

# **Auckland District Health Board**

## **Board Meeting**

**Wednesday 7 September 2011**

**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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***1***

**KARAKIA**



## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

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

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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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

<b>NAME OF BOARD MEMBER</b>	<b>ORGANISATION</b>	<b>ROLE</b>	<b>FINANCIAL INTEREST</b>	<b>NATURE OF INTEREST</b>	<b>DATE OF LATEST DISCLOSURE</b>
<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>	Senior Lecturer Nursing, Auckland University Casual Staff Nurse ADHB		Salary  Salary		21 April 2010
<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	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member	Fees  Hourly fee  Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
<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**

**- WEDNESDAY 1 AUGUST 2011**



# Auckland District Health Board Minutes



<b>MEETING DETAILS</b>											
Time and Date	2:00 pm, Wednesday, 3 August 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 2:15pm. 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>Dr Chris Chambers</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  Taima Campbell – Executive Director Nursing  Naida Glavish – Chief Advisor Tikanga, General Manager Maori Health  Janice Mueller – Director Allied Health  Vivienne Rawlings – General Manager Human Resources  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Rob Cooper was still on leave of absence.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Chris Chambers	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Dr Lester Levy (Chair)	Jo Agnew										
Peter Aitken	Judith Bassett										
Susan Buckland	Dr Chris Chambers										
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.										
<b>4.1</b>	<b>CONFIRMATION OF MINUTES 6 JULY 2011</b>										
	<p>An email had been received from the complainant about smoking on-site thanking the Board for the way it had responded. Security guards were now more active and while there was still some staff dissatisfaction a quit line, hotline level 5 and web activity had increased with 75 suggestions for improvement from people. Children in Starship had done artwork in relation to the quit smoking message which would be shared at the next meeting. The interview on Morning Report was also noted.</p> <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 6 July 2011 with the amendment deleting the comment on staff performance be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

<b>5</b>	<b>ACTION POINTS 6 JULY 2011</b>
	A number of actions had been covered in the CPHAC meeting and the Board had received 3 weekly updates on primary care. Categorising the primary care initiatives was work in progress.
<b>7.1</b>	<b>CHIEF EXECUTIVE'S REPORT</b>
	<p>The Chief Executive thanked the Board for their support during his medical leave and acknowledged Denis Jury as Acting CEO and the whole leadership team.</p> <p>There would be a more comprehensive review of the end of year results and targets next month and the Communications team were working on that publication. This would include delivery to the District Annual Plan and savings plan. The new year had commenced and it was important to maintain achievement of the targets. DHBs had agreed to rollover the Community Pharmacy agreement with a process to resolve a new contract.</p> <p>Primary care surgical referrals are sent to accredited GPs with the question raised as to who does the accrediting criteria to include or exclude providers. This raised the question of managing credentialing in primary care noting the processes within the College of GPs and Cornerstone programmes with most based on clinical pathways. A paper on credentialing would be provided.</p> <p>The Board performance priorities were being incorporated into the report and with "Live Within Our Means" this should not be restricting in the sense of just seeking savings but be used to drive productivity and change. Cardiac waiting lists numbers had increased from May however they were still below the target waiting list number and efforts would be made to reduce the number to the early 60s. Care of congestive cardiac failure is being migrated to the shared care plans for long term conditions.</p>
<b>7.2</b>	<b>Minister's Six Health Priorities</b>
	The immunisation target had been met. A number of strategies had been tried, including a resource in Starship, but now coordinators were working with practices and sharing best practice. The 3 Diabetes Coordinators were starting to show results. The roles of coordinators may be combined.
<b>7.3</b>	<b>Towards Excellence</b>
	<p>The work of Dr Divya Dhar was acknowledged.</p> <p>The proposal was an Academic Health Alliance, and not a Centre which inferred bricks and mortar, to show the value of working with the Faculty of Medical and Health Sciences and other faculties of the University of Auckland such as the Business School, Law and IT. It was thought that excellence had to be earned and it was hoped that, through the Alliance, research and teaching will become to be seen as excellent. A start would be with two HSGs being oncology, both medical and radiation, and cardiac inclusive of cardiology with these two HSGs being pilots. Governance was complex so the pilots would be used to test the models with DHB, University and networks. The Alliance was not exclusive of private and it was noted that it was important to give private opportunities and to create better cooperation. It was noted that private had very philanthropic investors.</p> <p><u>Moved Gwen Tepania-Palmer; seconded Lee Mathias</u></p> <p><i>That the ADHB Board supports the concept of an Academic Health Alliance with the Faculty of Medical and Health Sciences, University of Auckland.</i></p> <p><u>Carried</u></p>

<b>7.4</b>	<b>NORTHERN REGIONAL HEALTH PLAN BUDGET</b>
	<p>The Board had previously approved its share of \$1.2m based on PBF with this proposal being on the “First Do No Harm” component.</p> <p><u>Moved Lester Levy; seconded Jo Agnew</u></p> <p><i>That the ADHB Board approves its population based share of the additional \$955,000 budget for the “First Do No Harm Campaign” element of the Northern Region Health Plan for 2011/2012 subject to:</i></p> <ul style="list-style-type: none"> <li>(a) <i>clarification of the IHI contract and probity assurances, \$300k total budget expenditure;</i></li> <li>(b) <i>CEO signoff on acceptable project costing and scope for regional spatial and asset management plan (\$150k total cost), Information Systems and Population Health Workstream (\$100k total cost) and advance care planning and training (\$150k total cost);</i></li> <li>(c) <i>Only actual costs to be charged with no substitution without ADHB signoff as per relevant delegation of authority;</i></li> <li>(d) <i>ADHB receiving a PBF share of the training places available and;</i></li> <li>(e) <i>Monthly project reporting on all milestones in the plan, including monthly reporting on expenditure against budget.</i></li> </ul> <p><u>Carried</u></p>
<b>8.1</b>	<b>Committee Recommendations</b>
	<p><b>After Hours Proposal for Auckland Metro Region</b></p> <p>The CPHAC Committee had approved the proposal for discussion but not to increase funding. Staff had endeavoured to obtain more detail and had become more concerned about that lack of detail and the timeline to 1 September. There were serious issues on access for low pays and the general capability of PHOs to put the proposal together and manage it. PHOs were reluctant to invest.</p> <p>A plan B alternative was being developed which would not be about structures or hinder further future development including with Integrated Family Health Clinics. The alternative plan still sought to lower co-payments and has different overnight arrangements using EDs and more structured triage of the patient to get them to the right place for treatment at the right time through a structured pathway approach. Data was being shared between ADHB and St Johns which had exciting opportunities as they did have information on frequent users.</p> <p>The update was noted.</p> <p><b>Community Pharmacy Contract Renewal</b></p> <p>The existing contract had been agreed to be rolled over to 30 June 2012.</p>
<b>10.1</b>	<b>Finance Committee Recommendations</b>
	<p><b>University Steam Agreement Extension</b></p> <p><u>Moved Lee Mathias; seconded Robyn Northey</u></p> <p><i>That the Board agrees that:</i></p> <ol style="list-style-type: none"> <li>1. <i>Upon expiry of the current steam agreement, to enter a new agreement to supply steam to the University of Auckland’s School of Medicine campus for a further ten years. The new agreement will commence on 1 November 2012 and have an estimated annual value of approximately \$340,000 p.a.</i></li> <li>2. <i>The CEO be delegated authority to execute the contract.</i></li> </ol> <p><u>Carried</u></p>

**Roster and Timesheet Automation Project (RiTA)**

Moved Lee Mathias; seconded Robyn Northey

*That the Board approves and seeks National IT approval to the commitment of \$2m of capital and opex of \$543k pa for the implementation by ADHB of a regional Roster and Timesheet Automation project.*

Carried

**Annual Report Financial Information 2011**

The Board asked that a draft resolution be circulated to address all the issues related to the Annual Report financial information being the revaluation of property, audit management letter signoff, letter of representation etc. This is to be circulated to members to respond by email by close of business on Monday.

**Crown Funding Agreement Extension of Term until 30 June 2012**

Moved Ian Ward; seconded Chris Chambers

*That the ADHB Board:*

- *Notes the proposal of the Minister of Health to extend the term of the existing Crown Funding Agreement (CFA) until 30 June 2012, and*
- *Agrees to the Minister's proposal to make the following substitutions in the CFA*
- *Substitute all references in the CFA to "District Annual Plan" or "DAP" with "Annual Plan" or "AP". This is to reflect changes made by the New Zealand Public Health and Disability Amendment Act 2010.*
- *Approves the extension of term of the CFA for the period 1 July 2011 to 30 June 2012, estimated amount \$987m (GST excl).*

Carried

**Tamaki 300: Pathways to Health Careers Programme**

This is a complex initiative and would be discussed by the Board in public exclusion.

**10.2 Finance Report**

The financial results were noted. The result for the sector was a deficit of \$20m against budget deficits of \$70m which was a good sector result.

<b>14</b>	<b>PUBLIC EXCLUSION</b>															
	<p><u>Moved Jo Agnew; seconded Robyn North</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="204 546 1358 913"> <thead> <tr> <th data-bbox="204 546 580 663">General subject of each matter to be considered:</th> <th data-bbox="580 546 979 663">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="979 546 1358 663">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="204 689 580 748">14.1 Confidential Board Minutes 6 July 2011</td> <td data-bbox="580 689 979 748">To enable the Board to carry on without prejudice or</td> <td data-bbox="979 689 1358 748">That the public conduct of the relevant part of the</td> </tr> <tr> <td data-bbox="204 748 580 777">14.2 Human Resources</td> <td data-bbox="580 748 979 777">disadvantage commercial</td> <td data-bbox="979 748 1358 777">meeting would be likely to</td> </tr> <tr> <td data-bbox="204 777 580 831">14.3 Criteria Leased ADHB Premises</td> <td data-bbox="580 777 979 831">activities and negotiations:</td> <td data-bbox="979 777 1358 831">result in the disclosure of</td> </tr> <tr> <td data-bbox="204 831 580 884">14.4 Ministerial Consent to NRSSO</td> <td data-bbox="580 831 979 884">Official Information Act 1982 s.9(2)(i) and s.9(2)(j)</td> <td data-bbox="979 831 1358 884">information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.</td> </tr> </tbody> </table> <p><u>Carried</u></p> <p>Matters discussed in public exclusion were the Confidential Minutes 6 July 2011, Human Resources; Criteria Leased ADHB Premises, Ministerial consent to NRSSO and the Tamaki 300: Pathways to Health Careers Programme.</p> <p><u>Moved Robyn Northey; seconded Lee Mathias</u></p> <p><i>That the ADHB Board 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 6 July 2011	To enable the Board to carry on without prejudice or	That the public conduct of the relevant part of the	14.2 Human Resources	disadvantage commercial	meeting would be likely to	14.3 Criteria Leased ADHB Premises	activities and negotiations:	result in the disclosure of	14.4 Ministerial Consent to NRSSO	Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	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 4:30 pm</p> <p>The next scheduled meeting is: 2:00pm, Wednesday, 7 September 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>															
	<p><b>CONFIRMED</b></p> <p><b>CHAIR:</b></p> <p><b>DATE:</b></p>															



**ACTION POINTS**

**- WEDNESDAY 1 AUGUST 2011**



**Board  
Action Points from the meeting on Wednesday 3 August 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
Carried forward	Delegated Authorities look at aligning across ADHB/WDHB	Ian Bell	Memo sent to Chair and CEO
Carried forward	Primary Care summary of initiatives categorise, status (where at), expected completion date	Denis Jury	
7.1	A paper on managing credentialing in primary care noting the processes within the College of GPs and Cornerstone programmes with most based on pathways	Denis jury	
10.2	A draft resolution be circulated to address all the issues related to the annual accounts financial information being the revaluation of property, audit management letter signoff, letter of representation etc. This is to be circulated to members to respond by email by close of business on Monday.	Brent Wiseman	Actioned and confirmed



## **CHAIRMAN'S REPORT**



# **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 JULY</b>
<b>2</b>	<b>EVENTS AND NEWS IN AUGUST</b>
<b>3</b>	<b>MANAGING THE WIDER HEALTH SYSTEM</b>
<b>4</b>	<b>BOARD PERFORMANCE PRIORITIES</b>

## Introduction

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

## 1 Events and news in July

### 1.1 Events

During June the following events took place:

- An oxygen leak occurred in the Oncology Day Stay Unit at Auckland City Hospital one Thursday afternoon. This required the evacuation of 12 patients and some 400 staff as a precaution on the advice of the Fire Service.
- Following this event there were numerous media requests for information regarding the oxygen leak and these were responded to.
- ADHB facilities and staff were filmed and interviewed for a TVNZ Close Up story about paediatric carers.
- In the previous month's report we highlighted other June events including the publication of The Statement of Intent and Annual Plan, the launch of National Women's Health new website and recent patient news for fundraising and media coverage. We noted the reporting of ADHB's achievements against the six MoH health targets in NOVA and the opening of the refurbished ADHB Contact Centre and Central Referrals new offices.

## 2 Events and news in August

### 2.1 Events

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

#### People

- Dr. Jack Watt passed away on the August 2. Dr Watt was the Director of Anaesthesia for Auckland Hospitals from 1958 until he retired in 1983.
- Starship Anaesthetist Paul Baker won first place at the Scientific and Educational Exhibit Awards at the International Anaesthesia Research Society (IARS) Annual Meeting in Vancouver.
- Colorectal Nurse Specialists Debbie Perry and Esther Menzi were placed first for their paper: The Colorectal Nurse Specialist Rectal Bleeding Clinic – improved waitlist efficiencies at the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) at the tripartite colorectal meeting in Cairns, Australia.
- Twenty-four new mothers on the maternity wards contribute to the breaking of the national record for the "Big Latch On" for World Breastfeeding Week. ADHB's participation was a first and was spearheaded by lactation consultant Gerry Smith.

- An announcement has been made that ADHB physiotherapist, Kirsty Johnson Cox, will represent NZ at the World Triathlon Champs in China next month.
- Kids' Domain (ADHB's early childhood centre) has been nominated for a national teaching award.

### **Media**

- A request has been received to interview planners at the DHBs with major involvement in the Rugby World Cup to gain a picture of preparedness and staffing arrangements.
- Auckland Sexual Health Service capitalises on the Telecom "Abstain" campaign to launch its own "Consent-Crouch-Touch-Condom-Engage" safe sex campaign.
- There have been an unusually large number of enquiries about patients admitted with meningitis and road and work accident injuries.

### **Internal**

- The ADHB Healthcare Excellence Award applications are open for submissions.
- New CPR guidelines were rolled out at ADHB – displays were held at ACH, Greenlane and Starship.

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

### **3.1 System performance**

DHBs have discussed the lessons learned from the 2011/12 planning with the Ministry of Health and National Health Board to assist the process for 2012/13. This noted that the collaboration between DHBs and the National Health Board had resulted in improvements to the statement of forecast service performance and allowed a positive exchange of views during the process. Issues shared included the difficulty in creating the Statement of Intent from the annual plan modules, late changes and errors in the financial templates and poor alignment between the Office of the Auditor-General and the Ministry of Health.

The metro-Auckland DHB planning teams are working with the Auckland Regional Public Health Service to develop a working relationship with Auckland Council. A briefing paper for Boards will be available in September to enable DHB Boards to provide submissions on the draft Auckland Plan. This work is also linked to the asset and spatial planning activity included in the Northern Region Health Plan.

The auditors have given audit signoff of the net financial results and the audited CFIS return was filed prior to the deadline. The auditors are now in the process of completing their work on the presentation aspects of the annual report for the year ended 30 June 2011.

The first month of the new financial year comes during mid winter with the attendant challenges of managing acute demand in the provider arm whilst maintaining elective services performance. Work is also in hand to ensure that the key project initiatives

for 2011/12 are under way to deliver the health gains and operational benefits anticipated in the Annual Plan and Statement of Intent. Good progress has been made on all accounts.

July was the first month reported to the combined ADHB and WDHB joint Board Committees. The reporting process will continue to evolve but the first reports were able to provide comprehensive coverage from regional, joint and single DHB perspectives.

### **3.2 Financial performance**

A full report is included in the Audit and Finance Committee papers, but in summary the organisation achieved an overall \$1.2 million surplus for the month, \$0.2 million favourable against the budget. The Funder and Governance Arms recorded favourable variances and the Provider Arm an unfavourable variance. The Provider Arm variance resulted from a lower internal revenue allocation from the Funder Arm than budgeted partly offset by lower expenditure, principally in direct treatment costs. The favourable Funder Arm variance primarily resulted from the lower internal funding allocation, partly offset by lower IDF revenues than budgeted.

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

#### **Patient Safety Scorecard**

Work is progressing on the design of the ADHB Organisational Patient Safety Scorecard. Approximately 80 indicators are under consideration in 7 categories (adverse events, nosocomial infection, timeliness of treatment, peri-operative complications, deteriorating patient, mortality and readmission).

Adult services have been the initial focus, but indicators for children's and mental health will be added. The current indicators are predominately at HSG and whole organisation level, with a second phase planned to establish appropriate service-level patient safety measures. The indicators will be reviewed by a range of clinicians to ensure the indicators and indices are valid (and reliable) measures for providing assurance. The content of the scorecard will be available in September. Indicators will be populated with data progressively over the next few months.

#### **“First do no harm”**

As part of the Northern Region Health Plan, ADHB is partnering with the other northern DHBs to develop and implement a multi-faceted patient safety programme. The specific intervention areas are central-line associated bacteraemia, falls causing harm, pressure injury, transfers of care / handover, patient identification and high-risk medication safety.

#### **Global Trigger Tool**

As part of the “First do no harm” programme, a random sample case-note review process to provide monthly measures of adverse event rate is being implemented. This uses the “Global Trigger Tool” methodology from the Institute of Healthcare Improvement (Boston) which is independent of voluntary reporting. The measure 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”.

It is important to note that it only includes events related to the active delivery of care, and therefore excludes events due to omission. Similarly, preventability is not a requirement, only that the harm is unintended. In summary, it has a very strong patient focus i.e. healthcare delivery causing harm.

Four teams of nursing and medical reviewers have received training, and are starting their first reviews this week. Data will only be made available after a stable baseline has been established, probably by early 2012.

### **Central Line - Associated Bacteraemia (CLAB)**

The infection of vascular access lines placed into the central circulation is now nearly completely preventable. A target of zero CLAB in intensive care units for the northern region has been set as part of the “First do no harm” programme. Current ICU rates are 3 – 6 infections per 1000 line-days. A combination of evidence-based standards (“bundles”) for central line insertion and daily maintenance will be progressively implemented for all services undertaking line placement. The outcome measure however will be limited to ICUs, as these are the first sites to introduce the interventions and reliable denominator data is difficult to establish in other settings.

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

An ADHB Steering Group has been established and has now met twice 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. 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 also include Pressure Injuries, given the similarities of goals in the NRHP and a similar patient population. This should work well also 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	The service is performing well but has some vacancies to fill in the next quarter.
Human Resources	40	There were no exceptions in July and the featured indicator for the month is discussed

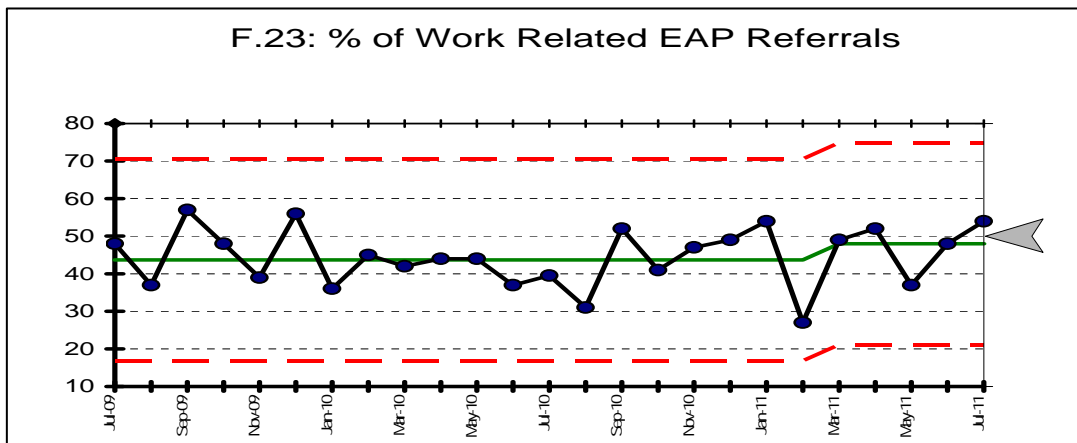
Service	Number indicators	Exceptions
		below.
Finance and shared services	15	The revenue to fixed assets ratio was impacted by the property devaluation of \$22 million. Within procurement, there have been some quality concerns around some clinical products which are being resolved.

### 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, or mental health, 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 fairly 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's 44%. Overall the trend is in alignment with the threshold of 50%.



### Managed Bargaining

Negotiations began on 7 July 2011 between representatives from the 20 DHBs and the 10 CTU affiliated unions that have mandated participation in the managed bargaining. Negotiations continued through July up to 11 August 2011. On 11 August the unions tabled a 'counter proposal' to the DHBs first formal offer on 27 July. The final 2 days of scheduled bargaining are set down for 22/23 August. A revised DHB offer will be put to the unions on Monday 22 August.

### **Ongoing Bargaining and Related Activities**

RDA – The RMO work programme continues to track well with local RMO engagement groups (LREGs) now established at most DHBs. ADHB/RDA first LREG meeting is scheduled for September and will be attended by a representative from the Partnership Resource Centre (Department of Labour). The national RMO engagement group (NREG) holds its second meeting on 29 August and there is a national forum to explore training issues on 2 September.

ASMS – SMOs – There is nothing new to report.

APEX - Clinical Physiologists – Bargaining initiated in July 2010. The Union is part of Contract Negotiation Services Group (CNS) that was earlier offered NToS type settlement, which was rejected. Workforces included in this MECA are clinical physiologists, clinical physiology technicians and electrocardiograph technicians. The MECA expired 31 August 2010. Bargaining proceeded from December 2010 to March 2011. The parties attended Mediation on 10 May 2011 and 25 July 2011 but did not make significant progress. The union has indicated it will seek facilitation through the Employment Relations Authority.

APEX - Medical Physicists – Bargaining will commence on 19/20 September.

APEX - Mediation Radiation Technologists – APEX initiated bargaining on 4 August splitting out the Sonographers into a separate MECA.

APEX - Psychologists – Settlement reached under old NToS parameters. The offer is currently with members for ratification and we will know the outcome on 26 August.

Clinical Perfusionists SECA (APEX) – Bargaining continues on 24 August.

### **3.4 Hospital services**

The coping strategies of the hospital were tested during July with an increase in acute presentations and admission resulting in the use of strategies such as flexi-beds, close management of length of stay and home based support packages to enable early discharge. This enabled a high level of performance that at 91% was nevertheless below the 95% target for patient flow management. Work has been completed on capacity forecasting to future bed requirements. This currently indicates a further acute spike in late August to mid September indicating a likely requirement for additional bed capacity through to mid December.

The provider arm experienced a \$2.6 million unfavourable variance in its net result for July primarily as a result of a revenue variance of some \$5 million, of which \$4 million was a lower internal revenue allocation. The revenue allocation includes estimated coding with the completion of further coding having subsequently increased the revenue allocation by some \$2 million. Estimates are used each month and based on past experience this month is an aberration rather than a trend. The higher coding allocated to the cases reduces the net result variance in the Provider Arm and the Funder Arm with no net impact on the overall organisation.

### **3.5 Primary care and community services**

Last month the completion of the PHO amalgamation was reported. This month the report continues to focus on areas where collaboration with primary care providers is enabling greater levels of efficiency and service through better coordination.

#### **Access to Diagnostics**

General practice utilisation of the ProExtra tool has continued to increase with 701 more requests (158% increase) generated through ProExtra in Q4 compared to the previous quarter. Customisation of the ProExtra Radiology tool for CMDHB is complete and pre-implementation pilot testing has occurred at eight Counties Manukau DHB practices and three Auckland DHB practices since May. Review of the Clinical Triage Criteria by the Project's Clinical Governance Group is almost complete and will then be forwarded to the Regional Radiology Forum for endorsement and adoption.

