



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

**Wednesday 6 July 2011**

**10.45am**

**A+ Trust Room**

**Clinical Education Centre**

**Level 5**

**Auckland City Hospital**

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



**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>	Senior Lecturer Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		21 April 2010
<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	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member	Fees  Hourly fee  Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
<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)	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	Fee (to Ngati Hine Health Trust)		
<b>Lee MATHIAS</b>	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting Director, company provides services to people with multiple physical disabilities especially cerebral Palsy Provider of business and professional services to midwives and other maternity services providers	31 May 2011
	Iris Limited	Director	Fee		
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited		

	Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education services contracted to the MoE. Statutory Authority	
	John Seabrook Holdings Limited	Director	No fee		
	AuPairlink Limited	Governance Advisor	Fee		
	NZ Council of Midwives Tamaki Transformation Transitional Board	Council member Chair	Fee Fee		
<b>Robyn NORTHEY</b>	Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
	Hope Foundation Northern Region	Board member	Nil		
	Ethics Committee	Member	Fee		
<b>Gwen TEPANIA-PALMER</b>	Waitemata District Health Board	Board member	Fee		18 May 2011
	Manaia PHO Ngati Hine Health Trust	Board member Chair			
	Te Taitokerau Whanau Ora	Committee member	Fee		
<b>Ian WARD</b>	Principal/Director C -4 Consulting Limited				4 May 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 1 JUNE 2011**



# Hospital Advisory Committee Minutes



<b>MEETING DETAILS</b>													
Time and Date	10:45am, Wednesday, 1 June 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 11:02am.</p> <p><b>Committee Members</b></p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tapania-Palmer</td> <td>Ian Ward</td> </tr> <tr> <td>Professor Iain Martin</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  Taima Campbell – Executive Director Nursing  Janice Mueller – Director Allied Health  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Rob Cooper was on leave of absence.</p>	Dr Chris Chambers (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tapania-Palmer	Ian Ward	Professor Iain Martin	Associate Professor Anne Kolbe
Dr Chris Chambers (Chair)	Jo Agnew												
Peter Aitken	Judith Bassett												
Susan Buckland	Dr Lester Levy												
Dr Lee Mathias	Robyn Northey												
Gwen Tapania-Palmer	Ian Ward												
Professor Iain Martin	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. Lee Mathias advised that she was Chair of the Tamaki Transformation Transitional Board; Lester Levy advised that he was a Trustee of the A+ Trust and Anne Kolbe advised that she was Chair of the National Health Committee.</p>												
<b>3</b>	<b>CONFIRMATION OF MINUTES WEDNESDAY 4 MAY 2011</b>												
	<p><u>Moved Gwen Tapania-Palmer; seconded Lester Levy</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 4 May 2011 with the amendments to refer to radiation oncology item General Business and an apology from Anne Kolbe be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>ACC intervention rates were being addressed nationally and would be reported back to the Committee. The PICU project was part of a review of national services.</p>												
<b>4</b>	<b>ACTION POINTS 4 MAY 2011</b>												
	<p>The action points were noted.</p>												

<b>5.1</b>	<b>Operational Performance Report</b>
	<p>The change in format of the HAC and Board papers with more explanation was favourably noted.</p> <p>The effect of the delay of the census to 2013 and impact on population based funding will be covered in the funding paper going to the Board at next month.</p> <p>Electives will be on target as to number of discharges but under on WIES. Contracts with other DHBs are based on WEIS values.</p> <p>Herceptin funding, which includes operational costs, had been reclassified from a subcontract to base funding. Uptake has been low. The Pharmac model may not look at operational costs but they do consult and get feedback.</p> <p>The Committee requested feedback on the Pharmac decisions relating to operational and capital costs that impact on the profit and loss.</p> <p>While there was outsourcing to deliver electives at a 35% increased rate for the last six months for this financial year there was some overlap of costs while recruitment was being undertaken to staff the refurbished operating rooms at Greenlane Surgical Centre. Outsourcing will be pulled back in 2011 - 2012 with next year planned production spread based on increased throughput and productivity.</p> <p>The over delivery in renal medicine of \$5m was noted with a question as to whether it was increased local demand or urgent transfers from other DHBs.</p> <p>The new diabetes training centre at Greenlane was being built and community centres were also being considered as part of the overall development and evolution of the service.</p> <p>The Committee asked whether costs were compared with national prices and asked for examples to be given.</p> <p>General surgery and orthopaedics had improvement projects and there were efforts to try and share data and be able to compare information between and across services.</p> <p>The nursing model of care was to have the skill mix of staffing appropriate to the number of patients predicted to be accommodated in a ward. The RITA regional rostering system is being implemented with explicit assumptions on sick leave, annual leave etc. 10 hour and 12 hour shifts are exceptions, but popular with some staff. They are not considered ideal and did create risk, although preferred by the younger workforce for managing their time off. A safe working environment was a prime focus.</p> <p>The lower FTE, but higher cost was due to a number of allowances being paid.</p> <p>RMOs are employed at the beginning of each year but can't undertake night work in the first six months so it is not appropriate to take all as PGY1. There were challenges in negotiations and the Medical Counsel was looking at PGY1 and PGY2 and their scope of practice. Australia did have a provisional registration system. There is a difference in practice on each side of the Tasman, with different interpretations of work readiness that needs resolution.</p> <p>The volumes and services were reviewed to manage staff numbers as well as productivity gains with the responsibility resting in each HSG, with a mechanism at the senior level to mediate between HSGs.</p> <p>The Committee asked for the process of employing Maori and Pacific nurses in the next financial year to be clarified.</p>
<b>5.2</b>	<b>Health Target Updates</b>
	<p>Rapid rounds were being rolled out to other services to assist adult acute patient flows with support from diversion of suitable patients to sub specialities. Children's acute patient flow has improved based on the development of a full hospital plan with daily reports on where it was thought there would be bed blocks and then proactively looking at occupancy at daily meetings to address these rather than allow blockage to occur.</p> <p>Elective surgery was looking good for May and the third theatre at GLCC opening would be</p>

	<p>dependent on staffing. Anecdotally the theatres were doing better than at ACH.</p> <p>Critical elements to well functioning teams are recognised to be having consistency of team and having teaching by observation rather than operational.</p> <p>Responsibility for training is recognised. There had been an Australian study on the cost of teaching in the private sector. There needed to be training of all groups with the question being how that training could be provided as it was needed for future services.</p> <p>Radiation therapy in the private sector has more flexibility than with the hospital MECA so different options were being considered. The reduced waiting times for radiotherapy target had been met for 451 days but there was still great variation in referrals. Non radiation and medical oncology waiting lists were also very good.</p> <p>Help for smokers was up to 80% but there was still issues of coding and recording especially with people moving around in the system. There were a lot of ideas of how to improve performance against this target, consideration is being given to what Waitemata was doing, daily reporting which is addressed to the charge nurse who takes responsibility, and suggestions of consideration of automatic advice, telephones and social media to get sustainability. Advice is to 15 year olds and over.</p> <p>Cardiac bypass surgery waiting lists had increased with an increase in transplanted patients and acute thoracic work. This was based on clinical priority.</p>
<b>6.1</b>	<b>DAP Projects Report</b>
	The improved commentary was noted and there was a focus on projects due to end in June.
<b>8</b>	<b>GENERAL BUSINESS</b>
	<p><b>Anti Coagulant</b></p> <p>Pharmac had approved a new generation anti-coagulant expected use to replace Warfarin, which had been around for 100 years, but its clinical effect is not be tested for as for Warfarin. There would be a need for an education programme if this class of drugs is introduced into routine clinical practice.</p> <p>Warfarin adverse events are not routinely collected.</p> <p><b>Midwifery Director</b></p> <p>Maggie O'Brien would be Midwifery Director full time for the first three months in Woman's Services and then reduce to 0.5.</p> <p><b>Medication Errors</b></p> <p>The use of the decimal point was recognised as an issue in medication errors.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 12:38pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 6 July 2011</p> <p>A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
<b>CONFIRMED</b>	
<b>CHAIR:</b>	<b>DATE:</b>



**ACTION POINTS**

**WEDNESDAY 1 JUNE 2011**



**Hospital Advisory Committee  
Action Points from the meeting on Wednesday 1 June 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
Carried forward	Tamaki P2HC revised proposal to MHAC	Taima Campbell	To MHAC June
Carried forward	Report on OR waste and efficiency	Greg Balla	
5.1	Advise committee on feedback on Pharmac decisions	Margaret Wilsher	
5.1	Do we compare our costs with national prices and give exception examples	Brent Wiseman	
5.1	Process for employing Maori and Pacific nurses next financial year	Taima Campbell	July



# **PROVIDER OPERATIONAL PERFORMANCE REPORT**

**5.1 Operational Performance Report**

**5.2 Health Target Updates**



## **5.1 Operational Performance Report**

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## 1. Summary

The provider arm has operated at 95% of contracted volume levels for the month (DRG services) and at 102% of non DRG services. It has continued to make progress on ADHB population elective discharges for the health target. The net operating position was a deficit of \$(0.6)m, however the budget was a surplus of \$3.4m leaving the result \$(3.9)m U to budget.

