



Auckland District Health Board

Board Meeting

Wednesday 7 April 2010

2:00pm

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

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

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Repl as Ltd	Owner/Managing Director.	Salary	Plastics Manufacturing Company	6 August 2009
	2. Matta Products Ltd	Owner/Director.		Plastics Manufacturing Company	
	3. Remat Group Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	4. Burkhardt Investments Ltd	Shareholder/Director			
	5. Burri s Ltd	Shareholder/Director			
	6. Re co Ltd	Director	Fee		
	7. ADHB Charitable Trust	Trustee		Government owned Maori Tourist operation	
	8. New Zealand Maori Arts and Craft Institute	Chairman		Plastics Manufacturing Holding Company	
	9. Matt I Ltd	Shareholder/Director		Plastics Distribution Company USA	
	10. Matta LLC	Trustee		Negotiator for Ngati Kuri o te Iwi Treaty of Waitangi claim	
	11. Deputy Chair and Negotiator Ngati Kuri o te Iwi	Consultant	Fee		
	12. Packaging Council of New Zealand	Executive Board Member			
Jo AGNEW	1. Senior Lecturer Nursing, Auckland University		Salary		4 February 2009

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust 2. New Zealand Research Centre for Growth and Development 3. James Henare Research Centre, University of Auckland 4. Manaia PHO, Whangarei 5. Whanau Ora Task Force 6. National Health Board	Chief Executive Board Member Advisory Board Member Shareholder Member Member	Salary Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee	Management of a Health, Disabilities, Social & Education Services Trust Governs a leading health sciences research centre Advises U o A on Maori research in Northland Governs a Whangarei based PHO Assists in the development of Government's Whanau Ora policy	17 February 2010
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				15 July 2009
Dr Ian SCOTT	1. Share holder Chair Auckland PHO 2. Locum GP 3. Waiheke "Integrated Family Health Centre" Steering Group	Chair Member	Meeting fee Contract rate		27 January 2010
Bob TIZARD	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure 2. Member, National Breast Screening Advisory Committee 3. Facilitator, RNZCGP General Practice Education Programme Stage II 4. ADHB Employee: contracted roster Doctor for Pohutukawa	Self employed contractor Member Contractor Contractor	Contract hourly rate Fee Contracted monthly fee Hourly rate	General practitioner services Consultant Pacific Advisor Educational Support and Training Forensic sexual assault examinations	1 November 2009
Ian WARD	1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C-4 Consulting Limited		Fee	Tender to National Shared Services	3 February 2010

CONFIRMATION OF MINUTES

- 3 MARCH 2010

Auckland District Health Board Minutes



MEETING DETAILS											
Time and Date	2:00 pm, Wednesday, 3 March 2010										
Venue	Pohutukawa Room, Sorrento in the Park, One Tree Hill Domain, Epsom										
1	<p>KARAKIA</p> <p>The Chair declared the meeting open at 1:02pm and Rob Cooper led the meeting with the karakia.</p>										
2	<p>ATTENDANCE AND APOLOGIES</p> <p>Board Members</p> <table> <tr> <td>Pat Snedden (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Dr Juliet Walker</td> <td>Ian Ward</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Denis Jury – Chief Planning and Funding Officer Dr David Sage – Chief Medical Officer Brent Wiseman - Chief Financial Officer Kay Hyman – General Manager Children’s and Woman’s Services Hilda Fa’asalele – General Manager Pacific Health Chris Morgan – Manager Materials Management Janice Mueller - Director Allied Health Vivian Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>An apology had been received from Dr Chris Chambers.</p>	Pat Snedden (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	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	Harry Burkhardt										
Rob Cooper	Dr Brian Fergus										
Dr Ian Scott	Rt Hon Bob Tizard										
Seiuli Dr Juliet Walker	Ian Ward										
3	<p>CONFLICTS OF INTEREST</p> <p>There were no notifications of conflicts of interest for any item on the agenda.</p>										
4	<p>CONFIRMATION OF MINUTES 3 FEBRUARY 2010</p> <p><u>Moved Rob Cooper; seconded Ian Scott</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 3 February 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The Laboratory Governance Group had met on 8 February 2010 where they considered things were progressing with the IANZ audit in March, KPIs being reported and a low level of complaints. The results of the tender for cervical screening were expected in March. A review of histology throughout the Auckland region was being undertaken including hospital laboratories.</p>										

6	PRESENTATION Director General of Health
	<p>Stephen McKernan, Director General of Health presented to the Board covering some of the current pressures and challenges including the economic and fiscal environment, driving productivity and value for money, workforce shortages, safety and quality, and equity of access and timely access, and making decision in the national interest including improving collaboration across DHB boundaries. Forthcoming challenges and pressures were population growth, increasing risk and prevalence of long term conditions, health inequalities, effective utilisation of the available workforce, effective application of technological advances and rising consumer expectations.</p> <p>A graphical example of New Zealand's population aging and distribution around the country showed that 4 DHBs were above the mean of New Zealand annual population growth and 5 DHBs were above the mean annual growth in 65 plus with the 3 Auckland regional DHBs being in both categories. In addition the savings challenge was compelling due to fiscal deficits forecast until 2016.</p> <p>Health system changes were the establishment of the National Health Board business unit and the Shared Services Establishment Board. The National Health Board was a business unit of the MoH and would cover funding and planning, services and performance monitoring. MoH would concentrate on policy and strategy. There were a number of government decisions pending concerning prioritisation of new technology and interventions, medical device procurement, quality improvement agency and national/regional/local decision making rights which would involve legislative change. Key priorities and expectations for 2010 - 2011 were to achieve financial stability, deliver against health targets, improve productivity and quality, implement change within primary care following the EOI process and enhance regional/national cooperation.</p> <p>Financial savings were expected to occur from a focus on productivity and quality improvements, procurement and shared back office support functions, other local saving initiatives and regional/national service planning initiatives. The MoH role was to provide joint sector leadership, system performance advice, support DHB productivity and quality improvement and to monitor DHBs performances. There was considerable sharing of information but there was also a need to have this interpreted and focused. Examples were average length of stay, day surgery rate, surgical case weights per theatre and across provider arms potential savings in excess bed days.</p> <p>He advised on learning's from a recent UK study tour with high performing in NHS Trusts being absolutely committed to national targets, having clear accountabilities for success and consequences for failure, stable leadership, strong clinical engagement and involvement and a strong focus on the patient. Further factors were strong measurement and reporting systems, a strong focus on benchmarking, strong commitment to improvement tools and methodologies and leadership actively planning and preparing for funding downturn.</p> <p>He advised 28% of admissions were ambulatory sensitive so the focus on targets was fundamental.</p> <p>The Chair thanked him for his presentation.</p>
5	ACTION POINTS 3 FEBRUARY 2010
	<p>City Mission</p> <p>The City Missioner would be coming to the Board meeting in May.</p> <p>Strategic Planning Day</p> <p>A proposed programme covering financial sustainability and clinical challenges with a future looking focus was tabled with the timing to be after the Budget or early June.</p>

7	CHAIRMAN'S REPORT
	<p>There had been an appearance before the Health Select Committee with a major focus on the Community Laboratories and ADHB had received compliments on its financial performance.</p> <p>He had met with the Royal College of General Practitioners on the Community Laboratories and they were engaged on getting information and a full survey of the sentinel practices. There had been a Regional Chair and CEO meeting and cooperation was good and regional service planning progressing although not fast enough. It had not achieved the step changes needed.</p> <p>The Chief Executive was asked for a regional governance report covering what had been achieved and what were impediments to progress.</p>
8.1	Chief Executive's Summary
	<p>The achievement of the immunisation rates target was acknowledged.</p> <p>Radiation oncology services needed a strategic regional plan to get to the four week waiting time. A total of 6 people had missed the six week waiting time target with some of those not wanting to be treated or having co-morbidities. The service was facing industrial action.</p> <p>In Health of Older People there were areas of contracted expenditure increasing so this was being watched carefully. ADHB was doing the assessments of people transferring from other DHBs with the reasons for coming to Auckland being mostly family and availability of more rest home facilities. The rate of increase over the last few months was less. ADHB did have a higher proportion of frail elderly.</p> <p>The EOIs had been signed off under delegated authority with all three supported with varying covenants. There had been concern expressed as to GP engagement.</p> <p>Emergency Department throughput was improving. The schedule of performance indicators had now been removed from the agenda with only exception reporting.</p> <p>The risk to the 2009/2010 results was being managed with weekly meetings chaired by the Chief Financial Officer with General Managers. With electives there was a planned slow down for Christmas and Easter. The funding of the new national configuration for paediatric oncology has not been resolved with a need for money to follow the patients. Shared Services were engaged with the Shared Services Establishment Board.</p>
8.2	Minister's Six Health Priorities 2009 - 2010
	<p>By the end of the year ADHB may not achieve all the targets, an example being an expected 18 months to achieve the ED waiting times. Diabetes "Get Checked" was reported at the GP level and there needed to be pressure on PHOs to ensure GPs are recording the data.</p> <p><u>Moved Pat Snedden; seconded Brian Fergus</u></p> <p><i>That the Chief Executive Summary and Minister's Six Health Priorities reports be received.</i></p> <p><u>Carried</u></p>