#### **Minor Skin Surgery – Skin Lesions**

The number of minor surgery referrals sent to accredited general practitioners has continued to steadily increase and the focus on raising awareness and confidence in the initiative will continue. Details about the skin surgery scheme were advertised in the primary care newsletter and distributed across the Metro Auckland region. A satisfaction survey is being sent to all patients who are referred to the general practitioner scheme from 1 July 2011 to 30 September 2011.

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

GAIHN will take over four regional projects: POAC (Primary Options Acute Care), Access to Diagnostics, Clinical Pathways, and Optimising Prescription Pharmaceuticals (Auckland DHB and Counties Manukau DHB Pharmaceutical project). Primary Care Planning and Funding representatives are meeting with GAIHN executives to progress the project transition and arrange for signing of the documents after the respective board meetings.

The Project Plan and Resourcing Plan for development and implementation of clinical pathways have been signed off by the Steering Group and will be submitted to GAIHN Alliance Leadership Team for approval in August. Implementation will take place over the next 12 months.

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

The Alliance Agreement and PHO Variation have been agreed by the DHBs and are with the NHC for review. The DHBs have agreed the Collaborative Agreement and this will be circulated to DHBs for signing shortly. The NHC will retain two Alliance Leadership Teams until December when they will be reviewed along with the transition of locally retained contracts.

There is a preference by DHBs to keep locality level targets and visibility of performance and progress. This is being reviewed by NHC, the PHO Performance Programme (PPP) team and the Ministry of Health together with the draft implementation plan. The creation of Support Alliance Leadership Teams (SALTs) is under discussion to progress the collection of data and set targets. These groups would utilise existing expertise within the DHBs.

### **Alliance Health + (AH+)**

AH+ have met with whanau to develop an outcomes framework underpinned by Results Based Accountability. Training for providers under AH+ will be provided with support from National Hauora Coalition and DHB planners and funders and the Clinical Governance Committee has met to establish an internal clinical work performance programme. The Mt Wellington Integrated Family Health Centre is on track to be completed by August 2011.

### **Community Pharmacy**

The National Pharmacy Working Group has extended the existing Pharmacy Services Agreement (PSA) for eight months to allow working groups to develop more detail for the long term conditions and aged residential care patient groups. The new agreement will come into effect on 1 April 2012. This roll over will not address growth issues in the community pharmacy budget and the northern region is developing strategies to manage outliers. This will be implemented on a local basis to both control growth and encourage a change in perceptions ahead of a likely change in rules from 1 April.

### **Youth Health project**

Auckland and Waitemata DHBs are funding the Collaborative Trust to lead a series of primary care training sessions based on an approach developed by the New South Wales Centre for Advancement of Adolescent Health. This will cover violence and abuse, eating disorders, traumatic stress, grief and depression, and anxiety. The training will also cover barriers to youth accessing health services which typically centre on factors such as a fear of embarrassment, cost, and a lack of knowledge about what is available.

### **Immunisation**

NIR data shows 92% of 2 year olds were fully immunised at age 2. Maori coverage increased to 92% (a 4% increase). Auckland DHB has resolved the previous equity gap for immunisation at age 2 for Maori and Pacific children, which is a significant achievement. Coverage of other ethnicities at age 2 are Pacific 94%, Asian 94%, NZE 92% and Other 85%. The 'Other' group will be examined to identify trends and opportunities. The national immunisation target for 2011/12 is 95% of all 2 year olds and this will be a challenging target as there is a decline rate at 2 years of 3.4% (53 children). As a result achieving 95% means locating almost all non-immunised, non-declined children.

### **Well Child Tamariki Ora Services**

The MoH has repatriated Well Child Tamariki Ora funding from DHBs and is contracting back at the same levels for these services via the Crown Funding Agreement (CFA) and in future as part of baseline funding. Auckland DHB has 4 Well Child Tamariki Ora providers:

- Health Star Pacific,
- Ngati Whatua O Orakei Health Centre,
- Tongan Health Society, and

- The provider arm service, Community Child Health & Disability Service (CCHADS).

The service provided by CCHADS has been enhanced and is now a multi disciplinary service working with deprived population groups with complex social and other needs. Identifying costs associated with providing a base level of service is a challenge and the issue is being resolved in discussion with the MoH.

### **Mental health alternative to admissions**

This service is now fully operational. The NGO provider has secured new long term premises that will be refurbished, based in Onehunga. The unit is likely to be open in late October subject to the usual council processes. A presentation on the new premises and service will be made by the provider to the ADHB inpatient and community teams in the next three months.

### **Mental health online therapy**

The online Cognitive Behavioural Therapy option is now available. Initially it is available through GP surgeries for mild to moderate mental health problems. Consideration is also being given to providing access for cancer services and how to best enable community mental health teams to access it for use as an adjunct to specialist care.

## **3.6 Intersectoral 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 Snug Homes. This is a programme that provides retrofitting of insulation to the homes of low income families (excluding Housing NZ tenants). Families of children who have received treatment at Starship Children's for respiratory illness are given priority. The programme began in 2006 and ADHB has been a funding partner of the programme since then contributing \$50,000 per annum. Other funders have included the Energy Efficiency and Conservation Authority (EECA), the ASB Communities Trust, Starship Foundation

(also \$50,000 per annum), the Auckland Council, ProCare and in latter years Counties Manukau DHB.




Each home costs approximately \$3,000 to insulate and to 30 June 2011 2,388 homes in the ADHB district have been insulated. In 2011/12 the ASB Communities Trust has decided to refocus their funding on a similar programme in Northland and the Starship Foundation has also decided not to fund the programme in the current year. The programme is continuing with a reduced number of funders. Although there is evidence to support such programmes there are data issues at ADHB that have precluded research being carried out on the impact of the programme on rates of admission to Starship of children with respiratory illness.

## 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	New models of care Chronic disease management Health of older people
Improved patient experience	Performance improvement	Better quality care Increased patient safety Staff engagement	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 work of loading the 2011/12 projects to the project management system is well advanced and will enable progress reporting to commence next month. The appropriate projects are also mapped to the Board's 10 priorities. The tables on the following pages are now prepared using the DAP reporting system.













The information set out below summarises the projects that support the Board's priorities and identifies their current phase, status and any exceptions.

Projects	This Month	Last Month	Change
<b>Not yet Started</b>	28	0	28
<b>Planning</b>	38	0	38
<b>Implementation</b>	0	0	0
<b>Cancelled</b>	0	0	0
<b>Completed</b>	0	0	0
<b>Total</b>	<b>66</b>	<b>0</b>	<b>66</b>



## Priority Status

Emergency Care	95% of patients are admitted, discharged or transferred from adult and children's EDs within 6 hours
	There was a small decline in ED performance with the onset of winter with a 91% performance against the target of 95%. Capacity forecasting has been undertaken which suggests further acute spikes will occur in late August to mid September and additional bed capacity will be required through to mid December.
Elective Surgery	Achieve the number of elective procedures specified in the DAP
	Elective surgery levels were at 94% of target reflecting the high winter demand on services. Mitigation strategies are in place to remedy the shortfall.
Shorter waits for cancer treatment	Radiation treatment within four weeks of first specialist assessment and medical oncology within agreed DAP timelines
	100% of eligible patients were treated within the four week target timeline. As at 31 July Radiation Oncology had delivered to the target for 461 consecutive days.
Health of Older People	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)
	A large number of initiatives and measures have been agreed as part of the District Annual Plan process and an assessment of detailed project requirements is being made as part of the establishment work for the project reporting system. A status report will be available at the next Board meeting.
Clinical Leadership	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
	The work to develop and align the systems and reports to the new operating structure is well advanced. The focus is now turning towards the leadership development requirements. This work is at an early stage and includes discussions at a regional level.
Culture	Professionalism, clinical excellence coupled with patient service and improved communication with patients
	The leadership walk around programme has been implemented and the planning process for coaching framework and the level 2 and 3 leaders open disclosure training will be completed over the next three months.
New Models of Care	New models of care for fast stream elective surgery, readmission prevention, Whanau Ora, health promotion, children and young persons and older people

	The work programme cover some 14 projects and these have been loaded to the DAP project reporting system. The first status reports are being prepared. This information will be available by the next board meeting
Chronic disease management	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
	<p>Cardio Screening - Cardiovascular risk assessment is measured quarterly and the Q4 result from the MOH indicates a 1.1% decrease from the previous quarter to 78.8% (this was 0.2% under target). Targets for Maori and Pacific were met (74.3% and 76.1% respectively against a target of 71%).</p> <p>Diabetes - This is a priority area in the regional health plan. Q4 results for diabetes measures indicated that the annual check programme exceeded target by 9% and the diabetes management performance was 74% against a target of 79%, but showing a 3% improvement for Q3.</p> <p>Cardiac Waiting List - (status yellow) 79 Bypass procedures were completed of which 65 were eligible to be counted. The remaining procedures were thoracic surgery for cancer or acute cardiac procedures. There were 81 patients on the waiting list at the end of July, contributing to a total bypass waiting list of 94, which is within the MOH target set for 2011/12.</p> <p>Clinical Pathways - Annual plan targets for 2011-12 have been set. The Project Plan and Resourcing Plan for development and implementation of pathways have been signed off by the Steering Group and are being submitted to GAIHN Alliance Leadership Team for sign off. The mechanism for achieving operational management and business integration is now being developed.</p>
Regionalisation through Collaboration	Collaboration as an overriding principle undertaken with studious intent and with a special focus on Waitemata DHB
	The work programme continues to focus on three focus areas. The initial transition to healthAlliance is largely complete and the first joint Board Committee meetings have taken place with WDHB using joint reports that work to identify common areas of work and collaborative initiatives to optimise service planning, patient care and communication strategies.
Living within our Means	Financial deficits are not acceptable under any circumstances
	The financial result for July 2011 recorded a small surplus of \$1.2 million. Further narrative on the financial results is included in the finance papers.

## Exceptions by project

Project	Phase	On Time	On Budget	Expected Outcome	Review
no projects found with exceptions					



**7.2 Minister's Six Health Priorities 2009/10**











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## 7.2 Health Target Updates


The information set out on the attached pages covers the six health target reports that are reported to the MOH each month. They comprise:


- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services

	Status	Comment
Adult acute patient flow		91% achieved against 95% target.
Child acute patient flow		92% achieved against 95% target.
Improved access to elective surgery		95% of target achieved.
Shorter waits for radiation therapy		100% of eligible patients treated.
Increased immunisation		Q4 performance was 92% and exceeded the 91% target. Next report Q1 2011/12.
Better help for smokers to quit		Below target but improving coverage with smoking status check in wards.
Diabetes checks		Q4 2010/11 target met. Next report Q1 2011/12.
Diabetes management		Q4 2010/11 74% achieved against a target of 79%. Next report Q1 2011/12.
Cardiovascular risk assessment		Q4 2010/11 performance only 0.2% below 79% target. Next report Q1 2011/12
Cardiac bypass surgery		Waiting times met. Volumes below target.

Key to symbols:

Proceeding to plan 

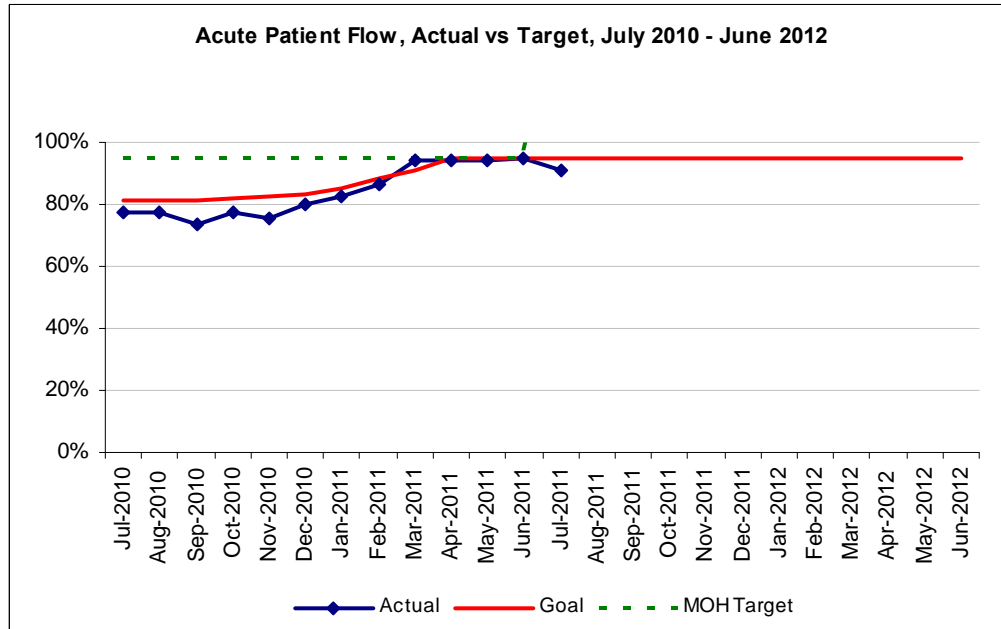
Issues being addressed 

Target unlikely to be met 

**Project:**

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

Date of Delivery: 30 June 2012

**Project Risks / Comments:**

Small decline in Shorter stays in ED performance with the onset of winter. Current quarter to date – 91%.  
 Actions taken across Adult and Children's service to respond to constraints impacting on flow.

## Project: Adult Acute Patient Flow

53

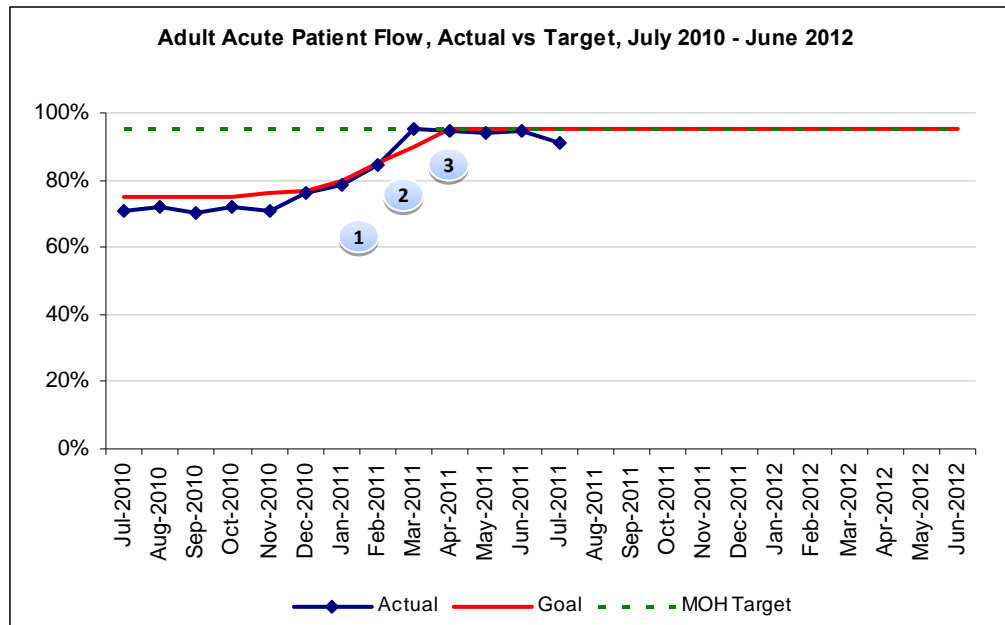
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2012

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



### Project Risks / Comments:

Small decline in number of patients admitted, discharged or transferred from Auckland Adult Emergency Department in July. Acute flow has been impacted by spikes in ED presentations (high presentation and admission days), longer length of stay in General Medicine and Orthopaedics, increased hospital occupancy resulting in access block and registrar changeover with some roster gaps. As a result; additional winter flex beds opened and occupancy triggers adjusted for further flex into cardiac day stay, Gen Med SMO rostered in ED / APU between 1600 and 2000hrs, transition lounge hours extended; Gerontology Nurse Practitioner visiting ED / APU to rapidly assess any patients that can be discharged home with enhanced Home based support package or back to Residential Care with support and review, daily 15 minute capacity review meeting implemented with expected date of discharge and acute / elective admission forecasting for next 48 hours. Work progressed on ACH capacity forecasting model to understand bed capacity requirements to meet both acute and elective bed demand. Forecasting suggests further acute spike late August to mid September and additional bed capacity is required through to mid December.

### Improvements to date:

**Streamlined AED processes and measurement and manage the challenge of growing demand**

Reviewed Medical / Nursing requirements for AED and approved business case for resource increase to match increased workload.

Charge nurse patient flow coordinator introduced

Improved access to Radiology

Streamlined documentation required for safe transfer

Improved triage processes.

### Managing bed block with additional resources

58 Additional beds opened 2009-2010

Winter Ward 31 General Medicine 10 additional beds August – October 2010

### Managing bed block & reducing the time patients wait through improved processes and teamwork

Daily Rapid Rounds introduced in General Medicine (Feb 2010) and Orthopaedics (July 2010)

Nurse Facilitated Discharging in General Medicine (April 2010)

Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.

Daily breach review meetings to understand root causes and implement short term solutions.

### Immediate actions to improve performance:

1. Increased engagement of Senior Leadership Team to support improvement activities and reduce road blocks to improvement.  
Increase communication and engagement of Clinical Directors, SMO's, RMO's  
Increase communication and engagement of Charge Nurses and RN's after hours to further reduce wait times for patient transfer from Emergency Department  
Engage with SMO's, RMO's and nurses one to one, by CD, Nurse Advisor or Level 2 clinical leader where resistance to required behaviour is demonstrated.  
Valuing patient time poster campaign
2. Establish ED short stay unit  
Implement APU flex beds  
Improve measurement of Ready to Go patients in ED  
Complete recruitment of remaining ED resource to improve weekend coverage  
Support General Medicine by diversion of patients to subspecialties  
Implement general surgery acute flow team initiatives to improve response time  
CMO to attend Orthopaedic SMO meeting to increase engagement.  
Relocate bed manager to ED after hours  
Implement ED discharge nurse on weekend  
Hands on support of ED flow Charge Nurse to reduce roadblocks to timely review and transfer of patients  
Commence physiotherapy facilitated discharge in Orthopaedics.  
Establish discharge co-ordination responsibility in Gen Med ward nursing team.  
Further increase timely overnight transfers from ED to inpatient wards once bed allocated.
3. Five day rapid improvement event planned for April to focus on improvement of process from decision to admit to patient transfer complete.  
Improve elective scheduling.

# Project: Children's Acute Patient Flow

54

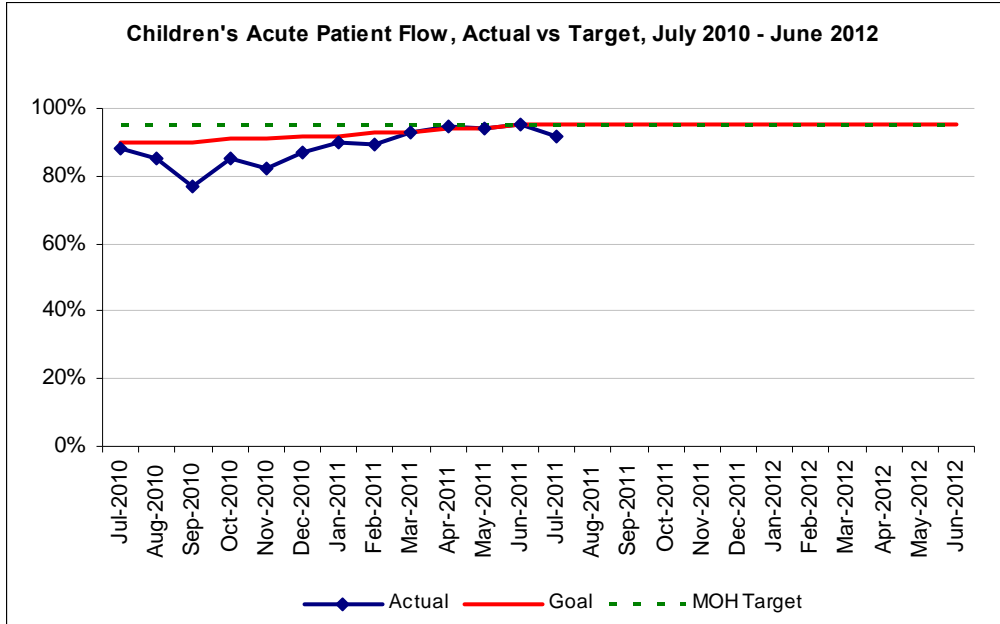
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: **30 July 2012**

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



**Project Risks /Comments:** As anticipated, July proved to be more of a challenging month for Starship Acute Patient flow, with 92% of patients being either admitted or discharged within six hours. While this result is below our goal, it is a 3% improvement on the same month last year and a significant 14% above 2009. The result of 92% is a reflection of eight days of 95% or better and 24 days of 90% or greater. Both presentation and admission volumes were similar to 2010. Our improvement activity continues to focus on a number of key initiatives.

- The 2 hour component of the 3-2-1 guide through improving response times from the Inpatient Specialist teams. We have identified five areas where improvement is required.
- Initiating a Capacity Planning Group whose role it is to facilitate patient flow by having the right number of beds available for the right patients at the right time. The group meets on a weekly basis to determine responses to both prior and predicted admissions with respect to planned bed availability and elective surgery intake.
- There is a renewed focus on improving the use of Estimated Discharge dates as this is pivotal to creating a more accurate view of future bed demand and capacity requirements. There has been significant improved accuracy, although there is a lot more improvement required to inform our capacity planning efforts.
- The discharging process itself has been identified as an area requiring improvement. We have held a first workshop with Senior Nursing and Management staff to identify Causes and Effects and this has provided us with some useful data to move a scoped project forward.

The initiative to convert all Starship wards to electronic Whiteboards has been completed. This has provided the hospital with a level of transparency of bed availability, CED activity and expected arrivals. It has also focused all staff updating activity onto one electronic system resulting in improved data integrity.

## Improvements to date:

Improvement in the Estimate Discharge Date (EDD's) for current inpatients

Improvement in the forecasting occupancy

## Immediate Actions to Lift Performance

Additional 11 medical beds opened

Increased awareness of ward staff regarding the transition lounge

Focus on EDD's

Implementation of the Capacity Planning Project

## Longer term projects

The Capacity Planning Project:

Ability to consistently predicate occupancy in order to plan ahead. The Capacity Planning Project is progressing well –formal meetings started on the 1<sup>st</sup> July, meet each Friday to review predication occupancy. Identifying and resolve issues that impacted on accurate predictions. Some of these have been late notification of elective admissions, late cancellation by bureau staff and staff sickness and inconsistent pattern of acute admissions. A daily meeting at 3pm also occurs to review bed status and identify expected demand on beds for the following day.

Lean six sigma projects rolling out to all wards

## Project: Improved access to elective surgery

55

Primary Objective: Increase ADHB Elective Surgical Discharges from 9,425 to 11,149

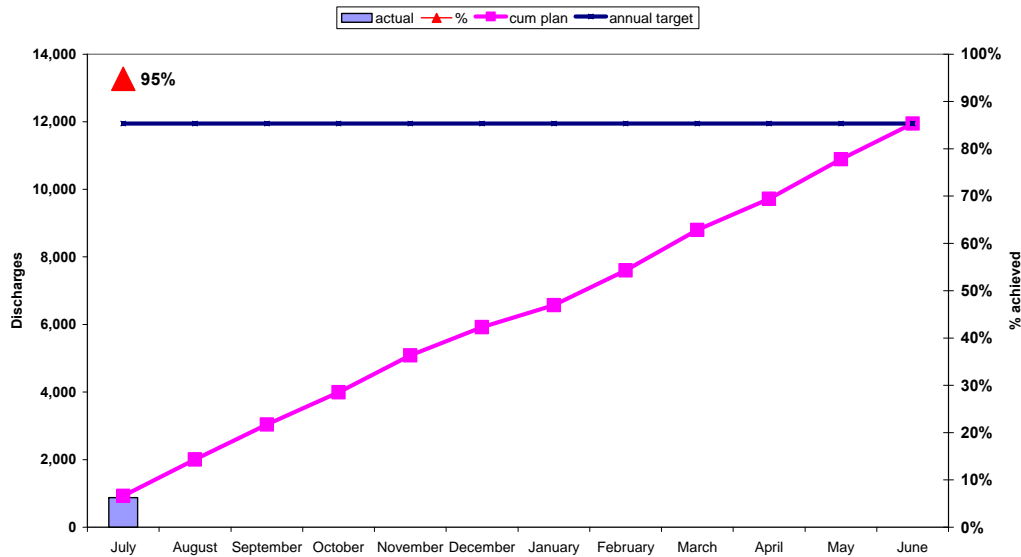
Date of Delivery: 30 June 2012

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

Steering Group: Ngaire Buchanan, Dr Vanessa Beavis, Margaret Dotchin, Fionnagh Dougan, Ian Civil.

