



**Auckland District Health Board**  
**Hospital Advisory Committee Meeting**

**Wednesday 2 November 2011**

**9.30am**

**A+ Trust Room**

**Cinical Education Centre**

**Level 5**

**Auckland City Hospital**

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



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

### IMPORTANT

If in doubt – declare.

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

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





**ADHB BOARD AND COMMITTEE (HAC)  
INTERESTS REGISTER**

<b>NAME OF BOARD MEMBER</b>	<b>ORGANISATION</b>	<b>ROLE</b>	<b>FINANCIAL INTEREST</b>	<b>NATURE OF INTEREST</b>	<b>DATE OF LATEST DISCLOSURE</b>
<b>Lester LEVY (Chair)</b>	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor  Waitemata District Health Board A+ Trust	Professor of Leadership  Chief Executive  Deputy Chair  Independent Chairman Chairman  Trustee			31 May 2011
<b>Jo AGNEW</b>	Professional Teaching Fellow, School of Nursing, Auckland University Casual Staff Nurse ADHB		Salary  Salary		9 September 2011
<b>Peter AITKEN</b>	Pharmacist  Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
<b>Judith BASSETT</b>	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Susan BUCKLAND</b>	Writing, editing and public relations services  Medical Council of NZ  Occupational Therapy Board  Northern Regional Ethics Committee	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member  Member	Fees  Hourly fee  Hourly fee  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
<b>Dr Chris CHAMBERS</b>	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Rob COOPER</b>	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust Advisory	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee		
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	Waitemata District Health Board	Member			
<b>Lee MATHIAS</b>	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting Provider of business and professional services to midwives and other maternity services providers Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education	4 October 2011
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited		
	Pictor Limited	Shareholder, Director	Fee		
	John Seabrook Holdings Limited AuPairlink Limited	Director Governance Advisor	No fee Fee		

	NZ Council of Midwives Tamaki Transformation Transitional Board	Council member Chair	Fee Fee	services contracted to the MoE. Statutory Authority	
<b>Robyn NORTHEY</b>	Self employed Contractor  Hope Foundation Northern Region	Project management, service review, planning etc. Board member	Fee  Nil	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	4 October 2011
<b>Gwen TEPANIA-PALMER</b>	Waitemata District Health Board Manaia PHO Ngati Hine Health Trust Te Taitokerau Whanau Ora	Board member  Board member Chair  Committee member	Fee   Fee		18 May 2011
<b>Ian WARD</b>	C -4 Consulting Limited NZ Blood Service	Principal/ Director Board Member	  Fee		24 August 2011

<b>NAME OF BOARD MEMBER</b>	<b>ORGANISATION</b>	<b>ROLE</b>	<b>FINANCIAL INTEREST</b>	<b>NATURE OF INTEREST</b>	<b>DATE OF LATEST DISCLOSURE</b>
<b>Anne KOLBE</b>	Private Paediatric Surgical Practice Employee Communio NZ	Director	Joint Owner		1 June 2011
	Siggins Miller, Australia Head, Auckland Clinical School, School of Medicine, University of Auckland	Senior Consultant	Contractor		
		Senior Consultant Employee	Contractor	Salary	
	Husband: Employee University of Auckland Risk and Audit Committee Whanganui District Health Board	Member	Fee		
	Pharmac Board South Island Neurosurgical Services Expert Panel National Health Committee	Member Chair	Fee Fee		
<b>Iain MARTIN</b>	University of Auckland Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010



**CONFIRMATION OF MINUTES**

**WEDNESDAY 5 OCTOBER 2011**



# Hospital Advisory Committee Minutes



<b>MEETING DETAILS</b>													
Time and Date	9:30am, Wednesday, 5 October 2011												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>												
	<p>The Chair declared the meeting open at 9:31am.</p> <p><b>Committee Members</b></p> <table> <tr> <td>Judith Bassett (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Susan Buckland</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Dr Lester Levy</td> <td>Dr Lee Mathias</td> </tr> <tr> <td>Robyn Northey</td> <td>Gwen Tepania-Palmer</td> </tr> <tr> <td>Ian Ward</td> <td>Associate Professor Anne Kolbe</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive  Dr Margaret Wilsher – Chief Medical Officer  Brent Wiseman – Chief Financial Officer  Greg Balla – Director Performance and Innovation  Ngaire Buchanan – General Manager Operations  Taima Campbell – Executive Director of Nursing  Janice Mueller – Executive Director of Allied Health, Scientific and Technical  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Apologies for lateness were recorded for Rob Cooper and Gwen Tepania-Palmer.</p> <p><u>Moved Lee Mathias, seconded Peter Aitken</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Judith Bassett (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Rob Cooper	Dr Chris Chambers	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	Associate Professor Anne Kolbe
Judith Bassett (Chair)	Jo Agnew												
Peter Aitken	Susan Buckland												
Rob Cooper	Dr Chris Chambers												
Dr Lester Levy	Dr Lee Mathias												
Robyn Northey	Gwen Tepania-Palmer												
Ian Ward	Associate Professor Anne Kolbe												
<b>2</b>	<b>CONFLICTS OF INTEREST</b>												
	<p>There were no declarations of conflicts of interest for any item on the agenda. The Board Administrator had been notified of changes to the interests register by Lee Mathias and Robyn Northey.</p>												
<b>3</b>	<b>CONFIRMATION OF MINUTES 7 SEPTEMBER 2011</b>												
	<p>The report on where patients 80+ year old transported by St Johns go would be made once the data is analysed. Automated coding at time of discharge for less complex cases applied to those from external DHBs.</p> <p><u>Moved Jo Agnew; seconded Robyn Northey</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 7 September 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>												

<b>4</b>	<b>ACTION POINTS 7 SEPTEMBER 2011</b>
	<p>The statutory definitions of the Hospital Advisory Committee and the Community and Public Health Advisory Committee did not support the HSG philosophy which was to look at the whole continuum of care including activity outside of hospital that had effects on the hospital i.e. diabetes, POAC etc.</p>
<b>5.1</b>	<b>Operational Performance Report</b>
	<p>The results were reasonable for the month and year to date but there were still challenges to work through. An updated Flash Report was tabled. The tables on Maori and Pacific acute data were roughly in line with their percentage of population although there was a caution that the data was variable. The development of the data and graphs was an evolutionary process.</p> <p>Production for the quarter would be at 100% with outsourcing being brought forward to achieve this. Going forward there were plans service by service to achieve sustainability. There was a capacity gap in orthopaedics.</p> <p>The aim of having zero patients waiting over six months for elective procedures had identified risk areas. Information was supplied on reasons for cancellations, with orthopaedics experienced the most. They are also unfairly impacted by acutes although cancellations were reducing. There was a capacity gap and with that service being asked to increase production 30% year on year there needed to be better planning tools to align resources.</p> <p>ESPI and health targets are not related. There was need for the rate of FSA and procedures to align i.e. with increased targets there needed to be an increase in FSA to get the throughput which required realignment of resources. The institution of buffers was to provide for contingencies and unforeseen situations. Each service was looking at the gaps and the need to outsource, which came from a total outsource pool, with outsourcing brought forward to be on track for the first quarter. Patient and Operational Demand Plans (POP) were used to match resources to what was needed to be delivered with this being on a daily, weekly, monthly basis which was helping to achieve a cultural shift to deliver to the plan.</p> <p>Gwen Tepania-Palmer joined the meeting at 10:05am.</p> <p>Resolution of the production issues would take time but the mechanisms are there. Cancer had demonstrated that if shorter times are demanded they can be achieved. It was noted that ADHB served a wider population than just it's own.</p> <p>It was the patient's prerogative to cancel. This may be the right outcome for the patient which may conflict with having efficient production although it was noted that there was some patient responsibility as they are using a community funded resource so do have some obligations. These are managed in some areas by over booking where there are higher cancellation rates and standby lists are also used. The key was what surgery was resourced and then wasted.</p> <p>Rob Cooper joined the meeting at 10:20am.</p> <p>Lists are negotiated and worked to finishing, either early or late. Work was being undertaken to try and predict peaks to smooth production as high demand days do cause bed blockages and across all areas to make the system more robust which required attention to detail and discipline. The visual aid of a "Green Shirt" being a person to go to was noted. Some areas are affected by staffing but the main driver is volume demand.</p> <p>The number of child acute patients waiting 12 hours or more had diminished significantly by changes in practice. Cardiac bypass surgery waiting lists were subject to huge variation in referrals, for example surges after well attended conferences to catch up. A predictive line of cardiac waiting lists were requested to be included in the graph. The goal was to have 81 patients on the list to achieve the most efficiency. It was noted that 1100 people had been given quit advice relating to smoking.</p>

9.1	<b>Resolution to Exclude the public from a meeting of the Hospital Advisory Meeting</b>											
	<p><u>Moved Judith Bassett; seconded Anne Kolbe</u></p> <p><i>That the exclusion of the public from the relevant part of the meeting is necessary to enable the Board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) of clause 32 of Schedule 3 of the Act are established in relation to all or any part of the meeting.</i></p> <p><i>THAT the public be excluded from the following part of the proceedings of this meeting, namely consideration of items 9 of the Agenda.</i></p> <hr/> <p><i>The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:</i></p> <table border="1" data-bbox="199 694 1356 1232"> <thead> <tr> <th data-bbox="199 694 582 817">General subject of each matter to be considered:</th> <th data-bbox="582 694 981 817">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="981 694 1356 817">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="199 817 582 907">11.1 Confidential HAC Minutes 7 September 2011</td> <td data-bbox="582 817 981 907" rowspan="6">To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)</td> <td data-bbox="981 817 1356 907" rowspan="6">That the public conduct of the relevant part of the <b>meeting would be likely to result in</b> the disclosure of information for which good reason for withholding <b>would exist under s 9</b> of the Official Information Act 1982.</td> </tr> <tr> <td data-bbox="199 907 582 952">11.2 Risk</td> </tr> <tr> <td data-bbox="199 952 582 996">11.3 Quality</td> </tr> <tr> <td data-bbox="199 996 582 1041">11.4 Productivity Report</td> </tr> <tr> <td data-bbox="199 1041 582 1086">11.5 Global Trigger Tool and Mortality Review</td> </tr> <tr> <td data-bbox="199 1086 582 1232">11.6 Performance Improvement Activities – Financial Impact</td> </tr> </tbody> </table> <p><u>Carried</u></p> <p>Items discussed in public exclusion were the risk register, quality, productivity report, global trigger tool and mortality review and the financial impact of performance improvement activities.</p> <p><u>Moved Jo Agnew; seconded Lee Mathias</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>	General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:	11.1 Confidential HAC Minutes 7 September 2011	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the <b>meeting would be likely to result in</b> the disclosure of information for which good reason for withholding <b>would exist under s 9</b> of the Official Information Act 1982.	11.2 Risk	11.3 Quality	11.4 Productivity Report	11.5 Global Trigger Tool and Mortality Review	11.6 Performance Improvement Activities – Financial Impact
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11.3 Quality												
11.4 Productivity Report												
11.5 Global Trigger Tool and Mortality Review												
11.6 Performance Improvement Activities – Financial Impact												
	<b>NEXT MEETING</b>											
	<p>The meeting closed at 12:13pm</p> <p>The next meeting is scheduled for 9:30am, Wednesday, 2 November 2011 A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton</p>											
	<p><b>CONFIRMED</b></p> <p><b>CHAIR: DATE:</b></p>											



**ACTION POINTS**

**WEDNESDAY 5 OCTOBER 2011**



**Hospital Advisory Committee  
Action Points from the meeting on Wednesday 5 October 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
3	Report from St John's data on where 80+ patients go	Ngaire Buchanan	December 2011
5.2	Prediction line on waiting list for Cardiac Bypass Surgery to be added	Fionnagh Dougan	Item 5.2
9.2	Interpretative report on complaints and trend to be added to agenda in private section	Andrew Keenan	Item 9.3



# **PROVIDER OPERATIONAL PERFORMANCE REPORT**

**5.1 Operational Performance Report**

**5.2 Health Target Updates**



## **5.1 Operational Performance Report**

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## Contents (with lead HAC attendee)

1.	Overview – G Balla.....
2.	Acute services performance – Dr M Wilsher .....
3.	Elective services performance – Dr.M Wilsher .....
4.	Productivity – G Balla .....
4.1	Improvement projects - G Balla .....
4.2	Savings schedule progress - G Balla .....
5.	Financial performance – B Wiseman.....
Appendix 1	Operating Statement September 2011 .....

## 1. Overview – Greg Balla

### Financial

Against a budgeted surplus of \$2.4M for the month of September, the provider arm recorded a surplus of \$2.3M, unfavourable to budget by \$(0.1)M.

Revenue was favourable to budget by \$1.4M for the month while operating costs were \$(2.1)M U and non operating costs were favourable by \$0.5M.

Against a budgeted surplus of \$5.4M for YTD September, the provider arm recorded a surplus of \$3.7M, unfavourable to budget by \$(1.7)M.

Revenue was unfavourable to budget by \$(2.3)M YTD while operating costs were \$(0.8)M U and non operating costs were favourable by \$1.3M.

FTE numbers for the *month of September* were unfavourable by (13) FTE (favourable by \$(99)k) FTE numbers YTD September were favourable by 23 FTE

Direct treatment costs were favourable to budget by \$0.4M September YTD with offsetting variances within the different categories.

A summary P&L may be found at Appendix 1.

### Volume Related Variance (cf. Plan)      YTD

ADHB inpatient services were +500 wies above plan for the three months to December while for non ADHB populations the variance was +100 WIES.

Non DRG services (all of the non inpatient services combined) are \$(4.5)m U to plan for the same period.

## Lessons from the First Quarter

### *Discharges vs WIES*

As noted elsewhere in this report, the ADHB elective contract is not identical to the Health Target on which we are monitored externally, thus for example we have hit the Health Target for the quarter although we are short on elective wies outputs for our own population by approximately (400) wies. While the Health Target achievement is significant, the Ministry monitors discharges but pays for its share of the Health Target on the basis of wies production so it is important to ensure *WIES production* is maintained as well as discharge production.

### *Customers*

We are currently favourable by a small margin on IDF DRG services, under the Crown funding rules we will be paid for the delivery of these additional services. In striving to meet the Health Target which is for our own population we also need to take account of the needs of patients from our other customers, in particular those on our wait list – while the Health Targets are assessed on the basis of the ADHB population our wait time compliance looks at all cases on the wait list.

### *Operating Costs and Outsourcing*

The lesson of Quarter 1 and therefore the challenge for the balance of the year is to ensure *the Provider meets targets through planned capacity and remains within fiscal constraints*.

We are overspending on operating costs while under-producing volumes and therefore revenue. Our operating costs are at 98.3% of revenue year to date compared with a budgeted 97.4%. For the three months to September, we have therefore incurred costs of \$2.5m more than the budget assessed would be required to earn the level of revenue achieved. A significant component of this additional cost is outsourcing of clinical workload brought forward from planned future periods (see also Section 6.4). The level of outsourcing can be partially illustrated by the following table, comparing last year and this:-

### **Elective discharges, ADHB population, Health Target eligible**

<b>Elective discharges</b>	<b>Q1 2010/11</b>	<b>Q1 2011/12</b>	<b>Change</b>
In house	2,260	2,512	+252
Off-site (outsource)	53	332	+279
<b>Total</b>	<b>2,313</b>	<b>2,844</b>	<b>+531</b>

By service the change from year to year is as follows:-

<b>Service</b>	<b>Change Q1 2011 to Q1 2012</b>	<b>% Change</b>
Cardiothoracic	-	
Vascular Surgery	+2	4%
General Surgery	+20	3%
Ophthalmology	+128	32%
Orthopaedics	+129	69%
Paediatric Neurosurgery	+3	60%
Paediatric ORL	+105	57%
Paediatric Orthopaedics	+6	16%
Paediatric Surgery	+4	5%
Neurosurgery	-2	-7%
ORL	+62	35%
Urology	+14	10%
Gynaecology	+61	17%
	<b>+531</b>	<b>23%</b>

Service managers have an awareness of discharge and budget targets, these are continually reviewed and having achieved the target in the first quarter has not produced complacency.