Although revenue was higher than budget for the month - \$2.3mF this was eroded by costs adverse to budget by \$(6.9)m U. Non operating costs were favourable to budget \$0.6m F

Staffing and outsourcing costs reflect two key elements – firstly, the resourcing that has been allocated to increase the throughput for electives and secondly, investment in the achievement of other health targets, such as the Adult Emergency Department. These variances have been analysed and are included in this report together with the control measures that are in place.

Elective services performance indicators were within allowable tolerances at a total ADHB level; having established ESPI compliance on a regular basis the challenge now switches to the need to ensure that no patient waits longer than six months for either a first specialist appointment or for surgery.

Volume and cost management will be the priorities for June. Financial performance will continue to see some cost overruns but efforts are being made to rectify this through close attention to requirements on a daily basis and initiatives to return FTE numbers to the 2010/11 budget wherever possible as outlined in this report. This will clearly require reductions in FTEs in one area to balance the additional FTEs engaged in meeting health targets or other approved initiatives.

## 2. Financial performance

The provider arm was adverse to budget for the month (\$3.9m U) and remains below budget year to date (\$16.2m 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	103,555	2,326F	1,073,161	8,658F
Operating Expenditure	95,520	6,862U	995,549	31,009U
Operating Surplus/(Deficit)	8,035	4,546U	77,612	22,351U
Non-Operating Expenditure	8,605	574F	95,262	6,179F
<b>Total Surplus / (Deficit)</b>	<b>(571)</b>	<b>3,962U</b>	<b>(17,650)</b>	<b>16,172U</b>

A table showing detailed income and cost categories is included in Appendix 1.

## 2.1 Revenue

Revenue was ahead of budget by \$2.3m for the month and \$8.6m year to date. At a detailed level there were a number of movements and the key elements are summarised below.

Category	Variance Month \$m	Variance YTD \$m	Explanation of major items
MOH - Base Funding	\$0.1mU	\$2.7mF	Reflects a higher revenue allocation from the Funder of \$2.7m across a wide number of contract lines – ADHB and IDF populations, <u>including</u> additional funding for the Herceptin programme of \$8.4m YTD (see below)
MOH - Funding Subcontracts	\$1.0mF	\$2.5mU	Reflects reclassification of \$8.4m Herceptin funding (see above). Otherwise the variance would be positive reflecting additional contract revenue for new unbudgeted services such as the eating disorder service and the familial cancer registry.
Other Patient Care Revenue	\$0.7mF	\$2.9mF	Higher revenue for non residents \$4.5m F offset by under provision on the ACC contract \$1.6m U
Sales of Service and Products	\$0.5mF	\$0.5mF	Key variance is research income higher than budget..
Financial income	\$0.3mF	\$3.7mF	Higher term deposit interest receipts \$2.4m, and a realised gain on interest rate swap instruments of \$1.3m provided this gain in revenue.

## 2.2. Volume performance

Volume management during May was characterised by continuing high acute volumes. Acute discharges were 8% higher than April and are at a similar level to last winter. The emphasis on improving acute flow has continued.

The service delivery for the eleven months year to date is running at 101% for acute volumes and 91% for electives, giving 98% overall compared to planned volumes. This is measured in terms of Weighted Inlier Equivalent Separations (WIES). A comparison with last year indicates overall volumes are 1.9% higher with 40% of the increase relating to the Auckland population.

**Acute (WIES)**

<b>DHB</b>	<b>Actual YTD</b>	<b>Variance to Plan</b>	<b>% of completion</b>
ADHB	46,548	407	100.9%
CMDHB	10,754	-482	95.7%
WDHB	16,867	557	103.4%
NLDHB	4,260	93	102.2%
Other DHBs	6,707	150	102.3%
<b>Total volume</b>	<b>85,136</b>	<b>725</b>	<b>100.9%</b>

**Elective (WIES)**

<b>HB</b>	<b>Actual YTD</b>	<b>Variance to Plan</b>	<b>% of completion</b>
ADHB	12,169	-1,656	88.0%
CMDHB	4,693	-234	95.3%
WDHB	5,855	-423	93.3%
NLDHB	1,907	-326	85.4%
Other DHBs	3,367	-172	95.1%
<b>Total volume</b>	<b>27,991</b>	<b>-2,811</b>	<b>90.9%</b>

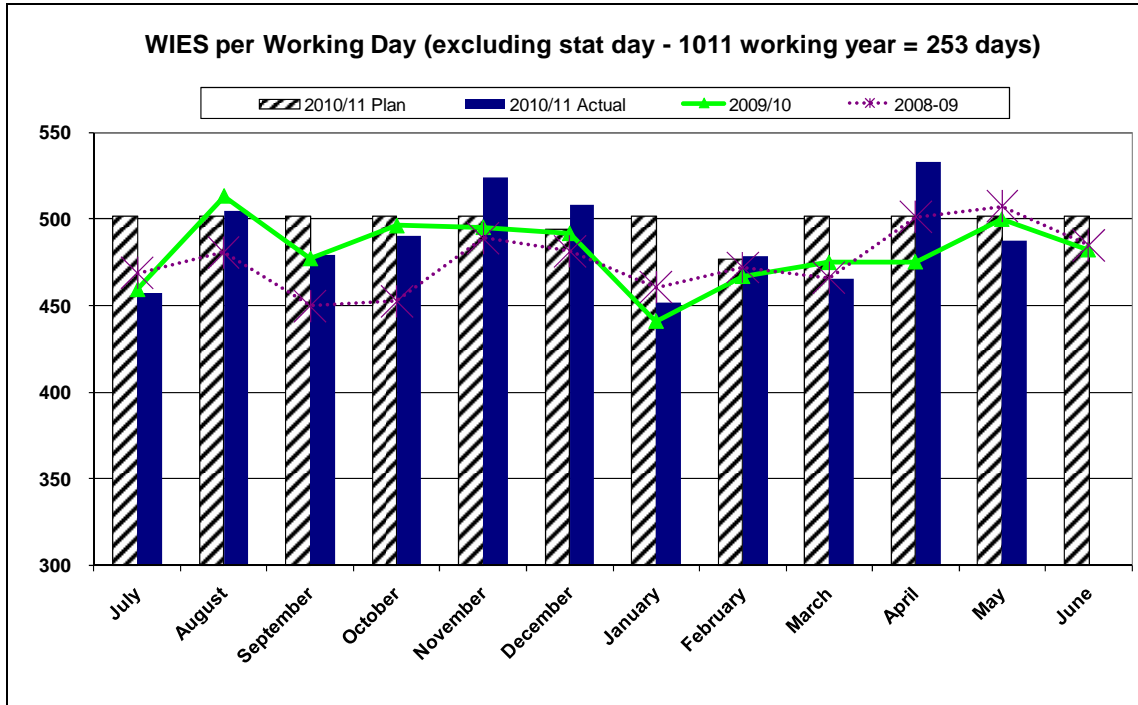
**Total (WIES)**

<b>DHB</b>	<b>Actual YTD</b>	<b>Variance to Plan</b>	<b>% of completion</b>
ADHB	58,717	<b>-1,249</b>	97.9%
CMDHB	15,447	<b>-716</b>	95.6%
WDHB	22,722	<b>134</b>	100.6%
NLDHB	6,167	<b>-233</b>	96.4%
Other	10,074	<b>-22</b>	99.8%
<b>Total volume</b>	<b>113,127</b>	<b>-1,249</b>	<b>97.9%</b>

Overall activity for May shows a increase in WIES per day compared to April (see below) but this is largely due to significantly more working days during May (22 compared to 19 in April). It is not regarded as a trend at this point.

At the time of reporting the coding was 79% complete for the month with the balance being an estimate. This is in accordance with standard practice but could also impact

the evaluation and any change in the figures will be reflected in next month's report. At the time of preparing this report, total wies production year to date has increased to 113,921, a result of an unusually high number of long length of stay cases for which the final coded wies was in excess of the estimate used for reporting.



The management of patient flows has been achieved within the ESPI requirements set by the MOH. The key measures that indicate assessment and treatment within six months are well within the requirements as shown below:

ESPI	Measure	Limit	Actual
2	Patients waiting longer than six months for a first specialist assessment	1.5%	0.8%
5	Patients given a commitment to treatment but not treated within six months	4%	1.9%

### **Elective Health Target 11,149 Discharges**

At 31 May 2011 ADHB had recorded 10,042 discharges (including outflows), which was 99% of the MOH plan target for 2010/11. This result is 115 discharges ahead of the re-drafted plan in February 2011. ADHB remains on track to meet the Health target by 30 June 2011 however we are experiencing elective cancellations due to bed availability and a shift of production to non-ADHB patients that are waiting greater than 6 months (which impacts health target volumes).

