Auckland District Health Board

Hospital Advisory Committee Meeting

Wednesday 5 May 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.	
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NOTING	
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4.	

Hospital Advisory Committee
Action Points

MEETING DETAILS	
Date and Time	

Item	Detail	Responsibility	Action
xx			
xx			
xx			
xx			

1

ATTENDANCE AND APOLOGIES

2

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.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

Date: 28/04/2010

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	3 September 2008
	2. Wate rcare Services Limited	Director	Fee	Wholesale supplier of water and waste water services to the Auckland region	
	3. Housing New Zealand	Chair	Fee	Has a joint multi-million Healthy Housing programme with Health Board	
	4. Tamak i Establishment Board	Chair	Fee via HNZC	Investigating a comprehensive cross agency intervention related to the Tamaki area including ADHB	
	5. Quality Improvement Committee	Chair	Fee	Oversees implementation of quality programmes in DHB nationwide	
	6. Chief Crown Negotiator Ngati Kahu Claim	Consultant	Fee	Crown Negotiator Ngati Kahu Treaty of Waitangi Claim	
	7. Chief Crown Negotiator Muriwhenua Forum	Consultant	Fee	Crown Negotiator Muriwhenua Treaty of Waitangi Claim	

Date: 28/04/2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Repl as Ltd 2. Matta Products Ltd 3. Remat Ltd 4. Matt I Ltd 5. Matta LLC 6. New Zealand Maori Arts and Craft Institute 7. Auckl and District Health Board 8. ADHB Charitable Trust 9. Ngati Kuri Trust Board 10. Packaging Council of New Zealand 11. Ngati Whatua o Orakei Health Clinic Ltd	Managing Director and shareholder Director and shareholder. Director and shareholder Shareholder/Director Trustee Chairman Deputy Chair, Chair Finance Committee Trustee Deputy Chairman and Treaty Negotiator Executive Member Chairman	Salary Honorarium	Plastics Manufacturing Company Plastics Manufacturing Company Plastics Manufacturing Holding Company Plastics Manufacturing Holding Company Plastics Distribution Company USA Government owned Maori Tourist operation	6 April 2010
Jo AGNEW	1. Senior Lecturer Nursing Auckland University 2. Casual Staff Nurse ADHB		Salary Salary		21 April 2010

Date: 28/04/2010

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

Date: 28/04/2010

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

Date: 28/04/2010

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

Date: 28/04/2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rev Alfred NGARO	1. **4pm Group Ltd** 2. P acific Advisory Committee, PHAC CPHAC member 3. National Task Force for Family Violence MSD 4. Family and Community Services national advisory group 5. Auckl and Safer Communities 6. Tama ki Achievement Pathways Schooling improvement 7. Tamaki College Board of Trustees 8. Tama ki Community Development Trust	Consultant Chair Member Task Force member Advisory Member Executive member Chair Elected Trustee Member	Salary Fee Fee Fee Voluntary Voluntary Fee Voluntary	Community Development Pacific Advisory for ADHB PHAC representative Representative from Family and Community Services national advisory group Development and implementation of a comprehensive social intervention logic for supporting families nationally Development of Auckland Safer City plans Chair management committee for cluster of 13 schools in management improvement initiative Disciplinary and property Committee NGO delivering social services within the Tamaki area	11 May 2009
Farida SULTANA	1. Nil				6 August 2008

Date: 28/04/2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	1. Maternity Services Consumer Council 2. Auckl and Women's Health Council 3. Membe r National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee	Employee Employee	Salary Salary		4 August 2008
Iain MARTIN	1. University of Auckland	Employee	Salary		26 June 2008
Anne KOLBE	1. Private Paediatric Surgical Practice 2. Employee Communio NZ 3. Head, Auckland Clinical School, School of Medicine, University of Auckland 4. Hu sband: Employee University of Auckland 5. Member Risk and Audit Committee Whanganui District Health Board				12 December 2008

3

CONFIRMATION OF MINUTES

THURSDAY 7 APRIL 2010

Hospital Advisory Committee
Minutes

MEETING DETAILS	
Time and Date	10:45am, Wednesday, 7 April 2010
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

1 ATTENDANCE AND APOLOGIES

Committee Members

Dr Chris Chambers (Chair)
Susan Buckland
Dr Brian Fergus
Pat Snedden
Seiuli Dr Juliet Walker
Associate Professor Anne Kolbe
Jo Agnew
Rob Cooper
Dr Ian Scott
Rt Hon Bob Tizard
Ian Ward
Lynda Williams

Management in Attendance

Garry Smith - Chief Executive
Dr Denis Jury – Chief Planning & Funding Officer
Brent Wiseman - Chief Financial Officer
Greg Balla – Director of Performance & Innovation
Ngaire Buchanan – General Manager Operations
Margaret Dotchin - Nurse Director
Fionnagh Dougan – GM Mental Health, Ambulatory, Cancer & Blood Services
Aroha Haggie – Maori Health Gain Manager
Chris Morgan - Manager Materials Management
Vivienne Rawlings – General Manager Human Resources
Ian Bell - Board Administrator

Apologies

The Chair declared the meeting open at 10:55am.

Apologies had been received from Harry Burkhardt, Professor Iain Martin, Farida Sultana, David Sage and Kay Hyman.

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interest for any item on the agenda.

3 CONFIRMATION OF MINUTES 3 MARCH 2010

Margaret Wilsher was developing a Research Strategic Plan noting Professor Martin's comment about the need to be a vibrant research organisation. This would provide a more intentional relationship between ADHB and the University. Tony O'Connor would be contributing.

The Committee was advised that Professor Richard Reznick was undergoing a review of the University as to the structure of a Clinical Education Board in the Clinical School which would look at the interrelationship with the DHB. Research was the only flexible revenue stream for the University.

It was suggested that there be a discussion on where ADHB sat as a University teaching hospital at the Strategic Planning Day.

