



# **Auckland District Health Board**

## **Board Meeting**

**Wednesday 1 September 2010**

**2:00pm**

**A+ Trust Room  
Clinical Education Centre  
Level 5  
Auckland City Hospital  
Grafton**

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



**KARAKIA**



## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

## **Creator and Spirit of life.**

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

### IMPORTANT

If in doubt – declare.

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

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



## ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Pat SNEDDEN (Chair)</b>	1. Ngati Whatua o Orakei Maori Trust Board	Consultant	Hourly consulting rate	Member of Treaty Negotiation Team in respect of Claim 388 register with Waitangi Tribunal  Wholesale supplier of water and waste water services to the Auckland region  Has a joint multi-million Healthy Housing programme with Health Board  Investigating a comprehensive cross agency intervention related to the Tamaki area including ADHB  Oversees implementation of quality programmes in DHB nationwide  Crown Negotiator Ngati Kahu Treaty of Waitangi Claim  Crown Negotiator Muriwhenua Treat of Waitangi Claim	3 September 2008
	2. Watercare Services Limited	Director	Fee		
	3. Housing New Zealand	Chair	Fee		
	4. Tamaki Establishment Board	Chair	Fee via HNZC		
	5. Quality Improvement Committee	Chair	Fee		
	6. Chief Crown Negotiator Ngati Kahu Claim	Consultant	Fee		
	7. Chief Crown Negotiator Muriwhenua Forum	Consultant	Fee		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Harry BURKHARDT (Deputy Chair)</b>	1. Repl as Ltd	Managing Director and shareholder	Salary	Plastics Manufacturing Company	6 April 2010
	2. Matta Products Ltd	Director and shareholder.		Plastics Manufacturing Company	
	3. Remat Ltd	Director and shareholder		Plastics Manufacturing Holding Company	
	4. Matt I Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	5. Matta LLC	Trustee		Plastics Distribution Company USA	
	6. New Zealand Maori Arts and Craft Institute	Chairman	Honorarium	Government owned Maori Tourist operation	
	7. Auckl and District Health Board	Deputy Chair, Chair Finance Committee			
	8. ADHB Charitable Trust	Trustee			
	9. Ngati Kuri Trust Board	Deputy Chairman and Treaty Negotiator			
	10. Packaging Council of New Zealand	Executive Member			
	11. Ngati Whatua o Orakei Health Clinic Ltd	Chairman			
<b>Jo AGNEW</b>	1. Senior Lecturer Nursing, Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Susan BUCKLAND</b>	1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member	Fees  Hourly fee  Hourly fee	Writer, editor and public relations services  Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes  Lay member of PCC to assess complaints and determine outcomes	7 August 2009
<b>Dr Chris CHAMBERS</b>	1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Share holder, Ormiston Surgical 6. Surveyor Quality Healthcare NZ				7 July 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Rob COOPER</b>	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	21 April 2010
	2. New Zealand Research Centre for Growth and Development	Board Member	Fee (to Ngati Hine Health Trust)	Governs a leading health sciences research centre	
	3. James Henare Research Centre, University of Auckland	Advisory Board Member	Fee (to Ngati Hine Health Trust)	Advises U o A on Maori research in Northland	
	4. Manaia PHO, Whangarei	Shareholder	Fee (to Ngati Hine Health Trust)	Governs a Whangarei based PHO	
	5. Whanau Ora Task Force	Member	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	6. National Health Board	Member	Fee		
	7. Chair Whanau Ora Governance Group				
<b>Dr Brian FERGUS</b>	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				29 June 2010
	2. Northern (AK) Regional Ethics Committee	Chair	Fee		
<b>Dr Ian SCOTT</b>	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		27 January 2010
	2. Locum GP		Contract rate		
	3. Waiheke "Integrated Family Health Centre" Steering Group	Member			

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Bob TIZARD</b>	1. Nil				27 February 2008
<b>Seiuli Dr Juliet WALKER</b>	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure	Self employed contractor	Contract hourly rate	General practitioner services	5 May 2010
	2. Member, National Breast Screening Advisory Committee	Member	Fee	Consultant Pacific Advisor	
	3. Facilitator, RNZCGP General Practice Education Programme Stage II	Contractor	Contracted monthly fee	Educational Support and Training	
	4. ADHB Employee: contracted roster Doctor for Pohutukawa	Contractor	Hourly rate	Forensic sexual assault examinations	
	5. Panel Member, Medical Appeal Board, Work and Income		Fee		
<b>Ian WARD</b>	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C-4 Consulting Limited			Tender to National Shared Services	



**CONFIRMATION OF MINUTES**

**- WEDNESDAY 4 AUGUST 2010**



# Auckland District Health Board Minutes



<b>MEETING DETAILS</b>											
Time and Date	2:00 pm, Wednesday, 4 August 2010										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
<b>1</b>	<b>KARAKIA</b>										
	The Chair declared the meeting open at 2:10pm. Naida Glavish led the meeting with the karakia.										
<b>2</b>	<b>ATTENDANCE AND APOLOGIES</b>										
	<p><b>Board Members</b></p> <table> <tr> <td>Pat Snedden (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Juliet Walker</td> <td>Ian Ward</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith – Chief Executive  Dr Denis Jury – Chief Planning &amp; Funding Officer  Dr Margaret Wilsher – Chief Medical Officer  Brent Wiseman - Chief Financial Officer  Greg Balla – Director Performance &amp; Innovation  Ngaire Buchanan – General Manager Operations  Taima Campbell – Executive Director Nursing  Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health  Chris Morgan – Manager Materials Management  Janice Mueller – Director Allied Health  Vivienne Rawlings – General Manager Human Resources  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>An apology had been received from Harry Burkhardt.</p> <p><u>Moved Pat Snedden; seconded Susan Buckland</u></p> <p><i>That the apology be sustained.</i></p> <p><u>Carried</u></p>	Pat Snedden (Chair)	Jo Agnew	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Juliet Walker	Ian Ward
Pat Snedden (Chair)	Jo Agnew										
Susan Buckland	Dr Chris Chambers										
Rob Cooper	Dr Brian Fergus										
Dr Ian Scott	Rt Hon Bob Tizard										
Seiuli Juliet Walker	Ian Ward										
<b>3</b>	<b>CONFLICTS OF INTEREST</b>										
	<p>There were no notifications of conflicts of interest for any item on the agenda. Pat Snedden advised that a painting firm in which he had an interest was doing some work for Tihi Ora Mapo.</p> <p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the Interest Register be noted.</i></p> <p><u>Carried</u></p>										

4	<p><b>CONFIRMATION OF MINUTES 7 JULY 2010</b></p>
	<p><u>Moved Susan Buckland; seconded Jo Agnew</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 7 July 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>In response to a question whether the demand for emergency services is taken into account with the six hour target the Board was informed that ED is often under pressure with acute volumes which keeps pressure on the hospital. Central Auckland was experiencing a societal change with young involved with alcohol and drugs who presented in the latter part of the week and weekend as very sick and intoxicated which primary care After Hours services could not handle. With old patients there needed to be more effective primary care support for Aged Residential Care but it was important that older people seek admission rather than defer treatment.</p> <p>The new Auckland Council wards were logical for the locality approach to primary care.</p>
5	<p><b>ACTION POINTS 7 JULY 2010</b></p>
	<p><b>Board Planning Day</b></p> <p>This would take the format of two presentations in the morning and in the afternoon discussion and debate.</p>
7.1	<p><b>CHAIRMAN'S REPORT</b></p>
	<p>Pat Snedden advised that Cindy Kiro had been appointed the Chair of the combined Maori PHOs. The Tamaki Transformation Project was being considered at the Prime Minister level and he had presented to the CEs of the Social Sector Forum. Housing New Zealand planned for development of the area through public/private partnerships. There was commitment with community facilitators appointed, the pathways to health careers etc. The Pacific Health Advisory Committee would be involved to foster discussion with health providers, discussions with Alastair Woodward of the School of Public Health and Iain Martin looking at alliances with Maori and Pacific NGOs. 40% of the population was Pacific and this would dovetail with Whanau Ora. It was suggested this would be an ideal opportunity for health research on a multi sectorial project.</p>
7.2	<p><b>Summary of Performance Outcomes 2009/2010</b></p>
	<p>This would be discussed with the Minister and while there was still not a clear view on Maori progress anecdotally more was being done. There was a comprehensive regional agreement in DAPs on the health priorities. The target for diabetes Get Checked had been met with it exceeding the 55% target. Cardiovascular Risk Assessments were also better than target. There had been a high level of clinical involvement.</p> <p>The Summary of Performance Outcomes 2009/2010 was noted.</p>
7.3	<p><b>ADHB Strategic Planning Day</b></p>
	<p><u>Moved Pat Snedden; seconded Bob Tizard</u></p> <p><i>That the ADHB Board notes that the ADHB Strategic Planning Day is to be held on Wednesday 18 August 2010 and replaces and includes topics that would have discussed at the Community and Public Health Advisory Committee, Maori Health Advisory Committee and Pacific Health Advisory Committee and as such any attendance fees that would have been payable for those committees will be payable for that day.</i></p> <p><u>Carried</u></p>

