



Auckland District Health Board

Hospital Advisory Committee Meeting

Wednesday 7 April 2010

10:45am

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

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



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
Harry BURKHARDT (Deputy Chair)	1. Replas Ltd	Owner/Managing Director.	Salary	Plastics Manufacturing Company	6 August 2009
	2. Matta Products Ltd	Owner/Director.		Plastics Manufacturing Company	
	3. Remat Group Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	4. Burkhardt Investments Ltd	Shareholder/Director			
	5. Burris Ltd	Shareholder/Director			
	6. Reco Ltd	Director	Fee		
	7. ADHB Charitable Trust	Trustee		Government owned Maori Tourist operation	
	8. New Zealand Maori Arts and Craft Institute	Chairman		Plastics Manufacturing Holding Company	
	9. Matt I Ltd	Shareholder/Director		Plastics Distribution Company USA	
	10. Matta LLC	Trustee		Negotiator for Ngati Kuri o te Iwi Treaty of Waitangi claim	
	11. Deputy Chair and Negotiator Ngati Kuri o te Iwi	Consultant	Fee		
	12. Packaging Council of New Zealand	Executive Board Member			
Jo AGNEW	1. Senior Lecturer Nursing Auckland University		Salary		4 February 2009

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 2. New Zealand Research Centre for Growth and Development 3. James Henare Research Centre, University of Auckland 4. Manaia PHO, Whangarei 5. Whanau Ora Task Force 6. National Health Board	Chief Executive Board Member Advisory Board Member Shareholder Member Member	Salary Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust) Fee	Management of a Health, Disabilities, Social & Education Services Trust Governs a leading health sciences research centre Advises U o A on Maori research in Northland Governs a Whangarei based PHO Assists in the development of Government's Whanau Ora policy	17 February 2010
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 2. Locum GP 3. Waiheke "Integrated Family Health Centre" Steering Group	Chair Member	Meeting fee Contract rate		27 January 2010
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 	<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>General practitioner services</p> <p>Consultant Pacific Advisor</p> <p>Educational Support and Training</p> <p>Forensic sexual assault examinations</p>	1 November 2009
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 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
	2. Pacific Advisory Committee, PHAC CPHAC member	Chair	Fee		
	3. National Task Force for Family Violence MSD	Member	Fee		
	4. Family and Community Services national advisory group	Task Force member	Fee		
	5. Auckland Safer Communities	Advisory Member			
	6. Tamaki Achievement Pathways Schooling improvement	Executive member	Voluntary		
	7. Tamaki College Board of Trustees	Chair	Voluntary		
	8. Tamaki Community Development Trust	Elected Trustee	Fee		
Farida SULTANA	1. Nil	Member	Voluntary		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 	Employee	Salary		26 June 2008
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

- 3 MARCH 2010



Hospital Advisory Committee Minutes

MEETING DETAILS															
Time and Date	10:45am, Wednesday, 3 March 2010														
Venue	Pohutukawa Room, Sorrento in the Park, One Tree Hill Domain, Epsom														
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>Lynda Williams</td> <td></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 Margaret Dotchin - Nurse Director Fionnagh Dougan – GM Mental Health, Ambulatory, Cancer & Blood Services Dr Rick Franklin – Clinical Leader Ambulatory Services Kay Hyman - General Manager Women’s and Children’s Services Chris Morgan - Manager Materials Management Janice Mueller - Director Allied Health Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>The Chair declared the meeting open at 11:02am. Apologies had been received from Dr Chris Chambers and Farida Sultana. <u>Moved Lynda Williams; seconded Ian Ward</u> <i>That the apologies be sustained.</i> <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	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														
Lynda Williams															
2	CONFLICTS OF INTEREST														
	There were no declarations of conflicts of interest for any items on the agenda.														
3	CONFIRMATION OF MINUTES 3 FEBRUARY 2010														
	<p><u>Moved Jo Agnew; seconded Susan Buckland</u> <i>That the minutes of the Hospital Advisory Committee meeting held on 3 February 2010 be confirmed as a true and correct record.</i> <u>Carried</u></p>														

4	ACTION POINTS 3 FEBRUARY 2010
	<p>Professor Iain Martin</p> <p>Professor Martin addressed the Committee. There are only three functions of Hospital Advisory Committee stated in the Act but the view should be taken that this is a governance committee. Governance comes from the Greek word meaning to pilot and steer which infers that it does not delve into the mechanisms and management. The Committee does receive accurate reports on financial and operational performance and knows what's going on with reporting by exception showing confidence in the information. What the Committee does not address is the strategic issues three to five years out and requirements of the next decade and the hospital like the University are operational juggernauts that take time to turn around.</p> <p>New Zealand, for low investment gets a very high health outcome and this should not be forgotten and needs to be championed. Issues were equity with a significant minority and sustainability that looks to the whole system and is planned for with challenges for every country in the next five years being increasing older populations with decreasing tax revenues which would require containment of costs and management of expectations. In comparing three countries and expenditure at aged 74 compared with expenditure at age 50, were, in USA 11 1/2 times and Australia 4 1/2 times and in Sweden 2 times. What Sweden did was invest earlier in life and it is an egalitarian society as is New Zealand although New Zealand does have an equity issue. They were reaching a level where they could not increase taxation and young people could migrate through the European Union.</p> <p>Workforce investment was as integral an investment as the next operating theatre and to get sustainable workforce there needed to be evidence based changes.</p> <p>Quality was an important issue in service delivery with greater awareness in the public which would require leadership. There needed to be patient empowerment to be more responsible for their own healthcare using technology that patients can interpret and use themselves. There is a growing concept of personalised therapy that people expect an example being Herceptin and personalised hip replacements compared with manufactured runs. Another example was in oncology where at present only 30% benefit and 70% do not but we can not predetermine who would benefit.</p> <p>A vibrant research lead system is critical and this could be done better. While ACH and the University were next to each other they tended to talk across each other and needed to combine to have a Health Centre leading the country. Australia had announced Centres which may attract people from New Zealand. Over the next 5 - 10 years there needed to be strong leadership and ADHB and the University can provide that leadership in an evidenced based way. Presently research is heavily weighted to applied research rather than inquisitorial i.e. having no idea where the research would lead to. There needed to be more partnerships for research.</p> <p>The Chair suggested that the operational functions were in order but there was an opportunity and responsibility to be more indicative in a leadership sense and more provocative with leadership being a challenge for the Board.</p> <p>There was a contradiction in managing expectations and freedom of choice with personalised health being one of the biggest challenges but also could provide cost savings.</p> <p>The Chair thanked Professor Martin for his address.</p>
5.1	Operational Summary Report and Financials
	<p>There was a good result for January with leave taken and volumes down. Since the reports were produced there were a further 200 WIES but it had been a strong slow down. Treatment costs are an area of focus and are being tightly managed.</p>

5.2	Operational Indicator Exception Report
	<p>The reduction in Mental Health Total Community Face to Face Appointments reflected fewer presentations in January and these were now trending up.</p> <p><u>Moved Pat Snedden; seconded Rob Cooper</u></p> <p><i>That the operational performance reports be noted.</i></p> <p><u>Carried</u></p>
6.1	DAP Projects Report
	<p>The cardiac waiting list was presently 94 but should be down to 80 by the end of March with the team aiming for 60 as part of the improvement process as an internal target.</p>
7.1	Paediatric Acute Flow
	<p>Mike Sheppard, Clinical Director, Paediatric Emergency Medicine presented to the Committee supported by Janet Campbell, Charge Nurse CED, Sue Whaitiri, Charge Nurse Ward 24A Orthopaedics and Barry Allen, Process Improvement Specialist. The six hour goal needed a whole of hospital approach and should reflect improved patient care not just numbers. The areas of improvement were outlined being improved measurement system, improved bed allocation/management, early discharges, reduced wait time for early hour admissions and reduced less than 24 hour admissions.</p> <p>For measurement some children were better managed in ED longer than 6 hours and they needed to be differentiated. Bed management was looking at the transfer process and a hospital resource plan including a winter plan. Reducing occupancy had positive outcomes for the patient and with advanced planning provided information to the patient and caregiver. The project was using posters to increase awareness of what the project was doing around the whole hospital.</p> <p>Challenges were involving the whole of the hospital, the encroaching winter and a potential H1N1 outbreak together with financial constraints. Decisions to admit were collaborative decisions and while there were a few socioeconomic barriers to discharge experience was that patients were keen to go home which could be assisted by early documentation. The system was now more multi disciplinary and nurse coordinated. The Christchurch model had also been reviewed.</p> <p>The Chair thanked them for their presentation and for working for ADHB.</p>
	NEXT MEETING
	<p>The meeting closed at 12:20pm.</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 7 April 2010 A+ Trust Room Clinical Education Centre Level 5 Auckland City Hospital Grafton</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

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ACTION POINTS

3 MARCH 2010

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 3 March 2010**

Item	Detail	Designated	Action
	Nil		

OPERATIONAL PERFORMANCE

5.1 Operational Summary Report and Financials

**5.2 Operational Indicators Exception Report – No Exceptions
this Month**

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Overall Performance for the Month

The Provider produced a result \$1.7m favourable to budget for February 2010; with the Operational Division result \$1.8m favourable to budget (see table). Inpatient (wies funded) volumes were 224 lower than contract for the month but this was more than offset by a catch up related to previous months and non wies revenue favourable to contract.

Summary of Provider Results

\$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	12,371	10,566	1,805F	91,631	86,551	5,080F
Complementary	71	180	108U	1,087	1,016	72F
Functional	(11,095)	(11,066)	29U	(97,795)	(96,524)	1,271U
Ancilliary	(11,024)	(10,886)	138U	(96,708)	(95,508)	1,200U
Provider Net Surplus/(Deficit)	1,347	(320)	1,667F	(5,077)	(8,957)	3,880F

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.