### ADHB Eligible Elective Discharges



#### Planned activities:

1. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Fortnightly meetings between the Director of Elective Services and service managers focussing on ESPI compliance and elective production.
3. Continuing to review the production plan at a daily and weekly level.

#### Risks / Comments: (Amber)

1. July production against the health target was 95%.
2. Services are actively reviewing production plans to ensure we regain the lost production in August and September.

## Project: Shorter waits for Radiation Therapy

56

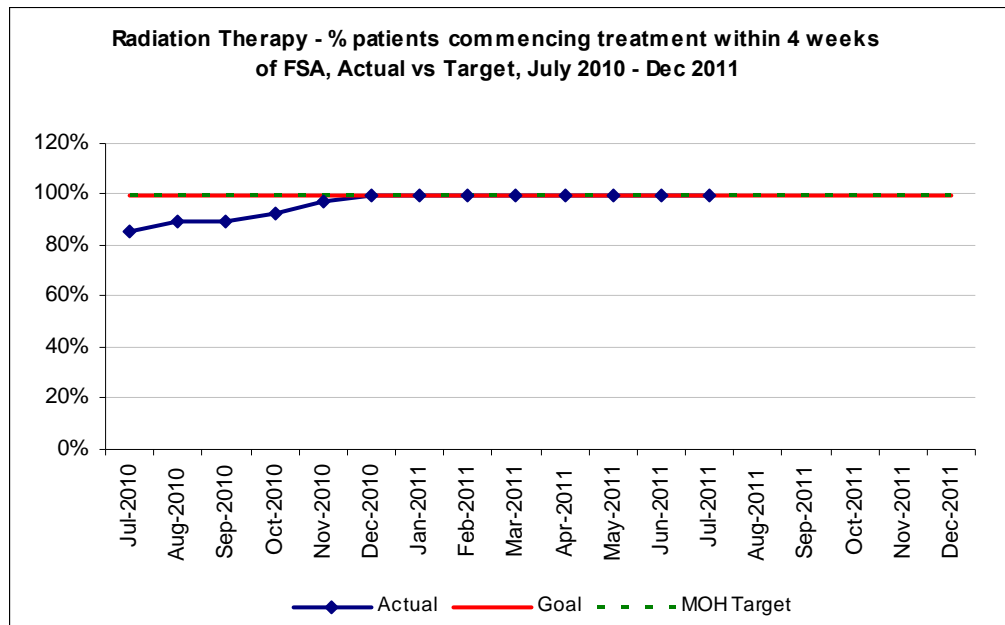
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



**The service is 100% compliant for July 2011**

**Key risks which may impact capacity to deliver to the target in the coming months:**

- MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement August - December 2011. This should be mitigated by our ARO Contract.
- RT staff vacancies and skill mix – there will be an improvement in RT staffing levels from July onwards due to positive interest from overseas applicants.
- Introduction of new technology during this time also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment.
- The HDR Brachytherapy machine was damaged mid July and is undergoing assessment and repair in Holland. It is expected to be operational again late August. Two patients required further HDR at Waikato Hospital and have now completed treatment. Waitlisted patients have the option of receiving LDR treatment at ACH or HDR at Waikato until the machine is operational again.

### **Radiation Oncology Wait times – July 2011**

In July 100% of eligible patients were treated within the 4 week target timeline. As at 31 July Radiation Oncology delivered to the target for 461 consecutive days.

### **Further improvements in progress to sustain delivery:**

**Pantak replacement** is now complete and patients are receiving treatment from August 2011.

**Replacement of MV6:** Decommissioning commences 22<sup>nd</sup> August until late December 2011. Evening shifts will be reinstated during this period to mitigate lost capacity

**Introduction of HDR** for Gynaecological patients is currently being rolled out with two patients receiving treatment in MV2 in July.

**A public/private Model of care** has been developed to enable our clinicians to treat public patients at ARO. Noting the variability in our referral flows, ARO have agreed to operate a 4 week rolling average of approx 4 patients per week from July 2011.

**Introduction of new technology:** The introduction of V-Mat treatment has the potential to reduce treatment times by up to 50% when fully implemented. A project team has been identified and will start work in July.

**Aria project:** A project is well underway to develop a full electronic record within the LINAC machine's operating system. The project has been reviewed recently by Varian with excellent incremental improvements noted month on month. Project end expected Dec 2011.

An **“Operational team”** measures KPI's to prioritise the waitlist and analyse performance on a weekly basis.

A **daily Waitlist report** enables daily monitoring and immediate remedial action if required.

# Project: Better help for smokers to quit

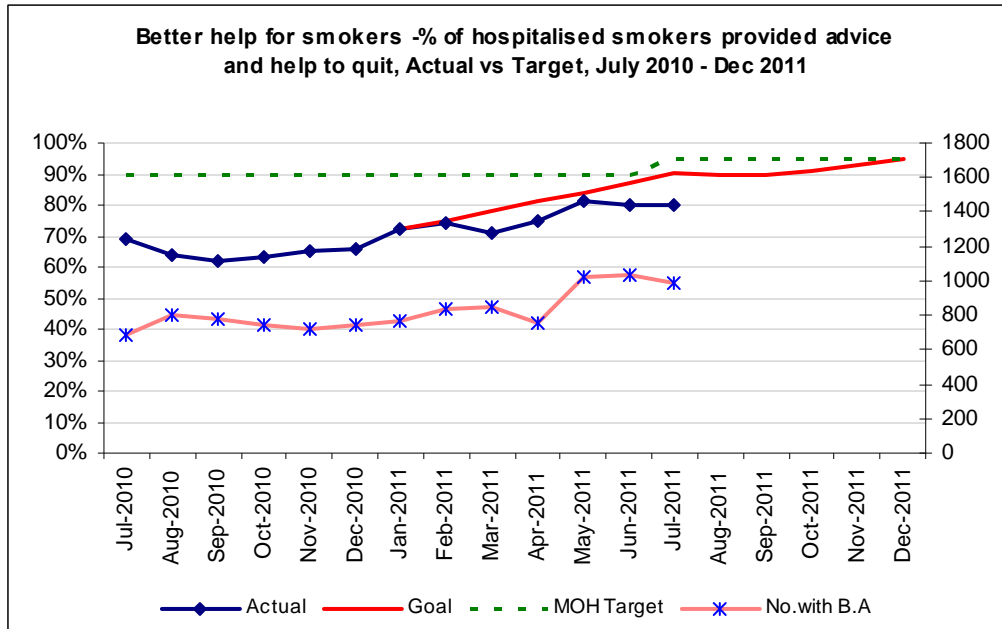
57

Primary Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

Steering Group: Di Roud, Anna Schofield, Maggie O'Brien, Stephen Child, George Laking, Jim Kriechbaum, Paul Bohmer, Arun Kulkarni, Michelle Stevens, Kristine Nicol, Bernadette Rehman, Paul Birch, Anne-Marie Pickering, Victoria Child, Jan Marshall, Kara Hamilton, Steven Stewart



## Improvements to date:

- AED – daily audits undertaken and staff performance posted weekly
- Increased communication on Smokefree environments and smoking on hospital grounds.

## Immediate Actions to improve performance by 15%:

### A. Continued focus on short stay and high volume areas to achieve 5%:

- Continued auditing and 1:1 coaching in AED and APU
- Women’s Health checking all smokers coding and requesting recoding to ensure target results are accurate. Brief Advice Brochure to be developed for Women’s Assessment Unit.

### B. Improve engagement of clinical workforce to achieve 5-8%:

- Campaign for a Call to Action to Senior Medical staff:.
- Monthly publication of results of Senior Medical Officer’s Better Help for Smokers to Quit performance commenced
- Steering Group meeting monthly to guide and monitor Health Target progress.
- Clinical research strategy under development

### C. Data collection systems and processes to achieve 5%:

- Weekly results to be circulated to services from 1 May
- Smoking and Brief advice column to be added to Ward Electronic Whiteboards to monitor the ABC
- Weekly audit of smokers records with no brief advice to identify any miscoding to be recoded before month’s end
- Short Stay Surgical Unit recording of ABC on day of surgery to be initiated to improve SSSU results
- Monthly reports and data analysis to identify and address areas of underperformance with services.
- Electronic Discharge Summary data to be audited for consistency and accuracy against patient clinical records

### D. Communications – planned activities

- Strategies to improve staff access and uptake of Quit Services
- Promotion of NRT to all clinical staff

## Project and Comments

Of the 8713 events coded in July 1238 (14%) were identified as smokers. 986 (80%) of all smokers were given brief advice to stop smoking. A review of Adult Health ward processes found that the well performing wards have instigated daily checks to ensure the ABC is completed. Other wards are encouraged to adopt this process. Several wards have already included smoking status and brief advice in the Electronic Whiteboard Columns we are looking to extend this into additional wards.

Collaboration is underway with the National Quitline to provide direct access to their cessation services for staff and visitors who want support to Quit.

# Project: Cardiac Bypass Surgery

58

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 94.

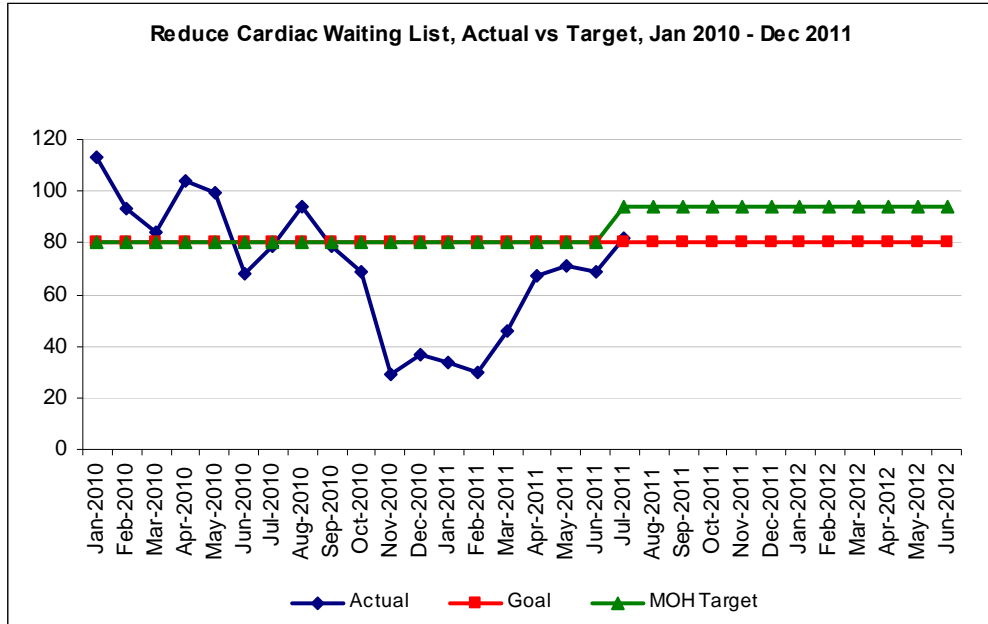
To support the national cardiac bypass intervention target, 940 bypasses should be completed in 2011/2012

Date of Delivery: 30 June 2012

Clinical Lead: Paget Milsom

Project Sponsors: Garry Smith, Fionnagh Dougan

Steering Group: Marian Hussey, Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam Freeman



## Revised MOH Target

The MOH target has been revised for 11/ 12 and the MOH have determined that as of 1 July the maximum number of eligible patients who should be on the waiting list at any time is 94. This reflects an increase from 81 in 10/11. The goal for the service remains at 81 as this number allows us to balance flow and treat all patients within acceptable timeframes.

### Monthly Performance

79 Bypass procedures were completed by the service during July. Only 65 of these procedures are eligible to be counted against the MoH target for the Northern region population. The "other" procedures are either thoracic surgery for cancer or "acute" cardiac procedures, both of which have a higher clinical priority than the elective cardiac volumes.

### Current Position

There are 81 patients on the waiting list for CABG and valve procedures (eligible for MoH contract) at the end of July 2011, contributing to a total bypass waiting list of 94

The "production line" has been constrained as we deal with the high priority cases and we have therefore commenced outsourcing. By doing this we aim to keep the number of eligible patients waiting below the 94 patient guideline provided by the Ministry. We are reviewing capacity v demand throughout the week to determine when we should complete weekend contracts and \ or outsource.

### Completed Improvement Activities:

- Developed and implemented electronic scheduling system
- Initiated pre-admit process
- Developed detailed operational reporting
- Set up development production process
- Approved business case for CVICU bed capacity
- Built capacity planning model for CVICU and Ward 42
- Developed patient load planning tool
  - Initiated daily bed management meeting
  - Enhanced recovery pathway in ICU
  - Scheduling workshop for productive theatres
  - Releasing time to care foundation modules
- CVICU\HDU merger

### Further improvements in progress:

- Standard theatre roster
  - Provide greater weekly standardisation in supply of theatre resource, to improve planning and co-ordination
- 3 in a row bypass (productive list)
  - Optimise the theatre schedule by planning a "productive list"
- ECMO – Resource planning process
  - To improve resource planning and day to day processes to reduce the impact of high ECMO demand on bypass cases
- The Productive Operating Room (NHS Programme)
  - To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- Delay to discharge – ward 42
  - To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Delay to discharge CVICU
  - To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Elective patient focused team project
  - To maintain elective throughput in the service during periods of constrained production

## Project: Diabetes

59

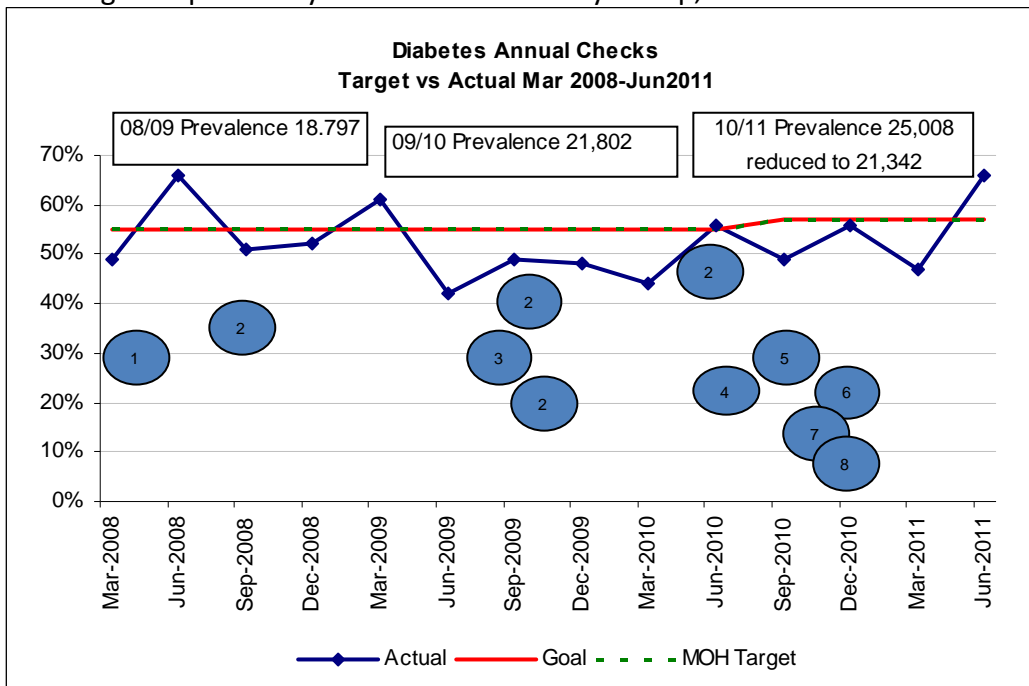
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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



### Recent and Current activities:

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

### Project Risks / Comments:

Q4 shows a significant increase in the number of Diabetes Annual Reviews (DAR's) from the previous quarter, reaching 66% (9 % above target). Performance has been increasing steadily over the months with DAR's at 59% in April, 65% in May and 73% in June. The performance for "Other", which is where all of the underperformance has fallen, has shown a steady increase from 47% in March, to 50% in April, 53% in May and 67% in June, contributing to an overall Quarter 4 performance for Other of 57% (1% under target of 58%). Performance against target for Maori and Pacific continues to be strong, with Q4 performance for Pacific at 79% and for Maori 63% (against a target of 55%).

The Long Term Condition Quality Improvement Coordinators have visited a significant number of practices in ADHB and have gained a good understanding of systems and management of diabetes in Primary Care. They have supported and assisted practices to establish an accurate register of patients with diabetes, establish recall systems and utilise IT systems, such as Dr Info, to better manage their patients with Long Term Conditions. They have also met with a considerable number of stakeholders, including the Auckland Diabetes Centre, as part of their work to improve coordination of care between primary and secondary services.

## Project: Diabetes

60

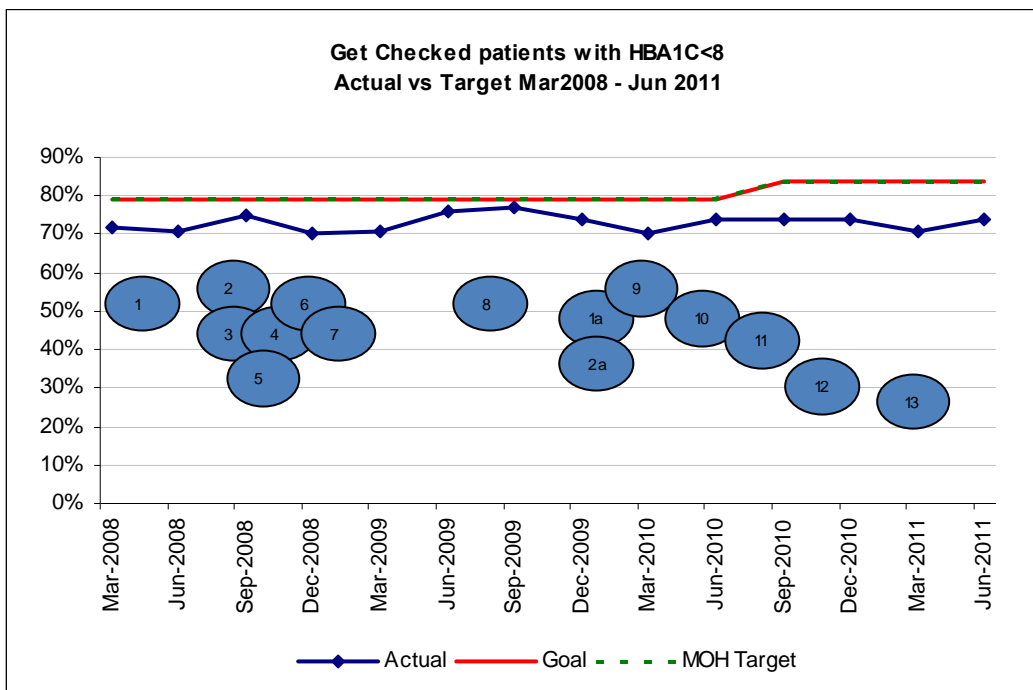
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

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

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

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



### Recent and Current activities:

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

### Project Risks / Comments:

Q4 data shows an increase from the previous quarter of 71% to 74%. Diabetes management for Maori and Pacific has also improved. In Q3 this was 60% for Maori and 55% for Pacific, while in Q4 this increased to 67% for Maori and 60% Pacific.

There are a number of activities to support this component of the target, including long term condition quality improvement initiative, who will be working with practices and secondary services to improve this performance. The Diabetes Self Management Education service provider has run 15 courses between February and May, with a focus on accessibility (in terms of access and cultural competency) to our high needs populations. Additionally a generic self management course for long term conditions (based on the Stanford model) is being implemented for our Pacific populations through the HVAZ framework, with two courses having been completed as at the end of June and 4 community based staff having been trained as Master Trainers at the end of June.

## Project: Cardiovascular Risk Assessment

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

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

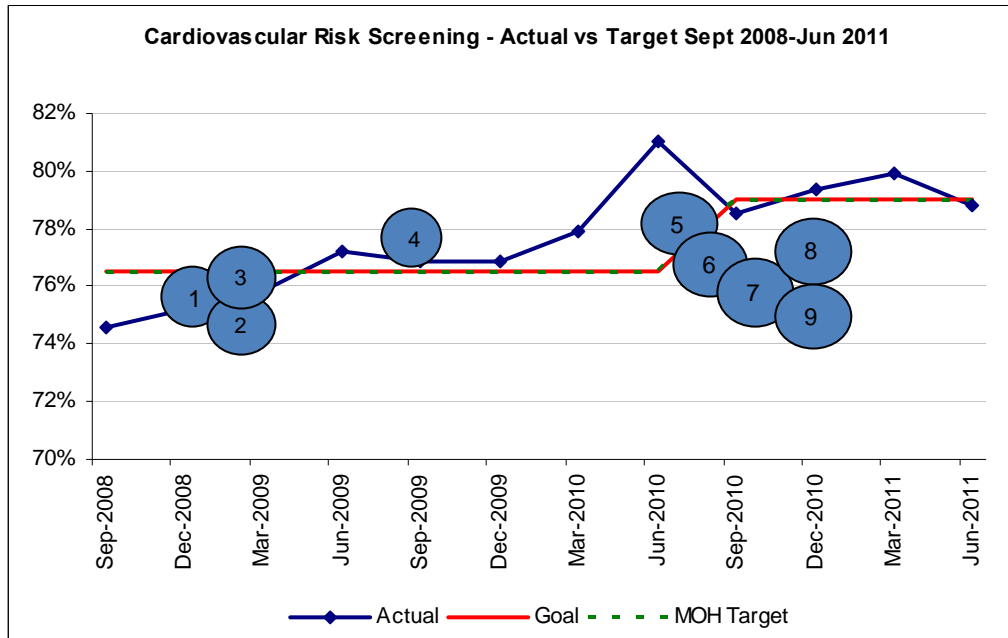
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team

### Recent and Current activities:

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



### Project Risks / Comments:

The Q4 CVD data shows a 1.1% decrease from the previous quarter to 78.8% (this is just 0.2% under target overall). Despite this small decrease targets for both Maori and Pacific were met (74.3% and 76.1% respectively against a target of 71%). Other was 0.4% under target.

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 (noted in the diabetes comments above) are also supporting CVD screening and management in primary care.

### Project: Increased Immunisation

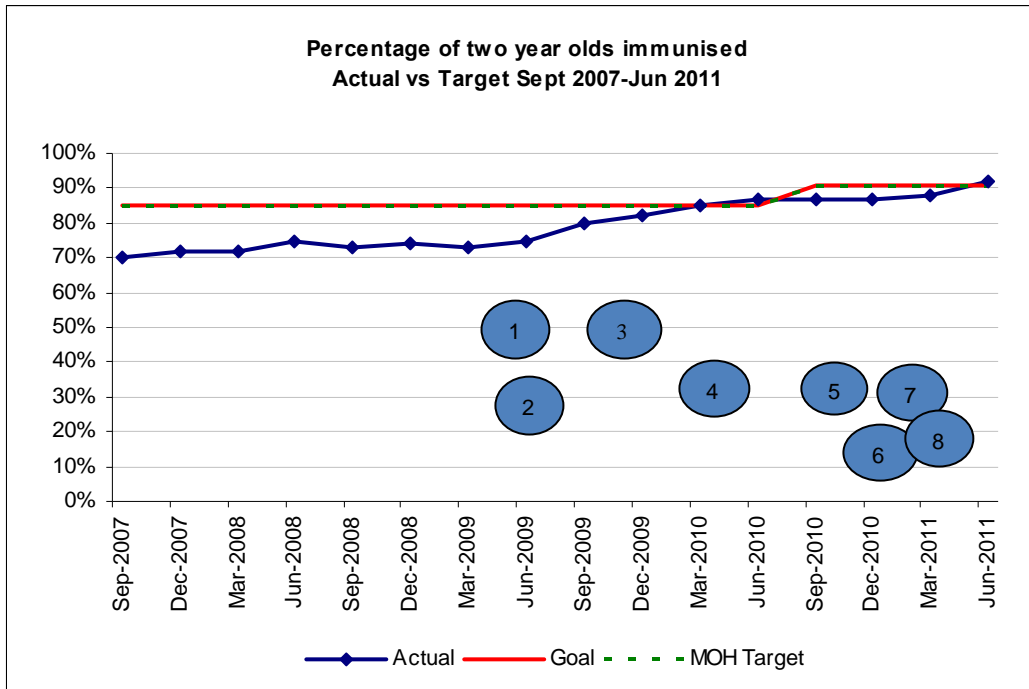
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

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

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

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



### Current activities

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct.

