



Auckland District Health Board
Hospital Advisory Committee Meeting

Wednesday 7 July 2010

10.45am

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

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



Hospital Advisory Committee

For discussion with Board

HAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
3.	
4.	



Hospital Advisory Committee Action Points

MEETING DETAILS

Date and Time

Item	Detail	Responsibility	Action
XX			
XX			
XX			
XX			

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Credentialing Committee for Ormiston private hospital 7. Surveyor Quality Healthcare NZ 				3 February 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	21 April 2010
	2. New Zealand Research Centre for Growth and Development	Board Member	Fee (to Ngati Hine Health Trust)	Governs a leading health sciences research centre	
	3. James Henare Research Centre, University of Auckland	Advisory Board Member	Fee (to Ngati Hine Health Trust)	Advises U o A on Maori research in Northland	
	4. Manaia PHO, Whangarei	Shareholder	Fee (to Ngati Hine Health Trust)	Governs a Whangarei based PHO	
	5. Whanau Ora Task Force	Member	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	6. National Health Board	Member	Fee		
	7. Chair Whanau Ora Governance Group				
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				15 July 2009
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		27 January 2010
	2. Locum GP		Contract rate		
	3. Waiheke "Integrated Family Health Centre" Steering Group	Member			
Bob TIZARD	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Seiuli Dr Juliet WALKER	<ol style="list-style-type: none"> 1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure 2. Member, National Breast Screening Advisory Committee 3. Facilitator, RNZCGP General Practice Education Programme Stage II 4. ADHB Employee: contracted roster Doctor for Pohutukawa 5. Panel Member, Medical Appeal Board, Work and Income 	<p>Self employed contractor</p> <p>Member</p> <p>Contractor</p> <p>Contractor</p>	<p>Contract hourly rate</p> <p>Fee</p> <p>Contracted monthly fee</p> <p>Hourly rate</p> <p>Fee</p>	<p>General practitioner services</p> <p>Consultant Pacific Advisor</p> <p>Educational Support and Training</p> <p>Forensic sexual assault examinations</p>	5 May 2010
Ian WARD	<ol style="list-style-type: none"> 1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C -4 Consulting Limited 		Fee	Tender to National Shared Services	3 February 2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rev Alfred NGARO	1. 4pm Group Ltd	Consultant	Salary	Community Development Pacific Advisory for ADHB	11 May 2009
	2. Pacific Advisory Committee, PHAC CPHAC member	Chair	Fee		
	3. National Task Force for Family Violence MSD	Member	Fee		
	4. Family and Community Services national advisory group	Task Force member	Fee		
	5. Auckland Safer Communities	Advisory Member			
	6. Tamaki Achievement Pathways Schooling improvement	Executive member	Voluntary		
	7. Tamaki College Board of Trustees	Chair	Voluntary		
	8. Tamaki Community Development Trust	Elected Trustee	Fee		
Farida SULTANA	1. Nil	Member	Voluntary	Disciplinary and property Committee NGO delivering social services within the Tamaki area	6 August 2008

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	<ol style="list-style-type: none"> 1. Maternity Services Consumer Council 2. Auckland Women's Health Council 3. Member National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee 	<p>Employee</p> <p>Employee</p>	<p>Salary</p> <p>Salary</p>		4 August 2008
Iain MARTIN	<ol style="list-style-type: none"> 1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee 	Employee	Salary		5 May 2010
Anne KOLBE	<ol style="list-style-type: none"> 1. Private Paediatric Surgical Practice 2. Employee Communitio NZ 3. Head, Auckland Clinical School, School of Medicine, University of Auckland 4. Husband: Employee University of Auckland 5. Member Risk and Audit Committee Whanganui District Health Board 				12 December 2008

CONFIRMATION OF MINUTES

- WEDNESDAY 2 JUNE 2010



Hospital Advisory Committee Minutes

MEETING DETAILS															
Time and Date	10:45am, Wednesday, 2 June 2010														
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton														
1	ATTENDANCE AND APOLOGIES														
	<p>The Chair declared the meeting open at 10:46am.</p> <p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td>Associate Professor Anne Kolbe</td> </tr> <tr> <td>Professor Iain Martin</td> <td>Farida Sultana</td> </tr> <tr> <td>Lynda Williams</td> <td></td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Taima Campbell – Executive Director Nursing Dr Richard Aickin – Director Child Health Margaret Dotchin - Nurse Director Fionnagh Dougan – General Manager Mental Health, Ambulatory, Cancer & Blood Services Kay Hyman – General Manager Women’s and Children’s Services’ Naida Glavish – Chief Advisor Tekanga, General Manager Maori Health Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Rob Cooper, Pat Snedden, Greg Balla, Ngaire Buchanan, and Denis Jury. Juliet Walker advised that she would be leaving the meeting early.</p> <p><u>Moved Brian Fergus; seconded Ian Scott</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Dr Chris Chambers (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Associate Professor Anne Kolbe	Professor Iain Martin	Farida Sultana	Lynda Williams	
Dr Chris Chambers (Chair)	Jo Agnew														
Susan Buckland	Harry Burkhardt														
Dr Brian Fergus	Dr Ian Scott														
Rt Hon Bob Tizard	Seiuli Dr Juliet Walker														
Ian Ward	Associate Professor Anne Kolbe														
Professor Iain Martin	Farida Sultana														
Lynda Williams															
2	CONFLICTS OF INTEREST														
	There were no declarations of conflicts of interest for any item on the agenda.														

3	CONFIRMATION OF MINUTES 5 MAY 2010
	<p><u>Moved Ian Scott; seconded Juliet Walker</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 5 May 2010 be confirmed as a true and correct record with the amendment that radiation treatment was being discussed by the Cancer Treatment Advisory Group.</i></p> <p><u>Carried</u></p> <p>The outcome of the Cancer Treatment Advisory Group discussion was that the waiting time targets would remain as they are moving to 4 weeks by December 2010. Professor Iain Martin and Garry Smith were continuing discussions on the relationship between the Board and the University.</p>
5.1	Operational Summary Report and Financials
	<p>The new Communications team of Mark Fenwick and Matt Rogers were introduced.</p> <p>The focus was on costs and ADHB electives. Revenue was favourable and the donation from the Starship Foundation was expected before the end of the financial year. The unfavourable variance in FTE was 191 down from 244 an improvement of 53 with 40 in nursing. Costs per FTE were favourable with a focus on reducing bureau usage, overtime and sick leave to get to the 1 July 2010 budgeted position. Bureau costs were higher than employed nurses.</p> <p>Orthopaedic outsourcing had been stopped and with electives offset by acutes there would need to be a catch up in the next year. High rates of throughput continued and since the close off ADHB electives were up 91 WEIS and down for other DHBs. Waitemata is reducing their electives which are taken up by ADHB electives. Waitemata were being encouraged to manage their referrals and planning. The ADHB Chief Executive attended their Hospital Advisory Committee to discuss managing to year end and improve how ADHB and Waitemata work together next year as their purchasing level had been lower than their referral level. While they wanted to manage down their purchases this raised the issue of equity of access. For regional services the 4 DHBs would have waiting lists that they needed to manage although clinical practice based on need. The split between acute and electives into separate streams would be considered. There was a duty to treat acutes and it raised an obligation to pay, whereas electives are in a customer relationship within an agreed set of principals with a need to get dialogue and decision making at the right levels.</p> <p>There had been a drop in ophthalmology and sexual health first specialist assessments. There had been less than 1% increase in direct treatment costs over the year in operating rooms. There has been a need to save \$32m in the FTE budget for 2009/2010. The next year's budget had been developed bottom up rather than top down.</p> <p>Juliet Walker left the meeting at 11:30am.</p>
5.2	Operational Indicators Exception Report
	<p>The % of stroke patients cared for within the stroke unit had increased with more beds opened in November. The target was now increased to 80% and was being achieved.</p>
6.1	DAP Projects Report
	<p>Neurology had an additional clinic and while they would get two new neurologists next month there is still excess referrals.</p>
7.1	Paediatric Specialty Services Review
	<p>This was an update of the "Through the Eyes of a Child" which had been a review of all paediatric services which was now a decade old. This review was more restricted looking at vulnerable services and only involved clinicians of tertiary services and not other paediatrics. The recommendations had been agreed at National Health Board level. Tier II funding had been</p>