### **Waiting Time Performance**

The table below shows the improved wait time performance in recent months as the increased delivery is achieved. Importantly, those waiting greater than 6 months are at some of the lowest recorded levels for several years. Moving to zero patients waiting greater than 6 months has become the priority. The numbers of seen/treated patients below indicates this can be achieved, however back-log humps will need to be managed and resourced. In some cases this may be in addition to the 2011/12 budgeted position – revenue and cost.

ADHB performance needs to move from ESPI compliance to achieving acceptable wait times for patients at a given threshold. As services move to balancing referrals and outputs we will seek to target resources at humps so wait times come down and we then have a more accurate view of demand for clinics and surgery (i.e. cannot measure demand when wait times are unacceptable for referrals).

People waiting	Clinic waitlist	Clinic > 6 months	% Limit 1.5%	Surgical Waitlist	Surgical > 6 months	% Limit 4%
	#	#	%	#	#	%
<b>May 11</b>	<b>12,296</b>	<b>448</b>	<b>0.8%</b>	<b>5,453</b>	<b>343</b>	<b>1.9%</b>
Apr-11	12,722	400	0.7%	5,580	371	2.1%
Mar-11	13,180	473		5,472	421	
Feb-11	13,719	860		5,702	489	
Jan-11	13,875	847		6,334	712	
Dec-10	13,730	557		6,495	742	
Sep-10	13,406	638		6,811	622	
Jun-10	13,256	454		6,585	517	
Mar-10	13,761	545		6,496	532	
Dec-09	13,293	991		5,945	383	
Sep-09	12,108	619		6,068	409	
Jun-09	11,893	587		6,260	508	
Mar-09	12,516	606		6,701	556	
Dec-08	12,410	477		6,801	452	
Sep-08	10,991	241		6,346	339	
Jun-08	11,500	270		6,058	320	
Seen/treated pa	56,600			21,000		

The measures to increase throughput to date have included outsourcing volume and the table below summarises the position for May Budget and YTD. The active management of outsourced volumes is discussed further under the cost section of this report and includes daily attention to internal capacity and therefore selective use of outsourcing.

<b>Outsourced Services</b>	<b>Budget</b>	<b>Actual YTD</b>	<b>Variance</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
CTSU	0	2,524	(2,524) U
General Surgery	828	727	101 F
Orthopaedics	1,113	2,521	(1,408) U
ORL	0	128	(128) U
Urology	0	51	(51) U
Neurosurgery	0	408	(408) U
Paediatric Surgery	304	374	(70) U
Paediatric ORL	0	947	(947) U
Paediatric Orthopaedics	969	1,216	(247) U
Gynaecology	0	70	(70) U
Oral Health	196	187	9 F
Cancer & Blood	2,385	3,131	(746) U
<b>Total</b>	<b>5,795</b>	<b>12,284</b>	<b>(6,489) U</b>

Against planned **non DRG outputs** of \$31.0m, the value of outputs delivered by the provider arm during April was \$32.5m, an over-delivery of \$1.5m. The over-delivery is \$10.4m year to date.

The top four areas of over-delivery by portfolio for non DRG services were:

Portfolio	Variance Month	Budget YTD	Variance YTD	Principal Drivers
	\$m	\$m	\$m	
Transplant, Renal, Urology, ORL, Neurosurgery	1.0m	41.2m	6.4m	Renal Medicine – all modalities \$5.3m, neurology outpatient \$0.6m, ORL \$0.2m, General Surgery \$0.2m (liver transplant related)
Operations	0.0m	20.8m	1.2m	Non-Schedule Community Laboratory Tests \$1.2m
AED, APU, DCCM, Air Ambulance	0.1m	4.5m	1.2m	Adult Emergency Department Attendances. \$1.2m
Ambulatory Health Services	0.0m	21.4m	0.9m	Diabetes services \$1.1m Dermatology \$(0.4)m

The main areas of over-delivery were renal dialysis treatment, non schedule laboratory tests and emergency department attendances. In general, over-delivery of this nature is not funded with additional revenue. For ADHB's population the population based funding is fixed and for other populations there is generally no provision for 'wash up' on non-DRG services. In certain cases, for example where a service is undergoing change, additional volumes will be funded and this is the case for renal services with Waitemata (overproduction approximately \$4m). Such agreements are negotiated between the DHB of Service (in this case Auckland) and the DHB of Domicile (where the patients live).

### 2.3. Costs

Operating expenditure was over budget for the month \$(6.9)m and year to date \$(31.0)m. The most significant variances were in direct treatment costs and outsourced services. This reflects a) savings initiatives that have not been met, b) higher usage due to high demand in some services and c) increased use of outsourcing to meet ESPI and Elective contract requirements.

The commentary below sets out the reasons for the variations and the next page includes actions being taken to control costs. It is not expected that the measures will eliminate the cost overruns for the year but they will help manage future costs.

Category	Variance YTD	Explanation of major items
	\$m	

Category	Variance YTD	Explanation of major items
Clinical Supplies	(6.9) U	Volume related costs primarily in OR&A (related to greater operating time than budgeted).
Patient appliances	(3.8) U	Mainly implants where actual volumes are higher than budget in Cardiology, Cardiothoracic, Paediatric Orthopaedics and Paediatric Cardiology.
Chemicals & Media	(2.7) U	The budget includes an assumption of a reduction in laboratory test volumes and a reduction in reagent prices. A reduction in internal referral volumes of tests has been achieved through Concord and there is ongoing work to identify further reductions for internal referrals as well as reductions in GP referrals. However, these savings have been more than offset by an increase in volumes of externally purchased tests (reflected in favourable LabPlus external revenue for the year to date) and community non schedule tests.
Drugs	(1.2) U	Very high cost drugs in Immunology (demand driven) and Paediatric Oncology (specific patients), partly offset by a favourable variance in Adult Oncology
Direct Treatment	(14.6) U	Sub total of above
Total Outsourced Clinical services	(7.1) U	Cardiac, Operations, Child Health, and Cancer services
Indirect treatment costs	(3.4) U	\$(2.5)m relates to non resident bad debts provision; (660)k to cost of sales for retail business (both offset by revenue)
Outsourced Employee costs	(5.7) U	Mainly recharges to Health Alliance reflected in reduced U variance for internal employee costs
Employee costs - internal	(1.2) U	FTE increased above budgeted levels in the new calendar year.

Initiatives are under way to reduce direct treatment cost overruns wherever possible. They include:

- Review of laboratory, radiology and direct treatment utilisation to identify practice changes for discussion with the clinical team.
- Assessment of the use of high cost drugs in paediatric oncology. This review has shown that all of these drugs are administered appropriately as per treatment protocols. The existing favourable mix variance in adult oncology continues and is being monitored and maintained.

- Management of ward stock to reduce overall stock level requirements and consequent obsolescence. Ongoing management through performance improvement projects/releasing time to care are being implemented
- Review of the use of clinical supplies, patient appliances and other volume related cost areas in conjunction with clinical partners, especially:
  - MRI utilisation to deliver a decrease in outsourcing MRI. Project underway to increase average throughput per MRI session
  - Review of send-away laboratories tests; and service delivery in Sexual Health. This is underway encompassing capacity and capability to deliver internally
- Review of the utilisation of blood in Haematology, subject to the acknowledged requirements for high blood product utilisation for a specific cohort of haematology patients. A reporting template has been developed by the service to illustrate monthly blood product usage (by blood product type) by patient. This report is presented to the Haematology medical team (SMO and RMO) for their consideration and evaluation. This report provides transparency and encourages peer review of prescribing practice. Specific savings have not been allocated to this initiative. The first report was generated for YTD 31 March; this will be rerun for the last quarter of 10/11 mid July. The report will be presented quarterly.

The management of staff costs is a specific and continuing focus, especially with respect to getting FTEs right in preparation for 2011/12. It reflects:

- Ensuring compliance with collective employment agreements e.g. shift length, rostering, allowances.
- Ensuring vacancies are reviewed prior to replacement with priority positions approved by the General Manager through the Management Focus Group. This strategy has a reduced impact due to the lower staff churn that is currently occurring. Overall FTE have reduced by 80 since February 2011, after allowing for the FTE reduction through transfer to health Alliance.
- Acknowledging specific investments that have been made to reach treatment goals.
- Ensuring that staff utilisation and productivity is maintained at acceptable levels through careful planning and rostering. This includes daily watch management, nursing model of care, bureau usage, overtime use/approval, annual leave and sick leave management.
- Eliminating costs through planned improvement initiatives within departments and services. This may involve service reviews. A strategy will be developed with each HSG.

The table below analyses the FTE numbers and variance both in numbers and value for the month and year to date.

