Auckland District Health Board

Hospital Advisory Committee Meeting

Wednesday 1 September 2010

10.45am

A+ Trust Room

Clinical Education Centre

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			

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).

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Date: 23/08/2010

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. Watercare 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. Tamaki 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: 23/08/2010

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

Date: 23/08/2010

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. Occupational Therapy Board	Self-employed Professional Conduct Committee member Professional Conduct Committee member	Fees Hourly fee Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
Dr Chris CHAMBERS	1. Employee, Auckland District Health Board 2. Wife employed by Safekids 3. Associate, Epsom Anaesthetic Group 4. Member, ASMS 5. Shareholder, Ormiston Surgical 6. Surveyor Quality Healthcare NZ				7 July 2010

Date: 23/08/2010

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				29 June 2010
	2. Northern (AK) Regional Ethics Committee	Chair	Fee		
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			

Date: 23/08/2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Bob TIZARD	1. Nil				27 February 2008
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procare 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 6. Bader Drive Healthcare	Self employed contractor Member Contractor Contractor Programme Facilitator	Contract hourly rate Fee Contracted monthly fee Hourly rate Fee Fee	General practitioner services Consultant Pacific Advisor Educational Support and Training Forensic sexual assault examinations Clinical Training Support	16 August 2010
Ian WARD	1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C -4 Consulting Limited		Fee	Tender to National Shared Services	3 February 2010

Date: 23/08/2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rev Alfred NGARO	1. **4pm Group Ltd** 2. Pacific Advisory Committee, PHAC CPHAC member 3. National Task Force for Family Violence MSD 4. Family and Community Services national advisory group 5. Auckland Safer Communities 6. Tamaki Achievement Pathways Schooling improvement 7. Tamaki College Board of Trustees 8. Tamaki 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: 23/08/2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	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	Employee Employee	Salary Salary		4 August 2008
Iain MARTIN	1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

Date: 23/08/2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	1. Private Paediatric Surgical Practice 2. Employee Communio NZ 3. Siggins Miller, Australia 4. Head, Auckland Clinical School, School of Medicine, University of Auckland 5. Husband: Employee University of Auckland 6. Risk and Audit Committee Whanganui District Health Board 7. Pharmac Board 8. South Island Neurosurgical Services Expert Panel	Director Senior Consultant Senior Consultant Employee Member Member Chair	Joint Owner Contractor Contractor Salary Fee Fee Fee		4 August 2010

3

CONFIRMATION OF MINUTES

- WEDNESDAY 4 AUGUST 2010

Hospital Advisory Committee
Minutes

MEETING DETAILS	
Time and Date	10:45am, Wednesday, 4 August 2010
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

1	**ATTENDANCE AND APOLOGIES**
	The Chair declared the meeting open at 11.02am. **Committee Members** Dr Chris Chambers (Chair) Susan Buckland Dr Brian Fergus Pat Snedden Seiuli Dr Juliet Walker Professor Iain Martin 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 Dr Richard Aickin – Director Child Health Greg Balla – Director Performance & Innovation Ngaire Buchanan – General Manager Operations Margaret Dotchin - Nurse Director Fionnagh Dougan - GM Mental Health, Ambulatory, Cancer & Blood Services Aroha Haggie – Maori Health Gains Manager Kay Hyman – General Manager Women's and Children's Services' Chris Morgan – Materials Management Manager Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator **Apologies** An apology had been received from Anne Kolbe. Moved Chris Chambers; seconded Jo Agnew *That the apology be sustained.* Carried
2	**CONFLICTS OF INTEREST**
	There were no declarations of conflicts of interest for any item on the agenda.

3	**CONFIRMATION OF MINUTES 7 JULY 2010**
	Moved Susan Buckland; seconded Bob Tizard *That the minutes of the Hospital Advisory Committee meeting held on 7 July 2010 be confirmed as a true and correct record.* Carried Eight services had been identified to go through the Health Excellence Programme and they would be reporting progressively back to the Committee. Progress on the regional Long Term Service Planning had been reported to the SLT, but not to the Committee yet.
4	**ACTION POINTS 7 JULY 2010**
	The action points were noted.
5.1	**Operational Summary Report and Financials**
	The Provider was $6.3m unfavourable for the month and $9.8m unfavourable for the year. The key variances were noted. The Berlin Heart is a mechanical heart covered by the high costs treatment pool for which approval had been obtained within the 48 hours. The negative variance in 3rd party treatment costs concerned outsourcing of cardiac bypass patients predominantly dependant on volumes. More analysis was being undertaken on acute throughput and a presentation on this will be made to the next meeting. Treatment costs budgets had been prepared without outsourcing which created the variance. An analysis of electives and acutes is being undertaken so that the best place to put in effort was visible and this was used to manage back to contract. There would be a presentation on the new reporting to major DHB customers, electives and acutes, with this being presented to the region so that there is increasing reporting and visibility to those customers. The report had taken two years to develop and would be a tool to manage work and relationships with major customers. This would be produced monthly but in the meantime last year's information was being shown so that the DHBs could get used to the tool. It would include waiting list times. Acute production for Waitemata was 107% to contract as they had reduced purchasing but did not have interventions to achieve the new contract volumes. Ways of delivery were being considered but there was a need to try and maintain equity of access by informing the DHBs of the volumes required to get equity. It was a question of prioritisation of the purchasing which had been based on an historical model, taking into account changes of population and growth. Counties Manukau was operating on a different funding model with money for unmet need. The transfer of revenue from General Medicine to Neurology for the stroke unit patients was noted, as were the two long stay in Child Health with one being admitted on a very low WEIS diagnosis but developing complications.
7.1	**Cardiac Excellence Programme**
	Peter Ruygrok, Clinical Director Cardiology, Anna MacGregor Nurse Unit Manager Cardiology, Daniel Hunt, Process Improvement and Elizabeth Shaw, Nurse Advisor Cardiology were in attendance and presented to the Committee. The target was to have all procedures in-house from July with no outsourcing, and capacity to do 920 bypass procedures in 2010/2011. There were ten work streams of which Patient Pathway Management was on hold and Future Resource Capacity Evaluation had been transferred into production planning. Progress against the goal had trended up with 18.2 procedures per week and the waiting list down. While July met the goal there was a need for more buffer in the system. The skill mix of nurses had improved with more experienced nurses. This enabled the reduction of the waiting list significantly. Rosters were being used across the week based on historic data and there had only been one cancellation due to unavailable staffing. A fast track room had been developed for straight forward patients. There was a work stream to develop better reporting, waiting times now averaged 4 weeks and E priority were seen within one week. Half of patients

	presented acutely and there are wide variances in referral patterns. A buffer would allow to progress from micro management. Clinical confidence was growing now that there was not a long waiting list and Maori and Pacific had the same access once they were in the service. A strategic partnership with Mercy was being developed to provide insurance although this had a cost. Learning's were that good leadership makes a great difference. Iain Martin acknowledged the achievement and raised the question of what training the University could provide working with the service to get sustainability in staffing resources such as training perfusionists in-house. The service fed into the national clinical network. The Committee thanked and congratulated the team.
6.1	**DAP Projects Report**
	The Primary/Secondary Integration project had had short term funding from Procare to get earlier intervention which was being evaluated. There had been improvement in relationships. The adult six hour project had maintained its improvement despite increased numbers presenting. AED admitting to wards was not being pursued at present. There would be a visit from the MoH on 20 August and the Greenlane Surgical Unit was progressing. There was pressure in the hospital at the moment with 8 red alerts in July with pressure in the weekends and after hours especially in AED from alcohol/drug affected younger people. Pressure had also increased in CED in the last few weeks. Ongoing industrial action was impacting on staff, 9 people were involved in strike planning and the action was very draining. Proposals had been put to Lab and MRT but there was no commitment as to when they would come back on the proposals. Suspension notices in the lab would be issued in the week. The Committee noted the extraordinary efforts of non-union staff and managers noting that it was not sustainable. The questions of life preserving situations were clearer when there was a full strike but with the ongoing action it was not so clear and difficult. The final outcomes of the action would not be seen for months and was not good medical practice.
	NEXT MEETING
	The meeting closed at 12:15pm The next meeting is scheduled for 10:45am, Wednesday, 1 September 2010 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton

CONFIRMED

CHAIR: **DATE:**

4

ACTION POINTS

WEDNESDAY 4 AUGUST 2010

Hospital Advisory Committee
Action Points from the meeting on Wednesday 4 August 2010

Item	Detail	Designated	Action
5.1	Presentation on Throughput Statistics to next meeting	Ngaire Buchanan	
5.1	Presentation on new reporting to major DHB customers electives and acutes	Johan Vendrig	

5

OPERATIONAL PERFORMANCE

5.1 OPERATIONAL SUMMARY REPORT

5.2 OPERATIONAL INDICATORS - EXCEPTION REPORT

5.1 Summary Report

Overall Performance for the Month

Summary of Provider Results

$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	(62,137)	(63,126)	989F	(62,137)	(63,126)	989F
Complementary	(291)	73	363U	(291)	73	363U
Functional	63,431	66,027	2,595U	63,431	66,027	2,595U
Ancilliary	63,141	66,099	2,959U	63,141	66,099	2,959U
Provider Net Surplus/(Deficit)	1,004	2,974	1,969U	1,004	2,974	1,969U

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 Public Health, A+ Trust, Research and Retail businesses.

Operational areas such as Adult Health, Cancer & Blood and Cardiac which are a subset of the total Provider are considered under the section headed 'Operational' below.

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 changes in the value of interest rate swap instruments and allowances for volume coding lag which are included in the 'Provider' section of the Finance Committee report as a result of including the support areas.the support areas.

With effect from 1 July 2010, MOH base contract income (Price Volume Schedule income) for both the ADHB population and IDF Funders is now held under Functional, and is not reported within the Operational group of services.

5.1.1 OPERATIONAL DIVISION OPERATING STATEMENT

Provider	Month			Year to Date		
Operating Statement - Jul 2010	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Total Income						
Internal Allocations - Ex Funder	83,607	87,685	(4,078)	83,607	87,685	(4,078)
MOH - Funding Subcontracts	3,551	3,228	323	3,551	3,228	323
Other Patient Care Revenue	2,906	2,712	194	2,906	2,712	194
Sales of Services & Products	4,626	4,450	176	4,626	4,450	176
Clinical Training & Education Income	1,673	1,674	(1)	1,673	1,674	(1)
Trust & Donation Income	1,089	423	666	1,089	423	666
Financial Income	536	316	220	536	316	220
Other Income	404	550	(146)	404	550	(146)
Profit on Disposal of Fixed Assets	16	0	16	16	0	16
Total Income	**98,407**	**101,038**	**(2,631)**	**98,407**	**101,038**	**(2,631)**
Operating Expenditure						
Employee Costs	59,661	61,280	1,620	59,661	61,280	1,620
Direct Treatment Costs	19,115	17,929	(1,187)	19,115	17,929	(1,187)
Indirect Treatment Costs	3,502	3,254	(248)	3,502	3,254	(248)
Property, Equipment & Transportation Costs	4,034	4,071	37	4,034	4,071	37
Administration Costs	1,856	1,616	(240)	1,856	1,616	(240)
Maintenance Programme	133	133	0	133	133	0
Indirect Service Billing	482	482	(0)	482	482	(0)
Loss on Sale of Fixed Assets	9	1	(8)	9	1	(8)
Total Operating Expenditure	**88,793**	**88,767**	**(26)**	**88,793**	**88,767**	**(26)**
Operating Surplus / (Deficit)	**9,615**	**12,271**	**(2,656)**	**9,615**	**12,271**	**(2,656)**
Non-Operating Expenditure						
Capital Charge	2,716	3,036	320	2,716	3,036	320
Depreciation	4,251	4,527	276	4,251	4,527	276
Finance Costs	1,644	1,734	91	1,644	1,734	91
Total :Non-Operating Expenditure	**8,610**	**9,297**	**687**	**8,610**	**9,297**	**687**
Total Surplus / (Deficit)	**1,004**	**2,974**	**(1,970)**	**1,004**	**2,974**	**(1,970)**

Key variances (> $250,000) for July 2010 for the provider were:-

1	Internal Allocations	$(4.078)m U
2	Patient Care Revenue	$0.517m F
3	Trust & Donation Income	$0.666m F
4	Employee Costs	$1.620m F
5	Direct Treatment Costs	$(1.187)m U
6	In-Direct Treatment Costs	$(0.248)m U

1 Internal Allocations

WIES Funded Services – 500 wies under contract ≈ $(2.2)m U

Non WIES funded services ≈ $(0.6)m U

2 Patient Care Revenue

The principal variances were as follows:-

Portfolio	Variance	Comments
Adult Health	$(0.251)m U	**MOH Funding Sub-Contracts** There is an unfavourable variance of $295k across the Operational services due to actual revenue for funding sub-contracts being held within Functional, whereas the budget is held within Operational. This will be corrected for future reporting periods. ACC $248k U primarily due to the continuation of low ACC OPH/Rehab bed days as well as elective Orthopaedic surgery. Non-Resident income $141k F mainly in Gen Surg & Respiratory Medicine.
Wom, Child, Cardiac, Operating Rooms	$0.312m F	Favourable non-resident and ACC income.
Mental Health, Ambulatory, Ophthalmology, Cancer & Blood	$0.296m F	Favourable adjustment in respect of 2009-10 PCT wash up.

As noted above, with effect from 1 July 2010, MOH base contract income (Price Volume Schedule income) for both ADHB and IDF Funders is now held centrally, under Functional, and is not reported within the Operational group of services.

3 Trust & Donation Income

Trust and Donation Income was $0.666m F for July 2010; this was due to a further receipt of income for the Starship MRI.

4 Employee Costs

Provider arm employee costs were $1.6m F to budget, a combination of FTEs and average cost per FTE under budget.

FTE Table 1 – FTEs for Month

FTEs	Budget FTE Month 2010-11	Actual FTE Month 2010-11	Variance
Adult Health	1,738	1,741	**-3**
Wom, Child, Card, OR&A	2,496	2,447	**49**
Operations	1,430	1,405	**25**
MH, Amb, Ophth, Cancer & Blood	1,295	1,252	**43**
Other Operational	1	1	**0**
Ancillary	966	942	**24**
TOTAL	**7,925**	**7,788**	**137**

FTE Table 2 – Cost per FTE

Provider Services - Staffing Variance			
Month 2010/11	**Budget**	**Actual**	**Variance %**
Employee Costs ($M)	61.3	59.7	2.64%
FTE Numbers	7,925	7,788	1.73%
Cost per FTE (Month)	7,732	7,661	0.93%
YTD 2010/11	**Budget**	**Actual**	**Variance %**
Employee Costs ($M)	61.3	59.7	2.64%
FTE Numbers	7,925	7,788	1.73%
Cost per FTE (Year to Date)	7,732	7,661	0.93%

5 Direct Treatment Costs

The principal variances in direct treatment costs were in drugs and clinical supplies:-

	Variance	**Variance**
Cost	**Month $M**	**YTD $M**
Drugs	(0.6)	(0.6)
Clinical Supplies	(0.4)	(0.4)
Chemicals & Media	(0.1)	(0.1)
3rd Party Treatment Costs	(0.1)	(0.1)
Patient Appliances	(0.1)	(0.1)
Contracted Services - Clinical	(0.1)	(0.1)
	(1.3)	**(1.3)**

Variances for drug costs were as follows:-

Portfolio	**Variance**	**Comments**
Wom, Child, Cardiac, Operating Rooms	$(0.390)m U	Blood products were approximately half of this variance $(190)k U and analysis is being undertaken on this variance. Aside from this major variance other variances were in respect of Child Health (malignant diseases and nutrition) and operating rooms (cardiovascular drugs)
Mental Health, Ambulatory, Ophthalmology, Cancer & Blood	$(0.109)m U	The largest single variance is $(70)k U in immunology driven by acute inpatient volumes.

