



Auckland District Health Board

Board Meeting

Wednesday 6 October 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*

1

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. Surveyor Quality Healthcare NZ 				7 July 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				29 June 2010
	2. Northern (AK) Regional Ethics Committee	Chair	Fee		
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		1 September 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Bob TIZARD	1. Nil				27 February 2008
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure	Self employed contractor	Contract hourly rate	General practitioner services	16 August 2010
	2. Member, National Breast Screening Advisory Committee	Member	Fee	Consultant Pacific Advisor	
	3. Facilitator, RNZCGP General Practice Education Programme Stage II	Contractor	Contracted monthly fee	Educational Support and Training	
	4. ADHB Employee: contracted roster Doctor for Pohutukawa	Contractor	Hourly rate	Forensic sexual assault examinations	
	5. Panel Member, Medical Appeal Board, Work and Income		Fee		
	6. Bader Drive Healthcare	Programme Facilitator	Fee	Clinical Training Support	
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	

CONFIRMATION OF MINUTES

- 1 SEPTEMBER 2010

MEETING DETAILS											
Time and Date	2:00 pm, Wednesday, 1 September 2010										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
1	KARAKIA										
	The Chair declared the meeting open at 2:04pm. Rob Cooper 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 & Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director Performance & Innovation Ngaire Buchanan – General Manager Operations Hilda Fa’asalele – General Manager Pacific Health Paul Green – Manager Materials Management Janice Mueller – Director Allied Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Harry Burkhardt, Naida Glavish, Taima Campbell and Vivienne Rawlings.</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> <p>Paul Green, Manager Materials Management, was introduced replacing Chris Morgan.</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. Juliet Walker advised that she was a facilitator to encourage Pacific to become GPs.										

4	<p>CONFIRMATION OF MINUTES 4 AUGUST 2010</p>
	<p><u>Moved Susan Buckland; seconded Jo Agnew</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 4 August 2010 be confirmed as a true and correct record noting the attendance of Hilda Fa'asalele.</i></p> <p><u>Carried</u></p>
5	<p>ACTION POINTS 4 AUGUST 2010</p>
	<p>Tamaki Transformation Project</p> <p>The opportunity for research has been referred to the Auckland School of Population Health through Alastair Woodward.</p> <p>Maori and Pacific Health Data</p> <p>A population based view of Maori and Pacific health would be coming through the Maori Health Advisory Committee and Pacific Health Advisory Committee and within the Hospital Advisory Committee data of admissions working through service by service showing access etc for Maori and Pacific to give more visibility working with Hilda Fa'asalele, Naida Glavish and Aroha Haggie.</p>
7.1	<p>CHAIRMAN'S REPORT</p>
	<p>The Strategic Planning Day had been very good and expansive initiated with the interesting presentation by Paul Winton and followed by the discussion of the relationship with the University.</p> <p>The Tamaki Transformation Project was expected to go to Cabinet in October and the proposal for 300 graduates had been advised to Health Workforce New Zealand.</p> <p>Pat Snedden apologised for not being at the special Board meeting. He had had minimal conversations with the Minister and while Cardiac had a workout plan this would be impacted by the strike.</p> <p>The Ministry was publishing the last quarter's targets with ADHBs performance having all the arrows showing improvement.</p> <p>Building 5 had had two proposals but one of the parties had withdrawn. This would need time to progress and a briefing was requested for the November meeting. The new car park had been approved and a contract signed with Mainzeal.</p>
	<p>Health Excellence</p>
	<p>Greg Balla introduced Daniel Hunt, Tim Winstone, Improvement Analysts and Maxine Stead, Communications.</p> <p>The Healthcare Excellence improvement framework was based on the Baldrige quality framework for performance excellence being a quality and safety framework looking at the organisation in a holistic way and getting better alignment with strong engagement of clinicians. While it was a good organisation now, with a very good clinical reputation and skilled staff, there were a range of performance improvement projects underway. Challenges were that the growth in funding would not match growth in costs and services were not well designed for patients, lacked standardisation and integration and there was very little buffer in the results with waste variation and harm.</p> <p>The Baldrige framework was developed in the 1980s and was chosen because it has well established criteria based on research of high performing organisations and was supported in New Zealand by the NZ Business Excellence Foundation. There were a number of Healthcare Excellence categories with points assigned totalling 1,000. The learning dimension was to move from reacting to problems, have general improvement orientation, systematic evaluation and improvement, learning and strategic improvement and organisational analysis and innovation. It was expected that if the organisation was scored now it would be in the 300 – 350 range. The journey would take time starting out with developing confidence, building momentum and then</p>

	<p>building towards excellence. Service excellence was a way to make ADHB better for its patients and its staff and was patient centric. Examples of projects underway were given being owned and directed by the Services.</p> <p>The team were congratulated on the work and progress being made.</p>
8.1	Chief Executive's Summary
	<p><u>Moved Pat Snedden; seconded Brian Fergus</u></p> <p><i>That the Chief Executive's Summary and the presentation on health excellence be noted.</i></p> <p><u>Carried</u></p>
8.2	Minister's Six Health Priorities 2009/2010
	<p>Elective surgery was at risk with the present strike action. The reports were noted.</p>
10.1	Committee Recommendations
	<p>Hospital Advisory Committee</p> <p>The Committee had noted the change in reporting with a concentration on costs and volume, the RMO and SMO workforce balance and AED becoming a bottleneck through increased volumes. The proposed development of paediatric service at Waitemata had been noted.</p> <p>Quality, Risk & Audit Committee</p> <p>The Committee had received a presentation on the National Women's Annual Clinical Report Day and can be proud of the way that it can look at itself. The DAP reporting system was reviewed and management is positive with this tool. There had been a presentation on General Medicine on how best to deliver services in a large area of the organisation and the leadership of change. The Mental Health KPI reporting needed to be put in context involving nine DHBs which was going to be published with the KPIs not to be taken in isolation.</p> <p>The current strikes were impacting on patients, safety and on staff. The Chair had discussed the matter with the DHBNZ lead ER Chair noting that it must be resolved within the financial framework. The Board supported clinicians and management reinforcing the national framework. While services were maintained as best as could be it is not optimal and is harmful to patients and families and, with a accumulative affect, it would take time to restore electives. It was thought that there may be some wrong messages to the Ministry of Health and Minister on how the hospital was managing with a need for direct communication to the Minister. The national team was continuing the negotiations but the Chair would talk to the Minister on the stress in the organisation.</p>
10.2	DAP Projects Report
	<p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the DAP projects report be noted.</i></p> <p><u>Carried</u></p>
11.1	Finance Committee Recommendations
	<p>Outsourcing Agreements Radiation Therapy</p> <p>The outsourcing arrangement had been considered by the Finance Committee who sought investigation of a risk sharing arrangement but asked the Board to improve the contracts to the \$600,000 minimum with no ability to spend above this amount until further discussion concerning risk sharing. It was understood that \$200k had been spent on outsourcing already. The rules in terms of shorter periods had changed and there should be cost sharing of this quality improvement.</p>

Moved Bob Tizard; seconded Brian Fergus

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

Carried

Motor Vehicles Replacement 2011

Moved Bob Tizard; seconded Ian Scott

That the ADHB Board approves the replacement of 50 vehicles at a cost of \$796k.

Carried

Debt Write-Offs

The Finance Committee had recommended the write-offs but had noted that the debts would be referred to Baycorp and had asked for a review of their performance.

Moved Ian Scott; seconded Bob Tizard

That the ADHB Board writes off \$108,966.05 and \$6,976.93 a total of \$115,942.98 in relation to a baby born at ACH and writes off \$123,786.91 in relation to cardio vascular.

Carried

Asset Value Write Down

Moved Ian Ward; seconded Ian Scott

That the ADHB approves the write down of \$27.739m net in land and building values as valued independently by Telfer Young as at the 30 June 2010.

Carried

The Committee had noted the good financial result for the month, been updated on the Greenlane Surgical Unit and the changes approved and had also approved seed money for developing the regional project for developing the rostering business case.

11.2 Finance Report

The results were a good start to the financial year.

Moved Pat Snedden; seconded Ian Scott

That the Finance Report be noted.

Carried

PUBLIC EXCLUSION

Moved Pat Snedden: seconded Ian Scott

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

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

- 1 Community Laboratory Services
- 2 Northern Regional Shared Services.

Reason for passing this resolution in relation to each matter:

*To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations:
Official Information Act 1982 s.9(2)(i) and s.9(2)(j)*

Ground(s) under clause 34 for the passing of this resolution:

That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.

Carried

Items were discussed in public exclusion concerning Community Laboratories Services and Northern Regional Shared Services.

Moved Ian Scott: seconded Pat Snedden

That the meeting resume in public.

Carried

NEXT MEETING

The meeting closed at 4:46 pm

The next scheduled meeting is :
2:00pm, Wednesday, 6 October 2010
A+ Trust Room, Clinical Education Centre
Level 5, Auckland City Hospital
Grafton

CONFIRMED

CHAIR: DATE:

ACTION POINTS

- 1 SEPTEMBER 2010

Board
Action Points from the meeting on Wednesday 1 September 2010

Item	Detail	Designated	Action
	Building 5 option update to November meeting	Paul Green	Verbal update

PRESENTATIONS

No Presentations

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			
District Annual Plan	Green	Sign off by Minister received.	Deliver on DAP targets / KPIs.
Annual Report	Green	Special NOVA edition at the Printer. Statutory requirements timeline okay.	
Industrial Action	Red	Ongoing impact on Community and Patient disruption.	Communication and managing Clinical risk.
Goal 2 Improve Performance			
Focus on Elective Surgery and Operating Rooms	Green	Programme of improvement activities launched and progressing well.	Clinical Leadership and Improvement Specialist coaching.
Recognition of technology developments.	Green	Telehealth gained Innovation Aware – ASPIRE – Finalist.	Celebrate achievement.
Goal 3 Live Within Our Means			
National and Regional Shared Services	Orange	Critical consultation and implementation phase.	Communication and ensuring benefits delivered.
Refinancing of \$70m Bond	Green	Refinancing of Bond w8ith CHFA went smoothly.	Financial benefit from transaction.

8.2 Minister's Six Health Priorities 2009/10

Project: Adult Acute Patient Flow

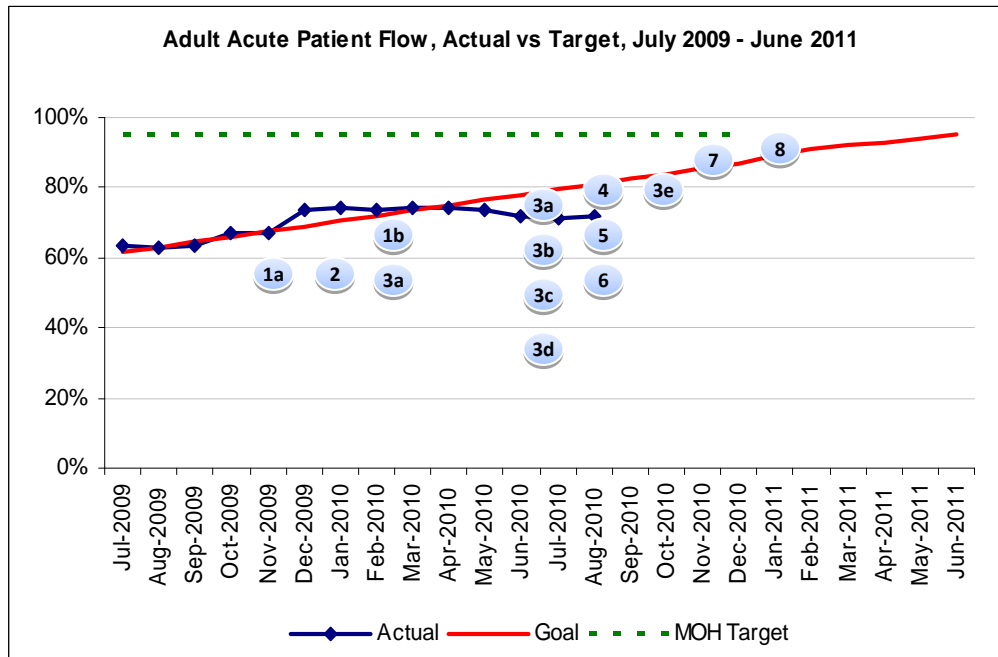
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin , Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



Project Risks / Comments:

Overall we have sustained 10 consecutive months above baseline performance averaging over 10% above previous years. Performance in admitted patients from AED has dropped off slightly as winter workload increased. Hospital wide communication programme has recently commenced titled 'valuing our patients time'. It is aimed at building ownership throughout the hospital to improve the flow of all patients. Additional resourcing has been approved to increase resources in AED especially in the weekend periods and to open an additional 10 winter beds. MOH visit completed with positive feedback on improvement activity underway.