<b>8.1</b>	<b>Chief Executive's Summary</b>
	<p>The Alliance Health+ launch was well attended with the Ministers of Health and Pacific Affairs. On the same day the announcement on the ACH Car Park was made. There was good progress on the 6 +1 health targets with a huge effort and commitment. The region had agreed the primary care locality approach. ADHB has been successful in its application as a site for the Productive Operating Theatre initiative with leads in cardiothoracic and Greenlane Surgical Unit getting the organisational structure right and discussions to get the right decisions. There was pressure in the hospital and with industrial action the staff were acknowledged in keeping patients safe.</p> <p>There was an extra \$1.8m in the Budget for electives and work was being done with the MoH to come up with a regional solution to cater for 1200 additional electives. Elective intervention rates were different across the region and there was a desire not to exacerbate this. There was funding to do more at Greenlane and lesions in primary care. The arrangement for radiotherapy at St George's Private Hospital in Christchurch was a further contingency back-up if Auckland capacity is reached. Waiting times were getting close to the December 4 week target now but there would be a blip when there was the replacement of a linear accelerator. The financial results were good.</p>
<b>8.2</b>	<b>Minister's Six Health Priorities 2009/2010</b>
	<p>The smoking cessation initiatives were coming to fruition with data coming in the next month relating to Maori and Pacific to the Quality, Risk and Audit Committee. There is a focus on use of NRT to manage withdrawal. It was suggested that information on Maori and Pacific be related to all targets to show how the DHB is addressing disparities and improving population health. The target for diabetes Get Checked was reached and exceeded for Maori and Pacific. In the coming year there would be a new denominator and pressure to get primary care to accept this as their target with support for primary care with a population health tool. Consideration was being given for nurses' limited prescribing rights for diabetes management.</p> <p>At the next months meeting would be a briefing on preparedness for managing the World Cup. In ED there were escalation procedures and a response team to ensure safety of staff with increased alcohol/drug and weapon incidents which were being monitored through the risk schedule.</p> <p><u>Moved Ian Ward; seconded Bob Tizard</u>  <i>That the Chief Executive's report be noted.</i>  <u>Carried</u></p>
<b>8.3</b>	<b>Starship Foundation Trust Deed</b>
	<p><u>Moved Ian Scott; seconded Rob Cooper</u>  <i>That the ADHB Board notes the changes to the Starship Foundation Trust Deed.</i>  <u>Carried</u></p>
<b>9.1</b>	<b>Committee Recommendations</b>
	<p><b>Community and Public Health Advisory Committee</b></p> <p>There had been a good presentation on diabetes.</p> <p><u>Moved Jo Agnew; seconded Susan Buckland</u>  <i>That the Board endorses that to enhance diabetes health and outcomes that they:</i></p> <ol style="list-style-type: none"> <li>1. Fund 3.0 FTE LTC diabetes Coordinators for 24 months and review (est. \$540,000.00 over two years)</li> <li>2. Fund \$500/annum towards population analysis tool annual license for 24 months (\$123,000.00 (over 2 years)).</li> </ol>

3. *Fund diabetes clinical care pathway coordinator for 18 months (est. \$50,000.00)*
4. *Fund a contribution of \$35,000 to support the review and linkage of the existing data collection forms in primary care.*
5. *Fund \$15,000 for consumer representation and input in care pathway development for 18 months then assess ongoing support requirements.*

*Total requested: Year 1: \$411,500 Year 2: \$351,500*

Carried

#### **Maori Health Advisory Committee**

Regionality had been discussed with Ngati Whatua responding with development of the Ngati Whatua Health Plan. Discussions with Tainui Waikato were work in progress as were with Te Waka Te Tokerau.

#### **Pacific Health Advisory Committee**

There was thoughtful discussions on abortion rates and the need for research this being a social and cultural issue. There had been a presentation on the Tamaki Transformation Project Pathways to Health Careers (P2HC) which had been endorsed. There was much interest in HVAZ with media reports and a dvd issued with the Steering Group managing ably. The Alliance Health+ had two ADHB representatives on the group.

### **11.1 Finance Committee Recommendations**

#### **Natural Gas**

Ian Ward advised to Vector and abstained from voting on this item.

Moved Ian Scott; seconded Bob Tizard

*That the ADHNB Board accept the tender from Genesis Energy Ltd to supply ADHB with natural gas for a term of two years nine months from 1 September 2010 at an estimated annual cost for gas energy of \$1,937,000 (total contract value over the term is \$5,327,000) and;  
That the CEO be delegated authority to execute the contract with Genesis Energy Ltd once it has been finalised.*

Carried

#### **Exceed Delegation Funder Contracts**

A background paper was tabled with the Home Based Support Services being a new model with capped expenditure and a move towards casemix.

Moved Ian Scott; seconded Chris Chambers

*That the ADHB Board approves delegation to the Chief Planning and Funding Officer (CPFO) to sign the renewal of the Mercy Hospice contract (total contract value \$12,193,375.89 over three years) and the four Health of Older People Enhanced Home Based Support Service contracts (total value \$18.8m per annum, for a one year period) and;*

*Approves the price variation to the Odyssey Trust contract to \$8,665,064.70 and delegation to the CPFO to sign the variation and;*

*Approves the price variation to the Affinity Services Limited contract to \$5,862,937.85 and delegation to the CPFO to sign the variation.*

Carried

#### **Uniservices MRI Scanner**

The Finance Committee had considered this and a further background paper was tabled. This was the best short term strategy with the next owned machine preferably located at Greenlane. The contract was based on existing contract arrangements just relocating the machine to ADHB premises.

	<p><u>Moved Ian Scott; seconded Pat Snedden</u></p> <p><i>That the ADHB Board endorses the proposal to contract sessions from Uniservices MRI Scanner located on Level 5, Radiology, ACH.</i></p> <p><u>Carried</u></p>
<b>9.1</b>	<b>Committee Recommendation (continued)</b>
	<p><b>Disability Support Advisory Committee</b></p> <p>There had been a presentation from Garry Williams of Housing New Zealand Corporation with a high turnout of attendees and a lot of spirited discussion. In September the Environment Access Audit would be presented and a regional DSAC meeting had been held at Counties Manakau which had not been attended by Waitemata or Northland.</p>
<b>10.1</b>	<b>Committee Recommendations</b>
	<p><b>Hospital Advisory Committee</b></p> <p>Tools for the management of patient volumes from other DHBs had been developed and Cardiac Services had made excellent progress. There had been changes in the profile of presentations to ED and industrial action was impacting on the hospital on staff.</p> <p><b>Quality Risk and Audit Committee</b></p> <p>The Committee had had a presentation on Physician Assistants which originated in the USA and was being piloted at Counties Manukau.</p>
<b>11.2</b>	<b>Finance Report</b>
	<p>The result for the year was a positive break even after making the necessary level of provisions. The Finance Committee would be meeting with the Auditors at the next meeting. Focusing on the budget for the next year would be based on historical data with still an aim to get staff off over Christmas/New Year but this would be a fine balance with spreading electives. Leave was being managed but can be difficult, however, there was monthly reporting to Level 2 and 3 management.</p> <p><u>Moved Pat Snedden; seconded Chris Chambers</u></p> <p><i>That the ADHB Board acknowledges the break even result for the financial year ended 30 June 2010 and congratulates the whole organisation on achieving that result.</i></p> <p><u>Carried</u></p>
<b>13</b>	<b>GENERAL BUSINESS</b>
	<p><b>Whanau Ora</b></p> <p>The team implementing Whanau Ora policy would be coming to talk to the DHBs about how funding and staffing may occur. The Government wanted to involve iwi more and there may be regulations through the Minister of Health on iwi governance seeking cooperation not an expression of entitlement. While changes would not be dramatic there would be a change of involvement as a continuous process. Children were central and fundamental to Whanau Ora and in Tamaki Makarau 17 applications made to the implementation team.</p>

	<b>NEXT MEETING</b>
	The meeting closed at 3:45pm The next scheduled meeting is : 2:00pm, Wednesday, 1 September 2010 A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital Grafton
<b>CONFIRMED</b>  <b>CHAIR:</b> <span style="float: right;"><b>DATE:</b></span>	

**ACTION POINTS**

- **WEDNESDAY 4 AUGUST 2010**



**Board**  
**Action Points from the meeting on Wednesday 4 August 2010**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
7.1	Suggested that Tamaki Transformation Project be an opportunity for health research	Margaret Wilsher	Noted



# PRESENTATIONS

**No Presentations**



**CHAIRMAN'S REPORT**



# CHIEF EXECUTIVE'S REPORT



## **8.1 Chief Executive's Summary**

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## Chief Executive Officer's Summary

	Traffic Light	Comment	Mitigation
<b>Goal 1 Lift the Health of the People of Auckland</b>			
Board Planning Day	Green	Valuable Board Engagement and comment.	Key strategic themes to be investigated. Confirmation of core plans noted.
Electives	Green	MoH target lifted by 600.	DAP target amended – higher intervention for ADHB population.
Primary Care	Green/Orange	Good progress with GAIHN during month. Langimalie Family Centre opened with Minister attending.	Ongoing strong engagement.
First of the new dental clinics in ADHB district (and whole of Auckland region) to open	Green	Opening of the facility at Sylvia Park Primary School, Mt Wellington	Deliver total Oral Health Programme.
<b>Goal 2 Improve Performance</b>			
MoH progress visit re 6 hour target	Green	Excellent presentations well received. A number of our system improvement processes to go on the Ministry of Health website.	Continued pressure to realise target.
Application successful for The Productive Operating Theatre Programme	Green	Solid process design and Clinical leadership made our application strong.	Delivery to plan. I have also been asked to Chair the National Theatre Productivity programme.
<b>Goal 3 Live Within Our Means</b>			
Regional Planning	Green	Improved progress with Clinical and back office projects.	Communication plans now being developed.
Industrial action	Red	Serious organisational disruption and impact on clinical care.	Improve link of DHB experience with the Strategy Group.
Chris Morgan	Green	Chris has left the organisation having provided excellent leadership and support in the Procurement and Supply chain area, Finance Committee and Long Term Planning.	Paul Green has been seconded to role.



**8.2 Minister's Six Health Priorities 2009/10**

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## Project: Adult Acute Patient Flow

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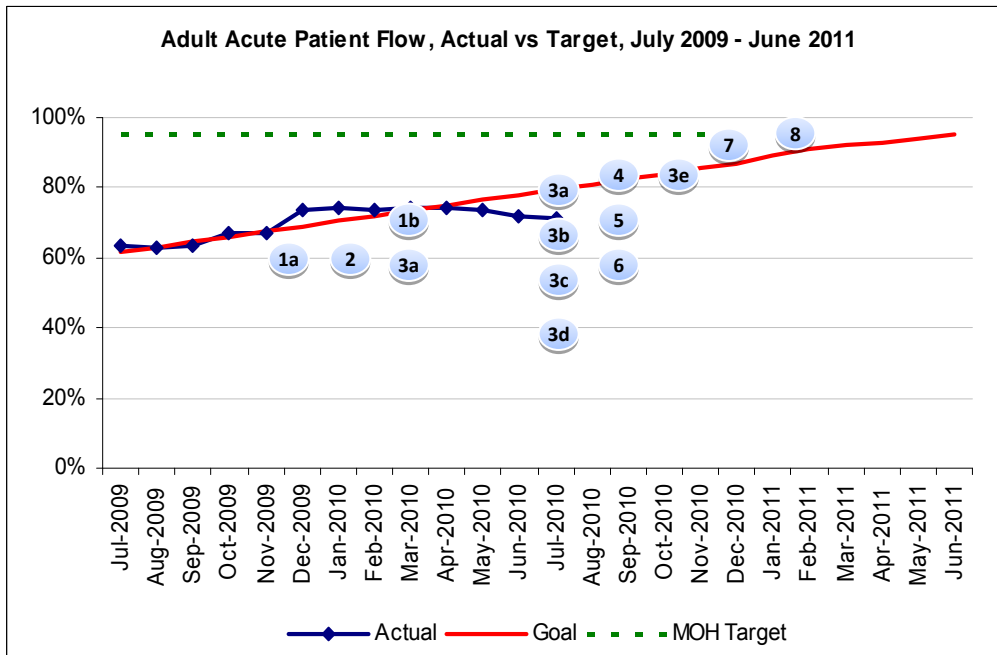
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin , Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

Steering Group: Nurse Director Margaret Dotchin, General Manager Ngaire Buchanan, Dr Tim Parke, Dr David Spriggs, Dr Wayne Jones, Dr Celia Palmer, Nurse Advisor Mark Entwistle.