The main variance for clinical supplies was in Women's, Children's, Cardiac and OR - unfavourable by $(315)k U, of which $(213)k was in operating rooms and anaesthesia.

6 In-Direct Treatment Costs

Indirect treatment costs were unfavourable by $248,000 for the month. Of this $258,000 was in CWORAC. This was due to a combination of bad debts written off and an increase in the provision for doubtful debts.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	Jul-10	Att per Day	Comparison to Last Month	Jun-10	Att per Day	Comparison to Last Year	Jul-09	Att per Day
APU	1,741	56	9.9%	1,584	53	10.0%	1,583	51
AED	4,598	148	8.2%	4,249	142	19.4%	3,852	124
CED	2,892	93	7.5%	2,691	90	-9.2%	3,184	103

Data by ethnicity:-

	Jul-10			Last Month			Last Year		
	Maori	Pacific	Other	Maori	Pacific	Other	Maori	Pacific	Other
AED	8.6%	12.9%	78.5%	9.0%	13.4%	77.6%	9.5%	14.8%	75.7%
APU	7.8%	10.7%	81.6%	7.8%	11.8%	80.4%	8.8%	11.3%	79.9%
CED	10.9%	18.6%	70.5%	11.3%	19.4%	69.2%	12.6%	25.8%	61.7%

AED - Record month, record daily rate, record percentage increase from same month last year (19.4% higher than July 2009). Nevertheless stable average and median LOS which remains significantly lower than previous years. Record high month for admissions.

APU - Record month and daily rate. A step up in the average LOS, but stable median LOS – this indicates a few longstayers, not unexpected for a month with capacity problems.

CED - An increase in volumes, but relatively stable LOS measures.

Throughput – by Admission Type

Electives

DHB	Contract	Actual	Variance	% of completion
ADHB	1,322	961	**-361**	73%
CMDHB	471	415	**-56**	88%
WDHB	600	540	**-60**	90%
Other	553	458	**-95**	83%
	2,946	2,374	**-572**	**81%**

Acutes

DHB	Contract	Actual	Variance	% of completion
ADHB	4,424	4,761	**337**	108%
CMDHB	1,075	1,015	**-60**	94%
WDHB	1,562	1,613	**51**	103%
Other	1,028	797	**-231**	78%
	8,089	**8,186**	**97**	**101%**

Acute & Elective Combined

DHB	Contract	Actual	Variance	% of completion
ADHB	5,746	5,722	**-24**	99.6%
CMDHB	1,546	1,430	**-116**	92.5%
WDHB	2,162	2,153	**-9**	99.6%
Other	1,581	1,255	**-326**	79.4%
	11,035	**10,560**	**-475**	**95.7%**

The wies position can change markedly for July volumes as coding resource concentrates on completion of the ‘old’ financial year. An update of this position will be provided at the HAC meeting.

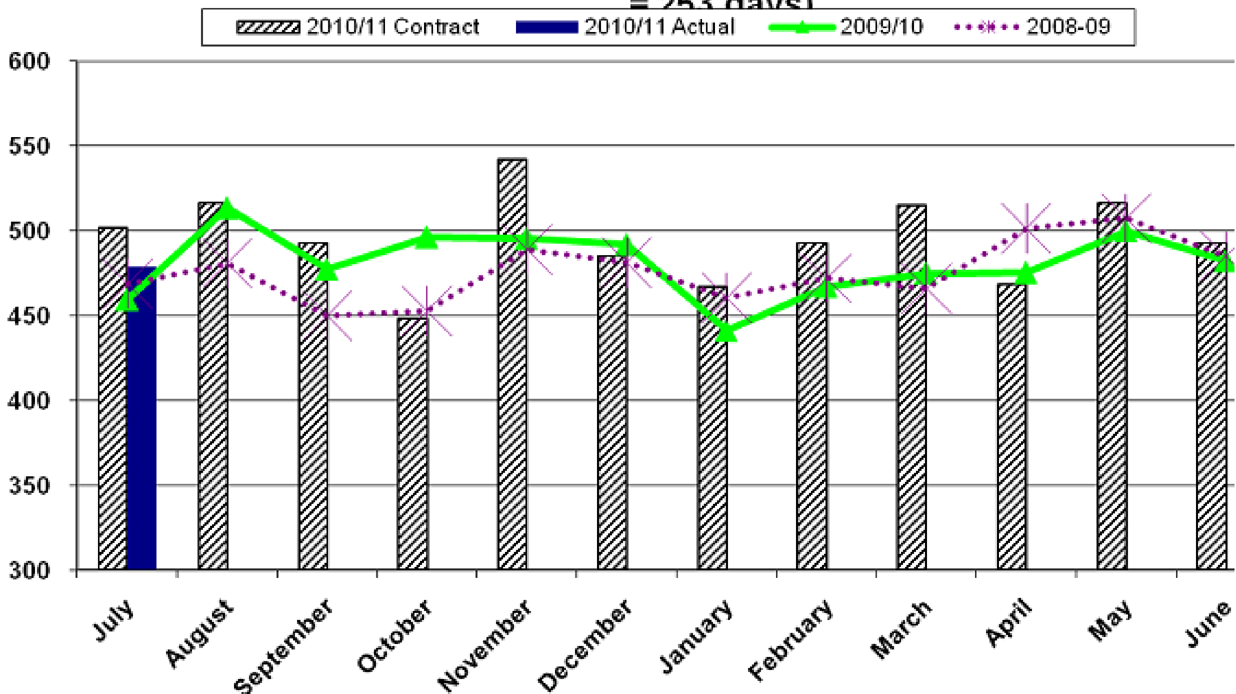
Throughput – Contract Volumes

The chart below shows the production recorded to July 2010.

At the time the results were finalised, the coding was 52.1% complete with the average WIES per discharge being 1.2% lower than last year for the same period. Discharges are up by 0.5% from last year.

Inpatient delivery to the most current Price Volume Schedule (Jul 2010) was 95.5% for the month.