8.3	2010 - 2011 District Annual Plan and Statement of Intent
	<p>A further iteration of the District Annual Plan 2010 - 2011 was tabled. There was no room to set aside funds for other initiatives with the Funder expenditure increasing \$20m greater than the funding increase. There was a page by page review of the plan.</p> <p><u>Moved Pat Snedden; seconded Harry Burkhardt</u></p> <p><i>That the ADHB Board notes the areas of changes required to the District Annual Plan 2010 – 2011; and</i></p> <p><i>notes that the Treaty partners have an interest in the District Annual Plan and are co-signatures to it; and</i></p> <p><i>notes the timeframes for printing the Statement of Intent; and</i></p> <p><i>approves signoff for submission to the Ministry by the Chair and Chief Executive.</i></p> <p><u>Carried</u></p>
9.1	Committee Recommendations
	<p>The CPHAC had discussed the DAP and had received a presentation from Professor Sir Peter Gluckman.</p> <p>The MHAC had very qualified support for the EOIs and had deferred the DNA report to a later meeting.</p> <p>The PHAC had considered the EOIs. It was noted that the Pasifika Week would be profiled from 8 – 12 March.</p> <p>The DSAC was considering holding monthly meetings and noted that other DHBs had disability coordinators. The last meeting had had a presentation from the CEO of the Elizabeth Knox Home on the Eden initiative which involved residents and working with them. HR would be advising the Committee on disability issues within ADHB. The Chair and Board members were invited to attend meetings.</p>
10.1	Committee Recommendations
	<p>The Quality Risk and Audit Committee had a good presentation by HR who did maintain excellent data bases.</p> <p><u>Moved Ian Ward; seconded Rob Cooper</u></p> <p><i>That the reports from the Committees be noted.</i></p> <p><u>Carried</u></p>
10.2	DAP Project Report
	<p><u>Moved Jo Agnew; seconded Juliet Walker</u></p> <p><i>That the DAP Projects Report be noted.</i></p> <p><u>Carried</u></p>

11.1	Finance Committee
	<p>The Committee had considered the DAP. There was a level of comfort of being able to deliver this year with management taking opportunities. The budget for the next year was achieved through bottom up budgeting so people owned the budgets and it was realistic.</p> <p><u>Moved Harry Burkhardt; seconded Ian Ward</u></p> <p><i>That the Auckland District Health Board agrees that the proposed repayment of \$10.5m to CHFA due in March 2010 as contained in the District Annual Plan 2009 – 2010 be suspended and that amount be lodged in an amortisation fund and that the redraw of \$13.5m of loan from CHFA be on the debt maturity profile as approved by the Committee, namely, \$3.5m to mature in 2012 and \$10m in 2019.</i></p> <p><u>Carried</u></p>
11.2	Finance Report
	<p>There was a good result for the month through planned leave and reduced production however the challenges going forward were not underestimated with savings increases required with this being addressed through weekly management meetings.</p> <p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the Financial Report be received.</i></p> <p><u>Carried</u></p>
12.1	2010 Triennial Election
	<p>A poll of members was conducted concerning the order of candidate's names on the voting papers with a majority in favour of the alphabetical order of candidate names.</p> <p><u>Moved Pat Snedden; seconded Harry Burkhardt</u></p> <ol style="list-style-type: none"> <i>1. The Auckland District Health Board confirms the appointment of Dale Ofsoske, electoral officer for the Auckland Council, as the electoral officer for the Auckland District Health Board for the conduct of the 2010 triennial election; and</i> <i>2. resolves for the 2010 Auckland District Health Board triennial election, to adopt the alphabetical order of candidate names as permitted under regulation 31 of the Local Electoral Regulations 2001; and</i> <i>3. resolves for the 2010 Auckland District Health Board triennial election to adopt the early processing of returned voting documents, as permitted under section 79 of the Local Electoral Act 200; and</i> <i>4. authorises the Chief Executive to approve and sign the Memorandum of Understanding on behalf of the Auckland District Health Board with the Auckland City Council, for the conduct of the 2010 triennial Board election.</i> <p><u>Carried</u></p>

	CEO Professional Development
	<u>Moved Brian Fergus; seconded Rob Cooper</u> <i>That the Auckland District Health Board approves the professional development programme for the Chief Executive in the 2010 calendar year noting that it spans two financial years.</i> <u>Carried</u>
	NEXT MEETING
	The meeting closed at 3:34pm The next scheduled meeting is : 2:00pm, Wednesday, 7 April 2010 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton
CONFIRMED	
CHAIR:	DATE:

ACTION POINTS

- 3 MARCH 2010

Board
Action Points from the meeting on Wednesday 3 March 2010

Item	Detail	Designated	Action
Carried forward	Presentation by City Mission	Garry Smith	Scheduled for May meeting
	Suggested Strategic Planning Day for the Board	Pat Snedden Garry Smith	Schedule for after Budget early June
7.	Regional governance report back from CEO's discussion	Garry Smith	X^!àæÅ] åæ^
8.2	Minister's "Get Checked" pressure PHO to ensure GPs are recording data	Denis Jury	ÔÚPCÔÅã & ••ã }

PRESENTATIONS

No Presentations this Month

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			
Pacific Awareness	Green	A week long programme organised by our Pacific team has been extremely well received.	N/A
Contract Review Process	Green	Process review complete – recommendation being formulated.	Excellent Communication and Presentation to next CPHAC.
EOI – Primary Care	Green/Orange	Key specific deliverables completed within one month.	One regional Primary Care plan, with identified approach to 4 – 6 specific deliverables.
Goal 2 Improve Performance			
District Annual Plan	Green	Need to ensure all projects are deliverable given pressure on key priorities.	Reconcile Key KPIs with DAP deliverables – a audit with SLT.
Regional Projects	Green	2 key work streams to deliver a result by the end of April.	Strong involvement to the two work streams and CEOs to deliver a result following 16 April meeting.
Healthcare Excellence	Green	Finalisation of branding and framework.	Plan to establish Board and SLT ownership prior to launch to organisation.
Goal 3 Live Within Our Means			
Forecast 2009/10	Red	Heavy emphasis to ensure budget is met.	Weekly meetings of the core team.
Electives	Orange	Impact of strike action on delivering result.	Close daily monitoring.
Strike Action	Red	Critical disruption to all patient flows.	Patient Safety focus from an expert Incident Management team.

8.2 Minister's Six Health Priorities 2009/10

Project: Adult Acute Patient Flow

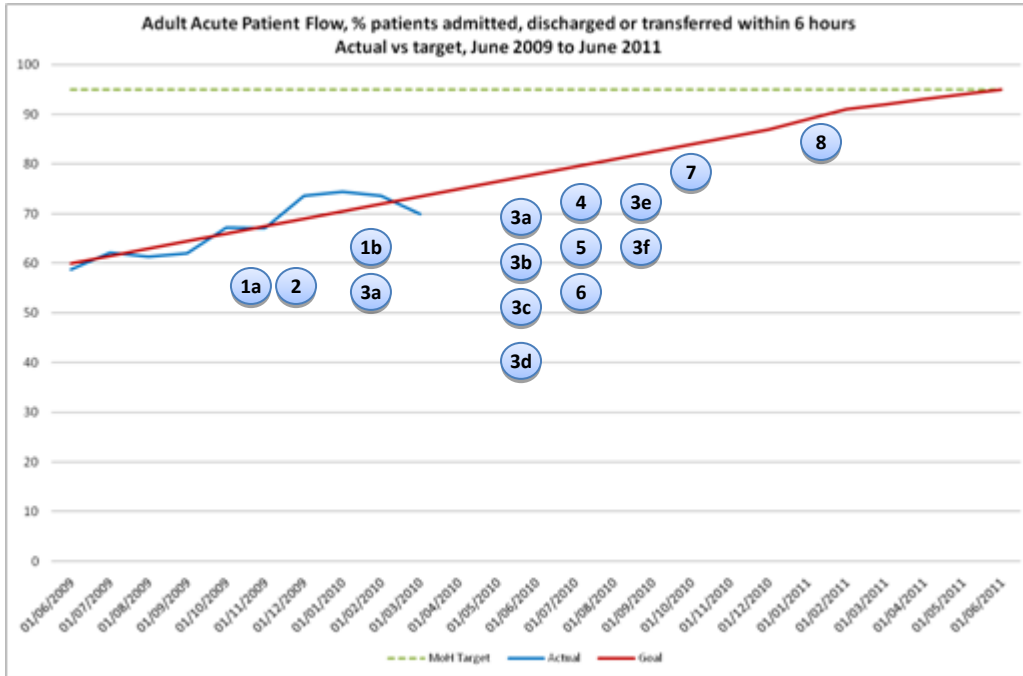
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

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:

Despite the peaks in patients presenting to ED, an increase of 4.3% on the same period last year, we have still seen a significant shift forward in target performance. Looking at the past two years results there has been a sustained improvement, with 20 consecutive weeks of above average performance. However, the current level of performance is still well below the 95% target and an increased operational management discipline is to be introduced to increase the urgency associated with the 6 hour target.

Recent and Current activities:

1. Additional beds opened in
 - a) November 2009
 - b) January 2010
 2. Improved Measurement systems to better identify clinical short stay patients
 3. Reducing ward occupancy
 - a) Expediting patient discharges from wards by the introduction of daily 'rapid rounds' - completed in General Medicine wards - now being implemented into Orthopaedics and General Surgery
 - b) Increase the number of weekend discharges in General medicine and Orthopaedics
 - c) Improve the volume and accuracy of estimated discharge dates in General Medicine wards
 - d) reduce short stay (<24 hr) admissions
 - e) Remove delays associated with NASC referrals
 - f) Remove delays associated with Taikura Trust patients
 4. Bed management CMS system enhancements
 5. Improved ED / Inpatient Team methods of communication
- Planned activities
6. Increased Operational management
 7. Improved scheduling of elective volumes
- Future activities
8. Phase 3 improvement initiatives focusing on occupancy and specialty service response time.