Employee Group	Variance Month	Variance YTD	Variance Month	Variance YTD
	#	#	\$000	\$000
Medical	(6) U	22 F	(1,379) U	(2,045) U
Nursing	(69) U	(51) U	(686) U	(3,874) U
Technical	4 F	17 F	(279) U	938 F
Hotel Services	(1) U	(3) U	(79) U	(459) U
Administration	262 F	121 F	1,073 F	5,302 F
Redundancy	-	-	(15) U	(254) U
Target Savings	(9) U	(9) U	(51) U	(55) U
<b>Total</b>	181 F	97 F	(849) U	(1,169) U
Staff related costs	-	-	(16) U	(10) U
Total variance before Outsourced Personnel	181 F	97 F	(865) U	(1,179) U
Outsourced personnel	(234) U	(95) U	(580) U	(5,681) U
<b>Total Employee related Variance</b>	(53) U	2 F	(1,445) U	(6,860) U

Note that the FTE variances for the month include movements to and from healthAlliance relating to the set up of Shared Services. FTE variances by service also reveal some interesting observations. Staff mix for instance in Adult Health and Operations has resulted in an unfavourable FTE variance YTD but a favourable cost variance. The issue is therefore being managed at both levels. The table below sets out the same FTE variances shown above, but by service.

	FTE Month	Variance to Budget	Cost Variance Month	Actual FTE YTD	Variance to Budget	Cost variance YTD
	#	#	\$000	#	#	\$000
Adult Health	1,719	4 F	(453) U	1,735	(16) U	1,363 F
Ambulatory	254	(12) U	(53) U	254	(12) U	(876) U
Women's & Children	1,340	(8) U	(828) U	1,339	(1) U	(2,388) U

	<b>FTE Month</b>	<b>Variance to Budget</b>	<b>Cost Variance Month</b>	<b>Actual FTE YTD</b>	<b>Variance to Budget</b>	<b>Cost variance YTD</b>
	<b>#</b>	<b>#</b>	<b>\$000</b>	<b>#</b>	<b>#</b>	<b>\$000</b>
Operations	1,427	2 F	(111) U	1,415	14 F	2,131 F
OR & Anaesthesia	720	(32) U	(487) U	697	(10) U	(2,682) U
Cancer & Blood	299	(1) U	(485) U	294	4 F	481 F
Cardiac Services	453	(3) U	(523) U	437	13 F	(2,320) U
Other Operational	1	0	0	2	(1) U	(234) U
Mental Health	719	.27 F	895 F	717	29 F	3,964 F
Ancillary	760	205 F	531 F	891	78 F	(618) U
<b>TOTAL Employees</b>	<b>7,691</b>	<b>182 F</b>	<b>(1,514) U</b>	<b>7,781</b>	<b>98 F</b>	<b>(1,179) U</b>
<b>Outsourced Personnel</b>						
Operational	43	(12) U	619 F	42	(11) U	(273) U
Mental Health	4	(4) U	(18) U	3	(3) U	(161) U
Ancillary Services	221	(219) U	(1,181) U	84	(81) U	(5,248) U
<b>TOTAL Outsourced</b>	<b>269</b>	<b>(234) U</b>	<b>(580) U</b>	<b>129</b>	<b>(95) U</b>	<b>(5,681) U</b>
<b>Grand Total</b>	<b>7,960</b>	<b>(52) U</b>	<b>(2,094) U</b>	<b>7911</b>	<b>2 F</b>	<b>(6,680) U</b>

The unfavourable variance in FTE includes additional FTE approved for managing electives and the six hour targets for the Emergency Department. However it is recognised that FTE need to be managed back to the budgeted levels for next year through re-prioritisation.

Although the year to date FTE shows a favourable variance, unfavourable monthly variances commenced in the new calendar year and recruitment activity is therefore being carefully managed. The unfavourable variance reduced by 44 FTE in April compared to March and by a further 15 FTE from April to May. There will be a further reduction of some 20 FTE after June reflecting the elimination of over recruitment for house officers who complete their run at the end of June and will not be retained. That will not help this financial year but will establish a better base going forward. The technique of over recruiting was a deliberate strategy to counter the risks of high staff churn. Better retention has created the imbalance. This will also be addressed by altering the appointment process with general appointments being made allowing house officers to be allocated to the services in most need.

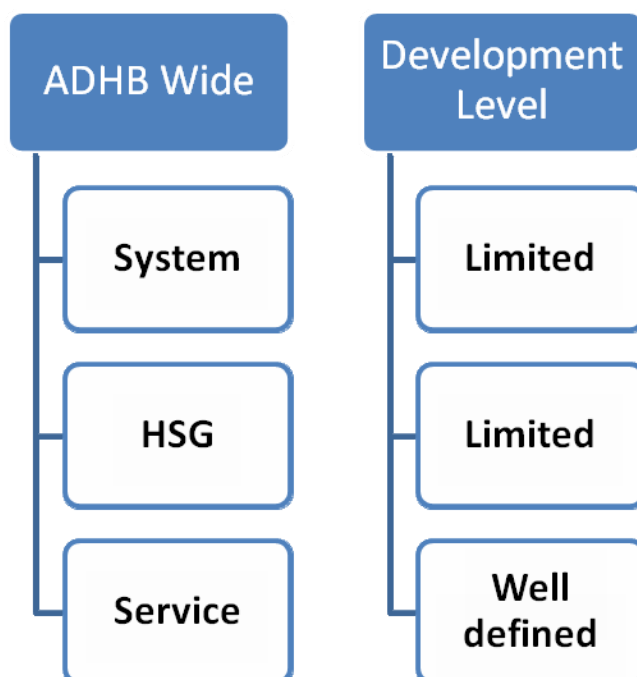
In addition to the staff costs variance shown above there is a YTD unfavourable variance within Outsource Services of \$(5.7)m. This unbudgeted line reflects the transfer of staff to healthAlliance as from 1 March and is offset by a corresponding reduction in internal payroll costs.

### 3. Productivity

**Productivity** is a measure of output from a production process, per unit of input. In a fiscally constrained environment where public services may not be able to add inputs to produce a given level of outputs the measurement of, and trend for, productivity is important to understand.

For a district health board, with its dual role of funder and provider, productivity measurement cannot be restricted solely to the provider arm; and even within the provider arm there are challenges in measuring productivity at an overall level because of the dissimilarity of outputs produced in various parts of the provider – obstetric follow ups and renal dialysis treatments for example.

In response to Board interest in productivity we propose to adopt the following hierarchy of productivity measurement:-



At an overall DHB or system level productivity indicators for a DHB have not been well defined, the nature of a DHB makes measurement difficult at this level and guidance from the State Services Commission suggests productivity measurement for state sector bodies should focus on the value to the client group of the *value* provided. We propose to focus productivity measurement in the following manner:-

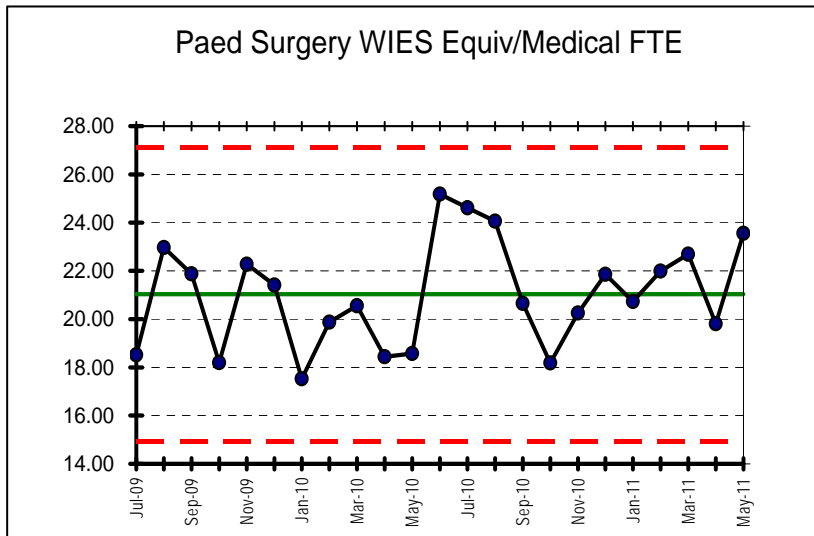
At an *system* level – a comparison of health outcomes and investment – a *value for money* approach.

At a *service level*, where outputs can be more closely linked to the input resources, a direct comparison of inputs and outputs, through time and, where available, compared to peers e.g. National Health Board benchmarking and the Health Round Table.

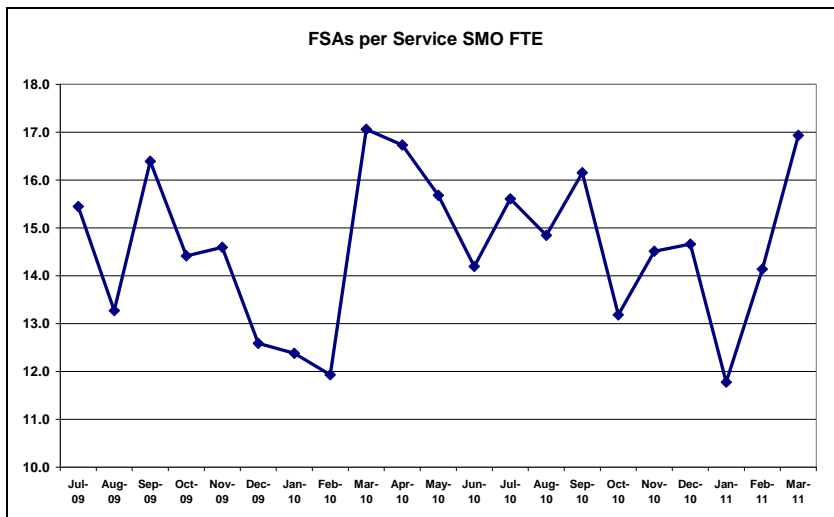
At an *HSG level*, a combination of the two approaches.

