



Auckland District Health Board
Hospital Advisory Committee Meeting

Wednesday 7 December 2011

9.30am

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

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)	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
Jo AGNEW	Professional Teaching Fellow, School of Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		9 September 2011
Peter AITKEN	Pharmacist Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	Writing, editing and public relations services Medical Council of NZ Occupational Therapy Board Northern Regional Ethics Committee	Self-employed Professional Conduct Committee member Professional Conduct Committee member Member	Fees Hourly fee Hourly fee Fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
Dr Chris CHAMBERS	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
Rob COOPER	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust Advisory	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee		
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	Waitemata District Health Board	Member			
Lee MATHIAS	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting Provider of business and professional services to midwives and other maternity services providers Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education	1 November 2011
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited		
	Pictor Limited	Shareholder, Director	Fee		
	John Seabrook Holdings Limited AuPairlink Limited	Director Governance Advisor	No fee Fee		

	NZ Council of Midwives Tamaki Transformation Transitional Board Health Promotion Establishment Board	Council member Chair Chair	Fee Fee	services contracted to the MoE. Statutory Authority	
Robyn NORTHEY	Self employed Contractor Hope Foundation	Project management, service review, planning etc. Board member	Fee Nil	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	1 November 2011
Gwen TEPANIA-PALMER	Waitemata District Health Board Manaia PHO Ngati Hine Health Trust Te Taitokerau Whanau Ora	Board member Board member Chair Committee member	Fee Fee		18 May 2011
Ian WARD	C -4 Consulting Limited NZ Blood Service	Principal/ Director Board Member	 Fee		24 August 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	Private Paediatric Surgical Practice Employee Communio NZ	Director	Joint Owner		1 June 2011
		Senior Consultant	Contractor		
	Siggins Miller, Australia Head, Auckland Clinical School, School of Medicine, University of Auckland	Senior Consultant Employee	Contractor		
	Husband: Employee University of Auckland		Salary		
	Risk and Audit Committee Whanganui District Health Board	Member	Fee		
	Pharmac Board National Health Committee	Member Chair	Fee Fee		

CONFIRMATION OF MINUTES

WEDNESDAY 2 NOVEMBER 2011

Hospital Advisory Committee Minutes



MEETING DETAILS											
Time and Date	9:30am, Wednesday, 2 November 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 9:30am.</p> <p>Committee Members</p> <table> <tr> <td>Judith Bassett (Chair)</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania Palmer</td> <td>Ian Ward</td> </tr> <tr> <td>Associate Professor Anne Kolbe</td> <td></td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Greg Balla – Director Performance and Innovation Ngaire Buchanan – General Manager Operations Taima Campbell – Executive Director of Nursing Janice Mueller – Executive Director of Allied Health, Scientific and Technical Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Jo Agnew, Peter Aitken and Rob Cooper.</p> <p><u>Moved Robyn Northey, seconded Anne Kolbe</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Judith Bassett (Chair)	Susan Buckland	Dr Chris Chambers	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania Palmer	Ian Ward	Associate Professor Anne Kolbe	
Judith Bassett (Chair)	Susan Buckland										
Dr Chris Chambers	Dr Lester Levy										
Dr Lee Mathias	Robyn Northey										
Gwen Tepania Palmer	Ian Ward										
Associate Professor Anne Kolbe											
2	CONFLICTS OF INTEREST										
	<p>There were no declarations of conflicts of interest for any item on the agenda. The Board Administrator had been notified of some changes to the Interests Register. Lee Mathias was Chair of the Health Promotion Establishment Board and Anne Kolbe advised that she was no longer Chair of the South Island Neurosurgical Services Expert Panel.</p> <p>The Chair reminded members that they were in the election period and that State Services Commission rules applied.</p>										
3	CONFIRMATION OF MINUTES 5 OCTOBER 2011										
	<p><u>Moved Anne Kolbe; seconded Ian Ward</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 5 October 2011 with the amendment to orthopaedics being negatively impacted by acutes be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

4	ACTION POINTS 5 OCTOBER 2011
	The Chair commented that there has been a great improvement in the clarity of reporting and all action points were up to date.
5.1	Operational Performance Report
	<p>There had been good performance in September and now quarterly information was flowing through. An updated Flash Report was tabled. The increase in operating costs was noted and healthAlliance was doing a review of overspend for the region in the supply chain management. The Committee asked for a report on stock holdings for the December meeting. healthAlliance and Health Benefits Ltd had raised the question of remanufacturing noting that in Australia they have their own manufacturing site operating under FDA approval.</p> <p>Outsourcing had been brought forward to allow for closing of the theatres at Christmas to upgrade for orthopaedic surgery and for Greenlane coming on stream in February. This mitigated the future risk and was part of production planning. Monthly target data was used to manage to achieve targets on a quarterly basis rather than just annually. Cardiac and Cancer services were cooperating with the private sector to have more internal and external resources available. This reduced a demand on capital and built long term relationships. Private was used if there was insufficient capacity due to changes in demand and for pressures while Greenlane is coming on stream. It would not be used if ADHB had the capacity. Planning had increased visibility for managers and the Committee noted the achievements so far.</p> <p>The cardiac waiting list was now at 92, (within the acceptable range which has a top of 94), through utilising MercyAscot to deliver the results required. The demand side continued at a new increased level for the whole region and there may have to be over-delivery to contract to keep within the waiting times target. Early signals had been given to the Board and other DHBs. This demand may reflect an older population with an increase in acuity presentations that needed surgery immediately. The previous waiting list target of 81 had been an internal target to maximise efficient production and the previous national target had been based on a volume number which had been replaced with a new target based on 10% of volume as an upper limit based on a contract of 940 procedures per annum. The aim was to get a list at about 7.5% of volume.</p> <p>While the reports showed the drive to get to target performance, there was a need to look at clinical evidence and the model of care to deliver the right treatment to the right populations. For example, when Cardiac data was analysed by ethnicity it was found that Maori and Pacific had a different kind of heart disease for which it was better to use surgery compared with using stents for the European population. Another population that needed this type of analysis was Asian and with changes in populations a 2 - 3 year planning frame may be better than 20 years. It was thought that the average age of patients in hospitals was now 10 years greater than before, which required more time per patient. The Committee was cautioned that improvements in primary care would not necessarily deal with the increased number of older people. We should not lose sight of the productivity target, but try new models and methods of care based on reliable medical evidence and use the Universities and research as a part of the relationship with the University noting that research questions are being asked and being funded. These are a potential source of help in planning future cardiac care in our region.</p> <p>WIES performance for the first quarter was above contract. POAC had received 350 referrals in September of which 87% were retained in the community. POAC information discloses ethnicity information for Maori and Pacific and by GP.</p> <p>October's elective performance was 96% and there was service by service planning. WIES was important for revenue and information on the top 3 and bottom 3 are provided to customers. But hile the WIES system was variable but there is no national move to change the system.</p> <p>Work was being done in Paediatric Cardiology on how to manage for the rest of the year noting that there was a person on sabbatical, but a locum had been obtained so the number waiting had reduced a bit. The main referrals from Northland related to oncology.</p> <p>The lagging performance at Greenlane related to the availability of medical staff and transfers of</p>

	<p>lists with a predicted discharge increase as new permanent staff are recruited.</p> <p>Overall the improvement projects were tracking well and would be updated quarterly.</p> <p>The financial performance was a surplus very close to plan for the month, but \$1.7m unfavourable year to date, of which \$1.4m is due to lower internal revenue allocation. FTE costs were favourable but the number of FTEs was unfavourable by 13 so was being monitored. Donation income was expected to be below budget in the current economic climate. The recruitment process was being reviewed as well as timing to see what variations can be tolerated by an organisation with a staff level of 7,700 through projecting staff coming on and managing at unit level looking forward. It was essential that in employment relations discussions, arrangements are made in the interest of the patient. There is some flexibility through use of annual leave and with bureau paying part hours to allow flexing down. Assistance from the Board would be focusing on planning and delivering health services in a different way, including how training of the workforce is done, in line with discussion with Colleges and educational institutions. The public were aware of the changing treatments and the dynamic movements in health.</p> <p>The Committee asked for a view of the future health system with this to be done by HSG with the HAC looking at the whole health system including models of care across the whole health continuum.</p> <p>Details on the recruitment of Maori and Pacific nurses would be brought to the next meeting as offers were still being responded to. A number of Maori midwives had applied, but they had accepted other positions.</p>
5.2	Health Target Updates
	<p>The committee noted that staff had responded splendidly to the acute flows during the Rugby World Cup which was a magnificent team effort fully supported by the Committee and the Board. The achievement would be acknowledged in the latest NOVA.</p> <p>It was suggested that the campus have notices of being smoke free, like the University. The use of social media was raised and this is being looked at to support the present letter and technology being used.</p> <p><u>Moved Gwen Tepania-Palmer; seconded Judith Bassett</u></p> <p><i>That the Operational Performance Report and Health Target Update reports be received.</i></p> <p><u>Carried</u></p>
7	GENERAL BUSINESS
	<p>General Medicine</p> <p>The Committee wished to have a report on the reorganisation of General Medicine, and asked that the new Clinical Director come to the March 2012 meeting.</p>
9.1	Resolution to Exclude the Public
	<p><u>Moved Judith Bassett; seconded Robyn Northey</u></p> <p><i>That the exclusion of the public from the relevant part of the meeting is necessary to enable the Board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) of clause 32 of Schedule 3 of the Act are established in relation to all or any part of the meeting.</i></p> <p><i>That the public be excluded from the following part of the proceedings of this meeting, namely consideration of items 9 to of the Agenda.</i></p> <p><i>The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:</i></p>

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
<p>9.1 Confidential Minutes 5 October 2011.</p> <p>9.2 Risk Register</p> <p>9.3 Quality</p> <p><u>Carried</u></p> <p>The items discussed in public exclusion were Confidential Minutes 5 October 2011, the Risk Register and Quality.</p> <p><u>Moved Judith Bassett; seconded Robyn Northey</u></p> <p><i>That the meeting presume in public.</i></p> <p><u>Carried</u></p>	<p>To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)</p>	<p>That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.</p>
NEXT MEETING		
<p>The meeting closed at 11:15am.</p> <p>The next meeting is scheduled for 9:30am, Wednesday, 7 December 2011 A+ Trust Room, Level 5 Clinical Education Centre Auckland City Hospital Grafton</p>		
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>		

ACTION POINTS

WEDNESDAY 2 NOVEMBER 2011

- 4.1 Nurse Entry to Practice Programme (NETP)
Including Maori and Pacific new graduates
- Taima Campbell**

- 4.2 Inventory Management – Greg Balla and Brent Wiseman**

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

Item	Detail	Designated	Action
Carried forward	Report from St John's data on where 80+ patients go	Ngaire Buchanan	Carried forward
5.1	The Committee asked for a report on stock holdings to the December meeting.	Greg Balla Brent Wiseman	Item 4.2
5.1	The Committee asked for a view of the future health system with this to be done by HSG with the HAC looking at the whole self health system including models of care across the whole health spectrum.	Garry Smith	March
5.1	Details on the recruitment of Maori and Pacific nurses would be brought to the meeting next month	Taima Campbell	Item 4.1
7.	The Committee wished to have a report on the reorganisation of General Medicine and the new Clinical Director would be brought to the March meeting.	Margaret Wilsher	March 2012

4.1 Nurse Entry to Practice Programme (NETP) including Maori and Pacific Graduates

Auckland District Health Board Paper

Date	27 November 2011			
To	Auckland District Health Board			
From	Taima Campbell, Executive Director of Nursing Viv Rawlings, GM Human Resources Hilda Fa'asalele, General Manager Pacific Health			
Authors	Taima Campbell, Executive Director of Nursing			
Functional Group	Nursing & Midwifery Leadership			
Subject	Nurse Entry to Practice Programme (NEtP) including Maori & Pacific new graduates			
1	Purpose To update the Board on the number of Maori & Pacific New Graduate Nurses hired in September 2011 and the number, to date, offered jobs for the January 2012 intake			
2	Recommendations			
		DAP	DSP	
	Budget			
	(a) note the processes change to new graduate nurse selection and recruitment	X		
	(b) note the target of 10 Maori or Pacific New Graduates per annum as per the ADHB annual plan	x		
3	Description of Solution (Option) <ul style="list-style-type: none"> Revision of current HR recruitment, selection and appointment processes (Appendix 1) Development of new prioritisation criteria for selection 			
4	Outcomes This paper updates and reports on our progress to meet the DAP target. The process changes reported in July 2011 were implemented for the September and January 2012 recruitment and selection process to increase the number of Maori and Pacific new graduate nurses. The following table outlines the outcomes to date.			
	Total eligible applicants/ yr	Number of Maori + Pacific applicants	Total Grads appointed	Total Maori + Pacific appointed/ yr
2008	367	10 + 9	138	3 + 3
2009	332	9 + 9	146	4 + 3
2010	365	13 + 8	112	6 + 5
Process changes introduced				
2011	508	29 + 25	102	3 + 9
(Sept 2011 only)	183	9 + 9	42	1 + 7
2012	423	26 + 23	77	9 + 3*
(Jan only)			(offered to date)	
Notes: Maori & Pacific applicants and appointments are included in the year total(s). Data for years prior to 2012 excludes mental health applicants and appointments. As at 23 November approved vacancies are still arising so this number may change up to approx mid January 2012.				

5 Analysis of results

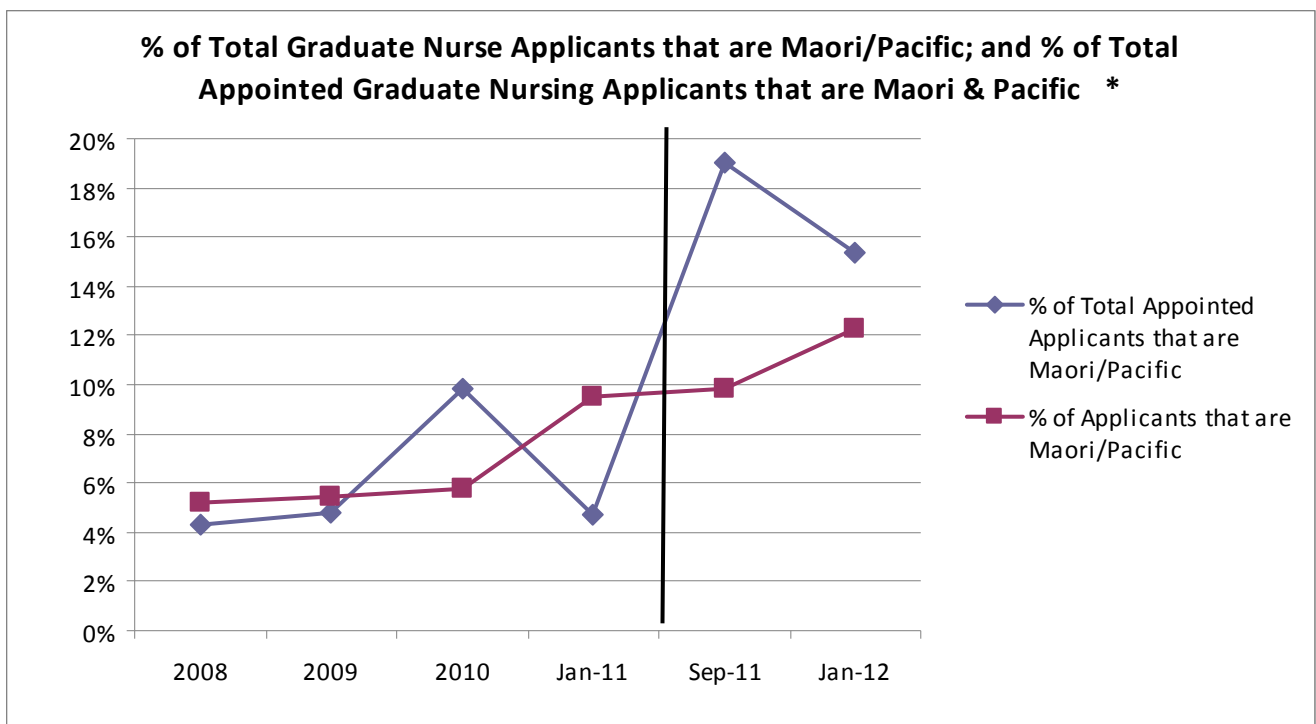
Of the 77 graduates offered roles for the January 2012 new graduate programme(s) 60 had pre registration placements within the ADHB. Of those offered for the January 2012 NETP programme one is an A+ Trust Scholarship recipient and one comes from the ADHB Rangatahi programme. Both graduates have accepted offers in DCCM.