Project: Children's Acute Patient Flow

43

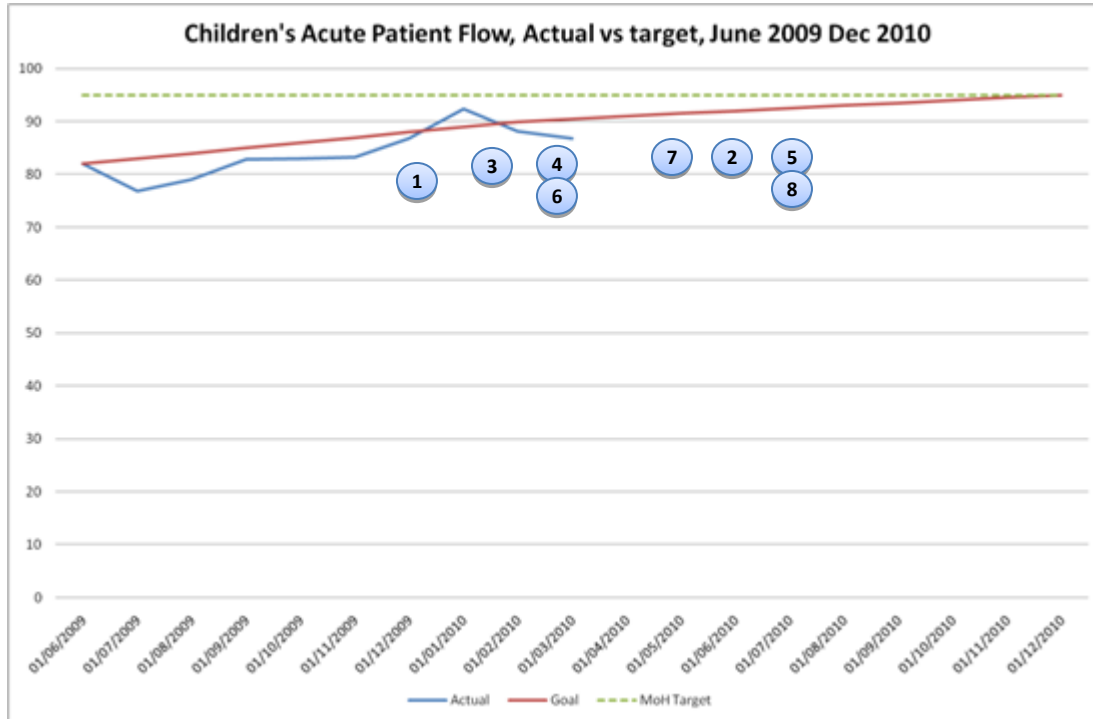
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

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:

January saw an extended period of high performance, with 25 days above 90%, and for the Jan – March quarter to date we have achieved a 7.5% increase in 6 hour performance compared to the same period last year, despite a 3.5% increase in patient volumes.

We are beginning to see a drop in performance as we move out of the summer period and an increased operational management discipline is to be introduced to increase the urgency associated with the 6 hour target.

Project: Increased Immunisation

45

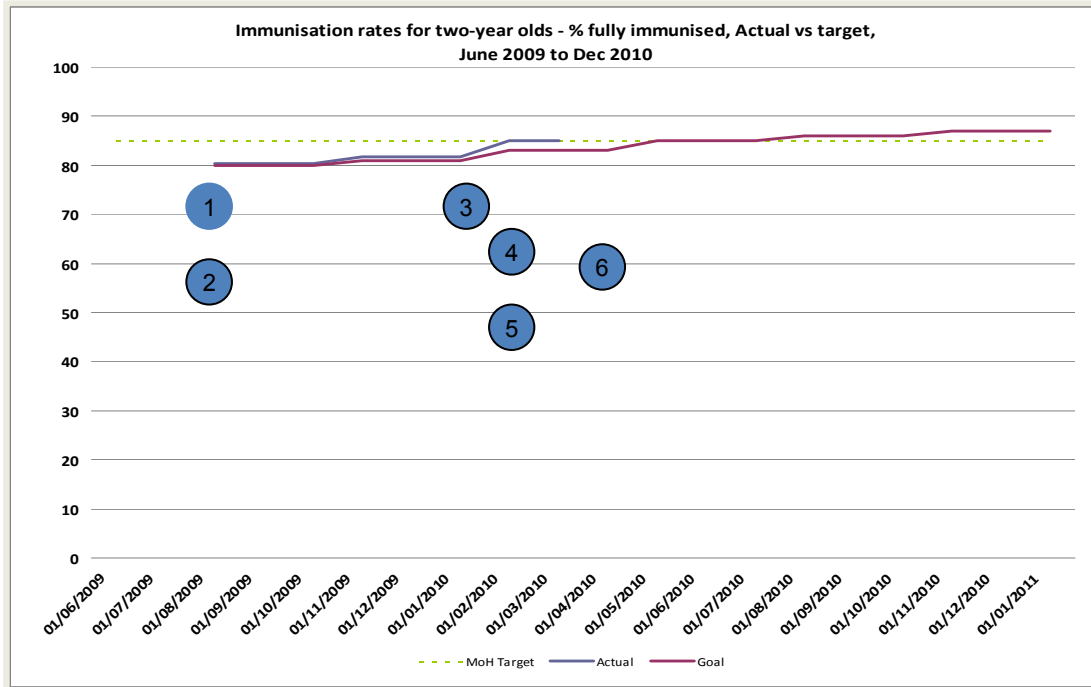
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 90% by July 2011 and 95% by July 2012

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

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

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



Current activities:

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded
3. ADHB Immunisation Strategy approved
4. Submission to Health Select Committee on actions to improve immunisation coverage
5. Funding application made to Starship Foundation to fund social marketing programme
6. Convene meeting of regional DHBs to agree regional immunisation target

Project Risks / Comments:

Annual target of 85% coverage was achieved in February which reflected a 3% increase over the previous month. This level has been maintained in March. Maori coverage at all milestone ages remains a challenge as does timeliness generally but in particular at 6 months and 18 months. The Ministry of Health requires DHBs to agree on achievement of regional targets (90%) in 2010/11 and ADHB will probably be expected to achieve higher than 90% to compensate for lower achieving DHBs.

Project: Improved access to elective surgery

47

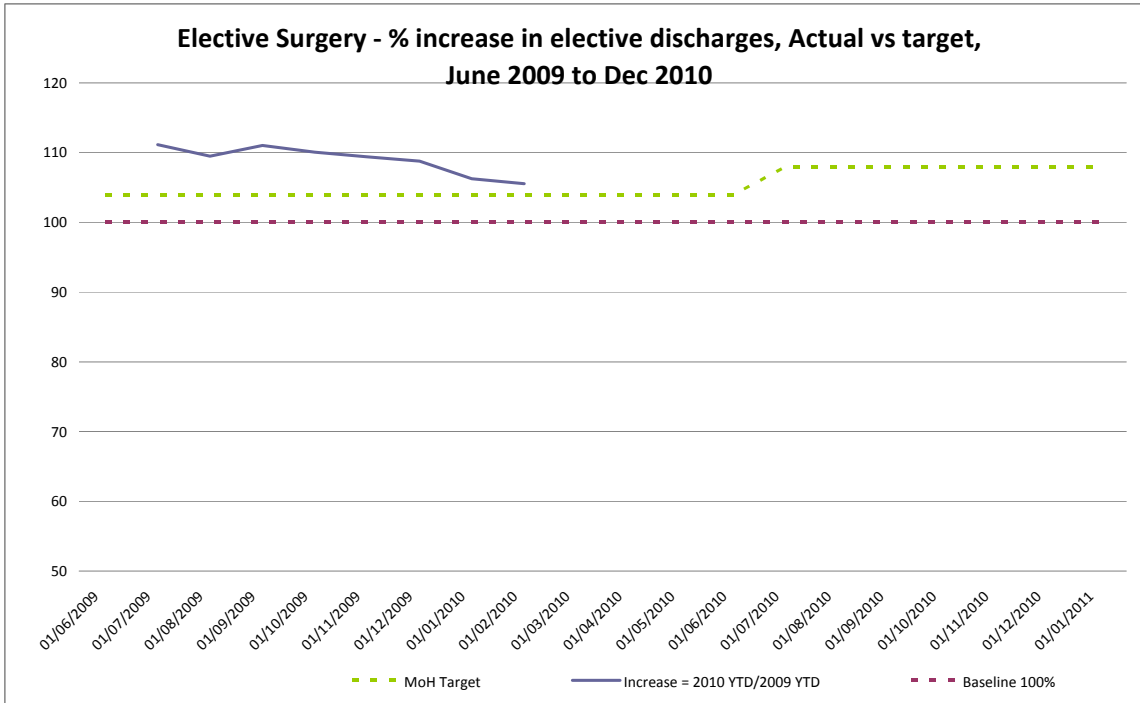
Primary goal: To increase the volume of elective surgery by an average of 4000 discharges per year (nationally)

Date of Delivery: 1

Clinical Lead:

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan



Planned Activities:-

1. Operationalisation of the Greenlane Surgical Unit.
2. Additional operating hours at Greenlane

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 caseweights 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. As outsourcing has declined due to budget constraints so too has the degree of increase over the prior year.