Recent and Current activities:

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

Project: Children's Acute Patient Flow

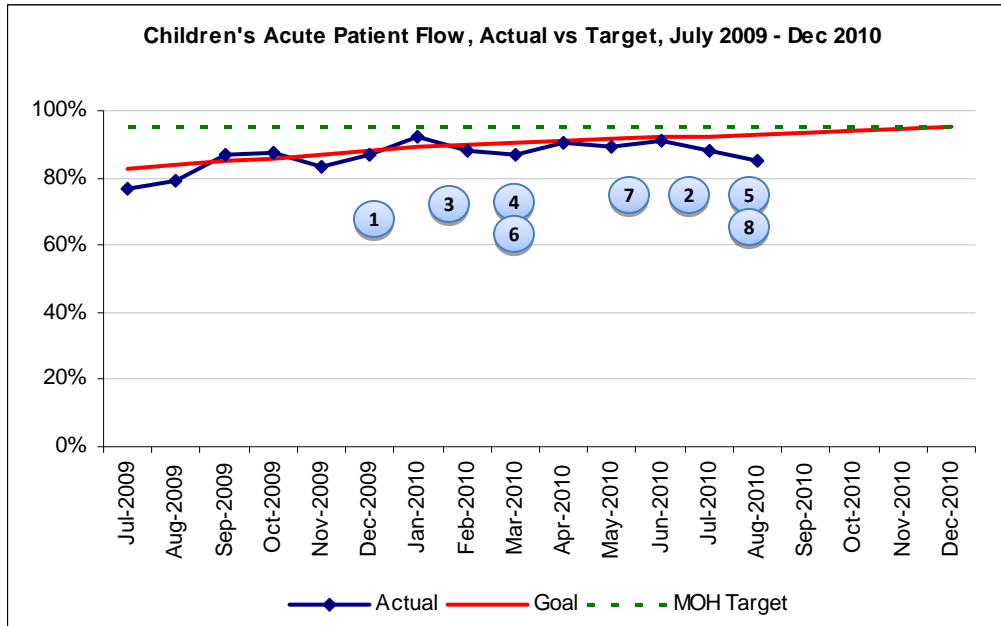
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

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:

There has been a reduction in the percentage of CED activity which meets the 6 hour target in July and August due to the impact of a very heavy influenza season and difficulty in accessing isolation beds within Starship. However performance remains significantly better than last year, reflecting the ongoing benefit of the process improvements achieved.

Project: Improved access to elective surgery

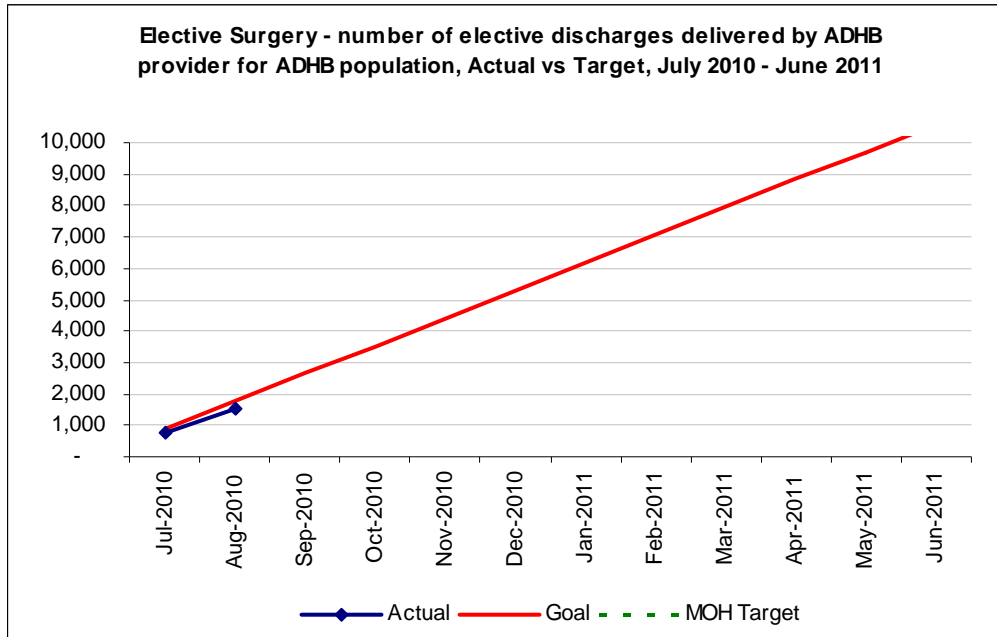
Primary Objective: To meet the MoH deliverable of elective discharges in surgical specialties for the ADHB population. The specified target is 93% of the overall population target, to account for ADHB population elective discharges from the ADHB provider.

Date of Delivery: 1

Clinical Lead:

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan, Dr Vanessa Beavis, Margaret Dotchin, Ngaire Sharp, Peter Lowry, Justin Kennedy- Good, Greg Balla (chair) Kay Hyman



Planned Activities:-

1. Operationalisation of the Greenlane Surgical Unit.
2. Additional operating hours at Greenlane
3. Auckland City Hospital Operating Rooms initiatives
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

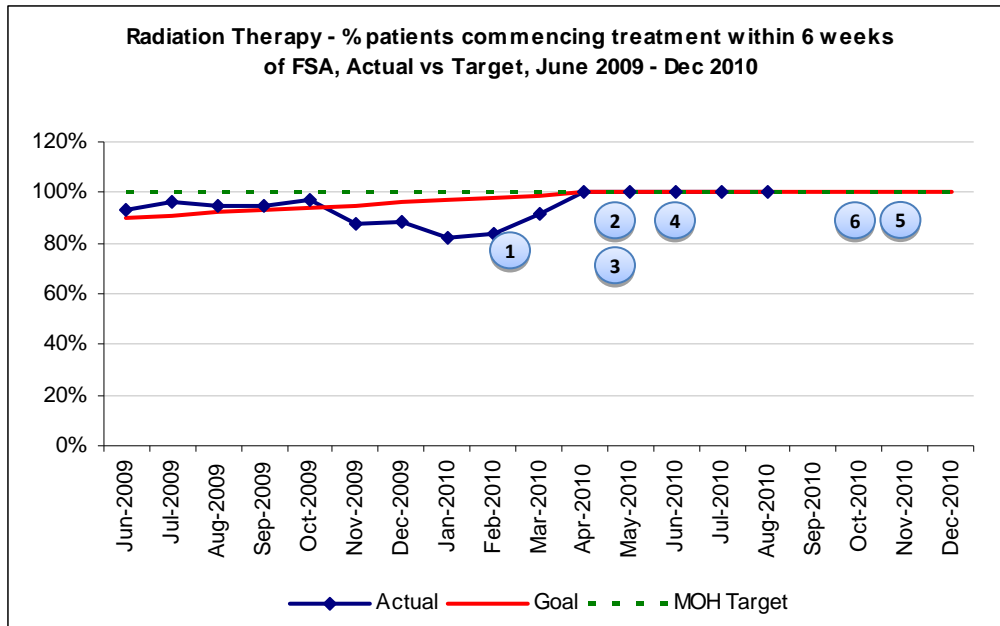
Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010 (Excludes D priority patients and Delay codes)

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

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



Project Risks / Comments:

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

A number of improvements were implemented during that time, including

- *Development of the capacity modelling tool is now in prototype phase*
- *Introduction of RT flexible working hours in June 2010 and ongoing*
- *Outsourcing to ARO, Waikato and St Georges (Christchurch)*
- *Daily waitlist reporting*
- *Improved forecasting capability*
- *Continual prioritisation and review of waiting list*

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

Current activities:

- 1. Weekly prioritisation meetings** continue, with a focus on detailed scheduling to review and accommodate urgent referrals as well as manage fluctuations in demand.
- 2. Operational Capacity Modelling.** This tool has been operational for 8 weeks and works in real time based on utilising referrals to calculate future capacity requirements.
- 3. Operation 28 days:** This project is designed to deliver on strategies to reduce cycle time utilising several work streams e.g. demand, resourcing, utilising machine capacity, throughput, outsourcing and operational management.
- 4. Flexible RT working hours** have been introduced to increase Linac capacity for an additional 1.5 hours per day.
- 5. Fast track commissioning of MV5** has commenced to ensure the new machine will be commissioned by November. This will deliver an additional 5 hours of treatment hours per day.
- 6. International recruitment strategy for Radiation Therapists and Physicists to address staff vacancies.** This strategy has resulted in a reasonable number of applications which we are pursuing.

Analysis of August results shows that for A, B & C Priority patients (without delay codes) the service achieved 93% compliance to the 4 week target (which takes effect from December 2010). This was whilst one linear accelerator was decommissioned to facilitate replacement.

Project: Cardiac Bypass Surgery

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

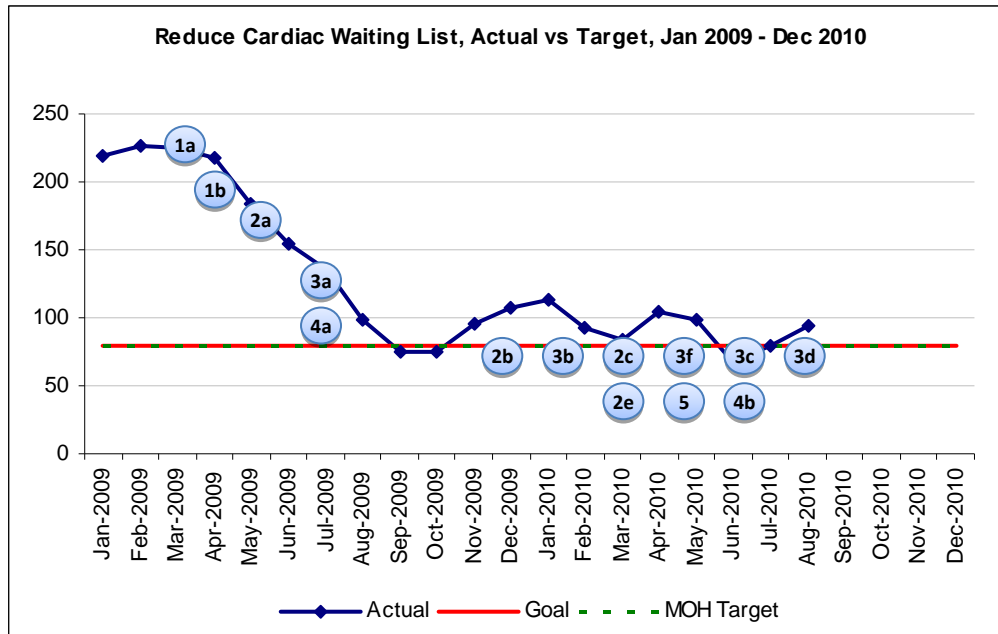
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2010

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Kay Hyman

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



Recent and Current activities:

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

Project Risks / Comments:

2010/11 started well with excellent throughput in house and no outsourcing. However, H1N1 patients from across New Zealand who required ECMO treatment in August, resulted in a bottleneck with CVICU beds with up to five beds blocked as a result of long stay (2 weeks+) ECMO patients. Whilst the service has created some capacity to deal with standard ECMO volumes, the unprecedented impact of H1N1 has not been able to be managed within existing resources. The waiting list increased during August to a high of 95. A recovery plan was immediately implemented. This has required outsourcing both locally and to other DHBs through New Zealand..

Project: Better help for smokers to quit

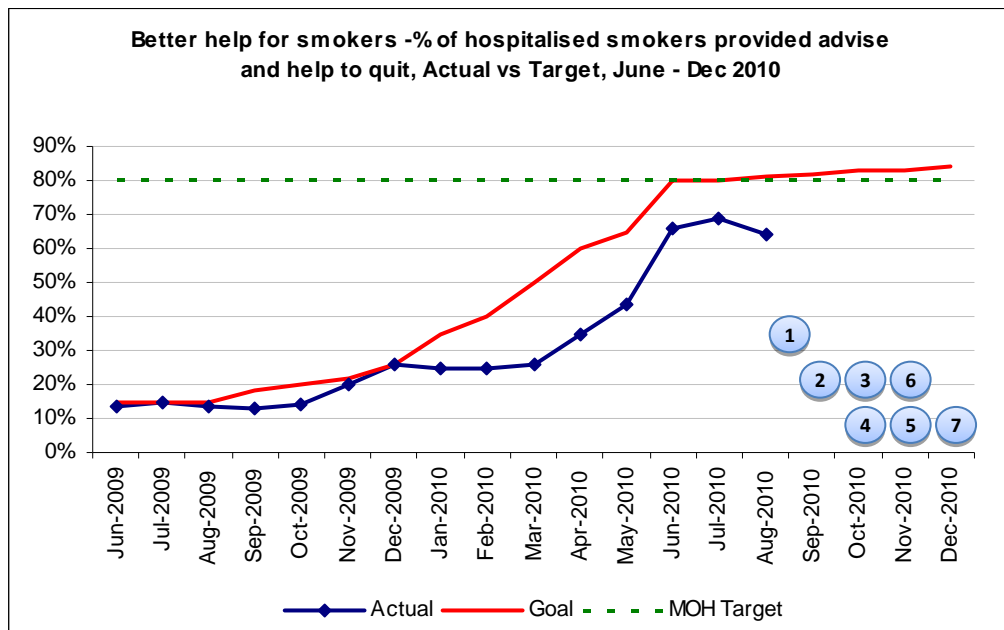
Primary Objective : % of hospitalised smokers provided advice and help to quit

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, Paul Bohmer 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

Efforts to meet the target at the end of the quarter have fallen short with brief advice and support recorded at **64% in August**. Work continues to embed the ABC of smoking cessation in services and reach the target. A programme of audits has commenced in Adult Health and National Women's Health services to determine how these services are progressing. In Adult Health the audit will also identify which disciplines are completing the ABC of smoking cessation. The outcome of the audits will indicate the services/ disciplines that require further training or systems support. A growing number of wards are including Better Help for Smokers to Quit as their Releasing Time to Care targets. A revised improvement plan is in the process of being implemented.