	<u>Moved Pat Snedden seconded Lynda Williams</u> *That the minutes of the Hospital Advisory Committee meeting held on 3 March 2010 be confirmed as a true and correct record.* <u>Carried</u>
7.1	**Adult Acute Flow Project**
	Margaret Dotchin; Tim Parke, Clinical Director Adult ED; Mark Gardener, Senior Physician championing the flow through ED project; Charlotte Porter, Charge Nurse Ward 68, a General Medical ward; and Tim Denison, Improvement Specialist presented to the Committee. The project was being undertaken as, had been advised at previous meetings, it was estimated that 38 patients per annum died due to delays and the 6 hour target set by the Minister was in fact good care as it is best to move people on and not have ED as a warehouse. Progress was being measured and there had been genuine improvement. Approximately 35% of patients are discharged direct from ED and do not move into the hospital system. Getting improvement in times waiting for a bed was slow progress due to the need to have the hospital working better. The project was coming to a turning point where there could be improvements to target or it could plateau or even fall. It was about not having electives interfere with acutes as while electives are planned there is not planning for acutes. The solutions were outlined being recognising short stay at Emergency Medicine with these patients to be accounted seperately from the 6 hour data, increased staffing with now a full compliment of RMOs and increased SMO input which provided more supervision and earlier decision making. Further improvements were access to investigations with 24 hour access to CT and faster radiology, improved efficiency by reducing occupancy which created more space to see patients, more liaison with APU and education to have more engagement by everyone. The work stream on ward admissions, the one hour work stream, had improved the time between bed request to admission from an average of 7.5 hours to 4.4 hours. Causes of delay were bed blockages and high occupancy, problems with weekend discharge and delays in discharge. Improvement activities were a daily rapid round of 15 minutes which covers every patient, day of discharge logistics, improved weekend discharge and re-launching of nurse facilitated discharges. There was daily bed management communication. Further beds had been opened in November with a further increase in January. In managing acute flows senior medical staff had more understanding when real examples were provided. There was a need to have beds empty and not filled with electives. There were measurable KPIs and there was an aim to get planned discharge date estimates 90% correct. Planning acutes can be very predictive and the Greenlane surgical unit will assist. There was also a project to focus on General Medicine to get a cultural change and conversation with the private sector. It was noted that Primary Care would not make a difference to the 6 hour target, the target was realistic but hard and Counties Manukau was compliant. Primary Care could improve discharge although it was noted that again this was run as a 5 day service rather than 7 day service. It was noted that hospitals were for sick people and provided a critical mass of skills where as it would be uncertain whether Primary Care could provide that critical mass. The Chair thanked the presenters.
7.2	**Maori DNA Rates**
	Linda Thompson, Manager Clinical and Projects Maori Health; John Paterson, Manager Provider Arm Services Maori Health; and Leigh Cleland, Manager Greenlane Clinical Centre presented to the Committee as they had to the Maori Health Advisory Committee. Information was provided that showed Maori DNA rates had decreased 1% from 2006 – 2008 and by another 1% 2008 – 2009 but still remains highest along with Pacific DNA. The Maori DNA rate of 10% was the lowest DNA amongst DHBs and complies with the Health Roundtable range of 5% - 10%. It was noted that 47% of DNAs were from outside ADHB. To address the problem six specialities had been targeted and of note was the 94% DNA for the 0 – 15 year olds audiology

	clinics which may be due to their dependence on people to bring them. Initiatives being undertaken were flyers to all patients, invitations to make appointments at times which suited them, a child play area, texting etc. It was suggested that mobile audiology may improve the low rate for children and it was noted that once the issues were identified and resources applied good results could be obtained. Recommendations would be going to the Clinical Board.
5.1	**Operational Summary Report and Financials**
	The financials were favourable with a lot of savings being made, not in FTE but in other ways. The MRI donation was expected in May. How to report on productivity was being reviewed. With radiation therapy it was known that there would be noncompliance for Quarter 2 and Quarter 3. Planning time was being reduced from 15 days to 8 days and there were discussions with AOR who were willing to flexed capacity over the next year. With the existing MECA there were constraints on radiation therapists outside hours work and there also needed to be a skill mix with ADHB having more less skilled. Cardiology was experiencing difficulties with the RT strike and Lab strike so there was some outsourcing. The Minister had been advised early and was concerned at getting back to the 81 waiting which at present sat at 84. The overall contract number for the year will be delivered and there is an aim to get a lower waiting list to provide a buffer to cover unforeseen circumstances. Arrangements with private providers for both radiology and cardiology were being reviewed to get better planning rather than stop/start arrangements. Radiation was reliant on having workforce issues resolved and getting the planned replacement machine. There was still a commitment to get to a target of 4 weeks by December 2010. The Government objectives were immovable in these areas so there may be a need to move resources from other areas whilst still achieving breakeven. If priorities shifted resources had to shifted. The improvement projects were being undertaken although there may be some time to get their benefits coming through.
9	**GENERAL BUSINESS**
	The Auckland City Hospital Car Park had been delayed with changes at the national level in the approval system and Capital Committee.
	NEXT MEETING
	The meeting closed at 12:50pm. The next meeting is scheduled for 10:45am, Wednesday, 5 May 2010 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton

CONFIRMED

CHAIR: DATE:

4

ACTION POINTS

THURSDAY 7 APRIL 2010

Hospital Advisory Committee

Action Points from the meeting on Wednesday 7 April 2010

Item	Detail	Designated	Action
3.	**Discussion on where ADHB sat as a University teaching hospital suggested for Strategic Planning Day**	**Garry Smith**	**Noted**

5

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 $4.2m un-favourable to budget for March 2010; with the Operational Division result $5.7m un-favourable to budget (see table). The Operational results saw patient care revenue adverse to budget but costs exceeding budget.

Summary of Provider Results

$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	**9,771**	**15,500**	**5,729U**	**101,402**	**102,051**	**649U**
Complementary	84	82	2F	1,171	1,098	74F
Functional	(6,917)	(8,492)	1,575F	(104,680)	(105,016)	336F
Ancilliary	**(6,832)**	**(8,410)**	**1,578F**	**(103,509)**	**(103,918)**	**409F**
Provider Net Surplus/(Deficit)	**2,939**	**7,090**	**4,151U**	(2,107)	(1,867)	239U

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

Operating Statement - March 2010	Month			Year to Date		
Operational	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Total Income						
Patient Care Revenue	89,707	92,132	2,425U	778,500	771,868	6,631F
Sales of Services & Products	988	1,084	95U	8,294	9,557	1,264U
Clinical Training & Education Income	1,608	1,392	216F	13,043	12,654	389F
Trust & Donation Income	548	807	259U	3,190	7,422	4,231U
Financial Income	-	-	0F	1	-	1F
Other Income	844	593	251F	4,763	4,421	342F
Profit on Disposal of Fixed Assets	6	-	6F	209	-	209F
Internal Sales (Service Billing)	9,098	9,093	5F	78,516	77,678	838F
Total Income	**102,800**	**105,101**	**2,302U**	**886,515**	**883,600**	**2,915F**
Operating Expenditure						
Employee Costs	56,131	55,395	736U	476,103	479,366	3,263F
Direct Treatment Costs	27,940	25,447	2,493U	233,249	223,877	9,371U
Funder Payments	(2)	-	2F	-	-	0F
Indirect Treatment Costs	3,106	3,005	101U	25,795	26,820	1,025F
Property, Equipment & Transportation Costs	2,400	2,392	8U	20,552	21,498	946F
Administration Costs	845	701	144U	6,478	6,481	3F
Indirect Service Billing	822	808	14U	7,260	7,272	12F
Loss on Sale of Fixed Assets	5	2	3U	103	16	87U
Total Operating Expenditure	**91,248**	**87,750**	**3,498U**	**769,540**	**765,330**	**4,210U**
Operating Surplus/(Deficit)	**11,552**	**17,351**	**5,799U**	**116,975**	**118,270**	**1,295U**
Non-Operating Expenditure						
Depreciation	1,771	1,842	71F	15,481	16,137	656F
Finance Costs	10	9	1U	92	82	10U
Total :Non-Operating Expenditure	**1,781**	**1,851**	**70F**	**15,573**	**16,219**	**646F**
Total Surplus / (Deficit)	**9,771**	**15,500**	**5,729U**	**101,402**	**102,051**	**649U**

Key adverse variances for March (> $250,000) were:-

Patient Care Revenue	$(2,425)m U	$6.631F YTD
Trust & Donation Income	$(0.6)m U	$(4.0)mU YTD
Employee Costs	$(0.736)m U	$3.263m F YTD
Direct Treatment Costs	$(2.493)m U	$(9.371)m U YTD

Patient Care Revenue
The principal variances were as follows:-

Adult Health	$2.2m U	The key driver of this is a backdated YTD correction for OPH DSS bed day income. The process for changing purchaser codes for ACC discharges from MOH to ACC was not working consistently and this has meant approximately $1.6M of ACC bed days were also being counted as DSS bed days. We are working with DSU and Coding to ensure this does not recur.
Wom, Child, Card, ORA (CWORAC)	$1.0m U	Volumes lower than contract in paediatric general medicine and medical subspecialties – approx $0.7m, deferral to balance sheet of approx $0.25m genetics revenue until contract conditions are met.
MH, Amb, Ophth, Cancer & Blood	$0.7m F	Driven by largely by volumes in the following services - Immunology, Oral Health, Ophthalmology and Haematology

42 elective cases (across a range of specialties) were deferred as a result of the MRT strike as well as 108 outpatient appointments (all orthopaedic). The revenue impact is assessed as being in the region of $500 - $600,000.

