



# **Auckland District Health Board**

## **Hospital Advisory Committee Meeting**

**Wednesday 3 March 2010**

**10:45am**

**Pohutukawa Room  
Sorrento in the Park  
One Tree Hill Domain Auckland**

**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:	
<b>DAP</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>KPIs</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
1.	
2.	
<b>RISKS</b>	
<b>RECOMMENDATIONS</b>	
1.	
2.	
<b>NOTING</b>	
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

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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](http://www.legislation.govt.nz)) and “Managing Conflicts of Interest – Guidance for Public Entities” ([www.oag.govt.nz](http://www.oag.govt.nz)).



## ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Pat SNEDDEN (Chair)</b>	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
<b>Harry BURKHARDT (Deputy Chair)</b>	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			
	8. New Zealand Maori Arts and Craft Institute	Chairman		Government owned Maori Tourist operation	
	9. Matt I Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	10. Matta LLC	Trustee		Plastics Distribution Company USA	
	11. Deputy Chair and Negotiator Ngati Kuri o te Iwi	Consultant	Fee	Negotiator for Ngati Kuri o te Iwi Treaty of Waitangi claim	
	12. Packaging Council of New Zealand	Executive Board Member			
<b>Jo AGNEW</b>	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
<b>Susan BUCKLAND</b>	<ol style="list-style-type: none"> <li>1. Writing, editing and public relations services</li> <li>2. Medical Council of NZ</li> <li>3. Occupational Therapy Board</li> </ol>	<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
<b>Dr Chris CHAMBERS</b>	<ol style="list-style-type: none"> <li>1. Employee, Auckland District Health Board</li> <li>2. Wife employed by Safekids</li> <li>3. Associate, Epsom Anaesthetic Group</li> <li>4. Member, ASMS</li> <li>5. Shareholder, Ormiston Surgical</li> <li>6. Credentialing Committee for private hospitals</li> </ol>				4 March 2009

<b>NAME OF BOARD MEMBER</b>	<b>ORGANISATION</b>	<b>ROLE</b>	<b>FINANCIAL INTEREST</b>	<b>NATURE OF INTEREST</b>	<b>DATE OF LATEST DISCLOSURE</b>
<b>Rob COOPER</b>	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	1 September 2009
	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	
<b>Dr Brian FERGUS</b>	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				15 July 2009
<b>Dr Ian SCOTT</b>	1. Shareholder Deputy Chair and Clinical Advisor Auckland PHO	Deputy Chair	Meeting fee		7 August 2009
	2. Locum GP		Contract rate		
	3. Waiheke "Integrated Family Health Centre" Steering Group	Member			
<b>Bob TIZARD</b>	1. Nil				27 February 2008

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Seiuli Dr Juliet WALKER</b>	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	Self employed contractor  Member  Contractor  Contractor	Contract hourly rate  Fee  Contracted monthly fee  Hourly rate	General practitioner services  Consultant Pacific Advisor  Educational Support and Training  Forensic sexual assault examinations	1 November 2009
<b>Ian WARD</b>	1. Chair, Advisory Board, Vision Health Limited		Fee		15 July 2009

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	Chair	Fee		
	3. National Task Force for Family Violence MSD	Member	Fee		
	4. Family and Community Services national advisory group	Task Force member	Fee		
		Advisory Member			
			Voluntary		
	5. Auckland Safer Communities	Executive member	Voluntary		
	6. Tamaki Achievement Pathways Schooling improvement	Chair	Voluntary		
		Fee	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		
7. Tamaki College Board of Trustees	Elected Trustee	Voluntary			
	8. Tamaki Community Development Trust	Member			
Farida SULTANA	1. Nil				6 August 2008

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Lynda WILLIAMS</b>	1. Maternity Services Consumer Council	Employee	Salary		4 August 2008
	2. Auckland Women's Health Council	Employee	Salary		
	3. Member National Antenatal HIV Screening Implementation Advisory Group				
	4. Chair Postnatal Distress Support Network Trust Board				
	5. ADHB Primary Maternity Services Steering Committee				
<b>Iain MARTIN</b>	1. University of Auckland	Employee	Salary		26 June 2008
<b>Anne KOLBE</b>	1. Private Paediatric Surgical Practice				12 December 2008
	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				



**CONFIRMATION OF MINUTES**

**- 3 FEBRUARY 2010**



# Hospital Advisory Committee Minutes

<b>MEETING DETAILS</b>															
Time and Date	10:45am, Wednesday, 3 February 2010														
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton														
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>														
	<p><b>Committee Members</b></p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Susan Buckland</td> <td>Harry Burkhardt</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Brian Fergus</td> </tr> <tr> <td>Dr Ian Scott</td> <td>Pat Snedden</td> </tr> <tr> <td>Rt Hon Bob Tizard</td> <td>Seiuli Dr Juliet Walker</td> </tr> <tr> <td>Ian Ward</td> <td>Associate Professor Anne Kolbe</td> </tr> <tr> <td>Professor Iain Martin</td> <td>Lynda Williams</td> </tr> </table> <p><b>Management in Attendance</b></p> <p>Garry Smith - Chief Executive  Dr David Sage –Chief Medical Officer  Dr Margaret Wilsher – Deputy Chief Medical Officer  Brent Wiseman - Chief Financial Officer  Greg Balla – Director Performance and Innovation  Ngaire Buchanan - General Manager Operations  Margaret Dotchin - Nurse Director  Dr Rick Franklin – Clinical Leader Ambulatory Services  Kay Hyman - General Manager Women’s and Children’s Services  Janice Mueller - Director Allied Health  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>The Chair declared the meeting open at 11:00am.  Apologies had been received from Farida Sultana, Clive Bensemman and Fionnagh Dougan.</p>	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	Associate Professor Anne Kolbe	Professor Iain Martin	Lynda Williams
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	Associate Professor Anne Kolbe														
Professor Iain Martin	Lynda Williams														
<b>2</b>	<b>CONFLICTS OF INTEREST</b>														
	<p>Chris Chambers advised of some changes to the interest register.  There were no declarations of conflicts of interest for any items on the agenda.</p>														
<b>3</b>	<b>CONFIRMATION OF MINUTES 2 DECEMBER 2009</b>														
	<p>The question of publishing the advanced care planning was raised to ensure older people can express their wishes. ADHB was introducing the Counties Manukau’s process initially in renal and then through the hospital which may take some number of years. In the cases of strokes the person may not be able to express their wishes so there needed to be that community discussion and a need to make wishes known to family. It was noted that if it was medically futile there would not be resuscitation.</p> <p>The CMO gave an update on plastics services advising that up to 2 years ago there was a work stream at NDSA with a project manager on regional service planning. This had been abandoned and now it was a matter of negotiation service by service between the DHBs in the absence of a regional service plan. With plastics there was no regional service process or strategic plan but</p>														

	<p>had developed at Middlemore in conjunction with the National Burns Unit. This provided services for ADHB. Services for breast reconstruction needed to be improved in 2010. Orthopaedics did receive a good service for adults. Payment was by way of IDF outflows and volumes were monitored and services monitored quality of service.</p> <p><u>Moved Pat Snedden; seconded Brian Fergus</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 2 December be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
7	<p><b>CANCER WAITING TARGETS</b></p>
	<p>Andrew Macann, Richard Sullivan and Robyn Dunningham were in attendance. The Cancer Control Programme was run through four regional networks overseen by a Cancer Steering Group. The aim was to cover the continuum from prevention through treatment to palliative care for example with lung cancer it included quit smoking, treatment and palliative care. The MoH target was for a maximum four week wait for radiotherapy. The Northern Region Network consisted of the four DHBs, NGO and primary care.</p> <p>ADHB provided a regional service and was applying a lean thinking approach including lung and bowel cancer work streams. It was a patient focus model to give appropriate equitable access to care. The Maori Leadership Group was one of the successes and sat across all services with very good engagement. In terms of equity, data was now being collected to measure the gap so there could be a focus on access. The four weeks target came into effect in December 2010.</p> <p>The increased linear accelerator capacity within the northern region with the opening of the ARO had increased the intervention rate with 40.3% being achieved for ADHB's population compared with the target of 40% in the 2009/2010 DAP. The optimal model intervention rate was 46%. Strategies to achieve the target were to develop a radiation oncology 10 year strategic plan and to improve treatment resource utilisation focused on efficiency gains related to linear accelerator operation. The operational requirements model was to calculate future capacity requirements and adjust practices to meet the target. The radiation therapists' operation model was to get greater flexibility to manage peaks and troughs and the MV5 linear accelerator replacement was crucial as it was replacing a 13 year old machine that could only operate at 50% capacity. Outsourcing to address peaks was to Waikato and talks were continuing with ARO. Changes in the future would be increased brachytherapy therapy.</p> <p>While there had been some tension with ARO due to loss of radiation therapists to them a collaborative relationship was trying to be developed. The strategic plan would include looking at linear accelerator replacements and where new linear accelerator should be located with work being done on historic models down to particular tumours. In terms of outcomes survival rate data was not collected.</p> <p>The Committee thanked the presenters.</p>
4	<p><b>ACTION POINTS 2 DECEMBER 2009</b></p>
	<p><b>DNA</b></p> <p>DNA rates had been discussed at the Quality, Risk and Audit Committee with a request for a report back from the project team, this to be to the HAC not Quality.</p> <p><b>Workforce Pressure</b></p> <p>Points to be considered were:</p> <ol style="list-style-type: none"> <li>1. Health and wellbeing of the workforce – burnout</li> <li>2. NHS pushback, planning of workforce; and</li> <li>3. Harassment.</li> </ol> <p>The management/clinical partnership had line responsibility for the workforce as a leadership function assisted by HR. There was a national Workforce Board which more appropriately planned rather than individual DHBs.</p>

<b>5</b>	<b>OPERATIONAL PERFORMANCE</b>
<b>5.1</b>	<b>Operational Summary Report and Financials</b>
	<p>The monthly result was slightly unfavourable with year to date overall favourable. While the first six months had gone well the next six months would be difficult due to the savings needed to be achieved and the patient acute flow being above contract. There is no evidence of inappropriate acute presentations.</p> <p>The variability of opening hours at Waitakere was having an impact on CED as people from the West bypassed Waitakere. Within the summer plan this had not functioned well for Orthopaedics with a increased number of outliers. Donation revenue was a matter of timing with the MRI funding expected April/May. There as an agreed process with the Starship Foundation, this included the likelihood of attracting sponsors, resulting in bringing more money into the system. The improved access to MRI for children would have a side affect of more MRI capacity for all services.</p> <p>Major direct treatment cost variances were clinical supplies and outsourcing above budget. There was the potential for employee costs to be worse. The outsourcing costs were greater than costs if done in-house. With the targeted savings if they were delayed or were not able to be achieved there would be a need to look at other ways to achieve them.</p>
<b>5.2</b>	<b>Operational Indicator Exception Report</b>
	<p>The apparent step changes in acute WIES volumes in the graph needed to be explained. There were some long stay patients which in Starship are defined as more than 14 days. These are reviewed weekly. There were a couple of patients over 100 days which may not be able to be discharged before 30 June.</p> <p>Patients waiting longer than 6 months for their FSA had increased particularly due to neurology being down one neurologist at present which impacted on FSA. Referral guidelines were also being reconsidered.</p>
<b>5.3</b>	<b>All Operational Indicators</b>
	<p>The employees with excess annual leave needed to be analysed by professional groups. It was understood that leave above 4 weeks could be paid out legally, that taking leave can be insisted upon however this needed to be balance with the need to maintain production.</p>
<b>6</b>	<b>IMPROVEMENT ACTIVITIES</b>
<b>6.1</b>	<b>DAP Projects Report</b>
	<p>Most projects are in the green category against the three goals. While some exceptions were noted overall there was satisfaction at the progress of projects. Management would have liked CONCORD to progress faster.</p>
<b>9</b>	<b>GENERAL BUSINESS</b>
	<p><b>Hospital Advisory Committee</b></p> <p>In response to a question on how the committee was going Iain Martin advised that the culture and feel of the Committee had been a big change and improved, however, there was a large quantity of data provided and there appeared to be a focus on the detail rather than the strategic bigger picture. There needed to be care in not being captured by the data detail. The CE advised that the data in the appendices were intended for information and that the variances being exception reports were being raised after investigation by managers. It was suggested that the full data set not be in a future agenda. It was noted however that a number of years ago there was no confidence in the data being provided but now that there is confidence there could be more focus on the strategic. Members were invited to consider how the HAC could be changed.</p>

	<b>NEXT MEETING</b>
	The meeting closed at 12:50pm. The next meeting is scheduled for 10:45am, Wednesday, 3 March 2010 Pohutukawa Room Sorrento in the Park One Tree Hill Domain Auckland
<b>CONFIRMED</b>	
<b>CHAIR:</b>	<b>DATE:</b>

**4**

**ACTION POINTS**

**3 FEBRUARY 2010**



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

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
9	Iain Martin and Members were invited to consider how the HAC could be changed.	Iain Martin All	



## **OPERATIONAL PERFORMANCE**

**5.1 Operational Summary Report and Financials**

**5.2 Operational Indicators Exception Report**



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## 5.1 Summary Report

### Overall Performance for the Month

The Provider produced a result virtually on budget for January 2010; with the Operational Division result almost \$5m ahead of budget (see table). Inpatient (wies funded) volumes were lower than contract for the month but the initiative to encourage staff leave was successful with employee costs in the operational areas \$3.6m favourable to budget.

### Summary of Provider Results

\$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>Operational</b>	6,096	1,121	4,975F	79,260	75,985	3,275F
Complementary	243	122	120F	1,016	836	180F
Functional	(16,457)	(11,555)	4,902U	(86,700)	(85,457)	1,242U
<b>Ancilliary</b>	(16,214)	(11,433)	4,781U	(85,684)	(84,621)	1,063U
<b>Provider Net Surplus/(Deficit)</b>	(10,118)	(10,311)	193F	(6,424)	(8,637)	2,213F

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

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

## 5.1.1 OPERATIONAL DIVISION OPERATING STATEMENT

Operating Statement - January 2010 Operational	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
<i>Total Income</i>						
Patient Care Revenue	74,318	74,461	144U	606,219	599,864	6,356F
Sales of Services & Products	801	888	87U	6,426	7,486	1,060U
Clinical Training & Education Income	1,245	1,376	131U	10,142	9,870	272F
Trust & Donation Income	97	805	709U	2,425	5,810	3,385U
Other Income	395	462	68U	3,549	3,370	179F
Profit on Disposal of Fixed Assets	-	-	0F	203	-	203F
<b>Total Income</b>	<b>76,855</b>	<b>77,993</b>	<b>1,137U</b>	<b>628,964</b>	<b>626,399</b>	<b>2,565F</b>
<i>Operating Expenditure</i>						
Employee Costs	48,955	52,592	3,637F	369,353	375,064	5,711F
Direct Treatment Costs	13,886	15,563	1,677F	121,375	114,422	6,953U
Funder Payments	2	-	2U	2	-	2U
Indirect Treatment Costs	2,784	2,979	195F	20,271	20,897	626F
Property, Equipment & Transportation Costs	2,056	2,387	331F	15,957	16,732	775F
Administration Costs	520	690	171F	5,040	5,098	58F
Indirect Service Billing	828	808	20U	5,705	5,656	49U
Loss on Sale of Fixed Assets	48	2	47U	127	12	115U
<b>Total Operating Expenditure</b>	<b>69,079</b>	<b>75,021</b>	<b>5,942F</b>	<b>537,828</b>	<b>537,882</b>	<b>54F</b>
<b>Operating Surplus/(Deficit)</b>	<b>7,776</b>	<b>2,971</b>	<b>4,804F</b>	<b>91,136</b>	<b>88,518</b>	<b>2,618F</b>
<i>Non-Operating Expenditure</i>						
Depreciation	1,669	1,841	171F	11,804	12,469	665F
Finance Costs	10	9	1U	72	64	8U
<b>Total :Non-Operating Expenditure</b>	<b>1,680</b>	<b>1,850</b>	<b>170F</b>	<b>11,876</b>	<b>12,533</b>	<b>657F</b>
<b>Total Surplus/(Deficit)</b>	<b>6,096</b>	<b>1,121</b>	<b>4,975F</b>	<b>79,260</b>	<b>75,985</b>	<b>3,275F</b>

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

**Trust & Donation Income**                      \$(0.7)m              U

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.

Favourable variances reflected the numbers of staff on leave and lower throughput, resulting in lower treatment costs.

## Employee Costs

Operational arm employee costs were \$3.6m favourable to budget for January. Staffing numbers exceeded budgeted numbers (Table 1), the average cost of staff was also lower than budgeted (Table 2).

**Table 1 – FTEs for Month**

<b>FTEs</b>	<b>Budget FTE Month 2009</b>	<b>Actual FTE Month 2009</b>	<b>Variance</b>
Adult Health	1,716	1,718	-2
Women, Child, Cardiac, OR&A	2,341	2,411	-69
Operations	1,374	1,426	-53
Ment Hlth, Amb, Ophth, Cancer & Blood	1,250	1,271	-21
Others	-1	1	-2
<b>TOTAL</b>	<b>6,679</b>	<b>6,826</b>	<b>-147</b>

**Table 2 – Cost per FTE**

<b>Operational Services - Staffing Variance</b>			
<b>Month 2009/10</b>	<b>Budget</b>	<b>Actual</b>	<b>Variance %</b>
Employee Costs (\$M)	52.6	49.0	6.91%
FTE Numbers	6,679	6,826	-2.21%
Cost per FTE (Month)	7,874	7,171	<b>8.92%</b>
<b>YTD 2009/10</b>	<b>Budget</b>	<b>Actual</b>	<b>Variance %</b>
Employee Costs (\$M)	375	369	1.52%
FTE Numbers	6,634	6,729	-1.44%
Cost per FTE (Year to Date)	56,541	54,889	2.92%

**Direct Treatment Costs**

Direct treatment costs for January were favourable to budget by \$1.7M. Drugs were favourable to budget by almost \$1m, reflecting, as noted elsewhere, lower throughput.

**Throughput**

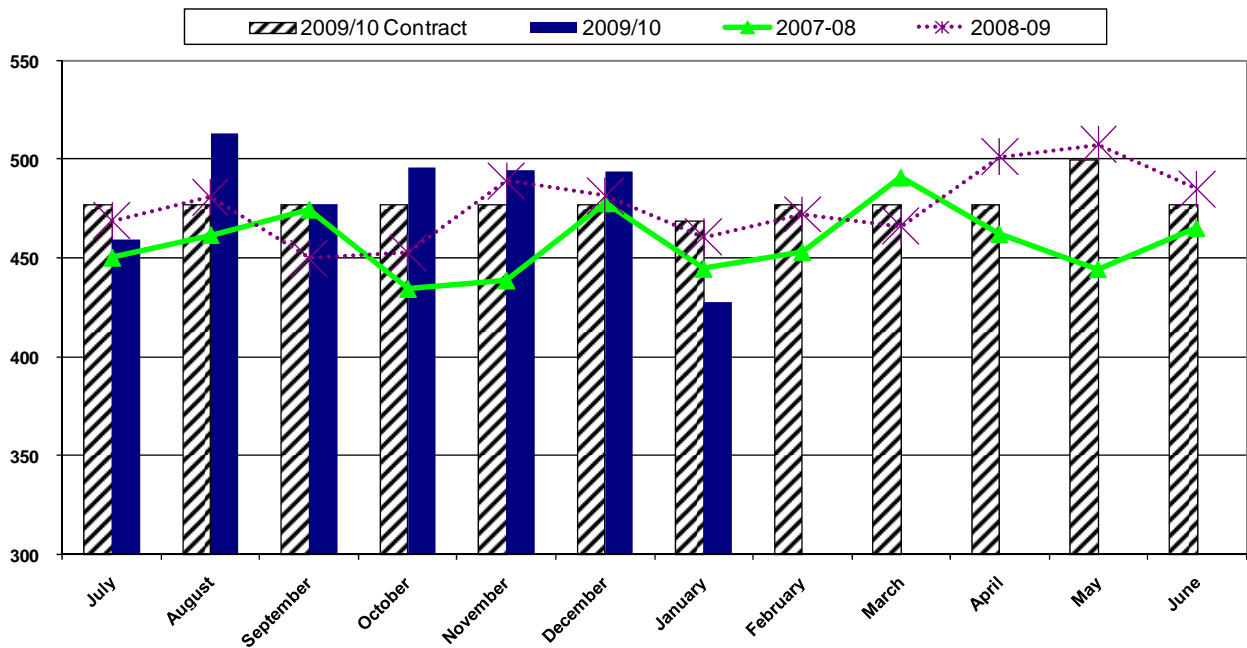
The chart below shows the production recorded to January 2010. Once again the lower January throughput is clear.

At the time the results were finalised, the coding was 55.7% complete (94.5% YTD) with the average WIES per discharge being 1% less than last year for the same period. Discharges are up by 3.5% from last year.

Inpatient delivery to the most current Price Volume Schedule (Jan 2010) was 92% for the month (101% YTD).