Recent and Current activities:

1. ABC Systems improvement, monitoring and feedback

- A programme of ward audits and feedback is underway to determine next steps for training and or systems support to assist services reach and maintain the target.
- Smokefree Liaison role being established in Adult Health wards
- Sample audits of clinical coding of smoking status and brief advice to be undertaken in October
- Feedback on service performance ongoing

2. ABC training & Coaching

- Ongoing promotion of MOODLE training.
- Further training needs to be determined by audit findings.
- ABC and NRT staff coaching to continue
- Promotion of ABC training to undergraduate health programmes and tertiary institutes

3. Improved utilisation of NRT for withdrawal management

- Promotion to medical staff on NRT products and prescribing planned for October - November 2010
- NRT Standing Order currently being simplified

4. Promotion & Communication

- ABC promotion ongoing. Plans are underway to recognise top performing wards in October/November.

5. Research & Evaluation

- Research programme to be developed over the next 6 months to identify successful interventions, foster innovation and engage clinicians

6. Governance & Leadership

- Role and function of the ADHB Tobacco Control Steering group is underway.

7. ABC sustainability plan

- to be developed to enable handover of ABC programme to services by 2012.

Project: Diabetes

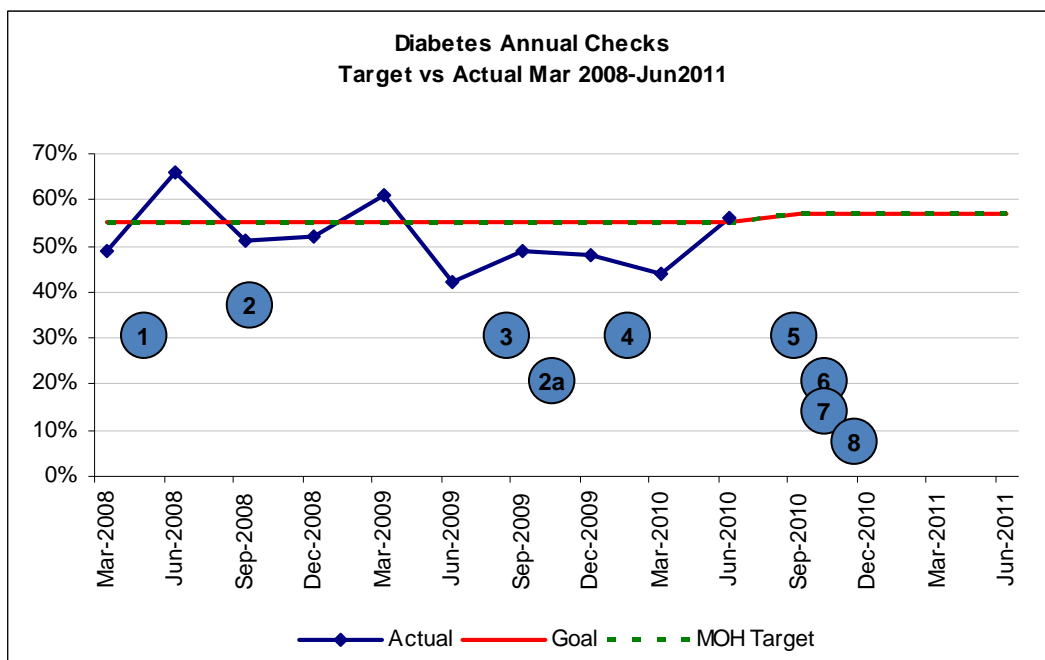
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

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 other feedback options
- 3) Improved understanding of IT linkages in Practice systems
- 4) Auckland Diabetes Advisory Team – structured agreed district plan of action
- 5) Routine reports to clinical advisory leadership meetings
- 6) Developing shared care pathway
- 7) Regional shared care pathway work
- 8) Develop regional shared target setting and service outcomes

Project Risks / Comments:

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

Project: Diabetes

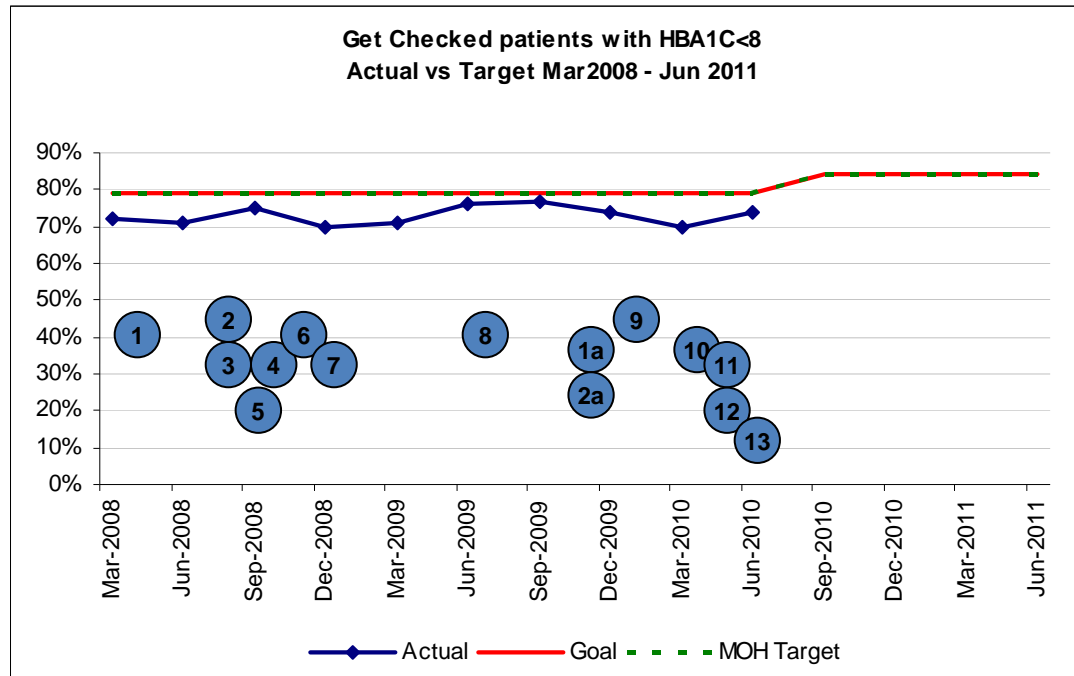
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

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

Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

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



Recent and Current activities:

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

Project Risks / Comments:

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

Project: Cardiovascular Risk Assessment

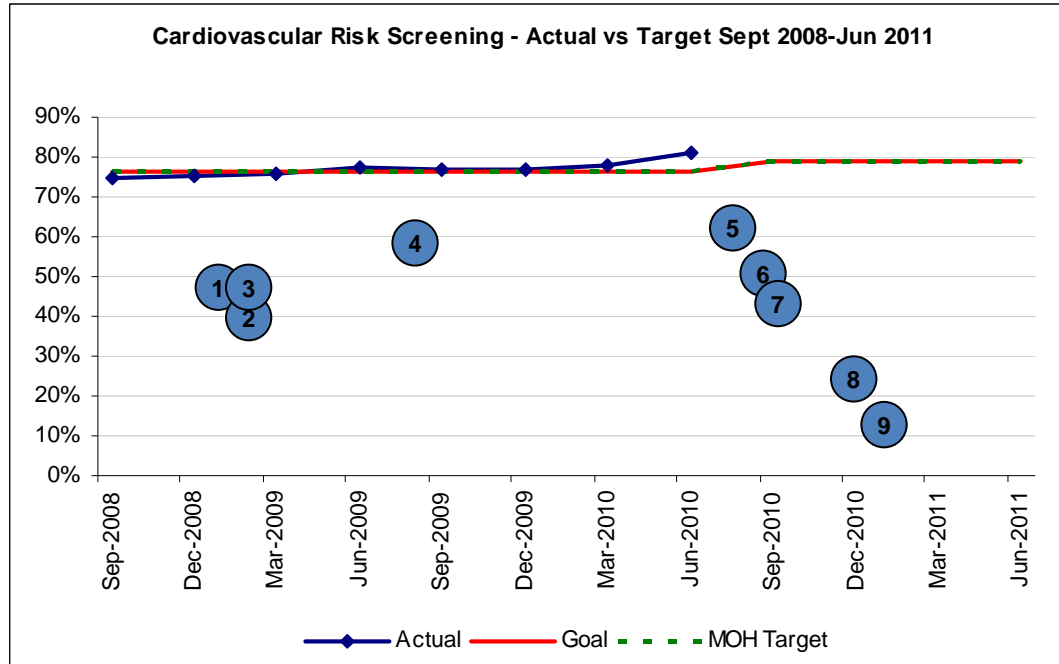
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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

Clinical Lead: Dr Celia Palmer

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



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.

Recent and Current activities:

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

Project: Increased Immunisation

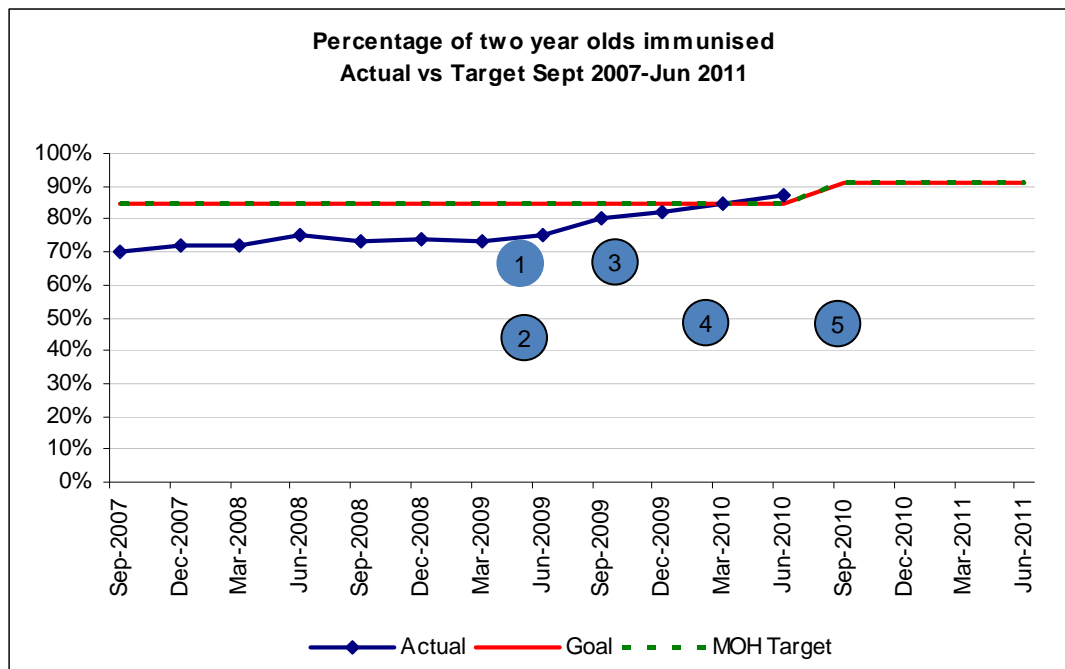
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

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



Current activities:

- 1. Practice level reporting available
- 2. Primary care Immunisation Co-ordinators funded - ongoing
- 3. ADHB Immunisation Strategy approved
- 4. Funding application made to Starship Foundation to fund social marketing programme
- 5. Data Cleansing exercise in primary care approved and funded.

Project Risks / Comments:

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

8.3 Letter from MoH – ADHB Health Target Performance 1009-2010



Office of Hon Tony Ryall

Minister of Health
Minister of State Services

6 SEP 2010

Mr Pat Snedden
Chair
Auckland District Health Board
Head Office
PO Box 92 189
Greenlane
AUCKLAND 1142

Rec. 8/7/10

Dear Mr Snedden *Pat*

I am pleased to advise you that national end of year results show very good improvement in performance in most health target areas in 2009/10.

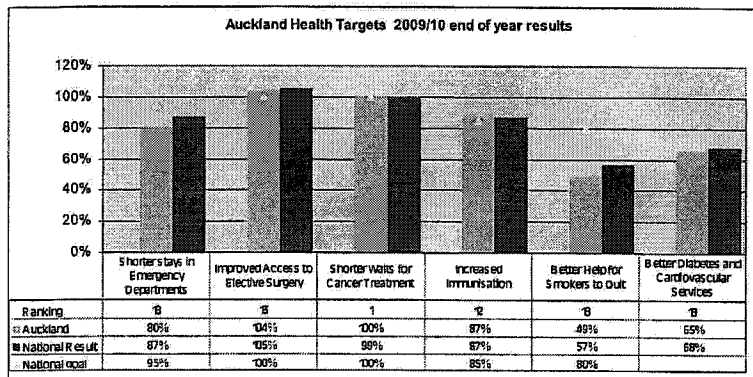
I appreciate the work done by your Board and management over the last year to support delivery of health targets. As you are aware, this year for the first time, target performance has been publicly reported in national newspapers, and responses have been very positive. I have also been encouraged by the efforts DHBs have made to share target results through local media, web based communications and a range of community focused material.

