



# **Auckland District Health Board**

## **Board Meeting**

**Wednesday 2 June 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. Replas 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. Auckland 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>	<ol style="list-style-type: none"> <li>1. Writing, editing and public relations services</li> <li>2. Medical Council of NZ</li> <li>3. Occupational Therapy Board</li> </ol>	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
<b>Dr Chris CHAMBERS</b>	<ol style="list-style-type: none"> <li>1. Employee, Auckland District Health Board</li> <li>2. Wife employed by Safekids</li> <li>3. Associate, Epsom Anaesthetic Group</li> <li>4. Member, ASMS</li> <li>5. Shareholder, Ormiston Surgical</li> <li>6. Credentialing Committee for Ormiston private hospital</li> <li>7. Surveyor Quality Healthcare NZ</li> </ol>				3 February 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				15 July 2009
<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			
<b>Bob TIZARD</b>	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Seiuli Dr Juliet WALKER</b>	<ol style="list-style-type: none"> <li>1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure</li> <li>2. Member, National Breast Screening Advisory Committee</li> <li>3. Facilitator, RNZCGP General Practice Education Programme Stage II</li> <li>4. ADHB Employee: contracted roster Doctor for Pohutukawa</li> <li>5. Panel Member, Medical Appeal Board, Work and Income</li> </ol>	<p>Self employed contractor</p> <p>Member</p> <p>Contractor</p> <p>Contractor</p>	<p>Contract hourly rate</p> <p>Fee</p> <p>Contracted monthly fee</p> <p>Hourly rate</p> <p>Fee</p>	<p>General practitioner services</p> <p>Consultant Pacific Advisor</p> <p>Educational Support and Training</p> <p>Forensic sexual assault examinations</p>	5 May 2010
<b>Ian WARD</b>	<ol style="list-style-type: none"> <li>1. Chair, Advisory Board, Healthvision Limited</li> <li>2. Principal/Director C -4 Consulting Limited</li> </ol>		Fee	Tender to National Shared Services	3 February 2010



**CONFIRMATION OF MINUTES**

**- 5 MAY 2010**



# Auckland District Health Board Minutes



<b>MEETING DETAILS</b>											
Time and Date	2:00 pm, Wednesday, 5 May 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 1:55pm and welcomed the AUT students in attendance and Diane Robertson the City Missioner who had made an enormous contribution to Auckland. Rob Cooper 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>Harry Burkhardt</td> </tr> <tr> <td>Jo Agnew</td> <td>Susan Buckland</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 Dr 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 and Funding Officer  Brent Wiseman - Chief Financial Officer  Ngairie Buchanan – General Manager Operations  Hilda Fa’asalele – General Manager Pacific Health  Julie Helean – Manager Planning and Service Development  Chris Morgan – Manager Materials Management  Vivian Rawlings – General Manager Human Resources  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Apologies had been received from Chris Chambers, Taima Campbell, Naida Glavish, Kay Hyman and Janice Mueller.</p> <p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Pat Snedden (Chair)	Harry Burkhardt	Jo Agnew	Susan Buckland	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward
Pat Snedden (Chair)	Harry Burkhardt										
Jo Agnew	Susan Buckland										
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>										
	<p>There were no notifications of conflicts of interest for any item on the agenda. Juliet Walker advised that she was a panel member of the Medical Appeal Board of Work and Income.</p> <p><u>Moved Brian Fergus; seconded Susan Buckland</u></p> <p><i>That the amendment to the Interest Register be noted.</i></p> <p><u>Carried</u></p>										

4	<b>CONFIRMATION OF MINUTES 7 APRIL 2010</b>
	<p><u>Moved Jo Agnew; seconded Ian Scott</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 7 April 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	<b>ACTION POINTS 7 APRIL 2010</b>
	The action points were noted.
6.1	<b>City Missioner – Diane Robertson</b>
	<p>The Chair acknowledged Diane Robertson the City Missioner as a force of change in Auckland and a voice for the voiceless. ADHB worked with the Mission with the CEO on the Homeless Steering Committee addressing rough sleepers.</p> <p>The Missioner presented to the Board advising that they had 100 employees working with the most marginalised people and once were the only service catering for those with HIV and AIDS. Their budget was \$8m of which 7% was from Government for drug and alcohol programmes and being outside Government they could take a strong advocate position.</p> <p>The current services including crisis and community services were outlined noting that numbers were not decreasing. Homeless services were focused on rough sleepers who were high cost and hard to work with. Statistics were 34,627 drop-ins, 3,600 items of clothing provided, 70 homeless enrolled in the medical centre and locating to housing 171 times. There was a detoxification programme which provided 3,136 nights, 361 clients had gone through the residential detox of which 56% were self referrals. The Calder centre had 6,329 doctors visits, 4,180 consultations, 558 enrolled patients at June 2009 of which 76% were in high deprivation. Distribution services dealt with \$1.8m of food and 6,400 loaves of bread with 3,000 of these contributed by Goodman Fielder.</p> <p>There had been increased demand with the depression. The Mission was supported by large numbers of volunteers who provided 25,000 Christmas presents for kids and 1,500 attendees at the Christmas dinner. Moving forward the Mission wanted to provide a gift in perpetuity and retain the Mission in the city with a project to provide 80 homeless studio apartments, 63 solo parent apartments to assist people to get back into the workforce within 3 years and integrated social services and medical centre as a community in the middle of Auckland.</p> <p>Outreach teams walked the city every night and early morning. Young homeless were better at looking after themselves but prostituted themselves and moved from friends to friends until they were no longer welcome. ADHB was on the Homeless Steering Committee and there were efforts to share information, especially in mental health, but there were issues of rights and privacy. Staff had clear boundaries and this was clearly communicated to clients. The medical centre was part of the Auckland PHO and funded through capitation.</p> <p>The Chair thanked Diane Robertson for her very informative presentation.</p>
7	<b>CHAIRMAN'S REPORT</b>
	<p>The accreditation process of Labtests was expected in the middle of the month and was expected to be positive. The laboratory was operating well but it will still take time to develop relationships at the clinical level but they were better at the population level. They had an 8 year contract and DML had a 4 year contract which was also working well. With Labtests there was two levels being actual delivery which was adequate and relationships where, although communication had improved, there still needed to build trust. One of the positive changes had been with midwives who were now receiving a better service than they had experienced previously.</p> <p>The primary care EOI had three plans sent to the MoH. Pacific went last Friday which was generally supported but there were some funding issues. Maori would be due at the end of May. GAIHN were developing an implementation plan which was due 21 May but they still had to</p>

	<p>address governance and leadership issues and how they would be held accountable creating a project governance structure around 8 projects.</p> <p>Building 5 suggests and contacts had been sent to CEO and meetings were being set up with Manager Materials Management.</p>
<b>8.1</b>	<b>Chief Executive's Summary</b>
	<p>Electives continued to be a focus and while the Minister's targets were being achieved the target for the ADHB population was not and there was a need to get to a higher target next year. A new Surgical Project had been launched as, to get the Greenlane Surgical Unit working, there would need to be change there and at ACH. This was a critical area. Children, Women's and General Surgery would be early movers.</p> <p>There had been feedback on the DAP with some conflicting advice so meetings with the relationship manager had been arranged. There was concern at their lack of understanding of ADHB business and while it was a brief DAP theirs was a demand for detail. The result would probably be the financial results and the main initiatives around the Minister's six priority goals in the graph format. The National Health Board wanted the key things and there appeared to be a layer of disconnect to the MoH who were seeking detail. There would be a primary and regional component in the DAP including the primary eight initiatives, regional shared services and regional service planning which would be agreed to be in all the regional DAPs.</p> <p>Ian Scott left the meeting at 3:07pm.</p> <p>The Walk Around programme was commencing with a briefing before the round and then a debrief. This was a quality improvement initiative with the core CEO/Clinical Partners supported by the Senior Leadership Team and there was recording of the issues raised.</p> <p>The State of the Nation presentation had generally positive feedback.</p> <p>The Auckland City Hospital Car Park had been due to be built 7 years ago and now has the agreed consents and design and had received a tender price better than expected which was valid for 90 days. The Capital Investment Committee's agreement had been obtained earlier but was now being queried with the restructuring in Wellington. The Finance Committee recommended to the Board support for this to be raise at a higher level by the Chair. Briefing notes for the Chair were to be prepared.</p> <p>To achieve the year end target weekly meetings were being held to manage.</p> <p>Non DRG volumes had been discussed at the Quality, Risk and Audit Committee with increased referrals for FSAs.</p> <p>A briefing on the ASPIRE project was included in the papers.</p> <p>This Board meeting was the last meeting for the retiring Chief Medical Officer, David Sage and the CEO expressed his appreciation and acknowledgement of the clinical partnership.</p> <p>The Board Strategic Planning Day was scheduled for 26 May to ensure that David Sage could present and was also after the Budget.</p>
<b>8.2</b>	<b>Minister's Six Health Priorities 2009/2010</b>
	<p>The adult acute patient flow and children's acute patient flow had been discussed earlier as had the improved access to elective surgery. Waits for radiation therapy was down to 3.9 weeks but there would be a bow wave created with the replacement of the linear accelerator in the third quarter. Better help for smokers to quit was, at 25%, below expected however April had improved to 35% with a plan to improve further. There were issues with coding as nicotine replacement data showed an increase. There was a smoke free day in May which would be used as a focus.</p> <p>Cardiac surgery had been referred to earlier with more transplants taking the list up to 98 however there was a recovery plan to bring it back to the 81 target. There had been progress coming from over 200 and a six month wait to the reduced number and a 3 month wait. The aim was to get to a lower waiting lists to handle fluctuations within the target level.</p> <p>The diabetes projects were below target but there are a number of initiatives to get to the target.</p>

	<p><u>Moved Ian Ward; seconded Jo Agnew</u></p> <p><i>That the Chief Executive Summary and Minister's Six Health Priority reports be noted.</i></p> <p><u>Carried</u></p>
<b>9.1</b>	<b>Committee Recommendations</b>
	<p><b>Community and Public Health Advisory Committee</b></p> <p>The Committee had discussed B4 School Checks with the proposal to use Well Child providers, PHO certification, the EOI business cases going forward and the Aged Residential Care contract review process which was a national process. The final contract for Home Based Support Services had been signed and will be monitored closely to get to the restorative model of care and managed costs. The Committee had a presentation on the SOI from the Auditors and it would be a challenge to get a draft SOI that was acceptable to the Auditor-General. Hon Pansy Wong would be at the June meeting with a focus on Asian health.</p> <p><b>Maori Health Advisory Committee</b></p> <p>The Committee had supported the contract review process and wanted a focus on smoking cessation. The Chair would be working on regional processes and acknowledged the people on the Committee.</p> <p><b>Pacific Health Advisory Committee</b></p> <p>The Committee had been advised that Pacific termination rates were three times higher than European which raised more questions than answers and had requested consideration of research into this issue. There had been a presentation on evaluation of the three DHBs' Pacific projects, including HVAZ, which showed the complexities that meant that one size did not fit all and that the programmes were all at different levels and there was a need to match capability and resources with appropriate measures in place. Churches were a good vehicle for change.</p> <p><u>Moved Pat Snedden; seconded Susan Buckland</u></p> <p><i>That the Committees' reports be received.</i></p> <p><u>Carried</u></p>
<b>10.2</b>	<b>DAP Projects Report</b>
	<p><u>Moved Pat Snedden; seconded Brian Fergus</u></p> <p><i>That the DAP Projects Report be noted.</i></p> <p><u>Carried</u></p>
<b>11.1</b>	<b>Finance Committee Recommendations</b>
	<p>The neurosurgery microscopes were budgeted for 2009/2010 but had been pushed to the next financial year but brought back again as the existing equipment had deteriorated.</p> <p>The high dose Brachytherapy machine was the first phase to replace a low dose machine and would be located in the existing bunker. Phase 2 would only be undertaken if it was necessary to relocate.</p> <p>ADHB had taken the risk of keeping the National Air Ambulance Service going but this proposal reduced that risk. ADHB had facilitated the national process and the contribution from Starship Foundation of \$1.5m was acknowledged.</p> <p>The replacement accelerator for radiation oncology was critical and a good price had been obtained linked to the previous purchase. This was necessary to get to 4 weeks waiting time by year end.</p> <p>The upgraded nurses call system was phase 2 of six year programme and would complete half the programme.</p>

