



Auckland District Health Board

Board Meeting

Wednesday 2 February 2011

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*

MIHI WHAKATAU

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
Lester LEVY (Chair)	1. University of Auckland Business School	Professor of Leadership			28 October 2010
	2. New Zealand Leadership Institute	Chief Executive			
	3. Health Benefits Limited	Deputy Chair			
	4. Tonkin & Taylor	Independent Chairman			
Jo AGNEW	1. Senior Lecturer Nursing, Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		
Peter AITKEN	1. Pharmacist	Pharmacy Locum	Hourly Fee		10 December 2010
	2. Pharmacy Care Systems Ltd	Shareholder/Director, Consultant		Medical Centre development and pharmacy lease	
Judith BASSETT	1. Nil				9 December 2010

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 Starship Trauma Service 3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School 4. Associate, Epsom Anaesthetic Group 5. Member, ASMS 6. Shareholder, Ormiston Surgical 7. Surveyor Quality Healthcare NZ 				12 December 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	25 February 2011
	2. James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	3. Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	4. National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	5. Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
Lee MATHIAS	1. Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	13 December 2010
	2. Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	3. Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	4. Pictor Limited	Shareholder, Director Director	Fee No fee	Biotech start-up focussing on diagnostic products Estate of late husband	
	5. John Seabrook Holdings Limited	Governance Advisor	Fee	Provider of early childhood education services contracted to	

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
	6. AuPairlink Limited 7. NZ Midwifery Council	Council member	Fee	the MoE. Statutory Authority	
Robyn NORTHEY	Self employed Contractor Hope Foundation	Project management, service review, planning etc. Board member	Fee Nil	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
Gwen TEPANIA-PALMER	1.				
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

- 2 DECEMBER 2010

Auckland District Health Board Minutes



MEETING DETAILS											
Time and Date	2:00 pm, Wednesday, 2 December 2010										
Venue	Board Room, Level 5, Administration Suite, Auckland City Hospital, Grafton										
1	Karakia										
	The Chair declared the meeting open at 11:16am 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>Harry Burkhardt</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Ian Ward</td> </tr> </table> <p>In Attendance</p> <p>Judith Bassett – New Board Member Robyn Northey – New Board Member</p> <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 Ngairé Buchanan - General Manager Operations Taima Campbell – Executive Director of Nursing Hilda Fa’asalele – General Manager Pacific Health Paul Green – Manager Materials Management Aroha Haggie – Maori Health Gains Manager Dr Scott Macfarlane (for Dr Richard Aickin) Director Child Health Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Seuli Dr Juliet Walker.</p> <p><u>Moved Pat Snedden; seconded Ian Scott</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Pat Snedden (Chair)	Jo Agnew	Harry Burkhardt	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Ian Ward
Pat Snedden (Chair)	Jo Agnew										
Harry Burkhardt	Susan Buckland										
Dr Chris Chambers	Rob Cooper										
Dr Brian Fergus	Dr Ian Scott										
Rt Hon Bob Tizard	Ian Ward										
3	CONFLICTS OF INTEREST										
	There were no notifications of conflicts of interest for any item on the agenda.										

4	CONFIRMATION OF MINUTES 3 NOVEMBER 2010
	<p><u>Moved Ian Scott; seconded Susan Buckland</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 3 November 2010 with amendments, that Hilda Fa'asalele was in attendance and that Southern Cross did the same level of elective surgery as the public sector, be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 3 NOVEMBER 2010
	<p>Refugee and Migrant Advisory Group</p> <p>This was noted for the new Chair and would be advised in a handover briefing by the present Chair.</p> <p>National Health Board</p> <p>ADHB had made its own submissions to the National Health Board but the pricing decisions had been made and it was acknowledged that they would not impact in 2011 - 2012 but in the next financial year 2012 - 2013. The pricing exercise involved a lot of micro analysis but no one took a macro overview i.e., the cost of secondary services growth exceeded that of tertiary cost growth. Implementing the changes would bring ADHB's spend to \$3.2m rather than \$6m. The role definitions related to the degree of tertiarieness. It was suggested that the models will be changing and that there was no perfect model.</p>
7	CHAIRMAN'S REPORT
	<p>The Chair noted that the national terms of settlement which covered 66% of costs had taken negativity out of the system through cooperation and collaboration of the unions with the DHBs. This was built on honour and trust. He requested that the Board champion this process which aligns employees with the goals of the DHB. If there was union distrust that would not be good for DHBs. The northern region covered 40% of the country's labour and the Health Sector Relationship Agreement made Unions visible.</p>
8.1	Chief Executive's Summary
	<p>Radiation therapy 4 week target had been presented to the Hospital Advisory Committee and would be achieved. Elective surgery was being focused on to deliver but there would be a cost. With Better Sooner More Convenient and the HSG model there would be better reporting. The focus of Celebration Week had been on performance improvement, quality improvement and the role of the A+ Trust, Richard Frith and Gill Naden was acknowledged. The feedback on the week was to continue with it as an annual event but to be more professional. New graduates hire needed to be operationalised to get the focus on Maori and Pacific with HR policies now aligned.</p> <p>Garry Smith acknowledged the Chair and outgoing Board for their support and giving freedom to operate and encouragement to the Senior Leadership Team.</p> <p>To achieve elective surgery there would be change with the move to the Greenlane Surgical Unit and implementation of new practices and new ways of working.</p>
8.2	Minister's Six Health Priorities 2009/10
	<p>There was a focus on patient flows in ED which was showing an improvement and the target line forecast has been revised. ADHB was not seeing any admissions that they should not have and the turnaround on the floor had improved. Any impact of GAIHN would take a long time. With rest homes there was a nurse practitioner that helped them manage who was referred. Of the elderly admitted 80% needed to be in the hospital and the 20% still needed a high level of care. Aged Residential Care cost \$100m of which rest homes were \$35m and private hospitals \$60m. Children's acute patient flows were improving and there were a number of sigma activities being</p>

implemented. Elective surgery had been impacted by the strikes. Waiting times for radiation therapy were good and with assistance to smokers there needed to be further engagement with wards with good wards sharing their experiences with those performing less well. The Cardiac waiting list had decreased and there was a risk that there would not be enough patients in the system to meet the target as well as the minimum contract with the private sector to keep it viable. Diabetes Get Checked was not improving although it was noted that the denominator had changed. Cardiovascular risk assessment was on target and for immunisation there were a number of things being undertaken at practice level.

The funding envelope for the next year had been received and there was a 2.7% increase of \$26m with 1.72% for cost pressures and 1.5% for demography although the weighting for PBF was dropping with a younger healthier population. There was an 8% increase in electives and an increase in pharmaceutical expenditure which was all on drugs but no compensation for the increase in dispensing costs. This had been raised with Pharmac. Overall the budget would be very tight.

Moved Pat Snedden; seconded Chris Chambers

That the Chief Executive's summary and Minister's Six Health Priorities reports be noted.

Carried

9.1 Committee Recommendations

Community and Public Health Advisory Committee

Auckland Region DHB Boards Memorandum of Understanding Host and Partner DHBs Managing BSCM Primary Care Alliances and Cross Boundary PHOs.

Moved Brian Fergus; seconded Susan Buckland

That the ADHB Board:

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

Carried

Maori Health Advisory Committee

Maori Mental Health and Addiction Services

Moved Rob Cooper; seconded Harry Burkhardt

That the ADHB Board:

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

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

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

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

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

Carried

Pacific Health Advisory Committee

The Committee had met but did not have a quorum. They had gained an understanding of the

	<p>MOU change in contract management with PHOs and the Committee was keen to be involved at a governance level in the Tamaki Transformation Project.</p> <p>Disability Support Advisory Committee</p> <p>The Committee had received the accessibility audit which was a result of the “Step Up” report.</p> <p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the reports from the Advisory Committees be noted.</i></p> <p><u>Carried</u></p>
10.1	DAP Projects Report
	<p>Noted were the changes in primary care with Better, Sooner, More Convenient and the IT resilience project. At the orientation day on 9 December 2010 there would be an item on how ADHB did their reporting.</p>
11.1	Finance Committee Recommendations
	<p>Low-Mid Range Surgical Instruments</p> <p>The procurement project had been run by Canterbury.</p> <p><u>Moved Harry Burkhardt; seconded Bob Tizard</u></p> <p><i>That the ADHB Board approves ADHB contracting with BBraun Ltd and Downs Distributors Ltd for the provision of low/mid range (defined by cost and complexity) surgical instrumentation for 3 years from 1 December 2010 to 30 November 2013 with an estimated spend of \$1m per annum.</i></p> <p><u>Carried</u></p> <p>Orthotic Services</p> <p>This was a contract renewal.</p> <p><u>Moved Harry Burkhardt; seconded Ian Scott</u></p> <p><i>That the ADHB Board approves the right to renew the current contract (C1284266) with the Orthotic Centre (NZ) Ltd for a further year from 1 June 2011 to 31 May 2012 at an estimated annual value of \$750,000 p.a. with an option to extend the agreement for one last term of one (1) year if exercised before 31 May 2011.</i></p> <p><u>Carried</u></p> <p>National Ostomy/Contenance/Urology Supply</p> <p>This had been a national tender run by healthAlliance and ADHB had selected a number of suppliers. Existing patients could continue with their existing suppliers.</p> <p><u>Moved Harry Burkhardt; seconded Ian Scott</u></p> <p><i>That the ADHB Board approves the take up of mirror national contracts for the Ostomy, Contenance and Urology categories for the suppliers and services from the following suppliers and contracts for the supply and distribution of Ostomy, Contenance and Urology products be approved as specified:</i></p> <p><i>Bard Australia Pty Ltd (Urology products – Community services)</i></p> <p><i>Coloplast Pty Ltd (Ostomy / Urology products – Hospital and Community services)</i></p> <p><i>ConvaTec (Australia) Pty Ltd (Urology products – Community services)</i></p> <p><i>Liberty Medical NZ Ltd (Ostomy / Urology products – Hospital and Community services)</i></p> <p><i>Universal Specialties Ltd (USL) (Contenance products – Hospital and Community services) and (Distribution of Ostomy and Contenance Products to the community patients)</i></p> <p><i>The term of these agreements is three years from 1 November 2010 to 31 October 2013, one 2 (two) year's right of renewal is available and if executed the agreements would finish on the 31 October 2015.</i></p> <p><u>Carried</u></p>

Sutures and Endosurgical Instruments

This was an exercise of a right of renewal.