### Project Risks / Comments:

As at 30 June 2011, ADHB's immunisation coverage (2 year olds full immunised all ethnicities) was 92% (regional target 90%, ADHB target 91%). On 30 June 2009 ADHB's immunisation coverage rate for Maori children aged 2 years was 68% (total coverage 75%). Maori coverage has now reached 88%, a 20 percentage points increase in two years. Pacific coverage was 78% and is now 95%. This achievement was the result of a huge effort by all providers, particularly general practices. It was also the result of more systematic and targeted approaches driven from ADHB Planning and Funding and the National Immunisation Register team. They were strongly supported by PHO based Immunisation Coordinators and more systematised outreach work by the Immunisation Advisory Centre based outreach team. Referrals to the outreach team nearly doubled earlier this year as the focus shifted to referring children overdue for scheduled immunisations much more quickly. This made the task of connecting with often mobile families easier. The relationship with PHO based Immunisation Coordinators has also been critical as has a district wide data analysis and improvement project. ADHB is committed to achieving the lowest possible incidence of vaccine preventable disease and to reducing inequalities by achieving the highest possible immunisation coverage across the whole population.

**7.3 Annual Review 2010 - 2011**

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# **Auckland District Health Board**

2010/11 Annual Review of Performance

**SEPTEMBER 2011**

## Contents

Introduction .....	3
ADHB’s responsibilities .....	4
Goal 1 Lift the health of people living in ADHB .....	5
1.1 The health status of our people .....	5
1.2 Population demographics .....	7
1.3 Our health problems .....	7
1.4 How we manage our health .....	9
1.5 Hospital admissions .....	10
Goal 2 Performance improvement .....	12
2.1 The move to Healthcare Service Groups (HSG) .....	12
2.2 Our work force .....	13
2.3 Clinical training .....	17
2.4 Clinical research .....	18
2.5 Working towards our goals .....	19
2.6 Significant capital projects .....	22
2.7 Meeting our targets .....	25
2.7.1 Faster treatment for ED patients .....	26
2.7.2 Timely cancer treatment .....	27
2.7.3 More patients receive elective surgery .....	28
2.7.4 Shaping our plan for better diabetes care .....	29
2.7.5 Immunisation target success .....	30
2.7.6 6,000 more smokers given help to quit .....	31
Goal 3 Living within our means .....	33
3.1 A summary of services delivered .....	33
3.2 Operational performance .....	36
3.3 Increased efficiency and cost savings .....	40
Appendix 1 Table of service performance .....	42

## Introduction

The Auckland District Health Board (ADHB) has three goals which drive planning and operational management. These goals map to the regional goals, Board priorities and the Ministry of Health (MOH) key result areas as shown in the table below. This report provides a review of the operational performance of the ADHB for the year ended 30 June 2011 based on these goal areas.

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

The continued work to establish closer working relationships during the year both regionally, and more specifically with Waitemata District Health Board progressed well and was assisted by the appointment of a common Chairman for both DHBs. These close working relationships will continue to grow as we move into 2011/12 and are reflected in a number of activities highlighted in this report.

The year also featured the establishment of the regional shared services structure at the beginning of the fourth quarter. This provides the impetus to secure further financial savings whilst other regional initiatives such as GHAIN look to secure an improved level of service integration with primary care providers.

There are strong links between the work completed in 2010/11 and the plans for the 2011/12 year. In addition to the projects such as the elective services enhancements that require more than 12 months to complete there are in excess of 140 projects reflected in the District Annual Plan.

As we move into 2011/12 the change in operating structure to Healthcare Service Groups takes effect and this will further improve the population health focus of the organisation in every area. An outline of the new structure is included in this report.

Overall it was a successful year that continued to show the commitment of all staff to the pursuit of excellent clinical practice and patient service. We did not achieve every goal and target but did achieve a significant number of them and narrowly missed a few more. We also maintained a financial break even position for the year indicating sound operational performance despite significant pressures in some services. The coming year brings new challenges but we are well prepared for the task ahead.

## **ADHB's responsibilities**

ADHB funds and provides community-based and secondary services to people in its population, tertiary services to the wider Auckland region, and tertiary services to those living in other parts of the country.

People living within the ADHB catchment have access to services from prevention and health promotion, to specialist treatments and, when needed, hospice or palliative care. Some of these services are provided within the hospital (which has over 80 separate specialty service areas), while others are provided by GPs, pharmacies, dentists, Maori organisations and many other community-based, non-government organisations.

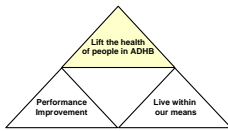
ADHB manages funding and other revenue totalling \$1.8 billion and provides services through its provider arm with a value in excess of \$1 billion. Revenue mainly comprises government funding with some additional amounts received via trusts and donations and the short term investment of funds.

ADHB operates New Zealand's largest public hospital with almost two million patient contacts each year, including local hospital and outpatient services for 446,000 Aucklanders. The hospital also has the largest elective surgery delivery system in New Zealand with 22,000 elective discharges, approximately 52% of which are for other DHB populations.

There are approximately 10,000 staff employed in the provider arm which equates to a little over 7,700 full-time equivalent positions (FTE). ADHB is the largest trainer of doctors in the country with approximately 1,477 medical staff of whom about 685 are in various stages of training. The hospital is also the largest clinical research facility in New Zealand, engaging in work that attracts funding and participation both here and overseas.

Auckland DHB is a specialist centre for the region and the rest of the country, providing tertiary services for the northern region (about 1.6 million people). Over half the work done within Auckland DHB hospitals is for people who live outside Auckland city.

Some tertiary services (e.g. clinical genetics and paediatric oncology) are also provided for people in the Northern, Midland and Central regions. Starship Children's Health provides sub speciality services nationally, with referred work contributing up to 70% of the throughput for some units, oncology biopsies and renal transplant donors, complex obstetric cases. Tertiary services often depend on a small number of highly specialised staff and this makes it especially important to maintain the stability of those services given they operate with relatively low volumes and there is a high level of competition for these staff internationally.



# Goal 1 Lift the health of people living in ADHB

## 1.1 The health status of our people

People living in Auckland DHB have relatively good health compared to the rest of the country. The city has the fourth lowest mortality rate among all the DHBs (2007). The Auckland population is also better than the national level in all indicators of health except high blood cholesterol and low physical activity which are significantly worse than the national level.

There are some unacceptable differences in health status between groups of people in the city. This is most prevalent amongst Maori, Pacific and South Asian communities, people living on low incomes and disabled people.

Category	Status
<b>Poverty</b>	<ul style="list-style-type: none"> <li>• Poverty contributes most to low life expectancy. Poverty is affected by ethnicity &amp; gender.</li> <li>• In self-assessed health status, there is a direct relationship between age, gender, ethnicity and income for all ethnic groups, except Pacific.</li> <li>• People who are poor, Pacific and those in age groups 14–24 and over 65 years score their health the lowest.</li> <li>• 49% of Maori and 64% of Pacific people live in the most deprived areas of Auckland city compared to 25% of the ‘Others’. Most Indians and Asians live in the Avondale-Roskill area – 46% and 33% of their populations respectively. The ‘Other’ populations are fairly evenly distributed across all Auckland wards.</li> <li>• The most populated areas in Auckland City are Albert-Eden-Roskill and Orakei wards – 35% and 18% of Auckland’s population respectively. Most Maori and Pacific people live in the Maungakiekie –Tamaki ward – 39% and 46% of their populations respectively.</li> <li>• Many of our children (41% of all 0–4 year olds) live in the most deprived areas of the city.</li> </ul>
<b>Maori</b>	<ul style="list-style-type: none"> <li>• 72% of non-Maori die over the age of 75 years of age compared to 16% for Maori.</li> <li>• Maori in Auckland are more likely (compared to NZ and to local non-Maori) to smoke tobacco and marijuana, to be obese and to drink alcohol in a hazardous manner.</li> <li>• Maori have higher years of lost life (YLL) rates than non-Maori.</li> </ul>

Category	Status
<b>Pacific</b>	<ul style="list-style-type: none"> <li>• 32% of Pacific people die over the age of 75 years compared to 72% for non-Pacific.</li> <li>• Pacific people are more likely (compared to New Zealand Pacific and to local non-Pacific) to be obese, smoke tobacco, and have a poor diet.</li> <li>• Pacific ethnic groups have higher years of lost life (YLL) rates than non-Pacific people.</li> </ul>
<b>Asian, migrants and refugees</b>	<ul style="list-style-type: none"> <li>• Auckland is one of the highest non-English, non-Maori speaking areas with over 100 different languages spoken.</li> <li>• Asian people make up 25% of Auckland's population. 36% of these are South Asian, and about 80% of this group are Indian.</li> <li>• 13% of our population need assistance or interpreting when attending health services.</li> <li>• Asians have good health compared to 'Others'. There are lower risks for Asians for all the indicators of health, except for regular exercise and vegetables consumption.</li> <li>• For South Asian and particularly for Indian people, while there is a lower mortality rate from cardiovascular disease, they have the highest rate of hospitalisation for myocardial infarction and angina. They are the highest users for angioplasty and CABG operations.</li> </ul>
<b>Disability</b>	<ul style="list-style-type: none"> <li>• About 1 in 5 Aucklanders live with impairment; most commonly loss of functioning related to mobility, agility and hearing. The rate of disability increases as people age.</li> <li>• Poorly informed social attitudes remain the most common barrier for disabled people.</li> </ul>
<b>Gender</b>	<ul style="list-style-type: none"> <li>• Men die younger than women by at least 3–4 years (rates are improving for both genders).</li> <li>• Men have poorer health than women: they smoke more tobacco and marijuana, have higher cholesterol, are more likely to be overweight and to have a poor diet.</li> <li>• Men are more likely to drink alcohol in a hazardous manner.</li> <li>• Men exercise more often than women.</li> <li>• Men assess their health as better than women except in the general health perceptions scores. In this area men assess their health as poorer than women.</li> </ul>

## 1.2 Population demographics

The ADHB population is expected to grow by 1.47% annually through to 2026, from 428,318 to 554,591 residents. Most of the growth is expected to be in the Asian group (4.1% annually from 106,956 to 195,259). However, Maori will grow by 0.8% annually (34,922 – 40,509) and Others by 0.7% annually (235,113 – 267,638). Pacific are not expected to grow and will maintain their numbers at 51,175. Two thirds of the Pacific peoples in New Zealand live in Auckland and consist of a number of diverse ethnic groups which include Samoa, Cook Islands, Tonga, Niue, Fiji, Tokelau and Tuvalu.

The ADHB population is growing older. Those over 65 years account for 9% (40,420) of the population but this will grow to 13% (72,287) by 2026. This is in contrast to Pacific which is a youthful population with some 49% under the age of 24 years.

With the growth in our population the ADHB overall life expectancy has improved from 80.1 years in 2011 to 81.7 years in 2010. However, life expectancy is not equitable between population groups or by gender. Female life expectancy has increased from 82.3 years in 2001 to 82.5 years in 2010 (1.2 years gain); male from 77.6 years to 79.9 years (2.3 years gain). For Pacific people life expectancy has improved from 74.6 years in 2001 to 77.4 years in 2010 (2.8 years gain); Others 81.2 – 82.8 years (1.6 years gain). Maori life expectancy has slightly decreased over this time from 75.5 years in 2001 to 74.8 years in 2010.

Life expectancy in years	2001	2010
Overall	80.1	81.7
Maori	75.5	74.8
Pacific	74.6	77.4
Others	81.2	82.8
Males Overall	77.6	79.9
Maori Males	73.9	72.7
Pacific Males	71.4	75
Others Males	78.7	80.9
Females Overall	82.3	83.5
Maori Females	76.8	76.9
Pacific Females	77.8	79.6
Others Females	83.4	84.6

## 1.3 Our health problems

Chronic diseases (in the table below) including cancers encompass nearly 47% of total Years of Lost Life (YLL). Asthma, arthritis and ischemic heart disease are the most major contributors to 'long term conditions' seen in the Auckland city population. The second most common cause is injuries and poisoning (33%), followed by

congenital and perinatal diseases (20%). The table below illustrates the Prevalence of major chronic diseases with expected number for the ADHB Population.

<b>Chronic conditions</b>	<b>Percent</b>	<b>Number of adults</b>
Asthma	13.3	24,800
Arthritis	12.9	52,196
Ischaemic heart disease	3.8	12,100
Dementia (Special population)	7.7	3,113
Chronic obstructive pulmonary disease	6.1	19,907
Depression	5.7	18,726
Diabetes	4.9	15,600
Stroke and mild stroke (TIAs)	2.1	6,900
Epilepsy	1.4	5,665
Total cancer since 1994 excluding deaths		7,550

75% of all deaths in our local population are due to diseases related to the circulatory system, cancer and the respiratory system.

<b>Causes of death</b>	<b>Percent</b>
Diseases of circulatory system	39
Cancer	27
Diseases of respiratory system	8
Injury, poisoning	5
Mental and behavioural disorders	4
Diseases of nervous system	4
Endocrine, nutrition and metabolic	3
Diseases of digestive system	3
Diseases of genitourinary system	2
Other causes	5

## 1.4 How we manage our health

According to Health Survey data between 2002/3 and 2006/7, Aucklanders have become more sedentary, drink more, have higher rates of diabetes, higher cholesterol and are more overweight and obese. Aucklanders now have the third lowest daily smoking rate nationally, have higher fruit consumption, the lowest asthma rates and improvements in the number of GP visits. The lifestyle indicators are illustrated below.

Lifestyle Indicator	2002/3	2006/7
Physical activity rates	Lowest in country	No improvement
Adult drinkers	15.2%	17.2% (lowest in country)
Asthma rate	-	7.7% (lowest in country)
Daily smoking	-	Third lowest rate in country
Diabetes rate	4.4%	5.1%
Fruit consumption	60.3%	61.8% (highest in country)
High cholesterol rate	6.2%	9.2%
Obesity rate	21.3%	No change: second lowest in country
Sedentary life style rate	21.9%	18.6%

Immunisation rates for two year olds have improved and the table below indicates the change over the last four years. Inequalities exist with Maori immunisation rates needing to be improved.

Immunisation rates	2007/8	2010/11
Maori	62%	89%
Pacific	66%	95%
Others	77%	95%

The rates for diabetes annual reviews have improved for all population groups but are highest for Pacific. These are annual checks for diabetes patients covering a range of health issues.

Check rates	2007/8	2010/11
Maori	44%	62%
Pacific	60%	79%
Others	44%	62%

HBA1C is a marker for diabetes control. A level of less than 8 is used as a marker for good diabetes control. As the table below indicates rates have improved for Others and for Maori but inequities still exist.

HBA1C <8 rates	2007/8	2010/11
Maori	56%	67%
Pacific	60%	60%
Others	78%	81%

Screening for diabetes has improved in all population groups but some inequities remain.

Diabetes screening	2007/8	2010/11
Maori	64%	74%
Pacific	46%	80%
Others	46%	76%

Screening for cardio-vascular disease (CVD) has also improved in all population groups and inequities appear to be reducing.

CVD screening	2007/8	2010/11
Maori	69%	74%
Pacific	71%	76%
Others	76%	80%

## 1.5 Hospital admissions

All hospital admission rates have increased in ADHB between 2001 and 2010. Most of the increase has occurred in the Pacific and Maori populations as indicated in the table below.

Admission rate/1,000	2001	2010
Maori	239	261
Pacific	276	324
Others	190	192

For accident related hospital admissions Maori rates increased by 1%, Pacific by 1.9%, and Others by 0.4%

<b>Admission rate/1,000</b>	<b>2001</b>	<b>2010</b>
Maori	43	53
Pacific	37	56
Others	32	36

Smoking related hospital admissions for those aged 15 and over decreased for Maori and Others but not Pacific.

<b>Admission rate/1,000</b>	<b>2001</b>	<b>2010</b>
Maori	46	44
Pacific	51	57
Others	34	28

The housing related hospitalisation rate/1,000 increased for Maori and Pacific.

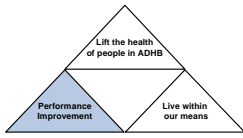
<b>Admission rate/1,000</b>	<b>2001</b>	<b>2010</b>
Maori	28	31
Pacific	40	42
Others	14	13

Ambulatory sensitive hospitalisation (ASH) rates for 45-64 for all ethnic groups were higher than the national rate.

<b>Rate in 45 – 64 year olds</b>	<b>2007</b>	<b>2010</b>
Maori	150%	126%
Pacific	118%	118%
Others	98%	118%

However, ambulatory sensitive hospitalisation (ASH) rates for children under 5 years were the best in the country in 2010 as shown below.

<b>under 5 years olds</b>	<b>2010</b>
Maori	68%
Pacific	76%
Others	57%



## Goal 2 Performance improvement

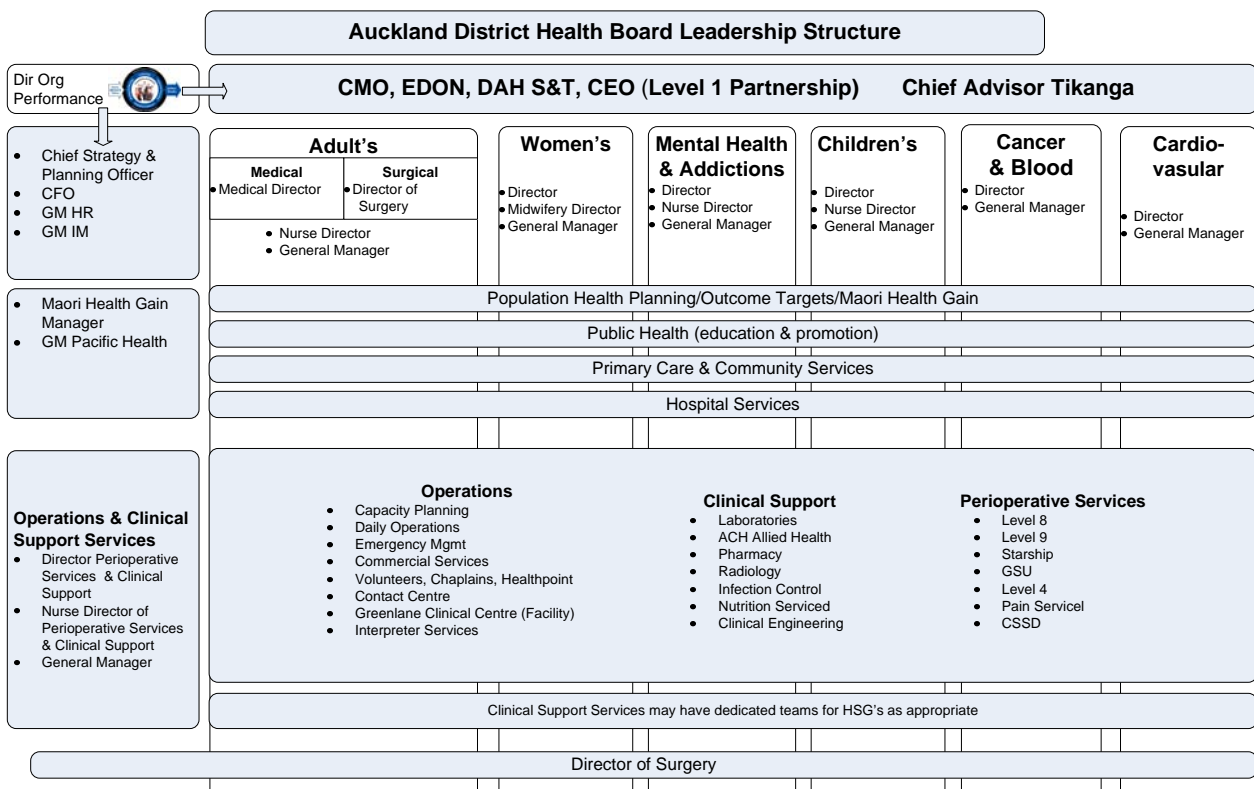
### 2.1 The move to Healthcare Service Groups (HSG)

ADHB has committed to the introduction of Healthcare Service Groups (HSG) to:

- Strengthen clinical leadership accountability for strategic, operational and professional governance performance.
- Ensure a focus on population health gain across the health care continuum.
- Integrate the person centric health continuum through the care settings and environments of community, primary, and hospital.
- Accelerate the introduction of the Healthcare Excellence Framework.
- Ensure clear accountability for positioning the provision of care (prevention, diagnosis, treatment and management) in the right settings to ensure quality, cost effective and convenient care for the consumer/patient.

The HSG structure has been introduced with effect from 1 July 2011 based on the project work undertaken during 2010/11. The new structure provides a planning and operating structure that is aligned with the overall ADHB framework of population health gain, core principles and other guidelines and accountabilities. HSGs have a broad mandate and a high degree of flexibility to use available resources to best respond to the health needs of the population in the context of their HSG. This flexibility is tempered by the need to conform to ADHB principles and the operational framework.

HSG accountabilities are linked to population health/clinical, customer service, and financial outcomes. The new structure operates as follows:



The new structure has required the appointment of clinical and nurse leaders in each HSG and this work was undertaken in the first half of 2011 and only two positions remained outstanding at year end. The open positions are being covered by other senior clinical leaders until suitable candidates can be found.

A centralised team in the Planning and Funding team currently provides a range of functions from needs analysis and population health management, the development and implementation of intervention strategies for health gain through to the transactional processes supporting a wide range of contracts. In the HSG environment, the transactional functions and population needs analysis remains centralised and the HSG Strategy and Planning managers are assigned to the HSGs.

This approach ensures a depth and breadth of strategy development and planning skills is maintained in the organisation. The Strategy and Planning managers work as a virtual team with much of their time committed to their assigned HSG, but with a wider role to support organisation planning and learning.

Each HSG uses its internal prioritisation and budgeting process to ensure the best use of the available funds to realise the maximum health gain for the ADHB population. The HSG is also responsive in providing services to other DHBs as agreed to on a local, regional or national basis. This process enables the HSG to determine the level of funding required for the HSG to operate and purchase services from within ADHB, from other HSGs or externally through private providers, primary care and other contracted services.

The development of the budget processes will occur during 2011/12 and will be used to guide budgeting processes for the 2012/13 budget. The 2011/12 budget will, by necessity, reflect historical patterns of expenditure. It will nevertheless be influenced by Ministerial/MOH requirements, regional planning and ADHB direction.

## **2.2 Our work force**

With over 10,000 staff ADHB is one of the largest employers in the Auckland region. During the year ADHB welcomed 1,977 new staff into the organisation. 1,219 of these appointments were referred to ADHB by existing staff and 280 were staff returning to work at ADHB. During the period there were 703 internal job movements. Voluntary employee turnover also continued to reduce and ended the year at 9%. The low level of staff turnover is a good indication that employees view ADHB as a positive work place and it results in a high level of consistency in teams.

The average age of the work force is approximately 42 years old and this is largely consistent across all employee groups. The average length of service is also stable at an average of 8.2 years. There is a gender bias towards female staff, particularly in Women's Health. At an organisation level medical staff comprise 55% male and 45% female employees.