All undergraduate applicants apply to multiple DHB's and potential employers in order to secure a job. This means that it is very likely that a candidate will have a preference closer to home if available. It should be noted that a larger number of Maori and Pacific applicants from outside of the Auckland region applied for jobs in Auckland. This is in part a reflection of the decrease in jobs in some parts of the country and the timing of new graduate recruitment and interviewing processes in other DHB's – which may be later than the agreed timeframes in the northern region. Very few candidates from outside of the Auckland region were interviewed, due in part to the significant number of local applicants who had met the category 2 priority criteria (Appendix 1)

Of the total of 49 Maori and Pacific applicants, 23 were interviewed and 14 offers made. 12 offers have been accepted so far and more interviews are pending. From the remaining applicants:

- 22 have accepted offers elsewhere (mainly closer to home or at Counties Manukau who had provided scholarships for a number of applicants). A small number have taken jobs overseas.
- 8 are still being considered for roles in primary health care, and other parts of ADHB
- 1 failed final exams and 1 candidate was rejected
- 6 are unknown and are still being followed up.

The following graph outlines the percentage of Maori and Pacific new graduate applicants and appointments. Note the line between Jan-11 and Sep-11 highlights the introduction of the revised preference process.



5 Opportunities for Improvement

The following table outlines key changes implemented for the September 2011 and January 2012 new graduate recruitment and selection process. However we know there are a number of opportunities for improvement required. These include but are not limited to:

- Increasing the number of Maori and Pacific nursing students on clinical placement in particular pre-registration placements in ADHB. A new metric will be developed for this purpose and included as a performance measure for both nursing schools and ADHB services.
- Introduction of school of nursing/ midwifery 'scorecard' to monitor performance with weighting placed on EFT's (educational fulltime equivalents) by ethnicity and qualification completion rates (graduates) to improve workforce supply.
- More frequent and timely meetings with Maori and Pacific undergraduates on career planning and clinical placement options. Feedback suggests some students were still not able to access their preferred clinical placements in ADHB.
- Monitoring of shortlisting criteria (Appendix 1) to ensure all category 1 candidates (including ADHB-sponsored graduates) are employed in ADHB.
- Better identification of candidates on scholarships from other DHB's.
- Introduction of a Fijian Indian category for self-identification to improve data on candidates who are ethnically Fijian.
- Ongoing education of hiring managers on the selection process and rationale. For example some hiring managers still stated a preference to select candidates based on academic performance.
- Data on declinations or rejections from hiring managers to provide feedback to schools and candidates and support ongoing process improvement.
- Ensuring senior nursing and midwifery leadership is consistently engaged in the process. Where this did occur, feedback from services was positive.
- All nurse/midwifery directors have a KPI for Maori and Pacific new graduate nurse and midwifery appointments by HSG. It should be noted that out of the 47 midwifery new graduates applicants, 6 were Maori and all were interviewed and offered appointments. All declined and took up posts in Counties where they had received scholarships and were eligible for the Ministry of Health voluntary bonding scheme.

Previous	Current/New	Result
Shortlisting criteria includes: <ul style="list-style-type: none"> • NZ residency • Ward/ service preference 	<ul style="list-style-type: none"> • New application questions implemented 	<ul style="list-style-type: none"> • Improved our ability to rank applicants according to prioritisation criteria as expected
Shortlisting undertaken by Hiring Manager	<ul style="list-style-type: none"> • Shortlisting based on new prioritisation criteria undertaken by NDU 	<ul style="list-style-type: none"> • Improved rigour applied to shortlisting – as expected • Decrease the time managers take to shortlist – as expected • Hiring Managers selected from first 3 categories and did not always interview Maori and Pacific applicants as a matter of priority – unexpected result
Shortlisted applicants interviewed by hiring managers	<ul style="list-style-type: none"> • Service-based panels established with Level 2 delegate; Charge Nurse representatives and cultural representative. • Standardised interview questions and note taking 	<ul style="list-style-type: none"> • Minimise the number of times an applicant is formally interviewed – as expected. • Culturally safe process – as expected • Ensure all applicants are aware of expectations of culturally safe practice – as expected

6	Options for consideration <ul style="list-style-type: none"> • Status quo: unlikely to make any significant change • Review impact and continue to improve the process to become 'business as usual'.
7	Issues and Risks for Chosen Option(s) <ul style="list-style-type: none"> • Hiring Managers perceptions of hiring applicants based on ethnicity versus merit is a risk. Increased access to undergraduate clinical placements is a key mitigation strategy along with education. • Hiring Managers potentially not being directly involved in the interview process may be a barrier. Panel membership, transparency of processes, interview notes and improvement in reference checking processes are strategies to mitigate. • Maori and Pacific nursing employee numbers in ADHB do not increase.
8	Budget Implications <ul style="list-style-type: none"> • Revision of the current process is cost neutral and uses existing resources associated with programme delivery. • There are likely to be productivity improvements associated with improved short listing; candidate selection and standardisation of interview processes for hiring managers • It could be argued that there are marginal benefits associated with the reduced cost of recruitment of graduates which could be re-invested into the recruitment of future graduates at pre-degree level or to offset the cost of scholarship/ cadetship costs.
9	Regional / National Implications <ul style="list-style-type: none"> • Regional workforce collaboration will continue to be explored.

Appendix 1:

The ADHB Recruitment and Selection policy makes the following provisions that are the basis for the changes to the current new graduate nurse recruitment and selection process:

- *Processes and decisions will reflect our commitment to fulfilling our Treaty of Waitangi obligations. ADHB acknowledges the need for greater involvement of Maori in the health sector and shall work towards ensuring greater participation and representation of Maori as employees of ADHB.*
- *In recognition of the principles of the Treaty of Waitangi and ADHB's commitment to improve health outcomes for Maori, ADHB will take measures to ensure that qualified Maori candidates are given every opportunity for employment. When appropriate, ADHB may adopt special measures to ensure Maori representation and participation at ADHB.*
- *Processes and decisions will reflect our commitment to greater involvement of Pacific people in the health sector and we shall work towards ensuring greater participation and representation of Pacific people as employees of ADHB. ADHB will take measures to ensure that qualified Pacific candidates are given every opportunity for employment. When appropriate, ADHB may adopt special measures to ensure Pacific representation and participation at ADHB.*
- *In the interests of staff development, we will seek to recruit internally where it is in the best interests of the position to do so.*

[http://adhbintranet/ADHB Policies and Procedures/Policies/ADHB Board/Staff/Recruitment&Selection.pdf](http://adhbintranet/ADHB_Policies_and_Procedures/Policies/ADHB_Board/Staff/Recruitment&Selection.pdf)

Revised recruitment and selection process

The key principles that underpin the new process include:

- *Retention of our investment:* where we have sponsored or invested in undergraduates to complete training – we want to retain these graduates and/or our staff in our workforce
- *Building work readiness:* undergraduates who have been placed in ADHB services have a better understanding of ADHB clinical systems and process and are more likely to be work ready. They have also had the benefit of ADHB nurse mentors and clinical coaches.

- *Identifying skills and attributes that will benefit our patients.* The ability to communicate in Te Reo or a Pacific language was identified as an attribute that would add value to the nursing workforce. Other communication skills & attributes include knowledge and understanding of cultural beliefs, social structures, and concepts of health; and are used as proxy for cultural connectedness.
- *Interview applicants once.* Interviewing applicants multiple times can be demoralising for potential graduates and inefficient for the organisation. Standardisation of the interview process and panel membership has the opportunity to improve the effectiveness and efficiency of this bi-annual process.
- *Application of organisational prioritisation criteria:* To enable better selection (and short listing) of applicants the following criteria have been introduced:

1. Maori and/or Pacific graduates who have undertaken clinical placements/ pre-reg placements in ADHB (or are already on our staff) and identify a service with a vacancy as their 1st or 2nd preference. Plus those who have participated in an ADHB scholarship programme.
2. Other NZ resident graduates who have undertaken clinical placements/ pre-reg placements in ADHB and identify an area with a service as their 1st preference
3. Maori and/or Pacific graduates who have undertaken clinical placements/ pre-reg placements outside of ADHB and identify a service with a vacancy as their 1st or 2nd preference.
4. Other NZ resident graduates who have undertaken clinical placements/ pre-reg placements in Auckland region and identify a service with a vacancy as their 1st preference
5. Other NZ resident graduates who have undertaken clinical placements/ pre-reg placements in

4.2 Inventory Management



Briefing Paper to Hospital Advisory Committee

Date: 7 December 2011

To: Hospital Advisory Committee

From: Greg Balla & Brent Wiseman

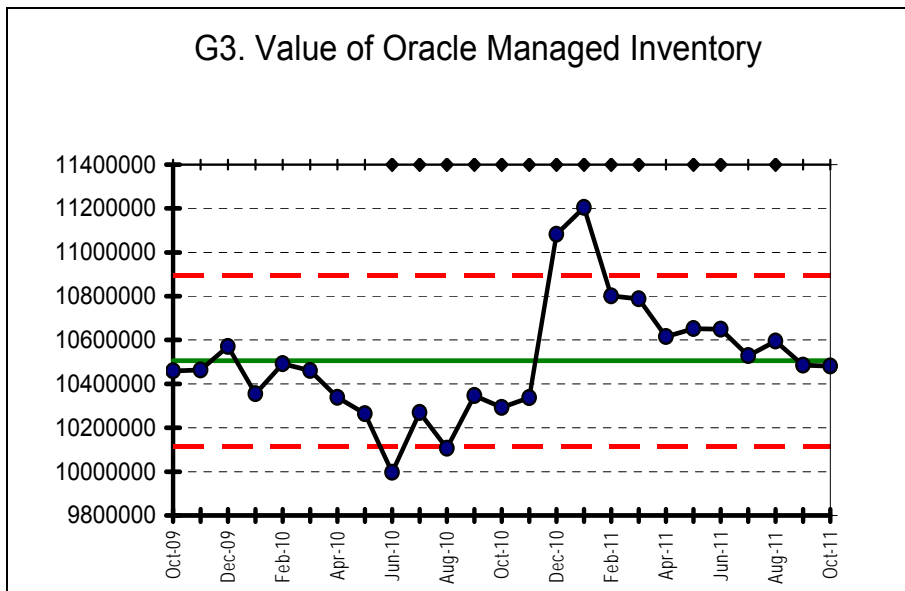
Subject: Response to Action Item re Inventory Management

INTRODUCTION

The Hospital Advisory Committee requested an update on the amount of inventory \$ we hold see the response below. We believe there are opportunities to reduce inventory and direct treatment cost and have a scoping project underway to identify these opportunities. We will bring a further paper on the improvement opportunities in March 2012.

Inventory on Hand

ADHB holds manages \$10.6 million of inventory in the Oracle system (See chart below). There are 8800 inventory items listed in oracle. There 295 stores with 30000 inventory item locations.



The back order rate is an average of 1.6 % of items.

Inventory turns = 5.5. (This means we hold approximately 2 months of usage.)

Opportunity for Improvement

We have a scoping activity underway to develop a programme of improvement. We believe there is opportunity to reduce inventory (cash flow benefit) and direct treatment cost in a range of areas including:

1. Clinical Practice (Standardisation, best practice protocols, management of new product introduction.)
2. Inventory Management. (Kanban and FIFO, Product tracking,)
3. Procurement and purchasing policy and practice.
4. Supply chain integration
5. Systems

We have already seen benefit through a range of improvement programmes.

1. Laboratory consumables reduction (Concord programme) \$ 220 K
2. Interventional radiology: Reduction in inventory \$ 150k, Reduced expired items \$144k estimate (Radiology Service Excellence)
3. Blood usage reduction (Concord Programme) \$1.6M
4. Sharp bin management \$121k

PROVIDER OPERATIONAL PERFORMANCE REPORT

5.1 Operational Performance Report

5.2 Health Target Updates

5.1 Operational Performance Report

Contents (with lead HAC attendee)

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Appendix 1 Operating Statement October 2011

1. Overview – Greg Balla

Overall Assessment

The Provider experienced a challenging month in October. While costs (operating and non operating combined) were relatively close to budget, volumes were below budgeted expectations, in turn this meant provider revenue was well below budget and this went to the bottom line resulting in a performance \$(3.5)M unfavourable to budget for the month.

Financial

Against a budgeted surplus of \$0.2M for the month of October, the provider arm reported a deficit of \$(3.3)M, unfavourable to budget by \$(3.5)M U.

Revenue was un-favourable to budget by \$(3.8)M for the month while operating costs were \$(0.2)M U and non operating costs were favourable by \$0.4M.

Against a budgeted surplus of \$5.6M for YTD October, the provider arm reported a surplus of \$0.4M, unfavourable to budget by \$(5.3)M U.

Revenue was un-favourable to budget by \$(6.0)M U YTD while operating costs were \$(1.0)M U and non operating costs were favourable by \$1.8M.

FTE numbers for the month of October were unfavourable by (33) FTE (unfavourable by \$709k). October YTD FTE were 10 favourable to budget (favourable by \$262k)

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

Volume Related Variance (cf. Plan) YTD

ADHB inpatient services were 130 wies above plan for the four months to October while for all non ADHB populations combined the variance was (230) wies below plan.

Non DRG services (all of the non inpatient services combined) are \$(2.2)M U to plan for the same period (all populations).

FTEs

As noted in Section 6.3 the Provider is now over budget on FTE numbers (33) FTE , the challenge for the Provider is to maintain service delivery within budgeted FTE. Each HSG is responsible for the management of this requirement.

Interpretation Note

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

2. Acute services performance – Margaret Wilsher

Acute discharges were lower than September (the graph on the following page illustrates the marked change for the ADHB population) and approximately the same as the same month last year. As with last financial year, acute volumes grew steadily through winter. For the four months to October, acute discharges are at a similar level to last year (reduction of 0.3%)

Acute (WIES)

DHB	Actual YTD	Variance to Plan	% of completion
ADHB	17,399	616	104%
CMDHB	4,305	72	102%
WDHB	5,825	-531	92%
NLDHB	1,781	246	116%
Other DHBs	2,357	30	101%
Total volume	31,667	434	101%

The primary care initiative to avoid acute admissions (POAC) received 325 referrals in July, 402 in August, 354 for September and 351 for October. Those cases managed without admission totaled 280 in July, 342 in August, 315 in September, and 309 in October a total of 1,245 admissions avoided. The average cost for October YTD was \$216. Without POAC these cases may have been treated in ED or admitted to hospital.

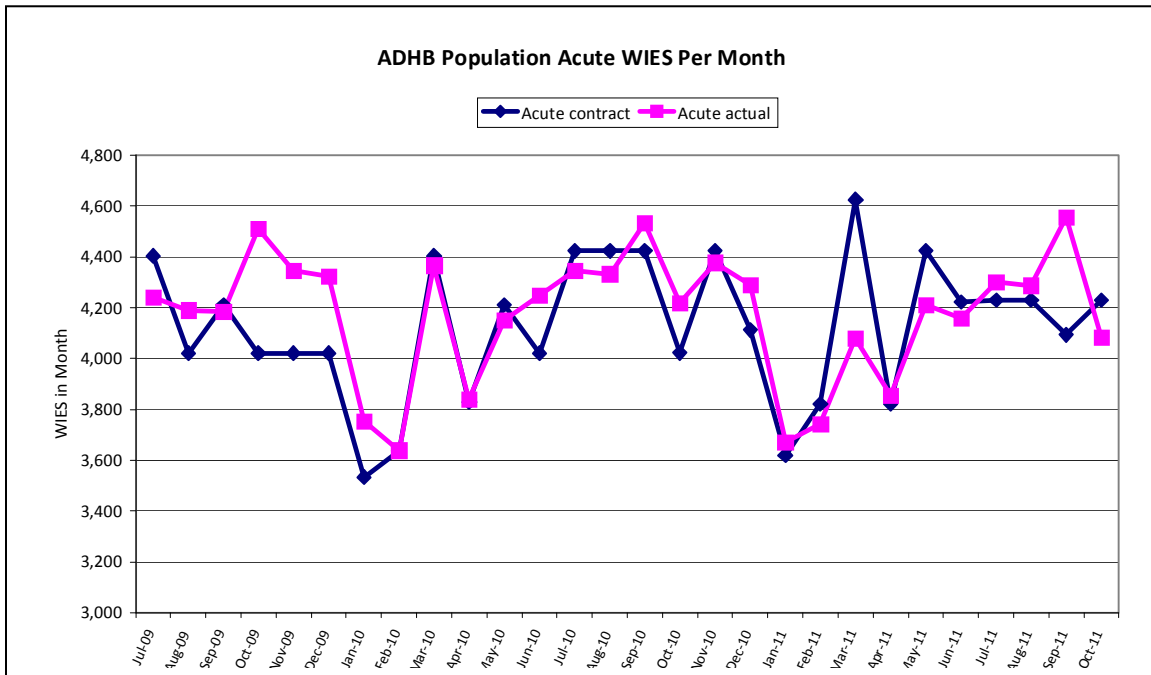
The average total cost of an attendance at ED is \$336.