Moved Harry Burkhardt; seconded Brian Fergus

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

Carried

ARPHS Building 15 Refurbishment Dispensation to Tender

Moved Harry Burkhardt; seconded Ian Ward

That the ADHB Board approves the business case for the ARPHS Building 15 refurbishment and the dispensation from open tender to a limited tender limited to ADHB's preferred facility contractors.

Carried

The business case payback was 3 years.

Debt Write-offs

Moved Pat Snedden; seconded Jo Agnew

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

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

Carried

Capital 2010 - 2011

The Finance Committee had received an updated capital forecast and with delays in some expenditure there were opportunities for expenditure to be brought forward in other areas.

Moved Pat Snedden ;seconded Harry Burkhardt

That the ADHB ratifies the decision of the Finance Committee in approving the updated capital forecast and approved changes in areas of spend.

Carried

11.2 Finance Report

There had been a break even result for October and a year to date favourable variance of \$1.9m. Increased revenue and favourable payroll had been offset by unfavourable direct treatment costs.

Moved Pat Snedden; seconded Jo Agnew

That the Finance Report for October 2010 be noted.

Carried

15	PUBLIC EXCLUSION						
	<p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>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.</i></p> <p><i>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:</i></p> <table border="1" data-bbox="204 539 1358 974"> <thead> <tr> <th data-bbox="204 539 579 660"><i>General subject of each matter to be considered:</i></th> <th data-bbox="579 539 979 660"><i>Reason for passing this resolution in relation to each matter:</i></th> <th data-bbox="979 539 1358 660"><i>Ground(s) under clause 34 for the passing of this resolution:</i></th> </tr> </thead> <tbody> <tr> <td data-bbox="204 660 579 974"> 15.1 Auckland Regional Health Technologies Innovation Hub. 15.2 Greenlane Surgical Centre 15.3 Tamaki Transformation: Pathways to Health Careers </td> <td data-bbox="579 660 979 974"> <i>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)</i> </td> <td data-bbox="979 660 1358 974"> <i>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.</i> </td> </tr> </tbody> </table> <hr/> <p><u>Carried</u></p> <p>The items discussed in public exclusion were the Auckland Regional Health Technologies Innovation Hub, Greenlane Surgical Centre and Tamaki Transformation: Pathways to Health Careers.</p> <p><u>Moved Pat Snedden; seconded Bob Tizard</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>	<i>General subject of each matter to be considered:</i>	<i>Reason for passing this resolution in relation to each matter:</i>	<i>Ground(s) under clause 34 for the passing of this resolution:</i>	15.1 Auckland Regional Health Technologies Innovation Hub. 15.2 Greenlane Surgical Centre 15.3 Tamaki Transformation: Pathways to Health Careers	<i>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)</i>	<i>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.</i>
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	NEXT MEETING						
	<p>The meeting closed at 1:10 pm</p> <p>The next scheduled meeting is : 2:00pm, Wednesday 2 February 2011 A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton</p>						
	<p>CONFIRMED</p> <p>CHAIR: _____ DATE: _____</p>						

ACTION POINTS

- 2 DECEMBER 2010

Action Points from the meeting on Wednesday 3 November 2010

Item	Detail	Designated	Action
Nil			

PRESENTATIONS

Nil

CHAIRMAN'S REPORT

CHIEF EXECUTIVE'S REPORT

8.1 Chief Executive's Summary

Chief Executive Officer's Summary

	Traffic Light	Comment	Mitigation
Goal 1 Lift the Health of the People of Auckland			
Elective Surgery	Red	Compliance risk for ESPI Targets and contract volumes behind plan.	Work out plan for each service for ESPI compliance for contract volumes. Daily monitoring of actions put in place including outsourcing.
New Years Honours	Green	3 ADHB staff recognised for services <ul style="list-style-type: none"> • Officer - Naida Glavish (JP) • Member – Associate Professor Ed Gane • Officer – Associate Professor John Ormiston 	Recognition in next NOVA edition
Goal 2 Improve Performance			
Diabetes	Red	Service under extreme demand pressure.	Service Excellence process commenced with Performance Improvement Team to complete end to end process review.
Green Belt Training	Green	The 3 rd Class of 20 have commenced training.	Each trainee assigned improvement project.
HSG Leadership Appointments	Green	Good progress with Clinical Leader appointments.	Advance financial appointments. Orientation and move to implement strategy.
Greenlane Surgical Centre	Green	Ministerial Approval received.	Criteria listed expected and deliverable.
Goal 3 Live Within Our Means			
Variances in Hospital Services costs	Orange	Labour and Clinical Supplies variance YTD unacceptably high.	Detailed analysis of original budget assumptions, savings targets met etc. Clinical leaders to lift engagement for work out plan.
Acute Demand	Orange	Impact on budget of seasonal fluctuation and on elective services.	Service by Service review and recasting 2 nd 6 months.
Regional Shared Services	Green	Good progress in formation of Regional Shared Service.	Separate briefing to Board.
DHBNZ	Green	Consultation on new way forward.	Support for new direction.

8.2 Minister's Six Health Priorities 2009/10

Project: Adult Acute Patient Flow

37

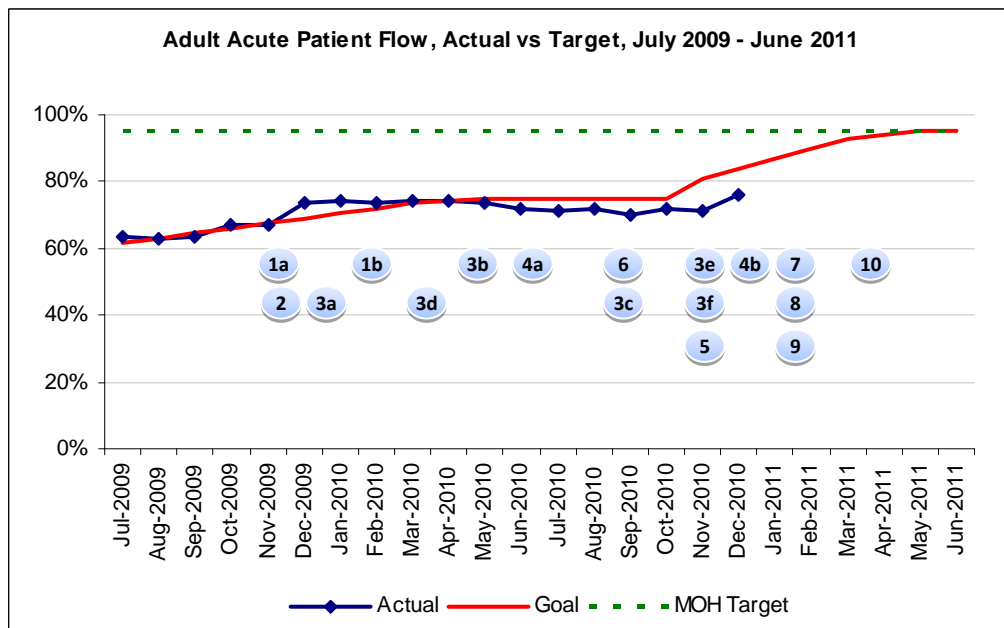
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



Project Risks / Comments:

Shorter Stays in ED health target performance for the 2nd quarter of the year for AED was 73% of patients stayed less than six hours in the ED compared to our goal of 95%. This represents a 2% increase on the previous quarter for AED.

December has been a demanding month for AED, as attendances were very high, 5.7% more than last month and 16% increase on this time last year. A significant increase in trauma is demonstrated through a 69% increase in Triage 1 patients and 12% increase of triage 2 as compared with Dec 2009.

Although the percentage of admissions has remained stable the increase in volume means that there has been a 5% rise in the number of patient requiring ward admissions. 50% of patients requiring ward beds were transferred out of ED within 2 hrs, this is an improvement of 37 minutes on this time last year.

Emergency Department resourcing plan to respond to increased volumes being implemented with the new SMO roster commenced in December – this should further improve the % of patients discharged directly from ED within 6 hours over the next few months.

Rapid Improvement Event to accelerate improvement and review current workstreams performance held with two initiatives identified for implementation to improve transfer of patients from ED to APU. ED service Excellence programme launched. Daily review of patients who stay longer than six hours in ED to be implemented in early 2011 to understand root causes and to inform further improvement activity to accelerate performance.

Recent and Current activities:

1. Additional beds opened in
 - a) November 2009
 - b) January 2010
2. Improved Measurement systems to better identify clinical short stay patients
3. Reducing ward occupancy
 - a) Expediting patient discharges from wards by the introduction of daily 'rapid rounds' into General Medicine wards
 - b) Introduce Rapid Rounds into Orthopaedics.
 - c) Introduce daily 'Whiteboard catch-up' meetings into General Surgery
 - d) Increase the number of weekend discharges in General medicine and Orthopaedics. 66 Nurse Facilitated discharges have been completed since the relaunch.
 - e) Improve the volume and accuracy of estimated discharge dates in Orthopaedics. Baseline performance identified that approximately 6% of patients have EDD within 8 hours of arrival on wards
 - f) Remove delays associated with Taikura Trust patients. Workshops have been held with both Taikura Trust team and ACH teams.
4. Bed management CMS system enhancements releases (4a & b)
5. Increased Operational management and daily exception reporting
 6. Improve triage processes in Emergency Department
 7. Reduced transfer times between AED and APU
 8. Reduced AED to Ward patient transfer times
 9. Improved time to acknowledge bed requests
 10. Improved scheduling of elective volumes

