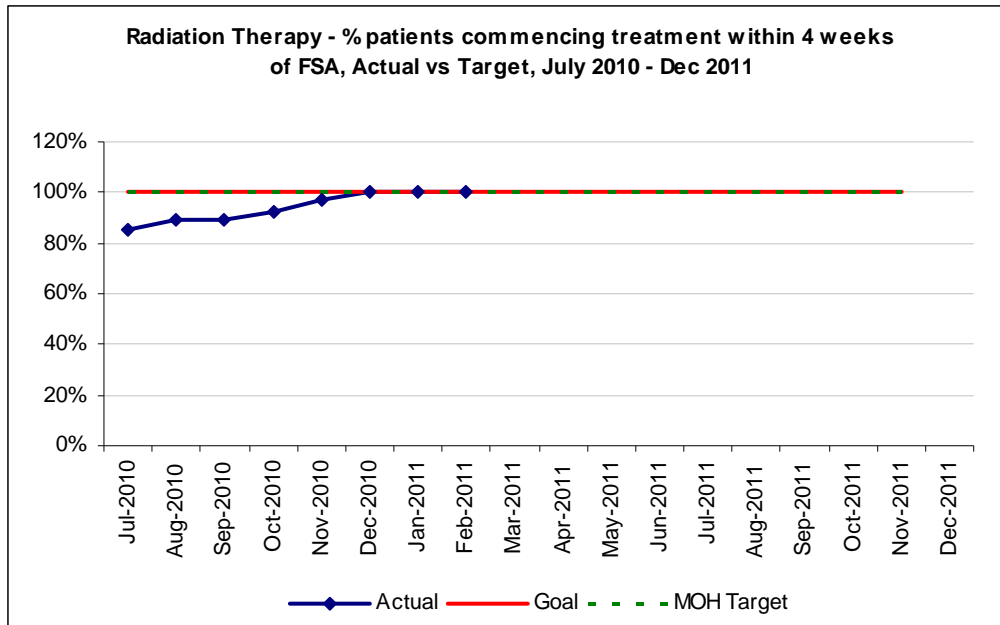
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

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

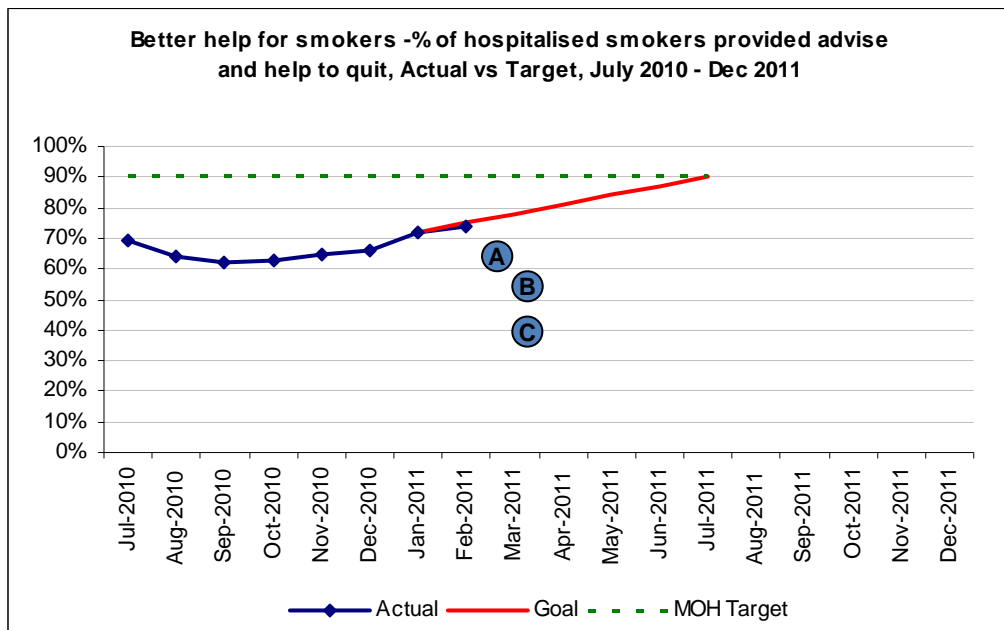
Primary Objective : % of hospitalised smokers provided advice and help to quit

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.