Trust & Donation Income

As noted in previous months this reflects a 'timing difference' between budget and likely receipt of Starship Foundation receipts. Actuals will be closer to, though less than, the annual budget by year end.

Employee Costs

Operational arm employee costs were $0.7m un-favourable to budget for March ($3.3m 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	Actual FTE Month 2009	Variance
Adult Health	1,717	1,766	**-49**
Women, Child, Cardiac, OR&A	2,342	2,479	**-137**
Operations	1,376	1,407	**-31**
Ment Hlth, Amb, Ophth, Cancer & Blood	1,243	1,268	**-25**
Others	-1	1	**-2**
TOTAL	**6,677**	**6,921**	**-244**

FTE Table 2 – Cost per FTE

Operational Services - Staffing Variance			
Month 2009/10	**Budget**	**Actual**	**Variance %**
Employee Costs ($M)	55.4	56.1	-1.33%
FTE Numbers	6,677	6,921	-3.65%
Cost per FTE (Month)	8,296	8,110	2.24%
YTD 2009/10	**Budget**	**Actual**	**Variance %**
Employee Costs ($M)	479	476	0.68%
FTE Numbers	6,717	6,858	-2.10%
Cost per FTE (Year to Date)	71,362	69,419	2.72%

The adverse staffing variance was due to the unfavourable FTE variance of 244 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

	Mar 10 Budget	**Mar 10 Actual**	**Variance ***	**Savings Targets incl in Budget**	**Var to Underlying Bud i.e. FTE Savings Achieved**
Adult Health	1,717	1,766	-49	99	50
Wom, Child, Card, ORA	2,342	2,479	-137	107	-30
Operations	1,376	1,407	-31	63	31
MH, Amb, Ophth, Cancer & Blood	1,243	1,268	-25	66	41
ACH Others	-1	1	-2	2	0
Total	**6,677**	**6,921**	**-244**	**337**	**93**

In previous meetings there has been discussion on the February 2010 graduate nursing intake, in light of the adverse variance on nursing FTEs.

The operational discipline to identify vacancies when recruiting new graduates is in place. The graduates have a 10 week (12 weeks in Operating Rooms) clinical workload sharing component during which time they work with a 'preceptor'; during this time they provide care at a level consistent with their new graduate status. Their independence in taking a full patient load increases over the 10 week period.

The February 2010 intake consisted of 80 graduates equivalent to 73 FTE – a large number of the graduates commenced work at 0.9 FTE the equivalent of 36 hours per week. The graduates were placed in vacant positions across the provider arm. The following table shows the numbers of graduates (head count), the FTE equivalent and the RN budget variance *for the areas where they were employed*, for the months of December, January, February and March. A negative number indicates an adverse variance i.e. nursing levels are higher than budgeted.

FTE Table 4 – Graduate Nurses

			RN Variance in Areas Graduates Employed			
	Graduates headcount	**Graduates FTE**	**Dec FTE**	**Jan FTE**	**Feb FTE**	**Mar FTE**
Adult Health	33	29.7	38.7	46.3	4.4	5.7
Cancer & Blood	2	1.8	4.7	3.5	3.5	1.6
Cardiac	6	5.4	(6.5)	(3.7)	(3.8)	(2.2)
Child Health	24	21.6	(1.4)	12.1	(7.3)	(5.9)
Women's	2	1.8	(0.9)	(0.3)	(2.6)	(2.7)
Operating Rooms	11	10.9	(5.7)	(3.4)	(13.4)	(12.0)
Ambulatory Health	2	1.8	2.2	2.2	0.6	0.4
	80	**73**	**31.1**	**56.7**	**(18.6)**	**(15.1)**

The key areas for comment are:-

Operating Rooms – the workload sharing component in OR lasts twelve weeks, all graduates were placed in known vacancies and by April FTE reporting are expected to be fully incorporated into rosters in budgeted positions i.e. the variance will eliminated.

Child Health – The Acting Starship Nurse Leader is working with the EDON and Starship senior nurses to review high levels of sick leave, patient acuity and the Starship nursing models of care in order to manage within the allocated nursing FTE budget. The disciplines outlined above of employing graduates to vacant positions is policy.

Cardiac – One of the FTE variance at March is a cardiac nurse currently supporting staff training in the acute mental health unit, this variance will be managed through an inter service cost transfer. The balance of the adverse variance for March will be resolved through an anticipated resignation in April.

Women's Health – The Womens Health Service Manager and Charge Nurse of Gynaecology is working with the EDON to review the Ward 97 Model of Nursing Care in order to manage within the allocated nursing FTE budget. The disciplines outlined of employing graduates to vacant positions is policy.

Overall there is a small increase of 38 FTE between March month actual and the 2010/11 budget. Within this there is a decrease in Nursing, predominantly in Adult Health, reflecting revised ward Nursing models of care to be implemented.

FTE Table 5 – Current FTE Compared to 2010/11 Budget

	Mar 10 Month Actual	Jul 10 Month Budget	Var Mar Act versus Jul Bud
By Portfolio			
Adult Health	1,766	1,738	-28
Wom, Child, Card, ORA (CWORAC)	2,479	2,496	17
Operations	1,407	1,429	22
MH, Amb, Ophth, Cancer & Blood	1,268	1,295	27
ACH Others	1	1	0
Total	**6,921**	**6,960**	**38**
By Category			
Medical	1,122	1,179	57
Nursing	3,247	3,182	-65
Technical	1,628	1,678	50
Hotel Services	210	203	-6
Stores	1	1	0
Administration	714	724	10
Target Savings	0	-9	-9
Total	**6,921**	**6,960**	**38**

Direct Treatment Costs

Direct treatment costs for March were unfavourable to budget by $2.5m U, ($9.4m U YTD). The key components were:-

Cost	Variance Month $M	Variance YTD $M	Comments
Clinical Supplies	(1.1)	(5.9)	Approximately half the variance - $560k U is in areas with negative budgets ie this is areas where overall savings have been assigned but may have been achieved, wholly or in part, elsewhere. Of the balance $386k was in respect of Level 4 and Level 8 theatres, both of which had unusually high theatre minutes, due in part to the level of transplant activity (see below).
3rd Party Treatment Costs	(0.8)	(3.9)	Cardiothoracic outsourcing $710k U, Oncology outsourcing including charges from Northland $325k U, offset by reduced external imaging costs.
Chemicals & Media	(0.2)	(1.0)	Laboratories $184k U - reflects overall higher test volumes than the budget assumption.
Contracted Services – Clinical	(0.2)	(1.1)	Outsourcing paediatric surgical cases $100k U, paediatric medical $95k U including $72k for National Rheumatology Service (Hutt Valley DHB)

Other variances totalled $(0.2)m U.

