



Auckland District Health Board

Board Meeting

Wednesday 5 May 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

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Pat SNEDDEN (Chair)	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
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<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
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Credentialing Committee for Ormiston private hospital 7. Surveyor Quality Healthcare NZ 				3 February 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	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				
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				15 July 2009
Dr Ian SCOTT	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			
Bob TIZARD	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Seiuli Dr Juliet WALKER	<ol style="list-style-type: none"> 1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure 2. Member, National Breast Screening Advisory Committee 3. Facilitator, RNZCGP General Practice Education Programme Stage II 4. ADHB Employee: contracted roster Doctor for Pohutukawa 	<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>General practitioner services</p> <p>Consultant Pacific Advisor</p> <p>Educational Support and Training</p> <p>Forensic sexual assault examinations</p>	1 November 2009
Ian WARD	<ol style="list-style-type: none"> 1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C -4 Consulting Limited 		Fee	Tender to National Shared Services	3 February 2010

CONFIRMATION OF MINUTES

- 7 APRIL 2010

Auckland District Health Board Minutes



MEETING DETAILS											
Time and Date	2:00 pm, Wednesday, 7 April 2010										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
1	KARAKIA										
	The Chair declared the meeting open at 2:15pm and Naida Glavish led the meeting with the karakia.										
2	ATTENDANCE AND APOLOGIES										
	<p>Board Members</p> <table> <tr> <td>Pat Snedden (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Dr Juliet Walker</td> <td>Ian Ward</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning and Funding Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director Performance Improvement & Innovation Ngaire Buchanan – General Manager Operations Taima Campbell – Executive Director Nursing Naida Glavish – Chief Advisor Tikanga, GM Maori Health Chris Morgan – Manager Materials Management Vivian Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Harry Burkhardt, David Sage and Kay Hyman.</p> <p><u>Moved Juliet Walker; seconded Susan Buckland</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Pat Snedden (Chair)	Jo Agnew	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward
Pat Snedden (Chair)	Jo Agnew										
Susan Buckland	Dr Chris Chambers										
Rob Cooper	Dr Brian Fergus										
Dr Ian Scott	Rt Hon Bob Tizard										
Seiuli Dr Juliet Walker	Ian Ward										
3	CONFLICTS OF INTEREST										
	There were no notifications of conflicts of interest for any item on the agenda.										
4	CONFIRMATION OF MINUTES 3 MARCH 2010										
	<p><u>Moved Bob Tizard; seconded Rob Cooper</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 3 March 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

5	ACTION POINTS 3 MARCH 2010
	<p>Two letters from the Minister had been circulated to the Board concerning radiotherapy waiting times and cardiac waiting lists.</p> <p>Regional governance had 2 work streams on business services and clinical services set by the CEOs for report back in May.</p> <p>“Get Checked” was being referred to the Primary Care Clinical Advisory Group.</p> <p><u>Moved Pat Snedden; seconded Chris Chambers</u></p> <p><i>That the action points 3 March 2010 be noted.</i></p> <p><u>Carried</u></p>
7	CHAIRMAN'S REPORT
	<p>The National Terms of Settlement covering 75% of the workforce had been agreed for an 18 month period at a sustainable level with this arising out of the Health Sector Relationship Agreement process showing a mutual sense of responsibility. It was expected this would have a flow on affect to other settlements with discussions with the APEX group unions which was relatively positive and a number of professional groups. RMOs and SMO were separate. The maturing of the relationship reflected working in non monetary ways such as engagement with the workforce and improvement activities. There had been a meeting with the new Auditor General who outlined an expectation for an improved level of service level reporting for DHBs of which ADHB would be a pilot. This new form of reporting would become mandatory in two years time as the present view was that health reporting did not give the public a clear view of what was going on. The aim was to have clarity from a lay point of view which would be challenging.</p> <p>Community Laboratories were weekly publishing KPIs with both parties delivering to those KPIs. The IANZ audit had been undertaken and the assessment work was expected to be completed shortly. When it had gone through the IANZ processes a summary of the report would be available for distribution to the Board but at present there were no signals of concern. A survey of the GP sentinel practices was also being undertaken and while Labtests had had a poor start last year they were actively improving relationships with the focus on clinical relationships. The governance arrangements were still the three CEOs, Chairs and CMOs and day to day management was provided by NDSA. Savings on the contract were \$10m per annum and the quality team that had operated had been paid for by Labtests. To assist the GAIHN EOI proposal with the MoH there had been a meeting of Chairs and Chief Planning and Funding Officers. GAIHN covered over one million people and had a month to provide more specificity and focus on 4 - 5 keys things. The Chair and CEO of Counties Manukau were taking a lead role for the region with a group of three people from each DHB with for ADHB, Denis Jury, Celia Palmer and Andrew Coe. Focuses were on access to diagnostics, minor surgery, expanding POAC, after hours care and clinical pathways i.e., FSAs and follow-ups could be handled better. The aim was to have one regional plan. There should be no financial implications on the District Annual Plan but there may be a move of funding with POAC costing \$300k. GAIHN was being encouraged to think about governance and any signoff would be by the Chair, CEO and Chief Planning and Funding Manager. There had been positive feedback on the Pacific proposal.</p> <p>There was consultation on the new quality and safety agency with interviews of people for that Board of 4 - 7 people. The focus of the agency would be consistent with the quality focus of ADHB.</p>

8.1	Chief Executive's Summary
	<p>Garry Smith acknowledged the Pasifika Week with positive feedback to encourage this being an annual event.</p> <p>The contract review process was reaching the end of the process.</p> <p>The Senior Leadership Team had met with the need for the District Annual Plan 2010 – 2011 to ensure it met the Minister's targets with an endeavour to have some buffers around those targets. Other targets in the DAP were being reviewed to ensure that there was not an over promise on what could be delivered and to ensure that there is linkage back to the key priority targets.</p> <p>The two regional work streams would be reporting back by the end of April.</p> <p>"Health Care Excellence" was a way of branding the quality excellence initiatives to get consistent messages to the organisation.</p> <p>The team meeting weekly to deliver on the required financial results was acknowledged noting that at the start of the year there had been a \$32m savings target. There was work on the start point 1 July 2010 and embedding this year's savings into next year's budgets.</p> <p>Electives were at risk with the industrial action so this was being monitored closely. It was hoped that the talks being undertaken would see the industrial action lifted.</p>
8.2	Minister's Six Health Priorities 2009/2010
	<p>The change to the presentation was work in progress. The target was shown as well as what interventions would be needed to get to the target and the risks. The processes were being embedded in the organisation. The project for better diabetes and cardiovascular services needed to change the way work was being done. There were operational management disciplines being put within the organisation to get the results, an example being the 15 minute Rapid Round.</p> <p>The Hospital Advisory Committee had had a presentation on the Acute Patient Flow project with the comment made that a number of people died as a result of delays in ED. It was difficult to get agreement on pathways with commitments required from the different groups which required leadership and cultural shifts in relationships between professionals. There was also a focus on General Medicine.</p> <p>While the previous focus of ADHB had been on breaking even, the focus was now on quality, engaging clinicians and training leaders which would be a five year journey.</p> <p><u>Moved Ian Ward; seconded Rob Cooper</u></p> <p><i>That the Chief Executive Summary and the Minister's Six Health Priorities 2009/2010 be noted.</i></p> <p><u>Carried</u></p>
8.3	Alexandra Trust
	<p><u>Moved Pat Snedden; seconded Susan Buckland</u></p> <p><i>That the Auckland District Health Board directs the A+ Charitable Trust to disburse all funds held in respect to the Alexandra Trust to the Ronald McDonald Trust for acquisition of accommodation for families from within the ADHB district, subject to completion of a Deed between the ADHB and RMT as proposed by Tim McAvoy of Kensington Swan, disbursement of those terms being consistent with both the objectives of the Alexandra Trust and a practical approach to conserve the use of the trust funds for those objectives into the future. The Alexandra Trust to then be wound up.</i></p> <p><u>Carried</u></p>