Project: Shorter waits for Radiotherapy

49

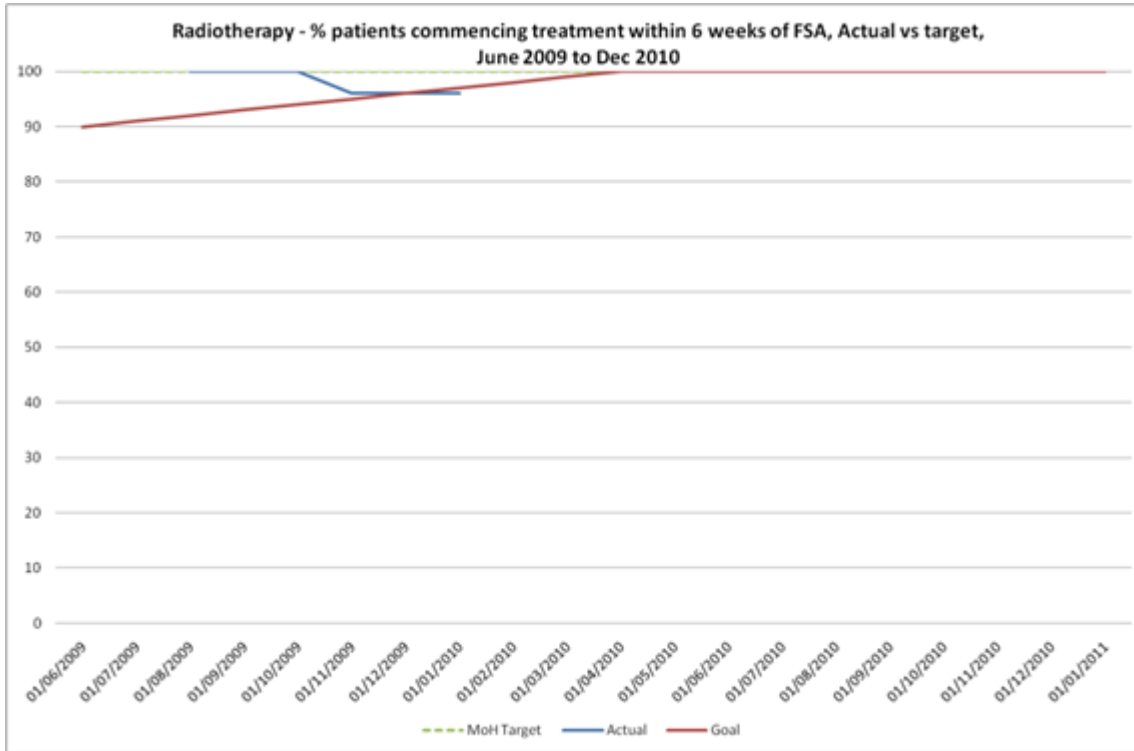
Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010

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

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



Risks / Comments:

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

In Quarters 2 and 3 some patients have been treated outside the 6 week target as a result of capacity constraints. As at 23 March 2010 it is expected that all patients awaiting treatment will commence treatment within 6 weeks (excluding category D patients who are not included in the MoH target)

Current activities:

- Weekly clinical prioritisation meetings continue, with a focus on detailed scheduling to review and accommodate urgent referrals as well as manage fluctuations in demand.
- Development and testing of a capacity modelling tool for future planning and management of workload based on acuity and demand is in progress.
- Evening shifts have been extended until the end of May - this provides an additional 3 Linac treatment hours per day.
- Project Manager appointed to the process improvement project is reviewing the structure and provision of radiation therapy treatment and services to meet MOH targets
- Outsourcing to Waikato Hospital - contingent on current wait time status, 9 patients have been treated at Waikato since mid Jan.
- "Flexible working hours" project in place to identify ways of increasing the treatment capacity within available FTE.
- Presentation of the business case for the replacement of MV5 to Regional Capital in March and ADHB Expenditure committee in April. On commissioning (Jan 2011) this will increase treatment capacity by 5 hours per day.

Project: Better help for smokers to quit

51

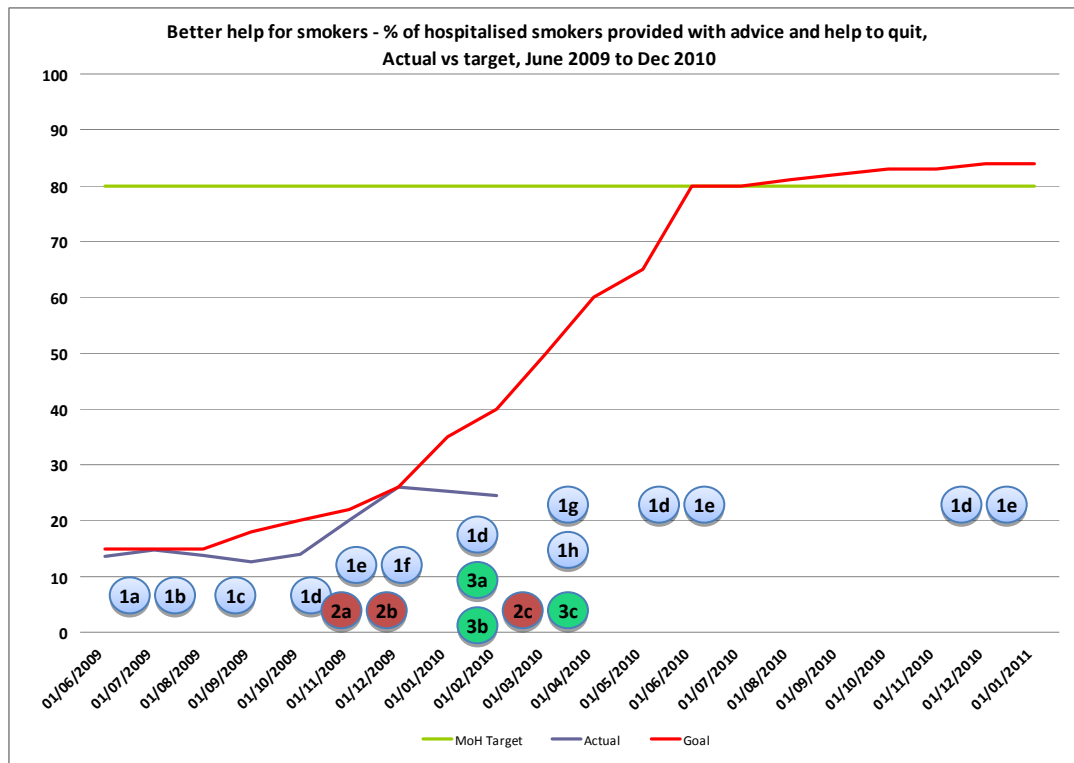
Primary goal : % of hospitalised smokers provided advice and help to quit

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

Clinical Lead: Stephen Childs

Project Sponsor: Taima Campbell

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



Project Risks and Comments

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

Recent and Current activities:

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

Project: Better diabetes and cardiovascular services

53

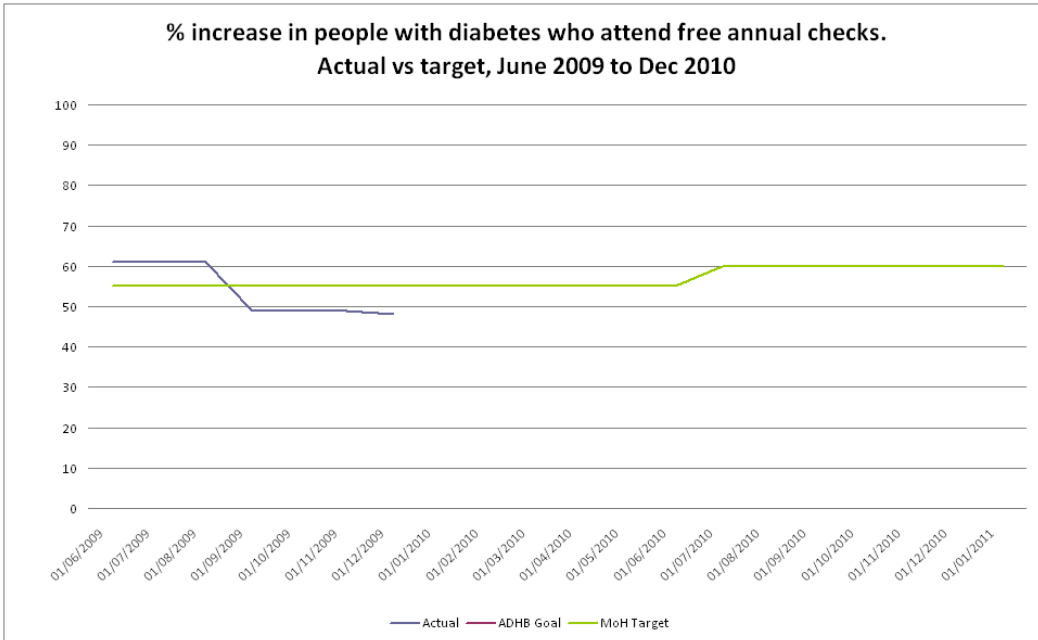
Primary goal : % increase in people with diabetes who attend free annual checks. Actual vs target, June 2009 to Dec 2010

Date of Delivery: December 2010

Clinical Lead: Celia Palmer (Interim)

Project Sponsor: Celia Palmer

Steering Group: Celia Palmer, Gayl Humphrey



Current activities:

- A revised approach is necessary to achieve this target.

Note: ADHB Goal and MOH target are the same.

Risks / Comments:

The diabetes get checked (annual diabetes check (DGC)) has not meet its targets for the past 6 months. The first quarter may have been influenced by the H1N1 operational procedures however, there should have been an increase in reviews in Q2. Communications with PHOs highlights that the system for collecting the DGC has some processes that need revisiting. However, the low uptake of this data collection does not mean that care is not being delivered, just that the use of the DGC forms are not being used. This is borne out when the PHO Performance Programme (PPP) which extracts data direct form the practise systems rather than relies on a form completion (DGC) the number of diabetes checks is examined and shows, annual diabetes reviews are sitting in the mid 50% . By having two places where data is captured does create an issue and is being discussed both regionally and comments to MoH are ongoing.

