



# **Auckland District Health Board**

## **Board Meeting**

**Thursday 2 December 2010**

**11:15am**

**Board Room  
Level 5, Administration Suite  
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>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. Share holder Chair Auckland PHO	Chair	Meeting fee		1 September 2010

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	16 August 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		
	6. Bader Drive Healthcare	Programme Facilitator	Fee	Clinical Training Support	
<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 3 NOVEMBER 2010**



# Auckland District Health Board Minutes



<b>MEETING DETAILS</b>													
Time and Date	2:00 pm, Wednesday, 3 November 2010												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
<b>2</b>	<b>ATTENDANCE AND APOLOGIES</b>												
	<p>The Chair declared the meeting open at 2:24pm. Rob Cooper led the meeting with the karakia</p> <p><b>Board Members</b></p> <table> <tr> <td>Pat Snedden (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Harry Burkhardt</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td></td> </tr> </table> <p><b>In Attendance</b></p> <p>Farida Sultana – Committee Member Lynda Williams – Committee Member Judith Bassett – New Board Member Lee Mathias – New Board Member Robyn Northey – New Board Member</p> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Taima Campbell – Executive Director of Nursing Paul Green – 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>Apologies had been received from Greg Balla and Denis Jury.</p>	Pat Snedden (Chair)	Jo Agnew	Harry Burkhardt	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	
Pat Snedden (Chair)	Jo Agnew												
Harry Burkhardt	Susan Buckland												
Dr Chris Chambers	Rob Cooper												
Dr Brian Fergus	Dr Ian Scott												
Rt Hon Bob Tizard	Seiuli Dr Juliet Walker												
Ian Ward													
<b>3</b>	<b>CONFLICTS OF INTEREST</b>												
	There were no notifications of conflicts of interest for any item on the agenda.												
<b>4</b>	<b>CONFIRMATION OF MINUTES 6 OCTOBER 2010</b>												
	<p><u>Moved Jo Agnew; seconded Chris Chambers</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 6 October 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>												

<b>5</b>	<b>ACTION POINTS 6 OCTOBER 2010</b>
	<p><b>Building 5</b></p> <p>The Chair outlined that Building 5, Greenlane was subject to a protection designation and that Susan Buckland had taken a role in trying to generate interest in uses for the building. The Manager Materials Management advised that there was no viable interest in refurbishment with the estimated cost being \$6.7m, including \$2.9m internal renovation, compared with the cost of a new building of \$3.2m.</p> <p>The options were adaptive use in conjunction with the Costley Block, looking for funding and challenging the designation however this was not advised at present as the Council would expect this only if there was a specific use for that space. In terms of raising funds, this had been delayed until the new Auckland Council came into being with now the proposal to write to the Mayor and Prime Minister seeking local and central Government support. The Board was committed to the Costley Block and the better proposition may be to have this as a 2 building precinct The site coverage plan developed a number of years ago had been developed to maximise use of the site and was not designed around particular health services.</p>
<b>7</b>	<b>CHAIRMAN'S REPORT</b>
<b>7.1</b>	<b>Report</b>
	<p>The Chair advised that the Minister had asked the three Chairs to be engaged in Board appointments whose announcements were expected in the last week of November. There was a good standard of person put forward.</p> <p>Strategic conversations had been held with Southern Cross concerning common alignment for a long term relationship. DHBs with the emphasis on elective surgery were eroding the private sector and insurance cover was dropping which would reduce total funding in the system. Southern Cross did the same level of elective surgery as ADHB and were happy to share information to inform on intervention rates and to work together.</p>
<b>7.2</b>	<b>Migrant &amp; Refugee Advisory Committee Proposal</b>
	<p>Farida Sultana had produced a paper and suggestions to have an Asian and migrant group to advise as ADHB has for Maori and Pacific. There were two proposed models, either an advisory group or a wider regional group. Research on young people Asian and migrant schooled here showed that they were not accessing the health system as they didn't see their parents accessing the system.</p> <p>There was a proposal for an on-line panel at the service improvement level with the project team discussing how a consumer council would work at its next meeting. There was still debate as to a need for a council and whether it is the right place for a relationship particularly with the locality approach being taken and wanting to work with the new Auckland Council Boards to find a better way to connect to communities. There was support for the group proposal as there was a need for advocacy and support for a sizeable community of Auckland's population with specific health needs and a need to link with other agencies adopting a Whanau Ora approach to have culturally competent delivery of health services.</p> <p>It was suggested that the structure needed to be right and what was happening regionally needed to be considered. The CEO with Farida Sultana and a small group would look at the governance options to put to the new Board in the new year noting the underlying support.</p> <p><u>Moved Pat Snedden; seconded Susan Buckland</u></p> <p><i>That the ADHB Board notes the paper on the Community Advisory Group: New Migrant and Refugee Representation and asks the CEO to work with a representative group to develop a recommendation to the new Board.</i></p> <p><u>Carried</u></p>

<b>8.1</b>	<b>Chief Executive's Summary</b>
	<p>Funding for the Tamaki Workforce Initiative was not forthcoming so there would be a paper in December on how to get more Maori and Pacific into the workforce which would require to be creative and innovative and looking at how Counties Manukau have achieved this. Industrial action was affecting electives with concerns at meeting ESPI compliance and the commitment to higher volumes. The impact of strikes was creating a clinical risk and a bow wave to catch up and was requiring outsourcing to manage the situation and how volumes would be recovered. It was understood that there were queries on what the union was doing with some staff changing to other unions or individual employment agreements and there was substantial work being done in the background noting that 95% of the workforce had agreed to similar terms and conditions.</p> <p>While there was tension in PHOs to achieve Better Sooner More Convenient the governance was settled down and there will be more detailed reporting both regionally and locally. The Regional Services Plan had been lodged and feedback was expected before Christmas with a further iteration due in March. The Plan had identified the early movers being Better Sooner More Convenient, Cancer, Cardiac, Diabetes and Health of Older People with the intention to cluster Planning and Funding across the region and develop regional and clinical governance. It was important in the tighter economic environment to get clinicians engaged trying to reduce variations within the region. Consultation on Phase I of the Regional Shared Services was complete and the decision would be advised to the staff the next day. This was good progress and there were a number of opportunities.</p> <p>The CEO's Vital Signs briefings were being done at present and this includes showing the way forward under the Healthcare Excellence programme. Briefings were being prepared for the new Board and also the new Auckland Council Boards. National Pricing work had issued a paper which required a response with the potential of \$6m reduction in revenue from the tertiary adjuster to pay for the increased costs being experienced in secondary DHBs. It was noted that this was an odd signal to subsidise the more inefficient. It was suggested that Auckland being an example of efficiency and quality makes its own presentations based on evidence to the National Health Board. IDF reporting was now well established with the one risk being Waitemata. Whanau Ora providers had been identified for Tamaki Makaurau and reporting on this new initiative will be included in the CEO's summary.</p>
<b>8.2</b>	<b>Minister's Six Health Priorities 2009/10</b>
	<p>The goals had been amended for the new year plan and further reporting against initiatives. Adult Acute Patient Flow had been through a tough winter and were now looking at processes within ED. There had been an audit by MoH who had approved the manner in which ADHB was addressing the issues. Children Acute Patient Flows seasonal changes will assist correction. Elective surgery reporting will be expanded and with Radiation Therapy the new linear accelerator was commissioned on time and on budget. Another six interventions had been developed for Better Help for Smokers to lift performance noting that the target was now 90%. The waiting list for Cardiac Bypass Surgery was manageable with some changes to the volumes and processes so the waiting time may not be the most appropriate measure. Diabetes and Cardiovascular Risk Assessment remained as priority areas and the target for Immunisation had been lifted noting that the Social Services Sector Group had adopted immunisation as one of their goals.</p> <p><u>Moved Pat Snedden; seconded Jo Agnew</u></p> <p><i>That the Chief Executive Summary and Minister's Six Health Priorities reports be noted.</i></p> <p><u>Carried</u></p>

9.1	<b>Committee Recommendations</b>
	<p><b>Community and Public Health Advisory Committee</b></p> <p>The Committee put forward a recommendation concerning payments to GAIHN and have noted the extension to the Birthcare contract.</p> <p><u>Moved Brian Fergus; seconded Ian Scott</u></p> <p><i>That the ADHB Board endorses the GAIHN Implementation Plan and approves payment of establishment funding to GAIHN of 61c per enrolled ADHB patient for the 2010-2011 financial year</i></p> <p><u>Carried</u></p> <p><b>Maori Health Advisory Committee</b></p> <p>There had been no meeting.</p> <p><b>Pacific Health Advisory Committee</b></p> <p>The Committee had expressed concern at the shift of the HVAZ contracts to be managed by Counties Manukau and had requested to see the MOU between Counties Manukau and ADHB being host DHB and partner DHB. HVAZ was a gem for ADHB. The Committee had also considered its role in the Tamaki Transformation Project being keen to work at the governance level. Data on ethnicity was important noting that 25% of CED attendance was Pacific children. This would be provided on all key indicators as noted in the Hospital Advisory Committee.</p> <p>Jo Agnew left the meeting at 3:50pm.</p> <p><b>Disability Support Advisory Committee</b></p> <p>The Committee would be meeting in November.</p> <p><u>Moved Pat Snedden; seconded Harry Burkhardt</u></p> <p><i>That the reports from the Advisory Committees be noted.</i></p> <p><u>Carried</u></p>
10	<b>PERFORMANCE IMPROVEMENT</b>
10.1	<b>DAP Projects Report</b>
	<p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the DAP project summary report be noted.</i></p> <p><u>Carried</u></p>
11	<b>LIVE WITHIN OUR MEANS</b>
11.1	<b>Finance Committee Recommendations</b>
	<p><b>Debt Write-Off</b></p> <p>This would be written off and advised to the collection agency.</p> <p><u>Moved Harry Burkhardt; seconded Ian Scott</u></p> <p><i>That the ADHB Board approves debt write-off Cardio Vascular of \$104,251.11.</i></p> <p><u>Carried</u></p>