9.1	Committee Recommendations
	<p>The Community and Public Health Advisory Committee</p> <p>The Committee had had a presentation on dementia and how it affected a wide spectrum of people. Information on Maori affected had been requested. There had been a presentation on population with the conclusion that increased demand for health services was 75% due to population growth and 25% due to the aging of the population.</p> <p>Hospital Advisory Committee</p> <p>The Committee had received information on cardiac and radiation therapy and there is was clear discussion of the evidence based need for allocation of resources to meet the demand. There were presentations on DNAs and the AED project. Maori Health Advisory Committee</p> <p>The Committee had received the presentation on DNA and Gwen Tepania-Palmer, a Waitemata District Health Board member, had been in attendance and was keen to have more regional collaboration. There had been a presentation from Tihi Ora Mapo on changes to that organisation.</p> <p>Pacific Health Advisory Committee</p> <p>The Pasifika week had been a focus at the hospital to support Pacific Best Practice and Pacific workforces.</p> <p><u>Moved Juliet Walker; seconded Ian Scott</u></p> <p><i>That the Board recommends that the Pasifika week be an annual event.</i></p> <p><u>Carried</u></p> <p>There would be more time for planning of the Pasifika event. The Committee had also received the evaluation of the 3 DHBs Pacific initiatives with endorsement that using churches for change was positive. There had been an update on HVAZ which was going from strength to strength.</p> <p>Disability Support Advisory Committee</p> <p>The GM, Human Resources had been in attendance and the Committee encouraged that disability be included in orientation for new staff. Counties Manukau and Waitemata had disability coordinators and they had been asked to attend the meeting to be held 13 May 2010 to which all members were invited to attend. It was hoped to establish quarterly regional meetings of the Disability Support Advisory Committees to foster regional collaboration. The monitoring of rest homes was moving from the DHB to MoH spot audits however DHBs would still continue to do issue based audits.</p> <p>Quality Risk and Audit Committee</p> <p>The Committee had endorsed the consumer input structure which has three levels. They had also had a paper on harassment in the workplace.</p> <p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the reports from the Committees be noted.</i></p> <p><u>Carried</u></p>
10.2	DAP Projects Report
	<p><u>Moved Pat Snedden; seconded Chris Chambers</u></p> <p><i>That the DAP projects report summary be noted.</i></p> <p><u>Carried</u></p>

11.1 Finance Committee**Provision of Pharmaceutical and Non Pharmaceutical Products**

Moved Ian Ward; seconded Bob Tizard

That the Auckland District Health Board approves the renewal and variation of the Product Supply agreements between the Auckland Northern Region District Health Boards (ANRDHB) and Health Support Limited (HSL) for the provision of Pharmaceutical and Non-Pharmaceutical Products on behalf of Auckland District Health Board. For the purposes of this proposal Auckland Northern Regional District Health Boards (ARNDHB) comprises of:

*Auckland District Health Board (ADHB)
Counties Manukau District Health Board (CMDHB)
Northland District Health Board (NDHB)
Waitemata District Health Board (WDHB)*

Contract renewal for a period of 5 years; total estimated value for the 5 year term:

<u>DHB</u>	<u>Est Value (5 Year)</u>
<i>Auckland DHB</i>	<i>\$184,500,000</i>
<i>Counties Manukau DHB</i>	<i>\$ 51,000,000</i>
<i>Northland DHB</i>	<i>\$ 17,500,000</i>
<i>Waitemata DHB</i>	<i>\$ 57,000,000</i>

Subject to wording to be checked in relation to "legislative" change.

Carried

Residential Treatment Odyssey House Trust**Residential Treatment Salvation Army New Zealand Trust**

Both suppliers were regarded highly and the Finance Committee had discussed extending the period of contracts but as they are regional it is subject to the IDF process.

Moved Brian Fergus; seconded Bob Tizard

That the Auckland District Health Board approves the Chief Planning and Funding Officer to sign a 2 year contract with Odyssey House Trust committing the DHB to up to \$8,505,494.12 (GST excl) based on full occupancy, noting that this is a Metro Auckland Regional contract providing services to all Metro Auckland DHBs.

That the Auckland District Health Board approves the Chief Planning and Funding Officer to sign a 2 year contract with Salvation Army New Zealand Trust committing the DHB to up to \$6,315,039 (GST excl) based on full occupancy, noting that this is a Northern Regional contract providing services to all Northern Region DHBs.

Carried

Supply of Pain Pumps and Consumables

This proposed reduced the number of pain pumps from 5 down to 1.

Moved Pat Snedden; seconded Ian Ward

That the Auckland District Health Board approves:

- 1. That a Direct Supply Agreement is entered into between ADHB and Smiths Medical Australasia Pty Ltd for the Supply of CADD Solis Pumps and accessories.*
- 2. That a Tripartite Supply agreement between ADHB, Smiths Medical Australasia Pty Ltd and Health Support Limited is entered into for the distribution of the associated consumables.*
- 3. Term of the contract is for 5 years (60 months) with an option to exercise a Right of Renewal for 2 years (24 months).*
- 4. The estimated value of the Contract(s) based on current fleet replacements over 7 years is:*
 - Capital: \$653,800*
 - Consumables \$891,238*
- 5. The Supplier has agreed to include the National Privity option which will enable other DHB's to*

	<p><i>access the Contract Pricing Schedule.</i></p> <p><i>Subject to appraising the Shared Services Establishment Board.</i></p> <p><u>Carried</u></p>
11.2	Finance Report
	<p>The results were on target for the month and year to date. The next 4 months would be difficult with March being the highest challenge although in that month payroll was close to budget. Volumes for March were yet to be finalised.</p> <p><u>Moved Pat Snedden; seconded Brian Fergus</u></p> <p><i>That the Financial Report for February 2010 be noted.</i></p> <p><u>Carried</u></p>
13	GENERAL BUSINESS
	<p>Building 5</p> <p>Susan Buckland advised of a couple of proposals for use of Building 5 one being possible client accommodation of a higher standard for older people and some suggestions from the President of the Auckland Civic Trust. It was noted that while ADHB's responsibility was to provide healthcare to its population any ideas were to be put to Management through the Manager Materials Management.</p> <p>CEO Continuing Education</p> <p>Garry Smith thanked the Board for their support for the Kaizen Lean Tour continuing education. He outlined his three objectives and five strategies that emulated from his learning's being to (1) change the Board Goal 2 from Performance Improvement to Improve Performance, (2) use visual management, (3) pursue customer satisfaction through continuous quality improvement and eliminating waste, (4) recognition of staff for ideas, innovation and improvement and, (5) having senior management going to the workplace.</p> <p>It had been a great learning experience and confirmed the journey that ADHB was taking.</p>
	NEXT MEETING
	<p>The meeting closed at 4:00pm</p> <p>The next scheduled meeting is : 2:00pm, Wednesday, 5 May 2010 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton</p>
CONFIRMED	
CHAIR:	DATE:

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ACTION POINTS

- 7 APRIL 2010

Board
Action Points from the meeting on Wednesday 7 April 2010

Item	Detail	Designated	Action
Carried forward	Presentation by City Mission	Garry Smith	Scheduled for May meeting
Carried forward	Suggested Strategic Planning Day for the Board	Pat Snedden Garry Smith	Arranged for Wednesday 26 May 2010
Carried forward	Minister's "Get Checked" pressure PHO to ensure GPs are recording data	Denis Jury	Raised with Primary Care Clinical Advisory Group
13	Building 5 suggestion to be raised with Facilities through Chris Morgan	Chris Morgan	Contacts provided by Susan Buckland. Meeting being arranged.

PRESENTATIONS

* '%''7]miA]gg]cbYf '!8]UbY'FcVYf]gcb

CHAIRMAN'S REPORT

CHIEF EXECUTIVE'S REPORT

8.1 Chief Executive's Summary

Chief Executive Officer's Summary

	Traffic Light	Comment	Mitigation
Goal 1 Lift the Health of the People of Auckland			
Elective Surgery	Orange	ADHB Population target not being met.	Surgery Project plus gearing to 2010/11 levels.
DAP Feedback	Green	Balanced response needing clarification	<ul style="list-style-type: none"> Meeting with account managers Align 6 Minister's targets Detail specific initiatives
Primary Care Plan	Green	Regional Plan to support EOI process	Move to Implementation Plan and resourcing
Goal 2 Improve Performance			
Walk Arounds	Green	Programme starts 10 May	N/A
State of Nation	Green	Series completed. Good engagement.	Focus on Minister's Priorities and financial, plus improvement processes.
Car Park	Orange	Approval Process stalled.	Tender Process proceeding with alternatives to be reviewed.
ASPIRE Project	Green	Go live of Phase 1 in May.	Refer to attached background details.
Goal 3 Live Within Our Means			
Forecast 2009/10	Red	Cost pressure and savings targets are a daily focus	Senior Leadership Team Commitment.
Non DRG Volumes	Red	ADHB and IDF volumes ahead of contract.	No wash-up – need to address as impact on FSA within 6 months.
Regional Projects	Green	Good progress on the two work streams.	Next 6 – 8 weeks verify priority services, statistics, and implementation plan. Discuss with Boards / Senior Leadership Team.