	<p>devolved and all services are now losing money. The Paediatric Society contract to advise on developing clinical networks had preceded the review but this may be a way to operationalise their recommendations. The National Health Board may take on 1 or 2 national services and national funds may be linked to national clinical networks rather than a particular service.</p> <p>The implication for Starship could be less general paediatrics and more specialities and surgical together with more outreach services which may allow the use of the building to be extended. Presently all secondary Waitemata paediatrics came to Auckland and they would be encouraged to get capacity. The co-location of National Women's and Starship was very beneficial. Changes were reliant on a strong transport service and the funding by the Starship Foundation of \$1.5m over 5 years for paediatric retrievals was acknowledged. The National Transport and Accommodation policy will need to be reviewed.</p> <p>The Committee gave strong support to the recommendations.</p>
7.2	Greenlane Surgical Centre Update
	<p>Peter Lowry was in attendance to brief the Committee on the Greenlane Surgical Centre and increasing elective outputs for 2010/2011 through improving the patient flow from referral from primary care through clinics operative phase and back to primary care and follow-up, workforce development and facility development. 3 shells had been completed and 1 theatre would be expanded by mid June with 2 operating rooms and the expanded theatre available 1 July. The design principles and order of activity were outlined and if referrals and outputs are lined up there would not need to be a waiting list which is achievable by managing production plans and referrals. An improvement project in Ophthalmology is gaining momentum which will link with the GSC. The Sterile Supply Services tender was being finalised and this would be operating in October which allowed redevelopment of Level 2 for Endoscopy and the fourth OR.</p> <p>Service planning was being developed to get the outcome and identify explicit training requirements. The ORs would be flexible to address different waiting lists and to take up the current outsourcing to get a higher level of intervention for ADHB's population.</p> <p>The MoH use Australia 80 percentile as a benchmark but it was suggested that it should be to the best in the world and it was noted that training was a five year minimum timeframe with the constraints being workforce rather than facilities. Surgeon feedback was that production at Greenlane Surgical Centre would improve with a list that took 5 hours at ACH being estimated to reduce to 1.5 hours.</p>
	NEXT MEETING
	<p>The meeting closed at 12:15pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 7 July 2010 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

ACTION POINTS

WEDNESDAY 2 JUNE 2010

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 2 June 2010**

Item	Detail	Designated	Action
Carried Forward	Discussion on where ADHB sat as a University teaching hospital suggested for Strategic Planning Day	Garry Smith	On programme Strategic Planning Day

OPERATIONAL PERFORMANCE

5.1 Operational Summary Report and Financials

5.2 Operational Indicators Exception Report

5.1 Summary Report

Overall Performance for the Month

The Provider produced a result \$2.8m adverse to budget for May 2010; with the Operational Division result \$1.7m adverse to budget (see table below).

Summary of Provider Results

\$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	13,944	15,693	1,749U	123,202	125,629	2,427U
Complementary	354	145	209F	1,487	1,323	163F
Functional	(11,903)	(10,613)	1,289U	(128,158)	(126,931)	1,226U
Ancilliary	(11,548)	(10,468)	1,080U	(126,671)	(125,608)	1,063U
Provider Net Surplus/(Deficit)	2,396	5,225	2,829U	(3,469)	21	3,490U

Note: In the table above we have set out the summary results of various sections which make up the Provider. Under the Functional heading are included areas, such as Finance, HR and IS which support the operational areas. Under the complementary heading are included areas such as A+ Trust, Research and Retail businesses.

While the majority of variances at the total provider arm level are the same as at an operational level there are some key variances, such as the increase in the value of interest rate swap instruments and the higher cost of long service leave and gratuities which are included in the 'Provider' section of the Finance Committee report as a result of including the support areas.

5.1.1 OPERATIONAL DIVISION OPERATING STATEMENT

Operational Operating Statement - May 2010	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
<i>Total Income</i>						
Patient Care Revenue	87,118	88,309	1,190U	943,764	935,597	8,167F
Sales of Services & Products	1,683	1,852	169U	17,091	19,875	2,784U
Clinical Training & Education Income	1,649	1,392	257F	15,991	15,438	554F
Trust & Donation Income	296	806	511U	3,969	9,033	5,065U
Financial Income	(1)	-	1U	-	-	OF
Other Income	618	464	154F	5,939	5,352	587F
Profit on Disposal of Fixed Assets	-	-	OF	209	-	209F
Total Income	91,363	92,823	1,460U	986,962	985,295	1,667F
<i>Operating Expenditure</i>						
Employee Costs	52,369	52,311	57U	583,532	585,856	2,324F
Direct Treatment Costs	16,278	16,099	179U	187,310	178,098	9,212U
Funder Payments	-	-	OF	-	-	OF
Indirect Treatment Costs	3,185	2,986	200U	31,900	32,769	869F
Property, Equipment & Transportation Costs	2,268	2,380	112F	25,098	26,265	1,167F
Administration Costs	759	709	50U	7,878	7,875	3U
Indirect Service Billing	801	808	7F	8,863	8,888	25F
Loss on Sale of Fixed Assets	4	2	2U	106	19	86U
Total Operating Expenditure	75,665	75,295	370U	844,687	839,771	4,916U
Operating Surplus / (Deficit)	15,698	17,529	1,830U	142,275	145,524	3,249U
<i>Non-Operating Expenditure</i>						
Depreciation	1,745	1,826	82F	18,963	19,795	832F
Finance Costs	9	9	0U	111	100	10U
Total :Non-Operating Expenditure	1,754	1,835	81F	19,073	19,895	822F
Total Surplus / (Deficit)	13,944	15,693	1,749U	123,201	125,629	2,427U

Key variances for May (> \$250,000) were:-

Patient Care Revenue	\$1.190m U	\$8.167m F YTD
Clinical Training Revenue	\$0.257m F	\$0.554m F YTD
Trust & Donation Income	\$(0.511)m U	\$(5.065)m U YTD

Patient Care Revenue

The principal variances were as follows:-

Adult Health	\$1.8m U	This is driven largely by unfavourable MOH base contract revenue at \$1.5M below budget. While volumes were reasonably consistent with prior months, the budget had been incorrectly phased based on 22 working days rather than the actual 21 working days, thus increasing budgeted volumes.
Mental Health, Ambulatory, Ophthalmology, Cancer & Blood	\$0.8m F	Oncology base volume activity (\$80K F) reflecting over performance in inpatient WIES; Haematology base funding activity \$174K F is result of over performance in inpatient WIES volume and blood transfusion. MOH - Other Contracts \$563K F is reflects (i) an error in PCT journals \$400K and (ii) release of \$ a 180K PCT accrual (related to 08/09)

The revenue shown in the Operational income and expenditure account is all revenue earned by services; the adjustment made to reverse out income for which no additional revenue is available (ADHB volumes, Counties volumes and other DHB non DRG services) is made in the 'Functional' group of services. For year to date May the adjustment totals \$9.9m.

