



Auckland District Health Board
Hospital Advisory Committee Meeting

Wednesday 4 May 2011

10.45am

A+ Trust Room

Clinical Education Centre

Level 5

Auckland City Hospital

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



Hospital Advisory Committee

For discussion with Board

HAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
KPIs	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
RISKS	
RECOMMENDATIONS	
1.	
2.	
NOTING	
1.	
2.	
3.	
4.	



Hospital Advisory Committee Action Points

MEETING DETAILS

Date and Time

Item	Detail	Responsibility	Action
XX			
XX			
XX			
XX			

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD AND COMMITTEE (HAC) INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY (Chair)	1. University of Auckland Business School 2. New Zealand Leadership Institute 3. Health Benefits Limited 4. Tonkin & Taylor 5. Waitemata District Health Board	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman			1 February 2011
Jo AGNEW	1. Senior Lecturer Nursing, Auckland University 2. Casual Staff Nurse ADHB		Salary Salary		21 April 2010
Peter AITKEN	1. Pharmacist 2. Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	1. Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	<ol style="list-style-type: none"> 1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board 	<p>Self-employed</p> <p>Professional Conduct Committee member</p> <p>Professional Conduct Committee member</p>	<p>Fees</p> <p>Hourly fee</p> <p>Hourly fee</p>	<p>Writer, editor and public relations services</p> <p>Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes</p> <p>Lay member of PCC to assess complaints and determine outcomes</p>	7 August 2009
Dr Chris CHAMBERS	<ol style="list-style-type: none"> 1. Employee, Auckland District Health Board 2. Wife employed by Starship Trauma Service 3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School 4. Associate, Epsom Anaesthetic Group 5. Member, ASMS 6. Shareholder, Ormiston Surgical 				20 April 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	2. James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	3. Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	4. National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	5. Waitemata District Health Board	Member	Fee (to Ngati Hine Health Trust)		
Lee MATHIAS	1. Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	1 February 2011
	2. Iris Limited	Director	Fee	Director, company provides services to people with multiple physical disabilities especially cerebral Palsy	
	3. Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	4. Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products	
	5. John Seabrook Holdings Limited	Director	No fee	Estate of late husband	
	6. AuPairlink Limited	Governance Advisor	Fee	Provider of early childhood education services contracted to the MoE.	

	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
Robyn NORTHEY	1. Self employed Contractor 2. Hope Foundation 3. Northern Region Ethics Committee	Project management, service review, planning etc. Board member Member	Fee Nil Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
Gwen TEPANIA-PALMER	1. Waitemata District Health Board 2. Manaia PHO 3. Ngati Hine Health Trust 4. Awanmarangi Waonangi 5. Te TAitokerau Whanau Ora	Board member Board member Chair Committee member Committee member	Fee Fee paid to NHHT Fee		2 February 2011
Ian WARD	1. Chair, Advisory Board, Healthvision Limited 2. Principal/Director C -4 Consulting Limited		Fee	Tender to National Shared Services	3 February 2010
Anne KOLBE	1. Private Paediatric Surgical Practice 2. Employee Communico NZ 3. Siggins Miller, Australia 4. Head, Auckland Clinical School, School of Medicine, University of Auckland 5. Husband: Employee University of Auckland 6. Risk and Audit Committee Whanganui District Health Board	Director Senior Consultant Senior Consultant Employee Member	Joint Owner Contractor Contractor Salary Fee		4 August 2010

Date: 27/04/2011

	7. Pharmac Board	Member	Fee		
	8. South Island Neurosurgical Services Expert Panel	Chair	Fee		

Date: 27/04/2011

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

CONFIRMATION OF MINUTES

- WEDNESDAY 6 APRIL 2011

Hospital Advisory Committee Minutes



MEETING DETAILS													
Time and Date	10:45am, Wednesday, 6 April 2011												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
1	ATTENDANCE AND APOLOGIES												
	<p>The Chair declared the meeting open at 10:48am.</p> <p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> <tr> <td>Associate Professor Anne Kolbe</td> <td></td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith – Chief Executive Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Greg Balla – Director Performance and Innovation Taima Campbell – Executive Director Nursing Janice Mueller – Director Allied Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Rob Cooper had been granted leave of absence and an apology had been received from Professor Iain Martin.</p> <p><u>Moved Robyn Northey; seconded Peter Aitken</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Dr Chris Chambers (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	Associate Professor Anne Kolbe	
Dr Chris Chambers (Chair)	Jo Agnew												
Peter Aitken	Judith Bassett												
Susan Buckland	Dr Lester Levy												
Dr Lee Mathias	Robyn Northey												
Gwen Tepania-Palmer	Ian Ward												
Associate Professor Anne Kolbe													
2	CONFLICTS OF INTEREST												
	There were no declarations of conflicts of interest for any item on the agenda.												
3	CONFIRMATION OF MINUTES 2 MARCH 2011												
	<p><u>Moved Jo Agnew, seconded Robyn Northey</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 2 March 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The organisation was good at attending to acute demand but there needed to be a cultural change to apply the same attention to electives and not have cancellations with the need to increase electives by 35% in the second half of the year. This applied to planning of resources including conference leave, leave etc. to provide cover as is done for acute patient to ensure that production keeps going. This was also a matter of being respectful to patients and families with disruption to them if elective procedures are cancelled.</p>												

4	ACTION POINTS 2 MARCH 2011
	<p>Northern Region's Health Plan</p> <p>This had been lodged with the National Health Board and when finalised there will be discussions with the Medical School.</p> <p>Networks</p> <p>There are 4 cancer networks in New Zealand and through the Northern network came out favourably in a national evaluation. The networks connect hospice, NGOs, patient advocacy alongside the regional cancer service. The evaluation report is to be distributed. A paper on networks had been prepared by Chris Mules several years ago and this is also to be distributed.</p>
5.1	Operational Report
	<p>February production was on plan and acutes above plan. There is work on labour costs, which are a challenge due to the high acute demand being at the winter model level before winter, and also on direct treatment costs. Peter Lowry is manager of elective production. The reasons for the increased demand were multi-factorial, running above population growth, with the factors such as chronic conditions, trauma, etc. It is not thought that access to services for adults and children were affected by the economic conditions with presentations being appropriate.</p> <p>The FTEs above budget were a problem with the savings plans premised on FTE reductions. It was thought that the budget savings were overly ambitious and had lacked actions to deal with such factors as service creep, new treatments without due approval or change of treatment pathways and inputs and budgeting to do a certain number of procedures, which may be completed in the first six months. This then leaves a problem for the rest of the year. There were also questions of doing work for other populations rather than ADHB's. The information was available but it was important to get this to the right decision making point in the organisation.</p> <p>Occupancy of PICU was subject to fluctuations in numbers of long stay patients, not necessarily cardiac, and there was a need to support clinicians to protect scarce resources and not accept referrals if they are not clinically appropriate. The Board would provide that support to clinicians to be more mindful that it is not an open door and there was a need for consistent access and model of care across the country. In terms of these national services it was important to get the price right recognising the availability of a 24 hour service through top sliced funding.</p> <p>WIES were stable with a slight average decline. The throughput in CED was within a margin of error however there was more variation in the 6 hours target which needs more process improvement work. ESPIs are compliant but in areas where they were not there were workout plans for patients to be treated within six months, a buffer zone would be created by May and there was management of the front door for elective patients by going back to first specialists appointments for people in the pipeline. This would also require work with bookers and schedulers with referrers. Once on the waiting list there was a commitment to patients and families so there needed to be more thought about their being put on the list considering capacity, thresholds and whether patients were clinically ready.</p> <p>There were a number of challenges in General Medicine. It is not as attractive as a specialty to clinicians as it had been and faces increased work volumes and RMO and SMO roster gaps. It was subject to an improvement project and was being discussed with the University in terms of improving its academic attractiveness. There were different models in the USA.</p> <p>A new Nurse Director for Child Health had been appointed, being recruited from the UK, who would start in July which filled a management vacancy.</p> <p>A report on January to March quarter on the 6 hour performance in EDs was tabled with excellent performance in adults, however there was a need to get this sustainable, and decrease the variability of performance for children.</p>

5.2	Health Targets
	<p>There had been increased effort in February to engage all staff, and January to March there had been a 10% increase in presentations. Elective surgery performance to 30 June was being managed by Peter Lowry to drive elective performance with the clinical directors and while on target for the month of February it was slightly under target in March. There was a review of data to ensure that there was consistency of counting performance with other DHBs including records outside the PIMS operating theatre system.</p> <p>Smoking advice was being addressed in ED and APU but there was still work to ensure that it was coded into the records and seeking to engage RMOs more.</p> <p>Cardiac was a success and continued to perform well having ICU properly staffed and the right clinical leadership. This was a result of focus on an important department, investing in performance improvement and getting staff engagement through the Health Excellence programme.</p>
6.1	DAP Projects Report
	<p>The reporting allowed management to track commitments made in the Annual Plan and overall there was pleasing progress. The exceptions were noted.</p> <p>The HSG model was to have GMs supporting the clinical leadership in improvement roles. The job descriptions for clinical leadership at the Level 3 had been completed but had been dependent on having the Level 2s in place first.</p> <p>While there was a lot of literature on efficient occupancy of hospitals at 85% operating somewhere between that and 90% was thought to be efficient.</p> <p>The progress over the last five years to progress to clinical management was a major achievement and needed to be celebrated. With long term service planning there was a need to fit that with workforce planning which would require workforces being used more creatively to ensure plans can be effective. An example of the change was nurses in diabetes having prescribing rights. Further changes foreseen were pharmacist prescribing and changes coming from work areas rather than being imposed from the top.</p>
	NEXT MEETING
	<p>The meeting closed at 12:18pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 4 May 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
<p>CONFIRMED</p> <p>CHAIR: DATE:</p>	

ACTION POINTS

WEDNESDAY 6 APRIL 2011

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 6 April 2011**

Item	Detail	Designated	Action
4	Report on Cancer network review to be distributed electronically	Margaret Wilsher Ian Bell	Action^å
4	Paper on networks by Chris Mules some years ago to be distributed	Garry Smith Ian Bell	Being sourced

OPERATIONAL PERFORMANCE

5.1 OPERATIONAL SUMMARY REPORT

PROVIDER OPERATING STATEMENT

SIGNIFICANT VARIANCES

**THROUGHPUT, FRONT DOOR, ADMISSION TYPE, ESPI
PERFORMANCE, CONTRACT VOLUMES**

5.2 HEALTH TARGETS UPDATES

5.3 OPERATIONAL INDICATORS - EXCEPTION REPORT

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5.1.1 PROVIDER (including support services) OPERATING STATEMENT

The ADHB Provider is made up of the clinical services (“Operational”) together with Ancillary Services - Finance, HR and IS, Public Health, A+ Trust, Research and our 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 changes in the value of interest rate swap instruments.

