



# **Auckland District Health Board**

## **Board Meeting**

**Wednesday 5 October**

**2:00pm**

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

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



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**KARAKIA**



## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

## **Creator and Spirit of life.**

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

### IMPORTANT

If in doubt – declare.

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

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



## ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Lester LEVY (Chair)</b>	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board A+ Trust	Professor of Leadership  Chief Executive  Deputy Chair  Independent Chairman Chairman  Trustee			31 May 2011
<b>Jo AGNEW</b>	Professional Teaching Fellow Auckland University Casual Staff Nurse ADHB		Salary  Salary		7 September 2011
<b>Peter AITKEN</b>	Pharmacist  Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
<b>Judith BASSETT</b>	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Susan BUCKLAND</b>	Writing, editing and public relations services  Medical Council of NZ  Occupational Therapy Board  Northern Regional Ethics Committee	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member  Member	Fees  Fee  Fee  Fee		7 September 2011
<b>Dr Chris CHAMBERS</b>	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Rob COOPER</b>	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust Advisory	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee		
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
<b>Lee MATHIAS</b>	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting Director, company provides services to people with multiple physical disabilities especially cerebral Palsy Provider of business and professional services to midwives and other maternity services providers	31 May 2011
	Iris Limited	Director	Fee		
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited		

	Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education services contracted to the MoE. Statutory Authority	
	John Seabrook Holdings Limited	Director	No fee		
	AuPairlink Limited	Governance Advisor	Fee		
	NZ Council of Midwives Tamaki Transformation Transitional Board	Council member Chair	Fee Fee		
<b>Robyn NORTHEY</b>	Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
	Hope Foundation Northern Region	Board member	Nil		
	Ethics Committee	Member	Fee		
<b>Gwen TEPANIA-PALMER</b>	Waitemata District Health Board	Board member	Fee		18 May 2011
	Manaia PHO Ngati Hine Health Trust	Board member Chair			
	Te Taitokerau Whanau Ora	Committee member	Fee		
<b>Ian WARD</b>	C -4 Consulting Limited	Principal/ Director			24 August 2011
	NZ Blood Service	Board Member	Fee		

## **CONFIRMATION OF MINUTES**

**4.1 Minutes – 1 September 2011**

**4.2 Minutes – 7 September 2011**



## **4.1 Minutes – 1 September 2011**

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# Auckland District Health Board EMERGENCY MEETING Minutes

<b>MEETING DETAILS</b>											
Time and Date	9:00 pm, Thursday , 1 September 2011										
Venue	Teleconference										
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>										
	<p><b>Board Members</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Dr Lester Levy (Chair)</td> <td style="width: 50%;">Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Chris Chambers</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td></td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Andrew Coe – Manager PHOs and Primary Care            Stuart Jenkins – Clinical Director Primary Care            Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Judith Bassett and Ian Ward.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	
Dr Lester Levy (Chair)	Jo Agnew										
Peter Aitken	Susan Buckland										
Dr Chris Chambers	Rob Cooper										
Dr Lee Mathias	Robyn Northey										
Gwen Tepania-Palmer											
<b>2</b>	<b>CONFLICTS OF INTEREST</b>										
	There were no declarations of conflicts of interest.										
<b>3</b>	<b>AUCKLAND REGIONAL AFTER HOURS NETWORK</b>										
	<p>The Chair welcomed all and thanked Board members for responding so constructively to the short notice of meeting. The proposal had been already approved by WDHB and CMDHB the day prior. The project was part of last years District Annual Plan. The proposal meets after hours requirements through a network of clinics with lower co-payments and elimination of the surcharges for public holidays.</p> <p>The contract is for a defined period of 22 months with a March 2012 review process to define value for money, quality and access.</p> <p>Monitoring of delivery would be by reporting through a structured process back to governance with weekly meetings and monthly reporting to senior management and Boards.</p> <p>Concern was expressed at the single legal entity. A limited liability company had been suggested by the A&amp;Ms to overcome their current organisational structures as this project comprises competitors coming together to work together.</p> <p>The review in March was to provide a check point and see that the model is working and reducing impacts on EDs.</p> <p><u>Moved Gwen Tepania-Palmer; seconded Jo Agnew</u></p> <p><i>That the ADHB Board:</i></p> <ol style="list-style-type: none"> <li>1. <i>Receives the information on the proposal for implementation of the Auckland Regional After Hours Network service, noting that this proposal has been approved by the Regional Governance Group and recommended for endorsement by DHB boards;</i></li> </ol>										

2. *Notes the opportunities and risks associated with the approach and associated funding;*
3. *Endorses the funding quantum of \$7.5 regionally to be shared between the 3 DHBs on a capped PBF allocation basis;*
4. *Endorses the signing and execution of the Letter of Agreement (attached or in similar terms) by Friday 1 September 2011 in order to give effect to the arrangement on Monday 5 September 2011;*
5. *Endorses the establishment of a clinically-led joint Governance group between DHB and the CCA to oversee the impact and progress of the network; and*
6. *Endorses a joint communications/press release approach with CCA by 1 September 2011.*

Carried

The approved proposal would be announced on Monday, 5 September 2011 effective immediately.

The meeting closed at 9:40pm.

**CONFIRMED**

**CHAIR:**

**DATE:**

## **4.2 Minutes – 7 September 2011**

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# Auckland District Health Board Minutes



<b>MEETING DETAILS</b>											
Time and Date	2:00 pm, Wednesday, 7 September 2011										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
<b>1</b>	<b>KARAKIA</b>										
	The Chair declared the meeting open at 2:08pm. Naida Glavish led the meeting with the karakia.										
<b>2</b>	<b>ATTENDANCE AND APOLOGIES</b>										
	<p><b>Board Members</b></p> <table> <tr> <td>Dr Lester Levy (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive  Dr Denis Jury – Chief Planning &amp; Funding Officer  Dr Margaret Wilsher – Chief Medical Officer  Brent Wiseman - Chief Financial Officer  Greg Balla – Director Performance and Innovation  Kristine Nicol – Professional Leader Allied Health  Margaret Dotchin – Nurse Director, Adult Health Services  Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health  Vivienne Rawlings – General Manager Human Resources  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>An apology had been received from Dr Chris Chambers.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Rob Cooper	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lester Levy (Chair)	Jo Agnew										
Peter Aitken	Judith Bassett										
Susan Buckland	Rob Cooper										
Dr Lee Mathias	Robyn Northey										
Gwen Tepania-Palmer	Ian Ward										
<b>3</b>	<b>CONFLICTS OF INTEREST</b>										
	There were no declarations of conflicts of interest for any item on the agenda. Susan Buckland advised that she had been appointed to the Northern Regional Ethics Committee. Jo Agnew advised that she was now Professional Teaching Fellow, School of Nursing, University of Auckland and Ian Ward advised that his consulting company was involved in a tender for work with Health Benefits Limited.										
<b>4.1</b>	<b>CONFIRMATION OF MINUTES 3 AUGUST 2011</b>										
	<p><u>Moved Gwen Tepania-Palmer; seconded Robyn Northey</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 3 August 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

<b>5</b>	<b>ACTION POINTS 3 AUGUST 2011</b>
	<p>The delegated authorities work was progressing. The primary care summary of initiatives, in its final form, would be circulated to the Board in the next couple of weeks. The paper on credentialing was carried forward and the resolution concerning annual financial accounts had been actioned and confirmed.</p>
<b>6.0</b>	<b>CHAIRMAN'S REPORT</b>
	<p>The Chair had attended the Chair's and CEO's meeting in Wellington with discussions on regionalisation and Better, Sooner, More Convenient. The CEOs and Chairs had asked for more direction from the National Health Board. There had been a briefing with the Minister who seemed quite pleased with the improved deficit situation for the sector and the targets, with the 6-hour target being at 92% across the whole sector.</p> <p>Two significant business cases had been approved by Health Benefits Limited in relation to management information systems and supply chain. The process would be for CEOs to provide some feedback and then they would be sent to the DHBs for feedback. These would address 85% of shared services' rationalisation.</p> <p>The consolidation of resources between ADHB and Waitemata would continue. The CEOs and the Chair had met on collaboration of primary care and Maori Health, which were symbolic of the direction being taken. In 2012 there would be an increase effort on regional collaboration.</p> <p>The Regional After Hours proposal had been approved and is now being implemented, with some issues on regional collaboration being resolved. Regional decisions would be based on principles. The monitoring of the Regional After Hours service would be resolved by the end of the month with data going to the Regional Funders Forum and final development of KPIs.</p>
<b>7.1</b>	<b>CHIEF EXECUTIVE'S REPORT</b>
	<p>This was the first month of the financial year. There was a move to reporting daily and weekly, both retrospective and prospective. While Te Whetu Tawera had been in the press, there had been positive improvements that were not reflected in their articles. A response is being prepared to highlight positive actions that they have not reported to provide a balanced view.</p> <p>The reporting on performance against priorities would be against the Board priorities. The improvement in immunisation was acknowledged.</p>
<b>7.2</b>	<b>MINISTER'S 6 HEALTH PRIORITIES</b>
	<p>Emergency department and electives had been discussed in the Hospital Advisory Committee. Better help for smokers needed to be better and Waitemata, who had made great gains, were on the steering group and providing information on their initiatives. The cardiac target had changed from a waiting time to a list target with the ADHB goal being less than the MoH target. There was still debate on the diabetes targets and how to measure that risk.</p>
<b>7.3</b>	<b>ANNUAL REVIEW 2010 - 2011</b>
	<p>The report was a detailed analysis on the year. A revised section on Goal 3 was tabled. It was noted that the operating expenditure was \$44m unfavourable in the Provider. A revised table of service performance would be provided once all the data had been collected. The purpose of the paper was for the Board and would be used for CE performance and SLT performance.</p> <p>The Audit Committee had reviewed the Annual Report and sought some improvement in readability of the Statement of Service Performance noting, however, that other means of communicating to the public would be used, including NOVA. The increases in nurse numbers were spread across the Greenlane Surgical Unit, Emergency and Operating Theatres.</p> <p>The CEO advised that the 3 things that should not have been done were having unrealistic budgets, not having more sophisticated production planning i.e. clinical supplies for increased volumes and not having made gains in the out-of-hospital environment. Demographic growth was</p>

	<p>1%, but the organisation was trying to grow faster and needed to step back and get spending improvement gains and these gains should not be spent as fast as they are made, but rather held to invest in the Board's priorities.</p> <p>He advised that the 3 best achievements in the year had been the improvement processes that were increasing, particularly with nursing initiatives, Radiology and Cancer services and the number of services who were now engaged in health improvement initiatives. The Health Services Group model and the clinical appointments had been established with this bringing clinical leadership in to action. There was some concern expressed by the Board as to accountability with the HSG director being responsible for strategy, the GM a performance director requiring commercial acumen, improvement and general management skills and the director and CMO responsible for clinical safety. This resolved the previous differences between clinicians and general managers. It was noted that the presentations that had been made to the Board had involved the Clinical Directors and Nurse Leaders. The other important improvement was the HealthCare Excellence initiative with all HSGs doing improvement projects.</p> <p>The progress in changing the workforce for Maori and Pacific was an objective of the Board and what ADHB was doing for Maori health needed more visibility. While the Maori Health Plan was linked to the Annual Plan, the reporting for Maori needed to be improved and consolidated from the differing venues that Maori statistics are reported, to get consolidated visibility to the Maori Health Gain Advisory Committee and the Board.</p>
8.1	<b>LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY</b>
	<p><b>Hospital Advisory Committee</b></p> <p>The Committee expressed their concerns for elective surgery and had asked Management to have more focus on getting to the elective target and progressively removing impediments. The Committee had expressed their support for General Medicine and it's concerned on recruitment, improving educational opportunities and resolving administration problems.</p>
9.0	<b>PERFORMANCE IMPROVEMENT</b>
	<p>All of the projects for the coming year had been loaded. The number of projects, with 850 research projects, 1000 IT projects in the region and 200 in the Annual Plan raised the question of whether there were too many projects for the resources available. It may be better to identify fewer larger changes that require investment and ring-fence the resources going into them.</p>
10.1	<b>FINANCE COMMITTEE RECOMMENDATIONS</b>
	<p><b>Relocation of Heart Towers</b></p> <p><u>Moved Gwen Tepania-Palmer; seconded Lee Mathias</u></p> <p><i>That the Board approves the capex of \$782,511 to fit-out vacant space in Building 16 of the Cornwall Complex on the Greenlane site for the Hearty Towers Service which will enable Hearty Towers to vacate Building 10 at Greenlane in accordance with the Exit Plan for that building approved by the Board in December 2007; and</i></p> <p><i>That the tender from Practec Ltd to undertake the fit-out works in Building 16 be accepted and the CEO be delegated authority to execute the contract once finalised on the condition that there were no more funds for exiting of Building 10 above the original approved overall budget of \$7.56m.</i></p> <p><u>Carried</u></p>