ASPIRE Project: Board Report April 2010**Background Information**

Output from the ADHB Transcription Service to all recipients (including GPs, patients and ADHB clinicians) is still done by printing and mailing out hard copy (paper). Feedback from GPs is that they want to receive clinic letters and other correspondence electronically. The current system does not meet customer expectations and is inefficient. Postage and printing costs alone exceed \$200k per annum. Meanwhile transcription volumes continue to increase, and the service must improve efficiency so that it can continue to deliver the required level of service within budget.

The ASPIRE Project (Automated Sending of Patient Information to Recipients Electronically)

The ASPIRE Project is set to deliver a solution for the electronic distribution of clinical documents from the ADHB Transcription Service to all internal (ADHB) and external recipients, including GPs and other healthcare providers. This Project's primary objective is to improve the efficiency of the Transcription Service, decrease expenditure and deliver improvements in the way ADHB communicates with other healthcare providers.

The ASPIRE solution has not only been designed to address the immediate business requirements of the Transcription Service. The system will be administered by the Clinical Records Department, and will provide a more efficient and customer-focussed mechanism for delivering a vast range of patient information to various recipients electronically, including radiology reports to GPs, and release of information requests to patients.

ASPIRE has also been built to provide a robust mechanism for the transmission of large volumes of patient information between various systems. ASPIRE is yet to go live, but is already in hot demand to meet other patient information distribution requirements. The solution will be used to distribute the following:

- Mental Health correspondence from HCC to other systems & people;
 - Maternity summaries from Healthware to other systems and people; and
 - Discharge Summaries from the Neonatal database to other systems and people,
- and the list of opportunities for efficient distribution of patient information continues to grow.

ASPIRE is also a Regional Asset

ASPIRE has now been included in the design for the new Auckland region Clinical Documents Repository. ADHB, CMDHB and WDHB will use ASPIRE to send health event summaries from various systems to the regional repository, to facilitate access by primary and secondary healthcare providers across the Auckland region.

Project Timelines

The Phase 1 go-live in May 2010 will deliver electronic distribution of all output from the Transcription Service to GPs and other healthcare providers via Healthlink. Phase 2 will go-live in July to deliver electronic distribution of all output from the Transcription Service to internal recipients (ADHB clinicians) via Concerto messaging.

The ASPIRE business case was approved by the Ministry of Health in January 2010. The Project is on time and on budget.

Linda Fletcher, Project Sponsor
Health Information Manager, IMTS

8.2 Minister's Six Health Priorities 2009/10

Project: Adult Acute Patient Flow

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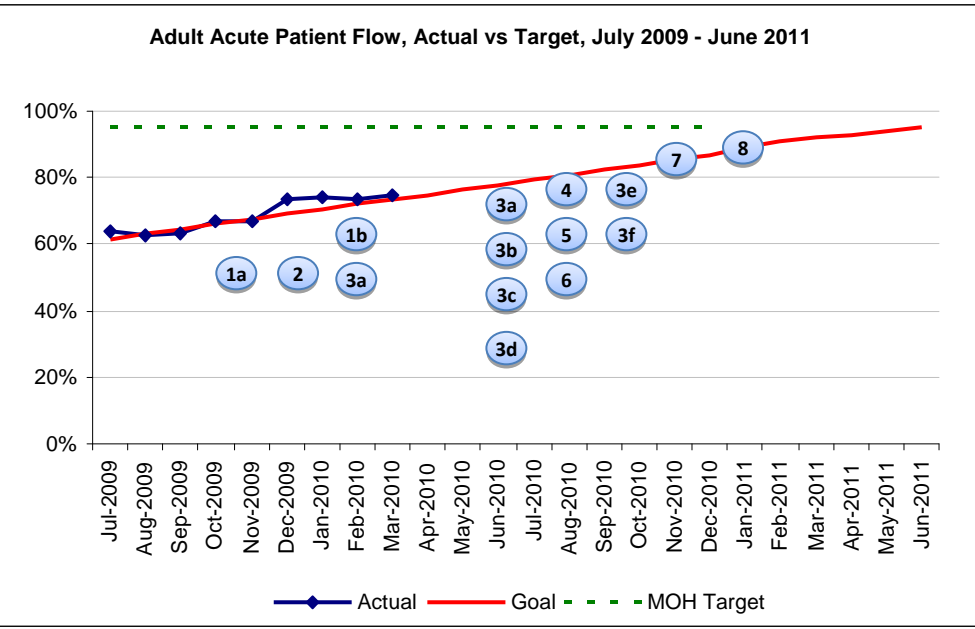
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin , Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



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 and General Surgery
- b) Increase the number of weekend discharges in General medicine and Orthopaedics
- c) Improve the volume and accuracy of estimated discharge dates in General Medicine wards
- d) reduce short stay (<24 hr) admissions
- e) Remove delays associated with NASC referrals
- f) Remove delays associated with Taikura Trust patients

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 Risks / Comments:

Despite the peaks in patients presenting to Adult ED YTD, an increase of 5.9% on the same period last year, we have still seen a significant improvement in target performance (26 consecutive weeks of above average performance). Adult ED has improved progress towards achievement of the shorter stays in Emergency Department target from 69% in Quarter 2 to 74.3% in Quarter 3. March has been another record high for patient attendances with 4,202 patients being treated in AED this month. This represents a 9.2% increase on the same month last year.

The ALOS in AED was 5 hours and 13 minutes and this is the fourth consecutive month for the ALOS being under 6 hrs. This continues the downward trend from August 09 when the ALOS was just over 7 hours with 3,900 attendances

An increased operational discipline will be required to continue this level of improvement as we enter into winter months with further peak activity including using flex bed capacity to ensure we maintain acute flow.

Many improvement initiatives are being led by ADHB senior clinical team leaders / CN's / senior nurses who are lean six sigma green belt practitioners.

Project: Children's Acute Patient Flow

42

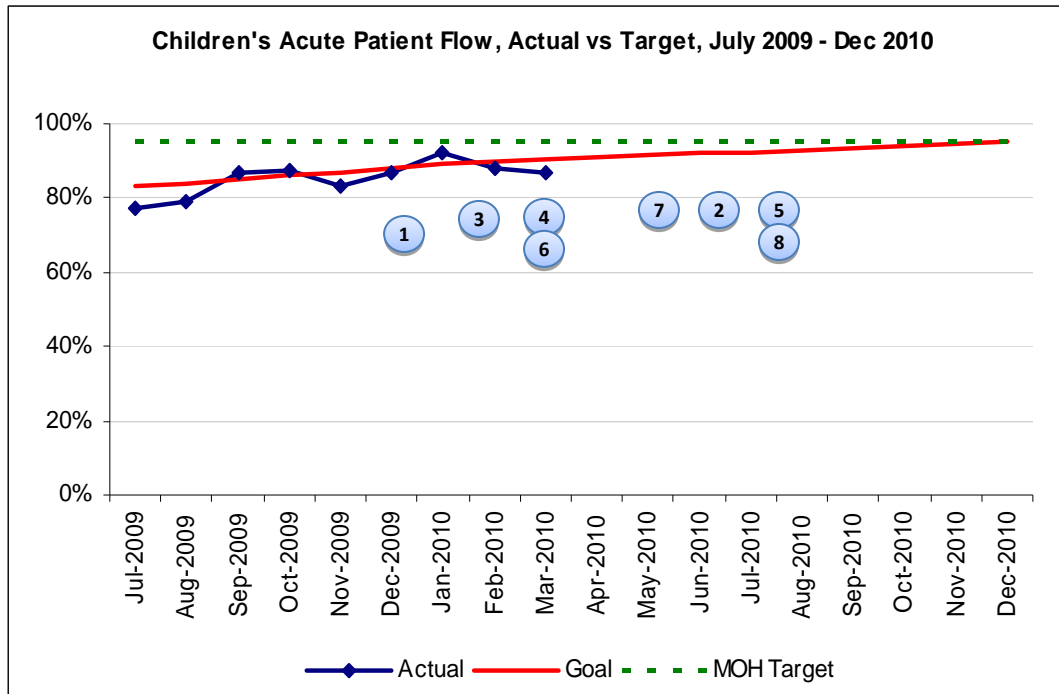
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 31 December 2010

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Current activities:

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

Project Risks / Comments:

CED 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

43

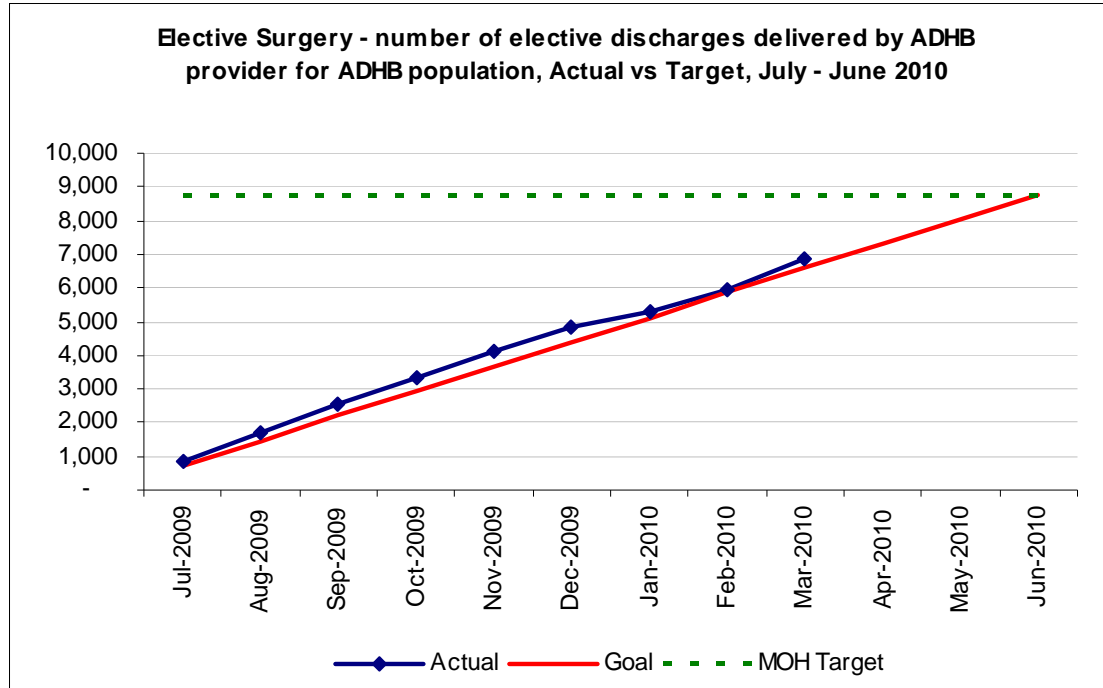
Primary Objective: To meet the MoH deliverable of elective discharges in surgical specialties for the ADHB population. The specified target is 93% of the overall population target, to account for ADHB population elective discharges from the ADHB provider.

Date of Delivery: 1

Clinical Lead:

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan



Planned Activities:-

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

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

Risks / Comments:

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

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

Project: Shorter waits for Radiation Therapy

44

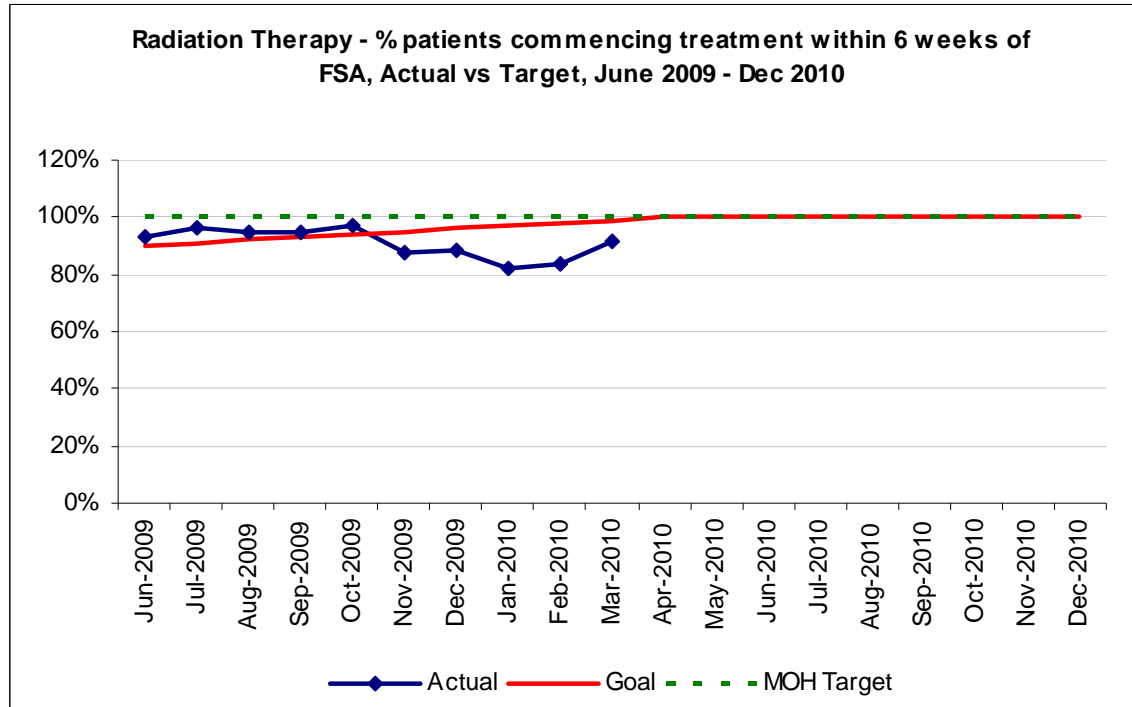
Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010

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 7 April, 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 are forecasting 100% compliance to the 6 week MoH target in the 4th 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 (implement April 2010).
- Evening shifts have been extended until the end of May - this provides an additional 3 Linac treatment hours per day.
- Process analysing opportunities to improve the provision of radiation therapy treatment and services to meet MOH targets
- Outsourcing to Waikato Hospital - contingent on current wait time status, 9 patients have been treated at Waikato since mid Jan.
- Continue to prioritise the "flexible working hours" project to identify ways of increasing the treatment capacity within available FTE.
- Presentation of the business case for the replacement of MV5 to Regional Capital in March and ADHB Expenditure committee in April. On commissioning (Jan 2011) this will increase treatment capacity by approx 5 hours per day.
- Agreement with ARO to outsource a minimum of 50 Patients per annum to manage peaks in demand.

Project: Better help for smokers to quit

45

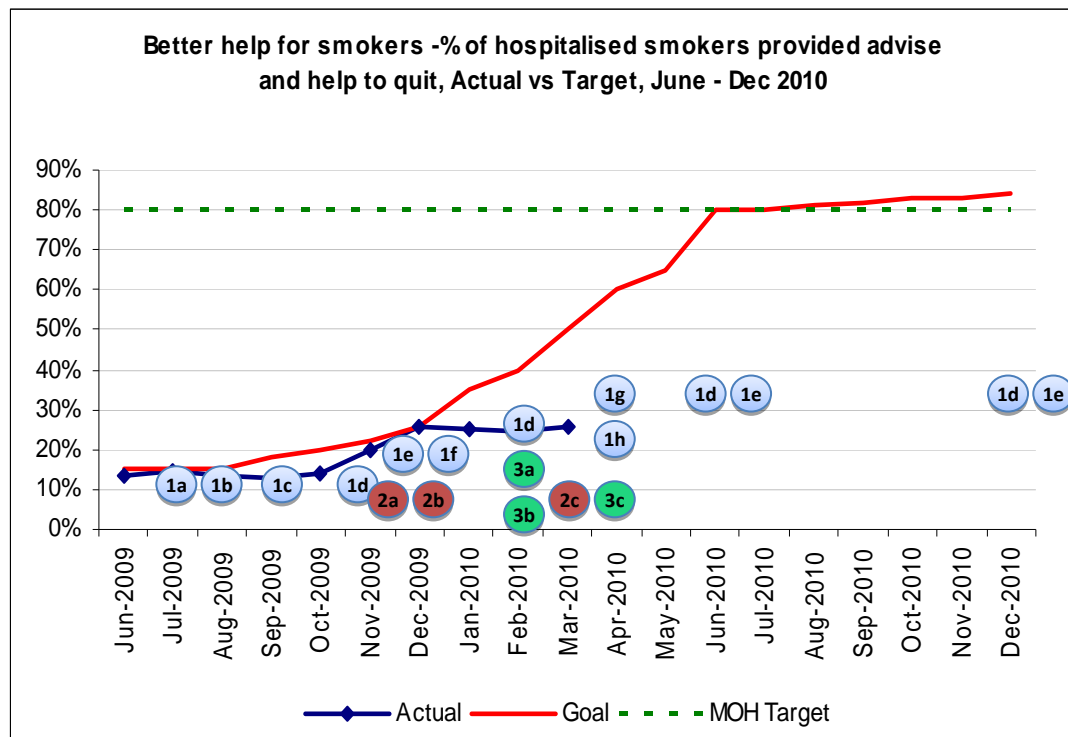
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

