



Auckland District Health Board

Board Meeting

Wednesday 2 November 2011

2:00pm

**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*

1

1

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY (Chair)	University of Auckland Business School	Professor of Leadership			31 May 2011
	New Zealand Leadership Institute	Chief Executive			
	Health Benefits Limited	Deputy Chair			
	Tonkin & Taylor	Independent Chairman Chairman			
	Waitemata District Health Board A+ Trust	Trustee			
Jo AGNEW	Professional Teaching Fellow, Scholl of Nursing, Auckland University		Salary		9 September 2011
	Casual Staff Nurse ADHB		Salary		
Peter AITKEN	Pharmacist	Pharmacy Locum	Hourly Fee		10 December 2010
	Pharmacy Care Systems Ltd	Shareholder/ Director, Consultant		Medical Centre development and pharmacy lease	
Judith BASSETT	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	Writing, editing and public relations services Medical Council of NZ Occupational Therapy Board Northern Regional Ethics Committee	Self-employed Professional Conduct Committee member Professional Conduct Committee member Member	Fees Fee Fee Fee		7 September 2011
Dr Chris CHAMBERS	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

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

	NZ Council of Midwives Tamaki Transformation Transitional Board	Council member Chair	Fee Fee	services contracted to the MoE. Statutory Authority	
Robyn NORTHEY	Self employed Contractor Hope Foundation Northern Region	Project management, service review, planning etc. Board member	Fee Nil	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	4 October 2011
Gwen TEPANIA-PALMER	Waitemata District Health Board Manaia PHO Ngati Hine Health Trust Te Taitokerau Whanau Ora	Board member Board member Chair Committee member	Fee Fee		18 May 2011
Ian WARD	C -4 Consulting Limited NZ Blood Service	Principal/ Director Board Member	 Fee		24 August 2011

CONFIRMATION OF MINUTES
- WEDNESDAY 5 OCTOBER 2011

Auckland District Health Board Minutes



MEETING DETAILS													
Time and Date	2:00 pm, Wednesday, 5 October 2011												
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton												
1	KARAKIA												
	The Chair declared the meeting open at 2:06pm. Rob Cooper led the meeting with the karakia.												
2	ATTENDANCE AND APOLOGIES												
	<p>Board Members</p> <table> <tr> <td>Dr Lester Levy (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Judith Bassett</td> </tr> <tr> <td>Susan Buckland</td> <td>Dr Chris Chambers</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Lee Mathias</td> </tr> <tr> <td>Robyn Northey</td> <td>Gwen Tepania-Palmer</td> </tr> <tr> <td>Ian Ward</td> <td></td> </tr> </table> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director Performance and Innovation Taima Campbell – Executive Director of Nursing Janice Mueller – Executive Director of Allied Health, Scientific and Technical Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator</p> <p>Apologies</p> <p>An apology had been received from Naida Glavish, Chief Advisor Tikanga, General Manager Maori Health.</p>	Dr Lester Levy (Chair)	Jo Agnew	Peter Aitken	Judith Bassett	Susan Buckland	Dr Chris Chambers	Rob Cooper	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	
Dr Lester Levy (Chair)	Jo Agnew												
Peter Aitken	Judith Bassett												
Susan Buckland	Dr Chris Chambers												
Rob Cooper	Dr Lee Mathias												
Robyn Northey	Gwen Tepania-Palmer												
Ian Ward													
3	CONFLICTS OF INTEREST												
	There were no declarations of conflicts of interest for any item on the agenda. The Board Administrator had noted changes to the Interests Register for Lee Mathias and Robyn Northey.												
4.1	CONFIRMATION OF MINUTES 1 SEPTEMBER 2011												
	<p><u>Moved</u> Gwen Tepania-Palmer; seconded Lee Mathias</p> <p><i>That the minutes of the Auckland District Health Board meeting held on 1 September 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>												

4.2	CONFIRMATION OF MINUTES 7 SEPTEMBER 2011
	<p><u>Moved Jo Agnew; seconded Lee Mathias</u></p> <p><i>That the minutes of the Auckland District Health Board meeting held on 7 September 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>
5	ACTION POINTS 7 SEPTEMBER 2011
	<p>Maori Statistics</p> <p>A first attempt had been made at providing ethnicity statistics at the Hospital Advisory Committee and would be included in the CPHAC and Board as these are developed. This work was being done in conjunction with Waitemata.</p> <p>Credentialing – Minor Skin Surgery Project</p> <p>The paper outlined the credentialing process which included a review panel and ongoing credentialing. It was a robust process and that level of credentialing was needed to have confidence with the primary care partners. The paper was noted.</p>
6.0	CHAIRMAN’S REPORT
6.2	Board and Committee Meeting Schedule 2012
	<p><u>Moved Jo Agnew; seconded Gwen Tepania-Palmer</u></p> <p><i>That the ADHB Board approves the meeting schedule for 2012 and continuation of the practice of CPHAC meetings at Takapuna and DSAC and MHGAC meetings at Greenlane.</i></p> <p><u>Carried</u></p>
7.1	CHIEF EXECUTIVE’S REPORT
	<p>The Board acknowledged the recent deaths of John Neutze, Paediatric Cardiology and Clinical Director Cardiology, Green Lane Hospital, Toby Whitlock, Physiologist and CMO Green Lane Hospital and Jack Watt, Anaesthetist and Head of Department of Anaesthesia at Auckland Hospital. The Board were also advised that a nurse staff member was in intensive care.</p> <p>Events and news included Te Whetu Tawera issues being raised in the media, closure of a rest home on Waiheke and Jonah Lomu’s illness. The NOVA publication had focussed on accomplishments for the year and Naida Glavish’s powhiri at Waitemata had been well attended.</p> <p>Indicator score cards would drill down to HSGs and there would be a quarterly report on regional projects at the next meeting. There were no exceptions to the Information Management indicators but a number of indicators had been included for information. The number of staff accessing EAP services were to be advised. This is a contracted service and there is an evaluation process. The improvement in coding completion was acknowledged.</p> <p>Project investment proposals for GAIHN were being developed but needed more work before coming to the Board. Proposals will come to the Audit and Finance Committee in due course.</p> <p>Work on smoking advice had been followed up with Waitemata and there had been improvement in the number of areas where counting was being undertaken so there should be an improvement to this target. The National Hauora Coalition (NHC) raised the question of how we worked regionally with them with the concern that funds were going into business cases rather than the delivery level.</p> <p>There was a report on the Board’s priorities and each project related to that priority. The Clinical Leadership Project was being defined and what needed to be developed looking at internal resources and network leadership at national, regional and local levels.</p> <p>The accountability framework was included, including the HSG structure with the Board</p>