**Replacement 3 General Rooms GCC Radiology**

Moved Susan Buckland; seconded Robyn Northey

*That the Board agrees to the replacement of the three Toshiba general rooms with direct capture General rooms at Greenlane Radiology noting that a budget of \$1.34M has been approved in the 2011/12 capital plan for this purchase and that a tender process will be carried out with Procurement and Radiology to select a vendor.*

Carried

**Northern DHB Support Agency Ltd Agency Agreement**

Moved Lee Mathias; seconded Robyn Northey

*That the Board:*

- i. Approves the Northern DHB Support Agency Limited entering into an agency agreement with Greater Auckland Integrated Health Network (GAIHN) partners with the objective of the Northern DHB Support Agency Limited acting as agent for GAIHN, holding funding and contracting with third parties for the delivery of services on behalf of GAIHN.*
- ii. Delegates to the Chief Executive Officer authority to vote at a special meeting of the Northern DHB Support Agency Limited in favour of the Northern DHB Support Agency Limited entering into an agency agreement with the GAIHN partners.*
- iii. Approves the Northern DHB Support Agency Limited entering into a funding agreement with the Ministry of Health for the funding of Migrant Health services.*

*noting that this is a requirement of Section 129 of the Companies Act in relation to major transactions.*

Carried

**Community Pharmacy Agreements - Extension of Term until 30 April 2012**

Moved Peter Aitken; seconded Jo Agnew

*That the Board that approves the Community Pharmacy Agreements Extension of Term until 30 April 2012 including for Auckland DHB t/a Auckland City Hospital Pharmacy and Grafton Pharmacy Limited t/a Grafton Pharmacy and delegates the signing of the Community Pharmacy Services Agreements for the period 1 September 2011 to 30 April 2012 to the CPFO.*

Carried

**Ach Carpark building tenancy – Long Term Leases**

Moved Lee Mathias; seconded Robyn Northey

*That ADHB seek a general approval from the Minister of Health to enter long term leases (5 to 20 years) for the retail and commercial premises in the new Auckland City Hospital Car Park Building.*

Carried

**10.2 FINANCE REPORT**

The report for the first month of the financial year was noted.

**12.0 GENERAL BUSINESS****Maori Services**

There had been a meeting between ADHB and WDHB with a view to bringing the tikanga Maori processes and resources together, reporting to a lead CEO and more integration with Ngati Whatua.

<b>14.0</b>	<b>PUBLIC EXCLUSION</b>						
	<p><u>Moved Robyn Northey; 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 14.</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="204 510 1362 884"> <thead> <tr> <th data-bbox="204 510 584 622">General subject of each matter to be considered:</th> <th data-bbox="584 510 983 622">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="983 510 1362 622">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="204 651 584 763">           14.1 Confidential Board Minutes                  3 August 2011            14.2 Cardiac Surgery            14.3 Banking Arrangements         </td> <td data-bbox="584 651 983 824">           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)         </td> <td data-bbox="983 651 1362 884">           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.         </td> </tr> </tbody> </table> <p><i>The items discussed in public exclusion were confidential minutes 3 August 2011, Cardiac Surgery and banking arrangements.</i></p> <p><u>Moved Lee Mathias; seconded Robyn Northey</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>	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:	14.1 Confidential Board Minutes 3 August 2011 14.2 Cardiac Surgery 14.3 Banking Arrangements	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.
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	<b>NEXT MEETING</b>						
	<p>The meeting closed at 4:32 pm</p> <p>The next scheduled meeting is:          2:00pm, Wednesday, 5 October 2011          A+ Trust Room          Clinical Education Centre          Level 5, Auckland City Hospital          Grafton</p>						
	<p><b>CONFIRMED</b></p> <p><b>CHAIR:</b> _____ <b>DATE:</b> _____</p>						



**ACTION POINTS**

- **WEDNESDAY 7 SEPTEMBER 2011**



**Board****Action Points from the meeting on Wednesday 7 September 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
Carried forward	A paper on managing credentialing in primary care noting the processes within the GP college and cornerstone programmes with most based on pathways	Denis jury	Carried forward
7.3	While there is different venues that Maori statistics are reported in they need to be consolidated together for the MHGAC to get visibility	Garry Smith Denis Jury	Review and report back to the Board





# Auckland District Health Board Briefing Paper Action Point

Date	Wednesday 5 October 2011
To	Auckland District Health Board
From	Dr Denis Jury Chief Planning and Funding Officer Greenlane Clinical Centre, Building 13, Level 8 Phone: (09) 630 9943 ext 8071 DenisJ@adhb.govt.nz
Functional Group	Planning and Funding
Subject	<b>Summary of the credentialing process for Auckland Regional Minor Skin Surgery project</b>
<b>1</b>	<p><b>Purpose</b></p> <p>This paper is in response to a Board request for a summary of the credentialing process for the Auckland Regional Minor Skin Surgery project.</p>
<b>2</b>	<p><b>Recommendations</b></p> <p>It is recommended that the Board:</p> <ol style="list-style-type: none"> <li><b>Notes</b> the selection process stage 1 and 2, clinical review panel and ongoing credentialing.</li> </ol>
<b>3</b>	<p><b>Summary of the credentialing process for Auckland Regional Minor Skin Surgery project</b></p> <p><b>The Selection Process</b></p> <p>Waitemata DHB Planning and Funding led a formal Registration of Interest (ROI) process in October 2010 for the provision of Minor Skin Surgery on behalf of the Metro Auckland region. A total of 35 responses were received and each response was considered by three evaluators from the Auckland Regional Minor Skin Surgery Clinical Governance group who had expertise in the provision of minor skin surgery.</p> <p>The responses were evaluated with regard to the practitioner's training, service delivery requirements, appropriate experience within pre agreed timeframe, and ability to provide service at the agreed DHB price. The ROI response was assessed in two stages.</p> <p><b>Stage 1:</b></p> <p>All ROI responses would be assessed by the Chair of the Auckland Regional Minor Skin Surgery Clinical Governance Group against the clear yes/no criteria including:</p> <ul style="list-style-type: none"> <li><b>Infection control</b> - The minimum requirement is infection control that equates to or exceeds the requirements for infection control as per the RNZCGP Aiming for Excellence infection control standards.</li> <li><b>Availability of appropriate equipment</b> - The minimum requirement is availability of a uni-polar diathermy device and capability of cardiac defibrillation equal to or greater than an Automated Electrical Defibrillator Device (AED).</li> <li><b>Training, qualifications and experience</b> - The minimum requirements for is completion of a minor skin surgery training course at the level of Auckland surgical skills training</li> </ul>

centre minor surgery course or greater; or completion of a general or plastic surgical training to the level of surgical training registrar or higher. In some instances when the respondent's training, qualifications and experience did not clearly meet the minimum requirements; the responses were collated by the ROI Secretariat and provided to the clinical governance group to advise on which training and qualifications meet the groups agreed standards.

**Stage 2:**

- Short-listed responses from Stage 1 were invited to submit a 'log book' of their most recent sequential 50 cases of skin surgery.
- The log books were collated, made anonymous and analysed according to the time taken to complete the 50 cases, malignancies of lesions, number and percentage of incomplete excisions and number and percentage of complications experienced.
- The log books were then assessed by the clinical review panel to reach unanimous agreement on which responses are to be recommended for progressing to the next stage.

Having received and reviewed the 35 responses, the evaluation team were able to unanimously recommend 16 preferred providers across 19 sites.

**The Clinical Review Panel:**

Dr John Cameron GP and Chair of the Clinical Governance Group until April 2011.

Dr Kim Bannister (GP & WDHB Clinical Advisor)

Mr John Kenealy (CMDHB Plastic Surgeon)

**Ongoing Credentialing**

This is provided via local peer review and training sessions within the respective DHB areas. The contracted GPs are required to attend these quarterly one of which is a regional meeting. Russell Smart (GP liaison) has run the CMDHB session for some time and their next meeting is in November. WDHB have their first session planned for the evening of Thursday 1 November, and Mr Richard Martin (WDHB General Surgeon) and Dr Kim Bannister will be leading this session. Dr Kathy McDonald (ADHB GP Liaison) and Mr Isaac Cranshaw (ADHB General Surgeon) are arranging the local sessions within ADHB. A regional review meeting is planned for February next year.

The contracted GPs are also required to send in the histology reports and a copy of the patient's discharge letter to the DHB. The clinical data (including number of lesions removed, principle diagnosis and any complications) is captured for each patient. This data can be used to inform the basis for discussion at the peer review sessions and a summary will be included in the project evaluation report.

## **CHAIRMAN'S REPORT**

**6.1 Report – Verbal**

**6.2 Board and Committee Meeting Schedule 2012**



## 6.1 Report - Verbal

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**6.2 Board & Committee Meeting Schedule 2012**

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## 5.1 2012 Board and Committee Meeting Schedule

### Recommendation:

- (a) That the Board approve the attached meeting schedule for 2012.
- (b) That with regard to meetings venues for the Community and Public Health Advisory Committee (CPHAC), the Disability Support Advisory Committee (DSAC) and the Maori Health Gain Advisory Committee (MHGAC) (all of which Committees operate on a collaborative model with Auckland District Health Board), the Board indicate its preference for 2012:
- Either** – to continue the pattern of CPHAC meeting at Takapuna and DSAC and MHGAC meeting at Greenlane
- Or** – to rotate meetings of each of those Committees between an Auckland DHB and a Waitemata DHB venue

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Prepared by: Paul Garbett, Board Secretary

### 1. Glossary

ADHB- Auckland District Health Board  
 CPHAC – Community and Public Health Advisory Committee  
 DSAC – Disability Support Advisory Committee  
 MHGAC – Maori Health Gain Advisory Committee  
 WDHB – Waitemata District Health Board

### 2. Summary

This report gives effect in terms of the meetings schedule for 2012 to decisions made in April/May 2011 by the Waitemata and Auckland District Health Boards to operate on a collaborative basis for CPHAC, DSAC and MHGAC meetings (commenced August 2011) and to move to a six weekly meetings cycle for 2012.

The proposed six weekly meetings cycle for 2012 is shown attached. The cycle follows the pattern (all meetings on Wednesdays):

Week 1 – ADHB Audit and Finance and combined MHGAC / DSAC (alternating)  
 Week 2 – WDHB Audit and Finance and combined CPHAC  
 Week 3 – No meetings (but may be used at times for Special meetings, workshops etc.)  
 Week 4 – ADHB HAC and ADHB Board  
 Week 5 – WDHB HAC and WDHB Board  
 Week 6 – No meetings (may be used at times for Special meetings, workshops etc.)

The only variation to this is in April/May, because Anzac Day in 2012 falls on a Wednesday.

The proposed cycle for the two Boards for 2012 commences on 25 January.

### 3. Issues

The Boards have already resolved to move to a six weekly cycle for 2012.

An issue for consideration is that of the venues for the three ADHB/WDHB committees which meet together: CPHAC, DSAC and MHGAC.

It was previously indicated (although not formally resolved) that the venues for each of these Committees would rotate between Takapuna and Greenlane for 2012.

The Board may wish to review this in view of the practical benefits of having a standard venue for each Committee: avoids confusion; is administratively more efficient; avoids difficulties for those Board members and staff who will have to travel for separate meetings at an ADHB Venue and WDHB venue on the same day.

Once both Boards have confirmed their preference a final schedule of meetings and venues will be distributed to Board members, staff and interested parties and included on the website.