Transplant activity is funded through two sources renal (kidney) transplants are funded via the wies system. Liver and heart transplants are funded through a national contract. The revenue for these national contracts is recognised on a 'straight line' basis ie one twelfth each month. An extrapolation of transplant activity for year to date March (based on historical trends) suggests that while March was a high month, year to date numbers are not abnormal and volumes are *likely* to be close to contract by year end.

Transplant analysis

	Liver		Heart		Lung	
	Actual	**Contract**	**Actual**	**Contract**	**Actual**	**Contract**
2006/07	31	46	9	14	12	10
2007/08	42	46	11	14	7	10
2008/09	40	47	11	14	13	10
2009/10 Mar YTD	34		8		7	
2009/10 Mar Extrap	**45**	**48**	**11**	**14**	**9**	**10**

Throughput – Acute Front Door

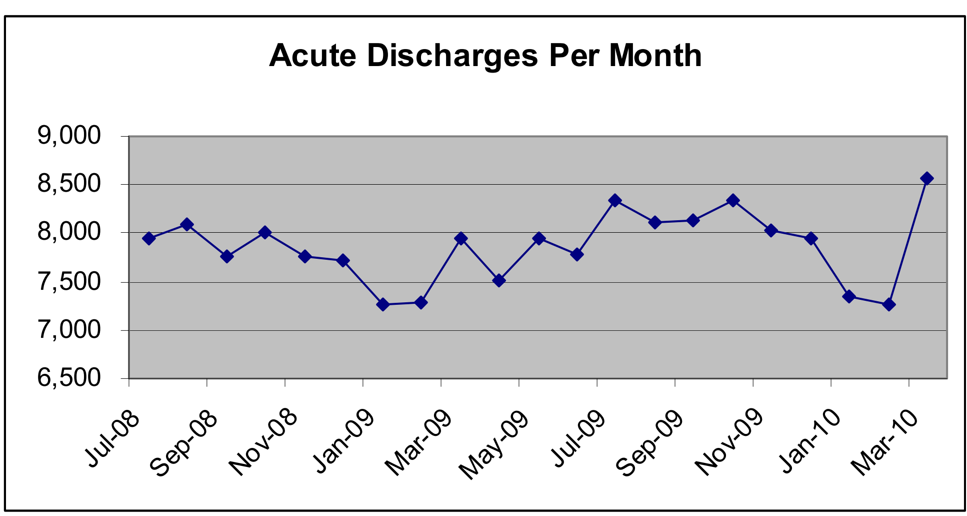
	Month	**Per Day**	**%**	**Last Month**	**Per Day**	**%**	**Last Year**	**Per Day**
	Mar-10	Att per Day	Comparison to Last Month	Feb-10	Att per Day	Comparison to Last Year	Mar-09	Att per Day
APU	1,671	54	14.1%	1,464	52	10.2%	1,516	49
AED	4,202	136	9.1%	3,852	138	9.2%	3,848	124
CED	2,682	87	14.9%	2,335	83	5.3%	2,548	82

AED. Record high monthly volumes although the daily rate of last month was not exceeded. On a per-day basis, the top three months are also the last three months. The average LOS remains considerably lower than last year. The ALOS in AED was 5 hours and 13 minutes and this is the fourth consecutive month for the ALOS being under 6 hrs.

APU. Record high monthly volumes and a high daily rate that matched the record set September 2009. Both LOS measures increased by more than an hour but remained more than four hours lower than March last year.

CED. The highest March of the last five years for volumes. A shift upwards in LOS measures but they compare well with previous March months.

The figures above are also reflected in the level of acute discharges in the month (below).



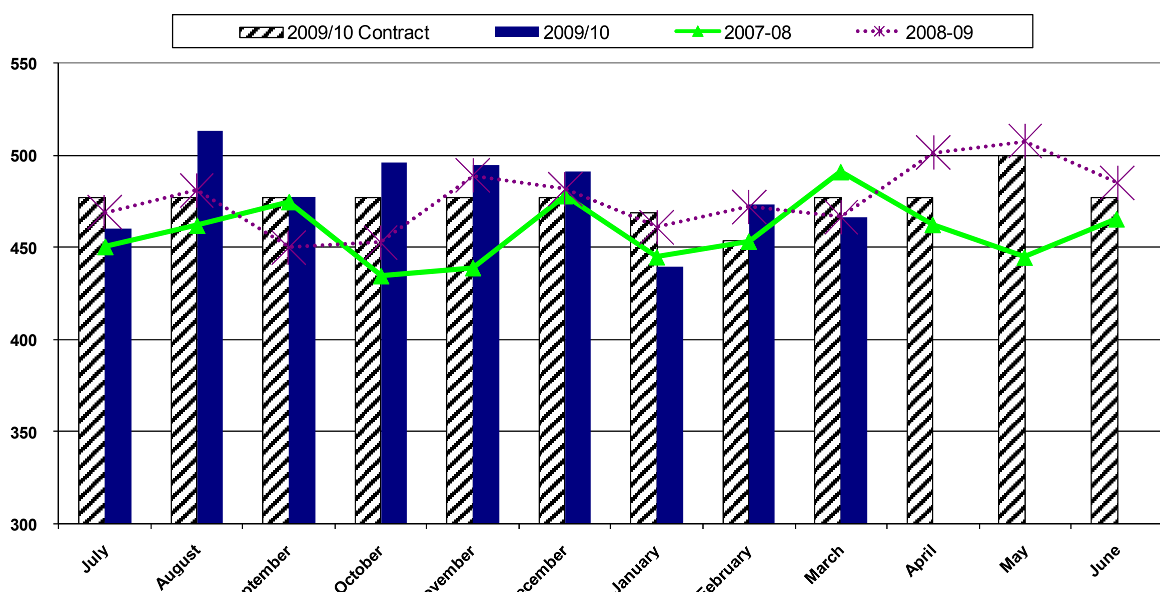
Throughput Statistics

The chart below shows the production recorded to March 2010.

At the time the results were finalised, the coding was 69.5% complete (96.3% YTD) with the average WIES per discharge being 0.8% less than last year for the same period. Discharge s are up by 3.4% from last year.

Inpatient de livery to the most current Price Volume Schedule (Mar 2010) was 98% for the month (101% YTD).

WIES Production & Delivery per working day						
`	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	10,712	10,966	254U	90,986	89,980	1,006F
WIES Delivery per day	466	477	11U	479	474	5F



Volumes YTD

Inpatient volumes year to date March 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 possibly into 2010/11.