WIES Production & Delivery per working day						
`	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	10,540	11,036	496U	10,540	11,036	496U
WIES Delivery per day	479	502	23U	479	502	23U

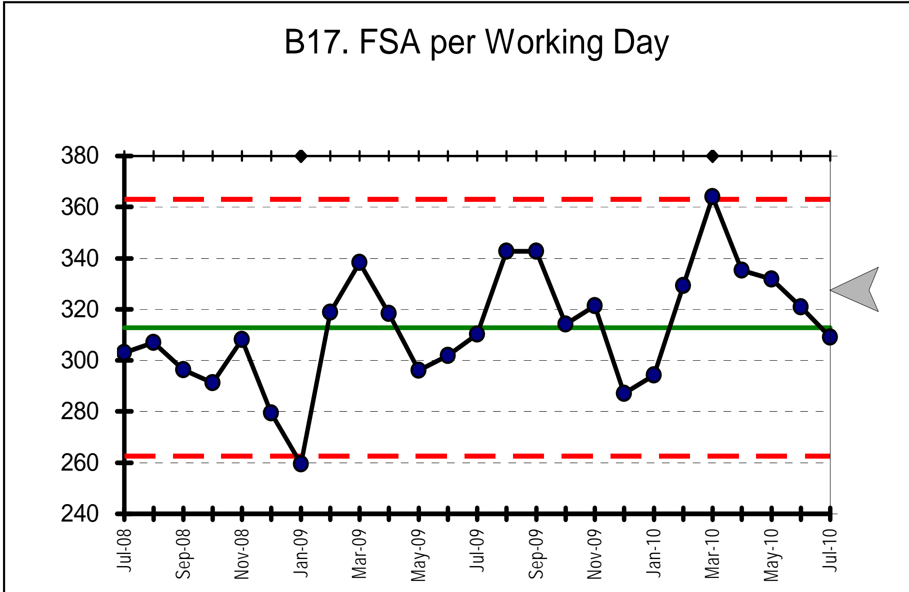


Outpatient Delivery

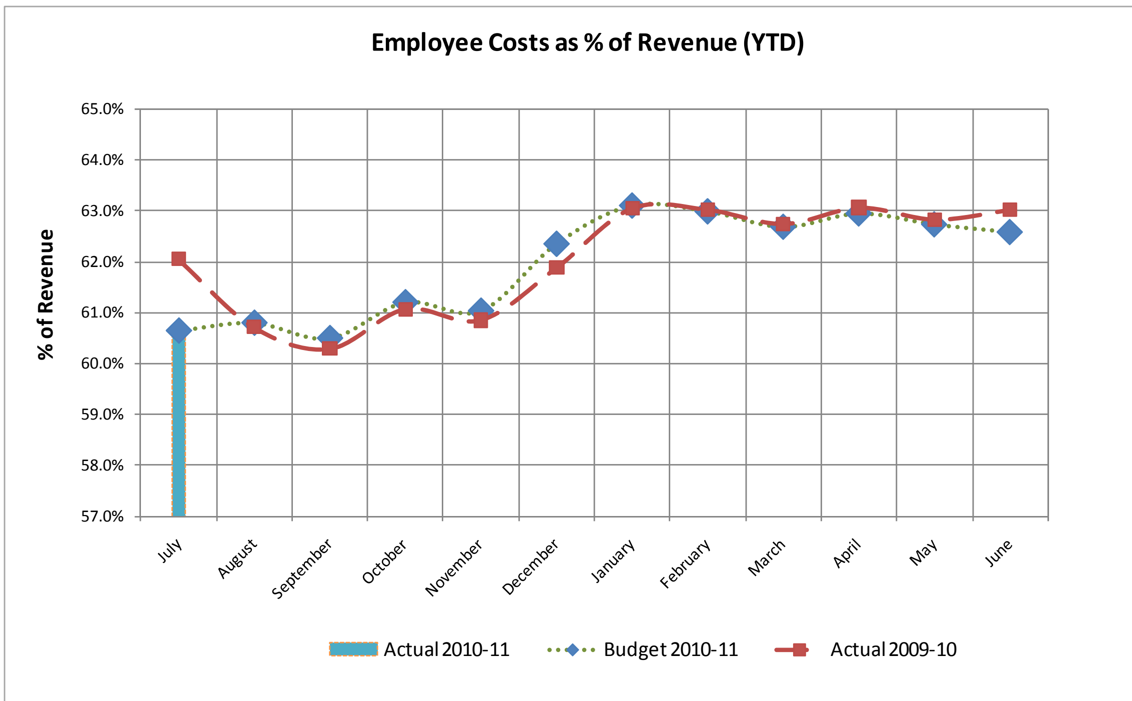
Overleaf is a graph of outpatient activity in the same manner as for inpatient activity - output per working day. As well as being a useful indicator of productivity, outpatient activity is, in part, the 'feeder' activity for much of our elective 'production line'.

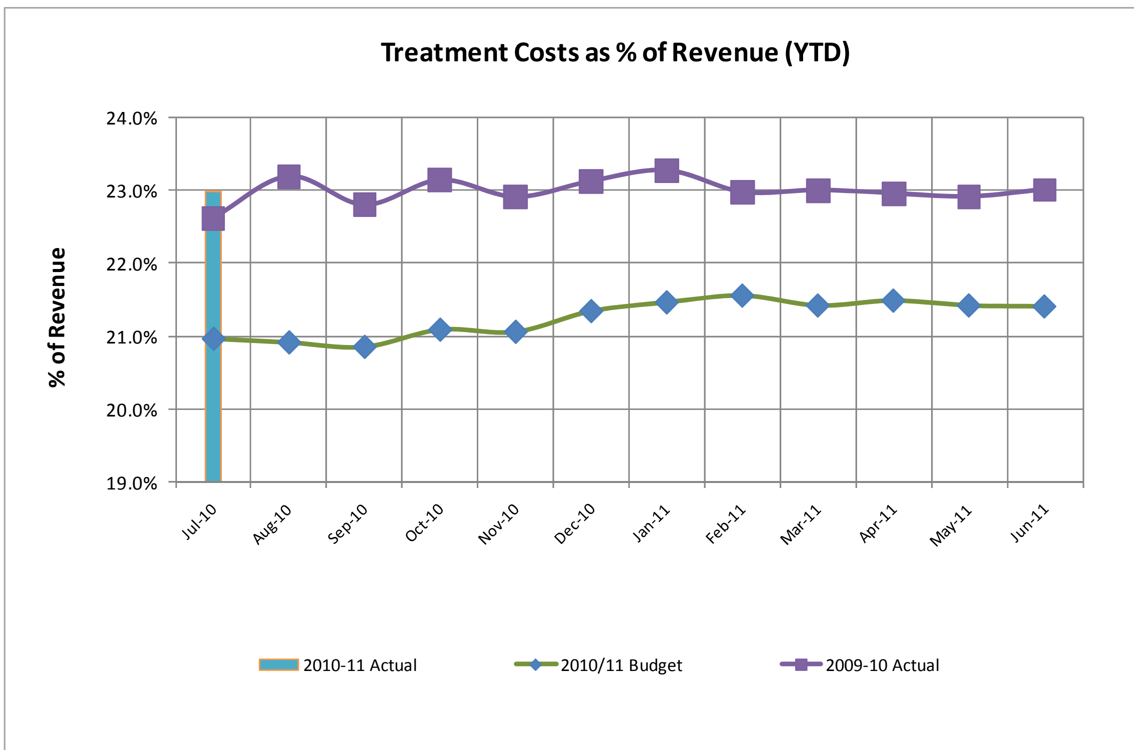
FSAs were 8% below contract for the month.