Example of the type of analysis which can be undertaken at a service level include (overleaf):-

**Surgical outputs per FTE:-**



**Key outputs per staffing FTE:-**



## Appendix 1 Provider Operating Statement May 2011

	Actual Month \$000	Variance \$000	Actual YTD \$000	Variance \$000
<b><i>Income</i></b>				
Internal Allocations - Ex Funder	87,537	(125)U	921,966	2,741F
MOH - Funding Subcontracts	3,988	1,064F	29,808	(2,544)U
Other Patient Care Revenue	4,850	763F	42,360	2,920F
Sales of Services & Products	4,321	576F	42,646	560F
Clinical Training & Education Income	1,577	(108)U	17,991	(339)U
Trust & Donation Income	743	(185)U	5,747	5F
Financial Income	579	263F	8,142	3,736F
Other Income	-41	77F	4,501	1,582F
Loss on Disposal of Fixed Assets	0	0	0	(2)U
<b>Total Income</b>	<b>103,555</b>	<b>2,326F</b>	<b>1,073,161</b>	<b>8,658F</b>
<b><i>Operating Expenditure</i></b>				
Employee Costs	62,004	(1,515)U	658,610	(1,179)U
Outsourced Services	4,552	(2,169)U	38,615	(12,742)U
Direct Treatment Costs	19,203	(2,850)U	192,476	(15,648)U
Indirect Treatment Costs	3,807	(554)	39,047	(3,391)U
Property, Equip & Transportation	3,631	298F	43,144	1,373F
Administration Costs	1,684	(50)U	16,613	838F
Maintenance Programme	139	(6)U	1,654	(187)U
Indirect Service Billing	482	0	5,303	0
Loss on Sale of Fixed Assets	19	(17)U	88	(72)U
<b>Total Operating Expenditure</b>	<b>95,521</b>	<b>(6,862)U</b>	<b>995,549</b>	<b>(31,009)U</b>
<b>Operating Surplus/(Deficit)</b>	<b>8,034</b>	<b>(4,536)U</b>	<b>77,611</b>	<b>(22,351)U</b>
<b><i>Non-Operating Expenditure</i></b>				
Capital Charge	2,901	154F	31,538	1,886F
Depreciation	4,181	230F	46,985	2,548F
Finance Costs	1,523	190F	16,739	1,745F
<b>Total Non-Operating Expenditure</b>	<b>8,605</b>	<b>574F</b>	<b>95,262</b>	<b>6,179</b>
<b>Total Surplus / (Deficit)</b>	<b>(571)</b>	<b>(3,962)U</b>	<b>(17,650)</b>	<b>(16,172)U</b>









## 5.2 Health Target Updates

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## 5.2 Health Target Updates

The information set out on the attached pages covers the six health target reports that are reported to the MOH each month. They comprise:

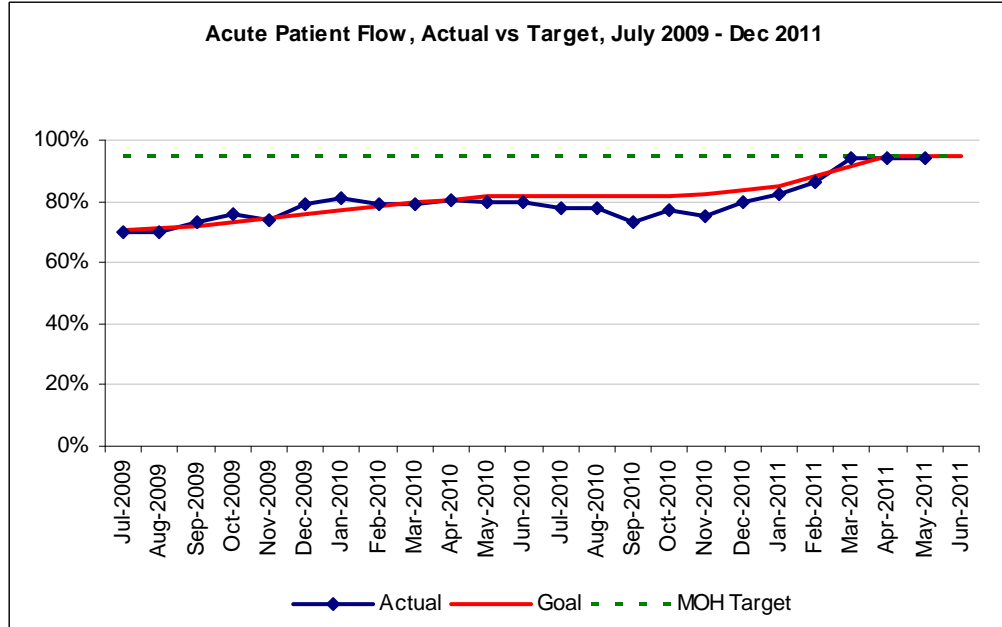
	Status	Comment
Adult acute patient flow		94% achievement and an improving trend
Child acute patient flow		94% achievement and a stable trend
Improved access to elective surgery		On track to complete planned volumes
Shorter waits for radiation therapy		100% of eligible patients treated
Better help for smokers to quit		Below target but improving trend
Cardiac bypass surgery		Waiting times met but volume below plan

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 2011



**Project Risks / Comments:**

Performance to achieve Shorter Stays in ED for both Adults and Children’s services continues to demonstrate improvement .

## Project: Adult Acute Patient Flow

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

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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

### Improvements to date:

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

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

Charge nurse patient flow coordinator introduced

Improved access to Radiology

Streamlined documentation required for safe transfer

Improved triage processes.

### Managing bed block with additional resources

58 Additional beds opened 2009-2010

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

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

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

Nurse Facilitated Discharging in General Medicine (April 2010)

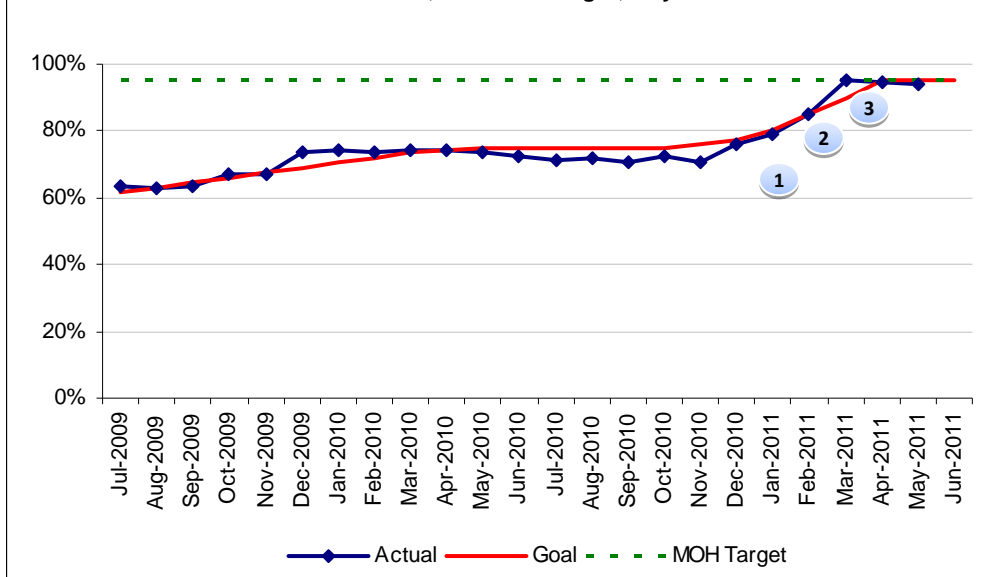
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.

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

### Immediate actions to improve performance:

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

Adult Acute Patient Flow, Actual vs Target, July 2009 - June 2011



### Project Risks / Comments:

Adult Emergency department admitted, discharged or transferred 94% of patients within six hours in May 2011.

To maintain improved performance as we enter winter months a review of ED weekend resourcing to meet variable demand, and escalation process to accommodate increasing presentations to ED is underway.

Further work is also required to improve elective scheduling and to establish daily operational triggers with response plans to maintain flow in times of high hospital occupancy, and increased acute or elective surgical demand.