Provider	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operating Statement - March 2011						
<i>Total Income</i>						
Internal Allocations - Ex Funder	87,522	90,936	3,414U	752,961	753,719	759U
MOH - Funding Subcontracts	2,969	3,021	53U	23,392	26,576	3,184U
Other Patient Care Revenue	3,220	2,670	550F	26,693	24,207	2,486F
Sales of Services & Products	4,443	4,548	105U	40,306	40,173	133F
Clinical Training & Education Income	1,618	1,685	67U	14,480	14,961	482U
Trust & Donation Income	572	428	145F	4,606	3,888	718F
Financial Income	1,375	830	545F	6,979	3,775	3,205F
Other Income	547	567	21U	4,761	4,761	0U
Profit on Disposal of Fixed Assets	-	0	0U	208	1	207F
Total Income	102,266	104,687	2,421U	874,385	872,062	2,323F
<i>Operating Expenditure</i>						
Employee Costs	64,083	63,298	785U	549,467	546,666	2,801U
Direct Treatment Costs	21,734	18,130	3,604U	172,831	157,589	15,242U
Funder Payments	(0)	-	0F	-	-	0F
Indirect Treatment Costs	3,487	3,256	231U	31,867	29,173	2,694U
Property, Equipment & Transportation Costs	3,750	3,865	114F	35,476	36,579	1,103F
Administration Costs	1,715	1,638	78U	13,376	14,188	812F
Maintenance Programme	107	133	26F	1,383	1,200	183U
Indirect Service Billing	482	482	0U	4,339	4,339	0U
Loss on Sale of Fixed Assets	(80)	1	81F	294	12	282U
Total Operating Expenditure	95,279	90,804	4,475U	809,033	789,746	19,287U
Operating Surplus/(Deficit)	6,987	13,882	6,896U	65,352	82,316	16,964U
<i>Non-Operating Expenditure</i>						
Capital Charge	2,883	3,051	168F	25,744	27,307	1,563F
Depreciation	4,206	4,422	216F	38,573	40,439	1,866F
Finance Costs	1,514	1,714	199F	13,739	15,100	1,361F
Total :Non-Operating Expenditure	8,603	9,186	583F	78,057	82,847	4,790F
Total Surplus/(Deficit)	(1,616)	4,696	6,312U	(12,704)	(531)	12,174U

Commentary on significant variances follows overleaf.

TOTAL INCOME**1 Patient Care Revenue (incorporating internal allocations from Funder, Ministry sub-contracts and Other Patient Care Revenue) – Year to Date \$(1.5)m Un-Favourable**

At a provider level patient care revenue is unfavourable year to date by \$(1.5)m.

The variances by 'type of' income are as follows

1	MOH - Base Funding	\$(0.8)m U
2	MOH - Funding Subcontracts	\$(3.2)m U
3	Other Patient Care Revenue	\$2.5m F

MoH Base Funding

MoH base funding is under budget because the provider arm has under-produced on a net basis as follows:-

Inpatient wies (acute and elective) work 2,276 wies \$(11.5)m U to financial budget.

Additional electives revenue unearned \$(3.2)m U

Offset by:-

Non inpatient work \$3.6m F to budget

Additional Herception revenue \$6.9m F to budget

Internal adjustments \$3.4m F

The DRG variance is split:

ADHB	(1,345) wies
Other DHBs	(931) wies

The inpatient variance was approximately 1,000 wies for the month of March, however since the cut off for financial reporting the figures above have increased by 270 wies as coding levels have increased.

Daily monitoring of elective production levels continues, focused on enabling ADHB to fulfill its discharge target by year end.

MOH - Funding Subcontracts

MoH subcontract revenue was lower than budget \$(3.2)m U driven by lower Herceptin programme funding (see 'contra' above in base revenue)

Other Patient Care Revenue

The significant variance in other patient care revenue year to date are:-

Non NZ Resident Income \$3.5m F to budget (Child Health and Cardiac are both almost \$1m F)
ACC Revenue \$(1.3)m U to budget (Orthopaedics is \$(1)m U and the Pain Service is (0.4)m U).

2 Trust & Donation Income – Year to Date \$0.7m Favourable

Trust and donation income is favourable by \$0.7m YTD; the timing of such receipts is variable especially in respect of the fund raising efforts of the Starship Foundation.

3 Financial Income Year to Date \$3.2m Favourable

Higher interest received on term deposits \$2.0m F and a realised gain on Interest Rate Swap Instruments \$1.2m F.

OPERATIONAL COSTS

4 Employee Costs (\$785K Unfavourable for month, \$(2.8)M Unfavourable YTD)

March was a significant month for employee costs with a number of areas exceeding FTE (134.5 FTE U) and cost budgets \$(785)K U.

As demonstrated in Table 1, most areas have exceeded FTE budgets for the month of March.

FTE Table 1 – FTEs for Month and YTD (March 2011)

FTEs	Month			YTD		
	Budget FTE Month 2010-11	Actual FTE Month 2010-11	Total FTE Variance 2010-11	Budget FTE Month 2010-11	Actual FTE YTD 2010-11	Total FTE Variance 2010-11
Adult Health	1,729	1,769	-41	1,726	1,746	-20
Ambulatory	249	265	-16	249	263	-14
Women's & Children's	1,342	1,372	-31	1,348	1,349	-1
Operations	1,429	1,429	-1	1,432	1,416	16
Operating Rooms & Anaesthesia	689	736	-47	689	696	-7
Mental Health	746	729	17	747	719	27
Cancer & Blood	299	296	3	299	295	5
Cardiac Services	451	441	10	451	437	14
Other Operational	1	2	-1	1	3	-2
Ancillary	972	1,001	-29	973	972	1
TOTAL	7,905	8,040	-135	7,914	7,896	19

The FTE numbers excluding Mental Health (which has a separate funding stream) is (152) FTE U for the month; and (8) FTE U YTD.

Significant FTE variances by employee group for the month of March:-

Medical	(23.91) U
Nursing	(102.91) U
Technical	(6.53) U
Hotel Services	(9.02) U
Admin	16.76 F

Significant FTE variances by employee group YTD:-

Medical	29.49 F
Nursing	(44.77) U
Technical	20.28 F
Admin	25.13 F

Medical

- Medical FTE overall are 21unfavourable in adult health, reflecting RMOs over budget due to an agreed approach with ARRMOS to over allocate to General Medical and General Surgery on the basis there are normally a high number of withdrawals (which does not appear to have been the case for this rotation). While FTE are unfavourable, dollars remain on budget due to SMO vacancies.

Nursing – 102.94 FTE over budget –

- The March result has been predominantly driven by high activity in PICU and NICU and increased LOS together with the highest theatre minutes and cases on record in OR&A. This combined activity is reflected in FTE numbers (64.98 FTE U).
- Approved unbudgeted additional positions in AED/APU to assist with acute flow and meeting the 6 hour target have contributed to 9 FTE unfavourable to budget.
- The unfavourable Nursing FTE over recent months (due to high General Medicine ward occupancy and psych watches) is being tightly managed, and these unfavourable variances have been reversed in March to be back within budget.

Technical

- The majority of the unfavourable FTE variance in Ancillary relates to additional contracts in ARPHS. FTE are unfavourable to budget however the DHB has secured additional funding for these positions and will remain slightly favourable to year end.

Staff Related Expenses

- Largely timing differences for recharging from ARRMOS and payment of registration fees, however SRE are forecast to be \$649K U to budget at year end.

FTE Table 2 – FTE Costs for Month and YTD (March 2011) (\$000)

\$000	Month			YTD		
	Budget FTE Month 2010-11	Actual FTE Month 2010-11	Total FTE Variance 2010-11	Budget FTE Month 2010-11	Actual FTE YTD 2010-11	Total FTE Variance 2010-11
Adult Health	14,460	14,408	52	126,187	124,359	1,828
Ambulatory & Ophthalmology	2,399	2,573	(175)	20,266	21,206	(940)
Women's & Childrens	11,589	11,963	(374)	100,688	101,648	(960)
Operations	9,530	9,518	12	81,140	78,957	2,183
OR & Anaesthesia & CSSD	5,854	6,513	(659)	50,669	52,750	(2,081)
Mental Health	6,125	5,907	218	52,347	49,646	2,701
Cancer & Blood	2,775	2,765	10	24,089	23,150	939
Cardiac	3,824	3,970	(145)	33,608	35,385	(1,777)
Other operational	12	31	(19)	106	340	(234)
Ancillary	6,731	6,436	295	57,566	62,026	(4,460)
Total	63,298	64,083	(785)	546,666	549,467	(2,801)

Significant cost variances by employee group for the month:-

Medical	\$398K F
Nursing	\$(547)K U
Technical	\$(126)K U
Admin	\$(194) K U
Staff related Expenses	\$(203) K U

Significant cost variances by employee group YTD:-

Medical	\$123 K F
Nursing	\$(3.003)M U
Technical	\$1.375 M F
Hotel Services	\$(306) K U
Admin	\$(207) K U
Target Savings	\$(456) K U

Explanation for YTD variances

The unfavourable cost variance in Children's and ORA reflects high activity and complexity levels. Although wies revenue is not above contract and discharges are not higher than expected, the LOS of patient has increased this year. Activity is reflected in the fact that has been 7 red alerts for Children this year compared with 1 last year. Although not all appointed there is an additional 47 FTE have been approved but not in the current budget for the Greenlane Surgical Centre. Similary staff have been unbudgeted, approved and appointed to support the new initiatives relating to theatre throughput e.g. longer theatre hours and an additional neurosurgery session at ACH.

The unfavourable cost variance in Ambulatory Health Services YTD primarily relates to the target vacancy assumption not achieved and additional staffing costs in Ophthalmology for Saturday theatre sessions to meet ESPI compliance.

The unfavourable FTE variance in Adult Health YTD relates to the accumulated impact over the year of (a) additional staff in AED/APU supporting shorter stays in AED, (b) additional staff in General Medicine due to higher occupancy than the budget assumption over the summer months as well as a high number of psych watches, and (c) house officers over-appointed in the December run due to a change in practice agreed with ARRMOS to address the on-going vacancies and gaps in run rosters. There are 23 approved but unbudgeted positions in AED and General Medicine supporting shorter stays in AED, as discussed above. The service are not forecasting to get completely back down to budget for this reason. The unfavourable Nursing FTE over recent months due to high General Medicine ward occupancy and psych watches is being tightly managed, and these unfavourable variances have been reversed in March to be back within budget. While overall FTE are unfavourable, dollars remain on budget due to SMO vacancies (refer Table 3 below).

The unfavourable variance for Ancillary services relates to additional provisions for known exposures in SMO Meca settlement\$1.8M, ACC \$0.7M and retirement Gratuities and Long Service leave \$1.2M. All

Favourable YTD cost in Operations is forecast to continue for the balance of the year.

Favourable YTD cost in Cancer & Blood services will offset additional outsourcing costs not budgeted.

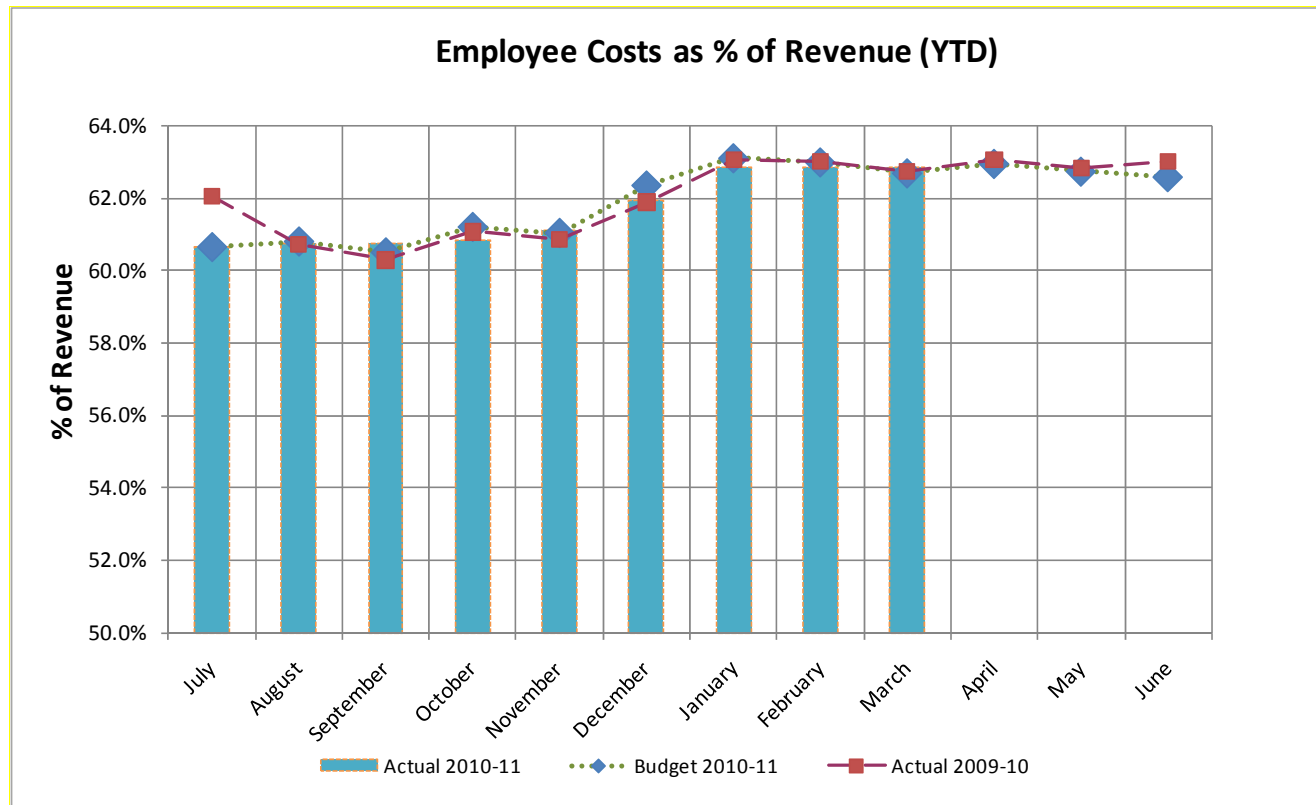
The unfavourable variance of \$(2.8)m U YTD includes estimated savings plans of \$(6.8)m, suggesting that \$4.0 M of the target savings have been achieved YTD..