	<p><u>Moved Ian Ward; seconded Brian Fergus</u></p> <p><b>2 Neuro Surgery Microscopes</b></p> <p><i>That the Auckland District Health Board approves the purchase of 2 Pentero microscopes manufactured by Carl Zeiss used for Neurosurgical operating on Level 8 Operating Rooms as a cost of \$850,000 subject to the Manager Materials Management doing due diligence with signoff delegated to the Chief Financial Officer.</i></p> <p><b>High Dose Rate Brachytherapy Machine</b></p> <p><i>That the Auckland District Health Board approves the purchase of a High Dose Brachytherapy Machine for \$810,000 subject to Facilities Management confirming that the allowance of \$10,000 was sufficient for the room modifications.</i></p> <p><b>National Air Ambulance Services</b></p> <p><i>That the Auckland District Health Board endorses the selection of The Life Flight Trust as the preferred provider for the National Air Ambulance Services noting; the contract will be for a three (3) year period commencing the 1st July 2010 with an optional two (2) year right of renewal with an estimated annual expenditure for National Air Ambulance for PICU and ECMO Services for the 21 DHBs of \$2,267,454. The total estimated annual value over the term of the contract (5 years) is \$11.34 million. Approval of this expenditure is subject to the approval of the Project Recommendation by the CEOs of the 21 DHB.</i></p> <p><b>Replacement Accelerator for Radiation Oncology</b></p> <p><i>That the Auckland District Health Board approves the purchase of replacement Linear Accelerator for Radiation Oncology for \$3,592,387.86.</i></p> <p><b>Upgrade Nurses Call System – ACH Level 6 &amp; 7</b></p> <p><i>That the Auckland District Health Board approves the capex of \$600,000 to upgrade the nurse call system on Levels 6 &amp; 7 of Auckland City Hospital and that the quote from Opine Patient Communications Ltd to undertake the upgrade be accepted subject to a manufacturers support undertaking in the form of a formal contract.</i></p> <p><u>Carried</u></p>
11.2	<p><b>Finance Report</b></p>
	<p>Results were \$1.2m favourable year to date but \$0.8m unfavourable for March with a number of one offs. Various initiatives were being followed to get to breakeven and manage in a variable environment. The Board asked that when results were produced that a one pager be sent to the Board over the next 3 months.</p> <p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the Finance Report be noted.</i></p> <p><u>Carried</u></p>
12.1	<p><b>Approval of 2010-2011 SOI</b></p>
	<p>The Statement of Intent was due to be filed on 14 May 2010 and would still be being updated until then.</p> <p><u>Moved Harry Burkhardt; seconded Juliet Walker</u></p> <p><i>That the Auckland District Health Board approves delegated authority to the Chair and CEO to approve the submission of the final draft of the SOI to the Ministry of Health on 14 May 2010.</i></p> <p><u>Carried</u></p>

13	<b>GENERAL BUSINESS</b>
	<p><b>Ronald McDonald House Auckland Trust Board</b></p> <p><u>Moved Susan Buckland; seconded Juliet Walker</u></p> <p><i>That the Auckland District Health Board appoints Dr Liz Segedin to the Ronald McDonald House Auckland Trust Board as trustee representing the ADHB.</i></p> <p><u>Carried</u></p> <p><b>David Sage CMO</b></p> <p>The Chair thanked David Sage on behalf of the Board noting that he had fronted the organisation and had shown good application of judgment enhancing the Board by his judgment and professionalism. In response he advised that he had seen a linear improvement of governance at Board level over the 10 years and the organisation was doing well.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 4:03pm</p> <p>The next scheduled meeting is :  2:00pm, Wednesday, 2 June 2010  A+ Trust Room  Clinical Education Centre  Level 5  Auckland City Hospital  Grafton</p>
<p><b>CONFIRMED</b></p> <p><b>CHAIR:</b> <span style="float: right;"><b>DATE:</b></span></p>	

**ACTION POINTS**

**- 5 MAY 2010**



**Board**  
**Action Points from the meeting on Wednesday 5 May 2010**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
Carried forward	Suggested Strategic Planning Day for the Board	Pat Snedden Garry Smith	Dates of 25 or 26 May being canvassed
8.1	Briefing note to Chair on ACH Car Park to raise with National Health Board	Brent Wiseman	Actioned
11.2	One pager on financial results to be sent to Board as soon as know on each of months to year end	Brent Wiseman	Sent to Chair



## **CHAIRMAN'S REPORT**



**CHIEF EXECUTIVE'S REPORT**



**+.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>			
Primary Care / EOI Process	Orange	DAP approved Projects need to advance to implementation. Minister's expectation requiring focused regional response.	DAP Projects to be project managed. Chairs / CEOs / CMOs/ P&FGMs are meeting to advance regional strategy.
Radiation Therapy – 4 week target	Green	Move to new target in December, need assurance we will meet.	Detailed Regional Plan shows target of 4 weeks will be met per attached Plan.
DAP / SOI	Green	Deadlines for these documents will / has been met.	Pre-approval of drafts and final sign off delegation Chair/CEO.
Bowell Cancer Screening Pilot	Green	Letter attached has been presented to Regional Bowel Cancer Steering Group and ROOG members. Both groups await the MoH's formal request for expressions of interest prior to developing a response. Preliminary discussions indicate significant interest in submitting a regional proposal to be a pilot site. The requirements for a pilot site cannot be met by any DHB working in isolation.	
<b>Goal 2 Improve Performance</b>			
Organisation Realignment	Green	Strong engagement in organisation. Some pressure points noted.	Have extended consultation time on Operating Rooms and Anaesthesia and included a workshop on this area of the plan.
Bone Marrow Transplant Unit	Red	Severe pressure on services.	National approach activated and Improvement Process Plan developed.
Disability	Orange	On the back of the Regional Intersectoral commitment to Disability as articulated by the Step Up Auckland campaign (Auckland City, ADHB and AUT), there has been significant momentum to achieve greater visibility of our disability responsiveness. A significant piece of work is now underway to gauge our performance as an organisation in terms of disability awareness and access. This review covers the spectrum of issues from access to physical spaces across all three sites to our	Increased SLT focus / action.

		<p>responsiveness to patients who have impairment.</p> <p>Staff attitudes, organisational policy and HR practices are all included in the review. A full report will be presented to DiSAC in September at which point we will look at how the learnings can be embedded into the organisational culture.</p> <p>We are also currently exploring the option of a disability advisor for the organisation in line with the model that both Counties and Waitemata have in place, with a dedicated resource based in HR but working across the entire DHB to effectively bridge the gap between the DHB and the disability community.</p>	
<b>Goal 3 Live Within Our Means</b>			
Cardiac Surgery	Orange	MoH intervention rate differs from DHB Funding signals.	Letter to each DHB plus discussions with NHB.
Car Park	Orange	Approval sought within 90 day tender expiry.	Chairman's action will deliver a decision in week of 24 May 2010.
Managing Core relationship with Waitemata DHB	Orange	Financial risk of Acute Elective and Non DRG work. Request for information / intervention to manage.	Attended the Board meeting and provided follow up material.
Forecast 2009/10	Red	Cost pressures, Elective targets and revenue management	Weekly meetings to review costs continue. SLT strong commitment and very close scrutiny.



# Office of Hon Tony<sup>37</sup> Ryall

Minister of Health  
Minister of State Services

10 MAY 2010

Pat Snedden  
Chair  
ADHB  
PO Box 92 189  
Greenlane  
AUCKLAND 1142

Dear Pat

## **Shorter wait times for cancer treatment**

The "Shorter wait times for cancer treatment" health target is very important both to the Government and to patients. New Zealanders should have timely, high-quality access to healthcare when they need it.

I have spoken this week with the Director-General of Health, Mr Stephen McKernan, the Director of the National Health Board, Mr Chai Chua, and the Acting Deputy Director-General Sector Capability and Innovation Dr Ashley Bloomfield about the progress DHBs are making towards achieving the four week waiting time target by December 2010. We are all concerned that your District Health Board is not on track to achieve the 4 week health target by December 2010.

It is essential that you concentrate on this priority health target. I expect to see focused activity that ensures you achieve both the six week target for quarter 4 and the four week target by December 2010. Sustainable performance is imperative.

Although I have received some information about the actions your DHB is undertaking, I would like you to provide me with the detailed actions you will undertake to rectify this situation and ensure you meet the target. I expect to receive your action plan by 28 May 2010.

Yours sincerely

Hon Tony Ryall  
Minister of Health



# Regional Cancer Service Radiation Therapy Waiting Times Improvement Plan

## Northern Region Radiation Oncology Service Service Improvement Plan May 2010

### Context

The current MOH target states that all patients referred for radiation therapy and eligible for treatment should commence treatment within six weeks of a decision to treat. This timeframe reduces to four weeks by December 2010.

Waiting times for the Northern Region radiation therapy service have historically been outside these targets, despite a commitment to capital replacement and workforce development. As a result patients waiting beyond clinically acceptable timeframes have been offered treatment overseas or at Waikato DHB.

Over the past year the service has been focussed on implementing initiatives to improve waiting time performance.

**The attached Radiation Oncology Service Improvement Plan describes the range of initiatives currently in place to achieve and sustain 100% compliance with the four week waiting time target.**

### Current Performance

Actual / Target

DHB	Compliance Qtr 1 (Jul – Sept 09)	Compliance Qtr 2 (Oct – Dec 09)	Compliance Qtr 3 (Jan – March 10)	Compliance Qtr 4 (Apr – June 10)	Compliance Qtr 1 (July – Sept 10)	Compliance Qtr 2 (Oct – Dec 10)	Compliance Qtr 3 (Jan – March 11)
Target	6 weeks	6 weeks	6 weeks	6 weeks	6 weeks	6 weeks – reducing to 4 Dec	4 weeks
ADHB	92%	92%	83%	100%	100%	100%	100%
CMDHB	96%	89%	88%	100%	100%	100%	100%
NDHB	91%	95%	77%	100%	100%	100%	100%
WDHB	97%	87%	86%	100%	100%	100%	100%
<b>Region Total</b>	<b>95%*</b>	<b>90%*</b>	<b>85%*</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

**As from 1 April 2010 all patients eligible for radiation therapy treatment (and without accepted delay codes) have commenced treatment within 6 weeks of request for treatment.**

Process/Project	Objective/Rationale	Responsibility	Progress to date (May 2010)	Timeline	Challenges	Regional Communication
<b>Development of a Strategic Plan for the Sustainable Delivery of Radiation Therapy to the Northern Region to 2019</b>	<p>The Northern Region needs an explicit plan which outlines the level of service/infrastructure (including workforce) required to respond to the needs of the Northern region population requiring radiation therapy.</p> <p>The objective of the plan is to specifically recommend the capacity requirements and optimal configuration of public radiation therapy services required over the next ten years.</p> <p>The plan also includes a specific capital replacement and technology upgrade plan, necessary to sustainably deliver current service delivery.</p> <p>Phase 2 of the Strategic Plan requires immediate implementation of agreed priority recommendations.</p>	<p>Pending establishment of a regional governance group relevant to Cancer service delivery, this project will be led by the GM of the lead provider (ADHB).</p>	<p>Plan complete. Approved by Regional CEOs in May 2010.</p>	<p>Phase 2 Implementation commencing June 2010, including business case development for the next linear accelerator capacity step required.</p>	<p>Capacity to fund the level of investment required to maintain current service capacity, and fund growth. To this end the Northern region have committed to the development of a sustainable funding model to support the recommendations included within the plan.</p>	<p>Monthly progress updates via ROOG (Regional Oncology Operations Group). Quarterly update on development to Regional CEO Group.</p>
<b>Operation 28 Days”</b>  <b>Linkages: This project has linkages to the following improvement projects: Timely FSA, Combined Chemo RT project, Operational Capacity Modelling tool.</b>	<p>A project approach is required to ensure the service has identified and is addressing all potential ‘blocks’ to effective utilisation of LINAC capacity. The primary objective of this project is to deliver on the MOH target of 28 days by December 2010.</p> <p>This project will also address variation in referrals for treatment, in turn maximising utilisation of treatment capacity with the MOH target.</p>	<p>GM Regional Cancer Service</p>	<p>A lean six sigma project has been initiated to review utilisation of treatment capacity following the case mix change evident after the opening of the private centre in late 2008. The project is in ‘analyse” phase.</p>	<p>Operational Plan in place by August 2010.</p>		<p>Monthly updates via ROOG.</p>

