



Auckland District Health Board

Hospital Advisory Committee Meeting

Wednesday 2 March 2011

10.45am

Sorrento

Cornwall Park

Greenlane

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



Hospital Advisory Committee

For discussion with Board

HAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
3.	
4.	



Hospital Advisory Committee Action Points

MEETING DETAILS

Date and Time

Item	Detail	Responsibility	Action
XX			
XX			
XX			
XX			

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD AND COMMITTEE (HAC) INTERESTS REGISTER

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

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	2. James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	3. Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	4. National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	5. Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
Lee MATHIAS	1. Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	1 February 2011
	2. Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	3. Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	4. Pictor Limited	Shareholder, Director Director	Fee No fee	Biotech start-up focussing on diagnostic products Estate of late husband	
	5. John Seabrook Holdings Limited	Governance Advisor	Fee	Provider of early childhood education services contracted to	

	6. AuPairlink Limited			the MoE.	
	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
Robyn NORTHEY	1. Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	2. Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
	3. Northern Region Ethics Committee	Member			
Gwen TEPANIA-PALMER	1. Waitemata District Health Board	Board member	Fee		2 February 2011
	2. Manaia PHO	Board member	Fee paid to NHHT		
	3. Ngati Hine Health Trust	Chair	Fee		
	4. Awanmarangi Waonangi	Committee member			
	5. Te TAitokerau Whanau Ora	Committee member			
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	
Anne KOLBE	1. Private Paediatric Surgical Practice	Director	Joint Owner		4 August 2010
	2. Employee Communitio NZ	Senior Consultant	Contractor		
	3. Siggins Miller, Australia	Senior Consultant	Contractor		
	4. Head, Auckland Clinical School, School of Medicine, University of Auckland	Employee	Salary		
	5. Husband: Employee University of Auckland		Fee		

Date: 23/02/2011

	6. Risk and Audit Committee Whanganui District Health Board	Member			
	7. Pharmac Board	Member	Fee		
	8. South Island Neurosurgical Services Expert Panel	Chair	Fee		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Iain MARTIN	1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

CONFIRMATION OF MINUTES
- WEDNESDAY 2 FEBRUARY 2011

Hospital Advisory Committee Minutes



MEETING DETAILS															
Time and Date	10:45am, Wednesday, 2 February 2011														
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton														
1	ATTENDANCE AND APOLOGIES														
	<p>The Chair declared the meeting open at 10:55am.</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>Rob Cooper</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> <tr> <td>Professor Iain Martin</td> <td></td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith –Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Dr Richard Aickin – Director Child Health Greg Balla – Director Performance and Innovation Ngairé Buchanan – General Manager Operations Taima Campbell – Executive Director Nursing Margaret Dotchin - Nurse Director Fionnagh Dougan - GM Mental Health, Ambulatory, Cancer & Blood Services, Cardiology Mark Fenwick – Communications Manager Paul Green – Manager Materials Management Aroha Haggie –Maori Health Gains Manager Andrew Keenan – Quality Manager Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Dr Barry Snow - Medical Director Adult Healthcare Service Group Dr Richard Sullivan – Director, Cancer & Blood Services Anna Schofield – Nurse Leader Mental Health Kirsty Walsh – Acting GM Woman’s Health Elizabeth Wood – Acting GM Children’s Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>An apology had been received from Dr Clive Bensemman, Director Mental Health Services.</p>	Dr Chris Chambers (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Rob Cooper	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	Rob Cooper														
Dr Lester Levy	Dr Lee Mathias														
Robyn Northey	Gwen Tepania-Palmer														
Ian Ward	Associate Professor Anne Kolbe														
Professor Iain Martin															
2	CONFLICTS OF INTEREST														
	There were no declarations of conflicts of interest for any item on the agenda. Amendments to the interest register were noted for Lester Levy and Gwen Tepania-Palmer.														

3	CONFIRMATION OF MINUTES 2 DECEMBER 2010
	<p><u>Moved Jo Agnew, seconded Susan Buckland</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 2 December 2010 be confirmed as a true and correct record noting that the meeting closed at 11:58am.</i></p> <p><u>Carried</u></p> <p>It had been agreed in a meeting with Waitemata before Christmas that there would be monthly meetings for six months to reinforce the communication flow on IDFs with reporting on each speciality with CMOs involved. Management resolution was sought on the historical issues which had been 90% resolved. There was a good spirit of working together and there would be an update to the next meeting. Management of acute flows was a particular issue to be managed. How networks worked in the future would evolve with perhaps funding devolving to the networks directly.</p>
4	ACTION POINTS 2 DECEMBER 2010
	<p>Plastic Surgery</p> <p>Plastic surgery undertaken for ADHB by Counties Manukau was, year to date, acutes under budget at 1,370 against a budget of 2,300 and with electives, year to date, 700 against a budget of 440 and for non DRGs, year to date, 8,500 against budget of 8,900. There were no clinical issues or access issues. The budget had been based on history, targets and intervention rates although the latter were significantly under national intervention rates.</p>
5.1	Operational Summary Report and Financials
	<p>While there was a lower deficit for the month, year to date should be corrected with the impact, in January, of reducing the annual leave accrual with staff taking holidays. There have been reduced elective volumes but higher acutes and occupancy than expected over the Christmas period. The issues to have corrective action were detailed with focused Management meetings addressing annual leave, vacancies etc. and included clinicians making efficiencies in clinical areas which included looking at clinical supplies and where savings could be clawed back i.e. reducing labs tests that were not clinically useful and doing testing internally rather than sending externally. This was a significant issue for the management/clinical group to pull back. The Committee did seek a forecast to year end. The increase in acutes, particularly in young adults, was noted, but also an increase in triage 3 presentations which may reflect the recession and inability to access after hours services. Year to date there had been an 8% overall increase in AED presentations and in Children's ED a 5 - 6% increase with again over Christmas folk finding it hard to access after hour services and GPs.</p> <p>There were two groups that could be influenced for adult admissions, young adults with alcohol and drugs being a particular factor and the aged population that did need hospital care but not acute care. There needs to be work across the sector including with aged residential care providers. The inner city population was growing and with older people there was a need for new models of care and care in place. It was noted in the Letter of Expectation the focus on older people. The Committee asked for further presentations on the issue of ED admissions to the CPHAC and HAC.</p> <p>Elective Service Performance Indicators (ESPI) are being met at present, however there was a risk of non compliance in February as to be compliant the six months to December 4% and January 4.9% needed to be recovered. Workout plans are being developed service by service as well as looking at a total organisational plan. While initially there was a deficit of 171 patients this had been reduced to 88 and plans in place to address a further 78. This was responding to the immediate problem but there was also a longer term recovery plan including Greenlane coming on-stream in April. The National Health Board and MoH were being fully informed. There were tensions created for ADHB's population and IDFs and between acuity and long stay impacting on capacity. There was good information support available to managers.</p> <p>Some areas will be outsourcing, commencing Saturdays lists and long waits were being included.</p>

	It was expected next year that the number of electives requested would increase and internal opportunities through improvement projects were being implemented rather than outsourcing. Recovery of ESPI will have a positive affect on the health targets.
5.2	Operational Indicators Exception Report
	There had been a 12% increase in triage 2 admissions to AED and a 27% increase in triage 3. These included triage by senior nurses. The reason for the change in volumes about April 2010 was unable to be identified. The summer planning had been for 90% occupancy but had been 95%. Triage 1 had shown a 69% growth with these being very sick people and with a considerable impact of alcohol.
6.1	DAP Projects Report
	Orange indicators related to the six hour project both in Adult and Children's as well as skin lesions.
7.1	Hospital Based Ministry Targets
	<p>The acute adult patient flow and acute children's patient flow were reported combined to the MoH. There had been a 2% improvement in adults to target with opening more beds and reducing waiting times but struggling with demand. A whole of hospital approach was being taken including discharges which also included timely discharges from ED. Ward discharges were addressed through daily rapid rounds and reduced length of stay and improvements in wards would be replicated in other services. There had also been improved nurse facilitated discharges and improved bed management systems focused on the top services under the Health Excellence umbrella. There would be more senior resources put into ED to achieve a cultural change, getting more staff involved in projects.</p> <p>CED had experienced its heaviest winter running out of beds which required capacity planning at the regional level, including catering for secondary services supplied to other DHBs and at the national level involving the National Health Board. This was to be raised at the next regional meeting.</p> <p>With radiation therapy ADHB were sending their clinicians to ARO and there was willingness between the organisations. The RT contract had been settled and a change in culture had been experienced with a recent linear accelerator with staff being flexible to address demand.</p> <p>With the smoking advice target there was a focus on areas where questions were not being asked however this could lead to conflicts with other targets i.e. in ED. Processes were being simplified including addressing coding issues. It was suggested that a similar advice approach be taken to alcohol.</p>
	NEXT MEETING
	<p>The meeting closed at 12:37pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 2 March 2011 Pohutukawa Room, Sorrento in the Park One Tree Hill Domain Epsom</p>
CONFIRMED	
CHAIR:	DATE:

ACTION POINTS

WEDNESDAY 2 FEBRUARY 2011

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

Item	Detail	Designated	Action
5	Year End financial forecast to be provided in report	Ngaire Buchanan	
7.1	Capacity planning for secondary services provided between DHBs to be raised at the regional meeting	Garry Smith	