Clinical Lead: Stephen Childs

Project Sponsor: Taima Campbell

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



Project Risks and Comments

Having gained momentum prior to Christmas progress towards meeting the target stalled over the holiday period. The programme is at risk until it becomes well embedded into all staff's routine practise. Since receiving specific feedback on their own performance many wards and services have planned and put in strategies to ensure that they meet the target. Many of the current activities will be ongoing however the next focus is skill based coaching to support staff to feel confident to address smoking as this is seen as a barrier. Continued refinement of systems is underway to improve documentation and coding of the ABC

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 commenced 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 – resulting in a marked improvement of recording of advice and support given
 - 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

Project: Cardiac Bypass Surgery

46

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

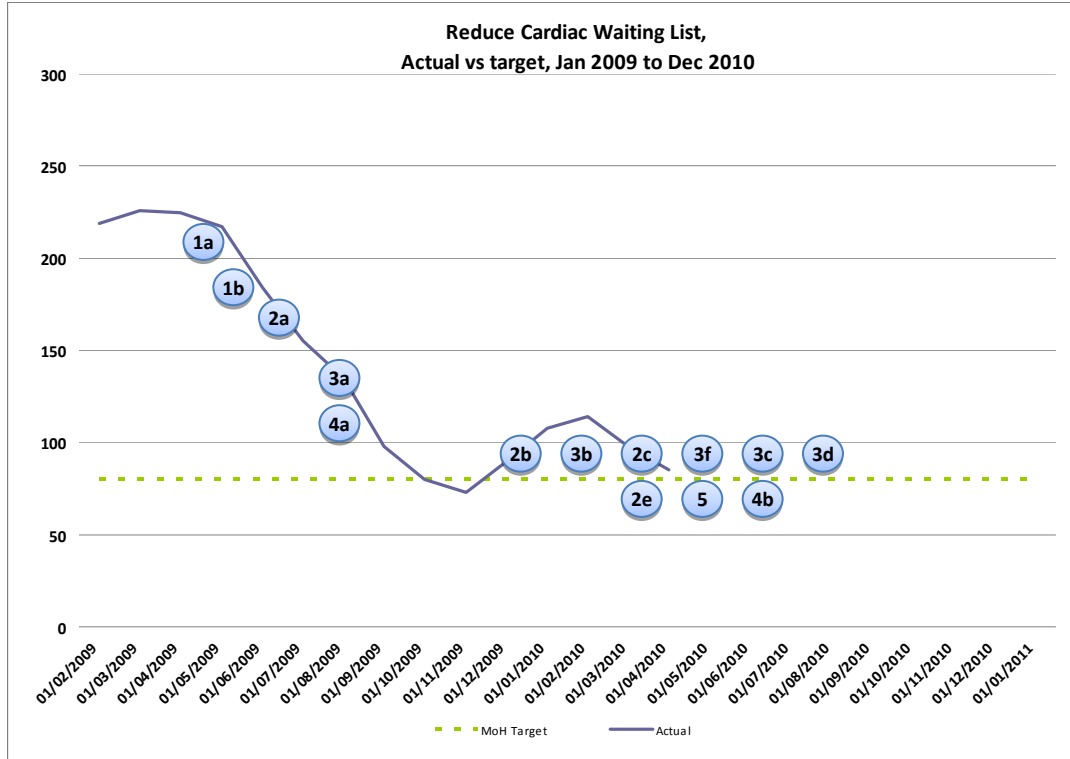
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2010

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Kay Hyman

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



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.

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: Diabetes

47

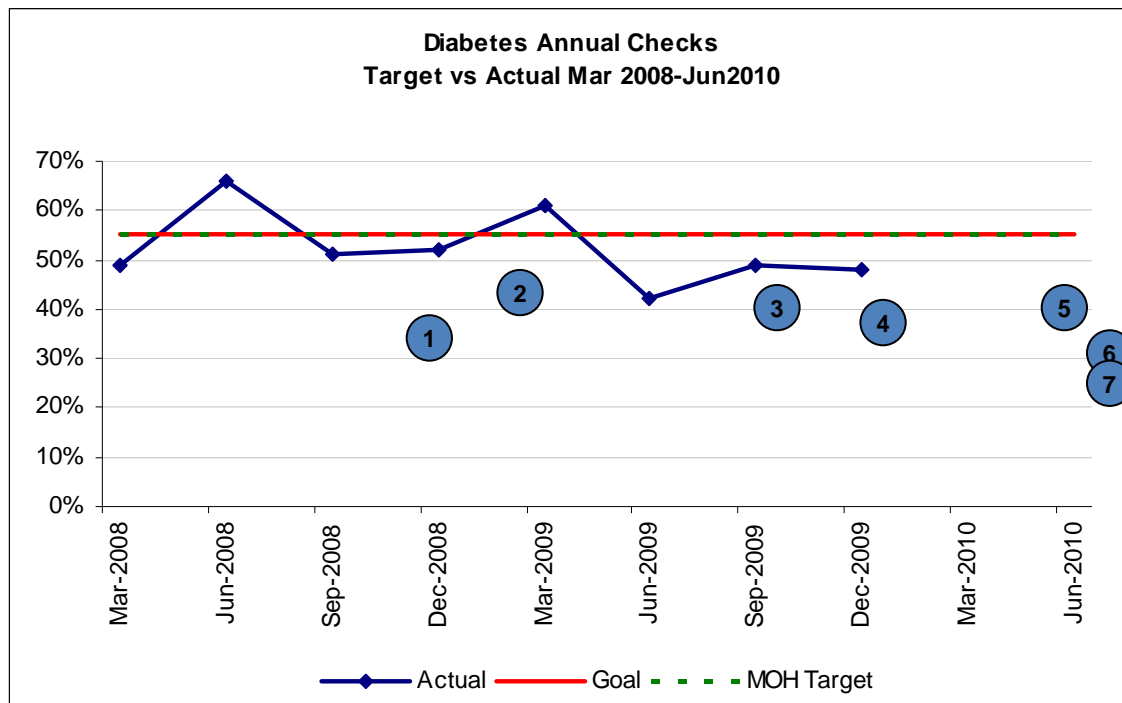
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

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



Recent and Current activities:

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

Project Risks / Comments:

We are still under our target for this quarter. The majority of gain has been in our Maori Diabetes Get Checked with an increase from 32 % April -June (2009), 43% July-September (2009) to 47% October-December (2009). We have also just passed our target for Pacific Peoples in this Oct – Dec period. 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 5000. 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

48

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

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

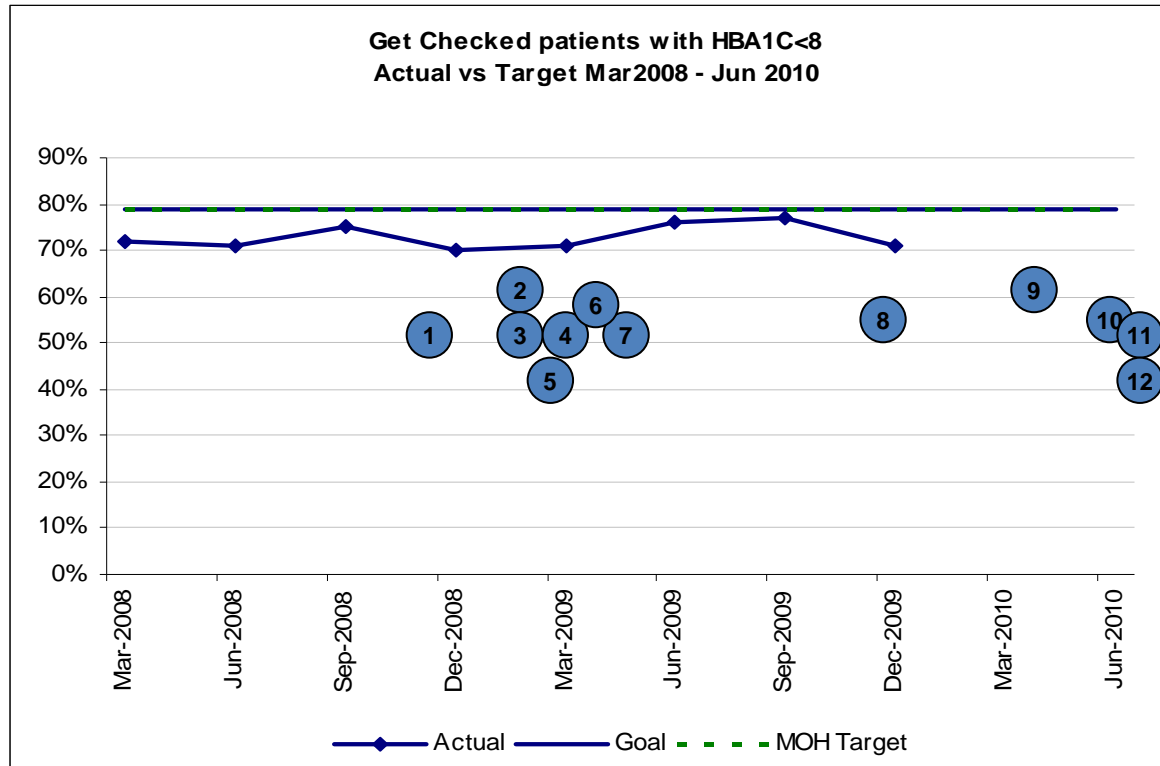
Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

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

Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 2) Practise based data (results) feedback
- 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
- 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



Project Risks / Comments:

We have slipped back on our progress this quarter and 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.