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



Cost Relationship Charts





Treatment Costs as % of Revenue (YTD)
% of Revenue
24.0%
23.0%
22.0%
21.0%
20.0%
19.0%
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
2010-11 Actual
2010/11 Budget
2009-10 Actual

Variances from budget for July YTD by portfolio are:-
In $,000's

Health Service Portfolio	Net Cost of Service ($ '000) Act	Bud	Var	Comments
Adult Health	(17,143)	(17,569)	426F	The variance is primarily driven by favourable employee costs, reflecting a number of SMO vacancies, and low Staff Related Expenses due to CNME write-offs following new year entitlements effective in July.
Women, Child, Cardiac, ORA	(26,114)	(26,108)	6U	Income is driven by $459k F var in Non resident revenue (Adult and Paed Cardiac services). Direct treatment costs $1.023m U reflecting patient activity - mainly in Drugs (blood products), implants eg 2 Melody valves for Paed Cardiac $60k in month with budget for 4 spread over full year, and clinical supplies. OR productivity was the 2nd highest for the past year with high voumes of transplants of all types (15 compared to average of 10 per month). This has driven high blood and general clinical supply costs - $323k for DTC for OR&A overall. Bad debt write offs $256k U. Donation income $696k F.
Operations	(13,638)	(13,479)	159U	The variance is primarily driven by unfavourable Direct Treatment Costs, most significantly outsourcing of MRIs $195k U. The new Starship MRI was not fully operational in July, with low volumes, tegrefor higher volumes were outsourced.
Ambulatory	(2,600)	(2,366)	235U	The unfavourable variance is primarily driven by employee costs $84K unfavourable, treatment costs $119K unfavourable (mainly due to Immunology blood products $69K unfavourable which is demand driven by Acute Inpatient volumes) and mis-coded depreciation $25K unfavourable.
Cancer & Blood	(4,158)	(4,668)	510F	Net cost $510K favourable to budget is due to 1) adjustment of PCT provision; 2) vacancies in medical, nursing and technical staff; 3) other costs on budget.
ACH Others	(13)	(13)	0U	On budget - nil variance.
Mental Health	(6,957)	(7,452)	495F	The favourable variance is mainly due to staff vacancies $364k favourable and lower staff related expenses primarily caused by timing of expenses $80k favourable.
Total Operational	**(70,623)**	**(71,654)**	**1,031F**	

Health Service Portfolio	Net Cost of Service ($ '000) Act	Bud	Var	Comments
Complementary	**(426)**	**(29)**	**397U**	The unfavourable variance is driven by a one off payment from the Alexandra Trust to Ronald McDonald House Trust Auckland for the provision of a facility for convalescing women and children $0.5m.
Functional	(11,548)	(12,888)	1,340F	The favourable variance is driven by lower staff related costs $0.1m, computer maintenance $0.1m, consulting fees $0.2m, depreciation driven by timing of capital projects $0.1m, and a lower capital charge driven by the downward revaluation of land and buildings as at 30 June 10 $0.3m
Provider Arm Provisions	(944)	(875)	69U	This responsibility centre holds budgets for overall Provider Arm provisions.
Net Cost of Service (Before Internal Transfers)	**(83,542)**	**(85,447)**	**1,905F**	
Internal Revenue from Funder	83,607	87,480	3,873U	This responsibility centre holds budgets for overall Provider Arm revenue.
Intra Provider Arm Revenue and Cost Transfers	939	940	1U	This responsibility centre holds budgets for service billing of revenue and costs within the Provider Arm.
Provider Arm Surplus/(Deficit)	**1,004**	**2,974**	**1,970U**	

Provider

Jul 2010

	YTD								
	Act 1011	% of Rev	Bud 1011	% of Rev	Act 0910	% of Rev	Var Budget	% Var to Bud	Var LY
Revenue									
MOH Base Funding	83,607		87,685		85,485		4,078 U	4.7%U	1,878 U
MoH Sub-contracts	3,551		3,228		2,376		323 F	10.0%F	1,175 F
Other Patient Care	2,906		2,712		2,176		194 F	7.1%F	730 F
	90,063		**93,625**		**90,037**		**3,561 U**	**3.8%U**	**26 F**
Services & Products	4,626		4,450		4,344		176 F	4.0%F	282 F
CTA	1,673		1,674		1,678		1 U	0.0%U	5 U
Trust & Donation Income	1,089		423		331		666 F	157.2%F	758 F
Other Income	956		866		1,660		90 F	10.4%F	704 U
	98,407		**101,038**		**98,050**		**2,631 U**	**2.6%U**	**358 F**
Expenditure									
Employee Costs									
Medical	18,876	19.2%	19,558	19.4%	19,504	19.9%	682 F	3.5%F	628 F
Nursing	19,596	19.9%	19,897	19.7%	19,753	20.1%	301 F	1.5%F	157 F
Technical	10,145	10.3%	10,333	10.2%	10,077	10.3%	188 F	1.8%F	68 U
Hotel Services	820	0.8%	799	0.8%	844	0.9%	21 U	2.6%U	23 F
Administration	7,322	7.4%	7,347	7.3%	7,695	7.8%	25 F	0.3%F	374 F
Other	2,902	2.9%	3,346	3.3%	2,972	3.0%	444 F	13.3%F	70 F
Total Employee Costs	59,661	60.6%	61,280	60.7%	60,845	62.1%	1,620 F	2.6%F	1,184 F
Direct Treatment Costs	19,115	19.4%	17,929	17.7%	19,347	19.7%	1,187 U	6.6%U	232 F
Indirect Treatment Costs	3,502	3.6%	3,254	3.2%	2,828	2.9%	248 U	7.6%U	674 U
Prop, Equip. & Transpt	4,034	4.1%	4,071	4.0%	4,222	4.3%	37 F	0.9%F	188 F
Administration Costs	1,856	1.9%	1,616	1.6%	1,114	1.1%	240 U	14.8%U	742 U
Maintenance Programme	133	0.1%	133	0.1%	1	0.0%	0 F	0.2%F	132 U
Indirect Service Billing	482	0.5%	482	0.5%	(11)	0.0%	0 U	0.0%U	494 U
Loss on Sale of Fixed Assets	9	0.0%	1	0.0%	-	0.0%	8 U	583.2%U	9 U
Total Operating Expenditure	**88,793**	**90.2%**	**88,767**	**87.9%**	**88,345**	**90.1%**	**26 U**	**0.0%U**	**447 U**
Operating Surplus/(Deficit)	**9,615**	**9.8%**	**12,271**	**12.1%**	**9,704**	**9.9%**	**2,656 U**	**21.6%F**	**90 U**
Capital Charge	2,716	2.8%	3,036	3.0%	3,031	3.1%	320 F	10.6%F	315 F
Depreciation	4,251	4.3%	4,527	4.5%	3,934	4.0%	276 F	6.1%F	317 U
Finance Costs	1,644	1.7%	1,734	1.7%	1,675	1.7%	91 F	5.2%F	31 F
Total Non Operating Costs	**8,610**	**8.7%**	**9,297**	**9.2%**	**8,640**	**8.8%**	**687 F**	**7.4%F**	**29 F**
Net Surplus / (Deficit)	**1,004**	**1.0%**	**2,974**	**2.9%**	**1,064**	**1.1%**	**1,970 U**	**66.2%U**	**60 U**

5.2 Operations Indicators Exception Report

ADHB HAC KPI Report

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

July 2010

Indicator	Frequency	Review date	KPI report page ref	
Volume				
B3. Acute WIES Volume - Auckland	M	Jul-10	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	Jul-10	10	
Acute Process				
A56. % of stroke patients cared for within the stroke unit	Q	Jul-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
July 2010

B3. Acute WIES Volume - Auckland

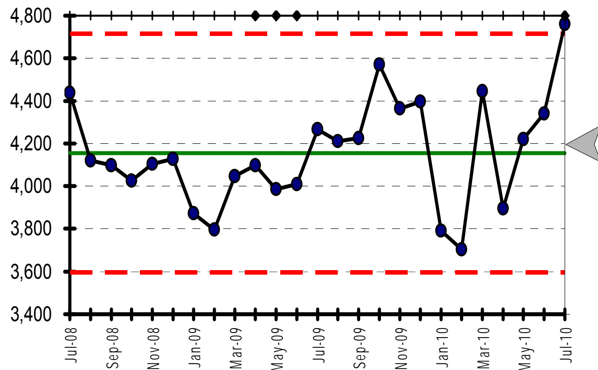
A 6% increase over June levels overall, consistent with ED activity levels. There were large increases in wies levels over June levels in General Medicine, Obstetrics and Respiratory Services, with a number of other smaller services having large % increases but smaller absolute increases in wies. There were reductions in acute wies for cardiothoracic and newborn services though in both cases these numbers fell back from very high June levels.