Project: Better diabetes and cardiovascular services

54

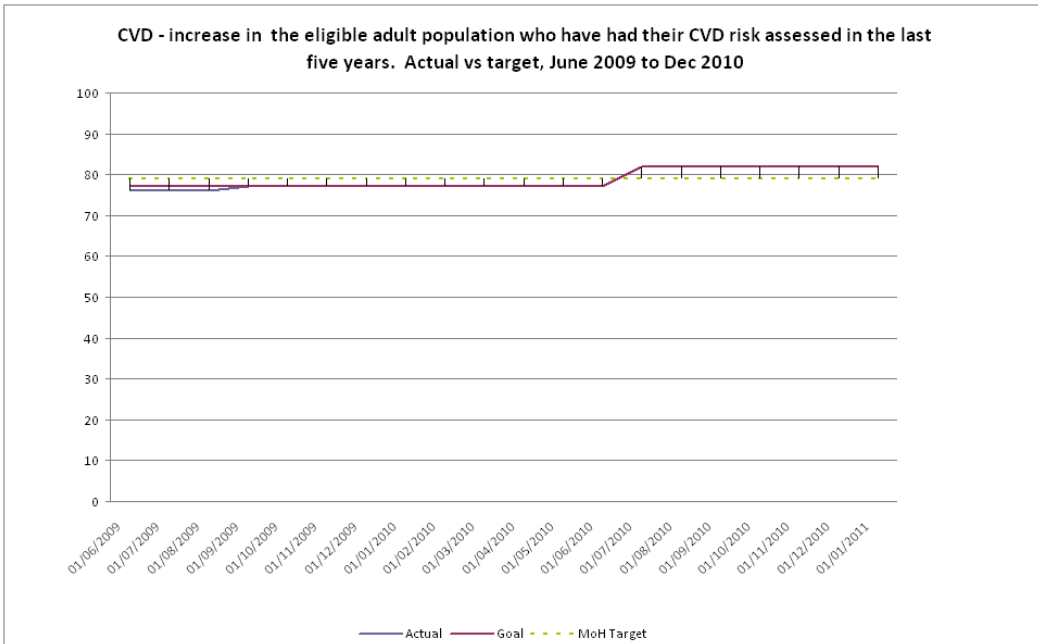
Primary goal : Increase in the eligible adult population who have had their CVD risk assessed in the last five years. Actual vs target, June 2009 to Dec 2010

Date of Delivery: December 2010

Clinical Lead: Celia Palmer (Interim)

Project Sponsor: Celia Palmer

Steering Group: Celia Palmer, Gayl Humphrey



Current activities:

- A revised approach is necessary to achieve this target.

Risks / Comments:

We are tracking well towards meeting our target and like to meet and exceed it. However this measure is using laboratory lipids and when a similar examination of the risk assessment tool that we fund for practises, the numbers are less. Again the two systems for data collection and analyses makes obtaining an accurate picture of activity difficult. Of note the achievement for Maori and Pacific is still tracking lower and efforts are being focused to maximise outcomes for these groups

Project: Better diabetes and cardiovascular services

55

Primary goal : Increase in people with diabetes who have satisfactory or better diabetes management, Actual vs target, June 2009 to Dec 2010

Date of Delivery: December 2010

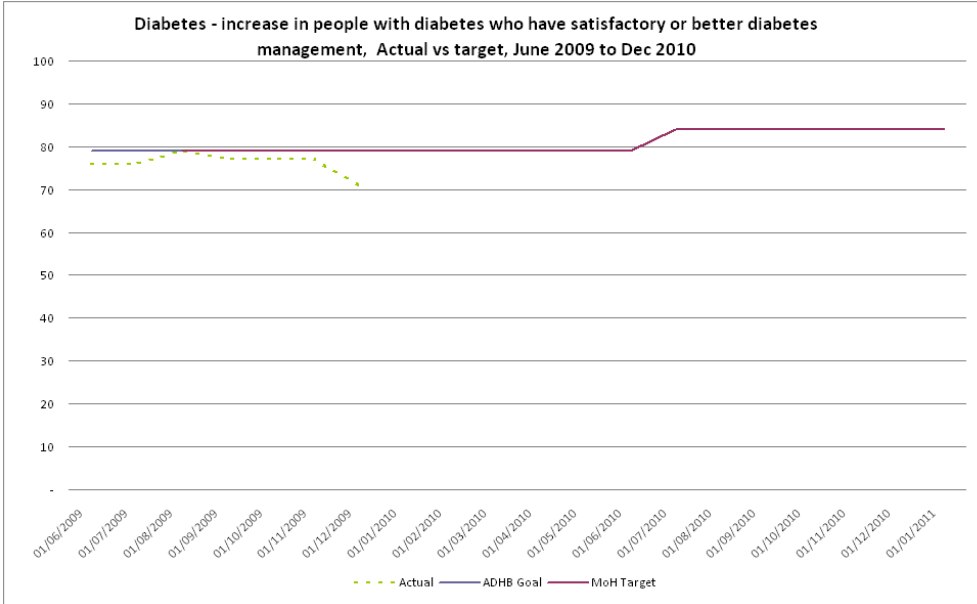
Clinical Lead: Celia Palmer (Interim)

Project Sponsor: Celia Palmer

Steering Group: Celia Palmer, Gayl Humphrey

Current activities:

- A revised approach is necessary to achieve this target.



Note: ADHB Goal and MOH target are the same.

Risks / Comments:

Overall, there are peaks and troughs with good management for people with diabetes. More efforts and attention to supported self management are needed to enable the information imparted in a clinical session to be built on and actioned.

Project: Cardiac Bypass Surgery

57

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

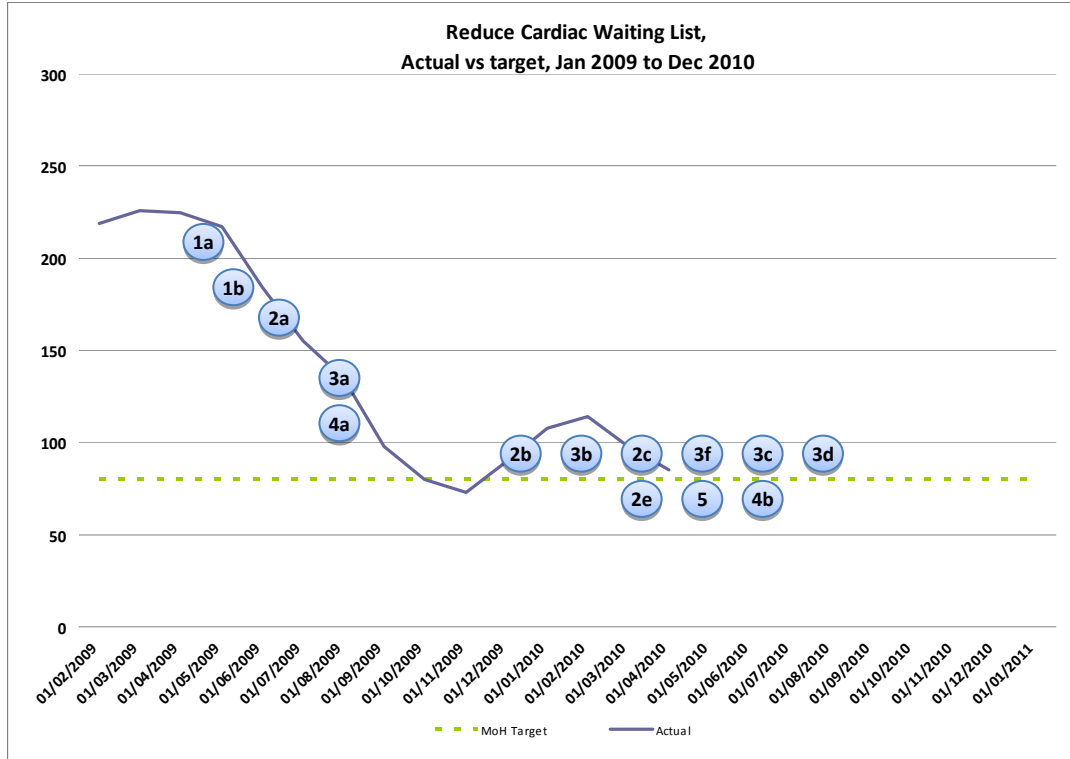
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2010

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Kay Hyman

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



Recent and Current activities:

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

Project Risks / Comments:

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

8.3 Alexandra Trust

ADHB Board**Author:** Bruce Northey (26876)**Subject:** Alexandra Trust**Recommendation**

That the Auckland District Health Board directs the A+ Charitable Trust to disburse all funds held in respect to the Alexander Trust to the Ronald McDonald Trust for acquisition of accommodation for families of within the ADHB district, subject to completion of a Deed between the ADHB and RMT as proposed by Tim McAvoy of Kensington Swan, disbursement on those terms being consistent with both the objectives of the Alexander Trust and a practical approach to conserve the use of the trust funds for those objectives into the future. The Alexander Trust to then be wound up.