Process/Project	Objective/Rationale	Responsibility	Progress <sup>41</sup> to date (May 2010)	Timeline	Challenges	Regional Communication
<p><b>Operational Capacity Modelling Tool.</b> The objective is to develop a tool which facilitates proactive utilisation of radiation therapy resources and triggers the requirement to flex capacity to service demand within MoH targets. Linkages: This project has linkages to Operation 28 days.</p>	<p>A Linac capacity modelling tool is required which can provide a daily view of referrals (by tumour type and triage category) to enable calculation of capacity requirements.</p>	<p>GM Regional Cancer Service</p>	<p>Tool in audit phase.</p>	<p>Tool currently being used (in a trial phase). Due to be fully operational June 2010.</p>	<p>The operation of the tool requires significant IT support.  To this end the service is preparing a business case for additional analytical support</p>	<p>Monthly updates via ROOG.</p>
<p><b>Secure private capacity to outsource radiation therapy as required to meet MOH targets.</b>  This capacity arrangement will be the mechanism used to ensure compliance with MOH waiting time targets as the service delivers on projects contained within this Plan. Outsourcing will also have an ongoing role to manage peaks in demand and through periods of machine downtime.</p>	<p>The regional service needs to secure capacity to enable the outsourcing of simple breast and prostate treatments to ensure compliance with waiting time targets.</p>	<p>GM Regional Cancer Service  Service Manager</p>	<p>Outsourcing commenced.  Formal trigger tool to be developed and agreed by the region (ROOG) by August. In the meantime decisions to outsource will be taken based on the experience of service clinical management.</p>	<p>Contract complete by June 2010</p>	<p>Potential impact on regional cost of service delivery</p>	<p>Monthly updates via ROOG. Regional communications to public to be coordinated via DHB communications units.</p>

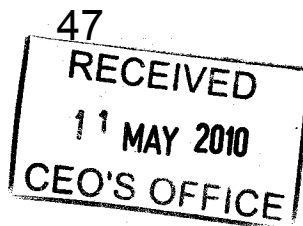
Process/Project	Objective/Rationale	Responsibility	Progress to date (May 2010)	Timeline	Challenges	Regional Communication
<b>Fast track replacement of oldest LA (MV5)</b>	Replacement of MV5 (13 years old) will deliver an additional 5 hours treatment capacity per day, and also ensures that Linear Accelerators MV4 & MV5 are paired machines. This is essential for efficient operation and for the six Linac fleet to be capable of delivering the latest treatment technology.	GM Regional Cancer Service	Business case approved by Regional Capital and ADHB Board in April/May 2010. Machine arrives in August 2010. Fast track commissioning will ensure that the machine is operational in November 2010 (two months sooner than initially planned).	Commissioned and clinical Nov 2010		Monthly updates via ROOG.
<b>Future Workforce Project (APEX/Northern Region Cancer Service)</b>	In order to deliver a sustainable service we need to recruit and retain a flexible workforce. This project is based on a desire to explore concerns expressed by APEX members and develop plan to address the barriers reducing the flexibility required to develop strategies for ensuring the public service environment is one in which radiation therapists wish to work.	GM Regional Cancer Service	Project scope complete and agreed by ADHB/APEX. Independent consultant commissioned to review the Radiation Therapy service. Draft report and recommendations will be presented to the steering group 15th May.	Workforce Plan for sustainability in place by August 2010.		Monthly updates via ROOG
<b>Focus on Radiation therapy Recruitment</b>	The Radiation Therapy service has historically had difficulty recruiting to full FTE establishment. The objective of the recruitment strategy is to attract and employ new and ex-employee Radiation Therapists to the service to fill vacancies. Longer term planning will also involve exploring more training placements within NZ and training opportunities to fast track registration.	GM Regional Cancer Service/ADHB Director of Allied Health.	The ADHB Careers Centre is in the process of contacting as many ex-employees as possible by email or telephone to canvas the number of Radiation Therapists who are currently in the Auckland metro area who may be considering a return to work and tailoring an offer to return to work that suits personal lifestyles. For staff living locally this may be the opportunity to work flexi or part time shifts.  RT's who are travelling overseas and are contactable by email are being offered a return to NZ work package that includes assistance with accommodation, flights and freight expenses. This is an ongoing campaign as many RT's are travelling or working overseas but intend to return in the future.		Limited staff available.	Monthly update to ROOG.

Process/Project	Objective/Rationale	Responsibility	Progress <sup>43</sup> to date (May 2010)	Timeline	Challenges	Regional Communication
			<p>2. Return to Work Payment: As per the APEX MECA, ADHB is the only NZ DHB that pays a \$5,000.00 return to work payment. This offer is being widely circulated as many RT's are not aware of this incentive.</p> <p>3. Recruitment campaign called "Fast Track New Zealand". The Careers Centre have purchased an international data base of Radiation Therapists for email communication which includes an information package on working in NZ. This campaign also offers immigration assistance.</p>		<p>There has been some interest but applicants tend to be junior staff whereas the service requires experienced RT's with 2-3 years experience. There is a limit to the number of junior staff that can be employed at any one time.</p>	<p>Monthly at ROOG.</p>
			<p>4. A new advertising format and new international advertising sites have been used for recruitment. Barriers include the long lead time for recruitment, registration and arrival in the country. This campaign is ongoing.</p> <p>5 The Radiation Therapy department has developed an information link / website (through ADHB Careers Website) to the service at Auckland City Hospital. It contains colour photographs of staff, machines, facilities and RT technical information.</p> <p>6 Trans Tasman Agreement: There is a Trans Tasman agreement in place for fast tracking RT registration between Australia and NZ. This has been reasonably successful.</p> <p>7. Attendance at international RT conferences. Next steps is to develop an information and recruitment strategy for ADHB RT staff to use at an RT conference planned in the UK in the latter part of 2010.</p>	<p>Ongoing</p>		

Process/Project	Objective/Rationale	Responsibility	Progress to date (May 2010)	Timeline	Challenges	Regional Communication
<b>Operation Timely FSA</b>	The coordination of receipt of Oncology referrals and the time from Referral to FSA clinic is variable. Performance against clinical guidelines for Referral to FSA clinic is not optimal. This project will deliver benefits to patients and referrers (increased communication regarding process, and shorter waiting time for FSA clinic) as well as DHB staff working within the process. Delay for FSA clinics places additional pressure on the urgency for RT delivery (for those patients who are referred for treatment) and may be a factor in managing the variation in referrals for radiation therapy treatment. Linkages: This project has linkages to Operation 28 days (refer below)	GM Regional Cancer Service	A lean six sigma project has been initiated for this project. The project is in 'Analyse phase.	Operational Plan in place by September 2010.  Interim improvements will be made as issues defined.		Monthly updates via ROOG.
<b>Combined Chemo/RT project</b>	The coordination of treatment plans for patients on combined therapies is becoming a significant issue for the service, exacerbated by the growth in these therapies. The service requires a specific process to ensure absolute communication for all stakeholders, and to efficiently deliver care within each subspecialty. The role of nurse specialist navigators will be trialled within this project. Linkages: This project has linkages to Operation 28 days (refer below).	GM Regional Cancer Service	Nurse specialist navigator role in place to trial proposed model.	Ongoing.		Monthly updates via ROOG.  Evaluation to be reported.

Process/Project	Objective/Rationale	Responsibility	Progress to date (May 2010)	Timeline	Challenges	Regional Communication
<b>RT Planning Timelines</b>	The key driver of this project was to reduce planning process time for all patients requiring volume based planning, improve the patient journey and achieve efficiencies through a more integrated multidisciplinary team approach. Outcomes of the project included reducing planning timeframes for "B" Curative patients to 7 days by July 1st 2009 and "C" Radical planning times to 7 days by October 1st 2009.	Service Manager	The project commenced in September 2008 with a completion date of April 2009. The project goals have been achieved.	The project is now in the evaluation phase with future improvement recommendations planned in 2010 with development of the ARIA patient management system to support dynamic documents and clinical assessment.		Monthly updates via ROOG.
<b>Develop and implement an improved communication and engagement strategy which provides regional stakeholders with detailed information regarding waiting times and sustains participation in decisions impacting capacity to deliver.</b>	Key regional stakeholders need to be involved in understanding the work the service is doing to achieve the target. This will enable collaborative working on strategies to meet target wait times.	GM Regional Cancer Service	Weekly internal reports are provided to key stakeholders in each northern region DHB. As a result there is improved visibility of referrals, treatment volumes and wait times for patients. (Report also includes strategies to address wait time results / targets).  Formal communication established through ROOG.  Wait time reports and notification re outsourcing sent to all key stakeholders.	Weekly reports Implemented March 2010.	The service is collating the report manually at present, but is developing capacity to automate reporting.	Monthly updates via ROOG. Weekly reports to ROOG plus nominated regional stakeholders and the MOH.





To Honnagh D to  
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Ref. No \_\_\_\_\_

5 May 2010

Garry Smith  
CEO  
Auckland District Health Board  
P O Box 92 189  
AUCKLAND MAIL CENTRE  
1142

Dear Mr Smith

### **Bowel cancer screening pilot announced**

The Minister of Health has announced a four year pilot will begin next year to assess whether New Zealand should introduce a population based bowel cancer screening programme. The pilot will be carried out in one or two DHBs which have a minimum sample population of 60,000 people aged 50 to 74 years, including at least 6000 Māori.

The Ministry of Health will shortly call for Expressions of Interest from DHBs wishing to submit a proposal to establish and operate the pilot. Detailed information on the EOI process will be sent to you within a month.

The main objectives of the pilot are to determine the level of participation, the number of people who tested positive, the number of cancers that were identified, the stage at diagnosis, the number of resulting colonoscopies performed, the impact on health services and the costs involved.

No decision will be made on whether to roll out a national bowel screening programme until the pilot is completed in 2015 and all monitoring and evaluation data has been analysed.

### **Bowel Cancer in New Zealand**

Bowel cancer is the most commonly diagnosed cancer in New Zealand, and our death rate from it is one of the highest in the developed world. In 2007, 2890 people were diagnosed with bowel cancer, and 1252 people died from the disease.

In New Zealand, there are clear inequities in bowel cancer diagnosis and treatment between Māori, non-Māori, Pacific and non-Pacific people. Evidence shows that Māori are less likely to develop bowel cancer, but those that do are diagnosed at a later stage and are more likely to die from the disease.

### **Screening programmes for bowel cancer**

International evidence shows that a bowel screening programme can save lives through early diagnosis and interventions. Modeling from Ireland indicates that after 10 years of a national screening programme for those aged 50 to 74 years, using the iFOBT test, 36 percent of bowel cancer deaths could be avoided.

In Ireland, where the sample population is a similar size to New Zealand's, this equates to about 270 lives saved every year.

Bowel screening programmes are either running or are being piloted in many developed countries including Australia, the United Kingdom, most countries in the European Union, parts of Canada, Japan and Israel.

The screening pilot will follow the most common model used for population-based screening programmes overseas. Eligible people aged 50 to 74 years living in the pilot DHB area/s will be invited to participate by their primary care provider and then mailed a faecal occult blood test which they can complete in their own home and post to a laboratory for assessment. A person with a negative result will be recalled in two years for a repeat test. A person with a positive result will be followed up and offered a diagnostic colonoscopy.

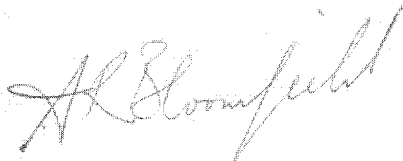
### **Improving existing bowel cancer services**

A key focus of the national Cancer Control Programme in 2010 is to improve existing bowel cancer services. This includes progressing a number of initiatives at a national, regional and local level.

- The Ministry will shortly announce the appointment of a National Clinical Lead, Gastrointestinal Endoscopy. This sector based position includes working with DHBs to implement colonoscopy service quality initiatives.
- The Ministry is supporting national initiatives including the development of training for colonoscopists and endoscopy nurses.
- All four regional cancer networks are working with DHBs to identify and establish opportunities for service improvement in bowel cancer at both a regional and local level. This will inform work being undertaken at a national level.
- Regional Cancer Networks are also working on bowel cancer tumour streams which will inform the development of a national bowel cancer patient management framework.
- Some DHBs are undertaking colonoscopy improvement initiatives.

If you would like further information please contact Mhairi Porteous, Bowel Cancer Programme Manager on [Mhairi\\_Porteous@moh.govt.nz](mailto:Mhairi_Porteous@moh.govt.nz) or 04 8164359 or Dr Carol Atmore, Bowel Cancer Programme Clinical Director on [Carol\\_Atmore@moh.govt.nz](mailto:Carol_Atmore@moh.govt.nz) or 021 2429477.