	requesting further explanation on accountability. The CEO needed the advice and support of the Clinical Partners supporting the ethos of clinical leadership with responsibility and combined expertise. Within HSGs the Performance Director and GM was one position and funding, on a population based funding basis, would be attached to each HSG and then, within that HSG, funding being utilised across the whole health continuum to performance criteria. While the Board supported the philosophy of clinical leadership there were concerns and disquiet on how the accountability lines in the HSG structure actually worked and also how the links between the Performance Director and clinical leadership worked. A further report would be provided.
7.2	MINISTER'S SIX HEALTH PRIORITIES
	These had been discussed at earlier meetings.
8	PRESENTATION
	<p>Cardiology – Cardiothoracic Trends</p> <p>Peter Ruygrok and Fionnagh Dougan were in attendance.</p> <p>Peter Ruygrok presented to the Committee noting that life expectancy had significantly increased over the years largely due to a reduction in cardiovascular mortality. Information was provided on the aging population and projected life expectancy at 2016 together with New Zealand population projections. Mortality from heart disease data was provided for New Zealand and separately for Maori together with mortality rate data for New Zealand versus the Auckland Region DHBs. Information on discharges can be drilled down to localities. The contributions to the mortality decline were approximately 33% related to reduced smoking, 33% related to other risk factor modifications and 33% related to medical and interventional treatments. The critical impact of obesity was noted.</p> <p>The Board thanked Peter Ruygrok for his informative presentation.</p>
10.1	DAP Projects Report
	The report was noted.
11.1	Finance Committee Recommendations
	<p>Northern DHB Support Agency Limited Agency Agreement</p> <p><u>Moved Robyn Northey; seconded Lee Mathias</u></p> <p><i>That the ADHB Board:</i></p> <ol style="list-style-type: none"> <i>Approves the Northern DHB Support Agency Limited entering into an agreement with Health & Disability Auditing New Zealand Limited for the provision of quality and service auditing of NGO service providers over a three year period for the financial years 2011/12 to 2013/14 at a cost of not more than \$2.65m over three years.</i> <i>Approves the Northern DHB Support Agency Limited paying an account of \$1.137m from Central Region TAS Limited for the northern region DHBs' share of the Year One budget of \$3.2m for the roll out of the interRAI comprehensive clinical assessment tool for aged residential care.</i> <i>Delegates to the Chief Executive Officer authority to vote at a special meeting of the Northern DHB Support Agency Limited in favour of the Northern DHB Support Agency Limited entering into an agreement with Health & Disability Auditing New Zealand Limited for the provision of NGO service provider quality and service audits over the three year period 2011/12 to 2013/14 at a cost of not more than \$2.65m over three years and paying the Central Region TAS Limited invoice of \$1.137m for the northern region DHBs' share of the Year One cost of roll out of the interRAI comprehensive</i>

clinical assessment tool for aged residential care.

4. *Approves the Northern DHB Support Agency Limited entering into an agreement with Health & Disability Auditing New Zealand Limited for the provision of NGO service provider quality and service audits over the three year period 2011/12 to 2013/14 at a cost of not more than \$2.65m over three years and paying the Central Region TAS Limited invoice of \$1.137m for the northern region DHBs' share of the Year One cost of roll out of the interRAI comprehensive clinical assessment tool for aged residential care.*

Carried

30 June 2011 Annual Report and Associated Letter of Representation

Moved Peter Aitken; seconded Lee Mathias

That the ADHB Board approves the following delegations to sign on their behalf:

- (a) Letter of Representation to Audit NZ – Board Chair and Audit and Finance Committee Chair.*
- (b) Annual Report and Year-end financial statements – Board Chair, Audit and Finance Committee Chair and Chief Executive.*

Noting that the Board Chair and Chair of the Audit And Finance Committee have received a Letter of Representation from the Chief Executive, Chief Financial Officer and Chief Medical Officer.

Carried

11.2 Finance Report

The report was noted.

15.0	PUBLIC EXCLUSION											
<p><u>Moved Robyn Northey; seconded Gwen Tepania-Palmer</u></p> <p><i>That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 15</i></p> <p><i>The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:</i></p> <table border="1" data-bbox="199 515 1356 974"> <thead> <tr> <th data-bbox="199 515 614 638">General subject of each matter to be considered:</th> <th data-bbox="614 515 981 638">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="981 515 1356 638">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="199 660 614 728">15.1 Confidential Board Minutes 7 September 2011</td> <td data-bbox="614 660 981 840" rowspan="4">To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)</td> <td data-bbox="981 660 1356 974" rowspan="4">That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.</td> </tr> <tr> <td data-bbox="199 739 614 772">15.2 Employment Relations</td> </tr> <tr> <td data-bbox="199 795 614 828">15.3 Strategic Partnership</td> </tr> <tr> <td data-bbox="199 851 614 918">15.4 National Health Innovation Hub</td> </tr> </tbody> </table> <hr/> <p><u>Carried</u></p> <p>The items discussed in public exclusion were Confidential Minutes 7 September 2011, Employment Relations, Strategic Partnership, Te Whetu Tawera and the National Health Innovation Hub.</p> <p><u>Moved Robyn Northey; seconded Peter Aitken</u></p> <p><i>That the meeting resume in public.</i></p> <p><u>Carried</u></p>				General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:	15.1 Confidential Board Minutes 7 September 2011	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.	15.2 Employment Relations	15.3 Strategic Partnership	15.4 National Health Innovation Hub
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15.2 Employment Relations												
15.3 Strategic Partnership												
15.4 National Health Innovation Hub												
NEXT MEETING												
<p>The meeting closed at 5:00pm</p> <p>The next scheduled meeting is: 2:00pm, Wednesday, 2 November 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>												
CONFIRMED												
CHAIR:		DATE:										

ACTION POINTS

- **WEDNESDAY 5 OCTOBER 2011**

Board**Action Points from the meeting on Wednesday 5 October 2011**

Item	Detail	Designated	Action
5.1	What numbers of staff access EAP services	Viv Rawlings	In 7.1 Report
7.1	Revise accountability explanation	Garry Smith	Further discussion at meeting

CHAIRMAN'S REPORT

CHIEF EXECUTIVE'S REPORT

- 7.1 Chief Executive's Report**
- 7.2 Minister's Six Health Priorities**
- 7.3 Management Operating System (MOS) - Presentation**

7.1 Chief Executive's Summary

CHIEF EXECUTIVE'S REPORT

1	EVENTS AND NEWS IN SEPTEMBER
2	EVENTS AND NEWS IN OCTOBER
3	MANAGING THE WIDER HEALTH SYSTEM
4	BOARD PERFORMANCE PRIORITIES
5	APPENDIX 1

Introduction

This report covers the month of September. It includes a brief summary of events of note in September and October, an update on management of the wider health system and a summary of progress against the Board's priorities to confirm these matters are being appropriately addressed.