Action Plans to reduce employee cost forecast variance to budget

- Continue to manage additional FTE appointed to support six hour rule (17 FTE in Adult) and elective and ESPI compliance (Womens, Children's and Level 8 Theatres 42.6 FTE U for March)
- Resolve over recruitment of RMO (Registrar & House Officer)
- Daily management of watches, nursing model of care and bureau usage, overtime use/approval and sick leave management in Women's and Children's, Adult, Cardiac and Blood & Cancer
- Review and implementation of actions to ensure compliance with collective employment agreements e.g. shift length, rostering, allowances
- Expedited implementation of productivity and performance improvement initiatives to maximise the use of budgeted nursing FTE to meet patient care requirements
- Review requirement to continue to produce additional ophthalmology volumes
- Additional resourcing of ED and APU will need to continue to year end to accelerate improvements in shorter stays in ED

Provider Services - Staffing Variance			
Month 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	63.3	64.1	-1.24%
FTE Numbers	7,905	8,040	-1.70%
Cost per FTE (Month)	8,007	7,971	0.45%
YTD 2010/11			
YTD 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	546.7	549.5	-0.51%
FTE Numbers	7,914	7,896	0.24%
Cost per FTE (Year to Date)	69,072	69,590	-0.75%

The chart below demonstrates the relationship between employee costs and revenue as a %, there has been a similar seasonal pattern in 2009-10 and 2010-11.



Significant Treatment Cost Variances and Actions 32

Direct and indirect treatment costs combined are \$(17.605)M unfavorable to budget year to date

Direct Treatment Costs \$(15.24)m of which an estimated \$(10.98)m is savings plans not achieved.
Indirect Treatment Costs \$(2.363)m of which \$(2.14)m is non resident bad debts.

Of the direct treatment costs variance of \$15.2m year to date, approximately 26% (\$4.1m) is related to outsourcing costs principally related to elective surgery (both the Ministry target and ESPI compliance) and cancer wait time targets. Refer Table 1.

With respect to elective targets costs of \$8.3m were approved to be incurred between February and June in order to assist in achieving the Ministry target of 11,149 ADHB elective discharges. This included an estimated \$1m for internal initiatives (GSU, ACH productive lists and ACH longer days) – a phased amount reflecting a period less than a year. Associated with these additional discharges is additional electives revenue, which is currently unearned.

The Director, Elective Services monitors elective production daily, at this stage the need for outsourcing to continue is still indicated because of:-

the challenging uplift in target discharges in the last quarter, previously reported to the Committee;
the need to ensure ongoing ESPI compliance, noting the heavy financial penalties which can be imposed for non compliance;
a focus on clearing patients waiting greater than 12 months for surgery (approximately 30 patients).

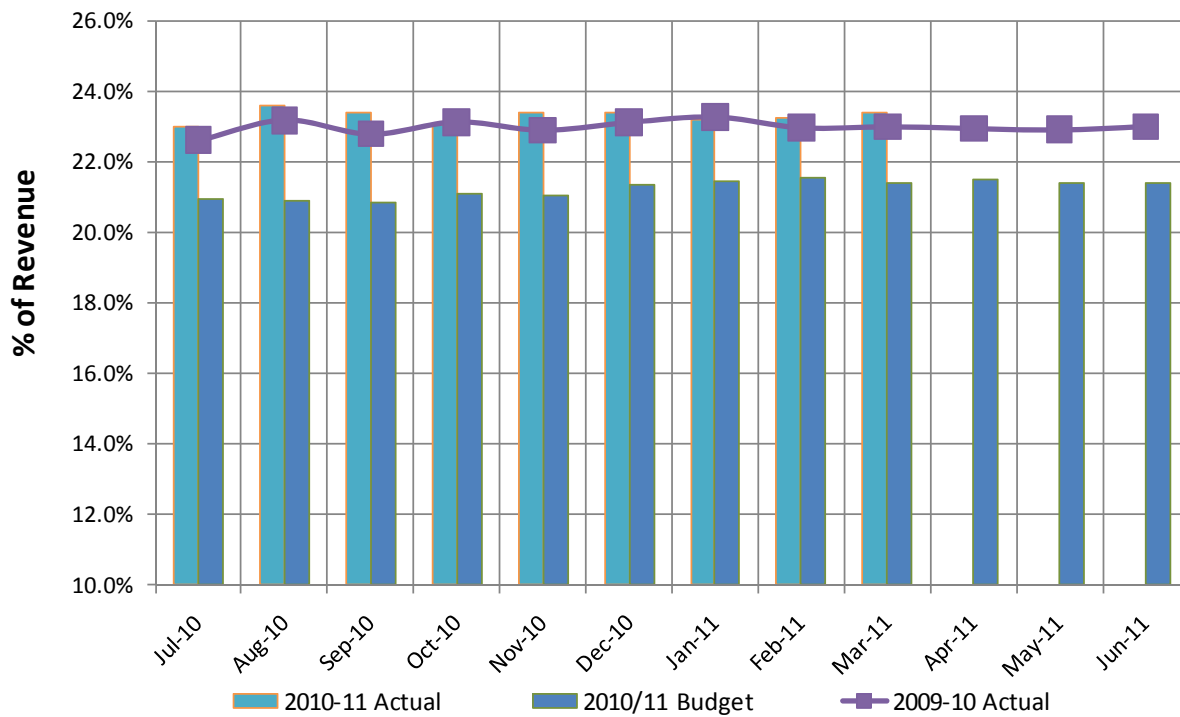
DTC Table 1: Outsourcing costs vs. Budget YTD

Outsource Budgets YTD March (\$000)

	budget	actual	variance
	\$000	\$000	\$000
CTSU	-	2,305	(2,305)
General Surgery	681	359	322
Orthopaedics	915	1,645	(730)
ORL	-	45	(45)
Paediatric Surgery	249	171	78
Paediatric ORL	-	619	(619)
Paediatric Orthopaedics	793	679	114
Gynaecology	2	28	(26)
Oral Health	160	149	11
Cancer & Blood	240	1,151	(911)
Total	3,040	7,151	(4,111)

The chart below demonstrates the relationship between direct treatment costs and revenue. The budget for direct treatment costs as a proportion of revenue fell from 2009-10 levels but actuals have remained largely unchanged.

33 Treatment Costs as % of Revenue (YTD)



DTC Table 2: Explanation for YTD direct and indirect cost variances:

Cost Item	YTD Position	Commentary on Year to Date Position
	\$m var to budget	
Clinical Supplies	\$(4.671)	Significant volume related costs primarily in OR&A (related to greater operating time than assumed in budget).
3 rd Party Costs	\$(4.839)	Cardiac, Operations, Child health, and Cancer services, offset by other areas where outsourcing has yet to commence (refer below).
Patient appliances	\$(2.95)	Actual volumes higher than budgeted assumption in Cardiac and Child Health e.g. Paed Orthopaedics, Paed Cardiac.
Chemicals & Media	\$(2.157)	Assumptions related to a reduction in laboratory test numbers and a reduction in reagent prices have not been achieved
Drugs	\$(0.8)	Very high cost drugs in Immunology and Paediatric Oncology (specific patients), offset by a favourable variance in Adult Oncology
Direct Treatment	\$(15.24)	Sub total of above
Indirect Treatment	\$(2.69)	\$(2.14)m relates to non resident bad debts; \$(426)k to cost of sales for retail business (offset by revenue)

Action Plans to reduce YTD unfavourable variance

- Continue daily review of DHB outsourcing plans in light of amount of DHB wide elective volume performance and coding reclassification.
- Targeted use of outsourcing to year end to enable radiation therapy health targets to be achieved. Discontinue outsourcing not required.
- Discontinue Cardiac outsourcing.
- Careful review of use of high cost drugs in paediatric oncology and maintenance of the existing favourable mix variance in adult oncology
- Ongoing tight management of ward stock
- Propose access of regional Mental Health under spend to support over utilization of SSH Eating Disorder beds
- Ongoing review in conjunction with clinical partners the use of clinical supplies, patient appliances and other volume related variances, examples ongoing include :
 - Review of MRI utilisation will deliver a decrease in outsourcing MRI.
 - Laboratories - continued review of send-away tests and service delivery in Sexual Health
- Review utilisation of blood in Haematology with is offsetting the financial benefits from the Concord blood utilisation project.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	Mar-11	Att per Day	Comparison to Last Month	Feb-11	Att per Day	Comparison to Last Year	Mar-10	Att per Day
APU	1,707	55	8.9%	1,568	56	2.2%	1,671	54
AED	4,647	150	8.5%	4,281	153	10.6%	4,202	136
CED	2,550	82	13.5%	2,247	80	-4.9%	2,682	87

- AED - A heavy month (third highest), but record low LOS measures – both average and median. The last three months have been the three busiest months ever, but have also had the three lowest average LOS results ever.
- APU - Increased volumes and their busiest March, but a significant drop in the median LOS and a big drop in the average LOS.
- CED - Volumes picked up in March but were not as high as March last year. LOS measures were similar to last month although lower than March last year.

Throughput – by Admission Type

36

Year to Date inpatient volumes for the eight months to March 2011 are as follows in the table below. The table compares volumes firstly this years contract (% of completion) and then compared to last year.

Electives (wies)

DHB	Actual Last Year	Contract This Year	Actual This Year	Variance	% of completion	% compared to last year
ADHB	9,690	11,360	9,390	-1,970	82.7%	96.9%
CMDHB	3,795	4,049	3,742	-307	92.4%	98.6%
WDHB	4,882	5,159	4,578	-581	88.7%	93.8%
NLDHB	1,690	1,834	1,508	-326	82.2%	89.2%
Other DHBs	2,356	2,909	2,661	-248	91.5%	112.9%
	22,413	25,311	21,879	-3,432	86.4%	97.6%

Acutes (wies)

DHB	Actual Last Year	Contract This Year	Actual This Year	Variance	% of completion	% compared to last year
ADHB	38,029	37,896	38,520	624	101.6%	101.3%
CMDHB	9,042	9,229	8,920	-309	96.7%	98.7%
WDHB	13,761	13,398	13,923	525	103.9%	101.2%
NLDHB	3,109	3,424	3,555	131	103.8%	114.3%
Other DHBs	5,061	5,388	5,574	186	103.5%	110.1%
	69,002	69,335	70,492	1,157	101.7%	102.2%

Acute & Elective Combined (wies)

DHB	Actual Last Year	Contract This Year	Actual This Year	Variance	% of completion	% compared to last year
ADHB	47,719	49,256	47,910	-1,346	97.3%	100.4%
CMDHB	12,837	13,278	12,662	-616	95.4%	98.6%
WDHB	18,643	18,557	18,501	-56	99.7%	99.2%
NLDHB	4,799	5,258	5,063	-195	96.3%	105.5%
Other	7,417	8,297	8,235	-62	99.3%	111.0%
	91,415	94,646	92,371	-2,275	97.6%	101.0%

The ADHB elective production plan is monitored on a daily basis. The cumulative year to date position as at March met the replacement target submitted to the MoH, 10 February 2011.