## Project: Children's Acute Patient Flow

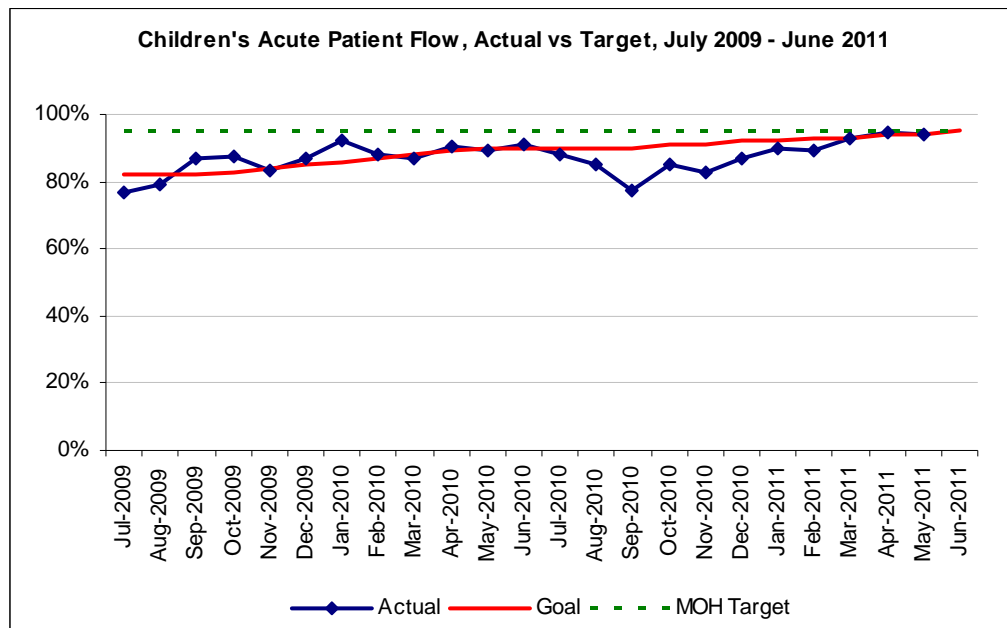
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Project Risks / Comments: The improved performance of prior months continued into May where Starship again achieved 94% of patients being processed within the six hour target. What was also pleasing about the May result was that there were 19 days where 95% or better was achieved. This compares with 5 days in 2010.

Metrics relating to each of the 3-2-1 components are distributed to each respective process owner group and reviewed with the Starship Acute Patient Flow Steering Group. The 2 hour component remains a primary objective that is fully supported by the Steering Group and to date has good levels of engagement from Clinicians.

A programme of work has commenced capacity planning with the aim of managing the number of resourced beds and balancing planned elective volumes with probable acute demand. Short term gains are being looked at first with relevance for the winter months ahead when acute bed requirements are at their highest.

We are also embarking on some a number of ward based initiatives including rapid rounds, Estimated Discharge Date and patient room mix. In addition to this the daily 6 hour breach meeting has been integrated with the daily bed meeting.

### Improvements to date:

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

### Immediate Actions to Lift Performance

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

### Longer term projects

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

## Project: Improved access to elective surgery

49

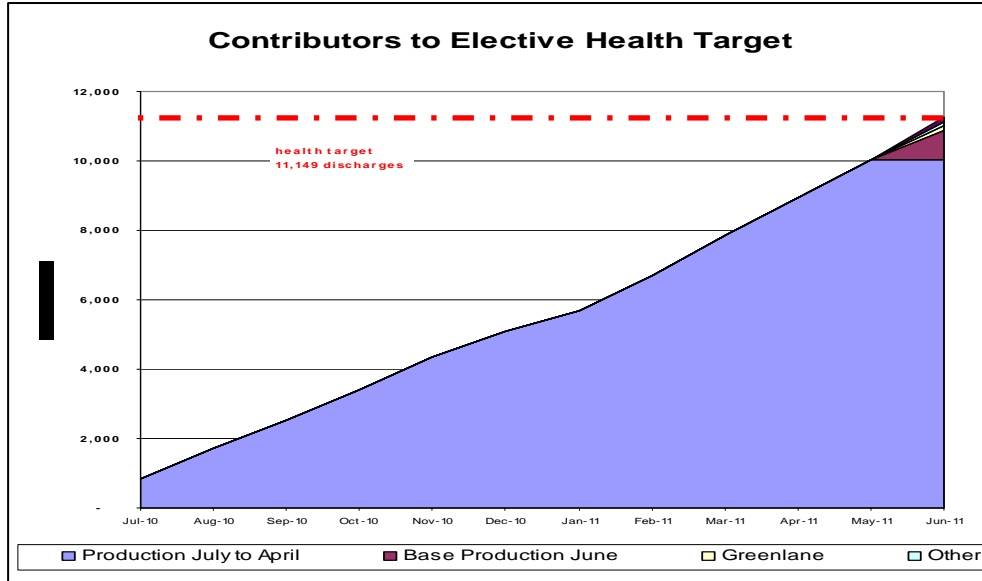
Primary Objective: Increase ADHB Elective Surgical Discharges from 9,425 to 11,149

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. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Fortnightly meetings between the Director of Elective Services and service managers focussing on ESPI compliance and elective production.
3. Continuing to review the production plan at a daily level

### Risks / Comments: (Amber)

1. June electives being adversely affected by bed availability resulting in elective cancellations and production shifting to non-ADHB patients waiting greater than 6 months
2. February was a record month for ADHB population access to surgical procedures at ADHB. This was exceeded by 11% in March. March was exceeded by 9% in May
3. Surgical waitlist reduced since January by 17%. Clinic waitlist reduced by 12%
4. People waiting greater than 6 months for clinic and surgery has more than halved since January
5. Over the last 5 months an extra 55 Auckland people are getting elective surgery each week compared to first 6 months.
6. Second 6 months production will be 37% above the reported first 6 months (23% after recodes).

Notable services by volume are

1. Ophthalmology, +353 discharges, +45%
2. General Surgery, +243 discharges, +24%
3. Paed ENT, +218 discharges, +61%
4. Adult ENT, +124 discharges, +34%

## Project: Shorter waits for Radiation Therapy

50

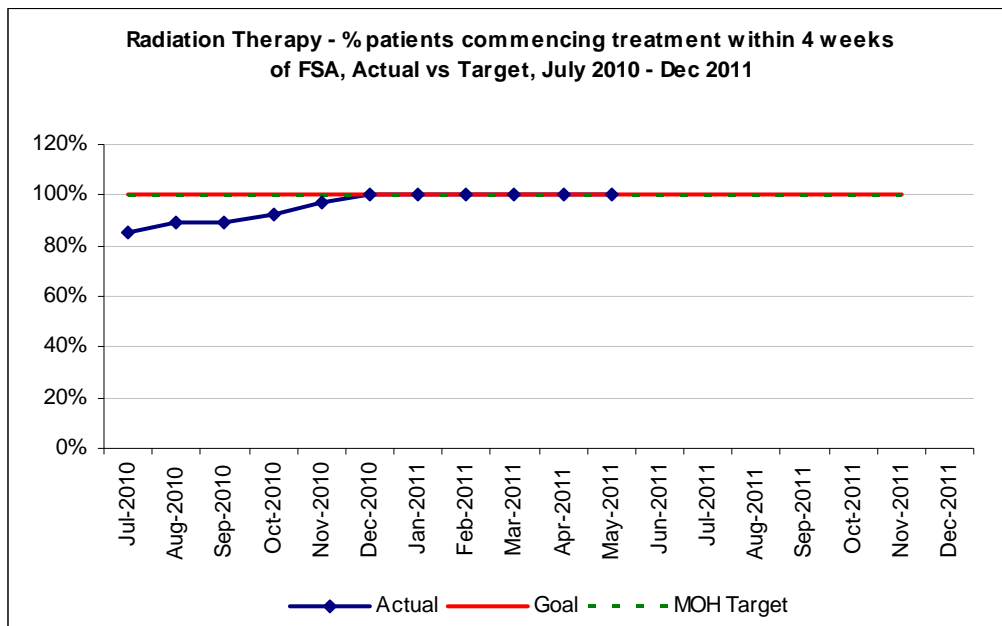
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

Date of Delivery: 31 December 2010 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



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

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

MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement August - December 2011.

An increase in Head & Neck Cases (Complex IMRT treatment).

RT staff vacancies and skill mix – pending resignations will impact staffing ratios during May however in June the service is able to schedule more treatment hours

From June MV2 will be utilised 9.30 -1200 hrs in addition to HDR gynae.

Introduction of new technology during this time also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment, QA testing of new technology.

A new international RT recruitment campaign is underway to attract overseas staff.

### Radiation Oncology Wait times – May 2011

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

**Further improvements in progress to sustain delivery:**  
**Pantak replacement** is planned from early May to July 2011

**Replacement of MV6:** Decommissioning commences early August until late December 2011. Evening shifts will be reinstated during this period to mitigate lost capacity

**Introduction of HDR for Gynaecological patients** is scheduled and on track to be implemented in May 2011.

**A public/private Model of care** has been developed to enable our clinicians to treat public patients at ARO. Effective from March 2011 and progressing well. 2 patients per week are outsourced to ARO.

**Breast hypo-fractionation implemented:** This has reduced treatment time and freed up capacity on the linear accelerators.

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

**Aria project:** A project is underway to develop a full electronic record within the LINAC machine's operating system by July 2011.