	<p><b>Replacement Ultrasound Machines Cardiology and Radiology Radiology Multi-slice CT Scanner</b></p> <p>The ultrasounds were part of a fleet replacement programme with joint procurement with the CT scanner. The old CT scanner would go to LabPlus mortuary for forensic work. The Finance Committee had asked for fleet replacement plans.</p> <p><u>Moved Harry Burkhardt; seconded Ian Scott</u></p> <p><i>That the ADHB Board approves the purchase of a maximum number of Ultrasound machines to \$1m (inclusive of the 1 already purchased this financial year for \$179,000) for Cardiology and Radiology: and</i></p> <p><i>That the ADHB Board approves the replacement of the Siemens 2 Slice CT Scanner with a 64 slice CT Scanner at Level 4 and to complete the purchase of the Siemens 2 slice CT Scanner for Forensic Departments, LabPlus mortuary totalling \$1.4m.</i></p> <p><u>Carried</u></p> <p><b>Home Based Support Services Contracts</b></p> <p><u>Moved Harry Burkhardt; seconded Ian Scott</u></p> <p><i>That the ADHB Board approves the increase in the Home Based Support Services contracts from \$18.8m to \$18.961m, an increase of \$161,000.</i></p> <p><u>Carried</u></p>
<b>11.2</b>	<b>Finance Report</b>
	<p>The result for the month of September was break even and year to date a \$1.8m favourable variance. Revenue and payroll favourable variances were off-set by increased direct treatment costs and indirect treatment costs. The movement in the balance sheet was between current liabilities and term liabilities with the repayment of the bonds financed by Crown Health Financing Agency. The variance between the Finance Report and the Treasury Report provided to the Finance Committee related to payroll timing and IDF revenue wash-up.</p> <p><u>Moved Pat Snedden; seconded Chris Chambers</u></p> <p><i>That the Finance Report for September 2010 be noted.</i></p> <p><u>Carried</u></p>
<b>13</b>	<b>GENERAL BUSINESS</b>
	<p><b>Next Meeting</b></p> <p>The MoH would be holding orientation for member of the new Board on 1 December 2010 so it was decided to hold the Board meeting on the next day, Thursday, 2 December 2010.</p>



**ACTION POINTS**

- **WEDNESDAY 3 NOVEMBER 2010**



**Action Points from the meeting on Wednesday 3 November 2010**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
7.2	Refugee and Migrant Advisory Group proposal to be discussed and managed with small group for recommendation to new Board	Garry Smith Denis Jury	GEFF
8.1	ADHB to make own representations to the National Health Board on pricing 2011-2012	Pat Snedden Garry Smith	8.1



# 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>			
Radiation Therapy	Green	Will meet 4 week target 1 Dec 10.	Ongoing close monitoring.
Elective Surgery	Orange	Volumes for ADHB Population behind.	Production planning / outsourcing.
Immunisation	Green	Last year's achievement to be recognised by Certificate Awarded by Associate Minister	Push for 2010/11 target.
Better, Sooner, More Convenient	Green	Culture shift being driven into HSG Model and designing better links	Ongoing strong engagement.
Tamaki Project, Workforce Pathways	Orange	Researching a way to bring this concept alive.	Refining the business case.
<b>Goal 2 Improve Performance</b>			
Celebration week	Green	Research, Education, Quality Improvement	Individuals, teams' recognition, A+ Trust new concepts.
Vital Signs – CEO Briefing	Green	400 – 500 attended and evaluation good.	On intranet plus plan for improvement based on feedback.
<b>Goal 3 Live Within Our Means</b>			
National Pricing Work	Red	Potential Funding Impact 2011/12.	Representation to National Health Board.
New Graduates	Orange	Finding innovative ways to ensure we do not upset flow given reduced turnover.	Particular focus on Maori and Pacific.
OIAs – Herald on Sunday	Orange	A number of requests around CEO expenditure	All DHBs have received. Full response being developed.



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

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# Project: Adult Acute Patient Flow

41

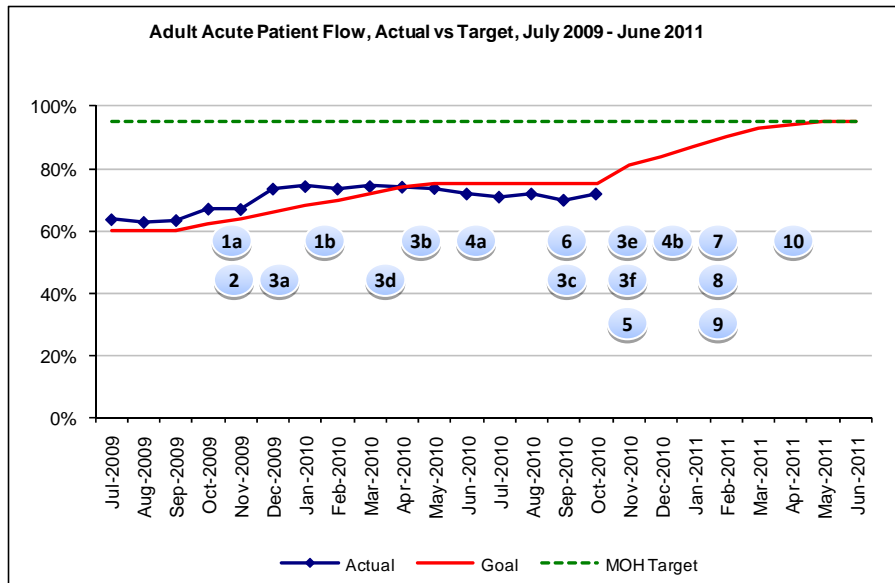
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin , Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



## Project Risks / Comments:

Improvement activity continues with improvement in bed request to admission from average of 10 hours to 2.8 hours in early October. Other results include; Daily rapid round results determined in Orthopaedic's with agreement to continue. Initial results demonstrate ½ day reduction in orthopaedic median LOS. Bed board in production to increase visual management of bed capacity across adult wards. Gen Med time of day of discharge project has resulted in two hour reduction in time from doctor clearance to bed vacated. 70 Nurse Facilitated discharges completed with an average of over 1 day saved per patient. Emergency Department resourcing plan to respond to increased volumes being implemented with the new SMO roster commencing next month and new CNS roles appointed and in training (not available until Feb). Active recruitment of MOSS doctors underway.

## 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' into General Medicine wards
  - b) Introduce Rapid Rounds into Orthopaedics.
  - c) Introduce daily 'Whiteboard catch-up' meetings into General Surgery
  - d) Increase the number of weekend discharges in General medicine and Orthopaedics. 66 Nurse Facilitated discharges have been completed since the relaunch.
  - e) Improve the volume and accuracy of estimated discharge dates in Orthopaedics. Baseline performance identified that approximately 6% of patients have EDD within 8 hours of arrival on wards
  - f) 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 releases (4a & b)
5. Increased Operational management and daily exception reporting
  6. Improve triage processes in Emergency Department
  7. Reduced transfer times between AED and APU
  8. Reduced AED to Ward patient transfer times
  9. Improved time to acknowledge bed requests
  10. Improved scheduling of elective volumes

## Project: Children's Acute Patient Flow

42

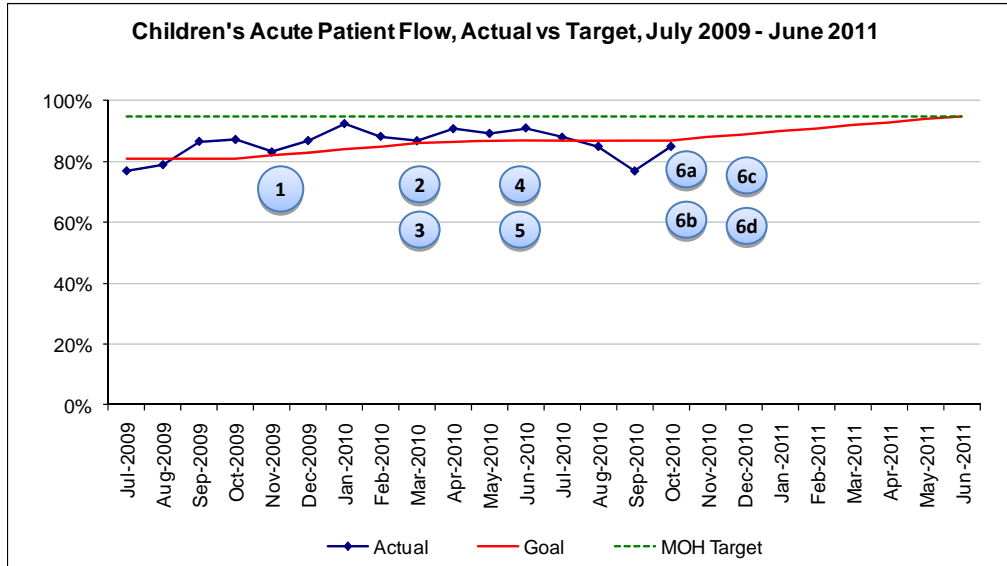
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

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



Completed and current activities:

1. Improved Measurement systems to better identify clinical short stay patients
2. Development of weekly dashboard reporting for CED to better track performance
3. Weekly communications of performance to ward level
4. Development underway of daily reviews to identify specific reasons for delays on a case-by-case basis and to communicate findings with relevant teams
5. Development of 'full hospital plan' to improve responsiveness when indicators of 'bed block' developing
6. Lean Six Sigma Green Belt projects recently commenced to improve
  - (a) Patient Transfers from CED to a ward where a bed is available
  - (b) Bed turnaround time in ward 24B - time to discharge from Doctor's clearance
  - (c) Inter-hospital Paediatric transfers
  - (d) Estimated Discharge Date accuracy in Paediatric Orthopaedics:

### Project Risks / Comments:

There has been an improvement in performance in October. This relates directly to peak of winter activity passing. Performance is reported for the month in total with an improvement through the month; with a further improvement expected in November. The issue remains transfer to inpatient beds. There are a number of Process Improvement projects focussed on improving access to inpatient beds underway which will continue to deliver improvements over the next months.

## Project: Improved access to elective surgery

43

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

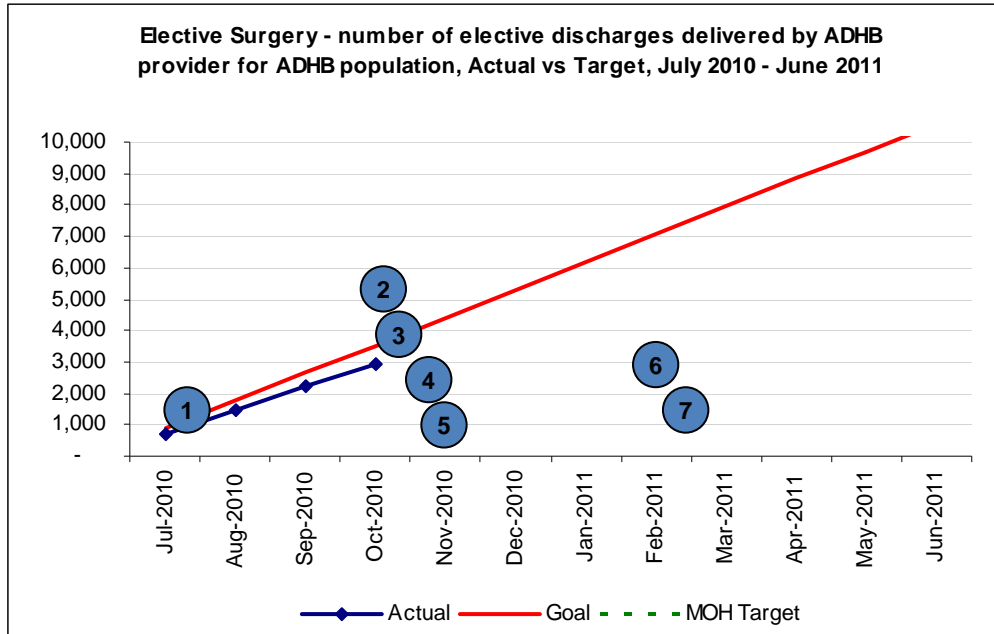
Date of Delivery: 1

Clinical Lead: Vanessa Beavis

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan, Dr Vanessa Beavis, Margaret Dotchin, Justin Kennedy- Good, Greg Balla (chair) Kay Hyman, Dr Judy Bent, Dr Margaret Wilsher, Fionnagh Dougan, Ian Civil.

### Planned Activities:-



1. Outsourcing Orthopaedics
2. GSU Theatre 1
3. Longer days at GSU
3. Saturday Neuro lists
4. Outsourcing for General Surgery, Orthopaedic
5. Orthopaedic production lists
6. GSU Theatre 2
7. Longer days at ACH

### Risks / Comments: (Amber)

Contingencies have been put in place to bring performance back on track. Individual service workout plans agreed to for meeting contract, ministry targets and ESPI compliance. Outsourcing has commenced for Adult Orthopaedics with contracts for the remaining services requiring outsourcing to be in place. The phasing for elective surgery has been aligned to the planned activities outlined on the right of the graph. The GSU theatre build is on track with the sterile supply unit expected to be operational by the end of November. The status for operationalising the operating rooms at GSU is now well under way with equipment ordered, Staff appointments commenced and awaiting start dates. A number of key issues have been identified which are currently being worked through. The implementation plan has been agreed for the productivity gains at ACH. The first activity to commence are the Orthopaedic service lists which are planned to commence mid November.

## Project: Shorter waits for Radiation Therapy

44

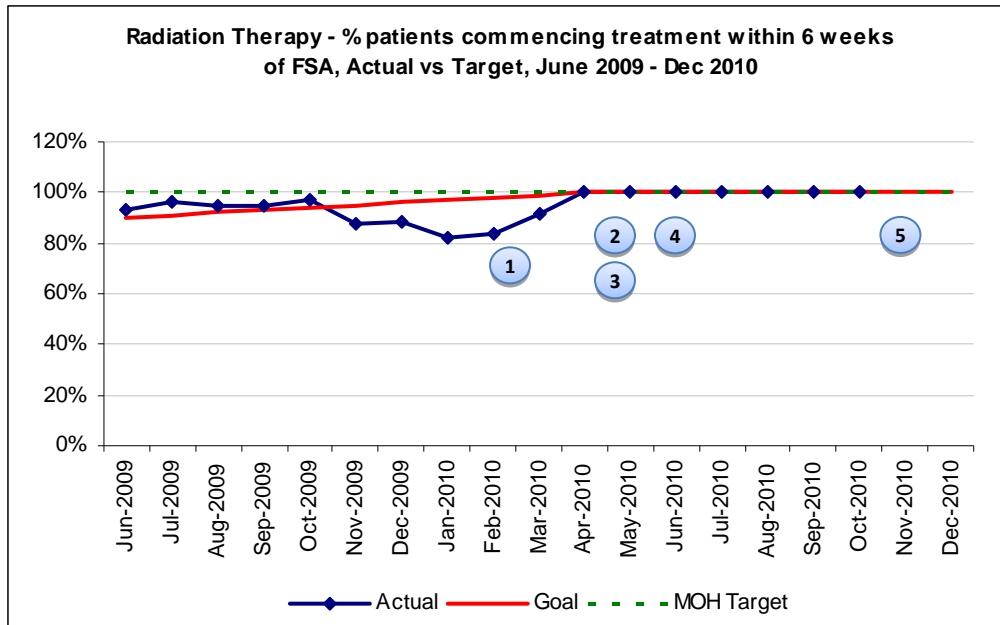
Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010 (Excludes D priority patients and Delay codes)

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



### Project Risks / Comments:

The service has achieved 100% compliance to the 6 week target since April 2010.

A number of improvements were implemented during that time, including

- Development of the capacity modelling tool now in prototype phase
- Introduction of RT flexible working hours in June 2010 and ongoing
- Outsourcing to ARO, Waikato and St Georges (Christchurch)
- Daily waitlist reporting
- Improved forecasting capability
- Continual prioritisation and review of waiting list
- Commissioning of MV5 linear accelerator from 1<sup>st</sup> November 2010.
- A comprehensive and ongoing recruitment plan to attract RT staff to the service. Full RT staffing to budget is expected by December 2010.

### Radiation Oncology Wait times – October 2010

In October the service achieved 100% delivery to the 6 week target for patients in priority categories A, B & C without a delay code and 95% to the 4 week target (the 4 week target is a progress report prior to implementation of the December target).

**Surge in demand:** During the last 7 weeks the service has experienced a consistent level of referrals above 60 per week with a record peak of 92. On average the service is receiving 5 more referrals per week than the corresponding time last year.

### Strategies to reduce wait times:

1. **MV5 Linear Accelerator** becomes operational as planned on November 1. This will deliver additional capacity and patients are now being booked onto MV5 reducing the current requirement to outsource patients.
2. **Extended hours:** Extended hours have been implemented for RT staff where this is an option within the terms of their contract. This enables an additional 9 slots per day.
3. **Outsourcing:** As a result of a sustained high referral rate there is a need to continue outsourcing to ensure we stay within target timeframes.
4. **Aria project:** The MOH has approved “one off” funding to develop a full electronic record with ARIA. This will speed up treatment processes and better match demand to capacity.
5. **A prototype weekly capacity modelling tool** is now being used for future Linac capacity planning and management of workload.

## Project: Better help for smokers to quit

45

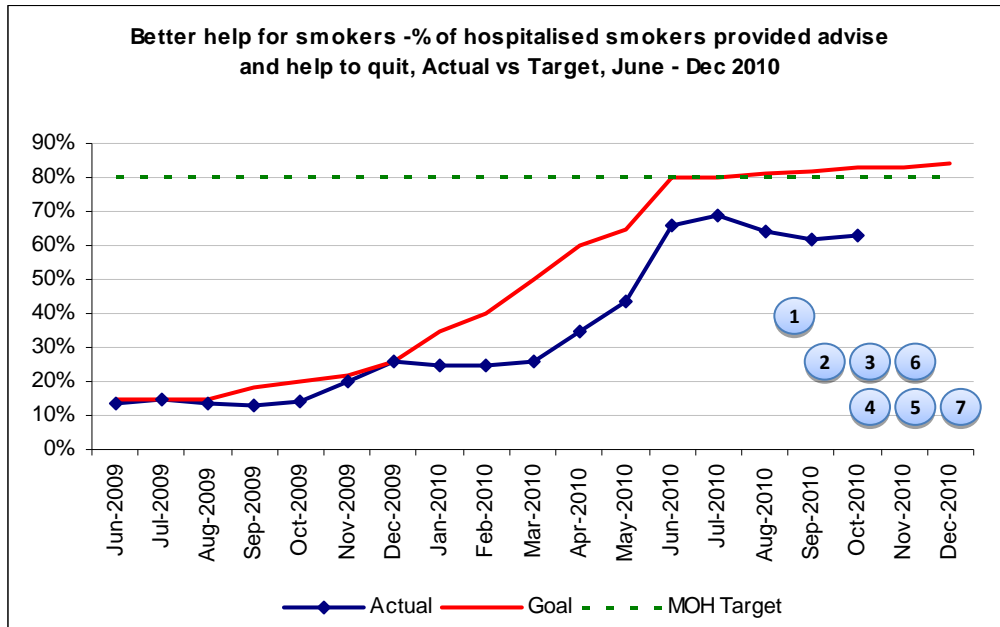
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

An audit of smokefree documentation in charts has been completed. The audit has revealed a small number of wards where the ABC systems have not been completely embedded. These areas will be the focus of additional training and monitoring over the coming months. The acute and shorter stay areas are missing the greatest number of patient's smoking status and brief advice. Activities are underway in the Adult Emergency Dept and Acute Care Area formerly (APU) to lift the number of patients receiving the ABC.

Recent and Current activities:

- 1. ABC Systems improvement, monitoring and feedback**
  - a) Ward audits completed support programme for under performing services to be implemented
  - b) Smokefree Liaison role being established in Adult Health wards
  - c) Sample audits of clinical coding of smoking status and brief advice to be undertaken in October
  - d) Feedback on service performance ongoing
- 2. ABC training & Coaching**
  - a) Ongoing promotion of MOODLE training.
  - b) Further training needs to be determined by audit findings.
  - c) ABC and NRT staff coaching to continue
  - d) Promotion of ABC training to undergraduate health programmes and tertiary institutes
- 3. Improved utilisation of NRT for withdrawal management**
  - a) Promotion to medical staff on NRT products and prescribing planned for October - November 2010
  - b) NRT Standing Order currently being simplified
- 4. Promotion & Communication**
  - a) ABC promotion ongoing. Plans are underway to recognise top performing wards in October/November.
- 5. Research & Evaluation**
  - a) Research programme to be developed over the next 6 months to identify successful interventions, foster innovation and engage clinicians
- 6. Governance & Leadership**
  - a) Role and function of the ADHB Tobacco Control Steering group is underway.
- 7. ABC sustainability plan**
  - a) to be developed to enable handover of ABC programme to services by 2012.

# Project: Cardiac Bypass Surgery

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

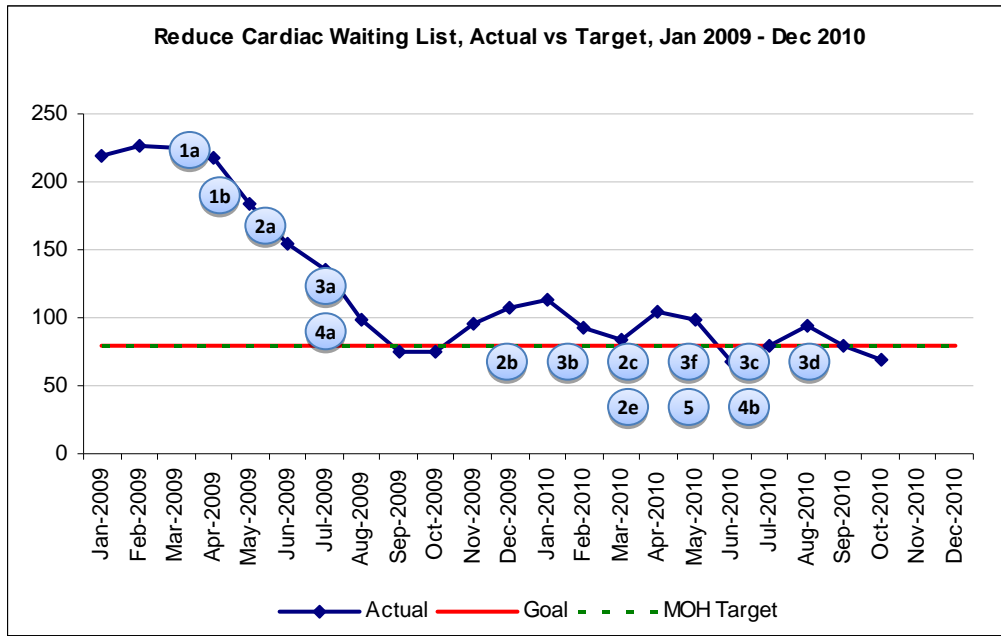
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

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 waiting list has returned to less than target. YTD throughput is 24 patients less than planned as at end October. Recovery plan to return to production plan target by end of December is in place. The shortfall in production relates directly to the impact of the H1N1 ECMO patients and industrial action.

## Project: Diabetes

47

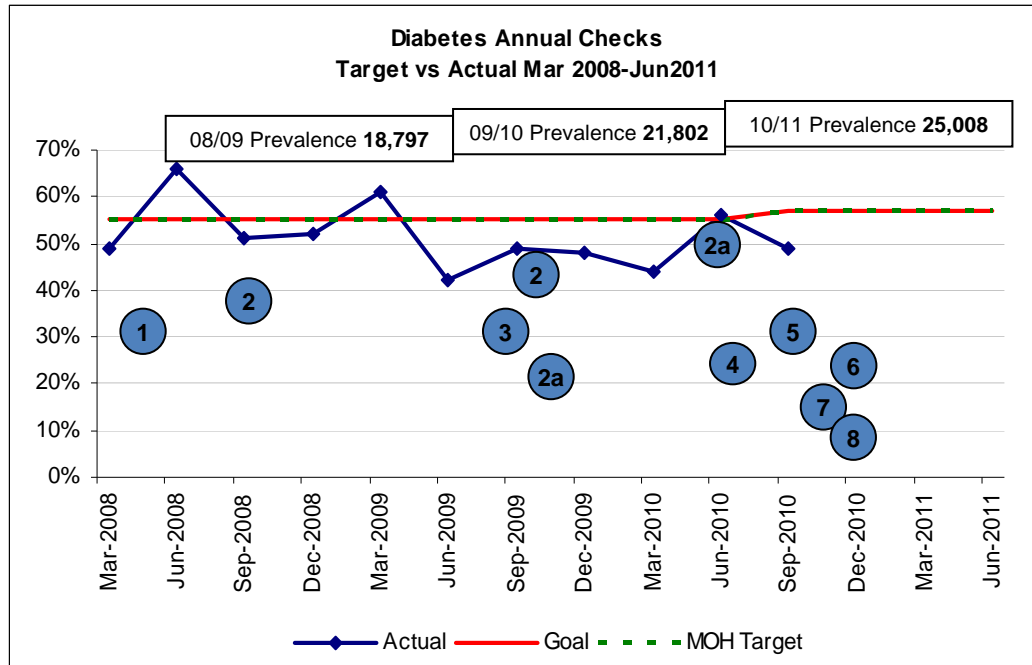
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

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
- 2) Practise based data (results) feedback
- 2a) Increase other feedback options
- 3) Improved understanding of IT linkages in Practice systems
- 4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
- 5) Routine reports to clinical advisory leadership meetings
- 6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
- 7) Regional shared care pathway work
- 8) Regional shared target setting and service outcomes

### Project Risks / Comments:

Q 1 for 2010/11 shows an overall decrease in the number of Diabetes Get Checks being done by primary practices, however the number of reviews for both the Pacific and Indian populations continue to perform above target. The DHB in conjunction with primary care are currently working on a comprehensive range of activities to improve DGC numbers and initiate a overall quality improvement framework. One initiative is a contract with the PHO's to employ three long term condition quality improvement coordinators, with an initial focus on diabetes, to work with our priority practices. The coordinators role includes supporting practices to create a diabetes register, developing a quality improvement plan, and developing strategies that improve systems and processes to better identify and monitor our diabetes population. The Population audit tool, also being funded to each practice, will enable practices to better interrogate their practice management system to identify and manage their population with long term conditions. We aim to have the contract signed with PHO's by end of November, with coordinators employed in the new year.

## Project: Diabetes

48

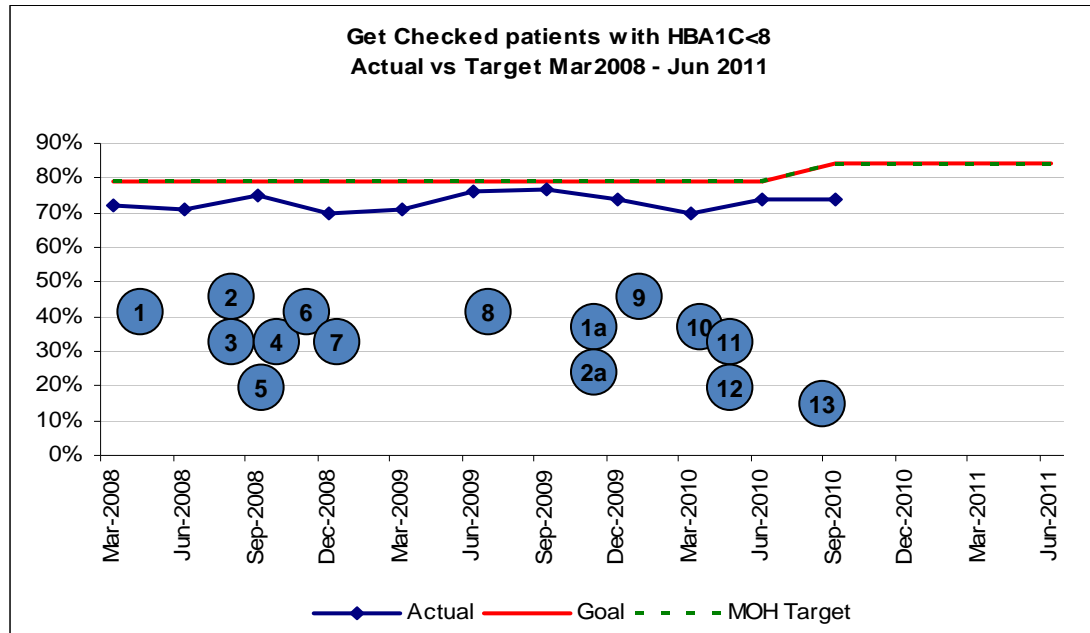
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

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

Clinical Lead: Gayl Humphrey

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) Implementation plan being developed for diabetes coordinators (quality improvement roles) and population audit tools for each practice.

### Project Risks / Comments:

Q1 of 2010/11 shows that overall we have not met our target of 84% of people having an HbA1C  $<$ 8; and are currently at 74%, as per last quarter. However for this quarter we have had a significant increase in management for Maori and have exceeded the target (74% against a target of 72%), have met target for Other and whilst not meeting target for our Pacific population, there has been a 2% increase. As noted in the last report, the activities currently being put in place to improve the DGC targets may initially reflect a downward measure in our management indicator, as identifying more of our population with diabetes will likely result in finding patients with poorly managed diabetes, however overtime it is expected that management will again improve due to the support of the new diabetes programme initiatives and activities.

## Project: Cardiovascular Risk Assessment

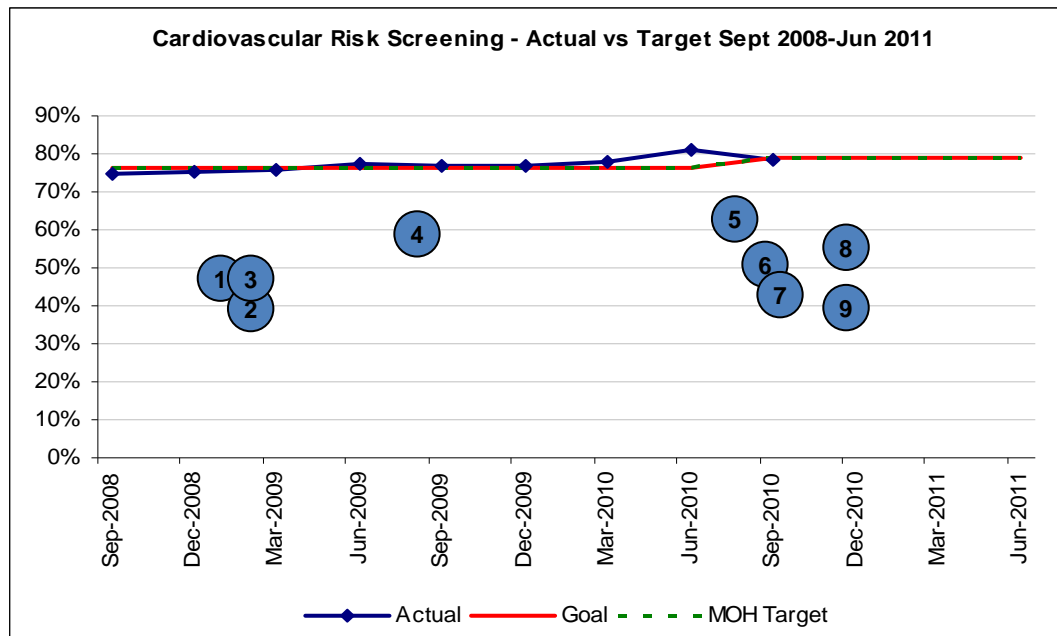
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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



### Project Risks / Comments:

Q1 information shows that we are just shy of reaching our target overall (0.6%), but have exceeded the target for Maori and Pacific populations. Overall activity under each group increased, and if this trend continues we are on track to meet our overall target at year end.

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentives based contract. The latest data shows an increase in number of people screened using the Predict and other screening and management tools, although there is variation in uptake between practices..

### 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: Increased Immunisation**

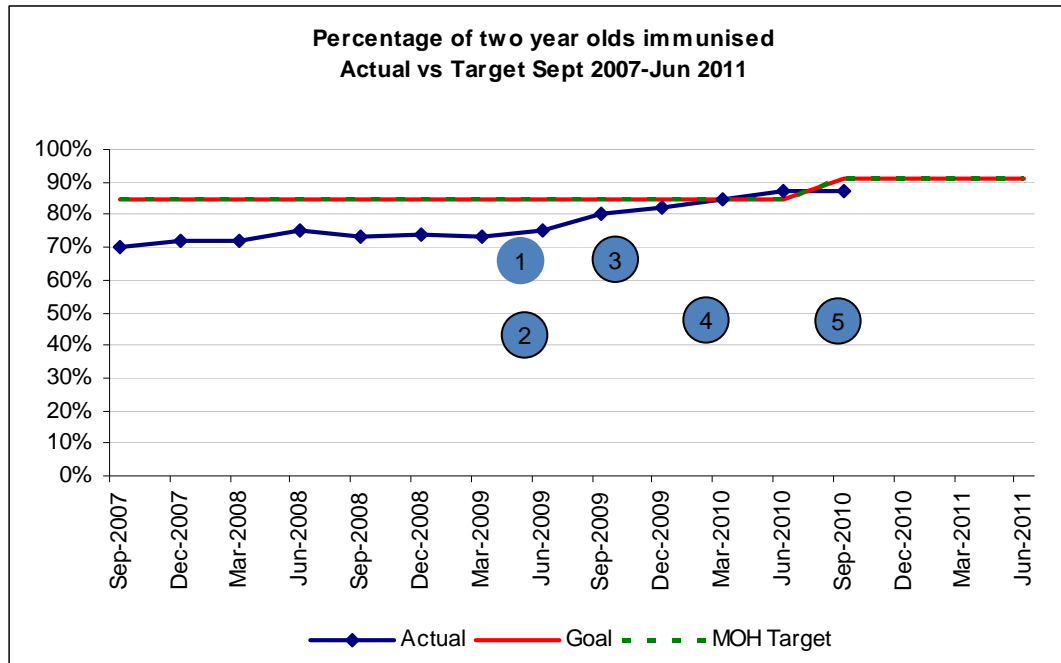
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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 - ongoing
- 3. ADHB Immunisation Strategy approved
- 4. Funding application made to Starship Foundation to fund social marketing programme
- 5. Data Cleansing exercise in primary care approved and funded.

## Project Risks / Comments:

Coverage for Quarter 1 2010/11 (2 years olds full immunised all ethnicities) remains at 87%. The date quality project to be rolled out over the next few months is expected to result in an increase in coverage. Maori coverage at all milestone ages remains a challenge as does timeliness, in particular at 6 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

#### ADHB Board

**Author:** Ian Bell (8077)

**Subject:** Auckland Region DHB Boards Memorandum of Understanding Host and Partner DHBs Managing BSMC Primary Care Alliances and Cross Boundary PHOS

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#### Recommendation

*That the ADHB Board:*

1. Notes that approval of the Ministry of Health is required under the Operational Policy Framework
2. Notes that although the Host DHB will be primary contact for the PHO the partner DHBs will retain direct relationships for key contracts if required
3. Notes that the Ministry of Health has approved the Memorandum of Understanding
4. Approves the Memorandum of Understanding
5. Approves that the Chief Executive sign the Memorandum of Understanding.

#### Background

This is a recommendation from the Community & Public Health Advisory Committee which met on 17 November 2010.

### Maori Health Advisory Committee Recommendations

#### ADHB Board

**Author:** Ian Bell (8077)

**Subject:** Maori Mental Health and Addiction Services

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#### Recommendation

*That the ADHB Board:*

**Notes** that is widespread support from all stakeholder groups for an iwi based solution for the delivery of kaupapa Maori mental health and addictions service in the ADHB area

**Notes** that a successful iwi based solution will necessarily be one that provides clinically and culturally competent kaupapa Maori services within a whanau ora framework

**Notes** that Tangata Whaiora and whanau expect to be central to planning and decision making in the development and implementation of an iwi based solution

**Agrees** that Te Runanga o Ngati Whatua as the ADHB Tiriti partner will be requested to assume a governance role in relation to the process of developing an iwi based solution

**Agrees** that Te Runanga o Ngati Whatua in co-operation with ADHB staff will bring back to the ADHB Board a proposed development pathway to establish a Kaupapa Maori Mental Health and Addictions service for the ADHB area by 31 March 2011.

#### Background

This is a recommendation from the Maori Health Advisory Committee which met on 17 November 2010.

**Pacific Health Advisory Committee Recommendations**

**Disabled Support Advisory Committee Recommendations**

# *10*

## **PERFORMANCE IMPROVEMENT**

### **10.1 "DAP" Drojects Report**





## **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	<p>1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including:</p> <p>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</p> <p>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</p>
	1.2a.2 Improve the oral health of children	<p>1.2a.2.1 Increase school dental clinics to six by June 2011</p> <p>1.2a.2.2 Four new mobile clinics in total established by June 2011</p> <p>1.2a.2.3 Reduce inequalities in the use of school dental services:</p> <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	<p>1.2b.1.1 Introduce the funding methodology for home-based services by July 2010</p> <p>1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services</p>
	1.2b.2 Quality improvement in residential care	<p>1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations</p> <p>1.2b.2.2 25% reduction in overall number of complaints from residential care</p>
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	<p>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+)</p> <p>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</p> <p>1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures</p> <p>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</p> <p>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</p>
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.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery 2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011 2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in: <ul style="list-style-type: none"> <li>- General medicine</li> <li>- Orthopaedics</li> <li>- Radiology</li> <li>- Paediatrics general surgery</li> <li>- General surgery</li> <li>- Ophthalmology</li> </ul>
	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</li> </ul>

High level strategy	Objective	Strategies to achieve objectives
		referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
<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

High level strategy	Objective	Strategies to achieve objectives
<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 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



# Group Pack Report

## Group/Committee: Board



### Goal Level Summary

DAP Projects - total projects: 95

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits									
			Plan		Do/Check	Improve	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red							
			Define	Measure																	Analyse	Control					
1 Lift the Health of the people in Auckland City	34	33	12	5	3	10	2	0	31	2	0	33	0	0	32	1	0	1	0	0	1	0	0	0	0	0	0
2 Performance improvement	50	47	13	4	4	23	1	0	35	11	2	46	1	1	42	6	0	2	0	0	2	0	0	0	0	0	0
3 Live within our means	11	9	3	1	2	1	1	0	8	2	0	10	0	0	9	0	1	1	0	0	0	0	0	0	0	0	0
<b>Total #</b>	<b>95</b>	<b>89</b>	<b>28</b>	<b>10</b>	<b>9</b>	<b>34</b>	<b>4</b>	<b>0</b>	<b>74</b>	<b>15</b>	<b>2</b>	<b>89</b>	<b>1</b>	<b>1</b>	<b>83</b>	<b>7</b>	<b>1</b>	<b>4</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>94%</b>	<b>29%</b>	<b>11%</b>	<b>9%</b>	<b>36%</b>	<b>4%</b>	<b>0%</b>	<b>78%</b>	<b>16%</b>	<b>2%</b>	<b>94%</b>	<b>1%</b>	<b>1%</b>	<b>87%</b>	<b>7%</b>	<b>1%</b>	<b>4%</b>	<b>3%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

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

#### Review

Good progress a wide range of projects contributing to this goal. All HBSS providers have agreed and signed contracts for the 2010/11 year, and working well together on the development and trialing of packages of care and casemix funding - it is great to see this collaborative developmental model underway here. Initiatives to support achievement of the national targets is progressing to plan.

### Goal: 2 Performance improvement

#### Review

The DAP projects related to the BSMC primary care strategy are progressing as discussed previously. In addition there has been considerable activity supporting the the PHOs with various mergers, the establishment of new contracts and developing the working relationships between the DHBs to be effective in the new primary care environment. Significant progress is being made in the Resilience programme of work with the phase 2 completed and the phase 3 implementation now well underway. Regional projects are progressing also in line with the revised timelines. Progress is also being made in our corporate records management area with acceptance of proposed approach and the EOI for enterprise content management tools.

### Goal: 3 Live within our means

**Review**

The month of October was again on budget maintaining the favourable ytd net result variance. Treatment costs are a significant unfavourable ytd cost variance within the Provider Arm although the October month variance was lower than prior months. Payroll costs continue to be favourable. Elective volumes continue to be below planned levels although Ministry phasing has been altered to later in the year. Industrial relations continue as a significant operational risk.

## **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:** Low/mid Range Surgical Instruments

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**Recommendation**

*That the ADHB Board approves ADHB contracting with BBraun Ltd and Downs Distributors Ltd for the provision of low/mid range (defined by cost and complexity) surgical instrumentation for 3 years from 1 December 2010 to 30 November 2013 with an estimated spend of \$1m per annum.*

**Background**

These will be considered by the Finance Committee on 30 November 2010.

**ADHB Board****Author: Ian Bell (8077)****Subject: Orthotic Services**

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**Recommendation**

*That the ADHB Board approves the right to renew the current contract (C1284266) with the Orthotic Centre (NZ) Ltd for a further year from 1 June 2011 to 31 May 2012 at an estimated annual value of \$750,000 p.a. with an option to extend the agreement for one last term of one (1) year if exercised before 31 May 2011.*

**Background**

This will be considered by the Finance Committee on 30 November 2010.

**ADHB Board****Author:** Ian Bell (8077)**Subject:** National Ostomy / Continence / Urology Supply

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**Recommendation**

*That the ADHB Board approves the take up of mirror national contracts for the Ostomy, Continence and Urology categories for the suppliers and services from the following suppliers and contracts for the supply and distribution of Ostomy, Continence and Urology products be approved as specified:*

*Bard Australia Pty Ltd (Urology products – Community services)*

*Coloplast Pty Ltd (Ostomy / Urology products – Hospital and Community services)*

*ConvaTec (Australia ) Pty Ltd (Urology products – Community services)*

*Liberty Medical NZ Ltd (Ostomy / Urology products – Hospital and Community services)*

*Universal Specialties Ltd (USL) (Continence products – Hospital and Community services) and (Distribution of Ostomy and Continence Products to the community patients)*

*The term of these agreements is three years from 1 November 2010 to 31 October 2013, one 2 (two) year's right of renewal is available and if executed the agreements would finish on the 31 October 2015.*

**Background**

This will be considered by the Finance Committee on 30 November 2010.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Sutures and Endosurgical Instruments

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**Recommendation**

*That the ADHB Board approves the exercise of the right of renewal for 2 years for the current contract for the provision of Sutures and Endosurgical Instruments.*

**Background**

This will be considered by the Finance Committee on 30 November 2010.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** ARPHS Building 15 Refurbishment Dispensation to Tender

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**Recommendation**

*That the ADHB Board approves the dispensation from open tender to a limited tender limited to ADHB preferred facilities contractors*

**Background**

This will be considered by the Finance Committee on 30 November 2010.

**ADHB Board****Author: Ian Bell (8077)****Subject: Debt Write-offs**

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**Recommendation**

*That the ADHB Board approves the write-off of the following debts:*

<i>Cardiac</i>	<i>\$325,909.90</i>
<i>General Surgery</i>	<i>\$103,536.23</i>
<i>Neurology</i>	<i>\$193,276.92</i>

**Background**

This will be considered by the Finance Committee on 30 November 2010.

## 11.2 Finance Report

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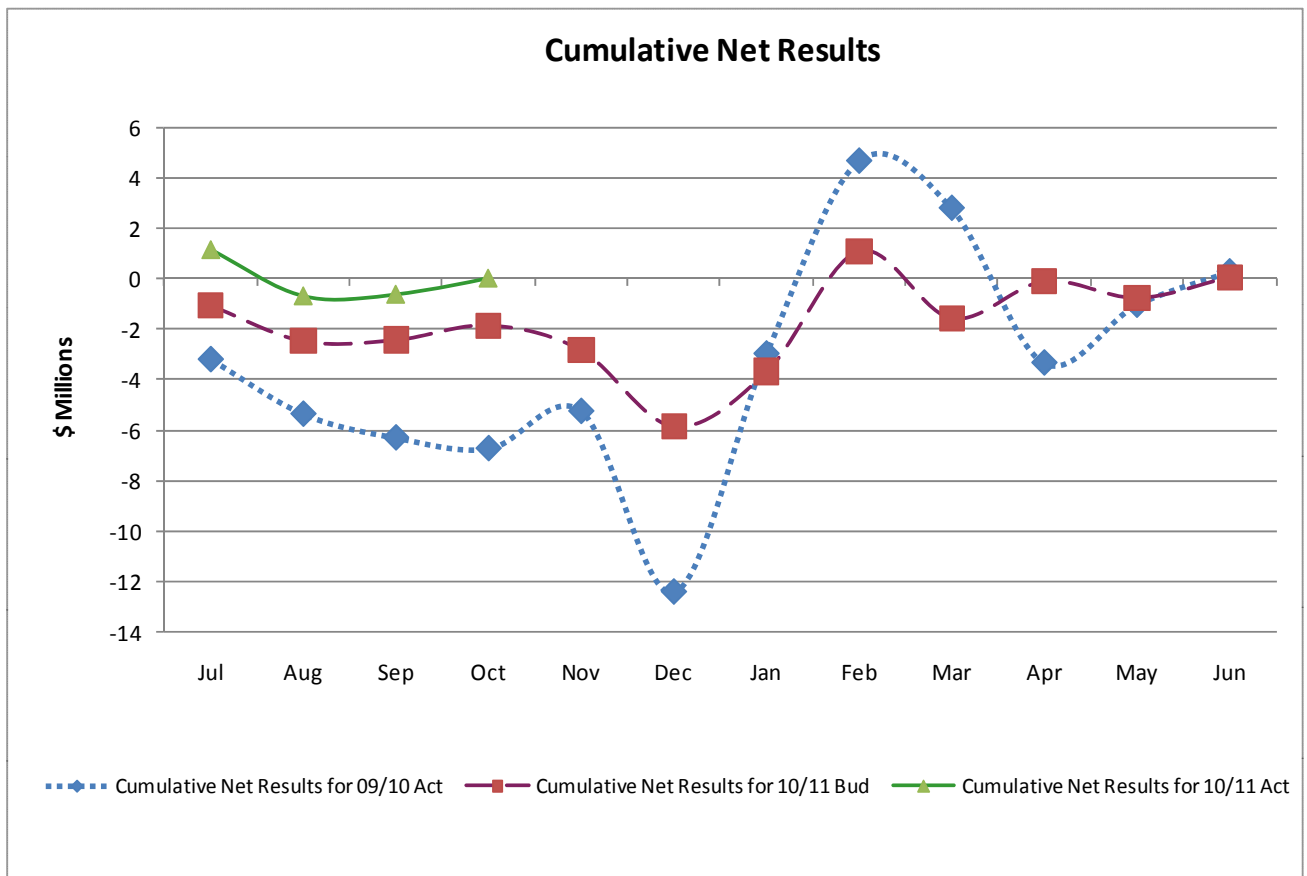
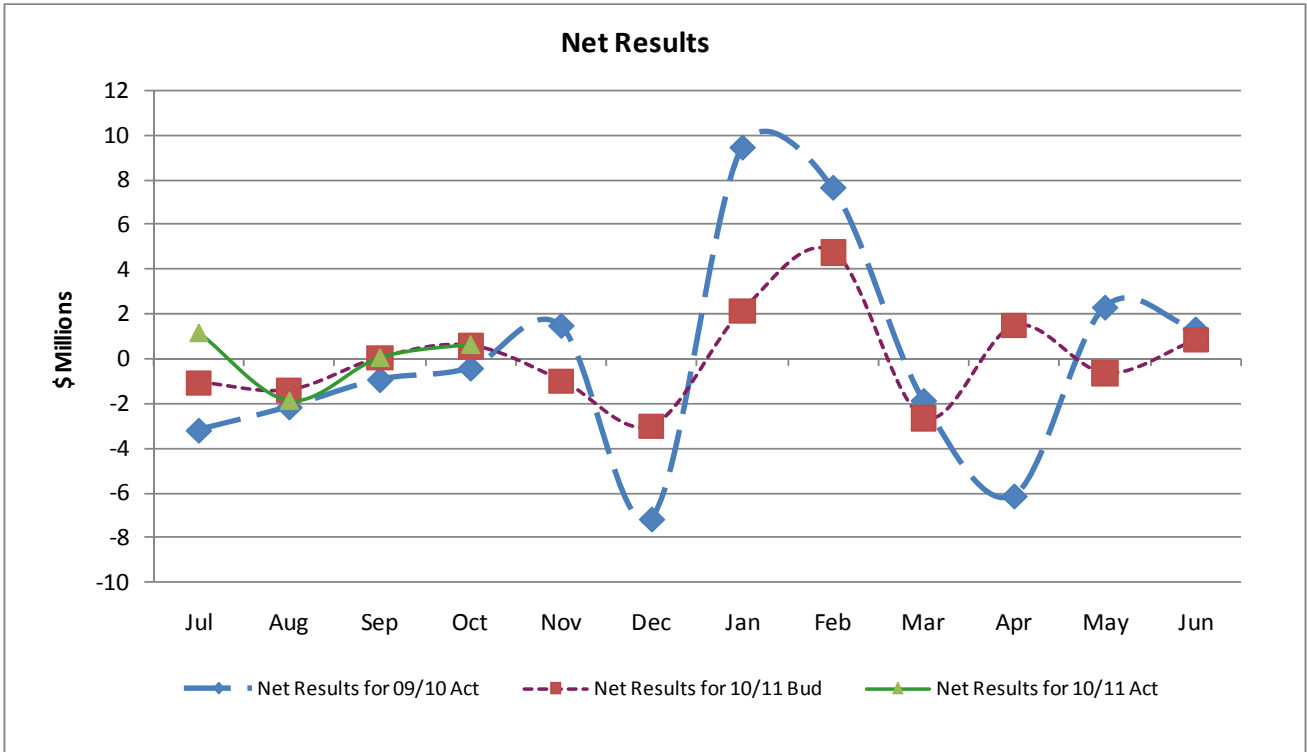
# Auckland District Health Board

## **Board Financial Report**

Prepared by Grant Barnett

October 2010

Performance Graphs by Month & YTD



Auckland District Health Board  
Summary Result  
Month of Oct-10

\$000s	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
<b>Income</b>						
PBF - AKL Population	80,507	79,701	806 F	320,610	318,805	1,805 F
Inter District Inflows	48,009	47,891	119 F	190,257	191,563	1,306 U
	128,517	127,592	925 F	510,867	510,367	499 F
MOH Sub-contracts	3,716	7,315	3,600 U	28,558	29,864	1,306 U
Other Patient Care	2,430	2,688	258 U	12,266	10,840	1,426 F
Services & Products	4,301	4,457	156 U	18,108	17,810	298 F
CTA	1,556	1,649	94 U	6,320	6,598	278 U
Trust & Donation Income	938	427	511 F	3,024	1,751	1,273 F
Financial Income	592	316	276 F	3,657	1,778	1,880 F
Other Income	979	540	439 F	2,666	2,246	420 F
	143,027	144,985	1,958 U	585,465	581,254	4,211 F
<b>Expenditure</b>						
Employee Costs						
Medical	18,905	19,062	157 F	77,727	78,469	742 F
Nursing	19,301	19,609	308 F	77,560	78,078	518 F
Technical	10,029	10,101	72 F	40,823	41,673	850 F
Hotel Services	746	718	28 U	2,893	2,922	29 F
Administration	7,510	7,344	165 U	30,560	30,333	227 U
Other	2,993	3,423	430 F	12,868	13,918	1,050 F
Total Employee Costs	59,484	60,257	773 F	242,430	245,393	2,963 F
Direct Treatment Costs	17,826	17,292	535 U	76,665	70,752	5,913 U
Indirect Treatment Costs	3,347	3,274	74 U	14,398	13,095	1,303 U
Funder Payments	38,410	39,444	1,034 F	157,469	157,774	306 F
Inter District Outflows	8,400	8,372	27 U	33,605	33,489	116 U
Prop, Equip. & Transport	4,102	4,362	259 F	16,604	16,851	248 F
Maintenance	134	133	0 U	627	533	93 U
Loss on Sale of Fixed Assets	5	1	3 U	33	5	28 U
Administration Costs	1,938	2,064	126 F	8,044	8,197	153 F
<b>Total Operating Expenditure</b>	133,645	135,199	1,553 F	549,876	546,091	3,785 U
<b>Operating Contribution</b>	9,382	9,786	405 U	35,589	35,162	427 F
Depreciation	4,359	4,523	163 F	17,712	18,098	386 F
Finance Costs	1,508	1,654	146 F	6,347	6,792	445 F
Capital Charge	2,867	3,034	167 F	11,502	12,121	619 F
<b>Total Non Operating Costs</b>	8,734	9,210	476 F	35,561	37,011	1,450 F
<b>Net Surplus / (Deficit)</b>	648	575	72 F	28	(1,849)	1,877 F