Project: Children's Acute Patient Flow

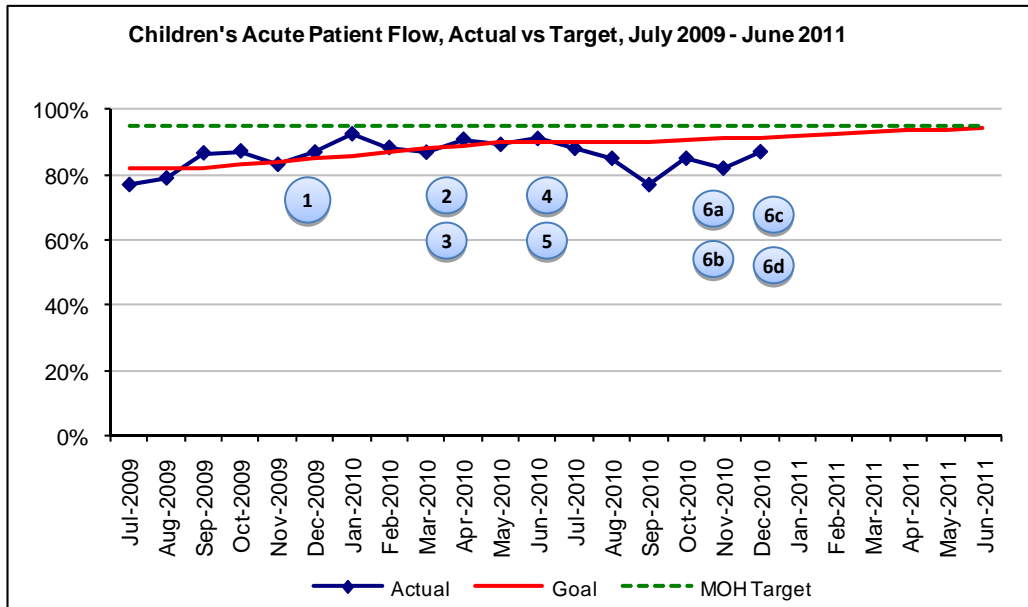
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Completed and current activities:

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

Project Risks / Comments:

The number one issue remains transferring children from Children's Emergency Department (CED) to inpatient wards. CED continues with good performance for those children discharged from the service (96%) but the result is pulled back by delays in inpatient transfers. The result improved during December as the intense pressure for inpatient beds reduced but December occupancy was still high (96%). There are a number of Process Improvement projects focussed on improving access to inpatient beds underway which will continue to deliver improvements over the next months.

Project: Improved access to elective surgery

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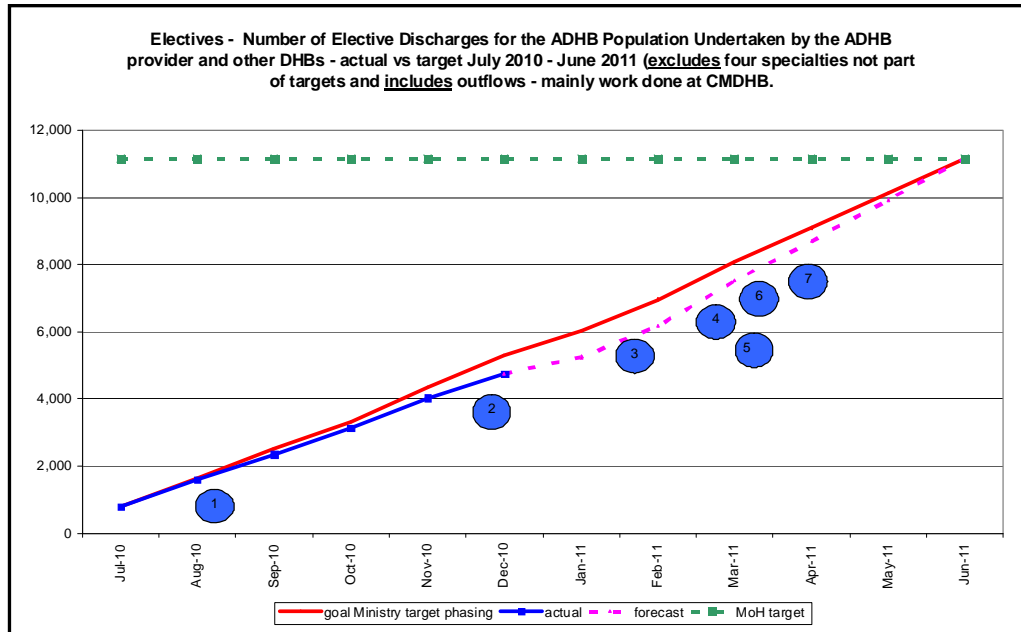
Primary Objective: Increase ADHB Elective Surgical Discharges from 10189 to 11149

Date of Delivery: 30 June 2011

Clinical Lead: Vanessa Beavis

Project Sponsor: Ngaire Buchanan

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



Planned Activities:-

1. Outsourcing Orthopaedics,
2. Production Lists - Orthopaedics
3. GSU Theatre 1
4. Outsourcing for General Surgery, ORL, Neurosurgery, Gynaecology and Paediatric Surgery
5. Longer days at GSU
6. Additional (temporary) ophthalmology lists at GSU
7. Longer days at ACH

Risks / Comments: (Amber)

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

Project: Better help for smokers to quit

40

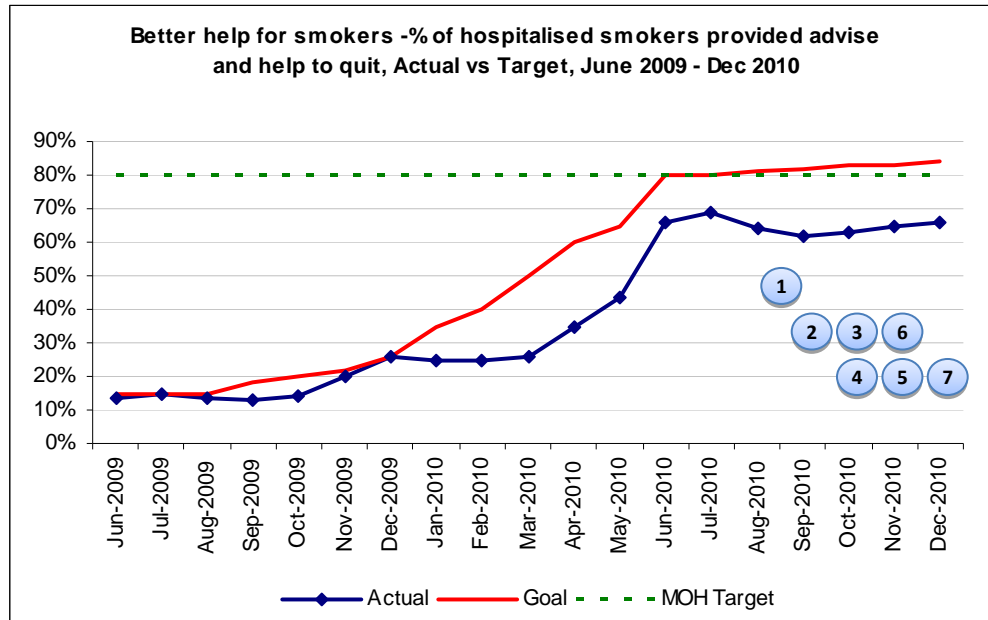
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

Clinical Lead: Stephen Childs

Project Sponsor: Taima Campbell

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



Project Risks and Comments

Based on the results of recent audits there a need to improve medical staff engagement in asking patients about their smoking and offering brief advice (doing the ABC). To this end the new intake of registrars were briefed on the ABC at their orientation in early December and given ABC and NRT lanyard cards and information sheets. An analysis of health target data by ward indicates that the services with a shorter length of stay e.g. under 6 hours are less likely to record brief advice. Emergency Medicine, General Surgery and General Medicine were identified as the areas with the highest patient volumes and therefore where the greatest gains could be made towards meeting the target. Consequently these services will be the focus for improvement. Work continues with the Adult Emergency Dept. and the Admission and Planning Unit to improve their results. Despite the continued pressure in AED for events coded in December there was a small increase in both the numbers of smokers identified from 204 in November to 224 in December and brief advice increased from 91 to 112 (44%-50%).

Recent and Current activities:

1. ABC Systems improvement, monitoring and feedback

- Follow up with wards as a result of the audits to improve ward performance.
- Feedback on service performance ongoing
- Audit of clinical coding completed results to be discussed with Clinical Coding team in January.
- Analysis of health target by service undertaken to determine focus of activities for 2011.

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 ABC and NRT planned for February
- NRT Standing Order currently being simplified

4. Promotion & Communication

- ABC promotion ongoing. Recognise top performing wards to continue in February

5. Research & Evaluation

- Research programme – Discussions held in December with the CTRU re development of a cessation research strategy for ADHB

6. Governance & Leadership

- Role and function of the ADHB Tobacco Control Steering group to be completed by February.

7. ABC sustainability plan

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

Project: Shorter waits for Radiation Therapy

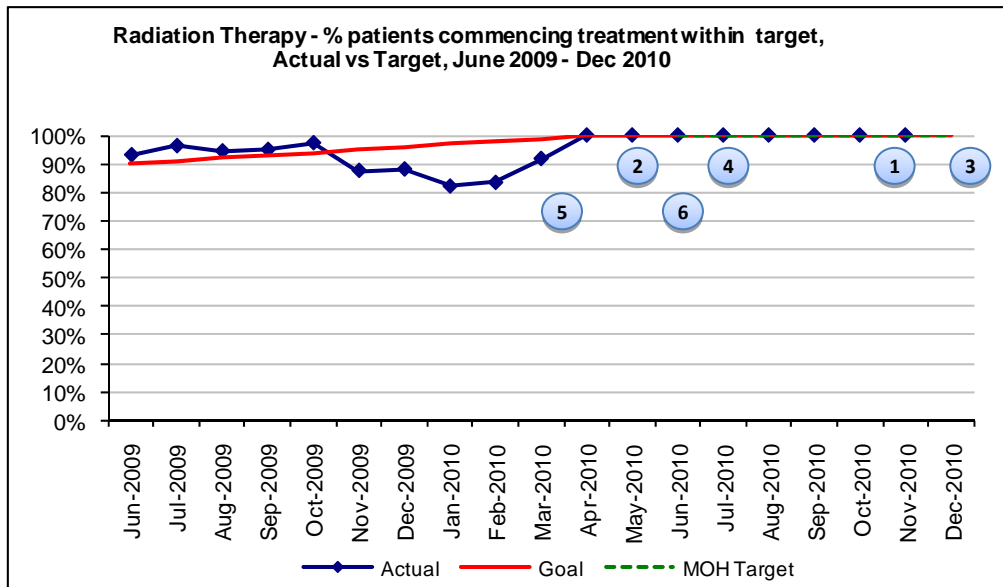
Primary Objective: That 100% of patients requiring radiation treatment will commence treatment within 6 weeks of their first specialist assessment by 1 July 2010, and within 4 weeks by 31 December 2010 (Excludes D priority patients and Delay codes)

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:

The service expects to be 100% compliant to the 4 week target by the end of December 2010.