1 Events and news in September

1.1 Events

During September the following events took place:

Media

- Intense media interest in former All Black Jonah Lomu. ADHB respected the family's wishes for no comment to media.
- The Liver Transplant Service began its build-up to the 25th anniversary of the first liver transplant to a New Zealander.
- Renewed interest from heritage interest groups in Building 10 on the ADHB Greenlane Clinical Centre site.
- Social media is becoming more frequently used by patients and their families, for example:
 - The mother of an 18-month-old boy with incurable kidney disease has complained on Facebook that ADHB and Pharmac will not fund a drug costing \$500,000 per year for her son.
 - The mother of an eight-year-old boy with HIV has launched a fundraising appeal through her online blog to take him overseas for treatment, claiming ADHB is not giving him access to the proper medications.

Internal

- Communications sent out to the organisation regarding The Northern Regional Training Hub (NoRTH) and its focus, in the first instance has been on RMOs within the northern region and across the four DHBs.
- Stroke Awareness Week 5-11 September.
- The draft Child Health Improvement Plan 2012- 2017 was made available for feedback.

2 Events and news in October

2.1 Events

During October the following events either have or will take place:

People

- John Neutze and Toby Whitlock passed away. Both will be acknowledged with ADHB obituaries.
- Naida Glavish was honoured with a powhiri acknowledging her appointment as joint Chief Advisor Tikanga ADHB and WDHB.

Media

- A modified Incident Management Team (IMT) has been established and is working closely with the Ministry of Health and Auckland Regional Public Health Service (ARPHS) to facilitate communications to health professionals, the media and the public regarding the measles outbreak.
- Multiple media requests for details and numbers of Adult Emergency Department numbers during peak weekend periods around Rugby World Cup matches.
- Multiple media requests for information about Jonah Lomu from organisations around the world.
- For the fourth year ADHB will participate in a TV series known as Rapid Response which is partially filmed at Auckland City Hospital. It involves cameras working with St John Ambulance crews gathering footage of consenting patients arriving at the hospital. No resource is required and it builds on our relationship with St John.

Internal

- Scotland's Rugby World Cup party presented a gift to Starship Children's Hospital. Led by stand-off Ruaridh Jackson, the team donated a 50" flat-screen TV to be enjoyed by both patients and staff.
- An independent review of ADHB mental health services requested by the Health and Disability Commissioner has been made public and made available on the front page of the ADHB website and intranet.

3 Managing the wider health system

3.1 System performance

Primary care integration and development work is progressing well and new facilities and service changes are being introduced in a number of areas, as set out later in this report. There is a focus on ensuring that the right resources are available for the task and that there is no duplication of services or processes.

Whilst the Rugby World Cup is still a factor in managing services, it has been the escalation in the number of measles cases that has caused the most concern.

Funding is being re-prioritised to support an increase in immunisation and health promotion as countermeasures.

The increasing focus on regional and national collaboration has been assisted by the amalgamation of the primary care funder teams from Waitemata DHB and ADHB. This is bringing early gains in terms of streamlined planning and system change for the many initiatives that are being undertaken in primary care.

3.2 Financial performance

A full report is included in the Audit and Finance Committee papers, but in summary the organisation achieved an \$2.3 million surplus for the month, \$0.9 million favourable to budget. The Funder and Governance Arms recorded breakeven, which was \$1.1 million favourable to budget, and the Provider Arm a surplus of \$2.3 million being adverse to budget by \$145,000.

3.3 Clinical quality and professional governance

This part of the report addresses clinical quality and governance matters that are of topical interest. As such the content varies each month.

Research activity

There are currently 819 active research projects being undertaken at ADHB. Forty-one A+ Trust Grants totalling nearly \$700K have been awarded to our own clinical researchers so they can undertake peer reviewed research or clinical audit.

Three ADHB employees have recently been awarded honorary professor titles by the University of Auckland: Professor Peter Ruygrok, Professor Ralph Stewart and Professor Ed Gane. The professorial title recognizes their academic success in research and teaching.

Professor Ed Gane has been awarded an HRC project grant to study whether surveillance can prevent liver cancer and death in Māori with Chronic HBV. This study is being undertaken in partnership with Massey University and the Hepatitis Foundation

Four AHB clinicians (Drs McArthur, Roberts, O'Carroll and Grant) are part of a group of world-leading scientists and flu researchers, led by ESR, recently awarded a prestigious international grant to study influenza. Funded by the US Department of Health and Human Services for the Influenza Division of the National Center for Immunization and Respiratory Diseases (NCIRD) of the United States Centers for Disease Control and Prevention (CDC), the SHIVERS (Southern Hemisphere Influenza Vaccine Effectiveness Research and Surveillance) project will look at how the influenza virus and other respiratory pathogens spread through populations.

Regional clinical network – Older People's services

The Regional Clinical Network for Older People's services has been established and will meet in the October for the first time. The network encompasses clinicians from across the region, including Northland and involves both DBH and NGO representatives.

The work programme is partly defined by the project activity set out at the end of this report under the Board priorities, which although at an early stage has made a promising start. The intention is to secure a collaborative and consistent approach to ensure compatibility of services and enable service users to transition from one area to another within the region.

Clinical Practice Committee

The CPC has released its Annual Report for 2010/11, see Appendix 1 included with these papers. Nine matters were considered during the year:

- Efficacy of vitamin C in the treatment of influenza given the considerable media interest in high dose vitamin C therapy – declined due to possibility of renal toxicity.
- The basis for offering ‘rescue’ angioplasty outside of normal hours for regional patients to improve the patient rate of survival – result pending.
- Assessing smoke evacuation procedures – new guidelines introduced.
- Assessing patient risk from aortic valve implementation in high risk patients – categories of risk assessed.
- Assessing risks from minimally invasive mitral valve surgery procedures – new clinical toolkit developed.
- Determining whether to restrict vitamin D testing – restrictions applied.
- Assessing patient risk from transcatheter aortic valve implementation in high risk patients – multidisciplinary selection committee formed to assess cases.
- Determining whether to restrict testing for Lipoprotein (a) and homocysteine, insulin and DHEA – restrictions applied.
- Assessing use of Avastin in the treatment of diabetic macular oedema – result pending.

Regional health plan

The first quarter has focused on mobilising the implementation plan with achievements including:

- Cancer services agreeing prioritisation criteria for colonoscopy. All gastro units in the region are implementing these to achieve regional consistency.
- The ‘First, do no harm’ work stream has agreed the methodology and measures designed to show improvements to patient safety in hospitals and rest homes.
- The Radiology Network has developed a comprehensive capital and asset plan which takes into account expected demand patterns and the capital impacts over the next 5-10 years.