Yours sincerely



**Dr Ashley Bloomfield  
Deputy Director General (Acting)  
Sector Capability and Innovation Directorate  
and Co-Chair Cancer Control Steering Group**

**+.2 Minister's Six Health Priorities 2009/10**

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## Project: Adult Acute Patient Flow

51

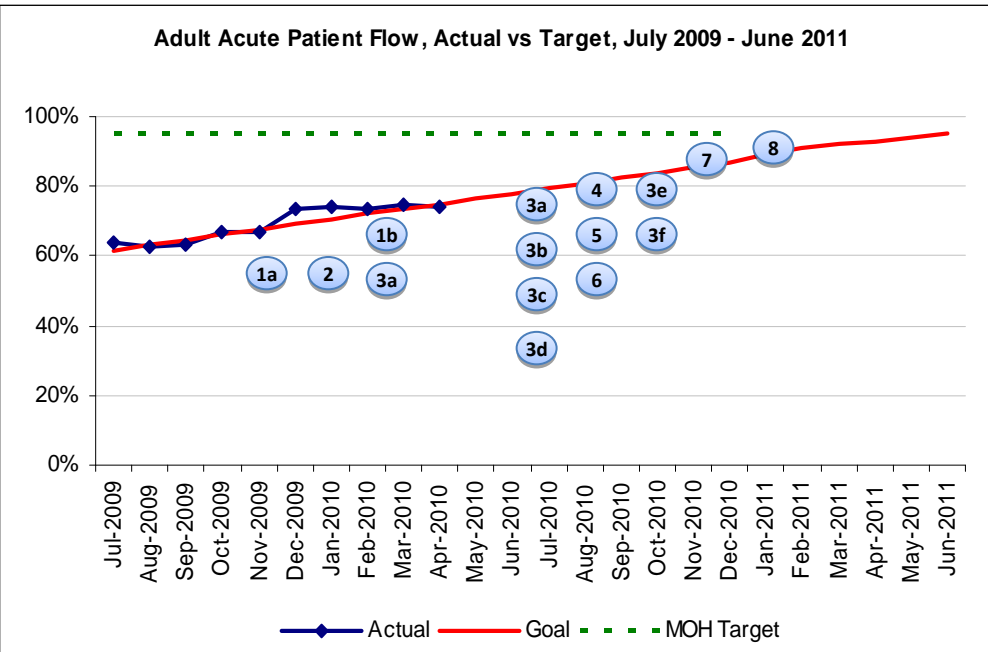
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

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: Progress in moving towards the achievement of the shorter stays in ED goal of adult Emergency Department patients being admitted or discharged within six hours (unless clinically indicated) has continued from 69% in Quarter 2 to 74% in Quarter 3. This has been maintained in April.

Some of further projects underway include:

Improving day of discharge logistics to reduce delays in time of discharge.

Improving admission to discharge planning. Minimum documentation requirements and responsibilities for AD planner to ensure safe and timely transfer of admitted patients from AED to receiving ward under discussion.

The biggest opportunity for improvement continues to be within the time taken from bed request to ward admission (workstream 1). The last 5 months has noted the best performance in this metric over the last two years. This has improved from an average of 7.6% of patients being transferred from AED to an inpatient ward in less than 1 hour to 11% in April with the average time taken reducing from 7 hours in April 2009 to 4.2 hours in April 2010.

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 - now being implemented into Orthopaedics following discussion at Orthopaedic team meeting.
- b) Increase the number of weekend discharges in General medicine and Orthopaedics. Nurse Facilitated discharge has been relaunched in General Medicine with increasing awareness of process and training of Charge Nurses and Clinical Nurse Advisors. Eighteen 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 NASC referrals
- 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

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

52

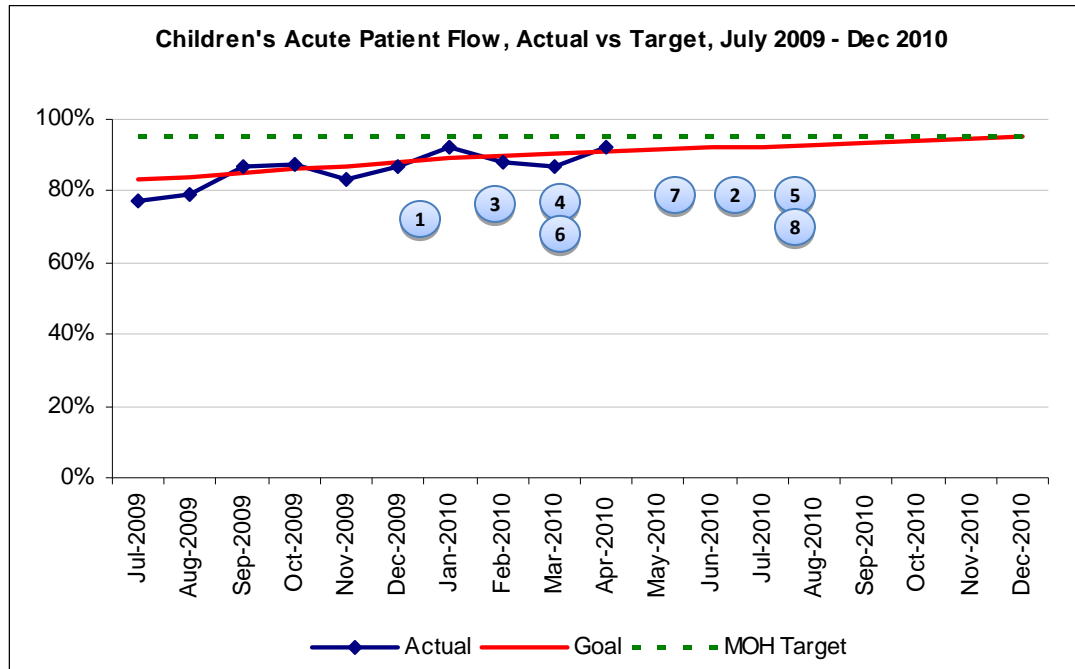
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

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 has achieved a significant improvement in percentage of stays less than 6 hours (80% for Jan-March 2010 versus 83% for the same quarter of 2009 with an increase of 4.7% increase in attendances comparing the two periods. There has been a drop in performance as we move out of the summer period and an increased operational management discipline is to be introduced to increase the urgency associated with the 6 hour target.*

*It is also planned to open an acute high dependency unit in June 2010. This will reduce the number of children who experience long delays in CED due to their care requirements being too intensive for them to be transferred to the ward and PICU at peak occupancy not able to take the patient.*

## Project: Improved access to elective surgery

53

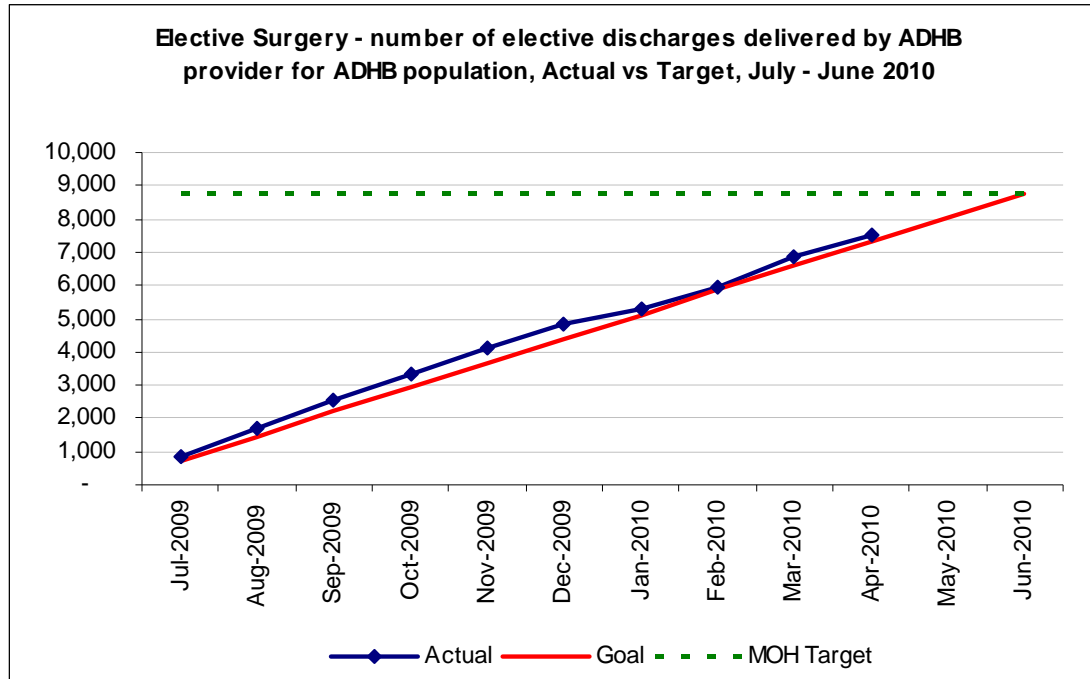
Primary Objective: To meet the MoH deliverable of elective discharges in surgical specialties for the ADHB population. The specified target is 93% of the overall population target, to account for ADHB population elective discharges from the ADHB provider.

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

54

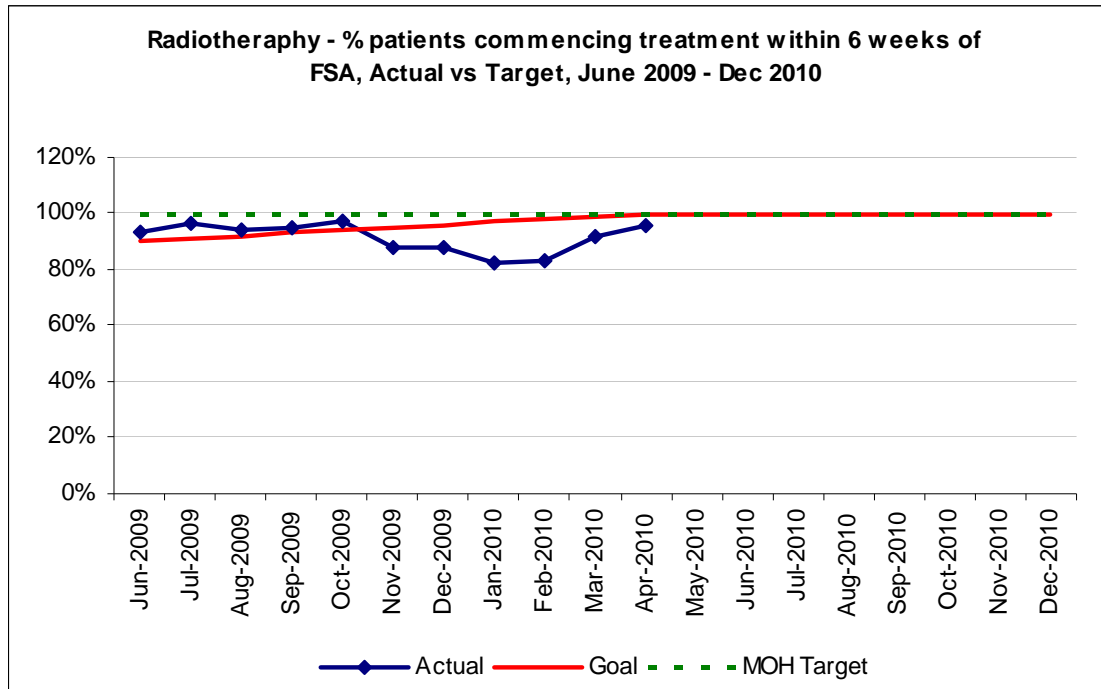
Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010

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:

*Performance to current MOH targets dropped last quarter during the period of decommissioning and replacement of a linear accelerator. Other contributing factors include increased demand, patient complexity and reduced capacity.*

*As at 10 May 2010 all patients awaiting treatment will commence treatment within 6 weeks (excluding category D patients which are outside of the MoH target). Currently all Patients with a decision to treat (On the wait list with A-C Priority) have a treatment date booked.*

*We will meet 100% compliance to the 6 week MoH target in the 4<sup>th</sup> quarter.*

### Current activities:

- Weekly prioritisation meetings continue, with a focus on detailed scheduling to review and accommodate urgent referrals as well as manage fluctuations in demand.
- Development of a capacity modelling tool for future planning and management of workload based on acuity and demand (staged implementation May 2010).
- Evening shifts have been extended until the end of May - this provides an additional 3 Linac treatment hours per day.
- Lean Six Sigma Project to improve the provision of radiation therapy treatment and services to meet MOH targets, now in analyse phase. Operational Plan in place by August 2010.
- Continue to prioritise the "flexible working hours" project to identify ways of increasing the treatment capacity within available FTE.
- MV5 (Linear Accelerator replacement) business case approved by Regional Capital Group and ADHB Board in April/May 2010. Machine will be delivered in August and commissioned in November 2010.
- Agreement with ARO to outsource a minimum of 50 Patients per annum to manage compliance with the target and peaks in demand.
- Outsourcing to Waikato Hospital - contingent on current wait time status, 9 patients have been treated at Waikato since mid Jan.