## Indicative 2012 Waitemata and Auckland DHB Board and Committee Meeting Schedule

A & F - Audit and Finance Committee; CPHAC - Community and Public Health Advisory Committee; DiSAC - Disability Support Advisory Committee; MaGAC - Maori Health Gain Advisory Committee; HAC - Hospital Advisory Committee

	January	February	March	April	May	June	July	August	September	October	November	December	
1		WDHB - Audit Joint - CPHAC						ADHB - HAC & Board					1
2					WDHB - Audit & Joint CPHAC								2
3										ADHB - Audit Joint MaGAC			3
4				WDHB - HAC & Board									4
5												ADHB - HAC & Board	5
6						WDHB - Audit Joint - CPHAC							6
7			ADHB - Audit Joint - DiSAC										7
8								WDHB - HAC & Board					8
9					ADHB - HAC & Board								9
10										WDHB - Audit Joint - CPHAC			10
11							ADHB - Audit Joint - MaGAC						11
12									ADHB - HAC & Board			WDHB - HAC & Board	12
13													13
14			WDHB - Audit Joint - CPHAC								ADHB - Audit Joint - DiSAC		14
15		ADHB - HAC & Board											15
16					WDHB - HAC & Board								16
17													17
18				ADHB - Audit Joint - MaGAC			WDHB - Audit Joint - CPHAC						18
19									WDHB - HAC & Board				19
20						ADHB - HAC & Board							20
21											WDHB - Audit Joint - CPHAC		21
22		WDHB - HAC & Board						ADHB - Audit Joint - DiSAC					22
23													23
24										ADHB - HAC & Board			24
25	ADHB - Audit Joint - MaGAC												25
26													26
27						WDHB - HAC & Board							27
28			ADHB - HAC & Board										28
29								WDHB - Audit Joint - CPHAC					29
30					ADHB - Audit Joint DiSAC								30
31										WDHB - HAC & Board			31



## AUCKLAND DISTRICT HEALTH BOARD MEETING PLANNING SCHEDULE – 2012

### Audit & Finance / Community and Public Health Advisory/ Maori Health Gain Advisory/ Disability Support Advisory/Hospital Advisory/ BOARD

Number in brackets indicates week in month, ie. 1st Thursday (1)

	<b><u>Audit &amp; Finance Committee</u></b>	<b><u>Community &amp; Public Health Advisory Committee</u></b>	<b><u>Maori Health Gain Advisory Committee</u></b> <b><u>Disability Support Advisory Committee</u></b> <b><u>Joint ADHB/WDHB</u></b>	<b><u>Hospital Advisory Committee</u></b> <b><u>Private Board</u></b> <b><u>BOARD</u></b>
<b>TIME</b>	8:30am - 11:30am	2:00pm – 4:30pm	<b>MHGAC</b> 2:00pm –4:30pm <b>DSAC</b> 2:00pm – 4:30pm	<b>HAC:</b> 9:30am - 12:30pm <b>Board Private</b> 1:00pm - 2:00pm <b>Board</b> 2:00pm – 5:00pm
<b>VENUE</b>	Sir Douglas Robb Board Room Level 7, Building 14 Greenlane	Waitemata DHB Board Room 15 Shea Terrace Takapuna	Marie Hosking Room, Level 7, Building14, Greenlane	A+ Trust Room Clinical Education Centre Auckland City Hospital Grafton
<b>JANUARY</b>	Wed 25 (4)		Wed 25 <b>MHGAC</b> (4)	
<b>FEBRUARY</b>		Wed 1 (1)		Wednesday 15 (3)
<b>MARCH</b>	Wed 7 (1)	Wed 14 (2)	Wed 7 <b>DSAC</b> (1)	Wednesday 28 (4)
<b>APRIL</b>	Wed 18 (3)		Wed 18 <b>MHGAC</b> (3)	
<b>MAY</b>	Wed 30 (5)	Wed 2 (1)	Wed 30 <b>DSAC</b> (5)	Wed 9 (2)
<b>JUNE</b>		Wed 6 (1)		Wed 20 (3)
<b>JULY</b>	Wed 11 (2)	Wed 18 (3)	Wed 11 <b>MHGAC</b> (2)	
<b>AUGUST</b>	Wed 22 (4)	Wed 29 (5)	Wed 22 <b>DSAC</b> (4)	Wed 1 (1)
<b>SEPTEMBER</b>				Wed 12 (2)
<b>OCTOBER</b>	Wed 3 (1)	Wed 10 (2)	Wed 3 <b>MHGAC</b> (1)	Wed 24 (4)
<b>NOVEMBER</b>	Wed 14 (2)	Wed 21 (3)	Wed 14 <b>DSAC</b> (2)	
<b>DECEMBER</b>				Wed 5 (1)

**CHIEF EXECUTIVE'S REPORT**



## **7.1 Chief Executive's Summary**

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# CHIEF EXECUTIVE'S REPORT

<b>1</b>	<b>EVENTS AND NEWS IN AUGUST</b>
<b>2</b>	<b>EVENTS AND NEWS IN SEPTEMBER</b>
<b>3</b>	<b>MANAGING THE WIDER HEALTH SYSTEM</b>
<b>4</b>	<b>BOARD PERFORMANCE PRIORITIES</b>
<b>5</b>	<b>HSG STRUCTURE – ACCOUNTABILITIES</b>

## Introduction

This report covers the month of August. It includes a brief summary of events of note in August and September, an update on management of the wider health system and a summary of progress against the Board's priorities to confirm these matters are being appropriately addressed.

## 1 Events and news in August

### 1.1 Events

During August the following events took place:

#### Media

- ADHB's achievement of national health targets generated publicity in local and national newspapers.
- Herald on Sunday Official Information Act seeking emails, agendas, minutes of meetings, diary notes, source material, incident reports and other material connected to the compilation of data on assaults within Te Whetu Tawera provided to the Herald on Sunday in May.
- High volume of requests for status updates for a one-year-old boy from Whangarei in the Paediatric Intensive Care Unit with meningococcal meningitis.

#### Internal

- Nova Special Edition celebrating Health Targets success is published.

## 2 Events and news in September

### 2.1 Events

During September the following events either have or will take place:

#### People

- Two ACH nurses Rachelle Phipps and Helen Sargent travelled to Zambia as part of a national mission to perform heart surgeries for people in need. The story was covered by East and Bays Courier.
- ADHB's Executive Director of Nursing, Taima Campbell, has been honoured with the Maarire Goodall Award. The award recognises valuable contribution towards improving the health of Maori.

#### Media

- ARPHS and ADHB have set up modified joint Incident Management Teams to manage and co-ordinate the public health and DHB responses to the measles outbreak in Auckland. This is a result of escalating numbers of notified and confirmed measles cases in the Auckland region. The outbreak is demonstrating epidemic characteristics but has not yet been declared as such.
- A decision by its operators to close the Seaside Sanctuary residential care facility on Waiheke Island attracted coverage in the Waiheke Island media and in one online media outlet. The closure is due to the need to invest capital to increase bed numbers and bring the facility up to the specifications of a council waste water abatement

- An agreement was reached on 20 September between ADHB and the Public Sector Association (PSA) to work together on addressing mental health workforce issues. The agreement will see six of the 58 beds temporarily closed in the acute inpatient service, Te Whetu Tawera, while new staff nurses are employed to fill vacant positions in the unit. The beds will be closed for one month, with a weekly review thereafter, with a view to re-opening them as soon as possible. ADHB is ensuring continuity of service for mental health patients while the beds are closed.
- High volume of calls from media wanting updates and interviews about the 8-year-old Ruatoki bus crash girl, who is currently in Starship.
- A Colombian drug courier died in the Emergency Department after being dropped outside while in cardiac arrest. The incident generated a large number of media requests.
- The Australian Women's Weekly profiled the four New Zealanders who were part of the successful paired-kidney transplant scheme, a first in NZ.
- A high volume of calls requesting information on ADHB's preparation for the Rugby World Cup.
- A high volume of calls regarding ED during the opening weekend of the Rugby World Cup.
- Auckland City Hospital Emergency Department doctors will accompany paramedics on Westpac rescue helicopter missions, in a trial that is the first of its kind in New Zealand.
- The month to mid-September volume of incoming media calls was the highest in 12 months.

#### **Internal**

- Family Violence Awareness Week (September 12 – 17). An internal campaign was visible throughout ADHB and Auckland Blues players visited kids at Starship to promote the week.
- Healthcare Excellence Awards have now received more than 60 entries. Applications have now closed.
- Stroke trial attracted 100 participants.

## **3 Managing the wider health system**

### **3.1 System performance**

Activity in the last month has brought a focus on the completion of the PHO amalgamation and transition to the work programmes that will deliver the health and efficiency gains anticipated.

August saw final preparations for the Rugby World Cup, which centred on being prepared for the unexpected. All staff responded well to the challenge as can be seen from the news section above.

This was the coldest month of the year so far with the inevitable pressure on services. With this in mind it has been good to see that a number of the initiatives with primary care are bearing fruit with positive feedback for instance on the transfer of minor surgery for skin lesions to GPs. The school dental clinic building programme is also progressing to plan.

August was the second month reported to the combined ADHB and WDHB joint Board Committees and a close working relationship is developing between the two teams, especially those that have merged such as the primary healthcare team.

### **3.2 Financial performance**

A full report is included in the Audit and Finance Committee papers, but in summary the organisation recorded an overall \$2.7 million deficit for the month, \$0.1 million favourable to budget. The Funder and Governance Arms recorded a net favourable variance of \$1.0 million and the Provider Arm an unfavourable variance of \$0.9 million.

Total revenue was \$2.1 million above budget due mainly to the PHO realignment changes and IDF variances. Total costs were \$2 million above budget due mainly to payments related to the PHO realignment increased revenue. The Provider Arm variance resulted from a lower internal revenue allocation from the Funder Arm than budgeted with higher expenditure in direct treatment costs and outsourcing partially offset by savings in staff costs with lower FTEs than budgeted.

### **3.3 Clinical quality and professional governance**

#### **Patient Safety Scorecard**

Work is continuing on the development of the 80 Organisational Patient Safety Scorecard indicators. These cover adverse events, nosocomial infection, timeliness of treatment, peri-operative complications, deteriorating patient, mortality and readmission.

Adult services are the initial focus with children's and mental health following. The first stage comprises HSG and whole organisation level indicators, with the intention to establish appropriate service-level patient safety measures later. The content of the scorecard will be available in September and indicators will be populated with data over the next few months.

#### **“First do no harm”**

The process of appointing the clinical lead and project manager for the programme is almost complete and will greatly assist the implementation of the programme.

In the meantime work is progressing on the multi-faceted patient safety programme. The intervention areas are central-line associated bacteraemia, falls causing harm, pressure injury, transfers of care / handover, patient identification and high-risk medication safety. The Health Quality and Safety Commission has formally recognised the programme and committed support to it through a Memorandum of Understanding.

#### **Global Trigger Tool**

The implementation of the random sample case-note review process is under way to provide monthly measures of adverse event rates. As previously reported this uses the “Global Trigger Tool” methodology from the Institute of Healthcare Improvement (Boston) which is independent of voluntary reporting. The measure relates to active delivery of care and is defined as “unintended physical injury resulting from or contributed to, by medical care that requires additional monitoring, treatment or hospitalisation, or that results in death”.

Four teams of nursing and medical reviewers are undertaking the review following training. Data will only be made available after a stable baseline has been established, probably by early 2012.

### **ADHB Falls & Pressure Injuries Steering Group**

The ADHB Steering Group is now meeting regularly to provide organisational governance and oversight for an ADHB Falls Programme, and to assist the organisation to meet the deliverables in the Northern Region Health Plan (NRHP). The deliverables from the First Do No Harm campaign within the NRHP are:

- Reduce the number of harmful falls in our hospitals by 20%.
- Reduce the number of patients who have pressure injuries in hospital or aged residential care by 20%.

The ADHB Sponsor is Janice Mueller (Director of Allied Health) with Dr Andrew Jull (Nurse Advisor, Quality) as the Clinical Lead. The Steering Group will include Aged Residential Care participation and we are actively seeking members from the sector. A decision was made at the August meeting to expand the Steering Group activity to include Pressure Injuries, given the similarities of goals in the NRHP and patient population. This should work well for the Aged Residential Care sector.