- Advanced Care Planning has developed a business case for workforce training as a foundation for future activity. Training will take place in January 2012

Early Warning Scores

Starship Hospital will shortly commence Evaluating Processes of Care and the Outcomes of Children in Hospital (EPOCH), which evaluates processes of care and the outcomes of children in hospital'. This is an international study on ways of identifying children in hospital at risk of deteriorating and how to prevent that occurring. It uses a score that is generated from the routine bedside observations that all patients undergo. The score informs the decision to call for more help and the type of help required. The aim of the study is to decrease the number of children who die in hospital and prevent significant clinical deterioration. There are a total of 22 international hospitals in the study, with Starship the sole participant within New Zealand.

Infection Prevention and Management Walk-Around

Starship has implemented a weekly senior nursing Infection Prevention and Control (IPC) hospital walk around. There are environmental challenges within the hospital and it is vital that all staff are aware of best practice in regard to prevention and control of infection to mitigate these risks.

The Nurse Director, Nurse Adviser and Clinical Nurse Specialist IPC request that the ward Charge Nurse and the link IPC nurse accompany them on the round. They use the opportunity to raise the profile of best practice, address any educational issues and assess risks. Risks are reported back as a standing item on the Charge Nurse and the Nurse Educators' meetings to align best practice across children's health services.

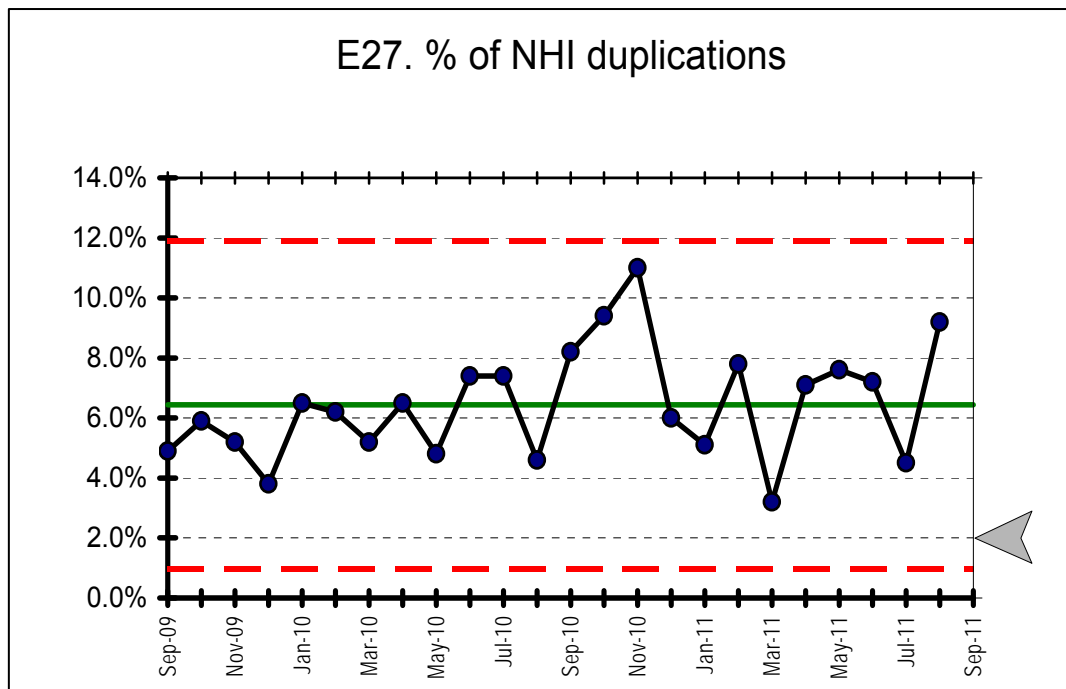
3.4 Support services

A summary of the current position for performance indicators for IT, Human Resources and Finance/Shared Services is shown below:

Service	Number of indicators	Exceptions
Information management	26	The exception for September relates to duplicate NHI numbers and this is the featured indicator.
Human Resources	40	There were no exceptions in August and the featured indicator for the month is discussed below.
Finance and shared services	15	There were no exceptions in August and the featured indicator for the month is discussed below.

Featured Information Management indicator – E27. Percentage of NHI Duplications

ADHB's rate of duplicate NHIs tracked consistently above the MOH threshold of 2% in previous years with ADHB being unfavourably compared with other DHBs on this measure. ADHB explained to the MOH that the reason for this was the MOH's method of calculating the duplicate NHI rate. This was calculated as the number of NHI duplications that require merging divided by the total number of NHI registrations created, excluding pre-allocated NHIs. ADHB is the only DHB in the country using pre-allocated NHIs for new baby registrations, and by excluding this large patient group from the denominator ADHB's duplicate NHI rate has been comparatively high. This disadvantaged ADHB when the duplicate NHI rate was compared across DHBs.



NB: September data not available from the MoH at time of writing

From July 1, 2011 the MOH changed the formula for the calculation of duplicate NHIs, so that all new baby registrations are excluded from the formula, regardless of whether they have been created from a pre-allocated number or not. This has had no impact on ADHB's rate or performance against this measure; however it has impacted all other DHBs. The rate is now being calculated consistently. As a result ADHB's relative position on the DHB comparison table has improved significantly (from worst performing DHB in FY2011 to number 10 of 21 at August 2011) and the ADHB result is now better than the national average. See table below.

Total No of NHI Duplicates July – August 2011

DHB	NHIs Created	Duplicates	Ratio
MidCentral	78	16	20.50%
Counties-Manukau	379	54	14.20%
Waitemata	546	69	12.60%
Waikato	217	27	12.40%
Northland	89	9	10.10%
Canterbury	282	28	9.90%
Hawkes Bay	79	7	8.90%
Tairāwhiti	23	2	8.70%
Bay of Plenty	165	14	8.50%
Hutt Valley	159	13	8.20%
Whanganui	28	2	7.10%
Auckland	913	65	7.10%
West Coast	76	5	6.60%
Taranaki	79	5	6.30%
Capital & Coast	267	16	6.00%
Otago	355	19	5.40%
South Canterbury	45	2	4.40%
Wairarapa	24	1	4.20%
Nelson Marlborough	229	9	3.90%
Southland	437	14	3.20%
Lakes	126	3	2.40%
DHB average	4596	380	8.30%

The MOH has set a new (higher) and more realistic threshold. DHBs are expected to achieve a duplicate NHI rate of less than or equal to 6%. The 6% target is realistic and ADHB will strive to improve performance on this measure. Data is reviewed each month to identify opportunities for follow up with individual staff members, with supplementary training where required. Pattern analysis indicates new staff/lack of NHI search training as an area requiring focus and follow up with individual services has occurred.

Featured Human Resources indicator - F.23: % of Work Related EAP Referrals

The Work Related EAP Referrals indicator was discussed at the September meeting and further detailed information on the programme has been provided below.