Clinical Training Revenue

A catch up on CTA revenue across most services in the Provider Operational arm.

Trust & Donation Income

As noted in previous months this reflects a 'timing difference' between budget and likely receipt of Starship Foundation funds, especially those in respect of the new MRI. Actuals will be closer to, though less than, the annual budget by year end with receipt of a major donation expected in June 2010.

Employee Costs

Operational arm employee costs were on budget for May (\$2.3m F YTD). Staffing numbers exceeded budgeted numbers (Table 1), however the average cost of staff was *lower* than budgeted (Table 2).

FTE Table 1 – FTEs for Month

FTEs	Budget FTE Month 2009/10	Actual FTE Month 2009/10	Variance
Adult Health	1,715	1,736	(21)
Women, Child, Cardiac, OR&A	2,342	2,455	(113)
Operations	1,376	1,393	(17)
Ment Hlth, Amb, Ophth, Cancer & Blood	1,243	1,251	(8)
Others	-1	1	(2)
TOTAL	6,675	6,836	(161)

Last months variance was (191) FTE, an improvement in the adverse variance of 30 FTE.

FTE Table 2 – Cost per FTE

Operational Services - Staffing Variance			
Month 2009/10	Budget	Actual	Variance %
Employee Costs (\$M)	52.3	52.4	-0.11%
FTE Numbers	6,675	6,836	-2.41%
Cost per FTE (Month)	7,837	7,661	2.24%
YTD 2009/10			
	Budget	Actual	Variance %
Employee Costs (\$M)	586	584	0.40%
FTE Numbers	6,710	6,857	-2.20%
Cost per FTE (Year to Date)	87,314	85,099	2.54%

The adverse staffing variance was due to the unfavourable FTE variance of 161 FTE. This in turn reflects the efficiency savings for 2009/10 being expressed as FTE reductions. In practice, YTD savings have been largely achieved through lower average cost per FTE arising from initiatives including the annual leave programme and a reduction in *higher cost staffing* such as bureau, contractors and overtime.

Table 3 below extends the FTE variance to show the savings included in the original budget. Given the overall FTE variance is the savings not achieved, the balance between savings not achieved and the savings included in the budget is the savings actually achieved through the methods above.

FTE Table 3 – FTEs and Savings

	May 10 Budget	May 10 Actual	Variance *	Savings Targets incl in Budget	Var to Underlying Bud i.e. FTE Savings Achieved
Adult Health	1,715	1,736	(21)	99	78
Wom, Child, Card, ORA	2,342	2,455	(113)	107	(6)
Operations	1,376	1,393	(17)	63	46
MH, Amb, Ophth, Cancer & Blood	1,243	1,251	(8)	66	58
ACH Others	-1	1	(2)	2	0
Total	6,675	6,836	(161)	337	176

Table 4 below shows May FTEs compared to the July 2010 budget position.

FTE Table 4 – Current FTE Compared to 2010/11 Budget

	May 10 Month	Jul 10 Month	Var:- May Act versus Jul Budget
	Actual	Budget	
<u>By Portfolio</u>			
Adult Health	1,736	1,738	2
Wom, Child, Card, ORA (CWORAC)	2,455	2,496	41
Operations	1,393	1,429	36
MH, Amb, Ophth, Cancer & Blood	1,251	1,295	44
ACH Others	1	1	0
Total	6,836	6,959	123
<u>By Category</u>			
Medical	1,108	1,180	72
Nursing	3,182	3,182	0
Technical	1,621	1,678	57
Hotel Services	207	203	-4
Stores	1	1	0
Administration	716	724	8
Target Savings	0	-9	-9
Total	6,836	6,959	123

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	May-10	Att per Day	Comparison to Last Month	Apr-10	Att per Day	Comparison to Last Year	May-09	Att per Day
APU	1,618	52	4.1%	1,555	52	8.5%	1,491	48
AED	4,360	141	6.0%	4,114	137	12.7%	3,867	125
CED	2,857	92	15.2%	2,480	83	12.3%	2,543	82

AED.

Record high volumes and daily rate. Record high transfers to both APU and to wards. Nevertheless LOS remains considerably lower than last year.

APU.

Volumes increased from last month but both LOS measures dropped back and are still much lower than last year. Highest May volumes ever.

CED.

Highest May volumes for the past five years – 12% higher than May last year.

Throughput Statistics

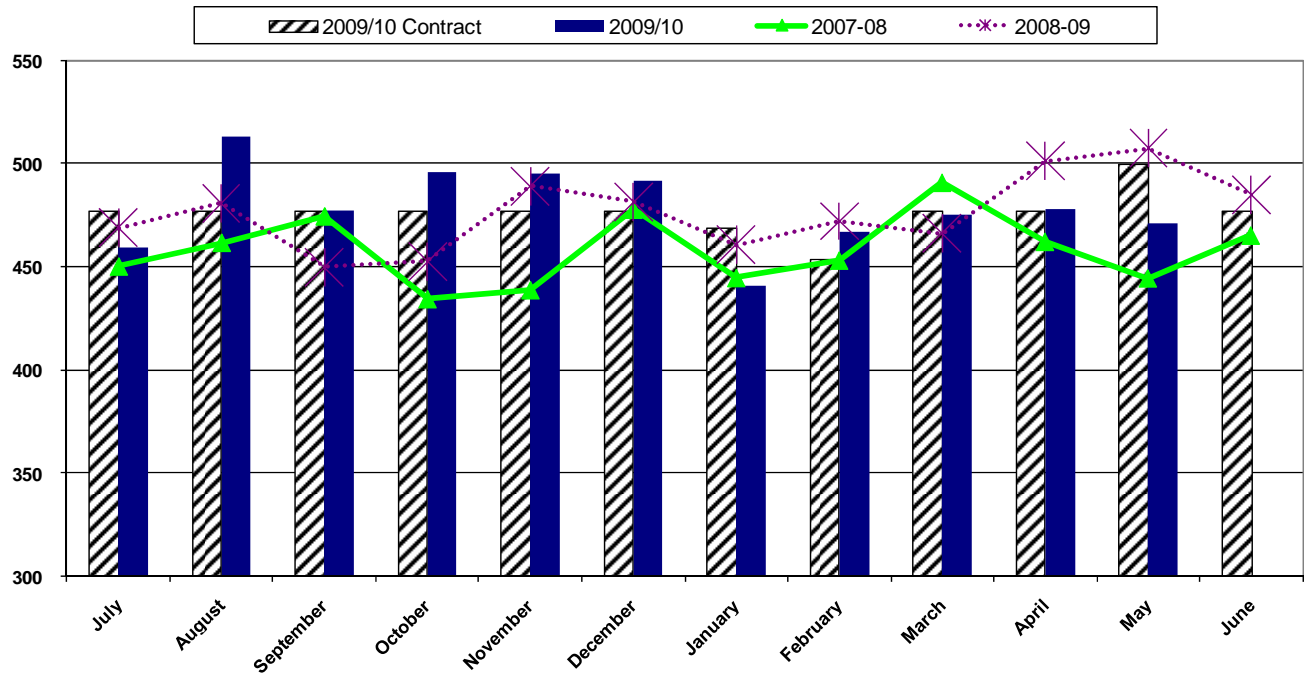
The chart below shows the production recorded to May 2010.