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Contract	Variance	Actual	Contract	Variance
WIES	8,132	8,892	760U	71,163	69,264	1,899F
WIES Delivery per day	428	468	40U	481	468	13F

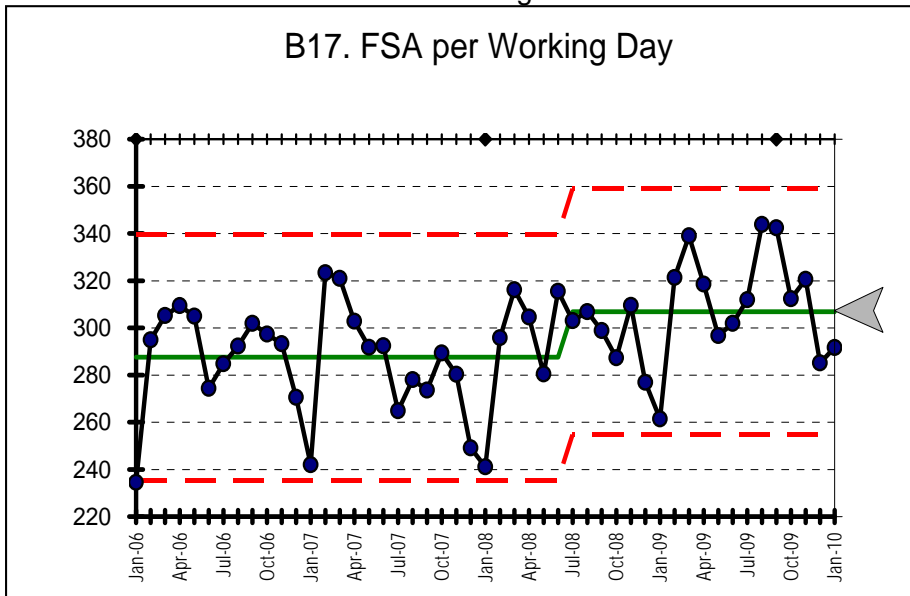
**WIES per Working Day (excluding stat day - 0910 working year = 252 days)**



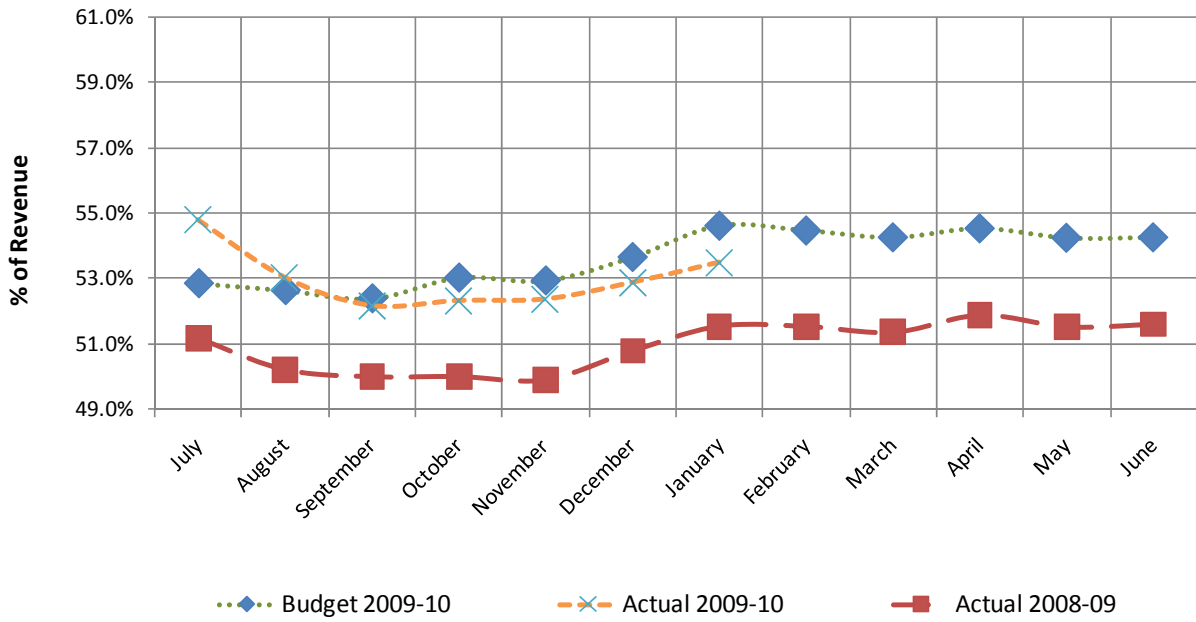
**Outpatient Delivery**

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'.

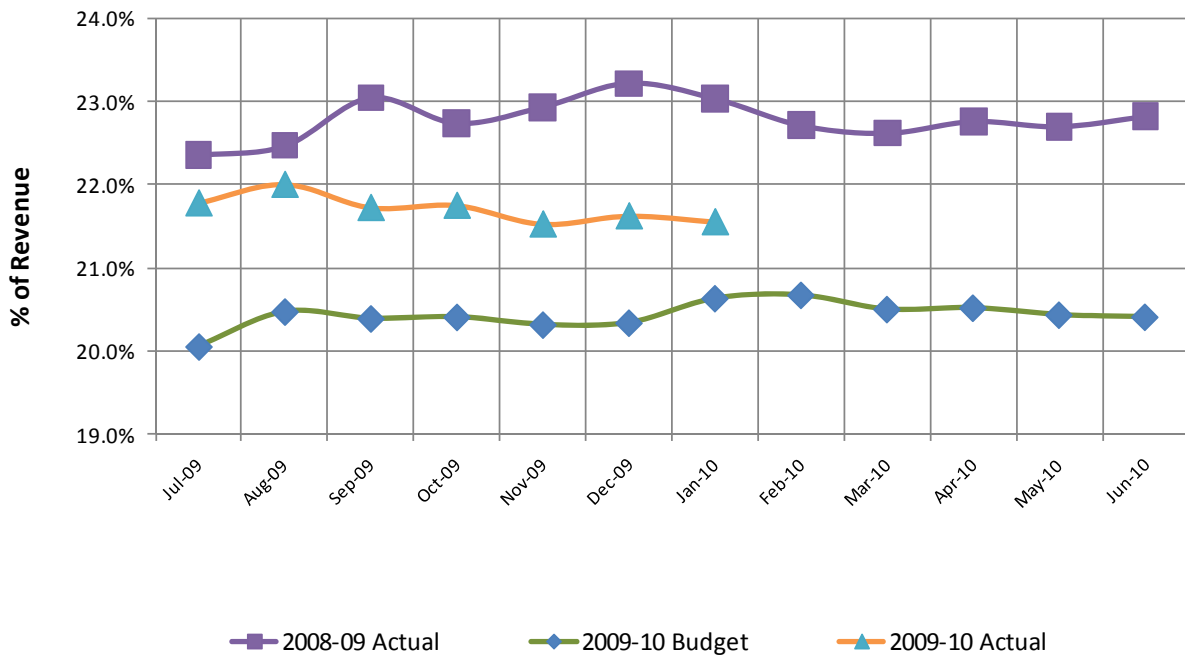
FSA= First Specialist Assessment  
Green Line= Average  
Arrow= Target



### Employee Costs as % of Revenue (YTD)



### Treatment Costs as % of Revenue (YTD)



The areas which differed from budget for January YTD are:-

Health Service Portfolio	YTD Surplus/(Deficit)			Var as % to Budgeted Revenue	Comments
	Act	Bud	Var		
Women's Health	17,464	14,918	2,546F	5.9%F	The favourable variance is driven by higher volumes particularly in FSA Obstetrics \$1.2m and Maternity \$0.9m without any significant variances from budgeted expenditure.
Child Health	25,603	21,075	4,528F	4.2%F	The favourable variance is driven by higher volumes in Medical \$5.5m offset by lower Paediatric Cardiac volumes \$(1.4)m. Lower costs are driven by FTE vacancies \$2.7m offset by outsourcing of surgical workload (tonsillectomies & grommets) \$(0.9)m, higher drug costs \$(1.3)m and higher clinical supply costs \$(0.7)m.
Cancer & Blood	13,804	13,238	566F	0.9%U	The favourable variance is driven by lower revenue resulting from lower Oncology and haematology base volume activity especially radiotherapy volume \$(0.5)m, lower haemophilia blood product demand \$(2.0)m offset by lower drug management fees and blood usage \$2.6m and savings targets to be delivered \$(0.4).
OR, Anaesthesia, CSSD	(57,932)	(59,856)	1,924F	N/A	The favourable variance is primarily driven by vacancies in both Anaesthetists & Anaesthetic Technicians. Workload is however being sustained and there has been increased leave taken over the Christmas period.
Cardiac Services	10,716	11,520	804U	1.3%U	While revenue is favourable to budget driven by the cardiac waiting list initiative \$1.2m this has been offset by the high cost of outsourcing \$(2.7)m to private providers.
CWORAC Management	10,938	18,788	7,850U	N/A	Timing of Donation income for the MRI \$(3.6)m and Targeted Savings to be achieved \$(4.3)m. It is anticipated that Donation income will move closer to budget by May 2010.
Operations Management	104	2,474	2,370U	N/A	Targeted Savings yet to be achieved \$(2.1)m. Savings targets for the Operations portfolio are held centrally. This unfavourable variance is substantially offset by favourable variances in individual services, with the overall YTD result for the total Operations portfolio \$0.3M unfavourable.
Others	58,563	53,824	4,739F	N/A	A range of Provider Services with variances less than \$0.5m
<b>Total Operational</b>	<b>79,260</b>	<b>75,981</b>	<b>3,279F</b>	<b>0.48%U</b>	

Operational

Jan 2010

YTD									
	Act 0910	% of Rev	Bud 0910	% of Rev	Act 0809	% of Rev	Var Budget	% Var to Bud	Var LY
<b>Revenue</b>									
MOH Base Funding	573,527		563,769		519,527		9,758 F	1.7%F	54,000 F
MoH Sub-contracts	13,781		16,307		10,240		2,527 U	15.5%U	3,541 F
Other Patient Care	18,912		19,787		20,574		875 U	4.4%U	1,662 U
	<b>606,219</b>		<b>599,864</b>		<b>550,341</b>		<b>6,356 F</b>	<b>1.1%F</b>	<b>55,879 F</b>
Services & Products	6,426		7,486		6,547		1,060 F	14.2%U	121 U
CTA	10,142		9,870		2,128		272 F	2.8%F	8,014 F
Trust & Donation Income	2,425		5,810		2,716		3,385 U	58.3%U	291 U
Other Income	3,752		3,370		3,473		382 F	11.3%F	279 F
	<b>628,964</b>		<b>626,399</b>		<b>565,205</b>		<b>2,565 F</b>	<b>0.4%F</b>	<b>63,759 F</b>
<b>Expenditure</b>									
<b>Employee Costs</b>									
Medical	124,164	19.7%	125,060	20.0%	114,674	20.3%	896 F	0.7%F	9,490 U
Nursing	135,872	21.6%	135,649	21.7%	125,849	22.3%	223 U	0.2%U	10,023 U
Technical	62,185	9.9%	64,926	10.4%	59,475	10.5%	2,741 F	4.2%F	2,710 U
Hotel Services	5,106	0.8%	5,080	0.8%	4,989	0.9%	25 U	0.5%U	116 U
Administration	23,821	3.8%	23,127	3.7%	24,887	4.4%	694 U	3.0%U	1,066 F
Other	18,206	2.9%	21,222	3.4%	16,074	2.8%	3,017 F	14.2%F	2,132 U
Total Employee Costs	369,353	58.7%	375,064	59.9%	345,948	61.2%	5,711 F	1.5%F	23,405 U
Direct Treatment Costs	121,375	19.3%	114,422	18.3%	113,632	20.1%	6,953 U	6.1%U	7,742 U
Indirect Treatment Costs	20,271	3.2%	20,897	3.3%	22,201	3.9%	626 F	3.0%F	1,930 F
Prop, Equip. & Transpt	15,957	2.5%	16,732	2.7%	15,893	2.8%	775 F	4.6%F	63 U
Administration Costs	5,040	0.8%	5,098	0.8%	5,187	0.9%	58 F	1.1%F	148 F
Indirect Service Billing	5,705	0.9%	5,656	0.9%	3,430	0.6%	49 U	0.9%U	2,275 U
Loss on Sale of Fixed Assets	127	0.0%	12	0.0%	63	0.0%	115 U	936.2%U	64 U
<b>Total Operating Expenditure</b>	<b>537,826</b>	<b>85.5%</b>	<b>537,882</b>	<b>85.9%</b>	<b>506,355</b>	<b>89.6%</b>	<b>55 F</b>	<b>0.0%F</b>	<b>31,472 U</b>
<b>Operating Surplus/(Deficit)</b>	<b>91,138</b>	<b>14.5%</b>	<b>88,518</b>	<b>14.1%</b>	<b>58,850</b>	<b>10.4%</b>	<b>2,620 F</b>	<b>3.0%U</b>	<b>32,288 F</b>
Depreciation	11,804	1.9%	12,469	2.0%	11,819	2.1%	665 F	5.3%F	15 F
Finance Costs	72	0.0%	64	0.0%	1,102	0.2%	8 U	13.2%U	1,030 F
<b>Total Non Operating Costs</b>	<b>11,876</b>	<b>1.9%</b>	<b>12,533</b>	<b>2.0%</b>	<b>12,921</b>	<b>2.3%</b>	<b>657 F</b>	<b>5.2%F</b>	<b>1,045 F</b>
<b>Net Surplus / (Deficit)</b>	<b>79,261</b>	<b>12.6%</b>	<b>75,985</b>	<b>12.1%</b>	<b>45,929</b>	<b>8.1%</b>	<b>3,277 F</b>	<b>4.3%F</b>	<b>33,332 F</b>

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# ADHB HAC KPI Report

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

January 2010

Indicator	Frequency	Review date	KPI report page ref	
<b>Volume</b>				
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		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	
<b>Productivity</b>				
B15. Acute WIES per Day	M		5	
B16. Elective WIES per Working Day	M	Jan-10	5	
B17. FSA per Working Day	M		5	
<b>Length of Stay</b>				
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
<b>Elective Process and Waiting Times</b>				
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	
B55. % of bone marrow patients attending FSA within 6 weeks of referral	M		9	
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	
A62. (ESPI 2). Patients waiting longer than six months for their FSA	M	Dec-09	10	
A63. (ESPI 5). Patients given a commitment to treatment but not treated within six months	M		10	
A64. (ESPI 6). Patients in active review with no clinical assessment within the last 6 months	M		10	
A65. (ESPI 8). Proportion of patients treated prioritised using nationally recognised processes or tools	M		10	
<b>Acute Process</b>				
A56. % of stroke patients cared for within the stroke unit	Q			Ω
B63. Mental Health percentage of people with relapse prevention plans	M	Jan-10	6	
<b>Cost</b>				
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			
<b>Human Resources</b>				
F.12 % of Total Employee Turnover (Monthly)	M		11	
F.21 Lost Time Injury Frequency Rate	M		11	

**B4. Elective WIES Volume-Auckland**

Elective outputs reduced due to a combination of: -

- greatly reduced outsourcing (with saving in direct treatment costs) due to closure of private hospitals,
- the application of the excess annual leave programme and
- in some services the impact of higher than anticipated acute volumes.

**B9. Total WIES Volume IDF**

With acute IDF wies falling in line with seasonal trends and elective wies reductions (reasons above) the combined impact was a marked drop off in volumes.

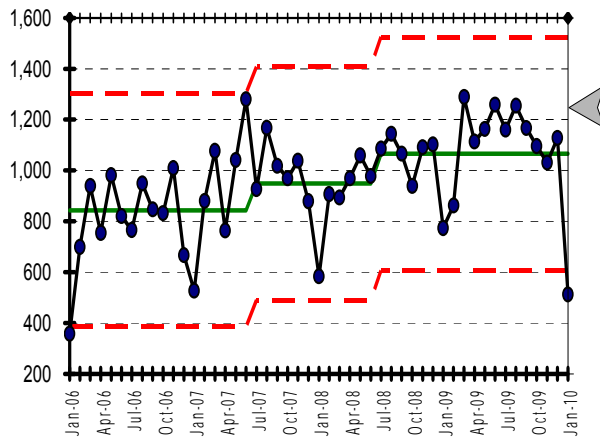
**B10. Non-DRG Revenue-IDF**

The 'straight line' target is too high compared to phased budget, non DRG IDF revenue was in fact higher than budget for the month.

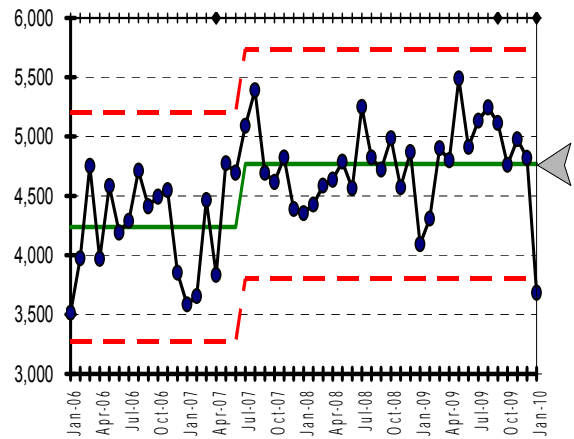
**B12. Elective WIES Volume - All DHBs**

See Auckland elective wies above.

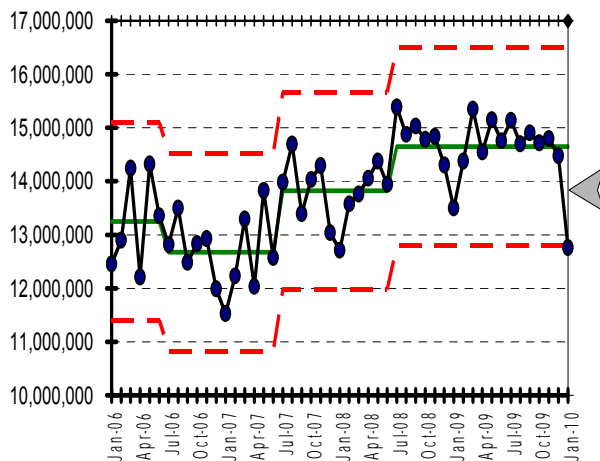
B4. Elective WIES Volume - Auckland



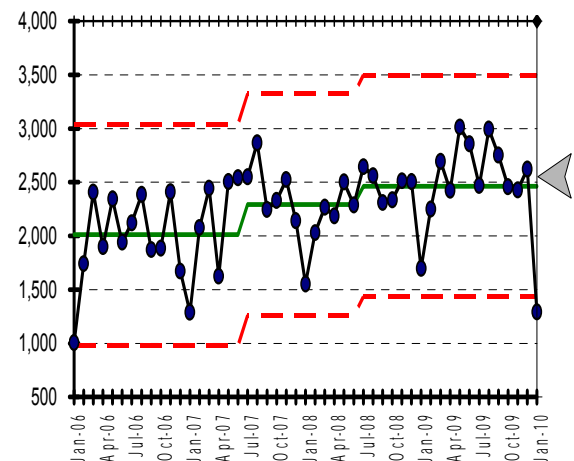
B9. Total WIES Volume \_IDF



B10. Non-DRG Revenue - IDF



B12. Elective WIES Volume -All DHBs



**B13. Total WIES Volume - All DHBs**

With acute wies falling in line with seasonal trends and elective wies reductions (reasons above) the combined impact was a marked drop off in volumes (for both ADHB and IDF).

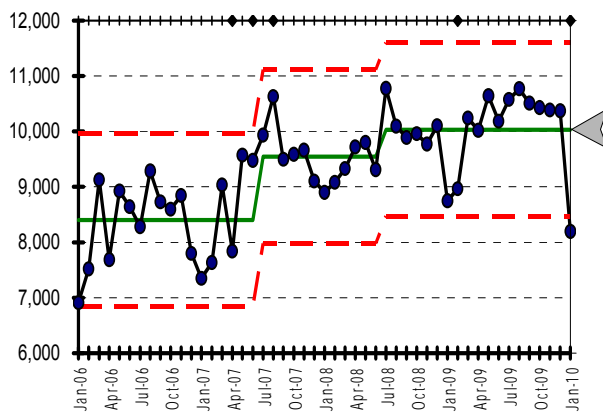
**B14. Non-DRG Revenue - All DHBs**

As above, non DRG revenue was in fact higher than the phased budget for the month, the target shown here is a straight line target ie stays the same each month (1/12th of annual amount).

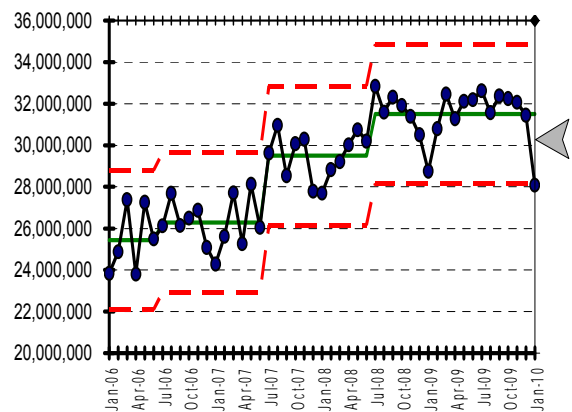
**B16. Elective WIES per Working Day**

See elective wies above

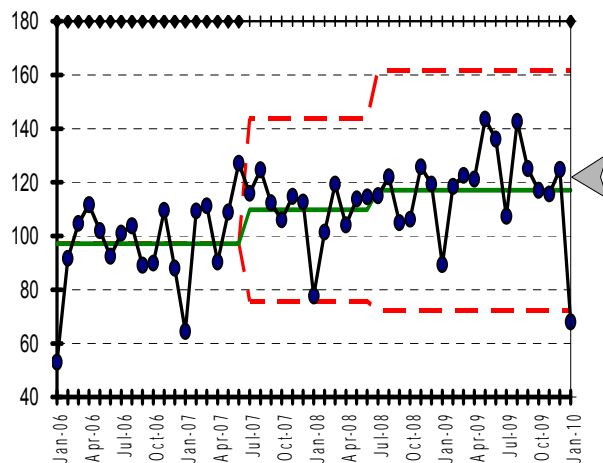
**B13. Total WIES Volume - All DHBs**



**B14. Non-DRG Revenue - All DHBs**



**B16. Elective WIES per Working Day**



**B40. Mental Health Total Community Face-to-Face Appts**

The number of appts. has dropped below the expected lower limit but this appears to reflect a trend each January.

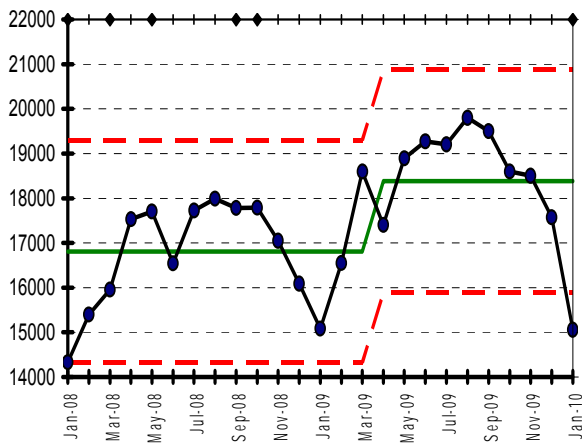
**B41. Mental Health Total Access - rate**

The monthly Access rate has also dropped below the expected lower limit but this appears to reflect a trend each January.