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5.1.1 OPERATIONAL DIVISION OPERATING STATEMENT

Operating Statement - February 2010	Month			Year to Date		
Operational	Actual	Budget	Variance	Actual	Budget	Variance
<i>Total Income</i>						
Patient Care Revenue	82,574	79,873	2,701F	688,793	679,737	9,057F
Sales of Services & Products	879	988	108U	7,305	8,474	1,168U
Clinical Training & Education Income	1,292	1,392	99U	11,435	11,262	173F
Trust & Donation Income	218	805	587U	2,643	6,615	3,972U
Financial Income	1	-	1F	1	-	1F
Other Income	369	458	89U	3,919	3,828	91F
Profit on Disposal of Fixed Assets	-	-	0F	203	-	203F
Total Income	85,334	83,515	1,819F	714,298	709,914	4,383F
<i>Operating Expenditure</i>						
Employee Costs	50,620	48,907	1,712U	419,972	423,971	3,999F
Direct Treatment Costs	14,516	15,423	908F	135,890	129,846	6,045U
Funder Payments	0	-	0U	2	-	2U
Indirect Treatment Costs	2,418	2,917	499F	22,689	23,814	1,125F
Property, Equipment & Transportation Costs	2,195	2,374	179F	18,152	19,106	954F
Administration Costs	593	682	89F	5,633	5,780	147F
Indirect Service Billing	733	808	75F	6,438	6,464	26F
Loss on Sale of Fixed Assets	(29)	2	31F	98	14	84U
Total Operating Expenditure	71,047	71,114	67F	608,875	608,995	121F
Operating Surplus / (Deficit)	14,287	12,401	1,886F	105,423	100,919	4,504F
<i>Non-Operating Expenditure</i>						
Depreciation	1,906	1,826	80U	13,710	14,295	585F
Finance Costs	10	9	1U	82	73	9U
Total :Non-Operating Expenditure	1,916	1,835	81U	13,792	14,368	576F
Total Surplus / (Deficit)	12,371	10,566	1,805F	91,631	86,551	5,080F

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

Trust & Donation Income \$(0.6)m U \$(4.0)mU YTD

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

Operational arm employee costs were \$1.7m un-favourable to budget for February (\$4.0m F YTD). Staffing numbers exceeded budgeted numbers (Table 1), however the average cost of staff was *lower* than budgeted (Table 2).

Table 1 – FTEs for Month

FTEs	Budget FTE Month 2009	Actual FTE Month 2009	Variance
Adult Health	1,716	1,765	-49
Women, Child, Cardiac, OR&A	2,342	2,462	-120
Operations	1,373	1,427	-55
Ment Hlth, Amb, Ophth, Cancer & Blood	1,247	1,273	-26
Others	-1	1	-2
TOTAL	6,676	6,927	-251

Table 2 – Cost per FTE

Operational Services - Staffing Variance			
Month 2009/10	Budget	Actual	Variance %
Employee Costs (\$M)	48.9	50.6	-3.50%
FTE Numbers	6,676	6,927	-3.76%
Cost per FTE (Month)	7,326	7,307	0.25%
YTD 2009/10	Budget	Actual	Variance %
Employee Costs (\$M)	424	420	0.94%
FTE Numbers	6,722	6,851	-1.91%
Cost per FTE (Year to Date)	63,068	61,305	2.80%

The adverse staffing variance was due to the unfavourable FTE variance of 251 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.

Direct Treatment Costs

Direct treatment costs for February were favourable to budget by \$0.9M. Drugs were favourable to budget by almost \$0.4m, and patient applicances favourable to budget by \$0.6m reflecting volumes below contract (in the month and ignoring backdated adjustments).

Throughput

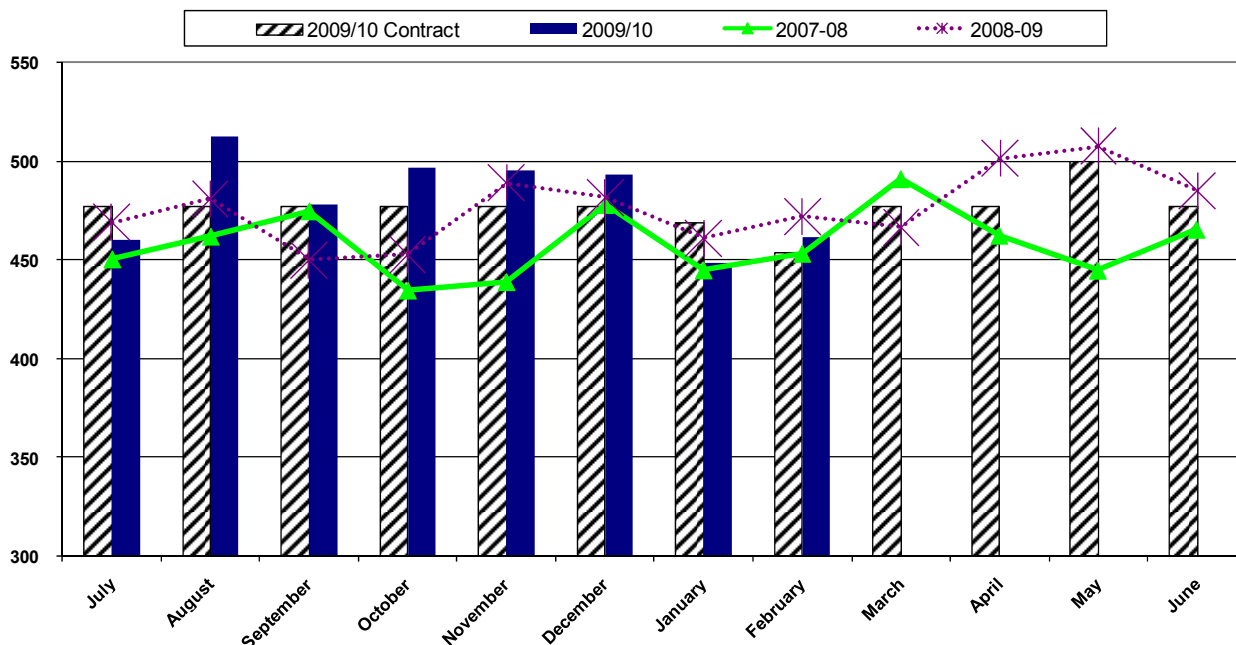
The chart below shows the production recorded to February 2010.

At the time the results were finalised, the coding was 75.5% complete (96.1% YTD) with the average WIES per discharge being 0.7% less than last year for the same period. Discharges are up by 2.9% from last year.

Inpatient delivery to the most current Price Volume Schedule (Feb 2010) was 98% for the month (101% YTD).

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	8,765	8,607	158F	80,290	79,013	1,277F
WIES Delivery per day	461	453	8F	481	473	8F

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



Volumes YTD

Inpatient volumes year to date February are shown below; 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.

Electives

DHB	Contract	Actual	Variance	% of completion
ADHB	9,891	8,482	-1,409	86%
CMDHB	2,836	3,212	376	113%
Other	7,491	7,725	234	103%
	20,218	19,419	-799	96%

Acutes

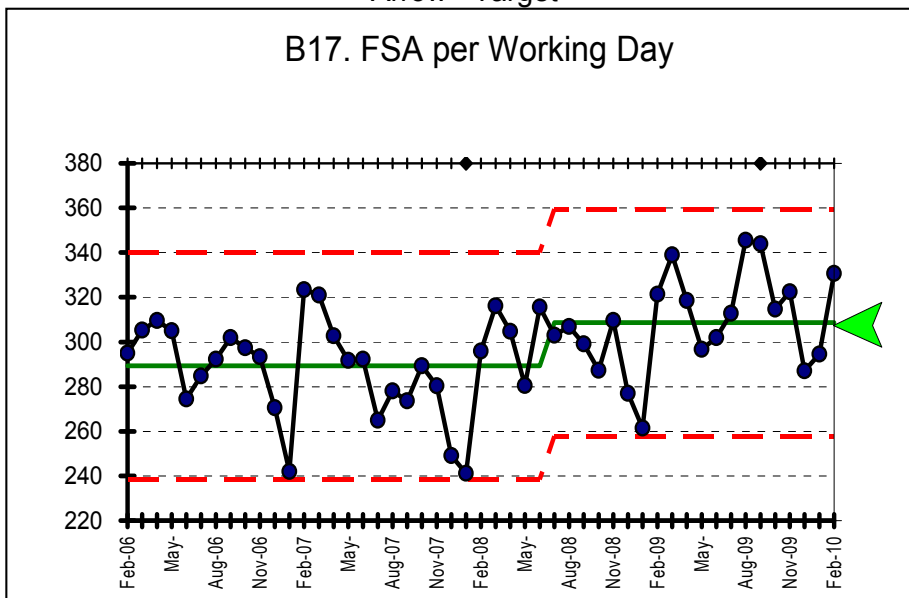
DHB	Contract	Actual	Variance	% of completion
ADHB	31,873	33,876	2,003	106%
CMDHB	8,169	7,835	-334	96%
Other	19,206	19,260	54	100%
	59,248	60,971	1,723	103%

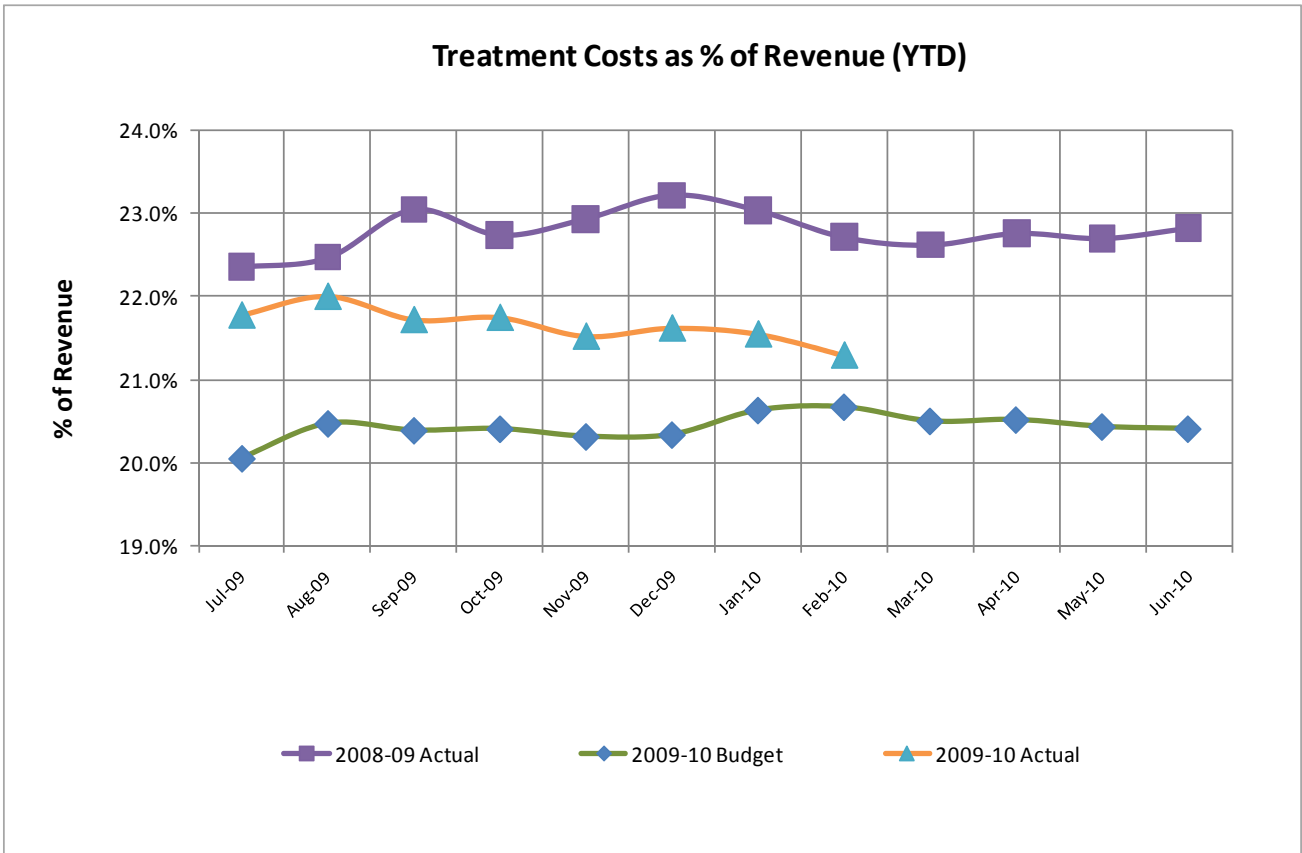
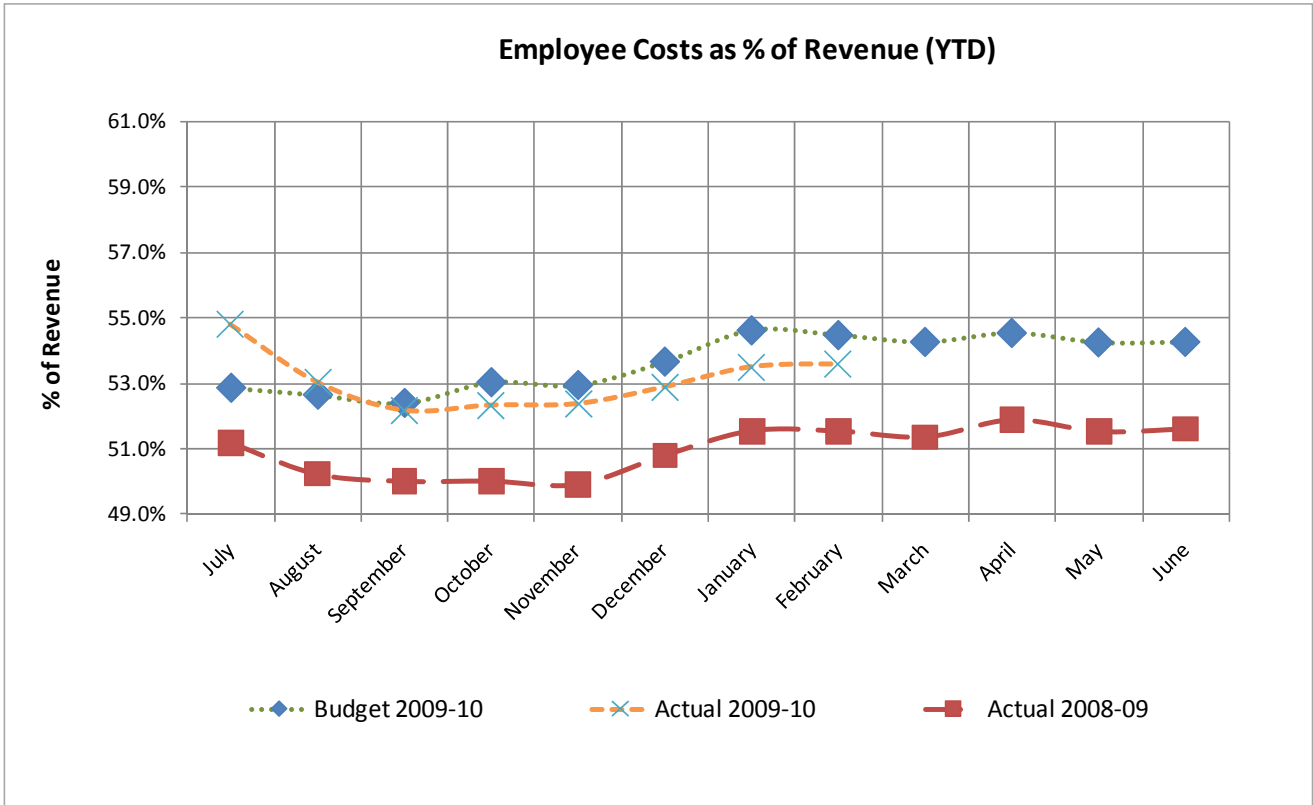
Acute & Elective

DHB	Contract	Actual	Variance	% of completion
ADHB	41,764	42,358	594	101.4%
CMDHB	11,005	11,047	42	100.4%
Other	26,697	26,985	288	101.1%
	79,466	80,390	924	101.2%

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'.

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





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

Health Service Portfolio	YTD Surplus/(Deficit)			Var as % to Budgeted Revenue	Comments
	Act	Bud	Var		
Women's Health	19,488	16,877	2,611F	5.3%F	The favourable variance is driven by higher volumes particularly in FSA Obstetrics \$1.2m and Maternity \$0.8m without any significant variances from budgeted expenditure.
Child Health	29,077	23,879	5,198F	4.3%F	The favourable variance is driven by higher volumes in Medical \$5.0m offset by lower coded Paediatric Cardiac volumes \$(1.4)m. Lower costs are driven by FTE vacancies & savings in superannuation \$2.6m offset by outsourcing of surgical workload (tonsillectomies & grommets) \$(0.8)m, higher drug costs \$(1.4)m and higher clinical supply costs \$(0.7)m.
Transplant, Renal, Urology, ORL, Neuro	28,643	26,713	1,930F	2.3%F	The favourable variance is the result of favourable employee costs \$2.5m, driven by medical and nursing FTE under budget due to the delayed opening of additional bed capacity and other efficiencies.
OR, Anaesthesia, CSSD	(65,721)	(67,922)	2,201F	N/A	The favourable variance is primarily driven by vacancies in both Anaesthetists & Anaesthetic Technicians \$2.2m. Anaesthetic Technicians vacancies have now been filled. Workload has however been sustained and there was increased leave taken over the Christmas period.
CWORAC Management	12,412	21,911	9,499U	N/A	Timing of Donation income for the MRI \$(4.3)m and Targeted Savings to be achieved \$(5.3)m. This is more than offset by the favourable variance of \$10.1m generated by the operational services in the portfolio.
Operations Management	118	3,012	2,894U	N/A	Target Savings \$(2.8)m. This unfavourable variance is substantially offset by favourable variances in individual services.
Others	67,614	62,081	5,533F	N/A	A range of Provider Services with variances less than \$0.5m
Total Operational	91,631	86,551	5,080F	0.65%F	

Operational

Feb 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	651,559		638,616		591,016		12,943 F	2.0%F	60,544 F
MoH Sub-contracts	16,014		18,518		12,618		2,504 U	13.5%U	3,396 F
Other Patient Care	21,220		22,603		22,671		1,383 U	6.1%U	1,451 U
	688,793		679,737		626,304		9,057 F	1.3%F	62,489 F
Services & Products	7,305		8,474		7,396		1,168 U	13.8%U	91 U
CTA	11,435		11,262		2,446		173 F	1.5%F	8,989 F
Trust & Donation Income	2,643		6,615		4,044		3,972 U	60.0%U	1,401 U
Other Income	4,121		3,828		3,906		293 F	7.7%F	215 F
	714,297		709,914		644,096		4,383 F	0.6%F	70,201 F
Expenditure									
Employee Costs									
Medical	141,443	19.8%	141,343	19.9%	130,192	20.2%	100 U	0.1%U	11,252 U
Nursing	154,260	21.6%	153,334	21.6%	143,767	22.3%	926 U	0.6%U	10,493 U
Technical	70,682	9.9%	73,245	10.3%	66,813	10.4%	2,563 F	3.5%F	3,869 U
Hotel Services	5,812	0.8%	5,739	0.8%	5,686	0.9%	72 U	1.3%U	126 U
Administration	26,944	3.8%	26,103	3.7%	28,354	4.4%	841 U	3.2%U	1,410 F
Other	20,832	2.9%	24,207	3.4%	19,209	3.0%	3,375 F	13.9%F	1,623 U
Total Employee Costs	419,972	58.8%	423,971	59.7%	394,020	61.2%	3,999 F	0.9%F	25,952 U
Direct Treatment Costs	135,890	19.0%	129,846	18.3%	129,248	20.1%	6,045 U	4.7%U	6,642 U
Indirect Treatment Costs	22,689	3.2%	23,814	3.4%	23,980	3.7%	1,125 F	4.7%F	1,291 F
Prop, Equip. & Transpt	18,152	2.5%	19,106	2.7%	17,915	2.8%	954 F	5.0%F	237 U
Administration Costs	5,633	0.8%	5,780	0.8%	5,864	0.9%	147 F	2.5%F	231 F
Indirect Service Billing	6,438	0.9%	6,464	0.9%	4,265	0.7%	26 F	0.4%F	2,173 U
Loss on Sale of Fixed Assets	98	0.0%	14	0.0%	64	0.0%	84 U	598.9%U	34 U
Total Operating Expenditure	608,872	85.2%	608,995	85.8%	575,355	89.3%	123 F	0.0%F	33,518 U
Operating Surplus/(Deficit)	105,425	14.8%	100,919	14.2%	68,741	10.7%	4,505 F	4.5%U	36,683 F
Depreciation	13,710	1.9%	14,295	2.0%	13,753	2.1%	585 F	4.1%F	43 F
Finance Costs	82	0.0%	73	0.0%	1,260	0.2%	9 U	12.6%U	1,177 F
Total Non Operating Costs	13,792	1.9%	14,368	2.0%	15,012	2.3%	576 F	4.0%F	1,220 F
Net Surplus / (Deficit)	91,633	12.8%	86,551	12.2%	53,729	8.3%	5,081 F	5.9%F	37,904 F

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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
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Improve the effectiveness & efficiency of Healthcare System</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Primary healthcare</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Improve Primary Secondary system efficiency -decrease total system cost</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Improve hospital efficiency / throughput</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Reduce waiting times for elective services</p>	Implementation of PHO-DHB primary healthcare plan	1. Implement approach to providing efficient & effective coordinated care in the neighbourhood
	Improve access to after hours primary care	1. Develop after-hours services including palliative and residential care
	Improve information availability across system	1. e-referrals, health event summaries and electronic outpatient letters 2. Increase access to diagnostic tests in primary care 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
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Improve Leadership Capability</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Improve clinical quality & professional governance</p>	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
	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
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Strengthen the health workforces</p>	Improve safety and quality of care	1. Implement the resilience improvement plan
	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)
<p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px;">Information management</p> <p style="background-color: #e0ffe0; border-radius: 10px; padding: 5px; margin-bottom: 5px; margin-left: 20px;">Planning</p>	Develop response to Long Term Services Plan	1. National 2. Regional 3. Local
	Improve resilience and availability of core IT systems	
Regional Strategic Plan		
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	Control	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	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0		
2) Performance Improvement	14	3	5	2	4	0	0	9	4	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		
Totals #	15	3	5	2	5	0	0	10	4	1	15	0	0	11	4	0	0	0	0			
Totals %	100%	20%	33%	13%	33%	0%	0%	67%	27%	7%	100%	0%	0%	73%	27%	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		Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green	Orange	Red			
		Define	Measure	Analyse	Improve	Control	Cancelled															
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			
1.2 Improve outcomes in priority areas	1	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			
Totals #	1	1	0	0	1	0	1	0	0	1	0	0	1	0	0	0	0	0	0			
Totals %	100%	100%	0%	0%	100%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	0%	0%	0%	0%			

Objectives

Objective	Objective Owner	Comment
Exceptions		

There are no projects that have been marked as an exception

High Level Summary Report

Goal 2 Performance improvement

DAP Projects

Total Projects: 27

DAP HLS	Number Started	Current Phase				On Time			On Budget			Expected Outcome			Post Implementation Benefits			
		Plan		Do/Check		Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver	Green	Orange	Red
		Define	Measure	Analyse	Improve	Act	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
2.2 Improve the efficiency and effectiveness of the healthcare system- decrease total system cost- primary secondary interface	2	0	1	1	0	0	1	1	0	2	0	0	1	0	0	0	0	0
2.3 Improve the efficiency and effectiveness of the healthcare system - hospital efficiency /throughput	6	0	1	0	5	0	3	3	0	6	0	0	5	1	0	0	0	0
2.4 Improve the efficiency and effectiveness of the healthcare system – reduce waiting times for elective services	3	3	2	1	0	0	3	0	0	3	0	0	3	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
2.6 Improve leadership performance in clinical quality & professional governance	1	1	0	1	0	0	1	0	0	1	0	0	0	1	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
2.8 Information management	12	12	2	0	1	8	0	6	3	10	2	0	11	1	0	0	0	0
2.9 Planning	3	3	1	1	1	0	0	2	0	1	3	0	2	1	0	0	0	0
Totals #	27	27	5	5	3	13	0	16	7	4	25	2	0	22	5	0	1	0
Totals %	100%	100%	19%	19%	11%	48%	0%	59%	26%	15%	93%	7%	0%	81%	19%	0%	4%	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	Ngairie 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 ESP12 with neurology the key adverse service, action is underway to address ibncluding recruitment and additional clinics.
2.4.2	Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation and medical oncology	Fionnagh Dougan (ADHB)	Waiting time increase to an average of 5.7 wks - further work in scoping phase as the project is required to develop an ongoing plan for sustainability.
2.4.3	Improve outpatient management for surgical patients while improving patient satisfaction	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	Budget	Expected Outcome	Sponsor Review	DAP project?
Adult 6-hour project	ADHB	Improve				Despite the peaks in patients presenting to ED, an increase of 4.3% on the same period last year, we have still seen a significant shift in forward shorter stays in ED target performance. Looking at the past two years results there has been a sustained performance, with 20 consecutive weeks of above average performance. However, the current level of performance is still well below the 95% target and an increased operational management discipline is to be introduced to increase the urgency associated with the six hour target. The sustained improvement in % of patients admitted from AED with stay < 6 hours reflects the relatively low levels of access block (due to increased bed availability) over recent months. In addition a smaller percentage of patients are being admitted than previously from ED (35%) to the wards and APU. This means AED has buffered the hospital considerably from the increased workload presenting at the front door. The percentage performance at 55% (target 95%) is unacceptably low. Green belt practitioners have commenced a number of projects which will assist implementation of ward improvement initiatives. Close monitoring of performance is required as workload (acute and elective) increases over winter months. The sustained improvement in % of patients discharged from AED with ED stay < 6 hours reflects an increased focus on speed and efficiency in AED made possible by adequate medical staffing numbers and the AED flow project delivering on improvement initiatives including documentation of clinical short stays.	yes
Starship 6 hour project	ADHB	Improve				Within the 'improve phase' a number of solutions are currently being implemented, second quarter results show an improvement from 80% to 84%. The first two months of 2010 has seen a further improvement to 90.4%. The challenge is for the project to maintain current gains and to embed operations management disciplines prior to the winter period.	yes
CONCORD Project	ADHB	Measure				Concord now has several projects completed and more underway. There is an increasing level of organisation interest and engagement. Some of the larger projects will not deliver all benefits in this financial year.	yes
eReferrals Ph1	Regional	Analyse				Contract negotiations at a crucial point. Chair and CMDHB CIO involved to get back on track.	yes
Auckland Region Cardiac Surgery Service Development	Regional	Improve				1/3/10 Progress continues to be made across all 10 workstreams.	yes
GSC	Regional	Define				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				February 2010: The average wait time for "C" Radical breast continues to be outside the MOH 6 week wait time however all "C" radical breast patients seen since the end of January will commence treatment within six weeks and all "C" Radical prostate patients seen since the beginning of February will commence treatment within 6 weeks (other than delays unrelated to capacity). Outsourcing simple breast and prostate patients to Waikato Hospital continues and has resulted in 9 patients receiving treatment since mid January. It is anticipated that capacity delays as a result of the lag effect of clearing patients seen in December and January and the increased capacity (following the opening of the new high energy Linac) will further reduce wait times in March. In order to deliver sustainable services the region requires an increasingly flexible workforce model. This can only be achieved through alternative employment strategies for key employment groups.	yes

Regional LTSP	Regional	Analyse				No change on previous report - NDSA's facilitated workshop to pull together the outputs from the work streams into a cohesive whole is now delayed until 12 Feb 2010. Significant focus will be required on work force planning. Intention is then to conclude write-up of Phase 2 during Feb/Mar 2010.	yes
PACS upgrade	ADHB	Define				Version upgrade will take place March 2010	no
PAS replacement plan	ADHB	Define				Given tight capital budget and lack of national support for full replacement strategy, it is likely we will extend us of CIMS/PHS for 3 to 5 years - some further planning required in Mar/July to confirm this approach	no
TestSafe Pharmacy	National	Analyse				Eclair platform upgraded - pilots successfully completed - team now preparing for wider roll-out over next few months	no

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	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		
3.2 Improve productivity	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		
Totals #	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

7

PAPERS

- 7.1 ADULT ACUTE FLOW PROJECT
- 7.2 MAORI DNA RATES

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Adult Acute Patient Flow
HAC Presentation
7 April 2010

Margaret Dotchin, Charlotte Porter, Mark Gardener, Tim Parke and Tim Denison

Adult Acute Patient Flow – Overall project fortnightly Report – 12 March 2010. Compiled by John McTaggart

Goal: That all Adult Emergency Department patients are discharged from AED or admitted to an inpatient ward within 6 hours (unless clinically indicated)

Define - Problem Definition / Background Completed

Problem statement

The current performance of 62.5% in the period July to September 2009 of Acute Adult patients discharged from AED or admitted to a ward within 6 hours is outside the Health Minister's goal of 95%.

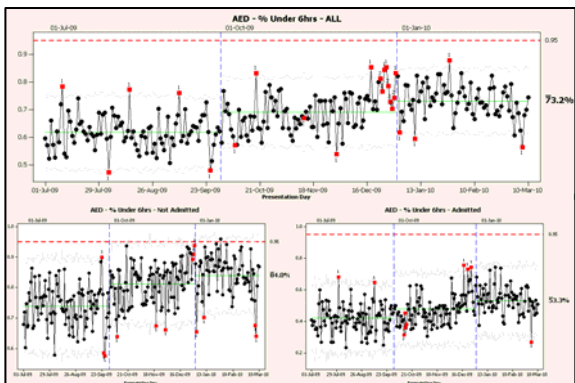
In scope

- All ADHB services and activities that potentially impact the flow of patients through AED and admitted to wards

Out of scope

- CED (A separate project will run concurrently with this project)
- Other DHB Emergency Departments
- Anything that will result in a significant negative impact on clinical effectiveness or patient satisfaction

Measure - Current performance for Admitted Patients Completed



- Initial baseline was 62% and has improved to 69% in the second quarter, with a further improvement to 73.2% in the Jan – March 2010 quarter (to 12 March)

Improve – identification & implementation of improvements Underway

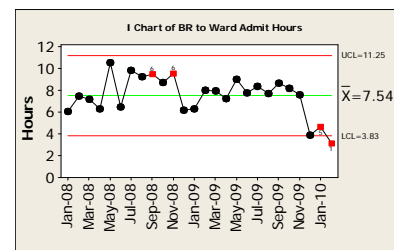


Recording of Clinical short stays by AED continues to improve, with a significant increase in the number of <6hr clinical short stays recorded. The daily median was 3 in November 2009, and this has doubled to 6 since December 2009 with a notable increase in March 2010

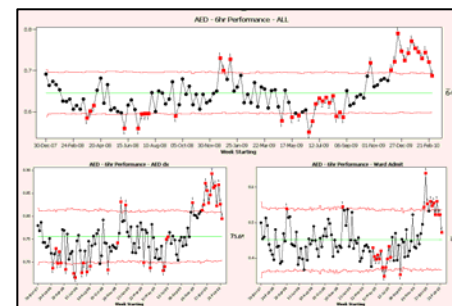
A number of improvements are currently being implemented to improve the flow of patients out of AED into wards, and initial data suggests that these are having an impact in the time taken to admit patients. Work currently underway includes

- Implementation of Rapid Rounds
- Improved Bed Management communication
- Increasing the number of patients discharged on weekends
- Improved Admission to Discharge planning

Lean Six Sigma Practitioner training commenced on 9 March, with 22 participants of which 9 are working on projects directly related to Acute Patient Flow. Each of these projects have been scoped and are currently in Define phase



Control – key metrics



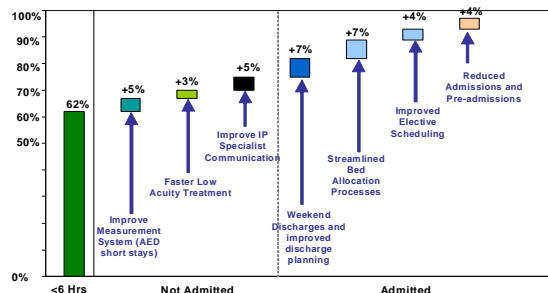
Primary output metrics currently being monitored are;

- % of AED patients discharged from AED within 6 Hrs
- % of AED patients discharged directly from AED within 6 Hrs
- % of AED patients transferred to a ward within 6 Hrs

Recent analysis shows a significant shift in performance when compared to the past 2 years, in both the admitted patients and those discharged directly from AED

Analyse – Identifying the Root Causes Completed

A number of root causes have been identified, none of which if implemented alone will achieve the shift in performance to 95%. A number of improvements will be required across a broad range of activities in order to create a significant increase in performance



Past and Planned activities - 2 February – 26 February

Past (1-15 March)

- Week one training delivered (9-11 March)
- Project reviews commenced
- CMS improvement development finalised

Planned (15-29 March)

- Green Belt projects to move to Measure phase
- Roll out of Rapid Rounds to continue
- Checking on the robustness of iBleep to continue
- Opportunities for more significant changes to management practices to be explored

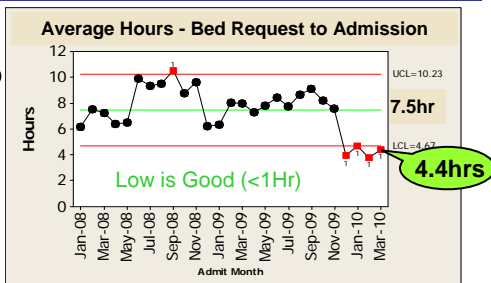
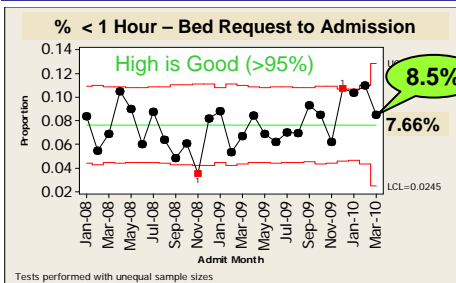
1. Define - Problem Definition / Background

Problem statement: In 2008 and 2009, the average time from bed request to ward admission was 7 ½ hours with 7.66% transferred in less than 1 hour compared to the ADHB goal of 95%. This long wait contributes to negative clinical outcomes and more patients with overall AED stays of over 6 hours.

In scope: All ADHB activities that impact the flow of patients from the decision to admit to ward admission through to patient discharge from wards.

Out of scope: CED, other DHBs, and anything that will result in a negative impact on clinical effectiveness or patient satisfaction.

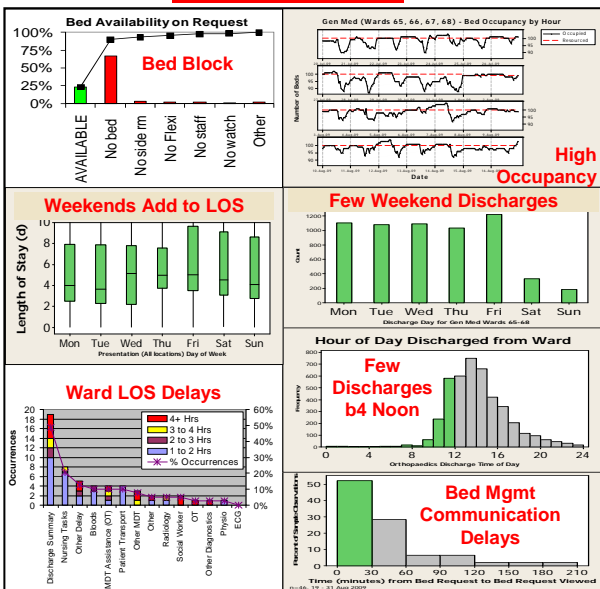
2. Measure – AED Bed Request to Ward Admit Data through 09 Mar 2010



Last 4 Months = Lowest Average Hours in over 2 years!

3. Analyse – Identifying the Root Causes

Root Causes Identified



Solution Design Objectives

Overall Objective: Ensure the right resourced bed on the right ward is available when the patient needs it and their transfer from AED is not delayed by communication

1. Ensure a patient's length of stay is appropriate for their care through **Proactive Admission to Discharge Planning**
 - ↓ bed block & occupancy
 - ↑ access to ward & timely referrals
2. Ensure **Weekend Care** does not add disproportionately to a patient's length of stay
 - ↓ bed block & occupancy
 - ↑ access to ward & weekend care
3. Ensure **Bed Management Communication** does not delay a patient's admission to ward
 - ↓ transfer delays

Solutions currently out of scope:

- Reduce admissions (Out of Scope)
- Increase # of beds (Out of Scope)

4. Improve – identification & implementation of improvements

1 Proactive Admission to Discharge Planning – Current Activity

Gen Medicine Daily Rapid Rounds	<ul style="list-style-type: none"> All Gen Med wards have implemented Daily Rapid Rounds Next Steps: Monitor (attendance, preparedness, timeliness) and train back-up facilitators 	<input type="checkbox"/>
Gen Medicine time of day discharge	<ul style="list-style-type: none"> Reduce delays for day of discharge logistics Green Belt project to commenced 9 March 2010 Key metric – patients discharged within 2hrs of approval 	<input type="checkbox"/>
Orthopaedics Estimated Disch Date Accuracy	<ul style="list-style-type: none"> Improve accuracy of estimated discharge dates to assist in patient plan and bed management Green Belt project to commenced 9 March 2010 	<input type="checkbox"/>
Orthopaedics Proactive A/D Planning	<ul style="list-style-type: none"> Workshop on 3 March to identify causes for longer than appropriate LOS. Key cause categories are Communication, External Factors, OPH/Rehab, and Weekends Data collection to validate causes to commence 15Mar-15Apr 	<input type="checkbox"/>
General Surgery Daily Rapid Rounds	<ul style="list-style-type: none"> Daily Rapid Rounds trial agreed for Ward 78 at Chg Nurse Planning w/ key stakeholders scheduled to commence April 19th Currently Communicating for Buy In – particularly doctors 	<input type="checkbox"/>

2 Weekend Care – Current Activity

Gen Med Nurse Facilitated Discharging	<ul style="list-style-type: none"> Planning relaunch in March – Green Belt Project Process agreed and finalised Commenced training with Charge Nurses and CNAs 	<input type="checkbox"/>
Orthopaedics Weekend Disch.	<ul style="list-style-type: none"> Increase # of weekend discharges on wards 75 & 77 Green Belt project to commenced 9 March 2010 	<input type="checkbox"/>

3 Bed Management Communication – Current Activity

Improve Delay Tracking and Time to View Bed Req.	<ul style="list-style-type: none"> CMS Changes (~50% to be completed in April Release) Next Steps: Improved tracking of causes for delays to AED discharge / ward admission – objective to assign delay reasons to every patient who spends longer than 6 hours in AED 	<input type="checkbox"/>
--------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------

5. Control – key metrics

- Bed Request to Ward Admission → % within 1 Hour and Average Time

Past and Planned activities - 1 March – 26 March

Past (1 March – 12 March)

- Orthopaedics workshop complete to identify causes for longer than appropriate LOS
- Lean Six Sigma week 1 training complete
- General Surgery agreement to trial Daily Rapid Rounds on Ward 78 – start date set: Apr 19th

Planned (15 March – 26 March)

- Orthopaedics data collection to commence on causes for longer than appropriate LOS
- General Surgery Daily Rapid Rounds – “Communicate for Buy In” to commence
- General Medicine Nurse Facilitated Discharge relaunch date to be set & training completed

Project: Adult Acute Patient Flow

60

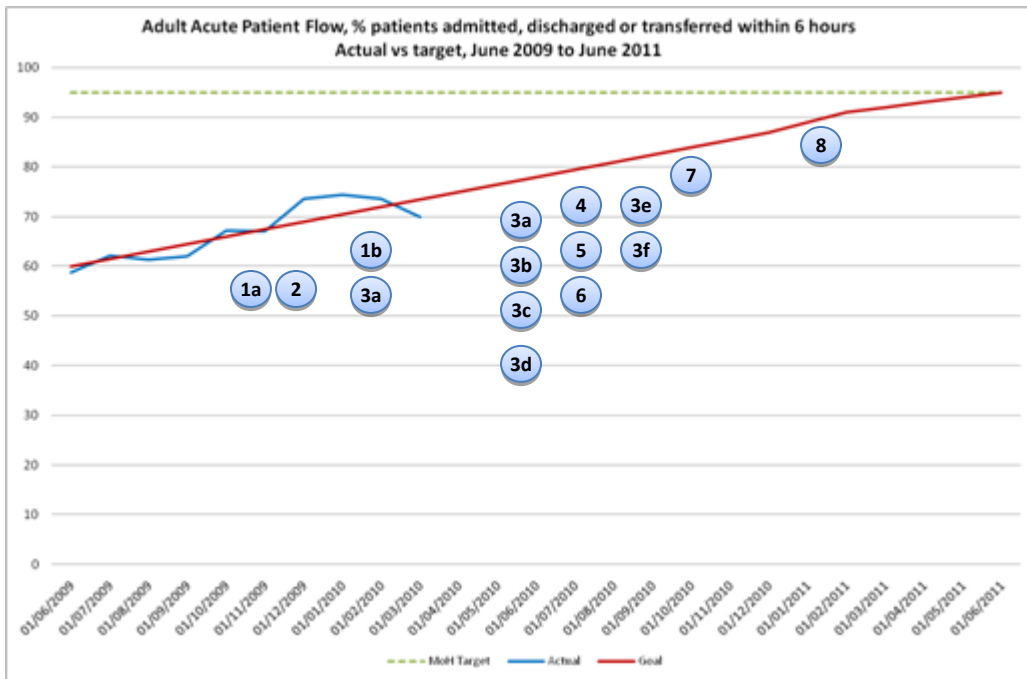
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin , Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

Steering Group: Nurse Director Margaret Dotchin, General Manager Ngaire Buchanan, Dr Tim Parke, Dr David Spriggs, Dr Wayne Jones, Dr Celia Palmer, Nurse Advisor Mark Entwistle.



Project Risks / Comments:

Despite the peaks in patients presenting to ED, an increase of 4.3% on the same period last year, we have still seen a significant shift forward in target performance. Looking at the past two years results there has been a sustained improvement, with 20 consecutive weeks of above average performance. However, the current level of performance is still well below the 95% target and an increased operational management discipline is to be introduced to increase the urgency associated with the 6 hour target.

Recent and Current activities:

1. Additional beds opened in
 - a) November 2009
 - b) January 2010
 2. Improved Measurement systems to better identify clinical short stay patients
 3. Reducing ward occupancy
 - a) Expediting patient discharges from wards by the introduction of daily 'rapid rounds' - completed in General Medicine wards - now being implemented into Orthopaedics and General Surgery
 - b) Increase the number of weekend discharges in General medicine and Orthopaedics
 - c) Improve the volume and accuracy of estimated discharge dates in General Medicine wards
 - d) reduce short stay (<24 hr) admissions
 - e) Remove delays associated with NASC referrals
 - f) Remove delays associated with Taikura Trust patients
 4. Bed management CMS system enhancements
 5. Improved ED / Inpatient Team methods of communication
- Planned activities
6. Increased Operational management
 7. Improved scheduling of elective volumes
- Future activities
8. Phase 3 improvement initiatives focusing on occupancy and specialty service response time.

+2 AUcfj'8 B5 'FUy



Māori Health Advisory Committee Hospital Advisory Committee

7.2

Date	17th March 2010										
To	Māori Health Advisory Committee (MHAC) Hospital Advisory Committee (HAC)										
From	Māori DNA Project Group Linda Thompson, Manager Clinical and Projects, He Kamaka Oranga John Paterson, Manager provider Arm Services, He Kamaka Oranga Leigh Cleland, Manager Greenlane Clinical Centre Ronald Ma, Analyst Planner, Auckland Regional Public Health Services										
Functional Group	The Integration Group										
Subject	Māori Patients - Did Not Attend (DNA) rates - ADHB										
1	<p>PURPOSE</p> <p>This paper backgrounds the work carried out on the Māori DNA project including recent activities of the DNA Project Group from September 2009.</p> <p>The Māori Health Team at He Kamaka Oranga reported in 2007 that Māori Did Not Attend (DNA) rates were a problem that contributed to inequalities in healthcare and health outcomes for Māori. The numbers of patients who were booked for, but who 'Did Not Attend' outpatient clinics at Auckland District Health Board facilities was significant and represented poor utilisation of services and resources, plus loss of an opportunity to impact positively on the health of Māori.</p> <p>The Māori DNA Review Report (<i>Ref: 10, 2008</i>) highlighted the rate of Māori DNA against all other DNA rates for the northern region inclusive of the District Health Boards for: Auckland (ADHB), Waitemata (WDHB), Counties Manukau (CMDHB), and Northland (NDHB) that were: "16% of all the appointments made to attend ADHB services and clinics, and were 17% of all DNAs across all the DHBs" (p.7).</p> <p>The Māori DNA Project was established (2008-09) to identify services with high Māori DNA rates, propose solutions and provide an implementation plan to improve service delivery and reduce Māori DNA rates. He Kamaka Oranga believed that improvements in this area would contribute to improved health outcomes for Māori and Māori whānau.</p> <p>In July 2009, the project became a District Annual Plan (DAP) objective for ADHB. A Māori DNA Project Group was then convened to proactively address the Māori DNA rate and to align their activities to the 2009/2010 DAP, which stated goal one, to "Reduce inequities in health status", and objective one, to "Reduce DNA rates in hospital services from 16% to 11%" (<i>Ref: 6, p.28</i>). This objective was in alignment with the ADHB Statement of Intent (2008–2011) target of an annual 5% reduction in DNAs for Māori using provider arm services. (<i>Ref: 1, p.v1</i>)</p>										
2	<p>Recommendations</p> <p>Following are the recommendations of the Māori DNA Project Group:</p> <table border="1"> <thead> <tr> <th></th> <th>DAP</th> <th>DSP</th> <th>Budget</th> </tr> </thead> <tbody> <tr> <td>1 Accept that the inequity between Māori and non-Māori DNAs will continue to be monitored and supported in a broader context by other He Kamaka Oranga and Service Specialty initiatives. <i>Refer to section 4, Tables (iv) & (v) of this paper.</i></td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> <td></td> </tr> </tbody> </table>				DAP	DSP	Budget	1 Accept that the inequity between Māori and non-Māori DNAs will continue to be monitored and supported in a broader context by other He Kamaka Oranga and Service Specialty initiatives. <i>Refer to section 4, Tables (iv) & (v) of this paper.</i>	✓	✓	
	DAP	DSP	Budget								
1 Accept that the inequity between Māori and non-Māori DNAs will continue to be monitored and supported in a broader context by other He Kamaka Oranga and Service Specialty initiatives. <i>Refer to section 4, Tables (iv) & (v) of this paper.</i>	✓	✓									

		DAP	DSP	Budget
2	Continue monitoring the implementation of the DNA initiatives across all specialties, focused firstly on specialties with high Māori DNA rates. <i>Refer to section 5 of this paper.</i>	✓		
3	Agree that the Māori DNA project will move to business as usual at the end of the 2009/10 DAP cycle. The timeframe given for this project was to February 2010. Initiatives have since been implemented at the Greenlane Clinical Centre facility and will be ongoing from this point, with implementation and monitoring occurring simultaneously between the Operations and Maori Health management teams	✓		
4	Agree that the Māori DNA rate is now being measured accurately and has reduced. <i>Refer to section 3 of this paper.</i>	✓		
5	Agree that ADHB compares reasonably with the Health Roundtable good practice recommendation of having a DNA rate of between 5% and 10%. <i>Refer to section 3 of this paper – ‘Benchmarking’</i>			
6	Agree that ADHB compares favorably to other DHB’s considering the efforts required to reduce Māori DNA rates especially as ADHB manages a large portion of other DHBs’ patients. <i>Refer to section 3, Table (ii) of this paper</i>			
7	Formalise the recommendations to the Clinical Board in an ADHB DNA Protocol following Clinical Board approval. <i>Refer to section 5, p.4 of this paper – ‘<u>Recommendations for presentation to the Clinical Board</u>’</i>			

3 BACKGROUND

Benchmarking

The Project Group found that the Health Roundtable information on improving the journey for outpatients stated - “Good Practice for ‘did not attend’ (DNA) rates for specialist medical clinics in the public sector” was between 5% and 10%. (Ref: 9, p.1)

The Project Group commenced implementation of a set of DNA solutions from October 2009. The Māori DNA rate at that time was being measured at 16%. The first task of the project team was to ensure we were collecting our data accurately and recording it in a manner that allowed for accurate trending over past and ensuing months and years. Data integrity was in question and with the assistance of a Data Analyst resource the DNA rate was accurately reported at 11%. ADHB utilises the Atlas Datawarehouse system and extrapolates DNA trends from regular monthly and yearly reports. Both financial years (30 June – 01 July) and calendar years (01 Jan – 31 Dec) have been used to inform the various DNA reports.

Table (i) Māori DNA Rate by ethnicity by Financial Year

Ethnicity	2006	2007	2008	2009
Asian	5%	5%	5%	5%
European	4%	4%	4%	4%
Māori	12%	12%	11%	10%
Other	7%	7%	6%	7%
Pacific	11%	11%	11%	11%

This table demonstrates that while the Māori DNA rate decreased by 1% between 2006-08 and by another 1% between 2008-09, it still remains highest along with Pacific DNA.

As part of the project information gathering we also reviewed and compared the ADHB Māori DNA rate with other DHB's: Waitemata DHB, Counties Manukau DHB, Northland DHB, and Capital and Coast DHB.

Table (ii) District Health Board comparative findings.

2009 Calendar Year	TOTAL APPOINT	TOTAL DNAs	TOTAL DNA RATE	MĀORI APPOINT	MĀORI DNAs	MĀORI DNA RATE
CMDHB	176445	19020	11%	24756	5579	23%
WDHB	185834	18476	10%	13981	2967	21%
NDHB	64361	6549	10%	19042	3584	19%
CCDHB	157402	13959	9%	16095	2759	17%
ADHB	670348	36054	5%	67209	6462	10%

- Of the total number of Māori appointments for ADHB, 10% DNA'd
- ADHB has the lowest total DNA rate and the lowest Māori DNA rate (by approximately half) of all the other DHBs

We also looked at Māori patients who are resident within other DHB areas but are referred to services provided by ADHB.

Table (iii) Maori appointments and DNA, based on place of residence. (2009 Calendar Year)

DHB of Residence	Booked	DNA	% of Total
Auckland	26,414	3,416	53%
Waitemata	18,246	1,337	20.5%
Counties Manukau	13,297	1,273	19.5%
Northland	4,858	244	3.5%
Other	4,394	192	3.5%
Grand Total	67209	6462	100%

- 53% of all DNA reside in the ADHB area.
- The above DNA rates only relate to clinics that are held either at GCC or ACH.
- These DNA rates do not include out-reach clinics i.e. clinics that are held off the ACH or GCC sites.

4 FINDINGS

1. The overall Māori DNA rate is currently 10%, however in some individual specialties the DNA rate is significantly higher than this as depicted in the top 6 specialties in the table below.
2. The project group identified the top 6 specialties that had the highest Māori DNA rates.
3. These top 6 specialties represented just under 30% of the total Māori DNA rates.

Table (iv) Māori DNA rate per specialty for the months of July 2009 to Jan 2010.

DNA%	Jul 09	Aug	Sep	Oct	Nov	Dec	Jan 10	Change from Oct to Dec 09
Audiology	45%	32%	30%	32%	50%	54%	41%	22% ▲
General Surgical	19%	17%	17%	21%	31%	19%	14%	- 2% ▼
Gynaecology (General)	11%	9%	14%	27%	22%	26%	11%	- 1% ▼
Maternity	18%	15%	14%	17%	21%	20%	18%	3% ▲
Orthopaedics Clinic	38%	35%	31%	33%	29%	36%	26%	4% ▲
Respiratory - Chest Clinic	42%	22%	47%	43%	21%	36%	38%	- 8% ▼

- Most of the initiatives to reduce DNAs were implemented in October 09, and the changes shown above represent both a downward trend in 3 of the Top 6 clinics (General Surgical, Gynaecology General, and Respiratory-Chest Clinic); and an increase in the other 3 clinics (Audiology, Maternity and Orthopaedics)
- The following Table (iv.a) provides an age breakdown of the Top 6 Clinics

Table (iv.a) Māori DNA Top 6 Clinics by age group for 2009

ClinicDesc	0-15	16-45	46-70	>71	Grand Total
Audiology	285	42	26	2	355
General Surgical Outpatients		76	72	7	155
Gynaecology (General)	5	121	39		165
Maternity Outpatients	4	425			429
Orthopaedics Outpatient Clinic	8	244	92	9	353
Respiratory Services - Chest Clinic		159	188	20	367
Grand Total	302	1,067	417	38	1,824

Cont'd –	Table (v) Inequity data reviewed as part of the over arching DAP objective and to “Reduce inequities in health status”																			
	<table border="1"> <thead> <tr> <th>DNA%</th> <th>2006</th> <th>2007</th> <th>2008</th> <th>2009</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>12%</td> <td>11%</td> <td>11%</td> <td>10%</td> </tr> <tr> <td>Non-Māori</td> <td>6%</td> <td>6%</td> <td>6%</td> <td>5%</td> </tr> <tr> <td>Grand Total</td> <td>6%</td> <td>5%</td> <td>5%</td> <td>5%</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • The Māori DNA rate had reduced 2% since 2006 • The disparity between Māori and Non Māori DNA rates has reduced 1% since 2006 • The following initiatives in Section 5 highlight the areas for targeted Māori DNA reductions 	DNA%	2006	2007	2008	2009	Māori	12%	11%	11%	10%	Non-Māori	6%	6%	6%	5%	Grand Total	6%	5%	5%
DNA%	2006	2007	2008	2009																
Māori	12%	11%	11%	10%																
Non-Māori	6%	6%	6%	5%																
Grand Total	6%	5%	5%	5%																

5 The following is a table of initiatives that have been implemented in the top 6 specialties in point 3 above.

Generic Initiatives that have improved the Māori DNA rate

Flyer and 0800 number	Implemented. <u>Every</u> patient receives a flyer with their appointment letter reminding them of the importance of attending their appointment and consequences of not.
Invitation to Contact	Implemented in top 6 clinics, focusing on Māori in the first instance
Texting to confirm	Implemented in top 6 clinics, focusing on Māori in the first instance.
Children's play area in the main outpatients	Plans are underway to install a play area in the main OPD waiting area. Funded from the Starship Foundation and Hector Trust.

Initiatives that are aimed at reducing inequity

Contacting patients who have or are likely to due to a history of non attendance, focusing on Māori.	Via OP25 report. Patients who have in the past DNA'ed and have an appointment coming up are called to ensure they attend. This will be fully underway in the top 6 specialties by early March 2010.
Tracking on a daily basis the reasons why Māori people have not attended their appointments	Via OP25 report we now receive daily the patients who have DNA'ed the previous day and they are called to understand why they DNA'ed and to manage their appointment.

Initiatives for consideration that are aimed at reducing inequity and increasing awareness.

- Extended hours for clinics, after 5pm or at weekends
- External media, General Manager Māori to discuss Māori DNA rates on weekly radio.
- Consultation with Māori community through hui, to provide appropriate messages on the importance of attending clinic appointments, benefits and contributions to their own good health care, and whanau ora, explaining the Flyer etc.

	<p><u>Recommendations for presentation to the Clinical Board</u></p> <ol style="list-style-type: none"> 1. That any patient that has historically DNA'ed 3 or more times is returned to their GP for care. 2. That when a patient DNA's a letter is sent to them and their GP giving them 10 days to contact ADHB and rebook their appointment. If no contact a further letter is sent to return their care to their GP. 3. That consultation is undertaken with the service concerned to achieve a service level agreement around which patients can be automatically returned to their GP for care and which patients need to have their notes reviewed by the ADHB SMO and a decision made to either return their care to the GP or to reschedule their appointment. 4. That only those patients who confirm their appointments will be scheduled one. Patients who do not confirm will be returned to the waitlist or their GP if they have failed to confirm their appointment 3 or more times. This is a SMO decision <ol style="list-style-type: none"> a. That clinic cancellation data is collated and continues to be sent to the Service Manager / Clinical Director partnership on a monthly basis. This report now allows sorting of data by ethnicity. b. That there is a centralised managed and updated grid for both the ACH and GCC clinic facilities. 5. That eligibility for all patients of all ethnicities is checked in conjunction with the Eligibility team by the CRO in the first instance, when a referral is received. 6. That if a patient is graded A or B then they would continue to be booked with clear communication to them that states that they will have to pay for their care if they do not prove their residency before or at their appointment. 7. That any patients graded C or D are not entered onto the waitlist until they have proved their eligibility.
6	<p>OUTCOMES/NEXT STEPS</p> <p>These are listed as the recommendations to this paper on pp.1 & 2</p>
7	<p>REFERENCES</p> <ol style="list-style-type: none"> 1. Auckland DHB Statement of Intent, 2008 -11 March, 13 v7, p.v1; 2008 2. Auckland District Health Board Health Improvement Plan 2006 to 2010; Health Communities, Quality Healthcare Hei Oranga Tika Mo Te Iti Me Te Rahi; 18 June 2007 3. Auckland District Health Board District Strategic Plan to 2010; February 2006 4. Auckland DHB District Annual Plan, 2007-08 5. Auckland DHB District Annual Plan, 2008-09 6. Auckland DHB District Annual Plan, 2009-10 7. DNAs for Planning and Funding Travel Plan 01/09/06 to 31/08/07. <i>The findings from the current analysis of DNA (for ADHB) in outpatient clinics; confirms that 17% (6900) of Māori patients do not attend an outpatient clinic.</i> 8. He Kamaka Oranga Māori Health Action Plan: Te Aratakina "A Pathway Forward" 2006 - 2010 9. The Health Roundtable Ltd. <i>Issue November 2007, "How to Improve the Journey for Outpatients"</i> CAN 071 387 436, NSW, Australia 2074, 2008 10. Report on the Project to Reduce Do Not Attend Rates for the Māori Population at Outpatient Clinics, He Kamaka Oranga, ADHB, August 2008

	<p>DHB Comparative data sources:</p>
--	--------------------------------------

- NDHB – Scorecard
- C&CDHB - Scorecard
- WDHB – Crystal data base system
- CMDHB – Scorecard
- ADHB – Atlas Datawarehouse data base system

MĀORI DID NOT ATTEND PROJECT

March 2010

HISTORICAL SUMMARY

2007 He Kamaka Oranga

Issue – Māori Did Not Attend (DNA) rates

2007-08 Māori DNA

Report – after initial review

2008-09 Māori DNA Project established

Aim – to reduce Māori DNA rates

2009 DNA Project a District Annual Plan (DAP) objective for ADHB

Project Group – convened to address Māori DNA rates



Table (i) Māori DNA Rate by ethnicity per year: 2006 – 2009

Ethnicity	2006	2007	2008	2009
Asian	5%	5%	5%	5%
European	4%	4%	4%	4%
Māori	12%	12%	11%	10%
Other	7%	7%	6%	7%
Pacific	11%	11%	11%	11%

- **Māori DNA rate decreased 1% 2006 – 08;**
- **& by another 1% 2008 – 09**
- **Remains highest along with Pacific DNA**

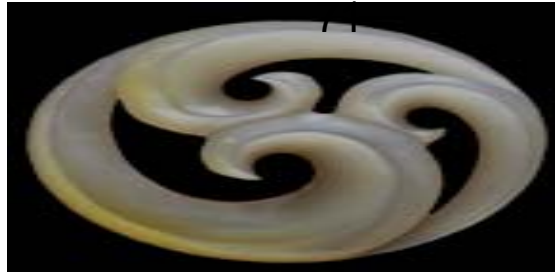


Table (ii) District Health Board comparative findings

2009 calendar year	Tot appt	Tot DNA	Tot DNA rate	Māori appt	Māori DNA	Māori DNA rate
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CCDHB	157402	13959	9%	16095	2759	17%
ADHB	670348	36054	5%	67209	6462	10%

- ADHB – more than 3 times as many appointments than other DHBs & just 5% DNA
- ADHB – of total number of Māori appointments DNA = 10%
- ADHB – lowest total DNA rate and lowest Māori DNA rate of all other DHBs
- ADHB – complies with Health Roundtable rec'd DNA range of 5 – 10%

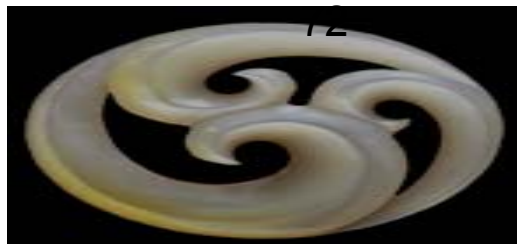
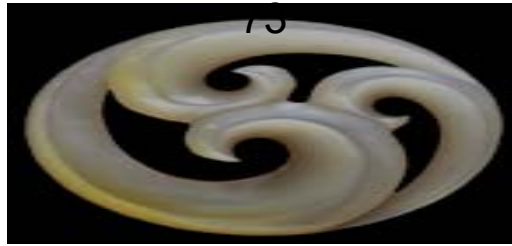


Table (iii) ADHB MĀORI APPTS & DNAs
 – includes those from other DHB areas (2009)

DHB of Residence	Booked	% of total Māori Booked	DNA	% of total Māori DNA
Auckland	26,414	39%	3,416	53%
Waitemata	18,246	27%	1,337	21%
Counties Manukau	13,297	20%	1,273	20%
Northland	4,858	7%	244	4%
Other	4,394	7%	192	4%
TOTAL	67209	100%	6462	100% (%’s rounded)

- 53% of all Māori DNA reside in the ADHB area**
- (47% reside outside area)**
- Figures are for GCC & ACH clinics / Not out-reach clinics**



FINDINGS

Table (iv) Māori DNA rate per specialty for the months of July 2009 to Jan 2010

DNA % Specialty	July 09	August	Septemb	October	Novemb.	Decemb.	Jan 10	Change from Oct to Dec 09
Audiology	45%	32%	30%	32%	540%	54%	41%	22% ▲
General Surgical	19%	17%	17%	21%	31%	19%	14%	- 2% ▼
Gynaecol. General	11%	9%	14%	27%	22%	26%	11%	- 1% ▼
Maternity OP	18%	15%	14%	17%	21%	20%	18%	3% ▲
Orthopaed.	38%	35%	31%	33%	29%	36%	26%	3% ▲
Respirat.- Chest	42%	22%	47%	43%	21%	36%	38%	- 7% ▼ (%s rounded)



SUMMARY

- Māori DNA rate is currently 10%
- But - some specialties have DNA rate significantly higher
- Top 6 specialties with highest Māori DNA identified
- Top 6 specialties represent just under 30% of Māori DNA rate
- DNA reduction strategies implemented from October 09
- Changes represent both a downward trend (3 clinics) and an upward trend (3 clinics)

AGE FACTOR related to Top 6 Clinics/Specialties:

- 0 -15yr olds are 94% DNA at Audiology Clinic
- 71+yr olds are 52% DNA at Chest Clinic
- 46 – 70yr olds 45% DNA at Chest Clinic
- 16 – 45yr olds are 39% DNA at Maternity Outpatients

High DNA %'s correlate with at least 2 of the 3 clinics demonstrating increased DNA rates

[Table (iv)]

Table (v) Inequity data reviewed - DAP objective

DNA%	2006	2007	2008	2009
Māori	12%	11%	11%	10%
Non Māori	6%	6%	6%	5%
Total	6%	5%	5%	5%



- **The Māori DNA rate reduced 2% since 2006**
- **The disparity between Māori and Non Māori has reduced 1% since 2006**



INITIATIVES

Improving DNA Rates

- Flyer and 0800 number
- Invitation to Contact
- Texting to confirm
- Children's play area

INITIATIVES

Reducing Inequities (Māori)

- Direct, regular contact with patients – OP25 reports & resource person
- Tracking reasons for DNA on a daily basis – OP25 reports & resource person

For consideration to reduce inequity and increase awareness

- Extended hours for clinics, after 5pm or at weekends
- External media
- Consultation with Māori community through hui

OUTCOMES

1. **Māori DNA rate - now measured accurately - has reduced**
2. **Inequity between Māori and non-Māori DNAs – monitoring system in place and supported**
3. **ADHB compares reasonably with recommended DNA rate of 5% - 10%**
4. **ADHB compares favorably to other DHBs' Māori DNA rates**

NEXT STEPS

1. **DNA initiatives across all specialties – monitored for implementation**
2. **Māori DNA project - move to business as usual**
3. **Formalise Clinical Board recommendations into ADHB DNA Protocol**



FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

Use document at start of Meeting Pack

GENERAL BUSINESS

10

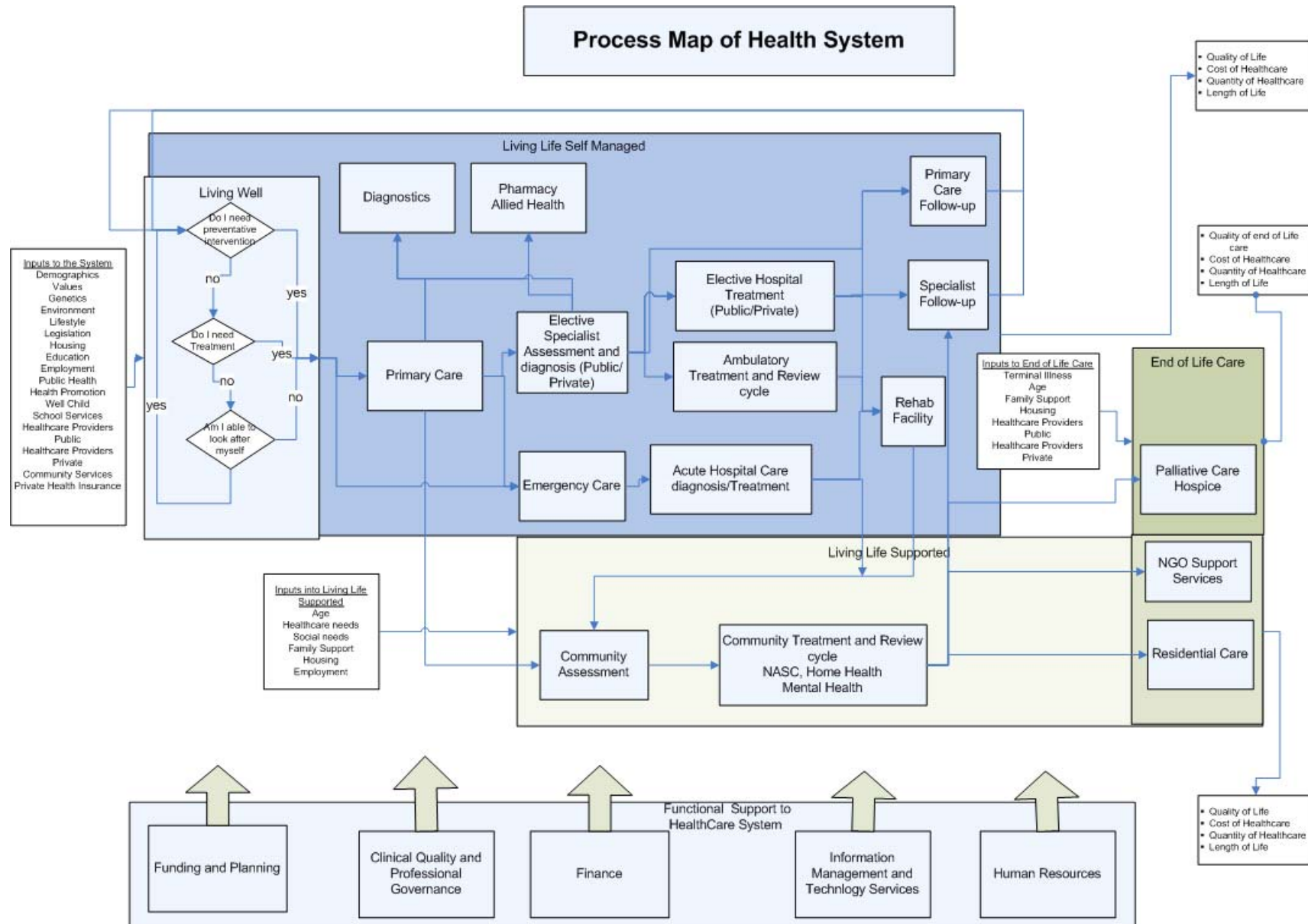
APPENDICES

10.1 Healthcare System Diagram

10.2 Clinical Indicators Exception Report and Full Indicator Set

10.3 Ministry of Health Indicators

10.1 Healthcare System Diagram



MEETING DETAILS		
Time and Date	10:45am – 12:15pm, Wednesday 7 April 2010	
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton	
Members	Dr Chris Chambers (Chair), Jo Agnew, Susan Buckland, Harry Burkhardt, Rob Cooper, Dr Brian Fergus, Dr Ian Scott, Pat Snedden, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward, Assoc Prof Anne Kolbe, Prof Iain Martin, Farida Sultana, Lynda Williams	
Apologies		
In Attendance	Garry Smith, Dr David Sage, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Margaret Dotchin, Fionnagh Dougan, Dr Rick Franklin, Kay Hyman, Chris Morgan, Janice Mueller, Vivienne Rawlings, Ian Bell.	
COMMITTEE FUNCTIONS		
To monitor the financial and operational performance of the hospitals (and related services) of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.		
	Item	Page No
1	Attendance and Apologies	001
2	Conflicts of Interest	003
3	Confirmation of Minutes 3 March 2010	015
4	Action Points 3 March 2010	021
5	Operational Performance 5.1 Operational Summary Report and Financials 5.2 Operational Indicators Exception Report – No Exceptions this Month	025
6	Improvement Activities 6.1 DAP Projects Report	041
7	Papers 7.1 Adult Acute Flow Project 7.2 Maori DNA Rate	053
8	Feedback to Board	079
9	General Business	081

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10	Appendices 10.1 Healthcare System Diagram	083
NEXT MEETING		
Time and Date: 10:45, Wednesday 5 May 2010 Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton		

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