At the time the results were finalised, the coding was 51.4% complete (95.5% YTD) with the average WIES per discharge being 1.6% lower than last year for the same period. The uncoded discharges include two particularly long stay patients discharged from Starship (total of 691 days) which when coded will increase the WIES outputs by at least 300 WIES. These have been very expensive patients for whom the incurred costs are already reported in the year to date result. Discharges are up by 2.8% from last year.

Inpatient delivery to the most current Price Volume Schedule (May 2010) was 99.4% for the month (100.3% YTD).

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	9,885	10,489	604U	110,607	110,457	150F
WIES Delivery per day	471	499	29U	479	478	1F

WIES per Working Day (excluding stat day - 0910 working year = 252 days)



Volumes YTD

Inpatient volumes year to date May are shown below (reported numbers); the mix by DHB of domicile is clearly not 'optimal' from a financial perspective and may be impacted for the balance of the year by the decision of Waitemata DHB to see individual approvals for all secondary electives undertaken by the ADHB provider arm; thus far the approval process has had minimal impact on our volumes, it is to continue at least until 30 June 2010 and probably into 2010/11.

DHB	Contract	Actual	Variance	% of completion
ADHB	13,741	11,626	-2,115	85%
CMDHB	3,941	4,521	580	115%
WDHB	5,386	5,910	524	110%
Other	5,019	4,700	-319	94%
	28,087	26,757	-1,330	95%

Acutes

DHB	Contract	Actual	Variance	% of completion
ADHB	44,320	46,607	2,287	105%
CMDHB	11,358	10,679	-679	94%
WDHB	15,737	16,808	1,071	107%
Other	10,955	9,855	-1,100	90%
	82,370	83,949	1,579	102%

Acute & Elective Combined

DHB	Contract	Actual	Variance	% of completion
ADHB	58,061	58,233	172	100.3%
CMDHB	15,299	15,200	-99	99.4%
WDHB	21,123	22,718	1,595	107.6%
Other	15,974	14,555	-1,419	91.1%
	110,457	110,706	249	100.2%

The table below shows the marked impact on our elective outputs arising from the additional cardiac surgery undertaken in 2009/10.

Elective Split by CTSU/Other

	Contract	Actual	Variance
Electives	28,087	26,757	(1,330)

Split by:-

CTSU	3,275	4,150	+875
Other	24,469	22,264	(2,205)

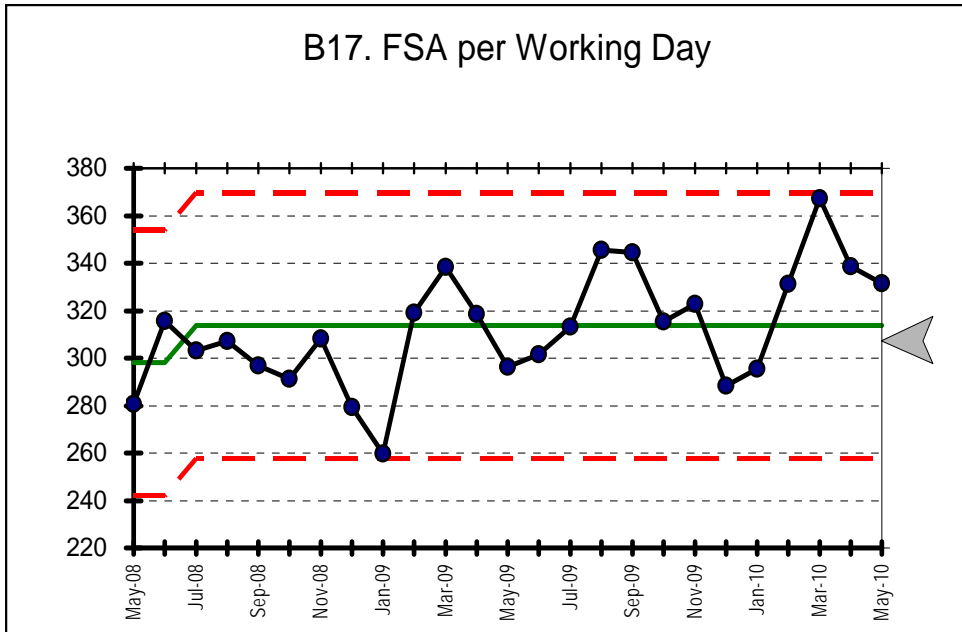
Outpatient Delivery

Below is a graph of outpatient activity in the same manner as for inpatient activity - output per working day. As well as being a useful indicator of productivity, outpatient activity is, in part, the 'feeder' activity for much of our elective 'production line'.