What is the Employee Assistance Programme?

The employee assistance programme (EAP) is provided to help staff deal with work and personal issues which may affect their work performance.

Confidential counselling services are provided to ADHB staff by an external provider contracted to ADHB. The current contract is with EAP Works. This is an arms-length service and confidential will only be broken if:

- The counsellor believes a person is in danger to themselves or others (including ADHB patients)

- Or a crime has been or is about to be committed

Who is entitled to free counselling?

All ADHB employees are entitled to three sessions per issue. In most cases employees do not request repeated access, but in some cases this may be a set of three sessions every couple of years. The service is only provided to ADHB employees. Contractors, students and volunteers are not eligible for free EAP counselling sessions.

Referral to staff counselling services may be made by:

- A self-referral process. An employee contacts the supplier directly for individual advice and support
- A manager can make a formal referral to the counselling service supplier for an individual employee when an issue is seriously affecting work performance

Why do people go to EAP?

Provision of counselling services will, in most cases, facilitate the early intervention of work or non-work related issues before the issues impairs the employee's work performance. Issues affecting individuals or groups may be person or work related. Examples of the types of issues:

Personal	Work Related
<ul style="list-style-type: none"> • Personal/family relationships • Anxiety, depression, grief, anger (highest) • Financial or legal • Alcohol/gambling 	<ul style="list-style-type: none"> • Relationship with co-worker or manager • Work environment conditions • Work stress (highest) • Career choices, retirement • Harassment, discrimination • Redundancy, restructuring • Discipline, performance manager, dismissal • Exposure to violence (including staff to staff violence), work trauma

EAP usage at ADHB

Approximately 525 employees attended 1,200 counselling sessions in 2010/11. This is approximately 5% of ADHB staff and is the average corporate usage according to the EAP contractor. The usage across the business groups is approximately equivalent to the percentage of employees in the group, for example, Adult Healthcare Service Group has 21% of the fte and uses 18% of the EAP referrals, Operations has 19% of the fte and uses 20% of the EAP referrals. The only

exception to this is Mental Health & Addictions Healthcare Service Group which has 9% of the FTE and used 14% of the EAP referrals.

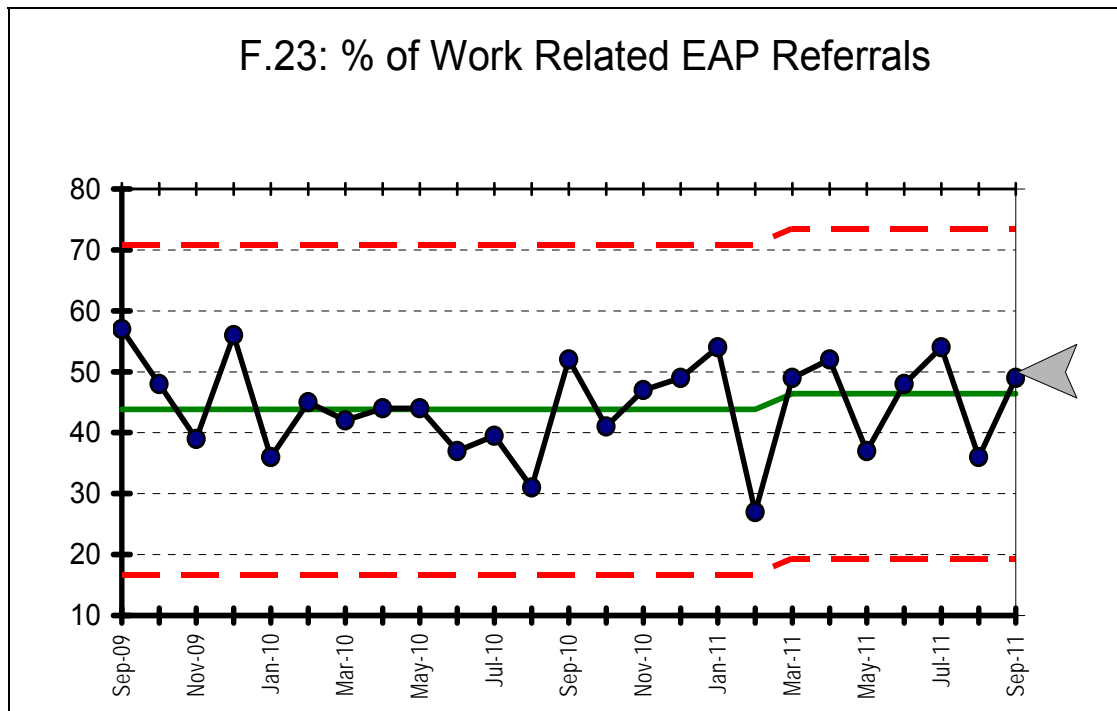
The demographics (role, gender, age) are closed matched to ADHB workforce demographics and no particular role, gender or age group stands out.

The quarterly table below shows that over the past four years the majority of visits to EAP are related to personal issues, with work related issues very close to 50%.

REASON FOR EAP VISIT		
	Work Related	Personal
1 st 07-08	44%	56%
2 nd 07-08	53%	47%
3 rd 07-08	42%	58%
4 th 07-08	40%	60%
1 st 08-09	38%	62%
2 nd 08-09	45%	55%
3 rd 08-09	41%	59%
4 th 08-09	33%	67%
1 st 09-10	47%	53%
2 nd 09-10	48%	52%
3 rd 09-10	41%	59%
4 th 09-10	37%	63%
1 st 10-11	41%	59%
2 nd 10-11	46%	54%
3 rd 10-11	43%	57%
4 th 10-11	44%	56%

September Indicator

The percentage of Work Related EAP Referrals can be considered as a barometer for staff wellness, where a low percentage is more desirable than a high one, as it suggests that work issues are less concerning for our employees than personal issues. As indicated by the run chart, a fluctuating pattern has been displayed from month to month over the last 12 months. The mean percentage for the 10/11 year was 44%, which is the same as the 09/10 year's 44%. Overall the trend is in alignment with the threshold of 50%.



Contract Arrangements

An RFP process was recently undertaken by the four Northern Region DHBs in order to award a new contract for a northern region supplier. A steering group, made up of representatives from each DHB was formed to aid and inform the tender evaluation process. Negotiations were held with four suppliers and a preferred supplier has been chosen. The contract is for 2 years plus 2 further years with 1 year rights of renewal.

The regional full term forecast spend and savings are detailed below. The term saving for the northern region is forecast at 11%.

DHB	Full Term Spend	Full Term Saving	Full Term Saving
	\$	\$	%
ADHB	466,400	46,000	10
CMDHB	226,200	11,600	5
WDHB	229,120	15,140	7
NDHB	212,800	48,560	23
Total	1,134,520	121,300	11

The final draft contract supply agreement will be reviewed in late October and the preferred supplier will be offered a contract by the end of October and all tenderers will be informed of the outcome.