Project Risks / Comments:

Overall we have sustained 10 consecutive months above baseline performance averaging over 10% above previous years. Overall performance has been maintained at 74% despite an increase of 19.4% in ED presentations compared to July 2009. 85% of non-admitted patients (or those discharged directly from AED) discharged within 6 hours. Weekend presentations to AED have grown at a faster rate than weekday presentations since 2009 with eight weekends in 2010 averaging over 160 presentations per day to adult ED. We have also seen a sharp increase in patient volumes aged 15 to 29 years.

General Medicine patient numbers increased sharply from 28 June 2010 with consistently 20+ more Gen Med patients in ACH than any other time of the year. Additional winter 'flex' beds opened from July 10.

Whilst we are still have significant improvement to make to reach our goal of 95% of patients admitted, transferred or discharged from ED within 6 hours:

- We have reduced AED average length of stay by over 25%.
  - We have reduced bed request to ward admission time by 50%.
  - Rapid Rounds and Nurse Facilitated Discharge are making a difference to Gen Med length of stay in Ward 68.
- Recommendations to invest in increasing ED resources to respond to increasing volumes and resource additional Gen Med beds up to end of October agreed by Senior Leadership team.

Recent and Current activities:

1. Additional beds opened in
    - a) November 2009
    - b) January 2010
  2. Improved Measurement systems to better identify clinical short stay patients
  3. Reducing ward occupancy
    - a) Expediting patient discharges from wards by the introduction of daily 'rapid rounds' - completed in General Medicine wards. Agreement to implement into orthopaedics from 14 June 2010.
    - b) Increase the number of weekend discharges in General medicine and Orthopaedics. Nurse Facilitated discharge Twenty One nurse facilitated discharges have been completed since the relaunch.
    - c) Improve the volume and accuracy of estimated discharge dates in Orthopaedics. Baseline performance identified that approximately 7% of patients have EDD within 8 hours of arrival on wards
    - d) Improve triage processes in Emergency Department
    - e) Remove delays associated with Taikura Trust patients. Workshops have been held with both Taikura Trust team and ACH teams.
  4. Bed management CMS system enhancements
  5. Improved ED / Inpatient Team methods of communication
- Planned activities
6. Increased Operational management
  7. Improved scheduling of elective volumes
- Future activities
8. Phase 3 improvement initiatives focusing on occupancy and specialty service response time.

## Project: Children's Acute Patient Flow

42

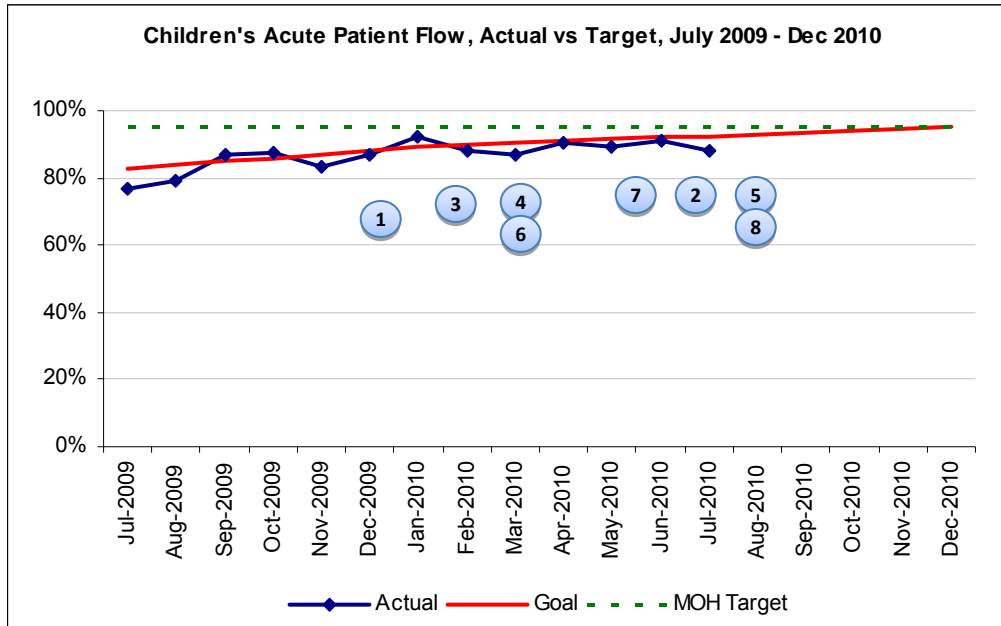
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 31 December 2010

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Current activities:

- 1.Improved Measurement systems to better identify clinical short stay patients
- 2.Improved bed management and patient transfer process
- 3.Expediting patient discharges from wards by improved application of estimated discharge dates
- 4.Development of weekly dashboard reporting for CED to better track performance
- 5.Workstream recently commenced to reduce short stay (<24 hr) admissions
- 6.Weekly communications of performance to ward level
- 7.Development underway of daily reviews to identify specific reasons for delays on a case-by-case basis and to communicate findings with relevant teams
- 8.Development of 'full hospital plan' to improve responsiveness when indicators of 'bed block' developing

### Project Risks / Comments:

*CED continues to maintain improved performance against the target – 91% for June (average of 87% for the year). This improved performance has been achieved in the face of a 4% increase in volumes from 2008/09 with the percentage of children admitted being constant at 22% between the two years. The improved result has been achieved as the result of increased focus across Starship. Maintaining this focus, particularly in inpatient areas will be essential if we are to maintain the increased results through the peak of winter activity.*

*An additional 4high dependency beds opening in PICU on 21 June and these will assist in providing appropriate admission location for children who require intensive nursing care.*

## Project: Improved access to elective surgery

43

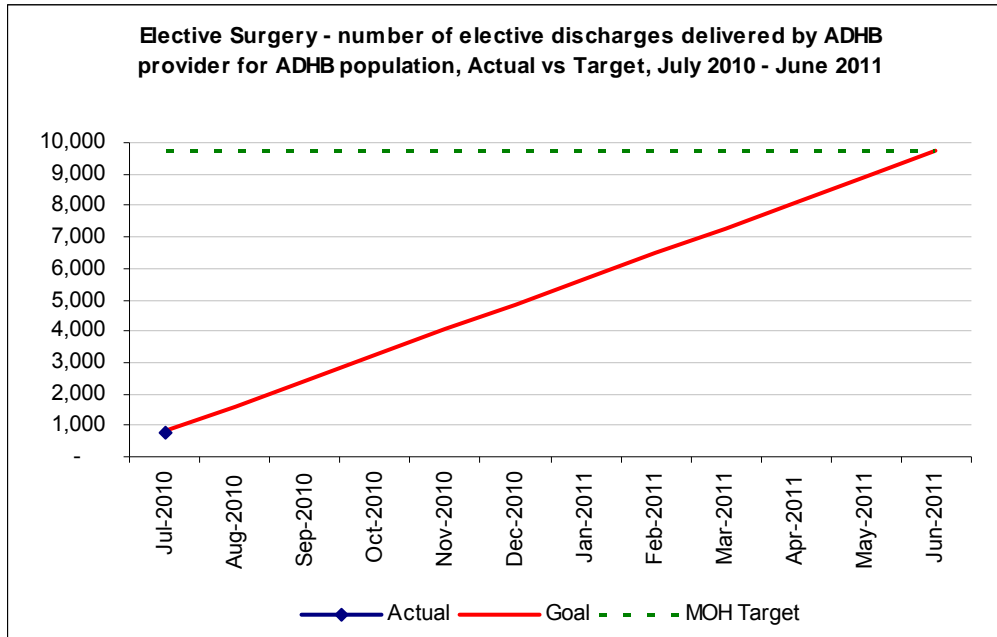
Primary Objective: To meet the MoH deliverable of elective discharges in surgical specialties for the ADHB population. The specified target is 93% of the overall population target, to account for ADHB population elective discharges from the ADHB provider.

Date of Delivery: 1

Clinical Lead:

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan



Planned Activities:-

1. Operationalisation of the Greenlane Surgical Unit.
2. Additional operating hours at Greenlane
3. Increasing DOSA
4. Operating Room productivity improvements

**Data above is indicative based on DHB provider and outsourcing, ADHB outflows e.g. plastic surgery at CMDHB are not yet included - approximately 6% of wies .**

### Risks / Comments:

*We have increased elective surgery delivery by 36% over the 3 years since 2005/06.*

*On a standardised basis, we have increased elective surgical discharges by 31% and case weights by 29% (ie 10% year on year). This is a significant increase in an organisation where 50% of surgical production is for other DHBs (acute and elective services). In the current year much of the increase has been due to a combination of improved cardiothoracic volumes and outsourcing. The plan is to increase in-house capacity to meet the increase.*

## Project: Shorter waits for Radiation Therapy

44

Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010 (Excludes D priority patients)