### **3.4 Support services**

The performance indicators for IT, Human Resources and Finance/Shared Services do not contain any significant exceptions and a summary of the current position is shown below:

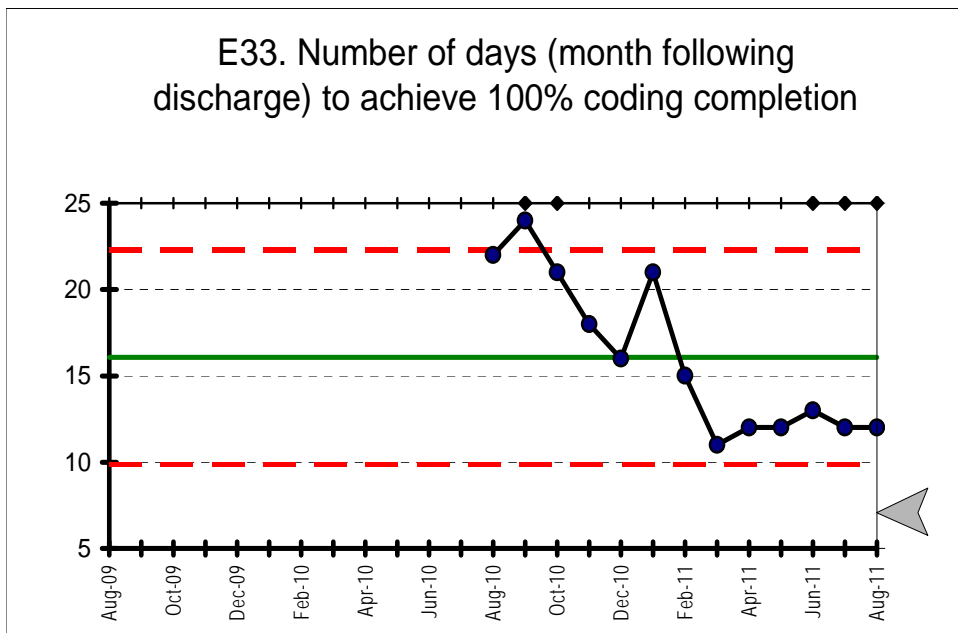
<b>Service</b>	<b>Number indicators</b>	<b>Exceptions</b>
Information management	26	There were no exceptions in August and previous issues around transcription times have been resolved through planning and the approval of a clinical record scanning solution to be implemented over the next 12 months.
Human Resources	40	There were no exceptions in August and the featured indicator for the month is discussed below.
Finance and shared services	15	There were no exceptions in August.

**Featured Information Management indicator - E33.** Number of days (month following discharge) to achieve 100% coding completion.

All FY2010/2011 discharges were coded by 12th July; nearly seven weeks ahead of the MoH deadline of 21st August.

The impact of the Clinical Coding Lean Six Sigma Project is that the coders are now processing records within a much shorter turnaround time. In May 2010 only 32% of records were coded within seven days of patient discharge. In August 2011 the coding turnaround time was within twelve days of patient discharge. In September the coding turnaround time is now within eight days of patient discharge. The service is making incremental

improvements each month, and the goal of coding completion within seven days of patient discharge will be achieved in October for the September discharges.

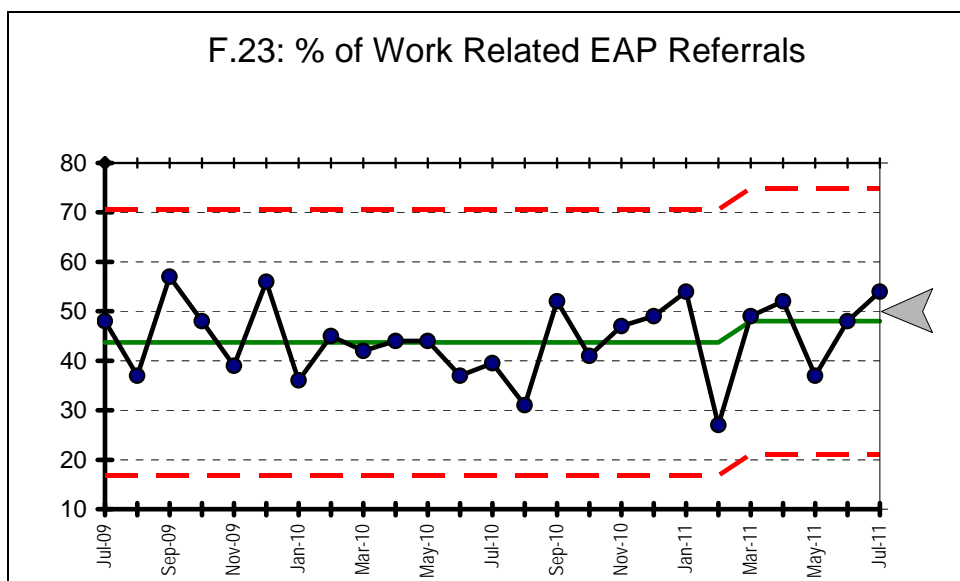


**Featured Human Resources indicator - F.23: % of Work Related EAP Referrals**

The employee assistance programme (EAP) is provided to help staff deal with work and personal issues which may affect their work performance.

The percentage of Work Related EAP Referrals can to some extent be considered one barometer for staff wellness, where a lower percentage is more desirable than a higher one, as it suggests that work issues are less concerning for our employees than personal issues. Although, we cannot measure whether work issues have an indirect impact on staff that might manifest as non-work issues, we have been providing employees an opportunity to talk to a qualified professional about any issues which may be affecting them via the EAP.

As indicated by the run chart, a fluctuating pattern has been displayed from month to month over the last 12 months. The mean percentage for the 2010/11 year was 44%, which is the same as the 2009/10 year. Overall the trend is in alignment with the threshold of 50%.



**Featured finance/shared services indicator – G9. Motor vehicle running expenses**

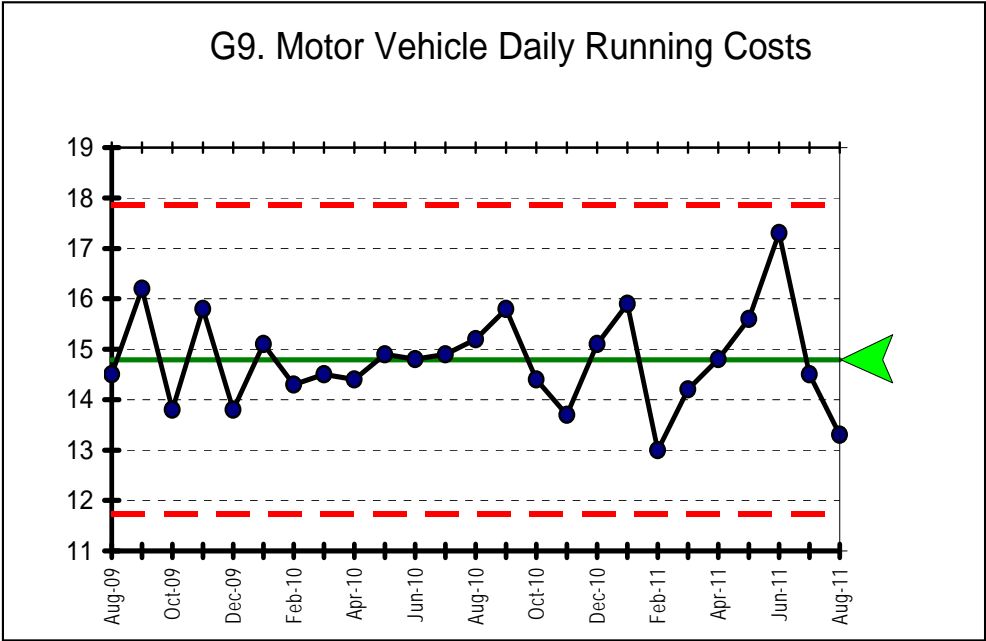
A record of vehicle running costs is maintained on a monthly basis. Costs are Fuel, Servicing (including Damage, Tyres and Registration) and Lease / Depreciation charges. The target is to maintain costs at or below approximately \$15 per vehicle per day. Results for the last 5 financial years have been:

Year	Cost per day	Fleet numbers
2006/07	\$14.79	365
2007/08	\$14.55	372
2008/09	\$15.05	383
2009/10	\$14.61	387
2010/11	\$15.21	380

The result for the 2 months to August 2011 was \$14.11, and August month was \$13.25 as a result of lower fuel consumption than usual. Current fleet numbers are 375.

The bulk of the vehicle fleet is smaller sized cars used for community services and over this period the Hyundai Getz 1400cc has proved to be very effective in providing a vehicle fit for purpose at an economic cost. Costs have been held during this period by replacing manual vehicles with automatic vehicles, which saves both on fuel consumption and wear and tear.

Vehicles coming off their six year lease term have been purchased at their residual value and held for a further two years. An eFleet electronic booking system is being piloted in order to further assist in managing costs



**3.5 Hospital services**

August is always a challenging month for managing patient flows. This proved to be the case again and Adult ED achieved 91% of its six hour target whilst Children’s ED improved over the July figure to 93%, both still short of the 95% target. The coping strategies are being reinforced to maximise throughput with bed availability being the key constraint, requiring the full cooperation of all staff. The spike in demand is expected to last through September and

the previously reported requirement for additional bed capacity through to mid December remains the current prediction.

The pressure on services caused a drop in elective services performance although this was still 96% of target and mitigation strategies are being implemented to achieve the full requirement for the first quarter. Radiation therapy continues to perform to target but a spike in the number of cardiac patients resulted in missing the targets for bypass surgery. The smoking cessation target has not been achieved despite improvements and other targets are reported quarterly and are not yet due.

### **3.6 Primary care and community services**

#### **Regional focus**

The completion of the PHO amalgamation process, albeit with some residual issues relating to North Waikato PHO, is allowing time to focus more on Better, Sooner, More Convenient Primary Care initiatives and the Metro-Auckland DHBs are working collectively on implementing the regional components.

The work to improve the efficiency of the primary / secondary interface, have proceeded well during the month. The work on access to diagnostics has resulted in a proposal to GAIHN requesting an investment of \$25,000 to cover unbudgeted programming costs in updating ProExtra, and this has been approved in principle.

The transfer of minor skin surgery to nominated GPs has reached the first measurement point with the opportunity to analyse feedback from 22 patient satisfaction surveys and 118 GP opinion surveys. The feedback from both surveys was positive. A review of the price paid to contract GPs under the scheme has also been undertaken. Reports are being developed covering both these matters.

The process for developing clinical pathways has also been completed and has been signed off by the GAIHN Alliance Leadership Team and is being implemented.

The success of these initiatives is further highlighted by the actions taken to manage acute demand through primary care options. The statistics indicate that for August 2011 there were some 1,433 referrals, (YTD 3,053), 88% of which were managed without admission to hospital.

#### **Greater Auckland Integrated Health Network (GAIHN)**

Project Investment proposals for six work streams have been prepared. Funding of \$2,212,250 is required from the Network partners and the programme has been presented to the joint CPHAC, which endorsed the approach. The matter will now be presented to the Audit and Finance Committee with information to confirm:

- Return on investment.
- Measurable deliverables.
- Future funding requirements.
- Governance and accountabilities.

Most of the project and clinical leads have been identified for the work streams. The remainder will be confirmed following approval of funding. Implementation will involve approximately 180 people across metro Auckland.

## **National Hauora Coalition (NHC)**

The National Hauora Coalition and the PHO Performance Programme (PPP) have been discussing the best means of managing and monitoring performance through locality-set targets linked to the National PHO targets. The discussions have also focussed on the practicalities of collecting data and setting targets. The teams will use expertise from the DHBs.

It has also been agreed that rationalisation of contracts will be necessary before transferring them to NHC. NHC will work with members and DHBs to agree the timing for transfer of the contracts.

## **Alliance Health+**

The process to recruit a Clinical Director is underway and a clinical secondment has been arranged with a public health physician from CMDHB to support the clinical leadership. They have also established an outcomes framework blueprint that will include clinical, Whanau and provider indicators.

## **Public health**

During August, measles notifications were received and these were spread across the region, in some cases with unknown links. There were a large number of case contacts notified each day needing follow up, many requiring intervention at schools and early child care centres. There were notifications of Meningococcal disease, which is expected at this time of year and one death in the region. A contact trace was also undertaken in a West Auckland secondary school following notification of a smear positive Pulmonary Tuberculosis case in a member of the school community.

## **Smoking cessation**

The Waitemata DHB Smokefree team presented to the ADHB Steering Committee on their approach on 17 June 2011. Following discussions between Margaret Dotchin and Alan Wilson (COO WHDB) a meeting has been arranged for Margaret, Linda Wakeling (GM Information Services), Jan Marshall (Smokefree Co-ordinator) and the Waitemata team at North Shore Hospital on the 29 September. During the visit the team will meet with key staff across wards and departments with a focus on understanding what has made a difference to accelerate Waitemata's performance and identify the enablers used.