Although national results show a strong improvement trend, some targets have not been met, and continued efforts in each target area are important as we move into the 2010/11 year.

I wish to congratulate you on exceeding the national Increased Immunisation target, achieving 87 percent coverage for the total population. I also note that the DHB did well to achieve the Shorter Waits for Cancer Treatment target in the fourth quarter. Further assurance is needed that you can meet the four week target through a smart use of both the public and private sectors.

Auckland DHB is ranked 18th in the three target areas; the Shorter stays in Emergency Departments, Better Help for Smokers to Quit, and Better Diabetes and Cardiovascular Services. While I am advised that encouraging progress has been made in each of these target areas, efforts to improve performance need to continue into 2010/11.

Auckland does need to improve elective delivery. Your DHB results for the year are set out below, and a one page summary showing how your DHB has performed in 2009/10 is attached to this letter.




I meet regularly with the Ministry target champions to discuss progress in each target area, and I encourage you to ensure your DHB engages with the champions so that drivers of good performance can be shared, and support put in place early where there are problems in meeting targets. Feedback from the target champions is attached to this letter.

As we move into the 2010/11 year, there will be some minor changes to the way target results are presented. Details will be provided to your management teams, but in summary the changes are:

- progress with addressing smoking cessation in primary care will be monitored and publicly reported through the PHO performance programme
- in relation to the CVD/Diabetes target, public reporting in newspapers will only display results for the CVD Risk Assessment indicator. The Diabetes Detection and Diabetes Management indicators will remain part of the target and performance will be included on Ministry and DHB websites and in all other target publications. The three indicators will be reported separately rather than as a composite indicator.

Once again thank you for your efforts to support achievement of the health targets to date. I look forward to continuing to work with Auckland DHB to improve performance across the sector.

Yours sincerely


 Hon Tony Ryall
 Minister of Health

cc: Garry Smith, CEO, Auckland DHB

Feedback from Target Champions

Mike Ardagh, Champion, Shorter stays in Emergency Departments

With the onset of the winter months, Auckland DHB did well to maintain its performance of 80 percent against the Shorter Stays in Emergency Departments target in quarter four. This result, compared to the 70 percent recorded in quarter one, reflects the good approach and initiatives that the DHB has implemented so far. However, Auckland DHB remains one of the poorer performing DHBs in respect to this target and is still some distance from the 95 percent target. Greater emphasis and momentum in this target area will therefore be required if the DHB is to achieve the 95 percent target by the end of 2010/11.

Response from ADHB Sponsor

Additional investment in resources to support AED increased performance especially afterhours and weekend approved by Senior Leadership Team in early August 2010. Lean Six Sigma Improvement Specialist has begun with AED to 'tackle' more difficult process and improvement activity. Starship access to beds in particular single rooms needs close monitoring.

Clare Perry, Champion, Improved access to elective surgery

Auckland DHB's performance against the health target-Improved Access to Elective Surgery has been excellent, with 9766 people receiving elective surgery in 2009/10. The DHB has delivered 104 percent of plan. However, Auckland DHB's delivery remains below its equitable share of the elective surgery provided nationally in 2009/10. The commitment demonstrated by the DHB to lifting elective surgery levels in 2010/11 is commendable.

Response from ADHB Sponsor

The Elective Services target: Agree with the comment. This year's elective volumes will be a further stretch for the provider arm. Current capacity planning has indicated a need for contingency plans required for services. This includes summer elective programmes being worked up now.

John Childs, Champion, Shorter waits for cancer treatment

The target for the population was met for this quarter. The DHB is encouraged to continue work to ensure performance is maintained and positioned to meet the target change of all patients being treated within four weeks from December 2010.

Response from ADHB Sponsor

ADHB as regional provider has met the Q1 target for Cancer waiting times and is on track to meet the 4 week target by Dec 2010.

Target achievement has been possible only through dedication to this target and at considerable financial expense. Due to historical delays for capital investment within the Northern region, outsourcing will be required to meet the 4 week target pending the establishment of additional capacity. The service has outsourced RT attendances to Waikato DHB during 2010, but this has now stopped as their capacity is no longer available. Contracts are in place with ARO (48 patients have been outsourced to date). A contract is also being agreed with St Georges in Christchurch to provide additional contingency capacity.

The requirement to outsource is highly variable due to the complex nature of the process. Therefore scenario analysis has been completed to illustrate the possible range of exposure. This analysis confirms 2010/11 exposure of \$3.0m to \$5.0m. 2010/11 budgeted costs will be inadequate to cover required expenditure. Regional Funders have declined to contribute additional funding to meet this cost on the basis that the Oncology service currently delivers as sizeable contribution to ADHB. Regional funders will be asked to fund additional costs in excess of the contribution margin. The service has applied to the MoH for strategic change funding to mitigate costs, however this application has been declined in favour of other projects which will invest strategically in public infrastructure.

The significant requirement to outsource in quarter 4 2009/10 and continue into 2010/11 stems from the decommissioning of the oldest linear accelerator for replacement, together with loss of RT FTE, which combined with low skill mix resulted in the cessation of the evening shift on 1 June. The Auckland public position is expected to remain tenuous until the MV5 Linear Accelerator is commissioned in November and public staffing has increased by at least 5 FTE. As such the service will require significant support from external providers for at least the next twelve months. Continued focus on the Radiation Therapy Service Improvement Plan will ensure that public capacity is maximised, in turn reducing the reliance on outsourcing to private.

The strategic plan for the sustainable delivery of Radiation Oncology services has been developed to provide a regional plan which defines the current and future demand for radiation oncology for the Northern region, including related areas such as workforce and technology. The plan was endorsed by regional CEOs in June 2010 and includes a plan to expand Northern Region capacity to meet population and cancer registration growth together with increased intervention rates. This expansion requires immediate business case development for investment in additional linear accelerators and related capacity.

A regional project group has been formed to complete 3 projects for presentation to Regional CEOs in November 2010:

1. Completion of an affordability assessment defining the total cost of the recommendations outlined in the strategic plan to 2019
2. Recommendation regarding a sustainable funding framework that will enable the regional service provider to undertake the capital investment to increase treatment capacity and implement other recommendations contained within the strategic plan.
3. Completion of a business case to support the acquisition and commissioning of the 7th and 8th public linear accelerators for the Northern Region. This work stream will include substantial focus on workforce development (with MOH cancer team involvement).

It is expected that lower public waiting times, together with development of the MDM framework/care coordination model, will result in increased referrals to the public service. This is likely to trigger the need for additional outsourcing until additional public capacity is commissioned.

Pat Tuohy, Champion, Increased immunisation

Auckland DHB exceeded the national target, achieving 87 percent immunisation coverage for the total population. Excellent planning processes over the years have produced clear results for all ethnicities. Coverage for Maori improved quarter on quarter to 79 percent which exceeded the DHB's target of 75 percent. Measures to further enhance immunisation coverage for Maori children will contribute to improving coverage rates for the total population.

Response from ADHB Sponsor

ADHB will continue working with primary care to support initiatives shown to be successful. These have included the provision of regular information and analysis to PHOs, funding Immunisation Coordinators in primary care and facilitating closer relationships amongst all immunisation stakeholders. ADHB is currently funding a data cleansing project in primary care which is expected to have a positive impact on coverage rates. A Maori Immunisation Working Group is being reconvened to consider strategies for increasing immunisation rates and timeliness for Maori children.

Ashley Bloomfield, Champion, Better help for smokers to quit

Well done on making significant progress towards the tobacco health target in quarter four. The monthly breakdown of results shows that there have been increases in every month of quarter four, with the DHB reaching 66 percent in June. This is a vast improvement from quarter one and reflects the focus on senior leadership, systematic education programmes and systems improvements over the year, and a commitment to identifying and removing barriers that were limiting progress in earlier quarters. There is still some way to go to meet the target, and we look forward to seeing a continued focus on these areas in 2010/11 to reach the 90 percent target.

Following discussion with the Minister, it has been confirmed that the full quarter four results will be the results published. This is to ensure that we maintain consistency in the data that is being publicly reported. The Ministry is aware that Auckland DHB achieved higher results in the final month of the quarter, and would encourage you to comment on the June data in any local media and communications about the tobacco target. This information has been shared with the DHB Smokefree Coordinator.

Response from ADHB Sponsor

The first 2 months of this quarter have seen the health target reach 69% and 64%. The majority of services have systems in place to prompt and record the ABC of smoking cessation a number are reaching the 80% and getting close to the new 90% target.

Work continues to support services meet and maintain the Health Target Better Help for Smokers to Quit and an increasing number of wards are taking ownership of the target developing their own strategies to meet it. Activities underway or planned include:

ABC systems improvement and monitoring

Improvement of ABC systems and processes to ensure sustainability. Includes ongoing analysis of target figures to identify any services/disciplines without ABC systems and working with services that are underperforming to enhance the numbers of smokers recorded and brief advice given.

ABC and NRT Coaching will continue in services for nursing staff.

Smokefree Liaison nurse role is in process of being established in Adult Health wards.

Ongoing Monitoring and feedback

Ongoing spot audits are being undertaken in services and feedback given to Charge Nurses and support given where necessary.

Audits of ABC coding practise about to commence to ensure that documentation of the ABC is being coded accurately.

Improved utilisation of NRT for patient withdrawal management

Promotion to Medical staff on Nicotine Replacement Therapy (NRT) prescribing for withdrawal Management planned before the year's end.

Simplification of the NRT Standing Order form is underway.

In New Year looking to introduce offering NRT to family members and visitors.

Investigation into better measurement of NRT prescribing in process.

Promotion and communication

ABC promotion is ongoing with a push to come before Christmas including celebrating those services that are consistently meeting and exceeding the target. In the medium term there will be a plan focused on the public to increase demand for smoking cessation support.

Training and Education

The online smoking cessation abs training is being promoted and a growing number of staff are completing the course. Face to face training will continue based on the service's needs.

Research and Analysis

Research will be a major focus in the future which will identify gaps and areas of need. Analysis of the accuracy of the reported rate of smoking prevalence is underway and analysis of brief advice and support given to Maori and Pacific Patients.

Addressing smoking beyond the "Health Target" areas

Starship Children's Hospital ABC systems to be reviewed and a plan to support parents/caregivers to stop smoking to be implemented.

Brandon Orr-Walker and Sandy Dawson, Champions, Better Diabetes and Cardiovascular Services

While Auckland DHB has recorded a small improvement in its overall performance against the Better Diabetes and Cardiovascular Services target over the 2009/10 year, increasing from 63 percent in quarter one to 65 percent in quarter four, it remains one of the lower ranked DHBs. Performance in the Diabetes Free Annual Checks indicator continues to be the major weak link with Auckland the second poorest performing DHB for 2009/10 with a result of 43 percent. It is therefore reassuring that new funding and strategies directed at assisting primary care to improve diabetes outcomes, including diabetes free annual check numbers, are to be implemented over the next 12 months. We look forward to seeing this translate into strong improvements in performance during 2010/11.

Response from ADHB Sponsor

It is pleasing to see that this indicator will be unpacked from its aggregated format to report the target outcomes separately. ADHB are meeting our targets for CVD and for Diabetes management and we are working to improve this outcome into the 2010-2011 year. The diabetes annual review outcome for ADHB is an area where extra effort is needed to enable serious improvement. A raft of initiatives are being established that are aimed to achieve this, for example, quality improvement coordinators to support work flow and system change, connecting information within systems better, and a regional diabetes pathway which includes consumer input. By the second half of 2010-2011 the impact of these initiatives should become evident.

How did your DHB perform in 2009/10?

www.moh.govt.nz/healthtargets

2009/10 Health Targets

Shorter stays in Emergency Departments
95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Improved access to elective surgery
The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1,000 per year).

Shorter waits for cancer treatment
Everyone needing radiation treatment will have this within six weeks by the end of July 2010, and within four weeks by December 2010.

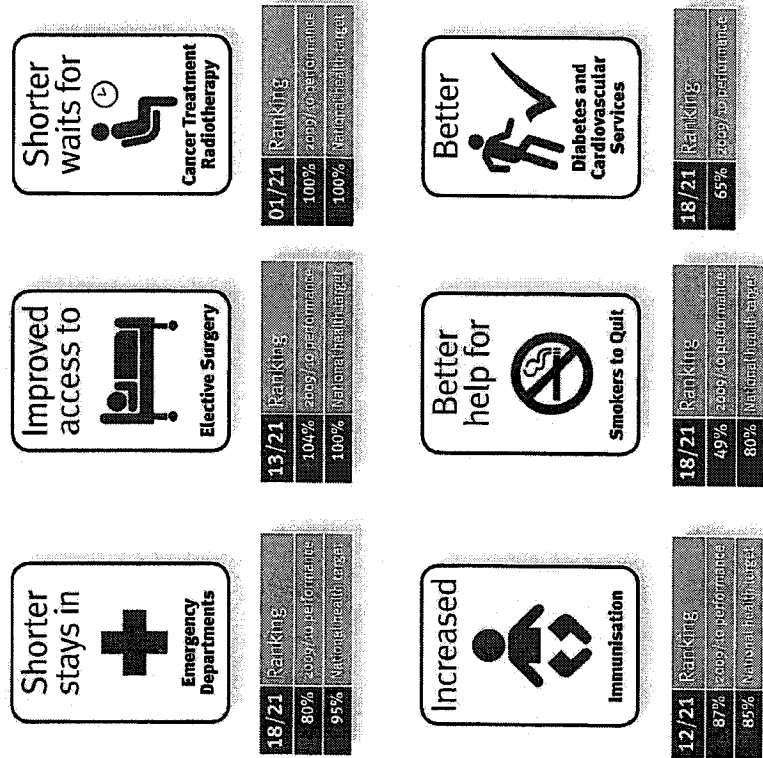
Increased immunisation
85 percent of two year olds will be fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.