Throughput – Elective Service Performance Indicators ³⁷

ESPI 2 – waiting for first specialist appointment

We were compliant at the end of March 2011; the projection at the end of April is also for compliance.

ESPIs 2 Status

as at end of March-11

Health Service Group		Total FSA Waitlist	ESPI 2: FSAs				
			Seen 12 Months	Level	Status	Limit	Imp. Req'd
Adult Health Services	Cardiology	336	2206	1	0.0%	33	0
	Cardiothoracic	10	146	0	0.0%	2	0
	Gastroenterology	379	1944	0	0.0%	29	0
	General Medicine	58	272	0	0.0%	4	0
	General Surgery	1347	3530	51	1.4%	53	0
	Haematology	93	847	0	0.0%	13	0
	Infectious Diseases	43	336	0	0.0%	5	0
	Medical Oncology	81	1909	0	0.0%	28	0
	Neurology	572	4489	14	0.3%	67	0
	Neurosurgery	177	540	1	0.2%	8	0
	ORL	1098	2564	90	3.5%	38	-52
	Orthopaedics	927	1667	35	2.1%	25	-10
	Radiation Oncology	104	2638	0	0.0%	39	0
	Renal Medicine	88	504	1	0.2%	8	0
	Respiratory Medicine	496	1858	33	1.8%	28	-5
Urology	268	1454	1	0.1%	22	0	
Vascular Surgery	338	1246	4	0.3%	19	0	
Total: Adult Health Services		6415	28150	231	0.8%	419	0
Ambulatory Health Services	Dermatology	410	1131	0	0.0%	17	0
	Diabetes						
	Endocrinology	452	1264	6	0.5%	19	0
	Immunology	342	934	5	0.5%	14	0
	Ophthalmology	1999	9909	88	0.9%	148	0
	Oral Health	0	0	0	0.0%	0	0
	Rheumatology	285	707	12	1.7%	11	-1
The Auckland Regional Pain Service	243	223	16	7.2%	3	-13	
Total: Ambulatory Health Services		3731	14168	127	0.9%	211	0
Women & Childrens Health Services	Paediatric Endocrinology	62	318	0	0.0%	5	0
	Paediatric ORL	337	1584	10	0.6%	24	0
	Paediatric Gastroenterology	28	135	0	0.0%	2	0
	General Paediatrics	185	1634	0	0.0%	24	0
	Gynae Oncology	10	339	0	0.0%	5	0
	Gynaecology	788	3256	1	0.0%	49	0
	Paediatric Haem/Onc						
	Paediatric Immunology	103	286	0	0.0%	4	0
	Paediatric Infectious Diseases	13	193	0	0.0%	3	0
	Paediatric Neurosurgery	13	90	0	0.0%	1	0
	Paediatric Neurology	104	515	0	0.0%	8	0
	Paediatric Orthopaedics	281	2146	16	0.7%	32	0
	Paediatric Cardiac	107	615	2	0.3%	9	0
	Paediatric Renal Medicine	20	153	0	0.0%	2	0
	Paediatric Respiratory Medicine	45	160	3	1.9%	2	-1
Paediatric Rheumatology	9	51	0	0.0%	1	0	
Paediatric Surgery	520	1771	72	4.1%	26	-46	
Total: Women & Children's Health Services		2625	13246	104	0.8%	197	0
ALL HBO		12771	55564	462	0.8%	828	0

ESPI 5 – waiting for surgery

We have achieved compliance for March 2011 and we forecast that we will remain compliant for April 2011.

ESPI 5

		March-11				April-11est			
		ESPI 5 - Certainty				ESPI 5 - Certainty			
Health Service Group	Specialty	Level	Status	Limit	Imp. Req'd	Level	Status	Limit	Imp. Req'd
<i>Includes Data Entry up to end of 10/04/2011</i>									
Adult Health	Cardiology	14	0.9%	61	0	14	0.8%	66	0
	Cardiothoracic	0	0.0%	35	0	0	0.0%	35	0
	General Surgery	39	1.6%	99	0	38	1.5%	101	0
	Neurosurgery	39	10.5%	15	10	40	10.8%	15	-25
	ORL	5	1.2%	16	0	2	0.6%	14	0
	Orthopaedics	48	5.9%	32	-6	73	9.0%	32	-41
	Urology	38	3.5%	44	0	41	3.7%	44	0
	Vascular Service	0	0.0%	10	0	0	0.0%	10	0
Adult Health Services Total		169	2.7%	252	0	194	3.1%	252	0
Ambulatory Health	Ophthalmology	152	4.2%	145	-7	173	4.8%	145	-28
	Oral Health Greenlane	6	0.4%	59	0	5	0.3%	60	0
Ambulatory Health Services Total		158	3.1%	205	0	178	3.5%	205	0
Women & Children's	Adult Congenital Medical Heart (ACHD)	1	1.6%	2	0	1	1.5%	3	0
	Adult Congenital Surgical	1	2.6%	2	0	1	2.6%	2	0
	ENT	4	0.3%	57	0	4	0.3%	58	0
	Gastroenterology Paediatric	1	0.6%	7	0	7	4.0%	7	0
	Gynaecology Inpatients	12	0.6%	75	0	10	0.5%	74	0
	Neurosurgery	1	1.2%	3	0	3	3.6%	3	0
	Orthopaedics Paediatric	24	5.4%	18	-6	29	6.7%	17	-12
	Paed Cardiology	13	6.6%	8	-5	21	9.9%	8	-13
	Paediatric CTSU	5	3.0%	7	0	6	3.6%	7	0
	Respiratory Paediatric	0	0.0%	1	0	0	0.0%	1	0
Surgery Paediatric	25	2.5%	41	0	18	1.8%	40	0	
Women & Children's Health Services Total		86	1.6%	218	0	99	1.8%	217	0
ADHB Total		413	2.5%	674	0	471	2.8%	673	0

Throughput – Contract Volumes 39

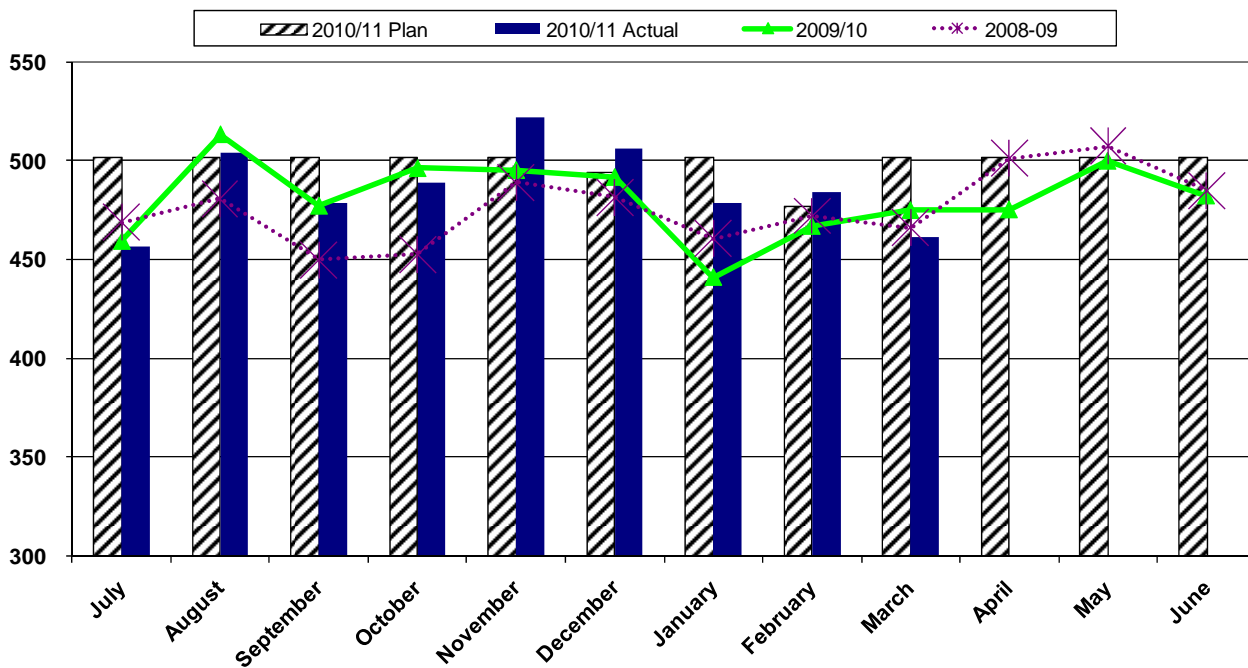
The chart below shows the production recorded to March 2011.

At the time the results were finalised, the coding was 82.3% complete with the average WIES per discharge being 0.8% higher than last year for the same period. Discharges are up by 0.1% from last year.

Inpatient delivery to the most current Price Volume Schedule was 92% for the month and 97% YTD.

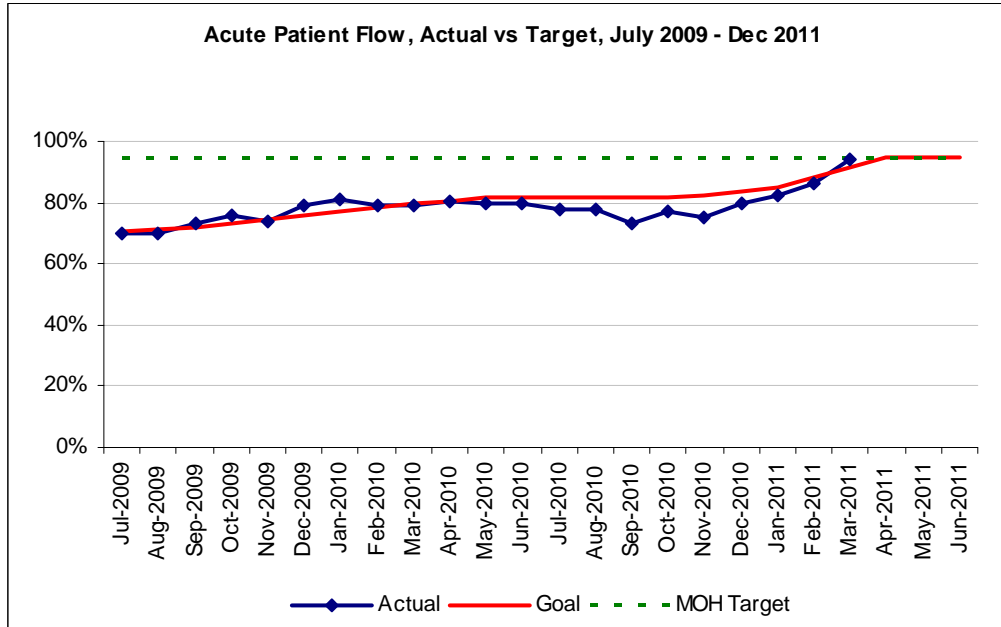
WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	10,611	11,537	926U	92,391	91,647	744F
WIES Delivery per day	461	502	40U	484	480	4F

WIES per Working Day (excluding stat day - 1011 working year = 253 days)



5.2 Health Target Updates

Project:
 Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours
 Date of Delivery: 30 June 2011



Project Risks / Comments:

Performance to achieve Shorter Stays in ED for both Adults and Children’s services continues to demonstrate improvement . Overall performance for month of February was 86%. This has further improved in March (1 March to 25 March) to 94.2% of patients admitted, discharged or transferred within 6 hours.