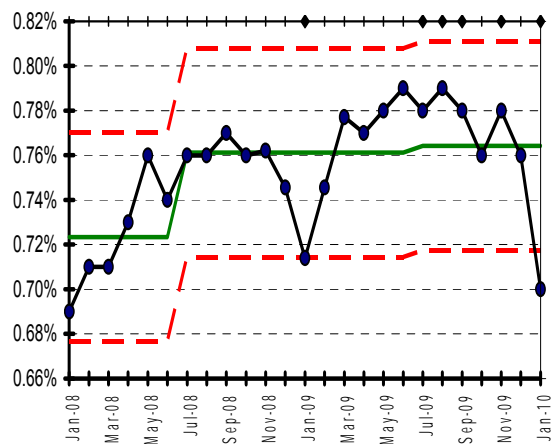
**B63. Mental Health Percentage of people with relapse prevention plans**

Compliance plans compliance are above the 90% threshold once again this month.

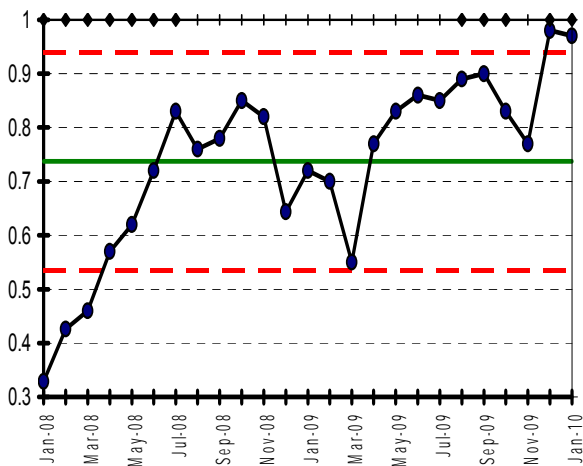
**B40. Mental Health Total Community Face-to-Face Appts**



**B41. Mental Health Total Access - rate**



**B63. Mental Health Percentage of people with relapse prevention plans**



**B50 to B54 (chemotherapy and radiotherapy)**

96% of patients starting chemotherapy treatment in January were treated within 6 weeks of FSA (refer KPI B51). 3 patients waited more than 6 weeks as the patients deferred treatment while on holiday.

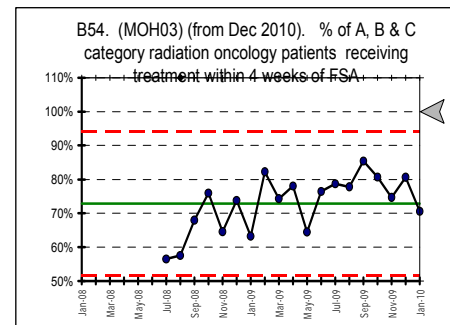
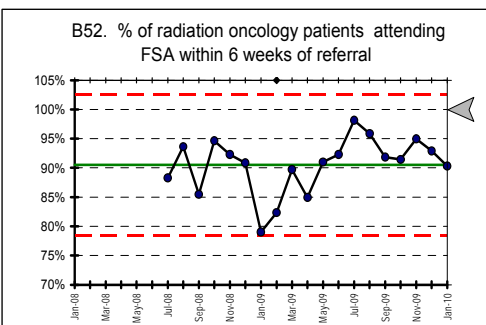
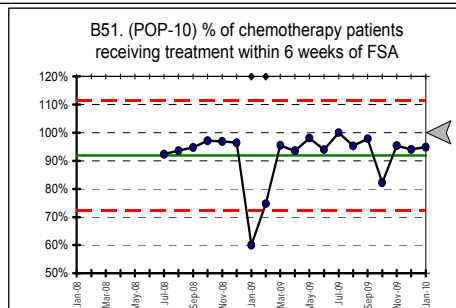
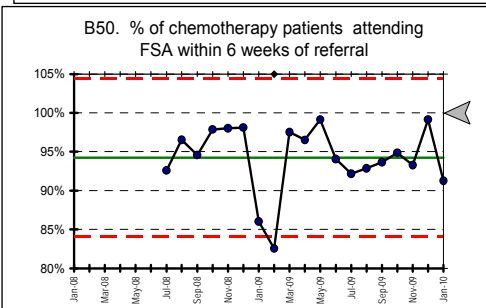
The radiotherapy service is aiming to meet the 6 week average waiting time target which is effective from 1 July 2010. The current average wait time for "C" Radical breast is currently greater than this. Compliance for the first and second quarters was 86% and 84% respectively (six month average compliance 85%). The average wait time in January is 6.3 weeks. The >6 week wait time is related to Linac capacity, increased demand and high acuity.

The service has developed a tool to forecast demand for treatment capacity, reflecting trends by tumour type as well as linear accelerator technological capability. This model demonstrates a need to increase treatment capacity by 5 hours per day in order to meet the 6 week target by 1 July.

Outsourcing simple breast and prostate patients to Waikato Hospital (2 per week) commenced in mid January with 3 patients commencing treatment. A communications plan has been released to all stakeholders and the MOH notified.

The replacement linac (MV4) was commissioned on the 25th January and increases capacity of the fleet. The service has an evening shift commencing in March to extend treatment capacity by 4 hours per day. The service expects to see a gradual improvement in wait times over the next quarter.

Additional evening shift hours are required to compensate for the obsolescence of the oldest Linear accelerator (13 years vs. 10 year useful life and running only 2 hours per day). The business case for this replacement is being prepared and will be presented to Regional Capital during April, in line with the Strategic Plan for delivery of Radiation Oncology for the Northern Region to 2019.

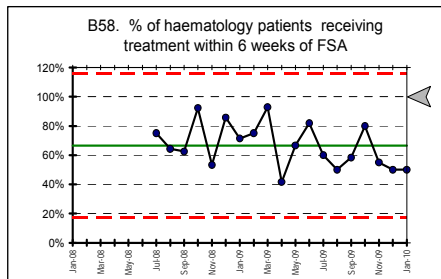
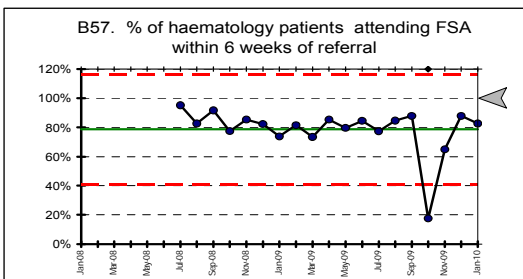
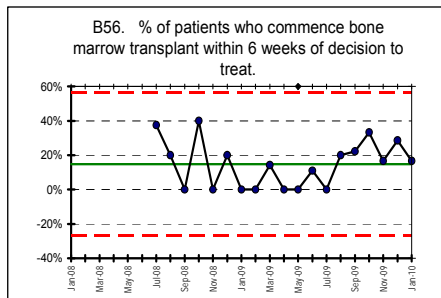
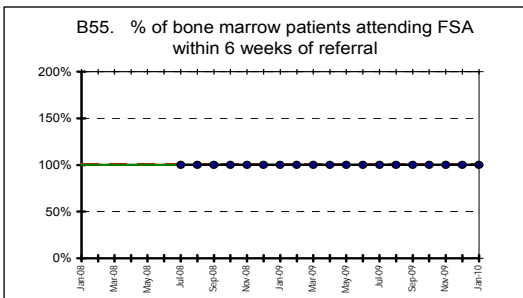


**B55 to B58 (haematology)**

Demand for the adult stem cell transplant programme continues to increase when compared to previous years . The increase in referral numbers and patients added to the wait list has created pressure on the adult service in terms of delivery within existing resource. Outsourcing options are limited with Waikato Hospital holding one autologous transplant slot per month but pre transplant workup and follow up load remains at ACH. There is no other national capacity available for these patients.

Options to address demand are being explored but may result in the service:

- (a) being unable to accept new cases,
- (b) being unable to schedule more urgent transplants
- (c) Lengthy delays or deferral of less urgent cases, which may adversely affect patient outcomes.
- (d) Raising transplant thresholds
- (e) Exploring new models of care i.e. an outpatient based autograft service



## **IMPROVEMENT ACTIVITIES**

### **6.1 DAP Projects Report**



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

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

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

High Level Strategy	Objective	Strategies to achieve Objective
<p style="margin: 0;"><b>Improve the effectiveness &amp; efficiency of Healthcare System</b></p>		
<p style="margin: 0;">Primary healthcare</p>	Implementation of PHO-DHB primary healthcare plan	1. Implement approach to providing efficient & effective coordinated care in the neighbourhood
<p style="margin: 0;">Improve Primary Secondary system efficiency -decrease total system cost</p>	Improve access to after hours primary care	1. Develop after-hours services including palliative and residential care
<p style="margin: 0;">Improve hospital efficiency / throughput</p>	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)
<p style="margin: 0;">Reduce waiting times for elective services</p>	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
<p style="margin: 0;">Improve Leadership Capability</p>	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
<p style="margin: 0;">Improve clinical quality &amp; professional governance</p>	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
<p style="margin: 0;">Strengthen the health workforces</p>	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
<p style="margin: 0;">Information management</p>	Improve resilience and availability of core IT systems	
	Regional Strategic Plan	
<p style="margin: 0;">Planning</p>	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"> <li>1. IDF annual agreements ensure we are paid for what we do.</li> <li>2. Participate in National pricing process</li> </ol>
	Reduce Administration Cost	<ol style="list-style-type: none"> <li>1. Improve HR payroll processing and leave management</li> <li>2. Reduce back office cost (regional shared services)</li> <li>3. Manage administration of M&amp;A FTE cap</li> </ol>
Improve Productivity	Improve Clinical Effectiveness	<ol style="list-style-type: none"> <li>1. Improve clinical resource utilisation</li> <li>2. Reduce variation in Clinical Practice</li> </ol>
	Health Service Process Improvement	<ol style="list-style-type: none"> <li>1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.</li> </ol>
	Achieve procurement savings	<ol style="list-style-type: none"> <li>1. Leverage national/regional procurement initiatives</li> <li>2. Refine procurement strategy</li> <li>3. Deliver direct treatment cost savings</li> <li>4. Deliver indirect treatment cost savings</li> <li>5. Monitor and collect rebates within contracts for supplies and services</li> </ol>
	Optimise stock holding	<ol style="list-style-type: none"> <li>1. Revisit replenishment parameters</li> <li>2. Improve supply chain systems and processes</li> </ol>
Manage Cash	Sustainable Cash Management Plan	<ol style="list-style-type: none"> <li>1. Asset Management Plan alignment with the Long Term Services Plan</li> <li>2. Improve prioritisation process for new capital</li> <li>3. Long term financial modelling process is implemented</li> </ol>



## 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	13	2	5	2	4	0	0	0	10	3	1	14	0	0	10	4	0	0	0	0	0
3) Living within our Means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Totals #</b>	<b>15</b>	<b>14</b>	<b>2</b>	<b>5</b>	<b>2</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11</b>	<b>3</b>	<b>1</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>11</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Totals %</b>	<b>100%</b>	<b>93%</b>	<b>13%</b>	<b>33%</b>	<b>13%</b>	<b>33%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>73%</b>	<b>20%</b>	<b>7%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>73%</b>	<b>27%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

## 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	0
1.2 Improve outcomes in priority areas	1	1	0	0	0	1	0	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	0
<b>Totals #</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Totals %</b>	<b>100%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

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

Review

Nil to comment this month

#### Objectives:

Objective	Objective Owner	Comment
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#### Exceptions:

There are no projects to display

## 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	1	0	0	1	0	0	0	2	0	0	2	0	0	1	1	0	0	0	0	0
2.3 Improve the efficiency and effectiveness of the healthcare system - hospital efficiency /throughput	5	5	0	1	0	4	0	0	2	3	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	2	1	0	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	0	2	1	0	0	0	2	0	1	3	0	0	2	1	0	0	0	0	0
<b>Totals #</b>	<b>14</b>	<b>13</b>	<b>2</b>	<b>5</b>	<b>2</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>3</b>	<b>1</b>	<b>14</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Totals %</b>	<b>100%</b>	<b>93%</b>	<b>14%</b>	<b>36%</b>	<b>14%</b>	<b>29%</b>	<b>0%</b>	<b>0%</b>	<b>71%</b>	<b>21%</b>	<b>7%</b>	<b>100%</b>	<b>0%</b>	<b>0%</b>	<b>71%</b>	<b>29%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

### Goal 2 Performance improvement

Review

Most projects on track. Those exceptions do have good sponsor overview. Announcement for a manager for the plan will see this project move forward. A number of IT projects under being monitored.

**Objectives:**

Objective	Objective Owner	Comment
2.3.1 Improve the performance of ED	Margaret Dotchin (ADHB)	Improvement in performance noted in December and January. This is due to reduced hospital occupancy allowing improved flow, improvement in ED medical staffing and processes. Monitoring of sustainability as workloads increase post holiday period.
2.3.2 Improve acute capacity management	Ngaire Buchanan (ADHB)	The surgical OR project on track and into implementation stage. Summer Plan has now been reviewed through the monthly report. Occupancy lower than planned. From the staffing costs over this period indicates appropriate staffing levels overall although daily staffing sheets indicates there could have been more staff on leave.
2.3.3 Improve cardiac surgery throughput	Kay Hyman (ADHB)	Good progress continues however December performance adversely impacted by injury to surgeon.
2.4.1 Increase elective services to National intervention rates	Ngaire Buchanan (ADHB)	Elective services show overall compliance and currently exceeding the MOH ADHB target. Note that this is not the standardised intervention rates. High acute volumes exceeding ADHB contract will require a close watch on the impact for elective services capacity and therefore delivery to contract.
2.4.2 Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation and medical oncology	Fionnagh Dougan (ADHB)	Waiting time increase to an average of 5.7 wks - further work in scoping phase as the project is required to develop an ongoing plan for sustainability.
2.4.3 Improve outpatient management for surgical patients while improving patient satisfaction	Ngaire Buchanan (ADHB)	Project on hold due to resource requirements for the Elective services work. However the outcome of ESU will be a base for future improvements. No change this month.
2.9.1 Improve capacity management	Ngaire Buchanan (ADHB)	Revised capacity management approach for monthly review and reporting to be piloted
2.9.2 Long term services planning	Ngaire Buchanan (ADHB)	Scoping and approach well under way. Due for completion of this stage Feb/March

**Exceptions:**

Short Name	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Adult 6-hour project	ADHB	Improve	▲	●	●	Good Progress continues into February with improvement in both the seen not admitted and admitted to a ward patients. This will be due to both service improvements as well as lower occupancy over the summer period. Sustainable improvement will be required by all workstreams as occupancy increases
Starship 6 hour project	ADHB	Improve	▲	●	●	Focus areas continue in teh areas of earlier discharges, bed allocation process, reduced wait time for early hour admissions. Improvement maintained over the last month Will need to ensure a sustainable improvement as bed occupancy levels increase
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.
Auckland Region Cardiac Surgery Service Development	Regional	Improve	●	●	●	Solution development phase in progress. Exciting potential and good engagement from the work teams. Communication around the project has improved. 2/10/09 Have achieved MoH requirements ahead of target. Waiting list now less than 3 months and being managed according to acuity. Overall project ready to begin implementation of all phases 3/11/09 Excellent progress continues in all workstreams.
GSC	Regional	Define	●	●	●	Project structure is now in place. Workstreams are focussed on designing the new process and confirming the design principles
Radiation oncology waiting times	ADHB	Measure	●	●	●	Process improvement project on track. Waiting time for Radiation Therapy reduced to an average of 4.7 weeks. Further work in scoping phase as project is required to develop an ongoing plan for business sustainability in the context of increasing flows of simple procedures to the private centre.
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.

## High Level Summary Report (Operations)

### 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
<b>Totals #</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Totals %</b>																					

### Goal 3 Live within our means

**Review**

At this stage the project ownership is under another functional grouping. However OFG contributing to these where appropriate.

**Objectives:**

Objective	Objective Owner	Comment
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**Exceptions:**

There are no projects to display

**PAPERS**

**7.1 PAEDIATRIC ACUTE FLOW**



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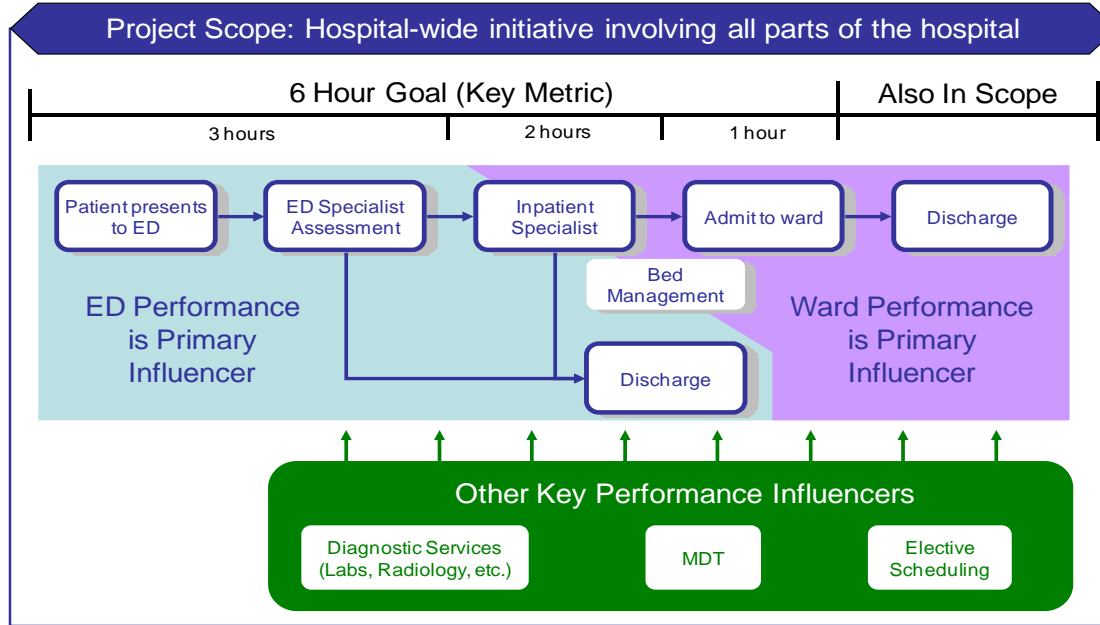
# **Starship Acute Patient Flow Project**

Hospital Advisory Committee

03 March 2010

# Introduction

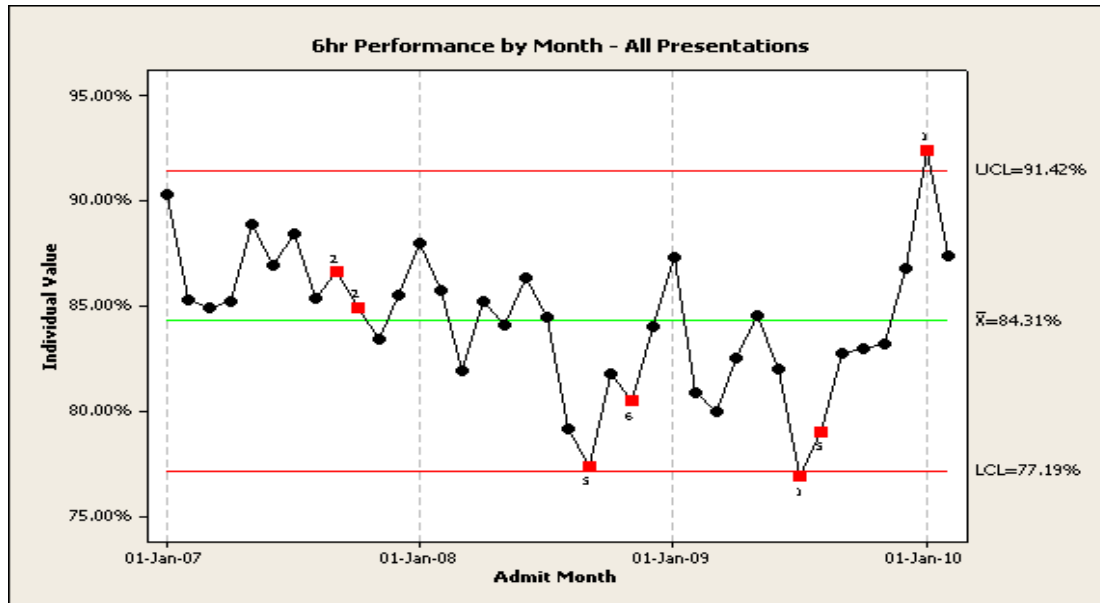
## Scope:



Requires a hospital wide solution.