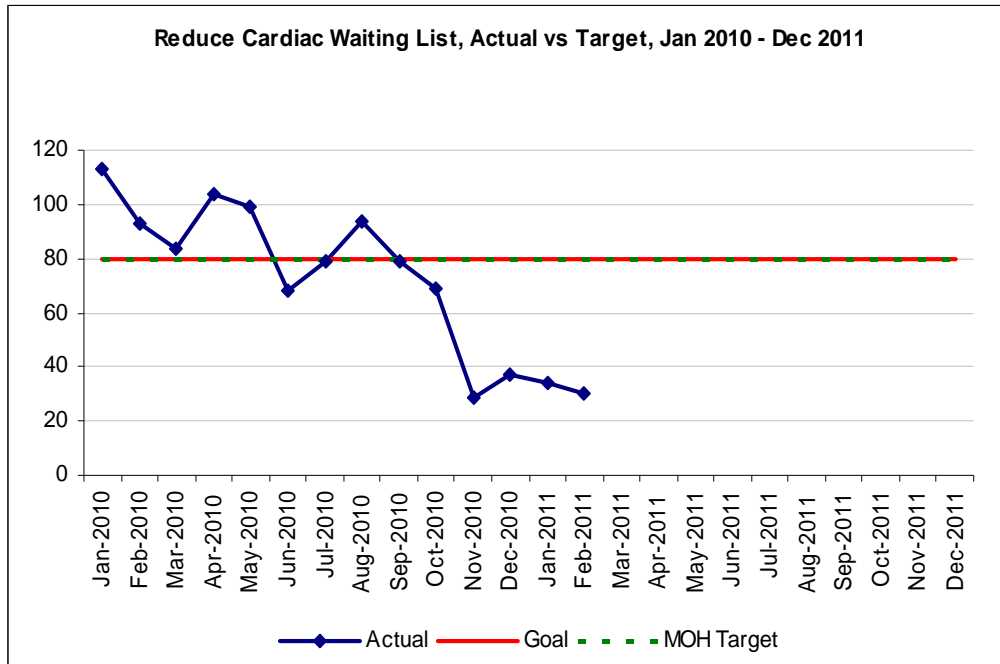
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