Project: Adult Acute Patient Flow

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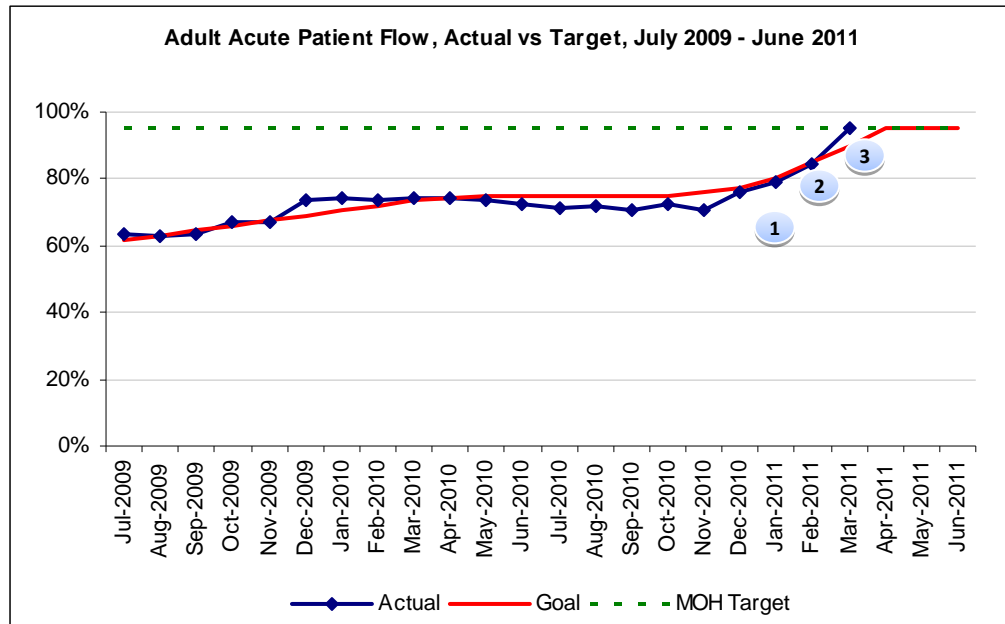
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

Steering Group: Nurse Director Margaret Dotchin, General Manager Ngaire Buchanan, Dr Tim Parke, Dr Art Nahill, Dr Wayne Jones, Dr Andrew Old, Nurse Advisor Mark Entwistle.



Project Risks / Comments:

Significant improvement noted in March with 95% of patient discharged or transferred from ED within 6 hours. A 5-day Rapid Improvement event is planned for 11-15 April to identify and implement further solutions from decision to admit to leaving ED. Further work is also underway on weekend resourcing to meet variable demand, establishment of Short Stay Unit, understanding triggers and escalation process to accommodate increasing admissions to APU and manage bed block in winter months.

Improvements to date:

Streamlined AED processes and measurement and manage the challenge of growing demand

Reviewed Medical / Nursing requirements for AED and approved business case for resource increase to match increased workload. Charge nurse patient flow coordinator introduced. Improved access to Radiology. Streamlined documentation required for safe transfer. Improved triage processes.

Managing bed block with additional resources

58 Additional beds opened 2009-2010
Winter Ward 31 General Medicine 10 additional beds August – October 2010

Managing bed block & reducing the time patients wait through improved processes and teamwork

Daily Rapid Rounds introduced in General Medicine (Feb 2010) and Orthopaedics (July 2010)
Nurse Facilitated Discharging in General Medicine (April 2010)
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.
Daily breach review meetings to understand root causes and implement short term solutions.

Immediate actions to improve performance:

1. Increased engagement of Senior Leadership Team to support improvement activities and reduce road blocks to improvement.
Increase communication and engagement of Clinical Directors, SMO's, RMO's
Increase communication and engagement of Charge Nurses and RN's after hours to further reduce wait times for patient transfer from Emergency Department
Engage with SMO's, RMO's and nurses one to one, by CD, Nurse Advisor or Level 2 clinical leader where resistance to required behaviour is demonstrated.
Valuing patient time poster campaign
2. Establish ED short stay unit
Implement APU flex beds
Improve measurement of Ready to Go patients in ED
Complete recruitment of remaining ED resource to improve weekend coverage
Support General Medicine by diversion of patients to subspecialties
Implement general surgery acute flow team initiatives to improve response time
CMO to attend Orthopaedic SMO meeting to increase engagement.
Relocate bed manager to ED after hours
Implement ED discharge nurse on weekend
Hands on support of ED flow Charge Nurse to reduce roadblocks to timely review and transfer of patients
Commence physiotherapy facilitated discharge in Orthopaedics.
Establish discharge co-ordination responsibility in Gen Med ward nursing team.
Further increase timely overnight transfers from ED to inpatient wards once bed allocated.
3. Five day rapid improvement event planned for April to focus on improvement of process from decision to admit to patient transfer complete.
Improve elective scheduling.

Project: Children's Acute Patient Flow

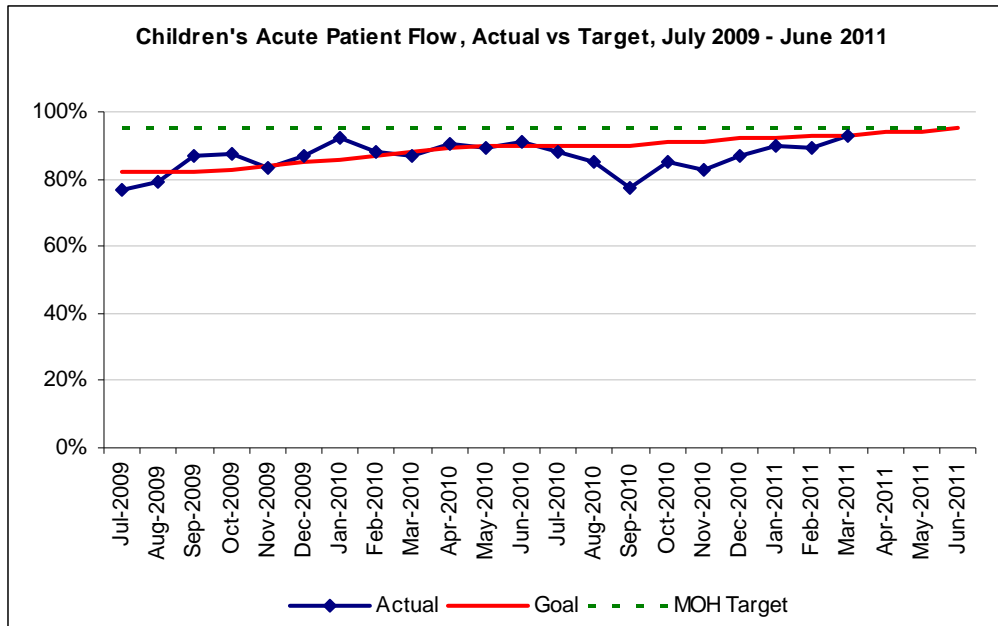
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan, Richard Aickin, Michael Shepherd, Janet Campbell, Stuart Dalziel



Project Risks / Comments: While the March performance of 93% was short of the target, the result represented a further improvement over prior months and 6% over the same month last year. There were some 12 days at 95% or better which comfortably surpassed the performance of all prior months. The improving results continue to reflect a number of activities and projects within Starship. Of particular note in March was: Increased Management focus and engagement.

Daily review of all 6 hour breaches with feedback and improvement actions being taken in the relevant areas. Heightened staff awareness brought about by Valuing our Patients Time Campaign which publishes results on a weekly basis. The importance meeting the 6 hour target and results achieved have been on the agenda at meetings throughout Starship. Implementation of an Electronic Whiteboard in CED. This has resulted in a greater level of transparency as to where patients are in their CED journey to enable prioritisation of patients that may breach the 6 hour time. The transfer time from CED to ward (relative to the 1 hour recommendation) made a significant improvement with the mean falling by 34% over February's results. All wards are now using the Estimated Dates of Discharge.

Improvements to date:

- Business Case to develop CED Nurse Practitioners – 2x Nurse Specialist (in training for NP) appointed in January
- Improved Measurement systems to better identify clinical short stay patients
- Development of weekly dashboard reporting for CED to better track performance
- Daily reviews to identify specific reasons for delays on a case-by-case basis and to communicate findings with relevant teams
- Weekly communications of performance to ward level
- Development of 'full hospital plan' to improve responsiveness when indicators of 'bed block' developing
- Enhancement of electronic tracking systems for acute patient flow – going live in March

Immediate Actions to Lift Performance

- Opening of 4 additional beds
- Increase use of transition lounge to improve bed availability
- Additional CNA to assist wards receiving patients to stop delays on patient transfer.
- Two nurse specialists to immediately take case load in CED
- Greater Starship CD engagement, Enhance communications to Charge nurses

Longer term projects

- Lean Six Sigma Green Belt projects in progress:
 - a) Patient Transfers from CED to a ward where a bed is available
 - b) Bed turnaround time in ward 24B - time to discharge from Doctor's clearance
 - c) Inter-hospital Paediatric transfers
 - d) Estimated Discharge Date accuracy in Paediatric Orthopaedics:

Project: Improved access to elective surgery

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Primary Objective: Increase ADHB Elective Surgical Discharges from 9,425 to 11149

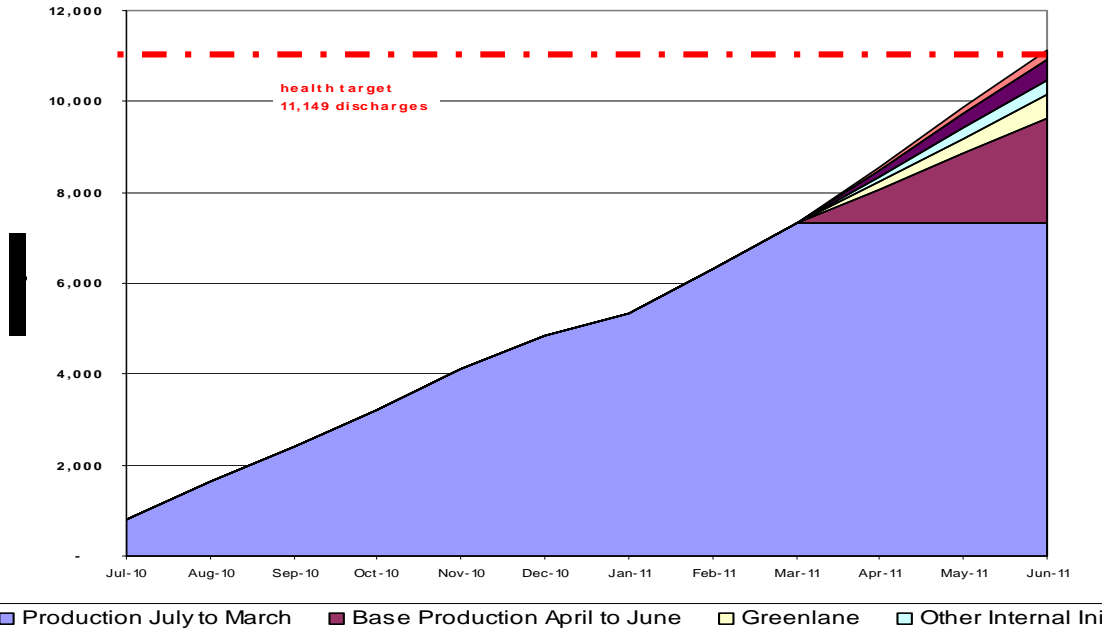
Date of Delivery: 30 June 2011

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

Steering Group: Ngaire Buchanan, Dr Vanessa Beavis, Margaret Dotchin, Fionnagh Dougan, Ian Civil.