Background

I refer to the letter from the Chair of the A+ Charitable Trust, Richard Frith, to the ADHB Board recommending the application of funds held from the Alexandra Trust towards the acquisition of a facility by Ronald McDonald Trust, subject to the RMT entering into a Deed that confirms the funds will be applied consistently with the terms of the Alexandra Trust. I note this recommendation is expressly stated by Richard Frith to be endorsed by Tim McAvoy, an experienced trust lawyer and partner of Kensington Swan. As shown by the 2008 email set out below it was also my conclusion that application of the Alexandra trust funds to this purpose would be consistent with the terms of the Alexandra Trust.

The only difference between my conclusion and that of the A+ Charitable Trust is the proposition that the funds be donated, subject to a Deed, rather than lent. The A+ Charitable Trust's approach appears to be more pragmatic, as it will terminate the ongoing obligations of ADHB to manage the Alexandra Trust, an obligation that has proved a minor challenge. However, in making its decision the Board must balance that pragmatism with the terms of the Alexandra Trust, as modified, which states that the Trustees (now the Board) are to ensure "reasonable steps be taken to conserve the corpus of the trust funds."

Also, it is not clear if the RMT have agreed to the proposed deed, in particular clause 3.

From: Bruce Northey**Sent:** Friday, 29 August 2008 15:47**To:** Richard Frith (ADHB)

Cc: Roger Jarrold (CFO); Janet Latimer

Subject: Alexandra Trust

As you are aware, Ronald McDonald House has been in touch via Garry Smith about applying the funds held in the ADHB Charitable Trust from the Alexandra Home Trust (AHT) towards the purchase of a property in Grafton. Our records show that ADHB, via the Trust, is holding \$419K derived from the AHT.

I have reviewed the materials held by Janet Latimer, which relate to the formal modification of the AHT deed of trust by the Attorney-General in 2001 to change the purposes of the AHT to “the health of women and children who shall be resident within the [regions of the three DHBs]”. In that modification it was noted that the original AHT funds were now distributed amongst the three Auckland DHBs.

Importantly, the restructuring also recognised the history of the AHT, being the gifting of a house as a convalescent home, the modification deed noting it “involved the use of a capital asset which, in its nature, would have preserved the capital intact”, proceeding to state that “should the Trustees consider ... that the interests of health and women ... would be promoted by acquiring property ... the Trustees may expend ... capital in making such acquisition” and that “reasonable steps be taken to conserve the corpus of the trust funds.”

With the caveat as to the extent to which RMH provides services to residents of ADHB or greater Auckland it is my legal opinion that the purpose proposed by RMH has a clear alignment with the original and present purposes of the AHT. As the trustee of the AHT (the Board of ADHB) can not acquire the property an alternative that conserves “the corpus of the trust funds” would be to lend the funds on hand to the RMH interest free for a term or until demanded. Probably with security over the building being purchased.

I outlined these issues to Beth Harman at RMH last month, suggesting that in addition to making an application to the ADHB Trust she also ask both the other DHBs if they held any residue from the AHT.

The process from here would be for RMH to formally apply to you for the funds. I note that while the Trustees would consider that request, if the decision were to approve a loan the Board of ADHB would need to endorse that as the Trustees of the AHT are officially the boards of the three DHBs.

Regards

Bruce Northey

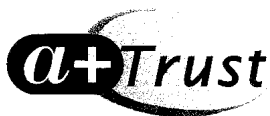
General Counsel

Auckland DHB

+ 64 9 6309943 ext 26876

Mobile 021 938104

bnorthey@adhb.govt.nz



Mr P Snedden
Chairman
Auckland District Health Board
Green Lane

16 March 2010

Dear Pat

Re : Alexandra Trust and Ronald McDonald House, Auckland

The Alexandra Trust is a subtrust of the Auckland District Health Board Charitable Trust. The funds have been held for many years to assist with the convalescence of women and children within the ADHB district. Several attempts have been made in the past for these funds to be used, without success.

As you know, Ronald McDonald House is planning an expansion. Their board has applied to the Trust for funds to support this. The Trustees of the ADHB Charitable Trust consider that the total sum within the Alexandra Trust should be applied to this project. We are satisfied that the purposes fit the appropriate Deed for the subtrust.

Disbursement of funds from the Alexandra Trust requires approval of the ADHB Board and I would appreciate you considering this.

Tim McAvoy, a Partner of Kensington Swan, who is an external Trustee on the ADHB Charitable Trust, has suggested that this donation, if approved by the ADHB Board, should be accompanied by a Deed between the ADHB Board and Ronald McDonald House Charitable Trustees which would state the following (or to similar effect):

1. RMH acknowledges receipt of \$[] from the Alexandra Trust for the purposes of the acquisition of facilities being rooms [] and [] at its premises at 52-54 Grafton Rd, Auckland, for the purpose of the health of women and children within the ADHB district.
2. RMH acknowledges the use of the trust moneys in the acquisition of the two-room facilities by permanent notice that the particular rooms have been acquired with moneys from the Trust for the benefit of the health of women and children in the ADHB district.
3. In the event that such rooms cease to be available for any reason for the said purposes then RMH will apply a sum of money representative of the value of such rooms having regard to the value of the facility as a whole towards the health of women and children in the ADHB district, with these provisions to apply to any replacement facility, and so on, so that the Trust's charitable purposes are given effect to in perpetuity.

The Trustees believe the funds should be advanced not by the way of a loan but be applied for the acquisition of the facilities. The Trust would then, effectively, be wound up.

If you require further information, please feel free to contact me.

Enclosed is a copy of the application from the Alexandra Trust.

With kind regards
Yours sincerely

RICHARD W FRITH
Neurologist
Chairman, A+ Charitable Trust

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

9.1 Committee Recommendations

9.1 Committee Recommendations

Community and Public Health Advisory Committee Recommendations

Maori Health Advisory Committee Recommendations

Pacific Health Advisory Committee Recommendations

Disabled Support Advisory Committee Recommendations

10

PERFORMANCE IMPROVEMENT

10.1 Committee Recommendations

10.2 DAP Projects Report

10.1 Committee Recommendations

Hospital Advisory Committee Recommendations

Verbal by Committee Chair

Quality, Risk and Audit Advisory Committee Recommendations

Verbal by Committee Chair

10.2 DAP Projects Report

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

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

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

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

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

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



Total Projects: 81

DAP GOAL	Number (#)	Started (#)	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1) Lifting the Health of the people in Auckland City	25	25	5	2	7	6	2	0	24	1	0	25	0	0	24	0	1	3	3	0	0
2) Performance Improvement	45	44	13	8	10	10	2	0	35	9	1	45	0	0	39	6	0	1	1	0	0
3) Living within our Means	11	10	3	1	2	2	1	0	8	3	0	11	0	0	11	0	0	1	1	0	0
Totals #	81	79	21	11	19	18	5	0	67	13	1	81	0	0	74	6	1	5	5	0	0
Totals %	100%	98%	26%	14%	23%	22%	6%	0%	83%	16%	1%	100%	0%	0%	91%	7%	1%	6%	6%	0%	0%

Goal 1

Review

Overall good progress with implementation of a range of initiatives. The MoH initiated primary care EOI process and the subsequent business plan development work for the successful EOIs has impacted on the timeline for implementation of some projects (particularly the DAP plans regarding service Long Term Condition management, and other initiatives related to primary care).

Goal 2

Review

Overall projects in goal 2 are progressing well. Regional LTSP is still a concern and the steering committee is meeting in April to review and define path forward. Solution implementation for the Adult and Childrens 6 hr projects is underway across many areas. Concord program continues to gain momentum with several projects completed. eReferrals development is waiting for completion of contracts. Aspire development well underway and on track for go live before July. Implementation planning study for Regional Clinical Documents is nearing completion also - which will be final step before confirmation of business case and implementation. IT Resilience project progressing to plan - expect new end-to-end application monitoring for top 5 systems and load balancing for Concerto to go live in March - National IT board has approved phase 3.

Goal 3

Review

Progress being made on a number of the objectives. After seven months, the organisation is favourable to budget but this includes some significant favourable one-off events. Accordingly, the critical challenge for the balance of the year is to achieve financial impacts from the project concord and other initiatives.

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: Provision of Pharmaceutical and Non-Pharmaceutical Products****Recommendation**

That the Auckland District Health Board approves the renewal and variation of the Product Supply Agreements between the Auckland Northern Region District Health Boards (ANRDHB) and Health Support Limited (HSL) for the provision of Pharmaceutical and Non-Pharmaceutical Products on behalf of Auckland District Health Board.

For the purposes of this proposal Auckland Northern Region District Health Boards (ARNDHB) comprises of:

Auckland District Health Board (ADHB)

Counties Manukau District Health Board (CMDHB)

Northland District Health Board (NDHB)

Waitemata District Health Board (WDHB)

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

DHB	Est Value (5 Year)
Auckland DHB	\$184,500,000
Counties Manukau DHB	\$51,000,000
Northland DHB	\$17,500,000
Waitemata DHB	\$57,000,000
<u>Auckland Northern Region</u>	<u>\$310,000,000</u>

Background

This was considered by the Finance Committee on 6 April 2010.

ADHB Board**Author: Ian Bell (8077)****Subject: Residential Treatment Odyssey House Trust**

Recommendation

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

Background

This was considered by the Finance Committee on 6 April 2010.

ADHB Board**Author: Ian Bell (8077)****Subject: Residential Treatment Salvation Army New Zealand Trust**

Recommendation

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

Background

This was considered by the Finance Committee on 6 April 2010.