## **Rugby World Cup**

Rugby World Cup preparations were completed during the month with training and readiness workshops for staff and on-call arrangements confirmed for the period of the event. Monitoring and reporting processes based on Ministry of Health directives were also confirmed. Terrorism and deliberate criminal act planning and Mass Arrivals planning were also put in place at a regional level.

## **ADHB Child Health Plan 2012/17**

The draft Child Health Plan will be available for public and staff consultation in early September. The development process has been managed by a Steering Group with wide intersectoral representation. Targeted consultation has already occurred with a number of hui with Maori. These were facilitated by He Kamaka Oranga.

## **Maternity Service Specifications**

The MOH has published new draft maternity service specifications. They raise concerns in relation to the definition of post natal care and could have major implications for DHBs whose systems depend upon the transfer of women and babies to a primary maternity facility for post natal care. Discussions are continuing.

### **3.7 Intersect   oral relationships**

The ability of the health sector to achieve health gain on its own is limited in many areas where the determinants of health are social in nature. The health sector therefore works with other sectors such as housing, income support, welfare and education in order to achieve its goals. Each month this part of the report focuses on topical intersectoral initiatives and projects.

It is often difficult to directly influence outcomes due to the absence of direct authority over the processes and the lack of aligned strategic goals. As a result the best outcomes are often achieved through consultation, informal partnerships and working relationships and exchange of information. Good examples are the ADHB Immunisation Governance Group which has members from a wide range of other sectors, primary care and community organisations, and the initiative related to homeless people where the targets are clear and the action plan has a wide base of support from the various agencies involved.

Special initiatives in the last year have included Snug Homes (insulation of homes with children with respiratory disease), Strengthening Families programme (a formal intersectoral programme with the aim of coordinating services provided to families) and the Tamaki Transformation project (establishing health career pathways).

The special focus in this month's report is on the ADHB Child Health Stakeholder Advisory Group. This forum was established in 2006 and has met every two months since that time. It has wide intersectoral membership that includes senior managers from key government departments including Housing, Child, Youth & Family, MSD and Education as well as representation from Maori, Pacific, primary care, Auckland Council and Plunket, and ADHB clinicians and managers from child health, women's health, public health and mental health. Representatives from Waitemata DHB and Counties Manukau DHB are also invited to attend.




The overall role of the group is to advise ADHB on emerging child health trends and issues, to review progress and provide advice on achievement of ADHB child health related strategic outcomes and to facilitate intersectoral understanding and joint child health initiatives. Meetings of the group focus on specific topics and over the last year these have included development of a new child health plan for the Child Healthcare Service Group, Whanau Ora, Community Links (MSD), a Draft Charter on the Rights of Children and Young People in Healthcare in New Zealand, Clinical Networks, child and youth injury and the Community Response Model (FACS, MSD). Judge Andrew Becroft is attending the October 2011 meeting to talk about youth issues and the importance of early intervention.

## 4 Board performance priorities

The Board has set 10 priority areas. These have been mapped to the Regional and DAP goals and the key result areas specified by the MoH as follows:

Regional goal	Auckland DHB Goal	Auckland DHB Key Result Areas	Board Priorities
Improved population health	Lift the health of people living in the ADHB area	Improved health status	Chronic disease management Health of older people
Improved patient experience	Performance improvement	Better quality care Increased patient safety Staff engagement	New models of care Emergency care Elective surgery Shorter waiting times for cancer treatment Clinical leadership Culture
Cost and productivity management	Live within our means	Economic sustainability	Regionalisation through collaboration Living within our means

Progress in each area is summarised in this report under three headings:

- Scope of the work programme Proceeding to plan 
- Current status Issues being addressed 
- Expected outcome for the year Target unlikely to be met 




































The information set out on the following pages summarises the projects that support the Board's priorities and identifies the current phase and status of each project. The table below summarises the status of those projects and provides a summary of progress by comparing the position with last month. A negative figure in the last column therefore indicates the number of projects that have moved beyond that phase.




The projects for New Models of Care are included in this analysis for the first time to better align project classifications to the Board priorities.


<b>Projects</b>	<b>This Month</b>	<b>Last Month</b>	<b>Change</b>
Not yet Started	0	42	-42
Planning	77	38	39
Implementation	3	0	3
Cancelled	0	0	0
Completed	0	0	0
<b>Total</b>	<b>80</b>	<b>80</b>	<b>0</b>






















## Board Priorities

















<b>1</b>	<b>Emergency Care</b>	<b>95% of patients are admitted, discharged or transferred from adult and children's EDs within 6 hours</b>			
		Adult ED achieved 92% of its six hour target whilst Children's ED improved over the July figure to 93%, both still short of the 95% target. The coping strategies are being reinforced to maximise throughput with bed availability being the key constraint, requiring the full cooperation of all staff. The spike in demand is expected to last through September and the previously reported requirement for additional bed capacity through to mid December remains the current prediction			
<b>Projects</b>		<b>Phase</b>	<b>On Time</b>	<b>On Budget</b>	<b>Expected Outcome</b>
1044 - Implement primary care initiatives to reduce acute hospital presentations that could have been prevented with earlier intervention		Define			
1046 - Streamline and improve the process of referral to inpatient specialties and admission to the inpatient ward or discharge		Define			
1047 - Reduction in patient length of stay		Improve			
1045 - Streamline Emergency Department processes to reduce the time to be seen in the Emergency Department		Define			
<b>2</b>	<b>Elective Surgery</b>	<b>Achieve the number of elective procedures specified in the DAP</b>			
		Quarterly production to 11 September was 96% against the health target and the services are reviewing their production planning in order to achieve the Q1 target. Services have scheduled some volumes into Q2 and Q3 for increased lists and outsourcing.			
<b>Projects</b>		<b>Phase</b>	<b>On Time</b>	<b>On Budget</b>	<b>Expected Outcome</b>
978 - Increase surgical and inpatient bed capacity at GSU		Define			
981 - Improve outpatient efficiency and patient experience		Define			
983 - Implementation of Production Planning by service area		Define			
980 - Improve Pre Admission Process		Define			
982 - Reduce waiting time for patients for First Specialist Assessment and Elective Surgery		Define			
1058 - Implement the productive operating theatre programme/lean improvement programmes (TPOR)		Define			


























<b>3</b>	<b>Shorter waits for cancer treatment</b>	<b>Radiation treatment within four weeks of a decision to treat. Medical oncology first specialist assessment and treatment to be provided within agreed target timelines</b>
	In August 100% of eligible patients were treated within the four week target timeline. As at 31 August Radiation Oncology had delivered to the target for 492 consecutive days.	


















































Projects	Phase	On Time	On Budget	Expected Outcome
1043 - Establish a service delivery model aligned with the recommendations outlined in the Radiation Therapy Strategic Plan	Define			


























<b>4</b>	<b>Health of Older People</b>	<b>Integrate and streamline services, one point of entry to specialists, specialised inpatient areas for stroke, dementia and delirium, co-ordination of discharge planning, improve respite care and ensure effective outreach programmes (primary and community)</b>
	<p>Good progress has been made with Enhanced Community Services. The three year change process is largely complete with Restorative services now passed to business as usual. Further enhancements are being made to the Casemix funding model and InteRAI assessment tool. The model has met with significant national interest and other DHBs are following suit, particularly with the devolution of the Needs Assessment function to community providers. An evaluation of the programme will be undertaken in the next 4 to 6 weeks.</p> <p>The Regional Health of Older Persons Clinical Network is also close to complete establishment. They have an ambitious three year work plan which focuses on alignment of service models, access and quality across the region.</p>	


Projects	Phase	On Time	On Budget	Expected Outcome
1020 - Review specialist support to Aged Residential Care	Define			
1015 - Establishment of the Regional Clinical Network	Define			
1019 - Implement pathways for Older People with Cognitive Decline	Define			
1018 - Review and evaluate capacity for respite care	Define			
1021 - Scope workforce shortages	Define			
1017 - Review rates of access to Aged Residential Care by age across the region	Define			
1016 - Services closer to home that are more flexible and responsive	Define			

<b>5 Clinical Leadership</b>	<b>Leadership from bedside to boardroom, clinicians involved in all strategic and operational decisions, leadership development for clinicians and development, management and monitoring of clinical networks</b>			
	<p>Only 2 level 2 clinical leader roles remain unfilled and both are in recruitment phase. The appointed leaders comprise the Clinical Leadership Group which has replaced the Clinical Board. The level 3 CD position description has been rewritten and a level 3 clinical leaders toolkit is in development.</p> <p>A stocktake of existing resources is underway. HWNZ has commissioned the University of Auckland to progress the NZ Centre for Excellence in Health Leadership.</p> <p>Two clinical network leaders are in position and the others in recruitment. Network activity continues to expand with key highlights including the MOH publication on Advanced Care Planning and appointment of the First Do No Harm campaign leads.</p> <p>Cardiac and Cancer are progressing the Academic Health Alliance concept with Academic leads joining the HSG planning and operational meetings and shared research and teaching programmes.</p> <p>The Senior Registrar team has been formed and has its first meeting with the CMO and HSG directors this month.</p> <p>The Director of Allied Health &amp; Technical and Director of Nursing have just returned from a Performance Excellence study tour of The USA. The tour included visits to a number of organisations (including health care facilities) who have adopted performance excellence criteria. Feedback to senior management and the Board is planned for October.</p>			
<b>Projects</b>	<b>Phase</b>	<b>On Time</b>	<b>On Budget</b>	<b>Expected Outcome</b>
1102 - Develop a talent identification and development programme for future clinical leaders	Define			
1100 - Support the development of, and provide leadership to, implement regional/national multidisciplinary clinical networks, inclusive of whole of sector participation	Control			
1099 - Develop and implement a comprehensive leadership programme for clinical leaders and senior managers	Define			
1101 - Develop and implement Auckland DHB Healthcare Excellence Framework	Measure			
1098 - Continue to implement the clinical leadership model for level 2 and 3	Improve			

<b>6</b>	<b>Culture</b>	<b>Professionalism, clinical excellence coupled with patient service and improved communication with patients</b>			
	<p>Reo Ora - Health Voice has been launched and can be accessed at <a href="http://www.healthvoice.org.nz">http://www.healthvoice.org.nz</a>. This service is part of improving communication and encourages patients to share their thoughts and experiences about ADHB's health service through surveys and online discussions. The results of the survey are also made available through the site. Feedback from last year that is being put into action includes making improvements at check-in and waiting to be prepared for their procedure. The majority of staff are doing an excellent job and the focus is on keeping patients better informed about both their procedure and how long they are likely to have to wait.</p> <p>As part of the Northern Region Health Plan, ADHB working with the other northern DHBs to develop and implement a patient safety programme. The areas covered are central-line associated bacteraemia, falls causing harm, pressure injury, transfers of care / handover, patient identification and high-risk medication safety.</p>				
<b>Projects</b>		<b>Phase</b>	<b>On Time</b>	<b>On Budget</b>	<b>Expected Outcome</b>
1053 - Improve Risk Mitigation Management and Root Cause Analysis		Define			
1055 - Improve Feedback Process		Define			
1054 - Establish an integrated complaints framework		Define			
1051 - Continue to implement our consumer and community engagement framework		Define			
1052 - Bereavement management framework is developed and implemented		Define			
1050 - Introduce a staff engagement survey tool		Define			
1048 - Develop a culture of patient safety, open disclosure, timely and empathetic communication		Define			
1049 - Develop our clinical leaders and managers to be more effective at developing culture and taking action within our management operating system		Define			