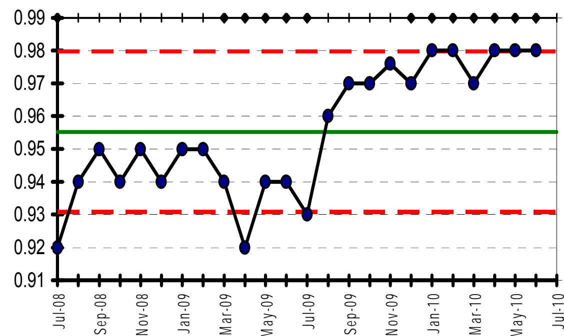
A65. (ESPI-8). Proportion of patients prioritised using nationally recognised processes or tools

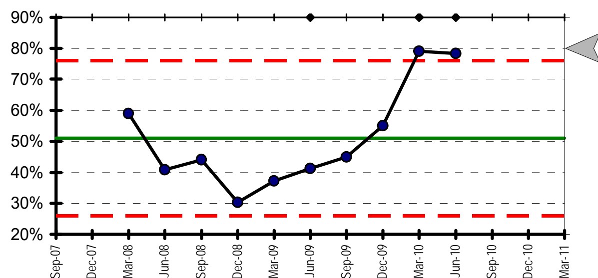
The figures reflect the growth through time of the use of national tools. This is an indicator which should be as high as possible.

A56. Percentage of stroke patients cared for within the stroke unit

This improvement is a result of the opening of the additional adult beds in November 2009 enabling the establishment of an inpatient acute stroke unit on Ward 63.







6

IMPROVEMENT ACTIVITIES

6.1 DAP Projects Report

Auckland District Health Board

District Annual Plan *2010 - 2011*

22 June 2010

Priority and Developmental Work for 2010-11

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

High level strategy	Objective	Strategies to achieve objectives
1.1 Reduce inequities in health status	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: – develop Integrated Family Health Centres/Whanau Ora Centres – develop specific activities that achieve Whanau Ora – develop indicator measures for Whanau Ora – develop a Whanau Ora approach for all services devolved 1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015 1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases 1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases 1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan 1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates 1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules 1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool 1.1.4.2 Audit report completed on accessibility: specifically physical access, culture,

High level strategy	Objective	Strategies to achieve objectives
	to health care and support services	employment and advocacy 1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system
1.2 Improve outcomes in priority areas		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: – improving access by taking services to pre-schools – enhancing oral health education – increasing early enrolment with a focus on Maori and Pacific populations
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+) 1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system

High level strategy	Objective	Strategies to achieve objectives
		1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures 1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed 1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes) 1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed 1.2d 3.2 At least 2 cardiac rehabilitation courses are run in the community 1.2d 3.3 At least 10% of retinal screening to be undertaken in the community
	1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base 1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce 1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome 1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011 1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme

More detail on some of these performance measures is included on page 36

Goal 2: Performance improvement: sooner, better, more convenient

High level strategy	Objective	Strategies to achieve objectives
2.1 Efficient and effective health care system		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters 2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients 2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year 2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services 2.1b.1.5 Improve access to primary care for palliative care clients by 15% 2.1b.1.6 Implement a clinically led "proof of concept" process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of $1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes) 2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10% 2.1c.1.3 Improve performance against the Emergency Department six-hour measure

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		from 76% to 95% by implementing project solutions in the adult and children's acute flow projects 2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)* 2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24 2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery 2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011 2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in: – General medicine – Orthopaedics – Radiology – Paediatrics general surgery – General surgery – Ophthalmology
	2.1c.2 Improve mainstream effectiveness	2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11) 2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.5 Reduce waiting times for oncology	2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway – Implement new model of care and workforce roles in the Greenlane Surgical Centre – Maintain past elective surgery improvement by including primary care in the referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against "In Good Hands" implementation
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care
2.3 Improve Clinical Quality and Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s

High level strategy	Objective	Strategies to achieve objectives
		2.3.2.5 Implement Senior Leadership Team 'Walk-around' safety programme i.e. growth and training in clinical leadership 2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.7 Evaluation against Health Excellence Framework 2.3.2.8 Continue roll out of Cornerstone accreditation across primary care 2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces 2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme 2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015) 2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme 2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time 2.5.1.2 KPI reporting for end-to-end application performance in place 2.5.1.3 IMTS user satisfaction increases by >10% against previous year 2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month 2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance 2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
2.6 Planning	2.6.1 Long term planning and	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines

High level strategy	Objective	Strategies to achieve objectives
2.6 Planning (cont)	change management	2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030: – description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases 2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to

* Refer to appendix 8

Goal 3: Live within our means

High level strategy	Objective	Strategies to achieve objectives
3.1 Break-even position maintained		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and mange any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
3.2 Sustainable balance sheet		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans

Group Pack Report

Group/Committee: Hospital Advisory Committee

Goal Level Summary

DAP Projects - total projects: 22

Goal	Number	Started	Current Phase: Plan: Define	Current Phase: Plan: Measure	Current Phase: Plan: Analyse	Current Phase: Do/Check: Improve	Current Phase: Act: Control	Current Phase: Cancelled	On Time: Green	On Time: Orange	On Time: Red	On Budget: Green	On Budget: Orange	On Budget: Red	Expected Outcome: Green	Expected Outcome: Orange	Expected Outcome: Red	Finished	Post Implementation Benefits: Green	Post Implementation Benefits: Orange	Post Implementation Benefits: Red
1 Lift the Health of the people in Auckland City	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
2 Performance improvement	20	19	5	0	1	9	1	0	15	2	0	17	0	0	16	1	0	3	3	0	0
3 Live within our means	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0
Total #	**22**	**20**	**5**	**0**	**1**	**9**	**1**	**0**	**16**	**2**	**0**	**18**	**0**	**0**	**16**	**1**	**1**	**4**	**3**	**1**	**0**
Total %	**100%**	**91%**	**23%**	**0%**	**5%**	**41%**	**5%**	**0%**	**73%**	**9%**	**0%**	**82%**	**0%**	**0%**	**73%**	**5%**	**5%**	**18%**	**14%**	**5%**	**0%**

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

High Level Summary - total projects: 1

High Level Strategy	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	Green	Orange	Red		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
1.2a Improve outcomes for children and young people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2c Improve outcomes for mental health and addictions	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
1.2d Improve outcomes for long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2e Improve outcomes for Palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**
Total %	**100%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**100%**	**0%**	**100%**	**0%**

Objectives

No Objectives have been entered for this committee or group against this goal.