Project: Cardiovascular Risk Assessment

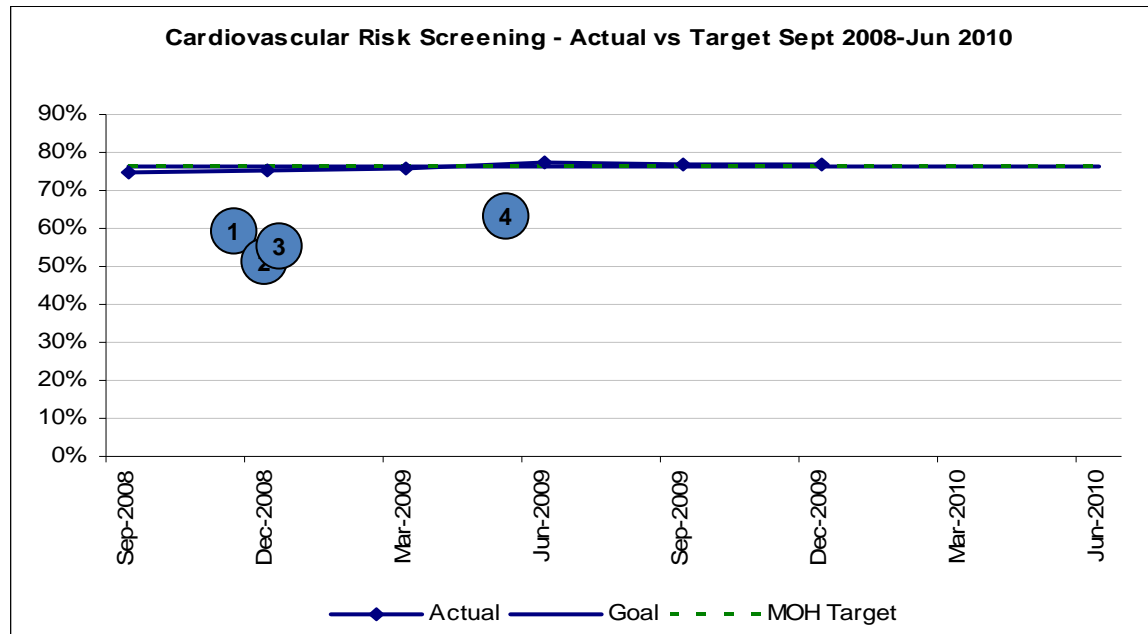
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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

Project Risks / Comments:

We are only slightly below our target goal. However, the indicator is not based on the electronic risk tool data but on a laboratory test extraction undertaken and analysed by the MoH to produce our result. It is a proxy measure for CVD risk assessment however, it is not a measure that assists in understanding good management of those whom are identified as having an increased risk. This information is produced using the supported electronic tool and is examined quarterly, albeit not all the PHOs have chosen to use the DHB sponsored one. An annual report is produced at the end of the financial year for all PHOs to illustrate both their assessments and their management. This will be available for 2009/2010 year end July.

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

9.1 Committee Recommendations

9.1 Committee Recommendations

Community and Public Health Advisory Committee Recommendations

Maori Health Advisory Committee Recommendations

Pacific Health Advisory Committee Recommendations

Disabled Support Advisory Committee Recommendations

10

PERFORMANCE IMPROVEMENT

10.1 Committee Recommendations

10.2 DAP Projects Report

10.1 Committee Recommendations

Hospital Advisory Committee Recommendations

Verbal by Committee Chair

Quality, Risk and Audit Advisory Committee Recommendations

Verbal by Committee Chair

10.2 DAP Projects Report

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

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 & 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 & 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"> 1. IDF annual agreements ensure we are paid for what we do. 2. Participate in National pricing process
	Improve Productivity	Reduce Administration Cost
Improve Clinical Effectiveness		<ol style="list-style-type: none"> 1. Improve clinical resource utilisation 2. Reduce variation in Clinical Practice
Health Service Process Improvement		<ol style="list-style-type: none"> 1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.
Achieve procurement savings		<ol style="list-style-type: none"> 1. Leverage national/regional procurement initiatives 2. Refine procurement strategy 3. Deliver direct treatment cost savings 4. Deliver indirect treatment cost savings 5. Monitor and collect rebates within contracts for supplies and services
Manage Cash	Optimise stock holding	<ol style="list-style-type: none"> 1. Revisit replenishment parameters 2. Improve supply chain systems and processes
	Sustainable Cash Management Plan	<ol style="list-style-type: none"> 1. Asset Management Plan alignment with the Long Term Services Plan 2. Improve prioritisation process for new capital 3. Long term financial modelling process is implemented



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	6	2	0	23	2	0	24	1	0	24	0	1	4	3	0	0
2) Performance Improvement	45	44	12	7	11	11	2	0	33	11	1	44	1	0	38	7	0	1	1	0	0
3) Living within our Means	11	10	2	2	2	2	1	0	8	3	0	11	0	0	11	0	0	1	1	0	0
Totals #	81	79	19	10	20	19	5	0	64	16	1	79	2	0	73	7	1	6	5	0	0
Totals %	100%	98%	23%	12%	25%	23%	6%	0%	79%	20%	1%	98%	2%	0%	90%	9%	1%	7%	6%	0%	0%

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. IT Resilience project progressing well, however complexity of implementation is causing concern about the number of planned outages that may be required to get the new infrastructure in place. Team is working on scenarios to minimise impact on the user community but this may cause further delay.

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.

LIVE WITHIN OUR MEANS

11.1 Finance Committee Recommendations

11.2 Finance Report

11.1 Finance Committee Recommendations

ADHB Board

Author: Ian Bell (8077)

Subject: 2 Neuro Surgery Microscopes

Recommendation

That the Auckland District Health Board approves the purchase of 2 Pentero microscopes manufactured by Carl Ziess used for Neurosurgical operating on Level 8 Operating Rooms as a cost of \$850,000.

Background

This was considered by the Finance Committee on 4 May 2010.

ADHB Board**Author: Ian Bell (8077)****Subject: High Dose Rate Brachytherapy Machine**

Recommendation

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.

Background

This was considered by the Finance Committee on 4 May 2010.

ADHB Board**Author: Ian Bell (8077)****Subject: National Air Ambulance Services**

Recommendation

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.

Background

This was considered by the Finance Committee on 4 May 2010.

ADHB Board

Author: Ian Bell (8077)

Subject: Replacement Accelerator for Radiation Oncology

Recommendation

That the Auckland District Health Board approves the purchase of replacement Linear Accelerator for Radiation Oncology for \$3,592,387.86.

Background

This was considered by the Finance Committee on 4 May 2010.

ADHB Board**Author: Ian Bell (8077)****Subject: Upgrade Nurses Call System – ACH Level 6 & 7**

Recommendation

That the Auckland District Health Board approves the capex of \$600,000 to upgrade the nurse call system on Levels 6 & 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.

Background

This was considered by the Finance Committee on 4 May 2010.