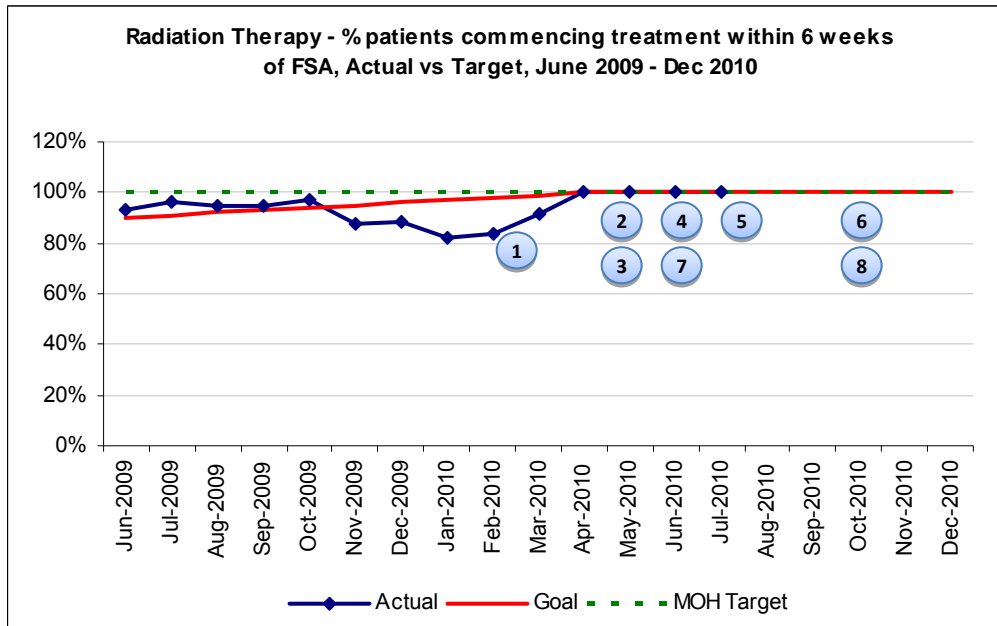
Date of Delivery: 1 July 2010 (6 weeks), 31 December 2010 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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

Current activities:



### Project Risks / Comments:

*Performance increased to 100% compliance in the 4th quarter and is forecast to continue in Quarter 1..*

*A number of improvements were implemented during that time, including*

- *Development of the capacity modelling tool*
- *Introduction of RT flexible working hours*
- *Outsourcing to ARO and Waikato*
- *Daily waitlist reporting*
- *Improved forecasting capability*
- *Continual prioritisation and review of waiting list*

*The period of decommissioning and replacement of the MV5 linear accelerator, increased demand, patient complexity and Radiation Therapist vacancies continue to be significant risks. In order to deliver a sustainable service it is critical to recruit and retain a flexible RT workforce.*

- 1. Weekly prioritisation meetings** continue, with a focus on detailed scheduling to review and accommodate urgent referrals as well as manage fluctuations in demand.
- 2. Operational Capacity Modelling.** This tool has been operational for 4 weeks and works in real time based on utilising referrals to calculate future capacity requirements.
- 3. Operation 28 days:** This project is designed to deliver on strategies to reduce cycle time utilising several work streams e.g. demand, resourcing, utilising machine capacity, throughput, outsourcing and operational management.
- 4. Flexible RT working hours** have been introduced to increase Linac capacity for an additional 1.5 hours per day.
- 5. Fast track commissioning of MV5** has commenced to ensure the new machine will be commissioned by November. This will deliver an additional 5 hours of treatment hours per day.
- 7. International recruitment strategy for Radiation Therapists to address staff vacancies.** This strategy has resulted in a reasonable number of applications which we are pursuing.

A histogram of RT Cycle time i.e. request to treatment January – July 2010 for A, B & C Priority patients (without delay codes) suggests that the service is achieving 90% compliance to the 4 week target. (Noting that the 4 week target is effective by December 2010)

## Project: Better help for smokers to quit

45

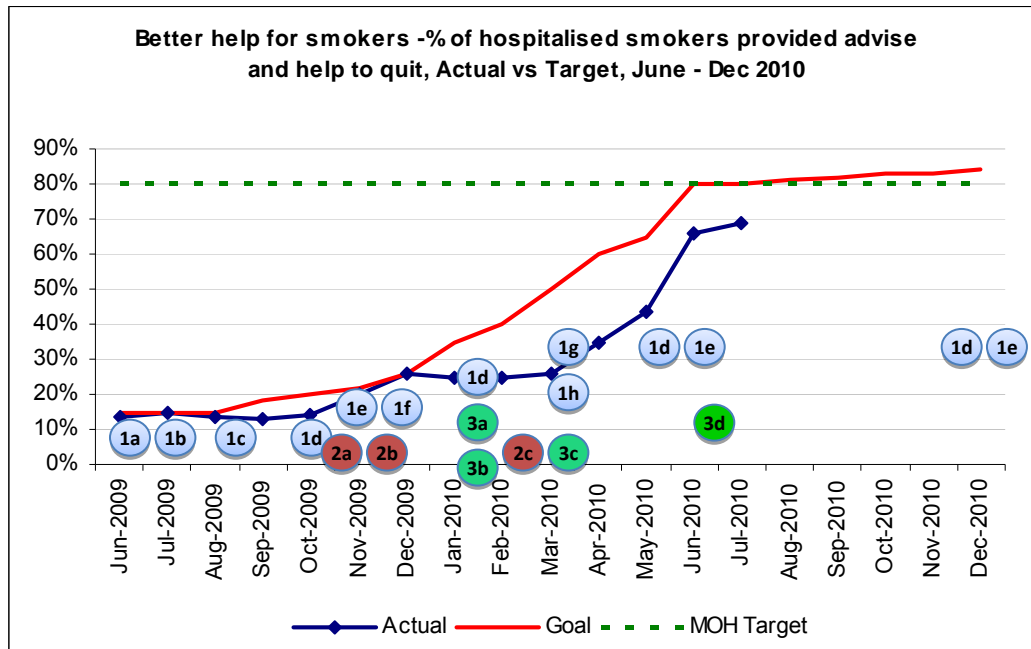
Primary Objective : % of hospitalised smokers provided advice and help to quit

Date of Delivery: 80 % by 1/07/2010, 90% by 1/07/2011, 95% by 1/07/2012

Clinical Lead: Stephen Childs

Project Sponsor: Taima Campbell

Steering Group: Taima Campbell, Stephen Child, Jan Marshall, Anna Schofield, Anne Bannatyne, Paul Bohmer, Leani O'Connor, Cheryl Hamilton, Nicki Jackson, Jim Kriechbaum, Kerry Hiini, Lyndsay Le Comte, Rachel Morris



### Project Risks and Comments

While the brief advice and support given to patients that smoke continues to increase to 69% in the July the June target of 80% is yet to be met. There has been substantial movement in terms of numbers being given brief advice in the Admission and Planning Unit, Adult Emergency Dept. and Ophthalmology Services. A number of services are consistently meeting the 80% target. The current focus is to work with wards/services that have not yet met the target, to determine the cause and work on strategies to assist them meet and maintain it.

Recent and Current activities:

1. *Training and coaching n The ABC of Smoking Cessation*
  - a. *Clinical Coding team updated on new interpretation of ICD codes for smoking brief advice and support*
  - b. *Nurse training commenced and is ongoing . 1500 nursing staff have attended education sessions on the ABC of smoking cessation, since August 2009.*
  - c. *Since September 09 240 ADHB staff have successfully completed the Ministry of Health (MoH) National Smoking Cessation ABC on line learning tool via MOODLE.*
  - d. *House Officer training on ABC and prescribing NRT at Quarterly orientations from Nov. 09*
  - e. *Registrar orientation ABC training ongoing.*
  - f. *Standing Order training commenced*
  - g. *Staff coaching programme to be introduced to support staff confidence in completing ABC*
  - h. *Implement strategy to improve medical staff buy in*
2. *Ongoing review of documentation and Systems to Support clinical staff do the ABC and for this to be coded.*
  - a. *Standing Order for NRT rollout commenced.*
  - b. *Mental Health Tobacco Assessment live on HCC*
  - c. *Smoking Cessation ABC included in Electronic Discharge Summary.*
3. *Monitoring, feedback and communication activities promote improved performance*
  - a. *Monthly feedback to GMs, Service Mangers and Charge nurses commenced*
  - b. *Ward Audits and feed back on documentation*
  - c. *Revised Communications plan to be implemented*
  - d. *World Smokefree and Ask About the Elephant Promotion 31 May*

# Project: Cardiac Bypass Surgery

46

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

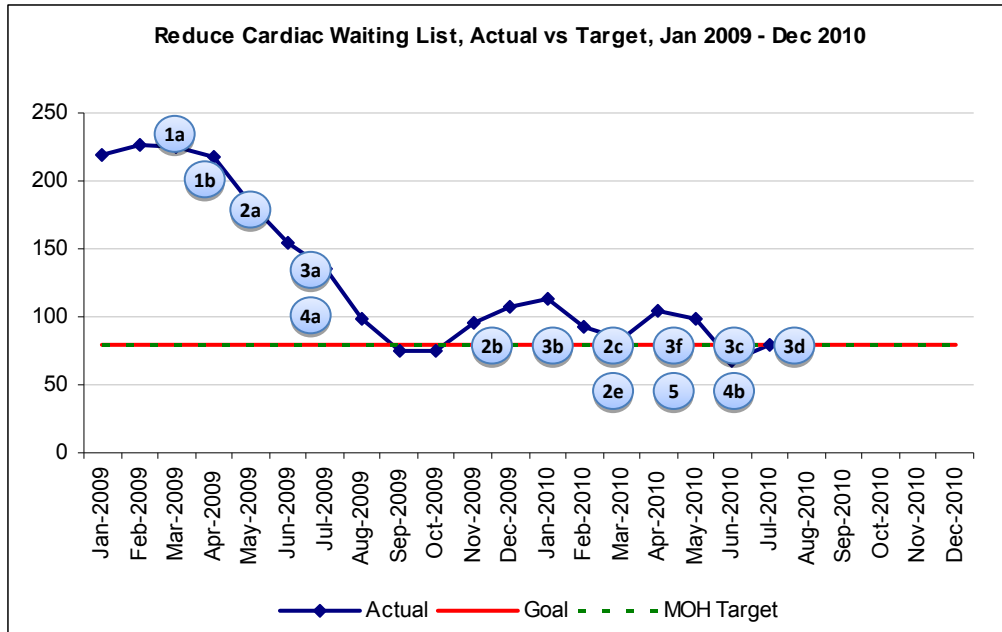
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2010

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Kay Hyman

Steering Group: Marian Hussey, Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam McCormack, Greg Balla, Gordon Davies



Recent and Current activities:

1. Initial drive for an improvement to the waiting list
  - a) Successful recruitment campaign for CVICU nurses shortage
  - b) Outsource push to reduce the waiting list
2. Improve measurement and reporting
  - a) The development of improved operational measurement systems
  - b) The development of surgical clinical outcome reporting
  - c) Ongoing improvement of CTSU Throughput Meeting
3. Improve co-ordination and synchronisation between units to improve utilisation and throughput:
  - a) Daily bed management meeting
  - b) Development of online scheduling system
  - c) Development of ward load planning system
  - d) Development of the patient pathway management system
  - e) Capacity plan model developed for CVICU and Ward 42
  - f) Flex CVICU roster to optimise resource cover and reduce cancellations
4. Reduce patient related cancellations
  - a) Initiation of pre-admission process/clinic
  - b) Review and refinement of the referral process to achieve 'full kit' patient information
5. Provide clinical leadership
  - a) Evaluate the position of 'Cardiac Clinical Leader'

## Project Risks / Comments:

The project initially achieved the waiting list target of 80 in Oct 2009. Unfortunately the waiting list increased over the Christmas/New Year holiday period due to one of the small number of surgeons who was working over the period of reduced activity injuring his finger and being unable to operate. As other staff were on leave this resulted in lost opportunity. The waiting list next returned to target in March. Again a holiday period, namely Easter impacted with Surgeon Conference extending the Easter period. A recovering plan was then put in place to ensure delivery of the required 918 procedures and a waiting list of 81 or less by 30 June. The recovery plan, which included outsourcing, delivered the essential result and the waiting list was 68 on 30 June and 923 by-pass procedures were performed during the year.