#### *FTEs*

As noted in Section 6.3 the Provider is now over budget on FTE numbers for the month of September (13) FTE, the challenge for the Provider is to maintain service delivery within budgeted FTE. Each HSG is responsible for the management of this requirement.

#### **Interpretation Note**

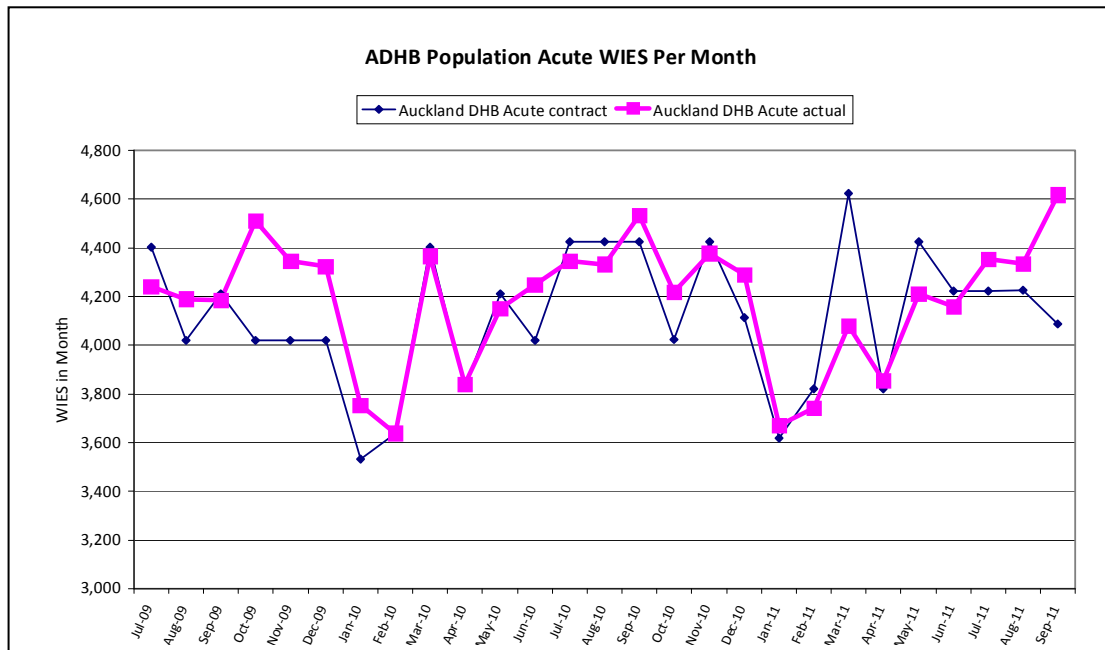
*The ADHB Provider for which results are presented here comprises the "operational" areas such as Adult Health, Cancer & Blood and Cardiac as well as "functional" services such as Finance, HR and IS which support the operational areas and finally "complementary" services such as Public Health, A+ Trust, Research and the retail businesses.*

## 2. Acute services performance – Margaret Wilsher

Acute discharges were 2.1% higher than August and 2.6% higher than the same month last year. As with last financial year, acute volumes have grown steadily through winter. For the three months to September, acute discharges are at a similar level to last year.

### Acute (WIES)

DHB	Actual YTD	Variance to Plan	% of completion
ADHB	13,424	888	107%
CMDHB	3,326	87	103%
WDHB	4,428	-369	92%
NLDHB	1,349	200	117%
Other DHBs	1,758	47	103%
<b>Total volume</b>	<b>24,285</b>	<b>853</b>	<b>104%</b>



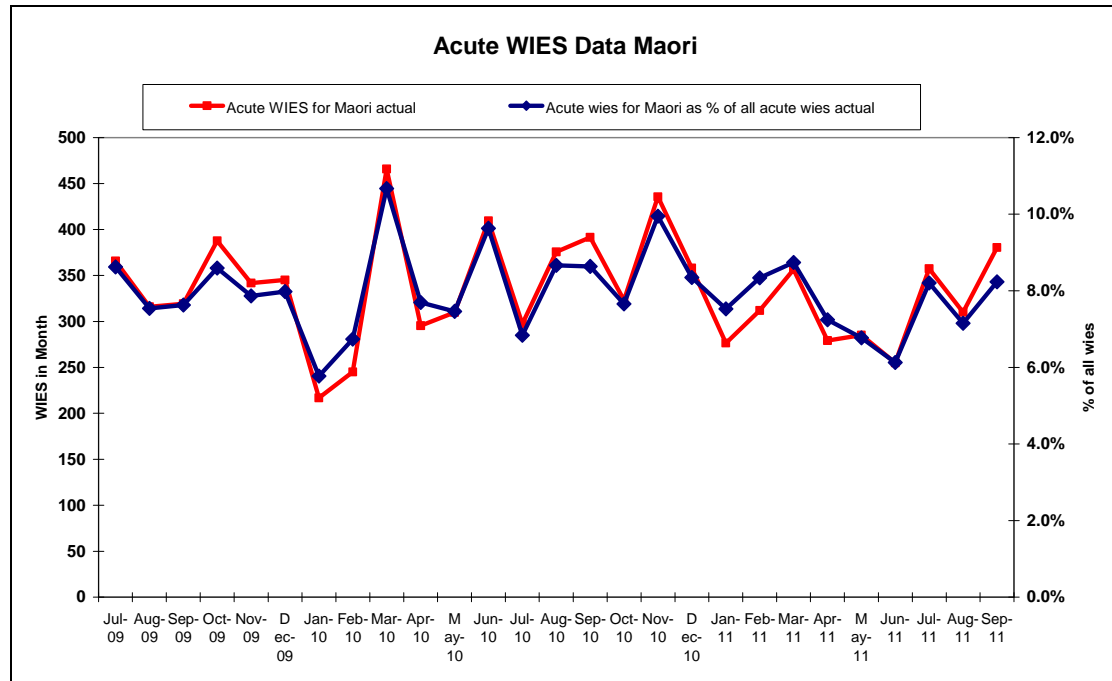
The primary care initiative to avoid acute admissions (POAC) received 330 referrals in July and 387 in August. Those cases managed without admission totaled 291 in July and 340 in August, a total of 631 admissions avoided. The average cost of each was \$219.40. Without POAC these cases may have been treated in ED or admitted to hospital.

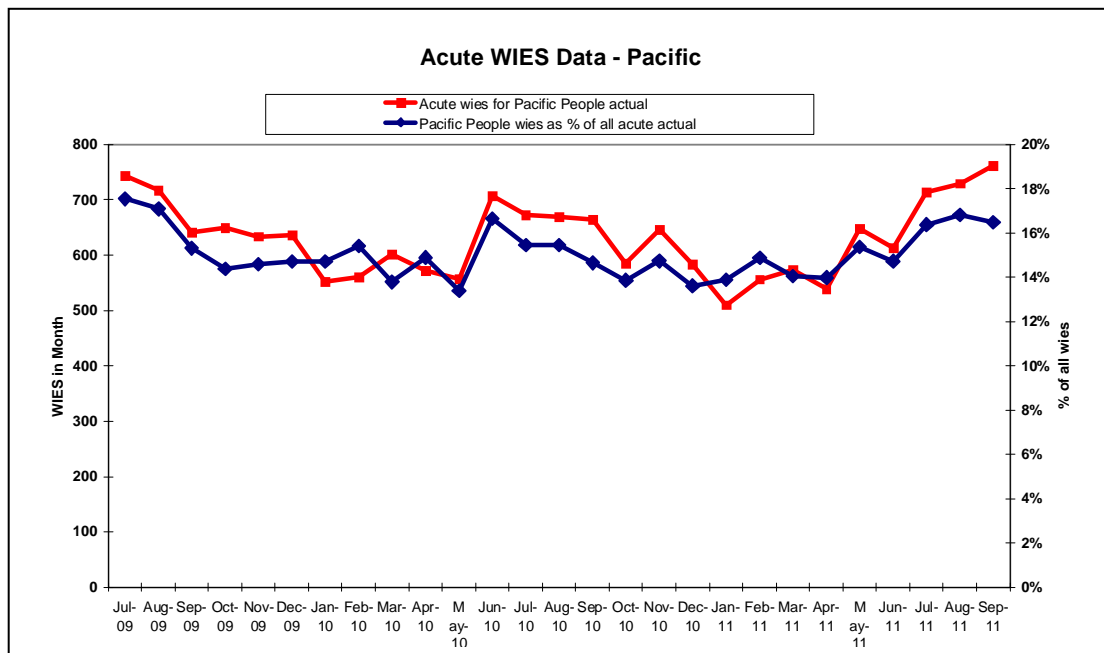
The average total cost of an attendance at ED is \$336.

The average total costs of a General Medicine bed day in Auckland City Hospital is \$982. This is the service which would be the most likely destination of these patients were they to be admitted. (Source : ADHB Decision Support, PCM Costing System) {data for September awaited}.

**Interpretation Note**

We have been asked previously to provide additional ethnicity based data in the HAC report. The following charts were provided last month They show total acute wies for Maori and Pacific people – absolute numbers of wies and as a share of all acute wies. We acknowledge that the information they contain can be ambiguous – if the share of acute wies for Maori is higher than their population share this can indicate unmet need in the community, conversely if the share of acute wies for Maori is lower than their population share this can indicate access issues. Hospital management have commenced discussions with He Kamaka Oranga to gain more insight into these issues. Issues which will be explored in the future include: comparison to national data, comparison of intervention levels for specific procedures or groups of procedures.





#### **Interpretation Note**

The charts above represent a view of ADHB population treated at ACH, not a comprehensive population view which would incorporate the ADHB population treated at other hospitals.

### **3. Elective services performance – Margaret Wilsher**

#### **Overall**

Inpatient Performance for Northern Region DHBs for Year to Date September (in wies) was: ADHB 90%, CMDHB 85%, Northland 83%, Waitemata 105%. This reflected an overall level of elective wies production of 7,159 wies against a target 7,783 (92%).

At the time of writing this report, the elective wies due to completion of further coding had increased to 7,280 (93%). The data which follows is based on the **reported** volumes.

Elective wies production for the Northern Region was 87 % of all production in the first three months of the year.

Services are currently reviewing elective outputs and the corresponding plans to identify corrective actions.

Cases are not selected in order to meet plan as the decision to treat is necessarily based on clinical need, not DHB of domicile. This can result in fluctuation against targeted volumes.

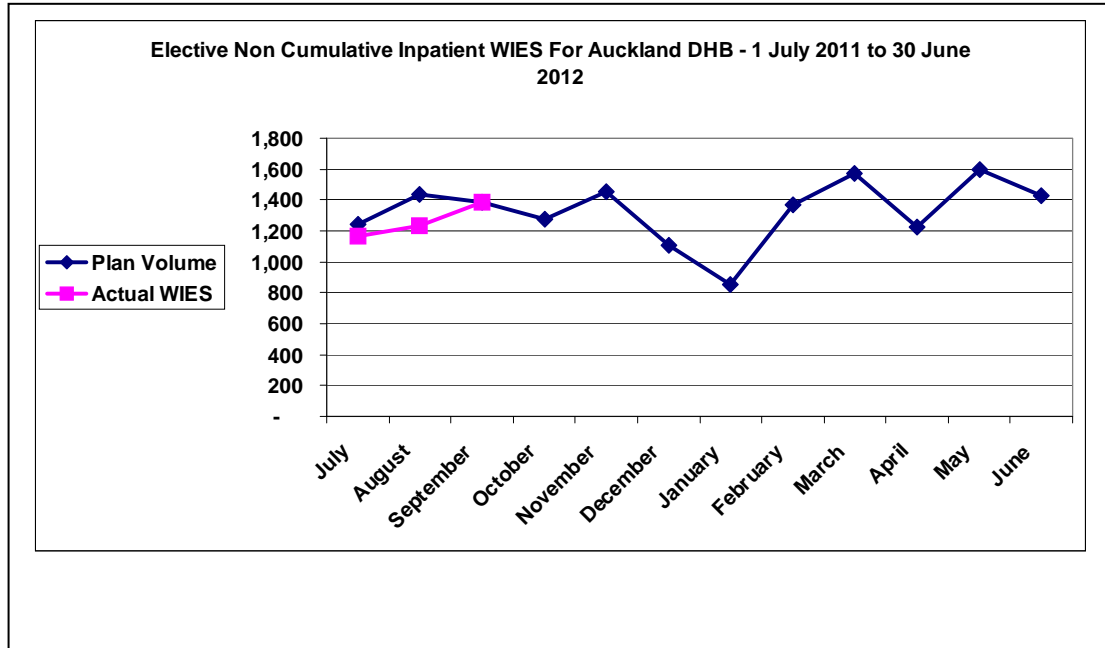
**Interpretation Note: Health Target**

*Some elective services are not counted against the Health Target. The following services are excluded: dermatology, oral health, paediatric cardiac, adult congenital heart and cardiology. The Health Target for elective outputs is also different from the wies production data which follows in that:*

- The Health Target is measured in discharges (patient numbers) not wies; for Health Target purposes a cardiac bypass case of 7 wies is the same as an eye procedure of 0.5 wies.*
- Some of the discharges counted against the Health Target are not included in the wies system and accordingly do not appear at all in the charts which follow – the main example being surgical treatment of skin lesions.*
- The Health Target excludes the services listed above.*
- The Health Target is for ADHB's own population only.*

*The charts and tables below provide a graphical presentation of the volumes for ADHB's population and the work completed for other DHBs.*