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

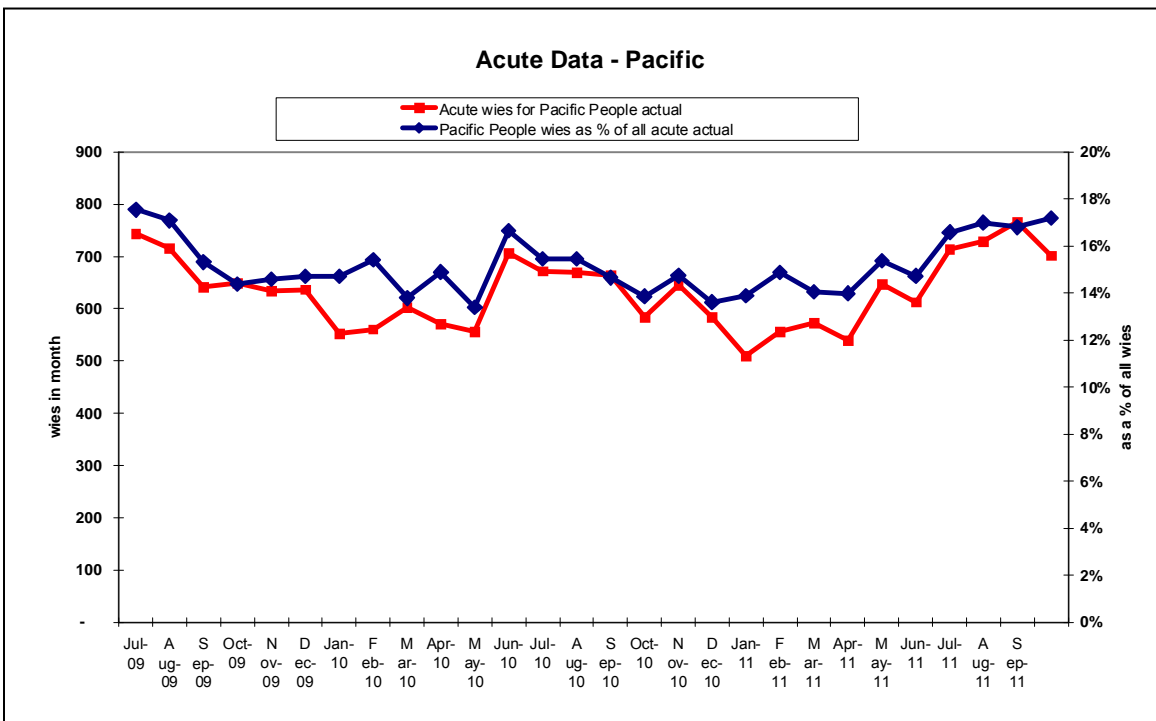
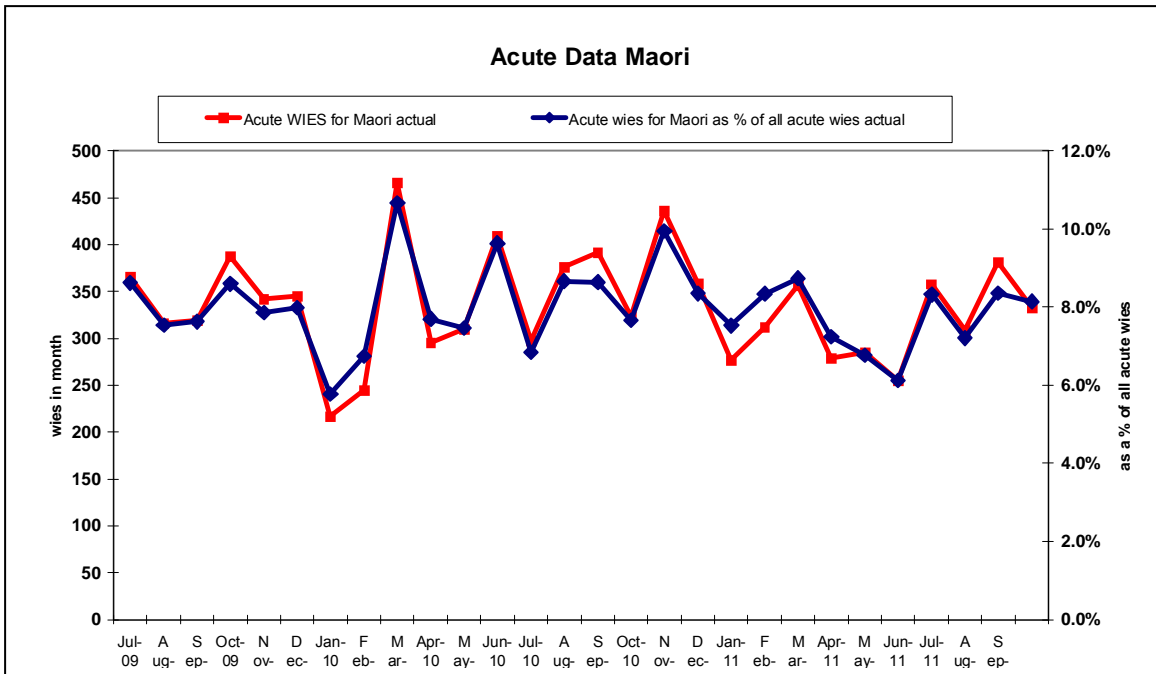
Interpretation Note

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

- Continue with existing dataset.
- Add specific indicators suggested for Maori and Pacific People.
- Consider additional data especially those related to the interface between hospital services and primary care.
- Critical to the approach will be the identification of a key contact to provide comment and context on the data to the authors of Committee reports.



ADHB acute wies are 616 ahead of plan year to date, each wies is 'worth' approximately \$4,500. Because the revenue for the ADHB population is fixed via the population based funding mechanism, the DHB does not receive more revenue for this production.



Interpretation Note

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

3. Elective services performance – Margaret Wilsher

Overall

Inpatient Performance for Northern Region DHBs for Year to Date October (in wies) was: ADHB 91%, CMDHB 87%, Northland 84%, Waitemata 104%. This reflected an overall level of elective wies production (for the “Northern Region”) of 9,438 wies against a target 10,186 (93%).

At the time of writing this report, the elective wies due to completion of further coding had increased to 9,532 (94%). The data which follows is based on the reported volumes.

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

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

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

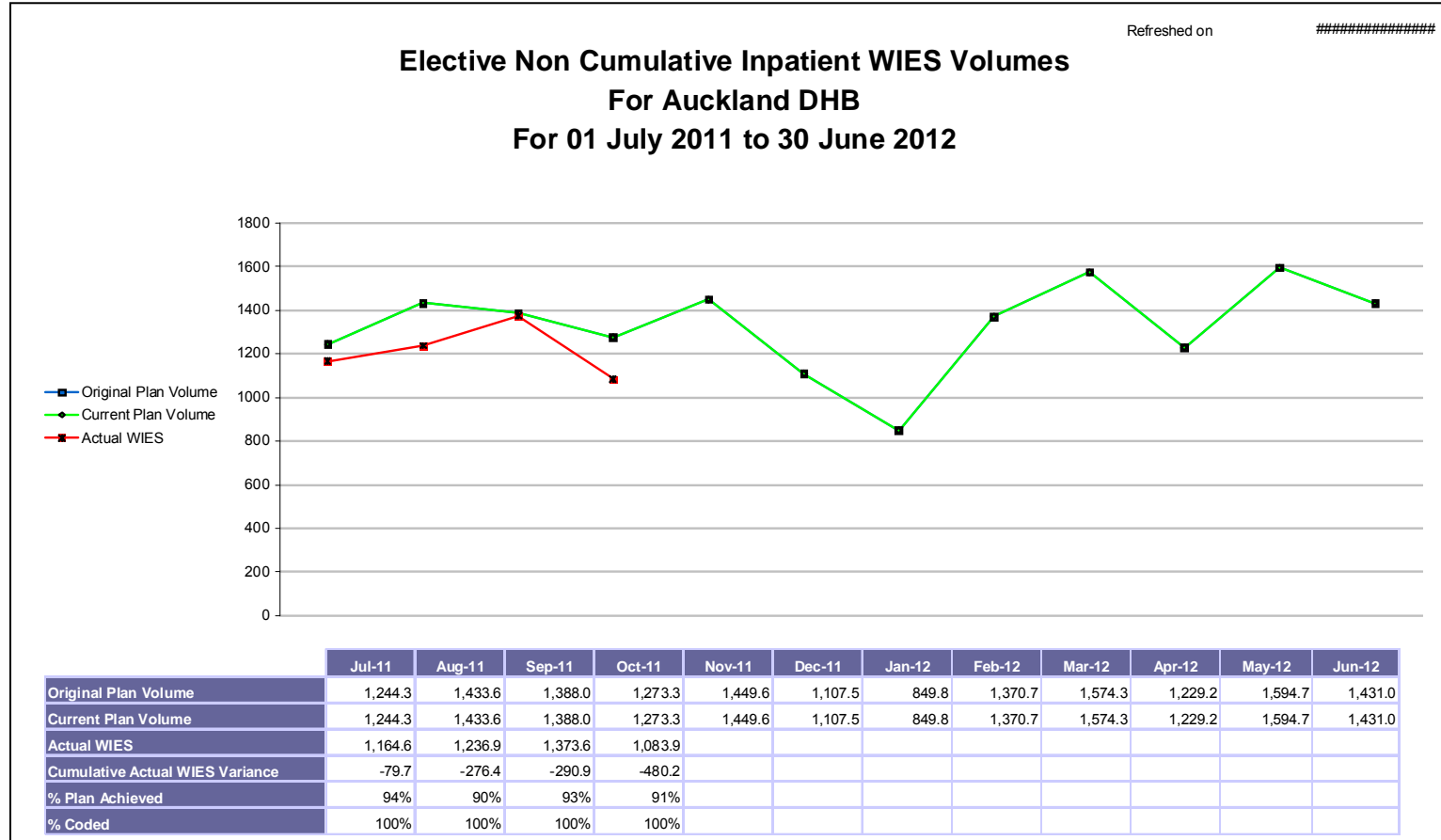
Interpretation Note: Health Target

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

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

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

Auckland DHB - WIES



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

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

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

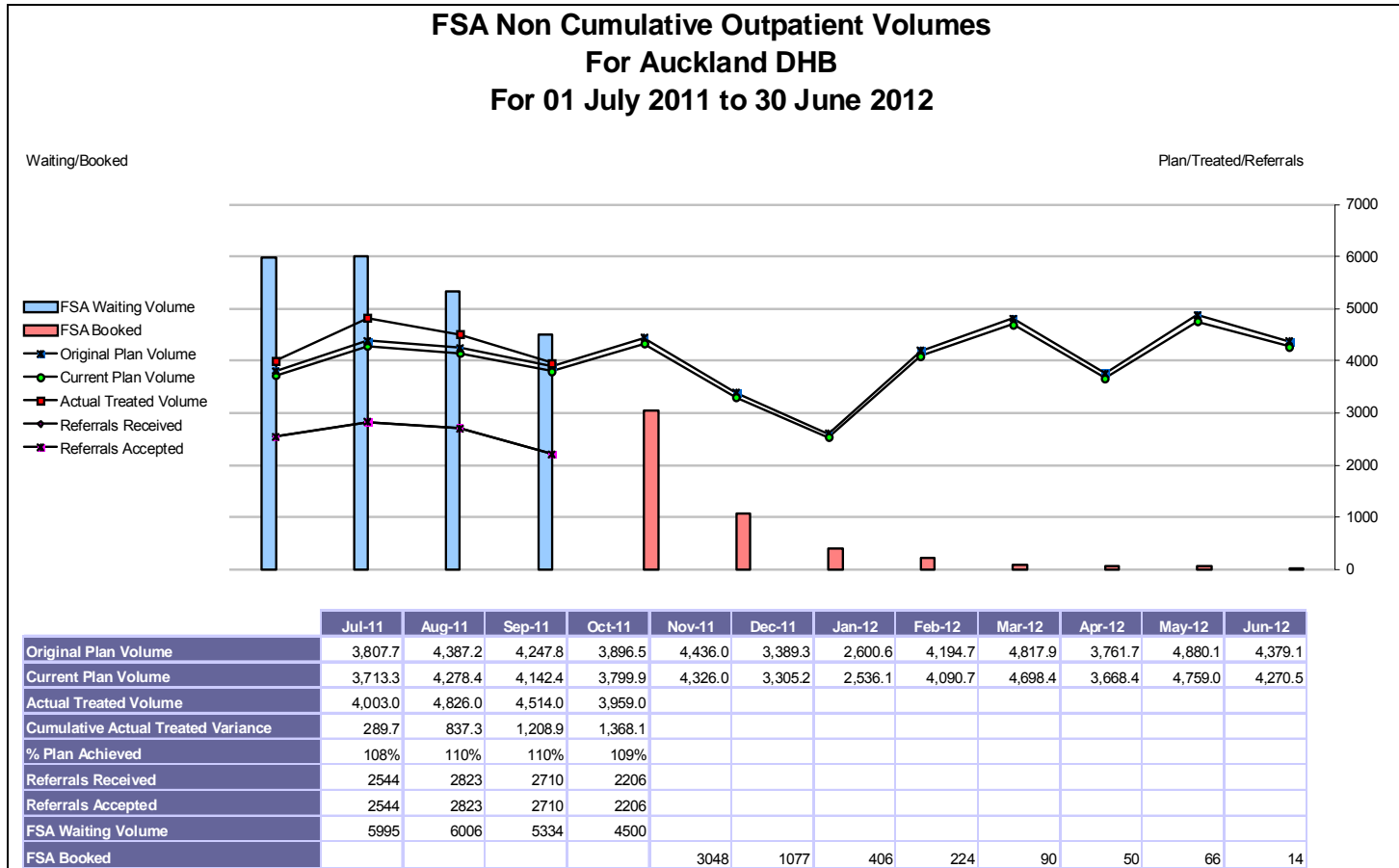
First specialist assessment performance for Northern Region DHBs

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

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

Auckland DHB - FSAs

Auckland population FSAs are ahead of target.