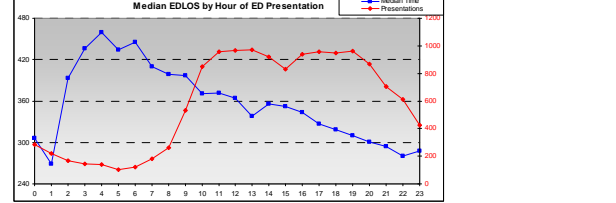
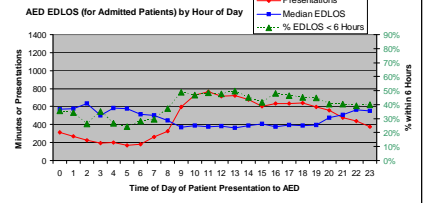
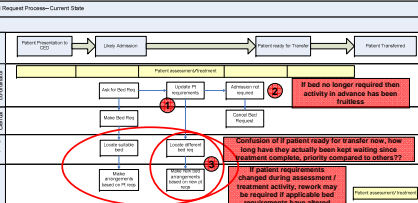
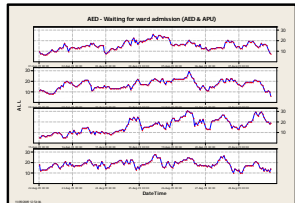
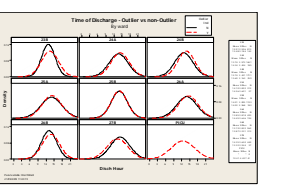
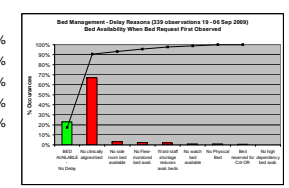
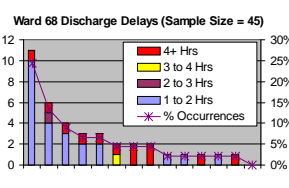
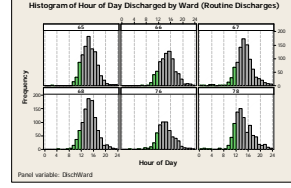
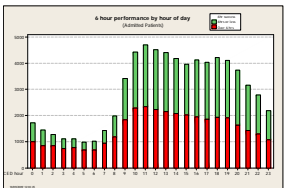
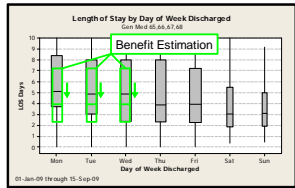
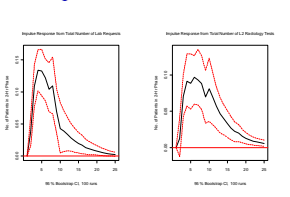
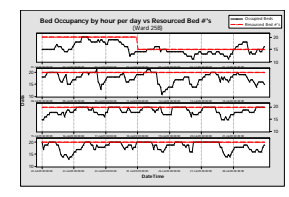
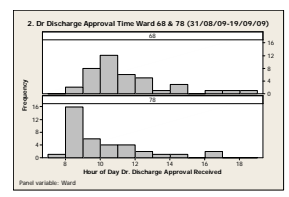
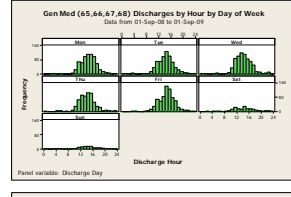
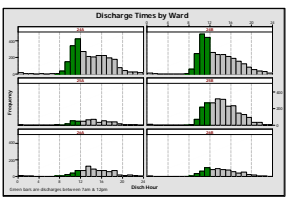
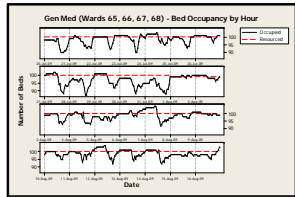
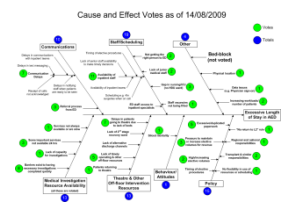
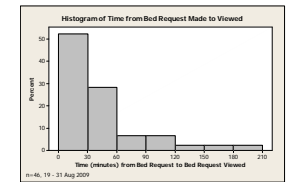
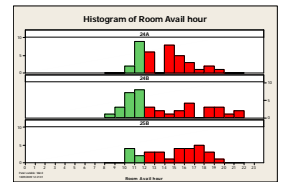
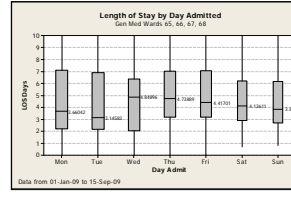
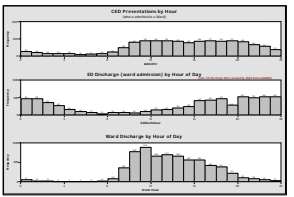
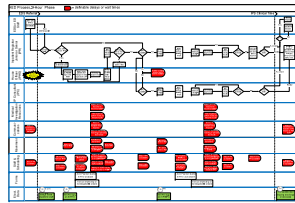
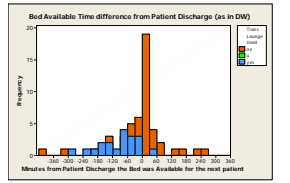
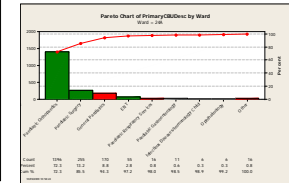
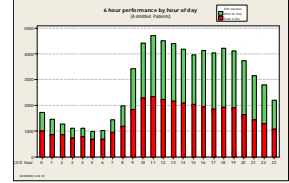
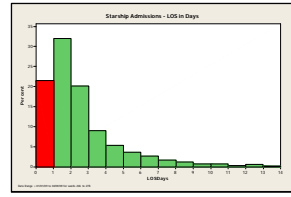
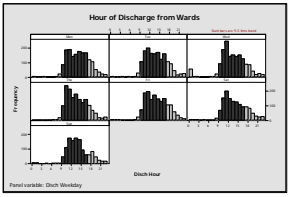
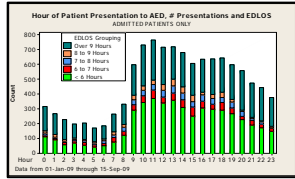
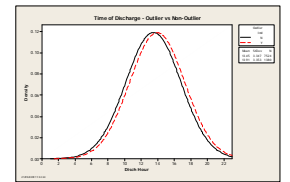
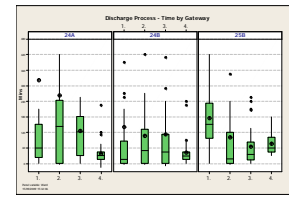
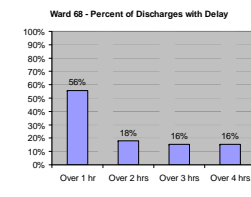
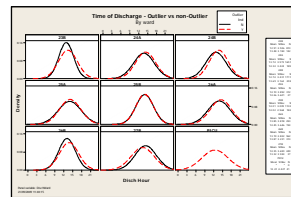
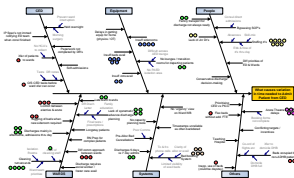
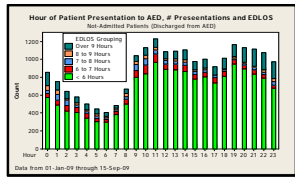
**Key metric:**  
95% of patients admitted, transferred or discharged from the emergency department within 6 hours

## 6 Hour Performance

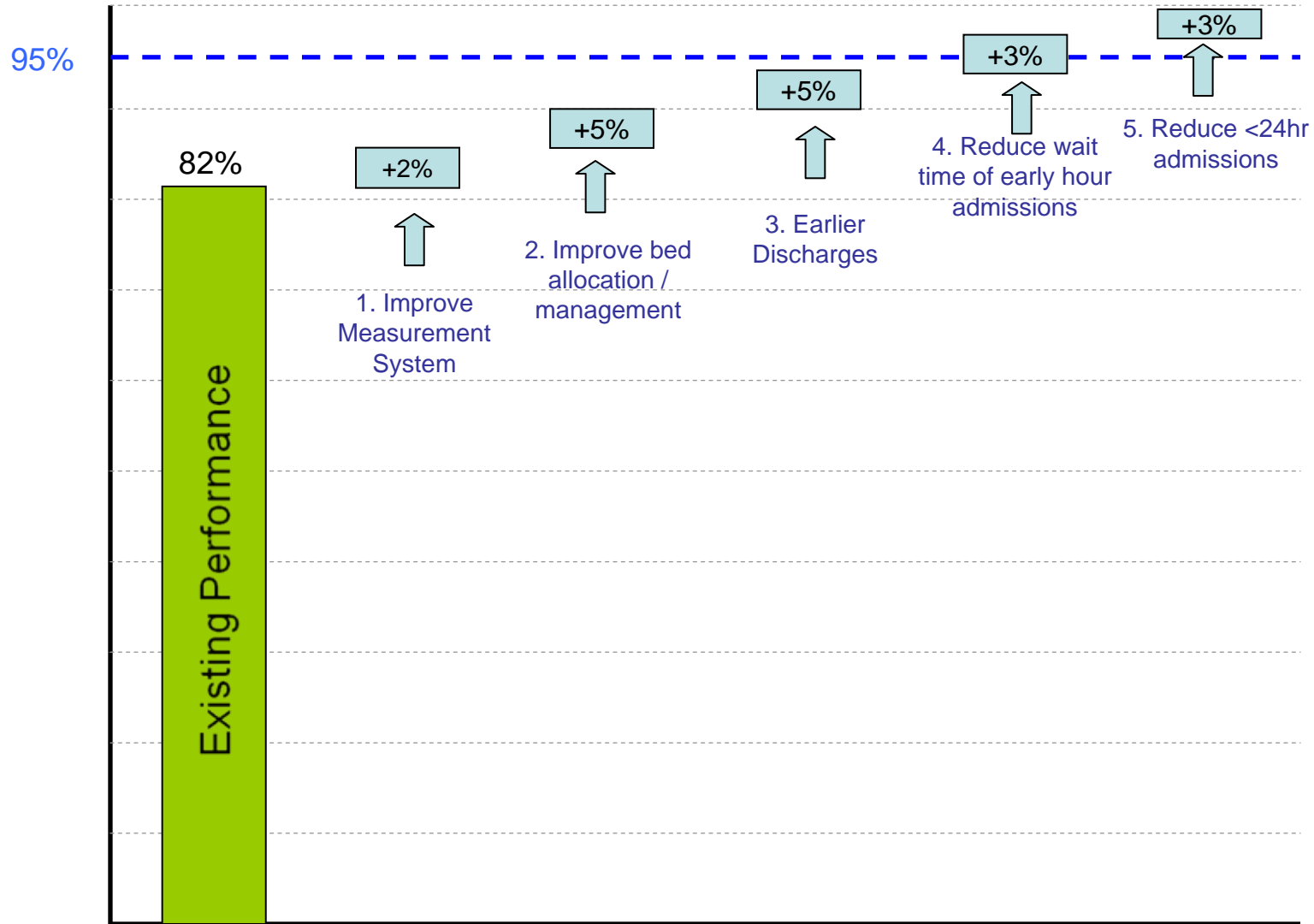


Strong seasonal impact. Year to year average of 82-85%.

# Problem Analysis to identify Root Cause



# The need for a number of improvement areas

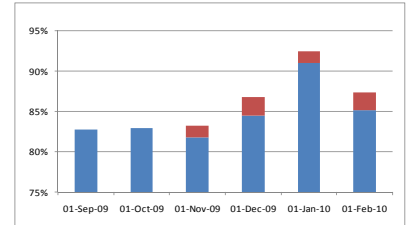


No single improvement likely to deliver the required leap to 95%, but a collection of improvements will

(note: improvement percentages need to be calculated & quantified via additional analysis)

# Improvement Work-streams

	Activity	Objective	Status
Measurement Systems	Clinical Short Stays	Establish process to differentiate 'clinical short stays' (where exempt from 6hr rule due to clinical interests of patient) from other CED presentations	<ul style="list-style-type: none"> <li>Number of Clinical Short Stays quantified</li> <li>1.8% lift in CED 6hr performance as result of clinical short stays being recorded since Nov-09.</li> </ul>
	Capturing stages throughout 6 hr process	Provide capability to accurately measure performance & drill-down into sub-groups of 6hr performance.	<ul style="list-style-type: none"> <li>Manual process implemented to CED practices providing 'ready for transfer' times for 80% of admissions.</li> <li>Ongoing activity to improve compliance with system development planned to integrate into Chips functionality</li> </ul>
Bed Management	Patient Transfer / Admission process	Reduce delays faced in transferring patients from CED to the wards by: <ul style="list-style-type: none"> <li>-Streamlining the required steps</li> <li>- Improving communications</li> <li>- Improving visibility and awareness</li> </ul>	<ul style="list-style-type: none"> <li>Review of existing transfer steps and value-add assessment completed</li> <li>Redesign activity initiated to address waste-contributing actions</li> </ul>
	Hospital Resource Plan	Ensure that decisions made in regard to bed resourcing are fully informed and considering both financial/budget constraints and potential impact to acute patient flow	<ul style="list-style-type: none"> <li>To be initiated</li> </ul>



# Improvement Work-streams

	Activity	Objective	Status
Reducing Occupancy	Estimated Discharge Dates	Develop improved advance planning to ensure readiness for day of discharge and achieve earlier discharging	<ul style="list-style-type: none"><li>• EDD practices introduced to General Paediatrics and Orthopaedics wards from Dec-09.</li><li>• All inpatients assigned an EDD from day of admission, and flagged with visible indicators when within 24hrs of predicted discharge day</li><li>• Reviewing 'barriers' to early discharges and systematically addressing most common</li></ul>
	Reducing unnecessary admissions	To admit patients only when admission is definitely required, reducing pressure on single largest process constraint	<ul style="list-style-type: none"><li>• 25% of Starship admissions are &lt;24 hours</li><li>• Stand-alone project being initiated to review need of these admissions and develop solutions to eliminate where viable</li></ul>
Reporting	CED Dashboard	To provide consolidated / informative performance data of key performance metrics	<ul style="list-style-type: none"><li>• Requirement specifications finalised and data extracts developed that provide required metrics</li><li>• Development of finalised reports in progress</li></ul>

# Shorter Stays in Emergency Departments

**6hrs**

**We Can  
We Will**

95% of patients admitted, discharged or transferred from the emergency department within 6 hours



## Shorter Stays in Emergency departments means:

- Improved clinical outcomes
- Shorter inpatient stays
- Better patient privacy & dignity

So get behind the Shorter Stays in ED programme & support initiatives aimed at delivering quality healthcare. Your support is critical to our success.

## Here's how we are performing this week (01 Feb - 07 Feb)

All ED Presentations			All Starship Admissions			24A Admissions		
Last Week 89.0%			Last Week 70.3			Last Week 60.9%		
Last Q	Curr Q	Change	Last Q	Curr Q	Change	Last Q	Curr Q	Change
% of all presentations to CED where time in ED 6 hours or less			% of all admissions from CED to all Wards where time in ED 6 hours or less			% of all presentations to CED where time in ED 6 hours or less		

## Healthier Communities – Quality Healthcare



## **FEEDBACK TO BOARD**

### **8.1 Hospital Advisory Committee Feedback to Board**



**GENERAL BUSINESS**

Use document at start of Meeting Pack

# ***10***

## **APPENDICES**

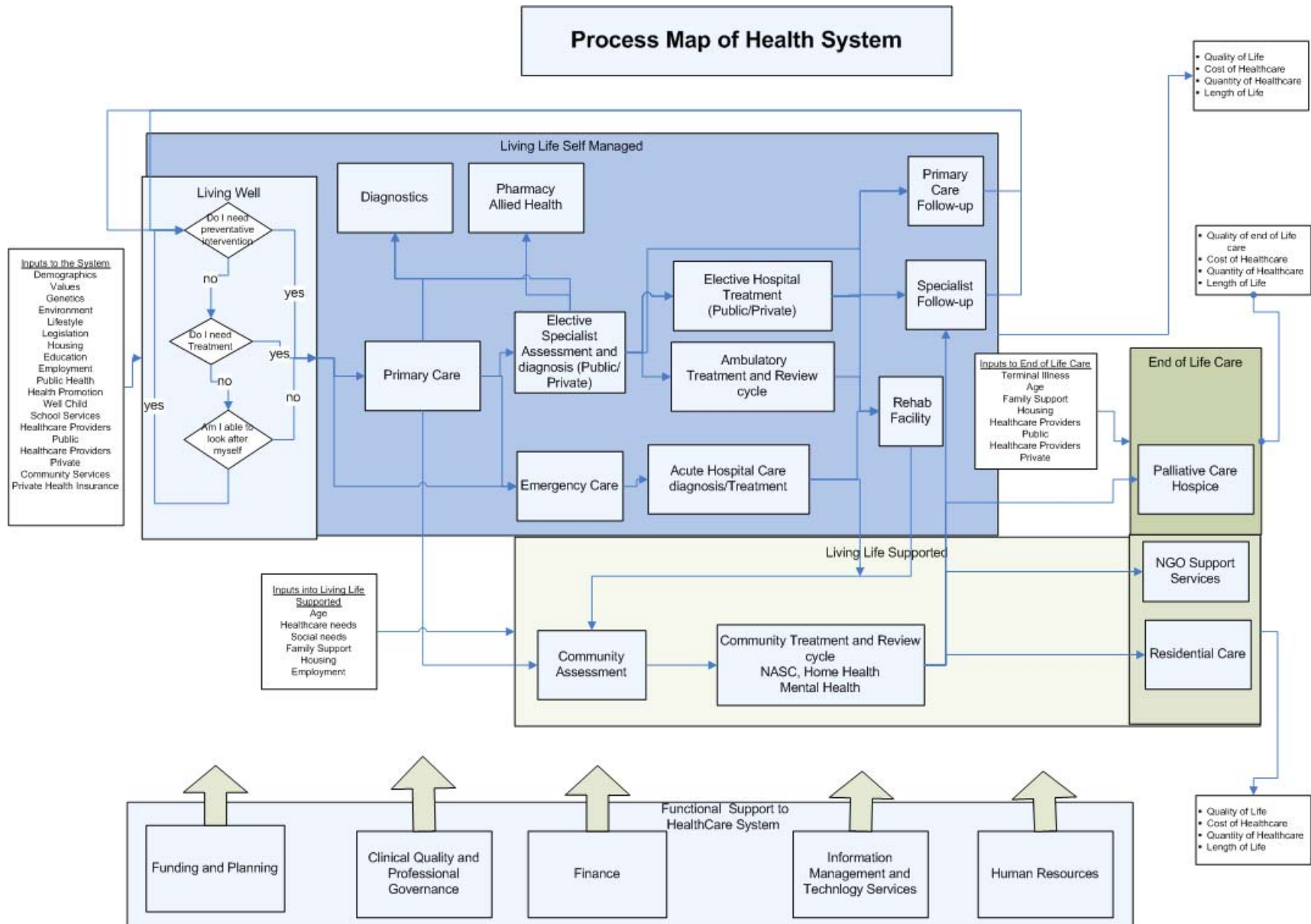
**10.1 Healthcare System Diagram**

**10.2 Clinical Indicators Exception Report and full Indicator set  
(excluding Primary Care)**

**10.3 Ministry of Health Indicators**



# 10.1 Healthcare System Diagram





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## 2.1 ADHB Clinical Indicators Exception Report

|                                                                                                                              | January     | 2010                |
|------------------------------------------------------------------------------------------------------------------------------|-------------|---------------------|
| Indicator                                                                                                                    | Review date | KPI report page ref |
| <b><u>Elective Process and Waiting Times</u></b>                                                                             |             |                     |
| A01. Median wait from referral to FSA (Weeks)                                                                                |             | 1                   |
| A02. Median time on surgical waiting list                                                                                    | Feb-09      | 1                   |
| A04. Cancelled procedures due to no beds                                                                                     | Oct-08      | 1                   |
| A52. DNA rate for specialist appointments -Total                                                                             | Jan-10      | 1                   |
| A52b. DNA rate for specialist appointments - Maori                                                                           |             | 2                   |
| A62. ESPI 2. Patients waiting longer than six months for their FSA                                                           | Jan-10      | 2                   |
| A63. ESPI 5. Patients given a commitment to treatment but not treated within six months                                      |             | 2                   |
| A64. ESPI 6. Patients in active review with no clinical assessment within the last 6 months                                  |             | 2                   |
| <b><u>Acute Process</u></b>                                                                                                  |             |                     |
| A46. % patients admitted from AED with ED stay <6hrs                                                                         | Jan-10      | 3                   |
| A47. % patients discharged from AED with ED stay <6hrs                                                                       | Jan-10      | 3                   |
| A49. % patients admitted from CED with ED stay <6hrs                                                                         | Jan-10      | 3                   |
| A50. % patients discharged from CED with ED stay <6hrs                                                                       | Jan-10      | 3                   |
| A05. AED Patients seen within Triage Time - Triage Category 2, (10 Minutes)                                                  | Oct-09      | 4                   |
| A07. AED Patients seen within Triage Time - Triage Category 3, (30 Minutes)                                                  | Aug-08      | 4                   |
| A09. CED Patients seen within Triage Time - Triage Category 2, (10 Minutes)                                                  | Feb-09      | 4                   |
| A11. CED Patients seen within Triage Time - Triage Category 3, (30 Minutes)                                                  | Jan-10      | 4                   |
| A13. APU Patients seen within Triage Time - Triage Category 3, (30 Minutes)                                                  | Aug-08      | 5                   |
| A20. Median acute time to theatre (decimal hrs) - all suites                                                                 |             | 5                   |
| A40. Median acute time to theatre (decimal hrs) - Level 8                                                                    | Apr-09      | 6                   |
| A41. Median acute time to theatre (decimal hrs) - level 9                                                                    | Oct-08      | 6                   |
| A42. Median acute time to theatre (decimal hrs) - level 4                                                                    | Oct-08      | 6                   |
| A43. Median acute time to theatre (decimal hrs) - Starship                                                                   | Oct-08      | 6                   |
| <b><u>Occupancy and Length of Stay</u></b>                                                                                   |             |                     |
| A21. Number of red alerts -Adults                                                                                            |             | 7                   |
| B1. Number of front door bed requests                                                                                        | Sep-09      | 7                   |
| A23. Midnight Bed Occupancy - Total                                                                                          | Jan-10      | 8                   |
| A24. Midnight Bed Occupancy - Adult                                                                                          | Jan-10      | 8                   |
| A25. Midnight Bed Occupancy - Child                                                                                          | Jan-10      | 8                   |
| A26. Midnight Bed Occupancy - Women                                                                                          | Jan-10      | 8                   |
| <b><u>Quality</u></b>                                                                                                        |             |                     |
| A57. Midnight Bed Occupancy - Mental Health Te Whetu Tawera                                                                  | Jan-10      | 9                   |
| A30. Adverse events causing significant harm (SAC 1&2)                                                                       |             | 10                  |
| A31. Total reported incidents                                                                                                |             | 10                  |
| A32. Number of complaints received                                                                                           | Nov-09      | 10                  |
| A33. Average number of days to resolution of complaints                                                                      | Mar-09      | 10                  |
| A34. (HBI) Adult bloodstream infections (per 1000 bed-days)                                                                  |             | 11                  |
| A35. (HBI) Child bloodstream infections (per 1000 bed-days)                                                                  |             | 11                  |
| A36. Pressure areas (per 1000 bed-days)                                                                                      | Apr-09      | 11                  |
| B60. (MOH-05) Percentage of hospitalised smokers offered advice and support to quit                                          |             |                     |
| B62. (MOH-05) Smoking prevalence of hospitalised patients                                                                    | Sep-09      | 11                  |
| TBC: Nicotine Replacement Therapy Utilisation (in progress)                                                                  |             |                     |
| A37. MRSA new isolates (per 1000 discharges)                                                                                 | Feb-09      | 12                  |
| A38. ESBL new isolates (per 1000 discharges)                                                                                 | Sep-09      | 12                  |
| A39. VRE new isolates (per 1000 discharges)                                                                                  |             | 12                  |
| A60. Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera                                             |             | 12                  |
| A58. % of medicines requiring reconciliation at admission to APU                                                             |             | 13                  |
| A59. % of APU patients (meeting criteria) whose medicines are reconciled within 24 hours of their admission Monday to Friday |             | 13                  |
| D33. Policies & Guidelines - Overdue Quantity - Organisation & Provider wide                                                 | Jan-10      | 13                  |
| <b><u>Workforce/Organisational Wellbeing (from HR)</u></b>                                                                   |             |                     |
| Number of notifications to regulatory authorities- All clinical staff                                                        |             |                     |
| F21. Lost Time Injury Frequency Rate                                                                                         |             | 14                  |
| F23. % of Work Related EAP Referrals                                                                                         |             | 14                  |

|                                               |  |    |
|-----------------------------------------------|--|----|
| F24b. % of Employees with Excess Annual Leave |  | 14 |
| F25a. Sick Leave (Average Days Annualised)    |  | 14 |

**A23. Midnight Bed Occupancy - Total**

Reduced occupancy is due to reduction in admission numbers, especially elective surgery, during the January holiday period, and a small increase in adult beds at the end of 2009.