## Auckland DHB - WIES



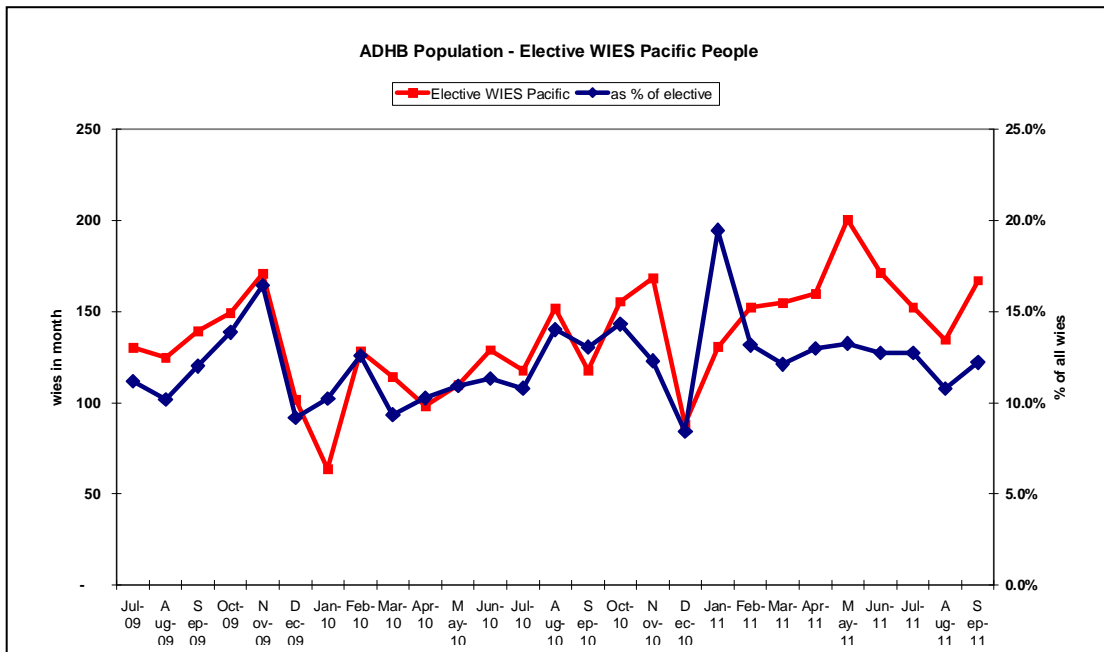
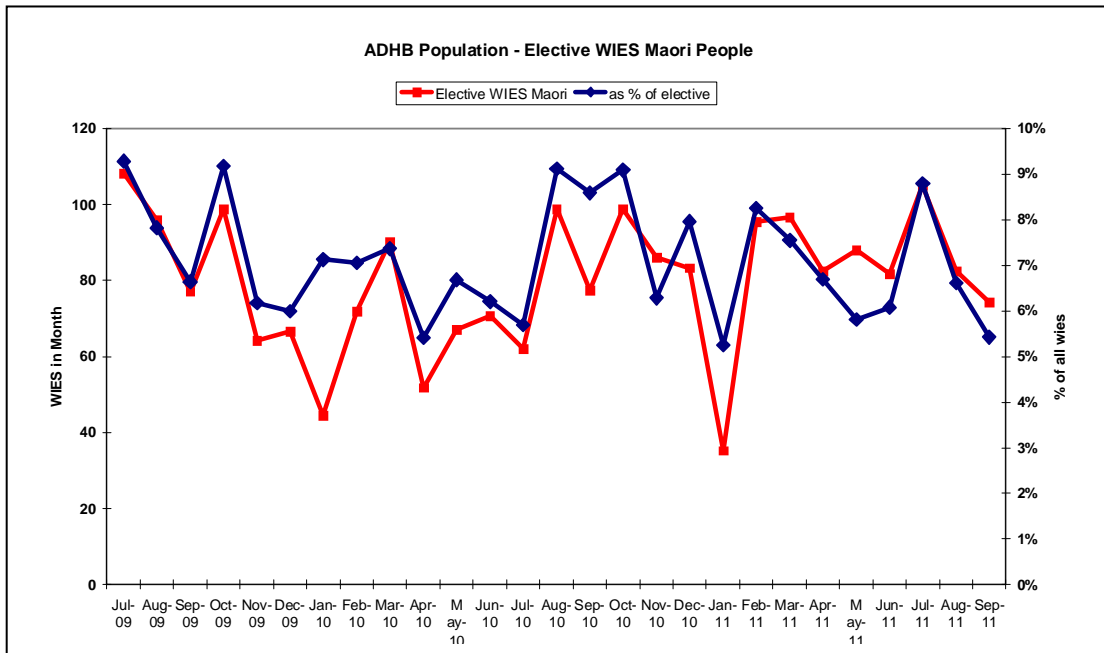
Expectation of recovering shortfall



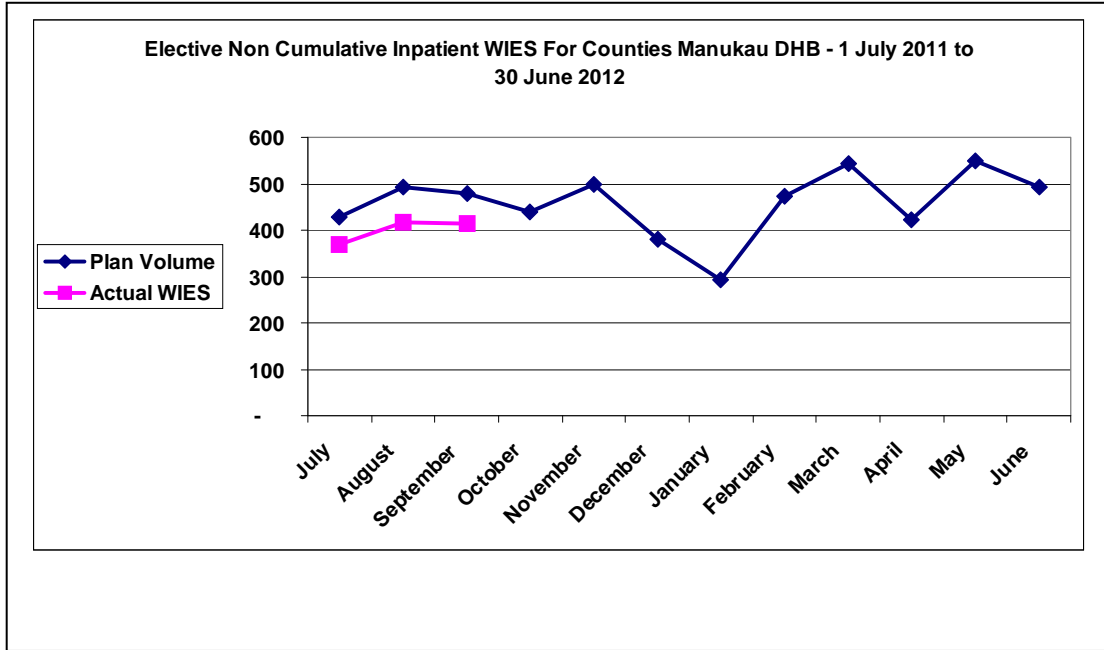
Auckland volumes remain the key focus for remedial action on the shortfalls reported here, contributing as they do approximately 50% of all elective work and forming the basis of the Health Target.

Because funding for ADHB's population is on the basis of a population based funding formula, an underperformance on ADHB elective WIES is not a revenue risk, except if it is matched by an underperformance on the Health Targets which have revenue attached (and for which the revenue is calculated on the basis of WIES production).

As noted above, the ethnicity based data for elective wies is still being reviewed for relevance and appropriateness and will be refined over time.

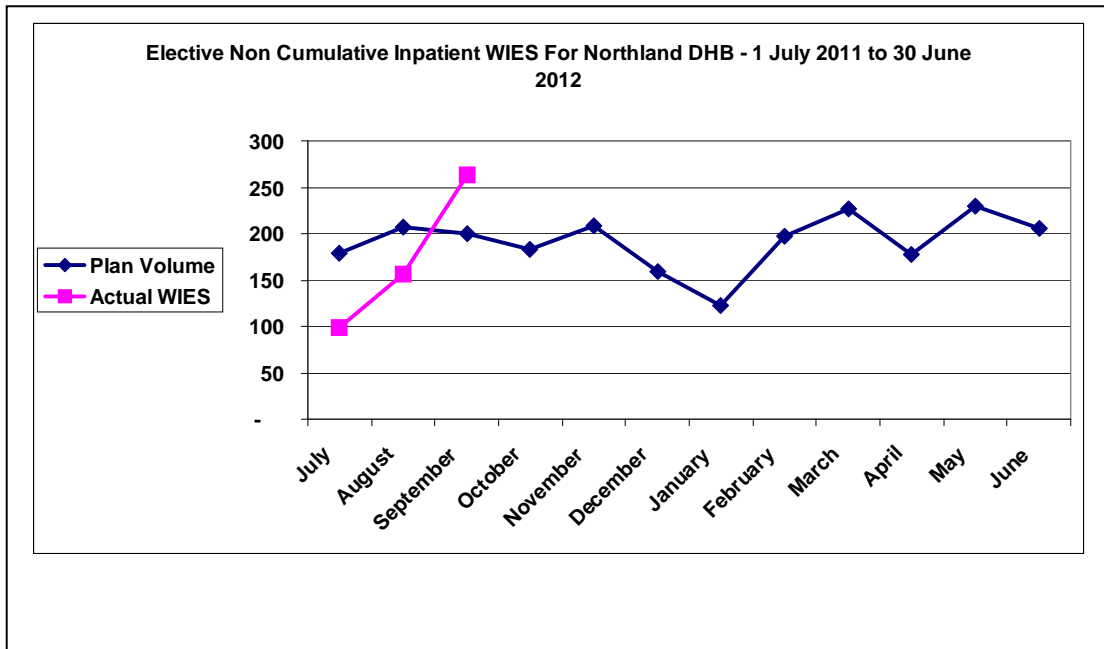


**Counties Manukau – planned and actual WIES**



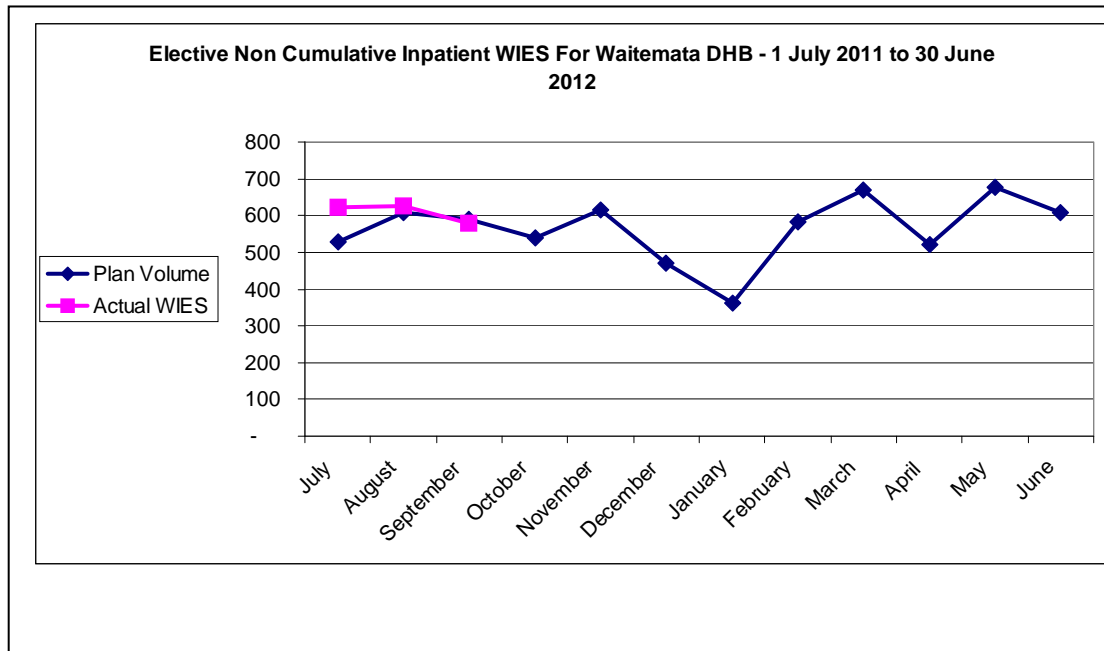
Expectation of recovering shortfall

**Northland – planned and actual WIES**



Expectation of recovering shortfall

## Waitemata – planned and actual WIES



No shortfall

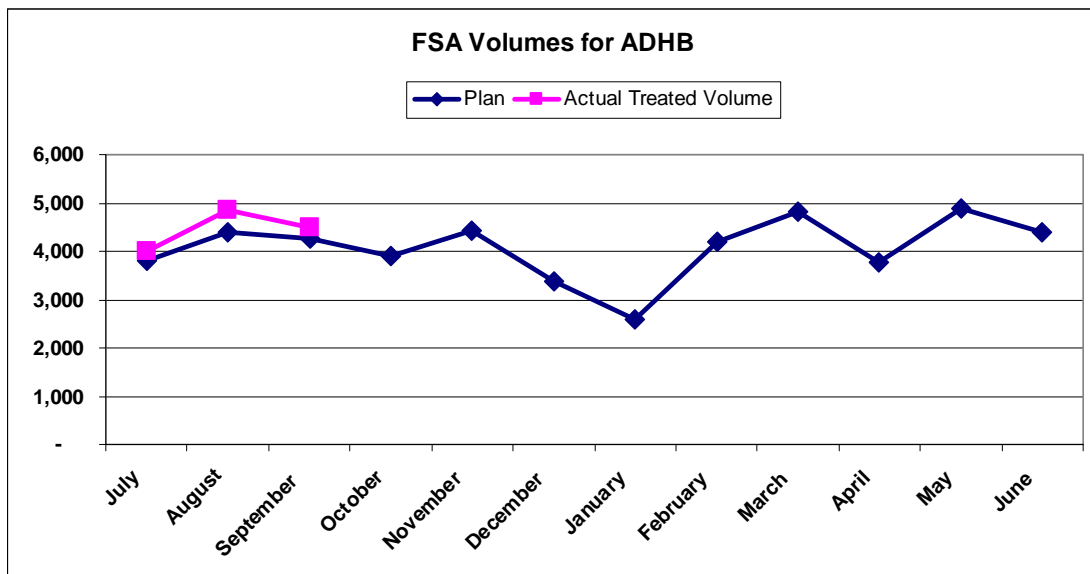
### First specialist assessment performance for Northern Region DHBs

First specialist assessments (FSA) are an important component of the elective flow. Patients having an FSA may be referred to a surgical wait-list, but they may also be managed medically and in some cases a decision may be made that no treatment is required. This has implication for production planning in that an increase of 100 in a target for surgical discharges *may* require an additional 200 – 300 FSAs to provide 100 additional surgical cases on the wait-list. For production planning purposes an assessment has been made *service by service* of the conversion rate of surgical service FSAs to the surgical waitlist. For General Surgery for example we estimate that some 70% of FSAs result in a referral to the surgical waitlist. Medical service FSAs do not typically result in referrals to a wait list but may do for example in respect of medical services closely associated with a surgical service e.g. Cardiology.

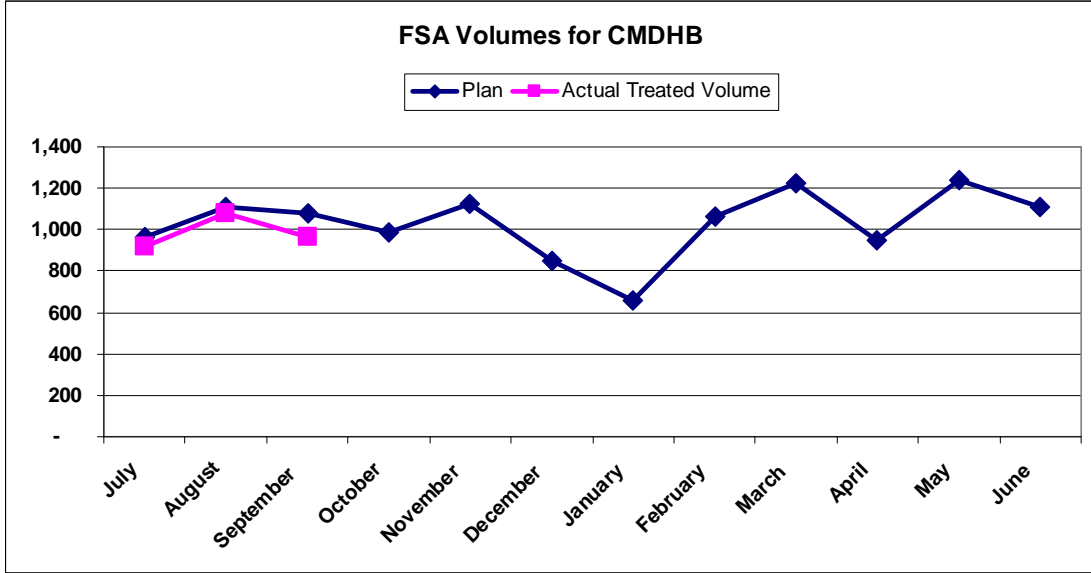
The charts which follow illustrate the FSA volumes through: actual numbers compared to planned numbers.