Featured Finance indicator KPI G10 – Non eligible patient revenue collection %

In addition to the usual internal revenue allocation and IDFs there is a small component of revenue that the ADHB earns from charging non eligible patients for services rendered. This can be a difficult area as the ADHB is required to provide acute services without questioning the patient's ability to pay. The ADHB has been successful in recovering a good proportion of the charges though, and also receives bad debt funding from the MOH based on historical patterns of recovery.

The measure reflects the percentage of invoices billed in the month that are collected, net of credit notes and other adjustments. The average over the last three financial years was:

Financial year	Annual performance	Monthly range
2008/09	77%	53% to 94%
2009/10	80%	50% to 90%
2010/11	79%	57% to 96%

Performance for the first 3 months of the current financial year was 64%. This reduced level of performance reflects a fall in level of billings at \$3.5 million compared with \$5.3 million for the same period last year. In addition to the fall in revenue the bad debt experience remained at \$1.4 million. The reduced level of billings was related to lower volumes for eligible patients. The sabbatical leave of key surgical staff also had an impact on services provided.

To improve matters going forward an eligibility team has been set up within Health Alliance with effect from October 2011. Cost recoveries for treating non-eligible patients will be monitored closely to ensure the correct level of recoveries is being pursued.

3.5 Hospital services

September month and YTD performance reached health target levels for elective services although overall performance was slightly below plan. Outsourcing continued to be a key part of the strategy to meet targets, particularly in supporting cardiac volumes. Inter district flows for DRG services whilst above plan will be covered by additional revenue.

Control of FTEs has largely worked to plan but an unfavourable variance of 13 FTE has arisen that is being addressed. Additional resources are needed for Adult Orthopaedics and increased session time at Greenlane in the New Year. These requirements will be accommodated by re-prioritising resources in other areas.

Direct treatment costs were close to budget with the unfavourable variance of \$300,000 being largely volume related, offset to some extent by lower than expected demand for Haemophilia blood products.

Performance to the other Ministry of Health targets has shown progressive improvement. The radiation therapy performance continues to be outstanding with

100% compliance for the last 522 days. Acute patient flow management has been a focus in all departments, not just ED, with the Rugby World Cup creating some spikes but progress being evident from the improvement strategies. As noted above the spike in August referrals for cardiac surgery is being progressively reduced through outsourcing of 26 procedures in September and a focus on increasing internal volumes.

The net result at a surplus of \$2.3 million was unfavourable to budget by \$145,000 with the most significant variance relating to the outsourcing referred to above.

3.6 Primary care and community services

Locality Approach for Health Service Planning

In September 2010, the ADHB Community and Public Health Advisory Committee approved a paper outlining a locality approach to the planning and delivery of healthcare. Implementation is being piloted in the Maungakiekie-Tamaki and Puketapapa localities. The process began with a qualitative and quantitative health needs assessment to ascertain health needs and priorities in the target community. Following analysis of feedback from participants, priorities for action are being established in partnership with the community through a Locality Health Plan.

Qualitative data collected to date highlights the main health issues relate to low incomes and poverty. This reflects health problems arising from issues related to food security, housing, overcrowding and inadequately heated and insulated homes. The work has established the foundation for development of the locality approach with the two pilot communities, and the qualitative work on health needs and priorities has provided the basis for developing health improvement strategies. The design of the pilot has also assisted Waitemata DHB with their plans to complete a pilot study with Whau.

Auckland Council – Draft Auckland Plan Submission

The Auckland Plan was released for public consultation on 20 September 2011. The Plan contains information that will help the DHBs plan for future healthcare facilities and service delivery.

The Plan has an increased focus on issues that impact on health outcomes compared to the Discussion Document. This is particularly noticeable in areas such as children and young people, living standards, housing quality and affordability, public transport and environment. A submission on the Draft Annual Plan is being finalised.

Oral Health

Waitemata and Auckland DHBs, together with the Northern DHB Support Agency (NDSA) administer the contracts with the Waitemata and Auckland district adolescent oral health providers. Counties Manukau DHB in conjunction with the NDSA manages and administers the contracts with adolescent oral health providers in their DHB area. Any child requiring treatment outside the scope of the School Dental Service or adolescent services, including the use of a general anaesthetic or sedation, is referred to services at Greenlane Hospital.

Auckland DHB has responsibility for implementing its Business Case which addresses the six action areas through new or refurbished facilities, an updated model of care and strategies to address workforce recruitment and retention. The plan phases the development of new child and adolescent oral health facilities over three years, and service delivery improvements over five years.

For pre-school children, improvements are supported through building relationships with Well-child providers to increase early enrolment and referrals to the service from other providers. This targeted early intervention enables children with high clinical needs to be referred at an early age and is showing a significant increase in new enrolments in the 0-4 age group. This is being achieved using three pre-school coordinators supported by a dental therapist.

The implementation of the Oral Health Business Case is on track overall and has seen significant progress in the recent quarter particularly regarding the development of facilities with six new facilities operational, four under construction and the remaining four in the planning stage. Four new mobiles are in commission and two more join the fleet in the second quarter of 2012.

Mental Health Information Paper

Over the past 20 years, Auckland and Waitemata DHBs have developed residential rehabilitation provision across the two districts. Waitemata DHB currently funds 10 providers to provide 155 beds in the community at a cost of just over \$6 million per annum. Auckland DHB funds nine providers to deliver 203 beds in the community at a cost of just over \$11 million per annum.

Following a recent review of community support and residential service provision, Waitemata and Auckland DHBs have agreed to move from a model based on number and level of rehabilitation beds to a support hours model of care. This will be implemented over the next nine months with the first providers for the change already identified and initial implementation meetings completed.

Community/Consumer Engagement

Auckland and Waitemata DHBs' Public Consultation and Engagement Policies refer to legislation that was repealed earlier this year. Aligning the Board's Policy with the new legislation presents an opportunity to consider other issues such as the Health Quality and Safety Commission's strengthening the consumer voice programme (expected October 2011), and the Ministry of Health's consultation guidelines to be released soon after.

Collaboration with Waitemata DHB has enabled development of a common consumer (i.e. patient and family) engagement programme to inform the process of updating policy and commenting on MOH draft guidelines.

GAIHN

The GAIHN Alliance Agreement has been signed by Auckland PHO, East Health and ProCare; the DHBs are yet to sign. Once all parties have signed, Sector Services will be instructed to prepare the PHO Variation and maximisation of Care Plus can begin. A transition plan for the Regional Annual Plan Projects to GAIHN has been

developed and is being implemented. Waitemata PHO has still not yet confirmed their partnership in GAIHN.