## Project: Better help for smokers to quit

55

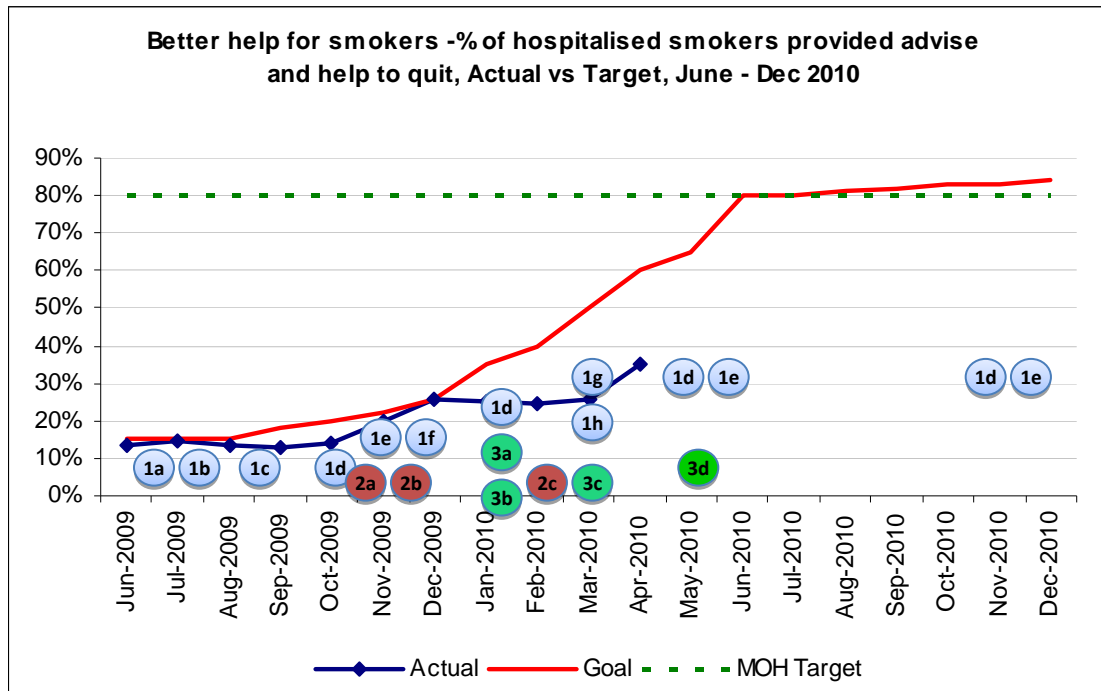
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

The increase in April is due to inpatient services taking responsibility and implementing strategies for meeting their own targets. A concerted effort is being made to ensure systems for recording the ABC and training are underway all outstanding services. These include ED, APU and Day Stay and Outpatient areas that feature in the Health Target data. Training is under way with Allied Health staff who will assist their services by documenting the Brief Advice. Options for anaesthetists to record Brief Advice are being explored. Liaison with the Clinical Coders to identify additional options to code smoking and brief advice is ongoing. Exploration is underway to make the Smoking section of the EDS mandatory.

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

56

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

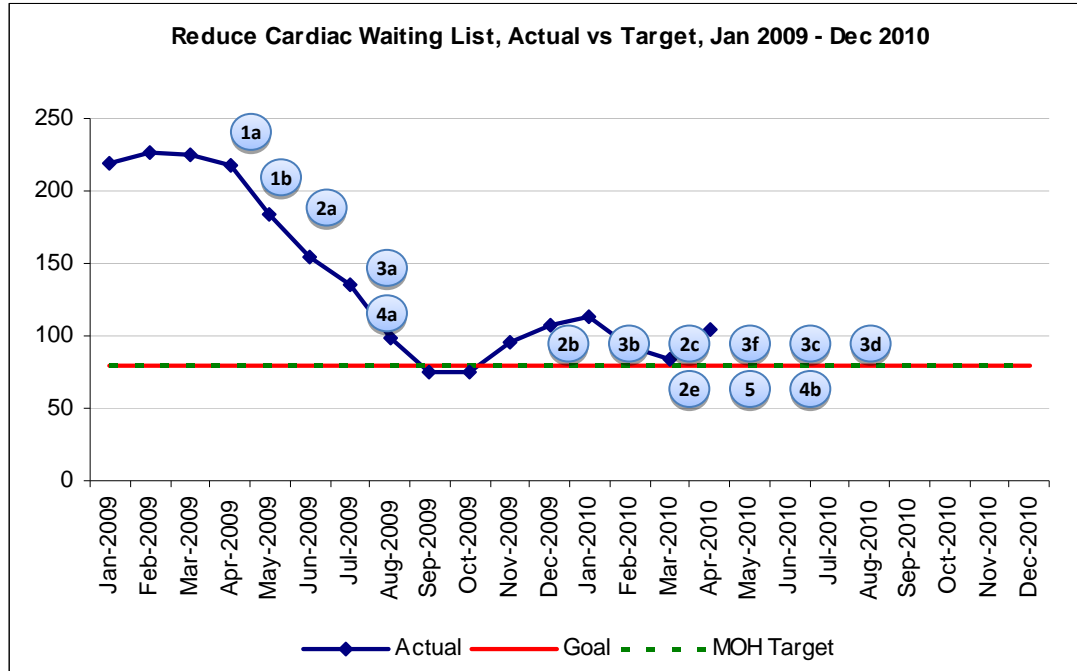
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

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 successfully achieved the waiting list target of 80 in Oct 2009. Current YTD volumes are also on target to achieve the required intervention levels (916 BP) having completed 668 bypass procedures at 21 March 2010. Over the Christmas holiday period a higher than historical referral rate and surgeon injury resulted in a steady incline in the waiting list. A recovery plan is in place with the waiting list tracking to be restored to target by the end of April. CTSU aim to further reduce the waiting list below the target of 80 to buffer against similar events in the future. Work continues to improve the performance and increase the throughput of the unit while also investigating the optimal outsourcing partnerships that will support the long term strategy for the Auckland Region.

## Project: Diabetes

57

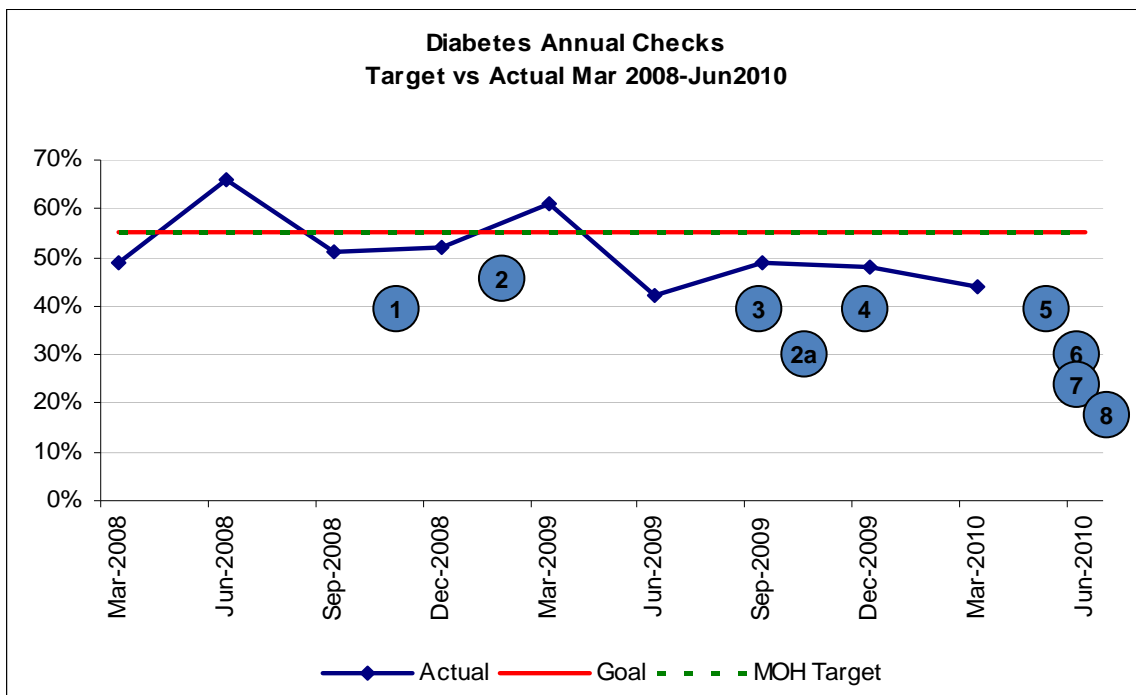
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

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



### Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 2) Practise based data (results) feedback
- 2a) Increase 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 are still under our target for this quarter, with a decrease from last quarter of 2%. The majority of effort has been focused on improving Maori Diabetes Get Checked with an increase from 32 % April -June (2009), 43% July-September (2009), 47% October-December (2009) to 55% Jan-March 2010. We have also just passed our target for Pacific Peoples, now at 52%. 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 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

58

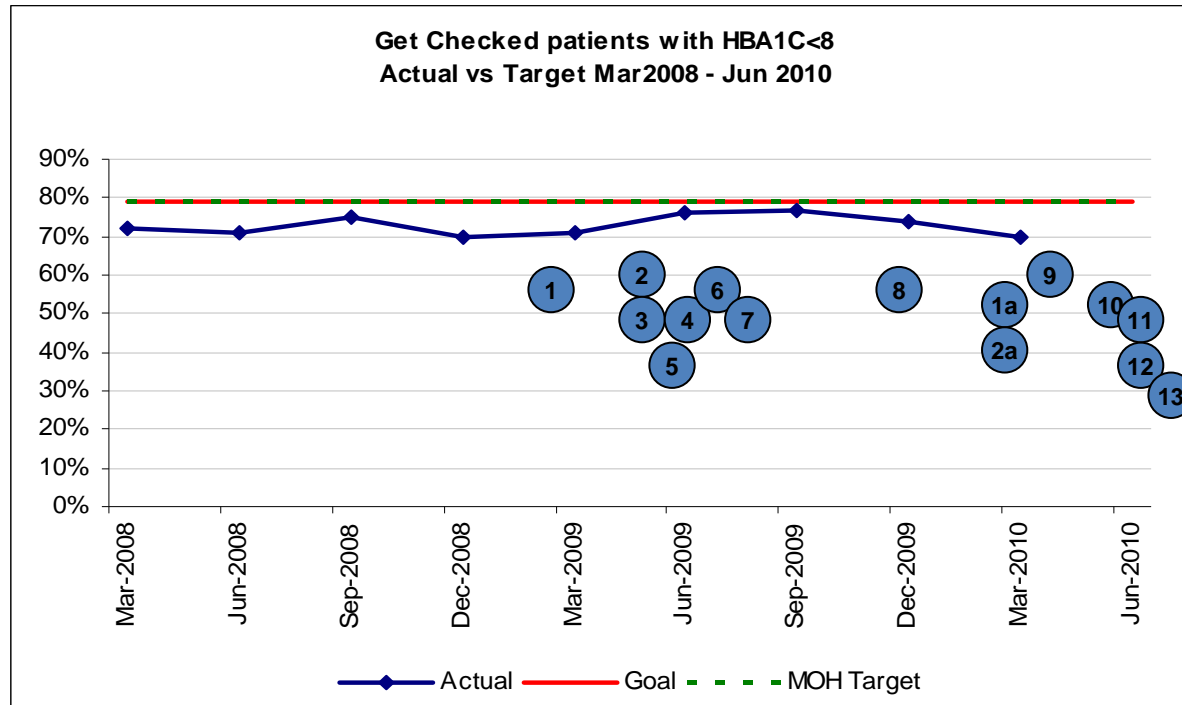
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

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 slipped back on our progress for the second quarter in a row. It is difficult to understand root cause the reasons. 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. In the coming months a range of activities are planned and this should show some impact on these targetes.