## Project: Diabetes

47

Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

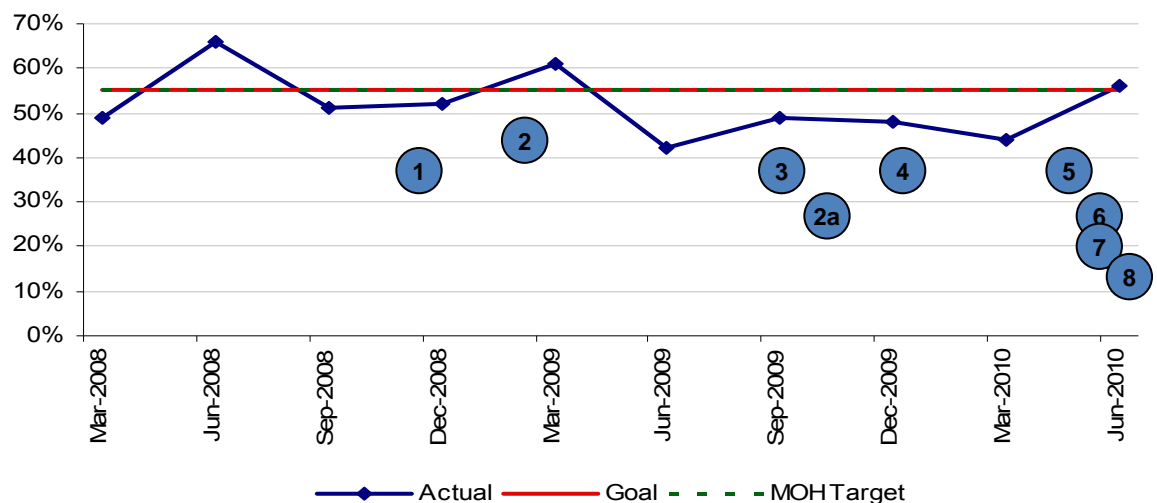
Date of Delivery: 55% June 2011

Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team

**Diabetes Annual Checks  
Target vs Actual Mar 2008-Jun2010**



### Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 2) Practise based data (results) feedback
- 2a) Increase other feedback options
- 3) Improved understanding of IT linkages in Practice systems
- 4) Auckland Diabetes Advisory Team – structured agreed district plan of action
- 5) Routine reports to clinical advisory leadership meetings
- 6) Developing shared care pathway
- 7) Regional shared care pathway work
- 8) Develop regional shared target setting and service outcomes

### Project Risks / Comments:

We met our target for this quarter, which is a reflection of the efforts of the primary care teams to finish the financial year with a positive outcome. There was a fantastic response for Maori and Pacific with gains 32% April-June (2009), to 61% April-June 2010 Maori and 53% April-June 2009 to 74% April-June 2010 for Pacific. Both passing their targets for the quarter. However, there is still a large amount of work to do especially as our prevalence data for the 2010 / 2011 year has increased our base by over 4000. This is an enormous challenge for our providers. A paper on how we can improve our care for people with diabetes (as reflected in our data) has been submitted to CPHAC. It is the culmination of a collective discussion between primary and secondary care and it is hoped that the collective planning and actions identified by the district partners will begin to assist in supporting reaching the targets for our population.

## Project: Diabetes

48

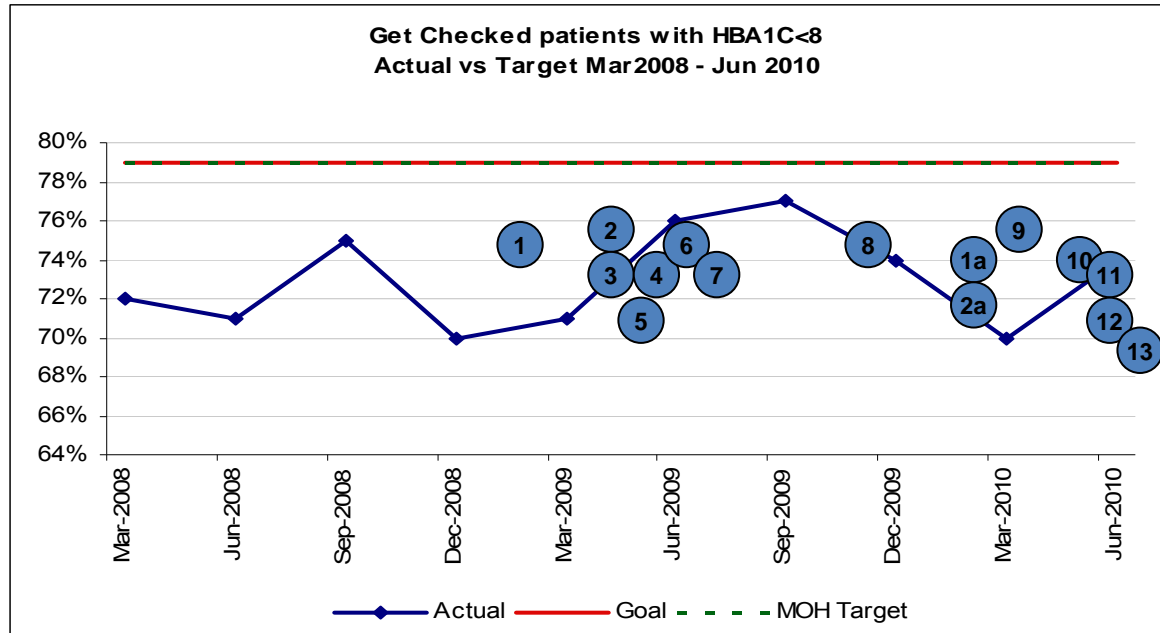
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

Date of Delivery: 79% of people with diabetes will have a HbA1c  $\leq$ 8%

Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



### Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 1a) reinforce awareness
- 2) Practise based data (results) feedback via various mediums including Health point
- 2a) increase feedback processes
- 3) Direct Secondary Service phone support for GPs
- 4) Increased community shared clinics with secondary care
- 5) Increased SEAsian Nurse Specialist access
- 6) Widened opportunity for self management to include greater than 2 year or less diagnosed people with diabetes
- 7) Improved culturally appropriate self management courses
- 8) Improved understanding of IT linkages in Practice systems (linking PPP)
- 9) Auckland Diabetes Advisory Team – structured agreed district plan of action
- 10) Redesign the supported self management to meet needs of population
- 11) Developing shared care pathway for Diabetes
- 12) Regional shared care pathway work including clinical workshop
- 13) Application for HRC funding to evaluate telephone support for LTC : Diabetes

### Project Risks / Comments:

We have improved this last quarter for the year. Our activities appear to having an impact which is positive. Discussions with our partner organisations are happening as this target will increasingly get more difficult as we increase the annual check volumes. This is because as we capture more of our diabetic population more will have complex needs and as such have a longer management care plans which will reflect in our management figures

## Project: Cardiovascular Risk Assessment

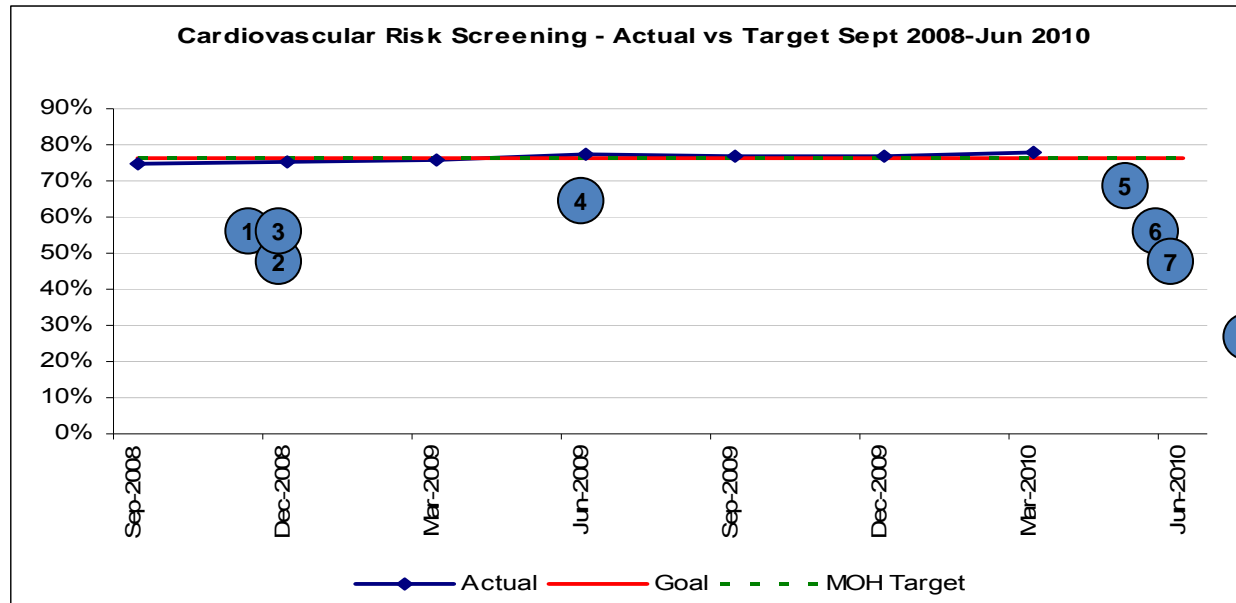
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

Date of Delivery: Overall goal is to have 80% of eligible population CVD risk assessed every five years.

Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



### Recent and Current activities:

- 1) Support the uptake of an electronic CVD tool
- 2) Training and information system support for electronic tool
- 3) IT help line for GPs for risk assessment tool
- 4) Increase the cumulative incentive payments for achieving both good assessment and good management together
- 5) Review and reshape incentives to link with PPP targets
- 6) Enhance links to Green Rx and maximise primary care uptake
- 7) Continue to work in various workplaces to enhance CVD risk assessment for men
- 8) Link in with research looking at ways to optimise Pacific males participation in health self management
- 9) Work regionally to have similar focus on incentive goals

### Project Risks / Comments:

We are right on target this quarter. Other analyses indicate that primary care are working hard in this area to identify and screen eligible people. It will be interesting to compare these figures with the outcomes from the electronic risk tool data the ADHB sponsor to assist in screening activity. An annual report will be available at the end of the financial year for all PHOs to illustrate both their assessments and their management. This will be available for reporting end July.

**Project: Increased Immunisation**

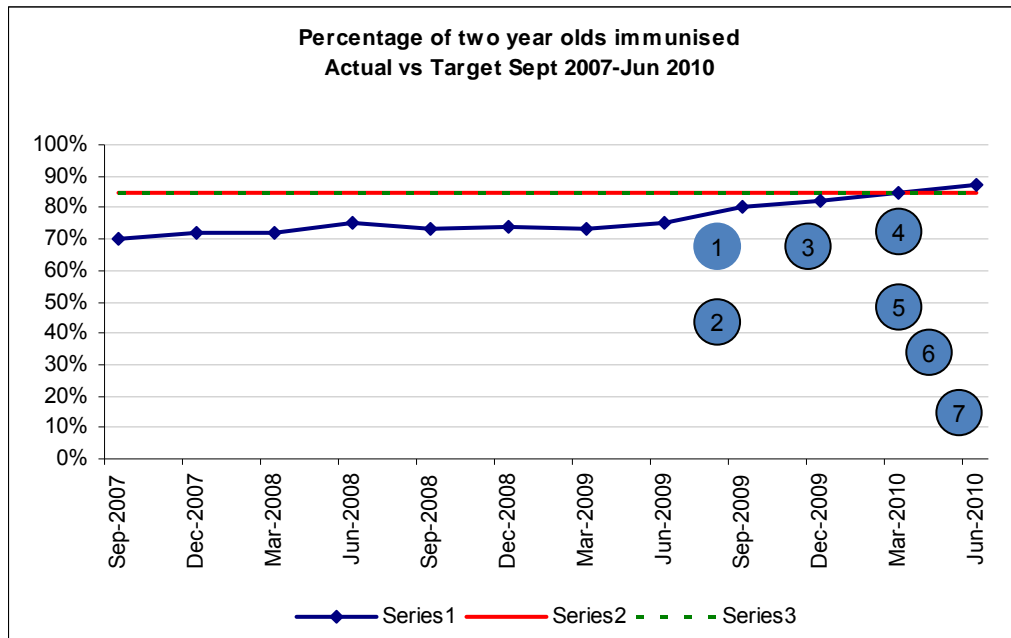
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

Date of Delivery: 1 July 2010, 1 July 2011 and 1 July 2012

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

Steering Group: Richard Aickin, Carol Stott, Hilda Faasalele, Ruth Bijl, Alison Leversha, Marion Hakaraia, IMAC, Auckland PHO, Public Health, Plunket, Commissioner for Children Office, Ministry of Health



## Current activities:

- 1. Practice level reporting available
- 2. Primary care Immunisation Co-ordinators funded
- 3. ADHB Immunisation Strategy approved
- 4. Submission to Health Select Committee on actions to improve immunisation coverage
- 5. Funding application made to Starship Foundation to fund social marketing programme
- 6. Meeting of regional DHBs to agree regional immunisation target held
- 7. Immunisation Governance Group exploring service delivery models to achieve maximum coverage

## Project Risks / Comments:

87% coverage at age 2 was achieved thereby exceeding the annual target for 2009/10 by 2%. A 12% increase in coverage was achieved over the year. Maori coverage at all milestone ages remains a challenge as does timeliness, in particular at 6 months and 18 months.

# **LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY**

## **9.1 Committee Recommendations**



## **9.1 Committee Recommendations**

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**Community and Public Health Advisory Committee Recommendations**

**Maori Health Advisory Committee Recommendations**

**Pacific Health Advisory Committee Recommendations**

**Disabled Support Advisory Committee Recommendations**



# *10*

## **PERFORMANCE IMPROVEMENT**

**10.1 Committee Recommendations**

**10.2 DAP Projects Report**



## 10.1 Committee Recommendations

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### **Hospital Advisory Committee Recommendations**

Verbal by Committee Chair

### **Quality, Risk and Audit Advisory Committee Recommendations**

Verbal by Committee Chair



## 10.2 DAP Projects Report

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## **Auckland District Health Board**

# **District Annual Plan *2010 - 2011***

*22 June 2010*

## Priority and Developmental Work for 2010-11

### Goal 1: Lift the health of people living in Auckland city

High level strategy	Objective	Strategies to achieve objectives
<b>1.1 Reduce inequities in health status</b>	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: <ul style="list-style-type: none"> <li>– develop Integrated Family Health Centres/Whanau Ora Centres</li> <li>– develop specific activities that achieve Whanau Ora</li> <li>– develop indicator measures for Whanau Ora</li> <li>– develop a Whanau Ora approach for all services devolved</li> </ul>
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
		1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
		1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access to health care and support services	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture, employment and advocacy
1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system		

High level strategy	Objective	Strategies to achieve objectives
<b>1.2 Improve outcomes in priority areas</b>		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: <ul style="list-style-type: none"> <li>- improving access by taking services to pre-schools</li> <li>- enhancing oral health education</li> <li>- increasing early enrolment with a focus on Maori and Pacific populations</li> </ul>
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+) 1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system 1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures 1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed 1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions

High level strategy	Objective	Strategies to achieve objectives
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes) 1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed 1.2d.3.2 At least 2 cardiac rehabilitation courses are run in the community 1.2d.3.3 At least 10% of retinal screening to be undertaken in the community
	1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base 1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce 1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome 1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011 1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme

More detail on some of these performance measures is included on page 36

**Goal 2: Performance improvement: sooner, better, more convenient**

High level strategy	Objective	Strategies to achieve objectives
<b>2.1 Efficient and effective health care system</b>		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters
		2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients
		2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year
		2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services
		2.1b.1.5 Improve access to primary care for palliative care clients by 15%
		2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes)
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10%
		2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children’s acute flow projects
		2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*
		2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		
	2.1c.2 Improve mainstream effectiveness	2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11) 2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.5 Reduce waiting times for oncology	2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway <ul style="list-style-type: none"> <li>– Implement new model of care and workforce roles in the Greenlane Surgical Centre</li> <li>– Maintain past elective surgery improvement by including primary care in the referral pathways and patient management</li> </ul>

High level strategy	Objective	Strategies to achieve objectives
		<ul style="list-style-type: none"> <li>- Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time</li> </ul>
<b>2.2 Improve leadership capability</b>	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against "In Good Hands" implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
<b>2.3 Improve Clinical Quality and Professional Governance</b>	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s 2.3.2.5 Implement Senior Leadership Team 'Walk-around' safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity
<b>2.4 Strengthen the health workforce</b>	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce

High level strategy	Objective	Strategies to achieve objectives
		from 7.4% to 8%
<b>2.5 Information management</b>	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time 2.5.1.2 KPI reporting for end-to-end application performance in place 2.5.1.3 IMTS user satisfaction increases by >10% against previous year 2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month 2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance 2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
<b>2.6 Planning</b> <b>2.6 Planning (cont)</b>	2.6.1 Long term planning and change management	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines 2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: <ul style="list-style-type: none"> <li>– description of future models of care across the continuum of care</li> <li>– plan the shape, size, setting, and location for future services and inter district flow patients</li> <li>– provide the strategic context for major future developments and business cases</li> <li>– develop workforce response to current and long term service plans via regional and the national workforce planning</li> <li>– increase the focus on regional planning and collaboration with the regional primary care business cases</li> </ul> 2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

\* Refer to appendix 8

**Goal 3: Live within our means**

High level strategy	Objective	Strategies to achieve objectives
<b>3.1 Break-even position maintained</b>		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and manage any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
<b>3.2 Sustainable balance sheet</b>		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans



## Goal Level Summary

DAP Projects - total projects: 96

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	36	28	6	4	3	10	3	0	31	3	0	34	0	0	24	2	8	2	1	1	0
2 Performance improvement	50	42	13	3	2	20	1	0	38	7	2	46	1	0	43	4	0	3	3	0	0
3 Live within our means	10	6	1	2	3	0	0	0	10	0	0	10	0	0	10	0	0	0	0	0	0
<b>Total #</b>	<b>96</b>	<b>76</b>	<b>20</b>	<b>9</b>	<b>8</b>	<b>30</b>	<b>4</b>	<b>0</b>	<b>79</b>	<b>10</b>	<b>2</b>	<b>90</b>	<b>1</b>	<b>0</b>	<b>77</b>	<b>6</b>	<b>8</b>	<b>5</b>	<b>4</b>	<b>1</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>79%</b>	<b>21%</b>	<b>9%</b>	<b>8%</b>	<b>31%</b>	<b>4%</b>	<b>0%</b>	<b>82%</b>	<b>10%</b>	<b>2%</b>	<b>94%</b>	<b>1%</b>	<b>0%</b>	<b>80%</b>	<b>6%</b>	<b>8%</b>	<b>5%</b>	<b>4%</b>	<b>1%</b>	<b>0%</b>

### Goal: 1 Lift the Health of the people in Auckland City

#### Review

Overall good start to the new financial year, particularly with regard to initiatives that support relevant national health targets (immunisation and diabetes)

### Goal: 2 Performance improvement

#### Review

Overall projects are progressing well. The primary care projects are making good progress due to collaboration across the three DHBs and primary care. While the resilience projects are behind the original schedule they are now making good progress.

### Goal: 3 Live within our means

#### Review

With the commencement of the new financial year, the various projects are generally at an early stage of development.