A number of improvements were implemented during that time, including

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

Radiation Oncology Wait times – December 2010

In December the service achieved 100% delivery to the 6 week target for patients in priority categories A, B & C without a delay code and 100% to the 4 week target. There has been a significant improvement in C-Radical wait times over the last three months October 4.2 wks, Nov 4.1 wks and Dec 3.2 weeks.

Strategies to reduce wait times:

1. **MV5 Linear Accelerator is now fully operational.**
Extended hours: Extended hours have been implemented for RT staff where this is an option within the terms of their contract.
2. **Outsourcing:** A short term agreement has been agreed with ARO for provision of public capacity. A short term / interim contract to outsource 3 pts per week (up to a maximum of 5 per week) is agreed to April 2011. A feasibility study is in progress to determine a long term public/private arrangement.
3. **Aria project:** A project is underway to develop a full electronic record within ARIA. This will increase treatment processes and better match demand to capacity.
4. **A prototype weekly capacity modelling tool** is now being used for future Linac capacity planning, improved forecasting capability and management of workload.
5. Weekly “operational” / prioritisation meetings and review of the wait list.
6. Daily Waitlist reporting and remedial action plan.

Project: Cardiac Bypass Surgery

42

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

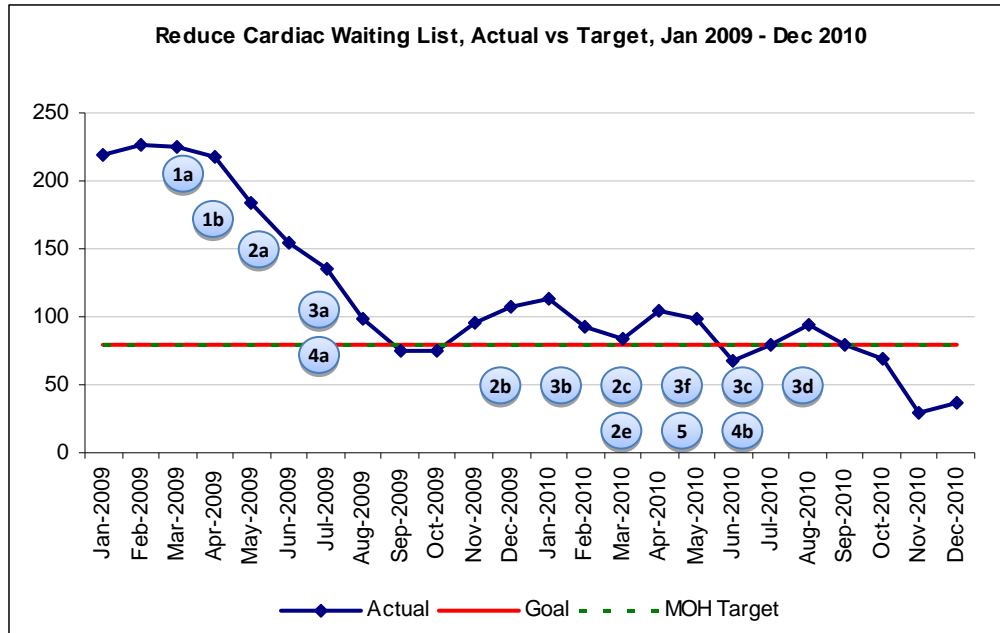
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

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:

There are 45 patients on the waiting list as at the end of December 2010. YTD throughput is 10 patients less than planned as at end December. The shortfall in YTD production relates directly to the impact of the H1N1 ECMO patients and industrial action. It is unlikely that we will return to the YTD production target until February as patients were understandably reluctant to proceed with cardiac surgery over the Christmas/New Year period.

Project: Diabetes

43

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

Date of Delivery: 55% June 2011

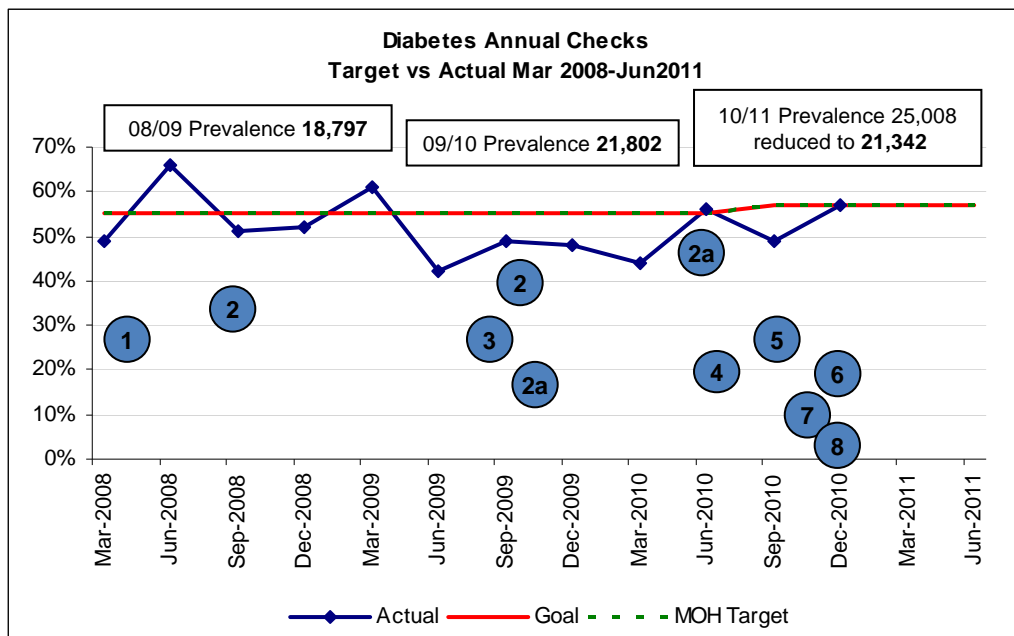
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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

Recent and Current activities:

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



Project Risks / Comments:

Q2 shows we are now meeting target for DGC, however this is primarily due to the MOH decreasing the denominator for the expected number of people with diabetes. The number of Diabetes Annual Reviews for the Pacific and Indian populations are performing over 20% above target, with reviews for Maori now also above target under the revised prevalence. However, the performance for the Other group continues to underperform against target (42% against a target of 58%). In order to improve performance, the DHB is working with primary care to implement a comprehensive range of activities to improve DGC numbers and initiate an overall quality improvement framework. One initiative is a contract with the PHO's (through Auckland PHO) to employ long term condition quality improvement coordinators to work with all our priority practices to improve get checked performance. The first two coordinators start in February 2011. Another initiative is the funding of a Population audit tool for each practice to enable them to better interrogate their practice management system to identify and manage their population with long term conditions. This contract will be signed shortly. [Please note that the activity from Tongan Health Society has been estimated due to their data not being received in time for this report].

Project: Diabetes

44

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

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

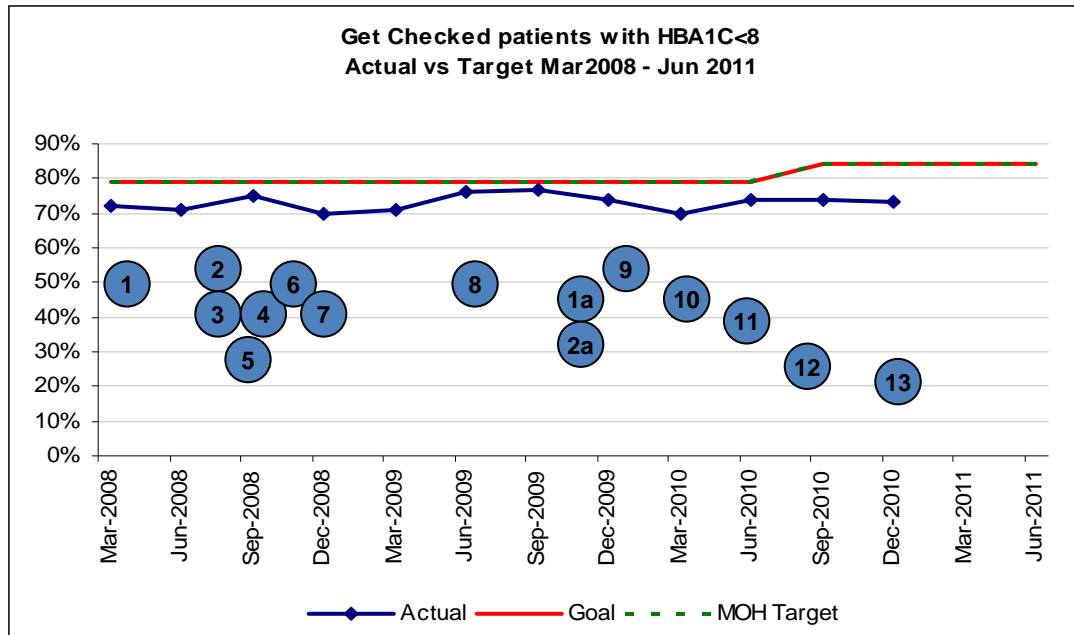
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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

Recent and Current activities:

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



Project Risks / Comments:

Q2 of 2010/11 performance continues in the same trend as the previous quarter, and we have only achieved 73% against a target of 84% of people having an HbA1C $<$ 8. The main areas of underperformance are in our diabetic management of Maori and Pacific populations. As noted in the DGC report, the activities currently being put in place to improve the DGC targets should impact on management in the long term. Additionally a new contract is being signed with Te Hononga O Tamaki Me Hoturoa to provide Diabetes Self Management Education for the ADHB region. With their focus on providing to our high needs populations, we look to see improvement in the self management capacity of our high needs populations with diabetes.