**A24. Midnight Bed Occupancy - Adult**

As above

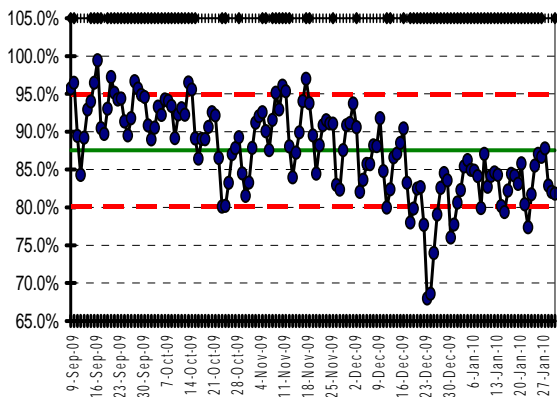
**A25. Midnight Bed Occupancy - Child**

Reduced occupancy is consistent with the usual summer pattern with less respiratory illness and a reduction in elective surgery in the Christmas - New Year period

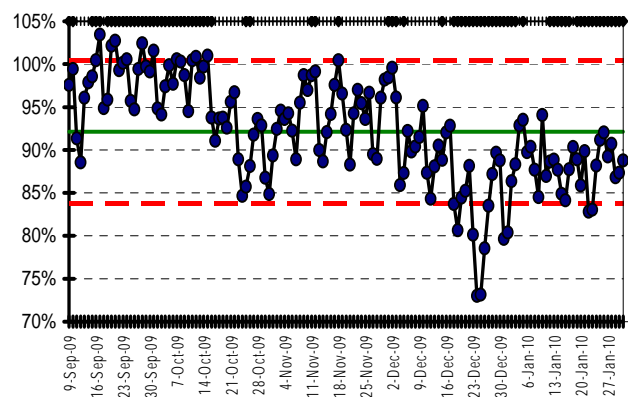
**A26. Midnight Bed Occupancy - Women**

No significant change other than during the Christmas - New Year period

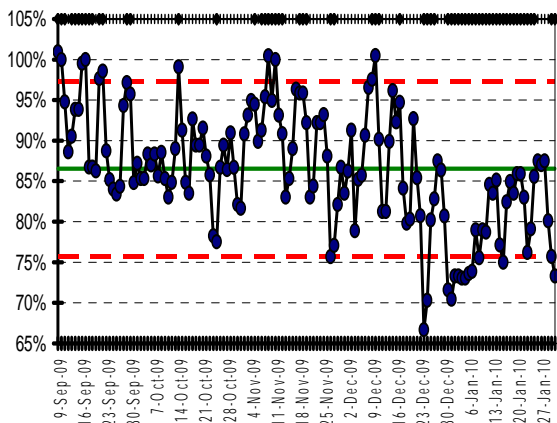
A23. Midnight Bed Occupancy - Total



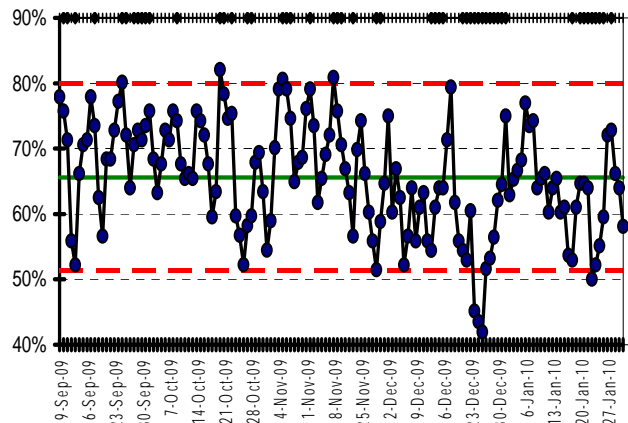
A24. Midnight Bed Occupancy - Adult



A25. Midnight Bed Occupancy - Child



A26. Midnight Bed Occupancy - Women



**A57. Midnight Bed Occupancy - Mental Health Te Whetu Tawera**

Occupancy has occasionally exceeded 100%. Generally it remains high but lower than during late 2009. This may be due to monthly fluctuations in demand or some benefit from discharge of a few very longstay patients improving bed flow, and new transition processes between inpatient and community care.

**A52. % DNA rate for outpatient appointments - All Ethnicities**

The DNA rate for all outpatient appointments across all ethnicities is currently 7.4%, the lowest it has been since January 2008. This is expected to be due the text to confirm and the Invitation to contact project's rolling out to additional specialties steadily over recent months. In addition a flyer has been introduced into every letter to patients encouraging them to attend their outpatient clinic. It is too soon to assess if this improvement is sustainable.

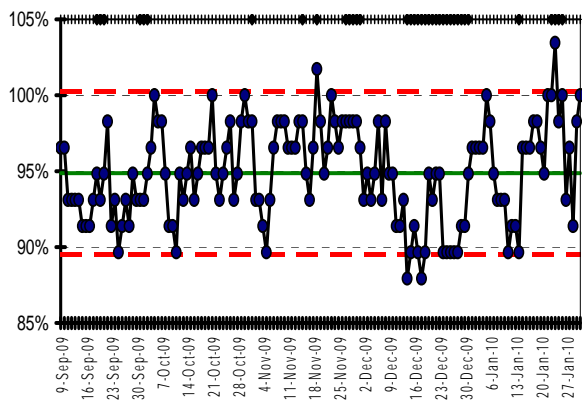
**A62. (ESPI 2) Patients waiting longer than six month for their FSA**

The principal concerns lie with neurology, ORL, neurosurgery and respiratory. Neurology has the largest number of referrals falling outside the limit - 389 as at the end of January. SMO recruitment and 'virtual' FSAs are being utilised by the service to address the issue. The other three services are, or will be, running additional clinics and respiratory has SMO recruitment in place.

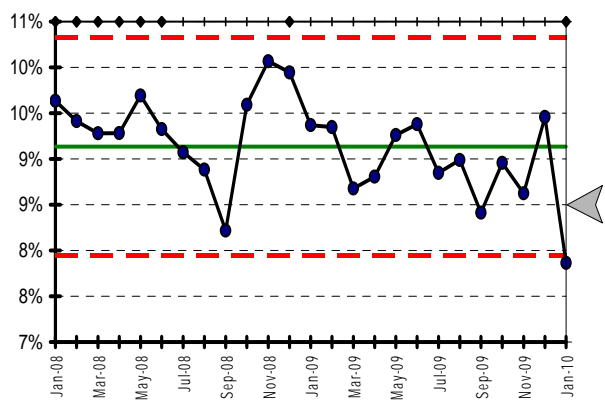
**A11. (HBI)CED Patients seen within Triage Time-Triage Category 3, (30 Minutes)**

Improved performance is related to reduced patient numbers in January and introduction of hospital patient flow initiatives (see also A49 and A50)

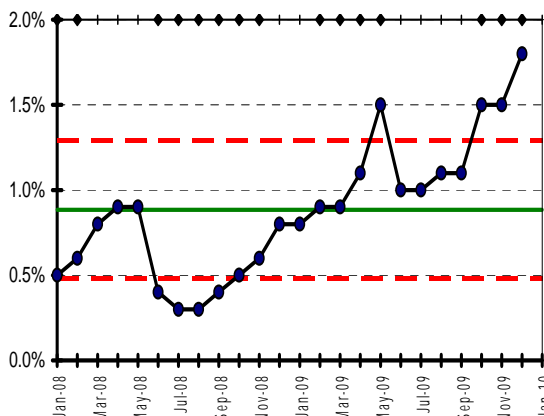
A57. Midnight Bed Occupancy - Mental Health Te Whetu Tawera



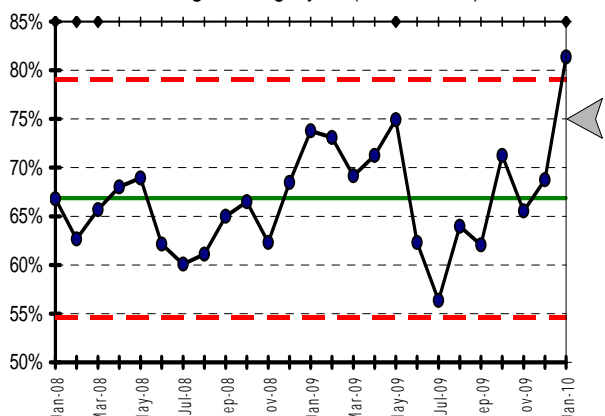
A52. % DNA rate for outpatient appointments -All Ethnicities



A62. (ESPI 2) Patients waiting longer than six months for their FSA



A11.(HBI) CED Patients seen within Triage Time - Triage Category 3, (30 Minutes)



**A46. % patients admitted from AED with ED stay <6hrs**

The improvement in this figure is thought to be largely due to reduced hospital occupancy allowing more efficient use of inpatient beds with rapid transit to wards. There has also however been improvement in the responsiveness of in-patient specialties following reminder to CDs of the AED "house rules", and increased speed of processing by the AED staff prior to referral through internal awareness of the 3 hour window.

**A47. % patients discharged from AED with ED stay <6hrs**

This has been achieved despite record numbers of attendances and is due to improvements in ED medical staffing, reduction in the percentage of blocked beds with fewer patients awaiting admission and increased awareness of the 6 hour target. There has been no change in triage casemix or percentage of patients referred for admission.

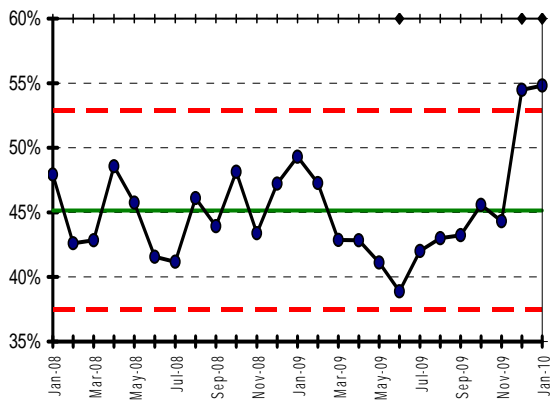
**A49. % patients admitted from CED with ED stay < 6hrs**

The Starship acute patient flow project is working in a number of areas to improve performance with regard to CED length of stay. However, the January improvement is largely as a result of reduced hospital occupancy which allowed more rapid transit to wards of those children who required admission.

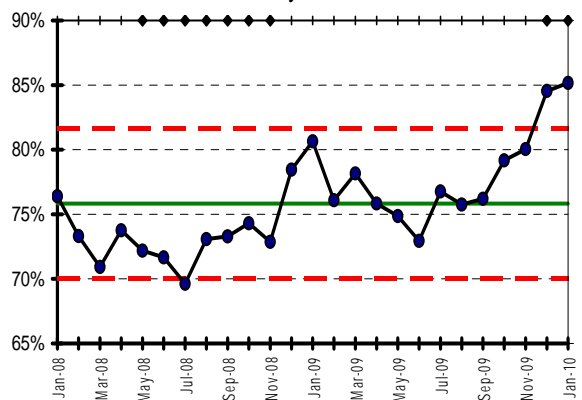
**A50. % patients discharged from CED with ED stay <hrs**

As above

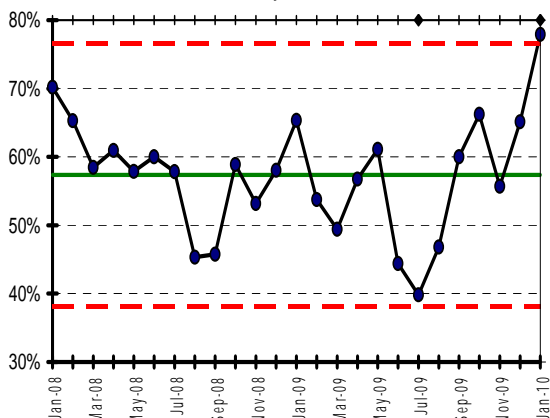
A46. % patients admitted from AED with ED stay <6hrs



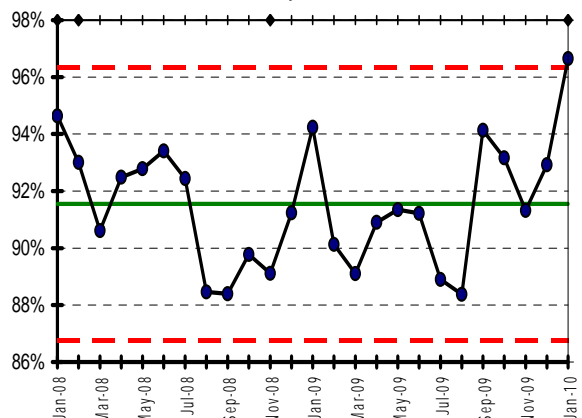
A47 % patients discharged from AED with ED stay <6hrs



A49. % patients admitted from CED with ED stay <6hrs



A50 % patients discharged from CED with ED stay <6hrs



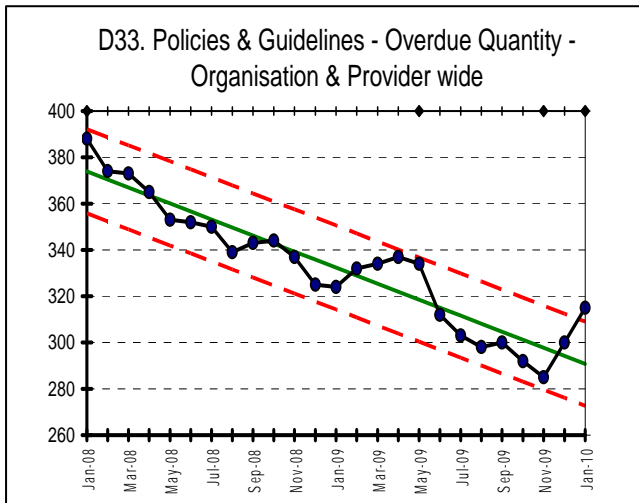
**D33. Policies & Guidelines - Overdue Quantity - Organisation & Provider wide**

**2008** targets were met **100%**. This equates to 325 documents per annum averaging 27 documents per month.

**2009** targets were **57%** met with June being the only month of achievement, perhaps due to the initial KPI reporting which highlighted the quantity and age of overdue policy documentation.

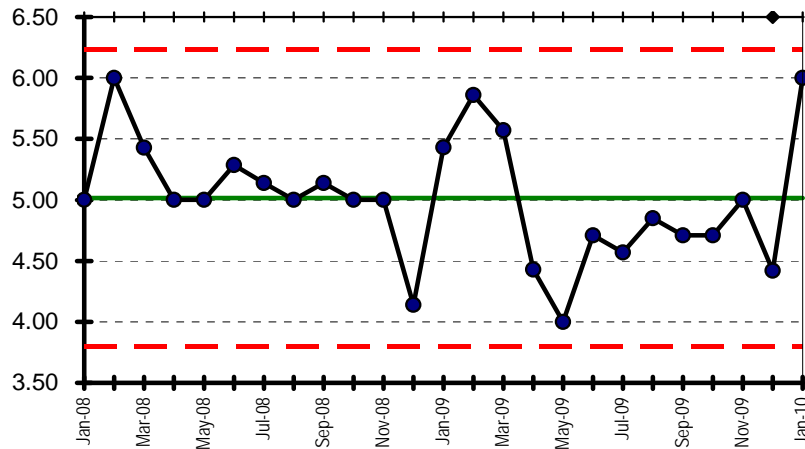
**2010** January target was **56%** met with only 15 documents completed.

Achieving targets of 27 per month will only avert the quantity of overdue documents from increasing. Additional effort is required to reduce the existing backlog. (The figure for 'overdue elapsed days' is 361,703).

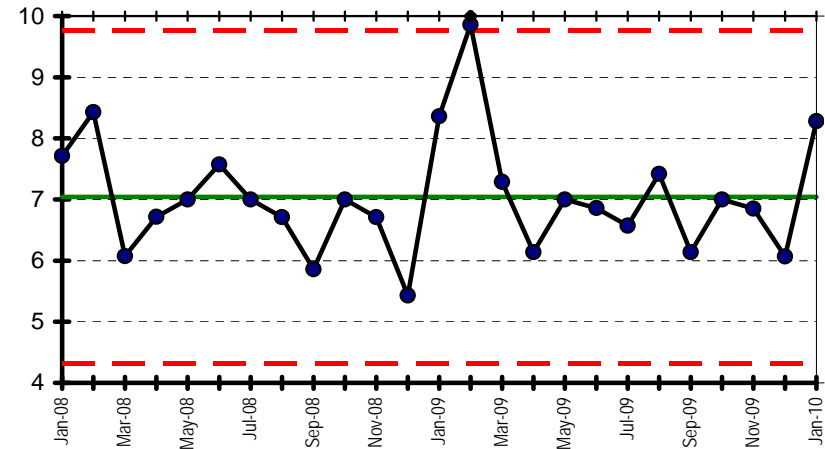


# Clinical Indicators QRA1

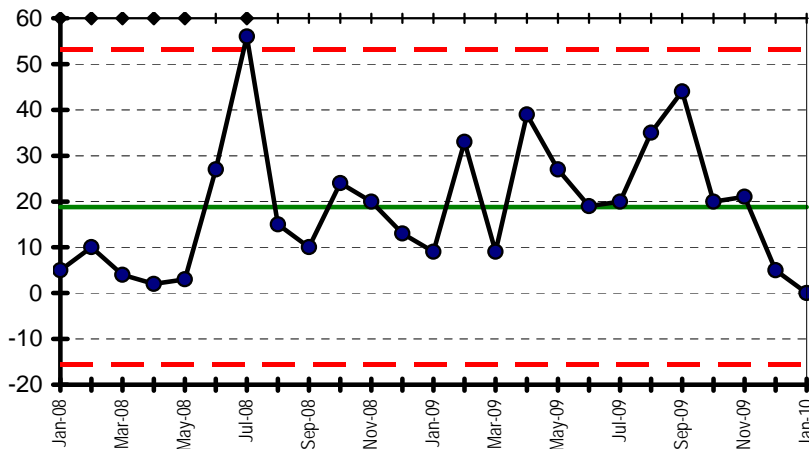
A01. Median wait from referral to FSA (Weeks)



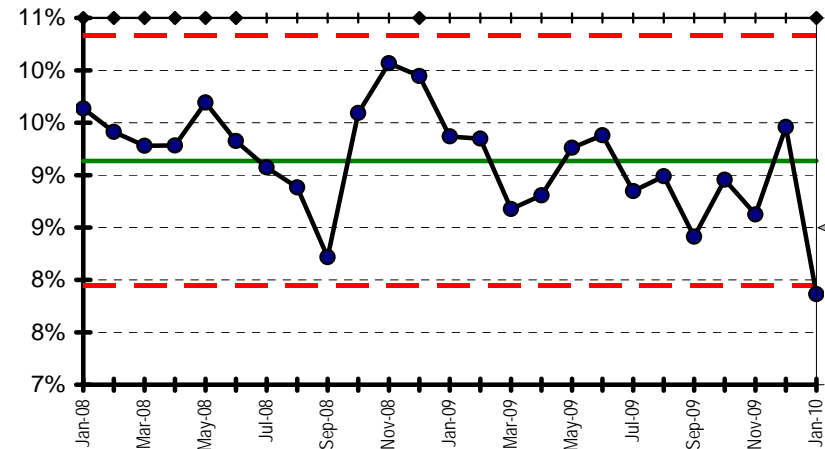
A02. Median time on surgical waiting list (Weeks)