#### Auckland DHB - FSAs

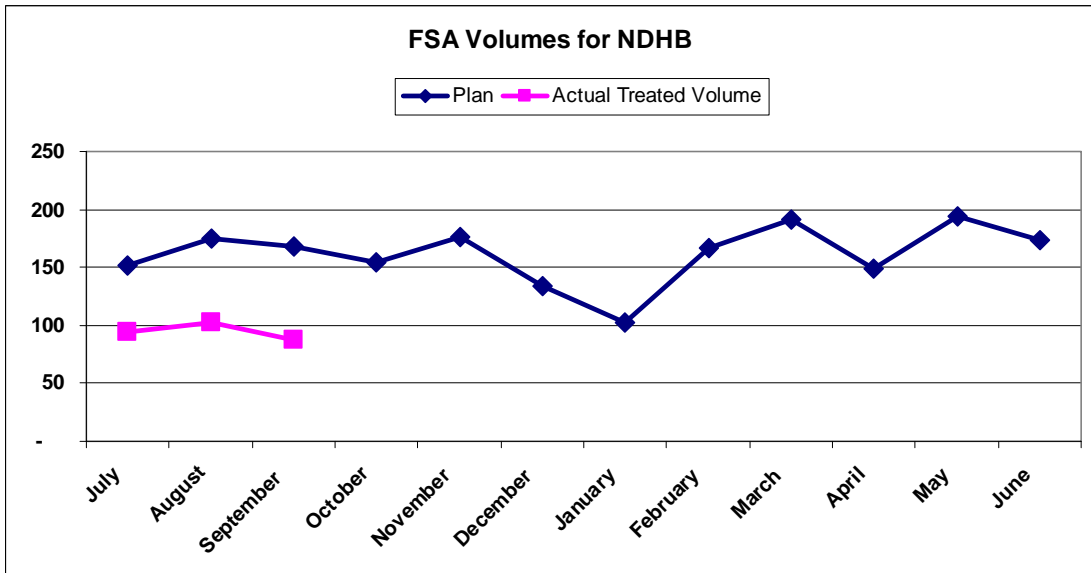
Auckland population FSAs are ahead of target.



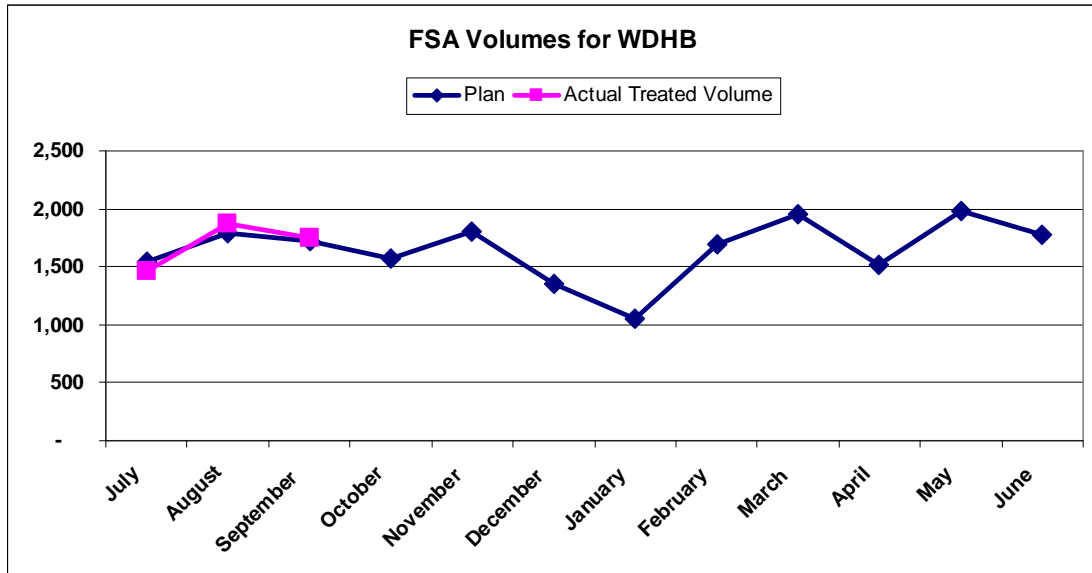
Counties Manukau DHB - FSAs



Northland DHB - FSAs



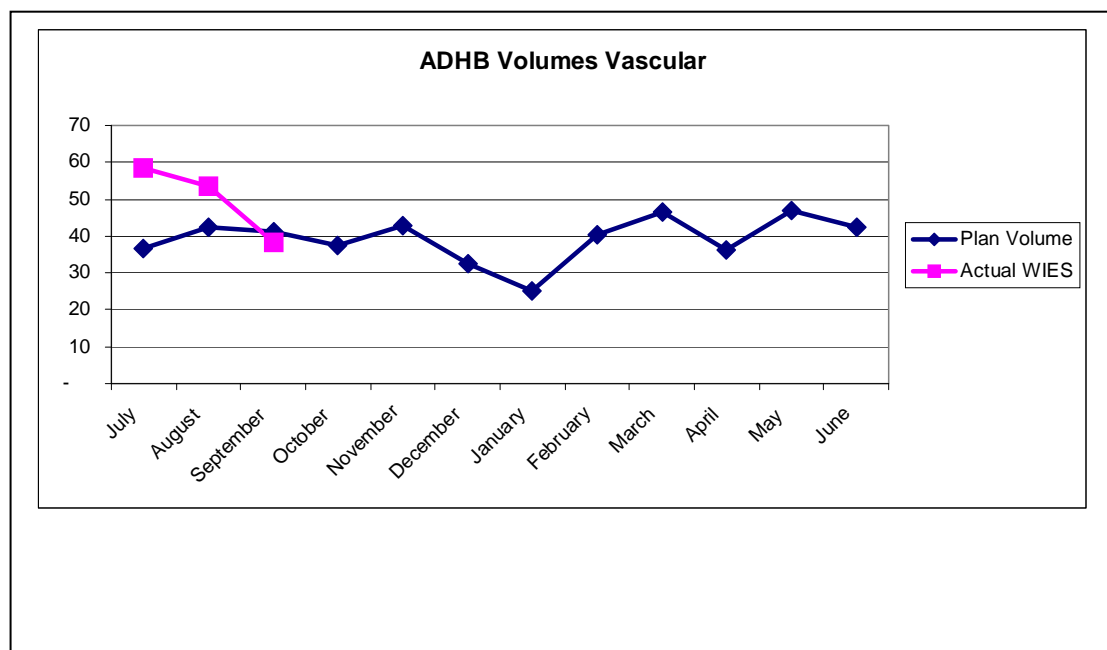
**Waitemata DHB - FSAs**



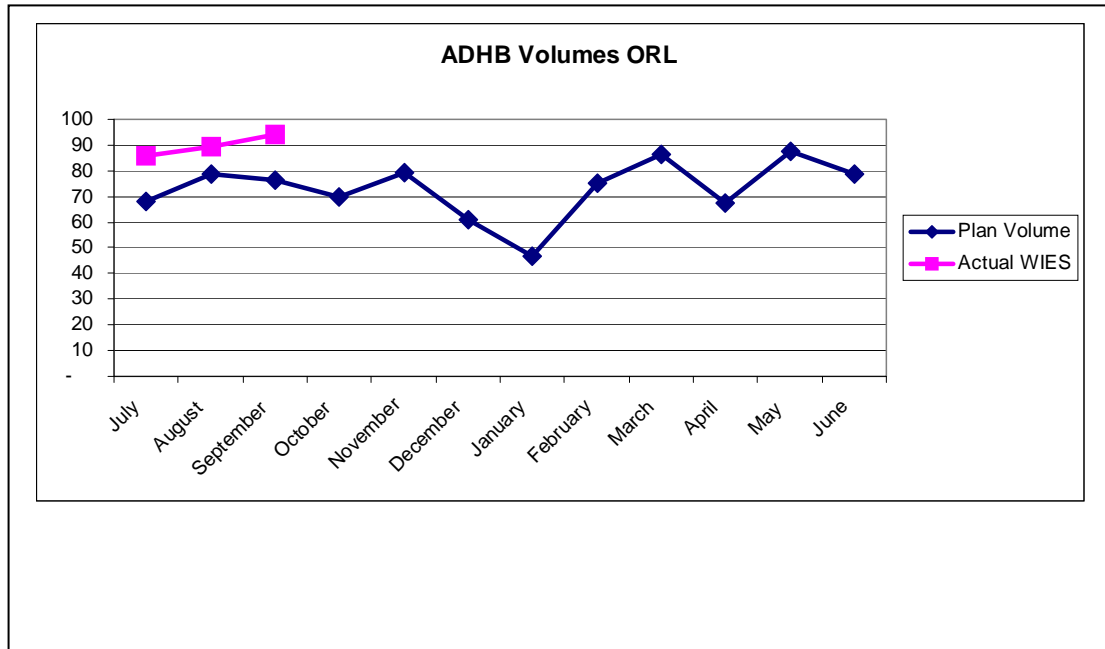
**Top Three Elective Services for Auckland Population**

The services with the largest positive wies variance for the Auckland population are vascular surgery, ORL and paediatric neurosurgery. As noted last month, vascular and paediatric neurosurgery are services with relatively large average wies per case and a small number of cases greater or lesser than planned can impact overall wies variance markedly.

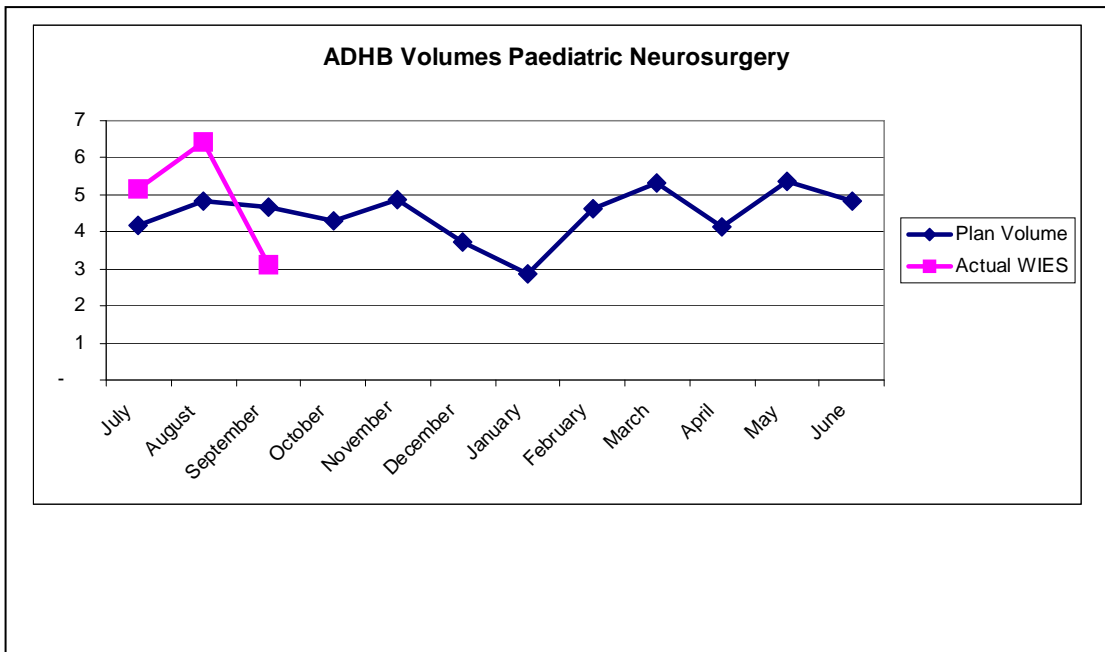
**Vascular Surgery – ADHB population**



## ORL – ADHB population



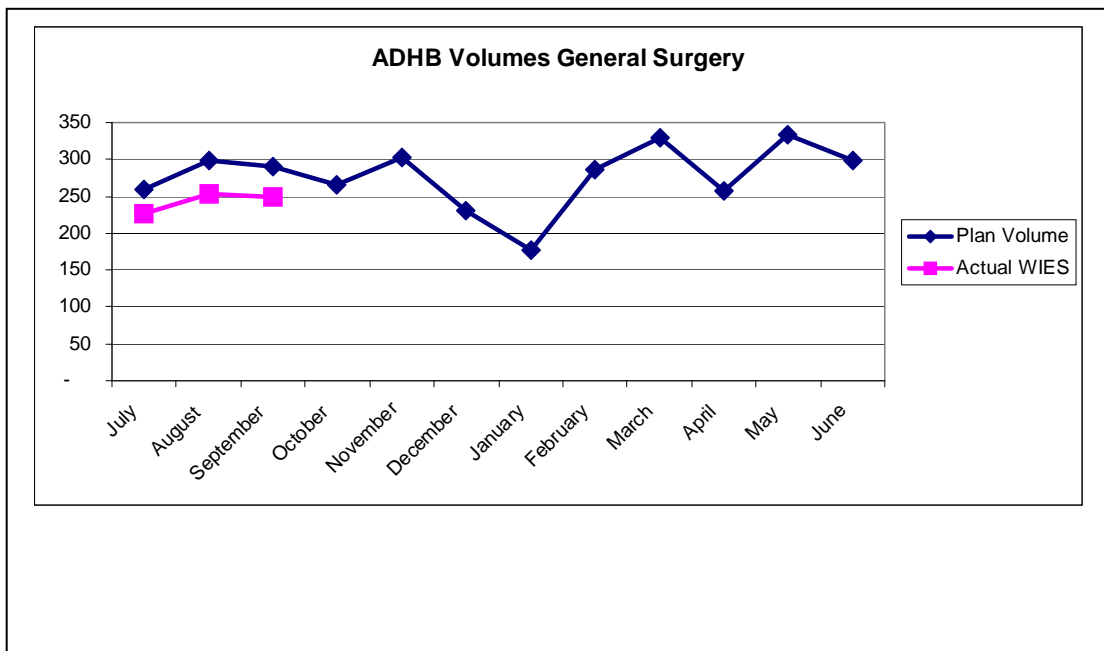
**Paediatric Neurosurgery – ADHB population**



**Bottom Services for Auckland Population**

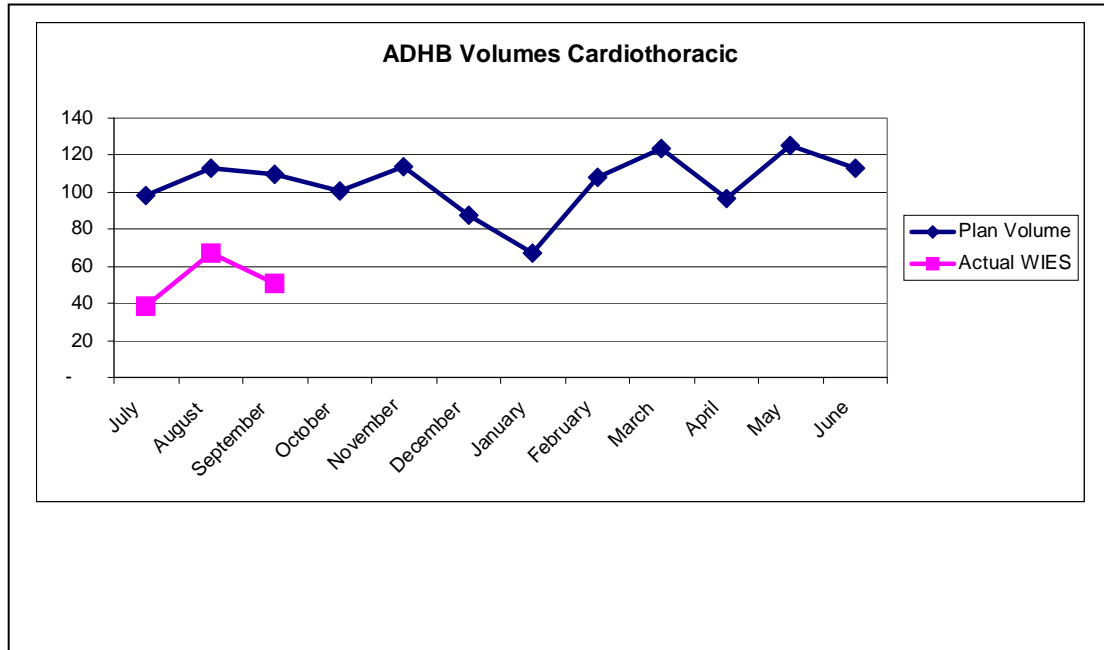
The services with the largest adverse variance after three months production are general surgery and cardiothoracic surgery.