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

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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 - January 2011						
Profit & Loss						
Total Income						
Internal Allocations - Ex Funder	71,569	74,569	3,000U	584,148	584,941	792U
MOH - Funding Subcontracts	2,468	3,016	548U	17,542	20,806	3,264U
Other Patient Care Revenue	2,564	2,601	37U	20,696	18,860	1,836F
Sales of Services & Products	4,310	4,399	90U	31,761	31,244	516F
Clinical Training & Education Income	1,372	1,493	122U	11,146	11,519	373U
:Trust & Donation Income	62	427	365U	3,740	3,033	707F
:Financial Income	671	316	355F	5,045	2,628	2,416F
Other Income	349	501	152U	3,638	3,694	57U
:Profit on Disposal of Fixed Assets	33	0	33F	130	1	129F
Total Income	83,397	87,323	3,926U	677,845	676,727	1,118F
Operating Expenditure						
Employee Costs	57,969	59,540	1,571F	426,118	427,045	927F
Direct Treatment Costs	14,742	16,199	1,457F	132,037	122,488	9,549U
Indirect Treatment Costs	3,403	3,242	161U	25,203	22,730	2,472U
Property, Equipment & Transportation Costs	3,446	3,840	393F	27,967	28,795	828F
Administration Costs	1,091	1,619	527F	10,361	10,923	561F
Maintenance Programme	272	133	138U	1,080	933	147U
:Indirect Service Billing	482	482	0U	3,375	3,375	0U
Loss on Sale of Fixed Assets	19	1	18U	360	10	351U
Total Operating Expenditure	81,424	85,056	3,633F	626,501	616,298	10,202U
Operating Surplus/(Deficit)	1,973	2,266	294U	51,344	60,429	9,084U
:Non-Operating Expenditure						
:Capital Charge	2,717	3,030	313F	19,939	21,194	1,255F
Depreciation	3,941	4,432	491F	30,178	31,582	1,405F
Finance Costs	1,512	1,714	201F	10,831	11,804	973F
Total :Non-Operating Expenditure	8,170	9,176	1,006F	60,948	64,581	3,633F
Total Surplus / (Deficit)	(6,197)	(6,909)	712F	(9,604)	(4,152)	5,452U

Commentary on significant variances follows overleaf.

1 Patient Care Revenue (incorporating internal allocations from Funder, Ministry sub-contracts and Other Patient Care Revenue) – Year to Date \$(2.2)m Unfavourable

Patient care revenue (comprising internal allocations from Funder, Ministry sub-contracts and Other Patient Care Revenue) was unfavourable year to date (YTD) by \$(2.2)m U.

The Operational areas are 1,420 wies under plan YTD (6.3)m offset by \$4.7m overproduced in non DRG services.

2 Trust & Donation Income – Year to Date \$0.7m Favourable

Trust and donation income is favourable by \$0.7m YTD, the timing of such receipts is variable especially in respect of the fund raising efforts of the Starship Foundation.

3 Financial Income

Higher than budget interest on term deposits \$355k F; YTD - Higher interest received on term deposits \$1.5m F and a realised gain on Interest Rate Swap Instruments \$0.9m F

OPERATIONAL COSTS**4 Employee Costs (Year to date \$0.9m Favourable)****FTE Table 1 – FTEs for Month and YTD (January 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	1,762	-45	1,726	1,737	-11
Ambulatory	249	260	-11	249	263	-14
Women's & Children's	1,342	1,329	12	1,350	1,346	4
Operations	1,439	1,439	0	1,431	1,410	21
Operating Rooms & Anaesthesia	689	697	-8	689	686	2
Mental Health	746	723	23	747	717	30
Cancer & Blood Services	300	295	5	299	294	5
Cardiac Services	451	435	16	451	436	15
Other Operational	1	1	0	1	3	-2
Ancillary	968	984	-17	974	966	8
TOTAL	7,901	7,925	-24	7,917	7,858	58

The FTE numbers excluding Mental Health (which has a separate funding stream) is (47) FTE U for the month; and 28 FTE favourable YTD.

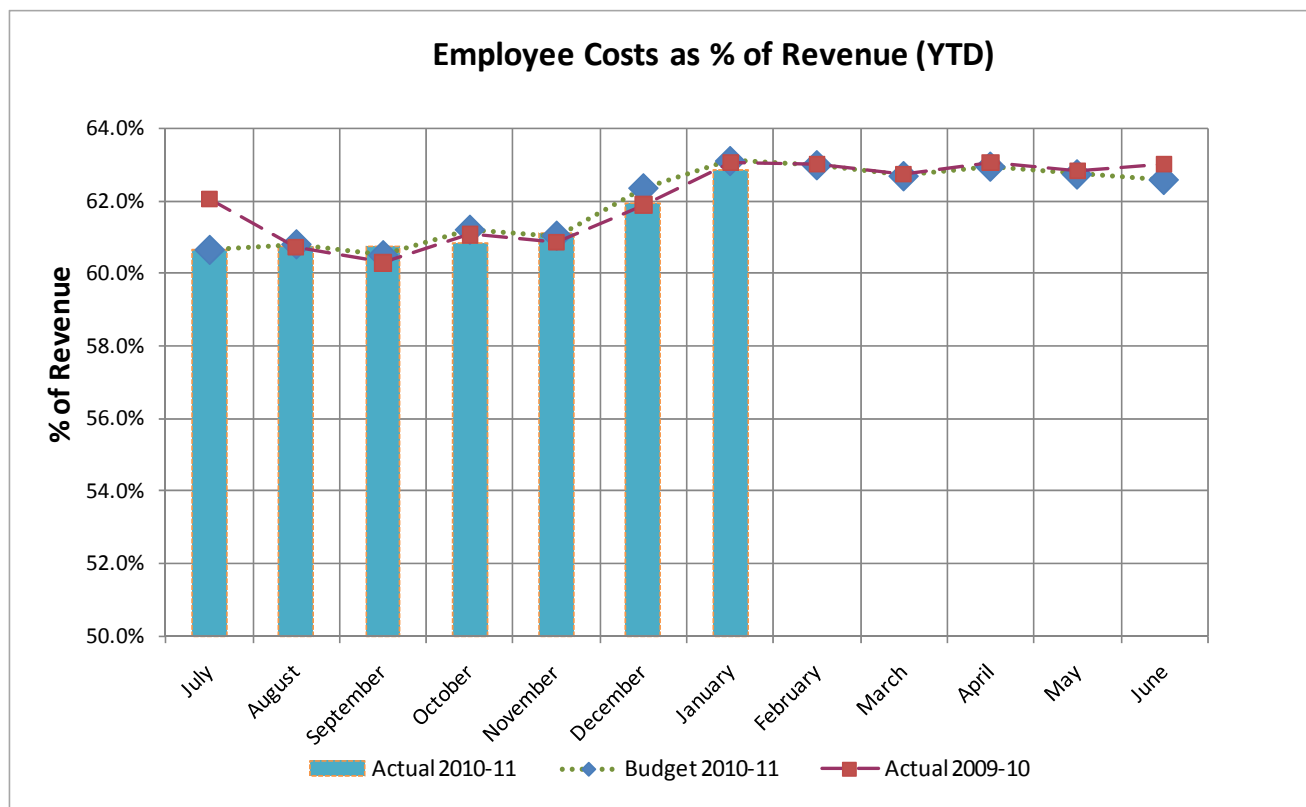
The unfavourable variances in Adult Health YTD relate to the accumulated impact over the year of (a) 15 house officers over-recruited due to a change in practice with ARMOSS (b) 16 staff in ED/APU supporting shorter stays in ED (c) 13 staff in General Medicine due to higher acute volumes than budgeted.

The unfavourable variance in Ambulatory Care YTD relates to anticipated retirements not having occurred and vacancy factor assumptions in the budget not achieved.

Provider Services – Staffing Variance			
Month 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	59.5	58.0	2.64%
FTE Numbers	7,901	7,925	-0.31%
Cost per FTE (Month)	7,536	7,314	2.94%
YTD 2010/11			
Budget	Actual	Variance %	
Employee Costs (\$M)	427.0	426.1	0.22%
FTE Numbers	7,914	7,858	0.70%
Cost per FTE (Year to Date)	53,963	54,228	-0.49%

Within the favourable variance of \$0.9m F YTD, there is an estimated figure of \$(0.9)m savings included in budgets but not achieved leaving an underlying favourable variance of \$1.8m on staff costs.

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 \$0.5m F to budget.