**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”** 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

51

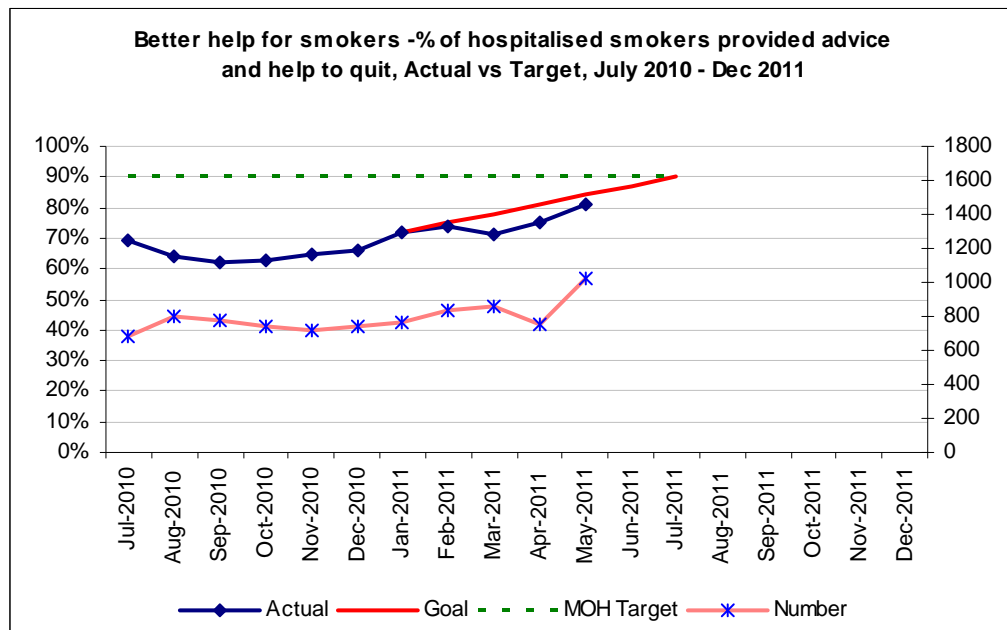
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

Steering Group: Di Roud, Anna Schofield, Pam Hewlett, Stephen Child, George Laking, Jim Kriechbaum, Paul Bohmer, Arun Kulkarni, Michelle Stevens, Kristen Nicol, Bernadette Rehman, Paul Birch, Anne-Marie Pickering, Victoria Child, Jan Marshall



## Improvements to date:

- AED - Brief advice handout developed for Clinical Nurse Specialists to give to all short stay smokers.
- ABC chart reminders placed in Adult Health charts.
- EDON met with Medical Director of Oncology to identify the challenges and solutions for this service to meet the target

## Immediate Actions to improve performance by 15%:

- A. Continued focus on short stay and high volume areas to achieve 5%:**
- Continued auditing and 1:1 coaching in AED and APU
  - Women's Health checking all smokers coding and requesting recoding to ensure target results are accurate. Brief Advice Brochure to be developed for Women's Assessment Unit.
- B. Improve engagement of clinical workforce to achieve 5-8%:**
- Campaign for a Call to Action to Senior Medical staff: Smokefree Clinical Champion presentation to House Officer training and Medical Grand Round in May .
  - EDON to meet with all Medical Directors to boost clinical support for the target
  - Monthly publication of results of Senior Medical Officer's Better Help for Smokers to Quit performance commenced
  - Steering Group meeting monthly to guide and monitor Health Target progress.
  - Clinical research strategy under development
- C. Data collection systems and processes to achieve 5%:**
- Weekly results to be circulated to services from 1 May
  - Weekly audit of smokers records with no brief advice to identify any miscoding to be recoded before month's end
  - Analysis of Short Stay Surgical Unit recording of ABC and initiate a process to improve SSSU results
  - Monthly reports and data analysis to identify and address areas of underperformance with services.
  - Electronic Discharge Summary data to be audited for consistency and accuracy against patient clinical records

## Project Risks and Comments

Of the 8879 events coded in May, 1265 (14.2%) of patients were identified as smokers. There was a sharp rise in the number of smokers recorded as receiving brief advice to 1025 (81%). Sustained audits and training have continued in AED and APU whose results have continued to improve. This will be maintained throughout June. Twenty-one wards attained 90% and over this month compared to 13 in April six reached 100%.

Weekly results were tracked during the month and sent to all services with suggestions on how wards could improve their results. Many wards have enhanced their own internal checks to ensure the ABC is being completed

ABC Communications activities were boosted to coincide with World Smokefree Day. Using the tagline "smoking is too big to ignore" a large banner was hung in the foyer of ACH and stands placed in the staff cafeteria to remind staff to document the ABC. Leaflets are in production which will be handed to patients in short stay areas to augment the brief advice message. One on one briefings are underway with the new round of House Officers and are planned for the new run of Registrars who will start in June.

# Project: Cardiac Bypass Surgery

52

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 81.

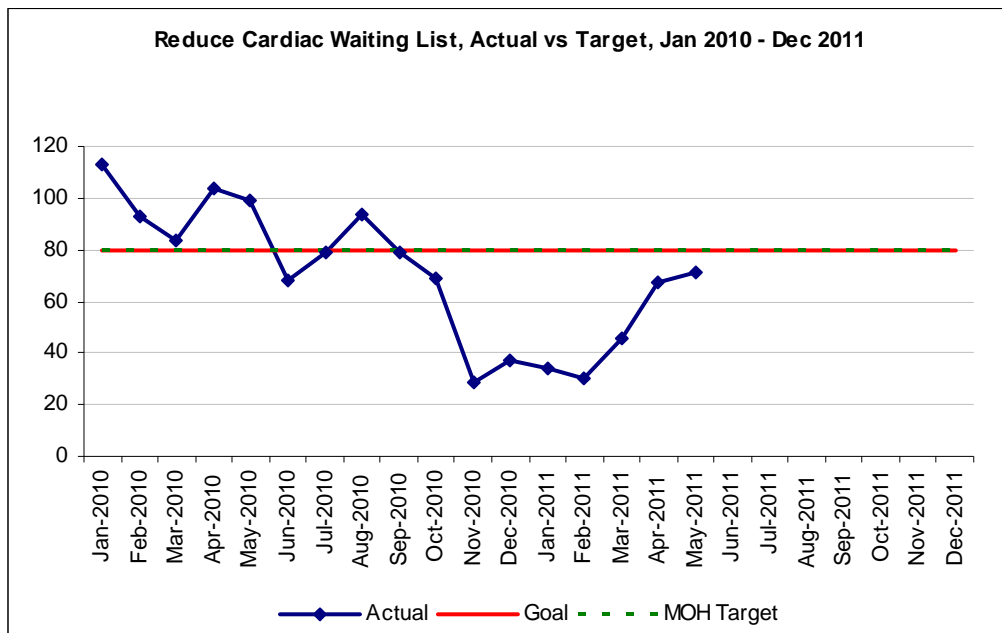
To support the national cardiac bypass intervention target, 916 bypasses should be completed in 2010/2011

Date of Delivery: 31 December 2011

Clinical Lead: Paget Milsom

Project Sponsors: Garry Smith, Fionnagh Dougan

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



## 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

## 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
- 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

## Project Risks / Comments:

There are 78 patients on the waiting list as at the end of May 2011. During May the service delivered 65 cases against a plan of 79. During this period patients have been outsourced to ensure alignment with targets. A total of 25 cases will be outsourced to Mercy during May/June. Production has been impeded by acute demand in terms of thoracic cancer patients and urgent bypass cases. The “enhanced recovery clinical pathway” is now in use in ICU and this piece of work in conjunction with the “delays to discharge project” should deliver a reduction in the LOS of patients in the CVICU. Our overall target for the year was 916 cases. We will not deliver to that level, mainly as a result of a lack of eligible patients presenting throughout the year. Our current priority is to ensure that at no time will the number of eligible patients waiting for surgery exceed 81. In order to deliver to this target we will continue to outsource to mitigate CVICU bed block which is occurring as a result of acute demand. Work continues to develop a preferred option for the sustainable delivery of an effective cardiac surgery service.

# IMPROVEMENT ACTIVITIES

## 6.1 DAP Projects Report



## 6.1 District Annual Plan Progress Report

The information set out on the attached pages covers progress for the 56 improvement activities the ADHB provider arm committed to as part of the 2010/11 District Annual plan.

All 56 projects have been started with 31% in the planning stage, 58% in implementation and 11% completed. No projects have been cancelled. All projects focus on performance improvement.

	This month	Last month	Change
Planning	17	18	-1
Implementation	33	31	2
Completed	6	7	-1
Total	56	56	1

Three projects are running behind their implementation schedule with a further 12 projects addressing potential issues with mitigation strategies in place. The exception reports cover these matters in more detail.

In terms of overall project status 64% of projects are on time, 84% on budget and 77% are expected to deliver expected outcomes. Outcome expectations are slightly lower than last month reflecting the reclassification of one project above. The changes are summarised below.