<b>Auckland District Health Board</b>				
<b>Statement of Financial Position</b>				
<b>As at Oct 2010</b>				
	<b>Oct-10 Actual \$ 000s</b>	<b>Oct-10 Budget \$ 000s</b>	<b>Sep-10 Actual \$ 000s</b>	<b>Jun-10 Actual \$ 000s</b>
<b>Crown Equity</b>				
Opening Balance	569,409	569,304	569,409	566,089
Equity Injections/(Repayments)	-	1,015	-	3,320
Closing Balance	569,409	570,319	569,409	569,409
<b>Revaluation reserve</b>				
Opening Balance	353,538	381,278	353,538	381,278
Revaluation Adjustments	-	-	-	(27,740)
Closing Balance	353,538	381,278	353,538	353,538
<b>Retained Earnings</b>				
Opening Balance	(468,367)	(468,437)	(468,367)	(468,645)
Surplus/(Deficit) Current Year	28	(1,850)	(619)	279
Closing Balance	(468,338)	(470,287)	(468,986)	(468,367)
<b>Total Crown Equity</b>	<b>454,608</b>	<b>481,310</b>	<b>453,961</b>	<b>454,578</b>
<b>Represented by:</b>				
<b>Fixed Assets</b>				
Land	181,497	201,337	181,497	181,497
Buildings	579,743	533,587	581,476	586,094
Clinical, Other Equipment & Motor Vehicles	82,758	166,128	84,239	79,856
Work in Progress	26,456	23,648	23,575	23,166
<b>Total Fixed Assets</b>	<b>870,453</b>	<b>924,700</b>	<b>870,787</b>	<b>870,612</b>
<b>Derivative Financial Instruments</b>	<b>5,321</b>	<b>4,399</b>	<b>5,321</b>	<b>7,061</b>
<b>Investments</b>				
Associated Company Investments	95	386	95	470
Trust Deposits	7,078	8,000	10,078	10,078
<b>Total Investments</b>	<b>7,172</b>	<b>8,386</b>	<b>10,172</b>	<b>10,547</b>
<b>Current Assets</b>				
Cash & Short Term Deposits	68,399	33,891	61,297	56,815
Trust Deposits	14,572	11,508	11,550	11,747
Debtors	16,998	24,435	23,956	25,691
Accrued Income	22,575	23,198	36,869	31,221
Prepayments	3,542	2,320	3,236	2,245
Inventory	11,700	12,106	11,758	11,220
<b>Total Current Assets</b>	<b>137,785</b>	<b>107,457</b>	<b>148,667</b>	<b>138,938</b>
<b>Current Liabilities</b>				
Borrowings	1,941	23,146	4,762	75,027
Trade & Other Creditors, Provisions	210,128	208,795	221,393	222,910
Income Received in Advance	25,388	18,888	27,175	20,087
Taxes Payable	21,953	19,101	20,996	18,040
Funds Held in Trust	1,078	1,078	1,071	1,067
<b>Total Current Liabilities</b>	<b>260,488</b>	<b>271,008</b>	<b>275,397</b>	<b>337,132</b>
<b>Working Capital</b>	<b>(122,703)</b>	<b>(163,550)</b>	<b>(126,730)</b>	<b>(198,193)</b>
<b>Non Current Liabilities</b>				
Borrowings	283,046	271,746	283,038	213,014
Employee Entitlements	22,589	20,880	22,551	22,435
<b>Total Non Current Liabilities</b>	<b>305,635</b>	<b>292,625</b>	<b>305,589</b>	<b>235,449</b>
<b>NET ASSETS</b>	<b>454,608</b>	<b>481,310</b>	<b>453,961</b>	<b>454,578</b>

Statement of Cashflows for the Year ended 30 June 2011							
	Oct-10			Year to Date			
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>Operations</b>							
Revenue Received	161,902	147,944	13,958	604,497	593,937	10,560	
Payments	(151,348)	(154,136)	2,788	(578,117)	(576,871)	(1,246)	
<b>Net Operating Cashflows</b>	<b>10,554</b>	<b>(6,192)</b>	<b>16,746</b>	<b>26,380</b>	<b>17,066</b>	<b>9,314</b>	
<b>Investing</b>							
Income	592	370	222	2,195	1,479	716	
Capital							
Sale of Assets	0	1	(1)	1	5	(4)	
Purchase Fixed Assets	(4,027)	(6,460)	2,433	(17,553)	(25,842)	8,289	
<b>Net Investing Cashflows</b>	<b>(3,435)</b>	<b>(6,089)</b>	<b>2,654</b>	<b>(15,357)</b>	<b>(24,358)</b>	<b>9,001</b>	
<b>Financing</b>							
Equity Injections	0	0	0	0	1,014	(1,014)	
New Loans	0	0	0	70,000	70,000	0	
Loans Repaid	0	0	0	0	375	(375)	
Equity Repayment	0	0	0	0	0	0	
Loans Repaid	0	0	0	(70,000)	(70,000)	0	
<b>Net Financing Cashflows</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,389</b>	<b>(1,389)</b>	
<b>Total Net Cashflows</b>	<b>7,119</b>	<b>(12,281)</b>	<b>19,400</b>	<b>11,023</b>	<b>(5,903)</b>	<b>16,926</b>	
<b>Opening Cash</b>	33,933	36,407	(2,474)	30,029	30,029	0	
<b>Closing Cash</b>	41,052	24,126	16,926	41,052	24,126	16,926	

## Financial Performance

The result for October was a surplus of \$0.6m against a budgeted surplus of \$0.6m. The result year to date to October was breakeven a favourable variance to budget of \$1.9m. The result year to date, was driven by higher revenue \$4.2m offset by higher expenditure of \$(2.3)m.

Year to date revenue was higher than budget by \$4.2 m. This was the result of:-

- a) Favourable Base Revenue \$0.5 m driven higher base contract variations, including additional Herceptin Funding \$3.0m, offset by provision for potential IDF volume variations for 10/11 year to date
- b) Lower MoH Subcontract revenue \$(1.3)m, driven by lower Herceptin funding (now in base revenue) \$(1.8)m and lower Additional Elective revenue \$(2.5)m as a result of lower volume delivery.
- c) Higher volumes of non resident activity \$1.7m
- d) The timing of donations \$1.3m
- e) Higher interest received on term deposits \$0.8m.
- f) A realised gain on Interest Rate Swap Instruments \$1.1m

Year to date expenditure was higher than budgeted by \$(2.3)m.

- The favourable variance in employee costs of \$3.0 m was driven by vacancies in Mental Health \$1.1m, Cancer \$0.3m, Radiology \$0.4 m and across Adult Health \$1.3 m. In addition lower Continuing Medical Education \$1.0m has been driven by the expiry of Nursing CME accruals for balances greater than 3 years old \$0.4 m and the anniversary, and consequential expiry of entitlements, of SMO CPE \$0.6m . These favourable variances were partially offset by high Medical staff allowances in Paediatric \$(0.3) m and Adult Cardiac \$(0.6) m, driven by a high number and complexity of implant procedures and high dependency patients.
- Direct Treatment costs are \$(5.9) m unfavourable to budget driven by high blood, Oncology and Cardiovascular drug usage \$(0.8) m, Implant usage \$(1.3) m and Clinical Supplies costs \$(1.7) m predominantly as a result of Adult and Paediatric Cardiac Implant procedures and other high dependency patients and higher outsourcing costs \$(1.1) m for radiotherapy \$(0.5) m, MRI Scanning \$(0.4) m and Cardiac \$(1.0) m. The above processes have been supported by higher laboratory material usage \$(0.8) m.
- Funder Payments are \$0.2m under budget. There are offsetting variances arising from the cost of settlement of prior year's pharmaceutical claims \$(1.0) m offset by an accrual no longer required \$1.0m.
- Indirect Treatment Costs are \$(1.3) m unfavourable primarily due to provisioning for doubtful non resident debts driven by the increased revenue described above.
- Administration costs are favourable to budget \$0.2 m primarily due to the timing of consulting expenditure \$0.8m for performance improvement projects offset by 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.
- Depreciation is lower than budget \$0.4m driven by the timing of capitalisation of capital projects
- Finance Costs are lower than budget \$0.4 m driven by lower than planned interest rates and CHFA loans not being drawn down.

- The Capital Charge is lower than budget \$0.6m driven by the revaluation of Land & Buildings downwards at balance date.

### **Financial Position**

- The opening balance of fixed assets was \$(34.3) 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 \$17.6m, under budget by \$(8.3)m. Baseline and Facilities projects are behind budget by \$(4.7)m and Information Systems projects are behind budget by \$(3.6)m driven by the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$68.4m (excluding Trust deposits). At month end there is an unused overdraft facility of \$63.0m.



# *12*

## PAPERS

No Papers



# *13*

## **GENERAL BUSINESS**



**APPENDICES**

**No Appendices**



*15*

**PUBLIC EXCLUSION**



**AUCKLAND DISTRICT HEALTH BOARD**

**RESOLUTION TO EXCLUDE THE PUBLIC  
FROM A MEETING OF THE BOARD**

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

That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 15.

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:
15.1 Auckland Regional Health Technologies Innovation Hub. 15.2 Greenlane Surgical Centre 15.3 Tamaki Transformation: Pathways to Health Careers	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.

<b>MEETING DETAILS</b>	
Time and Date	11:15am – 1:00pm, Thursday 2 December 2010
Venue	Board Room, Level 5, Administration Suite, 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, Paul Green, 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 3 November 2010</b>	<b>017</b>
<b>5</b>	<b>Action Points 3 November 2010</b>	<b>025</b>
<b>6</b>	<b>Presentations - Nil</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 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>069</b>
<b>12</b>	<b>Papers - Nil</b>	<b>089</b>

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13	General Business	091
14	Appendices - Nil	093
15	Public Exclusion	095
<b>NEXT MEETING</b>		
	<b>Time and Date:</b>	2:00pm, Wednesday 2 February 2011
	<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