Project: Cardiovascular Risk Assessment

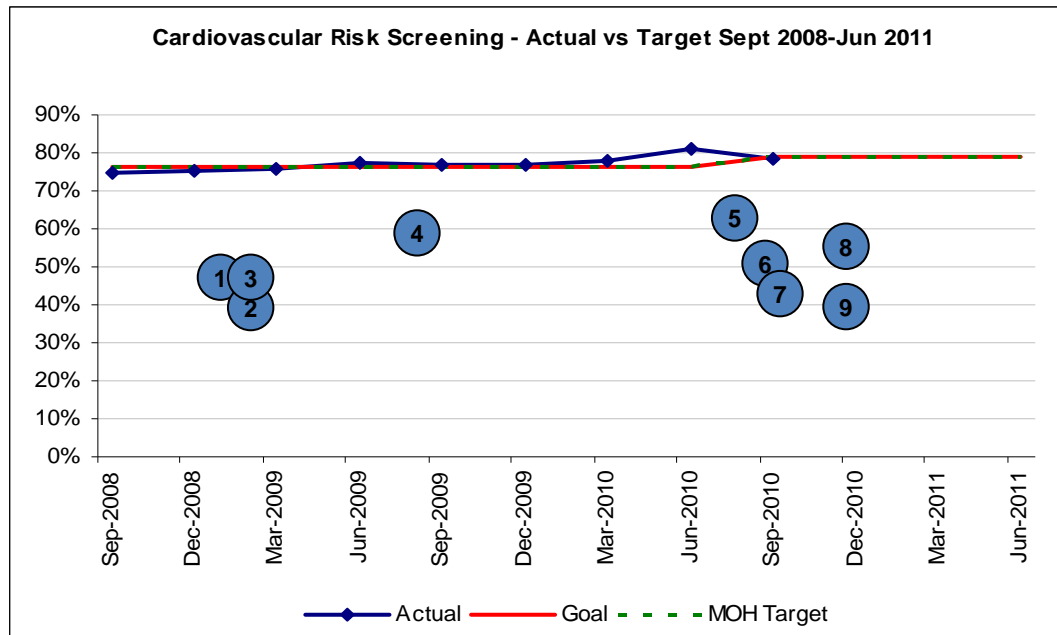
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

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

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



Project Risks / Comments:

Q2 CVD data is not available from the MOH until February 2011. However the previous quarter showed that we are very close to reaching our overall target (78.5% against a target of 79%).

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract.

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

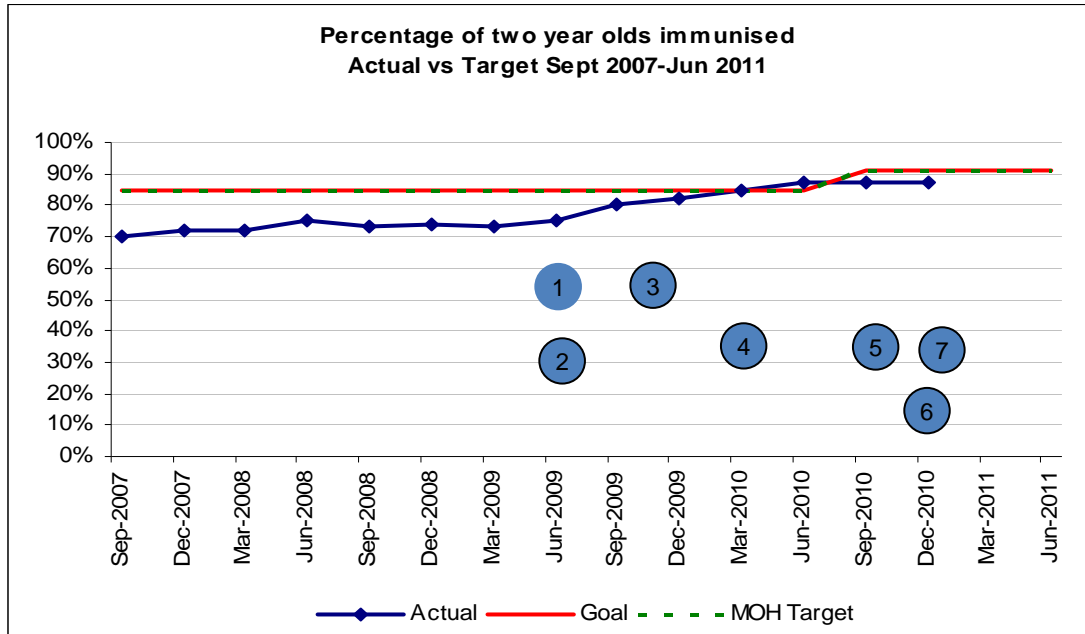
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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, Aroha Haggie, Hilda Faasalele, Ruth Bijl, Alison Leversha, 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 project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.

Project Risks / Comments:

Coverage for Quarter 2, 2010/11 (2 years olds full immunised all ethnicities) remains at 87%. The data quality and practice nurse education project targeting systems issues has just began and is expected to result in increased coverage. Maori coverage at all milestone ages remains a challenge as does timeliness, in particular at 6 and 18 months. Opportunities to further engage high needs families through initiatives in MSD, MoE, Corrections and other agencies may help facilitate access for those highest needs children and their families/whanau.

8.3 Quarter One 2010/11 Performance – MOH Report



RECEIVED
22 DEC 2010
CEO'S OFFICE

17 December 2010

Mr Garry Smith
Chief Executive Officer
Auckland District Health Board
Chief Executives Office
PO Box 92 189
Greenlane
AUCKLAND 1142

Dear Garry

QUARTER ONE 2010/11 PERFORMANCE

We have developed an 'at a glance' dashboard to assess DHB performance against the performance expectations in this years' District Annual Plan (DAP). This approach aims to provide the Minister of Health, the National Health Board and DHBs with a more balanced, and integrated view of DHB performance, covering both non-financial and financial aspects of performance.

Attached is your Performance Overview (based on your quarterly reports to the Ministry). As you can see, the Performance Overview contains;

- a Health Targets overview
- high-level results for each Performance Measure by Dimension
- other key performance information: Monitoring Intervention Framework (MIF) status and Financial Performance summary
- performance issues: brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue
- performance highlights: brief analysis of areas where a DHB is performing above expectations, either from achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading a innovation process that will lead to performance improvement.

This is the format that is being used to report DHB performance to the Minister, and we hope it will be helpful for DHBs to see the summary view of their performance.

The dashboard shows that Auckland DHB has a performance highlight for Shorter waits for cancer treatment and Better help for smokers to quit. Auckland DHB is generally performing ahead of plan. There are issues in relation to your electives target performance.

If you would like to see further information around your DHB's performance for quarter one 2010/11, please refer to the DHB Quarterly Reporting Website.



As we have discussed, the Performance Measures shown in this report are the measures agreed for the 2010/11 DAPs. We are working to improve the measures for 2011/12 to ensure the best available measures are used.

At a recent Joint Oversight Group, we agreed, in future, to send you your DHB's dashboard at the same time the Performance report is sent to the Minister, so you have the information at hand if he should contact you to discuss.

If you have any queries relating to this, please give me a call.

Yours sincerely



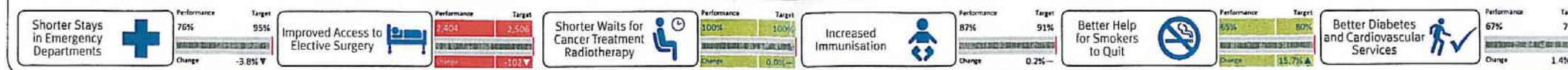
Michael Hundleby
Director, Performance, Accountability, Monitoring & Funding
National Health Board

cc Auckland DHB Funding and Planning Manager



Auckland DHB Quarter One 2010/11 Performance Overview

Health Targets



Performance Measures

Policy Priorities			System Integration			Ownership		
Actual	Target	Change	Actual	Target	Change	Actual	Target	Change
Clinical Leadership			Electives			Productivity		
PP1 Clinical Leadership self-assessment			SI4 Elective services standardised intervention rates			OS3 Elective and arranged inpatient length of stay	4.19	<4.15
Primary Care			System Effectiveness			Quality		
PP2 Implementation of Better, Sooner, More Convenient primary care	Achieved	NA	SI1 Ambulatory sensitive (avoidable) hospital admissions			OS8 Acute readmissions to hospital	11.97%	<10.40%
Oncology			Child & Youth			Planning and Production		
PP5 Waiting times for chemotherapy treatment	100%	100%	SI7 Improving breast-feeding rates			OS10 Improving the quality of data provided to National Collection Systems		
Mental Health			Māori Initiatives			Resource Management		
PP6 Improving the health status of people with severe mental illness			SI5 Agreed Funding for Māori Health and disability initiatives			OS1 Staff turnover	Achieved	NA

Other Key Performance Information

Monitoring & Intervention Framework
Ministry MIF Status: Standard Monitoring

Financial Performance
Status: On Track

YTD net result ending October 2010					2010/11 Net Result			
Fund	Government	Provider	Total	YTD Plan	YTD Variance	Forecast as at 30 Sep	Full Year as Per 2010/11 DAP	Forecast variance
(2,530)	(405)	2,963	27	(1,849)	1,876	58	58	0

Capital Expenditure to Plan YTD net result ending September 2010

Actual	Planned	Variance
13,526	19,382	(5,856)

Performance Highlights

- Shorter waits for cancer treatment: The regional cancer centre at Auckland DHB achieved the target with 100 percent of patients treated within six weeks during a quarter of reduced linear accelerator capacity. Further, during the month of September the cancer centre also met the four week target.
- Better help for smokers to quit: The DHB has made significant progress towards the target this quarter.

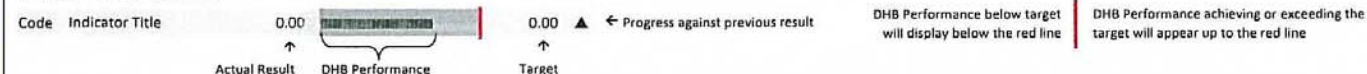
Performance Issues

- Improved access to elective surgery: The DHB is at 96 percent—102 discharges behind plan. Delivery is expected to improve in quarter two, and be back on track in quarter three. Increased capacity will come on line at the Greenlane Surgical Centre, and extended operating hours are planned at Auckland City Hospital. Outsourcing will be extended if required.