**General Surgery – ADHB population**



General Surgery have commenced outsourcing to address this shortfall (and additional skin lesion lists to address the associated shortfall in elective discharges).

### Cardiothoracic – ADHB population



Cardiothoracic volumes were the subject of a discussion paper at the September Board meeting at which additional outsourcing and internal resourcing was approved to address this shortfall.

## Elective Performance: Zero Patients Waiting Over 6 Months

An ADHB DAP objective is that no patients are waiting over 6 months for clinic or surgery by 30 June 2012.

Individual services have targeted the timeframes as set out below. These are more challenging than advised to NHB to allow for increased understanding of referrals flows and to allow for data anomalies and classification issues to be worked through the system.

### ZERO WAITERS > 6 MONTHS



Green as compliant with zero or on target to meet timeframe for achieving target  
Amber for service not achieving zero or timeline target at risk in a minor way  
Red for services that are at high risk of not achieving zero by required timeline

Service Timelines for Zero Patients Waiting > 6 Months	Services Plan 2011/12												Traffic Light	Clinic at date of report	Surgery at date of report
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	No. Pts	No. Pts	No. Pts
Gastroenterology	Clinic												1		1
General Medicine	Clinic														
General Surgery				Clinic Surgery									2+6	2	6
Infectious Diseases	Clinic													0	
Haematology	Clinic													1	
Liver Transplant			Clinic												
Neurology								Clinic						2	
Neurosurgery Adult								Clinic				Surgery		11	9
Medical Oncology	Clinic														
Ophthalmology												Clinic Surgery		163	79
ORL Adult				Surgery				Clinic						28	1
Oral Health						Surgery								0	1
Orthopaedics Adult												Clinic Surgery		38	23
Renal	Clinic														
Urology	Clinic											Surgery			27
Cardiology															32
Cardiothoracic	Clinic Surgery														0
Respiratory			Clinic												
Vascular Service	Clinic		Surgery											2	1
Dermatology	Clinic														
Endocrinology						Clinic								3	
Immunology			Clinic											4	
Rheumatology			Clinic												
Tarps	Clinic														
Gynaecology General	Clinic		Surgery											6	12
Paed ENT						Clinic Surgery								1	1
Paed Endocrinology	Clinic														
Gen Paeds	Clinic														
Paed Gastroenterology	Clinic														
Paed Immunology	Clinic														
Paed Infectious Diseases			Clinic												
Paed Neurology			Clinic											6	6
Paed Neuro services	Clinic					Surgery								2	2
Paed Orthopaedics						Clinic		Surgery						3	16
Paed Cardiology					Clinic Surgery									19	19
Paed CTSU					Surgery										2
Renal-Paed			Clinic												
Paed Respiratory			Clinic											2	1
Paed Rheumatology	Clinic														
Paed Surgery						Clinic		Surgery						4	15

Gastroenterology	Now zero
General Surgery	Plans in place to clear these
Immunology	Clinic: Sept 4 pts >6 months, all have Nov. appts however plan needs adjusting, long waiters increase again for Oct
Gynaecology	Clinic and surgery not on track have contacted service regarding this, plans being firmed up by them
Paeds Neuroservices	Clinic now zero, surgery 1x booked Oct, 1x not date for surgery but have reminded service their 'zero' month is December
Paediatric Neurology	Service clarifying status of patients
Paed Cardiology	Clinics on track. POP plan needs to be adjusted to accommodate level of surgical non compliance. Mainly Paeds EP
Paediatric Respiratory	Service clarifying status of patients

There are some services that had target dates of July 2011 that have small numbers waiting (eg gynaecology clinics) that we are working through at a service level.

***Interpretation Note – Wait time penalties***

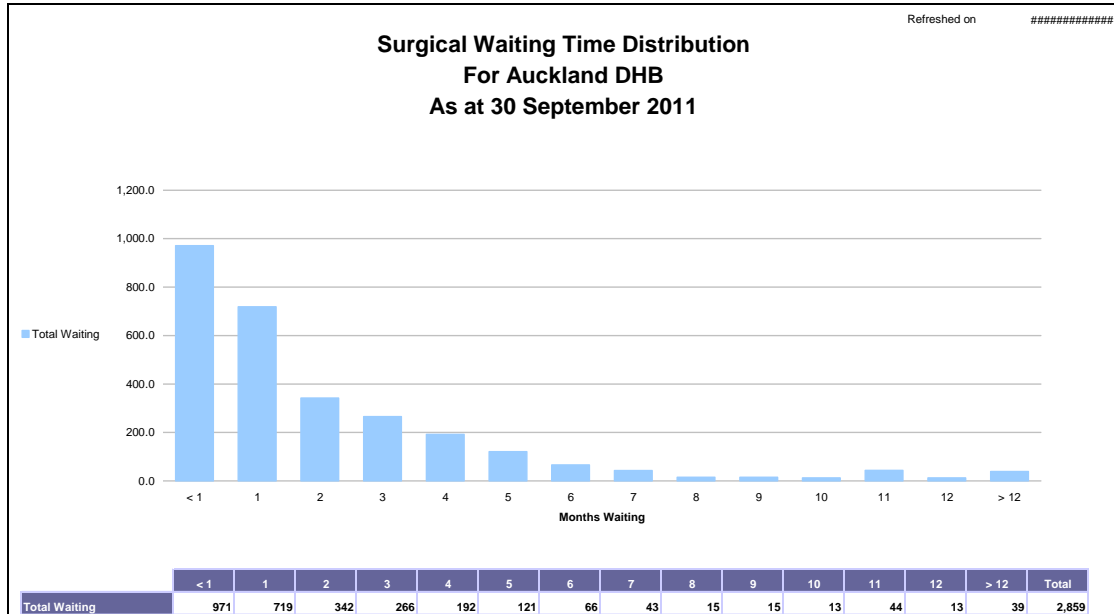
*NHB has written to ADHB advising that from 1 July 2012 all patients are to be seen within 6 months and that the following estimated buffers will apply from 1 July 2012, clinics 40 patients (currently 311) and surgery 50 patients (currently 225).*

*The NHB current policy is that where a DHB is non-compliant (ie patients waiting > 6 months) on 3 consecutive months (or any 5 months in a year) the DHB will be penalised 1/12th of its additional elective revenue for each month of non-compliance with a minimum of 2 months.*

- *ADHB's annual additional elective revenue is approximately \$24m per annum therefore a penalty of \$2m per month or minimum of \$4m.*
- *ADHB has raised with NHB the disproportionate quantum of the penalty and the NHB are looking to review this policy prior to January 2012.*

While there are a number of risks across the specialties these are more apparent for those services that plan to be compliant in the month of June 2012 ie orthopaedics, urology, ophthalmology and neurosurgery. ADHB has used the Patient and Operational Demand (POP) plan to inform the additional resourcing required for those services to become compliant by 30 June 2012. Some of these services have significant IDF components within their waitlists (eg Ophthalmology) which may require ADHB to deliver above planned levels in order to deliver services within the 6 months or the appropriate waiting time for the assigned patient priority.

## Surgical Wait List Distribution for the ADHB Population



A number of the cases waiting more than 12 months are for staged/planned surgery i.e. cases where surgery cannot be undertaken within 12 months because for example clearance from another medical specialty is required. Such cases are legitimate exclusions from Ministry reporting. Future reports will separate off these exclusions.

### % of waiters by ethnic group (all DHB populations)

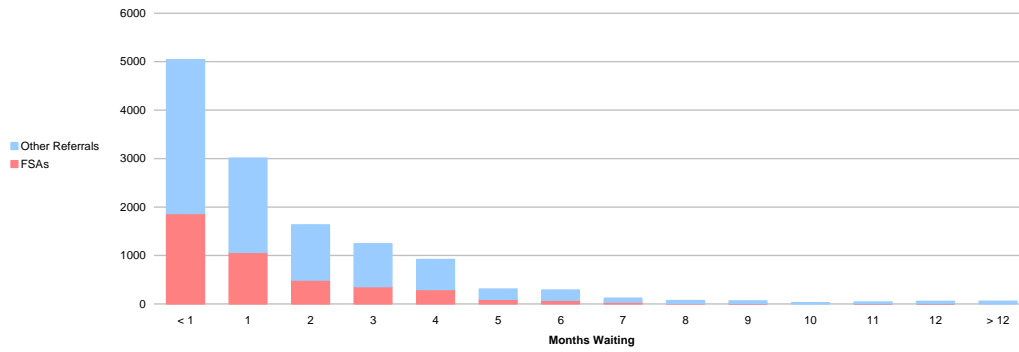
	1 Month	2 Month	3 Month	4 Month	5 Month	6 Month	> 6 Month
<b>Maori</b>	11%	9%	12%	10%	9%	9%	16%
<b>Pacific</b>	12%	13%	13%	14%	14%	15%	15%

As with the overall ADHB population a number of those waiting > six months are for staged/planned procedures.

**Outpatient Wait List Distribution for the ADHB Population**

Refreshed on #####

**Outpatient Waiting Time Distribution  
For Auckland DHB  
As at 30 September 2011**



	< 1	1	2	3	4	5	6	7	8	9	10	11	12	> 12	Total
FSAs Waiting	1864	1064	490	358	296	94	76	37	13	7	1	3	2	1	4306
Other Referrals	3180	1946	1142	887	622	213	211	83	56	58	27	36	52	57	8570
Total Waiting	5044	3010	1632	1245	918	307	287	120	69	65	28	39	54	58	12876

Ministry monitoring (ESPI 2) relates to the FSA line.

**% of waiters by ethnic group (all DHB populations)**

	1 Month	2 Month	3 Month	4 Month	5 Month	6 Month	> 6 Month
<b>Maori</b>	8%	8%	8%	9%	8%	7%	7%
<b>Pacific</b>	12%	11%	12%	12%	11%	12%	13%

The ethnic data shown here will be subject to the same review (of relevance and appropriateness) as other ethnic data referred to in this pack.

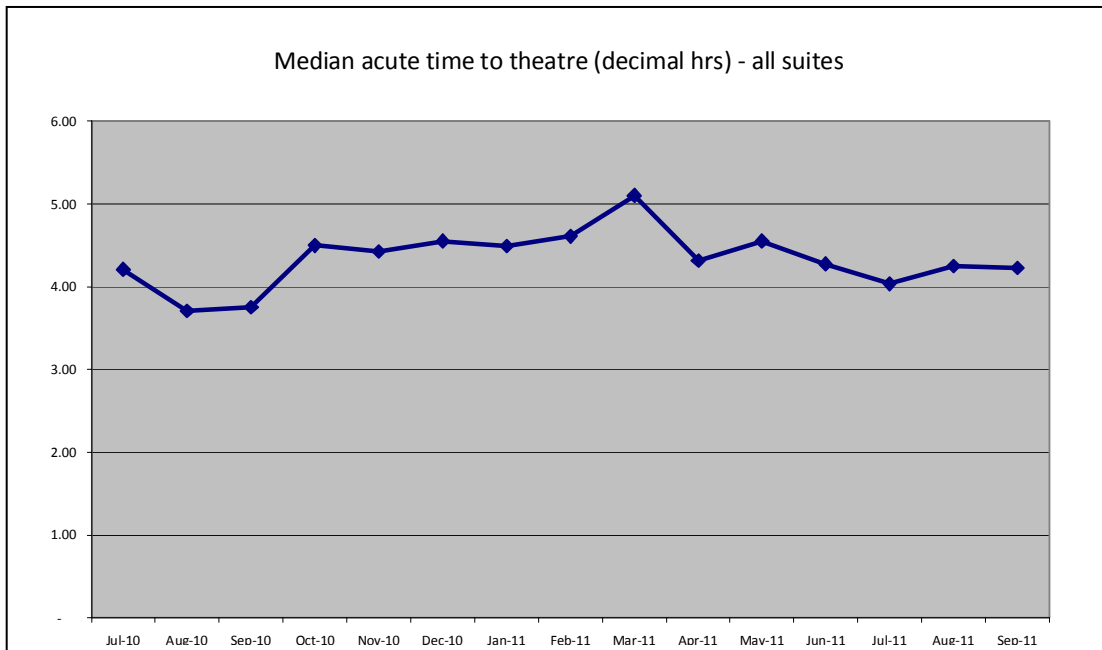
## OR Performance Statistics

OR management maintain and report on a wide range of operational KPIs. Included among these is elective theatre utilisation. The benchmark figure for OR utilisation is 85%. ADHB theatres typically exhibit utilisation close to this benchmark:-

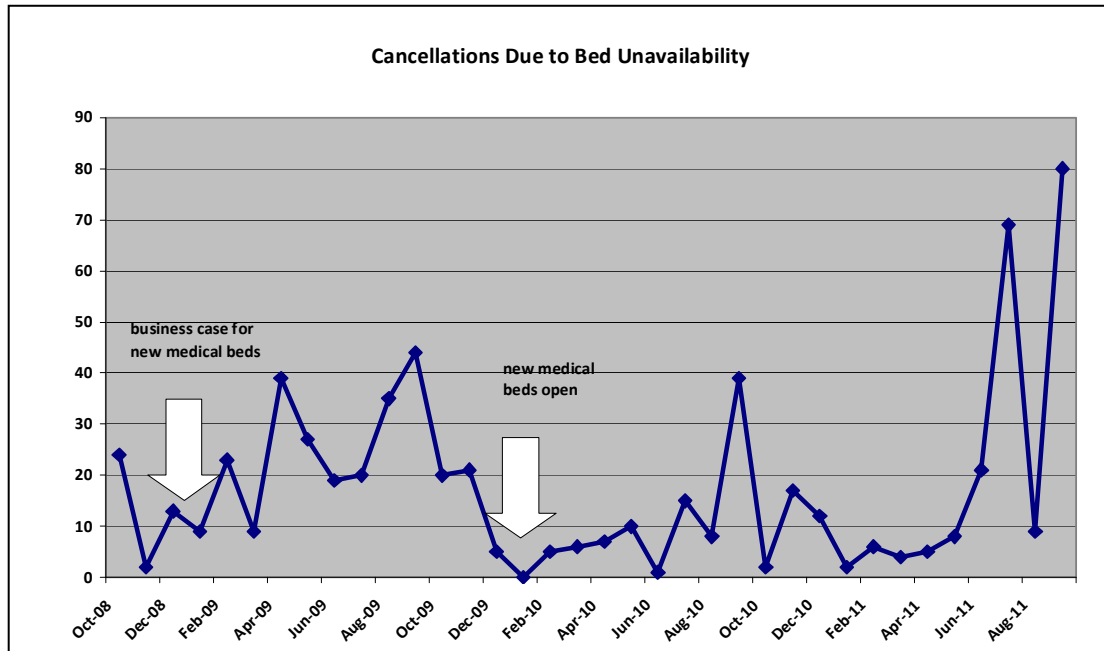
September 2011 utilisation:-

	<b>Sept</b>	<b>Aug</b>	<b>Jul</b>
Level 4	<b>76%</b>	81%	83%
Level 8	<b>87%</b>	82%	82%
Level 9	<b>83%</b>	82%	82%
Starship	<b>74%</b>	76%	74%
Greenlane	<b>79%</b>	83%	80%

The ongoing replacement of cancelled cases with other cases waiting surgery is evidenced by these utilisation rates. At the same time median acute time to theatre has been reducing.