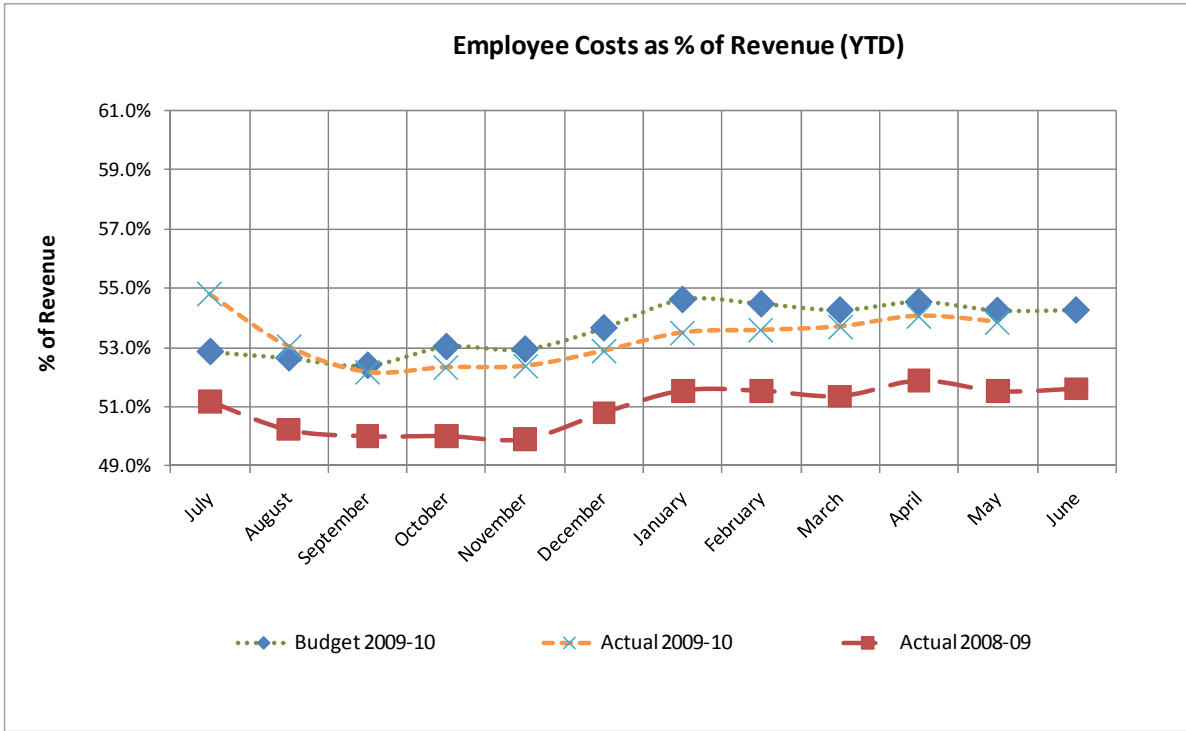
Of the FSAs year to date in 2009/10 (including virtual FSAs), 33% are in medical services (including neurology), approximately 45% are in surgical services or medical services having an elective contract (the largest being cardiology). Sexual Health is 16% of all FSAs (acute demand), the balance is obstetrics (6%).

While FSA numbers for the month fell away from last month's high numbers, FSAs were at 103% of contract. For the 11 months to May, FSAs are over contract by about 5,000. However, 3,500 of this is in obstetrics FSAs, this is the first year of funding obstetrics in a this manner and the contract was struck incorrectly. In recognition of this the 2010/11 FSA contract for obstetrics has increased by 3,600 FSAs (an increase of 335%)

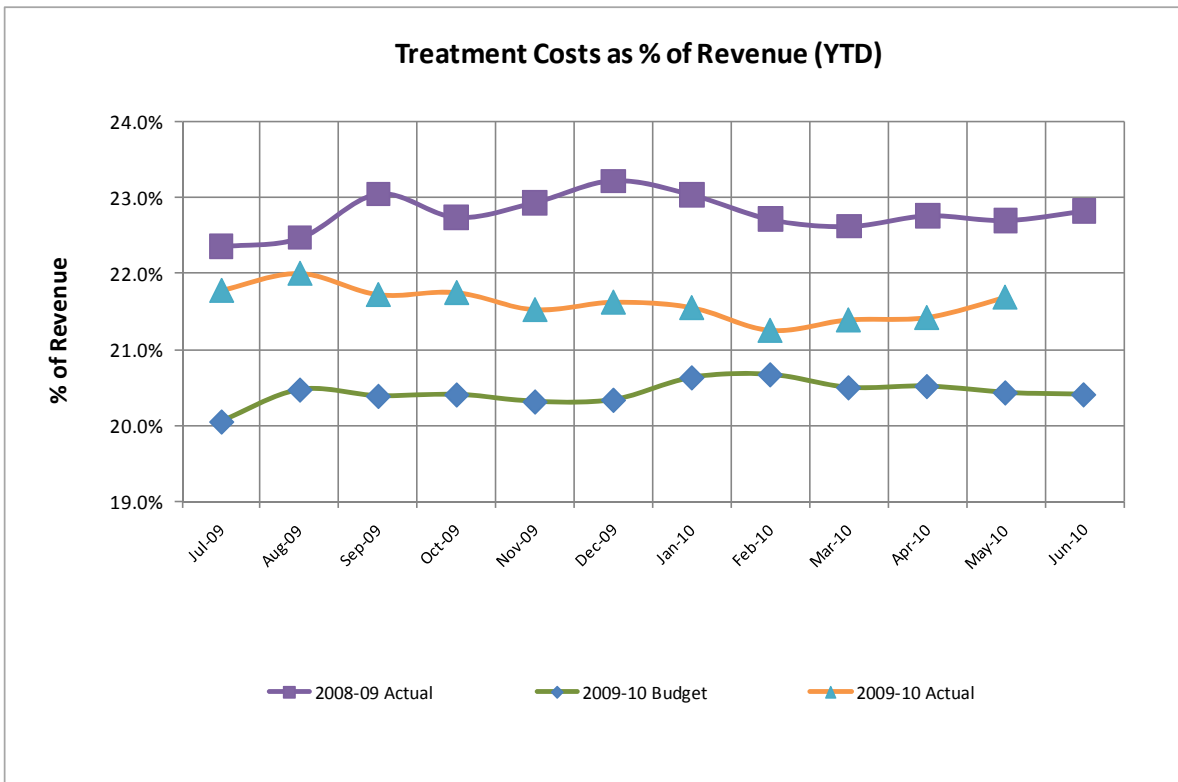
FSA= First Specialist Assessment
Green Line= Average
Arrow= Target



Cost Trend Charts



For the purposes of deriving this % calculation, revenue includes internal revenue.



While treatments costs as a % of revenue have been running at a level less than that of the previous financial year, some cost items eg clinical supplies (\$7.8m U YTD) have been running significantly above budgeted levels.

For the purposes of deriving this % calculation, outsourcing costs have been excluded from direct treatment costs (and the corresponding revenue excluded from revenue).

The principal areas which differed from budget for May YTD are:-
In \$,000's

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Health Service Portfolio	YTD Surplus/(Deficit)			Var as % to Budgeted Revenue	Comments
	Act	Bud	Var		
Women's Health	27,882	24,037	3,845F	5.7%F	The favourable variance is driven by higher volume delivery particularly in FSA Obstetrics \$2.3m 249% F without any significant variances from budgeted expenditure. However, it should be noted that total internal revenue exceeds the PBF funding received by the DHB.
Child Health/CWORAC Management/ORA	(37,247)	(28,394)	8,853U	4.5%U	The unfavourable variance is the result of the timing of Donation income for the MRI \$(4.5)m and Targeted Savings to be achieved \$(6.7)m. It is also driven by lower coded Paediatric Cardiac volumes \$(2.1)m, outsourcing of surgical workload (tonsillectomies & grommets) \$(0.9)m, higher drug costs \$(2.0)m and higher clinical supply costs \$(1.6)m. This unfavourable variance is offset by higher volumes in Medical/ Surgical \$6.3m and FTE vacancies & savings in superannuation \$2.9m; (ORA) delays in the opening of new theatre & vacancies in both Anaesthetists & Anaesthetic Technicians \$2.6m. Anaesthetic Technicians vacancies (now filled), increased leave taken over the Christmas period.
Transplant, Renal, Urology, ORL, Neuro	39,230	37,654	1,576F	1.4%F	The favourable variance is the result of favourable employee costs \$1.5m (net of savings targets \$1.8m), driven by medical and nursing FTE under budget due to the delayed opening of additional bed capacity and other efficiencies.
G Med, A+ Links, ID, NSAD, Orthopaedics	41,739	44,982	3,243U	2.4%U	The unfavourable variance is driven by lower volume delivery particularly in General Medicine & Infectious diseases \$(2.5)m
Operations Management	203	4,573	4,370U	N/A	Target Savings \$(3.9)m. This unfavourable variance is substantially offset by favourable variances in individual services.
Others	51,394	42,777	8,617F	N/A	A range of Provider Services with variances less than \$0.5m
Total Operational	123,201	125,629	(2,427)U	0.22%F	