Exceptions

There are no projects that have been marked as an exception

Goal: 2 Performance improvement

High Level Summary - total projects: 20

High Level Strategy	Number	Started	Current Phase: Plan: Define	Current Phase: Plan: Measure	Current Phase: Plan: Analyse	Current Phase: Do/Check: Improve	Current Phase: Act: Control	Cancelled	On Time: Green	On Time: Orange	On Time: Red	On Budget: Green	On Budget: Orange	On Budget: Red	Expected Outcome: Green	Expected Outcome: Orange	Expected Outcome: Red	Finished	Post Implementation Benefits: Green	Post Implementation Benefits: Orange	Post Implementation Benefits: Red
2.1a Efficient and effective Primary health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	12	12	3	0	1	7	0	0	11	0	0	11	0	0	10	1	0	1	1	0	0
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	9	8	1	1	0	3	1	0	6	1	0	7	0	0	7	0	0	2	2	0	0
2.4 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
2.5 Information management	4	3	0	0	0	3	0	0	2	0	2	4	0	0	3	1	0	0	0	0	0
2.6 Planning	1	1	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0
Total #	**20**	**19**	**5**	**0**	**1**	**9**	**1**	**0**	**15**	**2**	**0**	**17**	**0**	**0**	**16**	**1**	**0**	**3**	**3**	**0**	**0**
Total %	**100%**	**95%**	**25%**	**0%**	**5%**	**45%**	**5%**	**0%**	**75%**	**10%**	**0%**	**85%**	**0%**	**0%**	**80%**	**5%**	**0%**	**15%**	**15%**	**0%**	**0%**

Objectives

Objective	Objective Owner	Comment
2.1c.1 Improve service throughput and productivity	Ngaire Buchanan (ADHB)	There are 8 projects associated with this objective all at different stages. Cardiac surgery throughput, Emergency six hour measure, releasing time to care, increasing Starship OR capacity and the Service improvement projects are all under way. Eliminating unnecessary outpatient folow ups will be within the service improvement programme. Improving operating rooms productivity will commence in late August with the TPOT programme.
2.1c.2 Improve mainstream effectiveness	Ngaire Buchanan (ADHB)	Maori DNA project has gone to BAU. The remaining 3 projects to commence.
2.1c.3 Improve relapse prevention planning in mental health	Fionnagh Dougan (ADHB)	The MOH have established a target which requires specific clients to have a relapse prevention plan in place. We have been formally reporting against this target during 09/10. As of August 2010 this project is included in the suite of DAP reports to ensure increased visibility.
2.1c.4 Hospitalised smokers given assistance to stop smoking	Taima Campbell (ADHB)	There has been substantial movement in terms of numbers being given brief advice in the Admission and Planning Unit, Adult Emergency Dept. and Ophthalmology Services. A number of services are consistently meeting the 80% target. The current focus is to work with wards/services that have not yet met the target, to determine the cause and work on strategies to assist them meet and maintain it.
2.1c.5 Reduce waiting times for oncology	Fionnagh Dougan (ADHB)	The MOH target is that all patients requiring radition therapy treatment receive this within 6 weeks. We are achieving this target although at times this is being delivered through outsourcing to Waikato and the private centre in Auckland.

2.1c.6 Increase elective surgical discharges to 10,227	Ngaire Buchanan (ADHB)	Surgical Steering group formed with Terms of Reference including a number of different pieces of work to come within this programme, including service improvement with TPOT, GSU, Capacity planning and MOH productivity

Exceptions

There are no projects that have been marked as an exception

Goal: 3 Live within our means

High Level Summary - total projects: 1

High Level Strategy	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	Green	Orange	Red		Green	Orange	Red
3.1a Manage revenue to maintain break-even position	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0
3.1b Cost management to maintain break-even position	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.2a Manage cash for sustainable balance sheet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**
Total %	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**0%**	**0%**

Objectives

No Objectives have been entered for this committee or group against this goal.

Exceptions

There are no projects that have been marked as an exception

7

PAPERS

7.1 ORGANISATION ACUTE FLOW – NGAIRE BUCHANAN

7.2 RUGBY WORLD CUP (RWC) – JUSTIN RAWIRI

+"% Cf[Ub]gUh]cb 5 Wh Y : `ck DfYgYbhUh]cb

+.2 Fi [VmiK cf`X˙7 i d˙fFK 7Ł˙

Chief Executive's Office
Level 1 Building 10
Greenlane Clinical Centre
Auckland
P O Box 92 189
Victoria Street West
Auckland 1142
Phone 09 630 9943 ext 4402
Fax 09 638 0347
garrys@adhb.govt.nz

30 July 2010

Briefing for Hon Tony Ryall
Minister of Health

Subject: Rugby World Cup Planning in the Northern Region

Introduction

The Rugby World Cup is the third largest sporting event in the world and as such brings with it a number of challenges for the health sector. Although uncertainties relating to the volume, timing and distribution of visitor activity remain, the Ministry of Economic Development and Ministry of Tourism have released a preliminary forecast which indicates that a cumulative total of 85,000 international visitors will arrive specifically for the Rugby World Cup across the duration of the competition.

Whilst these numbers are below the levels experienced during the Christmas and tourism season peak, the difference is that the majority of these visitors will be within the Auckland area during the latter part of the competition with the semi-finals, bronze final and final all being staged at Eden Park.

Police are the lead agency for the Rugby World Cup and are responsible for the co-ordination of planning at national, regional and local levels. The health sector has been identified as a vital component of planning and response processes at all levels.

Health planning within the Auckland region has been categorised into three key components comprising of regional, local District Health Boards and Interagency.

Regional

The Health Co-ordinating Executive Group Chaired by Ron Dunham, Counties Manukau District Health Board, Chief Operating Officer, is the strategic management body responsible for co-ordinating health emergency management activities within the Northern region. With membership comprising of representatives from the four northern region District Health Boards, St John, the Ministry of Health, the Primary Care Sector, Auckland Regional Public Health Service and the Ministry of Civil Defence Emergency Management, one of the key responsibilities of Health Co-ordinating Executive Group is to identify areas for planning and improvement in health emergency management.

The northern region has well established health emergency management processes and procedures, and as a result of this, it has been agreed that any Rugby World Cup focused emergency management activities will utilise existing regional and local structures.

The Health Co-ordinating Executive Group has classified the Rugby World Cup planning as a high priority on the work plan for the attention of its Operational Sub Group.

The objectives of the planning are:
1. Increase capacity and capability of Primary Care and St John to limit non acute presentation to the hospital Emergency Departments.
2. Temporary increase for triage and treatment capacity and capability within the hospital services.

3. Planning and implementation for the Medical Officer of Health powers for public health matters associated specifically with the Rugby World Cup.
4. Ensure appropriate interagency collaboration for planning and implementation.

Note that objective 4 is as a result of a key risk identified in the linkages between the different agencies at the national, regional and local level. Currently we are investigating the best way for collaboration and communication between agencies.

As part of the approach to planning there will be review of the planning and learning's from similar national and international events. To date these include the 2005 Lions Tour, the 2003 Rugby World Cup in Australia as well as 'Christmas in the Park' which attracts up to 300,000 people concentrated in the Auckland Domain on the one day.

The Operational Sub Group has identified the high likelihood and high consequence events that will potentially impact on health to be managed by each District Health Board and the regional co-ordination through the Health Co-ordinating Executive Group.

Local
At a local level each District Health Board in the northern region has existing emergency management arrangements to ensure they are capable of responding to any actual or impending event that may significantly impact on hospital or District Health Board functions.

The local level planning will also span the risk spectrum of potential events with particular attention given to the high likelihood events such as increased numbers of alcohol related presentations to Emergency Department and Primary Care, and the higher consequence event such as a major incident resulting in large numbers of casualties.

High likelihood events
Auckland currently manages a number of large events and as such the metro District Health Boards have a number of well established strategies to cope with surges in Emergency Department presentations.

Each of the objectives has identified what work needs to be completed and are at different stages within the work plan. These include working with and supporting St John and the primary care sector to limit non acute presentations to hospital emergency departments, and increasing triage and treatment capacity of hospital emergency departments.