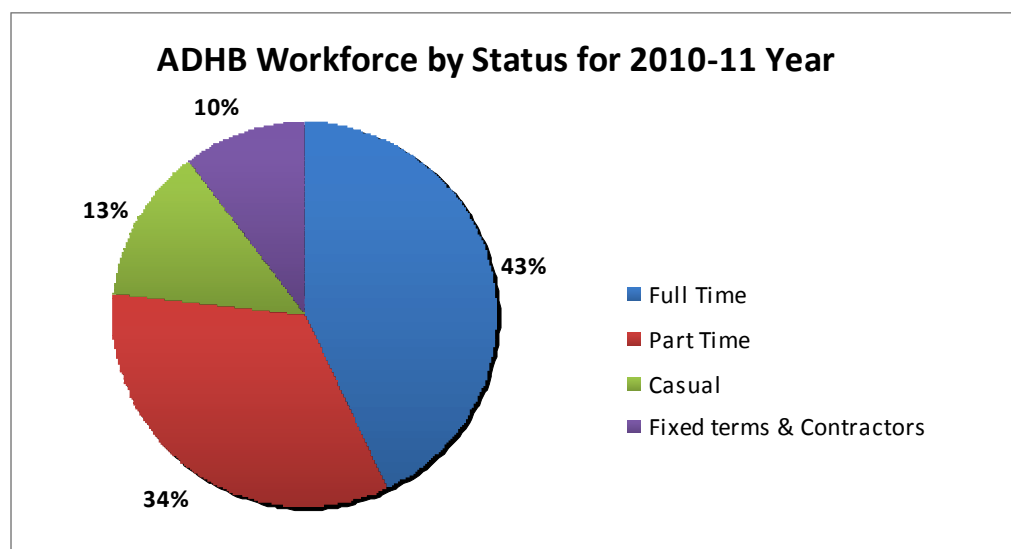
At 47%, European is the largest ethnic group at ADHB, followed by Asian, Pacific at 6.8% and Maori at 3.2%. Asian has increased from approximately 12.8% of the total workforce in 2005 to around 21% today, whilst the proportion of Maori and Pacific employees has slightly decreased from 11% in 2005 to 10% in 2011. We recognise that addressing health inequalities will require growth in our Maori and Pacific workforces. We are working with the other DHBs in the region to put in place a range

of initiatives that focus on developing tomorrow's clinical leaders, providing health career programmes in schools, establishing scholarships, and training and mentoring programmes.

Employee numbers have been closely managed through the year, as highlighted in the table below. There have been a number of challenges including the impact of SMO job sizing that saw FTE requirements increase; however increased efficiency enabled overall numbers, including temporary staff, to be kept within budget levels. The reduced actual FTE in May and June 2011 reflect successful initiatives taken to hold a number of vacancies to help manage budgets.

Month	Permanent Staff			Temporary/Bureau			Combined		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
<b>Jul</b>	7,735	7,934	199	79	12	-67	7,813	7,946	132
<b>Aug</b>	7,743	7,925	182	70	12	-58	7,813	7,937	124
<b>Sep</b>	7,759	7,926	167	95	12	-83	7,854	7,938	84
<b>Oct</b>	7,810	7,928	117	75	12	-63	7,885	7,939	54
<b>Nov</b>	7,840	7,903	64	80	12	-68	7,920	7,915	-5
<b>Dec</b>	7,884	7,928	44	51	12	-40	7,935	7,940	5
<b>Jan</b>	7,847	7,909	62	101	12	-89	7,948	7,921	-27
<b>Feb</b>	7,971	7,906	-65	68	12	-57	8,040	7,918	-122
<b>Mar</b>	7,811	7,910	99	245	12	-233	8,056	7,922	-134
<b>Apr</b>	7,771	7,913	142	260	12	-248	8,030	7,925	-106
<b>May</b>	7,716	7,912	196	77	12	-65	7,793	7,924	131
<b>Jun</b>	7,678	7,918	240	69	12	-57	7,747	7,930	183

In proportional terms the figures above illustrate the continued flexibility that engaging part time staff offers and contractors.



The contractor component of the workforce is mainly comprised of bureau nursing. With around 4,500 of ADHB's employees being nursing, bureau usage is a necessity

for cover and it also enables the right numbers of staff to be brought in depending on seasonal variation and work load fluctuations.

Month	Temporary and Bureau	Med Fees	Locums	Independent midwifery	Tech Fees	Nursing Business Units
	#	#	#	#	#	#
Jul	57	4	3	3	5	7
Aug	52	3	3	2	5	6
Sep	68	6	3	3	8	7
Oct	53	3	2	2	7	7
Nov	58	4	2	3	7	6
Dec	32	2	2	2	6	7
Jan	81	4	2	2	6	7
Feb	46	5	3	2	5	7
Mar	219	4	2	3	9	7
Apr	238	3	2	2	8	7
May	51	4	4	1	10	6
Jun	50	-2	5	1	8	6

ADHB is typical of health organisations and has a high union presence with 95% of our employee groups having union coverage. The table below shows the collective agreements, unions and coverage at ADHB:

Agreement Name/Coverage	Union	DHB Coverage	ADHB Employees Covered	Start of Term	Expiry Date
<i>Clerical &amp; Administration</i>	<i>PSA</i>	<i>Northern Region</i>	<i>992</i>	<i>01/04/2010</i>	<i>31/10/2012</i>
<i>Clinical Perfusionists</i>	<i>APEX</i>	<i>ADHB</i>	<i>14</i>	<i>n/a</i>	<i>n/a</i>
<i>Clinical Physiology</i>	<i>APEX</i>	<i>National</i>	<i>57</i>	<i>01/09/2007</i>	<i>31/08/2010</i>
<i>Clinical Psychologists</i>	<i>APEX</i>	<i>National</i>	<i>new</i>	<i>01/10/2010</i>	<i>30/04/2012</i>
<i>Dental Assistants</i>	<i>SFWU</i>	<i>ADHB</i>	<i>22</i>	<i>31/12/2010</i>	<i>31/08/2011</i>
<i>Medial Radiation Therapists (RTs)</i>	<i>APEX</i>	<i>National</i>	<i>70</i>	<i>01/10/2009</i>	<i>30/09/2011</i>
<i>Medical Laboratory Workers</i>	<i>MLWU</i>	<i>National</i>	<i>289</i>	<i>01/12/2009</i>	<i>31/12/2011</i>
<i>Medical Physicists</i>	<i>APEX</i>	<i>National</i>	<i>10</i>	<i>01/02/2010</i>	<i>31/07/2011</i>
<i>Medical Radiation Technologists (MRTs)</i>	<i>APEX</i>	<i>National</i>	<i>149</i>	<i>01/10/2009</i>	<i>30/09/2011</i>
<i>Mental Health and Public Health Nursing</i>	<i>PSA</i>	<i>Auckland Region</i>	<i>451</i>	<i>01/04/2010</i>	<i>30/06/2012</i>
<i>Midwives</i>	<i>MERAS</i>	<i>National</i>	<i>153</i>	<i>01/04/2010</i>	<i>30/09/2011</i>
<i>Nurses and Midwives</i>	<i>NZNO</i>	<i>National</i>	<i>3892</i>	<i>01/04/2010</i>	<i>30/09/2011</i>
<i>Professional, Allied, and Technical Staff</i>	<i>PSA</i>	<i>Auckland Region</i>	<i>1506</i>	<i>01/04/2010</i>	<i>30/04/2012</i>

Agreement Name/Coverage	Union	DHB Coverage	ADHB Employees Covered	Start of Term	Expiry Date
<i>Resident Medical Officers (RMOs)</i>	<i>NZRDA</i>	<i>National</i>	<i>528</i>	<i>28/03/2011</i>	<i>31/03/2012</i>
<i>Senior Medical and Dental Officers (SMOs)</i>	<i>ASMS</i>	<i>National</i>	<i>911</i>	<i>01/07/2007</i>	<i>01/05/2011</i>
<i>Service &amp; Food Workers</i>	<i>SFWU</i>	<i>National</i>	<i>149</i>	<i>31/12/2010</i>	<i>31/08/2011</i>
<i>Service Workers (Orderlies)</i>	<i>NDU</i>	<i>ADHB</i>	<i>85</i>	<i>31/12/2010</i>	<i>31/08/2011</i>
<i>Sonographers</i>	<i>APEX</i>	<i>Auckland Region</i>	<i>45</i>	<i>02/10/2007</i>	<i>01/04/2012</i>
<i>Support Services (Stores)</i>	<i>NDU</i>	<i>heathAlliance</i>	<i>8</i>	<i>31/12/2010</i>	<i>31/08/2011</i>

Key to Union abbreviations	
APEX	Association of Professional and Executive Employees
ASMS	Association of Salaried Medical Specialists
MERAS	Midwifery Employee Representation and Advisory Services
MLWU	Medical Laboratory Workers Union
NDU	National Distribution Union
NZNO	New Zealand Nurses Organisation
NZRDA	New Zealand Resident Doctors Association
PSA	Public Service Association
SFWU	Service & Food Workers Union Nga Ringa Tota

The Health Sector Relationship Agreement (HSRA) is a tripartite agreement between the Government, the DHB's and the Council of Trade Unions (CTU) health sector unions and was established in 2008. Its purpose is to promote collaborative and constructive working relationships across the sector that ensure the delivery of high quality health services.

The HSRA requested that possible options or approaches that might be taken for the 2011 bargaining in the DHB sector be explored. This resulted in the "managed bargaining" process. The three CTU unions, the PSA, NZNO and SFWU endorsed an interim step proposal for settling the MECAs that expired on 31 December 2010 that would extend the term to end of August 2011.

The common pay rise covering thousands of health sector employees was a landmark agreement. Employment relations bargaining is often a difficult time in the health sector and this landmark agreement provided the basis and opportunity to focus energy on improving the health system.

ADHB collaborates with other DHBs in the northern region to ensure a consistent approach. One example of this has been the Senior Medical Officer (SMO) Job Sizing & Remuneration Project. The need for this arose originally from the settlement of the 2003-2006 SMO MECA and commenced in 2005 and the aims were to:

- Ensure that SMOs are appropriately remunerated
- Enable transparency and fairness around employment terms and conditions;
- Develop regional consistency in the approach to SMO remuneration

The project was successful in delivering a commitment to treat University SMOs in an equivalent manner to ADHB employees. This has been reflected in the establishment of an ADHB SMO intranet site that holds all material on Protocols, Principles and FAQs. Regional Protocols provide the framework for application of the SMO MECA.

Other initiatives included a better programme for managing the junior doctor workforce with a focus on matching supply to demand. The use of indicators to identify normal operating parameters and enable early action to be taken when change occurs has proved a valuable tool. This helps manage vacancy rates, monitor workforce satisfaction and costs.

ADHB has also undertaken many other initiatives involving the other staff groups with probably the most significant being the change to the HSG structure.

### **2.3 Clinical training**

The Clinical Education and Training Unit (CETU) was founded at ADHB in May 1999 with the overall responsibility for post entry medical training, with particular focus on first and second year new graduates.

Throughout the last 12 years, CETU has been a national and international leader in prevocational medical education and research with many of its projects and programmes being adopted on a wider stage. For example, CETU has developed a weekly clinical teaching programme for house officers that is highly regarded both within ADHB and among other DHBs for both its robust clinical content, consistency and the caliber of registrar and consultant tutors.

For the last seven years, CETU has successfully run a Ministry of Health-tendered programme for International Medical Graduates to assist them back in to the New Zealand medical workforce. This programme has received favourable external reviews, increased doctor numbers in a depleted medical workforce and brought in unbudgeted revenue to the DHB.

During 2010/11 CETU was contracted to run an additional programme to assist overseas-trained doctors complete their licensing exam which is a New Zealand first. Each programme runs for 12-weeks and consists of observation of clinical practice in a hospital setting, practice OSCEs and workshops.

In addition to this, CETU, with the sponsorship of Ian Civil, has contracted for a franchised pre cardiac arrest, multidisciplinary course called ALERT. Since being introduced in 2008, this multi-professional course has taught some 370 junior

doctors, nurses and physiotherapists how to anticipate, recognise and prevent critical illness at an early stage.

CETU is the national leader for careers development for junior doctors, managing annual, region-wide careers fairs and a careers website [www.careermed.co.nz](http://www.careermed.co.nz).

This work is analysed and presented as part of peer reviewed published work. Over the past 11 years, CETU has supported junior doctors to undertake research projects that investigate the education and working conditions of junior doctors. Their findings were presented at the annual Australasian prevocational medical education conference and have been published in the New Zealand Medical Journal. This year, ADHB staff will present eleven research papers at the November prevocational medical education conference, which will be held in New Zealand. Some further commentary and examples of ADHB research activity is included in the next section.

## **2.4 Clinical research**

During the year some 250 new projects were approved and 150 commercial clinical trials were active. ADHB was also involved in a number of public good clinical trials as part of professional collaborative groups. Whilst many of the research projects involved staff members affiliated to the University of Auckland Faculty of Medical and Health Sciences there were a number of projects completed by non-university staff with international reputations in their particular specialties.

Despite a challenging economic climate, financial support remained solid due to our international reputation, the scale of our clinical research facility and the quality of our research teams. This made ADHB attractive to sponsor companies and ADHB researchers were also able to obtain funding from the Health Research Council despite highly competitive funding rounds.

The strength of ADHB's clinical teams and researchers is celebrated this year with the inaugural Healthcare Excellence Awards. These awards will reward excellence at ADHB, with one of the four categories dedicated to excellence in research.

The largest category of research at ADHB is audit activity, undertaken to examine treatment, care and resource allocation to review current practice. At the heart of research is the sustained search for truth; for a better way of doing things – the same things that drive performance improvement and excellence in education, clinical practice, process and systems improvements. Some examples are included below.

About half of the Haematology trials are paid for by pharmaceutical companies to evaluate new agents. Many important studies are developed by international co-operative groups of medical experts. These investigate new drug combinations, modifications for disease subtypes and reduction of side-effects, and better ways to track disease such as biomarkers. Co-operative studies secure free drug supply, but running expenses for trial staff and pharmacy costs often require charitable funding.

The key studies completed during the year included the BRIGHT trial for Indolent Non-Hodgkin and Mantle Cell Lymphoma. This was an international Phase 3 study designed to compare the effectiveness of the drug bendamustine hydrochloride (Treanda®) combined with rituximab against the standard R-CHOP. It proved a successful trial, enrolling over double the expected patients during the 2010-11 year.

Another example was AML17, is a highly complex risk-based study for Acute Myeloid Leukaemia. Chemotherapy was allocated according to individual patients' disease markers. De-escalation of care was being investigated and thus a clinical trial setting was an ethical necessity. Standard risk patients were randomised to receive either four (normal care) or three chemotherapy cycles. Stem cell transplant, which carries a strong risk of complications, was avoided. High risk patients were escalated early to aggressive treatment and those with a donor, to stem cell transplant. There were several other randomisation procedures for four experimental drugs also incorporated within the study. While AML17 was completely unfunded, prized new agents were supplied free and involvement in the study contributed major savings on standard treatment plans and supportive care.

The focus on malnutrition in the critically ill reflected the increased complications and risk of death, prolonged mechanical ventilation and patient stay in the intensive setting. Feeding protocols are increasingly becoming therapeutic tools and ADHB's Department of Critical Care Medicine has made a contribution to the International ICU Nutrition Survey, which considers the standards of nutrition practice delivery. Each contributing ICU receives an individual benchmarking report comparing practices with other like ICUs and ADHB has been ranked in the top ten ICUs worldwide over several years.

## **2.5 Working towards our goals**

The projects undertaken during the year were undertaken to deliver the objectives and benefits set out in the District Annual Plan in accordance with the three goal areas relating to population health, performance improvement and living within our means. The implementation of these strategies required a singular focus on four core elements, all of which were approached with a strong orientation towards improving healthcare for patients and communities:

- Providing effective leadership
- Effective strategy and planning
- Ensuring an engaged workforce
- Implementing improved processes

In some cases, such as the drive to improve electives services, there is a capital expenditure component to the work and this is discussed in the next section.

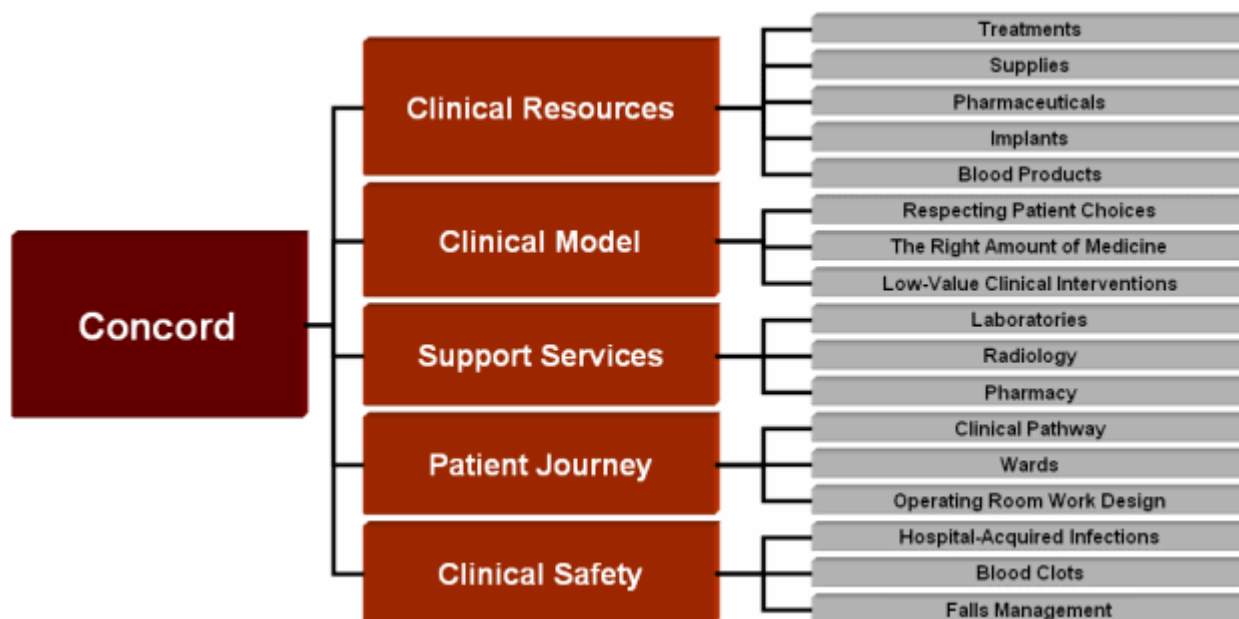
Whilst project activity is managed and tracked at a local level, there are also a number of regional projects. These address issues that affect the DHBs collectively, such as GHAIN, where the focus is on better health of children and better management of primary care to reduce acute episodes which result in unplanned hospital admissions. There are also national initiatives to secure service and financial benefits, such the formation of Health Benefits Limited and the four regional shared services organisations. HBL is tasked with creating \$700 million of sustainable savings for the sector over a five year period. These major initiatives are at a formative stage with structures in place and work plans established for the next year.

Returning to local initiatives, one of the most significant and visible initiatives in 2010/11 has been the improvement of elective services capabilities. Increasing the capacity of the Greenlane Clinical Centre to handle elective surgery and various improvements to a range of consultation services is a two year project. In this first year the building work to create three additional operating theatres has been completed and work is now focused on the clinics and wards. The section on capital projects below provides further detail on this work. This programme of work will start to deliver tangible benefits in 2011/12.

Another project of significance has been the development of Concord, which engages the whole ADHB workforce in the search to reduce clinical waste and improve the quality of healthcare. The aim is to provide the right amount of healthcare in the right way. Concord was clinically led by Dr Barry Snow in 2010/11, the Medical Director Adult Health Services, and is sponsored by Margaret Wilsher, the Chief Medical Officer.

Concord uses a scorecard for project outcomes with measures of success. The approach is holistic to ensure the system is optimised as a whole without detriment to other parts. There are the 11 measures used to define success relating to quality, capacity, patient flow management, cost and risk management, and patient satisfaction.

The scope of the programme is represented in the diagram below:



These major programmes of work are focused towards the provider arm, although there are wider benefits for the health system arising from this work. In the non DHB provider arm services there have been some highly successful initiatives, the most significant of which is the improvement in the immunisation programme. This work is covered in more detail in the targets section later in this report.

The focus on working with the broader provider network is also highlighted in initiatives such as the introduction of long term condition quality improvement coordinators for diabetes and cardiovascular disease management. The primary care

network provides approximately 90% of the care requirements for these groups so using a dedicated coordination team to assist primary care practices in improving their records, systems and patient care planning will provide significant benefits in the long term. Chronic disease creates high long term costs for ADHB so a strategic perspective on creating better shared care arrangements and an improved model for service delivery is essential.

The care of older people is another area where successful investment has occurred. During the year the service model was implemented and is now part of business as usual. Successful outcomes in the year included an increase in the number of older people supported in their own home, and a corresponding decrease in the number of older people being admitted to aged residential care.

We are also supporting a higher level of clinical acuity in the community than was previously possible. There has been significant progress in the shared care model of delivery between our specialist providers and the four agencies that we contract to deliver care for older people in the community. The use of the InteRAI suite of tools for comprehensive assessment of every one of the 2,700 clients has also provided useful clinical data to help inform planning at a regional and local level.

The other key deliverable for care for older people has been the completion of the case mix funding methodology, which now informs the case weighted price of each client according to their clinical complexity and level of support required. Providers are now empowered to deliver flexible care in conjunction with the older person, which is based on a package of funding and support from their families and the funded and unfunded programmes on offer in their communities.

The investment in Child and adolescent oral healthcare noted in the capital projects section also warrants comment. The area has had little investment since the 1960's and the infrastructure no longer met the modern requirements for service delivery and hygiene. In 2007 the MOH announced the availability of capital and operational funding for improvements in oral health service delivery.

Whilst the service is managed on a regional basis by Waitemata DHB, it was necessary for ADHB to define its own population needs and submit a business case. This was successful in securing \$10.4 million of capital funding and \$3 million of annual operational funding to improve services in the ADHB area.

The funding has been used to build 14 new dental clinics based in schools and to purchase four mobile clinics. To date five of the new clinics have been built with five more due for completion by October 2011. The remainder will be completed in the period to June 2012. The structure of the service has also been improved with more front line staff, improved patient tracking and recall, and an expansion of service hours to include late nights, weekends and school holidays. The service is in a transitional phase so the full extent of the benefits will not be secured for some time yet, but good progress is being made.

In all there were 106 major projects undertaken during 2010/11 and the table below provides a snapshot of the status at 30 June 2011. Only one project was cancelled during the year and 65 projects were carried forward to 2011/12 having made good progress during 2010/11.

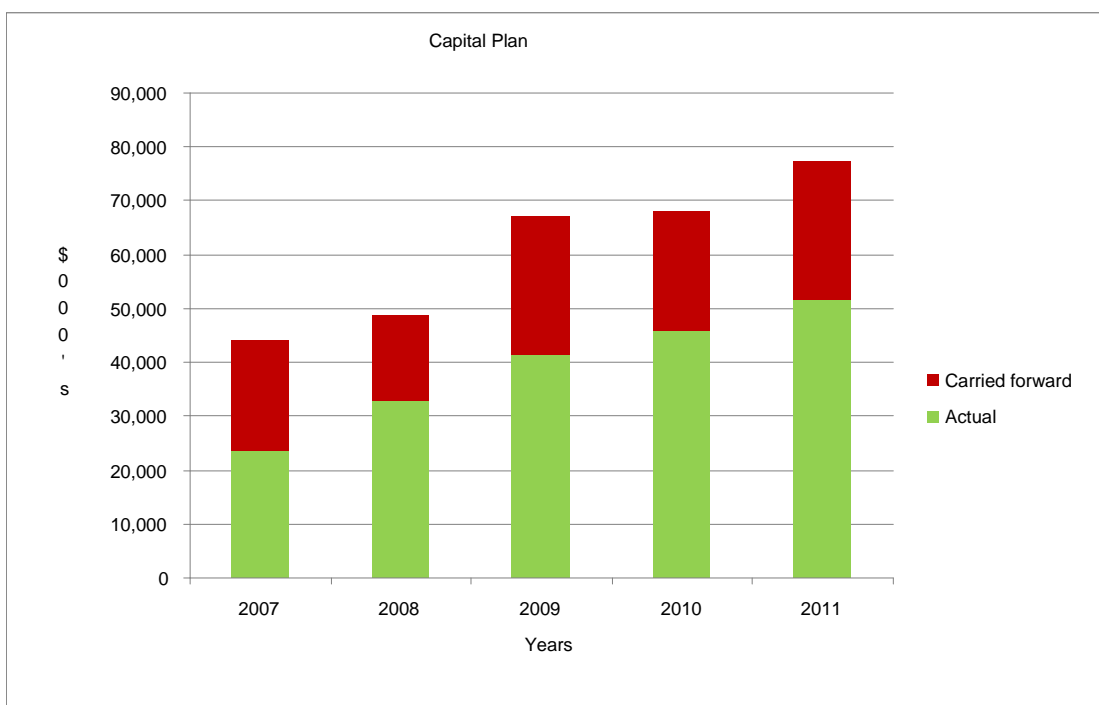
Project phase at 30 June 2011	Projects
Planning	20
Implementation	45
Cancelled	1
Completed	40
<b>Total</b>	<b>106</b>

Only 10 projects were running behind time indicating that the remaining 55 projects had planned end dates later than 30 June 2011. A status summary for projects still running at 30 June is shown below.