A04. Cancelled procedures due to no beds

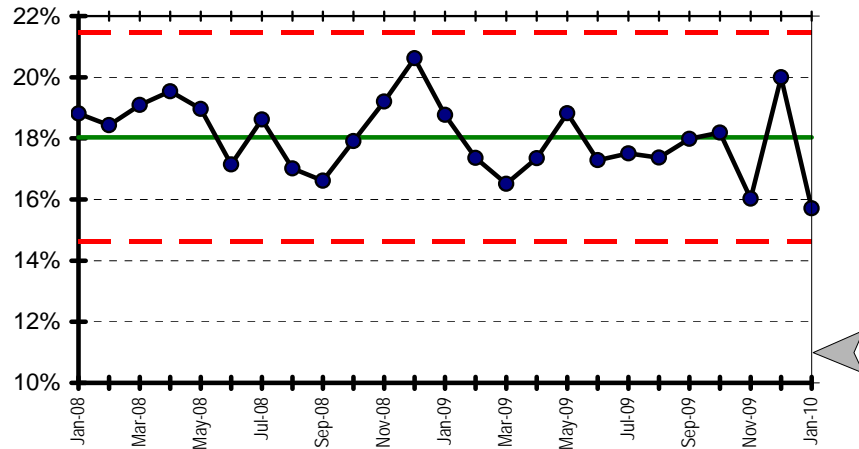


A52. % DNA rate for outpatient appointments -All Ethnicities

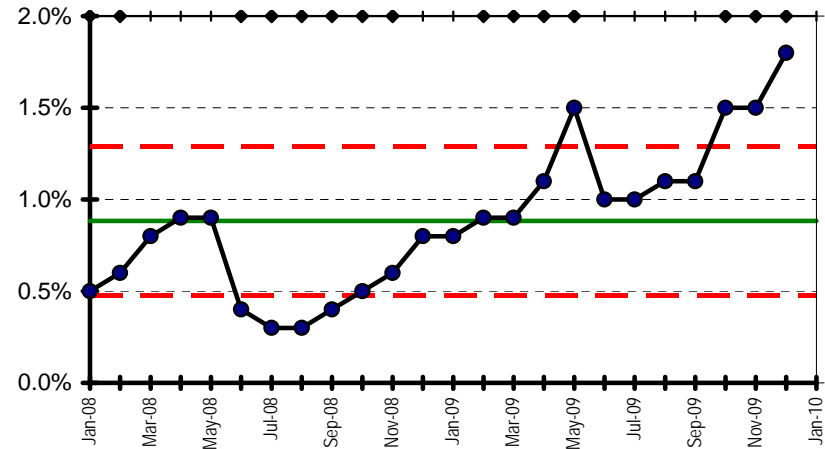


# Clinical Indicators QRA2

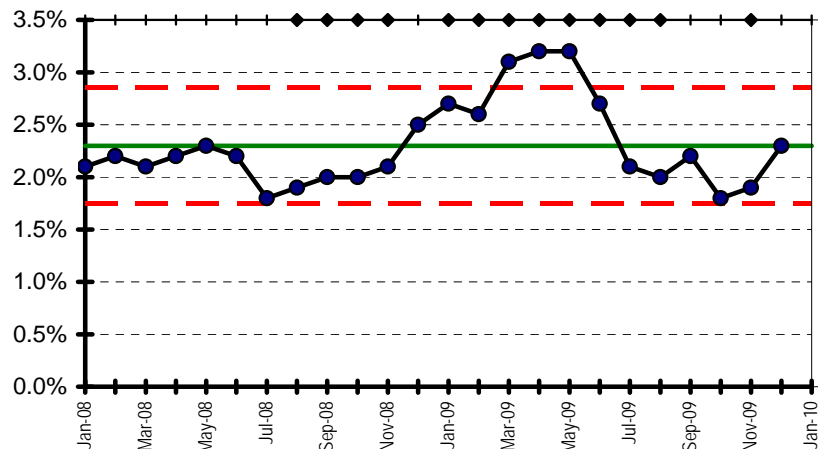
A52b. % DNA rate for outpatient appointments - Maori Only



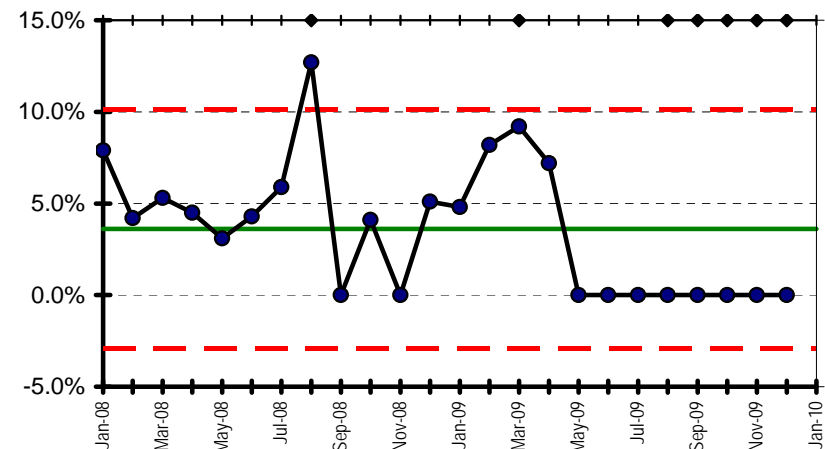
A62. (ESPI 2) Patients waiting longer than six months for their FSA



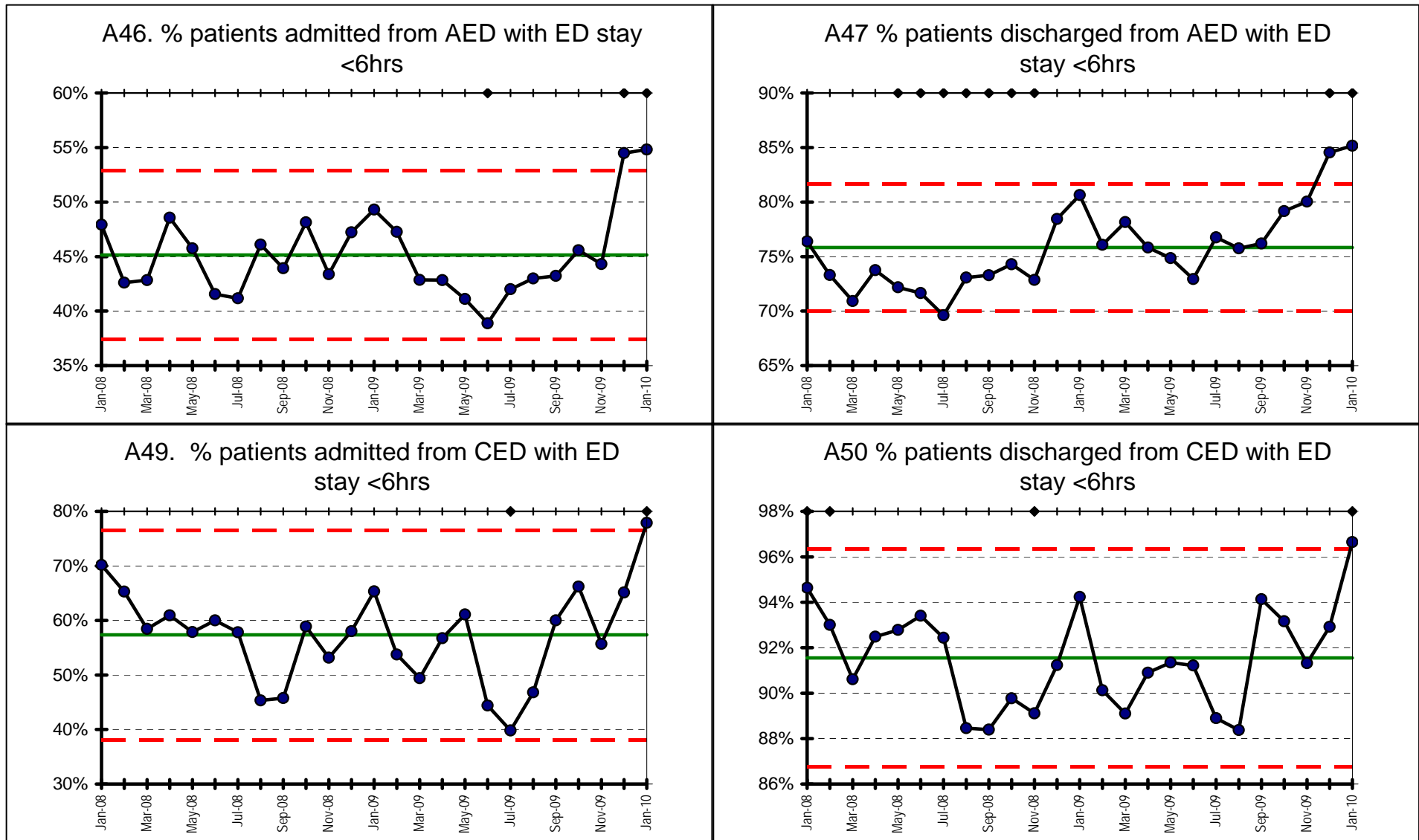
A63. (ESPI 5) Patients given a commitment to treatment but not treated within six months



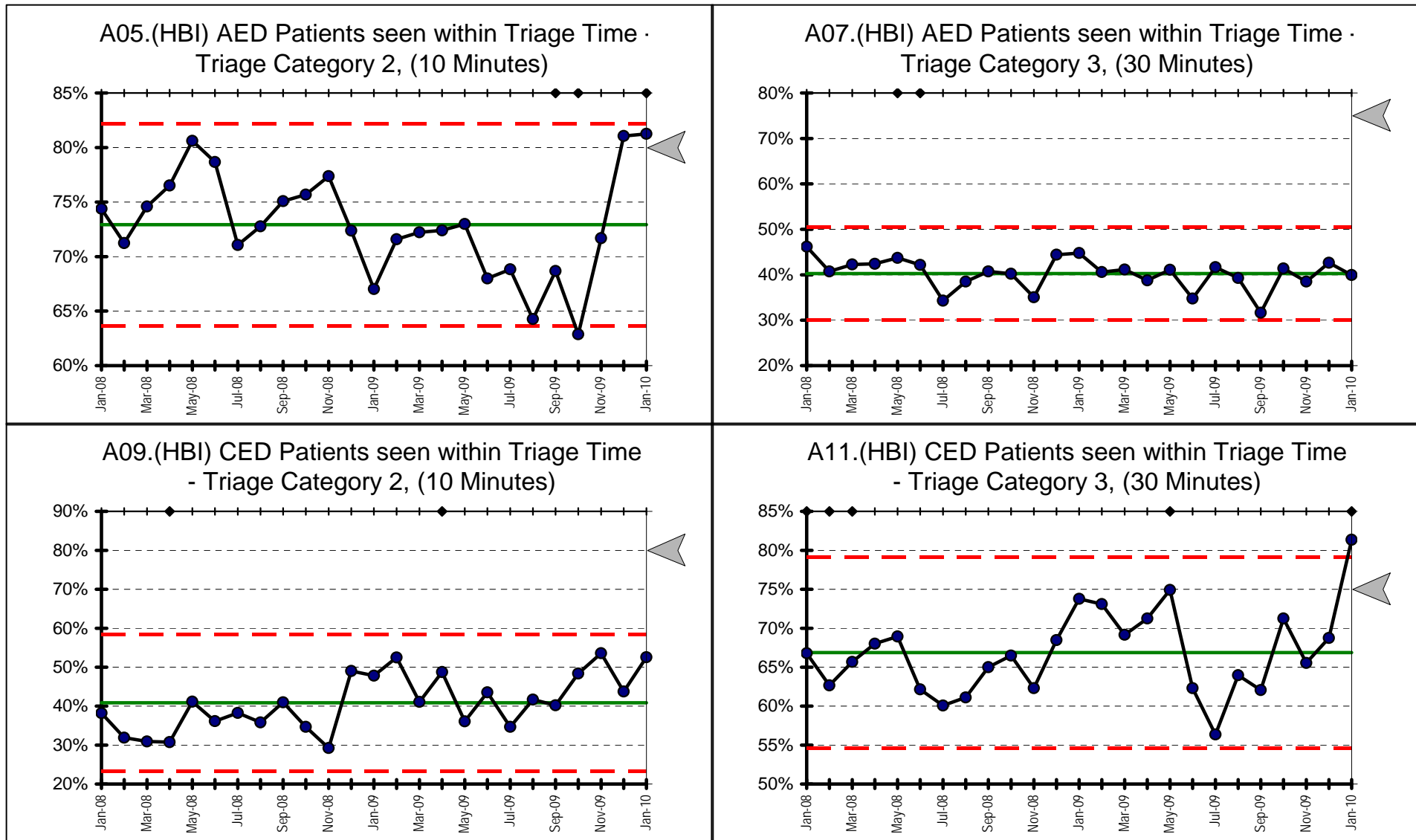
A64. (ESPI 6) Patients in active review with no clinical assessment within the last 6 months



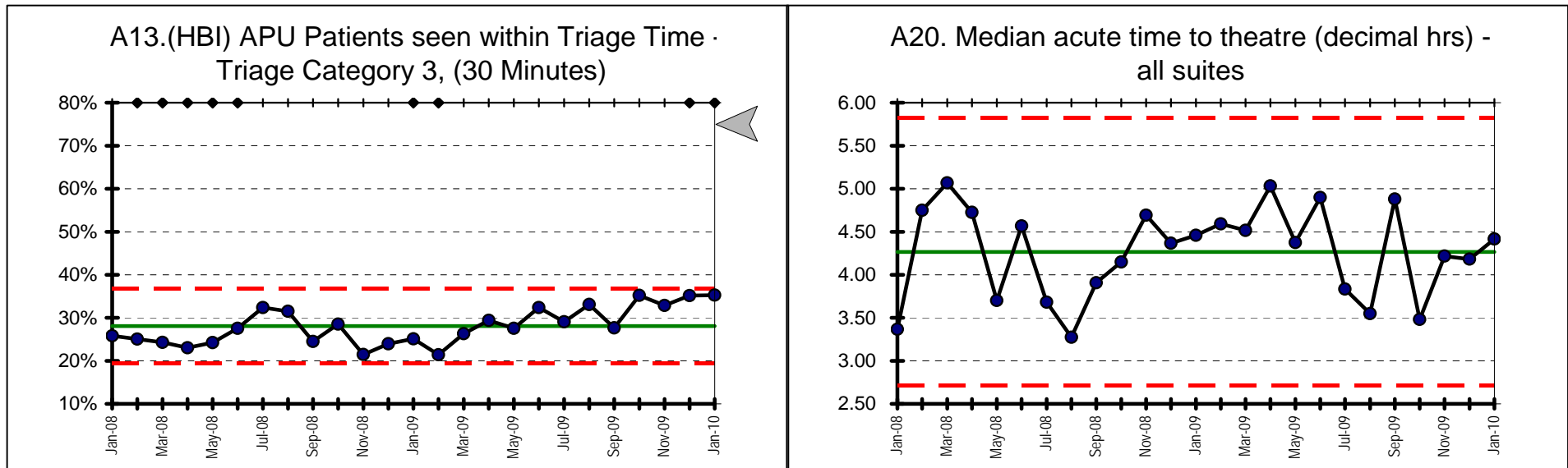
# Clinical Indicators QRA3



# Clinical Indicators QRA4

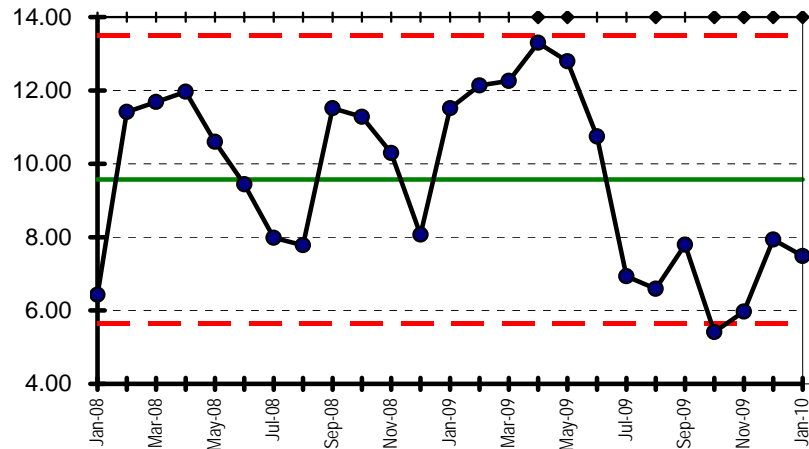


# Clinical Indicators QRA5

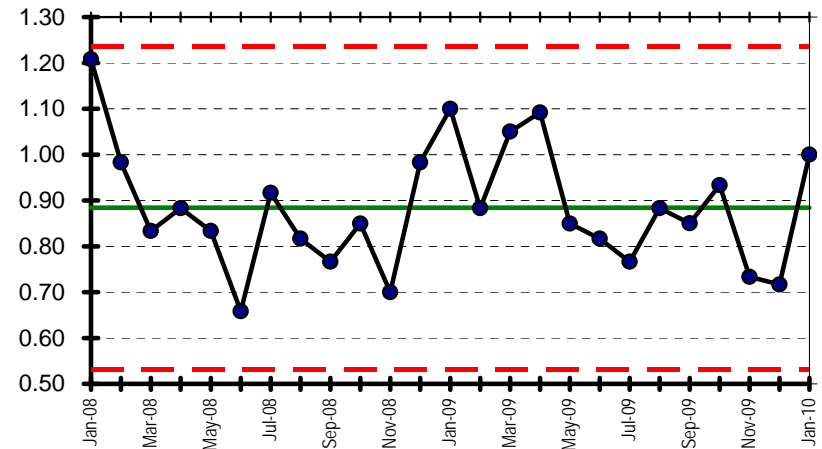


# Clinical Indicators QRA6

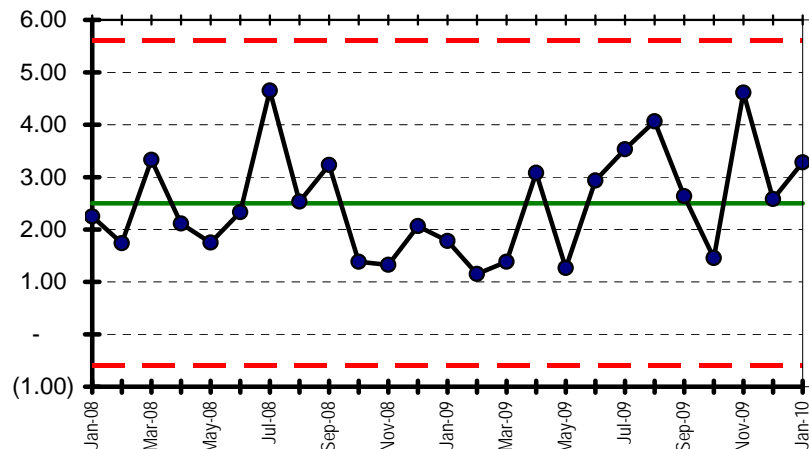
A40. Median acute time to theatre (decimal hrs) - Level 8



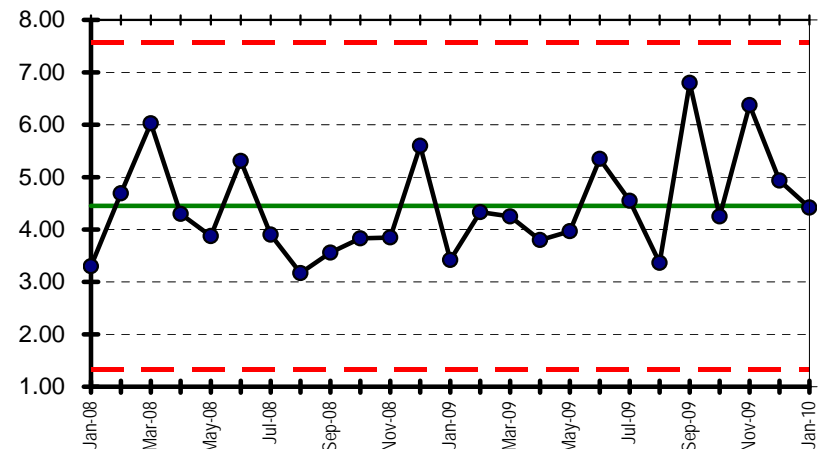
A41. Median acute time to theatre (decimal hrs) - level 9



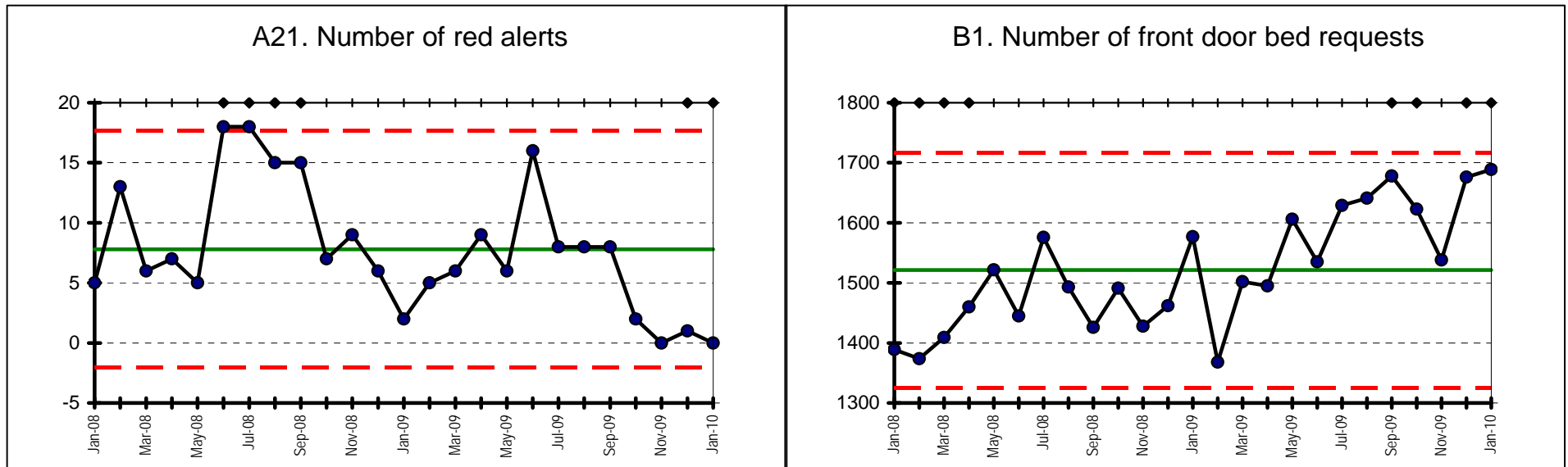
A42. Median acute time to theatre (decimal hrs) - level 4