## Project: Cardiovascular Risk Assessment

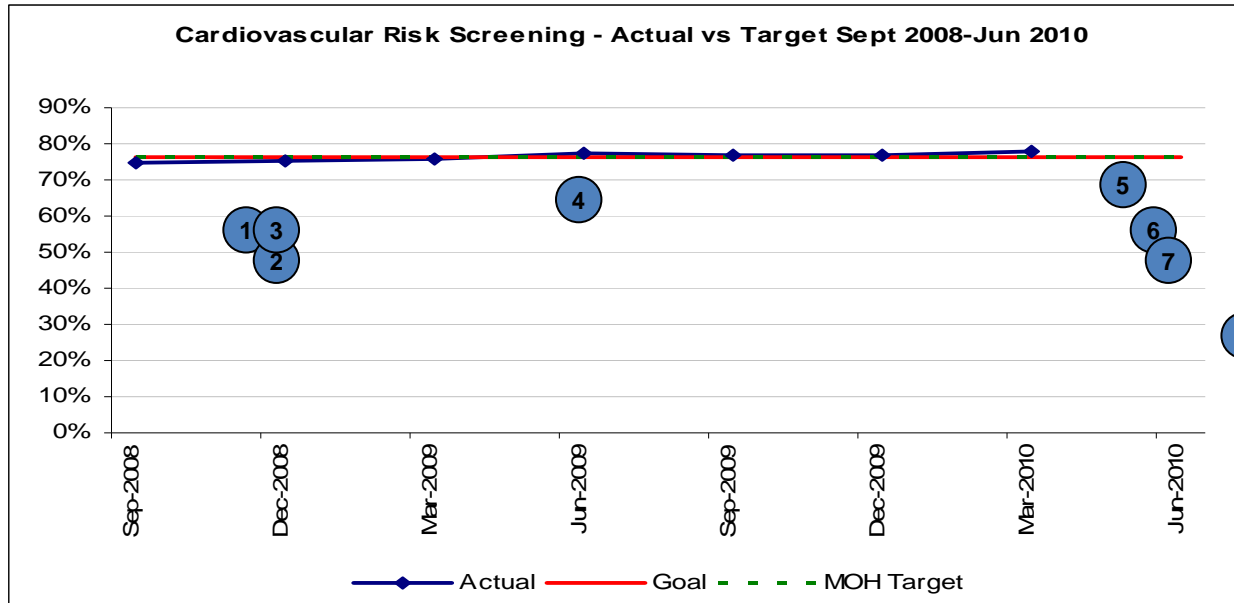
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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**

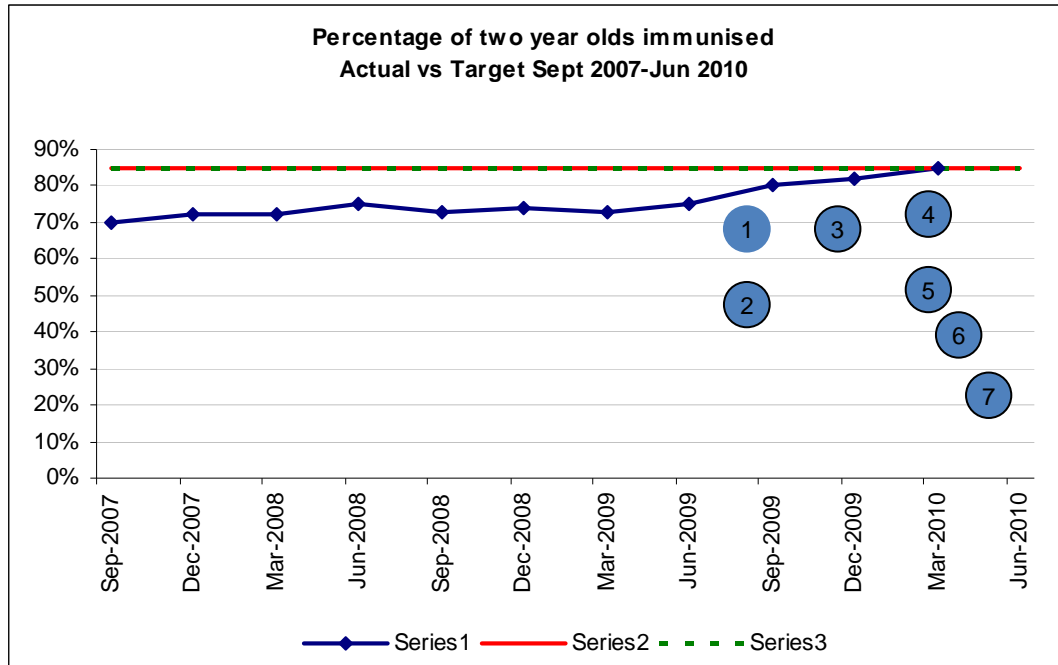
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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:**

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

**Project Risks / Comments:**

Annual target of 85% coverage was achieved in February which reflected a 3% increase over the previous month. This coverage level has been maintained. Maori coverage at all milestone ages remains a challenge as does timeliness in particular at 6 months and 18 months. The Ministry of Health has required DHBs to agree on achievement of a 90% regional target in 2010/11. ADHB's target is 91% to enable the regional target to be achieved.

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

## **8.1 Committee Recommendations**



## **, .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**



# **PERFORMANCE IMPROVEMENT**

- 9.1 Committee Recommendations**
- 9.2 DAP Projects Report**



## **- .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



## **- .2 DAP Projects Report**

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

High Level Strategy	Objective	Strategies to achieve objectives
Reduce inequities in health status	Maori	<ol style="list-style-type: none"> <li>1. Reduce Maori DNA rates.</li> <li>2. Increase enrolment of Maori in PHOs</li> <li>3. Rangatiratanga - Maori Health Equity Framework</li> </ol>
	Pacific	<ol style="list-style-type: none"> <li>1. Healthy Village Action Zone (HVAZ) evaluation</li> <li>2. Implement and monitor revised KPIs for HVAZ Parish Community Nurses</li> <li>3. Healthy Village Action Zone leadership and coordination</li> </ol>
Improve outcomes in priority areas	Children & young people	<ol style="list-style-type: none"> <li>1. Increase PHO/primary care involvement in managing immunisation</li> <li>2. Practice level reporting</li> <li>3. Practice nurse NIR training</li> <li>4. Maori immunisation initiative</li> </ol>
		<ol style="list-style-type: none"> <li>1. Auckland DHB wide oral health promotion</li> <li>2. Implement new service model</li> </ol>
	Older People	<ol style="list-style-type: none"> <li>1. Create a single point of entry to services</li> <li>2. Develop clinical triage according to need (direct referral to community support)</li> <li>3. Establish new Home Based Support Services</li> <li>4. Increase packages of care available</li> <li>5. Restorative care process implemented</li> </ol>
	Mental Health	<ol style="list-style-type: none"> <li>1. Eating Disorder Services</li> <li>2. Reconfigure Maori Mental Health Services</li> <li>3. Reconfigure current level 3 &amp; 4 residential rehab services</li> <li>4. Implement share care project (PROGRESS+) Primary /secondary integration</li> </ol>
	Palliative Care	<ol style="list-style-type: none"> <li>1. Unbundle current resources</li> <li>2. Restructure programs to achieve effective use of general and specialist services</li> <li>3. Increase the input of primary care teams in palliative care services</li> </ol>
		<ol style="list-style-type: none"> <li>1. Work with Healthy Village Action Zones initiative to spread lessons</li> <li>2. Plan the approach to maximise community engagement</li> <li>3. Achieve target for cardiovascular risk screening</li> </ol>
		<ol style="list-style-type: none"> <li>1. Increase efficiency, capacity and options of self-management approaches</li> </ol>
Prevent & manage long term conditions		<ol style="list-style-type: none"> <li>1. Run a GP clinical network for long term conditions that develops planned care</li> <li>2. Increase retinal screening capacity</li> <li>3. Develop care pathways for people with long term conditions</li> </ol>
		<ol style="list-style-type: none"> <li>1. Pilot case management</li> <li>2. Increase the percentage of people utilising cardiac rehabilitation</li> <li>3. Develop workforce for Kaupapa Maori cardiac rehabilitation</li> </ol>

## Goal 2: Performance Improvement (Better, Sooner, More Convenient)

High Level Strategy	Objective	Strategies to achieve Objective
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Improve the effectiveness &amp; efficiency of Healthcare System</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; padding-left: 20px;">Primary healthcare</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; padding-left: 20px;">Improve Primary Secondary system efficiency -decrease total system cost</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; padding-left: 20px;">Improve hospital efficiency / throughput</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; padding-left: 20px;">Reduce waiting times for elective services</p>	Implementation of PHO-DHB primary healthcare plan	1. Implement approach to providing efficient & effective coordinated care in the neighbourhood
	Improve access to after hours primary care	1. Develop after-hours services including palliative and residential care
	Improve information availability across system	1. e-referrals, health event summaries and electronic outpatient letters 2. Increase access to diagnostic tests in primary care 3. Transfer some services to primary/community
	Improve access & efficiency of service delivery	1. Projects to improve performance against 6 hr benchmark (OPJ) 2. Increase the use of and capacity of primary options
	Improve the performance of ED	1. OPJ Starship theatre project 2. Adult inpatient capacity step (beds and workforce)
	Improve the acute capacity management	1. OPJ Cardiac surgery project
	Improve Cardiac Surgery Throughput	1. Increase Greenlane capability to a full elective services centre (feasibility)
	Increase elective services to National Intervention rates	1. Improve service scheduling process & utilisation of day stay 2. Tumour specific model implementation 3. Optimising the patient journey projects
	Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation & medical oncology	1. Patient centred scheduling and communication 2. Accurate waiting time information. Reduced Waiting time 3. Increased input from GP's
	Improve Outpatient Management for Surgical Patients while improving patient satisfaction	1. Establish a new elective services centre
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Improve Leadership Capability</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; padding-left: 20px;">Improve clinical quality &amp; professional governance</p>	Reduce unmet need for elective services	1 Leadership development, mentoring and engagement process 2 Integrated governance reporting implemented 3. Define baldrige roll out plan and complete base line
	Clinical leadership model: implement, monitor and evaluate	1. Develop GP network (collaborative) with primary care
	Improve senior leadership team performance	1. Implement NQIP Medication Safety, Infection Prevention & Control, Mortality Review, Incident Management 2. Increase the number of GP practices with Cornerstone accreditation
	Implement sector wide clinical networks	1. Targeted recruitment ICU, Midwives, RMOs, OR staff 2. Define, train and implement new workforce roles 3. Review performance based incentive programs 4. Improve the ease of application and entry
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Strengthen the health workforces</p>	Improve safety and quality of care	1. Implement the resilience improvement plan
	Improve clinical staff retention	1. Regional Strategic Plan development in alignment with NZ HIS 2009
	Healthy workplace	1. Implement dynamic planning process (right beds, staff, facilities)
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Information management</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; padding-left: 20px;">Planning</p>	Develop response to Long Term Services Plan	1. National 2. Regional 3. Local
	Improve resilience and availability of core IT systems	
Regional Strategic Plan		
Improve Capacity Management		
Long Term Services Planning		

### Goal 3: Live Within Our Means (Improve Value for Money)

High Level Strategy	Objective	Strategies to achieve Objective
Manage Revenue	Ensure revenue received for services provided	<ol style="list-style-type: none"> <li>1. IDF annual agreements ensure we are paid for what we do.</li> <li>2. Participate in National pricing process</li> </ol>
Improve Productivity	Reduce Administration Cost	<ol style="list-style-type: none"> <li>1. Improve HR payroll processing and leave management</li> <li>2. Reduce back office cost (regional shared services)</li> <li>3. Manage administration of M&amp;A FTE cap</li> </ol>
	Improve Clinical Effectiveness	<ol style="list-style-type: none"> <li>1. Improve clinical resource utilisation</li> <li>2. Reduce variation in Clinical Practice</li> </ol>
	Health Service Process Improvement	<ol style="list-style-type: none"> <li>1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.</li> </ol>
	Achieve procurement savings	<ol style="list-style-type: none"> <li>1. Leverage national/regional procurement initiatives</li> <li>2. Refine procurement strategy</li> <li>3. Deliver direct treatment cost savings</li> <li>4. Deliver indirect treatment cost savings</li> <li>5. Monitor and collect rebates within contracts for supplies and services</li> </ol>
Manage Cash	Optimise stock holding	<ol style="list-style-type: none"> <li>1. Revisit replenishment parameters</li> <li>2. Improve supply chain systems and processes</li> </ol>
	Sustainable Cash Management Plan	<ol style="list-style-type: none"> <li>1. Asset Management Plan alignment with the Long Term Services Plan</li> <li>2. Improve prioritisation process for new capital</li> <li>3. Long term financial modelling process is implemented</li> </ol>





Total Projects: 81

DAP 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	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1) Lifting the Health of the people in Auckland City	25	25	5	1	7	5	3	0	22	3	0	24	1	0	23	1	1	4	3	0	0
2) Performance Improvement	45	45	12	6	10	12	2	0	34	8	3	44	1	0	37	8	0	3	1	0	0
3) Living within our Means	11	10	2	1	3	2	1	0	8	3	0	11	0	0	11	0	0	1	1	0	0
<b>Totals #</b>	<b>81</b>	<b>80</b>	<b>19</b>	<b>8</b>	<b>20</b>	<b>19</b>	<b>6</b>	<b>0</b>	<b>64</b>	<b>14</b>	<b>3</b>	<b>79</b>	<b>2</b>	<b>0</b>	<b>71</b>	<b>9</b>	<b>1</b>	<b>8</b>	<b>5</b>	<b>0</b>	<b>0</b>
<b>Totals %</b>	<b>100%</b>	<b>99%</b>	<b>23%</b>	<b>10%</b>	<b>25%</b>	<b>23%</b>	<b>7%</b>	<b>0%</b>	<b>79%</b>	<b>17%</b>	<b>4%</b>	<b>98%</b>	<b>2%</b>	<b>0%</b>	<b>88%</b>	<b>11%</b>	<b>1%</b>	<b>10%</b>	<b>6%</b>	<b>0%</b>	<b>0%</b>

## Goal 1

### Review

Overall good progress with implementation of a range of initiatives, but the impact of the EoI initiative continues to have an impact on the nature and timing of some initiatives as discussed previously. Areas impacted by this process have noted as exceptions below (and similarly for Goal 2).