ADHB Board**Author: Ian Bell (8077)****Subject: Supply of Pain Pumps and Consumables****Recommendation**

That the Auckland District Health Board approves:

1. That a Direct Supply Agreement is entered into between ADHB and Smiths Medical Australasia Pty Ltd for the Supply of CADD Solis Pumps and accessories.
2. That a Tripartite Supply Agreement between ADHB, Smiths Medical Australasia Pty Ltd and Health Support Limited is entered into for the distribution of the associated consumables.
3. Term of the contract is for 5 years (60 months) with an option to exercise a Right of Renewal for 2 years (24 months).
4. The estimated value of the Contract(s) based on current fleet replacements over 7 years is:

• Capital:	\$653,800
• Consumables	\$891,238
5. The Supplier has agreed to include the National Privy option which will enable other DHB's to access the Contract Pricing Schedule.

Background

This was considered by the Finance Committee on 6 April 2010.

11.2 Finance Report

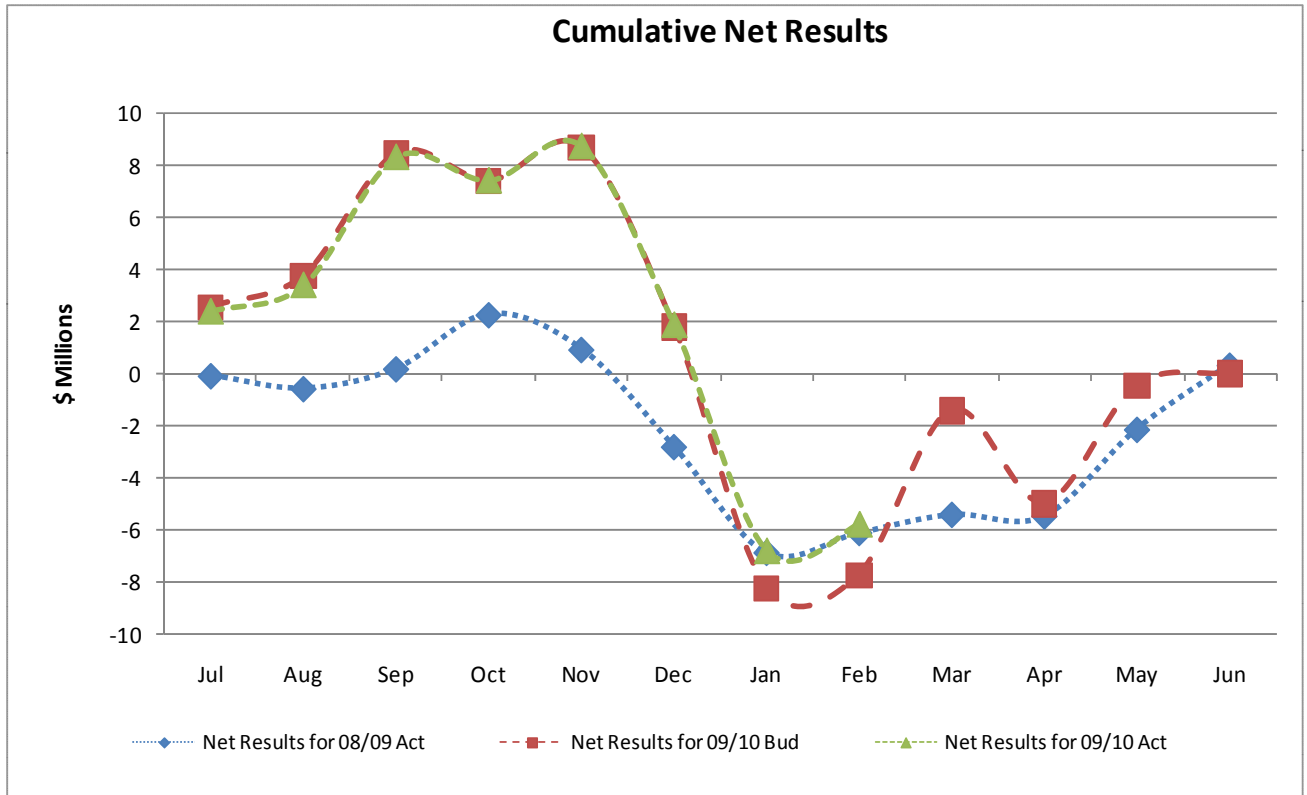
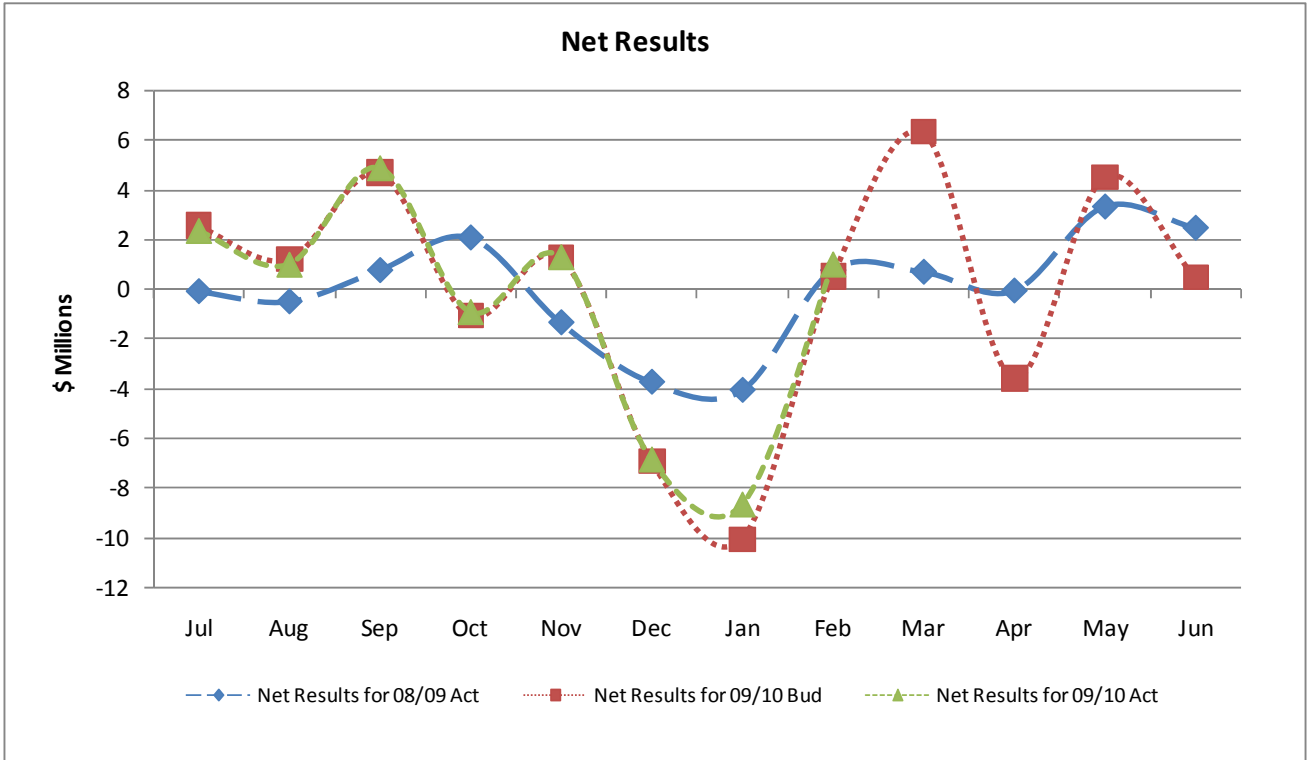
Auckland District Health Board

Board Financial Report

Prepared by Grant Barnett

February 2010

Performance Graphs by Month & YTD



Auckland District Health Board
Summary Result
Feb 2010 Month & Full Year Forecast

	\$000s			YTD A	YTD B	YTD Var
	Month A	Month B	Month Var			
Income						
PBF - AKL Population	73,232	72,633	600 F	624,353	620,901	3,452 F
Inter District Inflows	46,078	46,989	911 U	371,316	375,913	4,597 U
	119,310	119,622	311 U	995,668	996,814	1,145 U
MOH Sub-contracts	6,655	5,301	1,354 F	47,633	44,999	2,635 F
Other Patient Care	2,401	2,989	588 U	21,801	23,992	2,192 U
Services & Products	3,542	3,460	82 F	28,903	28,488	415 F
CTA	1,549	1,657	108 U	13,844	13,053	791 F
Trust & Donation Income	122	846	724 U	2,714	6,944	4,230 U
Financial Income	344	311	33 F	3,546	224	3,322 F
Other Income	427	566	139 U	5,010	4,479	530 F
	134,350	134,752	402 U	1,119,119	1,118,993	127 F
Expenditure						
Employee Costs						
Medical	18,543	17,455	1,088 U	152,750	152,474	276 U
Nursing	17,435	16,763	672 U	146,434	145,465	969 U
Technical	9,284	9,027	257 U	77,480	79,696	2,216 F
Hotel Services	919	887	32 U	7,670	7,666	4 U
Administration	6,736	6,570	166 U	58,179	57,511	668 U
Other	4,072	4,383	310 F	34,487	35,987	1,500 F
Total Employee Costs	56,990	55,085	1,905 U	477,000	478,799	1,799 F
Direct Treatment Costs	15,851	16,779	928 F	146,200	140,762	5,438 U
Indirect Treatment Costs	2,833	3,141	308 F	25,885	25,605	280 U
Funder Payments	36,051	36,226	175 F	314,411	311,728	2,683 U
Inter District Outflows	7,784	8,093	309 F	47,543	48,557	1,014 F
Prop, Equip. & Transpt	3,623	4,093	470 F	31,530	34,276	2,746 F
Maintenance	66	133	67 F	1,297	1,067	230 U
Building Compliance	0	0	0	F (400)	0	400
Loss on Sale of Fixed Assets	10	2	8 U	167	14	153 U
Administration Costs	1,337	1,506	169 F	12,151	12,496	345 F
Total Operating Expenditure	124,545	125,055	511 F	1,055,785	1,053,304	2,481 U
Operating Contribution	9,805	9,697	108 F	63,334	65,689	2,355 U
Depreciation	4,171	4,257	86 F	32,074	33,739	1,666 F
Finance Costs	1,606	1,636	30 F	13,454	13,451	2 U
Capital Charge	3,010	3,291	281 F	23,587	26,211	2,624 F
Total Non Operating Costs	8,787	9,184	397 F	69,114	73,401	4,287 F
Net Surplus / (Deficit)	1,018	513	505 F	(5,780)	(7,713)	1,933 F