What the colour's mean

Grey Text = Not monitored in Quarter
Blue Text = Monitored in Quarter
Red Box = Performance Issue
Green Box = Performance Highlight

How to read the Graphs



8.4 Better Sooner More Convenient



BRIEFING PAPER TO THE BOARD

Date: 2 February 2011

To: **Auckland District Health Board – Board Meeting**

From: Denis Jury, Chief Planning & Funding Officer
Phone: 630 9943 ext 8071

Subject: Better Sooner More Convenient (BSMC)

1.0 Information

As an Organisational Priority BSMC will be a regular Report.

Implementation of Government's BSMC Primary Care Strategy:

Regional Progress to Date:

The Metro Auckland DHBs collectively continue to make significant progress with implementation of the regional components of Government's Better Sooner More Convenient Primary Health Care (BSMC).

- **Contracting Framework**

The three Auckland DHBs have developed a collaborative agreement establishing a host / partner DHB arrangement to simplify the contracting process for cross boundary PHOs.

- **Business Cases**

Active involvement continues to support the three Business Cases in development and rollout of their respective Implementation Plans.

- **Progress with PHO Consolidation**

The amalgamation of the three ProCare Network PHOs into a single entity is on track to be completed by 1 January 2011. ADHB as Host DHB for this amalgamation is heavily involved in the variety of systems and processes.

ADHB Specific Progress to Date:

In addition to active involvement in the above regional work programmes ADHB PHO & Primary Care team work plan progress includes:

Progress with the ADHB Primary Care Plan

Following on from the successful development of the B4 School Checks ADHB District PHO/DHB Alliance discussions are underway with the 4 ADHB PHOs toward developing a District Alliance. It is anticipated that this alliance will operationalise primary care initiatives for ADHB. The District Alliance using the ADHB approved Locality Plan (approved 15 September 2010) which aligns to the wards of Auckland Super City will be the ADHB vehicle for achieving:

- Consolidation and operationalisation of the three Business Cases
- Devolution of services
- Functional and functioning IFHC / Whanau Ora Centres.

Improve Primary – Secondary System Efficiency: The 8 DAP Projects

1. Access to Diagnostics – Radiology Project:

ADHB is the Lead DHB for this Project which is progressing well in terms of both the establishment of the systems and processes required to support the referrals, and with strong clinical leadership and support. 100 ADHB Practices were trained and had full ProExtra functionality by the end of 2010 and four of six Community Radiology Providers are now fully operational with the project.

The DAP target of 4,000 procedures will not be met, but importantly the systems to achieve this will be in place well before financial year end. The focus now is to ensure that we are able to produce an annualised target of 4,000 by year end.

Unfortunately a number of the DAP targets were prepared in haste and under pressure and a more realistic view of these have evolved with significantly increased clinical involvement and project implementation.

CMDHB & WDHB 'requirements exercise' is currently progressing.

2. Minor Surgery – Skin Lesions

Provider selection across the region has now been completed. Contracts for the three ADHB providers are being put in place and there is confidence that the target will be met.

3. Clinical Pathways

This project is progressing well and will achieve its target of five new pathways by year end.

4. Acute Demand / POAC

The DAP target of 5,000 additional POAC referrals for the year ending 30.06.11 will be met; currently total volumes are tracking above target.

5. After Hours Project

Overall the project is on track with good progress being made with the required financial modeling, population profiling, locality identification and costs establishment. Issues regarding the mechanism for the procurement of providers are currently being addressed.

Currently ADHB is considering the use of its ED for the provision of 2400-0800 Hrs provision.

6. Pharmaceuticals – Optimising Prescribing Project

ProCare has been managing this project and have been hindered by both the recruitment of the appropriate staff and accessing data in sufficient detail. Staff and processes are now in place, and while it is unlikely that the savings target of \$1.5m will be met but the set up costs of \$600k will be covered.

7. Maori Service Devolvement

WDHB and CMDHB are devolving Maori health services currently provided by the DHB are on track for completion by financial year end.

8.) Greenlane Surgical Unit

BRIEFING PAPER***ADHB***

Date: 2 February 2011

To: ADHB Board

From: Peter Lowry

Subject: Greenlane Surgical Centre (GSC) Project Update

Purpose

To advise the Board of the receipt of the Ministers approval for the GSC project per the attached letter. The conditions of the approval are per ADHB plan.

Recommendations

That the Board;

1. **Note** receipt of the Ministers approval for the GSC project.
2. **Note** that GSC project will be the subject of a Board update in March.



Office of Hon Tony Ryall

Minister of Health
Minister of State Services

18 JAN 2011

Dr Lester Levy
Chair
Auckland District Health Board
PO Box 92 189
Greenlane
AUCKLAND

Dear Dr Levy

Approval of Auckland District Health Board – Greenlane Surgical Centre Project

Ministers have considered the Auckland District Health Board's (ADHB) request for the final approval of the Greenlane Surgical Centre Project, and I am pleased to advise that the request is approved. I note that the total project cost for the Greenlane Surgical Centre Project, including the new Ophthalmology Clinic, is now to be no more than \$27.0M (GST excluded).

Your DHB have proposed to use more of its own cash reserves to fund this project rather than call on additional Crown capital funding. I appreciate your understanding of the capital pressures the Crown has.

Your DHB has proposed to de-scope the fourth additional elective theatre from this project. As you are aware increased delivery of elective volumes, through the construction of additional Dedicated Elective Theatres, is a Government priority and your DHB has agreed to lift its provision of elective services to the equivalent of Counties Manukau DHB intervention levels. I will take personal interest in how your DHB performs to this target and its justification for deferring the fourth theatre. When your DHB is prepared to further develop the Greenlane Surgical Centre it will be subject to the new capital approval process.

Approvals for all capital projects are subject to conditions. The conditions of approval for the business case are that:

- the project budget for the construction of the Greenlane Surgical Centre is not to exceed \$27.0M excluding GST
- the no new Crown funding of the project is to be provided
- \$21.0M of existing Crown Health Financing Agency debt financing facility can now be drawn
- the ADHB is to provide \$6.0M from its own cash resources for this project

- the quarterly project assurance report for this project is required from receipt of this letter
- the quarterly project assurance letter will report on the following:
 - a) progress against the project milestones
 - b) confirmation of project costs against the approved budget
 - c) progress on the implementation of the model of care, productive operating theatre and service excellence programmes
 - d) the delivered volumes of elective services against the agreed production schedules.

Congratulations on securing approval. Please pass on my thanks to your team for their excellent work on this proposal.

Yours sincerely



Hon Tony Ryall
MINISTER OF HEALTH

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 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	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 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 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
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: <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	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	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+) 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 1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures 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 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
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: 100

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Define	Measure	Analyse	Do/Check/Improve	Act/Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
1 Lift the Health of the people in Auckland City	34	34	10	7	3	11	2	0	31	2	0	33	0	0	32	1	0	1	1	0	0
2 Performance improvement	55	53	10	6	8	24	3	0	38	15	0	48	4	1	48	5	0	2	2	0	0
3 Live within our means	11	10	2	1	4	1	1	0	8	2	0	10	0	0	10	0	0	1	1	0	0
Total #	100	97	22	14	15	36	6	0	77	19	0	91	4	1	90	6	0	4	4	0	0
Total %	100%	97%	22%	14%	15%	36%	6%	0%	77%	19%	0%	91%	4%	1%	90%	6%	0%	4%	4%	0%	0%

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

Review

Good progress on a wide range of projects contributing to this goal. Our attention is on increasing the number of retinal screens and a mobile community screening service is being provided on an interim basis while software issues are resolved for the new community service.

Goal: 2 Performance improvement

Review

Overall progress has been satisfactory although a number of the DAP projects relating to the primary care business cases have been slower than expected to start. Over the past month considerable activity has continued supporting the PHOs with various mergers, the establishment of new contracts and development of the mechanisms to support the DHBs working together to support the new primary care environment. Resilience programme of work progressing well. Focus now shifting to Phase 4 to progress further virtualisation and network improvements. Work has also started on planning for resilience of voice services (upgrade PABX, microwave link, etc.) - expected to start investments in July 2011. Regional projects such as eReferrals phase 1, Regional Clinical Documents and Pharmacy Dispensing are progressing in line with the revised timelines and are all expected to be completed before end of the financial year. Progress is also being made in our corporate records management area with acceptance of proposed approach and the completion of the EOI for enterprise content management tools. The Releasing Time to Care, Service Excellence and Concord programmes are continuing to make good progress.

Goal: 3 Live within our means

Review

December net financial result favourable to budget, increasing the ytd favourable variance. Provider Arm remains unfavourable variance to budget and elective volumes performed by the Provider Arm are below planned levels although Ministry phasing has been altered to later in the year. However, this will add additional cost pressures to the second half of the year, as will any future spending of the ytd mental health surplus.

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:** Relocation of Contact Centre and Referrals

Recommendation

That the ADHB approves the capex of \$586,614 to fit-out vacant space in Building 11 on the Greenlane site for the Contact Centre and Referrals Service to enable these services to vacate Building 10 at Greenlane in accordance with the Exit Plan for that building approved by the Board in December 2007; and

that the tender from Teak Construction Ltd to undertake the fit-out works in Building 11 be accepted and the CEO be delegated authority to execute the contract once finalised.

Background

This will be discussed by the Finance Committee at their meeting on ADHB Board

1 February 2011.

ADHB Board**Author: Ian Bell (8077)****Subject: CT Scanner, Ultrasounds and Mobile Image Intensifier**

Recommendation

That the ADHB endorses and approves the procurement process for the purchase of the CT Scanner for Auckland at \$1,247,230; the 7 Ultrasound machines for Cardiology and Radiology at \$812,786 and the Mobile Intensifier for Auckland at \$141,717 and associated building work.

Background

This will be discussed by the Finance Committee at their meeting on 1 February 2011.