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

5.3 Operations Indicators Exception Report

ADHB HAC KPI Report

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

February 2011

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	Jan-11	2 Ω
B9. Total WIES Volume _IDF	M	Jan-10	2 Ω
B10. Non-DRG Revenue - IDF	M	Jan-11	2 Ω
B11. Acute WIES Volume -All DHBs	M		3 Ω
B12. Elective WIES Volume -All DHBs	M	Jan-11	3 Ω
B13. Total WIES Volume - All DHBs	M	Jan-11	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
B41. Mental Health Total Access - Rate	M	Dec-10	6
B41b. Mental Health Access Rate - Maori	M	Dec-10	6
B40. Mental Health Total Community Face-to-Face Appts.	M	Jan-10	12
B42. Mental Health Community New Referrals	M		12
Productivity			
B15. Acute WIES per Day	M		5
B16. Elective WIES per Working Day	M	Jan-11	5
B17. FSA per Working Day	M		5
A27. Inhouse Elective WIES through Theatre - Per day	Q		Q2
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
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
B65. DOSA Rate - Neurosurgery	M	Jan-11	10
A03b. Elective Day of Surgery Admission (DOSA) Rate - Maori	Q		Q1
A03d. Elective Day of Surgery Admission (DOSA) Rate - Pacific Island	Q		Q1
B50b. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Maori	Q		Q3
B50c. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Other	Q	Jan-11	Q3
B50d. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Pacific	Q		Q3
B51b. Percentage of chemotherapy patients receiving treatment within 6 weeks of FSA - Maori	Q		Q4
B51c. Percentage of chemotherapy patients receiving treatment within 6 weeks of FSA - Other	Q		Q4
B51d. Percentage of chemotherapy patients receiving treatment within 6 weeks of FSA - Pacific	Q		Q4
B52b. Percentage of radiation oncology patients attending FSA within 6 weeks of referral - Maori	Q		Q5
B52c. Percentage of radiation oncology patients attending FSA within 6 weeks of referral - Other	Q		Q5
B52d. Percentage of radiation oncology patients attending FSA within 6 weeks of referral - Pacific	Q		Q5
B54b. Percentage of A,B&C category Rad Onc pts receiving treatment within 4 wks of FSA - Maori	Q		Q6
B54c. Percentage of A,B&C category Rad Onc pts receiving treatment within 4 wks of FSA - Other	Q		Q6
B54d. Percentage of A, B & C category Rad Onc pts receiving treatment within 4 wks of FSA - Pacific	Q		Q6
Acute Process			
A56. Percentage of stroke patients cared for within the stroke unit - Total	6 monthly	Jul-10	Ω
A56b. Percentage of stroke patients cared for within the stroke unit - Maori	6 monthly		
A56d. Percentage of stroke patients cared for within the stroke unit - Pacific	6 monthly		
B63. Mental Health percentage of people with relapse prevention plans	M	Jan-10	12
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
February 2011

No exceptions for this month

IMPROVEMENT ACTIVITIES

6.1 DAP Projects Report

Group Pack Report

Group/Committee: Quality, Risk and Audit Committee - Goal 2



Goal: 2 Performance improvement

High Level Summary - total projects: 56

High Level Strategy	Number	Started	Current Phase							On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Define	Measure	Analyse	Do/Check/Improve	Act/Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green		Orange	Red	
																						Green
2.1a Efficient and effective Primary health care	3	3	1	0	0	2	0	0	3	0	0	3	0	0	2	1	0	0	0	0	0	0
2.1b Improve primary-secondary system efficiency	8	7	2	1	0	4	0	0	5	3	0	7	1	0	6	2	0	0	0	0	0	
2.1c Improve quality of hospital care while improving productivity	21	21	2	3	4	11	0	0	16	4	0	20	0	0	19	1	0	1	1	0	0	
2.2 Improve leadership capability	1	1	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0	
2.3 Improve Clinical Quality and Professional Governance	10	9	2	1	1	2	2	0	8	1	0	9	0	0	9	0	0	1	1	0	0	
2.4 Strengthen the health workforce	6	6	0	1	1	4	0	0	4	1	1	5	0	1	5	0	1	0	0	0	0	
2.5 Information management	6	6	1	1	1	2	1	0	3	3	0	4	2	0	6	0	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 #	56	54	9	7	8	25	3	0	40	13	1	50	3	1	49	4	1	2	2	0	0	
Total %	100%	96%	16%	13%	14%	45%	5%	0%	71%	23%	2%	89%	5%	2%	88%	7%	2%	4%	4%	0%	0%	

Objectives

Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	Andrew Coe (ADHB)	ADHB continues participation at national, regional and local level regarding primary care planning and implementation. The GAIHN "Clinical Activity Groups" have reported back to the GAIHN ALT and programmes and funding are currently being reviewed. A number of RFPs are currently being prepared and complexities around these with regard to conflicts of interest and public law requirements are being worked through with all stakeholders.
2.1b.1 Improve access and efficiency of service delivery for primary-secondary system	Andrew Coe (ADHB)	The primary care DAP projects progressing to varying degrees, access to diagnostic radiology is progressing well with regard to establishing the systems and processes with good ongoing update by general practice there is now increasing confidence that the target can be met (work is focussed in this area at the moment). The rest of the projects are progressing well and there is confidence that the targets can be met.