A43. Median acute time to theatre (decimal hrs) - Starship

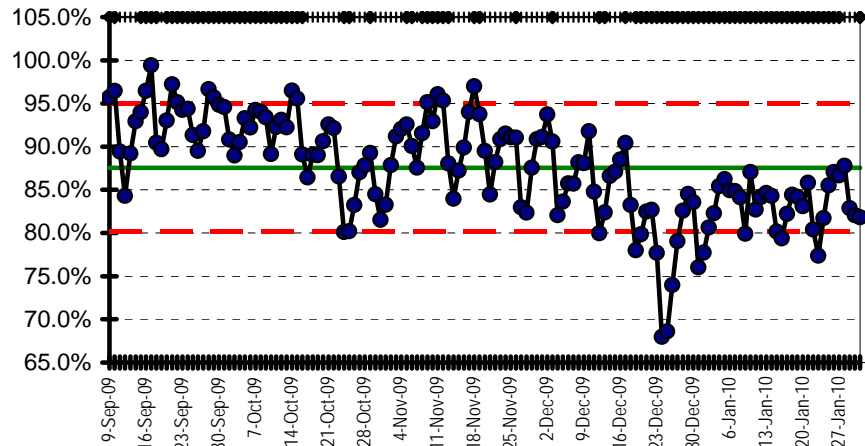


# Clinical Indicators QRA7

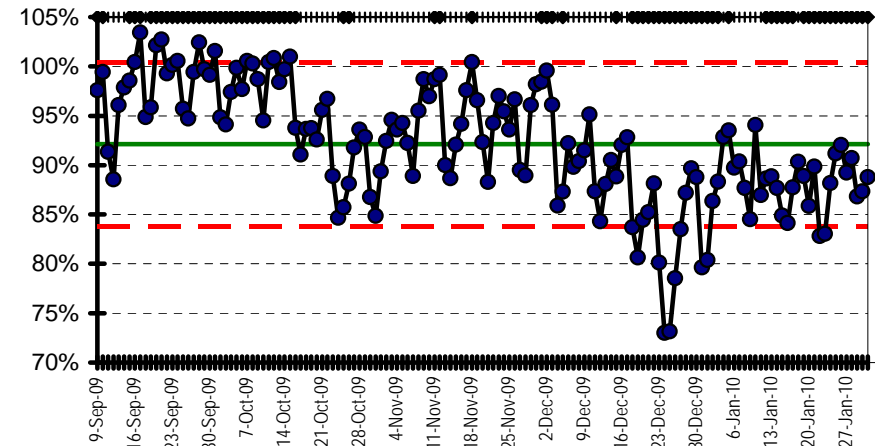


# Clinical Indicators QRA8

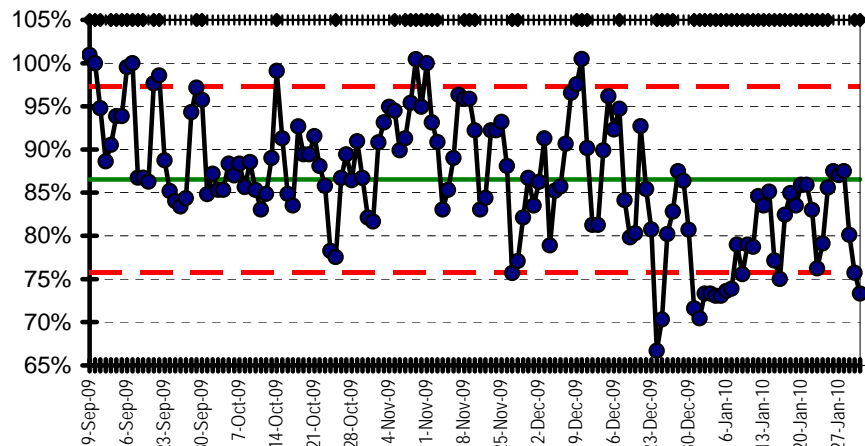
A23. Midnight Bed Occupancy - Total



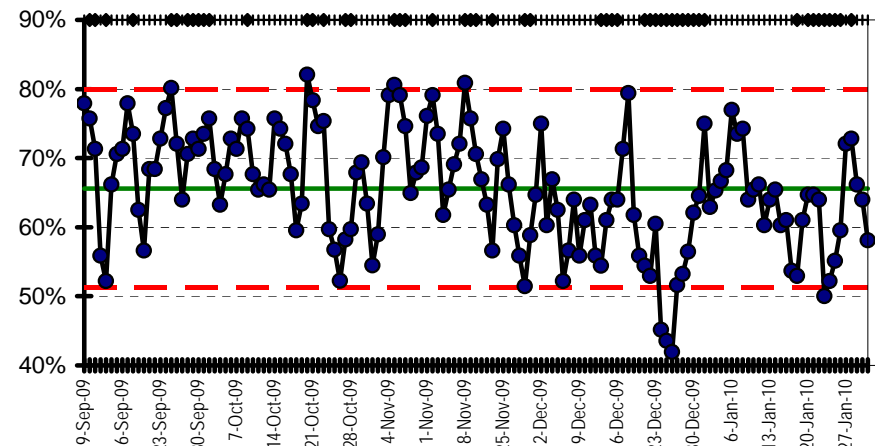
A24. Midnight Bed Occupancy - Adult



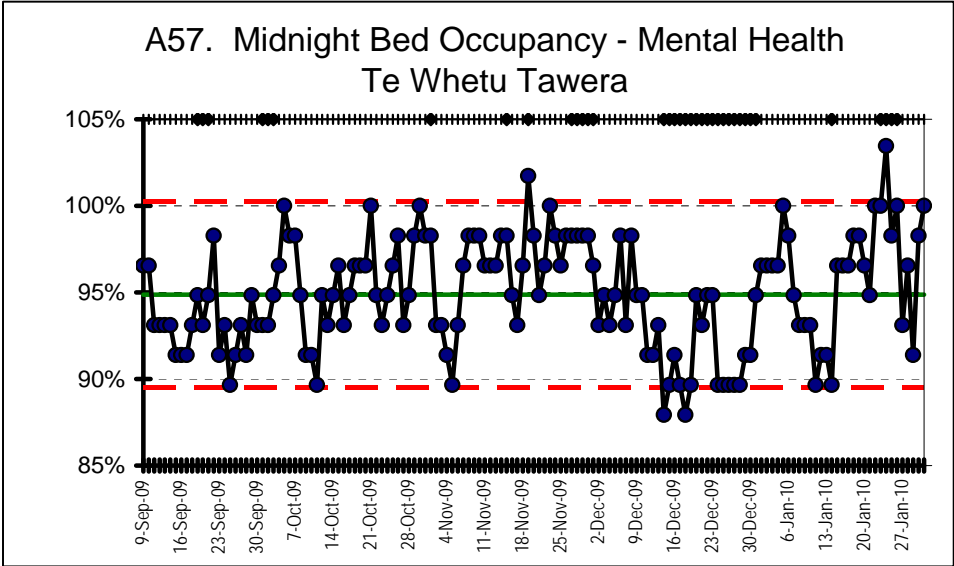
A25. Midnight Bed Occupancy - Child



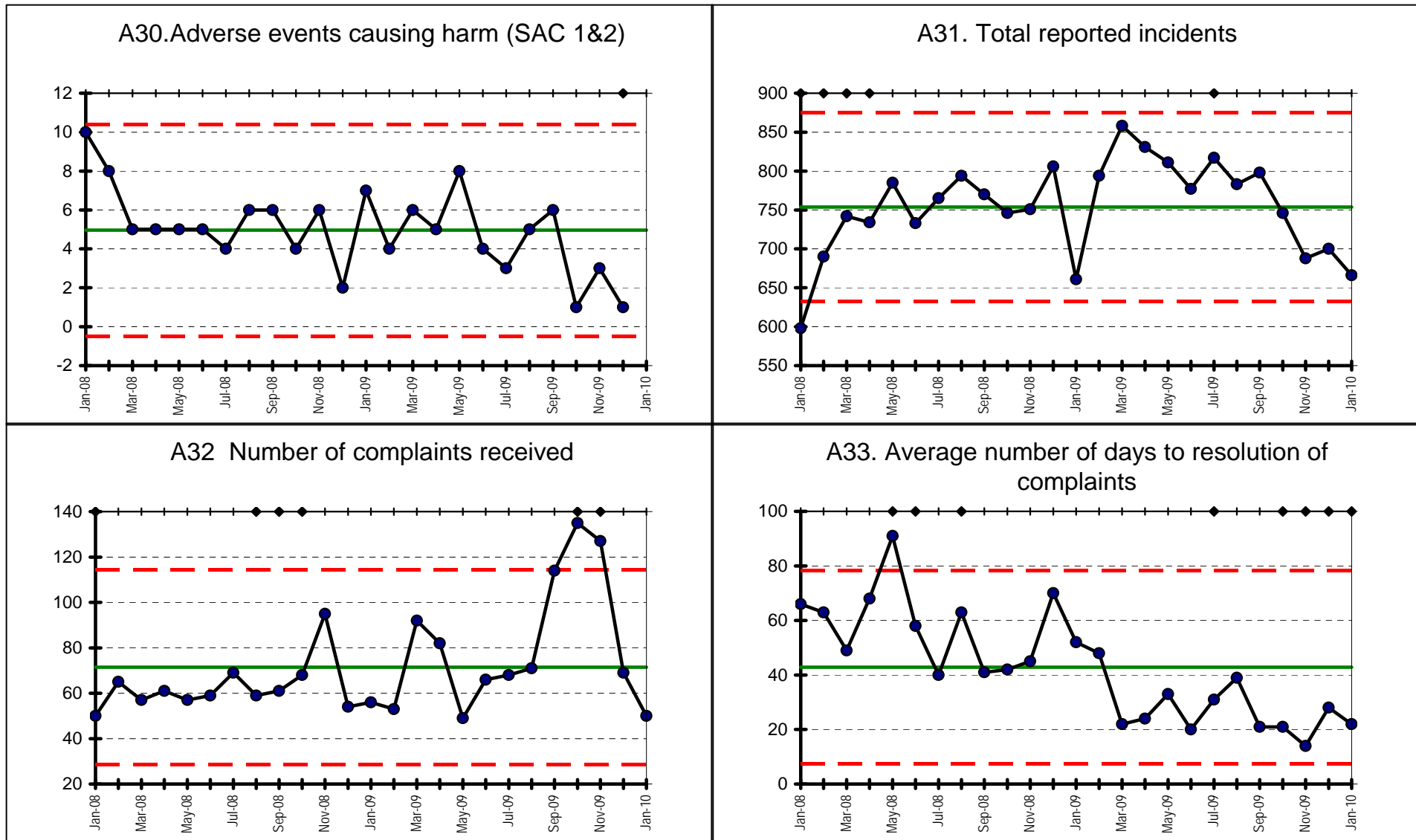
A26. Midnight Bed Occupancy - Women



# Clinical Indicators QRA9

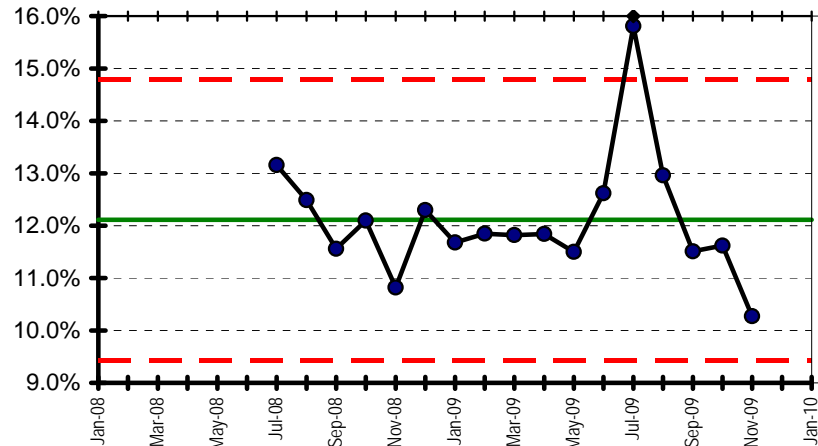


# Clinical Indicators QRA10

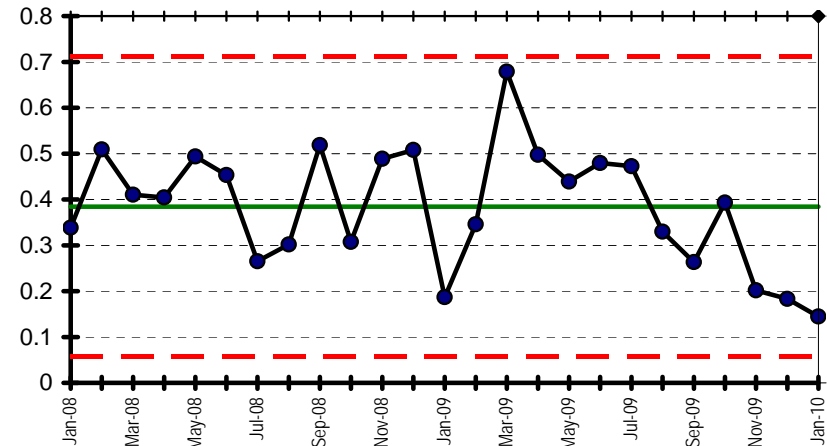


# Clinical Indicators QRA11

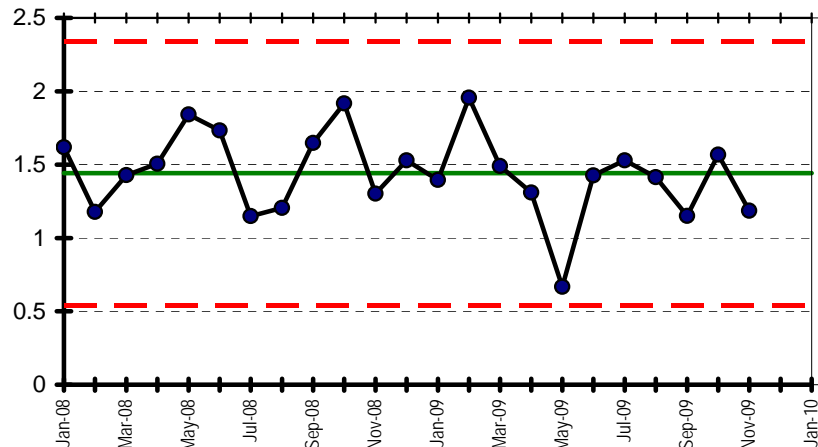
B62. (MOH-05) Smoking prevalence of hospitalised patients



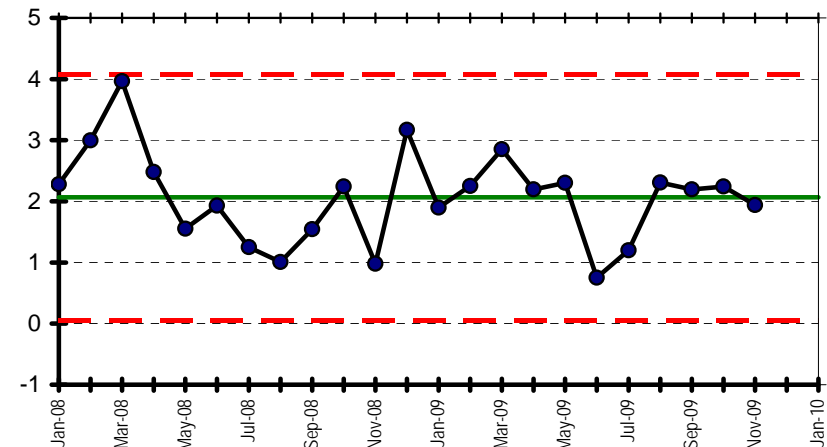
A36. Adult pressure areas (per 1000 bed-days) [inpatient acquired only from Apr-09]



A34. (HBI) Adult bloodstream infections (per 1000 bed-days)

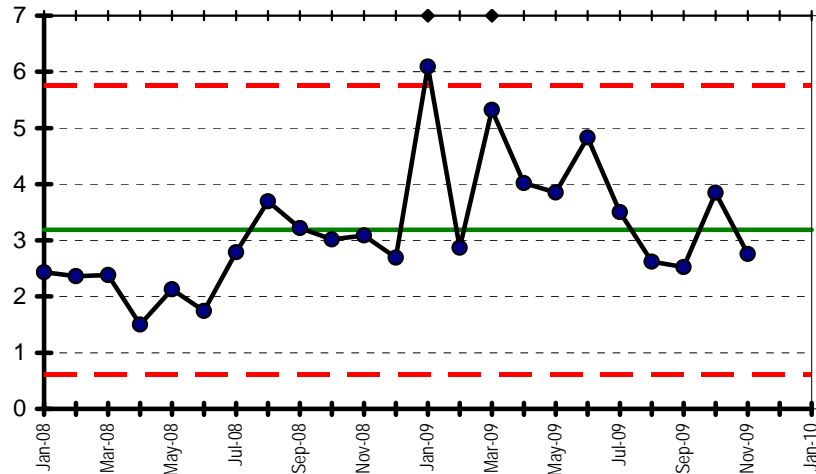


A35. (HBI) Child bloodstream infections (per 1000 bed-days)

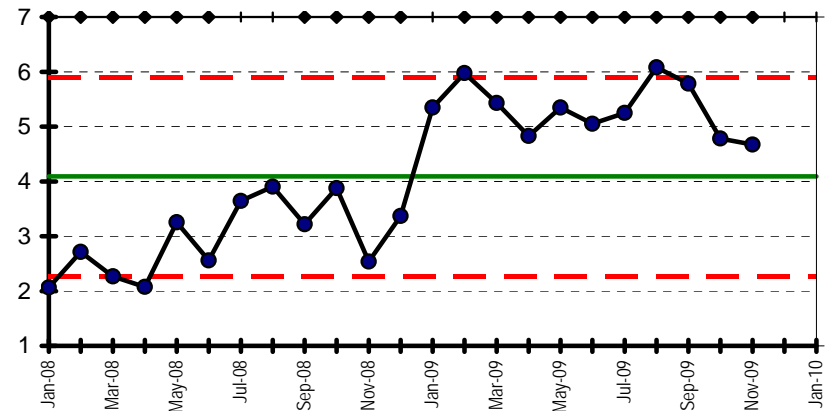


# Clinical Indicators QRA12

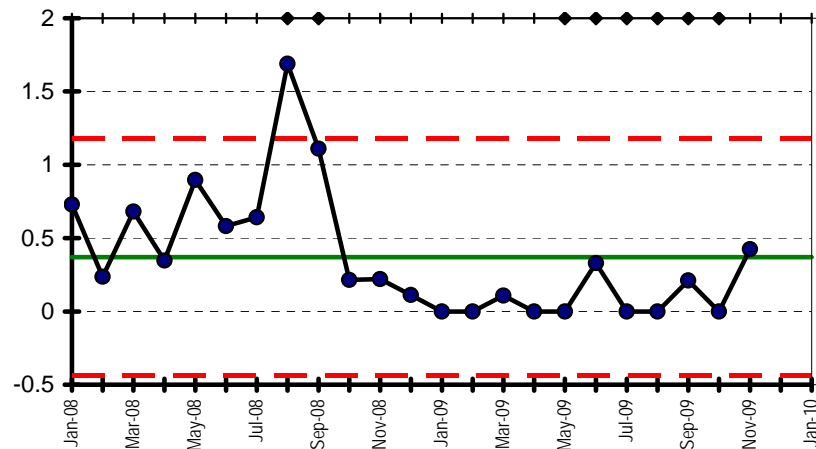
A37. MRSA new isolates (per 1000 discharges)



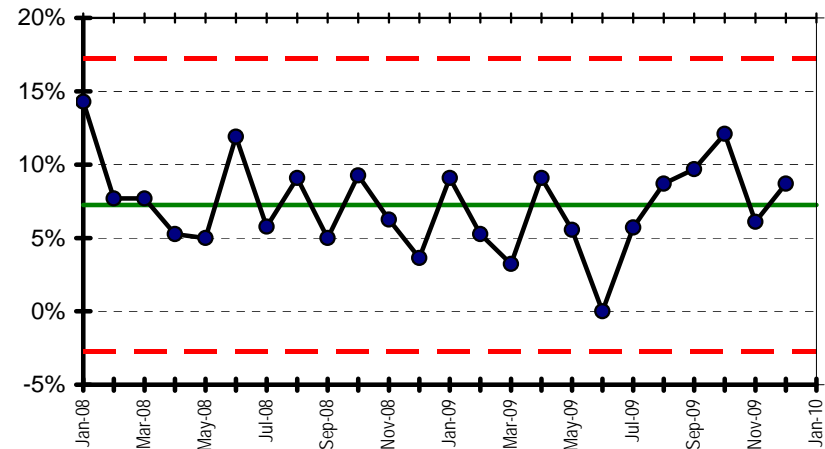
A38. ESBL new isolates (per 1000 discharges)



A39. VRE new isolates (per 1000 discharges)

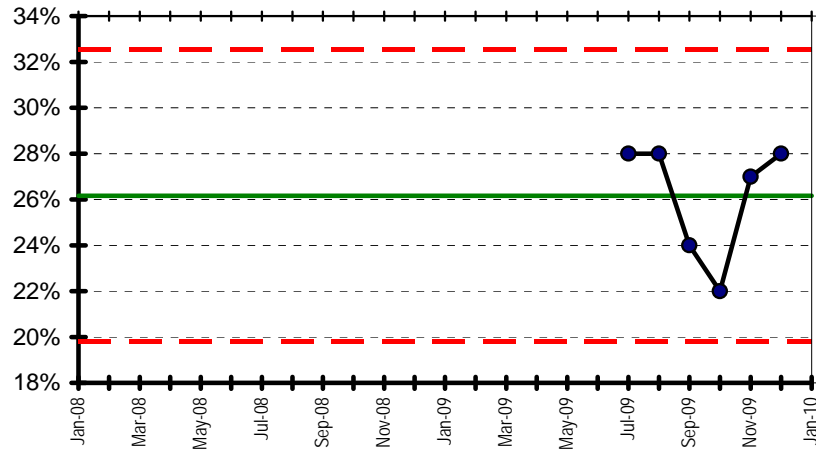


A60. Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera

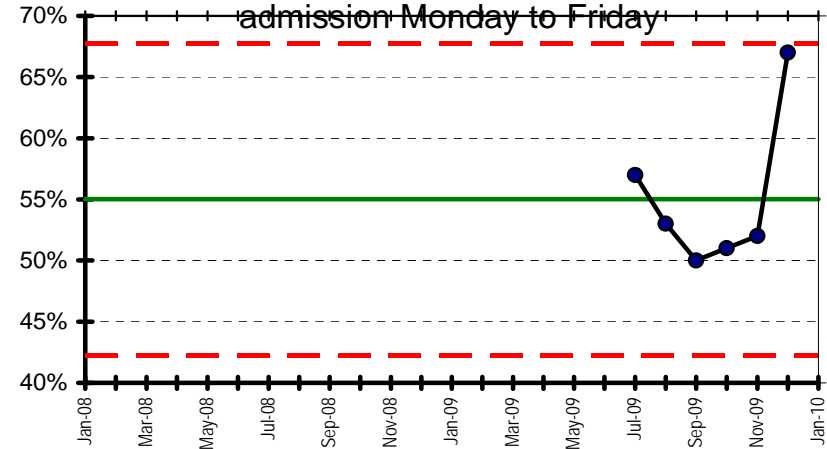


# Clinical Indicators QRA13

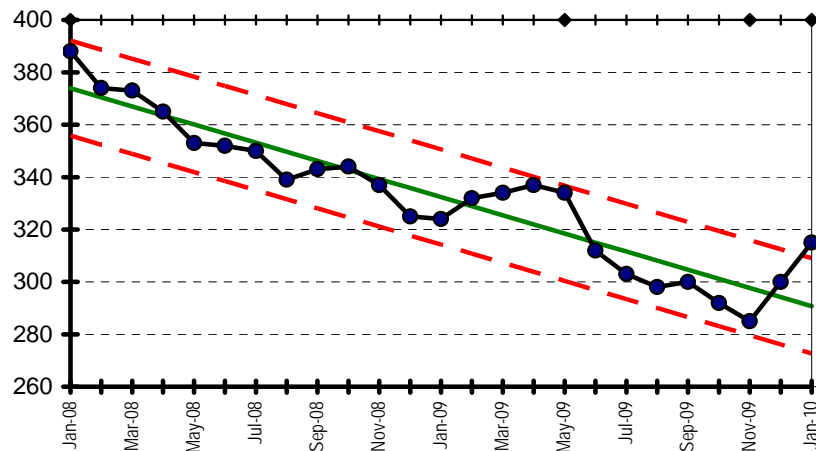
A58. % of medicines requiring reconciliation at admission to APU