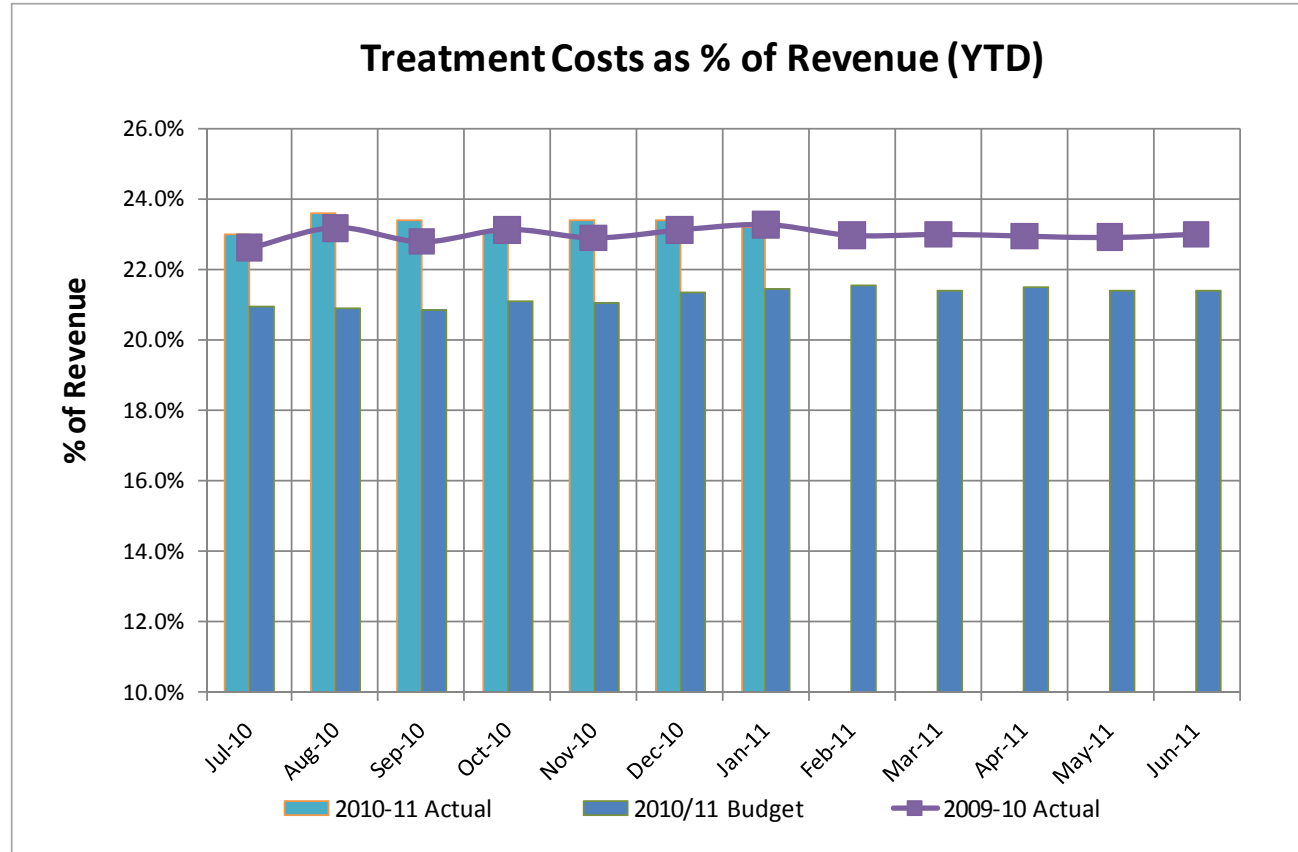
Significant Treatment Cost Variances and Actions 28

Direct and indirect treatment costs combined are \$12m adverse to budget year to date.

Direct Treatment Costs \$(9.5)m of which \$(3.3)m is savings targets not achieved.

Indirect Treatment Costs \$(2.5)m of which \$(2.0)m is non resident bed 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	\$(2.5)	Significant volume related costs primarily in OR&A (related to greater operating time than assumed in budget).
3 rd Party Costs	\$(2.1)	Cardiac, Operations and Cancer services \$3.3m, offset by other areas where outsourcing has yet to commence.
Patient appliances	\$(2.1)	Actual volumes higher than budgeted assumption in Cardiac laboratories (adult and paed) and Paediatric Surgery.
Chemicals & Media	\$(1.6)	Assumptions related to a reduction in laboratory test numbers and a reduction in reagent prices have not been achieved
Drugs	\$(1.1)	Very high cost drugs in Immunology and Paediatric Oncology (specific patients), offset by a favourable variance in Adult Oncology
Direct Treatment	\$(9.5)	Sub total of above
Indirect Treatment	\$(2.5)	\$(2.0)m relates to non resident bad debts; \$(300)k to cost of sales for retail business (offset by revenue)

As shown above, of the \$9.5m overspend in direct treatment costs YTD, the significant components are:-

- Outsourcing in achieving health targets (cardiac and radiotherapy wait times) \$2.1m - 22%
- Cost savings in budgets not achieved in direct treatment costs \$3.3m - 35%
- Volume related Costs (ie costs arising from volumes > assumed in budget) \$4.1m - 43%

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. A discussion of these costs will occur elsewhere in the agenda.
- Careful review of use of high cost drugs in immunology and paediatric oncology, maintain favourable mix variance in adult oncology.
- Continued FTE management to substitute savings for those not achieved in direct treatment costs.
- Review in conjunction with clinical partners the use of clinical supplies, patient appliances and other volume related variances.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	January 11	Att per Day	Comparison to Last Month	Dec 2010	Att per Day	Comparison to Last Year	Jan 10	Att per Day
APU	1,639	53	2.4%	1,600	52	6.3%	1,542	50
AED	4,656	150	0.6%	4,630	149	10.9%	4,198	135
CED	2,321	75	-11.4%	2,620	85	2.1%	2,274	73

- AED. Growth persists: record high volumes, 11% higher than January 2010. The admission rate was 22% and the median LOS stayed low after creeping up for most of last year.
- APU. Similar volumes to last month but their highest January. LOS measures were either similar or less than last month, but both were roughly one hour higher than January last year. This may be due to closed ward beds over the summer, high AED volumes, and/or higher acuity patients being accommodated in APU.
- CED. A reduction from December, but nevertheless the highest January for CED.

Discussion on the degree of compliance with the six hour rule health target is later in this agenda.

Throughput – by Admission Type

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Year to Date January 2011 (7 months - measured in wies)

Electives (wies)

DHB	Contract	Actual	Variance	% of completion
ADHB	8,836	6,853	-1,983	77.6%
CMDHB	3,149	2,700	-449	85.7%
WDHB	4,012	3,357	-655	83.7%
NLDHB	1,427	1,158	-269	81.1%
Other	2,263	2,057	-206	90.9%
	19,687	16,125	-3,562	81.9%

Acutes (wies)

DHB	Contract	Actual	Variance	% of completion
ADHB	29,450	30,686	1,236	104.2%
CMDHB	7,174	7,075	-99	98.6%
WDHB	10,415	11,134	719	106.9%
NLDHB	2,663	2,825	162	106.1%
Other	4,190	4,312	122	102.9%
	53,892	56,032	2,140	104.0%

Acute & Elective Combined (wies)

DHB	Contract	Actual	Variance	% of completion
ADHB	38,286	37,539	-747	98.0%
CMDHB	10,323	9,775	-548	94.7%
WDHB	14,427	14,491	64	100.4%
NLDHB	4,090	3,983	-107	97.4%
Other	6,452	6,369	-83	98.7%
	73,579	72,157	-1,422	98.1%

31 Throughput – Elective Service Performance Indicators

Previously we had advised that ADHB was at risk of ESPI compliance for ESPI 5 (patients waiting greater than 6 months for surgery) as we were non-compliant in December 2010 and we expected to be non-compliant in January with a risk of February being non-compliant. If ADHB went 3 months non-compliant then the revenue penalty would be \$3.7m. The table below shows that ADHB has remedied the compliance risk for February such that we are significantly under the threshold (forecast 469 patients waiting longer than 6 months).

ESPI 2 is for patients waiting greater than 6 months for a first specialist appointment. ADHB was non-compliant in January and expects to be non-compliant in February. Again if we are non-compliant in March ADHB will incur a \$3.7m revenue penalty. The services are working to ensure this does not occur.

ADHB: Surgical Elective Service Performance Indicator Summary:

ESPIs 5 and 6

Includes Data Entry up to end of 20/02/2011

Health Service Group		January-11								February-11est							
		ESPI 5 - Certainty				ESPI 6 - ActiveReview				ESPI 5 - Certainty				ESPI 6 - ActiveReview			
		Level	Status	Limit	Imp. Req'd	Level	Status	Limit	Imp. Req'd	Level	Status	Limit	Imp. Req'd	Level	Status	Limit	Imp. Req'd
Adult Health	Cardiology	12	0.9%	54	0	104	53.1%	29	-75	12	0.8%	59	0	111	56.6%	29	-82
	Cardiothoracic	0	0.0%	36	0	0	0.0%	0	0	0	0.0%	36	0	0	0.0%	0	0
	General Surgery	92	4.0%	93	1	0	0.0%	0	0	57	2.4%	94	0	0	0.0%	0	0
	Neurosurgery	58	16.2%	14	-44	0	0.0%	0	0	52	14.6%	14	-38	0	0.0%	0	0
	ORL	21	4.1%	21	0	0	0.0%	0	0	11	2.2%	20	0	0	0.0%	0	0
	Orthopaedics	57	6.8%	34	-23	0	0.0%	0	0	59	7.2%	33	-26	0	0.0%	0	0
	Urology	59	5.5%	43	-16	0	0.0%	0	0	45	4.3%	42	-3	0	0.0%	0	0
	Vascular Service	1	0.4%	10	0	1	3.8%	4	0	0	0.0%	10	0	2	7.7%	4	0
Adult Health Services Total		288	4.6%	250	-38	1	3.6%	4	0	224	3.6%	250	0	2	7.1%	5	0
Ambulatory Health	Ophthalmology	163	4.7%	139	-24	0	0.0%	0	0	149	4.3%	140	-9	0	0.0%	0	0
	Oral Health Greenlane	24	1.7%	58	0	0	0.0%	0	0	4	0.3%	58	0	0	0.0%	0	0
Ambulatory Health Services Total		187	3.8%	197	0	0	0.0%	0	0	153	3.1%	198	0	0	0.0%	0	0
Women & Children's	Adult Congenital Medical Heart (ACHD)	2	3.8%	2	0	0	0.0%	0	0	3	5.2%	2	-1	0	0.0%	0	0
	Adult Congenital Surgical	0	0.0%	1	0	0	0.0%	0	0	1	2.9%	1	0	0	0.0%	0	0
	ENT	97	7.9%	49	-48	0	0.0%	0	0	5	0.4%	49	0	0	0.0%	0	0
	Gastroenterology Paediatric	1	0.6%	7	0	0	0.0%	0	0	2	1.2%	7	0	0	0.0%	0	0
	Gynaecology Inpatients	16	0.9%	73	0	0	0.0%	0	0	22	1.2%	74	0	0	0.0%	0	0
	Neuroservices	4	4.7%	3	-1	0	0.0%	0	0	2	2.2%	4	0	0	0.0%	0	0
	Orthopaedics Paediatric	13	3.0%	17	0	0	0.0%	2	0	18	4.2%	17	-1	0	0.0%	3	0
	Paed Cardiology	1	0.7%	6	0	0	0.0%	0	0	5	3.1%	6	0	0	0.0%	0	0
	Paediatric CTSU	2	1.1%	8	0	0	0.0%	0	0	4	2.1%	8	0	0	0.0%	0	0
	Respiratory Paediatric	1	1.5%	3	0	0	0.0%	0	0	1	1.9%	2	0	0	0.0%	0	0
	Surgery Paediatric	45	4.4%	41	-4	0	0.0%	0	0	32	3.1%	41	0	0	0.0%	0	0
Women & Children's Health Services Total		180	3.4%	209	0	0	0.0%	2	0	92	1.8%	209	0	0	0.0%	3	0
ADHB Total		655	4.0%	656	0	1	2.3%	7	0	469	2.9%	657	0	2	4.5%	7	0