ADHB Board**Author:** Ian Bell (8077)**Subject:** Orthopaedic Trauma Implants and Instrumentation

Recommendation

That the ADHB approves and recommends to the Board the approval of Supply Agreements between Counties Manukau DHB, Waitemata DHB and Auckland DHB and a panel of suppliers. Biomet Ltd. Johnson & Johnson, LMT, Medartis, Medtronic, Smith & Nephew, Stryker, Zimmer, Synthes. With the contracts being for 3 years plus 2 year right of renewal with fixed pricing.

Background

This will be discussed by the Finance Committee at their meeting on 1 February 2011.

ADHB Board**Author: Ian Bell (8077)****Subject: Retinal Screening**

Recommendation

That the ADHB approves the ADHB Optimize Retinal Screening Project of \$529,032 noting the regional processes and waiting list priority but subject to the Regional Capital Committee approval and that of the MoH.

Background

This will be discussed by the Finance Committee at their meeting on 1 February 2011.

ADHB Board**Author: Ian Bell (8077)****Subject: Mental Health Child and Family Unit Upgrade**

Recommendation

That the Finance Committee recommends that the ADHB approves the release of \$75,000 seed money to develop a final business case to upgrade the Mental Health Child and Family Unit and approves in principle total capital expenditure of approximately \$1,500,000 subject to that business case.

Background

This will be discussed by the Finance Committee at their meeting on 1 February 2011.

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11.2 Finance Report

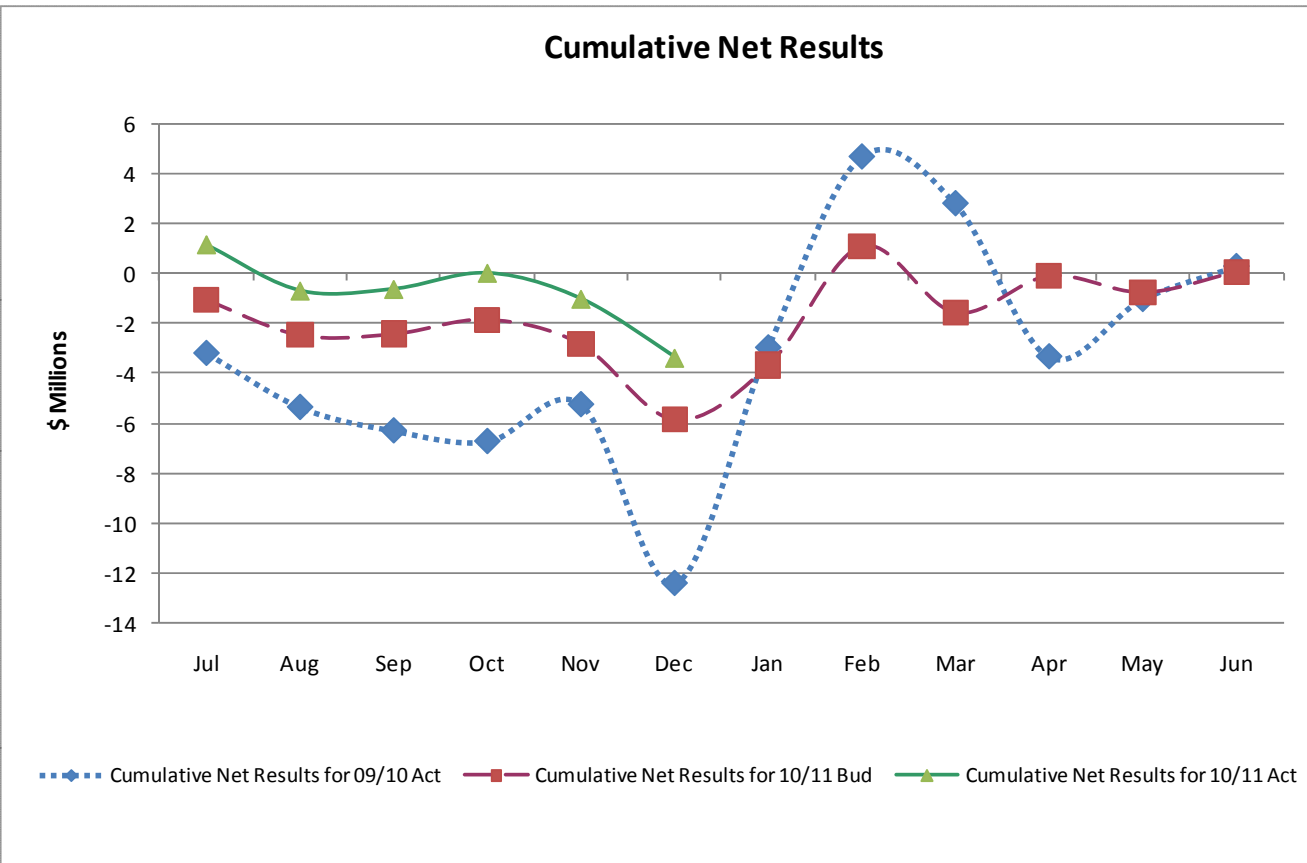
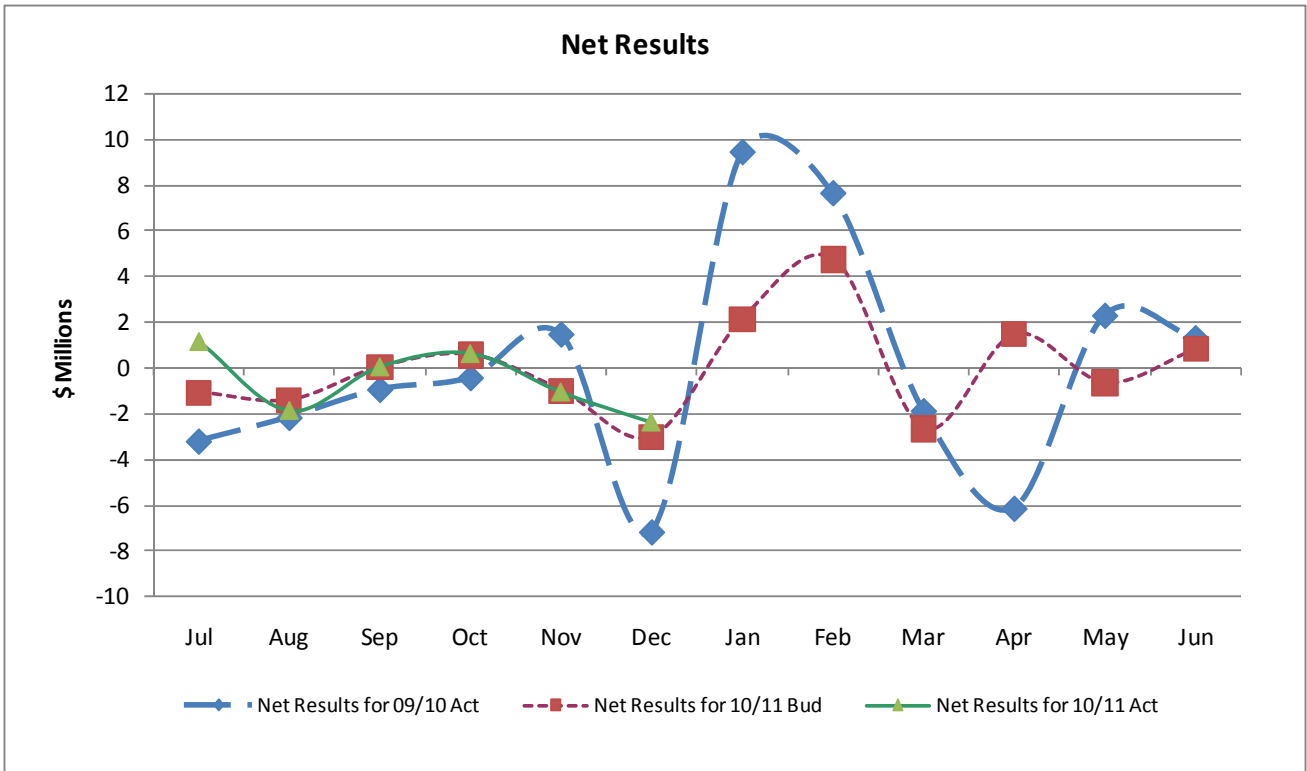
Auckland District Health Board

Board Financial Report

Prepared by Grant Barnett

December 2010

Performance Graphs by Month & YTD



Auckland District Health Board
Summary Result
Month of Dec-10

\$000s	Month	Month	Month	YTD	YTD	YTD
	A	B	Var	A	B	Var
Income						
PBF - AKL Population	80,114	79,701	413 F	480,838	478,207	2,630 F
Inter District Inflows	52,257	47,891	4,366 F	293,413	287,344	6,070 F
	132,371	127,592	4,779 F	774,251	765,551	8,700 F
MOH Sub-contracts	7,681	7,488	194 F	43,122	44,752	1,630 U
Other Patient Care	2,920	2,721	199 F	18,190	16,259	1,931 F
Services & Products	4,332	4,556	224 U	27,456	26,845	611 F
CTA	1,907	1,778	130 F	9,769	10,026	257 U
Trust & Donation Income	294	428	134 U	3,678	2,606	1,072 F
Financial Income	116	219	103 U	4,373	2,313	2,061 F
Other Income	1,225	599	626 F	5,114	3,194	1,920 F
	150,847	145,380	5,467 F	885,955	871,545	14,409 F
Expenditure						
Employee Costs						
Medical	21,931	20,906	1,025 U	120,369	119,201	1,168 U
Nursing	20,391	20,150	241 U	117,347	117,380	33 F
Technical	11,192	11,129	64 U	62,671	63,310	639 F
Hotel Services	4,476	4,427	49 U	25,594	25,223	371 U
Administration	4,411	4,289	122 U	24,914	24,633	280 U
Other	4,239	3,507	732 U	21,016	21,333	317 F
Total Employee Costs	66,641	64,408	2,233 U	371,910	371,080	830 U
Direct Treatment Costs	20,118	17,733	2,385 U	117,312	106,302	11,010 U
Indirect Treatment Costs	3,329	3,280	48 U	21,928	19,632	2,296 U
Funder Payments	39,736	39,450	286 U	238,016	236,674	1,342 U
Inter District Outflows	8,400	8,372	27 U	49,310	50,234	924 F
Prop, Equip. & Transport	4,098	4,157	59 F	24,975	25,379	404 F
Maintenance	143	133	9 U	809	800	9 U
Building Compliance	0	0	0 F	0	0	0 F
Loss on Sale of Fixed Assets	(0)	1	2 F	339	8	331 U
Administration Costs	2,049	1,605	444 U	11,808	11,856	47 F
Total Operating Expenditure	144,511	139,140	5,373 U	836,410	821,966	14,444 U
Operating Contribution	6,336	6,240	94 F	49,545	49,580	35 U
Depreciation	4,343	4,539	196 F	26,380	27,156	776 F
Finance Costs	1,504	1,687	183 F	9,319	10,091	772 F
Capital Charge	2,851	3,015	164 F	17,223	18,164	941 F
Total Non Operating Costs	8,699	9,241	542 F	52,922	55,410	2,488 F
Net Surplus / (Deficit)	(2,363)	(3,001)	637 F	(3,377)	(5,831)	2,454 F