Operational

May 2010

YTD								
Act 0910	% of Rev	Bud 0910	% of Rev	Act 0809	% of Rev	Var Budget	% Var to Bud	Var LY
Revenue								
MOH Base Funding								
899,485		887,341		822,769		12,145 F	1.4%F	76,717 F
MoH Sub-contracts								
15,473		17,172		19,553		1,699 U	9.9%U	4,080 U
Other Patient Care								
28,806		31,085		30,488		2,279 U	7.3%U	1,681 U
943,764		935,597		872,809		8,167 F	0.9%F	70,955 F
Services & Products								
17,091		19,875		10,356		2,784 U	14.0%U	6,734 F
CTA								
15,991		15,438		3,405		554 F	3.6%F	12,587 F
Trust & Donation Income								
3,969		9,033		7,117		5,065 U	56.1%U	3,149 U
Other Income								
6,147		5,352		5,776		795 F	14.9%F	372 F
986,962		985,295		899,462		1,667 F	0.2%F	87,500 F
Expenditure								
Employee Costs								
Medical								
197,141	20.0%	195,892	19.9%	181,061	20.1%	1,249 U	0.6%U	16,081 U
Nursing								
212,386	21.5%	211,640	21.5%	202,696	22.5%	746 U	0.4%U	9,690 U
Technical								
98,378	10.0%	101,083	10.3%	92,188	10.2%	2,705 F	2.7%F	6,190 U
Hotel Services								
8,100	0.8%	7,899	0.8%	7,832	0.9%	201 U	2.6%U	268 U
Administration								
37,432	3.8%	36,252	3.7%	38,262	4.3%	1,180 U	3.3%U	830 F
Other								
30,094	3.0%	33,090	3.4%	27,754	3.1%	2,996 F	9.1%F	2,340 U
Total Employee Costs								
583,532	59.1%	585,856	59.5%	549,793	61.1%	2,324 F	0.4%F	33,740 U
Direct Treatment Costs								
187,310	19.0%	178,098	18.1%	182,131	20.2%	9,212 U	5.2%U	5,179 U
Indirect Treatment Costs								
31,900	3.2%	32,769	3.3%	32,570	3.6%	869 F	2.7%F	670 F
Prop, Equip. & Transpt								
25,098	2.5%	26,265	2.7%	25,108	2.8%	1,167 F	4.4%F	10 F
Administration Costs								
7,878	0.8%	7,875	0.8%	8,285	0.9%	3 U	0.0%U	407 F
Indirect Service Billing								
8,863	0.9%	8,888	0.9%	6,396	0.7%	25 F	0.3%F	2,467 U
Loss on Sale of Fixed Assets								
106	0.0%	19	0.0%	108	0.0%	86 U	448.6%U	2 F
Total Operating Expenditure								
844,687	85.6%	839,771	85.2%	804,392	89.4%	4,916 U	0.6%U	40,296 U
Operating Surplus/(Deficit)								
142,275	14.4%	145,524	14.8%	95,071	10.6%	3,249 U	2.2%F	47,204 F
Depreciation								
18,963	1.9%	19,795	2.0%	18,848	2.1%	832 F	4.2%F	115 U
Finance Costs								
111	0.0%	100	0.0%	1,730	0.2%	10 U	10.3%U	1,620 F
Total Non Operating Costs								
19,073	1.9%	19,895	2.0%	20,578	2.3%	822 F	4.1%F	1,505 F
Net Surplus/ (Deficit)								
123,201	12.5%	125,629	12.8%	74,493	8.3%	2,427 U	1.9%U	48,709 F

5.2 Operations Indicators Exception Report

ADHB HAC KPI Report

†	MOH top 6
‡	IDP
Ω	SOI
Π	HBI
Φ	Mental Health KPI set

May 2010				
Indicator	Frequency	Review date	KPI report page ref	
Volume				
B3. Acute WIES Volume - Auckland	M	Oct-09	1	Ω
B4. Elective WIES Volume - Auckland	M	Jan-10	1	Ω
B5. Total WIES Volume - Auckland	M		1	Ω
B6. Non-DRG Revenue - Auckland	M	Mar-10	1	Ω
B7. Acute WIES Volume - IDF	M	Feb-09	2	Ω
B8. Elective WIES Volume -IDF	M		2	Ω
B9. Total WIES Volume _IDF	M	Jan-10	2	Ω
B10. Non-DRG Revenue - IDF	M	Jan-10	2	Ω
B11. Acute WIES Volume -All DHBs	M		3	Ω
B12. Elective WIES Volume -All DHBs	M	Jan-10	3	Ω
B13. Total WIES Volume - All DHBs	M	Jan-10	3	Ω
B14. Non-DRG Revenue - All DHBs	M	Jan-10	3	Ω
B30. Inpatient WIES Cumulative Variance to Contract - Acute/Elective by DHB	M	Apr-09	4	Ω
B31. Inpatient WIES Cumulative Variance to Contract - Total by DHB	M	Apr-09	4	Ω
B32. Inpatient WIES Cumulative Variance to Contract - Total all DHBs	M	Apr-09	4	Ω
B33. NON-DRG Revenue Cumulative Variance to Contract by DHB	M	Apr-09	4	Ω
B40. Mental Health Total Community Face-to-Face Appts.	M	Jan-10	6	
B41. Mental Health Total Access - Rate	M	Jan-10	6	
B42. Mental Health Community New Referrals	M		6	
Productivity				
B15. Acute WIES per Day	M		5	
B16. Elective WIES per Working Day	M	Jan-10	5	
B17. FSA per Working Day	M		5	
Length of Stay				
A22. Raw Average Length of Stay - WIES funded patients (days)	M		7	Ω
A61. Mental Health - Average Length of Stay (KPI Discharges) - Te Whetu Tawera	M	Aug-09	7	Φ
Elective Process and Waiting Times				
A03. Elective Day of Surgery Admission (DOSA) Rate	M		7	Π
B61. Raw Elective Surgical daycase rate	M		7	
B50. % of chemotherapy patients attending FSA within 6 weeks of referral	M		8	
B51. (POP-10) % of chemotherapy patients receiving treatment within 6 weeks of FSA	M		8	‡
B52. % of radiation oncology patients attending FSA within 6 weeks of referral	M		8	
B54. MOH-03 (from Dec 09). % of A, B & C category radiation oncology patients receiving treatment within 4 weeks of FSA	M		8	
B56. % of patients who commence bone marrow transplant within 6 weeks of decision to treat.	M		9	
B57. % of haematology patients attending FSA within 6 weeks of referral	M		9	
B58. % of haematology patients receiving treatment within 6 weeks of FSA	M		9	
A65. (ESPI 8). Proportion of patients treated prioritised using nationally recognised processes or tools	M	Feb-10	10	
Acute Process				
A56. % of stroke patients cared for within the stroke unit	Q	Mar-10		Ω
B63. Mental Health percentage of people with relapse prevention plans	M	Jan-10	6	
Cost				
B34. Cost and revenue for WIES funded inpatient events -all services	6 monthly			
B35. Cost and revenue for WIES funded inpatient events -child	6 monthly			
B36. Cost and revenue for WIES funded inpatient events -adult	6 monthly			
B37. Cost per WIES for WIES funded inpatients - all	6 monthly			
Human Resources				
F.12 % of Total Employee Turnover (Monthly)	M		11	
F.21 Lost Time Injury Frequency Rate	M		11	