Electives

DHB	Contract	Actual	Variance	% of completion
ADHB	11,253	9,646	**-1,608**	86%
CMDHB	3,228	3,695	**468**	114%
WDHB	4,411	4,886	**475**	111%
Other	4,110	3,962	**-148**	96%
	23,002	**22,190**	**-813**	**96%**

Acutes

DHB	Contract	Actual	Variance	% of completion
ADHB	36,278	38,195	**1,917**	105%
CMDHB	9,298	8,822	**-475**	95%
WDHB	12,884	13,734	**850**	107%
Other	8,971	8,048	**-923**	90%
	67,430	**68,799**	**1,369**	**102%**

Acute & Elective

DHB	Contract	Actual	Variance	% of completion
ADHB	47,531	47,841	**309**	100.7%
CMDHB	12,525	12,518	**-8**	99.9%
WDHB	17,295	18,620	**1,325**	107.7%
Other	13,081	12,010	**-1,071**	91.8%
	90,432	**90,988**	**556**	**100.6%**

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

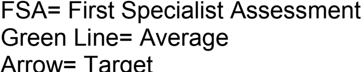
Elective Split by CTSU/Other

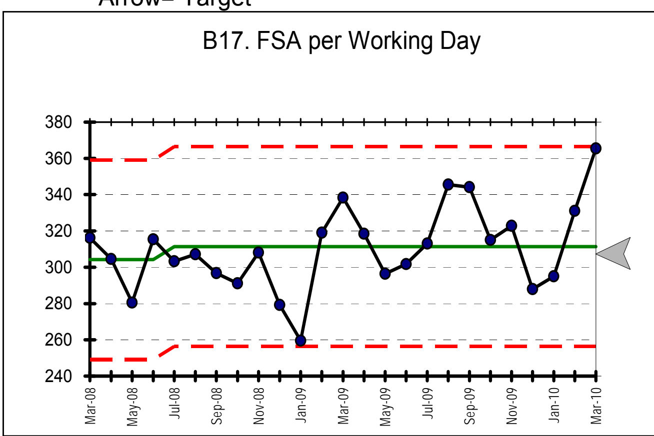
	Contract	Actual	Variance
Electives	23,002	22,190	(813)
Split by:-			
CTSU	2,963	3,894	+931
Other	20,039	18,296	(1,744)

Outpatient Delivery

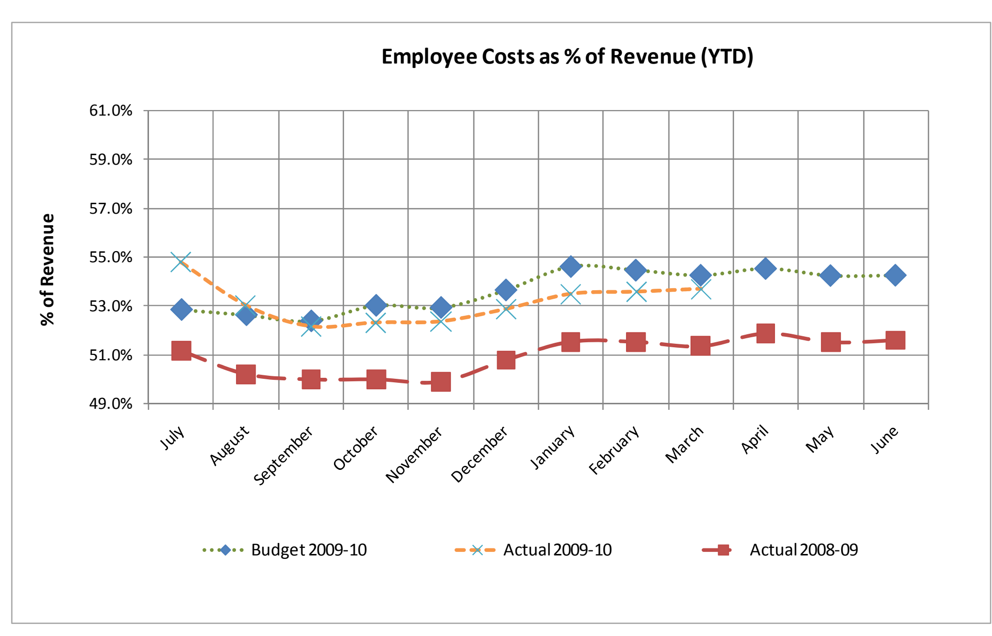
Below is a graph of outpatient activity in the same manner as for inpatient activity - output per working day. As well as being a useful indicator of productivity, outpatient activity is, in part, the 'feeder' activity for much of our elective 'production line'. Of the FSAs year to date in 2009/10 (including 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 (noted separately by virtue of its size), the balance is obstetrics (6%).

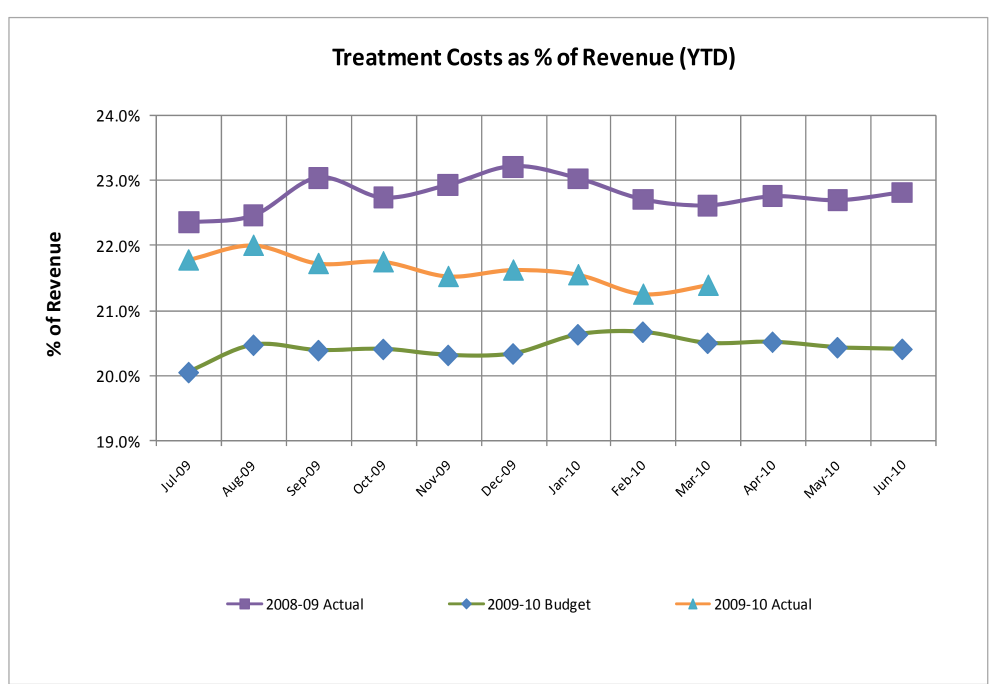
Whilst a number of services e.g. ophthalmology had extremely high months for first specialist assessments, for some of these services this was balanced by relatively low number of follow up appointments.





Cost Trend Charts





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 ($5.9m U YTD) have been running significantly above budgeted levels.