Better help for smokers to quit
80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012.

Better diabetes and cardiovascular services

- (a) increased percent of the eligible adult population will have had their CVD-risk assessed in the last five years
- (b) increased percent of people with diabetes will attend free annual checks
- (c) increased percent of people with diabetes will have satisfactory or better diabetes management.

Refer to the health targets website for more information
www.moh.govt.nz/healthtargets.



New Zealand Government

8.4 Employment Relations

Date	13 September 2010
To	Quality, Risk & Audit Committee
From	Vivienne Rawlings, General Manager Human Resources Extension 23942 vrawlings@adhb.govt.nz
Subject	Resident Medical Officer (RMO) Negotiations
<p>Purpose The purpose of this paper is to provide information to Quality, Risk & Audit Committee on the current RMO Negotiations.</p>	
<p>Executive Summary DHBs are negotiating with the Resident Doctors Association on a new Multi Employer Collective Agreement (MECA) for Resident Medical Officers (RMOs).</p> <p>Over the past two years, a significant amount of work has gone into examining issues in the medical profession, focussing on RMOs.</p> <p>The independent RMO Commission produced a report – <i>Treating People Well</i> – that pointed to issues in the way the RMO workforce was managed. The Medical Training Board also produced a report for government that coincided with a review of the Clinical Training Agency.</p> <p>These reviews and reports all draw the conclusion that the ‘status quo is not an option’ for the medical workforce. The health sector needs to change rapidly and the status quo is not an option for any workforce, including RMOs.</p> <p>In the current negotiations, DHBs want to:</p> <ul style="list-style-type: none"> ▪ Improve services to the public ▪ Build relationships between resident and senior doctors ▪ Improve the training experience for RMOs <p>Attached are a number of information sheets:</p> <ul style="list-style-type: none"> ▪ The DHB approach to RMO bargaining ▪ Background information ▪ RMO Training ▪ Flexibility and RMO rostering ▪ RMO Remuneration 	

RMO Bargaining Information

The DHB approach to RMO Bargaining 2010

This information is for senior managers and clinical leaders who work with RMOs, to help them understand the issues and the new provisions offered by DHBs in bargaining.

Managers should not directly approach RMOs who are NZRDA members about matters related to bargaining.

BACKGROUND

After difficult negotiations in 2005 and 2007, a significant amount of work has gone into examining the issues in the medical profession, focusing on RMOs.

The independent RMO Commission produced a report – *Treating People Well* – that pointed to significant issues in the way the RMO workforce was managed. The Medical Training Board also produced a report for government that coincided with a review of the Clinical Training Agency.

These reviews and reports all drew the conclusion that the 'status quo is not an option'.

Bargaining is under way again. The MECA is a small part of what is happening nationally, but it is a significant document that, along with all other activities, will require change to improve flexibility in the workplace, and to improve or enhance the training experience for RMOs.

WHAT DO DHBs WANT TO ACHIEVE THROUGH NEGOTIATIONS?

- The health sector needs to change rapidly and the status quo is not an option for any workforce, including RMOs. This includes the current MECA, which does not deliver the flexibility and accountabilities that DHBs need.
- We want to enshrine and improve the current protection on working hours that makes the New Zealand health

system one of the most attractive places for RMOs to work and train.

- We want to pay our RMOs well for the hours they work and provide extra reward for those who provide services during unsocial hours, nights and weekends.
- We want to improve the current relationship dynamics for RMOs as our employees by providing formal structures at a local level for engagement between RMOs, SMOs and senior management.
- We want to improve the training experience and career pathway options for RMOs, including options around part-time work and secondment to primary care.
- We have formally indicated to the union that nothing in the offer is designed to save or remove money from the current MECA spend on RMOs.
- We recognise that these negotiations are about responding to current needs and also building the future medical workforce.

WHAT ARE DHBs OFFERING?

DHBs have tabled an offer for RMOs that will significantly change the current MECA. The offer seeks to protect the working hours of RMOs and to provide mechanisms to allow for innovation and change at a local level. We believe this innovation and change will help improve services to the public, build relationships between resident and senior doctors, and improve the training experience.

FURTHER INFORMATION

If you need more information, please first contact your GMHR or ER Manager.

You can provide feedback to the DHB negotiation team at:
rmoinfo@dhbz.org.nz

This information sheet is authorised by the DHBs' Employment Relations Strategy Group on behalf of the 20 DHBs.

The DHBs' proposal aims to change the way we pay RMOs to a model that pays them for the hours they work and includes a premium for unsocial hours and weekends. This does not sound unusual, but currently RMOs who work shifts are paid for hours they do not work during the day and are sometimes not rewarded for hours they do work.

The current model encourages rosters that expect RMOs to be at work Monday to Friday between 7:30 am and 5:30 pm as well as do extra hours to meet service and training demands.

The DHBs' proposal will allow DHBs and RMOs to review rosters and services at a local level to decide what best suits patient needs and how training is best delivered in that service.

DHBs seek to strengthen relationships between RMOs and SMOs and managers at a local level by proposing formal structures to discuss training, career and employment matters.

To allow for flexibility at a local level, DHBs are offering a MECA that will protect the hours RMOs can work. The protection will ensure that RMOs in New Zealand continue to enjoy some of the best hours and highest quality of doctor training in the world.

The DHBs have tabled improved and clearer entitlement to training, including additional provisions for House Officers who have just achieved General Scope. The provisions strengthen the relationship between an SMO supervisor and an RMO, and encourage career planning through new approval processes.

The DHB offer is intended to be managed within affordable financial parameters, similar to those in the recent national Nurses and PSA settlements. This offer will obviously change some payment structures from the current MECA, which may result in some redistribution, but it is not intended to lead to savings.

WHAT IS THE UNION ASKING FOR?

Negotiations are currently focused on the DHBs' offer, but the union has also tabled a document for a national MECA. This document, estimated to increase employment costs by over 30%, places further restrictions on roster patterns, rotations, weekend and shift work and increases penalty provisions, such as a claim for \$1000 per day for anticipated cross cover.

Despite acknowledging that RMOs usually need to work *more* than 40 hours per week, on average, to meet training needs, the union wants a pay system based on a 40-hour working week, with overtime paid when RMOs work more than 8 hours a day and 40 hours a week. This would mean having to manage RMOs by timesheets, and would present significant financial challenges to training programmes.

WHERE TO FROM HERE?

The union rejected the DHBs' proposals at bargaining and is holding stopwork meetings with RMOs to discuss options (including industrial action).

Further bargaining is set for 13/14 September, when the DHBs expect feedback from the union on the employer offer.

RMO Bargaining Information

Background information

This information is to help interested parties understand the issues and the new provisions offered by the DHBs in bargaining.

Managers should not directly approach RMOs who are NZRDA members about matters related to bargaining.

FURTHER INFORMATION

If you need more information, please first contact your GMHR or ER Manager.

You can provide feedback to the DHB negotiation team at: rmoinfo@dhubnz.org.nz

This information sheet is authorised by the DHBs' Employment Relations Strategy Group on behalf of the 20 DHBs.

- The term 'RMO' (Resident Medical Officer) covers doctors in their first year after graduating from medical school through to doctors in the final stages of their advanced training to become medical specialists.
 - About 3100 RMOs employed by the 20 District Health Boards (DHBs) are covered by a single national Multi-Employer Collective Agreement (MECA) that expired at the end of December 2009.
 - The last RMO MECA was settled in August 2008 and provided RMOs with a 10.8% increase in base salary, spread over 16 months, as well as a 5% lump sum payment.
 - RMOs are a highly mobile workforce, moving frequently between DHBs as part of their training and career development. In the Auckland region alone in the year to October 2009 there were more than 650 instances of RMOs moving between the three metropolitan DHBs.
 - The current RMO remuneration system is complex. The expected weekly hours of each group of RMOs is averaged and falls into one of six 'run categories' of between 40 and 65+ hours a week. RMO salaries then depend on their classification and years of postgraduate experience, and whether they're working in an urban or non-urban DHB.
- A number of additional rules mean this run category may be inflated above the actual hours an RMO works. For example, when an RMO works (and is paid for) a night shift, they are also paid for the 8 ordinary hours during the day (whether worked or not).
- There are 264 different steps with salary rates ranging from \$52,843 per annum for a first-year House Officer on a 40 to 45 hours per week run in an urban DHB up to \$172,243 per annum for a Registrar with 10 or more years service on a 65 or more hours per week run in a non-urban DHB.
 - RMOs are also reimbursed for the costs of their annual practising certificates, professional membership fees, training and conference costs, professional indemnity insurance, relocation expenses etc. In the Auckland region these costs were estimated to average approximately \$6000 per RMO in the year to August 2009.
 - RMOs receive 30 days (six weeks) of annual leave each year and up to six weeks' leave per year to study, attend courses and conferences or to sit exams.

RMO Bargaining Information

RMO Training

This information is for senior managers and clinical leaders who work with RMOs, to help them understand the issues and the new provisions offered by the DHBs in bargaining.

Managers should not directly approach RMOs who are NZRDA members about matters related to bargaining.

BACKGROUND

RMOs are qualified doctors in their own right. They are also, however, a workforce in training. The report of the RMO Commission – *Treating People Well* – acknowledged the importance of the medical apprenticeship model based on the relationship between RMOs and their senior colleagues and recommended steps be taken to reinvigorate it.

While this is mainly a professional issue, rather than a matter for contract negotiations, DHBs want a MECA that supports the training experience of New Zealand's RMO workforce and supports the medical apprenticeship model.

WHAT ARE DHBs SEEKING TO ACHIEVE?

DHBs propose some changes to the MECA, responding to the RMO Commission's report and anticipating changes being signaled by Health Workforce NZ. The main drivers for the changes are:

- strengthening the link between RMOs and SMOs
- providing strengthened and mutually planned training at all stages of an RMO's career

- bolstering provisions for RMOs who have just achieved general scope
- retention
- remaining employed by DHBs while training in the primary sector
- improving clarity of entitlement to reimbursements
- being clear about when a 1st-year House Officer can be rostered on nights as part of the training experience.

WHAT ARE DHBs OFFERING AROUND TRAINING?

New Zealand already offers RMOs some of the best training provisions in the world, with reimbursement of practically all the costs incurred on a vocational pathway and generous medical education leave and conference leave to support training.

DHBs also propose introducing targeted leave and study reimbursement for House Officers who have just achieved General Scope and, as part of discussions with their SMO supervisor, choose study that gives early direction to their career pathway. It is expected that an RMO will have worked for the DHBs for a year before using this new provision

FURTHER INFORMATION

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(including their first year) to encourage retention of RMOs. There is an option for a second year of this type of study as part of the DHBs' offer.

To further strengthen the link between collegial support/supervision and training, and to tighten accountability for training costs, DHBs are seeking pre-approval (via the supervisor) of training that will incur a cost. It is expected, not unreasonably, that an RMO will need to have any leave and associated costs approved by the DHB they will be working for at the time the costs will be incurred.

DHBs have offered a secondment provision to RMOs who may wish or be required to work outside the DHB sector in New Zealand as part of their training, such as for GP training. The provision would enable an RMO to be paid on the MECA unless agreed otherwise at the time of agreeing to the secondment.

With increasing numbers of 1st-year House Officers seeking placement with DHBs, DHBs propose lessening the time restriction for experience on nights, as long as MCNZ guidelines are met and relevant supervision support structures are in place. The 6-month time barrier remains where these requirements are not met.

WHAT DOES THE UNION CLAIM IN REGARD TO TRAINING?

The union has stated that there is nothing wrong with either training or the relationship between RMOs and SMOs.

However, in regard to training, the union has claimed:

- standardisation of protected training time of four hours for everyone
- \$16,000 p.a. continuing medical education funding for all RMOs working in the three Auckland DHBs and Capital & Coast DHB
- that DHBs (or colleges by default) should not be able to rotate RMOs in the Auckland region without separate agreement
- a 'smorgasbord' of options for RMOs (value \$10,000 per year) as a retention tool, including leave for research or humanitarian work.

WHERE TO FROM HERE?

The union rejected the employer proposals at bargaining and is holding stopwork meetings with RMOs to discuss options (including industrial action). Further bargaining is set for 13/14 September at which point the DHBs expect feedback from the union on the employer offer.

RMO Bargaining Information

Flexibility & RMO rostering

This information is for senior managers and clinical leaders who work with RMOs, to help them understand the issues and the new provisions offered by the DHBs in bargaining.