Status	Status at 30 June 2011
On time	71%
On budget	95%
Expected outcome	89%

## 2.6 Significant capital projects

ADHB manages a capital budget of some \$70 million each year covering new initiatives, essential replacements and upgrades to facilities. The proposed projects are prioritised within the available funding. The sector typically has a lag in completing its budgeted capital expenditure spend within the financial year and it is therefore usual for a large proportion of the projects to be carried over to successive years. The table below illustrates this pattern over the past five years.



Status	2007	2008	2009	2010	2011
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
Actual	23,790	32,977	41,381	45,938	51,697
Carried forward	20,419	15,939	25,939	22,107	25,830
<b>Total</b>	<b>44,209</b>	<b>48,916</b>	<b>67,320</b>	<b>68,045</b>	<b>77,527</b>
Actual	54%	67%	61%	68%	67%
Carried forward	46%	33%	39%	32%	33%
Total	100%	100%	100%	100%	100%

The key projects undertaken during 2010/11 were focused on improving facilities to assist patient access to services, improving patient information systems and increasing the ability of the organisation to deliver elective services.

The new car park at Grafton will have a total cost of \$14.9 million with \$6 million spent to 30 June 2011, and the remainder being spent in 2011/12. This project will significantly improve patient access and the business case is based on the project being cost neutral due to the revenue flows from the parking and retail and office accommodation. The project is running on time and budget with building works now at an advanced stage. The leasing programme is also under way with high level decision making around the parameters for tenant mix and pricing being the current focus.

The electives programme at Greenlane is a strategy to enable better delivery of elective services. The project is worth \$27 million with \$12 million spent to 30 June 2011. The work covers a wide range of facilities including:

- Three new operating theatres
- New sterile supply department
- Improved patient waiting and processing areas

The new operating theatres have been completed and work is now being completed on the Haemodialysis unit, the Ophthalmology Clinic relocation to the ground floor and new wards. The reconfiguration improves patient access and flows and provides separation of acute, non acute, adult and paediatric patients.

The third major project is the continuation of the \$10.4m Oral Health Project with \$6m spent to 30 June 2011, and the remainder falling into 2011/12. This project will significantly improve the oral health of primary school children across the region. 4 mobile units and 5 clinics have been commissioned to date. A further 2 mobile units and 9 clinics will be commissioned during the 2011/12 year.

The fourth major programme of work undertaken in 2010/11 was in relation to IT systems to support initiatives to improve patient flow and communication with primary

care providers. The \$7 million spend to 30 June 2011 included \$4 million of replacement IT equipment and infrastructure upgrades across the DHB, of which the largest part was spent improving the resilience of the network and its failover capability in the event of problems occurring. Other IT projects were also completed for Endoscopy patient information and ROERS (Radiology Order Entry and Results sign off). Work on eReferrals, Maternity records and ARMHIT was started and will continue into 2011/12.

The ROERS project was based on the presumption that no patient should have an x-ray taken in circumstances where the reports become lost, or for any reason do not get seen and acknowledged by the requesting doctor. The project provided an electronic order system to ensure sign-off and reconciliation of radiology results by clinicians. It took almost two years to complete and has been successfully rolled out to all clinical specialities at ADHB. The new system provides a speedy service with reduced administrative time required to maintain it. The quality of clinical information has been improved and the system's simplicity allows House Officers and Registrars to use it with minimal training and support. As a measure of its success, the ROERS application was handed over to users on 10 June 2011 and by the end of June, 85% of all Radiology orders were being placed using ROERS.

In addition to the substantial projects already mentioned there were other capital building works of \$5m which included construction of the Chemotherapy Production unit at a cost of \$2 million.

\$5 million worth of clinical equipment was purchased to improve the therapies available to patients and reduce the waiting time for cancer treatment radiotherapy assisting the goal of meeting the health targets. This programme included the commissioning of a replacement linear accelerator and kilovoltage irradiation and brachytherapy machines. A further \$10.7 million was spent on improving patient care through the replacement and upgrading of clinical equipment.

The table set out below summarises the capital projects undertaken during the year by purpose:

<b>Project</b>	<b>\$million</b>
Increase patient access	6
Enhance elective services	12
Improve oral health	6
Improve patient flow and communication,	7
Building works to enhance patient services	5
Reduce cancer treatment waiting times	5
Complete routine replacements	10.7
<b>Total Spend</b>	<b>51.7</b>

## 2.7 Meeting our targets

The annual Statement of Service Performance (SSP) is a requirement under the Crown Entities Act 2004 Section 153. It describes each class of output supplied by ADHB during the financial year and compares service delivery performance with forecast performance, and revenue earned and output expenses incurred compared to budget. The information included in this section of the Annual Review comprises extract from the SSP together with additional commentary where appropriate.

The SOI (which the SSP reports upon) reflects the long term vision of Auckland DHB which is 'Healthy Communities, Quality Healthcare, Hei Oranga Tika Mo Te Iti Mei Te Rahi. Three goals overarch and focus all aspects and levels of the Auckland DHB healthcare system and eight high level outcomes (also called our vital health outcomes) provide direction for achievement of goals and the ability to report healthcare provision in a manner consistent with the four output classes required by the SSP:

- Output Class 1: Public & Population Services
- Output Class 2: Primary & Community Services
- Output Class 3: Hospital Services
- Output Class 4: Support Services

While complying with the Public Health and Disability Act 2000, DHBs also have to meet requirements set by the Ministry of Health and the Minister of Health. These requirements are summarised in the table below.

The majority of revenue cannot be related to the output classes and expenditure is therefore used as a means to determine the allocation of resources in accordance with the needs of the population and Government Health Priorities. The table below summarise the revenue and expenditure by output class.

The focus on moving care to a primary setting where possible and hosting of Procure by ADHB for the northern DHBs is reflected in the increase in early detection and management expenditure compared to the previous year. The increase is reflected in the slight decrease in funding and expenditure for intensive assessment and treatment.

Summary by Output Class	Actual 2010	Actual 2011	Plan 2012	Estimate 2013	Estimate 2014
	\$'000	\$'000	\$'000	\$'000	\$'000
<b>Early Detection &amp; Management</b>					
Revenue	418,117	532,936	526,423	539,083	553,023
Expenditure	-420,608	-543,832	-528,134	-541,084	-555,160
<b>Surplus/(Deficit)</b>	<b>-2,491</b>	<b>-10,896</b>	<b>-1,711</b>	<b>-2,001</b>	<b>-2,137</b>
<b>Intensive Assessment &amp; Treatment</b>					
Revenue	1,132,783	1,101,254	1,193,064	1,221,756	1,253,350
Expenditure	-1,119,120	-1,093,056	-1,179,471	-1,207,519	-1,238,639
<b>Surplus/(Deficit)</b>	<b>13,663</b>	<b>8,198</b>	<b>13,593</b>	<b>14,238</b>	<b>14,712</b>
<b>Rehab &amp; Support</b>					

<b>Summary by Output Class</b>	<b>Actual 2010</b>	<b>Actual 2011</b>	<b>Plan 2012</b>	<b>Estimate 2013</b>	<b>Estimate 2014</b>
Revenue	138,383	159,196	144,382	147,854	151,677
Expenditure	-148,830	-157,746	-155,441	-159,247	-163,388
<b>Surplus/(Deficit)</b>	<b>-10,447</b>	<b>1,450</b>	<b>-11,059</b>	<b>-11,393</b>	<b>-11,711</b>
<b>Prevention Services</b>					
Revenue	22,741	27,521	19,353	19,819	20,331
Expenditure	-23,187	-26,132	-20,078	-20,561	-21,092
<b>Surplus/(Deficit)</b>	<b>-446</b>	<b>1,389</b>	<b>-725</b>	<b>-742</b>	<b>-761</b>
<b>Total</b>					
Revenue	1,712,024	1,820,908	1,883,222	1,928,512	1,978,382
Expenditure	-1,711,745	-1,820,766	-1,883,125	-1,928,410	-1,978,279
<b>Surplus/(Deficit)</b>	<b>279</b>	<b>142</b>	<b>98</b>	<b>102</b>	<b>103</b>

The SSP includes a set of tables summarising service performance against the many national and DHB specific targets. A copy of this is included in Appendix 1. In the SSP filed with the MOH there are also a series of commentaries covering each response in the table. These are not included here but can be viewed in the SSP. Performance against the national targets is set out below.

### 2.7.1 Faster treatment for ED patients

**Goal: For 95% of patients to be admitted, discharged or transferred from emergency departments within six hours**

**ADHB result: 95%**

Delays for patients presenting through our adult and children's emergency departments have been cut dramatically over the last two years. A hospital-wide campaign to value our patients' time has seen ADHB achieve the 2010/11 waiting time target despite a 21 per cent increase in patient numbers since 2009. An extra 3,400 people have received treatment within the six-hour national target time in the last six months.

The reduction of delays embedded in systems has allowed faster patient transfers from the emergency departments, which, in turn, has reduced bottle-necks at the front door. Reducing the ED length of stay means increased efficiency and capacity to treat other patients, with 33 per cent more ED patients now treated within six hours than in mid-2009. The average length of patient stay has almost halved over two years to 3.6 hours.

The overriding challenge was to reduce time across the whole patient journey by focusing on removing unnecessary delays. This required hospital-wide ownership of the target, rather than it being seen as a problem for the EDs to manage. The aim was to get the patient to the right place sooner to receive the care they need.

Meeting this goal has required different thinking about the flow of acute patients across the hospital and ensuring beds and inpatient specialists are available to respond quickly to their needs. The ongoing challenge is to maintain the momentum that has been achieved, particularly during the challenging busy winter months.

### **Key initiatives**

- Physical and process changes in the triage registration areas reduced the times patients spend waiting for their initial triage assessment.
- The Handover Hotline allows staff in the Adult ED and Admission Planning Unit to arrange a timely patient handover process. The Flow Coordinator position in ED prompts staff to improve efficiency and keeps patients better informed.
- Nurse-facilitated discharge allows patients to go home hours sooner by removing the need for a doctor to see them before departing. This allows improved bed turn-around times and efficiency.
- The Rapid Rounds initiative sees ward staff using a five-minute team meeting to ensure the team knows the plan for each patient's stay, ensuring their stay is right for their needs.

The concerted effort over the past two years has produced the following improvements:

<b>Measure</b>	<b>June 2009</b>	<b>June 2011</b>
Number of patients waiting over 24 hours for a bed	98	0
Patients waiting over 12 hours for a bed	21%	0.3%
Average wait for a bed – all patients	7hrs 48 mins	1hr 18 mins
General medicine patients – average wait for a bed	8hrs 32mins	1hr 26 mins
Orthopaedics patients – average wait for a bed	8hrs 6mins	1hr 18 mins
General surgery patients – average wait for a bed	10hrs 10 mins	1hr 3 mins

### **2.7.2 Timely cancer treatment**

<b>Goal: For all patients needing radiation therapy to receive it within four weeks of the decision to treat.</b>	<b>ADHB result: 100%</b>
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ADHB maintained its perfect record of all cancer patients requiring radiation therapy receiving it within four weeks of their first specialist assessment. The 100 per cent result was good news not only for patients within our own population area but also the cancer patients from the Northland, Waitemata and Counties Manukau DHB areas covered by our regional service.

The service achieved the target despite having between 40 and 60 new patients starting treatment each week. By the end of June, 2129 courses of treatments had been delivered during 2010/11. The team maintained the service levels despite the challenge of managing variations in demand and complexity.

The Ministry of Health cancer waiting time target reduced from six weeks to four weeks from the end of December. The service has consistently met the reduced wait time target of four weeks every month since it came into effect. Consistently

achieving targets requires ongoing weekly monitoring of the wait list, prioritisation and planning using a multi-disciplinary approach. It required the commitment and hard work of radiation oncologists, physicists, radiation therapists and scheduling staff to improve systems and processes and, therefore, patient waiting times.

Looking forward there will be some loss of capacity during the decommissioning and replacement of a linear accelerator this month and there is an ongoing international recruitment programme aims to maintain radiation therapist staffing levels and the right skill mix to run the service.

### **Key initiatives**

The new linear accelerator will complement the machine installed late last year that enables the team to deliver the latest treatment technologies available. It will also deliver more efficient patient throughput (particularly for complex treatments) and improved targeting of radiation therapy to the tumour site. A new machine using the latest technology in the treatment of skin cancers and superficial tumours is also being commissioned.

Meanwhile, the number of treatment 'fractions' delivered to breast cancer patients was reduced in February, based on clinical evidence. This reduced the total treatment time for the patient and freed-up linear accelerator capacity. The introduction of High-Dose Radiation Therapy will bring more convenient treatment for gynaecological patients. HDR treatment for prostate patients is planned at a later stage.

More flexible radiation therapist shift patterns are allowing the department to extend treatment hours when needed and a move to full electronic recording is expected to further reduce patient planning and waiting times.

A total of 128 patients were referred for treatment by a local private provider (Auckland Radiation Oncology) or Waikato DHB last year. A long-term partnership with ARO will allow ADHB clinicians to treat public patients at their facility to ensure sustainable capacity across the region as demand increases.

The net benefit of the service development work that has been undertaken is that as of 30 June, the Radiation Oncology team had achieved the cancer target waiting time for more than 430 consecutive days. In May and June, the average waiting time for patients clinically-assessed as requiring treatment within four weeks was down to 3.1 weeks.

### **2.7.3 More patients receive elective surgery**

Goal: To deliver 11,149 elective surgery discharges in 2010/11	ADHB result: 11,182 discharges
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ADHB's success against the Elective Surgery Health Target required an 18 per cent lift in the discharge target in a single year. A number of daily and monthly discharge records were set on the way to achieving the target, resulting in more patients receiving the procedures they need sooner. Over the full 2010/11 year, the target increase was for more than 1700 additional patients to receive elective surgery through ADHB. The increased surgical volumes resulted in some excellent waiting time performances and a reduction in the patient backlog.

In the second half of the year, 468 fewer people were waiting more than six months for their surgical procedure, a 66% improvement. At the same time, the surgical waitlist reduced by 17%. The clinic waitlist also fell by 12% and the number of people waiting greater than six months for clinic treatment was reduced by 48%.

### **Key initiatives**

The opening of the new Greenlane Surgical Centre (GSC) is having a significant impact on ADHB's capacity to meet targets. Many of the services based at the GSC achieved major increases in patient throughput in the second half of the year once the facility was up and running.

ADHB is reviewing the Patient Flow Operational Plans for 2011-12 to focus on the wait times and production required to ensure patients in all services wait no longer than six months for their procedure.

The net effect of these efforts saw 55 extra patients a week receive elective surgery between January 1 and June 30, compared to the previous six months. Up until 31 December, ADHB discharged 195 elective surgery patients a week on average. This had rose to 250 patients a week by 30 June 30.

### **2.7.4 Shaping our plan for better diabetes care**

Goal 1. To increase cardiovascular risk assessments to 79% of the eligible adult population	79.9% for Oct-Dec
Goal 2. To increase the rate of people with diabetes attending free annual checks to 57%	54%
Goal 3. To increase people with diabetes having satisfactory or better diabetes management to 84%	73%

The targets for diabetes annual reviews and better management are set by individual DHBs to take into account the specific needs of their populations. ADHB set high targets, reflecting our commitment to improving services to people in our community living with diabetes. However, the consequence of setting high targets and falling short of them is comparison with DHBs that have significantly different and often lower targets.

One of the highlights of ADHB's results was the performance for all ethnicity groups on free diabetes annual checks, particularly for Maori and Pacific diabetics. These results were significantly higher than those of our counterparts. The aim was for 55% of both groups to receive their yearly check. The Pacific target was exceeded by 18% (73% of the population whose free annual check occurred during the reporting period were tested) and the Maori target was beaten by 5% (60%).

The appointment of Long-Term Condition Quality Improvement Coordinators between February and April paid off with better results in April and May. The 'get checked' result was 59% in April against the 57% target and in May it rose to 65%.

ADHB and its primary health organisation (PHO) partners recognise work still needs to be done to sustainably improve the diabetes annual review and management health outcomes. A range of long-term initiatives are being developed and rolled-out

but these will take time to reflect improvements. Once foundations are firmly established, gains should become more noticeable.

Varying performance levels by PHOs are being addressed by working with those with the highest diabetic populations to drive improvements. Improvements in performance over the last year have been confined to achievements among the Maori, Pacific and Indian populations.

### ***Key initiatives***

The three Long-Term Condition Quality Improvement Coordinators working in primary care have a clear focus on improving diabetes health outcomes. They are working with practices to establish and maintain diabetes registers and recall systems to improve annual review rates.

Other initiatives to boost performance include providing a population audit tool to all primary care practices to identify people with long-term conditions and other technology assistance for smaller PHOs. Culturally and linguistically-appropriate courses will be available to support people self-managing diabetes.

A Pacific self-management facilitator will train Healthy Village Action Zone parish nurses, community health workers and lay people and there will be enhanced diabetes retinal screening, particularly in high-needs populations. ADHB was one of the first DHBs to sign-up to the Diabetes Nurse-Prescribing project.

### **2.7.5 Immunisation target success**

Goal: For 90% of two-year-olds to be fully-immunised by July, 2011.	ADHB result: 92%
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The immunisation partnership between ADHB and its community-based service providers has proved successful. This alliance enabled ADHB to meet and exceed its 2010/11 Health Target goal for the full immunisation of 90 per cent of two-year-olds. This was achieved by the ADHB primary care practices boosting coverage by five per cent in this age group.

The result contributed to a 17 per cent improvement within the ADHB population over the last two years for this age cohort. A project to improve patient information has enabled teams to target those infants overdue for their shots and have them brought back up to speed quickly. The result of the team approach was the full immunisation of a total of 1,388 of the 1,513 two-year-olds in ADHB's population area.

Immunisation was declined by 3.6 per cent of families among ADHB's population last year, leaving a slim margin for achieving the target. In future there will be ongoing work to increase coverage among six-month-olds, which currently stands at 74% for age across the whole population and less among Maori (56%) and Pacific (67%). Babies are most vulnerable up to around nine months of age, so it is critical that the six-week, three-month and five-month immunisations are delivered on time.

Barriers to families immunising their children include lack of awareness, competing priorities, fear, concerns about their child's health and access to primary care for reasons including cost (although immunisation is free for all children) and transport.

Achieving very high immunisation rates requires an excellent record of children and their immunisation status.

### **Key initiatives**

The National Immunisation Register is a key tool for achieving high coverage rates as it allows teams to target solutions at individual children. Primary care systems of pre-calling and re-calling parents for scheduled immunisation are another important way of ensuring compliance.

A general practice's relationship with a child's family and the immunisation knowledge of health professionals is valuable and ADHB's Outreach Immunisation Service, provided by the Immunisation Advisory Centre (IMAC), is also supporting those often-mobile families who face the greatest difficulties in attending a routine appointment with their primary care practice. To get almost complete coverage means that all parts of the system need to work closely together.

The net result of efforts to date have seen Immunisation rates among children from key ethnicity groups improving significantly over the last 12 months.

- Pacific immunisation up 11% in a year to 95%.
- Maori immunisation up 9% to 88%.
- And Asian immunisation is up 3% to 94%.

### **2.7.6 6,000 more smokers given help to quit**

Goal: For 90% of hospitalised smokers to be given advice and help to quit.	ADHB result: 80%
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A big effort to reach out to hospitalised smokers with advice and help to quit has seen an extra 6,000 patients take the first step over the last year. Although ADHB fell just short of its 2010/11 goal, performance against this target came a long way over the course of the year.

Brief advice about quitting was given to 9,008 patients last year, up from 2,924 the previous year. The number of referrals to smoking cessation services for 2010/11 was another success story – up more than a third to 1,811 from 1,167 the previous year.

When the targets were introduced in July 2009, only 15% of smoking patients were given brief advice on giving up. By the end of June, the number had risen to 80%. That was 14% up on a year earlier. The improvements are significant considering tobacco-related harm is a major contributor to avoidable disease and death.

The philosophy behind ADHB's approach to the target is that tobacco is the problem, not the smoker. It recognises that quitting is difficult and smokers may want to give up but need help.

The challenge to reaching the target in future is identifying and closing gaps which see some smoking patients not offered brief advice on quitting by staff. When the Adult Emergency Department and Admission Planning Unit joined the programme last June, it saw an immediate spike in the overall rate of patients being given advice

to quit. Due to the high volume of patients passing through those units, it is critical to keep working hard to ensure patients aren't missed or significant further gains will be difficult to achieve.

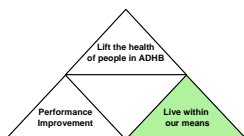
Elective surgery patients are asked about their smoking status by the Short Stay Surgical team and those identifying as smokers are given brief advice on quitting. A process is being implemented that will see the same messages reinforced on the day of surgery.

### ***Key initiatives***

System refinement and staff training over the last two years has led to better results but sustained improvement will need to come from wards taking ownership of the target and incorporating their own checks. Ongoing nurse training and nurse-initiated provision of Nicotine Replacement Therapy on wards in the form of gum and patches is helping patients cope with withdrawal whilst in hospital. The introduction of a mandatory smoking section on the Electronic Discharge Summary has been an important tool for 'capturing' smoking patients.

Weekly performance 'league tables' are enabling wards and services to compare their results and generate ideas about improving data collection. Daily chart audits have been introduced to help guard against patients being missed and have led to a significant reduction in the number who are not asked about their smoking status. Innovation on wards has seen the introduction of measures such as checklists on daily handover sheets and routine daily checks by a designated staff member to ensure that patients have not been missed.

Based on evidence that one in 40 smokers will quit as a result of receiving brief advice from a health professional, around 225 of the 9,008 ADHB patients contacted last year will give up smoking. If that number could be replicated at each DHB around the country, New Zealand would have almost 4,500 fewer smokers.



## Goal 3 Living within our means

### 3.1 A summary of services delivered

ADHB has continued to complete a high volume of work for other DHBs. This volume which comprises some 50% of clinical service delivery results from two key factors. The first is historical patient flows, and this is being progressively addressed as other DHBs increase their ability to provide services locally from their own facilities. The second recognises that a number of ADHB services are highly specialised and are either tertiary or quaternary in nature requiring a centre of excellence setting to deliver the best service in areas such as the national level services for child health and liver transplants.

The table below summarises the activity for DRG services during the year. It is interesting to note that the acute services were almost exactly on budget, a most unusual occurrence based on experience in previous years. It is usual for there to be growth in the order of 2.5% and this has not occurred, resulting in a greater ability to deliver elective services.

The major change in DRG service activity occurred in the fourth quarter. This coincided with the start of initiatives to increase the involvement of the primary care sector in delivering a coordinated set of services, and the increase in service capacity at Waitemata DHB.