2.1b.2 Reduce acute demand	Andrew Coe (ADHB)	The regional Extended POAC project on track to achieve DAP targets.
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. TPOR (The Productive Operating Room) is working through the define stage. Elective Services are behind target at 89%. A dedicated workout plan is being prepared to go to the ministry. As part of the plan to improve ESP15 and the health target a Director of Elective Performance has been introduced until the two HSG GM roles are recruited. Starship OR business case has been reviewed. There will need to have further work to enable sign off. Until that is completed there will be further design work completed as well as work up needed for the ministry gateway process. The expenditure committee has signed off the release of funds to begin design work while the business case is completed.
2.1c.2 Improve mainstream effectiveness	Ngaire Buchanan (ADHB)	Being managed with Pacific Health Manager. First piece of work has been the collection on the DNA rate for Pacific people. Projects underway.
2.1c.3 Improve relapse prevention planning in mental health	Fionnagh Dougan (ADHB)	96% of eligible clients had a relapse prevention plan documented in their notes this month. This percentage exceeds the MOH requirement for 2010/2011.
2.1c.4 Hospitalised smokers given assistance to stop smoking	Taima Campbell (ADHB)	Of the 7960 events coded in January, 1064 (13.4%) patients were identified as smokers and 762 (72%) of the smokers were were documented as receiving advice or support to quit. While work continues to meet the target ADHB other indicators show that the ABC implementation has had a positive effect on inpatient nicotine withdrawal management. NRT dispensed to all services doubled in 2010 with a total of 66,818 NRT units dispensed compared to 31,092 in 2009. To improve the target figures a programme of ABC coaching and training updates are planned for February focussing on the high volume areas including the Adult Emergency Department, APU, General Surgery and General Medicine. A review of the ABC processes in National Women's Health will commence in February and strategies developed to improve the consistency of recording brief advice by all NWH services included in the target figures.
2.1c.5 Reduce waiting times for oncology	Fionnagh Dougan (ADHB)	Eligible patients referred for treatment to the regional service are being treated within 4 weeks.
2.1c.6 Increase elective surgical discharges to 10,227	Ngaire Buchanan (ADHB)	February ESPI compliance identified and non compliant. As a result of the initiatives put in place we are able to report that we have remedied the compliance risk for the month of February such that we are significantly under the threshold and has allowed a small buffer. For the ADHB Health target February showed a record month of 900 discharges. A programme to sustain this is underway which includes such initiatives as the introduction of a dedicated Director of Elective Performance role, reviewing our elective coding practices, converting an FTE post into a training and data cleansing role and ensuring our production planning is in place with the assistance of the service improvement specialist.
2.2.1 Strengthen Clinical Leadership model	Margaret Wilsher (ADHB)	Recruited all level 2 medical leaders with exception of Womens Health which is to be advertised. Midwifery Director appointed and Nurse Director Child Health and Nurse Director Perioperative & Clinical Services in recruitment process.
2.2.2 Improve Senior Leadership Team Performance	Greg Balla (ADHB)	There are two projects against this objective this year. Establishing a succession planning process and, the optimisation of the Leadership Walkaround Programme. The plan for this objective will be enhanced after the Healthcare Excellence Evaluation.
2.3.1 Implement regional clinical networks	Margaret Wilsher (ADHB)	CD Cardiac network appointed. Good progress with RHSP clinical engagement and leadership across all streams. Diabetes key clinical leaders shaping up network. OPH also forming clinical network.
2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	Margaret Wilsher (ADHB)	Patient safety is a key campaign in the proposed Northern Region Health Services Plan. This will be a DAP deliverable 2011/12. The plan has been accepted at the recent challenge workshop but needs further refinement in terms of IT support. Pressure areas and falls seem likely safety targets for year one.
2.3.3 Improve research	Margaret Wilsher (ADHB)	Software solutions for KPI capture are currently under evaluation. The research office is now supported by a performance improvement