<b>7</b>	<b>New Models of Care</b>	<b>New models of care for fast stream elective surgery, readmission prevention, Whanau Ora, health promotion, children and young persons and older people</b>			
	The work streams in primary care are progressing well. The amalgamation of the PHOs is complete and initiatives such as the transition of minor skin surgery to nominated GPS have received positive feedback from recent surveys. The building programme for school dental clinics is proceeding to plan will provide a much improved network for managing oral health for children and young people. Several performance improvement programmes are have commenced and are in the planning phase with both regional and local initiatives being included in the project listing below.				
Projects		Phase	On Time	On Budget	Expected Outcome
1057 – Increase the number of wards in Adults, Children’s, Cancer, Cardiothoracic and Mental Health services using Releasing Time to Care		Define			
1058 - Implement the productive operating theatre programme/lean improvement programmes (TPOR)		Define			
1059 – Performance improvement actions focused on- radiology, cardiac surgery, research, general medicine, general surgery, adult ED, operating rooms		Define			
1061 – Develop new mental health services for as an alternative to admission service young people, adults, older adults and Maori		Define			
1062 – Increase awareness of mental health services for high risk minority groups Muslim, Lesbian, Gay, Bi-sexual and Transgender (LGBT), Pacific		Define			
1063 – Increase responsiveness to those with a coexisting problem (CEP)		Define			
1064 – Scope low secure rehabilitation service for high and complex needs		Define			
1066 – Implement medical oncology service improvements		Define			
1067 – Continue regional lung tumour stream development and service improvement in care pathways		Improve			
1068 – Continue regional bowel tumour stream development and service improvement in care pathways		Analyse			
1069 – Establish a regional mechanism to strengthen the delivery capacity of palliative care providers		Define			
1070 – Participate in the establishment of a Haematology Clinical network		Measure			
1071 – Renal Services work with primary care to design, devolve, and deliver Adult Haemodialysis (AH) for patients who are unable to home dialyse		Define			
1072 – New model of care to integrate kidney disease prevention, early intervention, and chronic kidney disease management services		Define			
1073 – Agree the principles which will inform a new service design for rehabilitation services		Define			
1075 – Improve the outcomes for people with COPD		Define			

<b>8 Chronic disease management</b>	<b>Better assessment of cardiovascular risk, enhanced treatment for heart disease and diabetes, reduced waiting times for elective cardiac surgery and clinical pathways to be across the care continuum</b>				
	At this stage Q4 remains the latest data we have available, which showed us at just 0.2% below target for CVD and 9% above target for Diabetes annual reviews. We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract. The work being undertaken by the Long Term Condition Quality Improvement Coordinators are supporting both CVD and diabetes screening and management in primary care.				
<b>Projects</b>	<b>Phase</b>	<b>On Time</b>	<b>On Budget</b>	<b>Expected Outcome</b>	
995 - Strengthen self management via links to wider lifestyle activities e.g. green prescription	Define				
990 - Report on care planning for people screened who either have diabetes or a risk assessment >15%	Define				
994 - Develop core competencies for diabetes self management courses with supported self-management specifically for Maori and other high needs groups	Define				
991 - Quality improvement coordinators support primary care to identify people who are diabetic and have not received their review	Define				
992 - Implement a community retinal screening service	Define				
996 - Boost workforce development for self-management skill development	Define				
989 - Evaluate 2 community-based cardiac rehabilitation programmes	Define				
993 - Raise PHO awareness re Diabetes Get Checked programme for diabetic patients -- practices encouraged to keep Get Checked in high awareness	Define				

<b>9 Regionalisation through Collaboration</b>	<b>Collaboration as an overriding principle undertaken with studious intent and with a special focus on Waitemata DHB</b>				
	<p>The initial transition to healthAlliance is largely complete and the first joint Board Committee meetings have taken place. Joint ADHB / WDHB CPHAC and Maori Health committees have occurred and the joint DiSAC is scheduled to meet in September. Work is underway between the two DHBs to identify further areas for collaboration around service planning and delivery.</p> <p>The Northern Region Health Plan has been accepted by the National Health Board. Key milestones are on target. The Cardiac Clinical Network director has been appointed and the network is operational. The Diabetes network has a CMO acting as lead and is in early formation with progress being made to the plan. Radiology, Older Peoples Health and First do No Harm networks are shaping up with formal leadership roles being advertised. All clinical networks are planned to be fully operational by the end of this financial year.</p>				

Projects	Phase	On Time	On Budget	Expected Outcome
1129 - The stronger bilateral opportunity offered by a shared chair and Maori board membership will allow us to optimise service planning and delivery across our two organisations	Define	●	●	●
1128 - Reduce back-office costs through standardisation and consolidation of systems and processes in the regional entity	Define	●	●	●
1127 - The informed patient	Define	●	●	●
1126 - Life and Years	Define	●	●	●
1125 - First Do No Harm: Regional work to improve patient safety	Define	●	●	●

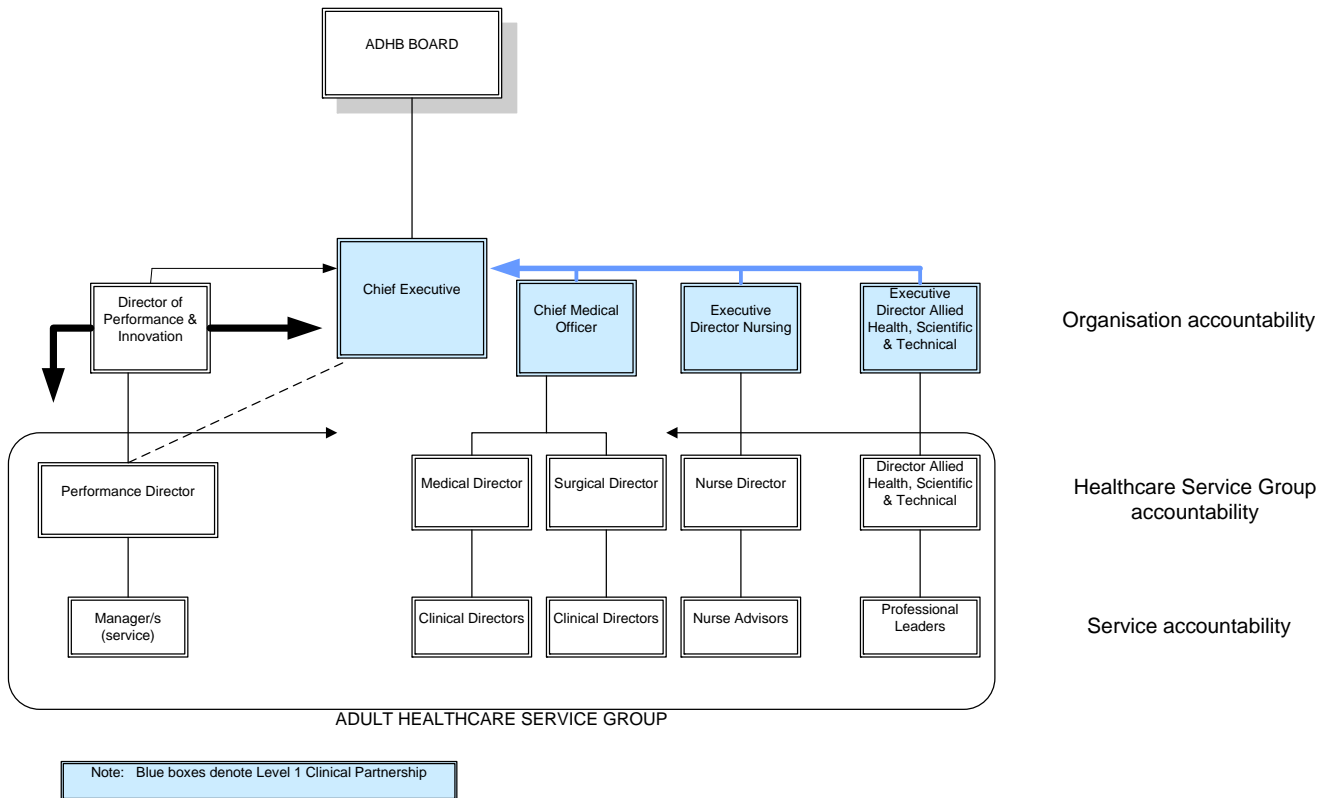
<b>10</b>	<b>Living within our Means</b>	<b>Financial deficits are not acceptable under any circumstances</b>		
●	A full report is included in the Audit and Finance Committee papers, but in summary the organisation recorded an overall \$2.7 million deficit for the month, \$0.1 million favourable to budget.			

Projects	Phase	On Time	On Budget	Expected Outcome
1116 - Strengthen collaboration within and outside the organisation	Define	●	●	●
1118 - Non Clinical: Implement new Health Alliance organisation	Define	●	●	●
1109 - Managing Administration and Management staff numbers within the cap	Define	●	●	●
1117 - Clinical: Review service models for cancer and cardiac and integrate with private sector	Define	●	●	●
1114 - Utilisation of new and existing clinical supplies monitored for clinical effectiveness	Define	●	●	●
1113 - Clinical Supply Costs	Define	●	●	●
1115 - Leverage national and local procurement	Define	●	●	●
1112 - Deliver productivity and quality gains by HSG	Define	●	●	●
1120 - Waitemata and Auckland DHBs integrate services where there is service quality and cost opportunities	Define	●	●	●
1107 - People Cost	Define	●	●	●
1110 - Manage and review impact of MECA Settlements	Define	●	●	●
1111 - Productivity	Define	●	●	●

Projects	Phase	On Time	On Budget	Expected Outcome
1119 - National contracts to transfer to NHB	Define	●	●	●
1104 - Elective volume and funding: Implementing a patient and operations planning process to ensure early visibility of variances to plan and corrective action	Measure	●	●	●
1106 - Disciplined volume and funding risk management for IDFs. Continue IDF relationship management process with key IDF customers	Define	●	●	●
1103 - Disciplined volume and funding risk management for the Auckland DHB Population	Define	●	●	●
1105 - Acute volumes: Manage volume and cost risk through productivity improvement and BSMC initiatives	Define	●	●	●
1122 - Ensure BSMC + 3 Business cases deliver improved processes and realise the planned benefit from defined projects	Define	●	●	●
1124 - Oral Health capital expenditure programme within budget	Define	●	●	●
1121 - Manage contracts within budget , with particular focus on Community Pharmacy, Laboratories, Rest homes	Define	●	●	●
1123 - NHB new payment system eliminates transaction error	Define	●	●	●

## ACCOUNTABILITY FRAMEWORK

The purpose of this document is to explain the Healthcare Service Group (HSG) accountability framework.



As shown in the chart above the Level 2 roles have a direct reporting relationship with the Level 1 Clinical Partners. The Level 2 Performance Director has a direct reporting relationship to the Director of Performance and Innovation and an indirect reporting relationship with the Chief Executive to facilitate quick and cohesive communication and a single point of contact for the CEO to the HSG.

The Level 2 roles have shared accountability for the performance of the HSG and roles will take individual responsibility on a day-to-day basis for actions to deliver specific key result areas:

### Accountability

Shared accountability for Healthcare Service Group (HSG) Key Result Areas:

- Patient Safety
- Quality of Care
- Economic Sustainability
- Health Status
- Staff Engagement

### Responsibility

Level 2 roles will take individual responsibility for particular actions within each key result area.

<b>Key:</b>	
	<b>Lead responsibility</b>
	<b>Lead for professional group</b>
	<b>All roles accountable</b>

<b>ACTIONS</b>	<b>Medical Director</b>	<b>Surgical Director</b>	<b>Nurse Director</b>	<b>Professional Leader</b>	<b>Performance Director</b>
<b>STRATEGY DEVELOPMENT</b>					
• Annual and 3 year system-wide plan development					
• Prioritise and approve performance improvement objectives					
• Facilitates overall plan development					
<b>STRATEGY DEPLOYMENT</b>					
Align and engage to deliver improvement					
• Set performance objectives					
• Coach and mentor deliver improvement					
• Monitor and report on improvement actions					
<b>MANAGE PERFORMANCE</b>					
<b>Health Targets</b>					
• Shorter Stays in Emergency Department					
• Improved Access to Elective Surgery					
• Better Help for Smokers to Quit					
• Better Diabetes Service					
<b>Operational Performance</b>					
Monitors and reports on performance					
• Financial					
• Daily volume and waitlist management					
• Annual production plan management					
• FTE Management					
• Asset Management, Equipment, Technology					
• Monitor and improve patient access					
• Health and safety					
• Legislative compliance					
• Facilitate improvement and innovation					
<b>Overall Clinical Safety</b>					
<b>Professional Governance</b>					
• Staff monitoring and oversight of clinical and cultural competencies and ethical standards					
• Individual performance monitoring, development and management					
• Compliance with credentialing and scopes of practice					
• Workforce planning and development					
• Medical Teaching and training					
• Learning through research and audit					
• Recruitment					

## **7.2 Minister's Six Health Priorities**

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## PRESENTATIONS

### 8.1 Cardiology – Clinical Leader – Cardiothoracic Trends



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

## **9.1 Committee Recommendations**



## **9.1 Committee Recommendations**

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**Community and Public Health Advisory Committee Recommendations**

**Maori Health Advisory Committee Recommendations**

**Pacific Health Advisory Committee Recommendations**

**Disabled Support Advisory Committee Recommendations**



# **PERFORMANCE IMPROVEMENT**

**10.1 DAP    Projects Report**



## 9.1 District Annual Plan Progress Report

The information set out on the attached pages covers progress with improvement activities ADHB has committed to in the 2011/12 District Annual plan.