Cancellations due to non-availability of an inpatient bed has also been an issue over the winter:-



Source: Monthly Throughput Report and PIMs Report TH039

#### *Interpretation Note*

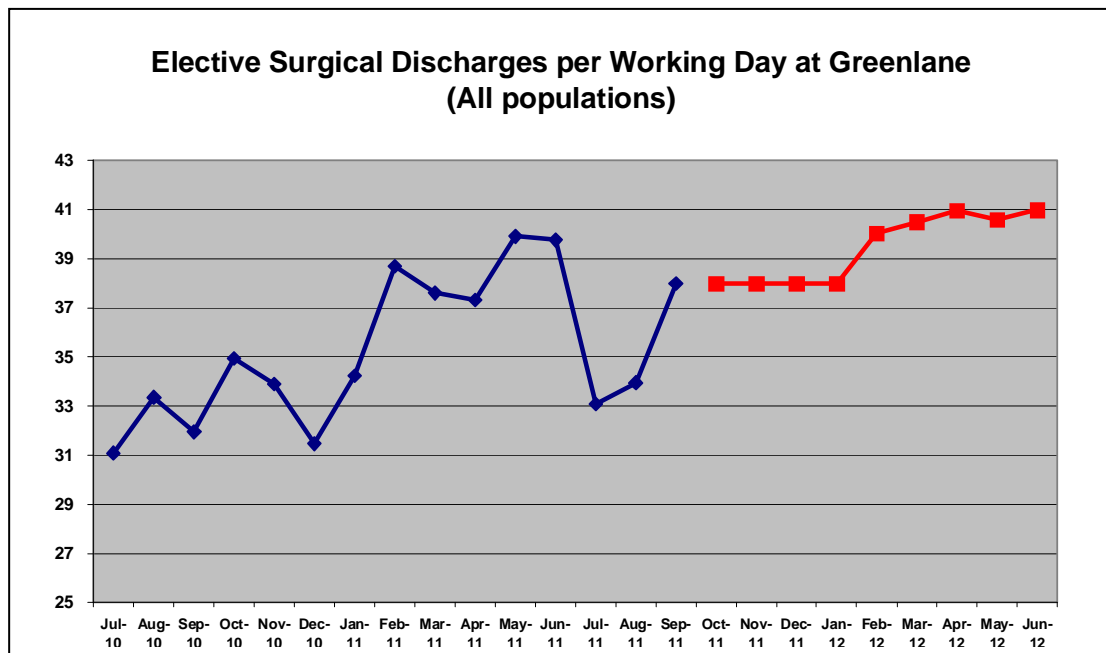
*In reviewing cancellation statistics it's important to appreciate that some issues of data quality have been identified as part of The Productive Operating Theatre (TPOR) work. These issues will be systematically addressed as the project proceeds.*

**Production Plan**

Our production plan shows a Quarter 1 performance of 101%, October monthly performance is 97% at the time of preparing the report. As with other key metrics an update of the month in progress will be provided at the meeting.

**Greenlane Surgical Unit Production**

GSU elective discharge outputs (expressed as discharges per working day) have reduced from the high level at the end of the previous financial year. A key driver for the high numbers in the latter part of the year were additional lists in Ophthalmology; these lists will resume in the new financial year once recruitment has provided the additional staffing required.



## **4. Productivity – Greg Balla**

### **4.1 Improvement projects**

ADHB teams are involved with a large number of performance improvement activities. The improvements reflect either the release of resources for further service volumes or a reduction in costs. The majority of projects are at an early stage as shown in the table on the next page, but all have been started.

The work to release resources through improved processes provides the most innovative opportunity for improvement and requires the full engagement of the clinical workforce and the careful validation of the revised processes to ensure the excellence of patient care is maintained or improved. This close working relationship is creating a culture of continuous improvement that will ensure the longevity of this way of thinking.

## 4.1 Improvement projects

The improvements projects reflect either the release of resources for further service volumes or a reduction in costs. Whilst most projects remain in the planning phase there has been good progress for the projects in the implementation phase and one project has been completed during the month.

	Total	Started	Plan					On Time			On Budget			Finished	Benefits			
			Define	Measure	Analyse	Improve	Control	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red	
<b>2 Performance improvement</b>																		
01. Improved services / reduced wait time: shorter stays in Emergency Department	4	4	3	0	0	1	0	4	0	0	4	0	0	0	0	0	0	0
03. Shorter waits for cancer treatment - Radiation therapy	1	1	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0
07. Clinical Leadership	5	5	2	1	0	1	1	4	1	0	5	0	0	0	0	0	0	0
08. Services Closer to Home	10	10	10	0	0	0	0	10	0	0	9	1	0	0	0	0	0	0
14. Healthcare Excellence	33	33	25	1	4	2	0	32	1	0	33	0	0	1	1	0	0	0
<b>Totals</b>	<b>53</b>	<b>53</b>	<b>41</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>1</b>	<b>51</b>	<b>2</b>	<b>0</b>	<b>52</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>

<b>Id</b>	<b>Project Name</b>	<b>Phase</b>	<b>On Time</b>	<b>On Budget</b>	<b>Expected Outcome</b>
No Projects Flagged or with Exceptions					

## 4.2 Savings schedule progress

Progress to date is shown in the table below

Category	Gains this month	Gains Year to date
	<b>\$000</b>	<b>\$000</b>
Direct treatment costs	569	1,577
FTE Productivity	193	3,240
Indirect treatment costs	366	1,092
<b>Total gains achieved</b>	<b>1,128</b>	<b>5,909</b>

### Direct Treatment Costs (\$ 1,577k Year to Date)

The main contributors to Direct Treatment Savings YTD are Procurement savings locked in by Materials Management effective this financial year (\$633k) and reduction in blood usage through a reduction in unnecessary usage of blood. (\$604k).

### FTE Productivity (\$3,240k Year to Date)

The major contributor to this is the Releasing Time to Care Programme which is currently operating in 33 wards and is achieving an additional 5% direct patient contact time for on average 35 nurses a ward (\$1,060k).

Other significant contributions came from reducing stay in AED \$412k and CED \$334k.

These savings are re-invested as quality gains within the respective services.

### Indirect Treatment Costs (\$1,092k Year to Date)

Improved contract pricing from Materials Management is now reported as savings attributed to Health Benefits but the benefit is a saving to ADHB. Year to date this amounts to \$1,092k.

## 5. Financial Performance – Brent Wiseman

### 5.1 Overview

The provider arm was unfavourable to budget for the month by \$(0.1)M U. YTD is \$(1.7)M U.

	<b>Actual Month</b>	<b>Variance</b>	<b>Actual YTD</b>	<b>Variance</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
Income	104,870	1,422 F	307,484	(2,258) U
Operating Expenditure	94,940	(2,058) U	280,925	(779) U
Operating Surplus/(Deficit)	9,929	(637) U	26,559	(3,037) U
Non-Operating Expenditure	7,608	492 F	22,827	1,318 F
<b>Total Surplus / (Deficit)</b>	<b>2,321</b>	<b>(145) U</b>	<b>3,731</b>	<b>(1,719) U</b>

### 5.2 Revenue

Revenue was favourable to budget by \$1.4M F for the month, \$(2.2)M U YTD. The key variances are summarised below.

<b>Category</b>	<b>Variance Month</b>	<b>Variance YTD</b>	<b>Explanation of major items (YTD)</b>
	<b>\$M</b>	<b>\$M</b>	
MOH - Base Funding	(0.8) F	(1.4) U	Net DRG volumes higher than planned \$2.7m and lower non DRG revenues than planned
Trust & Donation income	(0.2) U	(0.6) U	This variances arises from lower receipts of Starship Foundation donations than planned.
Financial Income	(0.4) F	(0.4) F	Gain on the quarterly mark to market revaluation of interest rate swap instruments.

### 5.3 Workforce

The tables below analyses the FTE numbers and variance both in numbers and value for the month.

Employee Group	Actual FTE Month #	Variance FTE Month #	Variance Month \$000's	Actual FTE YTD #	Variance FTE YTD #	Variance YTD \$000's
Medical	1,196	(28) U	347 F	1,187	(18) U	911 F
Nursing	3,355	(67) U	2 F	3,337	(49) U	(482) U
Technical	1,763	55 F	422 F	1,759	60 F	1,265 F
Hotel Services	231	(2) U	(9) U	229	(1) U	(55) U
Administration	1,140	80 F	294 F	1,143	77 F	818 F
Other	2	0	2 F	2	0	3 F
<b>Total (excl Outsourced Staff)</b>	<b>7,686</b>	<b>38 F</b>	<b>1,058 F</b>	<b>7,656</b>	<b>69 F</b>	<b>2,461 F</b>
Outsourced staff	92	(51) U	(395) U	85	(45) U	(739) U
<b>Total (incl Outsourced Staff)</b>	<b>7,777</b>	<b>(13) U</b>	<b>663 F</b>	<b>7,741</b>	<b>23 F</b>	<b>1,722 F</b>
Other Staff Related Costs			(564) U			(751) U
<b>Total Employee Costs</b>	<b>7,777</b>	<b>(13) U</b>	<b>99 F</b>	<b>7,741</b>	<b>23 F</b>	<b>971 F</b>

HSG / Service	Actual FTE Month #	Variance Month #	Variance Month \$000's	Actual FTE YTD #	Variance YTD #	Variance YTD \$000's
Operational	6,270	(58) U	(191) U	6,237	(24) U	(457) U
Mental Health	722	17 F	139 F	727	12 F	440 F
Ancillary Services	786	27 F	151 F	778	35 F	988 F
<b>Total Employee Costs</b>	<b>7,777</b>	<b>(13) U</b>	<b>99 F</b>	<b>7,741</b>	<b>23 F</b>	<b>971 F</b>

Employee Costs are tracking favourably to budget for the YTD with total FTE (including Outsourced and Temporary staff) below budget for the YTD.

This month, however, FTEs are slightly above budget at 13U. The increase in FTE has been escalated to the leadership teams, and all level 2 managers are now reviewing recruitment activity to ensure we stay within budget levels.

By category, Medical and Nursing FTE are both above budget, with these variances offset by Technical, Hotel and Administration which are all below budget. These offsetting variances reflect the difference mix in the types of staff between the initial budget assumptions and the prioritisation of staffing resources that is being undertaken by each HSG.

#### 5.4 Clinical Services Outsourcing Costs

Outsourcing costs were \$(1.5)M U for the month. YTD is \$(1.7)M U.

There was a significantly higher level of (brought forward) outsourcing activity during the month when compared to budget and previous months in order to achieve the first quarter ADHB population elective discharge target. The key areas of higher expenditure against budget are in Orthopaedics, Cardiothoracic, General Surgery and Paediatric ORL. The higher level of activity enabled us to meet the first quarter targets, but we now need to ensure we meet balance of year targets with a lower level of outsourcing than in the first quarter. This is being worked through at a detailed level within the POP production plans.

#### 5.5 Direct Treatment Costs

Direct treatment costs remain close to budget at \$(0.3M) U for the month and \$0.4M F YTD.

Within this there are three key variances YTD, as follows:

Category	Variance YTD \$M	Explanation of major items
Drugs	2.4 F	Cancer & Blood \$1.6m F - lower demand for Haemophilia blood products \$0.5m F (offset by lower revenue), together with lower demand for PCT drugs \$0.2m F. The remaining \$0.9m F relates to a budget adjustment reflecting the revised PVS production plan together with repatriation of services to Northland from 1 July.  Adult - \$0.5m F reflects a combination of savings achieved in the Concord "Blood is a Gift" project, as well as total inpatient volumes being below plan YTD.
Clinical Supplies	(1.4) U	Volume related costs spread across the provider driven by activity in Perioperative Services \$(0.5)M U, Cardiology \$(0.3)M U and Adult \$(0.2)M U. While total Provider Arm volumes are behind plan for YTD, the mix of volumes has resulted in unfavourable variances in renal haemodialysis, cardiac and OR where volumes are ahead of plan.
Patient Appliances	(0.6) U	Volume related costs in Cardiology \$(0.3)M U and Paediatric Cardiac \$(0.2)M U. Cardiology reflects EP, ICD and pacemaker procedures and Paediatric Cardiac reflects 6 Melody valve procedures in the first quarter against a full year budget of 5 procedures. For both services full reviews are underway of activity against budget.

## Appendix 1 Provider Operating Statement September 2011 and YTD

\$000s	September			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<b><u>Income</u></b>						
ADHB Funder Sourced	90,214	89,386	828 F	267,654	269,055	(1,401) U
MoH Sourced (Incl CTA)	4,210	4,119	91 F	12,269	12,532	(263) U
Other Income	8,518	8,214	304 F	24,253	24,554	(301) U
Trust & Donation Income	138	319	(181) U	327	957	(630) U
Financial Income	1,789	1,410	380 F	2,981	2,643	337 F
	104,870	103,448	1,422 F	307,484	309,741	(2,258) U
<b><u>Expenditure</u></b>						
Employee Costs	59,282	59,776	494 F	178,890	180,600	1,710 F
Outsourced Staff	4,164	3,769	(395) U	12,047	11,307	(739) U
Outsourced Clinical Services	3,912	2,407	(1,505) U	9,024	7,305	(1,719) U
Treatment Costs - Direct	18,009	17,737	(272) U	52,903	53,284	381 F
Treatment Costs - Indirect	3,731	3,514	(217) U	10,939	10,578	(361) U
Other Costs	5,842	5,680	(162) U	17,123	17,072	(51) U
<b>Total Operating Expenditure</b>	94,940	92,882	(2,058) U	280,925	280,146	(779) U
<b>Operating Contribution</b>	9,929	10,566	(637) U	26,559	29,596	(3,037) U
Depreciation, Interest & Capital Charge	7,608	8,100	492 F	22,827	24,146	1,318 F
<b>Net Surplus / (Deficit)</b>	2,321	2,466	(145) U	3,731	5,450	(1,719) U







## 5.2 Health Target Updates

The Ministry of Health targets areas applicable to the provider arm are set out in the table below. Two of the six targets have been met, and in the case of radiation therapy for 522 consecutive days. Meeting the elective surgery target for the month hand quarter was pleasing and indicates that performance strategies are working.


Acute patient flow management is a focus in all departments, not just ED. The Rugby World Cup has created some spikes but the improvement strategies are working.

The cardiac bypass surgery targets have been affected by an increase in numbers last month and this is being reduced back towards target levels through outsourcing of 26 procedures in the month and a focus on increasing internal volumes.


The quit smoking targets are proving difficult to achieve. This is not a widespread issue and the focus is on improving the underperforming areas.

	Status	Comment
Adult acute patient flow		92% achieved against 95% target.
Child acute patient flow		93% achieved against 95% target.
Improved access to elective surgery		100% of target achieved and 101% for the quarter.
Shorter waits for radiation therapy		100% of eligible patients treated.
Better help for smokers to quit		81% achieved against 95% target
Cardiac bypass surgery		Patients waiting 114 against a target of 94 reflecting a reduction from the 121 spike last month. Volumes were below target at 60 plus 26 more outsourced.