Status	This month	Last month	Change
On time	64%	63%	1%
On budget	84%	82%	2%
Expected outcome	75%	79%	-4%



# Group Pack Report

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



### Goal: 2 Performance improvement

High Level Summary - total projects: 56

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits			
			Define	Measure	Analyse	Improve	Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red	
																						Plan
2.1a Efficient and effective Primary health care	3	3	1	0	0	2	0	0	3	0	0	3	0	0	2	1	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	8	8	2	1	0	5	0	0	5	2	1	7	1	0	6	2	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	21	21	0	1	3	11	3	0	15	3	0	18	0	0	16	2	0	3	3	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	10	2	1	0	4	1	0	6	1	1	8	0	0	7	1	0	2	2	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	0	1	1	3	0	0	2	3	0	4	1	0	5	0	0	1	1	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	
<b>Total #</b>	<b>56</b>	<b>56</b>	<b>6</b>	<b>5</b>	<b>6</b>	<b>29</b>	<b>4</b>	<b>0</b>	<b>36</b>	<b>11</b>	<b>3</b>	<b>47</b>	<b>2</b>	<b>1</b>	<b>43</b>	<b>6</b>	<b>1</b>	<b>6</b>	<b>6</b>	<b>0</b>	<b>0</b>	
<b>Total %</b>			<b>11%</b>	<b>9%</b>	<b>11%</b>	<b>52%</b>	<b>7%</b>	<b>0%</b>	<b>64%</b>	<b>20%</b>	<b>5%</b>	<b>84%</b>	<b>4%</b>	<b>2%</b>	<b>77%</b>	<b>11%</b>	<b>2%</b>	<b>11%</b>	<b>11%</b>	<b>0%</b>	<b>0%</b>	

## Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Better help for smokers to quit	National	Improve				Of the 8879 events coded in May, 1265 (14.2%) of patients were identified as smokers. There was a sharp rise in the number of smokers recorded as receiving brief advice to 1025 (81%). Sustained audits and training have continued in AED and APU whose results have continued to improve. This will be maintained throughout June. Twenty-one wards attained 90% and over this month compared to 13 in April six reached 100%. Weekly results were tracked during the month and sent to all services with suggestions on how wards could improve their results. Many wards have enhanced their own internal checks to ensure the ABC is being completed ABC Communications activities were boosted to coincide with World Smokefree Day. Using the tagline "smoking is too big to ignore" a large banner was hung in the foyer of ACH and stands placed in the staff cafeteria to remind staff to document the ABC. Leaflets are in production which will be handed to patients in short stay areas to augment the brief advice message. One on one briefings are underway with the new round of House Officers and are planned for the new run of Registrars who will start in June.
Pharmaceuticals	Regional	Measure				Optimal prescribing – to improve medicines safety for patients and to improve prescribing quality of providers through a multi-faceted approach which utilises bulletins, analysis and prescriber level data through GP cell groups to encourage peer review and pressure to inform 'best practice' prescribing. By adopting 'best practice' prescribing efficiencies can be made through the quantity and type of medications prescribed and the reduction in polypharmacy in the elderly. The project was originally envisioned to save at least \$1.5million of pharmaceutical expenditure in the 2010 / 2011 financial year which would be divided equally with the project. This was a joint project with CMDHB and involves Procure and East Health Trust. The project's programme of interventions is progressing well and is gaining traction with GPs. There has been difficulty in agreeing on a methodology for calculating savings as it is a complex process which involves pharmaceutical rebates which are unknown and there are so many external factors that can impact on pharmaceutical spend. The project is on budget, ADHB has contributed \$300K to the project which is expected to be covered by the pharmaceutical savings made (once a methodology is agreed). However the target of \$1.5 million in savings may have been too ambitious as highlighted above external factors can impact and plans for reduced costs or additions to the schedule which have fallen through will have impacted on the original savings estimated. Regardless of the savings the project is improving the quality of prescribing and so is improving clinical practice and optimising community pharmacy budget.
Tamaki P2HC project	Regional	Analyse				A proposal and presentation outlining options and recommendations for implementation of the programme was tabled with MHAC in June. The proposal was endorsed by MHAC. The proposal will now require endorsement by PHAC prior to the formal business case being tabled at the Finance Committee.

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Legend: Red - , Orange - , Green -

**FEEDBACK TO BOARD**



**GENERAL BUSINESS**

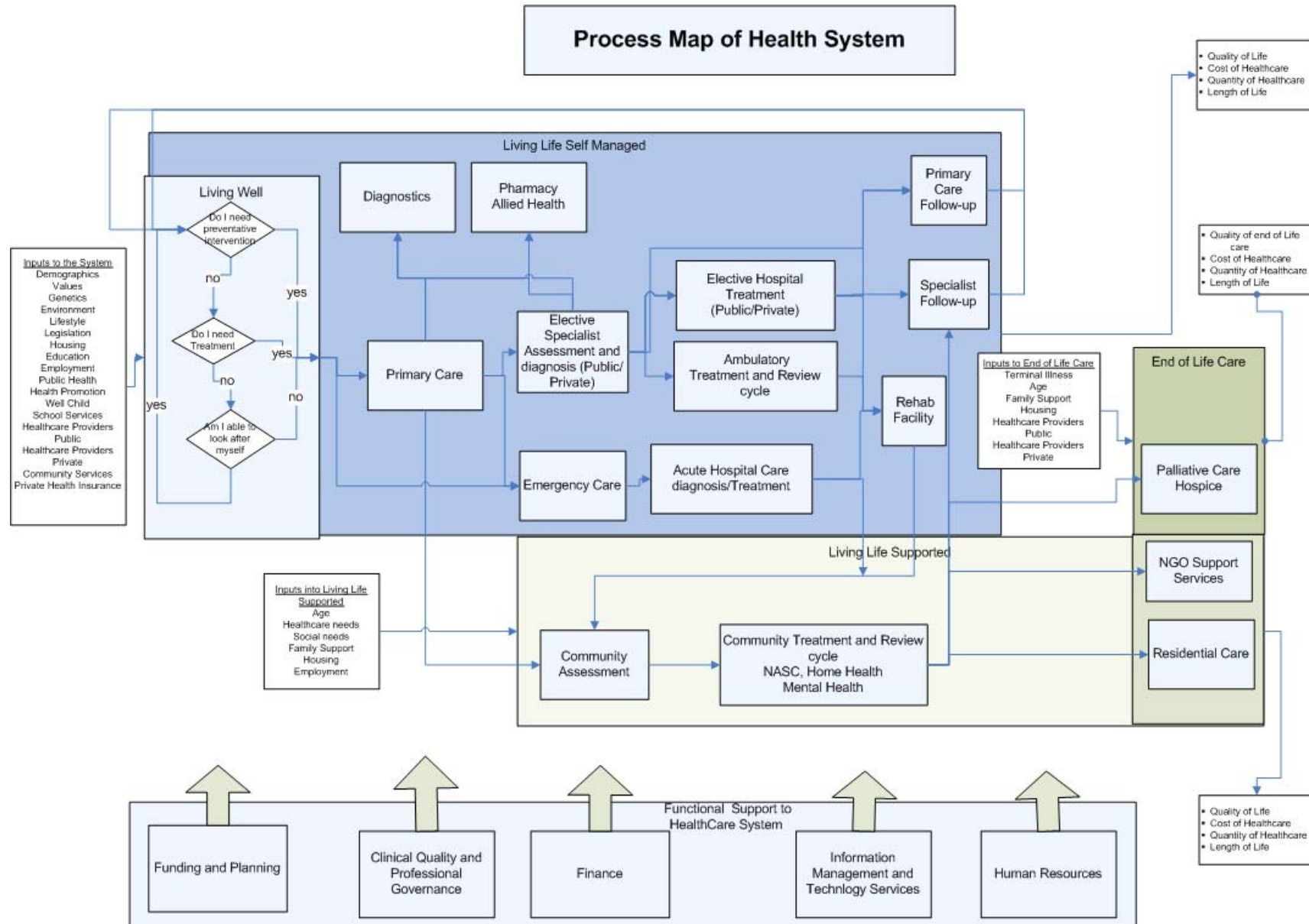


## **APPENDICES**

### **9.1 Healthcare System Diagram**



# 9.1 Healthcare System Diagram



<b>MEETING DETAILS</b>		
Time and Date	10:45am – 12:15pm, Wednesday 6 July 2011	
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital	
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, 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>
1	<b>Attendance and Apologies</b>	001
2	<b>Conflicts of Interest</b>	003
3	<b>Confirmation of Minutes</b> Wednesday 1 June 2011	013
4	<b>Action Points</b> Wednesday 1 June 2011	019
5	<b>Provider Operational Performance Report</b> 5.1 Operational Performance Report 5.2 Health Target Updates	013
6	<b>Improvement Activities</b> 6.1 DAP Projects Report	053
7	<b>Feedback to Board</b>	059
8	<b>General Business</b>	061
9	<b>Appendices</b> 9.1 Healthcare System Diagram	063
<b>NEXT MEETING</b>		
<b>Time and Date:</b> 10:45AM, Wednesday, 3 August 2011		
<b>Venue:</b> A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital		