



Auckland District Health Board
Hospital Advisory Committee Meeting

Wednesday 2 June 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			

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

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

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

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

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

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

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

CONFIRMATION OF MINUTES

- WEDNESDAY 5 MAY 2010



Hospital Advisory Committee Minutes

MEETING DETAILS															
Time and Date	10:45am, Wednesday, 5 May 2010														
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton														
1	ATTENDANCE AND APOLOGIES														
	<p>Committee Members</p> <table> <tr> <td>Pat Snedden (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Seiuli Dr Juliet Walker</td> <td>Ian Ward</td> </tr> <tr> <td>Associate Professor Anne Kolbe</td> <td>Professor Iain Martin</td> </tr> <tr> <td>Farida Sultana</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr David Sage – Chief Medical Officer Dr Margaret Wilsher – Deputy Chief Medical Officer Brent Wiseman - Chief Financial Officer Dr Richard Aickin – Director Child Health Greg Balla – Director of Performance & Innovation Ngairie Buchanan – General Manager Operations Margaret Dotchin - Nurse Director Fionnagh Dougan – GM Mental Health, Ambulatory, Cancer & Blood Services Dr Rick Franklin – Clinical Director Ambulatory Services Aroha Haggie – Maori Health Gain Manager Chris Morgan - Manager Materials Management Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>The Chair declared the meeting open at 10:48am.</p> <p>Apologies had been received from Chris Chambers, Clive Bensemman, Kay Hyman and Janice Mueller.</p> <p><u>Moved Pat Snedden; seconded Harry Burkhardt</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Pat Snedden (Chair)	Jo Agnew	Susan Buckland	Harry Burkhardt	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Rt Hon Bob Tizard	Seiuli Dr Juliet Walker	Ian Ward	Associate Professor Anne Kolbe	Professor Iain Martin	Farida Sultana	Lynda Williams
Pat Snedden (Chair)	Jo Agnew														
Susan Buckland	Harry Burkhardt														
Rob Cooper	Dr Brian Fergus														
Dr Ian Scott	Rt Hon Bob Tizard														
Seiuli Dr Juliet Walker	Ian Ward														
Associate Professor Anne Kolbe	Professor Iain Martin														
Farida Sultana	Lynda Williams														
2	CONFLICTS OF INTEREST														
	<p>There were no declarations of conflicts of interest for any item on the agenda. Juliet Walker advised that she was a panel member of the Medical Appeal Board for Work and Income and Iain Martin advised that he was Chair of the Peri-Operative Mortality Review Committee.</p> <p><u>Moved Pat Snedden; seconded Bob Tizard</u></p> <p><i>That the changes in interests register be noted.</i></p> <p><u>Carried</u></p>														

3	CONFIRMATION OF MINUTES 7 APRIL 2010
	<p><u>Moved Ian Ward; seconded Ian Scott</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 7 April 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
4	ACTION POINTS 7 APRIL 2010
	The discussion as a teach hospital was scheduled for the Strategic Planning Day.
5.1	Operational Summary Report and Financials
	<p>March had been difficult with an adverse variance of \$5.7m. The adverse variance in Adult Health was a mismatch of ACC codings which were double counted and had been corrected. Work was focused to break even. There was an issue of volumes from Waitemata and there is a monthly report issued to the major customer regional DHBs showing acute, non DRG and elective volumes. In a letter from Waitemata there were concerns at exposure to wash-ups and incorrect statements made so the CEO would be attending a Waitemata meeting to address who owns referrals, manages volumes and waiting lists. Concern was expressed that Waitemata management was not correctly advising their Board and there was a need to get cohesion between the DHBs District Annual Plans which was proving difficult.</p> <p>The MRI building consent and resource consent had been obtained so the donation was expected as budgeted. With FTE the main variance to budgeted savings were in Women's, Children's, Cardiology, ORA. Graduate nurses are used on workload sharing for a period of time. With lower turnover there may be a struggle to place the September graduates and those next January. It was noted that New Zealand tended to over train the number of nurses due to historic migration and staff turnover but as this reduces there would be an over supply although there was still needs in some areas i.e., Mental Health.</p> <p>The number of transplants was an anomaly for the first quarter of 2010 but was close to contract year to date. Transplants did bring Intensive Care Unit to a halt and with Cardiac holidays and conferences back to back, there had been a magnitude of work which had put strain on the system. While it was critical to have MoH understand the impacts however the achievements need to be celebrated as a service to New Zealand. Revenue is bulk funded however if someone donates they had to be acted on. As noted year end transplants should be close to contract as there had been a low June to December however if donation campaigns were successful there may be a need to change the level of service.</p> <p>The Chair noted the fantastic response by staff, the focus on the Minister's targets and performance to target with the reduced Cardiac waiting list from over 200 to delivering on contract getting the list down to 80 and now having to have lower to manage variability. There could be mixed messages with the demand to reach targets and contract as well as breakeven.</p> <p><u>Moved Pat Snedden; seconded Iain Martin</u></p> <p><i>That the Operational Summary Report be noted.</i></p> <p><u>Carried</u></p>
5.2	Operational Indicators Exception Report
	The non DRG revenue reflected the ACC funding double-up. The portion of patients treated prioritised using the national recognised processes and tools showed compliance with a high percentage.

6.1	DAP Projects Report
	<p>Projects were on target. The improved performance in ED had shown recognition that it was a whole hospital issue and how patients worked through the whole system including referrals to specialists, beds etc with a more visible collaborative approach and sharing problems. Cancer waits were down to 3.9 weeks with outsourcing capacity agreed and in place and although it was not being used at that moment. ADHB would still do the FSA and manage the patients. While the national working group had accepted the target of 4 weeks there was some queries as for some types of cancers 4 weeks has less clinical efficacy for that cancer which was a clinical concern.</p> <p>A regional radiation plan was going to the CEOs and signoff for the purchase of the replacement linear accelerator was on the Board's agenda. With extra capacity in primary the next piece of work would be where the next linear accelerators should be based. Referring physicians needed to understand their part of the whole system as extreme variability in referrals from each DHB was being seen. ADHB uses a central referral process to try and smooth the patient's journey and protect demand. There was increased demand and incidences of cancers particularly lymphoma and bone marrow. Looking at the whole treatment with radiation part of the cancer continuum raised the question of whether waiting times were a good proxy or there could be better measures. It was understood this was being discussed at the National Health Board level.</p>
9	GENERAL BUSINESS
	<p>The Committee members were to visit Wards 81 and 83 which included looking at Releasing Time to Care and would then join the Hand Hygiene presentation.</p>
	NEXT MEETING
	<p>The meeting closed at 11:40am.</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 2 June 2010 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

ACTION POINTS

WEDNESDAY 5 MAY 2010

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 5 May 2010**

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

OPERATIONAL PERFORMANCE

5.1 Operational Summary Report and Financials

5.2 Operational Indicators Exception Report

5.1 Summary Report

Overall Performance for the Month

The Provider produced a result on budget for April 2010; with the Operational Division result also on budget to budget (see table). The Operational budgeted surplus of \$7.8m was achieved with revenue favourable to budget by \$1.1m and operating costs adverse by a similar amount.

Summary of Provider Results

\$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	7,855	7,884	29U	109,257	109,935	679U
Complementary	(39)	81	120U	1,132	1,178	46U
Functional	(11,126)	(11,302)	176F	(116,255)	(116,318)	63F
Ancilliary	(11,165)	(11,222)	56F	(115,122)	(115,140)	17F
Provider Net Surplus/(Deficit)	(3,310)	(3,337)	27F	(5,866)	(5,204)	661U

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

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

5.1.1 OPERATIONAL DIVISION OPERATING STATEMENT

Operational

Operating Statement - April 2010

	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
<i>Total Income</i>						
Patient Care Revenue	84,349	83,004	1,345F	862,849	854,872	7,976F
Sales of Services & Products	911	882	29F	9,205	10,439	1,234U
Clinical Training & Education Income	1,299	1,392	93U	14,342	14,046	296F
Trust & Donation Income	483	805	322U	3,673	8,227	4,554U
Financial Income	-	-	0F	1	-	1F
Other Income	558	467	91F	5,321	4,888	433F
Profit on Disposal of Fixed Assets	0	-	0F	209	-	209F
Total Income	87,600	86,549	1,050F	895,599	892,471	3,127F
<i>Operating Expenditure</i>						
Employee Costs	55,060	54,179	882U	531,164	533,545	2,381F
Direct Treatment Costs	16,299	15,800	499U	171,032	161,999	9,033U
Indirect Treatment Costs	2,919	2,963	44F	28,714	29,783	1,069F
Property, Equipment & Transportation Costs	2,278	2,387	110F	22,830	23,885	1,055F
Administration Costs	641	686	45F	7,119	7,166	47F
Indirect Service Billing	801	808	7F	8,062	8,080	19F
Loss on Sale of Fixed Assets	(1)	2	2F	102	18	84U
Total Operating Expenditure	77,998	76,824	1,174U	769,022	764,476	4,546U
Operating Surplus / (Deficit)	9,601	9,725	123U	126,577	127,995	1,419U
<i>Non-Operating Expenditure</i>						
Depreciation	1,737	1,831	94F	17,218	17,968	750F
Finance Costs	10	9	0U	101	91	10U
Total :Non-Operating Expenditure	1,746	1,840	94F	17,319	18,060	740F
Total Surplus / (Deficit)	7,855	7,884	29U	109,257	109,935	678U

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

Patient Care Revenue	\$1.345m F	\$7.976m F YTD
Trust & Donation Income	\$(0.322)m U	\$(4.554)m U YTD
Employee Costs	\$(0.882)m U	\$2.381m F YTD
Direct Treatment Costs	\$(0.418)m U	\$(8.699)m U YTD

Patient Care Revenue

The principal variances were as follows:-

Adult Health	\$0.5m F	Favourable base income for the month due to prior month WIES catchup and high current month non DRG income.
Wom, Child, Card, ORA (CWORAC)	\$0.6m F	High volumes in paediatric surgery (\$0.4m F), paediatric medicine (especially sub specialties) (\$0.5m F) and cardiology (\$0.5m F), offset by adverse variances in paediatric cardiac (\$0.3m U) and cardiothoracic (\$0.7m U – 210 wies adverse to contract)

Further analysis has being undertaken to ascertain the extent of the revenue and cost impact of the MRT strike during March; 42 elective cases (across a range of specialties)

were deferred as a result of the strike and 108 outpatient appointments (all orthopaedic). Taking into account, revenue loss (offset by lower direct costs), additional payments to medical staff and reduced wages to those on staff the overall impact on the DHB bottom line is estimated at approximately half a million dollars adverse.

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

Trust & Donation Income

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

Employee Costs

Operational arm employee costs were \$0.9m un-favourable to budget for April (\$2.4m F YTD). Staffing numbers exceeded budgeted numbers (Table 1), however the average cost of staff was *lower* than budgeted (Table 2).

FTE Table 1 – FTEs for Month

FTEs	Budget FTE Month 2009/10	Actual FTE Month 2009/10	Variance
Adult Health	1,715	1,744	(29)
Women, Child, Cardiac, OR&A	2,342	2,457	(115)
Operations	1,376	1,409	(33)
Ment Hlth, Amb, Ophth, Cancer & Blood	1,243	1,256	(12)
Others	-1	1	(2)
TOTAL	6,676	6,867	(191)

Last months variance was (244) FTE.

FTE Table 2 – Cost per FTE

Operational Services - Staffing Variance			
Month 2009/10	Budget	Actual	Variance %
Employee Costs (\$M)	54.2	55.1	-1.63%
FTE Numbers	6,676	6,867	-2.86%
Cost per FTE (Month)	8,115	8,018	1.20%
YTD 2009/10	Budget	Actual	Variance %
Employee Costs (\$M)	534	531	0.45%
FTE Numbers	6,713	6,859	-2.17%
Cost per FTE (Year to Date)	79,476	77,438	2.56%

The adverse staffing variance was due to the unfavourable FTE variance of 191 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

	Apl 10 Budget	Apl 10 Actual	Variance *	Savings Targets incl in Budget	Var to Underlying Bud i.e. FTE Savings Achieved
Adult Health	1,715	1,744	(29)	99	70
Wom, Child, Card, ORA	2,342	2,457	(115)	107	(8)
Operations	1,376	1,409	(33)	63	30
MH, Amb, Ophth, Cancer & Blood	1,243	1,256	(12)	66	54
ACH Others	-1	1	(2)	2	0
Total	6,676	6,867	(191)	337	146

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

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

	Apr 10 Month	Jul 10 Month	Var April Act versus Jul Budget
	Actual	Budget	
By Portfolio			
Adult Health	1,744	1,738	(6)
Wom, Child, Card, ORA (CWORAC)	2,457	2,496	39
Operations	1,409	1,429	20
MH, Amb, Ophth, Cancer & Blood	1,256	1,295	39
ACH Others	1	1	0
Total	6,867	6,959	92
By Category			
Medical	1,110	1,180	70
Nursing	3,207	3,182	(25)
Technical	1,630	1,678	48
Hotel Services	205	203	(2)
Stores	1	1	-
Administration	714	724	10
Target Savings	-	(9)	(9)
Total	6,867	6,959	92

Direct Treatment Costs

Direct treatment costs for April were unfavourable to budget by \$0.4m U, (\$8.6 m U YTD). The key components were:-

Cost	Variance Month \$M	Variance YTD \$M	Comments on Month
Clinical Supplies	(1.0)	(6.8)	Just under 60% of the variance is 'savings targets' posted to clinical supplies but achieved elsewhere. Other material variances were in OR – high theatre and case volumes, theatre minutes up 3% on last year and paediatric cardiac – high device usage and stock write off.
Chemicals & Media	(0.2)	(1.2)	Higher usage in labs due to test volumes exceeding budget assumptions.
3rd Party Treatment Costs	(0.2)	(4.1)	Cardiac outsourcing was \$0.4m U offset by a favourable variance in adult services (no outsourcing in month – YTD budget already fully utilised)
Contracted Services - Clinical	(0.1)	(1.2)	Surgical outsourcing in paediatrics.
Food	(0.0)	(0.2)	
Direct Patient Payments	(0.0)	0.0	
Interpreters	0.0	0.1	
Patient Appliances	0.4	2.1	\$184k F in Orthopaedics reflecting low elective/joint discharges in April (outsourcing has stopped), \$105k in A+ Links due back-dated prior period correction and \$100k F in cardiac physiology.
Drugs	0.7	2.9	\$0.5m F in Blood & Cancer due to lower than expected Herceptin usage and savings from Baxter drug management fees.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	Apr-10	Att per Day	Comparison to Last Month	Mar-10	Att per Day	Comparison to Last Year	Apr-09	Att per Day
APU	1,555	52	-6.9%	1,671	54	5.4%	1,476	49
AED	4,114	137	-2.1%	4,202	136	8.8%	3,780	126
CED	2,480	83	-7.5%	2,682	87	5.7%	2,346	78

AED.

AED had a very high daily rate in April, second only to February. An unusually high weekend (10 and 11 April) contributed to the first Red Alert issued on the Monday following (12 April).

APU.

APU had an increase in average LOS, despite a drop in volumes. APU has often been the first 'data indicator' of capacity issues related to high occupancy.

CED.

All throughput measures were between 4-6% higher than April last year.

Throughput Statistics

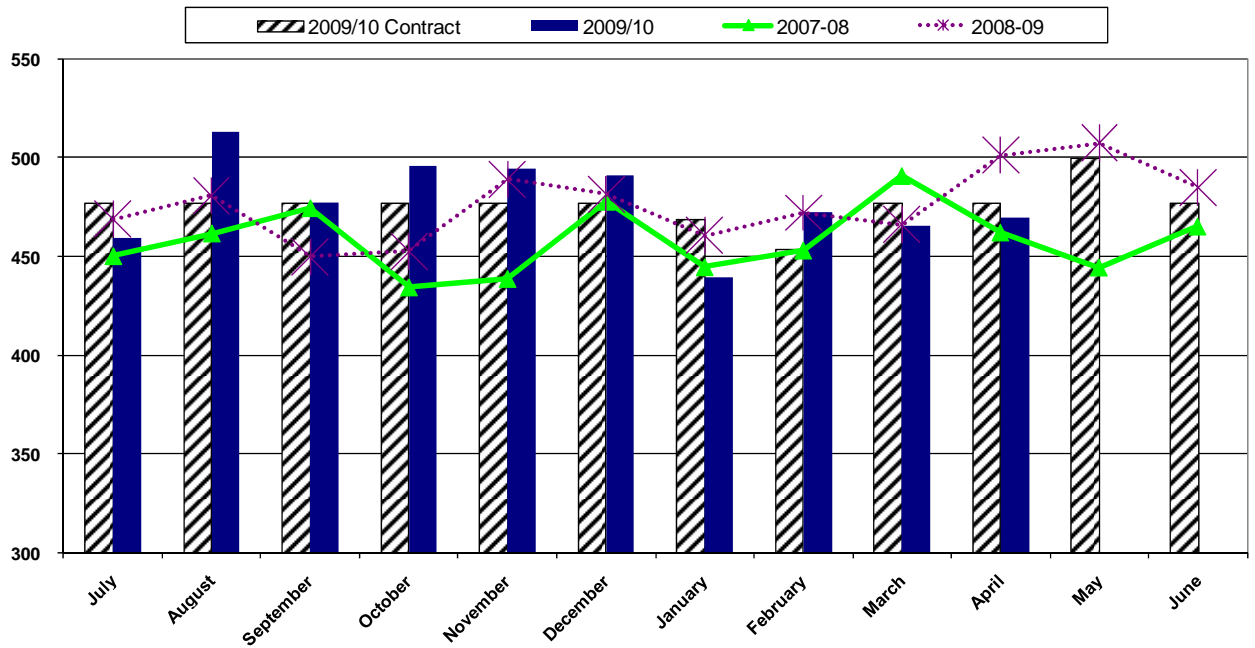
The chart below shows the production recorded to March 2010.

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. Discharges are up by 3.4% from last year.

Inpatient delivery 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	9,395	9,536	141U	100,135	99,516	619F
WIES Delivery per day	470	477	7U	477	474	3F

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



Volumes YTD

Inpatient volumes year to date April 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	12,438	10,573	-1,865	85%
CMDHB	3,567	4,143	576	116%
WDHB	4,875	5,388	513	111%
Other	4,544	4,397	-147	97%
	25,424	24,501	-923	96%

Acutes

DHB	Contract	Actual	Variance	% of completion
ADHB	40,107	42,305	2,198	105%
CMDHB	10,278	9,714	-564	95%
WDHB	14,242	15,275	1,033	107%
Other	9,917	8,883	-1,034	90%
	74,544	76,177	1,633	102%

Acute & Elective Combined

DHB	Contract	Actual	Variance	% of completion
ADHB	52,545	52,878	333	100.6%
CMDHB	13,845	13,857	12	100.1%
WDHB	19,117	20,663	1,546	108.1%
Other	14,461	13,280	-1,181	91.8%
	99,968	100,678	710	100.7%

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	25,424	24,501	(923)

Split by:-

CTSU	3,275	4,150	+875 (of which 485 funded by the Ministry)
Other	22,149	20,350	(1,798)

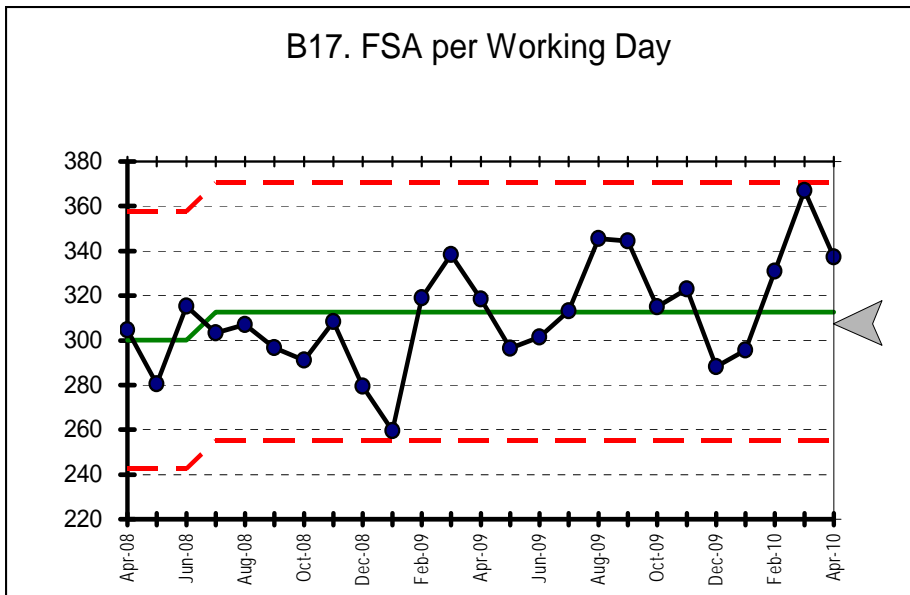
Outpatient Delivery

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'.

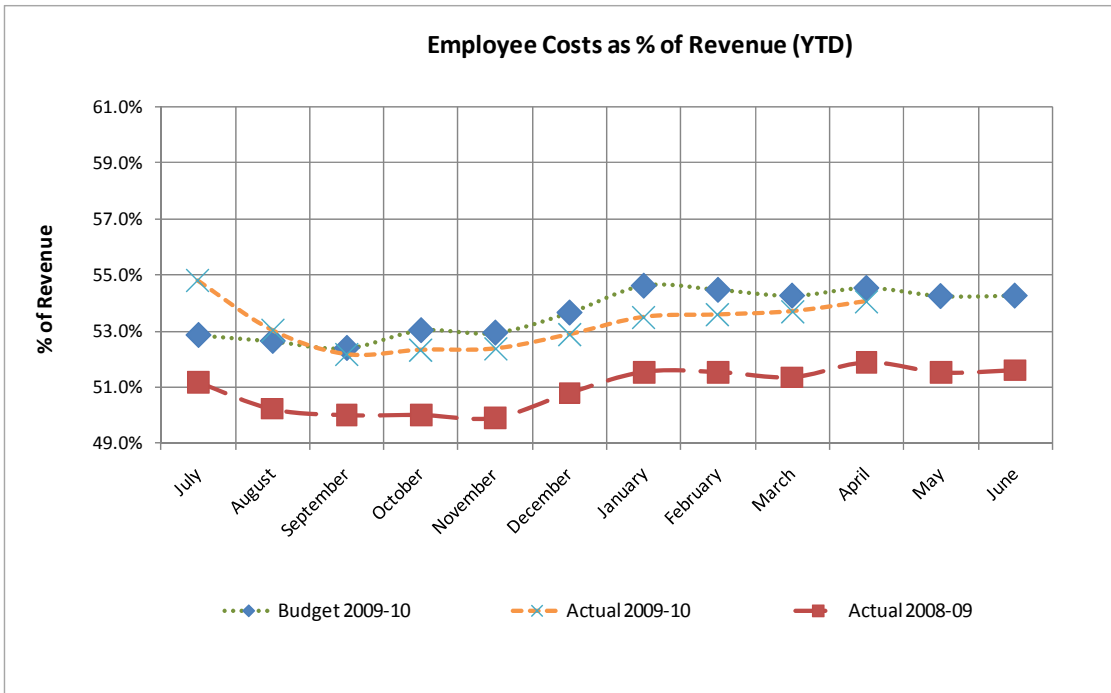
Of the FSAs year to date in 2009/10 (including virtual FSAs), 33% are in medical services (including neurology), approximately 45% are in surgical services or medical services having an elective contract (the largest being cardiology). Sexual Health is 16% of all FSAs (noted separately by virtue of its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

While FSA numbers for the month fell away from last month's high numbers, FSAs were at 110% of contract.

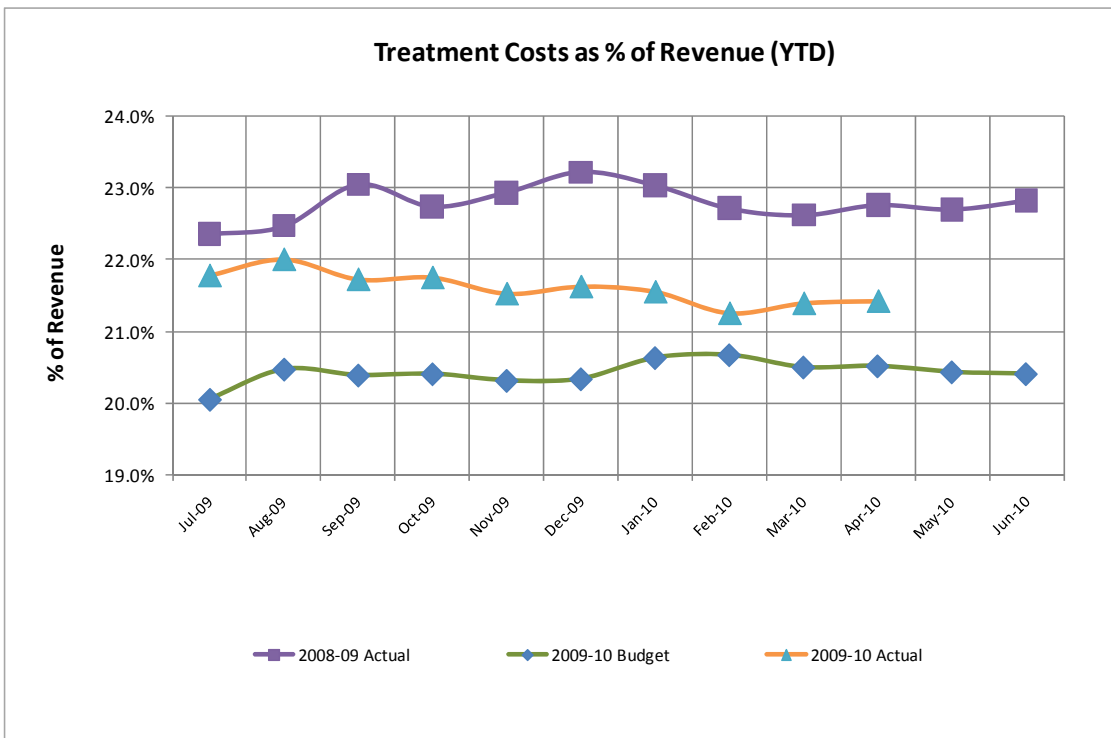
FSA= First Specialist Assessment
 Green Line= Average
 Arrow= Target



Cost Trend Charts



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



While treatments costs as a % of revenue have been running at a level less than that of the previous financial year, some cost items eg clinical supplies (\$6.8m U YTD) have been running significantly above budgeted levels.

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

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

Health Service Portfolio	YTD Surplus/(Deficit)			Var as % to Budgeted Revenue	Comments
	Act	Bud	Var		
Women's Health	24,721	21,481	3,240F	5.2%F	The favourable variance is driven by higher volume delivery particularly in FSA Obstetrics \$2.3m without any significant variances from budgeted expenditure. However, it should be noted that total internal revenue exceeds the PVS funding received by the DHB.
Child Health/CWORAC Management/ORA	(33,806)	(26,828)	6,978U	3.9%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 \$(5.9)m. It is also driven by lower coded Paediatric Cardiac volumes \$(1.7)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 \$6.4m and FTE vacancies & savings in superannuation \$2.5m; (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	36,479	33,812	2,667F	2.5%F	The favourable variance is the result of favourable employee costs \$3.0m, 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	37,541	40,304	2,763U	2.2%U	The unfavourable variance is driven by lower volume delivery particularly in General Medicine & Infectious diseases \$(1.9)m
Operations Management	144	4,045	3,901U	N/A	Target Savings \$(3.8)m. This unfavourable variance is substantially offset by favourable variances in individual services.
Others	44,178	37,121	7,057F	N/A	A range of Provider Services with variances less than \$0.5m
Total Operational	109,257	109,935	(678)U	0.07%F	

Operational

Apr 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	817,171		803,425		742,532		13,746 F	1.7%F	74,639 F
MoH Sub-contracts	19,486		23,184		16,500		3,698 U	15.9%U	2,986 F
Other Patient Care	26,191		28,264		27,672		2,072 U	7.3%U	1,481 U
	862,849		854,872		786,704		7,976 F	0.9%F	76,145 F
Services & Products	9,205		10,439		9,350		1,234 U	11.8%U	145 U
CTA	14,342		14,046		3,108		296 F	2.1%F	11,234 F
Trust & Donation Income	3,673		8,227		6,207		4,554 U	55.4%U	2,533 U
Other Income	5,530		4,888		5,260		643 F	13.1%F	270 F
	895,599		892,471		810,628		3,127 F	0.4%F	84,971 F
Expenditure									
Employee Costs									
Medical	179,060	20.0%	178,466	20.0%	164,528	20.3%	594 U	0.3%U	14,533 U
Nursing	193,926	21.7%	192,442	21.6%	184,024	22.7%	1,484 U	0.8%U	9,902 U
Technical	89,623	10.0%	92,317	10.3%	83,604	10.3%	2,695 F	2.9%F	6,018 U
Hotel Services	7,353	0.8%	7,227	0.8%	7,100	0.9%	126 U	1.7%U	253 U
Administration	33,973	3.8%	32,986	3.7%	34,757	4.3%	987 U	3.0%U	784 F
Other	27,229	3.0%	30,107	3.4%	25,300	3.1%	2,878 F	9.6%F	1,929 U
Total Employee Costs	531,164	59.3%	533,545	59.8%	499,313	61.6%	2,381 F	0.4%F	31,851 U
Direct Treatment Costs	171,032	19.1%	161,999	18.2%	164,443	20.3%	9,033 U	5.6%U	6,589 U
Indirect Treatment Costs	28,714	3.2%	29,783	3.3%	29,308	3.6%	1,069 F	3.6%F	594 F
Prop, Equip. & Transpt	22,830	2.5%	23,885	2.7%	22,825	2.8%	1,055 F	4.4%F	5 U
Administration Costs	7,119	0.8%	7,166	0.8%	7,527	0.9%	47 F	0.7%F	408 F
Indirect Service Billing	8,062	0.9%	8,080	0.9%	5,936	0.7%	19 F	0.2%F	2,126 U
Loss on Sale of Fixed Assets	102	0.0%	18	0.0%	90	0.0%	84 U	481.5%U	12 U
Total Operating Expenditure	769,022	85.9%	764,476	85.7%	729,442	90.0%	4,546 U	0.6%U	39,580 U
Operating Surplus/(Deficit)	126,577	14.1%	127,995	14.3%	81,186	10.0%	1,419 U	1.1%F	45,391 F
Depreciation	17,218	1.9%	17,968	2.0%	17,011	2.1%	750 F	4.2%F	207 U
Finance Costs	101	0.0%	91	0.0%	1,574	0.2%	10 U	11.1%U	1,472 F
Total Non Operating Costs	17,319	1.9%	18,060	2.0%	18,585	2.3%	740 F	4.1%F	1,265 F
Net Surplus / (Deficit)	109,257	12.2%	109,935	12.3%	62,601	7.7%	678 U	0.6%U	46,656 F

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ADHB HAC KPI Report

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

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

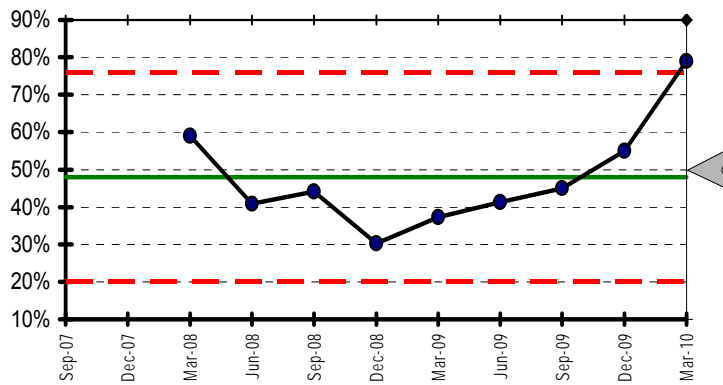
HAC Exception Report

April 2010

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.

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



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

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

High Level Strategy	Objective	Strategies to achieve Objective
<div style="border: 2px solid black; border-radius: 15px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Improve the effectiveness & efficiency of Healthcare System</div> <div style="border: 1px solid black; border-radius: 10px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Primary healthcare</div> <div style="border: 1px solid black; border-radius: 10px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Improve Primary Secondary system efficiency -decrease total system cost</div> <div style="border: 1px solid black; border-radius: 10px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Improve hospital efficiency / throughput</div> <div style="border: 1px solid black; border-radius: 10px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Reduce waiting times for elective services</div>	Implementation of PHO-DHB primary healthcare plan	1. Implement approach to providing efficient & effective coordinated care in the neighbourhood
	Improve access to after hours primary care	1. Develop after-hours services including palliative and residential care
	Improve information availability across system	1. e-referrals, health event summaries and electronic outpatient letters 2. Increase access to diagnostic tests in primary care 3. Transfer some services to primary/community
	Improve access & efficiency of service delivery	1. Projects to improve performance against 6 hr benchmark (OPJ) 2. Increase the use of and capacity of primary options
	Improve the performance of ED	1. OPJ Starship theatre project 2. Adult inpatient capacity step (beds and workforce)
	Improve the acute capacity management	1. OPJ Cardiac surgery project
	Improve Cardiac Surgery Throughput	1. Increase Greenlane capability to a full elective services centre (feasibility)
	Increase elective services to National Intervention rates	1. Improve service scheduling process & utilisation of day stay 2. Tumour specific model implementation 3. Optimising the patient journey projects
	Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation & medical oncology	1. Patient centred scheduling and communication 2. Accurate waiting time information. Reduced Waiting time 3. Increased input from GP's
	Improve Outpatient Management for Surgical Patients while improving patient satisfaction	1. Establish a new elective services centre
Reduce unmet need for elective services	1 Leadership development, mentoring and engagement process 2 Integrated governance reporting implemented 3. Define baldrige roll out plan and complete base line	
<div style="border: 2px solid black; border-radius: 15px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Improve Leadership Capability</div> <div style="border: 1px solid black; border-radius: 10px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Improve clinical quality & professional governance</div>	Clinical leadership model: implement, monitor and evaluate	1. Develop GP network (collaborative) with primary care
	Improve senior leadership team performance	1. Implement NQIP Medication Safety, Infection Prevention & Control, Mortality Review, Incident Management 2. Increase the number of GP practices with Cornerstone accreditation
	Implement sector wide clinical networks	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
	Improve safety and quality of care	1. Implement the resilience improvement plan
<div style="border: 2px solid black; border-radius: 15px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Strengthen the health workforces</div>	Improve clinical staff retention	1. Regional Strategic Plan development in alignment with NZ HIS 2009
	Healthy workplace	1. Implement dynamic planning process (right beds, staff, facilities)
	Develop response to Long Term Services Plan	1. National 2. Regional 3. Local
<div style="border: 2px solid black; border-radius: 15px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Information management</div>	Improve resilience and availability of core IT systems	
	Regional Strategic Plan	
<div style="border: 2px solid black; border-radius: 15px; padding: 5px; margin-bottom: 5px; background-color: #e0ffff;">Planning</div>	Improve Capacity Management	
	Long Term Services Planning	

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

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

Goal Level Summary Report (Hospital Advisory Committee)

DAP Projects

Total Projects: 15

DAP GOAL	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits			
			Plan		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green		Orange	Red		
			Define	Measure	Analyse	Improve															Control	
1) Lifting the Health of the people in Auckland City	1	1	0	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2) Performance Improvement	14	14	2	3	4	5	0	0	0	11	2	1	14	0	0	10	4	0	0	0	0	0
3) Living within our Means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	15	15	2	3	4	6	0	0	0	12	2	1	15	0	0	11	4	0	0	0	0	0
Totals %	100%	100%	13%	20%	27%	40%	0%	0%	0%	80%	13%	7%	100%	0%	0%	73%	27%	0%	0%	0%	0%	0%

High Level Summary Report

Goal 1 Lift the Health of the people in Auckland City

DAP Projects

Total Projects: 1

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

Objectives

Objective	Objective Owner	Comment
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Exceptions

There are no projects that have been marked as an exception

High Level Summary Report

Goal 2 Performance improvement

DAP Projects

Total Projects: 14

DAP HLS	Number	Started	Current Phase					On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits			
			Plan		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red	
			Define	Measure	Analyse	Improve															Control
2.1 Improve the effectiveness & efficiency of the healthcare system- primary care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.2 Improve the efficiency and effectiveness of the healthcare system– decrease total system cost- primary secondary interface	2	2	0	1	1	0	0	0	1	1	0	2	0	0	1	1	0	0	0	0	0
2.3 Improve the efficiency and effectiveness of the healthcare system - hospital efficiency /throughput	5	5	0	0	1	4	0	0	5	0	0	5	0	0	4	1	0	0	0	0	0
2.4 Improve the efficiency and effectiveness of the healthcare system – reduce waiting times for elective services	3	3	1	1	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	3	4	5	0	0	11	2	1	14	0	0	10	4	0	0	0	0	0
Totals %	100%	100%	14%	21%	29%	36%	0%	0%	79%	14%	7%	100%	0%	0%	71%	29%	0%	0%	0%	0%	0%







Objectives

Objective	Objective Owner	Comment
2.3.1 Improve the performance of ED	Margaret Dotchin (ADHB)	Close monitoring of performance is required as workload (acute and elective) increases. Green belt practitioners are picking up a number of projects which will assist rollout of improvement initiatives.
2.3.2 Improve acute capacity management	Ngaire Buchanan (ADHB)	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	Ngairé Buchanan (ADHB)	Elective services now non compliant ESPI2 with neurology the key adverse service, action is underway to address including 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	Ngairé 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	Ngairé Buchanan (ADHB)	Revised capacity management approach for monthly review and reporting being piloted.
2.9.2 Long term services planning	Ngairé Buchanan (ADHB)	Scoping and approach 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				Progress in moving towards the achievement of the shorter stays in ED goal of adult Emergency Department patients being admitted or discharged within six hours (unless clinically indicated) has continued from 69% in Quarter 2 to 74% in Quarter 3. This has been maintained in April. Some of the projects underway include: 1. Implementation of rapid rounds. These are now in place across all General Medicine wards with plans to implement in Orthopaedics following discussion at Orthopaedics team meeting. 2. Increasing the number and accuracy of estimated dates of discharge (EDD). Improvement activities will be implemented in Orthopaedics first. Baseline performance identified that approximately 7% of EDD's are assigned on CHIPs within 8 hours of admission. 3. Increasing the number of patients discharged in weekends in General Medicine and Orthopaedics. Nurse Facilitated discharge has been relaunched in General Medicine with increasing awareness of process and training of Charge Nurses and Clinical Nurse Advisors. Ten nurse facilitated discharges have been completed since the relaunch. 4. Improving day of discharge logistics to reduce delays in time of discharge. Baseline performance demonstrates it takes on average 4 hours to clear a bed on the CHIPS whiteboard post medical clearance for discharge. 5. Improving admission to discharge planning. Minimum documentation requirements and responsibilities for AD planner to ensure safe and timely transfer of admitted patients from AED to receiving ward under discussion. 6. Reducing delays with patients referred to Taikura Trust. Workshops have been held with both Taikura Trust teams and ACH teams. The biggest opportunity for improvement continues to be within the time taken from bed request to ward admission (workstream 1). The last 5 months has noted the best performance in this metric over the last two years. This has improved from an average of 7.6% of patients being transferred from AED to an inpatient ward in less than 1 hour to 11% in April with the average time taken reducing from 7 hours in April 2009 to 4.2 hours in April 2010. AED patient attendances were high again this month with 4,114 patients presenting. This is slightly down on last month presentations of 4202. Daily attendances of 137 is up from 126 patients per day last month. The ALOS in AED was the lowest ever recorded at 5 hrs and 9 minutes. This continues the steady downward trend in average length of stay since August 09 and reflects the work being done to increase the efficiency of the ED and hospital flow processes to allow the DHB to meet the MOH ED target. 36% of patients were admitted either to APU or an inpatient wards from AED and 30 patients were in AED for more than 24 hrs (as compared to 106 last year). Five patients waited in ED for more than 24 hrs for a bed after the bed request was made. A project is underway to improve triage processes within AED.	yes
Starship 6 hour project	ADHB	Improve				CED has achieved a significant improvement in percentage of stays less than 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	yes

from June 2010 which will reduce the number of children needing to be kept in CED where they are too intensive for the ward and PICU is full.

CONCORD Project	ADHB	Analyse				Concord progresses well with good clinical engagement. 3 projects completed, website active with new ideas posted regularly. Honouring patient choices project commenced in Renal services.	yes
Auckland Region Cardiac Surgery Service Development	Regional	Improve				1/3/10 Progress continues to be made across all 10 workstreams.	yes
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				April 2010 100% of patients referred and eligible for treatment across A-C categories met the MOH wait time target in April. No patients waited > than 6 weeks for treatment due to capacity. The average wait time for "C" Radical patients is 4.6 weeks (5.3 weeks in March & 8.1 weeks in February) therefore wait time compliance continues to improve month on month. The service is forecasting 100% compliance for Quarter 4. Strategies to reduce wait times include weekly prioritisation meetings and the capacity modelling tool will be trialled in early May. The service continues to actively recruit into vacant Radiation Therapist positions. Evening shifts finish on the 1st June due to Radiation Therapy staff vacancies and low skill mix. This will reduce capacity across the Linacs and has the potential to extend wait times if the service receives a peak in demand or acuity. The business case to replace Linac MV5 in November 2010 will be presented to the Finance Committee on May 5th. Strategies to manage wait times (to meet the 6 week target), as a result of peaks in work load/acuity, include the option to outsource simple breast and prostate patients to a private Auckland provider (ARO). 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 was to be scheduled during April but has not occurred due to NRN work.	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		Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green		Orange	Red	
			Define	Measure	Analyse	Improve															Control
3.1 Manage revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.2 Improve productivity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.3 Manage cash	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals %																					

Objectives

Objective	Objective Owner	Comment
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Exceptions

There are no projects that have been marked as an exception

PAPERS

7.1 Paediatric Specialty

7.2 Greenlane Surgical Centre Update

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Paediatric Speciality Services Review

Summary for ADHB HAC 19/5/2010

This review was performed by Ministry of Health staff with a small steering group¹ which included senior paediatric clinicians (medical & nursing), a child health manager, a Paediatric Society representative and the Chief Advisor Child & Youth MoH.

The current version of report dated April 2010 is still marked “draft and strictly confidential” and the information contained in this summary should be held confidential to this committee and ADHB board members.

Despite the status of the report, the steering group regard this as a final draft, and the key findings and recommendations have been presented to the National Health Board on 29/4/2010. A verbal endorsement of the recommendations was given unanimously by the Board.

The next step is for the National Health Board to pass the review & recommendations on to the National Health Board Business Unit for development of an implementation plan, followed by discussion with DHB CEOs. This is underway at present. If all recommendations are progressed we should expect early attention to the four subspecialty services which have been recognised as at highest risk.

I have been given approval to share the information noted below with the HAC/ADHB since the content is unlikely to change in any material way, but it should be noted that the final plan presented for discussion with DHB CEOs may have some differences.

Richard Aickin
Director of Child health
ADHB

Executive Summary of the review

Fortunately, most New Zealand children and young people are healthy most of the time and will never need to access the most specialised health and disability services. Nonetheless, when the occasion arises it is critical that children, young people and their whanau/families can access the services they need. For many children, contact with these highly specialised services will only be for a short time to meet an acute need. However, for children and young people who have complex needs, their interaction with these services often continues over a long period of time. New Zealand families can and should have confidence that they will be able to access high quality speciality services when they need them.

Paediatric sub-specialty services can be characterised “by their complexity, low volume and dependence on small numbers of highly trained staff. Patterns of disease and treatment vary considerably from one specialty to another.”² These factors, combined with the absence of a national overview to inform service planning, means paediatric sub-specialty services in New Zealand are vulnerable, and will continue to be so if nothing changes.

1. The Steering Group members were Dr Richard Aickin, Director of Child Health, Auckland DHB; Pauline Clark, General Manager, General Manager Women’s and Children’s Health, Canterbury DHB; Lynne Johnson, Charge Nurse Manager, Children’s Acute Assessment Unit, Christchurch Hospital; Dr Rosie Marks, President, Paediatric Society of New Zealand; Dr Pat Tuohy, Chief Advisor, Child & Youth, Ministry of Health; Dr William Wong, Clinical Director, Paediatric Medical Specialties, Starship Hospital, Auckland DHB.

2. The Scottish Government. 2008. *National Delivery Plan for Children and Young People’s Specialist Services in Scotland*. Edinburgh: The Scottish Government.

Recognising this, these services have been prioritised by the National Health Board (NHB) for early consideration for national planning and funding. This report represents the first step toward building more sustainable paediatric sub-specialty services that meet the health and disability needs of New Zealand children and young people. It has been prepared for the NHB, to inform the Board's advice to the Minister of Health on how to ensure paediatric sub-specialty services are sustainable now and into the future.

The starting point for this current review has been *Through the Eyes of a Child: a National Review of Paediatric Specialty Services*, published in 1998.¹ *Through the Eyes of a Child* was a response to the ad hoc development of paediatric sub-specialty services and consequent concerns about their ongoing sustainability. The work was undertaken by the Paediatric Society of New Zealand (the Paediatric Society) and the Health Funding Authority, with Ministry of Health participation. The process was clinician-led and the resulting report is still considered by many to be the seminal work on paediatric sub-specialty services in New Zealand. A great number of the recommendations from this review continue to be relevant today and correspondingly, they are reflected in the direction of the recommendations made in this report.

This report was never intended to replicate the detailed work underpinning *Through the Eyes of a Child*. It does, however, provide an update on progress in implementing the recommendations made in *Through the Eyes of a Child* and provides a picture of paediatric sub-specialty services today (found in the Specialty Reports contained in section 10). The nature of paediatric sub-specialty services means that all services are to some degree, vulnerable. While this report provides a snapshot of the current situation, it must be recognised that the viability of an individual service can change rapidly especially with the loss of one or two key personnel.

Planning to improve the viability of paediatric sub-specialty services must take account of the wider health and disability sector context, and in particular that the fiscal environment will constrain the rate of growth in public health funding into the future. As is the case internationally, the New Zealand health and disability system faces clinical and financial viability challenges as a result of:

- an aging population, population redistribution and an increasing prevalence of long-term health conditions
- rising public expectations and advancements in technology which combine to increase costs and expand the scope of what is treatable
- a global health workforce that is increasingly expensive and scarce.

Recognising these challenges and the need to make effective use of scarce health dollars and resources available, this report outlines a plan for building sustainable paediatric sub-specialty services now and into the future. Central to this is recognising that sub-specialty services are one part of a continuum of care. To create effective and efficient sub-specialty services, planning must also ensure that we retain capability at all levels of the system, ensuring care is consistently delivered at the most clinically appropriate level.

Taking into account the wider work on national and regional service planning and long-term sector planning, this report proposes:

¹ Paediatric Society of New Zealand, Health Funding Authority. 1998. *Through the Eyes of a Child: a National Review of Paediatric Specialty Services*. Wellington; HFA.

- developing an overarching plan to guide decisions about what paediatric sub-specialty services we as a country will invest in, and their configuration and distribution around New Zealand
- national planning of many of the sub-specialties, and improving service coordination and planning through clinical networks.

Clinical networks offer an important formal structure to bring together individuals to work across organisational and professional boundaries, and to coordinate activity across sub-specialty services. The Ministry of Health has contracted the Paediatric Society of New Zealand (the Paediatric Society) to work in partnership with the Ministry, health providers, and other sectors to advise on the development of child and youth clinical networks.

The development of clinical networks will be particularly important for services not identified among those services for early national planning and funding. In addition, consideration should be given to a 'grouped approach' to network development. Grouping services offers an opportunity to bring together communities of services to form single networks. It provides a more efficient way to organise networks for relatively small services and may improve clinical viability where there are strong service overlaps and resulting opportunities for mutual support. It also offers a way to get clinical networks for a larger number of services established earlier.

The large number of paediatric sub-specialty services - some 33 were identified in recent work means a phased approach to intervention will be necessary for these services. Analysis of the feedback received through this review suggests that paediatric pathology, metabolics, gastroenterology, and cardiology and cardiac surgery are currently our most vulnerable paediatric sub-specialty services and should therefore be the first services targeted for national planning and funding.

Though less vulnerable than some other services, the capacity limitations of paediatric intensive care, anaesthetics and imaging services are impacting on the functioning of other services. Given this, it is recommended that these services be included in the second phase of national service development. In addition, paediatric neurology, immunology/allergy and dermatology services were ranked just below those identified as most vulnerable and should also be targeted in the second phase for early network development.

Recommendations of the review

System level recommendations

1.	Note	that paediatric sub-specialty services have been identified as vulnerable services as a consequence of their high level of specialisation and low volumes resulting in significant challenges for workforce and financial sustainability
2.	Agree	that future service planning take particular account of the needs of Tamariki Māori and Pacific children, particularly as they are an increasing proportion of the child population
3.	Note	that feedback received from clinicians and health service managers identifies the following overarching issues for paediatric sub-specialty services: <ul style="list-style-type: none"> • access to paediatric sub-specialty services is inequitable • workforce is a significant driver of service vulnerability • financial sustainability is an issue for many sub-specialty services • linkages between sub-specialty service providers are generally poor and there is little long-term service planning • few sub-specialty services have defined best practice guidelines or referral pathways • continuity across the continuum of care is an issue
4.	Note	that the lack of an overarching plan for paediatric sub-specialty services has led to ad hoc service development, contributing further to service vulnerability
5.	Note	that future planning for paediatric sub-specialty services needs to occur at two levels; at the national level (an overarching national plan linked with the Long Term Health Sector Plan) and at the individual service level
6.	Agree	that the National Health Board develop an overarching national plan for paediatric sub-specialty services in New Zealand, in consultation with clinicians, health managers and service users, and linked with the Long Term Health Sector Plan
7.	Agree	that a national plan for paediatric sub-specialty services should include: <ul style="list-style-type: none"> • planning for an integrated national transport service to support regional, national and international referrals • a review of the National Travel Assistance policy that includes accommodation entitlements, to ensure it supports policy goals of equitable access and outcomes for New Zealand children and young people • developing a data base to collect information to support future service planning and clinical best practice • linking with existing work to progress electronic transfer of patient records • examining how best to provide telemedicine services
8.	Note	that <i>Through the Eyes of a Child</i> recommended the majority of paediatric sub-specialty services for national planning and/or funding
9.	Note	that there are two options for nationally planning of services, through designation as either: <ol style="list-style-type: none"> a. National Services, planned and funded by the NHB; OR

		b. Service improvement programmes, supported by national clinical networks
10.	Note	that the Paediatric Society has been contracted to advise on development of clinical networks across the continuum of care with an emphasis on the interface between tertiary and secondary paediatric services
11.	Agree	that service planning will include decisions on: <ul style="list-style-type: none"> • referral/clinical pathways to ensure care is provided at the most appropriate level within the health and disability system • service-wide standards, guidelines and protocols • appropriate audit and review • the provision of, and essential elements included in, outreach services • how service provision will be managed to ensure continuity of care for individual children and young people and their families
12.	Agree	that Ministerial support will be sought for designation of the following paediatric sub-specialty services as Phase One National Services: <ol style="list-style-type: none"> a. Pathology b. Metabolic services c. Gastroenterology d. Cardiology and cardiac surgery
13.	Agree	that national service planning for paediatric pathology be commenced at the earliest opportunity
14.	Note	that paediatric neurology, immunology/allergy and dermatology were also identified as highly vulnerable by this review and should be considered for intervention in Phase Two of national service planning and as early services for clinical network development
15.	Note	that early work is underway to determine whether neurosurgery (including paediatric neurosurgery) should be designated as a National Service and/or a national clinical network, and this may be expanded to include neurosciences more generally, including further work on paediatric neurology
16.	Agree	that the following services be included in the second phase of national planning due to their critical role in facilitating the delivery of other paediatric sub-specialty services: <ol style="list-style-type: none"> a. Anaesthetics b. Intensive care c. Imaging
17.	Agree	that a communication and engagement plan is progressed as soon as possible be developed to communicate the results of the review and the NHB's planned response.

Service level recommendations

In 1998 *Through the Eyes of a Child* set out a plan for the provision of paediatric sub-specialty services in New Zealand. This report updates progress against those original service-level recommendations, the majority of which continue to remain relevant today. These recommendations are contained within the individual Specialty Reports located in section 10 of this report along with comment on the degree of progress that has been made on them. We recommend these be considered in any future service level planning for paediatric sub-specialty services (refer to recommendations 4 and 5 above).

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Briefing Paper**ADHB HAC
Committee**

Date: 2 June 2010
To: OFG / Hospital Advisory Committee
From: Peter Lowry
Subject: Greenlane Surgical Centre Update

Purpose

Update Hospital Advisory Committee on GSC project.

Recommendations

That the Hospital Advisory Committee;

1. **Notes** the intention to complete the current development and stabilise processes and gains prior to next stage.
2. **Notes** the proposed improvements from the full OR day and patient preparation processes.
3. **Notes** the workforce approach.
4. **Notes** the requirement for services to develop production plans across ACH, SS and GCC and match service \$ to elective contracts.

Background

In November 2009 the ADHB Board committed to the phase 1 expenditure of \$9.737m of the GSC business case.

Key components of the business case include;

1. Improving elective outputs
2. Improving the patient flow from referral from primary care, through clinics, operative phase and back to primary care and follow-up,
3. Workforce development, and
4. Facility development,

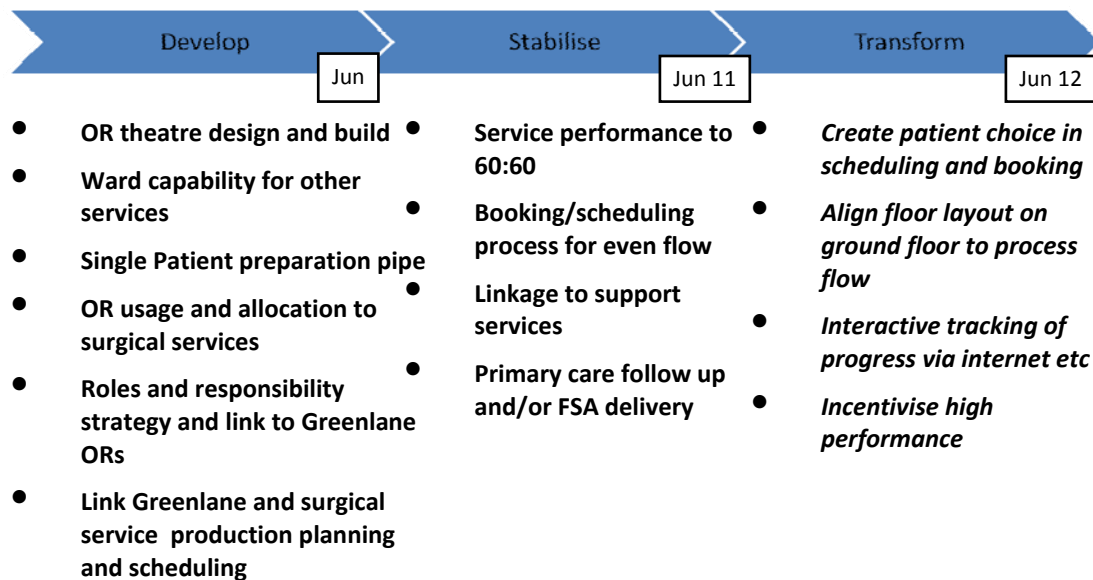
1. Improving Patient flow and elective Outputs

- enhance our elective surgical capability at Greenlane through additional Ors and improved workflows designed to achieve greater throughput
- It is designing from the patient perspective to improve the experience from primary care, through clinics, theatre and back to primary care
- The goal is to provide a high performing facility that assists ADHB to increase elective interventions, is an excellent place to work for all staff, and provides an excellent experience for patients

2. Design principles

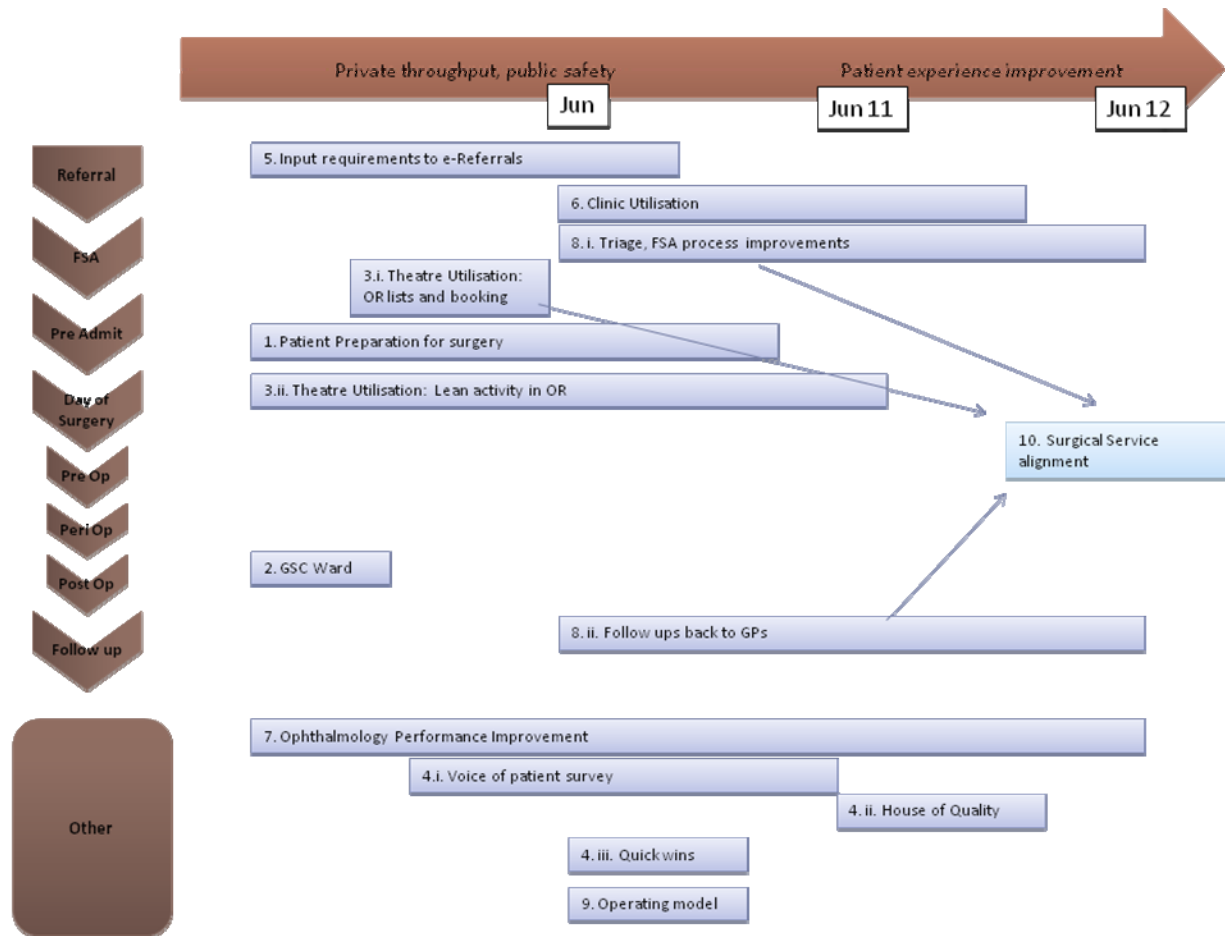
- | | |
|---|---|
| 1. Increase SMO responsibility for patient experience | 2. Create more certainty and convenience for patients |
| 3. Reduce wait times and waste in existing processes | 4. Create 'pull' for OR time and encourage even flow of work focused on managing wait times |
| 5. Incorporate workflow into facility construction | 6. Redirect appropriate cases from ACH to GSC |
| 7. Use GSC casemix to modify/enhance patient processes | 8. Create processes consistent with ACH requirements |
| 9. Enable management of performance based on patient experience, not compliance | 10. Encourage staff to deliver high throughput and good outcomes |
-