## Goal 2

### Review

Overall good progress is being made in Goal. As noted in Goal 1, the primary care EoI process has impacted on a number of initiatives that have been noted as exceptions below, eg devolution of services, neighbourhood approach. The revised primary Care DAP will now allow activities to progress and implementation plans for all proposals are well advanced and will be completed to meet moH deadlines at the beginning of May. Following significant delays in eReferrals and Regional clinical documents there is now more traction. Contract for eReferrals nearing completion and business case for Regional Clinical Documents has been completed and going through approval process. Aspire progressing to the revised (staged) implementation plan to allow for some extra change activity and catch-up with GP PMS vendors. IT Resilience project progressing suffering delays due to resourcing issues, complexities and delays in procurement. Significant effort going into the resolution of these issues to ensure project keeps moving forward towards goals.

## Goal 3

### Review

A wide variety of initiatives are being identified and managed with a weekly management meeting to focus specifically on the risk of variations in a large organisation with a very precise break-even target.



# *10*

## **LIVE WITHIN OUR MEANS**

**10.1 Finance Committee Recommendations**

**10.2 Finance Report**



**1\$.1 Finance Committee Recommendations**

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**ADHB Board****Author:** Ian Bell (8077)**Subject:** Heart Valves & Annuloplasty Rings

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**Recommendation**

*That the ADHB Board approves the proposals for Heart Valves and Annuloplasty Rings from:*

*Obex Medical Ltd Contract Number 1091-1, REM Systems Ltd Contract Number 1091-2, Edwards Lifesciences Pty Ltd Contract Number 1091-3, Medtronic Australasia Pty Ltd Contract Number 1091-4, Spectrumed Ltd Contract Number 1091-5.*

*Estimated Annual Value:*

<i>ADHB: \$1,840,000</i>	<i>Auckland</i>
<i>CCDHB: \$1,173,000</i>	<i>Wellington</i>
<i>WDHB: \$682,000</i>	<i>Waikato</i>
<i>ODHB: \$290,000</i>	<i>Dunedin</i>

**ADHB**

*Initial term of Contract 2 years, total current estimated ADHB value \$3,680,000  
If required – A further Right of Renewal of 1 year plus an additional 1 year, current estimated ADHB value of the ROR if taken up \$3,680,000  
Total estimated Contract Term if initial term and full ROR taken up - (2+1+1), \$7,360,000*

**Background**

This was considered by the Finance Committee on 1 June 2010.

**ADHB Board****Author:** Ian Bell (8077)**Subject:** Regional Clinical Documents Project

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**Recommendation***That the ADHB Board:*

- *Approves the Regional Clinical Document Project regional business case and ADHB's share of the Capital Expenditure of \$227,556 and additional annual support costs of \$7,067.*
- *Notes that \$200K was set aside for this project in the FY09/10 Capital Plan. The Capital budget for FY10/11 will be impacted by the fact that the actual cost is \$27K higher than was original estimated and the majority of this expenditure will take place in FY10/11 rather than FY09/10.*

**Background**

This was considered by the Finance Committee on 1 June 2010.

## 1\$.2 Finance Report

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# Auckland District Health Board

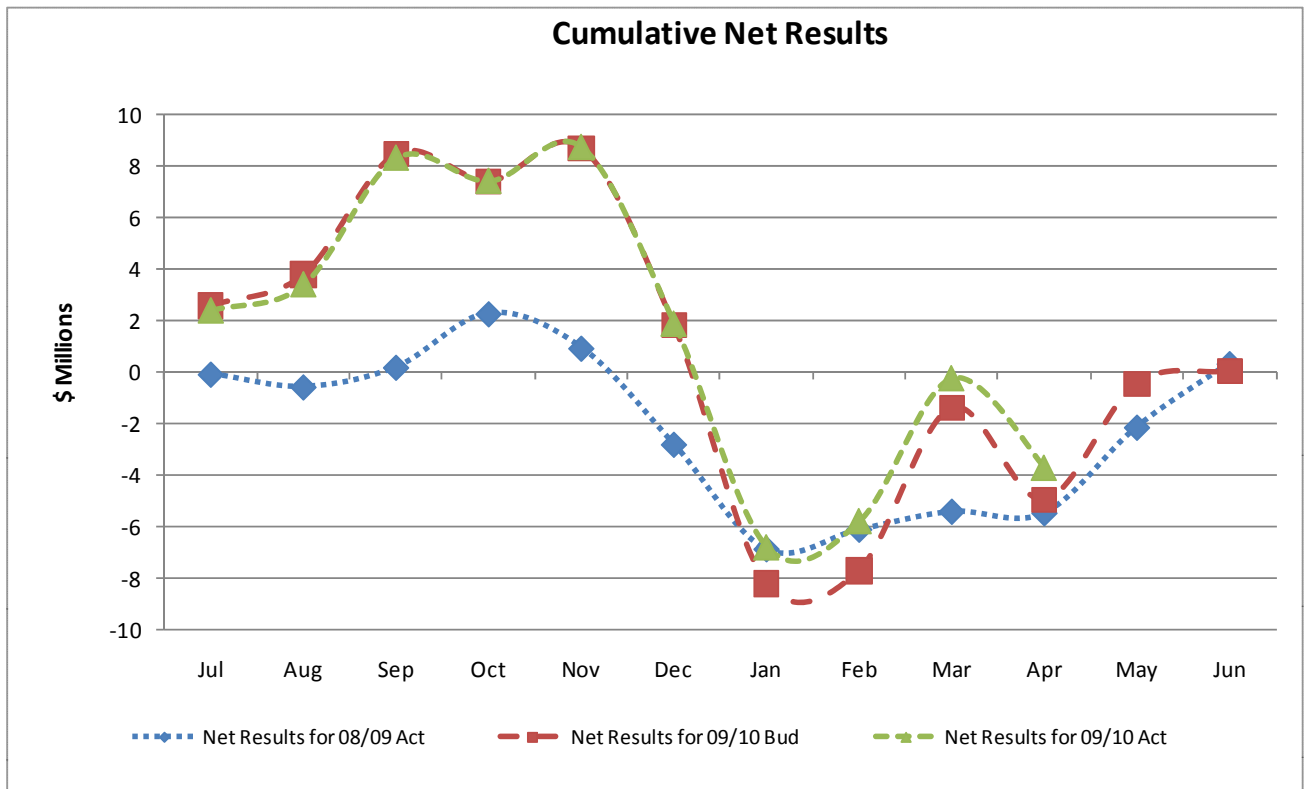
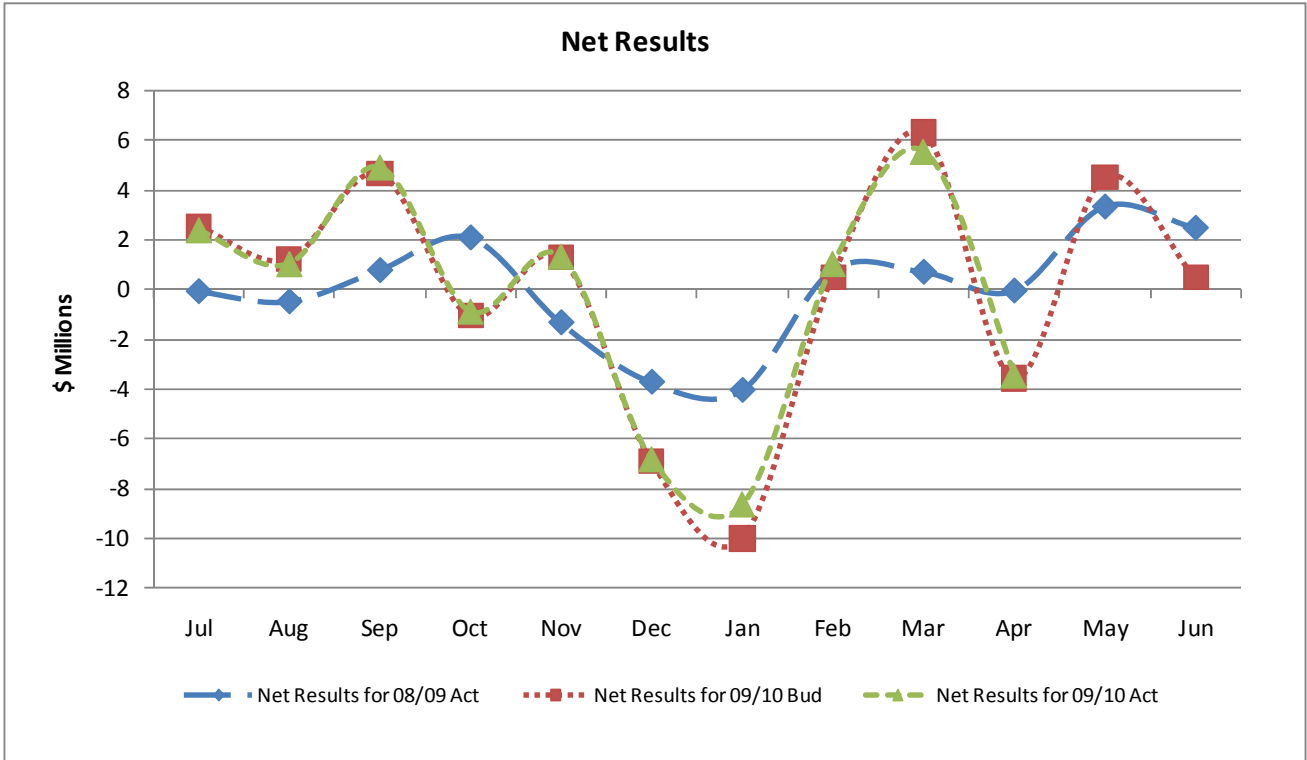
## **Board Financial Report**

Prepared by Grant Barnett

April 2010

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Performance Graphs by Month & YTD