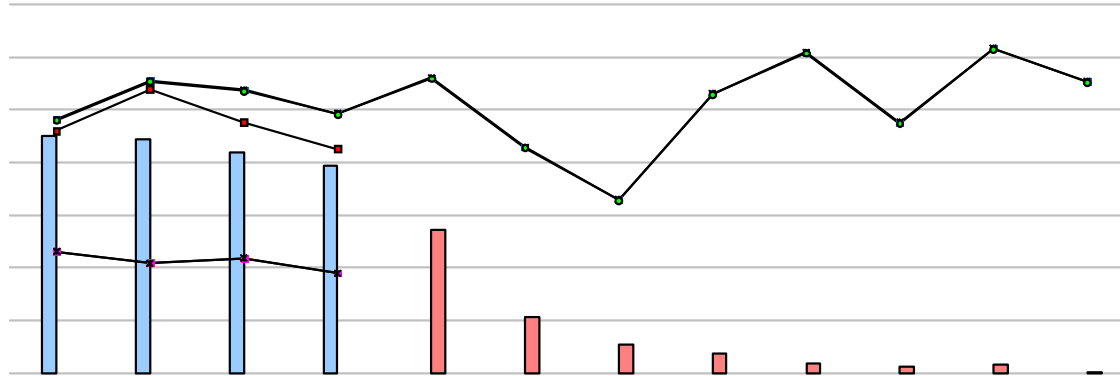
Counties Manukau DHB - FSAs

FSA Non Cumulative Outpatient Volumes
For Counties Manukau DHB
For 01 July 2011 to 30 June 2012

Waiting/Booked

Plan/Treated/Referrals

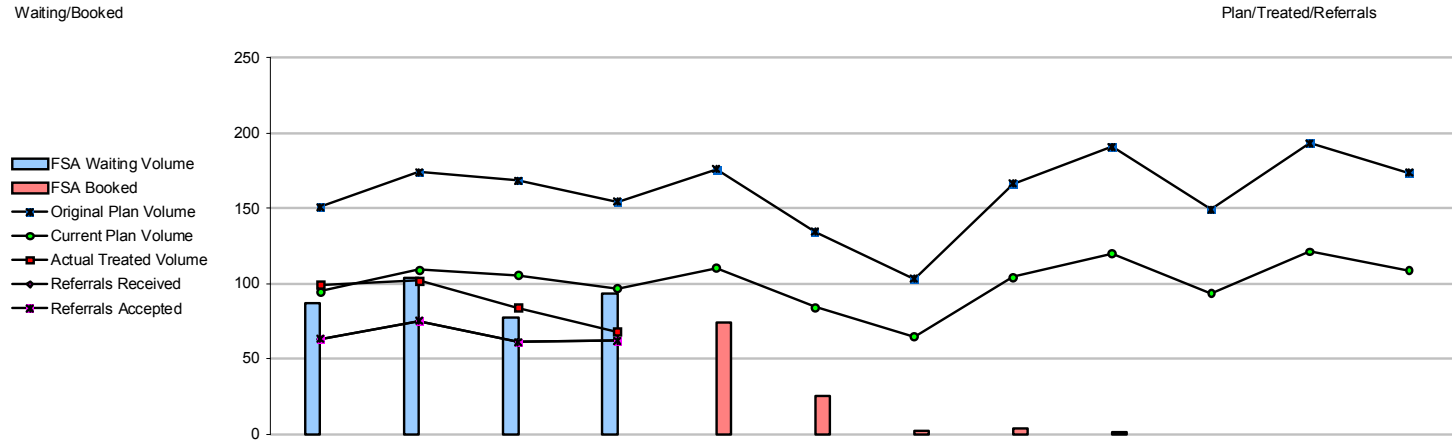
- FSA Waiting Volume
- FSA Booked
- Original Plan Volume
- Current Plan Volume
- Actual Treated Volume
- Referrals Received
- Referrals Accepted



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Original Plan Volume	962.8	1,109.3	1,074.1	985.2	1,121.7	857.0	657.6	1,060.6	1,218.2	951.1	1,233.9	1,107.3
Current Plan Volume	960.0	1,106.1	1,070.9	982.4	1,118.4	854.5	655.6	1,057.6	1,214.7	948.4	1,230.3	1,104.1
Actual Treated Volume	920.0	1,078.0	951.0	852.0								
Cumulative Actual Treated Variance	-40.0	-68.1	-188.0	-318.4								
% Plan Achieved	96%	97%	94%	92%								
Referrals Received	461	418	436	379								
Referrals Accepted	461	418	436	379								
FSA Waiting Volume	900	886	837	787								
FSA Booked					544	211	106	74	37	25	33	1

Northland DHB - FSAs

FSA Non Cumulative Outpatient Volumes
For Northland DHB
For 01 July 2011 to 30 June 2012



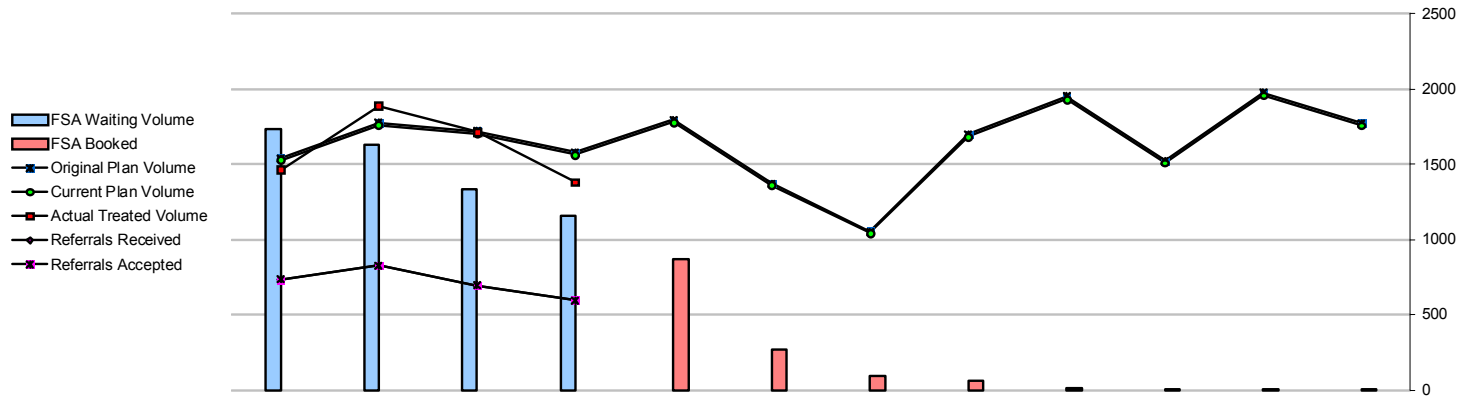
	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Original Plan Volume	150.9	173.9	168.4	154.5	175.9	134.4	103.1	166.3	191.0	149.1	193.5	173.6
Current Plan Volume	94.7	109.1	105.7	96.9	110.3	84.3	64.7	104.3	119.8	93.6	121.4	108.9
Actual Treated Volume	99.0	102.0	84.0	68.0								
Cumulative Actual Treated Variance	4.3	-2.8	-24.5	-53.4								
% Plan Achieved	105%	99%	92%	87%								
Referrals Received	63	75	61	62								
Referrals Accepted	63	75	61	62								
FSA Waiting Volume	87	104	77	93								
FSA Booked					74	25	2	4	1	0	0	0

Waitemata DHB - FSAs

FSA Non Cumulative Outpatient Volumes
For Waitemata DHB
For 01 July 2011 to 30 June 2012

Waiting/Booked

Plan/Treated/Referrals

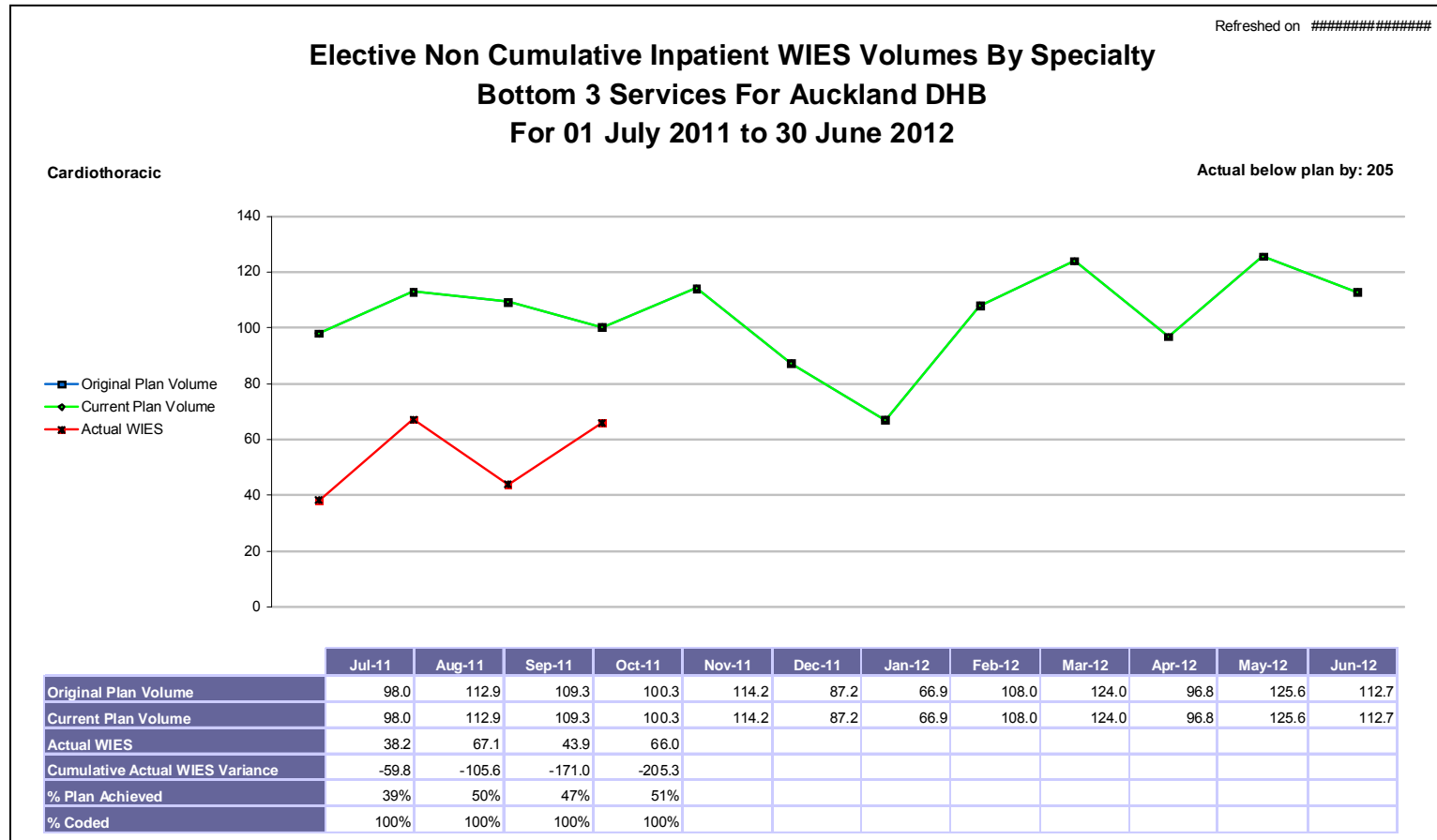


	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Original Plan Volume	1,542.3	1,777.0	1,720.6	1,578.3	1,796.8	1,372.8	1,053.4	1,699.1	1,951.5	1,523.7	1,976.7	1,773.8
Current Plan Volume	1,527.9	1,760.4	1,704.5	1,563.5	1,780.0	1,360.0	1,043.5	1,683.2	1,933.2	1,509.4	1,958.2	1,757.2
Actual Treated Volume	1,464.0	1,890.0	1,715.0	1,381.0								
Cumulative Actual Treated Variance	-63.9	65.7	76.3	-106.2								
% Plan Achieved	96%	102%	102%	98%								
Referrals Received	734	827	697	596								
Referrals Accepted	734	827	697	596								
FSA Waiting Volume	1731	1628	1336	1158								
FSA Booked					866	270	92	56	13	7	4	1

Bottom Services for Auckland Population

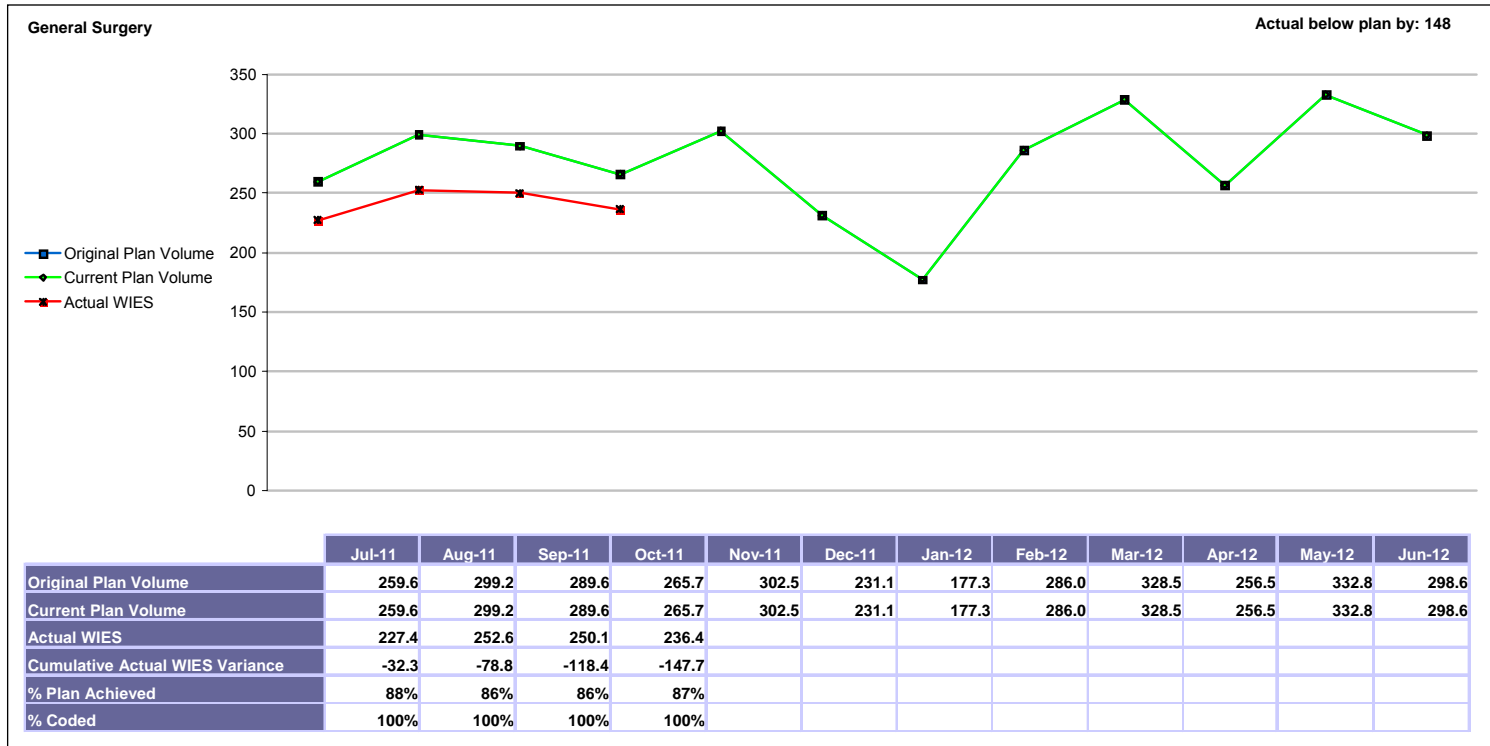
The services with the largest adverse variance after three months production are general surgery and cardiothoracic surgery.

Cardiothoracic – ADHB population



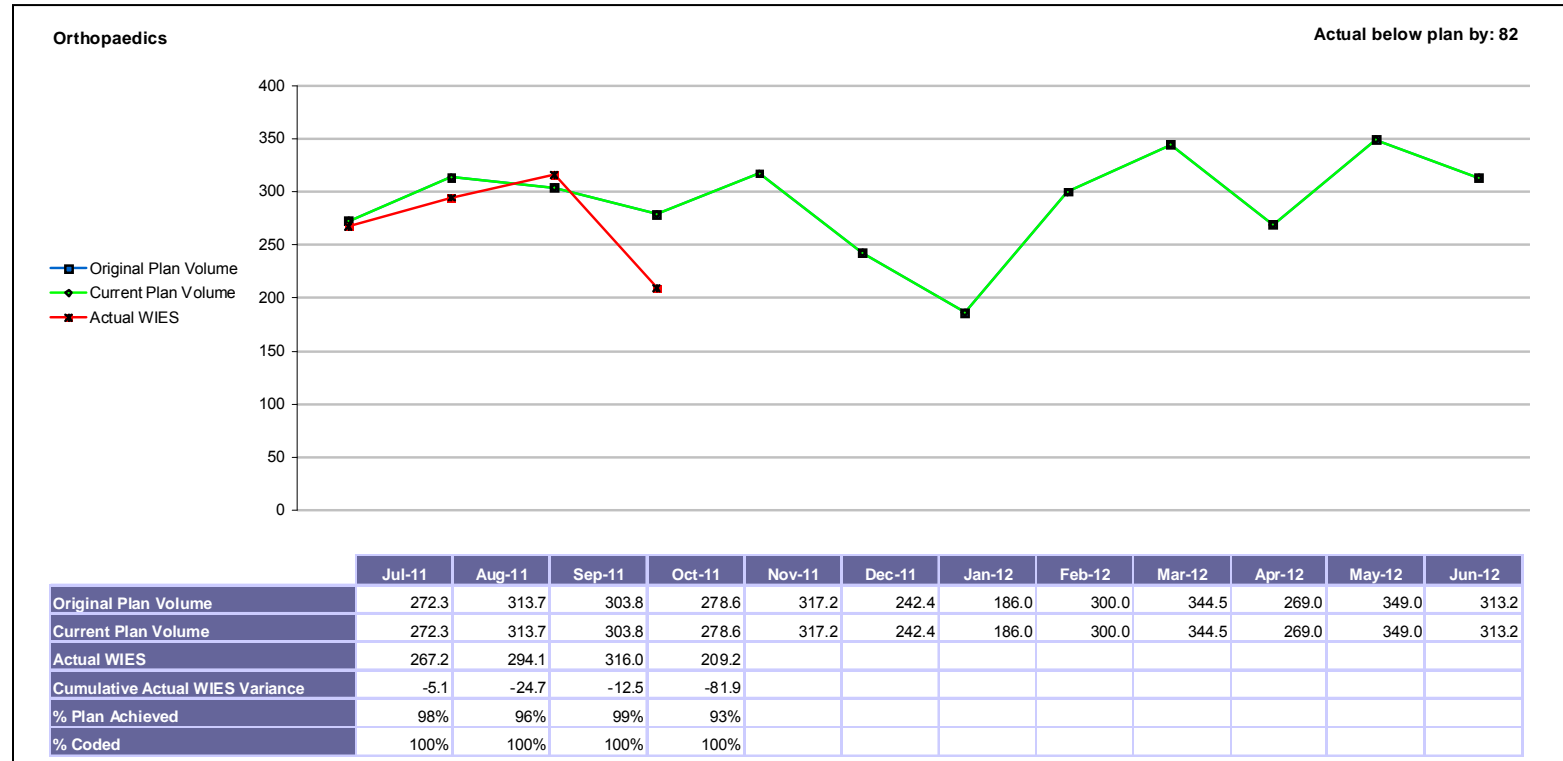
Cardiothoracic volumes were the subject of a discussion paper at the September Board meeting at which additional outsourcing and internal resourcing was approved to address this shortfall.