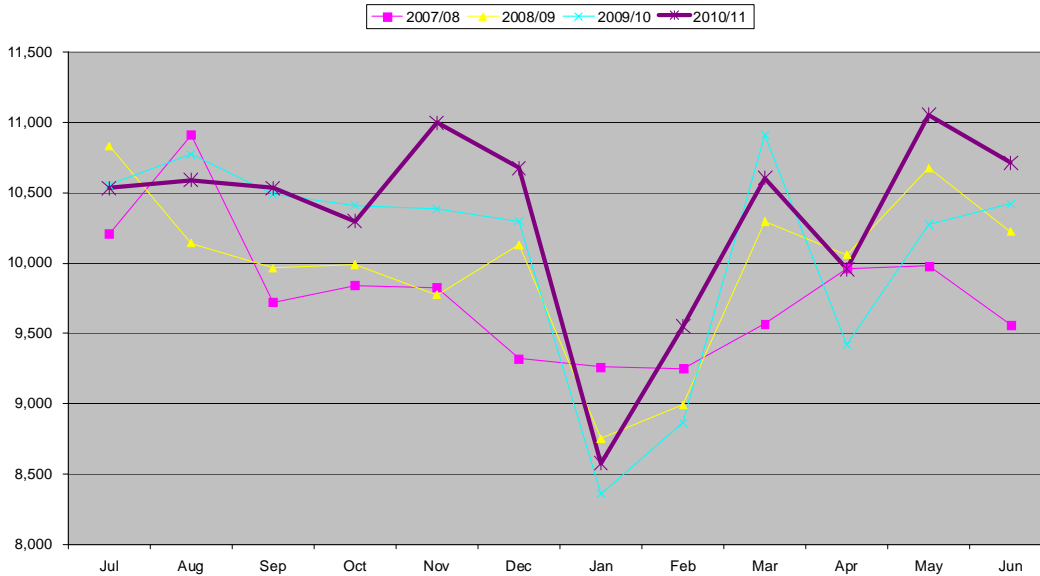
The increased focus on delivering elective services and higher volumes is always a challenge and the target for the year was successfully met. Although the WIES volume budget was not met, which is an indicator to improve intervention rate for ADHB population, the number of discharges exceeded the target. The waiting time for patients was also substantially improved.

Achieving these targets reflected the work on improving patient throughput. Some of the initiatives undertaken form part of the health target initiatives, but were augmented with others such as the development of the POP. These projects were further supported by a range of improvements projects secured through the TPOR programme. Going forward this will be managed through the new Concord system designed to capture ideas, manage projects and track results.

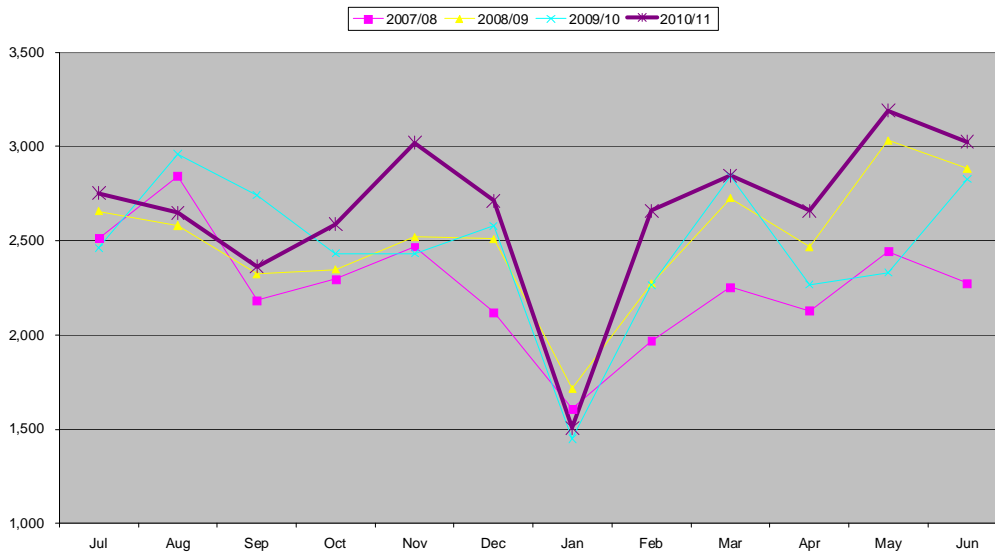
Category	ADHB			IDF			Total		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Acute	50,364	50,307	(57)	41,769	41,776	7	92,133	92,083	(50)
Elective	15,087	13,772	(1,315)	18,528	18,202	(325)	33,615	31,974	(1,641)
<b>Total</b>	<b>65,451</b>	<b>64,079</b>	<b>(1,372)</b>	<b>60,297</b>	<b>59,978</b>	<b>(318)</b>	<b>125,748</b>	<b>124,057</b>	<b>(1,690)</b>

The chart below provides an illustration of the movement in WIES volumes over the past five years. Seasonal patterns are very similar between years.

Acute and Elective WIES Month and Year



Elective WIES by Month and Year



Non-DRG service activity for the year was ahead of plan as illustrated in the table below. The most significant variance occurred in relation to renal services. This resulted from the slower than expected completion of service enhancements at Waitemata DHB and was compensated by increased funding.

	<b>Plan</b>	<b>Actual</b>	<b>Variance</b>
	<b>\$</b>	<b>\$</b>	<b>\$</b>
AED, APU, DCCM, Air Ambulance	4,897,742	6,269,900	1,372,158
Ambulatory Health Services	23,353,674	24,382,689	1,029,014
Cancer and Blood services	64,225,876	64,694,602	468,727
Cardiac Services	10,870,163	11,161,056	290,893
Gen Med, A+ Links, ID, NASC	37,025,243	36,853,874	-171,369
Gen Surgery, Trauma, Gastro, Respiratory	21,344,251	22,042,337	698,086
Genetics	1,823,050	1,870,697	47,647
Medical & Community services	30,155,833	29,797,437	-358,397
Operations	22,685,026	23,969,098	1,284,072
Ophthalmology	10,746,112	10,657,699	-88,413
Orthopaedics Adult	3,884,949	3,985,528	100,579
Paediatric Cardiac & ICU's	3,881,405	4,040,725	159,320
Surgical & Community services	7,136,022	7,507,585	371,563
Trans, Renal, Urology, ORL, Neurology	45,073,698	51,861,021	6,787,323
Women's Health	24,692,090	24,281,150	-410,940
<b>Total</b>	<b>311,795,135</b>	<b>323,375,397</b>	<b>11,580,263</b>

<b>Financial year</b>	<b>Value of DRG services</b>
	<b>\$ million</b>
2007/08	354.5
2008/09	379.4
2009/10	383.1
2010/11	388.2

The pattern for non DRG services over the past four year reflects increases in both volume and price. During the year major service improvement initiatives were undertaken to improve patient flow management in Children's and Adult emergency departments. It was pleasing to note that despite a higher than expected patient throughput the services were able to achieve the target of 95% of patients being admitted, discharged or transferred from emergency departments within six hours. Further commentary on this achievement is included in section 4.

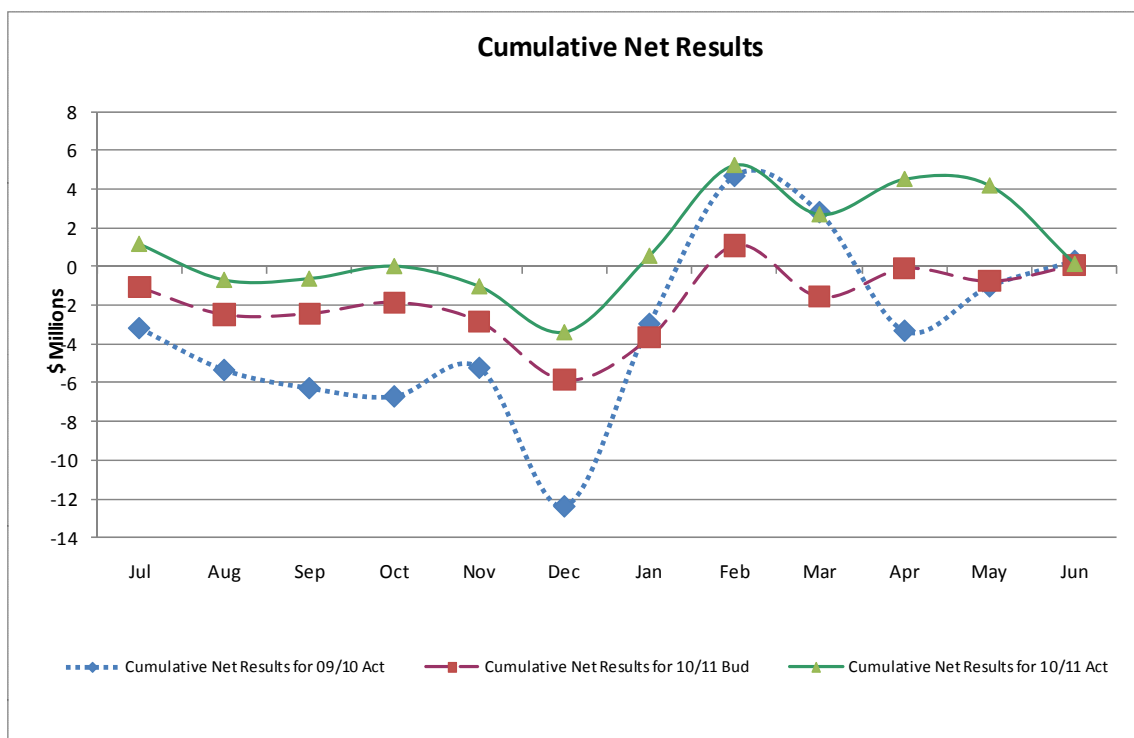
High levels of work continued to be undertaken for other DHB and the caseweights delivered for the year against plan are shown below.

DHB	Actual 2010	Actual 2011	Plan 2011	Variance 2011
	#	#	#	#
Auckland	63,246	64,207	65,451	-1,244
Counties Manukau	17,239	16,978	17,642	-663
Waitemata	24,706	24,933	24,653	280
Northland	6,447	6,781	6,985	-204
Other DHBs	9,977	10,999	11,017	-19
<b>Total</b>	<b>121,614</b>	<b>123,898</b>	<b>125,748</b>	<b>-1,849</b>

### 3.2 Operational performance

Divisional performance	Actual	Budget	Variance
Funder	20,724	899	19,825 F
Provider	(20,746)	113	20,858 U
Governance	163	(952)	1,116 F
<b>Net Surplus</b>	<b>141</b>	<b>60</b>	<b>82 F</b>

The operating result for the funder was a surplus of \$20.7 million. Population Based Funding was ahead of plan driven by variations received for Herceptin treatment and Oral Health funding. Inter District Flows were higher than planned as a result of PHO realignment funding flows through ADHB, Herceptin funding and higher IDF Washup volumes.



Subcontracts were ahead of plan driven by higher Sector Capability and Innovation funding, the achievement of MOH elective services delivery targets and higher MOH side contract revenue. With the new PHO realignment funding inflow, and the widening of the Laboratory contract, external payments were also higher.

<b>Organisational performance</b>	<b>Actual</b>	<b>Budget</b>	<b>Variance</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
MOH & IDF Sourced - Base	1,571,922	1,531,102	40,820 F
MoH Sourced (Other Contracts - Incl CTA)	126,920	109,471	17,450 F
Other Income	106,678	92,225	14,452 F
Trust & Donation Income	6,358	6,170	188 F
Financial Income	9,285	4,653	4,633 F
<b>Total income</b>	<b>1,821,163</b>	<b>1,743,620</b>	<b>77,542 F</b>
Provider Costs	1,095,301	1,051,266	44,035 U
Funder Costs (Including IDF Outflows)	617,050	575,521	41,529 U
Governance Costs	4,814	5,693	879 F
<b>Total Operating Expenditure</b>	<b>1,717,165</b>	<b>1,632,480</b>	<b>84,685 U</b>
<b>Operating Contribution</b>	<b>103,998</b>	<b>111,140</b>	<b>7,142 U</b>
Depreciation, Interest & Capital Charge	103,857	111,081	7,224 F
<b>Net Surplus</b>	<b>141</b>	<b>60</b>	<b>82 F</b>

The provider arm result for the year was influenced a significant increase in revenue and a matching increase in expenditure. The result is shown in the table below and a summary reconciliation is set out on the following page with brief explanations.

<b>Provider arm performance</b>	<b>Actual</b>	<b>Budget</b>	<b>Variance</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
Internal Revenue (Funder to Provider)	1,008,528	1,003,614	4,914 F
<b>Operational Costs</b>			
Adult Health	202,517	198,468	4,049 U
Women, Child, Cardiac, ORA	329,196	305,954	23,241 U
Operations	160,356	155,211	5,145 U
Ambulatory & Ophthalmology	29,803	27,908	1,896 U
Cancer & Blood	57,491	61,896	4,406 F
ACH Others	546	223	323 U
<b>Total Operational Costs</b>	<b>779,909</b>	<b>749,661</b>	<b>30,248 U</b>
Mental Health	85,257	88,806	3,550 F
Complementary (including Public Health)	511	838	327 F
Total Functional	64,733	62,157	2,577 U
Consolidation Adjustments	1,720	(2,621)	4,341 U
<b>Total Operational Costs Provider</b>	<b>932,130</b>	<b>898,841</b>	<b>33,289 U</b>
<b>Non Operational Income</b>			
Trust & Donation Income	6,358	6,170	188 F
<b>Non Operational Costs</b>			
Depreciation	50,954	54,299	3,346 F
Finance & Capital Charge	52,711	56,771	4,060 F
Internal Transfers between Divisions	(163)	(239)	77 F
<b>Total Surplus/(Deficit)</b>	<b>(20,746)</b>	<b>113</b>	<b>20,858 U</b>

The significant areas of change during the year are summarised in the table below and brief explanation are included under the table.

	MOH & IDF Base	MOH & CTA Contracts	Other Income	Provider Costs	Funder Costs & IDF
PHO Realignment	26,100		6,400		(32,500)
Additional Electives	2,400			(2,400)	
IDF Revenue	2,500			(2,500)	
Laboratory Contract	1,750				(2,500)
Herception Funding	8,500	(8,500)			
Mental Health (Eating Disorders)		3,400		(1,200)	(2,200)
MOH Side Contracts (Other)		14,600		(14,600)	
SCI Contracts		7,900		(7,900)	
<b>Total</b>	<b>41,250</b>	<b>17,400</b>	<b>6,400</b>	<b>28,600</b>	<b>37,200</b>

**PHO Realignment:** As part of the amalgamation of PHOs within the region, ADHB was given responsibility to host the regional contract for Procure, with other regional contracts being hosted by Counties Manukau DHB. This increased the numbers of people enrolled within PHOs hosted by ADHB from 474,000 to 926,000. The PHO costs (within Funder Costs) therefore increased by \$32.5 million. IDF income has increased by \$26.1 million as part reimbursement; with the balance in inter DHB revenue (within Other Income) as an end of year wash-up.

**Additional Electives:** The MOH provided \$2.4 million more funding to enable service improvements for elective services. This the lectivese service prdictivyu and work force development programme

**IDF Revenue:** This provided additional funding for volumes delivered by the provider arm.

**Laboratory Contract:** At the start of 2011 the regional laboratory contract was modified. This delivered, amongst other things, additional business for DML. The additional cost was shared among the three metro DHBs, with ADHB's share being \$0.75 million.

**Mental Health:** Additional funding to cover additional expenditure was received for Eating Disorders within Mental Health services.

**Herception Funding:** This changed from a MOH Side contract to a part of Core funding this year so was merely a coding reclassification.

**Other:** Reflects unbudgeted sub-contracts gained by the Provider Arm and amounted to \$14.6 million.

**SCI contracts:** These relate to Very Low Cost Access and Care Plus and are funded on a cost recovery basis. Actual delivery against this contract was \$7.9 million above budgeted figures.

### 3.3 Increased efficiency and cost savings

ADHB teams are involved with a large number of performance improvement activities each year and these are discussed in section 2 of this report. The improvements reflect either the release of resources for further service volumes or a reduction in costs.

The programme of work has been highly successful and the activities undertaken during the year released 2,446 bed days and the reduced length of stay for patients in the adult emergency department resulted in an increase in service volumes for the same FTE numbers. This provided benefit to over 50,000 patients. The work to improve elective services resulted in an additional 226 cases and new clinical methods resulted in substantial savings in blood costs. The “Releasing Time to Care” programme increased direct contact time for nurses on 35 wards from 30% to 37%. These are good results and continue to be enhanced by ongoing project work.

The work to release resources through improved processes provides the most innovative opportunities for improvement and requires the full engagement of the clinical workforce and the careful validation of the revised processes to ensure the excellence of patient care is maintained or improved. This close working relationship is creating a culture of continuous improvement that will ensure the longevity of this way of thinking.

The table below summarises the achievements for the year.

Category	\$000
Direct treatment costs	5,881
FTE productivity	8,319
Indirect treatment costs	135
<b>Total gains achieved</b>	<b>\$14,335</b>

A large number of activities were undertaken as projects and service led initiatives. An illustration of some of the larger components of the savings is set out below:

#### **Concord project \$1.7 million**

This ongoing programme of work focuses on clinical improvements to eliminate waste and inefficiency. During 2010/11 gains were made by reducing the use of blood components and laboratory reagents. A reduction in follow up visits has also been achieved releasing resources for other work.

#### **Radiology clinical supplies \$0.6 million**

Improved stock management provided significant benefits by eliminating over purchasing and reducing the incidence of expired items.

**Procurement contract      \$1.3 million**

Involvement in national and regional procurement programmes enabled cost reductions to be made in many areas including surgical implants and food costs.

**Orthopaedic review      \$0.8 million**

One significant benefit achieved was reducing the length of stay by one day enabling more people to be processed for the same resource use.

**Revised nursing model      \$3.6 million**

Releasing time to care enabled a reduction in the cost of lump sum payments and increased salaries by using staff within the service for leave cover and other staff absences.

**Reduce outsourcing      \$1.1 million**

The service excellence programme worked with services to improve the patient journey and linked with the productive operating room programme to improve the use of operating rooms.

**Emergency department      \$2.0 million**

The team analysed procedures to improve the efficiency of patient flow. This included engaging the wider work force to ensure that blockages did not occur elsewhere in the system.

In addition to the process based initiatives above there are procurement strategies which are seeking to continually reduce the costs of essential goods and services using traditional approaches. These are also making good gains.

## Appendix 1 Table of service performance

The table confirms the level of compliance with National and ADHB specific targets and is an extract from the Statement of Service Performance (SSP). The SSP includes additional information on each target area and readers should view that document if further comment is required.

Description	National	ADHB
Fully compliant	4	25
Partially compliant	2	0
Awaiting data	0	21
Non compliant	2	28
Total	8	74

### National Targets

SOI Ref	Measure	Target	Achieved Yes/No
1.1	Shorter stays in Emergency Departments-Adult	95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours	No (full year) Yes from March 2011
1.2	Shorter stays in Emergency Departments- Children's Emergency Department	95% of patients will be admitted, discharged or transferred from an Emergency Department within six hours. Baseline 2008/09 Actual 76%	No (full year) Yes from March 2011
2.0	Improved Access to Elective Surgery	11,182 discharges	Yes
3.0	Shorter waits for cancer treatment	100% of patients requiring radiation treatment will receive this within four weeks by Dec 2010	Yes
4.0	Increased Immunisation	90% of two year olds will be fully immunised by July 2011	Yes
5.0	Better help for smokers to quit	90% of hospitalised smokers provided with advice and help to quit by July 2011	No
6.1	Cardiovascular risk screening	Total 79%	No
6.2	Diabetes annual check	Total 57%	Yes

## ADHB Targets

SOI Ref	Measure	Target	Achieved Yes/No
1ai)	Health assessments done of early childhood education centre	100%	Yes
1aii)	Investigations to monitor/improve the quality of drinking water	Between 100-130	No
1aiii)	Emergency investigations on hazardous substances and new organisms	100%	Yes
1bi)	Number enrolled on Pacific smoking cessation programmes in ADHB (cumulative target)	240	Yes
1bii)	Number of healthy housing assessments and % referred to provider	Number of assessments 500	Yes
1biii)	Number of healthy housing assessments and % referred to provider	Number of referrals 80%	No
1biv)	Infants exclusively and fully breast fed -6 weeks	74%	No
1biv)	Infants exclusively and fully breast fed -3 months	58%	No
1biv)	Infants exclusively and fully breast fed -6 months	27%	Yes
1 ci)	Communicable disease control -Number of TB cases	100%	Yes
1 cii)	Communicable disease control -Number of other disease investigations	100%	Yes
1di)	Support GP's in submitting data to the National Immunisation Register (NIR) and follow-up babies not immunised	Up to 1,300 referrals	No
1 dii)	Percentage of two-year olds fully immunised for age	National Target see above	Yes
1diii)	L71. Percentage of children who have been consented and vaccinated via the school based programme	90%	No
1ei)	Eligible women participating in the National Cervical Screening Programme, Particularly: Maori, Pacific and Asian women(3 yr coverage rate for 20-65 yr women)	Contract targets met	No
1 eii)	B4 School Checks completed	3,600	No
2 ai)	Percentage of eligible patients having diabetes - Maori	National Target see above	Yes
2 ai)	Percentage of eligible patients having diabetes - Pacific	National Target see above	Yes
2 ai)	Percentage of eligible patients having diabetes - Total	National Target see above	Yes
2aii)	Percentage "Get Checked patients with an HbA1c>8 Maori	72%	No
2aii)	Percentage "Get Checked patients with an HbA1c>8	72%	No

SOI Ref	Measure	Target	Achieved Yes/No
	Pacific		
2aii)	Percentage "Get Checked patients with an HbA1c>8 Total	84%	No
2aiii)	Percentage of patients with diabetes retinal screened Maori	77%	No
2aiii)	Percentage of patients with diabetes retinal screened Pacific	77%	No
2aiii)	Percentage of patients with diabetes retinal screened Total	77%	No
2bi)	Percentage of eligible patients cardiovascular risk screened Maori	70%	Awaiting data
2bi)	Percentage of eligible patients cardiovascular risk screened Pacific	70%	Awaiting data
2bi)	Percentage of eligible patients cardiovascular risk screened Other	80%	Awaiting data
2bi)	Percentage of eligible patients cardiovascular risk screened Total	79%	Awaiting data
2bii)	Percentage increase in programmes and options available for cardiac rehabilitation	5% increase for all groups	Awaiting data
2ci)	Percent valid NHI on patient register	98%	No
2cii)	Percentage of Maori enrolled in PHOs	80%	No
2ciii)	Percentage of eligible enrolled patients enrolled on Care Plus(baseline 2008)	≥ 70% of eligible patients enrolled	Yes
2civ)	Percentage of palliative care clients in receipt of PHO services	15% of clients	Awaiting data
2di)	Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health Maori	Remain below 95% of the national average	Yes
2di)	Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health Pacific	Remain below 95% of the national average	Yes
2di)	Percentage of admissions to hospital for children under 5 that are avoidable or preventable by primary health Other	Remain below 95% of the national average	Yes
2dii)	Percentage of unnecessary hospital admissions for Maori, (45 to 64)	Remain below the national average	No
2dii)	Percentage of unnecessary hospital admissions for Pacific, (45 to 64)	Remain below the national average	No
2dii)	Percentage of unnecessary hospital admissions for Other, (45 to 64)	Remain below the national average	No
2diii)	Percentage of unnecessary hospital admissions for Maori, (0-74 age)	Remain below the national average	No

SOI Ref	Measure	Target	Achieved Yes/No
2diii)	Percentage of unnecessary hospital admissions for Pacific (0-74 age)	Remain below the national average	Yes
2diii)	Percentage of unnecessary hospital admissions for Other (0-74 age)	Remain below the national average	Yes
2ei)	Percentage of oral health use	68%	Yes
2eii)	Percentage of children carries free at 5 years Maori	50%	Yes
2eii)	Percentage of children carries free at 5 years Pacific	38%	No
2 eii)	Percentage of children carries free at 5 years Other	80%	No
2eii)	Percentage of children carries free at 5 years Total	66%	No
2eiii)	Number of teeth of 8 year olds decayed ,missing or filled (DMFT) Maori	1.0	Awaiting data
2eiii)	Number of teeth of 8 year olds decayed ,missing or filled (DMFT) Pacific	1.15	Awaiting data
2eiii)	Number of teeth of 8 year olds decayed ,missing or filled (DMFT) Other	.55	Awaiting data
2eiii)	Number of teeth of 8 year olds decayed ,missing or filled (DMFT) Total	.73	Awaiting data
3ai)	Patients requiring radiation treatment will receive this within four weeks(target by December 2010)	National Target see above	Yes
3bi)	Percentage of Emergency Department patients who are admitted, discharged or transferred within 6 hours	National Target see above	No
3ci)	Reduce average length of stay (ALOS) for elective and arranged impatient	4.15	Awaiting data
3cii)	Acute inpatient ALOS (average length of stay)	4.15	Yes
3ciii)	Elective and Arranged Day of Surgery Admission	60%	Yes
3civ)	Percentage of non attendance (DNA) for specialist appointments	8.5%	No
3cv)	Percentage of Maori patients DNA rates in hospital services	9%	No
3di)	At least 90% of long-term clients have up relapse prevention plans by July 2011	90%	Yes
3dii)	Percentage improved access to mental health services	3.30% (adult)	No
3ei)	Volume acute (all populations)	79,761	Yes
3eii)	Volume elective (all populations)	24,881	Yes
3fi)	Percentage of hospitalised smokers provided with advice and help to quit.	National Target see above	No
3gi)	Number of elective services discharges	National Target see above	Awaiting data

<b>SOI Ref</b>	<b>Measure</b>	<b>Target</b>	<b>Achieved Yes/No</b>
3hi)	Number of hospital in-patient deaths within 30 days of admission as a proportion of all discharges including day cases	1.39	Awaiting data
3hii)	Percentage of unplanned acute readmissions within 28 days of discharge	10.40%	Awaiting data
4ai)	Number of people $\geq 85$ years who are able to remain in their own homes with support	5% increase	Awaiting data
4aii)	Number of low level clients self managing on support packages with input from key workers	25% increase	Awaiting data
4aiii)	Number of reassessments for clients receiving home based support services	25% increase	Awaiting data
4bi)	Number of complaints	25% reduction	Awaiting data
4ci)	Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership	Increase to 100	Awaiting data
4di)	Percentage of residential mental health providers audited	30%	Awaiting data
4dii)	Percentage of people with enduring mental illness unpaid work, or education , or appropriate discharges	15%	Awaiting data

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

## **8.1 Committee Recommendations**



# **PERFORMANCE IMPROVEMENT**

## **9.1 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. It is anticipated the first monthly status reports will be available for the Board meeting on 5 October.