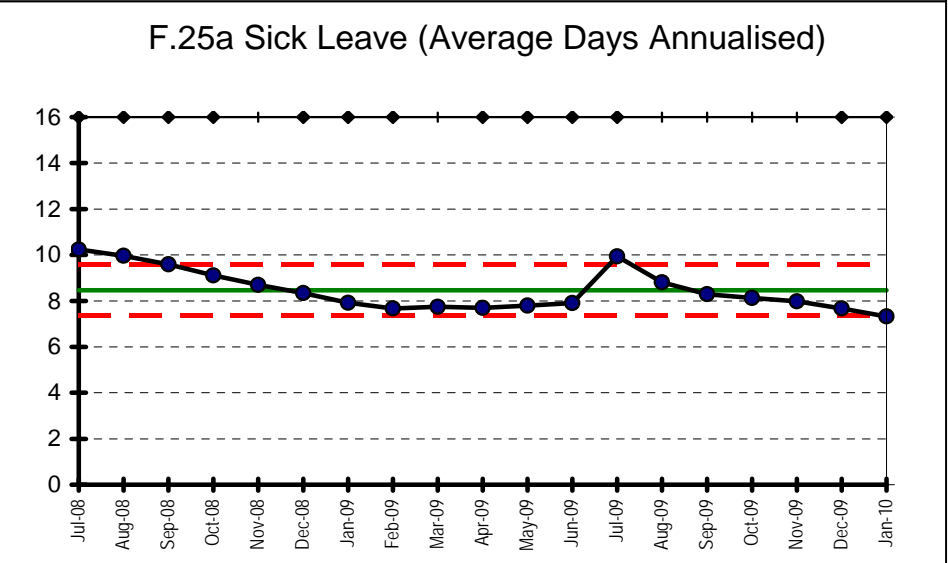
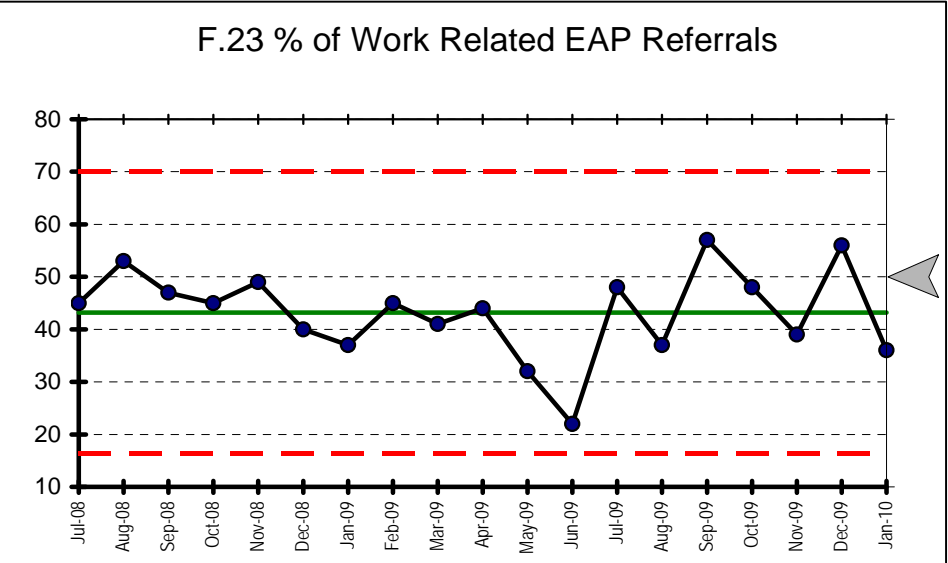
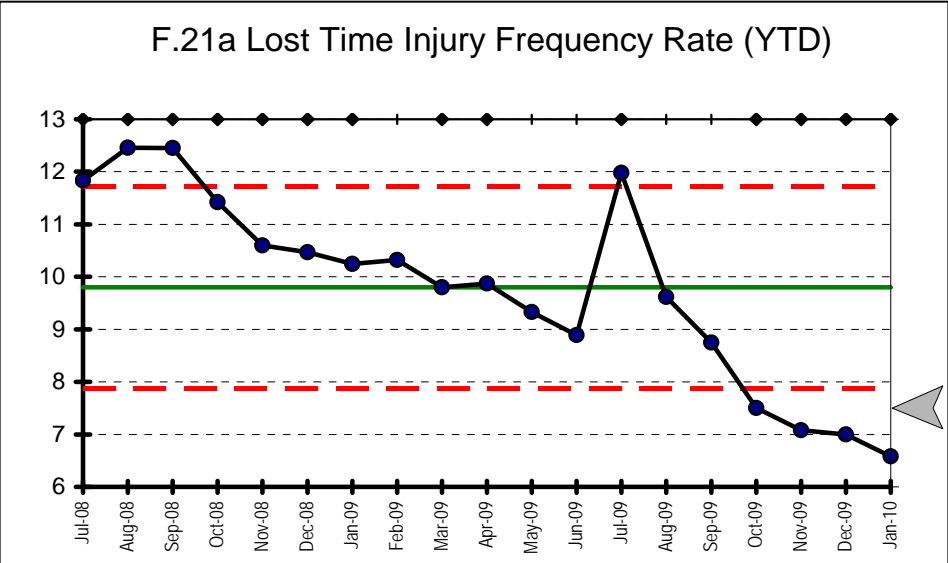
A59. % of APU patients (meeting criteria) whose medicines are reconciled within 24 hours of their admission Monday to Friday



D33. Policies & Guidelines - Overdue Quantity - Organisation & Provider wide



# QRA 14



%\$" A]b]g]f]m]c]Z<YU^h`~bX]WU]c]f]g



## Minister's Six Health Priorities 2009/10

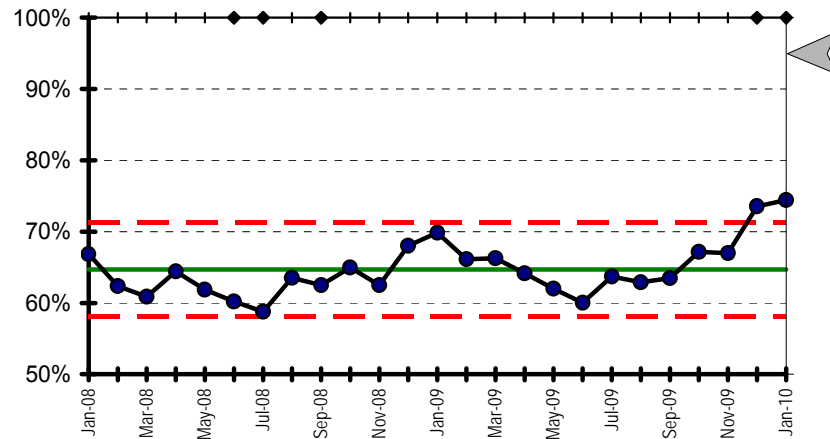
|   |                       |
|---|-----------------------|
| † | MOH top 6             |
| ‡ | IDP                   |
| Ω | SOI                   |
| Π | HBI                   |
| Φ | Mental Health KPI set |

January 2010

|                                                                                                          | Frequency |     | report page ref # |
|----------------------------------------------------------------------------------------------------------|-----------|-----|-------------------|
| A48. MOH-01% AED patients with ED stay <6hrs                                                             | M         | †   | 1                 |
| A51. MOH-01% CED patients with ED stay <6hrs                                                             | M         | †   | 1                 |
| B59. Number of Elective Discharges ADHB Population ADHB Provider (subset of MOH-02)                      | M         |     | 2                 |
| B53. MOH03. % of A, B & C category radiation oncology patients receiving treatment within 6 weeks of FSA | M         | †   | 3                 |
| B60. (MOH-05) Percentage of hospitalised smokers offered advice and support to quit                      | M         | †   | 3                 |
| L14 (MOH-04) % of 2 year olds fully immunised - Total                                                    | Q         | †,Ω | 4                 |
| L19. (MOH-06) Diabetes Annual Check - Total                                                              | Q         | Ω,† | 4                 |
| L20. (MOH-06) Get Checked Patients with an HbA1c<8 Total                                                 | Q         | Ω,† | 5                 |
| L22 (MOH-06) % of the eligible adult population having CVD Risk assessed in the last five years - Total  | Q         | Ω,† | 5                 |

# MOH Targets 1

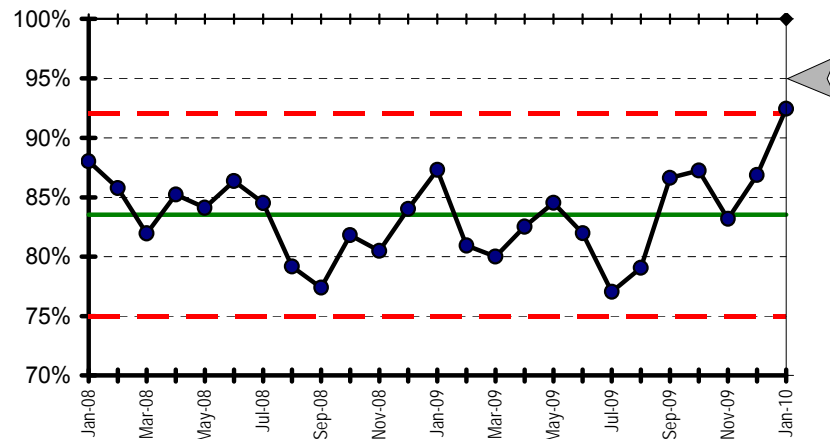
A48. (MOH-01) % AED patients with ED stay <6hrs



**MOH-01: By Jan 2010, 95% of AED patients are admitted discharged or transferred within 6 hours .**

Performance has continued to improve in January 2010.

A51. (MOH-01) % CED patients with ED stay <6hrs

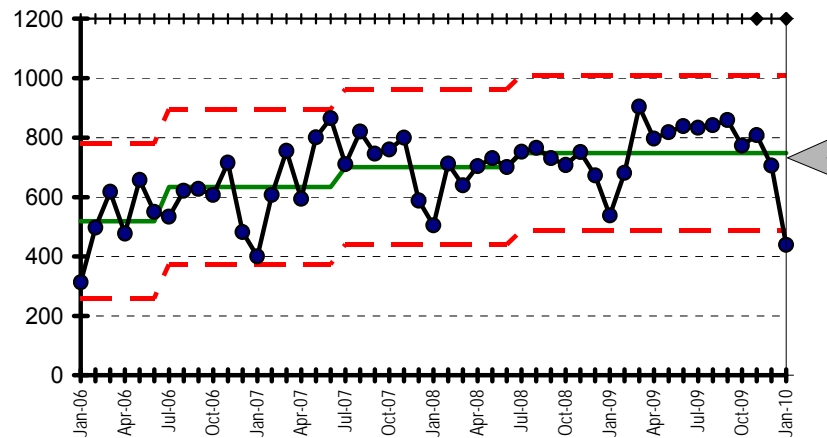


**MOH-01: By Jan 2010, 95% of CED patients are admitted discharged or transferred within 6 hours**

This has been achieved despite highest January attendances for six years. There has been no significant change in triage, casemix or percentage of patients referred for admission.

# MOH Targets 2

B59. Number of Elective Discharges, ADHB Population, ADHB Provider (Subset of MOH-02)



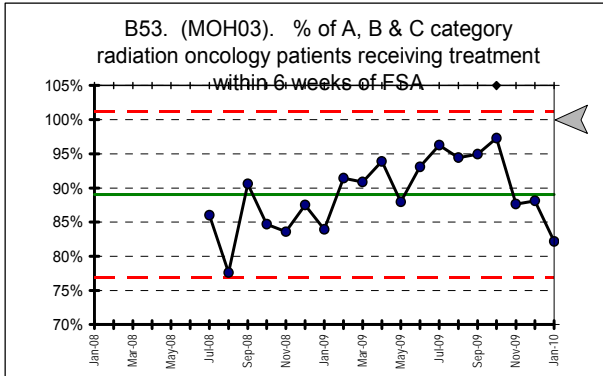
**MOH-02. 9425 Elective Surgical Discharges for ADHB population for 2009/10 year.** (The indicator measured monthly is the subset of the Target treated by the ADHB provider and comprises 93% of total: Target: 8790 or 733 per month)

Elective outputs reduced due to a combination of: -

- greatly reduced outsourcing (with saving in direct treatment costs) due to closure of private hospitals,
- the application of the excess annual leave programme and
- in some services the impact of higher than anticipated acute volumes.

YTD position - target =  $733 * 7 = 5,131$  discharges  
 actual = 5,259 discharges

# MOH Targets 3



**MOH-03. By July 2010, 100% of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).**

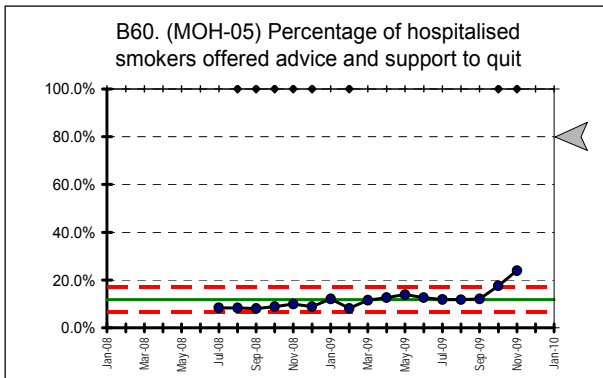
The service is aiming to meet the 6 week average waiting time target which is effective from 1 July 2010. The current average wait time for "C" Radical breast is currently greater than this. Compliance for the first and second quarters was 86% and 84% respectively (six month average compliance 85%). The average wait time in January is 6.3 weeks. The >6 week wait time is related to Linac capacity, increased demand and high acuity.

The service has developed a tool to forecast demand for treatment capacity, reflecting trends by tumour type as well as linear accelerator technological capability. This model demonstrates a need to increase treatment capacity by 5 hours per day in order to meet the 6 week target by 1 July.

Outsourcing simple breast and prostate patients to Waikato Hospital (2 per week) commenced in mid January with 3 patients commencing treatment. A communications plan has been released to all stakeholders and the MOH notified.

The replacement linac (MV4) was commissioned on the 25th January and increases capacity of the fleet. The service has an evening shift commencing in March to extend treatment capacity by 4 hours per day. The service expects to see a gradual improvement in wait times over the next quarter.

Additional evening shift hours are required to compensate for the obsolescence of the oldest Linear accelerator (13 years vs. 10 year useful life and running only 2 hours per day). The business case for this replacement is being prepared and will be presented to Regional Capital during April, in line with the Strategic Plan for delivery of Radiation Oncology for the Northern Region to 2019.

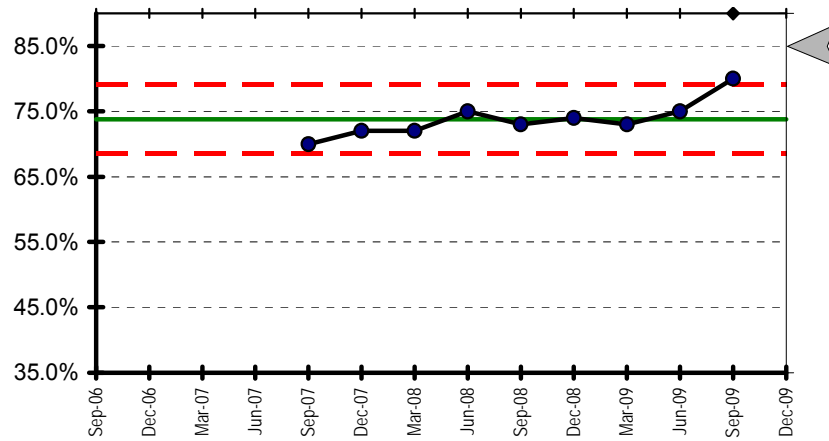


**MOH-05. 80% of hospitalised smokers are provided with advice and help to quit by July 2010**

This Quarter has seen an increase in the brief advice and support for smokers being recorded as a result of intensive training. Standing Orders for NRT was also introduced. While it is early days the amount of NRT being dispensed to provider arm services is steadily increasing.

# MOH Targets 4

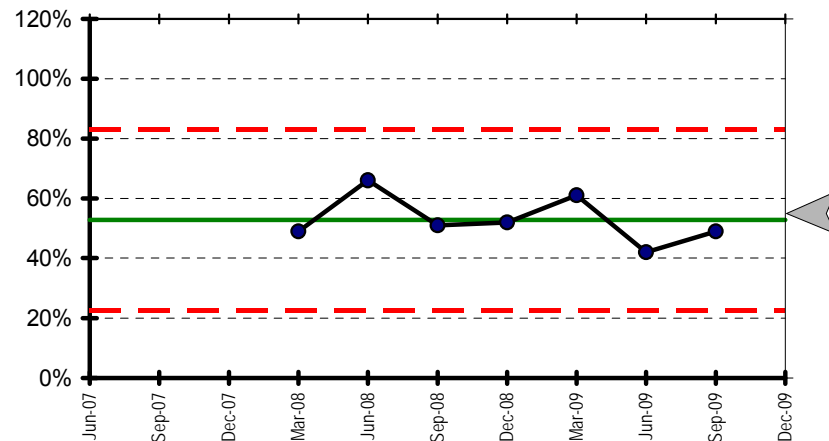
L14. (MOH-04) Percentage of two year olds immunised - Total



**MOH-04. 85% of two year olds fully immunised by July 2010**

This quarter has seen a significant jump in immunisation coverage rates due to changes made by the Ministry of Health to the NIR datamart reporting rules. ADHB is on track to achieve the 2009/10 target of 85% of 2 year olds fully immunised as agreed with the Ministry.

L19. (MOH-06) Diabetes Annual Check -Total

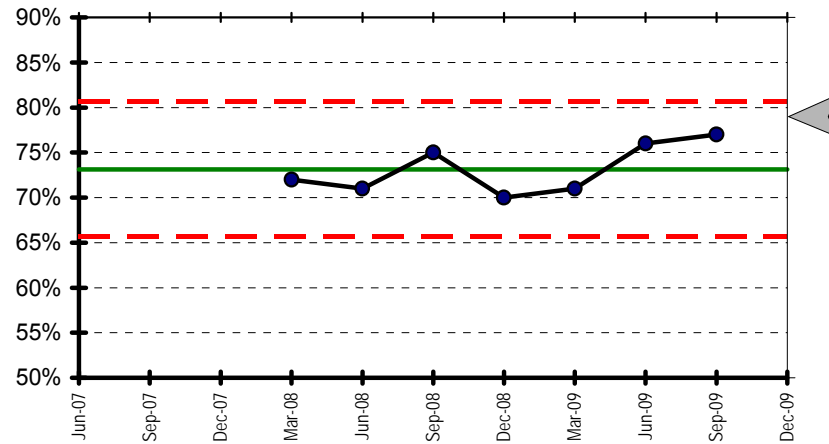


**MOH-06. 5% increase in people with diabetes who attend free annual checks. 2009/10 year target: 55%**

Effort to improve diabetes annual checks has resulted in an overall improvement in out performance however, further effort is required to meet our target.

# MOH Targets 5

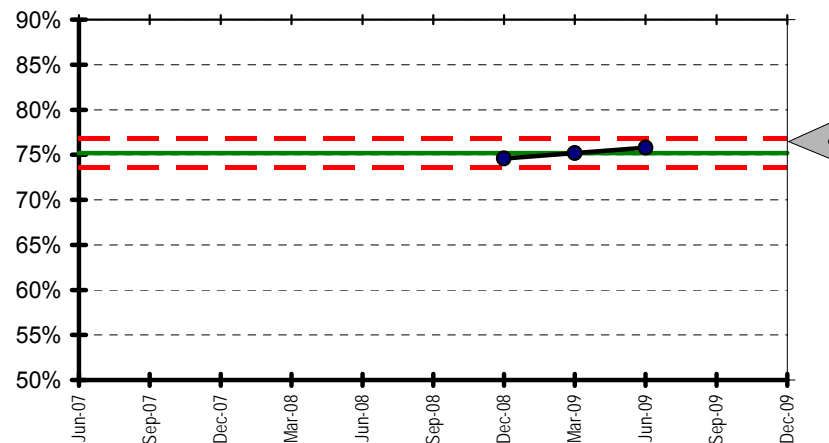
L20. (MOH-06) Get Checked Patients with an HbA1c<8 -Total



**MOH-06. 2% percent increase in people with diabetes who have satisfactory or better Diabetes management. 2009/10 year. target 79%**

Our overall management for our diabetes population is positive and improving each quarter. If looking at the separate graphs this experience holds true against all ethnicities.

L22. (MOH-06) Cardiovascular risk screening - Total



**MOH-06. 2% increase in the eligible adult population who have had their CVD risk assessed in the last five years. 2009/10 target 76.5%**

This is a new target capturing laboratory figures. We are tracking well on target for this and current work being undertaken is aimed at performing well above the MoH target with an overall goal of 80% being our internally driven goal.