Throughput – Contract Volumes 32

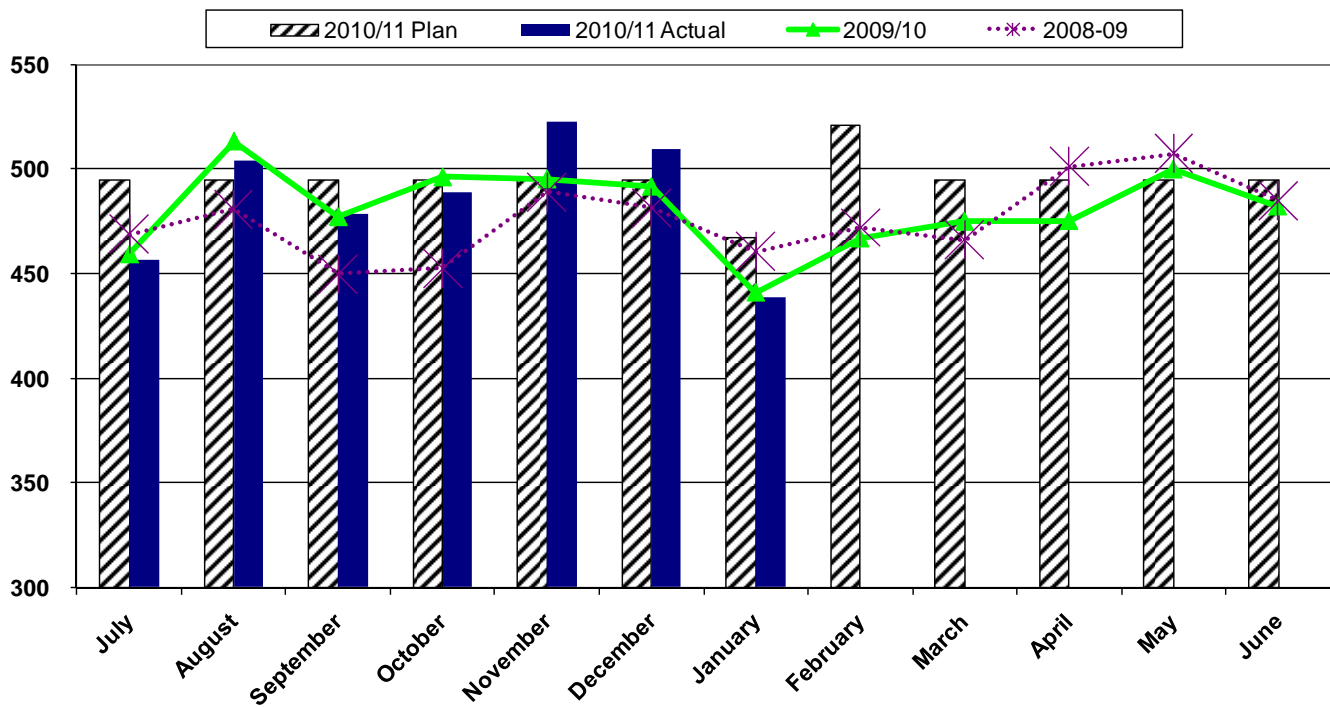
The chart below shows the production recorded to January 2011.

At the time the results were finalised, the coding was 62.6% complete with the average WIES per discharge being 1% higher than last year for the same period. Discharges are down by 0.1% from last year. The WIES target for January was based on working days and did not fully reflect the summer plan level of activity.

Inpatient delivery to the most current Price Volume Schedule was 96% for the month and 98% YTD.

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	8,340	8,877	537U	71,908	72,664	756U
WIES Delivery per day	463	493	30U	489	494	5U

WIES per Working Day (excluding stat day - 1011 working year = 250 days)



2010/2011 Savings Initiatives

33

	Year to date	Full year Plan
Service Budget Initiatives	\$6.3 m	\$10.8 m
Performance Improvement Projects:	\$4.2 m	\$ 9.7 m
Procurement	\$2.8 m	\$ 4.2 m
Total:	\$13.3 m	\$24.7 m

Performance Improvement Projects

•For the next Financial year 2011/2012 Performance Improvement Projects in progress are expected to produce additional annual savings of \$12.2m and a total bi annual financial benefit of \$22.0m

The above financial benefits have been derived from a balanced portfolio of improvement performance activities, more than a hundred initiatives impacting the following dimensions in more than one area:

- Improve patient safety and reliability of care: 48 projects
- Improve patient experience: 46 projects
- Improve staff well-being: 26 projects
- Improve efficiency of care: 82 projects

Main financial improvements achieved by these projects for 2011-2012 Financial years are:

Decrease outsourcing:	\$5.0 m
Direct treatment cost:	\$4.7 m
Length of stay:	\$3.3 m
FTE reduction time:	\$3.2 m
Increase elective revenue:	\$2.8 m
Bed days:	\$1.6 m
Other areas:	\$1.4 m
Total:	\$22.0 m

Annual Benefits of these projects

2,446 bed days saved per year

Reduced length of stay for 59,032 patients which enables to handle 11% increase in volume with no additional FTE increase

Reducing annual outsourcing cases by 1, 406

Increase elective volumes by 226 cases

Reduce inappropriate transfusion , avoiding wastage of blood components and non compliance with NZBS cold chain protocols by 10 % - total \$2.4 m

Advance Care Plan for 1000 patients per year

Improve Nursing direct care time from 30% to 37%

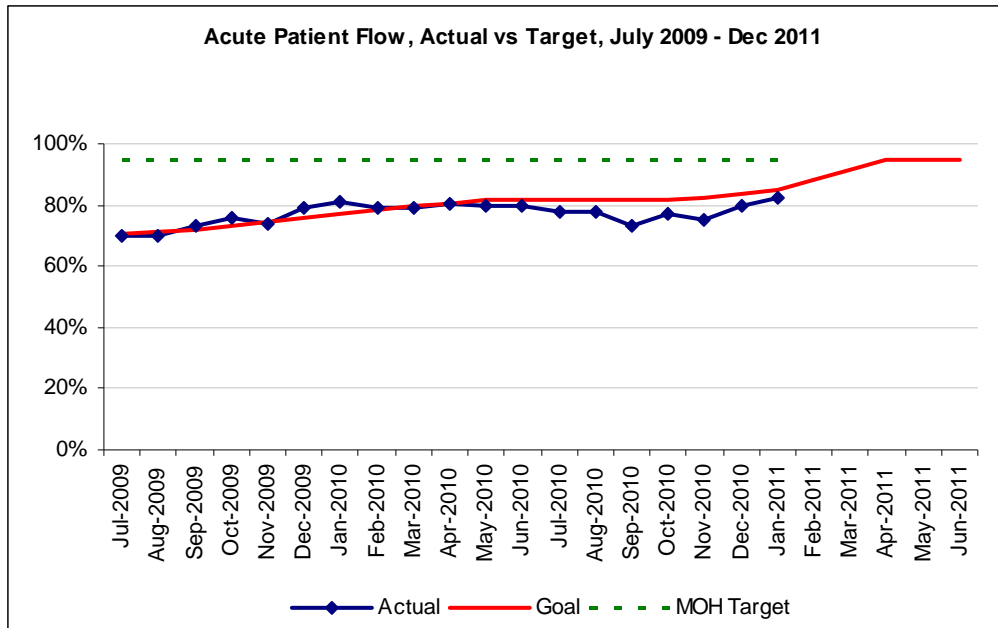
5.2 Health Targets

6 Hour Target

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:**

While we have made good progress to off set the volume increases we are still off target. Discussions have been held with both the Adult and Childrens project teams to indentify immediate actions to improve performance to target. These actions are noted in summary form on the following separate Adults and Childrens Acute flow pages. **A more detailed action plan will be presented at the Hospital advisory committee.**