Managers should not directly approach RMOs who are NZRDA members about matters related to bargaining.

BACKGROUND

Health services are delivered in a rapidly changing environment. Clinical leaders and managers believe that the current RMO Multi Employer Collective Agreement (MECA) is not a responsive document that supports change and, in some areas, provides the union with a broad right of veto over decisions on the delivery and organisation of services.

DHBs want to support flexibility and improve training and service delivery.

WHAT ARE DHBs SEEKING TO ACHIEVE?

DHBs want to ensure that the RMO MECA:

- provides the flexibility to implement rosters that respond to RMO training priorities, meet service and operational needs, and accommodate the preferences of individual RMOs
- enshrines and protects the limits on hours of work of RMOs
- promotes and enables local innovation and responsiveness
- better enables part-time work for RMOs.

HOW IS FLEXIBILITY BUILT IN TO THE DHBs' PROPOSALS?

The DHBs are looking for greater flexibility in how RMO rosters are set and changed. Health services are delivered in a 24/7 environment, and services need to align to patient demands (not vice versa).

DHBs find changing run descriptions can be extremely difficult under current provisions. DHBs are offering a new process involving consultation on proposed variations to rosters, and three months' notice of any permanent changes.

In parallel to this, DHBs want to enshrine and protect the existing framework of limits on RMO hours of work, but to apply this in a more flexible manner. Improvements during the term of the settlement (i.e. reductions in hours of work) are also proposed as part of the DHBs' offer.

Greater flexibility in RMO rostering will allow better alignment of working arrangements with other members of the clinical teams (especially with Senior Medical Officer colleagues) and support improved models of care.

DHBs are also looking for changes to support the development of regional services. Under the current MECA,

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no changes can be made to the way in which services are provided unless agreed with the RDA (rather than in consultation with the affected RMOs). DHBs recognise their obligations (both in law and good practice) to consult with their staff around change; decision making, however, *must* rest with those who are accountable for the service.

DHBs are proposing that local structures involving RMOs, SMOs and DHB management be established to work through local issues, including service change and innovation.

WHAT DOES THE UNION CLAIM IN REGARD TO FLEXIBILITY?

The union's claim includes further extension of the restrictions around rostering, hours of work, and deployment. These include:

- a process for the introduction of '10/4 rostering' (a maximum of 10 consecutive days on duty followed by 4 consecutive days off) for

all services on a national basis where requested by the RMOs

- no more than one in three weekends rostered on duty
- limits on the current practices of rotation of staff between hospitals operated by the same DHB or between DHBs in the Auckland region.

A number of other union claims place significant financial constraints on current practices, effectively adding another layer of restriction.

WHERE TO FROM HERE?

The union rejected the DHBs' proposals at bargaining and is holding stopwork meetings with RMOs to discuss options (including industrial action).

Further bargaining is set for 13/14 September at which point the DHBs expect feedback from the union on the employer offer

RMO Bargaining Information

RMO Remuneration

BACKGROUND

The current RMO remuneration system is complex – it has 264 different salary steps, based on a combination of an RMO's classification, run category, years of service, area of work, and the location of the DHB.

RMO base salary rates currently range from \$52,843 to \$173,166 p.a..

A key factor in setting salary is the category of the run on which the RMO is employed. Run categories are based on the average expected weekly hours of work, but include a number of rules that distort the relationship between hours and salary. This means that the expected hours of work for run category/salary purposes can represent a significantly greater number of hours than are actually worked.

RMOs are a salaried workforce. They are not paid overtime in the traditional manner, but overtime loadings *are* factored into salary rates.

A range of additional payments can also add an average of over \$9,000 per annum to a full-time RMO's earnings.

WHAT ARE DHBs SEEKING TO ACHIEVE?

Pay is invariably a significant focus of bargaining. DHBs are trying to ensure:

- a remuneration system that fairly pays RMOs for the hours they work
- that evening, night and weekend work is transparently recognised in setting salaries

- that salary costs are sustainable in an environment of constraints on DHB expenditure
- the retention of RMOs.

WHAT IS IN THE DHBs' OFFER AROUND REMUNERATION?

DHBs propose retaining the existing run categories for RMO salaries, but changing the basis of calculating these categories to more accurately reflect the actual hours RMOs are rostered to be at work, including transparent loadings for unsocial evening, night and weekend work.

The current RMO MECA includes 'ordinary' hours – 40 per week, 8 per day Monday to Friday between 7:30 am and 5:30pm – that relate to determining salary category (and are paid, whether worked or not), rather than to the actual hours worked. In practice, RMO rosters set the hours of work and the actual hours an individual RMO works can vary significantly week-to-week. DHBs *must* pay RMOs for the ordinary hours, whether they work them or not. They must then pay extra on top of this for evening and weekends shifts. If DHBs must pay for these ordinary hours, they tend to roster RMOs on at these times, reducing the flexibility to be able manage shifts efficiently.

The DHBs' offer retains the existing rules around the operation of the salary scale, including annual progression and accelerated increments to reward RMOs for completion of key training milestones.

While making some adjustments, the DHBs' offer maintains the existing

This information is for senior managers and clinical leaders who work with RMOs, to help them understand the issues and the new provisions offered by the DHBs in bargaining.

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arrangements around payments for on call, work on public holidays, provision of cross cover, undertaking additional shifts, and penalty payments for times when, due to service demands, an RMO works excessive hours and/or without a minimum break between duties.

The DHBs' offer does seek to limit the instances where RMOs are, in effect, paid twice for the hours worked (or in some instances, not worked).

DHBs have proposed restructuring the current salary loading for RMOs employed in defined non-urban DHBs into a one-off payment, to incentivise retention in these traditionally harder-to-staff DHBs.

To recognise the increased flexibility within the remuneration model (and more broadly within the MECA), the DHBs' offer enables a 2% increase to House Officer salaries and a 4% increase to Registrar salaries. These increases would come into effect in late 2010, aligned to the change in the basis of calculation of salary categories.

WHAT DOES THE UNION CLAIM IN REGARD TO REMUNERATION?

The union has claimed for radical changes to the remuneration model for RMOs. These include:

- a single 15-step scale for all RMOs with minimum entry steps for different designations
- the reintroduction of an 'industrial model' where RMOs would be paid for the hours they work, with overtime after 8 hours in any day,

and penal rates at evenings, nights and weekends. (Note: the proposed scale is based on the existing scale, which already incorporates overtime loadings and margins)

- a \$10,000 per annum/per RMO retention scheme, which could include one-off lump sum payments, superannuation payments (on top of the existing matching employer contribution of up to 6% of base salary)
- increasing the payment for anticipated cross cover (when an RMO covers for an absent colleague in addition to their own work) from \$150/day to \$1,000/day.

The union's proposed remuneration model has significant implications for how RMOs are managed at work, including greatly increased requirements for timekeeping and attendance recording. Moving from salaries to paying for hours worked would also mean significant week-to-week variations in RMOs' pay, based on current rosters. Moreover, and significantly, DHBs estimate the cost of translating to the union's model would increase RMO base salaries alone by over 20%, which is simply unaffordable in the current environment.

WHERE TO FROM HERE?

The union rejected DHBs' proposals at bargaining and is holding stopwork meetings with RMOs to discuss options (including industrial action). Further bargaining is set for 13/14 September at which point the DHBs expect feedback from the union on their offer.

FURTHER INFORMATION

If you need more information, please first contact your GMHR or ER Manager.

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rmoinfo@dhbz.org.nz

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BACKGROUND INFORMATION ON RMO REMUNERATION

- Over 80% of RMOs are paid a 'Category C' (55-59.9 hours per week) or greater, despite RMOs themselves reporting that they worked on average around 53 hours per week [source: New Zealand Medical Council – *Medical Workforce Report 2008*].
- New Zealand's junior doctors are paid well by New Zealand standards. A recent study of earnings in the first three years following graduation found that medical graduates had the highest one- and three-year post-study median earnings of any group. When adjusted for other factors likely to affect earnings, medical graduates had a sizeable earnings premium over other degrees – over two-and-a-half times the median earnings for a humanities degree graduate. [Source: David Scott, *What Do Students Earn After Their Tertiary Education?* Wellington, Statistics New Zealand (September 2009)].
- Recent settlements with the RDA have resulted in the following pay increases:

2007/08	2.00% from 1 July 2009 8.68% from 11 August 2008 (plus a 5% lump sum payment)
2006/07	2.93% from 25 December 2006 2.93% from 26 December 2005

- In addition to the base salary, the MECA currently provides a number of additional payments that are triggered in certain cases. The main payments are outlined below:

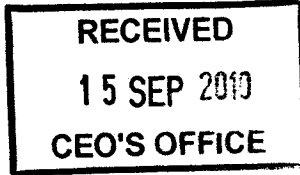
Additional duties/call back (minimum 4 hours)	\$45-\$100 per hour
Cross-cover	\$150 per day
If an RMO doesn't get an 8 hour break between duties	\$146 per occasion
If an RMO is rostered on duty for more than 72 hours/week	\$550 per occasion
If an RMO works more than 144 hours/fortnight	\$1,000 per occasion

The DHBs' offer retains all these provisions.

- This table sets out the average RMO earnings for the year to May 2010 calculated from DHB payroll information:

	House Officers	Registrars
Average Base Salary	\$87,500	\$112,000
Average Additional Salary Payments	\$7,500	\$11,400
Sub-Total	\$95,000	\$123,400
Employer Superannuation Payment	\$1,700	\$3,400

13 September 2010



Mr Garry Smith
Chief Executive Officer
Auckland District Health Board
Chief Executive's Office
PO Box 92 189 Victoria Street West
AUCKLAND 1142

To Greg
Duff's - this needs
to be referred to
board
Garry

133 Molesworth St
PO Box 5013
Wellington
New Zealand
Phone (04) 496 2000
Fax (04) 496 2340

Ref. No _____

Dear Mr Smith

**FEEDBACK ON INDICATORS OF DHB PERFORMANCE:
MINISTRY ASSESSMENT OF YOUR QUARTER FOUR 2009/10 PERFORMANCE**

This letter provides the Ministry of Health's (Ministry) final assessments of your District Health Board's (DHB) Quarter Four 2009/10 performance, for Auckland DHB's Indicators of DHB Performance (IDP).

Attached to this letter is a table showing all DHBs' 2009/10 Quarter Four final assessments.

The assessment for each IDP is and the ratings are:

- Outstanding Performer (O) rating is applied when DHBs demonstrate in their reports a higher level of performance than the agreed targets/expectations
- Achieved (A) rating is not obtained by the simple provision of a report for the IDP. DHBs must demonstrate in their reports that the targets/expectations have been met in full for that indicator
- Partially Achieved (P)
- Not Achieved (N)
- Nil Report (NR).

The final ratings have taken into account the DHB's response, if any, and this has been reflected in the Ministry's reporting to the Minister, where Auckland DHB received:

- one 'outstanding' performance rating
- 11 'achieved' performance ratings
- three 'partially achieved' ratings.

If you would like to see further information around your DHB's performance for Quarter Four 2009/10, please refer to the DHB Quarterly Reporting Website.

If there are queries relating to this feedback, your Ministry Relationship Manager should be contacted in the first instance.

Yours sincerely

Simon Harding
Acting Manager, DHB Relations & Accountability
National Health Board

cc Auckland DHB Funding and Planning Manager

2009/10 QUARTER FOUR DHBs' IDPs BY IDP

	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawkes Bay	Hutt Valley	Lakes	MidCentral	Nelson Marlborough	Northland	Otago	South Canterbury	Southeast	Tairāwhiti	Taranaki	Waikato	Waitemata	West Coast	Whanganui
HKO 01 Local Iwi Maori engaged in DHB decisions & strategies	A	A	O	A	A	O	A	A	O	A	A	P	A	A	P	A	A	A	A	P
HKO 03 Improving mainstream effectiveness	A	A	A	A	A	A	P	A	A	A	A	P	A	A	A	A	A	P	A	P
HKO 04 DHBs will set targets to increase funding for Māori Health and disability initiatives	P	P	P	A	P	A	A	P	P	P	O	A	A	A	A	A	A	A	A	P
PAC 01 Pacific provider service contracts ¹	A		A	A	A	A	A											A		
POP 06 Improving the health status of people with severe mental illness	A	P	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	N
POP 07 Alcohol and other drug service waiting times	A	A	A	P	A	A	A	A	A	A	A	A	A	A	A	P	A	A	A	A
POP 10 Chemotherapy treatment waiting times	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
POP 11 Family violence prevention	O	O	P	P	P	O	P	A	A	A	P	A	O	O	A	A	P	O	O	A
POP 14 Utilisation of DHB funded dental services by adolescents from Year nine up to and including age 17	A	P	P	P	O	O	P	O	O	O	A	O	A	O	P	A	P	O	O	O
POP 15 Ambulatory sensitive (avoidable) hospital admissions	P	N	P	O	N	P	N	N	P	A	P	A	A	N	N	P	A	P	A	N
POP 17 Improving mental health services	A	A	A	P	P	P	P	P	P	P	P	P	A	A	A	P	A	A	A	A
POP 18 Healthy Eating - Healthy Action: Improve breastfeeding rates	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	N
QUA 03 Improving the quality of data provided to National Collections Systems (NCS)	A	A	A	A	P	A	A	A	O	A	A	O	A	A	A	A	A	A	A	O
RIS 01 Service Coverage	A	A	A	A	A	A	A	A	N	A	A	A	A	A	A	A	A	A	A	A
SER 07 Low or reduced cost access to first level primary care services	A	A	A	O	O	O	O	O	A	O	O	O	A	O	O	O	O	O	O	O

O	Outstanding	A	Achieved	P	Partially Achieved	N	Not Achieved	NR	Not Reported
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¹ Only six DHBs with the highest pacific populations where assessed against this indicator.