The increased visitor volumes within primary care sector has already been raised to the Primary Care Technical Advisory Group for the groups to analyse the implications, impact and resources required to manage over this period.

High consequence events
With both the Queens Wharf and Eden Park in the Auckland District Health Board area, particular attention has been paid to the impact a mass casualty event would have on Auckland City Hospital.

The General Manager responsible for emergency management, Ngaire Buchanan, has formed a steering group for Auckland District Health Board with representation from a wide range of service areas to complete a multi-phased project to ensure preparedness for such an event. The first phase will incorporate the review and redevelopment of the existing major incident and associated plans, particularly in services areas which either have a key role in responding to a mass casualty event, or the potential to affect patient flows through the hospital.

The second phase of the project will involve exercising and evaluating key components of the Auckland District Health Board Major Incident and Mass Casualty Plans. The services associated with mass casualty service provision and the Incident Management Team will be the key players for the exercise organised for the beginning of December 2010.

Finally, the third phase will involve an evaluation of findings from the exercise to identify and develop corrective measures; this phase will be completed in a manner to allow re-testing of any deficiencies in the processes prior to the commencement of the Rugby World Cup.

Interagency working

Individual Health Co-ordinating Executive Group members have well established interagency relationships and are members of existing emergency management related groups at both regional and local levels. In these cases Health Co-ordinating Executive Group members will continue to actively participate and report back to the Operational Sub Group and the Health Co-ordinating Executive Group. Where additional or Rugby World Cup specific groups have been created, the Health Co-ordinating Executive Group has appointed health representatives to these groups as appropriate.

Conclusions

- The northern region has well established emergency management processes and procedures which will be utilised during the planning for, or response to Rugby World Cup related issues.
- The northern region has mandated the Operational Sub Group to co-ordinate the Rugby World Cup planning for health.
- A wide range of scenarios have been planned for.
- Both novel and established mitigation strategies will be investigated and utilised to cope with surges in hospital Emergency Department presentations.
- The implications of increased visitor numbers on the primary care sector have been identified and presented to the Primary Care Technical Advisory Group for review.
- The Health Co-ordinating Executive Group members will utilise current interagency relationships to ensure co-ordinated planning.
- The Auckland Regional Public Health Service will be responsible for public health planning for the region.

For further information please contact Ngaire Buchanan, General Manager Operations, Auckland District Health Board – contact details are: Phone: 09 631 0741, email: ngaireb@adhb.govt.nz

Authors: Justin Rawiri Manager, Emergency Management
Ngaire Buchanan, General Manager Operations

Garry R Smith
Chief Executive

8

FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

9

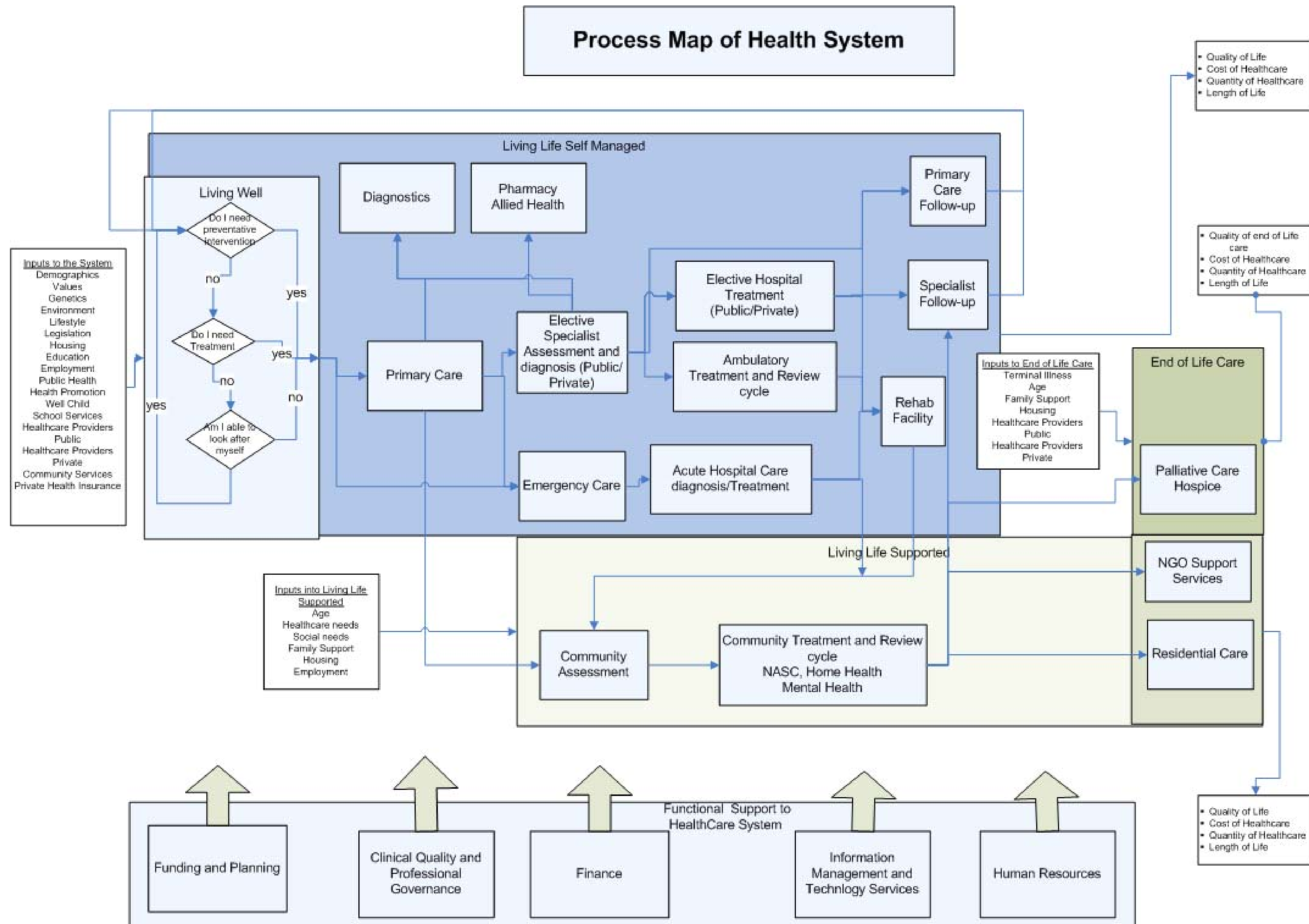
GENERAL BUSINESS

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 1 September 2010
Venue	A+ Trust Room, Clinical Education Centre, 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 Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Richard Aickin, Greg Balla, Taima Campbell, Margaret Dotchin, Fionnagh Dougan, Kay Hyman, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ngaire Buchanan, 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**	002
2	**Conflicts of Interest**	004
3	**Confirmation of Minutes Wednesday 4 August 2010**	016
4	**Action Points Wednesday 4 August 2010**	022
5	**Operational Performance** 5.1 Operational Summary Report and Financials 5.2 Operational Indicators Exception Report	026
6	**Improvement Activities** 6.1 DAP Projects Report	044
7	**Papers** 7.1 Organisation Acute Flow Presentation – Ngaire Buchanan 7.2 Rugby World Cup (RWC) - Justin Rawiri paper and presentation	062
8	**Feedback to Board**	072
9	**General Business** Scott Macfarlane – Ronald McDonald House	074

10	**Appendices** 10.1 Healthcare System Diagram	076

NEXT MEETING	
Time and Date:	Wednesday 6 October 2010
Venue:	A+ Trust Room, Clinical Education Centre, Auckland City Hospital

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