Project: Adult Acute Patient Flow

39

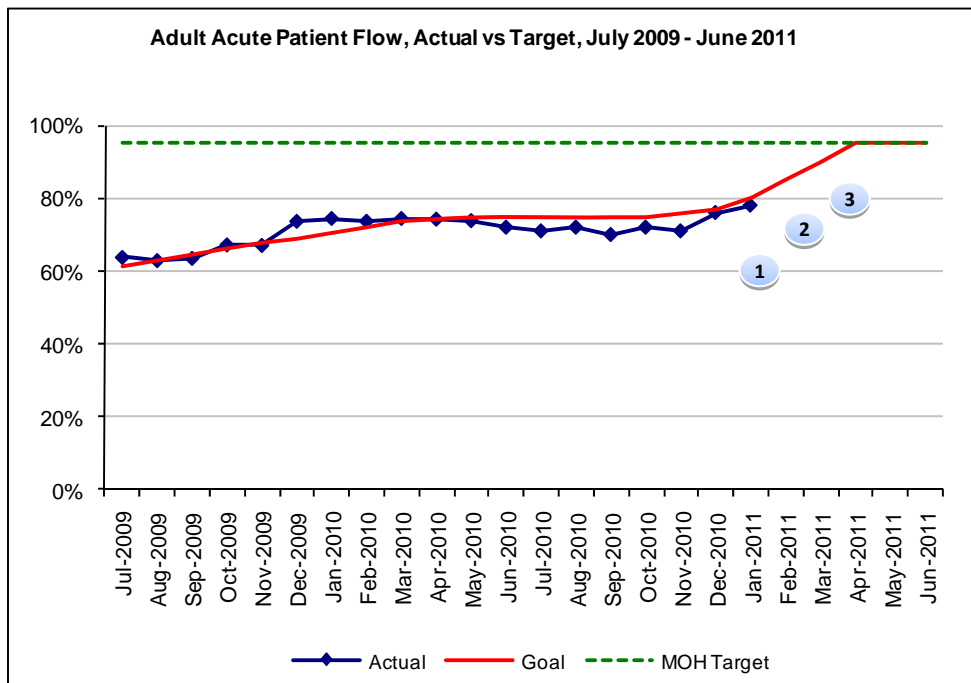
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

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:

Record numbers were experienced in the early part of January 2010.

Improvement noted in January and February (quarter to date) to 80%.

A number of activities are underway to boost performance immediately.

A 5-day Rapid Improvement event is planned for April to accelerate identification and implementation of solutions. This will ensure short term solutions become sustainable.

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.

A team recently visited CMDHB and WDHB with several strategies to be considered.

Main risks to ongoing improvement includes General Medicine continuing to be under considerable pressure due to workload, team cohesion and RMO vacancies. Mitigation includes medical subspecialty support. Also need to increase improvement focus in most medical and surgical specialties from time to referral from ED to time to be seen to reduce delays in decision to admit or discharge from ED.

A more detailed action plan on immediate actions to improve performance will be tabled at the HAC meeting.

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.

Our Focus – Improve patient flow for Emergency Medicine, General Medicine, Orthopaedics, and General Surgery patients who represent 82% of the Over 6 Hour patients in AED

Improvement Activities Completed

- Streamline AED processes and measurement and manage the challenge of growing demand
 - Reviewed Medical / Nursing requirements for AED and approved business case for resource increase
 - Charge nurse patient flow coordinator introduced
 - Improved access to Radiology
 - Improved measurement and identification of clinical short stays
 - Streamlined documentation required for safe transfer of patients to the wards
- Managing bed block with additional resources
 - Additional beds opened in November 2009 and January 2010
 - Surgical HDU 4 beds (August 2009) & Vascular 4 beds (July 2009 temporary winter flex as required)
 - 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 review of performance and any of patients who breach six hours briefing attended by key service and operations staff. The main purpose of this is to understand root causes for previous delays and implement quick solutions where possible
 - Increased overnight transfers of patients from ED to inpatient wards once bed is available.

Results: Significant Improved Performance in 2010 and 2011 to Date

- 0 patients in corridors (since 2004)
- 0 patients ramped in ambulance in 2010
- 1.5 hour reduction in average AED LOS in 2010
 - 23% decrease representing 75,000 patient hours saved
- 6,700 more patients meet the <6 hour goal in AED than in 2009
 - 79% of patients spend < 6 hours in AED in 2011 and 73% in 2010, compared to 64% in 2009
- 89% reduction in AED patients waiting over 24 hours for an inpatient ward bed
 - 546 patients in 2009; 58 patients in 2010; 0 patients in 2011
- 1/3rd day reduction in average LOS for General Medicine patients on Wards 65, 66, 67, 68
 - Estimated 1600 bed day per year savings reducing bed block
- 1/2 day reduction in median LOS for Orthopaedics patients (July on) on Wards 75 & 77
 - Estimated 1000 bed day per year savings reducing bed block
- 100+ successful Nurse Facilitated Discharges
- Reduced bed block leads to a 50% reduction in waiting time for patients needing an inpatient bed (from 8 hours in 2009 to under 4 hours in 2010, and less than 3 hours in 2011)
 - General Medicine – 55% reduction from 10 hours to 4.5 hrs
 - General Surgery – 60% reduction from 10 hours to 4.0 hours
 - Orthopaedics Patients – 50% reduction from 7 hours to 3.5 hours
- 69% reduction in Red Alerts (22 in 2010 compared to 71 in 2009)
- 96% of patients meet the 6 hour goal in AED for the first time on 16 February 2011
- Improved performance while sustaining a 10.5% increase in presentations to AED in 2010

Project: Children's Acute Patient Flow

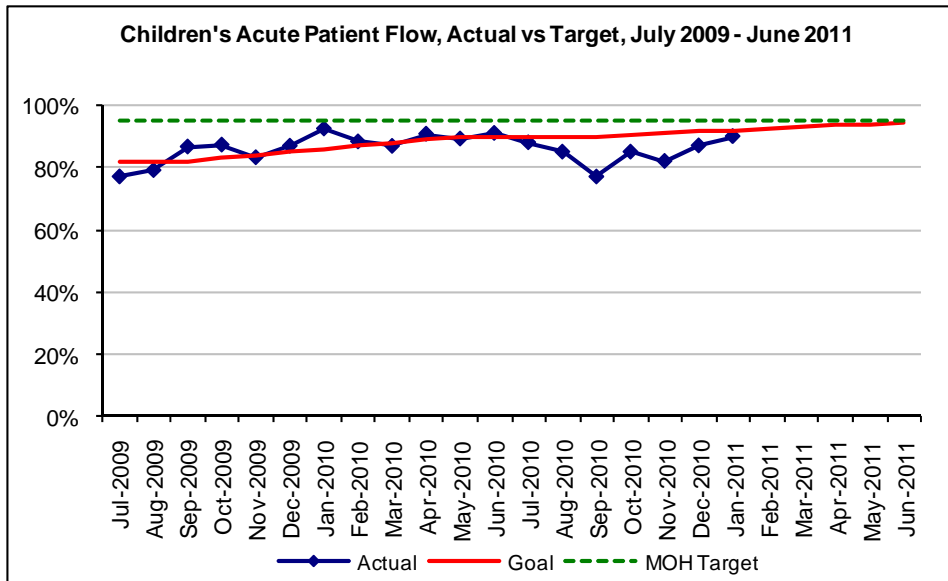
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

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 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.

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 to accommodate the mid week peaks – Tuesday, Wednesday, Thursday
- 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

Our Focus – Improve patient flow through the Children’s Emergency Department by targeting operational efficiency in Wards and better teamwork between stakeholders.

Improvement Activity Summary

- Introduced use of Estimated Discharge Dates in Wards 24A and 25A/B
 - Almost all patients in 24A & 25A/B now have an EDD
 - Focus moved to improving teamwork to enhance accuracy
- Reduced Bed Turnaround Times
 - Ward 24B Project reduced bed turnaround time by 50%
 - Project being replicated in other Wards
- Managing Bed Block with Additional Resources
 - Using capacity of Ward 25A to flex bed availability
 - Resourcing of beds flexed to requirements of 25A
 - CNA’s employed with key focus to improve patient flow
 - Additional Nurse Specialists placed in CED to take case load and improve flow
- Improved Management Information
 - Improved measurement & identification of Clinical Short Stays
 - Weekly dashboard reports with key performance metrics
 - Daily exceptions report showing all patients that exceeded 6hrs
 - Focus on CHIPS data quality and transitioning to Electronic Whiteboards (over next 3 – 4 months)

Results: Improved Performance in 2010

- In 2010 1,160 fewer patients exceed the 6hr limit than 2009
- In 2010 197 fewer patients waited more than 12 hours in CED versus 2009
- 11 minute reduction in waiting time for admitted patients
- Self discharges at 0.2% for past three months (historically fluctuations between 0.3% and 0.7%).
- 2010 Acute bed days reduced by 1% over versus 2009
- Achieved improvements on back of marginally increased presentations in 2010