All of the projects for 2011/12 have been loaded to the reporting system and managers who are accountable for the projects (sponsors) and those who are responsible for managing them are currently reviewing the entries and adding further data and status reports. The last month has been spent validating the content of the system and ensuring that there is no duplication and those unnecessary projects are removed. That has resulted in 51 projects being eliminated.

	This month	Last month	Movement
Status yet to be determined (new)	0	152	-152
Planning	125	17	108
Implementation	26	35	-9
Completed	5	3	2
	156	207	-51
Cancelled/removed	51	0	51
Total	207	207	0

96% of projects are on time, 100% on budget and 99% will deliver expected outcomes. The statistics reported last month related only to projects carried over from the previous year and to avoid as mismatch no comparative is shown.

Status	This month	Last month	Change
On time	96%	N/A	0%
On budget	100%	N/A	0%
Expected outcome	99%	N/A	0%

# Group Pack Report

Group/Committee: Board

## Goal Level Summary

DAP Projects - total projects: 156

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control		Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
1 Lift the Health of the people in Auckland City	61	61	50	0	1	6	3	0	57	3	0	60	0	0	59	1	0	1	1	0	0
2 Performance improvement	66	66	41	4	2	15	1	0	60	3	0	63	0	0	62	1	0	3	3	0	0
3 Live within our means	29	29	26	1	0	1	0	0	28	0	0	28	0	0	28	0	0	1	1	0	0
<b>Total #</b>	<b>156</b>	<b>156</b>	<b>117</b>	<b>5</b>	<b>3</b>	<b>22</b>	<b>4</b>	<b>0</b>	<b>145</b>	<b>6</b>	<b>0</b>	<b>151</b>	<b>0</b>	<b>0</b>	<b>149</b>	<b>2</b>	<b>0</b>	<b>5</b>	<b>5</b>	<b>0</b>	<b>0</b>
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>77%</b>	<b>3%</b>	<b>2%</b>	<b>15%</b>	<b>3%</b>	<b>0%</b>	<b>96%</b>	<b>4%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>99%</b>	<b>1%</b>	<b>0%</b>	<b>3%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>

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

#### Exceptions

There are no projects that have been marked as an exception

### Goal: 2 Performance improvement

#### Exceptions

There are no projects that have been marked as an exception

### Goal: 3 Live within our means

#### Exceptions

## **LIVE WITHIN OUR MEANS**

**11.1 Finance 7 ommittee Recommendations**

**11.2 Finance Feport**



**11.1 Finance Committee Recommendations**

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**ADHB Board****Author:** Ian Bell (8077)**Subject:** Northern DHB Support Agency Limited Agency Agreement

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**Recommendation***That the Board:*

- 1. Approves the Northern DHB Support Agency Limited entering into an agreement with Health & Disability Auditing New Zealand Limited for the provision of quality and service auditing of NGO service providers over a three year period for the financial years 2011/12 to 2013/14 at a cost of not more than \$2.65m over three years.*
- 2. Approves the Northern DHB Support Agency Limited paying an account of \$1.137m from Central Region TAS Limited for the northern region DHBs' share of the Year One budget of \$3.2m for the roll out of the interRAI comprehensive clinical assessment tool for aged residential care.*
- 3. Delegates to the Chief Executive Officer authority to vote at a special meeting of the Northern DHB Support Agency Limited in favour of the Northern DHB Support Agency Limited entering into an agreement with Health & Disability Auditing New Zealand Limited for the provision of NGO service provider quality and service audits over the three year period 2011/12 to 2013/14 at a cost of not more than \$2.65m over three years and paying the Central Region TAS Limited invoice of \$1.137m for the northern region DHBs' share of the Year One cost of roll out of the interRAI comprehensive clinical assessment tool for aged residential care.*
- 4. Approves the Northern DHB Support Agency Limited entering into an agreement with Health & Disability Auditing New Zealand Limited for the provision of NGO service provider quality and service audits over the three year period 2011/12 to 2013/14 at a cost of not more than \$2.65m over three years and paying the Central Region TAS Limited invoice of \$1.137m for the northern region DHBs' share of the Year One cost of roll out of the interRAI comprehensive clinical assessment tool for aged residential care.*

**Background**

This will be discussed by the Finance Committee at their meeting on 4 October 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** 30 June 2011 Annual Report and associated Letter of  
Representa tion

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**Recommendation**

*That the ADHB Board approves the following delegations to sign on their behalf:*

*(a) Letter of Representation to Audit NZ – Board Chair, Audit and Finance Committee Chair, Chief Executive and Chief Financial Officer*

*(b) Annual Report and Year-end financial statements – Board Chair, Audit and Finance Committee Chair and Chief Executive.*

**Background**

This will be discussed by the Finance Committee at their meeting on 4 October 2011. The Audit and Finance Committee having noted the information contained in the 2011 Annual Report and Letter of Representation makes this recommendation.

## 11.2 Finance Feport

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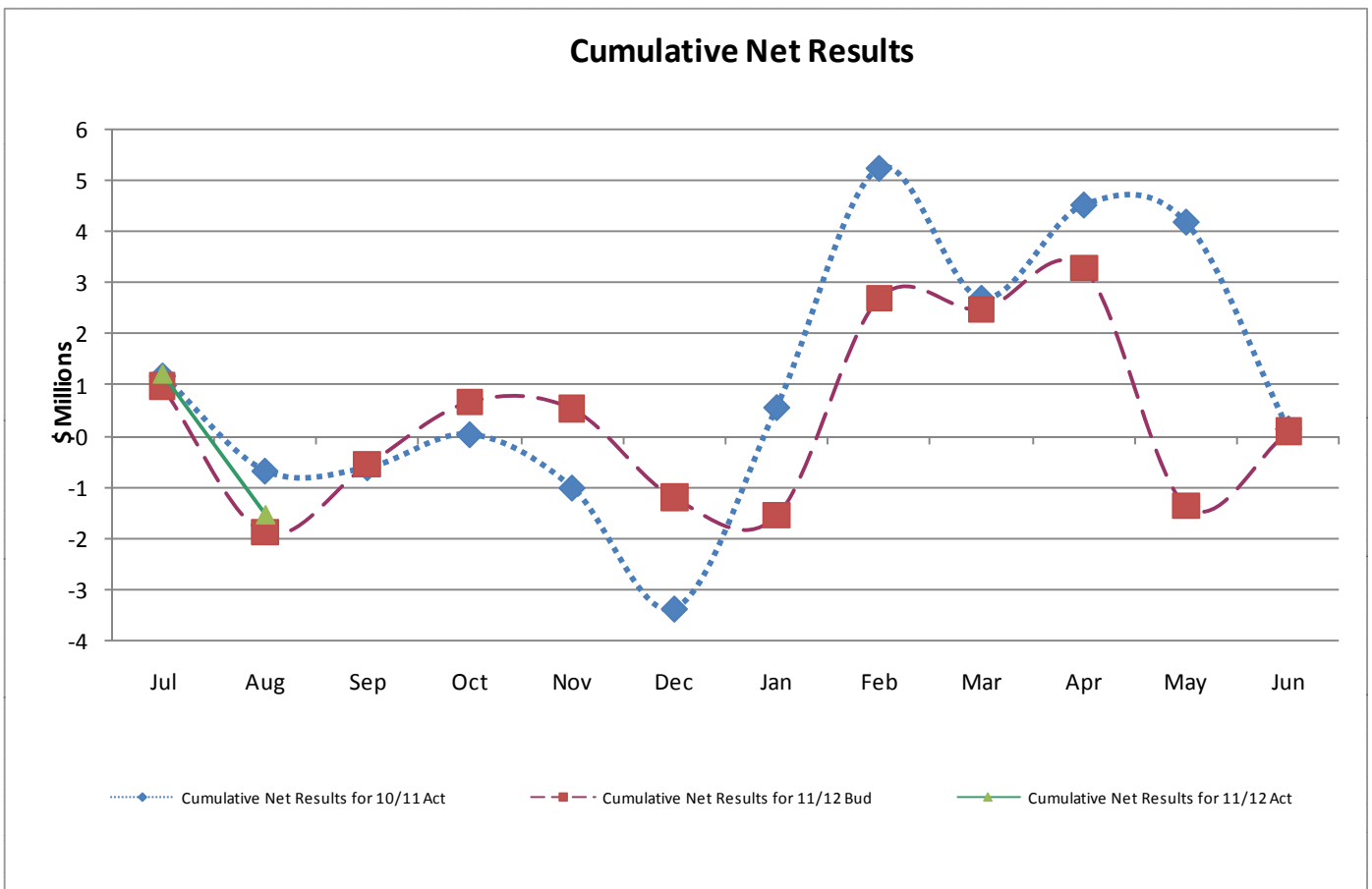
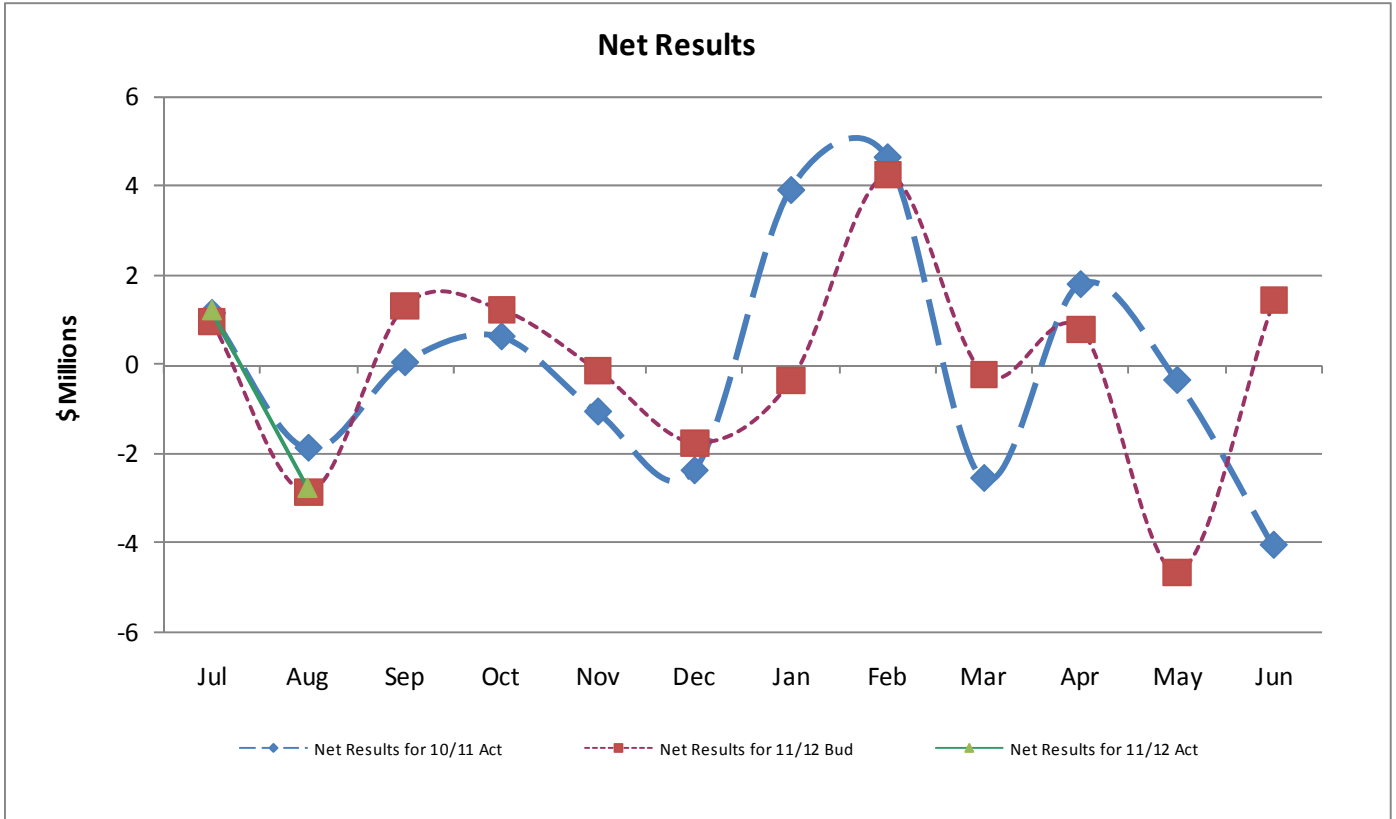