11.2 Finance Report

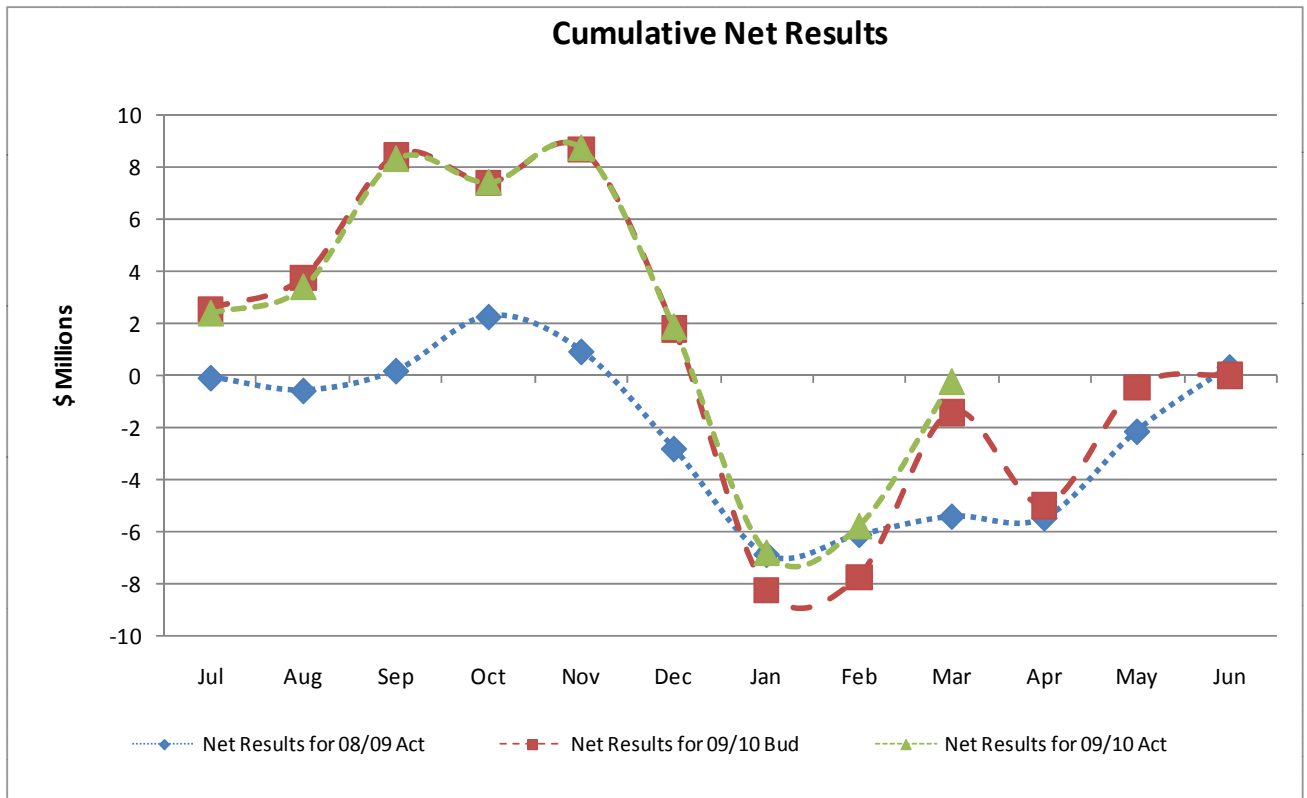
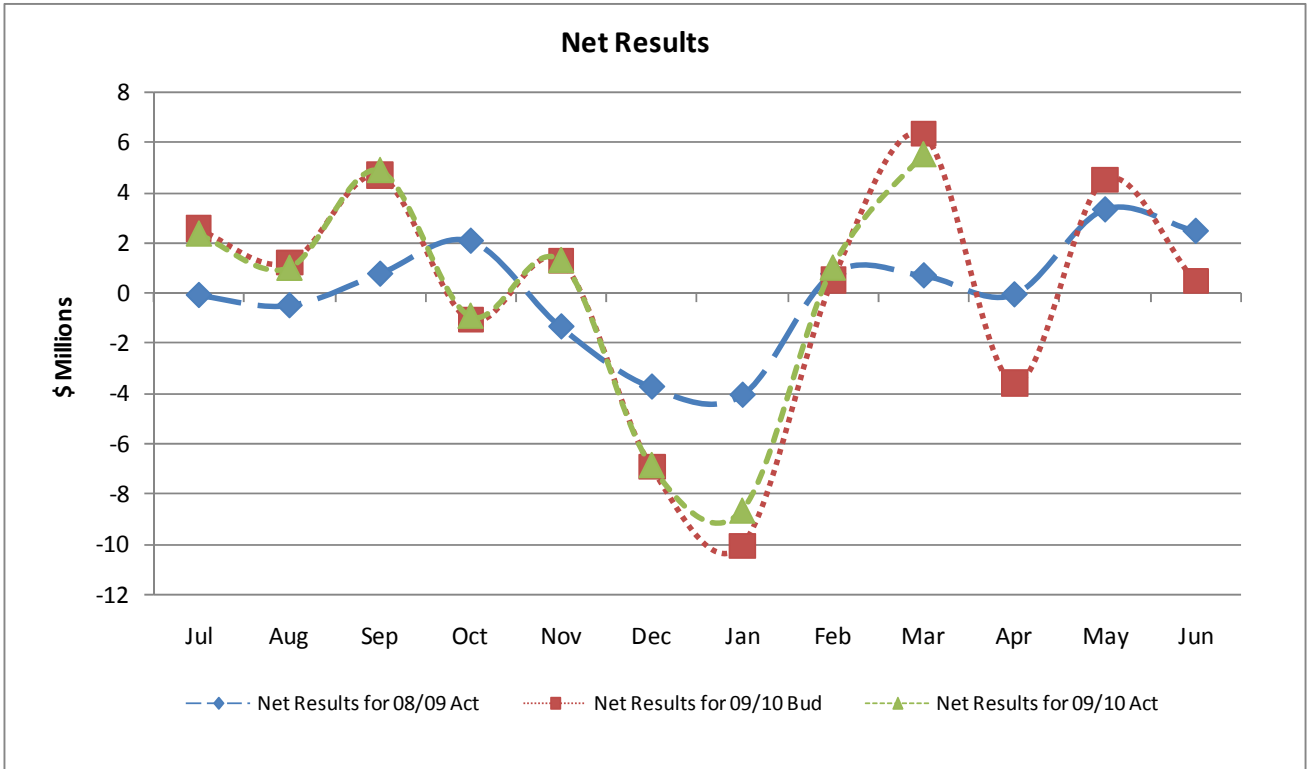
Auckland District Health Board

Board Financial Report

Prepared by Grant Barnett

March 2010

Performance Graphs by Month & YTD



Auckland District Health Board
Summary Result
Mar 2010 Month & Year to date

\$000s	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
Income						
PBF - AKL Population	87,744	84,724	3,019 F	714,802	705,625	9,177 F
Inter District Inflows	46,078	46,989	911 U	417,394	422,902	5,508 U
	133,822	131,713	2,108 F	1,132,196	1,128,527	3,669 F
MOH Sub-contracts	5,449	5,830	381 U	50,365	50,829	464 U
Other Patient Care	2,672	3,014	342 U	24,472	27,006	2,533 U
Services & Products	3,672	3,615	57 F	32,575	32,104	472 F
CTA	2,272	1,657	615 F	16,115	14,709	1,406 F
Trust & Donation Income	548	848	300 U	3,262	7,792	4,530 U
Financial Income	2,001	3,549	1,548 U	5,547	3,772	1,775 F
Other Income	970	651	319 F	5,980	5,130	850 F
Profit on Sale of Fixed Assets			0 F			0 F
	151,405	150,877	528 F	1,270,514	1,269,869	644 F
Expenditure						
Employee Costs						
Medical	20,062	19,435	627 U	167,463	166,179	1,284 U
Nursing	19,941	20,151	210 F	178,000	177,338	662 U
Technical	10,540	10,515	25 U	87,873	90,061	2,188 F
Hotel Services	824	828	5 F	7,312	7,215	97 U
Administration	8,032	7,903	129 U	67,534	66,836	698 U
Other	3,643	3,683	40 F	31,860	33,685	1,825 F
Total Employee Costs	63,042	62,515	527 U	540,042	541,314	1,272 F
Direct Treatment Costs	20,251	17,716	2,535 U	166,451	158,480	7,971 U
Indirect Treatment Costs	3,580	3,230	350 U	29,465	28,830	635 U
Funder Payments	36,370	37,934	1,563 F	335,212	333,476	1,736 U
Inter District Outflows	7,784	8,093	309 F	70,895	72,835	1,941 F
Prop, Equip. & Transpt	4,069	4,114	45 F	35,600	38,390	2,790 F
Maintenance	(54)	133	187 F	1,243	1,200	43 U
Building Compliance	0	0	0 F	(400)	0	400 F
Loss on Sale of Fixed Assets	5	2	3 U	173	16	157 U
Administration Costs	2,049	1,551	498 U	14,190	14,051	138 U
Total Operating Expenditure	137,097	135,289	1,808 U	1,192,871	1,188,593	4,277 U
Operating Contribution	14,308	15,588	1,279 U	77,643	81,276	3,633 U
Depreciation	4,031	4,273	243 F	36,105	38,013	1,908 F
Finance Costs	1,678	1,717	39 F	15,132	15,168	36 F
Capital Charge	3,072	3,293	221 F	26,659	29,504	2,845 F
Total Non Operating Costs	8,781	9,283	503 F	77,895	82,685	4,790 F
Net Surplus / (Deficit)	5,528	6,304	777 U	(252)	(1,409)	1,157 F