Other Targets

Project: Improved access to elective surgery

44

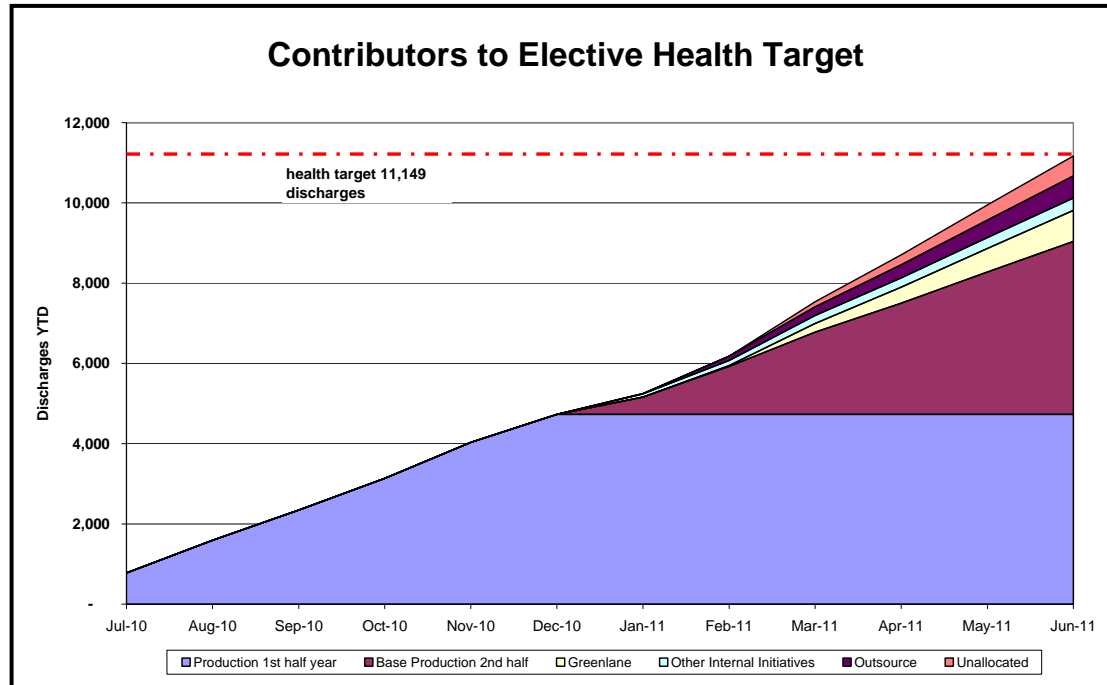
Primary Objective: Increase ADHB Elective Surgical Discharges from 10189 to 11149

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.



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 February and 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 500 unallocated discharges to services.
5. We are also reviewing some data issues eg 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)

Last month we indicated we had an ESPI 5 risk (patients waiting greater than 6 months for surgery) . ESPI non compliance would have a financial penalty of approximately \$3.7m however this risk has been mitigated by additional lists on weekends and outsourcing, improving scheduling and regular service meetings. We still have an ESPI 2 risk (patients waiting longer than 6 months for a first specialist assessment) we have actions in place to mitigate this risk by the end of March, providing the service and avoiding the penalty. Actions include prioritisation in existing clinics, extended clinic hrs during march, confirming requirements with patients and GP's. A more detailed plan for elective surgery will be provided at the Hospital Advisory Committee.

Project: Better help for smokers to quit

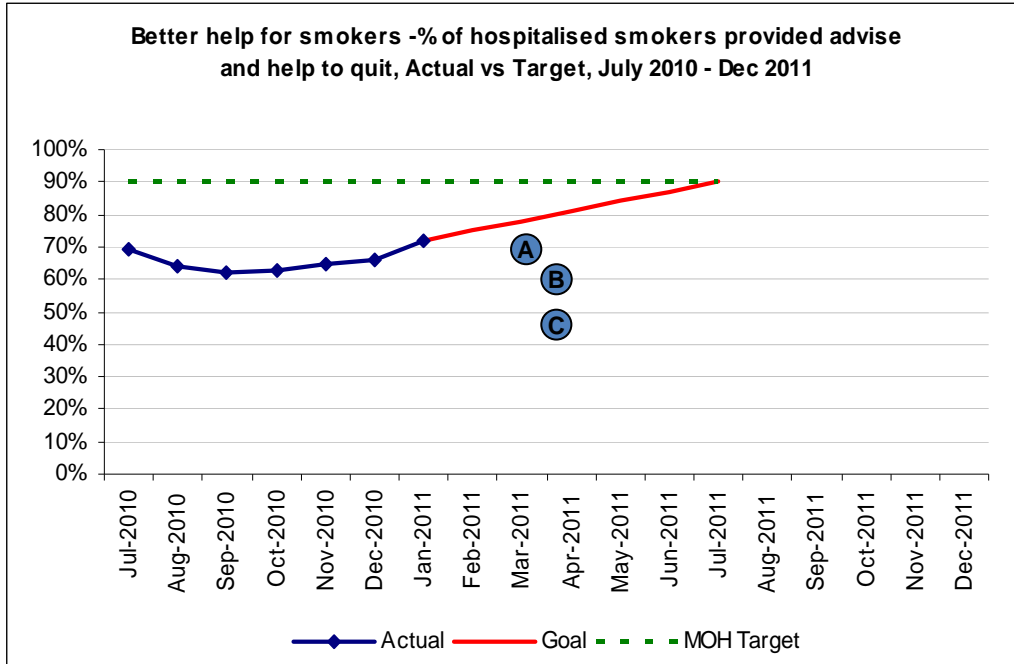
Primary Objective : % of hospitalised smokers provided advice and help to quit

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 7960 events coded in January, 1064 (13.4%) patients were identified as smokers and 762 (72%) of the smokers were documented as receiving advice or support to quit. Data suggests a positive trend in terms of 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.

Analysis of data by length of stay suggests that services with high volume and short length of stay (under 6 hrs) are less likely to be offered help to quit. To improve this a programme of ABC coaching and training updates are planned for February in Adult Emergency Department, APU, General Surgery and General Medicine. To improve clinical engagement and leadership of programme activities, membership of the Steering Group is under review.

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

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:

- New intake of House Officers on 28th February to be trained on documentation of ABC.
 - 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: Shorter waits for Radiation Therapy

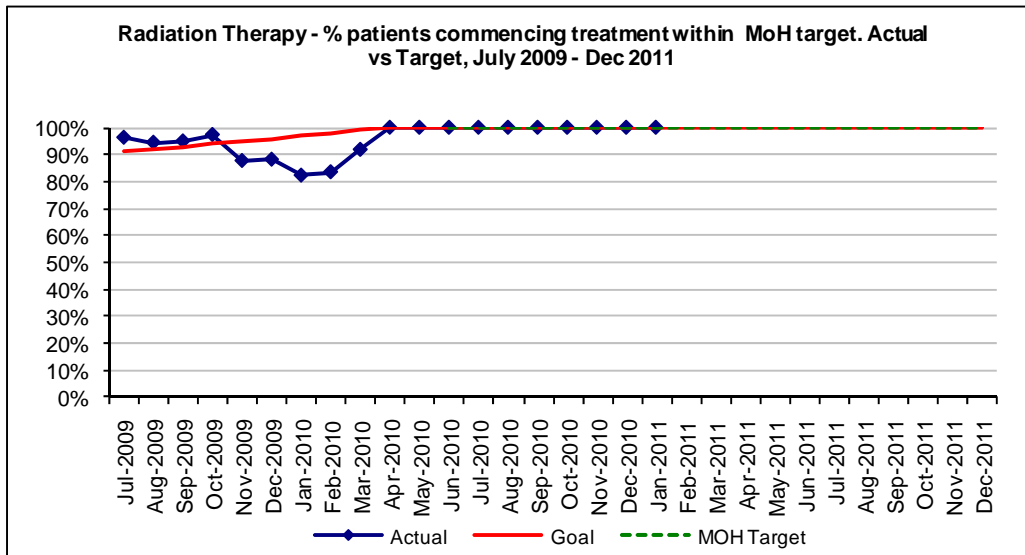
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



Risks / Comments:

The service expects to be 100% compliant to the 4 week target for Quarter 3.

Key risks which may impact capacity:

- Linear Accelerator breakdown – the service experienced loss of capacity in January as a result of a series of small Linear Accelerator breakdowns. Strategies to sustain the target included rescheduling patients onto other machines, working through lunchtimes, outsourcing patients, and RT's working extended hours and evening shifts.
- The CT Simulator is down to one unit due to staff training requirements. This is being monitored daily to ensure any bottleneck is appropriately managed.
- RT staff vacancies – 3 resignations were received in December/ January. The service has secured two senior RT's from Toowoomba to work in the department on fixed term contracts from mid February to April to ensure production is sustained.

Radiation Oncology Wait times – January 2011

In January 100% of eligible patients were treated within the 4 week target for patients in priority categories A,B & C.