## **LIVE WITHIN OUR MEANS**

**11.1 Finance Committee Recommendations**

**11.2 Finance Report**



## **11.1 Finance Committee Recommendations**

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**ADHB Board****Author: Ian Bell (8077)****Subject: Outsourcing Agreements Radiation Therapy**

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**Recommendation**

*That the ADHB Board endorses contracts with: Auckland Radiation Oncology (ARO) for the provision of Radiation Oncology (RT) services for the period 1 May 2010 to 30 April 2013, including annual review with a guaranteed minimum volume of 50 referrals per annum \$600,000; and St Georges Hospital, Christchurch for the provision of Radiation Oncology (RT) services for the period 1 May 2010 to 30 April 2013, including annual review with no guaranteed volumes.*

*The estimated 2010/11 cost of the combined contracts is estimated at \$3.0 – 5.0 million. The minimum cost for 2011/12 and 2012/13 will be \$600,000, reflecting the minimum guaranteed annual volume to ARO.*

**Background**

This will be considered by the Finance Committee on 31 August 2010.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Motor Vehicle Replacement 2011

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**Recommendation**

*That the ADHB Board approves the replacement of 50 vehicles at a cost of \$796K*

**Background**

This will be considered by the Finance Committee on 31 August 2010.

**ADHB Board****Author:** Ian Bell (8077)**Subject:** Debt Write Off – \$115,942.98

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**Recommendation**

*That the ADHB Board writes off \$108,966.05 and \$6,976.93 a total of \$115,942.98 in relation to a baby born at ACH*

**Background**

This was considered by the Finance Committee on 31 August 2010.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Debt Write Off - Cardio Vascular \$123,786.91

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**Recommendation**

*That the ADHB Board writes off \$123,786.91 in relation to cardio vascular*

**Background**

This was considered by the Finance Committee on 31 August 2010.

## 11.2 Finance Report

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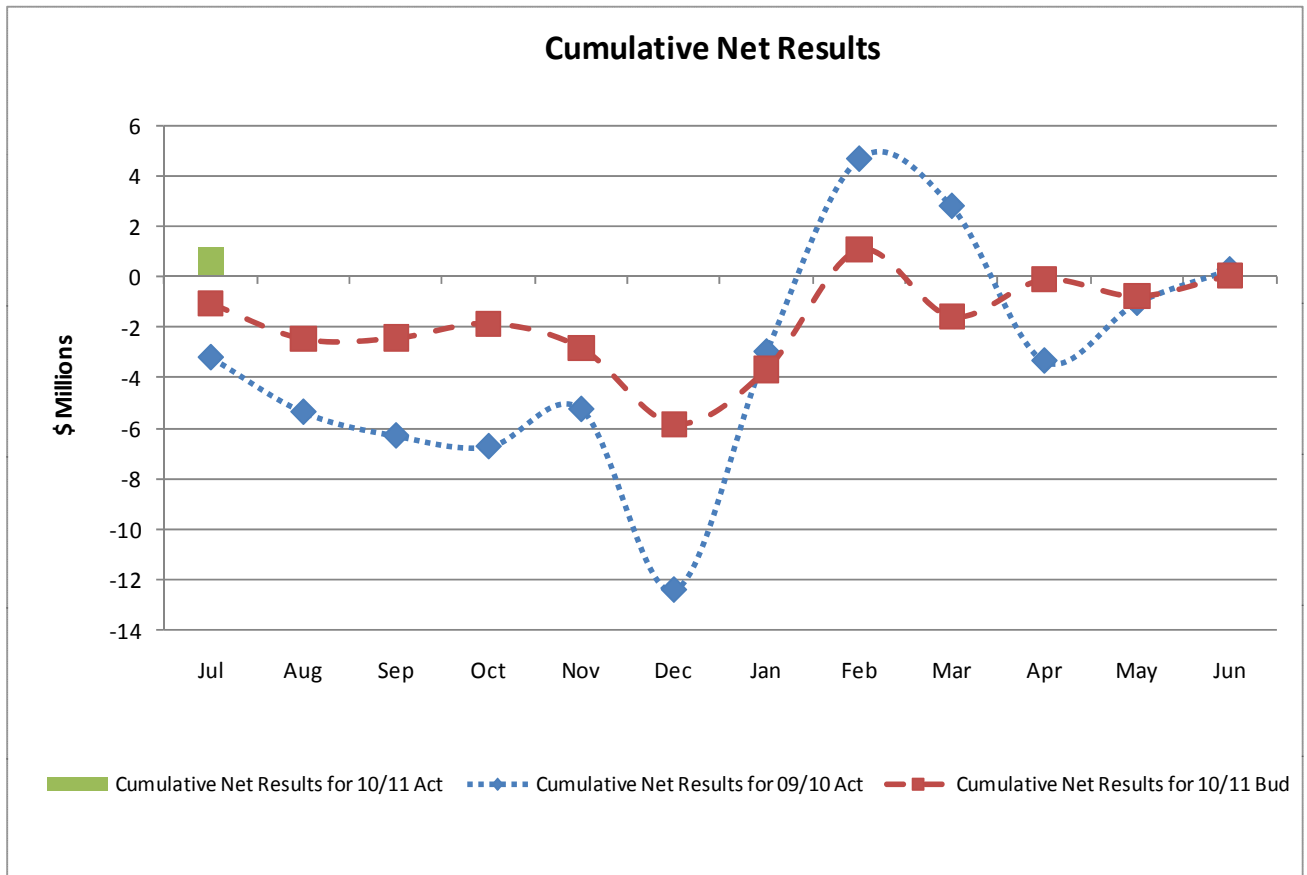
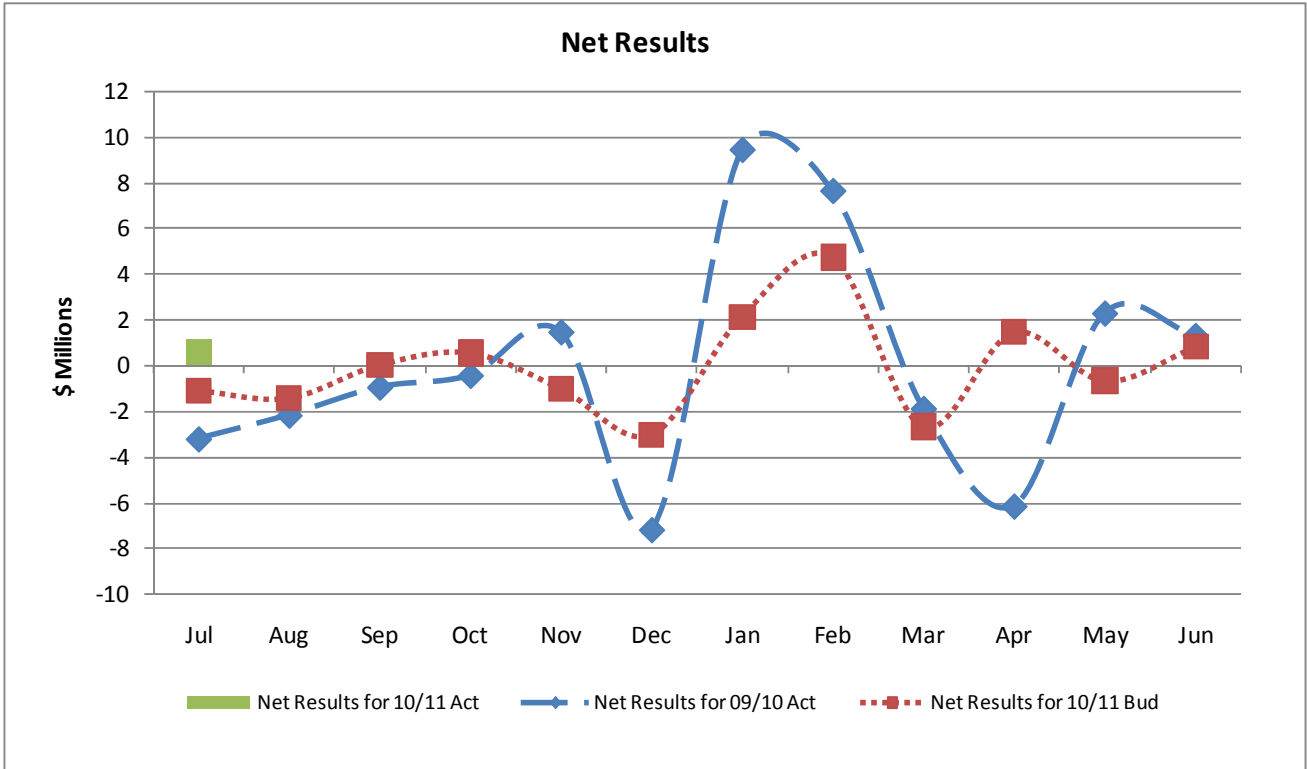
# Auckland District Health Board

## **Board Financial Report**

Prepared by Grant Barnett

July 2010

Performance Graphs by Month & YTD



Auckland District Health Board  
Summary Result  
Month of Jul-10

\$000s

	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
<b>Income</b>						
PBF - AKL Population	79,970	79,701	269 F	79,970	79,701	269 F
Inter District Inflows	47,137	47,891	753 U	47,137	47,891	753 U
	127,107	127,592	485 U	127,107	127,592	485 U
MOH Sub-contracts	8,607	7,722	885 F	8,607	7,722	885 F
Other Patient Care	2,906	2,712	194 F	2,906	2,712	194 F
Services & Products	4,626	4,450	176 F	4,626	4,450	176 F
CTA	1,673	1,674	1 U	1,673	1,674	1 U
Trust & Donation Income	1,089	423	666 F	1,089	423	666 F
Financial Income	536	316	220 F	536	316	220 F
Other Income	421	551	130 U	421	551	130 U
	146,964	145,439	1,525 F	146,964	145,439	1,525 F
<b>Expenditure</b>						
Employee Costs						
Medical	18,957	19,616	659 F	18,957	19,616	659 F
Nursing	19,596	19,897	301 F	19,593	19,897	303 F
Technical	10,145	10,333	188 F	10,145	10,333	188 F
Hotel Services	820	799	21 U	820	799	21 U
Administration	7,833	7,857	24 F	7,833	7,857	24 F
Other	2,857	3,365	508 F	2,860	3,365	506 F
Total Employee Costs	60,209	61,868	1,659 F	60,209	61,868	1,659 F
Direct Treatment Costs	19,116	17,931	1,185 U	19,116	17,931	1,185 U
Indirect Treatment Costs	3,517	3,278	239 U	3,517	3,278	239 U
Funder Payments	39,410	39,444	34 F	39,410	39,444	34 F
Inter District Outflows	8,406	8,372	34 U	8,406	8,372	34 U
Prop, Equip. & Transport	4,099	4,137	38 F	4,099	4,137	38 F
Maintenance	133	133	0 F	133	133	0 F
Building Compliance	0	0	0	F 0	0	0
Loss on Sale of Fixed Assets	9	1	8 U	9	1	8 U
Administration Costs	2,277	2,042	235 U	2,277	2,042	235 U
Total Operating Expenditure	137,177	137,206	28 F	137,177	137,206	28 F
Operating Contribution	9,787	8,233	1,553 F	9,787	8,233	1,554 F
Depreciation	4,255	4,528	273 F	4,255	4,528	273 F
Finance Costs	1,644	1,734	91 F	1,644	1,734	91 F
Capital Charge	2,716	3,036	320 F	2,716	3,036	320 F
Total Non Operating Costs	8,615	9,298	684 F	8,615	9,298	684 F
Net Surplus / (Deficit)	1,172	(1,065)	2,237 F	1,172	(1,065)	2,237 F