**Auckland District Health Board
Statement of Financial Position
As at Mar 2010**

	Mar-10 Actual \$ 000s	Mar-10 Budget \$ 000s	Feb-10 Actual \$ 000s	Jun-09 Actual \$ 000s
Crown Equity				
Opening Balance	566,089	569,698	566,089	601,089
Equity Injections/(Repayments)	268	-	268	(35,000)
Closing Balance	566,357	569,698	566,357	566,089
Revaluation reserve				
Opening Balance	381,278	417,016	381,278	417,019
Revaluation Adjustments	-	-	-	(35,741)
Closing Balance	381,319	417,016	381,319	381,278
Retained Earnings				
Opening Balance	(468,647)	(468,975)	(468,647)	(468,972)
Surplus/(Deficit) Current Year	(251)	(1,409)	(5,778)	325
Closing Balance	(468,898)	(470,383)	(474,425)	(468,647)
Total Crown Equity	478,777	516,331	473,250	478,719
Represented by:				
Fixed Assets				
Land	201,337	245,814	201,337	201,337
Buildings	595,757	573,266	597,035	605,970
Clinical, Other Equipment & Motor Vehicles	84,630	107,119	84,777	85,971
Work in Progress	15,447	10,950	15,663	8,288
Total Fixed Assets	897,170	937,149	898,813	901,566
Derivative Financial Instruments	4,690	2,823	6,204	6,954
Investments				
Associated Company Investments	386	366	386	386
Trust Deposits	10,000	5,500	8,000	8,000
Total Investments	10,386	5,866	8,386	8,386
Current Assets				
Cash & Short Term Deposits	52,073	56,635	50,773	35,287
Trust Deposits	10,910	15,264	12,931	11,780
Debtors	27,504	19,194	29,322	24,176
Accrued Income	23,324	17,794	20,345	36,920
Prepayments	2,718	2,604	2,825	2,320
Inventory	11,916	11,348	11,966	11,717
Total Current Assets	128,445	122,839	128,163	122,200
Current Liabilities				
Borrowings	74,905	88,145	91,854	18,372
Trade & Other Creditors, Provisions	208,213	197,383	204,174	216,416
Income Received in Advance	22,417	24,435	24,490	17,509
Taxes Payable	21,160	19,735	20,793	17,210
Funds Held in Trust	1,061	1,082	1,060	1,038
Total Current Liabilities	327,757	330,780	347,721	270,546
Working Capital	(199,312)	(207,941)	(219,558)	(148,346)
Non Current Liabilities				
Borrowings	212,992	195,748	199,484	269,168
Employee Entitlements	21,166	25,818	21,111	20,673
Total Non Current Liabilities	234,157	221,566	220,595	289,841
NET ASSETS	478,777	516,331	473,250	478,719

Statement of Cashflows for the Year ended 30 June 2010 **83**

	Mar-10			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	146,170	142,790	3,380	1,289,894	1,272,461	17,433
Payments	(137,985)	(131,206)	(6,779)	(1,248,526)	(1,237,797)	(10,729)
Net Operating Cashflows	8,185	11,584	(3,399)	41,368	34,664	6,704
Investing						
Income	416	904	(488)	3,657	3,773	(116)
Capital						
Sale of Assets	0	2	(2)	0	18	(18)
Purchase Fixed Assets	(2,388)	(5,658)	3,270	(31,710)	(44,022)	12,312
Net Investing Cashflows	(1,972)	(4,752)	2,780	(28,053)	(40,231)	12,178
Financing						
Equity Injections	0	0	0	268	3,609	(3,341)
New Loans	0	6,900	(6,900)	0	6,900	(6,900)
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	(10,500)	10,500	0	(10,500)	10,500
Net Financing Cashflows	0	(3,600)	3,600	268	9	259
Total Net Cashflows	6,213	3,232	2,981	13,583	(5,558)	19,141
Opening Cash	42,657	26,497	16,160	35,287	35,287	0
Closing Cash	48,870	29,729	19,141	48,870	29,729	19,141

Financial Performance

The result for March was a surplus of \$5.5m an unfavourable variance to budget of \$0.8m. On a year to date basis there is a deficit of \$(0.3)m a favourable variance to budget of 1.2m. The result year to date was driven by higher revenue of \$0.6m and lower expenditure of \$0.6m.

Year to date revenue is higher than budget by \$0.6m at \$1,270.5m.

- Higher revenue variance was driven by base revenue received for which expenditure has yet to be incurred \$1.2m, (recognised in accordance with current accounting principles), higher volume delivery \$2.4m (net of over delivery \$(8.5)m), higher CTA Income \$1.4m driven by additional volume and payment of arrears and higher volumes of retail pharmacy sales \$1.5m.
- Interest Rate Swap Instruments are recording a favourable variance of \$1.8m 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 \$(4.5)m, and lower ACC and Non resident fee volumes \$(2.5)m.

Year to date expenditure is lower than budget by \$0.6m at \$1,270.8m.

- Labour Costs are \$1.3m favourable 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 \$1.9m
 - b) Annual leave reduction over budget in Christmas New Year period \$3.0m
 - c) Medical & Technical staff vacancies \$10.6m
 - d) Savings in administrative staff 81 FTE \$4.6m
 - e) Superannuation contributions being below budget \$2.5m.
 - f) Redundancy Costs \$(0.8)m
 - g) Nursing 46 FTE over budget \$(2.6)m
 - h) Savings targets \$(18.0)m
- Direct Treatment costs are \$(8.0)m unfavourable to budget due to higher third party treatment costs \$(4.8)m, principally for Cardiac Services \$(3.6)m, driven by the waitlist reduction initiative, General Surgery \$(0.5)m and Orthopaedics \$(0.5)m for other outsourcing. In addition Clinical Supplies costs are \$(6.2)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 \$3.0m.
- Funder Payments are \$0.2m favourable to budget driven by higher PHO expenditure \$(4.4)m as a result of the payment of PHO performance management payments, demand driven enrolments and price increases, with a partial offset in the revenue, higher Laboratory expenditure \$(1.2)m driven by budget phasing and the introduction of a further contract, higher Health Of Older people expenditure \$(2.1)m driven by increased cost of residential and hospital care and higher Public Health expenditure \$(1.0)m. These unfavourable variances are offset by the timing of Mental Health expenditure \$2.0m, underspends in other personal health lines \$5.0m and IDF Outflows \$1.9m.
- Property Costs were favourable to budget \$2.8m mainly driven by lower costs for computer maintenance \$0.7m and lower property and clinical equipment maintenance \$1.2m.

- 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 \$2.8m 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 \$1.9m 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 \$31.7m, under budget by \$12.3m. Baseline and Facilities projects are under budget by \$7.7m and Information Systems projects are behind budget by \$4.6m driven by the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$52.1m (excluding Trust deposits). At month end and an unused overdraft facility of \$46.0m.

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PAPERS

12.1 Approval of 2010-2011 Statement of Intent (SOI)

12.1 Approval of 2010-2011 SOI

Auckland District Health Board Paper



Date	Wednesday 5 May 2010
To	Auckland District Health Board
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz
Author	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Approval of 2010/11 Statement of Intent (SOI)
1	<p>Recommendation</p> <p>That the Board;</p> <ol style="list-style-type: none"> 1. Note the changes to date made in the draft SOI as detailed in the table paper. 2. Approve 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
2	<p>Background</p> <p>Feedback from the MoH Audit Office has been received regarding previously approved draft SOI, and this was discussed at the April 2010 CPHAC meeting.</p> <p>ADHB is working with the Audit Office to address the issues raised and to produce an acceptable draft by 14 May.</p> <p>A paper detailing changes to the original draft will be tabled at the 5 May Board meeting.</p>

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GENERAL BUSINESS

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APPENDICES

None

MEETING DETAILS	
Time and Date	2:00pm Wednesday 5 May 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 David Sage, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ian Bell.

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3	Conflicts of Interest	007
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5	Action Points 7 April 2010	025
6	Presentations City Missioner – Diane Robertson	029
7	Chairman’s Report - Verbal	031
8	Chief Executive’s Report 8.1 Chief Executive’s Summary 8.2 Minister’s Six Health Priorities 2009/10	033
9	Lift the Health of People in Auckland City 9.1 Committee Recommendations	051
10	Performance Improvement 10.1 Committee Recommendations (Verbal by Committee Chair) 10.2 DAP Projects Report	055
11	Live Within Our Means 11.1 Finance Committee Recommendations 11.2 Finance Report	067

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NEXT MEETING		
	Time and Date:	2:00pm, Wednesday 2 June 2010
	Venue:	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