Auckland District Health Board				
Statement of Financial Position				
As at Dec 2010				
	Dec-10	Dec-10	Nov-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)	88	2,029	-	3,320
Closing Balance	569,497	571,333	569,409	569,409
Revaluation reserve				
Opening Balance	353,538	381,278	353,538	381,278
Revaluation Adjustments	(0)	-	(0)	(27,740)
Closing Balance	353,537	381,278	353,537	353,538
Retained Earnings				
Opening Balance	(468,367)	(468,437)	(468,367)	(468,645)
Surplus/(Deficit) Current Year	(3,376)	(5,832)	(1,013)	279
Closing Balance	(471,743)	(474,269)	(469,380)	(468,367)
Total Crown Equity	451,292	478,342	453,567	454,578
Represented by:				
Fixed Assets				
Land	181,497	201,337	181,497	181,497
Buildings	575,848	586,862	577,597	586,094
Clinical, Other Equipment & Motor Vehicles	77,680	113,971	80,273	79,856
Work in Progress	34,968	26,393	31,700	23,166
Total Fixed Assets	869,992	928,563	871,067	870,612
Derivative Financial Instruments	5,321	4,399	5,321	7,061
Investments				
Associated Company Investments	95	386	95	470
Trust Deposits	6,026	8,000	4,578	10,078
Total Investments	6,121	8,386	4,672	10,547
Current Assets				
Cash & Short Term Deposits	181,936	136,063	75,724	56,815
Trust Deposits	16,219	11,508	17,122	11,747
Debtors	23,795	24,435	18,153	25,691
Accrued Income	25,594	26,591	23,517	31,221
Prepayments	3,289	2,320	3,409	2,245
Inventory	12,162	12,106	11,726	11,220
Total Current Assets	262,995	213,023	149,652	138,938
Current Liabilities				
Borrowings	23,292	25,689	22,707	75,027
Trade & Other Creditors, Provisions	242,028	228,903	224,032	222,910
Income Received in Advance	108,823	98,461	24,712	20,087
Taxes Payable	32,182	29,246	18,933	18,040
Funds Held in Trust	1,084	1,090	1,080	1,067
Total Current Liabilities	407,409	383,388	291,463	337,132
Working Capital	(144,414)	(170,365)	(141,812)	(198,193)
Non Current Liabilities				
Borrowings	263,062	271,762	263,054	213,014
Employee Entitlements	22,667	20,880	22,628	22,435
Total Non Current Liabilities	285,728	292,641	285,682	235,449
NET ASSETS	451,292	478,342	453,567	454,578

Statement of Cashflows for the Year ended 30 June 2011						
	Dec-10			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	227,124	222,951	4,173	977,889	959,669	18,220
Payments	(117,794)	(120,640)	2,846	(831,534)	(829,272)	(2,262)
Net Operating Cashflows	109,330	102,311	7,019	146,355	130,397	15,958
Investing						
Income	602	370	232	3,397	2,218	1,179
Capital						
Sale of Assets	0	1	(1)	1	8	(7)
Purchase Fixed Assets	(3,268)	(6,460)	3,192	(26,373)	(38,764)	12,391
Net Investing Cashflows	(2,666)	(6,089)	3,423	(22,975)	(36,538)	13,563
Financing						
Equity Injections	88	1,015	(927)	88	2,029	(1,941)
New Loans	0	0	0	70,000	70,000	0
Loans Repaid	0	0	0	0	375	(375)
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	(70,000)	(70,000)	0
Net Financing Cashflows	88	1,015	(927)	88	2,404	(2,316)
Total Net Cashflows	106,752	97,237	9,515	123,468	96,263	27,205
Opening Cash	46,745	29,055	17,690	30,029	30,029	0
Closing Cash	153,497	126,292	27,205	153,497	126,292	27,205

Financial Performance

The result for December was a deficit of \$(2.4)m compared to a budgeted deficit of \$(3.0)m. The result year to date is a deficit of \$(3.4)m compared to a budgeted deficit of \$(5.8)m, a favourable variance to budget of \$2.4m.

Year to date revenue was higher than budget by \$14.4m. This was the result of:-

- a) Favourable Base Revenue \$8.7m driven by higher base contract variations, primarily being additional Heceptin Funding \$4.2m and provision for FY11 IDF Wash up's \$2.8m.
- b) Lower MoH Subcontract revenue \$(1.6)m, driven by lower Herceptin funding (now in base revenue) \$(4.2)m and lower Additional Elective revenue \$(2.9)m as a result of lower volume delivery offset by higher Other MoH Subcontract Revenue \$5.5m..
- c) Higher volumes of non resident activity \$2.1m
- d) Higher External Sales volumes \$0.6m
- e) The timing of donations \$1.1m
- f) Higher interest received on term deposits \$1.2m.
- g) A realised gain on Interest Rate Swap Instruments \$0.8m
- h) CMDHB Share of PHO Capitation Payments \$1.7m.

Year to date expenditure was higher than budgeted by \$(12.0)m.

- The unfavourable variance in employee costs of \$(0.8)m was driven by vacancies in Mental Health \$1.8m, Adult Health \$2.1m, Operations \$1.3m and Cancer \$0.7m, offset by increased employee costs in Child Health (\$0.9)m, Cardiac \$(0.6)m, Operating Theatres \$(0.6)m, Ambulatory \$(0.3)m, driven by increased volume and complexity. In addition further provision has been made for potential Meca settlements \$(2.2)m, increased long service and gratuity payments \$(0.8), and ACC liabilities \$(0.4)m.
- Direct Treatment costs are \$(11.0)m unfavourable to budget in the following services – Adult Health \$(0.8)m, Child Health \$(2.9)m, Cardiac Services \$(4.1)m, OR & Anaesthesia \$(1.9)m, Laboratories \$(1.8)m and Imaging \$(1.0)m. The increase in Direct Treatment Costs is due to Clinical Supplies \$(3.4)m, Outsourcing of various types \$(3.2)m, Implants \$(2.1)m, Chemicals & Media \$(1.4)m and Drugs \$(1.7)m. OR & Anaesthesia YTD has completed 27% more theatre minutes than budget and 23% more cases than budgeted.
- Funder Payments (excluding IDF Outflows) are over budget \$(1.4)m due to increased PHO costs due to the merger of an ADHB PHO with a CMDHB PHO which ADHB is hosting. Additional revenue is being received from CMDHB to cover the additional costs \$1.7m. There are also offsetting variances arising from the cost of settlement of prior year's pharmaceutical claims \$(1.3)m offset by an accrual no longer required \$1.0m.
- Indirect Treatment Costs are \$(2.3)m unfavourable primarily due to provisioning for doubtful non resident debts driven by the increased revenue described above (\$1.8)m and the cost of sales Retail Pharmacies for which additional revenue has been received.
- Administration costs are favourable to budget \$0.2 m primarily due to the timing of consulting expenditure \$0.8m for performance improvement projects offset by a one off payment from the Alexandra Trust to Ronald McDonald House Trust Auckland \$(0.5) m for the provision of a facility for convalescing women and children.
- Property costs are favourable to budget \$0.4m driven by lower property maintenance costs and lower computer maintenance costs.
- Loss on Sale of Fixed Assets is higher than budget \$(0.3)m following the review of the fixed asset register.

- Depreciation is lower than budget \$0.8m driven by the timing of capitalisation of capital projects.
- Finance Costs are lower than budget \$0.8m driven by lower than planned interest rates and CHFA loans not being drawn down.
- The Capital Charge is lower than budget \$0.9m driven by the revaluation of Land & Buildings downwards at balance date.

Financial Position

- The opening balance of fixed assets was \$(34.3) m below budget principally due to the downward revaluation of land & buildings \$(27.8) m as at 30 June 2010 and FY10 full year capital spending being \$(28.7)m lower than forecast.
- YTD Capital spending is \$26.0m, under budget by \$(12.7)m. Baseline and Facilities projects are behind budget by \$(6.5)m and Information Systems projects are behind budget by \$(6.2)m driven by the pace at which business cases are completed, approved and implemented.
- At month end there is an unused overdraft facility of \$65.0m.

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PAPERS

Nil

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GENERAL BUSINESS

APPENDICES

Nil

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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 15.

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

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
15.1 Confidential Board Minutes 2 December 2010 15.2 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.

MEETING DETAILS	
Time and Date	2:00pm, Wednesday 2 February 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital Grafton
Members	Dr Lester Levy (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Paul Green, Janice Mueller, Vivienne Rawlings, Ian Bell.

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5	Action Points 2 December 2010	021
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7	Chairman's Report - Verbal	027
8	Chief Executive's Report 8.1 Chief Executive's Summary 8.2 Minister's Six Health Priorities 2009/10 8.3 Quarter One 2010/11 Performance – MoH Report 8.4 Better Sooner More Convenient 8.5 Greenlane Surgical Unit	029
9	Lift the Health of People in Auckland City 9.1 Committee Recommendations	063
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NEXT MEETING		
	Time and Date:	2:00pm, Wednesday 2 March 2011
	Venue:	Sorrento in the Park, Pohutukawa Room, Sorrento in the Park, One Tree Hill Domain, Epsom

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