HAC Exception Report
May 2010

No Exception this month

IMPROVEMENT ACTIVITIES

6.1 DAP Projects Report

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

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

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

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

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

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

Goal Level Summary Report (Hospital Advisory Committee)

DAP Projects

Total Projects: 15

DAP GOAL	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits			
			Plan		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green		Orange	Red		
			Define	Measure	Analyse	Improve															Control	
1) Lifting the Health of the people in Auckland City	1	1	0	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2) Performance Improvement	14	14	2	3	3	6	0	0	0	11	2	1	14	0	0	10	4	0	0	0	0	0
3) Living within our Means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	15	15	2	3	3	7	0	0	0	12	2	1	15	0	0	11	4	0	0	0	0	0
Totals %	100%	100%	13%	20%	20%	47%	0%	0%	0%	80%	13%	7%	100%	0%	0%	73%	27%	0%	0%	0%	0%	0%

High Level Summary Report

Goal 1 Lift the Health of the people in Auckland City

DAP Projects

Total Projects: 1

DAP HLS	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green		Orange	Red	
			Define	Measure	Analyse	Improve															Control
1.1 Reduce inequalities in health status	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2 Improve outcomes in priority areas	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
1.3 Prevent and manage long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
Totals %	100%	100%	0%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	0%	0%	0%	0%

Objectives

Objective	Objective Owner	Comment
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Exceptions

There are no projects that have been marked as an exception

High Level Summary Report

Goal 2 Performance improvement

DAP Projects

Total Projects: 14

DAP HLS	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
2.1 Improve the effectiveness & efficiency of the healthcare system- primary care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.2 Improve the efficiency and effectiveness of the healthcare system– decrease total system cost- primary secondary interface	2	2	0	1	1	0	0	0	1	1	0	2	0	0	1	1	0	0	0	0	0
2.3 Improve the efficiency and effectiveness of the healthcare system - hospital efficiency /throughput	5	5	0	0	1	4	0	0	5	0	0	5	0	0	4	1	0	0	0	0	0
2.4 Improve the efficiency and effectiveness of the healthcare system – reduce waiting times for elective services	3	3	1	1	0	1	0	0	3	0	0	3	0	0	3	0	0	0	0	0	0
2.5 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Improve leadership performance in clinical quality& professional governance	1	1	0	1	0	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0
2.7 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.8 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.9 Planning	3	3	1	0	1	1	0	0	1	1	1	3	0	0	2	1	0	0	0	0	0
Totals #	14	14	2	3	3	6	0	0	11	2	1	14	0	0	10	4	0	0	0	0	0
Totals %	100%	100%	14%	21%	21%	43%	0%	0%	79%	14%	7%	100%	0%	0%	71%	29%	0%	0%	0%	0%	0%

Objectives

Objective	Objective Owner	Comment
2.3.1 Improve the performance of ED	Margaret Dotchin (ADHB)	Close monitoring of performance is required as workload (acute and elective) increases. Green belt practitioners are picking up a number of projects which will assist rollout of improvement initiatives.
2.3.2 Improve acute capacity management	Ngaire Buchanan (ADHB)	Main emphasis on the acute patient flow project deliverables. Remains on track. Refer to the Adults and




Children's acute patient flow projects



2.3.3 Improve cardiac surgery throughput	Kay Hyman (ADHB)	24/5/10 Progress continues with some activity streams becoming BAU. Other streams continue into Phase 2. Waiting list remains above target of 81 but plans in place to address before year end and to ensure target intervention rate met.
2.4.1 Increase elective services to National intervention rates	Ngaire Buchanan (ADHB)	Elective services project to commence for the 2010_11 year in line with the Service Excellence programmes. Static plan in progress
2.4.2 Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation and medical oncology	Fionnagh Dougan (ADHB)	Since 01 March 2010 all patients have been booked for treatment within 6 weeks. In May 2010 outsourcing will commence to enable the targets to be achieved once the evening shift is discontinued.
2.4.3 Improve outpatient management for surgical patients while improving patient satisfaction	Ngaire Buchanan (ADHB)	Project on hold due to resource requirements for the Elective services work. However the outcome of ESU will be a base for future improvements. Nil to update.
2.9.1 Improve capacity management	Ngaire Buchanan (ADHB)	Revised capacity management approach for monthly review and reporting. Production Planner currently inputting data to enable reporting from July 2010. Nil to update
2.9.2 Long term services planning	Ngaire Buchanan (ADHB)	Under management with the LTSP manager

Exceptions

Short Name	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	DAP project?
Adult 6-hour project	ADHB	Improve				Improvements continue to be implemented and data suggests that these are having an impact in the time take to admit patients to wards, with a sustained improvement over the past 5 months, although the results are still outside the goal of 95% of bed requests completed within one hour. 13% of patients completed bed request to admission to ward within one hour (improvement from 7.6%) and average hours taken reduced from 7.5hours to 3.7 hours in May. Work continues with implementation of rapid rounds – to be commence in orthopaedics from 14 June, and nurse facilitated discharges (21 completed to end of May). Bed Management communication team commenced looking at non bed block issues – initial CMS changes reveal after hour delays. There has been a significant increase in the number of AED presentations on Sundays. Further analysis has shown that this is being driven primarily by Triage 4 patients who are subsequently discharged directly from AED. Significant increase in Triage 2 patients also noted in May. Work has commenced on triage processes within AED to identify areas for improvement. Feasibility of 'buffer' ward to be explored. Activity follows to be completed in AED to identify areas of opportunity to create more patient care time.	yes
Starship 6 hour project	ADHB	Improve				Within the improve stage. Continued improvement has seen April @ 91% which is significant considering the previous quarter (at 89%) is in the traditionally quieter months.	yes
CONCORD Project	ADHB	Analyse				Concord progresses well with good clinical engagement. 3 projects completed, website active with new ideas posted regularly. Honouring patient choices project commenced in Renal services.	yes
Auckland Region Cardiac Surgery Service Development	Regional	Improve				24/5/10 Some work streams concluding with change being embedded in BAU. Other work streams continue as Phase 2 projects. Steady progress continues.	yes
GSC	Regional	Improve				Project structure is now in place. Workstreams are focussed on designing the new process and confirming the design principles	yes
Radiation oncology waiting times	ADHB	Measure				May 2010: 100% of patients referred and eligible for treatment across A-C categories met the MOH 6 week wait time target in April. No patients waited > than 6 weeks for treatment due to capacity. The average wait time for "C" Radical patients is 4.2 weeks (4.6 weeks last month and 5.3 weeks in March) therefore compliance continues to improve	yes

month on month. The service is forecasting 100% compliance for Quarter 4. A service improvement plan has been developed with a focus on initiatives to improve waiting time performance to meet the 4 week MOH target from December 2010. A Linac capacity model is underdevelopment that can calculate forward capacity requirements and trigger the requirement to flex capacity (via outsourcing if necessary) to meet demand within MOH targets. 9 patients have been outsourced to a private facility (ARO) for treatment in May. Waikato Hospital has available capacity and patients are being offered treatment at this facility with no uptake as yet.