General Surgery – ADHB population



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

Orthopaedics



As noted in previous reports, Orthopaedics has a significant shortfall in capacity for completion of its elective contract. over the past three financial years (2008/09, 2009/10, 2010/11), Adult Orthopaedics have achieved 82%, 74% and 72% respectively of the ADHB elective contract (expressed in wies).

Production including outsourcing has been as follows:-




ADHB Population	acute actual wies	elective	acute % of contract	elective
2008/09	4,538	2,638	114%	82%
2009/10	4,878	2,510	111%	74%
2010/11	5,183	2,424	104%	72%

Also noted in previous reports have been the actions undertaken by Adult HSG and Operating Rooms to identify potential additional operating space for Orthopaedics and the potential need to incur unbudgeted outsourcing to achieve the wies target shown above (as well as the associated Orthopaedic component of the Health Target).

Elective Performance: Zero Patients Waiting Over 6 Months

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

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

ZERO WAITERS > 6 MONTHS															> 6 months		
	Green as compliant with zero or on target to meet timeframe for achieving target																
	Amber for service not achieving zero or timeline target at risk in a minor way																
	Red for services that are at high risk of not achieving zero by required timeline																
Service Timelines for Zero Patients Waiting > 6 Months	Services Plan 2011/12													Traffic Light	Clinic at date of report	Surgery at date of report	
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	No. Pts	No. Pts	No. Pts		
Gastroenterology	Clinic														0	0	
General Medicine	Clinic														0	0	
General Surgery				Clinic Surgery										19	6	13	
Infectious Diseases	Clinic														0	0	
Haematology	Clinic														1	0	
Liver Transplant			Clinic														
Neurology								Clinic							1	0	
Neurosurgery Adult									Clinic			Surgery			22	8	
Medical Oncology	Clinic														0	0	
Ophthalmology												Clinic Surgery			184	92	
ORL Adult				Surgery				Clinic							18	5	
Oral Health						Surgery									0	0	
Orthopaedics Adult												Clinic Surgery			40	23	
Renal	Clinic														1	0	
Urology	Clinic											Surgery			0	25	
Cardiology															1	32	
Cardiothoracic	Clinic Surgery														0	5	
Respiratory			Clinic												1	0	
Vascular Service	Clinic		Surgery											3	2	1	
Dermatology	Clinic														0	0	
Endocrinology						Clinic									3		
Immunology			Clinic												7	0	
Rheumatology			Clinic												1		
Tarps	Clinic														0	0	
Gynaecology General	Clinic		Surgery												18	4	14
Paed ENT						Clinic Surgery									3	0	
Paed Endocrinology	Clinic														0	0	
Gen Paeds	Clinic														0	0	
Paed Gastroenterology	Clinic														0	0	
Paed Immunology	Clinic														0	0	
Paed Infectious Diseases			Clinic												0	0	
Paed Neurology			Clinic												4	0	
Paed Neuro services	Clinic					Surgery									1	0	1
Paed Orthopaedics						Clinic			Surgery						5	17	
ACHD (S)																6	
Paed Cardiology					Clinic Surgery										19	19	
Paed CTSU					Surgery											3	
Renal-Paed			Clinic												0	0	0
Paed Respiratory			Clinic												3	0	0
Paed Rheumatology	Clinic														0	0	0
Paed Surgery						Clinic			Surgery						9	14	
															316	278	

There are some services that had target dates which have passed that have small numbers waiting (e.g. gynaecology clinics) that we are working through at a service level.

Interpretation Note – Wait time penalties

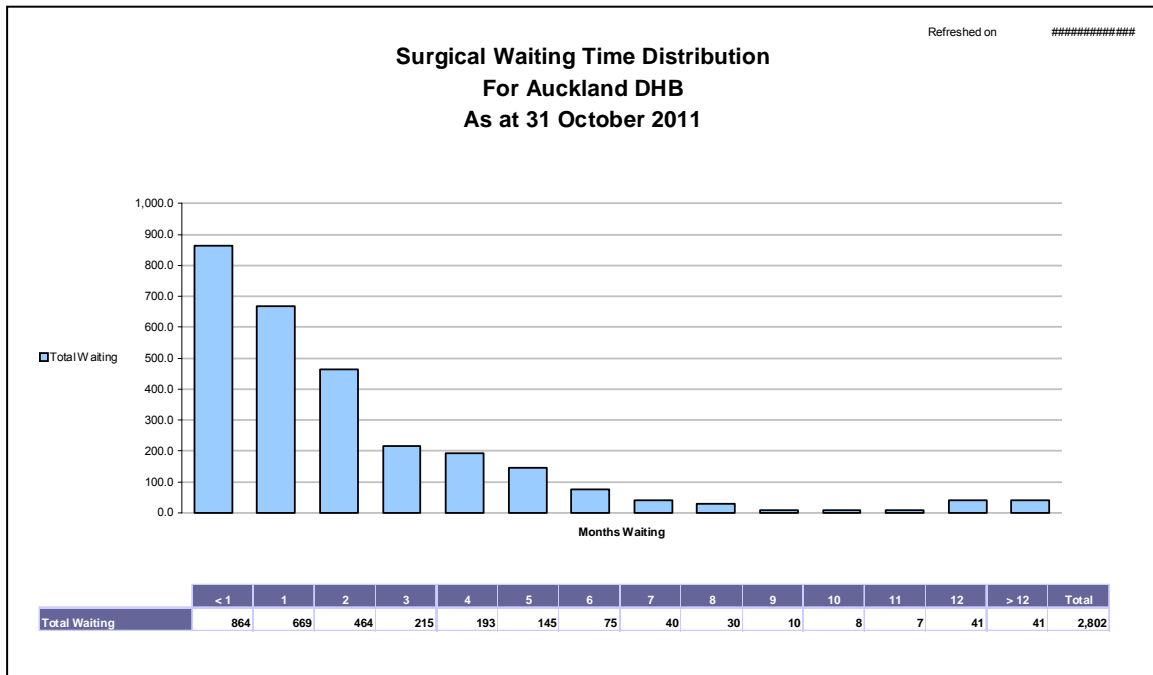
NHB has written to ADHB advising that from 1 July 2012 all patients are to be seen within 6 months and that the following estimated buffers will apply from 1 July 2012, clinics 40 patients (currently 311) and surgery 50 patients (currently 225).

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

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

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

Surgical Wait List Distribution for the ADHB Population



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

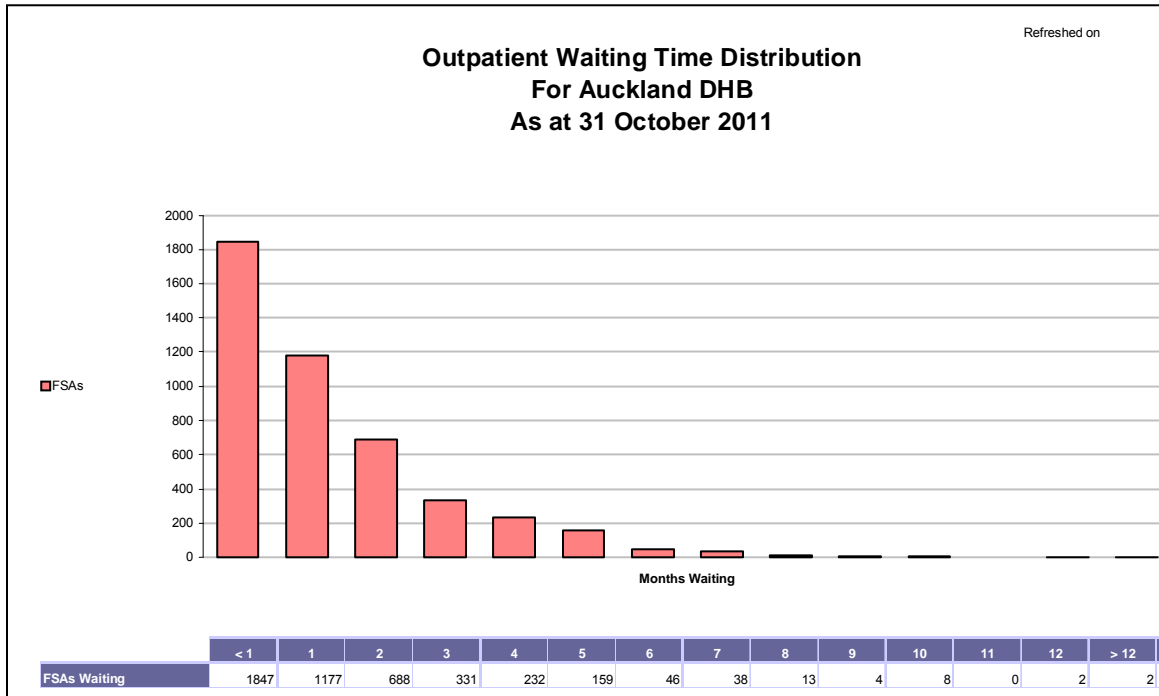
% of waiters by ethnic group (ADHB population)

% of waiters by ethnic group (ADHB population)

	1 Month	2 Month	3 Month	4 Month	5 Month	6 Month	> 6 Month
Maori	10%	9%	10%	8%	11%	10%	15%
Pacific	12%	13%	11%	15%	11%	17%	16%

A number of those waiting > six months are for staged/planned procedures.

Outpatient Wait List Distribution for the ADHB Population



% of waiters by ethnic group (ADHB population)

	1 Month	2 Month	3 Month	4 Month	5 Month	6 Month	> 6 Month
Maori	7%	7%	7%	7%	8%	8%	8%
Pacific	12%	11%	12%	12%	12%	14%	16%

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

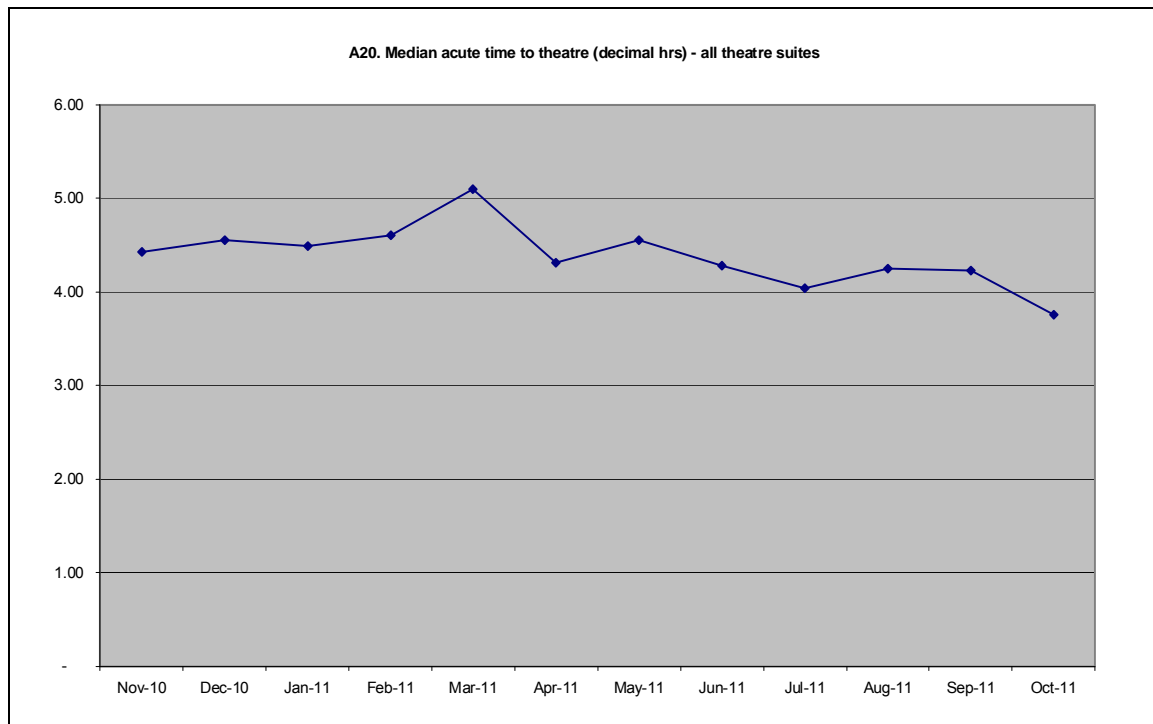
OR Performance Statistics

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

October 2011 utilisation:-

		Oct	Sept	Aug	Jul
Level 4 (cardiac, ORL)	77%	76%	81%	83%	
Level 8 (other adult)	84%	87%	82%	82%	
Level 9 (Women's health)	84%	83%	82%	82%	
Starship	74%	74%	76%	74%	
Greenlane (day stay)	82%	79%	83%	80%	

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



Source: Monthly Throughput Report and PIMs Report TH039

Interpretation Note

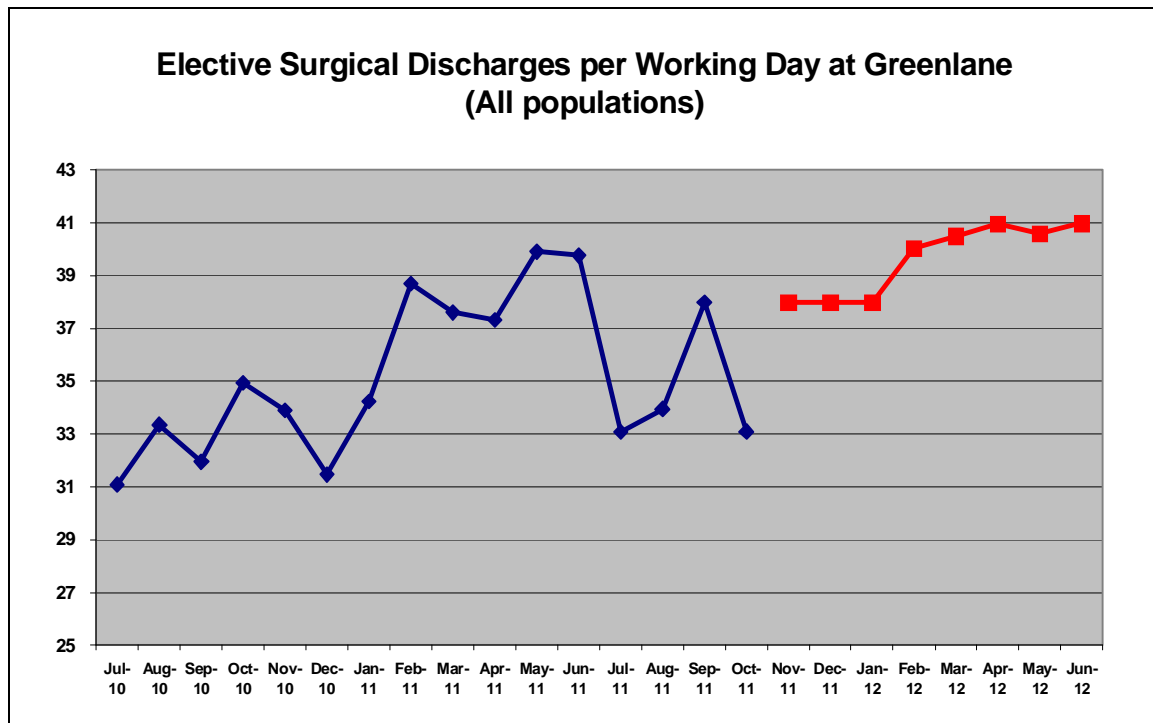
In reviewing cancellation statistics it's important to appreciate that some issues of data quality have been identified as part of The Productive Operating Theatre (TPOR) work. These issues will be systematically addressed as the project proceeds.