F

<b>Auckland District Health Board</b>			
<b>Statement of Financial Position</b>			
<b>As at Jul 2010</b>			
	<b>Jul-10</b>	<b>Jul-10</b>	<b>Jun-10</b>
	<b>Actual</b>	<b>Budget</b>	<b>Actual</b>
	<b>\$ 000s</b>	<b>\$ 000s</b>	<b>\$ 000s</b>
<b>Crown Equity</b>			
Opening Balance	569,409	569,304	566,089
Equity Injections/(Repayments)	-	-	3,320
Closing Balance	569,409	569,304	569,409
<b>Revaluation reserve</b>			
Opening Balance	353,538	381,278	381,278
Revaluation Adjustments	-	-	(27,740)
Closing Balance	353,538	381,278	353,538
<b>Retained Earnings</b>			
Opening Balance	(468,369)	(468,437)	(468,647)
Surplus/(Deficit) Current Year	1,171	(1,066)	279
Closing Balance	(467,198)	(469,503)	(468,369)
<b>Total Crown Equity</b>	<b>455,749</b>	<b>481,079</b>	<b>454,578</b>
<b>Represented by:</b>			
<b>Fixed Assets</b>			
Land	181,497	201,337	181,497
Buildings	584,741	592,682	586,094
Clinical, Other Equipment & Motor Vehicles	78,271	102,546	79,856
Work in Progress	27,768	22,323	23,166
<b>Total Fixed Assets</b>	<b>872,277</b>	<b>918,889</b>	<b>870,612</b>
<b>Derivative Financial Instruments</b>	<b>7,061</b>	<b>5,052</b>	<b>7,061</b>
<b>Investments</b>			
Associated Company Investments	95	386	470
Trust Deposits	10,078	8,000	10,078
<b>Total Investments</b>	<b>10,172</b>	<b>8,386</b>	<b>10,547</b>
<b>Current Assets</b>			
Cash & Short Term Deposits	64,043	44,696	56,815
Trust Deposits	11,422	11,508	11,747
Debtors	19,149	24,435	25,691
Accrued Income	32,422	32,508	31,221
Prepayments	2,907	2,320	2,245
Inventory	11,563	12,106	11,220
<b>Total Current Assets</b>	<b>141,507</b>	<b>127,573</b>	<b>138,938</b>
<b>Current Liabilities</b>			
Borrowings	76,237	86,973	75,027
Trade & Other Creditors, Provisions	222,773	219,498	222,910
Income Received in Advance	24,115	19,080	20,087
Taxes Payable	15,574	19,109	18,040
Funds Held in Trust	1,074	1,060	1,067
<b>Total Current Liabilities</b>	<b>339,773</b>	<b>345,719</b>	<b>337,132</b>
<b>Working Capital</b>	<b>(198,266)</b>	<b>(218,146)</b>	<b>(198,193)</b>
<b>Non Current Liabilities</b>			
Borrowings	213,022	212,222	213,014
Employee Entitlements	22,474	20,881	22,435
<b>Total Non Current Liabilities</b>	<b>235,495</b>	<b>233,102</b>	<b>235,449</b>
<b>NET ASSETS</b>	<b>455,749</b>	<b>481,079</b>	<b>454,578</b>

Statement of Cashflows for the Year ended 30 June 2011							
	Jul-10			Year to Date			
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>Operations</b>							
Revenue Received	155,844	149,461	6,383	155,844	149,461	6,383	
Payments	(143,872)	(138,834)	(5,038)	(143,872)	(138,834)	(5,038)	
<b>Net Operating Cashflows</b>	<b>11,972</b>	<b>10,627</b>	<b>1,345</b>	<b>11,972</b>	<b>10,627</b>	<b>1,345</b>	
<b>Investing</b>							
Income	488	370	118	488	370	118	
Capital							
Sale of Assets	0	1	(1)	0	1	(1)	
Purchase Fixed Assets	(5,938)	(6,460)	522	(5,938)	(6,460)	522	
<b>Net Investing Cashflows</b>	<b>(5,450)</b>	<b>(6,089)</b>	<b>639</b>	<b>(5,450)</b>	<b>(6,089)</b>	<b>639</b>	
<b>Financing</b>							
Equity Injections	0	0	0	0	0	0	
New Loans	0	0	0	0	0	0	
	-	375	- 375	-	375	- 375	
Equity Repayment	0	0	0	0	0	0	
Loans Repaid	0	0	0	0	0	0	
<b>Net Financing Cashflows</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>Total Net Cashflows</b>	<b>6,522</b>	<b>4,538</b>	<b>1,984</b>	<b>6,522</b>	<b>4,538</b>	<b>1,984</b>	
<b>Opening Cash</b>	30,029	30,029	0	30,029	30,029	0	
<b>Closing Cash</b>	36,551	34,567	1,984	36,551	34,567	1,984	

## Financial Performance

The result for July was a surplus of \$1.2m a favourable variance to budget of \$2.2m. The result, being for the month and year to date, was driven by higher revenue \$1.5m and lower expenditure of \$0.7m.

Year to date revenue was higher than budget by \$1.5m. Higher revenue was the result of:-

- a) Unfavourable Base Revenue variations \$(0.5)m driven by provision for potential IDF volume variations for 10/11 year to date
- b) Higher MoH Subcontract revenue \$0.9m, driven by variation to Sector Capability & Innovation funding (SCI) \$0.3m, higher volumes of Residential Care Loan Scheme funding \$0.2m and a wash up of PCT drugs for 09/10 \$0.2m
- c) The timing of donations \$0.7m
- d) Higher interest received on term deposits \$0.2m.

Year to date expenditure was lower than budget by \$0.7m.

- Labour Costs are \$1.6m favourable to budget year to date driven by Medical staff vacancies in Adult Health \$0.6m, overall vacancies in Mental Health \$0.5m and the expiry of CNME entitlements older than three years \$0.5m.
- Direct Treatment costs are \$(1.2)m unfavourable to budget due to higher Blood usage \$(0.4)m and Clinical Supplies costs \$(0.3)m largely driven by OR production following the completion of a high volume of transplants (15 vs an average 10 per month).
- Funder Payments are essentially on budget although there are some offsetting variances arising from the settlement of prior year's pharmaceutical claims \$(0.7)m offset by lower than expected expenditures for PHO's \$0.2m and Health of Older People \$0.3m.
- Indirect treatment costs are higher than budget driven by higher provisioning for non resident debts
- Property Costs are favourable to budget \$2.2m mainly driven by lower computer maintenance \$0.9m and lower property maintenance \$0.6m.
- Administration costs were unfavourable to budget primarily due to a one off payment from the Alexandra Trust to Ronald McDonald House Trust Auckland \$(0.5)m for the provision of a facility for convalescing women and children.
- The Capital Charge is lower than budget \$0.3m driven by the revaluation of Land & Buildings downwards at balance date.
- Depreciation is lower than budget \$0.3m driven by the timing of capitalisation of capital projects.

## Financial Position

- The opening balance of fixed assets was \$(56.5)m below budget principally due to the downward revaluation of land & buildings \$(27.8)m as at 30 June 2010 and FY10 full year capital spending being \$(28.7)m lower than forecast.

- YTD Capital spending is \$5.9m, under budget by \$0.5m. Baseline and Facilities projects are on budget at \$10.3m and Information Systems projects are behind budget by \$0.5m driven by the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$64.0m (excluding Trust deposits). At month end there is an unused overdraft facility of \$65.0m.



# *12*

## PAPERS

No Papers



# *13*

## **GENERAL BUSINESS**



# *14*

## **APPENDICES**

**No Appendices**

<b>MEETING DETAILS</b>	
Time and Date	2:00pm, Wednesday 1 September 2010
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
Members	Pat Snedden (Chair), Harry Burkhardt (Deputy Chair), Jo Agnew, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Brian Fergus, Dr Ian Scott, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ian Bell.

	<b>Item</b>	<b>Page No</b>
<b>1</b>	<b>Karakia</b>	<b>001</b>
<b>2</b>	<b>Attendance and Apologies</b>	<b>005</b>
<b>3</b>	<b>Conflicts of Interest</b>	<b>007</b>
<b>4</b>	<b>Confirmation of Minutes Wednesday 4 August 2010</b>	<b>017</b>
<b>5</b>	<b>Action Points Wednesday 4 August 2010</b>	<b>025</b>
<b>6</b>	<b>Presentations - None</b>	<b>029</b>
<b>7</b>	<b>Chairman's Report - Verbal</b>	<b>031</b>
<b>8</b>	<b>Chief Executive's Report</b> 8.1 Chief Executive's Summary 8.2 Minister's Six Health Priorities 2009/10	<b>033</b>
<b>9</b>	<b>Lift the Health of People in Auckland City</b> 9.1 Committee Recommendations	<b>051</b>
<b>10</b>	<b>Performance Improvement</b> 10.1 Committee Recommendations (Verbal by Committee Chair) 10.2 DAP Projects Report	<b>055</b>
<b>11</b>	<b>Live Within Our Means</b> 11.1 Finance Committee Recommendations 11.2 Finance Report	<b>073</b>
<b>12</b>	<b>Papers - None</b>	<b>091</b>

	Item	Page No
13	General Business	093
14	Appendices - None	095
<b>NEXT MEETING</b>		
	<b>Time and Date:</b>	2:00pm, Wednesday 6 October 2010
	<b>Venue:</b>	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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