Key to symbols:

Proceeding to plan 

Issues being addressed 

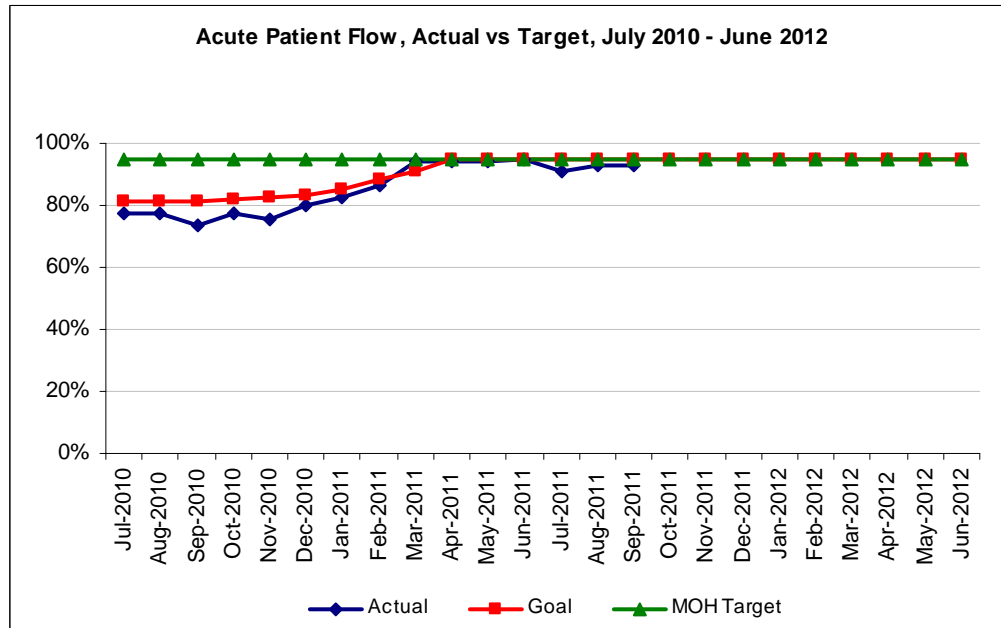
Target unlikely to be met 



**Project:**

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

Date of Delivery: 30 June 2012



**Project Risks / Comments:**

92% of patients admitted, discharged or transferred from Emergency Department within six hours in Qtr 1 11/12.

Actions continue to be taken across Adult and Children's service to respond to constraints impacting on flow.

## Project: Adult Acute Patient Flow

62

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 2012

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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

### Improvements to date:

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

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

Charge nurse patient flow coordinator introduced

Improved access to Radiology

Streamlined documentation required for safe transfer

Improved triage processes.

### Managing bed block with additional resources

58 Additional beds opened 2009-2010

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

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

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

Nurse Facilitated Discharging in General Medicine (April 2010)

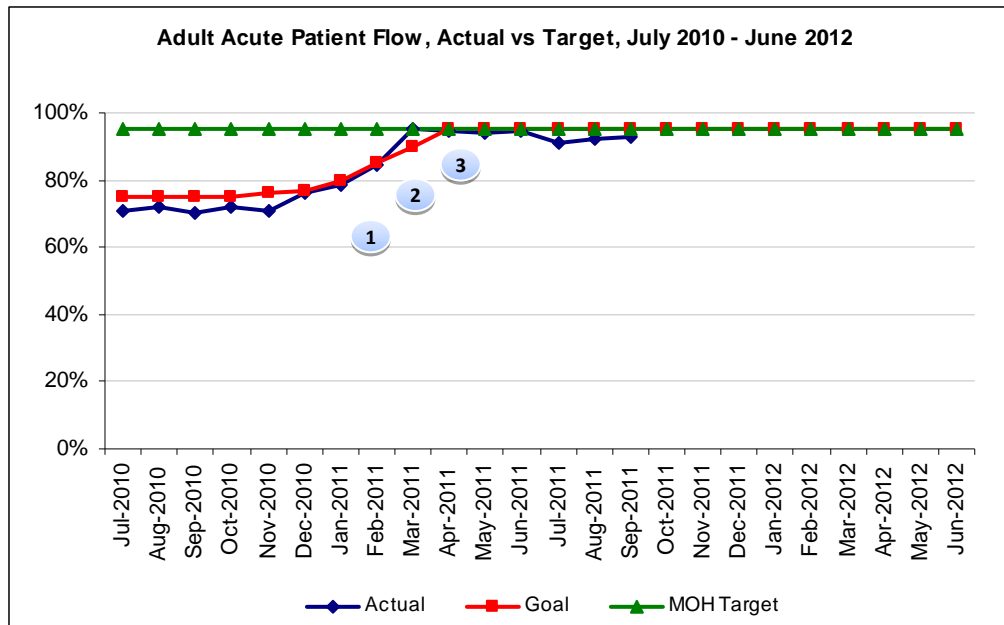
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.

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

### Immediate actions to improve performance:

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

Adult Acute Patient Flow, Actual vs Target, July 2010 - June 2012



### Project Risks / Comments:

92% of patients admitted, discharged or transferred from Adult Emergency Department within six hours in September.

Three areas for further focus include: reducing delays to ED sign on, reducing delays to inpatient specialty sign on post referral from ED, reducing access block (no beds available).

Measures underway to address these concerns include:

Finalising Adult ED escalation plan and incorporate into hospital wide plan.

Workshop review of 3 hour strategies to identify further improvement opportunities

Implement Gen med redesign

Develop acute and elective bed capacity forecasting to integrate with elective surgery POP.

Review effectiveness of breach meeting and improve.

# Project: Children's Acute Patient Flow

63

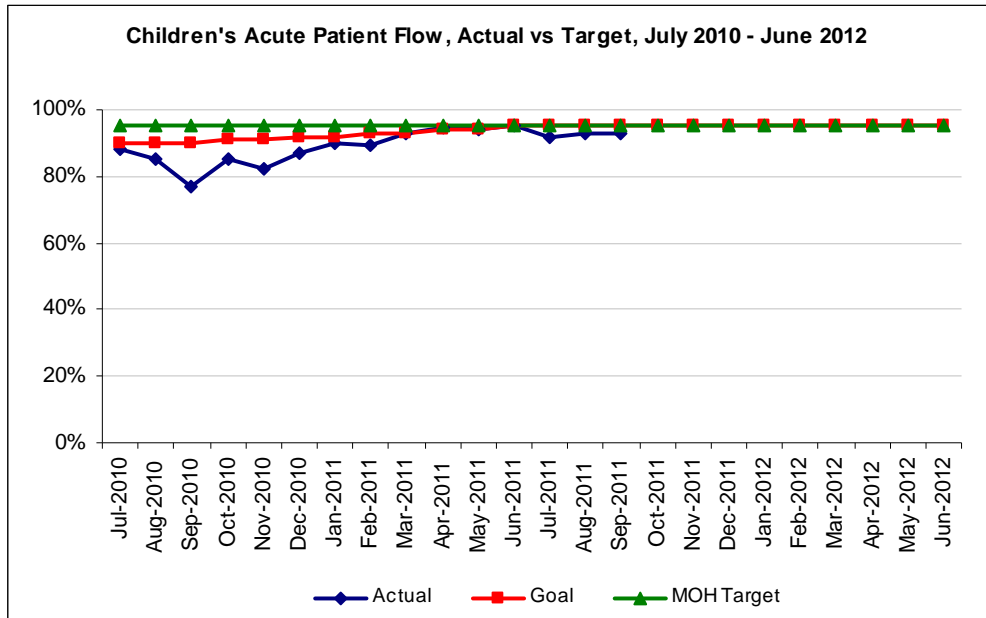
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: **30 July 2012**

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



### Project Risks /Comments:

September's results for Starship's Acute Patient Flow project came in at 93%, just two percentage points below our target. This performance was consistent with that of the prior month and a significant 14% above the equivalent month last year. In addition there were 11 days where we achieved 95% or greater.

A feature of September has been the somewhat inconsistent nature of Acute admissions. The random nature of presentations across each week and time of day has made management within CED and the wards more challenging. It has also led to random bed block, albeit for short periods of time as we attempt to balance the Acute admissions with our Elective lists. Our efforts with respect to Capacity Planning have proven to have been of real value within this period as while we can't remove random variation in Acute admissions we can forward project their likely effect and impact on resourcing.

Other key initiatives being undertaken to support the six hour target are:

We continue to progress the project on the 2 hour component of the patient journey. While progress continues to be slower than planned, we have strong clinical buy in to move the project forward as priorities dictate.

The use of Estimated Discharge Dates has been central to our efforts with Capacity Planning and each successive month, accuracy has been improving. Having greater predictability around discharging is not only beneficial to patient flow but is also highly desirable to the families of patients.

A further project is to be initiated on improving the discharging process and will be started in the next few weeks. Our Steering Group met recently to discuss progress. While we are generally pleased with progress made to date, there is open acknowledgement that there is still much work to be done before we can consider the process to be both robust and stable.

### Improvements to date:

Improvement in the Estimate Discharge Date (EDD's) for current inpatients – steady improvement in accuracy.

Improvement in the forecasting occupancy

### Immediate Actions to Lift Performance

We continue to progress the specific project we are operating on the 2 hour component. While advancement is slower than planned, we have identified five key areas for improvement and are moving these forward.

1. A new suite of reports including a breakdown of the 3-2-1 performance is now produced each Monday and is distributed to key stakeholders.
2. Ongoing focus to ensure timely discharging by improving the rounding process. General Pediatrics is paying particular attention to Nurse presence on rounds to enhance communication, particularly with parents.
3. In addition Pediatric Orthopedics has been operating a daily Rapid Round Meeting including the Multi Disciplinary Team to improve communication and agree actions for a co-ordinated discharge plan.
4. We have concluded a project on Bed Turnaround time in our Pediatric Surgical Ward and we will be replicating the project in other wards starting with Pediatric Orthopedics.
5. We continue to progress the specific project we are operating on the 2 hour component. While advancement is slower than planned, we have identified five key areas for improvement and are moving these forward as priorities allow.

### Longer term projects

Starship Capacity Planning Project

Starship's website is being upgraded, information for parents regarding the use the transition lounge will be included – launch date is expected to be in October.

# Project: Improved access to elective surgery

64

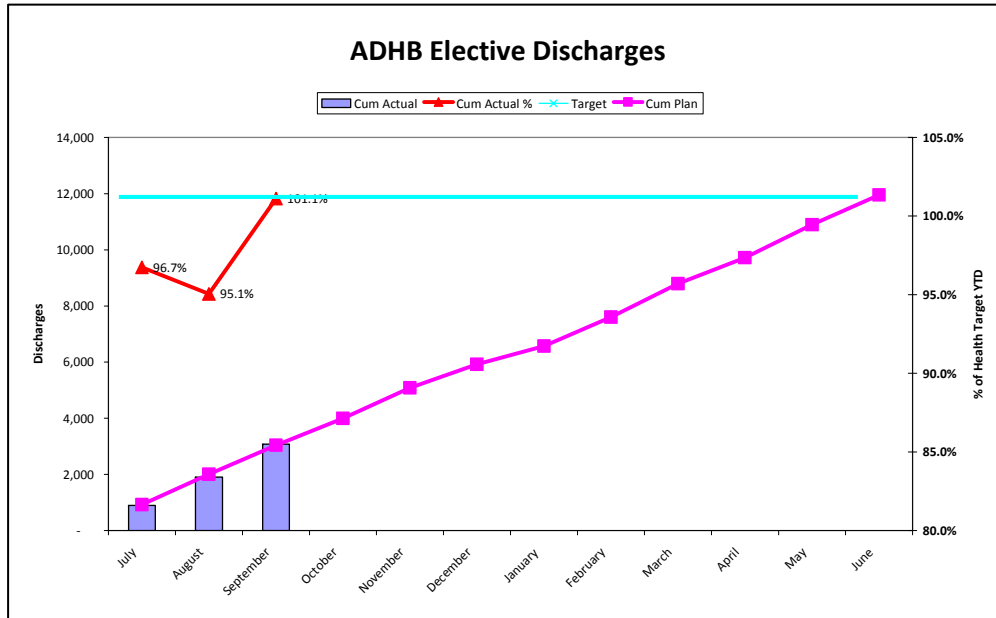
Primary Objective: Increase ADHB Elective Surgical Discharges from 11,149 to 11,950

Date of Delivery: 30 June 2012

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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



## Planned activities:

1. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Continuing to review the production plan at a daily and weekly level.

## Risks / Comments: (Amber)

1. Quarter 1 performance is expected to be 101% of target.
2. Month to date for October is 100% at time of report preparation.

## Project: Shorter waits for Radiation Therapy

65

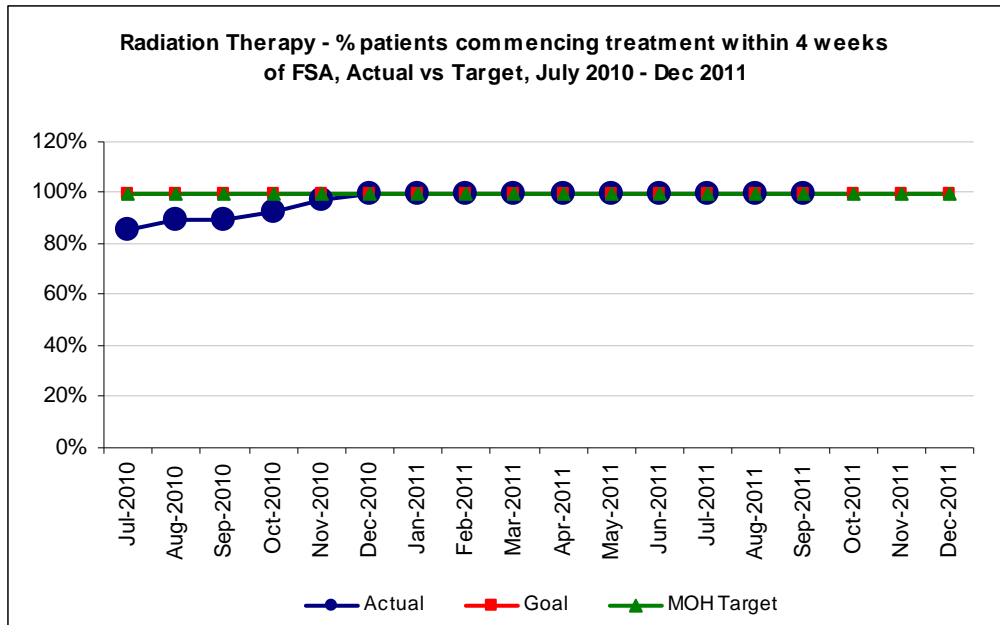
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



**The service is 100% compliant for September 2011**

**Key risks which may impact capacity to deliver to the target in the coming months:**

MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement August - December 2011. This will be mitigated by our ARO Contract.

Introduction of new technology also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment.

The HDR Brachytherapy machine was damaged mid July and following assessment by the manufacturers in Holland requires full replacement. The insurer has approved full replacement costs and a new machine is expected to arrive in November. In the interim patients are receiving LDR treatment.

### **Radiation Oncology Wait times – September 2011**

In September 100% of eligible patients were treated within the 4 week target timeline. As at 30 September Radiation Oncology delivered to the target for 522 consecutive days.

### **Further improvements in progress to sustain delivery:**

**Replacement of MV6:** Decommissioning commenced on the 22nd August until late December 2011. Evening shifts have been reinstated during this period to mitigate lost capacity

**Introduction of HDR** for Gynaecological patients is now being phased into the department (subject to the requirement to replace the machine – refer risks).

**A public/private Model of care** has been developed to enable our clinicians to treat public patients at ARO. Noting the variability in our referral flows, ARO have agreed to operate a 4 week rolling average of approx 3 patients per week from August 2011.

**Introduction of new technology:** The introduction of V-Mat treatment has the potential to reduce treatment times for specific tumour groups by up to 50% when fully implemented next year.

**Aria project:** A project is well underway to develop a full electronic record within the LINAC machine's operating system. Project end expected Dec 2011.