Concerns exist in relation to funding as GAIHN currently only has sufficient funds to sustain it until 30 November assuming current outstanding invoices are paid. A funding proposal has been prepared for \$475K from Waitemata DHB and \$310K from ADHB. The primary care team are working with GAIHN management to ensure there is no duplication of work, and assessing the financials and contingencies in the event a partner withdraws.

National Hauora Coalition (NHC)

The Alliance Agreement has been signed by all five of the DHB partners, pending receipt of the year two implementation plan from the NHC. The NHC reporting will be tailored to meet the needs of Host and Partner DHBs based on proposed changes to the DHB Operating Policy Framework. The DHBs have agreed to pay the management fee savings to NHC in two parts, the first 50% will contribute towards transitional costs and the second portion will be paid on an agreed plan of local activities.

Alliance Health + (AH+)

Regular monthly meetings are scheduled between Alliance Health +, CMDHB and Auckland DHB, and meetings are taking place to manage the transition plan. This has highlighted the need for more resources to support the AH+ business case and a decision will be made soon. Recruitment of the new Clinical Director was due to be completed by mid September but is still underway.

AH+ are reconciling BSMC and Whanau Ora strategies and activities to avoid duplication, and this is likely to require changes to the current infrastructure which are reflected in the second year of the implementation plan.

There has been an active programme of work with providers to refurbish facilities and transition services with examples including:

- Planning for BSMC and Whanau Ora integration.
- Transition of Southseas operations into Enhanced GP/Community Health services in Otara
- Refurbishment of facilities at the Mt Wellington Integrated Family Health Centre.
- Opening of the East Bays Nurse led clinic with a short term initiative to follow up on CVR High risk patients.
- Funding Mangere Family Doctors to run a cervical smear campaign with after hours contacts.
- Funding from TPK to run navigation services for 46 families over the next six months.

Minor Skin Surgery – Skin Lesions

The results of the GP opinion survey have been finalised and circulated. The results were positive and the suggestions made will be considered by the Reference Group in November. 43 patient satisfaction surveys were returned and this feedback was also positive.

A review of the current price paid to the contracted GPs has been undertaken, that has indicated the need for a modest increase in the price paid to the GPs. The level of the increase and timing is being considered. The matter will be discussed again when the Chairs of the Reference Group and Clinical Governance meet at the end of October.

Volume levels were slightly below target at 31 August, with 146 of the 200 target volumes having been achieved. The referral numbers vary between months and it is expected that numbers will increase as the scheme becomes better known and confidence in the system continues to increase.

Measles Outbreak

There has been an increase in the number of measles cases with over 200 cases confirmed and 30 hospitalisations, three of whom required intensive care.

ADHB will spend \$500-850,000 (\$1.5- 2.5 million for the region) of unbudgeted expenditure on a primary care led measles vaccination campaign in response to the increasing community carriage of this serious and highly contagious disease. Only the Auckland region is affected at this time and a regional response has been discussed and agreed with ARPHS and the MOH.

The campaign will see everyone born after 1969 offered MMR vaccination if they have not yet received 2 doses and children under 4 years having their scheduled vaccinations earlier. This requires one additional round of vaccines for the child cohort. This will be supported by community messaging and active primary care recall of enrolled patients.

Frontline DHB healthcare staff are being encouraged to ensure their own immunity through vaccination. This message has also been communicated to primary care practices.

The November Audit and Finance Committee will be requested to formalise the expenditure. Other planned expenditure will be reprioritised to cover the cost, as there is no additional funding from the MOH.

B4 School Check programme

National data supplied by the MOH on DHB B4SC programme performance in August showed ADHB as on the target year to date and the best performer of the eight largest DHBs. This is a significant improvement on performance in 2010/11. Agreement has now been reached with Plunket to become an additional provider of Checks and performance is expected to improve further once they begin undertaking Checks.

Rheumatic Fever

Rheumatic Fever rates in the Auckland area have increased significantly in recent years with Maori and Pacific children disproportionately affected. The Auckland area had 64% of patients with Rheumatic Fever in 2009. As of July 2011 there were 1,100 'active patients' across Auckland with the majority in the Counties Manukau area. However ADHB has a number of 'hot spots' with high numbers of children diagnosed with the disease, mainly in the Glen Innes / Tamaki area.

Budget 2011 allocated \$12 million over four years for a Rheumatic Fever elimination programme (\$8 million for sore throat programmes in targeted schools and \$4 million for health promotion activities and general practitioner training). The funding for sore throat swabbing in schools has now been allocated with Counties Manukau receiving approximately 30% of the available funds and Auckland DHB none. Information about the funding allocation method is being sought.

Maternity Service Specifications

The Ministry of Health has published revised draft maternity service specifications. Both ADHB and Counties Manukau DHB had concerns regarding a proposed change to the definition of post natal care for DHBs whose systems depend upon transfer of women and babies to a primary maternity facility for post natal care. The Ministry of Health acknowledged these concerns and agreed changes that have enabled ADHB and Counties Manukau DHB to endorse the draft specifications.

Health of Older People-Residential care

During the month it was announced that Seaside Sanctuary on Waiheke Island will close. This has been met with concern from (some) families, as well as interest from the community, media and politicians. The closure is being managed, and potentially presents opportunities for a small number of clients to take advantage of the new flexible funding arrangement introduced through the HBSS project, either at home or in small group home situations.

The provider is being supported by ADHB to manage media and political issues. A further community meeting with stakeholders is scheduled for next Tuesday, and will focus on looking for a sustainable solution for the provision of aged care in the future.

Health Service Groups

Planning processes for the Health Service Groups (HSGs) is under way. To date, cardiology and cancer have run planning sessions to develop health improvement plans. These longer-term plans lay the foundation for annual objectives and ensure that the newly formed HSGs are focused on activity across the continuum. These Plans will evolve over time as more health needs assessment data is considered. The planning process includes assessment of the areas where HSG activities intersect.

3.7 Maori Health

The broad range of activities related to Maori health gain covers primary care initiatives, Maori health plans, child health, Whanau ora, mental health, iwi relationships and Tikanga. The strong focus on primary care includes:

- Implementation of Better, Sooner, More Convenient (BSMC)
- The three business cases
- Whanau Ora
- Regional projects to improve primary/ secondary system efficiency.

Some of these areas have already been covered earlier in this report and the dialogue below provides further insight from a Maori Health perspective.

Business Cases

The GAIHN Alliance Agreement is facilitated by the Transition Plan for the Regional Annual Plan Projects to GAIHN which is being implemented. The Maori Health teams from Auckland DHB and Waitemata DHB are providing advice to GAIHN with regard to strategies for reducing inequalities and improving Maori Health gain and addressing their relationship with manawhenua.