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

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

Health Service Portfolio	YTD Surplus/(Deficit)				Comments
	Act	Bud	Var	Var as % to Budgeted Revenue	
Women's Health	22,468	19,480	2,988F	5.3%F	The favourable variance is driven by higher volume delivery particularly in FSA Obstetrics $2.3m without any significant variances from budgeted expenditure.
Child Health/CWORAC Management/ORA	(29,467)	(23,906)	5,561U	3.5%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 $(6.3)m. It is also driven by lower coded Paediatric Cardiac volumes $(1.4)m, outsourcing of surgical workload (tonsillectomies & grommets) $(1.3)m, higher drug costs $(1.5)m and higher clinical supply costs $(0.9)m. This unfavourable variance is offset by higher volumes in Medical/ Surgical $5.5m and FTE vacancies & savings in superannuation $2.8m; (ORA) delays in the opening of new theatre & vacancies in both Anaesthetists & Anaesthetic Technicians $2.1m. Anaesthetic Technicians vacancies (now filled), increased leave taken over the Christmas period.
Transplant, Renal, Urology, ORL, Neuro	32,674	30,790	1,883F	2.0%F	The favourable variance is the result of favourable employee costs $2.5m, 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	34,248	36,580	2,332U	2.0%U	The unfavourable variance is driven by lower volume delivery particularly in General Medicine & Infectious diseases $(1.5)m
Operations Management	140	3,525	3,385U	N/A	Target Savings $(2.8)m. This unfavourable variance is substantially offset by favourable variances in individual services.
Others	41,340	35,582	5,758F	N/A	A range of Provider Services with variances less than $0.5m
Total Operational	**101,402**	**102,051**	**(649)U**	0.07%F	

Operational

Mar 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	737,088		725,555		672,203		11,533 F	1.6%F	64,885 F
MoH Sub-contracts	17,734		20,871		14,316		3,137 U	15.0%U	3,418 F
Other Patient Care	23,679		25,443		25,356		1,764 U	6.9%U	1,678 U
	778,500		**771,868**		**711,875**		**6,631 F**	**0.9%F**	**66,625 F**
Services & Products	8,294		9,557		8,469		1,264 U	13.2%U	175 U
CTA	13,043		12,654		2,748		389 F	3.1%F	10,295 F
Trust & Donation Income	3,190		7,422		5,045		4,231 U	57.0%U	1,855 U
Other Income	4,972		4,421		4,516		551 F	12.5%F	456 F
	807,999		**805,922**		**732,654**		**2,077 F**	**0.3%F**	**75,345 F**
Expenditure									
Employee Costs									
Medical	160,726	19.9%	160,188	19.9%	147,532	20.1%	538 U	0.3%U	13,195 U
Nursing	173,714	21.5%	172,982	21.5%	162,861	22.2%	732 U	0.4%U	10,853 U
Technical	80,341	9.9%	82,946	10.3%	75,484	10.3%	2,605 F	3.1%F	4,857 U
Hotel Services	6,551	0.8%	6,482	0.8%	6,346	0.9%	69 U	1.1%U	205 U
Administration	30,503	3.8%	29,612	3.7%	31,758	4.3%	890 U	3.0%U	1,255 F
Other	24,269	3.0%	27,156	3.4%	22,349	3.1%	2,887 F	10.6%F	1,920 U
Total Employee Costs	476,103	58.9%	479,366	59.5%	446,328	60.9%	3,263 F	0.7%F	29,775 U
Direct Treatment Costs	154,732	19.2%	146,199	18.1%	147,378	20.1%	8,533 U	5.8%U	7,354 U
Indirect Treatment Costs	25,795	3.2%	26,820	3.3%	26,543	3.6%	1,025 F	3.8%F	748 F
Prop, Equip. & Transpt	20,552	2.5%	21,498	2.7%	20,563	2.8%	946 F	4.4%F	10 F
Administration Costs	6,478	0.8%	6,481	0.8%	6,666	0.9%	3 F	0.0%F	188 F
Indirect Service Billing	7,260	0.9%	7,272	0.9%	5,101	0.7%	12 F	0.2%F	2,159 U
Loss on Sale of Fixed Assets	103	0.0%	16	0.0%	81	0.0%	87 U	550.8%U	21 U
Total Operating Expenditure	**691,024**	**85.5%**	**687,652**	**85.3%**	**652,660**	**89.1%**	**3,372 U**	**0.5%U**	**38,364 U**
Operating Surplus/(Deficit)	**116,975**	**14.5%**	**118,270**	**14.7%**	**79,994**	**10.9%**	**1,295 U**	**1.1%F**	**36,981 F**
Depreciation	15,481	1.9%	16,137	2.0%	15,319	2.1%	656 F	4.1%F	162 U
Finance Costs	92	0.0%	82	0.0%	1,417	0.2%	10 U	11.9%U	1,325 F
Total Non Operating Costs	**15,573**	**1.9%**	**16,219**	**2.0%**	**16,736**	**2.3%**	**646 F**	**4.0%F**	**1,163 F**
Net Surplus / (Deficit)	**101,402**	**12.5%**	**102,051**	**12.7%**	**63,258**	**8.6%**	**649 U**	**0.6%U**	**38,144 F**

5.2 Operational Indicators Exception Report

ADHB HAC KPI Report

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

March 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	Mar-10	10	
Acute Process				
A56. % of stroke patients cared for within the stroke unit	Q			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