Auckland District Health Board  
Summary Result  
Month of Apr-10

\$000s	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
<b>Income</b>						
PBF - AKL Population	83,010	75,656	7,355 F	797,813	781,281	16,532 F
Inter District Inflows	46,078	46,989	911 U	463,472	469,891	6,419 U
	129,088	122,645	6,443 F	1,261,284	1,251,172	10,112 F
MOH Sub-contracts	6,049	5,595	454 F	56,414	56,423	9 U
Other Patient Care	2,669	2,994	326 U	27,141	30,000	2,859 U
Services & Products	3,448	3,363	85 F	36,023	35,467	556 F
CTA	1,627	1,657	29 U	17,743	16,366	1,377 F
Trust & Donation Income	532	846	314 U	3,794	8,639	4,844 U
Financial Income	481	63	418 F	6,028	3,835	2,193 F
Other Income	664	524	140 F	6,644	5,654	990 F
	144,559	137,687	6,871 F	1,415,071	1,407,557	7,515 F
<b>Expenditure</b>						
Employee Costs						
Medical	19,017	18,850	167 U	186,480	185,029	1,451 U
Nursing	20,651	19,472	1,180 U	198,651	196,810	1,841 U
Technical	10,124	10,145	20 F	97,997	100,205	2,208 F
Hotel Services	887	831	56 U	8,199	8,045	154 U
Administration	7,698	7,572	127 U	75,233	74,408	825 U
Other	3,634	3,651	16 F	35,495	37,337	1,842 F
Total Employee Costs	62,012	60,520	1,492 U	602,054	601,834	220 U
Direct Treatment Costs	17,559	17,149	410 U	184,010	175,632	8,377 U
Indirect Treatment Costs	3,400	3,187	213 U	32,865	32,022	844 U
Funder Payments	39,450	37,295	2,155 U	374,641	370,772	3,869 U
Inter District Outflows	10,945	8,093	2,853 U	81,840	80,928	912 U
Prop, Equip. & Transport	4,184	4,108	76 U	39,783	42,498	2,715 F
Maintenance	(2)	133	136 F	1,241	1,333	92 F
Building Compliance	0	0	0 F	(400)	0	400 F
Loss on Sale of Fixed Assets	2	2	0 U	174	18	156 U
Administration Costs	1,778	1,519	259 U	15,990	15,567	423 U
<b>Total Operating Expenditure</b>	139,327	132,007	7,320 U	1,332,197	1,320,600	11,597 U
<b>Operating Contribution</b>	5,232	5,680	448 U	82,874	86,957	4,082 U
Depreciation	3,987	4,263	275 F	40,092	42,275	2,184 F
Finance Costs	1,687	1,697	10 F	16,818	16,865	47 F
Capital Charge	3,026	3,290	264 F	29,684	32,794	3,110 F
<b>Total Non Operating Costs</b>	8,700	9,250	550 F	86,594	91,935	5,340 F
<b>Net Surplus / (Deficit)</b>	(3,468)	(3,569)	102 F	(3,720)	(4,978)	1,258 F

<b>Auckland District Health Board</b>				
<b>Statement of Financial Position</b>				
<b>As at Apr 2010</b>				
	<b>Apr-10</b>	<b>Apr-10</b>	<b>Mar-10</b>	<b>Jun-09</b>
	<b>Actual</b>	<b>Budget</b>	<b>Actual</b>	<b>Actual</b>
	<b>\$ 000s</b>	<b>\$ 000s</b>	<b>\$ 000s</b>	<b>\$ 000s</b>
<b>Crown Equity</b>				
Opening Balance	566,089	569,698	566,089	601,089
Equity Injections/(Repayments)	1,794	-	268	(35,000)
Closing Balance	567,883	569,698	566,357	566,089
<b>Revaluation reserve</b>				
Opening Balance	381,278	417,016	381,278	417,019
Revaluation Adjustments	41	-	-	(35,741)
Closing Balance	381,319	417,016	381,319	381,278
<b>Retained Earnings</b>				
Opening Balance	(468,647)	(468,975)	(468,647)	(468,972)
Surplus/(Deficit) Current Year	(3,718)	(4,978)	(251)	325
Closing Balance	(472,366)	(473,953)	(468,898)	(468,647)
<b>Total Crown Equity</b>	<b>476,836</b>	<b>512,761</b>	<b>478,777</b>	<b>478,719</b>
<b>Represented by:</b>				
<b>Fixed Assets</b>				
Land	201,337	245,814	201,337	201,337
Buildings	594,237	571,541	595,757	605,970
Clinical, Other Equipment & Motor Vehicles	82,759	109,922	84,630	85,971
Work in Progress	17,264	11,267	15,447	8,288
<b>Total Fixed Assets</b>	<b>895,596</b>	<b>938,544</b>	<b>897,170</b>	<b>901,566</b>
<b>Derivative Financial Instruments</b>	<b>4,690</b>	<b>2,823</b>	<b>4,690</b>	<b>6,954</b>
<b>Investments</b>				
Associated Company Investments	386	366	386	386
Trust Deposits	10,000	5,500	10,000	8,000
<b>Total Investments</b>	<b>10,386</b>	<b>5,866</b>	<b>10,386</b>	<b>8,386</b>
<b>Current Assets</b>				
Cash & Short Term Deposits	51,563	53,882	52,073	35,287
Trust Deposits	11,022	15,264	10,910	11,780
Debtors	29,548	19,571	27,504	24,176
Accrued Income	23,723	10,787	23,324	36,920
Prepayments	3,088	2,604	2,718	2,320
Inventory	11,912	11,348	11,916	11,717
<b>Total Current Assets</b>	<b>130,856</b>	<b>113,455</b>	<b>128,445</b>	<b>122,200</b>
<b>Current Liabilities</b>				
Borrowings	72,485	85,707	74,905	18,372
Trade & Other Creditors, Provisions	217,275	196,903	208,213	216,416
Income Received in Advance	23,813	24,397	22,417	17,509
Taxes Payable	15,835	18,248	21,160	17,210
Funds Held in Trust	1,063	1,088	1,061	1,038
<b>Total Current Liabilities</b>	<b>330,472</b>	<b>326,342</b>	<b>327,757</b>	<b>270,546</b>
<b>Working Capital</b>	<b>(199,616)</b>	<b>(212,886)</b>	<b>(199,312)</b>	<b>(148,346)</b>
<b>Non Current Liabilities</b>				
Borrowings	212,999	195,768	212,992	269,168
Employee Entitlements	21,221	25,818	21,166	20,673
<b>Total Non Current Liabilities</b>	<b>234,220</b>	<b>221,586</b>	<b>234,157</b>	<b>289,841</b>
<b>NET ASSETS</b>	<b>476,836</b>	<b>512,761</b>	<b>478,777</b>	<b>478,719</b>

Statement of Cashflows for the Year ended 30 June 2010							
	Apr-10			Year to Date			
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>Operations</b>							
Revenue Received	143,030	144,216	(1,186)	1,432,924	1,416,677	16,247	
Payments	(139,823)	(141,375)	1,552	(1,388,349)	(1,379,172)	(9,177)	
<b>Net Operating Cashflows</b>	<b>3,207</b>	<b>2,841</b>	<b>366</b>	<b>44,575</b>	<b>37,505</b>	<b>7,070</b>	
<b>Investing</b>							
Income	481	63	418	4,138	3,836	302	
Capital							
Sale of Assets	7	2	5	15	20	(5)	
Purchase Fixed Assets	(2,411)	(5,658)	3,247	(34,121)	(49,680)	15,559	
<b>Net Investing Cashflows</b>	<b>(1,923)</b>	<b>(5,593)</b>	<b>3,670</b>	<b>(29,968)</b>	<b>(45,824)</b>	<b>15,856</b>	
<b>Financing</b>							
Equity Injections	1,526	0	1,526	1,794	3,609	(1,815)	
New Loans	0	0	0	0	6,900	(6,900)	
Equity Repayment	0	0	0	0	0	0	
Loans Repaid	0	0	0	0	(10,500)	10,500	
<b>Net Financing Cashflows</b>	<b>1,526</b>	<b>0</b>	<b>1,526</b>	<b>1,794</b>	<b>9</b>	<b>1,785</b>	
<b>Total Net Cashflows</b>	<b>2,810</b>	<b>(2,752)</b>	<b>5,562</b>	<b>16,401</b>	<b>(8,310)</b>	<b>24,711</b>	
<b>Opening Cash</b>	48,878	29,729	19,149	35,287	35,287	0	
<b>Closing Cash</b>	51,688	26,977	24,711	51,688	26,977	24,711	

## Financial Performance

The result for April was a deficit of \$(3.5)m a favourable variance to budget of \$0.1m. On a year to date basis there is a deficit of \$(3.7)m a favourable variance to budget of \$1.2m. The result year to date was driven by higher revenue of \$7.5m offset by higher expenditure of \$(6.3)m.

Year to date revenue is higher than budget by \$7.5m at \$1,415.1m.

- The higher revenue variance was driven by higher production \$4.6m(net of over delivery \$8.5m) base revenue variations \$3.4m, the accrual of a revenue wash up of Careplus \$0.9m, higher CTA Income \$1.4m driven by additional volume and payment of arrears, and higher volumes of retail pharmacy sales \$1.7m.
- Interest Rate Swap Instruments are recording a favourable variance of \$2.2m driven by long term market interest rates being lower than budgeted.
- These favourable variances have been offset by lower external laboratory sales volumes \$(1.2)m, lower donation income mainly associated with the timing of Starship funded projects \$(4.8)m ,and lower ACC and Non resident fee volumes \$(2.8)m.

Year to date expenditure is higher than budget by \$(6.3)m at \$1,418.8m.

- Labour Costs are \$0.2m unfavourable to budget year to date mainly driven by
  - a) a favourable timing variance as a result of the budget phasing of the NZNO,RDA and PACT Meca's \$1.7m. This favourable variance will reverse in June.
  - b) Annual leave reduction over budget in Christmas New Year period \$1.2m
  - c) Medical & Technical staff vacancies and other price variances \$13.8m
  - d) Savings in administrative staff 81 FTE \$5.6m
  - e) Superannuation contributions being below budget \$2.8m.
  - f) Redundancy Costs \$(0.8)m
  - g) Nursing 46 FTE over budget \$(2.8)m
  - h) Savings targets \$(21.3)m
- Direct Treatment costs are \$(8.4)m unfavourable to budget due to higher third party treatment costs \$(5.3)m, principally for Cardiac Services \$(4.0)m, driven by the waitlist reduction initiative, General Surgery \$(0.4)m and Orthopaedics \$(0.3)m for other outsourcing. In addition Clinical Supplies costs are \$(6.5)m unfavorable to budget largely due to increased surgical volumes \$(2.9)m and savings targets to be delivered \$(3.3)m. These unfavorable variances are partially offset by lower blood usage in Cancer \$3.9m.
- Funder Payments are \$(4.8)m unfavourable to budget driven by higher PHO expenditure \$(5.0)m as a result of the payment of PHO performance management payments, demand driven enrolments and price increases (with a partial offset in the PHO revenue), higher Laboratory expenditure \$(2.3)m driven by budget phasing and the introduction of a further contract, higher Health Of Older people expenditure \$(3.0)m driven by increased cost of residential and hospital care and higher Public Health expenditure \$(1.1)m. These unfavourable variances are offset by the timing of Mental Health expenditure \$2.2m and underspends in personal health \$4.4m.
- Property Costs were favourable to budget \$2.7m mainly driven by lower costs for computer maintenance \$0.8m and lower property and clinical equipment maintenance \$0.9m.
- There has been a partial release of the provision for asbestos removal credited to Building Compliance Costs \$0.4m.

- The Capital Charge is lower than budget \$3.1m driven by the Ministry washup for FY09 \$1.0m and downward revaluation of Land & Buildings at balance date. This downward revaluation credit will be ongoing for the balance of the year.
- Depreciation costs are below budget by \$2.2m as a result of the reassessment of IS Software lives and the depreciation adjustment for property revaluation.

### **Financial Position**

- The opening balance of fixed assets was \$(29.3)m below budget principally due to the downward revaluation of land & buildings \$(35.7)m as at 30 June 2008.
- YTD Capital spending is \$34.1m, under budget by \$15.5m. Baseline and Facilities projects are under budget by \$10.2m and Information Systems projects are behind budget by \$5.3m driven by the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$51.6m (excluding Trust deposits). At month end there is an unused overdraft facility of \$44.6m.



# *11*

## **GENERAL BUSINESS**

<b>MEETING DETAILS</b>	
Time and Date	2:00pm, Wednesday 2 June 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>Tour – Clinical Records</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 5 May 2010</b>	<b>017</b>
<b>5</b>	<b>Action Points 5 May 2010</b>	<b>025</b>
<b>6</b>	<b>Chairman’s Report - Verbal</b>	<b>029</b>
<b>7</b>	<b>Chief Executive’s Report</b> 7.1 Chief Executive’s Summary 7.2 Minister’s Six Health Priorities 2009/10	<b>031</b>
<b>8</b>	<b>Lift the Health of People in Auckland City</b> 8.1 Committee Recommendations	<b>061</b>
<b>9</b>	<b>Performance Improvement</b> 9.1 Committee Recommendations (Verbal by Committee Chair) 9.2 DAP Projects Report	<b>065</b>
<b>10</b>	<b>Live Within Our Means</b> 10.1 Finance Committee Recommendations 10.2 Finance Report	<b>077</b>

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11	General Business	093
<b>NEXT MEETING</b>		
	<b>Time and Date:</b>	2:00pm, Wednesday, 7 July 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