Improvements to date:

- MV5 Linear Accelerator is now fully operational. Extended hours: Extended hours have been implemented for RT staff where this is an option within the terms of their contract.
- **Outsourcing:** A short term agreement has been agreed with ARO for provision of public capacity.
- Model of service delivery has been developed which would underpin a long term partnership has been agreed.
- **Aria project:** A project is underway to develop a full electronic record within the LINAC machine's operating system. This will better match demand to capacity.
- **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 for 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: Cardiac Bypass Surgery

47

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

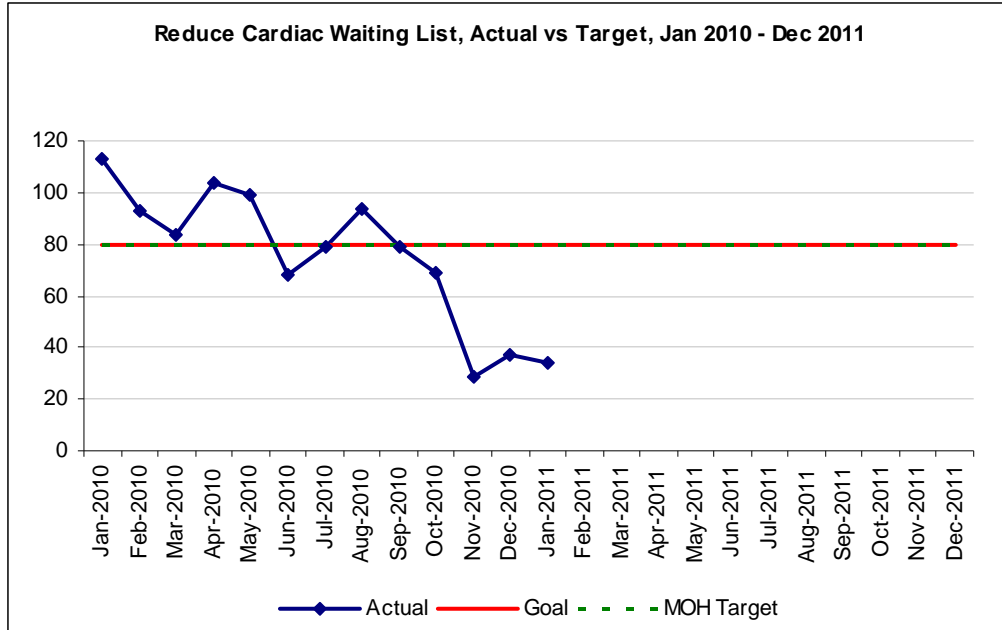
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

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 45 patients on the waiting list as at the end of January 2011. YTD throughput is 15 (3%) 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 153 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.' Operations Indicators Exception Report

ADHB HAC KPI Report

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

		January	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
January 2011

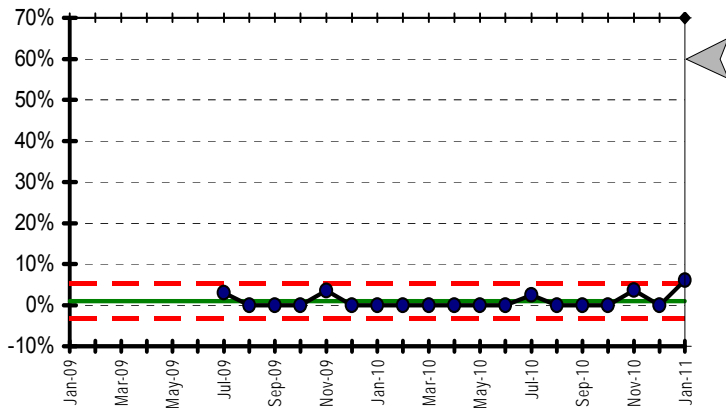
B65. DOSA Rate - Neurosurgery

A lean six sigma project has defined and is implementing a solution commencing March 2011. The appropriate patient group has been identified and the revised pre-admit process will commence at GCC

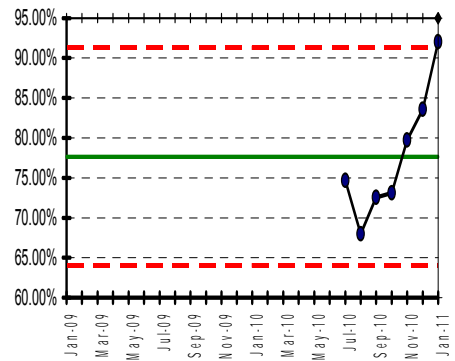
B50c. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Other

Additional clinics in January 2011 have increased the number of patients seen within six weeks of referral.

B65. DOSA Rate - Neurosurgery



B50c. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Other



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		
			Plan			Do/Check		Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control															
2.1a Efficient and effective Primary health care	2	2	1	0	0	1	0	0	2	0	0	2	0	0	1	1	0	0	0	0	0	0
2.1b Improve primary-secondary system efficiency	9	8	2	1	0	5	0	0	6	3	0	8	1	0	7	2	0	0	0	0	0	
2.1c Improve quality of hospital care while improving productivity	21	21	2	3	4	11	0	0	15	5	0	19	1	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	39	14	1	49	4	1	49	4	1	2	2	0	0	
Total %	100%	96%	16%	13%	14%	45%	5%	0%	70%	25%	2%	88%	7%	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" will be reported back during Jan with potential BSMC approaches -these are currently being reviewed and prioritised.
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. POAC and acute care will meet the DAP targets; access to diagnostic radiology is progressing well with regard to establishing the systems and processes with good ongoing update by general practice there is question about whether 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 -current volumes are ahead of target.
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 with presentation to the senior leadership in February. Elective Services are behind target at 89%. A dedicated workout plan is being prepared to go to the ministry. 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
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. This can then be aligned to the work completed for the Maori DNA project
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 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. A service by service and cross organisational plan in place. This is being monitored daily by ADHB and weekly by the ministry. Additional overnight bed space has been approved to increase potential numbers of patients. Operationalisation of GSU is mixed with the key risk area of reliance on staff appointments. The status for operationalising the operating rooms at GSU is now well under way with equipment ordered, Staff appointments commenced and awaiting start dates. A number of key issues have been identified which are currently being worked through. The implementation plan has been agreed for the productivity gains at ACH.
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
2.3.3 Improve research	Margaret Wilsher (ADHB)	Dashboard of research KPI developed for CAB. Focus is now on improving compliance with timely renewal of Ethics Approvals for all current

quality		projects.
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 readvertised 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. Following successful completion of a number of significant upgrades before Xmas, team is now focussed on next set of releases. 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 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 is nearing completion. The results look promising but again ROI and priority may not be sufficient to ensure capital can be prioritised to progress to implementation.
2.5.3 Improve data quality of Information Management systems	Johan Vendrig (ADHB)	NHI duplicate issue remains a significant problem. Although performance improved in last month, KPI control charts show that process is unstable. Discussions with the services and the MoH continue to look for improvement opportunities. Support from the performance improvement team may be required to define and run a formal performance improvement process if regular reporting and training activities do not address the underlying issues. 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.
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				Record numbers were experienced in the early part of January 2010. Improvement noted in January and February (quarter to date) to 80%. A number of activities are underway to boost performance immediately. A five day rapid improvement event is planned for April to accelerate identification and implementation of solutions. Daily results are now being posted in AED. Daily breach review meetings underway. Visits to CMDHB and WDHB completed with several successful strategies being implemented at ACH. Main risks ongoing include General Medicine continuing to be under considerable pressure due to workload, vacancies and team cohesion. Mitigation includes use of subspecialty teams to support. Further work also required in most medical and surgical specialities to improve time from referral from ED to time to decision to admit / discharge.

Better help for smokers to quit	National	Improve				Of the 7960 events coded in January, 1064 (13.4%) patients were identified as smokers and 762 (72%) of the smokers were documented as receiving advice or support to quit. Data suggests a positive trend in terms of 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. Analysis of data by length of stay suggests that services with high volume and short length of stay (under 6 hrs) are less likely to be offered help to quit. To improve this a programme of ABC coaching and training updates are planned for February in Adult Emergency Department, APU, General Surgery and General Medicine. To improve clinical engagement and leadership of programme activities, membership of the Steering Group is under review.
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				In December 2010 the Auckland DHB Board agreed to the continuation of the current 'early start' component of the Pathways Programme to maintain momentum and goodwill and as an important learning opportunity to inform a review of overall Programme design. Subject to completion of a detailed programme design and costings review to be tabled in April, funding to a maximum of 2.7m over the next 3 years (\$660,000 in 2011/12) to train and graduate 300 new Maori and Pacific health care workers is proposed. This revised proposal is significantly reduced from the original proposal to train 900 participants over seven years but still aligns to the original ADHB objective of increasing the number of Maori and Pacific in the ADHB health care workforce.

Legend: Red - , Orange - , Green - 

PAPERS

7.1 9`YWhj Y`HUf[Yhg

ADHB Hospital Advisory Committee

Author: Peter Lowry

Throughput- Electives and Elective Targets 2011/12

2011/12 Elective Targets

The government's objective for elective discharges is that they increase by 4,000 per annum and that total electives delivered by the public sector achieve a level of 180,000 by 2025 (Health Target 2010/11 140,000 discharges). This level of increase is in excess of population growth and reflects the government's objectives to increase elective intervention rates.

The MOH in implementing the government's requirement for an additional 4,000 discharges per annum is targeting the majority of the discharge increases at the Auckland and Waitemata DHBs for 2010/11 and 2011/12. The respective discharges for 2011/12 by DHB and proposed increases are set out at table 1 below. There are a number of issues associated with these targets for ADHB that are discussed in more detail below;

- Demand for publicly funded elective surgery from ADHB population and how this is grown over time
- Clinical capacity and how this is grown over time
- Level of base population revenue being directed toward increased electives over the 2009/10 – 2011/12 period and out-years.
- Targeting national intervention rates in elective when ADHB is over-expended in other services
- Risk of discharge equity being driven by smaller DHBs intervention rates
- ADHB clinical practice that sees procedures delivered in an outpatient setting while other DHB treat as an inpatient

In the table below it is proposed that ADHB increase volume by 7.7% over the 2010/11 Health Target (HT) which was a 14% increase over the 9,763 discharges delivered in 2009/10. The proposed target of 12,103 for 2011/12 would position ADHB at 94% of an equitable share of the national target of 12,830. This implies ADHB needs to increase by a further 817 discharges in future years plus an equitable share of the government's objective, estimated at around 400 per annum. In this scenario it is possible that by 2014/15 ADHB will be required to deliver 14,000 discharges i.e. a further 2,000 discharges above the proposed for 2011/12 or 17% increase.