Production Plan

Our production plan shows a Quarter 1 performance of 101%, Q2 performance is at 95%. As with other key metrics, an update of the month in progress will be provided at the meeting. We continue to monitor elective volumes and identify and implement solutions to specific service based issues. Key to ongoing achievement is sufficient operating room access for Orthopaedics and the successful expansion of Greenlane facilities in the new calendar year to assist the paediatric services but also General Surgery within the Adult HSG.

Greenlane Surgical Unit Production

GSU elective discharge outputs (expressed as discharges per working day) have reduced from the high level at the end of the previous financial year. A key driver for the high numbers in the latter part of the year were additional lists in Ophthalmology; these lists and others required to boost production to the target line below will commence with recruitment of staff (see Section 5.3).



Numbers of elective discharges per working day dipped in October due to a reduction in paediatric cases due to surgeon annual leave and because of high numbers of ophthalmology acute cases.

4. Productivity – Greg Balla

4.1 Improvement projects

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

	Total	Started	Plan					On Time			On Budget			Finished	
			Define	Measure	Analyse	Improve	Control	Green	Orange	Red	Green	Orange	Red		
2 Performance improvement															
01. Improved services / reduced wait time: shorter stays in Emergency Department	4	4	1	1	0	2	0	3	1	0	3	1	0	0	
03. Shorter waits for cancer treatment - Radiation therapy	1	1	1	0	0	0	0	1	0	0	1	0	0	0	
07. Clinical Leadership	5	5	2	1	0	1	1	4	1	0	5	0	0	0	
08. Services Closer to Home	10	10	9	1	0	0	0	10	0	0	9	1	0	0	
14. Healthcare Excellence	32	32	22	1	4	3	1	30	2	0	31	1	0	1	
Totals	52	52	35	4	4	6	2	48	4	0	49	3	0	1	

Id	Project Name	Phase	On Time	On Budget	Expected Outcome
No Projects Flagged or with Exceptions					

4.2 Savings schedule progress

Category	Gains this month	Gains Year to date
	\$000	\$000
Direct treatment costs	664	2,241
FTE Productivity	1,283	4,523
Indirect treatment costs	379	1,471
Total gains achieved	2,326	8,235

Direct Treatment Costs (\$ 2,241 Year to Date)

The main contributors to Direct Treatment Savings YTD are Procurement savings locked in by ADHB Materials Management effective this financial year of \$844 and reduction in blood usage through a reduction in unnecessary usage of blood of \$963.

FTE Productivity (\$4,523 Year to Date)

The major contributor to this is the Releasing Time to Care Programme which is currently operating in 34 wards and is achieving an additional 5% direct patient contact time for on average 35 nurses a ward \$1,413.

Other significant contributions came from reducing stay in AED \$549 and CED \$454. Adult Service has contributed savings of \$635 YTD.

Indirect Treatment Costs (\$1,471 Year to Date)

Procurement savings from the ex ADHB Materials Management function is now reported through healthAlliance to Health Benefits with the benefit being a saving to ADHB. Year to date this amounts to \$1,471.

5. Financial Performance – Brent Wiseman

5.1 Overview

The provider arm was unfavourable to budget for month \$(3.5)M U. YTD is \$(5.3)M U.

	Actual Month \$000	Variance \$000	Actual YTD \$000	Variance \$000
Income	96,281	(3,749) U	403,765	(6,006) U
Operating Expenditure	91,896	(253) U	372,821	(1,032) U
Operating Surplus/(Deficit)	4,386	(4,001) U	30,944	(7,038) U
Non-Operating Expenditure	7,725	438 F	30,552	1,756 F
Total Surplus / (Deficit)	(3,339)	(3,563) U	392	(5,282) U

5.2 Revenue

Revenue was unfavourable to budget by \$(3.7)M U for the month, \$(6.0)M U YTD. The key variances are summarised below.

Category	Variance Month \$M	Variance YTD \$M	Explanation of major items (YTD)
MOH - Base Funding	(3.5) U	(5.0) U	ADHB volumes 1.2 F; IDF volumes (6.2) U;
MOH Sourced	0.1 F	(0.3) U	Public Health Contract below budget (0.3) U
Other Patient Care Revenue	(0.9) U	(0.9) U	Non NZ resident income (1.0) U, ACC (0.5) U offset by revenue from other DHBs (non IDF revenue).
Trust & Donation income	(0.5) U	(0.8) U	Arises from lower receipts of Starship Foundation donations. The donations to be agreed for next calendar year are expected to return this to budget.
Financial Income	0	0.3 F	Gain on the quarterly mark to market revaluation of interest rate swaps

5.3 Workforce

The tables below analyses the FTE numbers and variance both in numbers and value:

Employee Group	Actual FTE Month	Variance Month	Variance Month	Actual FTE YTD	Variance YTD	Variance YTD
	#	#	\$000's	#	#	\$000's
Medical	1,221	(49) U	(78) U	1,195	(26) U	833 F
Nursing	3,328	(41) U	(311) U	3,335	(47) U	(792) U
Technical	1,780	46 F	20 F	1,764	57 F	1,285 F
Hotel Services	233	(5) U	(60) U	230	(2) U	(115) U
Administration	1,158	62 F	71 F	1,147	73 F	889 F
Other	2	() U	4 F	2	() U	7 F
Total (excl Outsourced Staff)	7,722	13 F	(354) U	7,672	55 F	2,108 F
Outsourced staff	86	(46) U	(495) U	85	(45) U	(1,234) U
Total (incl Outsourced Staff)	7,808	(33) U	(848) U	7,758	10 F	874 F
Other Staff Related Costs			140 F			(612) U
Total Employee Costs	7,808	(33) U	(709) U	7,758	10 F	262 F

HSG / Service	Actual FTE Month	Variance Month	Variance Month	Actual FTE YTD	Variance YTD	Variance YTD
	#	#	\$000's	#	#	\$000's
Operational	6,304	(81) U	(711) U	6,254	(38) U	(1,168) U
Mental Health	728	11 F	5 F	727	12 F	445 F
Ancillary Services	776	36 F	(3) U	777	36 F	985 F
Total Employee Costs	7,808	(33) U	(709) U	7,758	9 F	262 F

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

FTEs are, however, above budget for the month at (33)U. Of these additional 33 FTE, 18 relate to a payroll calculation re backpay for SMO job sizing payments. The balance are consistent with the increase which was incurred last month and which is being actively managed by the Level 2 HSG managers.

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

5.4 Clinical Services Outsourcing Costs

Outsourcing costs were \$(0.7)M U for the month. YTD is \$(2.4)M U.

Outsourcing activity continues to be bought forward in order to continue to achieve ADHB population elective discharge targets. The key areas of higher expenditure against budget are in Orthopaedics, Cardiothoracic, General Surgery and Paediatric ORL. The higher level of activity has enabled us to meet the first quarter targets, but we now need to ensure we meet balance of year targets with a lower level of outsourcing than in the first quarter. This is being worked through at a detailed level within the POP production plans.

5.5 Direct Treatment Costs

Direct treatment costs remain close to budget at \$0.9M F for the month and \$1.3M F YTD.

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

Category	Variance YTD \$M	Explanation of major items YTD
Drugs	3.5 F	<p>Cancer & Blood \$2.5m F - lower demand for Haemophilia blood products \$0.66m F, together with lower demand for PCT drugs \$0.3m F (both offset by lower revenue). The remaining \$1.5m F relates the the revised production plan together with repatriation of services to Northland from 1 July.</p> <p>Adult - \$0.7m F reflects a combination of savings achieved in the Concord "Blood is a Gift" project, as well as total inpatient volumes being below plan YTD.</p> <p>Child Health – \$0.2m F across most drug categories. This reflects the different mix of patients compared with the average last year.</p> <p>ORA - \$0.3m F also across most categories. Also a reflection of patient mix to date</p>
Clinical Supplies	(1.6) U	<p>Volume related costs spread across the provider driven by activity in Perioperative Services \$(0.6)M U, Research related \$(0.3)M U and Cardiac Services \$(0.3)M U. While total Provider Arm volumes are behind plan for YTD, the mix of volumes has resulted in unfavourable variances in renal haemodialysis and OR where volumes are ahead of budget.</p>
Patient Appliances	(0.7) U	<p>Volume related costs in Cardiothoracic \$(0.3)M U related to elective throughput. \$(0.3)M U related to Paed elective activity - Neurosurgery 165% of plan and Orthopaedics 140% of plan. These are contributing to maintaining the ADHB elective position overall favourable to plan. \$(0.2)m U for Paediatric Cardiac re costs for a wide range of implants eg Melody valves, ICDs, Pacemakers, Hancock valves</p>

6. Inter-District Flows – Ngaire Buchanan

The ADHB provider undertakes approximately half its workload for other DHBs. This work is known as Inter-District Flows (IDF) and is paid for by the other DHBs.

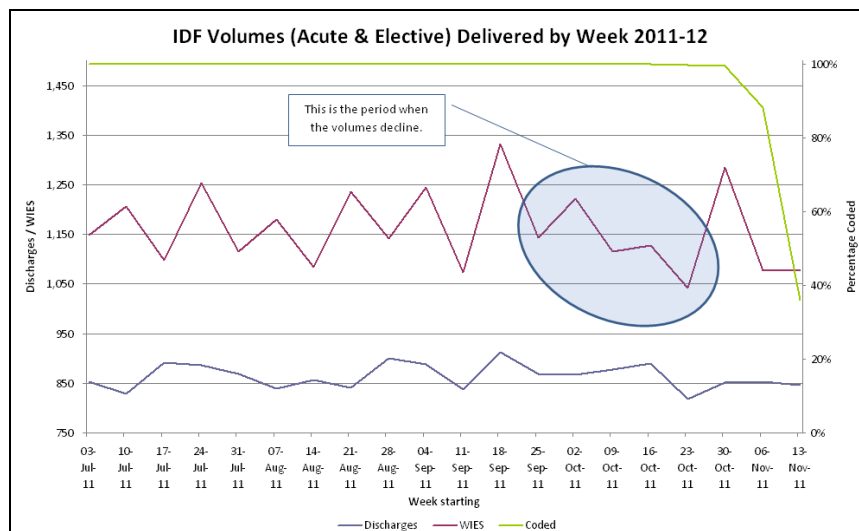
Inpatient work is paid on the basis of the wies generated by the work multiplied by the wies price, an indicative volume figure is agreed at the start of each financial year for inpatient work. If this figure is exceeded the referring DHB pays the value of the additional work. If this indicative figure is not reached i.e. the workload is less than the indicative figure, ADHB will receive less revenue than anticipated. This process is known as a “wash-up”.

In theory, a variance from plan for ADHB should mean an equal and opposite variance in the referring DHB – e.g. if the referring DHB has referred more say infectious diseases wies to the ADHB Provider, ADHB revenue will be above budget and the other DHB's costs will be higher than budget, and vice versa.

The IDF position presented below is based on updated volumes for YTD October i.e. they may differ from the reported volumes for that period.

IDF Weekly Volume Activity

The following graph shows the weekly IDF volumes and the unusual volumes behaviour that developed in the weeks commencing 9th to 23rd October before returning to a more normal behaviour the following week. The other major activity happening during this period was the Rugby World Cup and associated rescheduled school holidays. One hypothesis is that the resident Auckland population may have reduced during this period to make way for the non-resident rugby supporters.



IDF Position at the end of October 2011

The IDF position presented below is based on updated volumes for YTD October i.e. they may differ from the reported volumes for that period.

	Plan	Actual	Variance
Acute WIES	14,450	14,217	(233)
Elective WIES	6,071	6,118	47
Total WIES	20,521	20,335	(186)

The financial exposure for WIES services is therefore $(186) * \$4,567 = \$(849)k$

The wies variance by DHB is as follows:-

	Plan	Actual	Variance
Bay Of Plenty	437	480	42
Canterbury	266	270	4
Capital and Coast	221	260	39
Counties Manukau	6,072	5,912	(161)
Hawke's Bay	429	566	137
Hutt	93	121	28
Lakes	203	219	16
MidCentral	281	215	(66)
Nelson Marlborough	94	140	46
Northland	2,304	2,425	121
South Canterbury	39	42	3
Tairāwhiti	120	125	5
Taranaki	294	246	(48)
Waikato	717	750	33
Wairarapa	65	41	(24)
Waitemata	8,594	8,171	(423)
West Coast	12	29	17
Whanganui	92	73	(19)
Southern	187	250	63
	20,521	20,335	(186)

The table above illustrates why our customer based reporting tends to focus on Waitemata, Counties and Northland DHBs.

The IDF wies variance by HSG is as follows:-

**HealthServicesGroup
(HSG)**

	Plan	Actual	Variance
Adult Health Service	6,474	6,148	(326)
Cardiac Service	5,200	5,056	(145)
Children's Health Service	6,494	6,619	125
Cancer & Blood Service	1,174	1,260	86
Women's Health Service	1,179	1,252	73
	20,521	20,335	(186)

Analysis

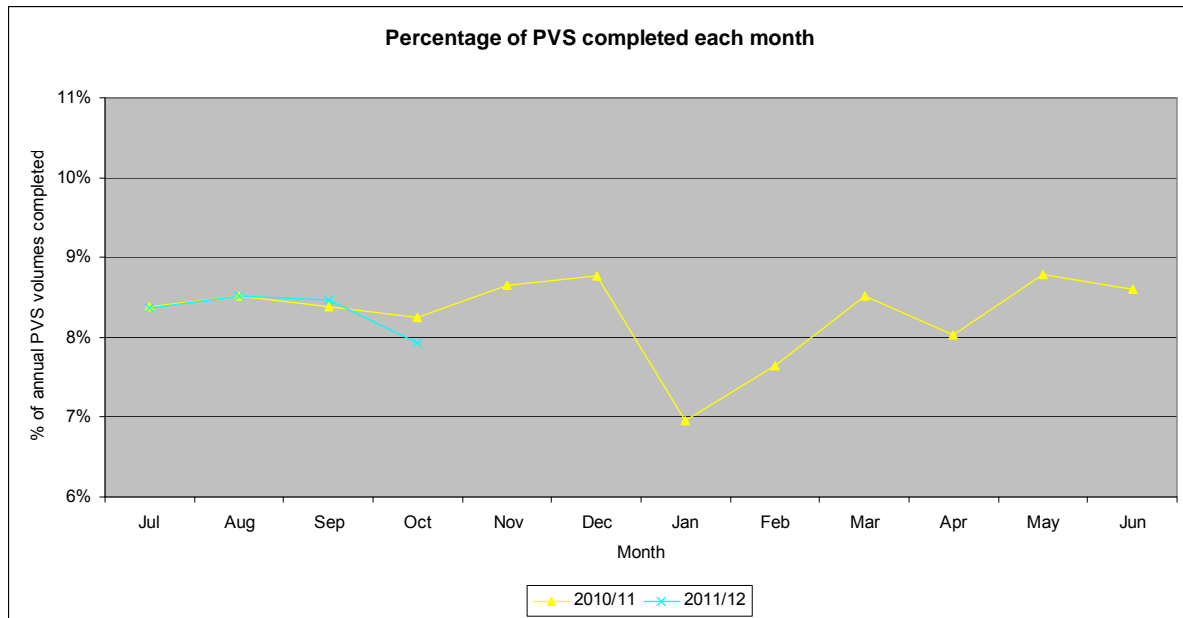
In terms of overall DRG inpatient activity the following table provides a contextual overview:

DRG Delivery Context		
	2010/11	2011/12
Annual Planned WEISS	60,297	61,130
YTD Oct Planned WEISS	20,677	20,521
YTD Oct Planned %	34.3%	33.6%
YTD Oct Actual WEISS	20,218	20,335
YTD Oct Actual %	33.5%	33.3%
Variance to Plan YTD Oct CWD	-	186
Percentage of YTD CWD volumes		-0.9%

In terms of year to date weis, the 186 lower volumes represent 0.9% of total October year to date volumes. The planned percentage of annual volumes (at 33.6%) is similar to the actual percentage of total volumes undertaken by October in the prior year (at 33.5%). And actual volumes at 20,335 WEISS are higher than the prior ytd actual 20,218 weis because of the plan to do more volumes in total this year.