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

	Feb-10 Actual \$ 000s	Feb-10 Budget \$ 000s	Jan-10 Actual \$ 000s	Jun-09 Actual \$ 000s
Crown Equity				
Opening Balance	566,089	569,698	566,089	601,089
Equity Injections/(Repayments)	268	-	220	(35,000)
Closing Balance	566,357	569,698	566,309	566,089
Revaluation reserve				
Opening Balance	381,278	417,016	381,278	417,019
Revaluation Adjustments	-	-	-	(35,741)
Closing Balance	381,319	417,016	381,319	381,278
Retained Earnings				
Opening Balance	(468,647)	(468,975)	(468,647)	(468,972)
Surplus/(Deficit) Current Year	(5,778)	(7,713)	(6,796)	325
Closing Balance	(474,425)	(476,687)	(475,444)	(468,647)
Total Crown Equity	473,250	510,027	472,184	478,719
Represented by:				
Fixed Assets				
Land	201,337	245,814	201,337	201,337
Buildings	597,035	574,996	595,469	605,970
Clinical, Other Equipment & Motor Vehicles	84,777	104,321	81,696	85,971
Work in Progress	15,663	10,634	22,165	8,288
Total Fixed Assets	898,813	935,764	900,667	901,566
Derivative Financial Instruments	6,204	2,823	6,204	6,954
Investments				
Associated Company Investments	386	366	386	386
Trust Deposits	8,000	5,500	8,000	8,000
Total Investments	8,386	5,866	8,386	8,386
Current Assets				
Cash & Short Term Deposits	50,773	53,428	60,785	61,937
Trust Deposits	12,931	15,264	12,414	11,780
Debtors	29,322	19,571	32,435	24,176
Accrued Income	20,345	10,271	24,635	36,920
Prepayments	2,825	2,604	2,711	2,320
Inventory	11,966	11,348	11,839	11,717
Total Current Assets	128,163	112,486	144,819	148,850
Current Liabilities				
Bank Overdraft	5,350	26	42,200	26,650
Borrowings	91,854	91,625	90,266	18,372
Trade & Other Creditors, Provisions	204,174	186,496	195,696	216,416
Income Received in Advance	24,490	24,473	25,319	17,509
Taxes Payable	20,793	18,070	12,818	17,210
Funds Held in Trust	1,060	1,076	1,060	1,038
Total Current Liabilities	347,721	321,766	367,360	297,196
Working Capital	(219,558)	(209,280)	(222,540)	(148,346)
Non Current Liabilities				
Borrowings	199,484	199,328	199,477	269,168
Employee Entitlements	21,111	25,818	21,056	20,673
Total Non Current Liabilities	220,595	225,146	220,533	289,841
NET ASSETS	473,250	510,027	472,184	478,719

Statement of Cashflows for the Year ended 30 June 2010

	Feb-10			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	140,582	139,564	1,018	1,145,645	1,129,671	15,974
Payments	(112,093)	(124,291)	12,198	(1,112,462)	(1,106,591)	(5,871)
Net Operating Cashflows	28,489	15,273	13,216	33,183	23,080	10,103
Investing						
Income	344	311	33	3,241	2,869	372
Capital						
Sale of Assets	0	2	(2)	-	16	(16)
Purchase Fixed Assets	(2,318)	(5,658)	3,340	(29,322)	(38,364)	9,042
Net Investing Cashflows	(1,974)	(5,345)	3,371	(26,081)	(35,479)	9,398
Financing						
Equity Injections	58	0	58	268	3,609	(3,341)
New Loans	0	0	0	0	0	0
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
Net Financing Cashflows	58	0	58	268	3,609	(3,341)
Total Net Cashflows	26,573	9,928	16,645	7,370	(8,790)	16,160
Opening Cash	16,084	16,569	(485)	35,287	35,287	0
Closing Cash	42,657	26,497	16,160	42,657	26,497	16,160

Financial Performance

The result for February was a surplus of \$1.0m a favourable variance to budget of \$0.5m. On a year to date basis there is a deficit of \$(5.8)m a favourable variance to budget of \$1.9m.

Year to date revenue is higher than budget by \$0.1m at \$1,119.1m.

- Higher revenue variance was driven by the release of IDF wash-up revenue over and above 0809 year end balances \$3.6m, higher MoH subcontract revenue \$2.6m predominantly for PHO performance management and other programmes such as HPV, higher CTA Income \$0.8m driven by additional volumes and payment of arrears and higher volumes of retail pharmacy sales \$1.4m.
- Interest Rate Swap Instruments are recording a gain of \$0.3m driven by a decrease in long term market interest rates, this being a favourable variance to budget of \$3.0m.
- These favourable variances have been offset by lower external laboratory sales volumes \$(1.0)m lower donation income associated with the timing of Starship funded projects \$(4.2)m, lower ACC and Non resident fee volumes \$(2.1)m and a provision against the non receipt of 0809 IDF receivables \$(3.8)m.

Year to date expenditure is lower than budget by \$1.8m at \$1,124.9m.

- Labour Costs are \$1.8m favourable to budget year to date mainly driven by
 - a) a favourable timing variance as a result of the budget phasing of the NZNO, RDA and PACT Meca's \$1.6m
 - b) Annual leave reduction over budget in Christmas New Year period \$5.6m
 - c) Medical & Technical staff vacancies \$7.0m
 - d) Savings in administrative staff 72 FTE \$4.0m
 - e) Superannuation contributions being below budget \$2.3m.
 - f) Redundancy Costs \$(0.8)m
 - g) Nursing 76 FTE over budget \$(2.3)m
 - h) Savings targets \$(15.2)m
- Direct Treatment costs are \$(5.4)m unfavourable to budget due to higher third party treatment costs \$(3.9)m, principally for Cardiac Services \$(3.0)m, driven by the waitlist reduction initiative, General Surgery \$(0.6)m, Orthopaedics \$(0.3)m and Child Health \$(0.9)m for other outsourcing. In addition Clinical Supplies costs were \$(5.0)m unfavourable to budget largely due to increased surgical volumes \$(2.2)m and savings targets to be delivered \$(2.8)m. These unfavourable variances are offset by lower blood usage in Cancer \$3.5m.
- Funder Payments are \$(2.1)m unfavourable to budget driven by higher PHO expenditure \$(3.6)m as a result of the payment of PHO performance management, with the partial offset referred to in the revenue above, higher Laboratory expenditure \$(1.9)m driven by budget phasing and the introduction of a further contract, higher Health Of Older people expenditure \$(2.1)m driven by increased cost of residential and hospital care and high Public Health expenditure \$(0.8)m. These unfavourable variances are offset by the timing of Mental Health expenditure \$1.0m, underspends in personal health \$2.3m and Medical/ Surgical \$3.0m.
- Property Costs were favourable to budget \$2.7m mainly driven by lower costs for computer maintenance \$0.6m and lower property and clinical equipment maintenance \$1.2m.

- There has been a partial release of the provision for asbestos removal credited to Building Compliance Costs \$0.4m.
- The Capital Charge is lower than budget \$2.6m driven by the Ministry washup for FY09 \$1.0m and downward revaluation of Land & Buildings at balance date. This downward revaluation credit will be ongoing for the balance of the year.
- Depreciation costs are below budget by \$1.7m as a result of the reassessment of IS Software lives and the depreciation adjustment for property revaluation.

Financial Position

- The opening balance of fixed assets was \$(29.6)m below budget principally due to the downward revaluation of land & buildings \$(35.7)m as at 30 June 2008.
- YTD Capital spending is \$29.3m, under budget by \$9.0 m. Baseline and Facilities projects are under budget by \$4.9m and Information Systems projects are behind budget by \$4.2m driven by the pace at which business cases are completed, approved and implemented.
- Cash on deposit stands at \$50.8m (excluding Trust deposits). There is an overdraft of \$(5.4)m at month end and an unused overdraft facility of \$59.6m.

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PAPERS

No Papers this Month

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GENERAL BUSINESS

APPENDICES

No Appendices this Month

MEETING DETAILS		
Time and Date	2:00pm, Wednesday 7 April 2010	
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton	
Members	Pat Snedden (Chair), Harry Burkhardt (Deputy Chair), Jo Agnew, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Brian Ferguson, Dr Ian Scott, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward	
Apologies		
In Attendance	Garry Smith, Dr Denis Jury, Dr David Sage, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ian Bell.	
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8	Chief Executive’s Report 8.1 Chief Executive’s Summary 8.2 Minister’s Six Health Priorities 2009/10 8.3 Alexandra Trust	033
9	Lift the Health of People in Auckland City 9.1 Committee Recommendations	065
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11	Live Within Our Means 11.1 Finance Committee Recommendations 11.2 Finance Report	081

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NEXT MEETING

Time and Date:	2:00pm, Wednesday 5 May 2010
Venue:	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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