3. Order of activity



** Italicised actions represent ideas about future options for Greenlane, they depend on a high performing facility and patient input to process design*

Previous work plan for process stream



Challenges for GSC process stream:

- Schedule development for ORs - Ability of Surgical Services to provide capacity plan that links to Greenlane
- Schedule development for ORs – an operating model for Greenlane that informs how SMO resource is provided
- 60:60 Wait time performance (clinic and surgery) - the Greenlane pipe needs the surgical services to perform well to deliver 60:60 to patients
- Obtaining voice of the patient

The process described by the original business case requires:

1. Continued focus on the “development” phase to refurbish the existing facility.
2. Scope clarification – The GSC project is working on 50% of ADHB elective volumes, what part does the GSC project play in delivering the enablers:
 - A single patient preparation pipe
 - Performance improvement for surgical services (for 60:60)
 - OR productivity improvement

3. Workforce Development

Staffing the GCC OR and associated services will be a combination of resource transfers, new fte for outsource work brought in-house and increased production capacity. The longer term workforce challenges and opportunities have been considered against the functions required across the each step of the patient journey from referral, through clinics, patient preparation, pre-op, operating, recovery, ward and back to primary care. This has suggested a number of functions that different workforces may be considered for. The training and development pathways for these workforces have been identified with associated actions. Some of these actions are more practical in terms of working with training providers to fast track some health professionals or increase training numbers. Others require more consultation and have longer development times in terms of role expansion.

4. Facility Development

Phase 1 development is proceeding on time and within budget of \$9.737m. We have brought forward some aspects from phase 2 and put back some phase 1 aspects.

OR development

Following Board approval in November detailed working drawings for the OR development were submitted to council for building consent in early December 2009 with consent was received 22 December 2009. The OR development completed 3 shells with major equipment being installed in 2 of these by mi-April. Currently work is being finished on expanding one of the existing OR. We are currently ordering equipment with long lead times for 2 additional OR to be available July (and 3rd subsequent to that).

Sterile Supply Development

Building consent lodged and received April and tenders are currently being evaluated. Construction to commence shortly with an October / November completion slightly later than originally planned.

Reception, Pre-op, Sterile Inventory and Ward areas – Phase 2 (partial phase 1)

Planning is continuing on the above areas that will form part of phase 2. We are working with the services to combine the ophthalmology ward with the other surgical service bed requirements. This will give 8 – 10 beds for non-ophthalmology patients which will be sufficient for the short term casemix. Some of the ward development is budgeted to occur within phase 1 and we will review this.

Endoscopy Development and 4th OR – Phase 2

No work has commenced on these phase 2 aspects as we need to match these developments with the

- demand requirements (including potential reductions)
- throughput from 3 new OR when these are all fully functioning, and

- the throughput gains from existing OR's

5. Operationalising OR

Services have developed indicative list plans. Services are required to complete detailed production plans across ACH, SS and GCC that demonstrate how elective volume targets and acutes are to be met. These will match the Service resources (\$) to the elective contracts and identify any gaps and how these are to be bridged.

The GSC project team will work with the services to confirm their throughput expectations for GCC OR.

FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

Use document at start of Meeting Pack

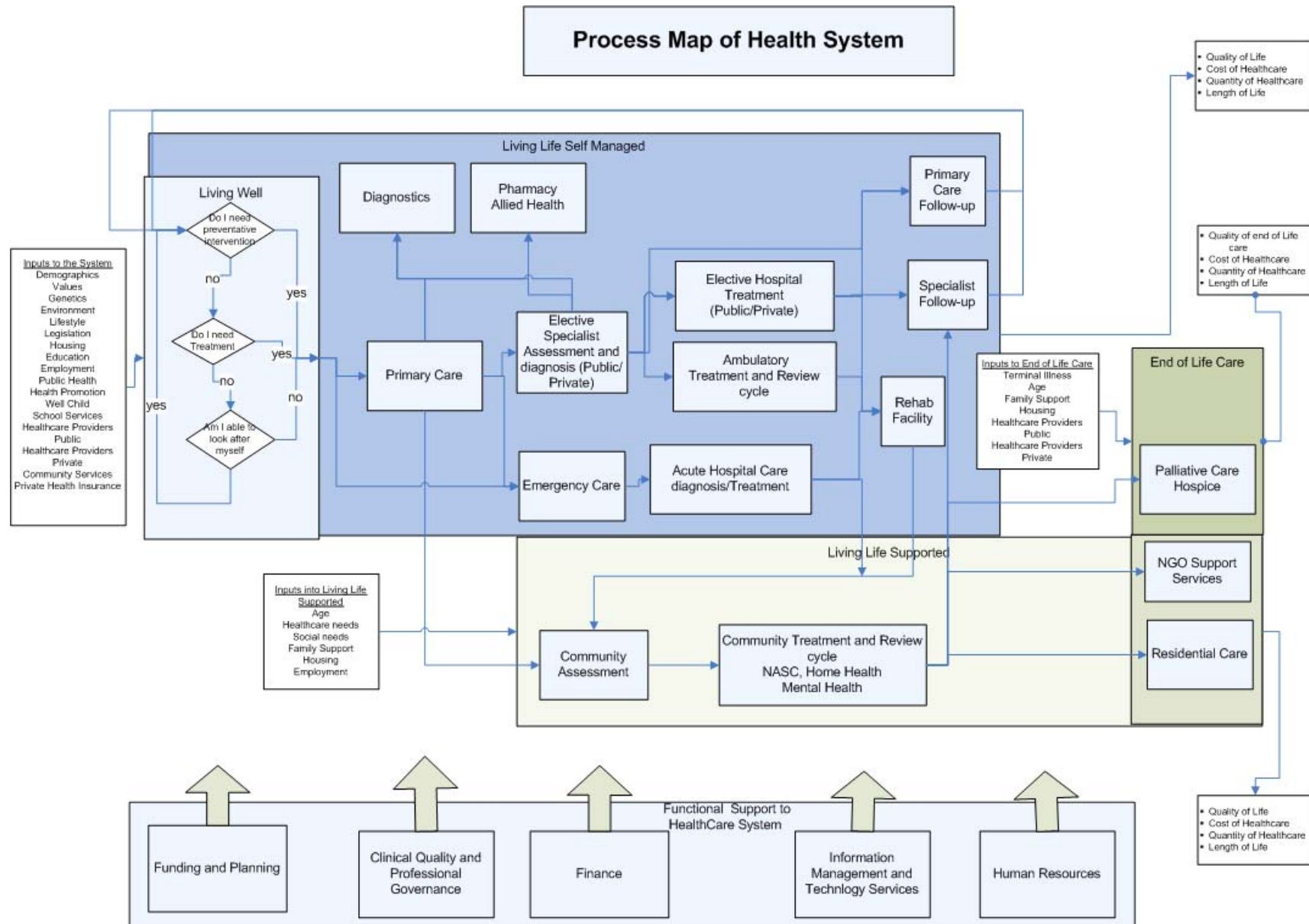
GENERAL BUSINESS

10

APPENDICES

10.1 Healthcare System Diagram

10.1 Healthcare System Diagram



MEETING DETAILS		
Time and Date	10:45am – 12:15pm, Wednesday 2 June 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 Margaret Wilsher, Brent Wiseman, Greg Balla, Margaret Dotchin, Fionnagh Dougan, Kay Hyman, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ian Bell.	
COMMITTEE FUNCTIONS		
To monitor the financial and operational performance of the hospitals (and related services) of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.		
	Item	Page No
1	Attendance and Apologies	001
2	Conflicts of Interest	003
3	Confirmation of Minutes Wednesday 5 May 2010	015
4	Action Points Wednesday 5 May 2010	021
5	Operational Performance 5.1 Operational Summary Report and Financials 5.2 Operational Indicators Exception Report	025
6	Improvement Activities 6.1 DAP Projects Report	043
7	Papers 7.1 Paediatric Specialty – Kay Hyman 7.2 Greenlane Surgical Centre Update – Peter Lowry	055
8	Feedback to Board	073
9	General Business	077

	Item	Page No
10	Appendices 10.1 Healthcare System Diagram	079
NEXT MEETING		
Time and Date: 10.45am – 12.15pm Wednesday 7 July 2010		
Venue: A+ Trust Room, Clinical Education Centre, Auckland City Hospital		

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