Part B: Indicators of DHB Performance IDPs

Level 2: 2009/10 Indicators of DHB Performance (IDP) Ratings

DHBs are to include proposed target/expectation¹ for 2008/09 for each of the IDPs in a summary table format.

In 2009/10, a standard assessment criterion will be used across all IDPs. This will include the assessment category of 'Outstanding Performer' or 'Sector Leader' applied only in the fourth quarter as part of the Ministry's Annual Report on DHB performance. DHBs rated as 'Outstanding Performers' or 'Sector Leaders' for an individual indicator will have made significant progress over and above agreed DHB and/or sector expectations. The following assessment criteria will be applied:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O²	1. Applied in the fourth quarter only (or on any HT which is reported annually in any quarter)—this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements where all requirements have not been met—at least 50% of the requirements have been achieved.
Not achieved – escalation required	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.
No report – escalation required	NR	1. There is no report with no explanation, or 2. The explanation for no report is not considered valid.

¹ "Target" where the indicator is quantitative.

² To be applied in all quarters for Electives.

FEEDBACK

IDP HKO 04 DHBs will set targets to increase funding for Maori Health and disability initiatives

Two of three requirements for this indicator have been achieved. The third (and reason for the 'P' partial achievement) was not achieved and relates to the quantification of funding spent specifically on services for Maori. This information is currently being extracted.

IDP POP 15 Ambulatory sensitive (avoidable) hospital admissions (ASH)

As noted previously, ADHB ASH rates are ahead of target for 0-5 and 0-74 year olds, but above target for 45-64 year olds. There are a number of initiatives targeting Maori and Pacific for CVD, diabetes and respiratory (the main causes behind the high 45-64 ASH rates) which should impact on these rates over time.

IDP POP 18 HEHA – improve breastfeeding rates

The breast feeding rate target was not achieved in general for Maori and Pacific. Despite a number of initiatives the rates for Maori and Pacific remain low, although the decline which has been apparent for a number of years has now stopped.

Denis Jury

Chief Planning & Funding Officer

Tuesday 28 September 2010

Quarter 4 (2009-10)	Responsible	Response and Rating
IDP HKO 04 DHBs will set targets to increase funding for Maori Health and disability initiatives	Aroha Haggie	Ministry Response Thank you for your report. A good level of information was provided for Measures 1 and 2. Measure 3 asks (where information is available) for your actual expenditure to be compared with the predicted expenditure for the same period in your 2009-110 DAP. Should this information be available, please provide these figures, with explanation of variances. Initial Rating: P Confirmed Rating: P
IDP POP 15 Ambulatory sensitive (avoidable) hospital admissions	Mazin Ghafel	Ministry Response Congratulations on continued good performance in this area. As you note, it's the 45-64 age group where ASH rates are above the national average. The initiatives you have planned should address this. Initial Rating: P Confirmed Rating: P
IDP POP 18 HEHA – improve breastfeeding rates	Kate Sladden	Ministry Response Thank you for this report. Can you please confirm whether you are collecting data from Well Child providers other than Plunket? You must have an established collection for the 2010 calendar year to be reported at the end of 2010 Initial Rating: NA Confirmed Rating: P

**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

ADHB Board

Author: Ian Bell (8077)

Subject: Member Disability Support Advisory Committee

Recommendation

That the ADHB Board appoints Brian Fergus to the Disability Support Advisory Committee effective from 1 September 2010.

Background

Brian Fergus has been attending and contributing to the Disability Support Advisory Committee and this request from the Committee is to confirm him as a member effective from 1 September 2010.

10.2 DAP Projects Report



Auckland District Health Board

District Annual Plan *2010 - 2011*

22 June 2010

Priority and Developmental Work for 2010-11

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

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

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

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

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

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

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

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery 2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011 2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in: <ul style="list-style-type: none"> - General medicine - Orthopaedics - Radiology - Paediatrics general surgery - General surgery - Ophthalmology
	2.1c.2 Improve mainstream effectiveness	2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11) 2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.5 Reduce waiting times for oncology	2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway <ul style="list-style-type: none"> - Implement new model of care and workforce roles in the Greenlane Surgical Centre - Maintain past elective surgery improvement by including primary care in the

High level strategy	Objective	Strategies to achieve objectives
		referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against “In Good Hands” implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
2.3 Improve Clinical Quality and Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s 2.3.2.5 Implement Senior Leadership Team ‘Walk-around’ safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity

High level strategy	Objective	Strategies to achieve objectives
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces
		2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme
		2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015)
		2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme
		2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time
		2.5.1.2 KPI reporting for end-to-end application performance in place
		2.5.1.3 IMTS user satisfaction increases by >10% against previous year
		2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month
		2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance
2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)		
2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met	
2.6 Planning 2.6 Planning (cont)	2.6.1 Long term planning and change management	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines
		2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: <ul style="list-style-type: none"> – description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases
		2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

* Refer to appendix 8

Goal 3: Live within our means

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

Group Pack Report

Group/Committee: Board

Goal Level Summary

DAP Projects - total projects: 96

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

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

Review

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

Goal: 2 Performance improvement

Review

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

Goal: 3 Live within our means

Review

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

LIVE WITHIN OUR MEANS

11.1 Finance Committee Recommendations

11.2 Finance Report

11.1 Finance Committee Recommendations

ADHB Board**Author:** Ian Bell (8077)**Subject:** HDR Brachytherapy

Recommendation

That the ADHB Board endorses the purchase of an HDR Brachytherapy system from Nucletron for the Radiation Oncology Department at ADHB noting a total of \$810,000 has been budgeted for this project with the price for the HDR of ~NZ\$620,000 (at A\$0.80); approximately \$120,000 of the remaining budget is required for training, associated test equipment (non-Nucletron) and minor room renovations.

Background

This will be considered by the Finance Committee on 5 October 2010.

ADHB Board

Author: Ian Bell (8077)

Subject: Oral Health Business Case

Recommendation

That the ADHB Board approves a total additional expenditure of \$5.334m with respect to the reconfiguration of ADHB Child and Adolescent Dental Services; notes that total approval for the project will now be \$10.416m, as per the Business Case, and that this amount is fully funded by the Ministry of Health; and notes that the final service configuration with respect to fixed site clinics, mobile dental clinics, and transportation mini vans may differ to that envisaged in the original Business Case..

Background

This will be considered by the Finance Committee on 5 October 2010.

ADHB Board

Author: Ian Bell (8077)

Subject: CBA Working Capital Facility

Recommendation

That the ADHB Board, having

- a) considered the transactions ("Transactions") contemplated by the documents listed in the schedule hereto ("Documents"), which relate to an amendment of ADHB's existing loan facility agreement with Commonwealth Bank of Australia ("Facility Agreement") extending the term of the facility to 30 September 2013 and changing the pricing for the facility;*
- b) noted that no member of the Board is interested in the Transactions;*
- c) received a recommendation from management and formed the opinion, after taking into account all relevant factors, that the Transactions would be in the best interests of ADHB; and*
- d) noted that the consent of the Minister of Finance was obtained to the initial borrowing under the Facility Agreement,*

resolves that

- 1) the Board approve the Transactions and the Documents and authorise execution of the Documents by ADHB;*
- 2) ADHB enter into, execute and perform its obligations under the Documents;*
- 3) each of the Documents requiring execution by ADHB be executed as required by law (in the case of the Deed of Amendment, by two members of the Board); and*
- 4) the persons previously authorised by the Board to give any notices and other communications, and take any other action required under or in connection with the Documents on behalf of ADHB continue to be so authorised.*

SCHEDULE

- 1) A Deed of Amendment relating to a Revolving Cash Advance Facility Agreement dated 5 February 2004 between ADHB and (now) Commonwealth Bank of Australia.*
- 2) All related letters, deeds, agreements and certificates which may be necessary or desirable in connection with the document listed in paragraph 1 above and the Transactions generally.*

Background

This will be considered by the Finance Committee on 5 October 2010.

ADHB Board

Author: Ian Bell (8077)

Subject: Annual Report 2009 – 2010

Recommendation

That the Auckland District Health Board approves the Annual Report to 30 June 2010; and

That the Auckland District Health Board delegates signing authority on their behalf:

- 1. Letter of Representation to Audit New Zealand to the Chair, Chief Executive and Chief Financial Officer; and*
- 2. Year end Financial Statements to the Chair and Chair of the Finance Committee.*

Background

This will be considered by the Finance Committee on 5 October 2010.

11.2 Finance Report

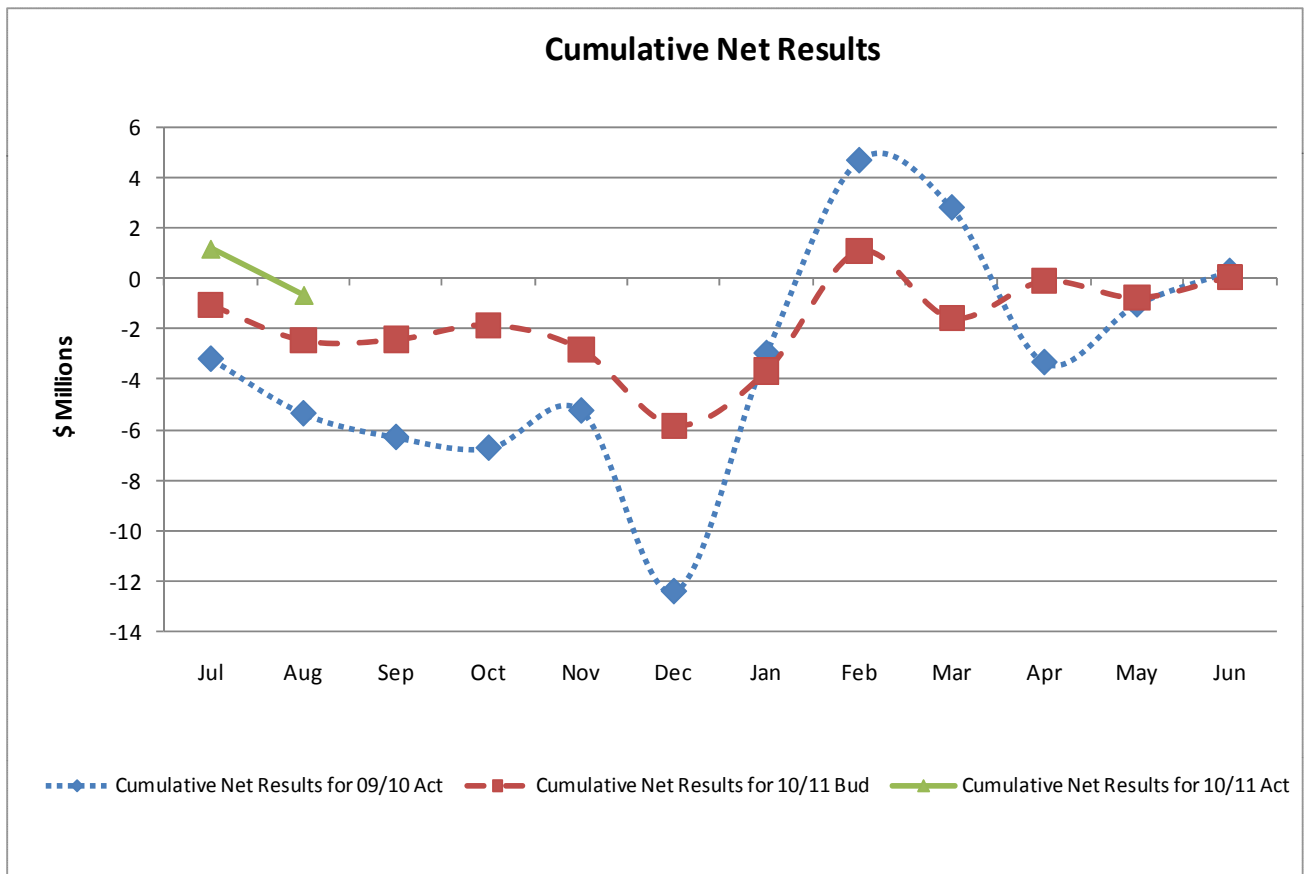
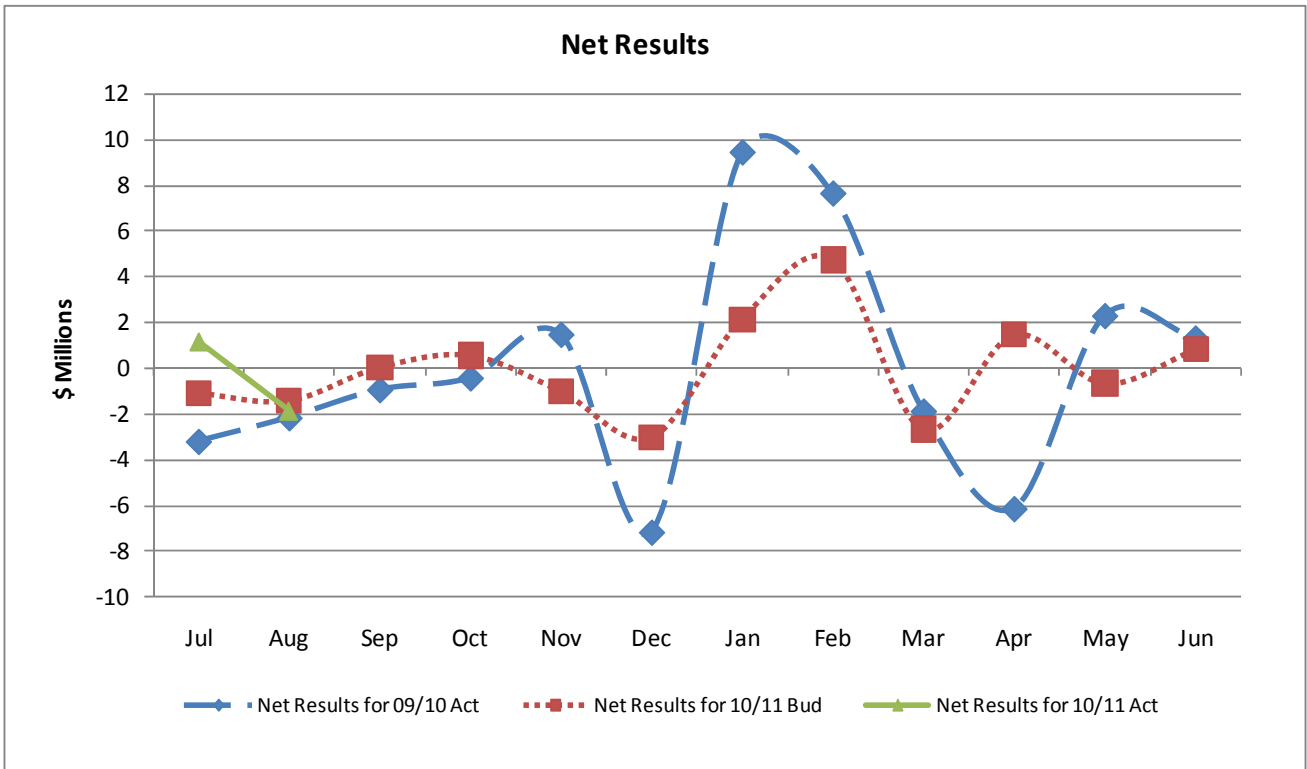
Auckland District Health Board