quality		specialist.
2.4.1 Ensure workforce capability is matched to service delivery current and future	Vivienne Rawlings (ADHB)	STRENGTHEN CLINICAL LEADERSHIP MODEL - Level 2 medical leaders for Healthcare Service Groups recruited. Women's HSG medical leader will be readertised later in 2011. The Midwifery Director for Women's HSG has been appointed. The Nurse Director for Children's HSG is under recruitment. Recruitment for HSG nursing leadership positions ongoing. RANGATAHI PROGRAMME - 20 student cadets completed work experience in December with good feedback from the services. SCHOLARSHIP PROGRAMME - 11 cadets in work placement over the holidays. 7 new cadets recruited in December 2010. TAMAKI PROJECT - Early starts have commenced and most commenced training in January. No further progress on funding to support programme at this time. WORKFORCE ACCESS TO EDUCATION & TRAINING - Project now complete and transitioned to business as usual. On line learning will continue to develop and evolve. 5,700 staff registered for on-line learning and over 80 courses listed with 11 under development.
2.5.1 Improve the resilience and availability of core IT systems	Johan Vendrig (ADHB)	IT Resilience projects moving forward well - decision to outsource some activities is proving to be successful because it has considerably improved the speed of implementation. Additional costs are being covered by IMTS underspend related to delay in maintenance fees. Phase 4 Resilience has been started thanks to release of some additional capital budget to address urgent issues with Network configurations. Capex has been approved and these workstreams have been started. Significant risk still exists around PACS, FMIS and CRIS with very old hardware so projects in these areas have been given higher priority. However PACS and FMIS are caught up in regional procurement and design processes so interim solutions may be required. A preferred vendor for the replacement of the CRIS system has been identified and the implementation study is underway. Regional Clinical Documents and eReferrals phase 1 progressing in line with their revised timelines with go-lives expected in April 2011. Aspire internal messaging went live which completes Phase 1b successfully.
2.5.2 Improve corporate records and knowledge management	Johan Vendrig (ADHB)	Corporate Records Manager is progressing to plan with introduction of policies and training related to improving management of corporate records. EOI for Enterprise content management system was completed. Limited RFP to select preferred vendor is now underway, regional timeline is somewhat protruded but progressing to plan. Some concern that project may not receive high enough priority in upcoming capital planning discussions so risk that project may stall if that is the case. Preferred vendor for CRIS replacement has been selected (3M) and the implementation planning study is underway. This will include a number of workshops with clinical teams to assess potential impact on current processes and also to explore how best to design integration with the Concerto Clinical Workstation. HR scanning proof of concept was completed successfully but unfortunately the ROI and priority did were not sufficient for this project to make it onto the FY11/12 capital budget list.
2.5.3 Improve data quality of Information Management systems	Johan Vendrig (ADHB)	NHI duplicate issue remains a significant problem. Performance is unstable. Discussions with the services and the MoH continue to look for improvement opportunities. We will be requesting support from the performance improvement team to define and run a formal performance improvent process. Discussions with MoH to adjust the KPI for ADHB continue. We believe KPI calculation is incorrect and does not take account of the way we use preallocated numbers for new born babies. Once this is corrected this will address part of the duplicate NHI KPI issue but not all of it.
2.6.1 Long term planning and change management	Brent Wiseman (ADHB) (CFO)	This project was initiated last year with a research phase being undertaken by Chris Morgan. CEO advises that Planning and Funding Unit to take over responsibility to progress and have appointed additional planning resource.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
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.
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.
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.
Skin Lesions	Regional	Improve				Project is now back on track. Contracting arrangements are currently being worked through.
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.
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.
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.

Legend: Red - , Orange - , Green -

FEEDBACK TO BOARD

7.1 Hospital Advisory Committee Feedback to Board

GENERAL BUSINESS

9

APPENDICES

9.1 Healthcare System Diagram

10.1 Healthcare System Diagram