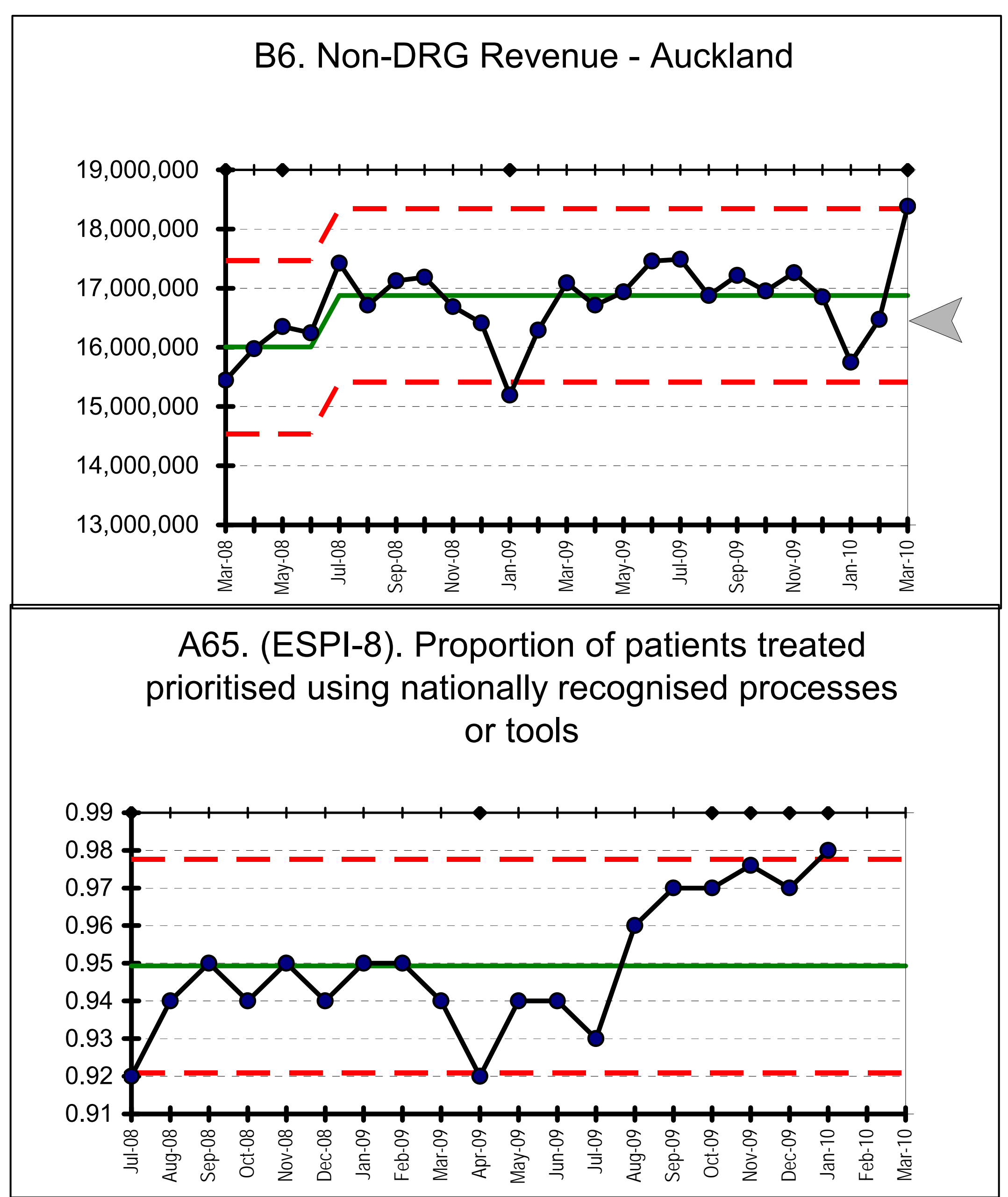
March 2010

B6. Non-DRG Revenue - Auckland

The high figure reflects the high number of working days in March, resulting in higher outputs, together with an overstatement of non DRG revenue by $300k in respect of a double up in DHB funded and ACC revenue. Also the target arrow is based ona 'straight line' allocation of the contract,the March contract is phased higher than the arrow indicates.

A65. (ESPI-8). Proportion of patients treated prioritised using nationally recognised processes or tools

This result reflects the ongoing commitment of services to the use of nationally recognised tools.



6

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	1. Reduce Maori DNA rates. 2. Increase enrolment of Maori in PHOs 3. Rangatiratanga - Maori Health Equity Framework
Pacific	Build healthy communities	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)	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	1. Auckland DHB wide oral health promotion 2. Implement new service model
Older People	Streamline access to older people's services	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	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	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	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	1. Increase efficiency, capacity and options of self-management approaches
	Proactive planned coordinated care	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	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
Improve the effectiveness & efficiency of Healthcare System		
Primary healthcare	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 Primary Secondary system efficiency -decrease total system cost	Improve information availability across system Improve access & efficiency of service delivery	1. e-referrals, health event summaries and electronic outpatient letters 2. Increase access to diagnostic tests in primary care 3. Transfer some services to primary/community
Improve hospital efficiency / throughput	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
Reduce waiting times for elective services	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
Improve Leadership Capability	Clinical leadership model: implement, monitor and evaluate Improve senior leadership team performance	1 Leadership development, mentoring and engagement process 2 Integrated governance reporting implemented 3. Define baldrige roll out plan and complete base line
Improve clinical quality & professional governance	Implement sector wide clinical networks	1. Develop GP network (collaborative) with primary care
	Improve safety and quality of care	1. Implement NQIP Medication Safety, Infection Prevention & Control, Mortality Review, Incident Management 2. Increase the number of GP practices with Cornerstone accreditation
Strengthen the health workforces	Improve clinical staff retention Healthy workplace Develop response to Long Term Services Plan	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
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	1. IDF annual agreements ensure we are paid for what we do. 2. Participate in National pricing process
Improve Productivity	Reduce Administration Cost	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	1. Improve clinical resource utilisation 2. Reduce variation in Clinical Practice
	Health Service Process Improvement	1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.
	Achieve procurement savings	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	1. Revisit replenishment parameters 2. Improve supply chain systems and processes
	Sustainable Cash Management Plan	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	1	0	0	1	0	0	1	0	0	0	0	0	0
2) Performance Improvement	14	14	2	4	3	5	0	0	10	3	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
Totals #	**15**	**15**	**2**	**4**	**3**	**6**	**0**	**0**	**11**	**3**	**1**	**15**	**0**	**0**	**11**	**4**	**0**	**0**	**0**	**0**	**0**
Totals %	**100%**	**100%**	**13%**	**27%**	**20%**	**40%**	**0%**	**0%**	**73%**	**20%**	**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														
			Define	Measure	Analyse	Improve	Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
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

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														
			Define	Measure	Analyse	Improve	Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
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	1	0	4	0	0	4	1	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	1	0	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**	**4**	**3**	**5**	**0**	**0**	**10**	**3**	**1**	**14**	**0**	**0**	**10**	**4**	**0**	**0**	**0**	**0**	**0**
Totals %	**100%**	**100%**	**14%**	**29%**	**21%**	**36%**	**0%**	**0%**	**71%**	**21%**	**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)	Revised daily status report is providing better, more timely information for matching resources to

		workload.
2.3.3 Improve cardiac surgery throughput	Kay Hyman (ADHB)	1/3/10 Good progress made in February to return waiting list to required levels. Outsourcing will continue through March until waiting list at target. Plans developed to avoid similar waiting list increase in future.
2.4.1 Increase elective services to National intervention rates	Ngaire Buchanan (ADHB)	Elective services now non compliant ESPI2 with neurology the key adverse service, action is underway to address ibncluding recruitment and additional clinics.
2.4.2 Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation and medical oncology	Fionnagh Dougan (ADHB)	Waiting time increase to an average of 5.7 wks - further work in scoping phase as the project is required to develop an ongoing plan for sustainability.
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. No change this month.
2.9.1 Improve capacity management	Ngaire Buchanan (ADHB)	Revised capacity management approach for monthly review and reporting being piloted.
2.9.2 Long term services planning	Ngaire Buchanan (ADHB)	Scoping and appraoch well under way. Due for completion of this stage during March