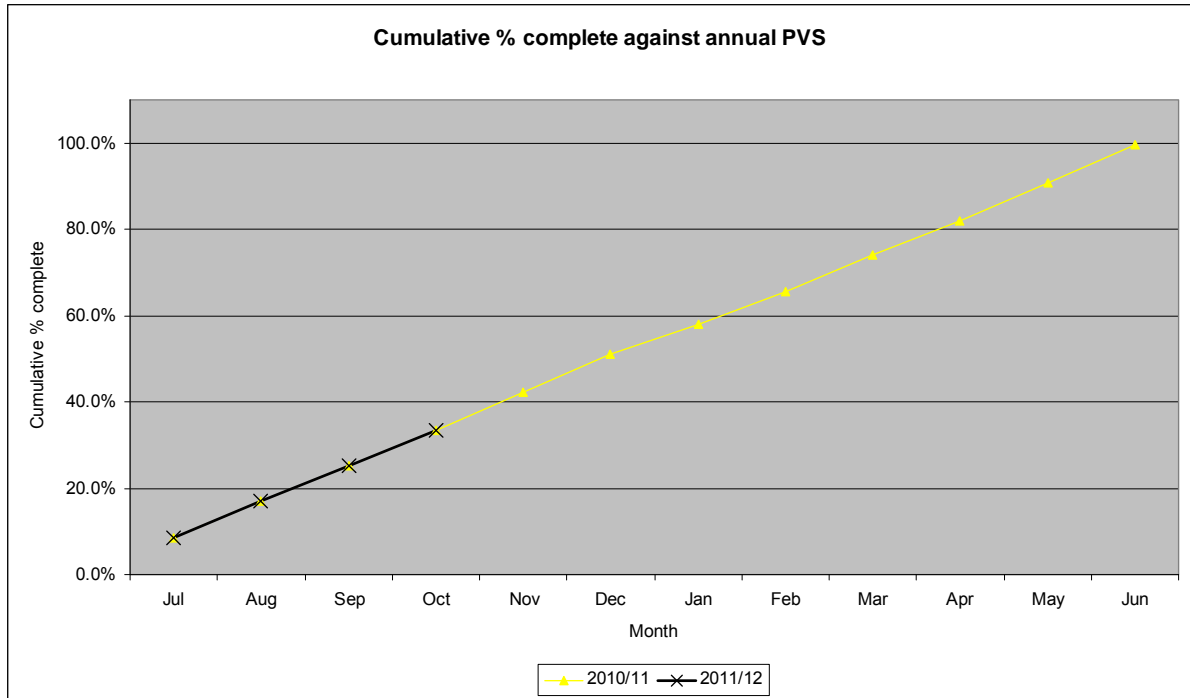
The feature of October was that the month volumes reduced by 246 weis such that the YTD favourable variance changed into a ytd unfavourable variance.

The monthly trend in the percentage completed is shown in the following graph which illustrates the change in activity that occurred in the October month:



The above graph also illustrates the future and far greater significance of the volume movements that occur during the January to February holiday period.

On the October year to date cumulative graph below, with approximately one third of volumes expected to be completed, the October month variation is not noticeable:



With the relatively small year to date percentage variation and the large changes in activity levels that occur during January and February, forecasting the year-end position is sensitive to relatively small percentage variations. A +/- 1% variation by year-end equates to +/- 611 weis which is +/- \$2.8 million.

Noting the above sensitivity, the current forecast position of each HSG for year end for inpatient services is as follows:

Adult	(150) weis below plan at year end.
Cardiac	NIL variance by year end.
Children's	100 weis above plan by year end
Cancer & Blood	NIL variance by year end.
Women's Health	NIL variance by year end

The Children's HSG has the most significant forecast range as paediatrics is particularly subject to long stay complex cases with resulting high weis. For example, there is currently one child referred from another DHB who has been a patient since January 2010 and the WEISS position would change significantly upon this patients discharge. For ADHB. 7 of the 14 undischarged long stay (>60 days) patients are IDF patients and three of the top five patients are within paediatric services. Accordingly, the Children's HSG forecast ranges from 200 below plan to 100 over plan.

HSG's are aware that any loss of revenue which results from an adverse variance on IDF activity will need to be mitigated through reduced costs within the service (or HSG collectively).

Appendix 1 Provider Operating Statement October 2011 and YTD

\$000s	October			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<u>Income</u>						
ADHB Funder Sourced	83,613	87,166	(3,552) U	351,268	356,221	(4,953) U
MoH Sourced (Incl CTA)	4,161	3,929	233 F	16,430	16,461	(30) U
Other Income	7,541	8,024	(483) U	31,794	32,578	(784) U
Trust & Donation Income	370	319	51 F	697	1,276	(579) U
Financial Income	596	593	3 F	3,576	3,236	341 F
	96,281	100,030	(3,749) U	403,765	409,771	(6,006) U
<u>Expenditure</u>						
Employee Costs	59,072	58,858	(214) U	237,962	239,458	1,496 F
Outsourced Staff	4,231	3,736	(495) U	16,277	15,043	(1,234) U
Outsourced Clinical Services	3,017	2,331	(686) U	12,046	9,636	(2,409) U
Treatment Costs - Direct	16,565	17,481	916 F	69,462	70,764	1,302 F
Treatment Costs - Indirect	3,486	3,532	47 F	14,425	14,110	(315) U
Other Costs	5,526	5,705	179 F	22,649	22,777	128 F
Total Operating Expenditure	91,896	91,643	(253) U	372,821	371,789	(1,032) U
Operating Contribution	4,386	8,387	(4,001) U	30,944	37,983	(7,038) U
Depreciation, Interest & Capital Charge	7,725	8,163	438 F	30,552	32,309	1,756 F
Net Surplus / (Deficit)	-3,339	224	(3,563) U	392	5,674	(5,282) U

5.2 Health Target Updates







The Health targets areas applicable to the provider arm are set out in the table below. Four of the six measures have been met.




Acute patient flow management is a focus in all departments, and both Adult and Child achieved the target of 95%.

There was an overall 1% improvement for 'better help for smokers to quit'. A number of initiatives have been put in place to raise performance, these include Best Practice Guidelines, and improved data collect and coach of AED and APU staff.

Cardiac bypass surgery meets the target this month. Outsourcing has continued and a plan is in place to reduce the impact of reduce patient flow through CVICU may have on bypass surgery throughput in the coming months.

Radiotherapy continues to meet the target of 100% having now delivered to target for 553 consecutive days

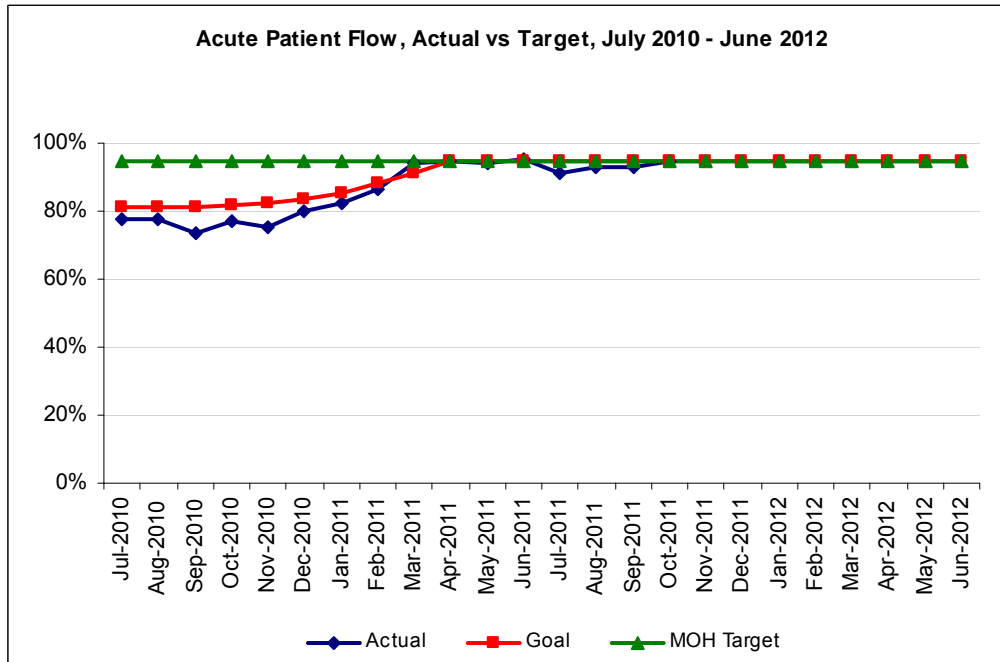
	Status	Comment
Adult acute patient flow		95% achieved against 95% target.
Child acute patient flow		95% achieved against 95% target.
Improved access to elective surgery		94% achieved against 100% target 99% YTD
Shorter waits for radiation therapy		100% of eligible patients treated.
Better help for smokers to quit		82% achieved against 95% target
Cardiac bypass surgery		Patients waiting 92 against a target of 94

Key to symbols	Proceeding to plan	
	Issues being addressed	
	Target unlikely to be met	

Project:

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

Date of Delivery: 30 June 2012



Project Risks / Comments:

95% of patients admitted, discharged or transferred from Emergency Department within six hours in October.

Actions continue to be taken across Adult and Children's service to respond to constraints impacting on flow and to sustain current level of performance.

Project: Adult Acute Patient Flow

83

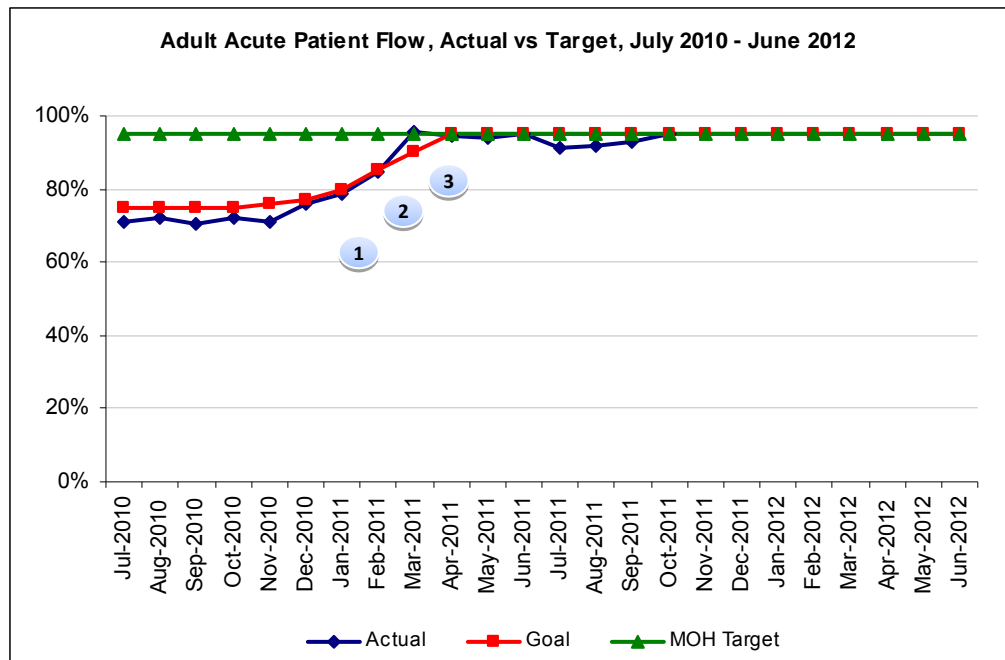
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2012

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



Project Risks / Comments:

95% of patients admitted, discharged or transferred from Adult Emergency Department within six hours in October.

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

Measures underway to address these concerns include:

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

Workshop review of 3 hour strategies to identify further improvement opportunities

Implement Gen med redesign

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

Review clinical documentation in ED to reduce duplication.

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.

Project: Children's Acute Patient Flow

84

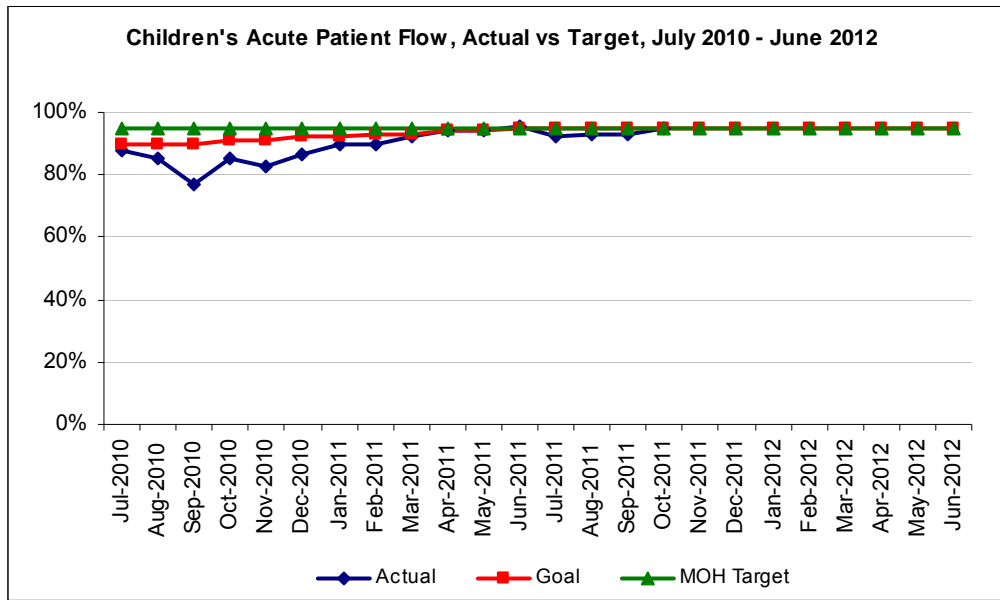
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: **30 July 2012**

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Project Risks /Comments:

We are very pleased to report that October proved to be a very successful month for achievement of the 95% of Patients within six hours target. Our 95% result represented a 2% improvement over the prior month and a significant 9% above the equivalent month last year.

While Acute patient presentations and admissions numbers were almost the same as last year, our Elective throughput was very favourable and this meant that Starship still operated at a relatively high level of occupancy. Our ability to achieve this we believe, in part, was due to our continued focus on the Capacity Planning process. Looking at the numbers of cancelled Electives for the period July to September for the past three years we have seen that 2011 was comfortably the lowest. While not conclusive in itself, the result is encouraging and we will monitor over the coming months.

Our focus on the use and accuracy of Estimated Discharge Dates continues and October produced our best results to date. This is proving to be very useful not only for discharging patients in a timely manner and communicating with families, but also for the Capacity Planning process.

As Acute volumes subside in the coming months we will be renewing our focus on the two hour component of the 3-2-1 breakdown of the six hour process. We have continued to share data with the appropriate teams to continue to improve awareness and engagement in the process.

Improvements to date:

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

Immediate Actions to Lift Performance

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

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

Longer term projects

Starship Capacity Planning Project

Project: Improved access to elective surgery

85

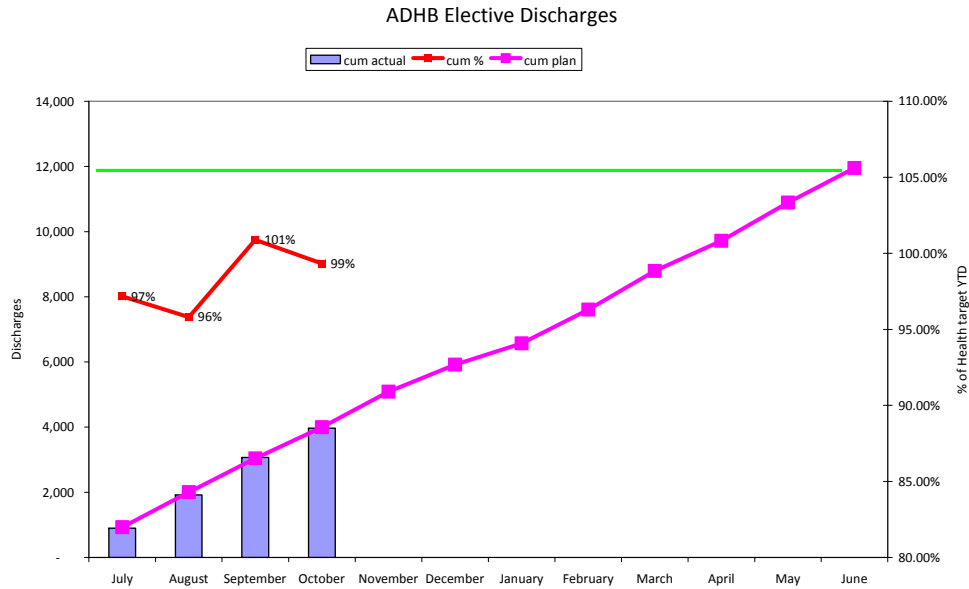
Primary Objective: Increase ADHB Elective Surgical Discharges from 11,149 to 11,950

Date of Delivery: 30 June 2012

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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



Planned activities:

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

Risks / Comments: (Amber)

1. Quarter 1 performance was 101% of target.
2. October was 94% of target.
3. Year to Date 31 October 2011 is 99% of target.
4. September is the only month we have met or exceeded monthly target.