As reported last month a number of 2010/11 projects have completion dates in 2011/12 or a later financial year and these are included in the statistics below. Three of these projects have been completed since the beginning of July.

	Projects
Status yet to be determined (new)	152
Planning	17
Implementation	35
Cancelled	0
Completed	3
Total	207

The statistics below presently relate only to the projects carried forward from 2010/11, but will represent the full project list next month. 92% of these projects are on time, 98% on budget and 98% will deliver expected outcomes.

Status	This month	Last month	Change
On time	92%	71%	21%
On budget	98%	95%	3%
Expected outcome	98%	89%	9%

# Goal Drill Down for Board

Goal	Number	Started	Current Phase							On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/ Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green		Orange	Red	
			Define	Measure	Analyse																	
1 Lift the Health of the people in Auckland City	106	41	9	3	3	21	5	0	94	11	1	105	1	0	105	1	0	0	0	0		
2 Performance improvement	72	12	0	1	1	8	0	0	69	1	0	70	0	0	70	0	0	2	0	0		
3 Live within our means	29	2	0	0	0	1	0	0	28	0	0	28	0	0	28	0	0	1	0	0		
<b>Total #</b>	<b>207</b>	<b>55</b>	<b>9</b>	<b>4</b>	<b>4</b>	<b>30</b>	<b>5</b>	<b>0</b>	<b>191</b>	<b>12</b>	<b>1</b>	<b>203</b>	<b>1</b>	<b>0</b>	<b>203</b>	<b>1</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>0</b>		

# *10*

## **LIVE WITHIN OUR MEANS**

**10.1 Finance Committee Recommendations**

**10.2 Finance Report**



**10.1 Finance Committee Recommendations**

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**ADHB Board****Author:** Ian Bell (8077)**Subject:** Relocation Hearty Towers

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**Recommendation**

*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*

*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.*

**Background**

This will be discussed by the Finance Committee at their meeting on 6 September 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Replacement 3 General Rooms GCC Radiology

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**Recommendation**

*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.*

**Background**

This will be discussed by the Finance Committee at their meeting on 6 September 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** Northern DHB Support Agency Limited Agency Agreement

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**Recommendation**

*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.

**Background**

This will be discussed by the Finance Committee at their meeting on 6 September 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

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

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**Recommendation**

*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.*

**Background**

This will be discussed by the Finance Committee at their meeting on 6 September 2011.

**ADHB Board**

**Author:** Ian Bell (8077)

**Subject:** ACH Car Park Bldg Tenancies – Long Term Leases

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**Recommendation**

*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.*

**Background**

This will be discussed by the Finance Committee at their meeting on 6 September 2011.



## 10.2 Finance Report

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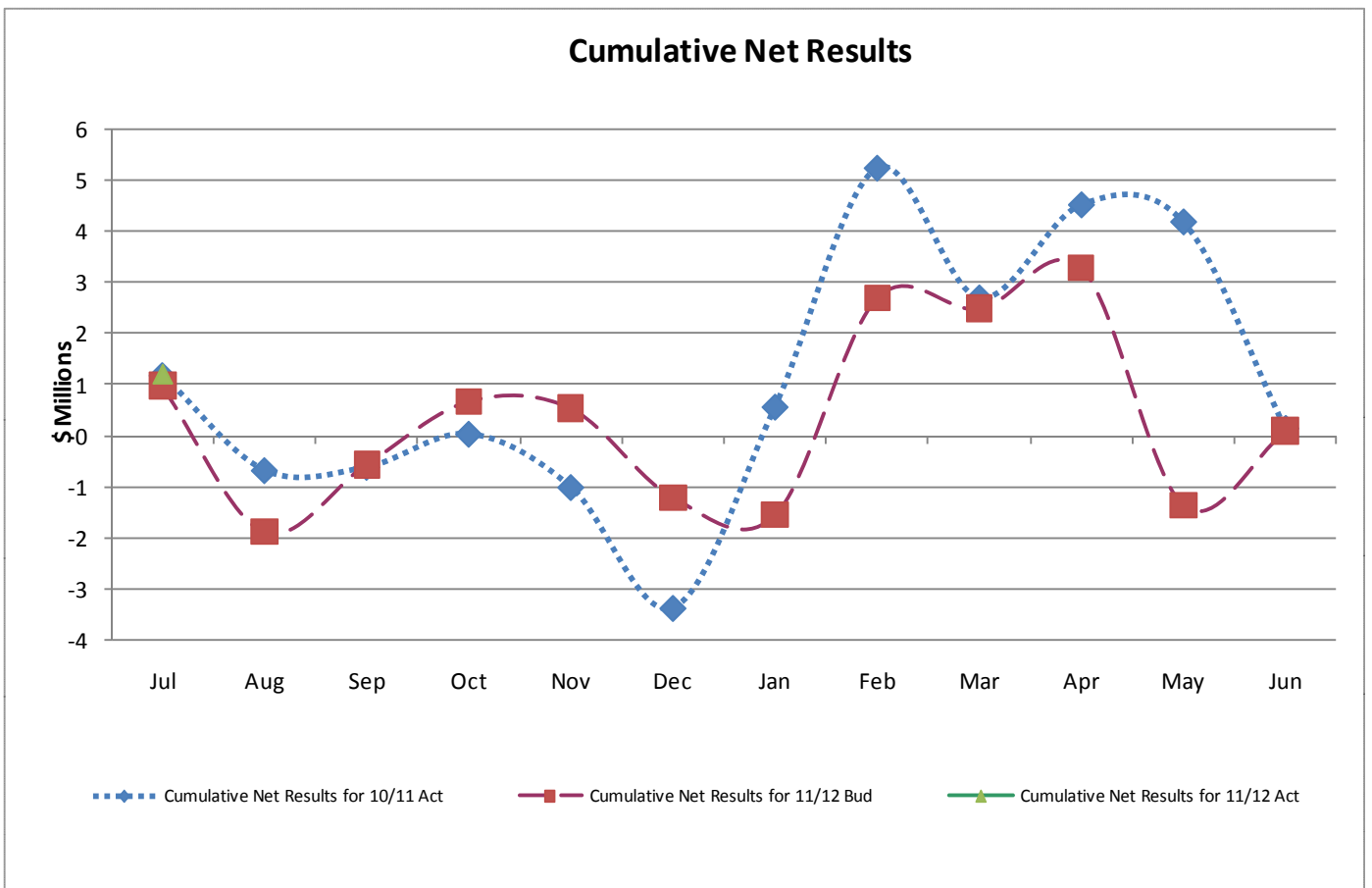
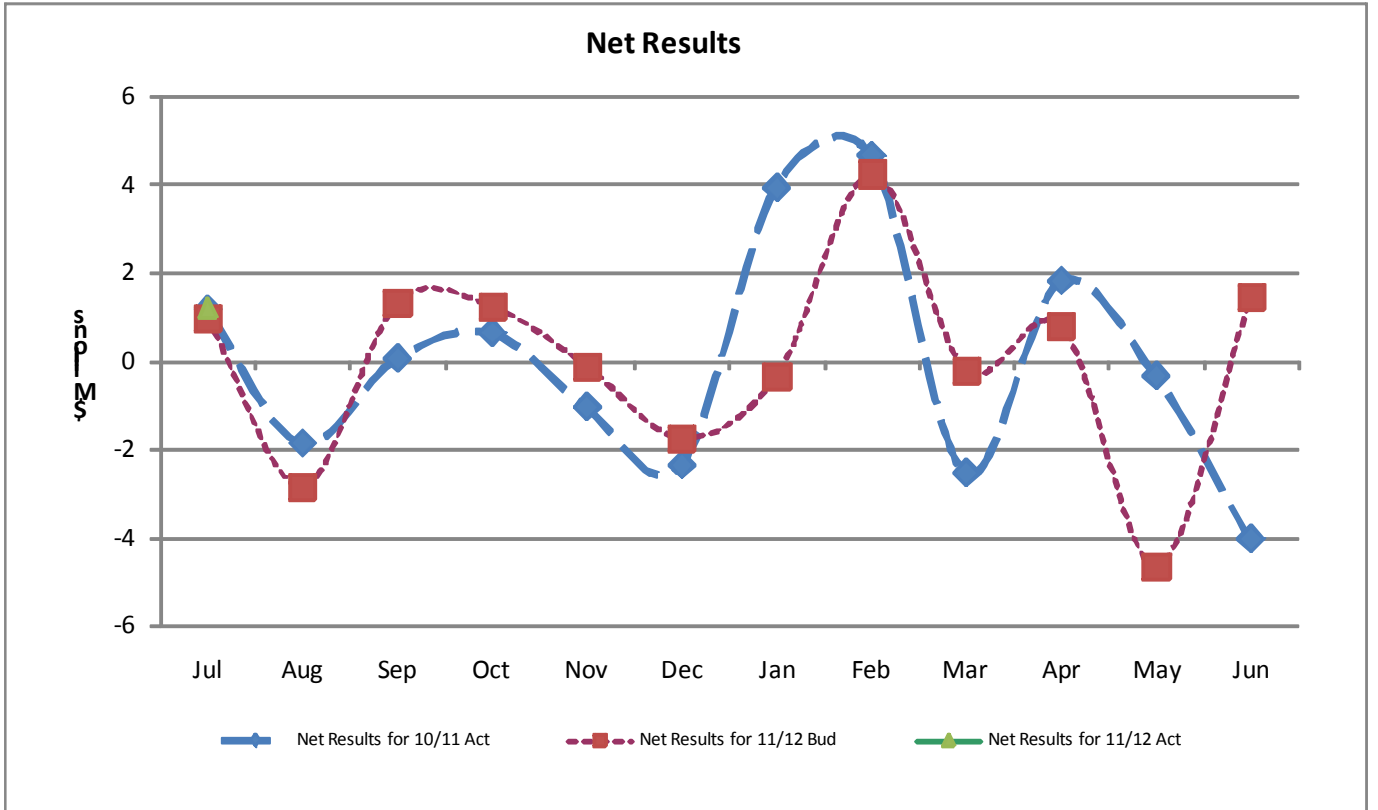


# Auckland District Health Board

## **Board Financial Report**

July 2011

Performance Graphs by Month & YTD



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

	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>\$000s</b>						
<b>Income</b>						
PBF - AKL Population	82,635	82,264	371 F	82,635	82,264	371 F
Inter District Inflows	53,301	55,265	1,965 U	53,301	55,265	1,965 U
	135,936	137,529	1,594 U	135,936	137,529	1,594 U
MOH Sub-contracts	8,733	8,197	536 F	8,733	8,197	536 F
Other Patient Care	4,557	3,696	862 F	4,557	3,696	862 F
Services & Products	3,557	3,988	431 U	3,557	3,988	431 U
CTA	1,690	1,628	62 F	1,690	1,628	62 F
Trust & Donation Income	78	319	241 U	78	319	241 U
Financial Income	599	617	18 U	599	617	18 U
Other Income	244	601	357 U	244	601	357 U
	155,394	156,576	1,181 U	155,394	156,576	1,181 U
<b>Expenditure</b>						
Employee Costs						
Medical	18,273	18,446	173 F	18,273	18,446	173 F
Nursing	20,239	20,033	207 U	20,239	20,033	207 U
Technical	9,445	9,965	520 F	9,445	9,965	520 F
Hotel Services	834	784	51 U	834	784	51 U
Administration	6,015	6,355	340 F	6,015	6,355	340 F
Other	3,375	3,600	225 F	3,375	3,600	225 F
Total Employee Costs	58,182	59,183	1,001 F	58,182	59,183	1,001 F
Outsourced Services	6,238	6,216	23 U	6,238	6,216	23 U
Direct Treatment Costs	16,931	17,954	1,024 F	16,931	17,954	1,024 F
Indirect Treatment Costs	3,698	3,630	68 U	3,698	3,630	68 U
Funder Payments	47,246	46,326	920 U	47,246	46,326	920 U
Inter District Outflows	8,441	8,497	55 F	8,441	8,497	55 F
Prop, Equip, & Maintenance	3,687	3,725	38 F	3,687	3,725	38 F
Administration Costs	2,017	2,082	65 F	2,017	2,082	65 F
<b>Total Operating Expenditure</b>	146,359	147,535	1,176 F	146,359	147,535	1,176 F
<b>Operating Contribution</b>	9,036	9,041	5 U	9,036	9,041	5 U
Depreciation	3,568	3,645	78 F	3,568	3,645	78 F
Finance Costs	1,518	1,525	7 F	1,518	1,525	7 F
Capital Charge	2,746	2,892	146 F	2,746	2,892	146 F
<b>Total Non Operating Costs</b>	7,831	8,062	231 F	7,831	8,062	231 F
<b>Net Surplus / (Deficit)</b>	1,204 F	978 F	226 F	1,204 F	978 F	226 F

## Statement of Financial Position

as at 31 July 2011

\$'000	Actual Jul-11	Budget	Variance	Actual Jun-11	Variance	Actual Jun-11
<b>Public Equity</b>	573,103	573,577	473U	573,103	0F	573,103
<b>Reserves</b>						
Revaluation Reserve	331,980	353,538	21,558U	331,989	9U	331,989
Accumulated Deficit from Prior Year's	(468,224)	(468,308)	84F	(468,367)	143F	(468,367)
Current Year's Surplus/(Deficit)	1,205	978	227F	143	1,062F	143
	(135,039)	(113,792)	21,247U	(136,235)	1,196F	(136,235)
<b>Total Equity</b>	<b>438,065</b>	<b>459,784</b>	<b>21,720U</b>	<b>436,869</b>	<b>1,196F</b>	<b>436,869</b>
<b>Non Current Assets</b>						
Fixed Assets	828,633	877,242	48,609U	829,642	1,010U	829,642
Derivative Financial Instruments	5,669	4,645	1,024F	5,669	0F	5,669
Investments	4,400	10,548	6,148U	4,400	0F	4,400
<b>Total Non Current Assets</b>	<b>838,701</b>	<b>892,435</b>	<b>53,733U</b>	<b>839,711</b>	<b>1,010U</b>	<b>839,711</b>
<b>Current Assets</b>						
Cash & Short Term Deposits	75,641	42,143	33,498F	83,325	7,685U	83,325
Trust Deposits	18,838	10,635	8,204F	19,160	322U	19,160
Trade & Other Receivables	57,483	58,868	1,385U	59,230	1,747U	59,230
Inventory	11,988	12,454	466U	12,021	33U	12,021
Property Intended for Resale	20,041	-	20,041F	20,041	0F	20,041
<b>Total Current Assets</b>	<b>183,991</b>	<b>124,100</b>	<b>59,891F</b>	<b>193,778</b>	<b>9,786U</b>	<b>193,778</b>
<b>Current Liabilities</b>						
Interest Bearing Loans & Borrowings	(24,667)	(4,670)	19,997U	(23,249)	1,418U	(23,249)
Trade & Other Payables	(136,538)	(142,211)	5,674F	(149,713)	13,176F	(149,713)
Employee Benefits	(134,588)	(116,823)	17,764U	(136,320)	1,732F	(136,320)
Funds Held in Trust	(1,095)	(1,106)	11F	(1,093)	2U	(1,093)
Loan - Associated Entities	(2,821)	14,420	17,242U	(1,386)	1,435U	(1,386)
<b>Total Current Liabilities</b>	<b>(299,709)</b>	<b>(250,391)</b>	<b>49,318U</b>	<b>(311,762)</b>	<b>12,053F</b>	<b>(311,762)</b>
<b>Working Capital</b>	<b>(115,718)</b>	<b>(126,291)</b>	<b>10,574F</b>	<b>(117,984)</b>	<b>2,267F</b>	<b>(117,984)</b>
<b>Non Current Liabilities</b>						
Interest Bearing Loans & Borrowings	(263,118)	(283,113)	19,995F	(263,110)	9U	(263,110)
Employee Benefits	(21,800)	(23,246)	1,445F	(21,748)	52U	(21,748)
<b>Total Non Current Liabilities</b>	<b>(284,919)</b>	<b>(306,359)</b>	<b>21,440F</b>	<b>(284,858)</b>	<b>61U</b>	<b>(284,858)</b>
<b>Net Assets</b>	<b>438,065</b>	<b>459,784</b>	<b>21,720U</b>	<b>436,869</b>	<b>1,196F</b>	<b>436,869</b>

Statement of Cashflows for the Year ended 31 July 2011				Year to Date		
	Jul-11			Actual	Budget	Variance
	Actual	Budget	Variance	Actual	Budget	Variance
<b>Operations</b>						
Revenue Received	159,391	155,625	3,766	159,391	155,625	3,766
Payments	(166,871)	(159,128)	(7,743)	(166,871)	(159,128)	(7,743)
<b>Net Operating Cashflows</b>	<b>(7,480)</b>	<b>(3,503)</b>	<b>(3,977)</b>	<b>(7,480)</b>	<b>(3,503)</b>	<b>(3,977)</b>
<b>Investing</b>						
Income	599	617	(18)	599	617	(18)
Capital						
Sale of Assets	0	7	(7)	0	7	(7)
Purchase Fixed Assets	(2,563)	(5,972)	3,409	(2,563)	(5,972)	3,409
<b>Net Investing Cashflows</b>	<b>(1,964)</b>	<b>(5,348)</b>	<b>3,384</b>	<b>(1,964)</b>	<b>(5,348)</b>	<b>3,384</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>(9,444)</b>	<b>(8,851)</b>	<b>(593)</b>	<b>(9,444)</b>	<b>(8,851)</b>	<b>(593)</b>
<b>Opening Cash</b>	61,021	61,021	0	61,021	61,021	0
<b>Closing Cash</b>	51,577	52,170	(593)	51,577	52,170	(593)

## Financial Performance

- The net result for the month was \$1.2m, a favourable variance to the budgeted net result of \$0.98m.
- The result for July is driven by lower revenue of \$1.09m compared with lower expenditure of \$1.41m.
- Revenue was lower than budget by \$1.09m. This was the result of:-
  - a) Unfavourable Base Revenue \$1.5m driven mainly by lower IDF volumes, offset by higher deliveries against Disability Support contracts
  - b) Higher MoH Subcontract revenue \$0.54m, driven by higher SCI funding \$0.21m and higher receipts against RCLM funding.
  - c) Lower volumes of non resident & ACC activity \$0.39m
  - d) Higher levels of inter DHB side contracts \$1.2m to meet PHO costs
- Expenditure was lower than budgeted by \$(1.41)m.
  - a) A favourable variance in employee costs of \$1.0m with actual fte below the budgeted level.
  - b) Direct & Indirect Treatment costs are \$0.96m favourable to budget in the following services – Adult Health \$0.27m, Child Health \$0.11m, OR & Anaesthesia \$0.08m, Laboratories \$0.05m and Imaging \$0.03m, with unfavourable variances in Cardiac Services \$(0.26)m and Pharmacy \$(0.01)m. The favourable variance is mainly in: Blood Products \$0.37m, Pharmaceuticals \$0.82m, Chemicals & Media \$0.11m and Third Party Treatment costs \$0.09m with unfavourable variances in Clinical Supplies \$0.36m.
  - c) Funder Payments (including IDF Outflows) are over budget \$(0.893)m mainly due to increased PHO expenditure following a process of realigning PHO's \$(1.787)m where additional Inter DHB revenue is being received to cover the additional expenditure incurred on behalf of the regional DHBs. There are also favourable variances in Mental Health \$0.31m, Disability Support \$0.14m and other Personal Health contracts \$0.32m. Inter District Outflows are favourable to budget \$0.05m.
  - d) Depreciation \$0.08m, Finance Charges \$0.01m and Capital Charge \$0.15m are all slightly favourable to budget.

## Financial Position

- The balance of fixed assets is \$(48.0)m below budget principally due to the downward revaluation of land & buildings \$(21.6)m as at 30 June 2011, the classification of \$20m worth of assets, due to be sold to Health Alliance, into Property Intended for Resale and the lower capital expenditure in the latter stages of 2010-11 and July 2011.
- At month end there is an unused overdraft facility of \$38.3m.

# ***11***

## **PAPERS**

**Papers - Nil**



# *12*

## **GENERAL BUSINESS**



# *13*

## **APPENDICES**

**Appendices - Nil**



***14***

**PUBLIC EXCLUSION**



## 14.1 Resolution

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**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 14

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:
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.



<b>MEETING DETAILS</b>	
Time and Date	2:00pm, Wednesday, 7 September 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
Members	Dr Lester Levy (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Janice Mueller, Vivienne Rawlings, Ian Bell.

	<b>Item</b>	<b>Page No</b>
<b>1</b> 2m to 2:02pm	<b>Karakia</b>	<b>001</b>
<b>2</b> 3m to 2:05pm	<b>Attendance and Apologies</b>	<b>005</b>
<b>3</b> 2m to 2:07pm	<b>Conflicts of Interest</b>	<b>007</b>
<b>4</b> 5m to 2:12pm	<b>Confirmation of Minutes 3 August 2011</b>	<b>015</b>
<b>5</b> 3m to 2:15pm	<b>Action Points 3 August 2011</b>	<b>023</b>
<b>6</b> 5m to 2:20pm	<b>Chairman's Report - Verbal</b>	<b>027</b>
<b>7</b> 15m 5m 30m to 3:10pm	<b>Chief Executive's Report</b> 7.1 Chief Executive's Report 7.2 Minister's Six Health Priorities 7.3 Annual Review 2010 – 2011	<b>029</b> <b>031</b> <b>049</b> <b>063</b>
<b>8</b>	<b>Lift the Health of People in Auckland City</b> 8.1 Committee Recommendations - nil	
<b>9</b> 5m to 3:15pm	<b>Performance Improvement</b> 9.1 DAP Projects Report	<b>113</b>

	Item	Page No
<b>10</b>	<b>Live Within Our Means</b>	<b>117</b>
5m	10.1 Finance Committee Recommendations	<b>119</b>
5m to 3:25pm	10.2 Finance Report	<b>127</b>
<b>11</b>	<b>Papers - Nil</b>	
<b>12</b>	<b>General Business</b>	<b>137</b>
<b>13</b>	<b>Appendices - Nil</b>	
<b>14</b>	<b>PUBLIC EXCLUSION</b>	<b>141</b>
30m to 3:55pm	14.1 Resolution	
<b>NEXT MEETING</b>		
	<b>Time and Date:</b>	2:00pm, Wednesday, 5 October 2011
	<b>Venue:</b>	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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