Exceptions

Short Name	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review	DAP project?
Adult 6-hour project	ADHB	Improve				Despite the peaks in patients presenting in Adult ED for the same period last year, we have still seen a significant improvement in target performance (26 consecutive weeks of above average performance). Adult ED has improved progress towards achievement of the shorter stays in Emergency Department target from 69% in Quarter 2 to 74.3% in Quarter 3. March has been another record high for patient attendances with 4,202 patients being treated in AED this month. This represents a 9.2% increase on the same month last year. The ALOS in AED was 5 hours and 13 minutes and this is the fourth consecutive month for the ALOS being under 6 hrs. This continues the downward trend from August 09 when the ALOS was just over 7 hours with 3,900 attendances An increased operational discipline will be required to continue this level of improvement as we enter into winter months with further peak activity. Improvement activities continue to make sound progress including: 1. Improved measurement systems to better identify clinical short stay patients in ED 2. Expediting patient discharges from wards by the introduction of daily 'rapid rounds' - completed in General Medicine wards - now being implemented into Orthopaedics and discussed for General Surgery 3. Increase the number of weekend discharges in General medicine and Orthopaedics 4. Improve the volume and accuracy of estimated discharge dates in wards 5. Bed management CMS system enhancements 6. Improved ED / Inpatient Team methods of communication Many of these initiatives are being led by ADHB senior clinical team leaders / CN's / senior nurses who are lean six sigma green belt practitioners. Sustained improvement noted across both % of patients admitted from ED with ED stay less than six hours and % patients discharged from ED with ED stay less than six hours.	yes
Starship 6 hour project	ADHB	Improve				CED has achieved a significant improvement in percentage of stays less that 6 hours. 80% for Jan-March 2010 with a 4.7% increase in attendances. There has been a drop in performance as we move out of the summer period and an increased operational management discipline has been put in place. It is also planned to put in a High Dependency Unit from June 2010 which will reduce teh number of children needing to be kept in CED where they are too intensive for the ward and PICU is full.	yes
CONCORD Project	ADHB	Measure				Concord now has several projects completed and more underway. There is an increasing level of organisation interest and engagement. Some of the larger projects will not deliver all benefits in this financial year.	yes
eReferrals Ph1	Regional	Analyse				Negotiations between the Chair and CIO have occurred. Although not complete confident a way forward has been agreed.	yes
Auckland Region Cardiac Surgery	Regional	Improve				1/3/10 Progress continues to be made across all 10 workstreams.	yes

Service Development							
GSC	Regional	Analyse	●	●	●	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	●	●	●	March 2010 91% of patients across A-C categories met the MOH wait time target in March. A total of 15 patients waited > than six weeks for treatment with compliance progressively increasing month by month since January 2010. As at the 27th March the average wait time for "C" Radical patients in 0.5 weeks – this is a significant improvement from February and there are currently no A-C priority patients waiting over six weeks. The service is forecasting 100% compliance for the 4th Quarter. Strategies to reduce waiting times include weekly capacity prioritisation meetings and weekly reporting to the MOH and regional stakeholders. Development of the capacity modelling tool and the process improvement project continues. Evening shifts are booked to continue to operate until May 2010 and presentation of the business case for the replacement of the MV5 Linear Accelerator to regional CEO's is planned for early May. Outsourcing to Waikato continues to be an option which is offered but there is no uptake this month due to the reduced waiting times in Auckland. ARO (Private facility at Mercy/Ascot) have agreed to outsourcing of up to 50 patients per annum – the contract is currently being formalised.	yes
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 is being scheduled during April.	yes

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 Define	Measure	Analyse	Do/Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
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

Exceptions

There are no projects that have been marked as an exception

7

PAPERS

7.1 NONE

8

FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

Use document at start of Meeting Pack

9

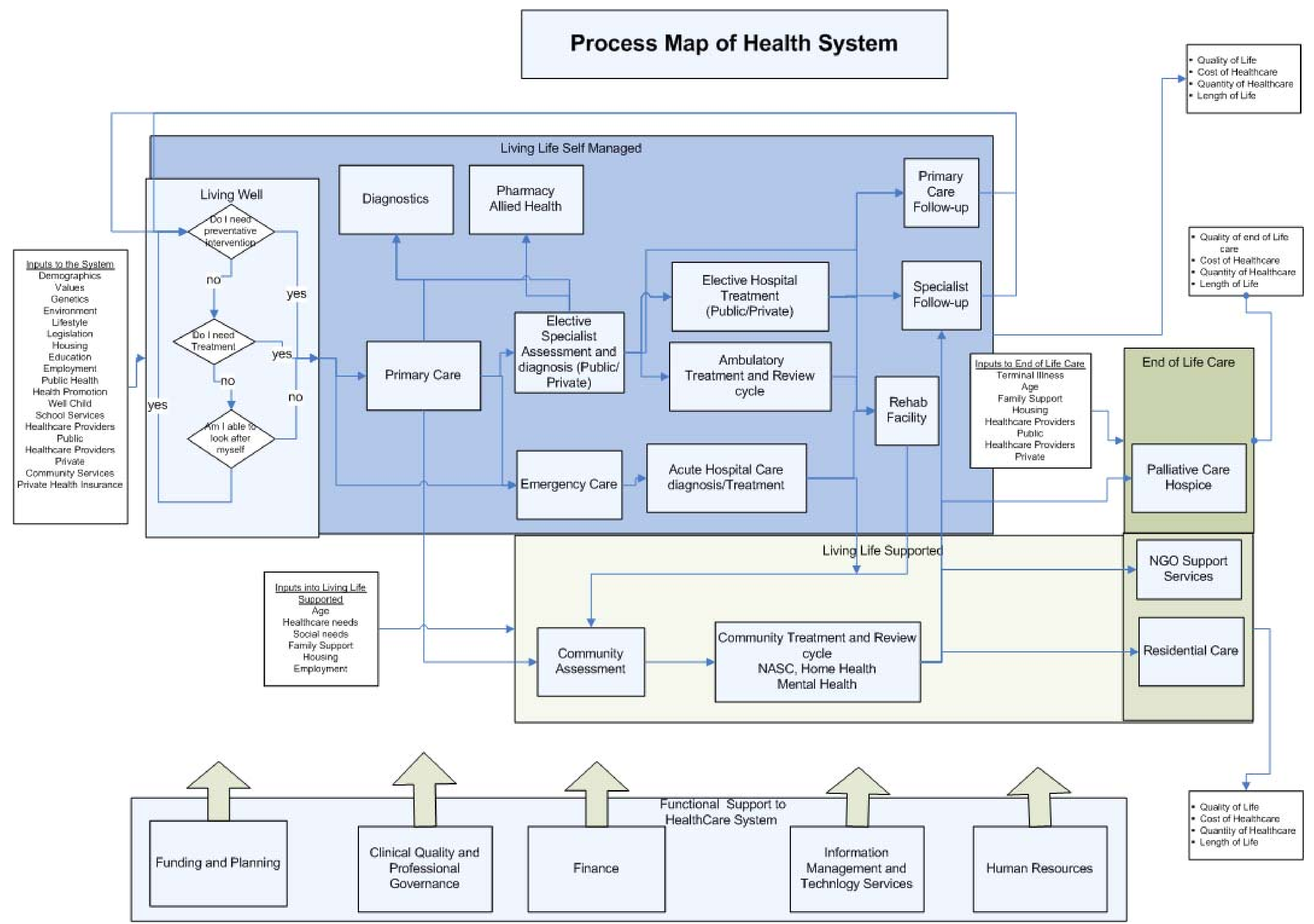
GENERAL BUSINESS

10

APPENDICES

10.1 Healthcare System Diagram

10.1 Healthcare System Diagram



Hospital Advisory Committee
Agenda

MEETING DETAILS	
Time and Date	10:45am – 12:15pm, Wednesday 5 May 2010
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
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 David Sage, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Margaret Dotchin, Fionnagh Dougan, Dr Rick Franklin, 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 3 March 2010**	015
4	**Action Points 3 March 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	045
7	**Papers**	057
8	**Feedback to Board**	059
9	**General Business** • **Ward Visit to Wards 81 and 83**	061

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10	**Appendices** 10.1 Healthcare System Diagram	063

NEXT MEETING	
Time and Date:	Wednesday 2 June 2010
Venue:	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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