Contributors to Elective Health Target



Planned activities:

1. Operationalising 2 new OR at Greenlane Surgical Centre during April. Official opening 27th April
2. Other internal includes additional ophthalmology lists at GSU in the last quarter and "longer days" at ACH & GSU.
3. Outsourcing across a range of specialties,
4. Activity is targeting high volume, low complexity volumes.
5. We are also reviewing some relevant data issues e.g.
 - review of patient discharge data for electives coded as acutes and
 - surgical discharges allocated to a medical specialty and not therefore not counted as an elective discharge and
 - coding practices for short cases which are inconsistent across different theatre settings.

Risks / Comments: (Amber)

At approximately 7,500 discharges ADHB is on target per the work-out plan sent to the Ministry in February 2011 and is 93% of the annual phased plan against which we will be reported for the 3rd quarter.

The Forecast to 30 June 2011 is still to meet the elective health target of 11,149 discharges.

Project: Shorter waits for Radiation Therapy

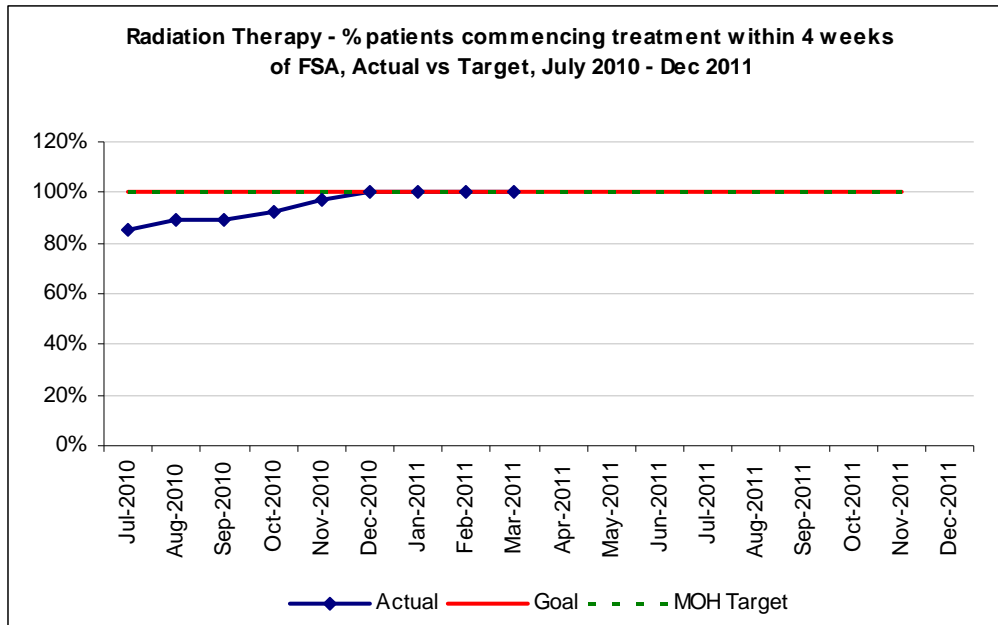
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2010 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

Steering Group: Fionnagh Dougan, Andrew Macann, Margaret White, Robyn Dunningham



Risks / Comments: *The service is 100% compliant to the 4 week target for Quarter 3.*

Key risks which may impact capacity to deliver to the target:

- MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement July – November 2011.
- Sustained demand – the service on average is receiving 5 more referrals pw as compared to the same period last year.
- RT staff vacancies and skill mix – pending resignations will impact staffing ratios during May – and flexi shifts cannot operate.
- The implementation of HDR treatment within an existing bunker may reduce capacity.
- Introduction of new technology transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment, QA testing of new technology.

Radiation Oncology Wait times – March 2011

In March 100% of eligible patients were treated within the 4 week target timeline.

Further improvements in progress to sustain delivery:

- **Pantak replacement** is planned from early May to July 2011
- **Replacement of MV6:** Decommissioning commences mid-July until late November 2011. Evening shifts will be reinstated during this period to mitigate lost capacity
- **Introduction of HDR for Gynaecological patients** is scheduled for May 2011.
- **A public/private Model of care** has been developed to enable our clinicians to treat public patients at ARO. Effective from March 2011 and progressing well.
- **Breast hypo-fractionation implemented:** Emerging clinical evidence supports the use of reduced fractions in a higher % of breast patients. This has reduced treatment time and freed up capacity on the linear accelerators.
- **Introduction of new technology:** The introduction of V-Mat prostate treatment has the potential to reduce treatment times by 50% when fully implemented. This is now in progress.
- **Aria project:** A project is underway to develop a full electronic record within the LINAC machine’s operating system.
- **A weekly capacity modelling tool** has been developed and is now being used for future LINAC capacity planning, improved forecasting capability and management of workload.
- An **“Operational team”** has been established whose key accountability is to measure KPI’s to prioritise the waitlist and analyse performance on a weekly basis.
- A **daily Waitlist report** enables daily monitoring and immediate remedial action if required.

Project: Better help for smokers to quit

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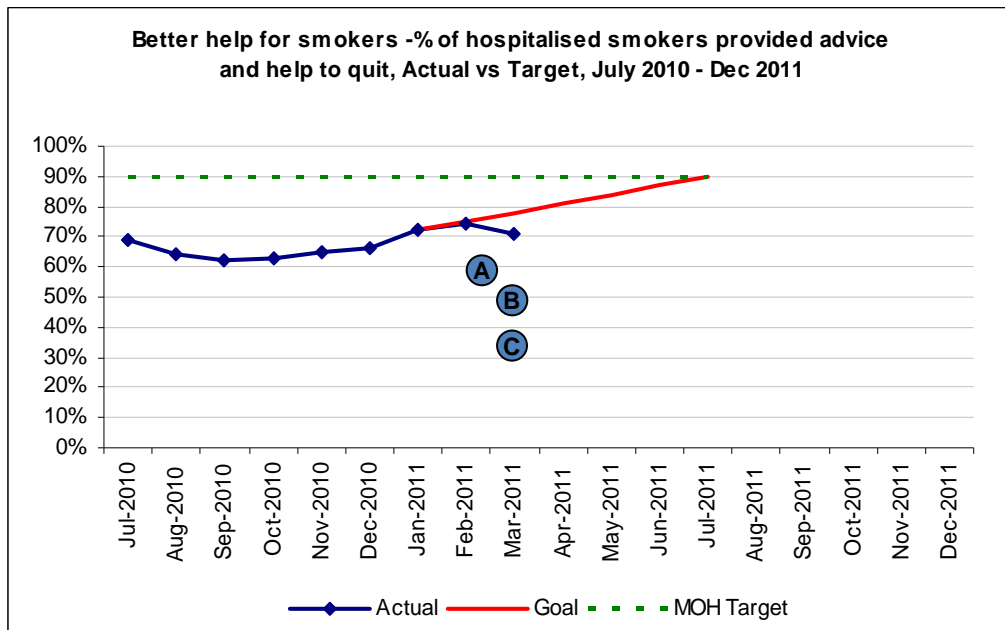
Primary Objective : % of hospitalised smokers provided advice and help to quit

Date of Delivery: 90% by 1/07/2011, 95% by 1/07/2012

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

Steering Group: Di Roud, Anna Schofield, Pam Hewlett, Stephen Child, George Laking, Jim Kriechbaum, Paul Bohmer, Arun Kulkarni, Michelle Stevens, Kristen Nicol, Bernadette Rehman, Paul Birch, Anne-Marie Pickering, Victoria Child, Jan Marshall



Improvements to date:

- Direct follow up with wards/services underperforming in ward audits.
- ABC Training and coaching of staff in AED & APU.
- ABC chart reminders placed all in AED & APU folders
- Better Help for Smokers to Quit included in Releasing Time to Care KPIs.
- New intake of House Officers on 28th February trained on documentation of ABC.

Immediate Actions to improve performance:

A. Focus on short stay and high volume areas:

- 1:1 ABC staff coaching to commence in General Medicine and General Surgery and AED and APU
- Negotiation with Women's Health to identify best options to improve target performance using funded resources.

B. Improve engagement with clinical workforce:

- Campaign for a Call to Action to Senior Medical staff to encourage Registrars and House Officers to routinely assess smoking with patients and document the ABC.
- Monthly publication of results of Senior Medical Officer's Better Help for Smokers to Quit performance.
- Details of all Quit Card Providers to be included in monthly reports to services.

- Better Help for Smokers to Quit Steering group Terms of Reference and membership revised.

- Clinical research strategy under development

C. Data collection systems and processes:

- Meet with Clinical Coding team to review coding practise and identify areas for improvement.
- Monthly reports and data analysis to identify areas of improvement and address areas of underperformance with services.
- Electronic Discharge Summary data to be audited for consistency and accuracy against patient clinical records

Project Risks and Comments

Of the 9221 events coded in March, 1208 (13.1%) of patients were identified as smokers and 853 (71%) of the smokers were documented as receiving advice to quit. While the number given brief advice is the highest ever the percentage was lower due to the high number of events coded in the period. The key areas for improvement remain the high volume areas of AED and APU. It has been identified that the "first aid" – type cases are currently being missed. Key staff AED staff are being trained in giving brief advice and supported with a Quit Smoking booklet and short letter to handed out to patients on discharge. The junior doctors are another key to lifting the target by recording the ABC in the clinical notes and accurately in the Electronic Discharge Summary. Direct feedback is being given to junior doctors where documentation is missing during the regular ward audits. National Women's Health has instigated a weekly check of ABC documentation and liaising with the coding team to ensure all brief advice given is captured. NWH are also monitoring systems and advising clinicians to record the ABC.

Project: Cardiac Bypass Surgery

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 80.

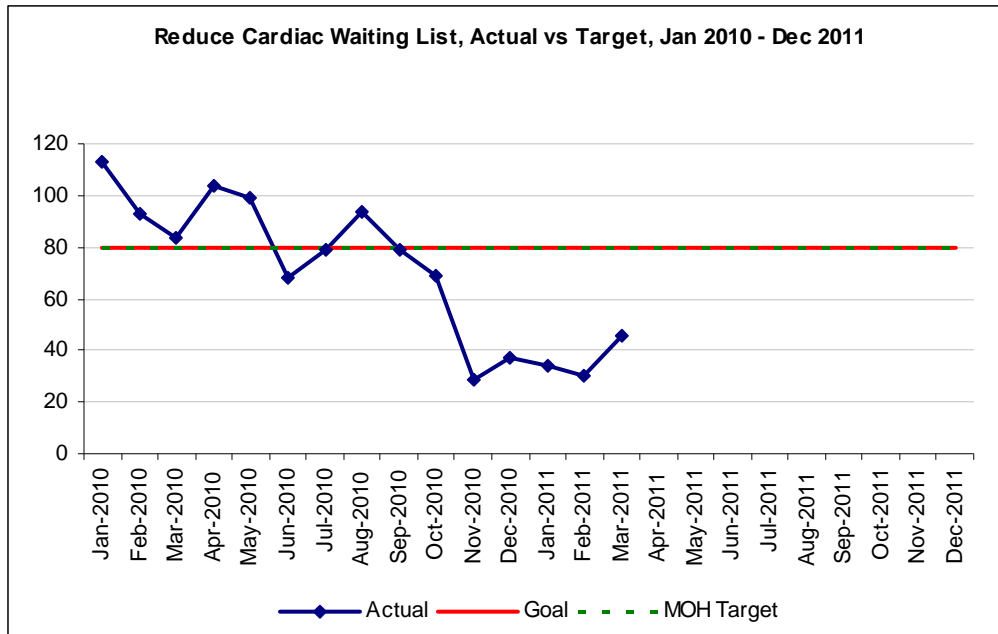
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2011