Board Financial Report

Prepared by Grant Barnett

August 2010

Performance Graphs by Month & YTD



Auckland District Health Board
Summary Result
Month of Aug-10

\$000s	Month A	Month B	Month Var	YTD A	YTD B	YTD Var
Income						
PBF - AKL Population	80,124	79,701	423 F	160,094	159,402	692 F
Inter District Inflows	47,490	47,891	400 U	94,628	95,781	1,153 U
	127,615	127,592	23 F	254,722	255,184	462 U
MOH Sub-contracts	8,340	7,402	938 F	16,947	15,124	1,823 F
Other Patient Care	2,962	2,714	248 F	5,867	5,426	442 F
Services & Products	4,495	4,438	56 F	9,120	8,888	232 F
CTA	1,572	1,625	53 U	3,245	3,299	54 U
Trust & Donation Income	325	473	148 U	1,414	897	517 F
Financial Income	554	316	238 F	1,089	631	458 F
Other Income	641	546	95 F	1,062	1,097	35 U
	146,502	145,106	1,397 F	293,467	290,545	2,922 F
Expenditure						
Employee Costs						
Medical	19,157	19,501	344 F	38,114	39,118	1,004 F
Nursing	19,721	19,840	119 F	39,316	39,736	420 F
Technical	9,866	10,245	380 F	20,011	20,578	567 F
Hotel Services	818	799	19 U	1,638	1,598	40 U
Administration	7,669	7,830	160 F	15,502	15,687	184 F
Other	3,744	3,771	26 F	6,602	7,136	534 F
Total Employee Costs	60,975	61,986	1,011 F	121,183	123,854	2,670 F
Direct Treatment Costs	20,300	17,752	2,549 U	39,417	35,682	3,734 U
Indirect Treatment Costs	3,750	3,286	464 U	7,266	6,564	702 U
Funder Payments	39,701	39,444	258 U	79,118	78,887	231 U
Inter District Outflows	8,400	8,372	27 U	16,799	16,745	54 U
Prop. Equip. & Transport	4,029	4,208	178 F	8,128	8,344	216 F
Maintenance	136	133	3 U	269	267	3 U
Building Compliance	0	0	0 F	0	0	0 F
Loss on Sale of Fixed Assets	19	1	18 U	28	3	25 U
Administration Costs	1,847	2,044	197 F	4,124	4,086	38 U
Total Operating Expenditure	139,158	137,226	1,932 U	276,334	274,432	1,902 U
Operating Contribution	7,345	7,880	536 U	17,133	16,113	1,020 F
Depreciation	4,495	4,526	32 F	8,750	9,055	304 F
Finance Costs	1,645	1,734	89 F	3,289	3,468	180 F
Capital Charge	3,062	3,022	40 U	5,778	6,058	280 F
Total Non Operating Costs	9,202	9,283	81 F	17,817	18,581	764 F
Net Surplus / (Deficit)	(1,857)	(1,403)	455 U	(684)	(2,468)	1,784 F

Auckland District Health Board				
Statement of Financial Position				
As at Aug 2010				
	Aug-10	Aug-10	Jul-10	Jun-10
	Actual	Budget	Actual	Actual
	\$ 000s	\$ 000s	\$ 000s	\$ 000s
Crown Equity				
Opening Balance	569,409	569,304	569,409	566,089
Equity Injections/(Repayments)	-	-	-	3,320
Closing Balance	569,409	569,304	569,409	569,409
Revaluation reserve				
Opening Balance	353,538	381,278	353,538	381,278
Revaluation Adjustments	-	-	-	(27,740)
Closing Balance	353,538	381,278	353,538	353,538
Retained Earnings				
Opening Balance	(468,367)	(468,437)	(468,369)	(468,645)
Surplus/(Deficit) Current Year	(684)	(2,468)	1,171	279
Closing Balance	(469,050)	(470,905)	(467,198)	(468,367)
Total Crown Equity	453,896	479,677	455,749	454,578
Represented by:				
Fixed Assets				
Land	181,497	201,337	181,497	181,497
Buildings	582,965	537,513	584,741	586,094
Clinical, Other Equipment & Motor Vehicles	82,511	158,402	78,271	79,856
Work in Progress	24,824	23,571	27,768	23,166
Total Fixed Assets	871,797	920,823	872,277	870,612
Derivative Financial Instruments	7,061	5,052	7,061	7,061
Investments				
Associated Company Investments	95	386	95	470
Trust Deposits	10,078	8,000	10,078	10,078
Total Investments	10,172	8,386	10,172	10,547
Current Assets				
Cash & Short Term Deposits	69,163	33,557	64,043	56,815
Trust Deposits	11,272	11,508	11,422	11,747
Debtors	17,202	24,435	19,149	25,691
Accrued Income	35,356	34,205	32,422	31,221
Prepayments	3,365	2,320	2,907	2,245
Inventory	11,550	12,106	11,563	11,220
Total Current Assets	147,909	118,131	141,507	138,938
Current Liabilities				
Borrowings	77,872	88,673	76,237	75,027
Trade & Other Creditors, Provisions	223,733	211,772	222,773	222,910
Income Received in Advance	23,881	19,016	24,115	20,087
Taxes Payable	20,946	19,079	15,574	18,040
Funds Held in Trust	1,068	1,066	1,074	1,067
Total Current Liabilities	347,500	339,606	339,773	337,132
Working Capital	(199,591)	(221,475)	(198,266)	(198,193)
Non Current Liabilities				
Borrowings	213,030	212,230	213,022	213,014
Employee Entitlements	22,512	20,880	22,474	22,435
Total Non Current Liabilities	235,542	233,109	235,495	235,449
NET ASSETS	453,896	479,677	455,749	454,578

Statement of Cashflows for the Year ended 30 June 2011						
	Aug-10			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	144,728	142,975	1,753	300,572	292,436	8,136
Payments	(136,299)	(148,028)	11,729	(280,171)	(286,862)	6,691
Net Operating Cashflows	8,429	(5,053)	13,482	20,401	5,574	14,827
Investing						
Income	554	369	185	1,042	739	303
Capital						
Sale of Assets	1	2	(1)	16	3	13
Purchase Fixed Assets	(4,009)	(6,462)	2,453	(9,932)	(12,922)	2,990
Net Investing Cashflows	(3,454)	(6,091)	2,637	(8,874)	(12,180)	3,306
Financing						
Equity Injections	0	0	0	0	0	0
New Loans	0	0	0	0	0	0
Loans Repaid	0	0	0	0	375	(375)
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
Net Financing Cashflows	0	0	0	0	375	(375)
Total Net Cashflows	4,975	(11,144)	16,119	11,527	(6,231)	17,758
Opening Cash	36,581	34,567	2,014	30,029	30,029	0
Closing Cash	41,556	23,423	18,133	41,556	23,798	17,758

Financial Commentary for August 2010

Financial Performance

The result for August was a deficit of \$(1.9)m an unfavourable variance to budget of \$0.5m. The result year to date for August was a deficit of \$(0.7)m a favourable variance to budget of \$1.8m. The result year to date, was driven by higher revenue \$2.9m offset by and higher expenditure of \$(1.1)m..

Year to date revenue was higher than budget by \$2.9m. This was the result of:-

- a) Unfavourable Base Revenue variations \$(0.5)m driven by provision for potential IDF volume variations for 10/11 year to date
 - b) Higher MoH Subcontract revenue \$1.6m, driven by variation to Sector Capability & Innovation funding (SCI) \$0.7m, higher volumes of Residential Care Loan Scheme funding \$0.2m, the release of Mental Health Funding \$0.9m and a wash up of PCT drugs for 09/10 \$0.3m
 - c) A higher volume of non resident activity \$0.8m
 - d) The timing of donations \$0.5m
 - e) Higher interest received on term deposits \$0.4m.
- Year to date expenditure was higher than budgeted by \$(1.1)m
 - The favourable variance in employee costs of \$2.7 m was driven by a budgetary provision for Meca increases \$1.1m, vacancies in Mental Health \$0.7m, Cancer \$0.3m and Laboratory \$0.5m offset by higher Medical staff allowances in Paediatric \$(0.2)m and Adult Cardiac \$(0.5)m, driven by a high number and complexity of implant procedures and high dependency patients. In addition, further provision has been made for increases in long service leave and gratuities \$(0.3)m offset by the expiry of Nursing CME accruals for balances greater than 3 years old \$0.4m.
 - Direct Treatment costs are \$(3.7)m unfavourable to budget driven by high blood product usage \$(0.8)m, Implant usage \$(1.0)m and Clinical Supplies costs \$(1.0)m predominantly as a result of Adult and Paediatric Cardiac Implant procedures and other high dependency patients and higher outsourcing costs \$(0.3)m for radiotherapy. The above processes have been supported by higher laboratory material usage \$(0.3)m.
 - Funder Payments are \$(0.3)m over budget. There are offsetting variances arising from the settlement of prior year's pharmaceutical claims and an even phasing of the pharmaceutical budget \$(1.9)m offset by a provision for palliative care no longer required \$1.0m.
 - Indirect treatment costs are higher than budget by \$(0.7)m driven by higher provisioning for non resident debts
 - Property Costs are favourable to budget \$0.2m mainly driven by lower computer maintenance costs.
 - Administration costs are favourable to budget \$0.1m primarily due to the timing of consulting expenditure \$0.5m for performance improvement projects offset by a one off payment from the Alexandra Trust to Ronald McDonald House Trust Auckland \$(0.5) m for the provision of a facility for convalescing women and children.
 - The Capital Charge is lower than budget \$0.3m driven by the revaluation of Land & Buildings downwards at balance date.
 - Depreciation is lower than budget \$0.3m driven by the timing of capitalisation of capital projects.

Financial Position

- The opening balance of fixed assets was \$(34.3) m below budget principally due to the downward revaluation of land & buildings \$(27.8) m as at 30 June 2010 and FY10 full year capital spending being \$(28.7)m lower than forecast.
- YTD Capital spending is \$9.9m, under budget by \$(3.0)m. Baseline and Facilities projects are slightly behind budget by \$(0.6)m and Information Systems projects are behind budget by \$(2.4)m driven by the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$69.2m (excluding Trust deposits). At month end there is an unused overdraft facility of \$63.0m.

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PAPERS

No Papers

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GENERAL BUSINESS

APPENDICES

No Appendices

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PUBLIC EXCLUSION

AUCKLAND DISTRICT HEALTH BOARD

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

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

That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 13.

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

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
13.1 Northern Region Shared Services Organisation	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.