Project: Shorter waits for Radiation Therapy

86

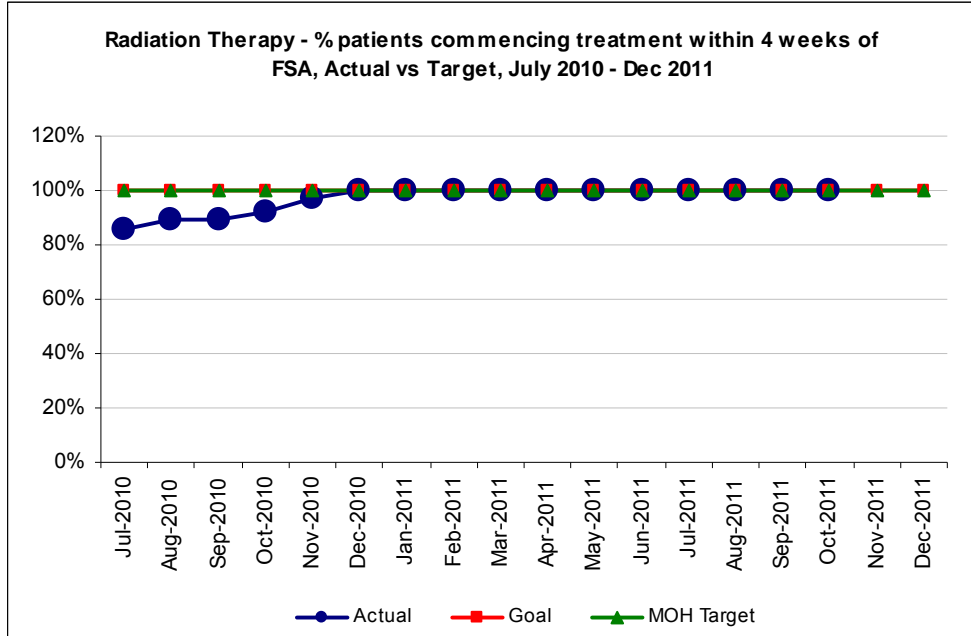
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



The service is 100% compliant for October 2011

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

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

Radiation Oncology Wait times – October 2011

In October 100% of eligible patients were treated within the 4 week target timeline. As at 31 October Radiation Oncology has delivered to the target for 553 consecutive days.

Further improvements in progress to sustain delivery:

Replacement of MV6: The replacement of MV6 is almost complete and is due to reopen on 21 November 2010.

Introduction of HDR for Gynaecological patients: The HDR machine has been replaced and will be operational in mid November.

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

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

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

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

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

Project: Better help for smokers to quit

87

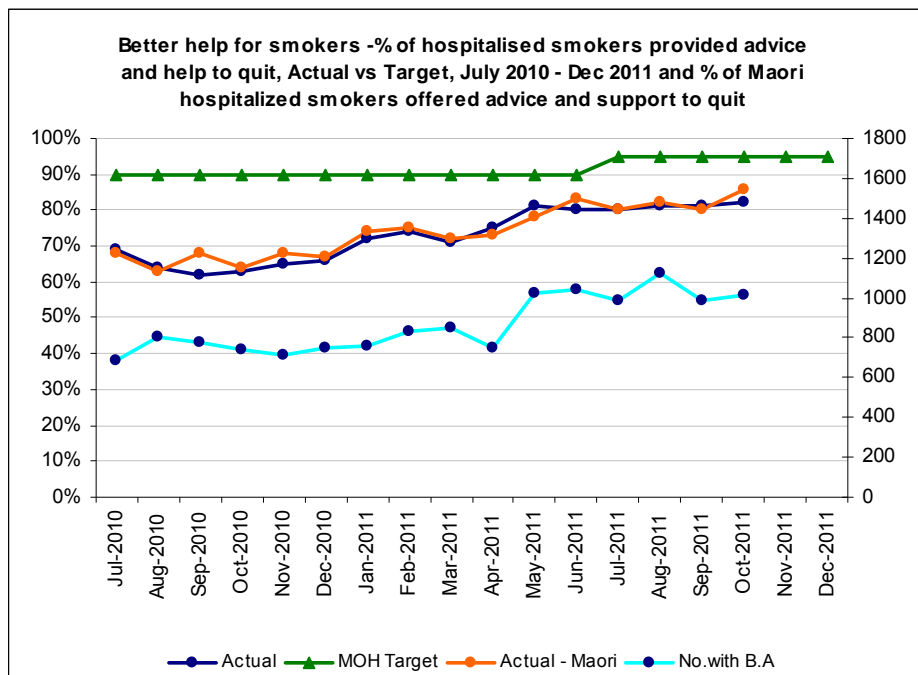
Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child

Programme Sponsor: Taima Campbell

Programme Manager: Jan Marshall

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



Comments

Result: Of the 8734 events coded in October 1231 (14%) were identified as smokers. 82% (1013) of all smokers were given brief advice to stop smoking. 86% of Maori patients were recorded with brief advice this month.

Systems to ensure brief advice is given and recorded at the Greenlane Surgical Unit have improved results and as reported in September our ability exclude the ex-smokers coded F17.1 from the smoking prevalence increased the brief advice result by 2%.

It is clear that the biggest gains to be made to lift the target over 90% and move to 95% will need to be made in the Adult Emergency Department and the Admission and Planning Unit. If AED and APU had reached the 95% target (recorded brief advice for an additional 100 patients) in October the overall ADHB result would have risen 8% to 90% . The Emergency Department is working to address the shortfall and the APU results continue to improve.

The remaining 5% is spread in relatively small numbers across other services. Weekly results including the number of patients missed by ward are distributed to indicate which areas need to improve their results.

Achievements in October:

- Greenlane Surgical Centre recording of ABC on day of surgery implemented and being monitored weekly

Immediate Actions to improve performance by 13%:

A. Focus on short stay/high volume areas to achieve 5-8%:

- Continued auditing and 1:1 coaching in AED and APU
- To reduce the "not asked/ documented" option in the Electronic Discharge Summary in AED from 27% to 10%

B. Improve engagement of clinical workforce to achieve 3-4%:

- Data on target now distributed weekly to senior leadership
- Best Practise Guidelines to be distributed to wards and updated weekly
- To work with Registrars to determine barriers and support mechanisms to assist junior doctors complete the ABC in clinical documents and EDS

C. Data collection systems and processes to achieve 1% :

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

D. Communications – planned activities

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

Project: Cardiac Bypass Surgery

88

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

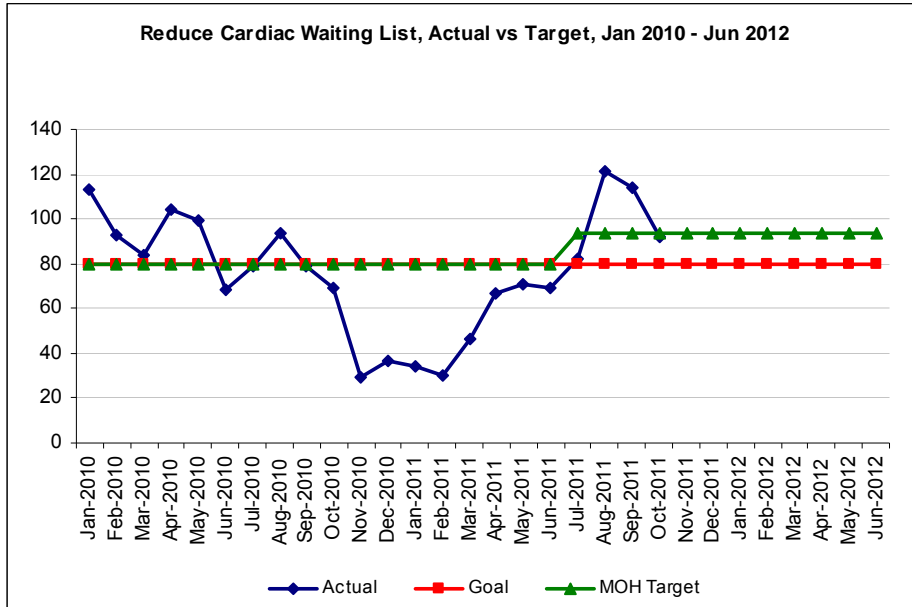
To support the national cardiac bypass intervention target, 940 bypasses should be completed in 2011/2012

Date of Delivery: 30 June 2012

Clinical Lead: Peter Ruygrok

Project Sponsors: Fionnagh Dougan

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



Monthly Performance

76 Bypass procedures were completed by the service during October. Of these completed procedures 64 are eligible to be counted against the MoH target for the Northern region population. There was a high demand for other bypass procedures in the month of October with four aortic dissections and a heart transplant completed in this month. In addition to these volumes 19 eligible bypass procedures were outsourced to Mercy Hospital. The outsourcing strategy has continued as part of the recovery plan to reduce the waiting list. At month end we were just under this limit which is ahead of our forecasted decrease.

Prior to this the average had been 21 referrals per week (FYTD). Coming into November we have a large number of inpatients who we are waiting to 'be ready' for surgery and are yet to be listed. If historical trends ring true November is also likely to be a month of high referrals and therefore we need to continue to outsource to mitigate an increase in the waiting list. Weekend contracts are also scheduled for completion throughout the month.

At the end of October the service was facing issues with long stay patients in CVICU causing theatre cancellations. To offset this a large quantity of thoracic procedures have been scheduled for the start of the month. The logic underpinning this approach is to increase our theatre utilisation as well as our potential bypass capacity later in the month. The enhanced recovery data has been captured throughout October and analysis of this will be completed shortly. Rapid rounds have started in ward 42 in October and this work ties in well with the delays to discharge projects in ward 42 and CVICU. The benefit of this work is to be captured in November.

Completed Improvement Activities:

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

Further improvements in progress:

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

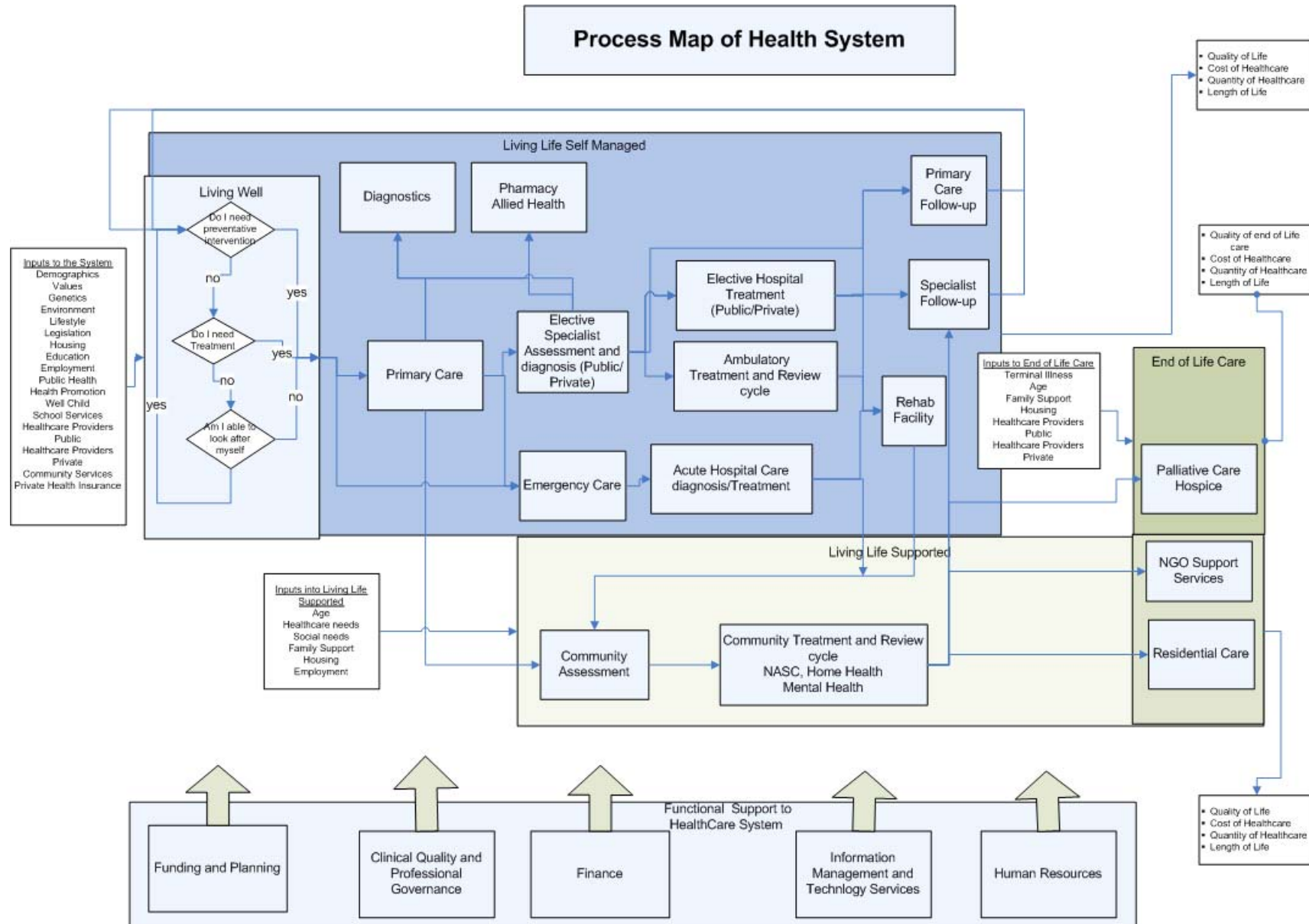
FEEDBACK TO BOARD

GENERAL BUSINESS

APPENDICES

8.1 Healthcare System Diagram

8.1 Healthcare System Diagram



APPENDICES

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

AUCKLAND DISTRICT HEALTH BOARD

**RESOLUTION TO EXCLUDE THE PUBLIC
FROM A MEETING OF THE HOSPITAL ADVISORY MEETING**

**Clauses 32 and 33, Schedule 3,
New Zealand Public Health and Disability Act 2000 (“Act”)**

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

1. THAT the public be excluded from the following part of the proceedings of this meeting, namely consideration of items 9 to of the Agenda.

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

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

MEETING DETAILS		
Time and Date	9:30am – 12:30pm, Wednesday, 7 December 2011	
Venue	A+ Trust Room, Level 5, Clinical Education Centre, Auckland City Hospital	
Members	Judith Bassett (Chair), Jo Agnew, Peter Aitken, Susan Buckland, Rob Cooper, Dr Chris Chambers, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward, Assoc Prof Anne Kolbe.	
Apologies	Peter Aitken (Leave of Absence), Susan Buckland	
In Attendance	Garry Smith, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Janice Mueller, 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 2m to 9:32am	Attendance and Apologies	001
2 3m to 9:35am	Conflicts of Interest	003
3 5m to 9:40am	Confirmation of Minutes Wednesday, 2 November 2011	013
4 10m 5m to 9:55am	Action Points Wednesday, 2 November 2011 4.1 Nurse Entry to Practice Programme (NETP) Including Maori and Pacific New Graduates – Taima Campbell 4.2 Inventory Management – Greg Balla and Brent Wiseman	019 023 031
5 30m 5m to 10:30am	Provider Operational Performance Report 5.1 Operational Performance Report 5.2 Health Target Updates	035 037 081
45m to 11:15am	Presentation – Cancer and Blood HSG	
6	Feedback to Board	089
7 5m to 11:20am	General Business	091

8	Appendices 8.1 Healthcare System Diagram	093
9 55m to 12:15pm	Resolution to exclude the public from a meeting of the Hospital Advisory Meeting 9.1 Resolution to exclude the public	097
NEXT MEETING		
Time and Date: 9.30am, Wednesday, 15 February 2012		
Venue: A+ Trust Room, Level 5, Clinical Education Centre, Auckland City Hospital, Grafton		

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