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Fionnagh Dougan

Steering Group: Marian Hussey, Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam McCormack, Greg Balla, Gordon Davies



Project Risks / Comments:

There are 39 patients on the waiting list as at the end of March 2011. YTD throughput is 37 patients less than planned as at end January 2011. Opportunities for additional capacity have been built into the production plan however catch up on the throughput target of 916 is constrained by a shortfall of additions to the waiting list. Work continues on improving the reliability and productivity of the service. The service has currently completed 80 more bypass (through the ACH facility) than last year (19% improvement)

Completed Improvement Activities:

- Developed and implemented electronic scheduling system
- Initiated pre-admit process
- Developed detailed operational reporting
- Set up development production process
- Approved business case for CVICU bed capacity
- Built capacity planning model for CVICU and Ward 42
- Developed patient load planning tool
- Initiated daily bed management meeting

Further improvements in progress:

- Standard theatre roster
Provide greater weekly standardisation in supply of theatre resource, to improve planning and co-ordination
- 3 in a row bypass (productive list)
Optimise the theatre schedule by planning a productive list
- ECMO – Resource planning process
To improve resource planning and day to day processes to reduce the impact of high ECMO demand
- The Productive Operating Room (NHS Programme)
To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- CVICU/HDU Merge
To increase the overall skill mix so that staff can work in both units, adding flexibility and reducing cancellations
- Enhanced recovery initiative
To provide a pathway for suitable patients, reducing average LOS and cancellations
- Delay to discharge – ward 42
To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Delay to discharge CVICU
To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations

5.3 Operations Indicators Report

ADHB HAC KPI Report

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

	March 2011		
Indicator	Frequency	Review date	KPI report page ref
Volume			
B3. Acute WIES Volume - Auckland	M	Aug-10	1 Ω
B4. Elective WIES Volume - Auckland	M	Jan-10	1 Ω
B5. Total WIES Volume - Auckland	M		1 Ω
B6. Non-DRG Revenue - Auckland	M	Mar-10	1 Ω
B7. Acute WIES Volume - IDF	M	Feb-09	2 Ω
B8. Elective WIES Volume -IDF	M	Jan-11	2 Ω
B9. Total WIES Volume _IDF	M	Jan-10	2 Ω
B10. Non-DRG Revenue - IDF	M	Jan-11	2 Ω
B11. Acute WIES Volume -All DHBs	M		3 Ω
B12. Elective WIES Volume -All DHBs	M	Jan-11	3 Ω
B13. Total WIES Volume - All DHBs	M	Jan-11	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
B41. Mental Health Total Access - Rate	M	Dec-10	6
B41b. Mental Health Access Rate - Maori	M	Dec-10	6
B40. Mental Health Total Community Face-to-Face Appts.	M	Jan-10	12
B42. Mental Health Community New Referrals	M		12
Productivity			
B15. Acute WIES per Day	M		5
B16. Elective WIES per Working Day	M	Jan-11	5
B17. FSA per Working Day	M		5
A27. Inhouse Elective WIES through Theatre - Per day	Q		Q2
Length of Stay			
A22. Raw Average Length of Stay - WIES funded patients (days)	M		7 Ω
A61. Mental Health - Average Length of Stay (KPI Discharges) - Te Whetu Tawera	M	Aug-09	7 Φ
Elective Process and Waiting Times			
A03. Elective Day of Surgery Admission (DOSA) Rate	M		7 Π
B61. Raw Elective Surgical daycase rate	M		7
B50. % of chemotherapy patients attending FSA within 6 weeks of referral	M		8
B51. (POP-10) % of chemotherapy patients receiving treatment within 6 weeks of FSA	M		8 ‡
B52. % of radiation oncology patients attending FSA within 6 weeks of referral	M		8
B56. % of patients who commence bone marrow transplant within 6 weeks of decision to treat.	M		9
B57. % of haematology patients attending FSA within 6 weeks of referral	M		9
B58. % of haematology patients receiving treatment within 6 weeks of FSA	M		9
A65. (ESPI 8). Proportion of patients treated prioritised using nationally recognised processes or tools	M	Aug-10	10
B65. DOSA Rate - Neurosurgery	M	Jan-11	10
A03b. Elective Day of Surgery Admission (DOSA) Rate - Maori	Q		Q1
A03d. Elective Day of Surgery Admission (DOSA) Rate - Pacific Island	Q		Q1
B50b. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Maori	Q		Q3
B50c. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Other	Q	Jan-11	Q3
B50d. Percentage of chemotherapy patients attending FSA within 6 weeks of referral - Pacific	Q		Q3
B51b. Percentage of chemotherapy patients receiving treatment within 6 weeks of FSA - Maori	Q		Q4
B51c. Percentage of chemotherapy patients receiving treatment within 6 weeks of FSA - Other	Q		Q4
B51d. Percentage of chemotherapy patients receiving treatment within 6 weeks of FSA - Pacific	Q		Q4
B52b. Percentage of radiation oncology patients attending FSA within 6 weeks of referral - Maori	Q		Q5
B52c. Percentage of radiation oncology patients attending FSA within 6 weeks of referral - Other	Q		Q5
B52d. Percentage of radiation oncology patients attending FSA within 6 weeks of referral - Pacific	Q		Q5
B54b. Percentage of A,B&C category Rad Onc pts receiving treatment within 4 wks of FSA - Maori	Q		Q6
B54c. Percentage of A,B&C category Rad Onc pts receiving treatment within 4 wks of FSA - Other	Q		Q6
B54d. Percentage of A, B & C category Rad Onc pts receiving treatment within 4 wks of FSA - Pacific	Q		Q6
Acute Process			
A56. Percentage of stroke patients cared for within the stroke unit - Total	6 monthly	Jul-10	Ω
A56b. Percentage of stroke patients cared for within the stroke unit - Maori	6 monthly		
A56d. Percentage of stroke patients cared for within the stroke unit - Pacific	6 monthly		
B63. Mental Health percentage of people with relapse prevention plans	M	Jan-10	12
Cost			
B34. Cost and revenue for WIES funded inpatient events -all services	6 monthly		
B35. Cost and revenue for WIES funded inpatient events -child	6 monthly		
B36. Cost and revenue for WIES funded inpatient events -adult	6 monthly		
B37. Cost per WIES for WIES funded inpatients - all	6 monthly		
Human Resources			
F.12 % of Total Employee Turnover (Monthly)	M		11
F.21 Lost Time Injury Frequency Rate	M		11

HAC Exception Report
March 2011

No exceptions for this month

IMPROVEMENT ACTIVITIES

6.1 DAP Projects Report

Group Pack Report

Group/Committee: Quality, Risk and Audit Committee - Goal 2



Goal: 2 Performance improvement

High Level Summary - total projects: 56

High Level Strategy	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	Green	Orange	Red		Green	Orange	Red	
			Define	Measure	Analyse	Improve	Control															
2.1a Efficient and effective Primary health care	3	3	1	0	0	2	0	0	3	0	0	3	0	0	2	1	0	0	0	0	0	0
2.1b Improve primary-secondary system efficiency	8	8	3	1	0	4	0	0	5	3	0	7	1	0	6	2	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	21	21	0	2	3	12	2	0	17	2	0	19	0	0	19	0	0	2	2	0	0	
2.2 Improve leadership capability	1	1	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	10	10	2	1	0	4	2	0	8	1	0	9	0	0	9	0	0	1	1	0	0	
2.4 Strengthen the health workforce	6	6	0	1	1	4	0	0	4	1	1	5	0	1	5	0	1	0	0	0	0	
2.5 Information management	6	6	0	1	1	3	0	0	2	3	0	4	1	0	5	0	0	1	1	0	0	
2.6 Planning	1	1	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	
Total #	56	56	7	6	6	29	4	0	40	11	1	49	2	1	48	3	1	4	4	0	0	
Total %	100%	100%	13%	11%	11%	52%	7%	0%	71%	20%	2%	88%	4%	2%	86%	5%	2%	7%	7%	0%	0%	




Objectives













Objective	Objective Owner	Comment
2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	Andrew Coe (ADHB)	ADHB continues participation at national, regional and local level regarding primary care planning and implementation. A number of RFPs are currently being prepared and complexities around these with regard to conflicts of interest and public law requirements are being worked through with all stakeholders.
2.1b.1 Improve access and efficiency of service delivery for primary-secondary	Andrew Coe (ADHB)	The primary care DAP projects progressing to varying degrees, access to diagnostic radiology is progressing well with regard and there is now increasing confidence that the target can be met. The rest of the projects are progressing well and there is confidence that the targets can be met apart from the savings target for the pharmaceutical utilisation project where although there have been demonstrable changes in utilisation the calculation of cost is difficult.

system		
2.1b.2 Reduce acute demand	Andrew Coe (ADHB)	RFP process underway for the provision of regional extended POAC services.
2.1c.1 Improve service throughput and productivity	Ngairie Buchanan (ADHB)	There are 8 projects associated with this objective all at different stages. Cardiac surgery throughput, Emergency six hour measure, releasing time to care, increasing Starship OR capacity and the Service improvement projects are all under way. Eliminating unnecessary outpatient follow ups will be within the service improvement programme. TPOR (The Productive Operating Room) is working through the define stage. Elective Services are behind target at 89%. A dedicated workout plan is being prepared to go to the ministry. As part of the plan to improve ESPI5 and the health target a Director of Elective Performance has been introduced until the two HSG GM roles are recruited. Starship OR business case has been reviewed. There will need to have further work to enable sign off. Until that is completed there will be further design work completed as well as work up needed for the ministry gateway process. The expenditure committee has signed off the release of funds to begin design work while the business case is completed.
2.1c.2 Improve mainstream effectiveness	Ngairie Buchanan (ADHB)	Being managed with Pacific Health Manager. First piece of work has been the collection on the DNA rate for Pacific people. Projects underway.
2.1c.3 Improve relapse prevention planning in mental health	Fionnagh Dougan (ADHB)	96% of eligible clients had a relapse prevention plan documented in their notes this month. This percentage exceeds the MOH requirement for 2010/2011.
2.1c.4 Hospitalised smokers given assistance to stop smoking	Taima Campbell (ADHB)	Of the 7960 events coded in January, 1064 (13.4%) patients were identified as smokers and 762 (72%) of the smokers were were documented as receiving advice or support to quit. While work continues to meet the target AHDB other indicators show that the ABC implementation has had a positive effect on inpatient nicotine withdrawal management. NRT dispensed to all services doubled in 2010 with a total of 66,818 NRT units dispensed compared to 31,092 in 2009. To improve the target figures a programme of ABC coaching and training updates are planned for February focussing on the high volume areas including the Adult Emergency Department, APU, General Surgery and General Medicine. A review of the ABC processes in National Women's Health will commence in February and strategies developed to improve the consistency of recording brief advice by all NWH services included in the target figures.
2.1c.5 Reduce waiting times for oncology	Fionnagh Dougan (ADHB)	Eligible patients referred for treatment to the regional service are being treated within 4 weeks.
2.1c.6 Increase elective surgical discharges to 10,227	Ngairie Buchanan (ADHB)	February ESPI compliance identified and non compliant. As a result of the initiatives put in place we are able to report that we have remedied the compliance risk for the month of February such that we are significantly under the threshold and has allowed a small buffer. For the ADHB Health target February showed a record month of 900 discharges. A programme to sustain this is underway which includes such initiatives as the introduction of a dedicated Director of Elective Performance role, reviewing our elective coding practices, converting an FTE post into a training and data cleansing role and ensuring our production planning is in place with the assistance of the service improvement specialist.
2.2.1 Strengthen Clinical Leadership model	Margaret Wilsher (ADHB)	Recruited all level 2 medical leaders with exception of Womens Health which is to be advertised. Midwifery Director appointed and Nurse Director Child Health and Nurse Director Perioperative & Clinical Services in recruitment process.
2.2.2 Improve Senior Leadership Team Performance	Greg Balla (ADHB)	There are two projects against this objective this year. Establishing a succession planning process and, the optimisation of the Leadership Walkaround Programme. The plan for this objective will be enhanced after the Healthcare Excellence Evaluation which will commence in 2011/12.
2.3.1 Implement regional clinical networks	Margaret Wilsher (ADHB)	CD Cardiac network appointed. Good progress with RHSP clinical engagement and leadership across all streams. Diabetes key clinical leaders shaping up network. OPH also forming clinical network.
2.3.2 Accelerated quality improvement including reduction of	Margaret Wilsher (ADHB)	Patient safety is a key campaign in the proposed Northern Region Health Services Plan. This will be a DAP deliverable 2011/12. The plan has been accepted at the recent challenge workshop but needs further refinement in terms of IT support. Pressure areas and falls seem likely safety targets for year one.