Regional LTSP	Regional	Analyse				NDSAs facilitated workshop to pull together the outputs from the work streams into a cohesive whole took place on 12 Feb 2010. A final Steering Committee meeting to review the concluded write-up was to be scheduled during April but has not occurred due to NRN work.
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Legend: Red - , Orange - , Green - 

High Level Summary Report

Goal 3 Live within our means

DAP Projects

Total Projects: 0

DAP HLS	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green		Orange	Red	
			Define	Measure	Analyse	Improve															Control
3.1 Manage revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.2 Improve productivity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.3 Manage cash	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals %																					

Objectives

Objective	Objective Owner	Comment
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Exceptions

There are no projects that have been marked as an exception

PAPERS

7.1 NONE

FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

Use document at start of Meeting Pack

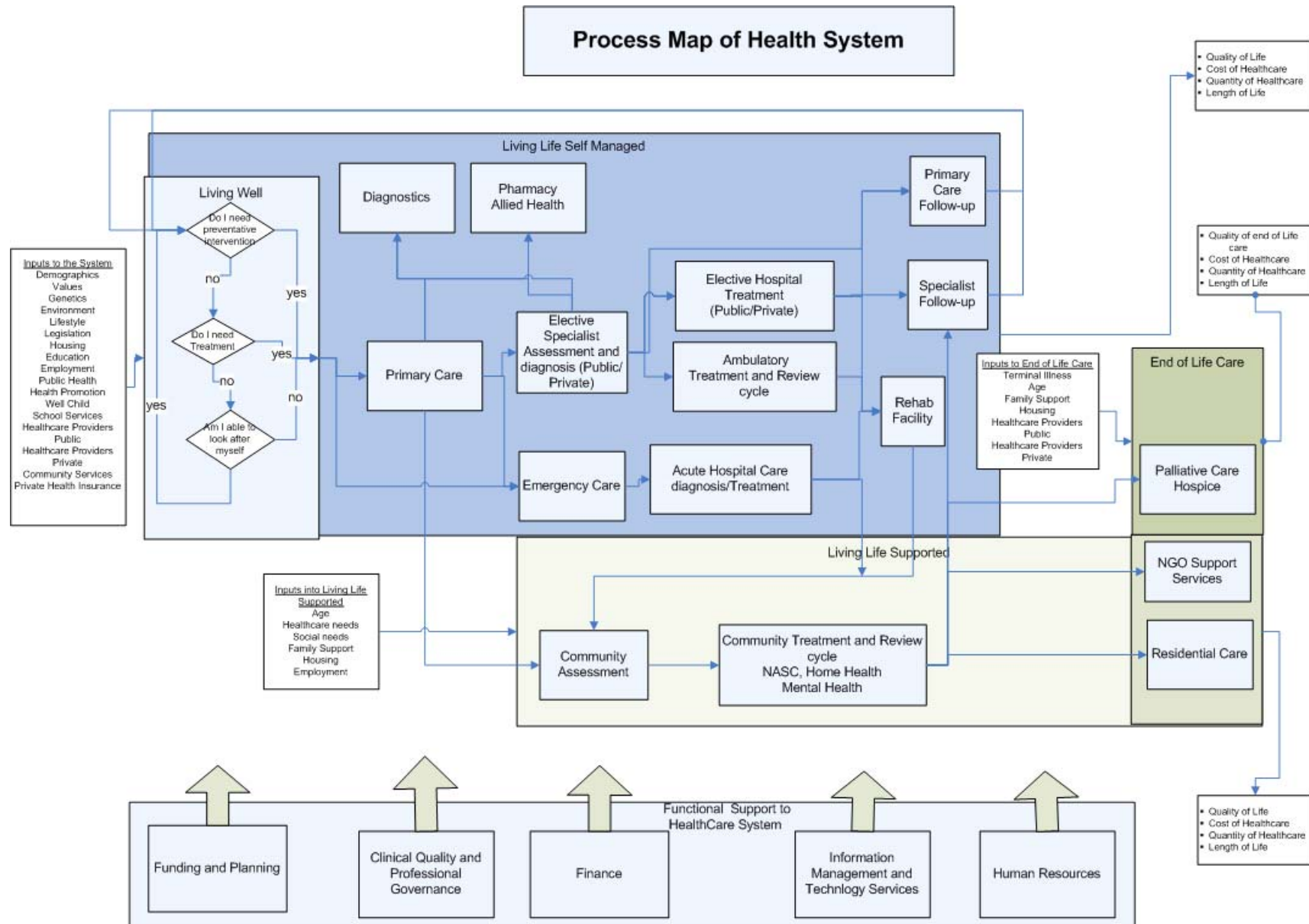
GENERAL BUSINESS

10

APPENDICES

10.1 Healthcare System Diagram

10.1 Healthcare System Diagram



MEETING DETAILS		
Time and Date	10:45am – 12:15pm, Wednesday 7 July 2010	
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital	
Members	Dr Chris Chambers (Chair), Jo Agnew, Susan Buckland, Harry Burkhardt, Rob Cooper, Dr Brian Fergus, Dr Ian Scott, Pat Snedden, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward, Assoc Prof Anne Kolbe, Prof Iain Martin, Farida Sultana, Lynda Williams	
Apologies		
In Attendance	Garry Smith, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Margaret Dotchin, Fionnagh Dougan, Kay Hyman, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ian Bell.	
COMMITTEE FUNCTIONS		
To monitor the financial and operational performance of the hospitals (and related services) of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.		
	Item	Page No
1	Attendance and Apologies	001
2	Conflicts of Interest	003
3	Confirmation of Minutes – Wednesday 2 June 2010	015
4	Action Points – Wednesday 2 June 2010	021
5	Operational Performance 5.1 Operational Summary Report and Financials 5.2 Operational Indicators Exception Report	025
6	Improvement Activities 6.1 DAP Projects Report	043
7	Papers 7.1 None	055
8	Feedback to Board	057
9	General Business	061
10	Appendices 10.1 Healthcare System Diagram	063

NEXT MEETING

Time and Date: 10.45am – 12.15pm, Wednesday 4 August 2010

Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital

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