**An "Operational team"** measures KPI's to prioritise the waitlist and analyse performance on a weekly basis.

**A daily Waitlist report** enables daily monitoring and immediate remedial action if required.

## Project: Better help for smokers to quit

66

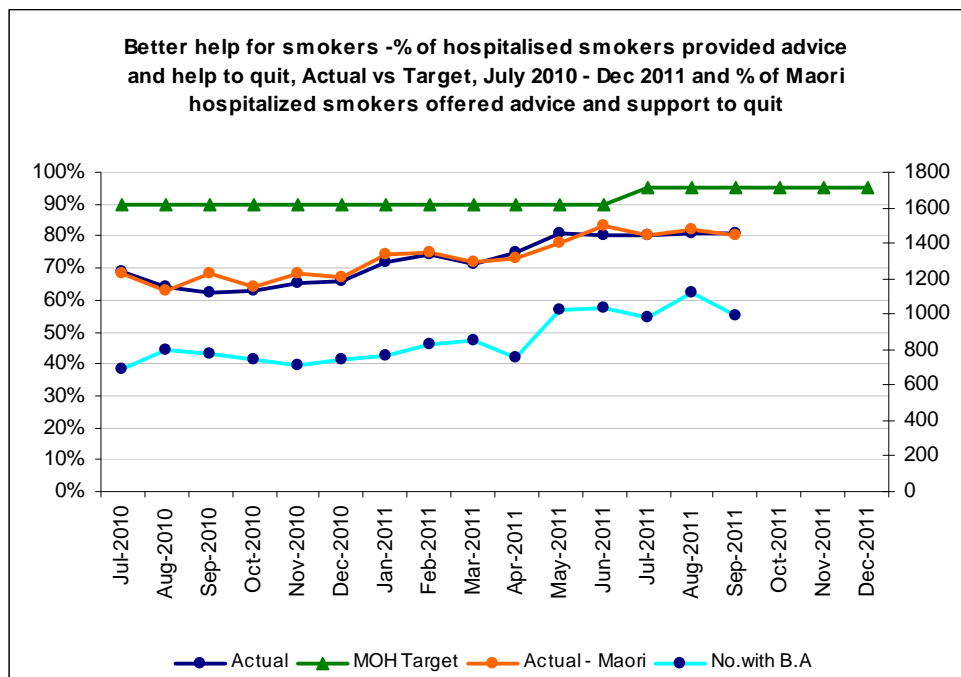
### Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child

Programme Sponsor: Taima Campbell

Programme Manager: Jan Marshall

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



### Comments

**Result: Of the 8810 events coded in September 1223 (14%) were identified as smokers. 81% (1124) of all smokers were given brief advice to stop smoking.**

Two gains were made in late September that will show up in the October figures. The Ministry has allowed DHBs to remove the Ex smokers coded F17.1 from the smoking prevalence. A system has been set up to do this and it is anticipated this will result in an increase of 2-4%. The Greenlane Surgical Unit instituted a system to record brief advice on the day of surgery which should translate into a 1-2% increase.

The GMs Adult Health and Information Management Services and Smokefree Coordinator visited Waitemata DHB to review the systems and processes that have aided WDHB met this target. As a result we are exploring the generation of an electronic "Brief Advice Brochure" to be given with the Discharge Summary in AED. A combination of factors lead to the WDHB achievement including prioritisation of the target at all levels and high level accountability across services. Due to delays in coding WHDB instituted daily reports from Charge Nurses to GMs up to the COO monitor ward performance which resulted in sharp increase in results.

### Achievements in August:

- Direct Dial Quitline phone at the Level 5 reception, fortnightly "Quit Clinics" for staff and visitors went live 27 September improve staff access and uptake of Quit Services
- Security staff stationed at Starship Hospital entrance has significantly reduced onsite smoking. Fencing erected and Smokefree boundary line in place at ACH main entrance.
- ADHB job applicants asked smoking status for statistical purposes

### Immediate Actions to improve performance by 15%:

#### A. Focus on short stay/high volume areas to achieve 4-5%:

- Continued auditing and 1:1 coaching in AED and APU
- To reduce the "not asked/ documented" option in the Electronic Discharge Summary in AED from 27% to 10%
- Greenlane Surgical Centre recording of ABC on day of surgery to be implemented

#### B. Improve engagement of clinical workforce to achieve 5-8%:

- Data on target now distributed weekly to senior leadership
- Letters to Level 2 leaders with monthly results requesting support from services not meeting the target
- Best Practise Guidelines to be distributed to wards and updated weekly
- To work with Registrars to determine barriers and support mechanisms to assist junior doctors complete the ABC in clinical documents and EDS

#### C. Data collection systems and processes to achieve 5%:

- Smoking and Brief advice column to be added to Ward electronic whiteboards to monitor the ABC completion
- Investigation of generation of a Brief Advice Brochure with the EDS for AED
- Research – ADHB joining 6 other DHBs is participating in a ABC Outcomes survey funded by the MOH to measure the outcomes of Brief Advice given in hospitals

#### D. Communications – planned activities

- An NRT working Group as been established to develop an NRT promotion campaign to all clinical staff
- Quit Banner to be set up at Level four entrance

# Project: Cardiac Bypass Surgery

67

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 94.

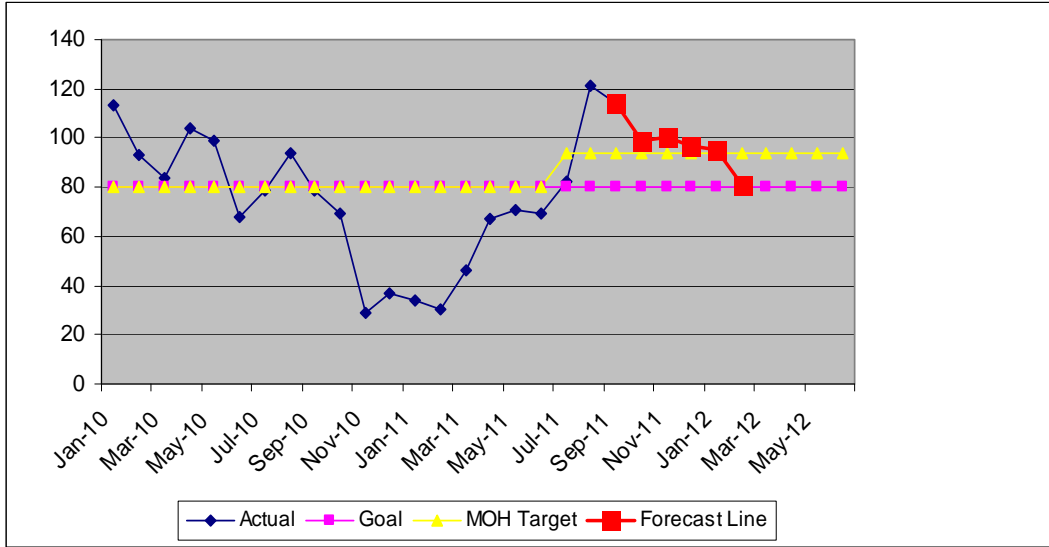
To support the national cardiac bypass intervention target, 940 bypasses should be completed in 2011/2012

Date of Delivery: 30 June 2012

Clinical Lead: Peter Ruygrok

Project Sponsors: Fionnagh Dougan

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



## Monthly Performance

65 Bypass procedures were completed by the service during September. Of these completed procedures 60 are eligible to be counted against the MoH target for the Northern region population. The 5 "other" procedures are comprised of Transplants as well as other procedures involving the use of a bypass but not revascularisation of arteries or valve repair/replacement. In addition to these volumes 26 eligible bypass procedures were outsourced to Mercy Hospital during September. Outsourcing of these procedures was necessary due to the volume of patients waiting for bypass surgery. Over the last 14 weeks the accepted referral volume has markedly increased over previous years. On average three additional patients have been accepted onto the wait list during FY 2011/2012 and compared to this time last FY we have accepted 28 additional referrals. Historically the referral rate often slows through October before picking up in November and then sustaining a decrease until May. Hopefully this is the case for the coming months as this would allow the service to deal with the backlog of waiting patients.

As the graph above shows we have been able to effect a slight reduction in the waiting list throughout September, however we are still above our target maximum waiting numbers and therefore we will continue to outsource throughout October. Weekend contracts also continue with the adult congenital service making surgical resource available to assist us in completing these lists going forward. As part of the FTE approval for CIVCU we will be addressing some of the historical bed blocking issues that have historically prevented weekend contracts being fully utilised.

## Completed Improvement Activities:

- Developed and implemented electronic scheduling system
- Initiated pre-admit process
- Developed detailed operational reporting
- Set up development production process
- Approved business case for CVICU bed capacity
- Built capacity planning model for CVICU and Ward 42
- Developed patient load planning tool
- Initiated daily bed management meeting
- Enhanced recovery pathway in ICU
- Scheduling workshop for productive theatres
- Releasing time to care foundation modules
- CVICU\HDU merger

## Further improvements in progress:

- 3 in a row bypass (productive list)
  - Optimise the theatre schedule by planning a "productive list"
- ECMO – Resource planning process
  - To improve resource planning and day to day processes to reduce the impact of high ECMO demand on bypass cases
- The Productive Operating Room (NHS Programme)
  - To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- Delay to discharge – ward 42
  - To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Delay to discharge CVICU
  - To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Elective patient focused team project
  - To maintain elective throughput in the service during periods of constrained production
- ICU Nursing FTE business case approved
- Weekend contract case certainty
- Rapid Rounds ward 42



**FEEDBACK TO BOARD**



**GENERAL BUSINESS**

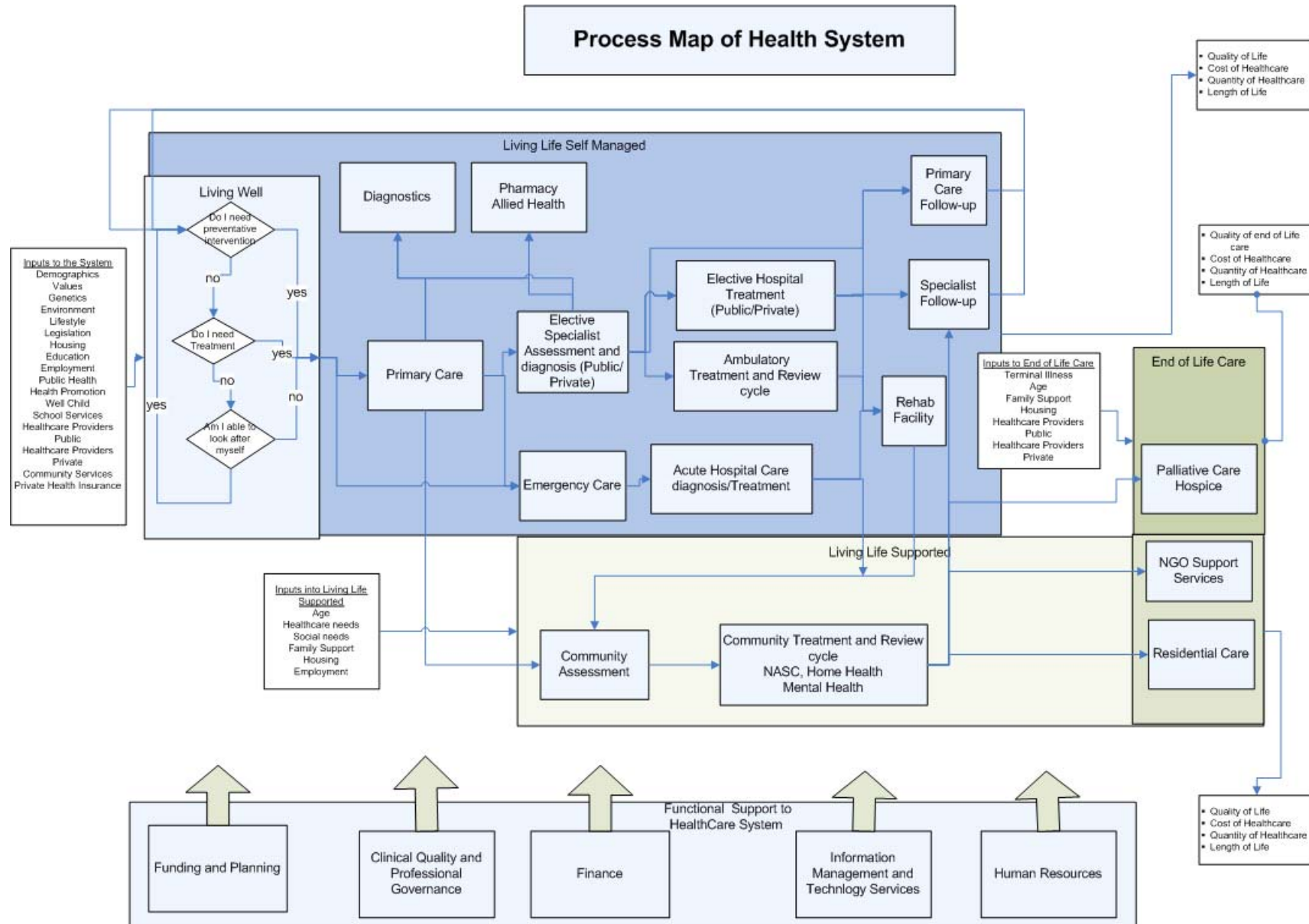


## **APPENDICES**

### **8.1 Healthcare System Diagram**



# 8.1 Healthcare System Diagram





## **APPENDICES**

- 9.1 Resolution to exclude the public from a meeting of the Hospital Advisory Meeting**



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

That the exclusion of the public from the relevant part of the meeting is necessary to enable the Board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) of clause 32 of Schedule 3 of the Act are established in relation to all or any part of the meeting.

**1. THAT** the public be excluded from the following part of the proceedings of this meeting, namely consideration of items 10 to of the Agenda.

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

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
9.1 Confidential Minutes 5 October 2011.	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.
9.2 Risk Register		
9.3 Quality		

<b>MEETING DETAILS</b>		
Time and Date	9:30am – 12:30pm, Wednesday, 2 November 2011	
Venue	A+ Trust Room, Level 5, Clinical Education Centre, Auckland City Hospital	
Members	Judith Bassett (Chair), Jo Agnew, Peter Aitken, Susan Buckland, Rob Cooper, Dr Chris Chambers, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward, Assoc Prof Anne Kolbe, Prof Iain Martin.	
Apologies	Jo Agnew	
In Attendance	Garry Smith, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Janice Mueller, Ian Bell.	
<b>COMMITTEE FUNCTIONS</b>		
To monitor the financial and operational performance of the hospitals and related services of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.		
	<b>Item</b>	<b>Page No</b>
<b>1</b> 2m to 9:32am	<b>Attendance and Apologies</b>	<b>001</b>
<b>2</b> 3m to 9:35am	<b>Conflicts of Interest</b>	<b>003</b>
<b>3</b> 5m to 9:40am	<b>Confirmation of Minutes Wednesday 5 October 2011</b>	<b>013</b>
<b>4</b> 5m to 9:45am	<b>Action Points Wednesday 5 October 2011</b>	<b>019</b>
<b>5</b> 40m 15m to 10:40am	<b>Provider Operational Performance Report</b> 5.1 Operational Performance Report 5.2 Health Target Updates	<b>023</b> <b>025</b> <b>059</b>
<b>6</b>	<b>Feedback to Board</b>	<b>069</b>
<b>7</b> 5m to 10:45am	<b>General Business</b>	<b>071</b>
<b>8</b>	<b>Appendices</b> 8.1 Healthcare System Diagram	<b>073</b>

<b>9</b>  70m to 11:55	<b>Resolution to exclude the public from a meeting of the Hospital Advisory Meeting</b>  9.1 Resolution to exclude the public	<b>077</b>
<b>NEXT MEETING</b>		
<b>Time and Date:</b> 9.30am, Wednesday, 7 December 2011 <b>Venue:</b> A+ Trust Room, Level 5, Clinical Education Centre, Auckland City Hospital		

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