avoidable variation and adverse events		
2.3.3 Improve research quality	Margaret Wilsher (ADHB)	Software solutions for KPI capture are currently under evaluation. The research office is now supported by a performance improvement specialist.
2.4.1 Ensure workforce capability is matched to service delivery current and future	Vivienne Rawlings (ADHB)	STRENGTHEN CLINICAL LEADERSHIP MODEL - Level 2 medical leaders for Healthcare Service Groups recruited. Women's HSG medical leader will be readertised later in 2011. The Midwifery Director for Women's HSG has been appointed. The Nurse Director for Children's HSG is under recruitment. Recruitment for HSG nursing leadership positions ongoing. RANGATAHI PROGRAMME - 20 student cadets completed work experience in December with good feedback from the services. SCHOLARSHIP PROGRAMME - 11 cadets in work placement over the holidays. 7 new cadets recruited in December 2010. TAMAKI PROJECT - Early starts have commenced and most commenced training in January. No further progress on funding to support programme at this time. WORKFORCE ACCESS TO EDUCATION & TRAINING - Project now complete and transitioned to business as usual. On line learning will continue to develop and evolve. 5,700 staff registered for on-line learning and over 80 courses listed with 11 under development.
2.5.1 Improve the resilience and availability of core IT systems	Johan Vendrig (ADHB)	IT Resilience phase 3 hampered by stability issues of the new hardware platform and virtualisation software. Suppliers involved. Rootcause found and resolution underway. This is causing delays. Contractors are being used to keep project moving because BAU resources are busy with high project and BAU activity overall. Phase 3b Resilience has been started thanks to release of some additional capital budget to address urgent issues with Network configurations. Capex has been approved and these workstreams have been started. Resilience Phase 4 will need review in light of regional shared service. This has offered some opportunities to better use regional data centres. Significant risk still exists around PACS, FMIS and CRIS with very old hardware so projects in these areas have been given higher priority. However PACS and FMIS are caught up in regional procurement and design processes so interim solutions may be required. A preferred vendor for the replacement of the CRIS system has been identified and the implementation study is underway. Regional Clinical Documents and eReferrals phase 1 progressing in line with their revised timelines with go-lives expected in April/May 2011. Aspire project completed; now working on extensions for Mental Health.
2.5.2 Improve corporate records and knowledge management	Johan Vendrig (ADHB)	Corporate Records Manager is progressing to plan with introduction of policies and training related to improving management of corporate records. RFP for Enterprise content management system nearing completion. Vendor presentations in May. Some concerns about total cost of the potential solutions. Project team asked to look for ways to introduce system in an incremental way rather than big bang. Preferred vendor for CRIS replacement (3M) has completed the implementation planning study and the business case will be presented to Expenditure CIE in April and Board in May. HR scanning proof of concept was completed successfully but unfortunately the ROI and priority did were not sufficient for this project to make it onto the FY11/12 capital budget list. Project team is exploring alternative (lower cost) ways to introduce the platform.
2.5.3 Improve data quality of Information Management systems	Johan Vendrig (ADHB)	NHI duplicate issue remains a significant problem. Although KPI performance has improved, the process remains unstable. Discussions with the services and the MoH continue to look for improvement opportunities continue. We will be requesting support from the performance improvement team to define and run a formal performance improvement process, however an improvement project has not as yet been defined due to resource constraints. Discussions with MoH about fact we believe KPI definition is not correct in relation to use of preallocated numbers for newborns has lead to MoH changing KPI measure for FY2011/2012. This should remove the (inappropriate) inflation of ADHB's duplicate KPI number and thus should assist us with achieving the national target. This should however not take away our focus on the real duplicates that are still created.
2.6.1 Long term planning and change management	Brent Wiseman (ADHB) (CFO)	This project was initiated last year with a research phase being undertaken by Chris Morgan. CEO advises that Planning and Funding Unit to take over responsibility to progress and have appointed additional planning resource.

Exceptions

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Better help for smokers to quit	National	Improve				A range of improvement strategies are in the process of being implemented with the assistance of the new steering group. Results remain unsatisfactory due to the high volumes of short stay patients to whom advice is not being routinely offered or documented. Confirmation of funding for Smokefree services for the 11/12 year has not been confirmed. Funding expires 30 June.

Skin Lesions	Regional	Improve				Project is now back on track. Contracting arrangements are currently being finalised and transition plan from ADHB provider to GP's is being developed.
Pharmaceuticals	Regional	Measure				Original benefits identified may not be delivered although work is underway to forecast benefits likely for the end of the financial year.
Starship 6 hour project	National	Improve				While the March performance of 93% was short of the target, the result represented a further improvement over prior months and 6% over the same month last year. There were some 12 days at 95% or better which comfortably surpassed the performance of all prior months. The improving results continue to reflect a number of activities and projects within Starship. Of particular note in March was: Increased Management focus and engagement. Daily review of all 6 hour breaches with feedback and improvement actions being taken in the relevant areas. Heightened staff awareness brought about by Valuing our Patients Time Campaign which publishes results on a weekly basis. The importance meeting the 6 hour target and results achieved have been on the agenda at meetings throughout Starship. Implementation of an Electronic Whiteboard in CED. This has resulted in a greater level of transparency as to where patients are in their CED journey to enable prioritisation of patients that may breach the 6 hour time. The transfer time from CED to ward (relative to the 1 hour recommendation) made a significant improvement with the mean falling by 34% over February's results. All wards are now using the Estimated Dates of Discharge.
Tamaki P2HC project	Regional	Analyse				A revised programme design and costings has been developed and agreed to by the SLT subject to funding. Funding for training for eligible Maori trainees has been transferred from He Kamaka Oranga to offset some of the cost

Legend: Red - , Orange - , Green - 

FEEDBACK TO BOARD

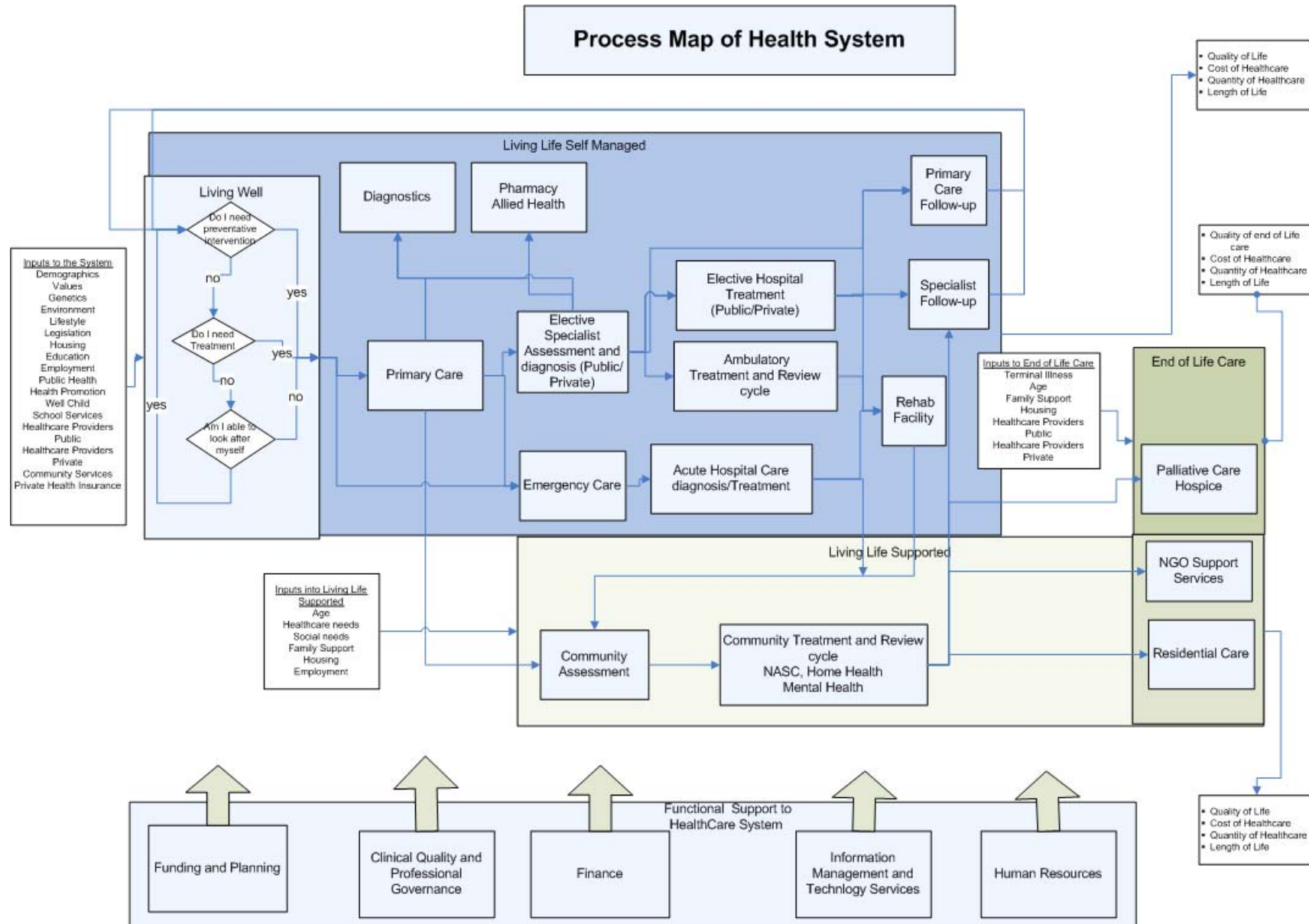
7.1 Hospital Advisory Committee Feedback to Board

GENERAL BUSINESS

APPENDICES

9.1 Healthcare System Diagram

9.1 Healthcare System Diagram



MEETING DETAILS		
Time and Date	10:45am – 12:15pm, Wednesday, 4 May 2011	
Venue	A+ Trust Room, Clinical Education Centre, Auckland City Hospital	
Members	Dr Chris Chambers (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Rob Cooper, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.	
Apologies	Rob Cooper (Leave of Absence)	
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Janice Mueller, Ian Bell.	
COMMITTEE FUNCTIONS		
To monitor the financial and operational performance of the hospitals and related services of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.		
	Item	Page No
1 2m to 10.47am	Attendance and Apologies	001
2 3m to 10.50am	Conflicts of Interest	003
3 5m to 10.55am	Confirmation of Minutes Wednesday 6 April 2011	013
4 10m to 11.05am	Action Points Wednesday 6 April 2011	019
5 10m 20m 5m to 11.40am	Operational Performance 5.1 Operational Report 5.2 Health Target Updates 5.3 Operational Indicators Report	023 025 041 051
6 10m to 11.50am	Improvement Activities 6.1 DAP Projects Report	055
7	Feedback to Board	061
8 5m To 12.10pm	General Business	063

	Item	Page No
9	Appendices 9.1 Healthcare System Diagram	065
NEXT MEETING		
Time and Date: 10.25am, Wednesday, 1 June 2011		
Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton		

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