This level of increased elective discharges is well in excess of the ADHB population discharges contained in the business case for the GSU expansion. We note that the same issue exists for IDFs as well.

Table 1 Discharges

DHB	2010/11 Health Target	Equitable share of 2011/12 Target	Variation from Equity	Required Increase	Indicative 2011/12 Health Target	% increases	% of Equitable Share 2011/12
Auckland	11,149	12,830	-1681	864	12,013	7.7%	94%
Bay of Plenty	8,357	8,127	230		8,357		103%
Canterbury	15,478	16,490	-1012	632	16,110	4.1%	98%
Capital & Coast	7,431	8,220	-789	397	7,828	5.3%	95%
Counties Manukau	14,469	14,946	-477	235	14,704	1.6%	98%
Hawkes Bay	5,709	5,609	100		5,709		102%
Hutt	4,946	4,633	313		4,946		107%
Lakes	3,406	3,535	-129	66	3,472	1.9%	98%
Mid Central	5,717	6,136	-419	211	5,928	3.7%	97%
Nelson Marlborough	6,029	4,996	1033		6,029		121%
Northland	6,098	6,298	-200	100	6,198	1.6%	98%
South Canterbury	2,634	2,168	466		2,634		121%
Souththorn	9,955	9,932	23		9,955		100%
Tairāwhiti	2,026	1,668	358		2,026		121%
Taranaki	4,133	4,082	51		4,133		101%
Waikato	12,545	12,800	-255	159	12,704	1.3%	99%
Wairarapa	1,841	1,588	253		1,841		116%
Waitemata	13,434	16,130	-2696	1337	14,771	10.0%	92%
West Coast	1,592	1,303	289		1,592		122%
Whanganui	3,114	2,508	606		3,114		124%
	-				-		
ZTotal	140,063	143,999	- 3,936	4,001	144,064	2.9%	100%

Per MOH FE 30 Nov 2010

Health Target and EI volume increases funded by ADHB

In 2009/10 AHB Health Target was 9,425 discharges. The increase of 2,588 discharges to 2011/12 and the increased ambulatory discharges are approximately \$12.0m of services funded from ADHB PBF resources.

National Interventions Variations in Counting

The intense focus on elective discharges by the MOH has identified inconsistent counting practices around the country.

An analysis by MOH has shown that DHBs have different practices in terms of what is coded as an elective discharge. For example nationally 8% of elective discharges are for the removal of skin lesions and ophthalmology avastin injections. For some DHBs the percentage of discharges attributable to this work is 12% - 15%. For ADHB the figure is 4% as we do not include avastin as an inpatient procedure nor do we for a significant portion of skin lesions. For ADHB 4% of volumes is approximately 450 discharges.

Elective Procedures not counted as inpatient discharge	ADHB Per Annum
Dermatology skin treatments	454
Avastin	652

MOH discussion re counts

We have discussed with MOH the count issue and they are not in a position to move to a nationally consistent approach as this would run counter to the Ministers requirement for 140,000 discharges + 4,000 more each year i.e. to remove all avastin and skins lesions would require the DHBs to replace 11,000 procedures that would be lost from the HT count.

This will be an ongoing problem as the casemix working group continues to identify procedures that should be excluded from casemix and put into an outpatient setting. Currently on the list are procedures discussed above like cataracts and varicose veins.

Summary of ADHB Position

ADHB is facing a number of risks:

- There is an indicative requirement to increase discharges by another 864 cases in 2011/12 giving a HT of 12,103
- National intervention targets are being driven by variable counting methods across the sector
- Substantially increases in electives may not be matched by demand in the short term as primary care changes their referral patterns

ADHB has discussed these issues with the MOH and they agree the position is inequitable for ADHB in terms of counting and signalled some willingness to negotiate the HT and the base elective wies.

ADHB will progress discussions with MOH for a lower elective base to protect earning of additional elective revenue and a lower Health Target. We will also consider a short-term approach to counting methods while MOH aligns sector counting methods in the medium term.

FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

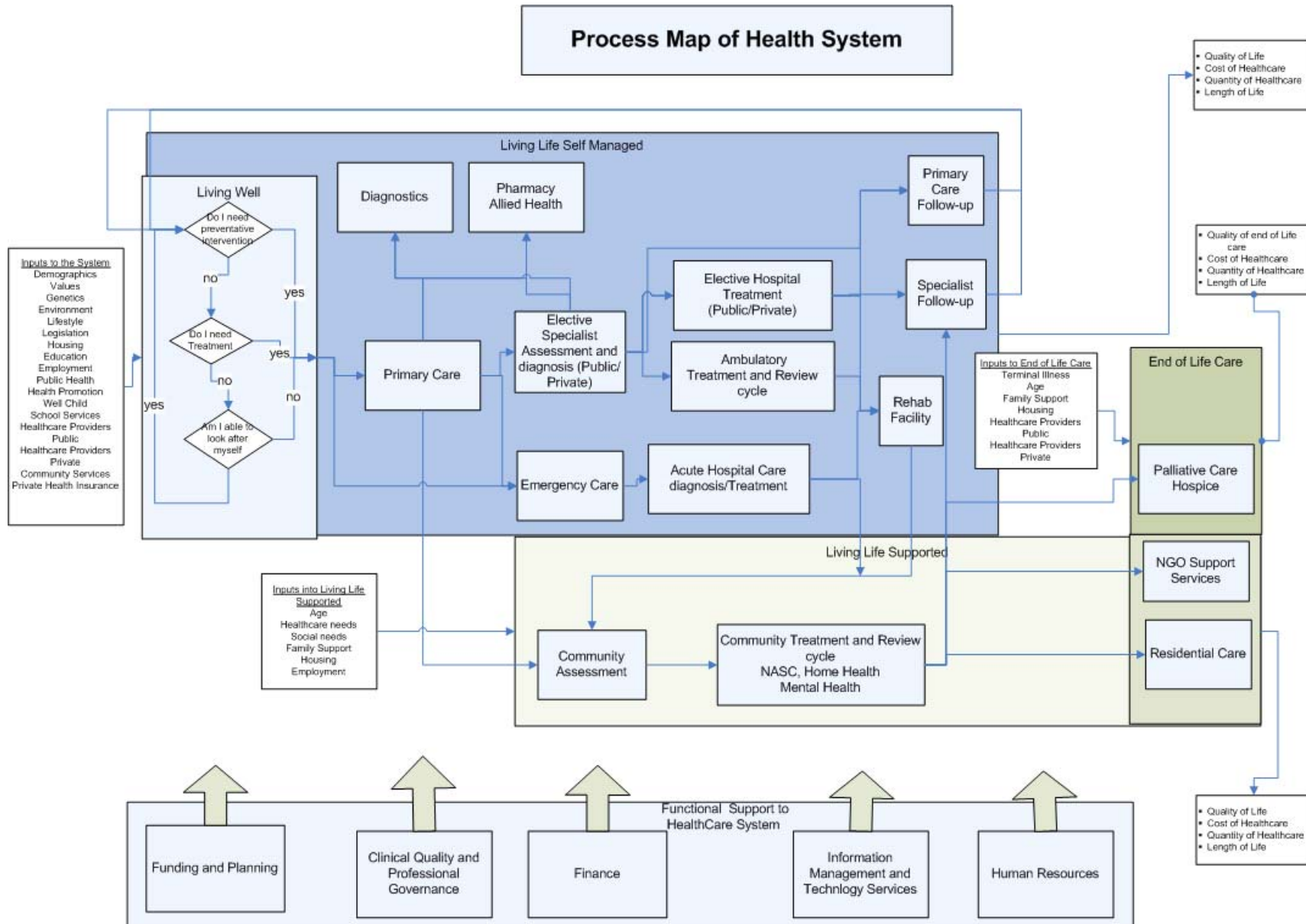
GENERAL BUSINESS

10

APPENDICES

10.1 Healthcare System Diagram

10.1 Healthcare System Diagram



MEETING DETAILS		
Time and Date	10:45am – 12:15pm, Wednesday, 2 March 2011	
Venue	Sorrento in the Park, Pohutukawa Room, Cornwall Park, Greenlane	
Members	Dr Chris Chambers (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Rob Cooper, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.	
Apologies		
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Richard Aickin, Greg Balla, Elizabeth Wood, Kirsty Walsh, Ngaire Buchanan, Taima Campbell, Margaret Dotchin, Fionnagh Dougan, Paul Green, Janice Mueller, Vivienne Rawlings, Richard Sullivan, Ian Bell.	
COMMITTEE FUNCTIONS		
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.		
	Item	Page No
1 2 m to 10.47am	Attendance and Apologies	001
2 3 m to 10.50am	Conflicts of Interest	003
3 5 m to 10.55am	Confirmation of Minutes Wednesday 2 February 2011	013
4 10 m to 11.05am	Action Points Wednesday 2 February 2011	019
5 10 m 20 m 5 m to 11.40am	Operational Performance 5.1 Operational Report 5.2 Health Target Updates 5.3 Operational Indicators Report	023 025 035 049
6 10 m to 11.50am	Improvement Activities 6.1 DAP Projects Report	053
7 15 m to 12.05pm	Papers 7.1 Electives and Elective Targets 2011/12 – Peter Lowry	059

Agenda

	Item	Page No
8	Feedback to Board	065
9 5 m to 12.10pm	General Business	067
10	Appendices 10.1 Healthcare System Diagram	069
NEXT MEETING		
Time and Date: 10.25am, Wednesday 6 April 2011		
Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital		

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