# Auckland District Health Board

## **Board Financial Report**

August 2011

Performance Graphs by Month & YTD



**Statement of Financial Performance**  
**Month & YTD - Aug 2011**

	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>\$000s</b>						
<b>Income</b>						
PBF - AKL Population	82,029	82,264	236 U	164,756	164,528	227 F
Inter District Inflows	53,688	55,265	1,577 U	106,989	110,530	3,542 U
	135,717	137,529	1,813 U	271,744	275,059	3,314 U
MOH Sub-contracts	8,499	8,353	146 F	17,232	16,560	672 F
Other Patient Care	7,491	3,790	3,701 F	12,048	7,520	4,528 F
Services & Products	4,266	4,052	214 F	7,823	8,040	217 U
CTA	1,894	1,924	30 U	3,584	3,552	32 F
Trust & Donation Income	110	319	209 U	188	638	450 U
Financial Income	592	617	25 U	1,191	1,233	42 U
Other Income	670	556	115 F	914	1,114	199 U
	159,239	157,140	2,099 F	314,725	313,715	1,010 F
<b>Expenditure</b>						
Employee Costs						
Medical	19,913	20,409	496 F	38,186	38,843	657 F
Nursing	20,749	20,470	278 U	40,988	40,503	485 U
Technical	10,770	11,094	324 F	20,215	21,059	844 F
Hotel Services	859	864	5 F	1,693	1,648	45 U
Administration	6,702	6,995	293 F	12,717	13,350	634 F
Other	3,593	3,197	396 U	6,968	6,796	171 U
Total Employee Costs	62,585	63,029	444 F	120,766	122,199	1,432 F
Outsourced Services	6,820	6,271	549 U	13,058	12,499	559 U
Direct Treatment Costs	17,965	17,551	414 U	34,895	35,506	610 F
Indirect Treatment Costs	3,627	3,550	77 U	7,244	7,103	142 U
Funder Payments	47,930	47,260	670 U	95,269	93,587	1,682 U
Inter District Outflows	9,734	8,497	1,237 U	18,175	16,993	1,182 U
Prop, Equip, & Maintenance	3,923	3,700	223 U	7,610	7,425	186 U
Administration Costs	1,963	2,061	98 F	3,979	4,143	164 F
<b>Total Operating Expenditure</b>	154,547	151,920	2,627 U	300,998	299,454	1,544 U
<b>Operating Contribution</b>	4,692	5,220	528 U	13,727	14,261	534 U
Depreciation	3,025	3,656	631 F	6,593	7,301	708 F
Finance Costs	1,516	1,525	9 F	3,033	3,050	17 F
Capital Charge	2,892	2,892	0 F	5,638	5,784	146 F
<b>Total Non Operating Costs</b>	7,433	8,073	640 F	15,264	16,135	871 F
<b>Net Surplus / (Deficit)</b>	2,741 U	2,853 U	112 F	1,537 U	1,875 U	338 F

**Statement of Financial Position**  
as at 31 August 2011

64

\$'000	31-Aug-11			31-Jul-11	30-Jun-11
	Actual	Budget	Variance	Actual	Actual
<b>Public Equity</b>	573,103	573,577	473U	573,103	573,103
<b>Reserves</b>					
Revaluation Reserve	331,808	353,538	21,730U	331,980	331,989
Accumulated Deficits from Prior Year's	(468,224)	(468,308)	84F	(468,224)	(468,367)
Current Deficit	(1,537)	(1,875)	339F	1,205	143
	(137,953)	(116,645)	21,308U	(135,039)	(136,235)
<b>Total Equity</b>	<b>435,151</b>	<b>456,932</b>	<b>21,781U</b>	<b>438,065</b>	<b>436,869</b>
<b>Non Current Assets</b>					
<b>Fixed Assets</b>					
Land	163,554	181,497	17,943U	163,554	163,331
Buildings	569,600	598,358	28,758U	571,072	573,160
Plant & Equipment	73,821	56,883	16,939F	74,704	75,452
Work in Progress	22,067	42,821	20,754U	19,303	17,699
	829,042	879,558	50,516U	828,633	829,642
<b>Derivative Financial Instruments</b>	5,669	4,499	1,170F	5,669	5,669
<b>Investments</b>					
Associate Company Investments	502	470	32F	502	502
Trust Funds	3,898	10,078	6,180U	3,898	3,898
	4,400	10,548	6,148U	4,400	4,400
<b>Total Non Current Assets</b>	<b>839,111</b>	<b>894,605</b>	<b>55,494U</b>	<b>838,701</b>	<b>839,711</b>
<b>Current Assets</b>					
Cash & Short Term Deposits	71,002	49,335	21,667F	75,641	83,325
Trust Deposits	19,067	10,635	8,432F	18,838	19,160
Debtors	19,793	26,426	6,633U	20,158	27,532
Accrued Income	35,921	31,204	4,717F	34,073	28,673
Prepayments	2,600	3,213	613U	3,253	3,025
Inventory	12,022	12,454	432U	11,988	12,021
Property Intended for Resale	20,041	-	20,041F	20,041	20,041
<b>Total Current Assets</b>	<b>180,445</b>	<b>133,267</b>	<b>47,178F</b>	<b>183,991</b>	<b>193,778</b>
<b>Current Liabilities</b>					
Borrowing	(29,659)	(6,162)	23,496U	(24,667)	(23,249)
Trade & Other Creditors, Provisions	(92,712)	(107,517)	14,805F	(88,562)	(105,338)
Income Received in Advance	(25,332)	(21,701)	3,631U	(25,974)	(23,445)
GST & PAYE Payable	(20,372)	(19,995)	377U	(22,002)	(20,931)
Employee Benefits	(129,838)	(122,965)	6,873U	(134,588)	(136,320)
Funds Held in Trust	(1,097)	(1,109)	12F	(1,095)	(1,093)
Loan - Associated Entities	(3,916)	14,876	18,791U	(2,821)	(1,386)
<b>Total Current Liabilities</b>	<b>(302,925)</b>	<b>(264,574)</b>	<b>38,351U</b>	<b>(299,709)</b>	<b>(311,762)</b>
<b>Working Capital</b>	<b>(122,480)</b>	<b>(131,307)</b>	<b>8,827F</b>	<b>(115,718)</b>	<b>(117,984)</b>
<b>Non Current Liabilities</b>					
Borrowings	(259,627)	(283,121)	23,494F	(263,118)	(263,110)
Employee Entitlements	(21,853)	(23,246)	1,393F	(21,800)	(21,748)
<b>Total Non Current Liabilities</b>	<b>(281,480)</b>	<b>(306,366)</b>	<b>24,886F</b>	<b>(284,919)</b>	<b>(284,858)</b>
<b>Net Assets</b>	<b>435,151</b>	<b>456,932</b>	<b>21,781U</b>	<b>438,065</b>	<b>436,869</b>

## Statement of Cashflows for the Year ended 30 June 2012

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	Aug-11			Year to Date		
	Actual B	udget	Variance	Actual	Budget	Variance
<b>Operations</b>						
Revenue Received	156,522	154,646	1,876	315,913	310,271	5,642
Payments	(159,527)	(141,664)	(17,863)	(326,398)	(300,792)	(25,606)
<b>Net Operating Cashflows</b>	<b>(3,005)</b>	<b>12,982</b>	<b>(15,987)</b>	<b>(10,485)</b>	<b>9,479</b>	<b>(19,964)</b>
<b>Investing</b>						
Income	592	617	(25)	1,191	1,234	(43)
Capital						
Sale of Assets	0	8	(8)	0	15	(15)
Purchase Fixed Assets	(3,092)	(5,972)	2,880	(5,655)	(11,944)	6,289
<b>Net Investing Cashflows</b>	<b>(2,500)</b>	<b>(5,347)</b>	<b>2,847</b>	<b>(4,464)</b>	<b>(10,695)</b>	<b>6,231</b>
<b>Financing</b>						
Equity Injections	0	0	0	0	0	0
New Loans	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
<b>Net Financing Cashflows</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total Net Cashflows</b>	<b>(5,505)</b>	<b>7,635</b>	<b>(13,140)</b>	<b>(14,949)</b>	<b>(1,216)</b>	<b>(13,733)</b>
<b>Opening Cash</b>	51,577	52,170	(593)	61,021	61,021	0
<b>Closing Cash</b>	46,072	59,805	(13,733)	46,072	59,805	(13,733)

## Financial Performance

- The net result for the month was a deficit of \$2.74m, a favourable variance against a budgeted deficit of \$2.85m. The net result year to date was a deficit of \$1.54m, a \$0.34m favourable variance against a budgeted deficit of \$1.88m.
- The result for the month is driven by higher revenue (\$2.1m), higher operational costs (\$2.6m) and lower non-operational costs (\$0.6m). Year to date the result reflects higher revenue (\$1.0m), higher operational costs (\$1.5m) and lower non-operational costs (\$0.9m).
- Revenue for the month was higher than budget by \$2.1m (\$1.01m YTD). This was the result of:-
  - a) Unfavourable Base Revenue \$1.8m (\$3.34m YTD) driven mainly by lower IDF volumes than planned.
  - b) Higher MoH Subcontract revenue \$0.15m (\$0.67m YTD), driven by higher SCI funding \$0.21m (\$0.42m YTD) and higher receipts against RCLM funding.
  - c) Lower volumes of non resident & ACC activity \$0.30m (\$0.69m YTD).
  - d) Higher levels of inter DHB side contracts \$1.9m for PHO costs (\$3.1m YTD) and DRG prior year washups \$2.0m (\$2.0m YTD).
- Expenditure for the month was higher than budgeted by \$1.99m (\$0.67m YTD). This was the result of:
  - a) A favourable variance in employee costs of \$0.4m (\$1.4m YTD) with actual fte below the budgeted level.
  - b) Direct & Indirect Treatment costs are \$0.49m unfavourable to budget (\$0.47m F YTD). The unfavourable variances are mainly in clinical supplies \$729k (\$1.09m U YTD), blood products \$0.15m (\$77k F YTD) and third party treatment costs \$0.05m (\$0.03m U YTD) with favourable variances in Chemicals & Media \$0.09m (\$0.2m F YTD) and Pharmaceuticals \$0.35m (\$1.17m F YTD).
  - c) Funder Payments (including IDF Outflows) are unfavourable to budget by \$1.9m (\$2.8m YTD) due mainly to increased PHO expenditure through the realignment of PHOs. This also drives the favourable variance in Inter DHB revenue above. There are also favourable variances in Mental Health \$0.15M (\$0.46m YTD) and other Personal Health contracts \$1.13m (\$1.44m YTD), with unfavourable variances in Disability Support \$0.12m (\$0.02m F YTD). Inter District Outflows are unfavourable to budget \$1.2m (\$1.2m YTD) due to realignment of PHOs to Counties Manukau.
  - d) Depreciation is \$0.63m favourable to budget (\$0.71m YTD) due to delays in capital expenditure and the devaluation of properties.
  - e) Finance Charges and Capital Charge are both favourable to budget for the month and year to date.

## Financial Position

- The balance of fixed assets is \$50.0m below budget principally due to the downward revaluation of land & buildings \$21.7m as at 30 June 2011, the reclassification of \$20m worth of assets, to be transferred to Health Alliance, into Property Intended for Resale and the lower capital expenditure in the latter stages of 2010-11 and Jul-Aug 2011.
- At month end there is an unused overdraft facility of \$34.5m.

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## PAPERS

Nil



# *13*

## **GENERAL BUSINESS**



**APPENDICES**

**Nil**



***15***

**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 7 September 2011	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.
15.2 Employment Relations		
15.3 Strategic Partnership		
15.4 National Health Innovation Hub		