A similar level of involvement has been achieved with the National Hauora Coalition (NHC) where Maori staff from He Kamaka Oranga at Auckland DHB have been seconded to the NHC to provide much needed expertise and support, especially in relation to the process of putting a Transition Plan in place. A first draft has been circulated, but has yet to be agreed.

The third business case for Alliance Health + is also progressing well and as previously reported the key focus is to reconcile both BSMC and Whanau Ora strategies and activities to avoid duplication and ensure that the current infrastructure evolves appropriately.

Maori Health Plans

A joint Maori health plan has been developed to consolidate the Auckland and Waitemata Maori health plans for 2011/12, align activities where appropriate, and provide a sustainable platform for Maori health Gain strategy development.

Comparisons of commonalities and differences between populations are key to setting priorities and identifying the most effective joint activities to undertake. Where significant work has already commenced and is being led by one DHB team, the approach is being shared, discussed and monitored for future transferability to the other DHB population. This joint approach maximises the use of resources across both DHBs.

Child Health

A regional youth training initiative that offers youth specific primary care training to raise the standard of care offered to young people in Auckland, Waitemata and Counties Manukau DHBs has begun. The training is CME approved and includes a manual which is designed to be used in general practice and training which is

designed to be delivered in three distinct workshop sessions approximately three hours each. One is designed for PHO managers (those in non-clinical roles), one for doctors and nurses in general practice and one for practice receptionists. This training is being delivered by Dr Sue Bagshaw and is being co-ordinated through the ADHB and Waitemata DHB Maori health teams.

Oral Health

In support of the wider DHB initiatives already reported both Auckland and Waitemata DHB Maori Health Teams are developing a strategy to improve access for Maori 0-4year olds. This will focus on;

- Increasing enrolment and examination of Maori preschool children
- Increasing health education to whanau
- Active follow up of non attendance
- Ensuring a focus on hard to reach

A decision paper will be submitted to the January Maori Health Gain Advisory Committee meeting.

Whanau Ora

A whanau ora conference was held for all the collectives of the TPK whanau ora Programme of Action (POA). These POA showcased the various models that they were developing, identified and discussed the key challenges and shared key learning's to date. Participation in the assessment of the POA has included all three metro DHBs

Mental Health

The plan sets out and reaffirms a vision for effective mental health and addiction services in the region, covering both Kaupapa Maori services (ie; by Maori for Maori) and all other mental health and addictions services that are likely to be accessed by Maori. The plan provides an overarching framework that seeks to improve outcomes for tangata whai ite ora and their whanau and aims to achieve equity between tangata whai ite ora and others accessing mental health services. It recognises that many tangata whai ite ora access general services and endorses the need for these services to be responsive to the needs of Maori and their whanau. The plan is going to RFF for final sign-off in October.

Iwi Relationships

Support is being provided to Te Kahupokere to assist in the enactment of the MOU relationship with TRoNW. This support includes information sharing, strategic advice and input into DAP and MHP objectives and exploring sustainability options.

The ongoing financial sustainability of the TRoNW – Te Kahupokere office is a concern, particularly with respect to maintaining TRoNW engagement in ADHB and Waitemata DHB strategic activities. Both ADHB and Waitemata DHB are working with iwi partners to facilitate the development of a business case for consideration by both boards by the end of the financial year.

Tikanga

The Boards of ADHB, Waitemata DHB and TRoNW have endorsed the establishment of a Chief Advisor Tikanga (CAT) across both the ADHB and Waitemata DHBs. The purpose of the role is to lead and support the DHBs to fulfil their obligations and responsibilities under the Treaty of Waitangi (and in accordance with the NZH&D Act). This will include providing advice across all levels of the DHB to guide service planning, development and delivery.

A report on Tikanga and its application within the ADHB was commissioned by He Kamaka Oranga with the purpose of documenting the application of tikanga and the role of the CAT in the ADHB. The report recommends the development of an ADHB and Waitemata DHB Tikanga Strategic Plan (discussed at the Maori Health Gain Advisory Committee October meeting)

3.8 Pacific Health

Pacific Health collaborates closely with Maori Health, and whilst many of the issues are common to both groups the approach with Pacific peoples and communities can be, and is very different. In addition to that collaboration the Pacific Health team continues to undertake additional initiatives with the Healthy Village Action Zone. This programme involves the Pacific churches and communities with PHO Parish Community Nurses and Community health workers. Over 62 churches are involved with health screening, education, and increased collaboration with GP's, agencies and NGO's ensuring referrals and follow-ups. Four Self Management Education courses have been delivered to 4 separate churches and evaluation of the programme has been provided to the HVAZ Steering Group.

The team are also delivering Pacific Best Practice Education workshops to clinical staff within ADHB. There has been a positive response on the impact this has generated on practice.

The New Grad recruitment process has also commenced which prioritises Maori and Pacific new graduates. Interviews are currently in progress.

The Pacific smoking cessation programme contract has continued. This supplements the internal DHB programme and targets community interaction.

3.9 Intersectoral relationships

The ability of the health sector to achieve health gain on its own is limited in many areas where the determinants of health are social in nature. The health sector therefore works with other sectors such as housing, income support, welfare and education in order to achieve its goals. Each month this part of the report focuses on topical intersectoral initiatives and projects.

It is often difficult to directly influence outcomes due to the absence of direct authority over the processes and the lack of aligned strategic goals. As a result the best outcomes are often achieved through consultation, informal partnerships and working relationships and exchange of information. Good examples are the ADHB Immunisation Governance Group which has members from a wide range of other sectors, primary care and community organisations, and the initiative related to

homeless people where the targets are clear and the action plan has a wide base of support from the various agencies involved.

The special focus in this month's report is on the ADHB Localities work. This is a Planning and Funding Project that aims to create the 'conditions in which families/whanau can take greater control over their lives and maximize their health'.

Localities are defined using the Auckland Council Local Board areas. They include all people usually resident in that Board area. A defining characteristic of the locality approach is its emphasis on intersectoral collaboration. This has included seeking partnerships with government and non-governmental agencies which have an influence on health and its wider determinants.

A focus of the work has included the development of collaborative projects to undertake research with communities. This includes a partnership with Ka Mau Te Wero, a community non-government organisation and Auckland University of Technology (AUT) to undertake a community action research project in Tamaki. The research covers an exploration of all aspects of health and wellbeing.

We are also collaborating on a second AUT supported research project being led by the Parnell Trust. This project is in response to a growing recognition that the demographic profile of the CBD is changing, including a growing number of young families. The research project is seeking to explore 'community connectedness' within the CBD. Feeling connected within local communities and knowing neighbours are important factors in promoting and protecting health.




The Localities approach is also facilitating greater collaboration with agencies such as Ministry of Social Development (MSD) and the Department of Internal Affairs (DIA). Both these organisations are developing initiatives in the Mt Roskill area and ADHB is represented at a DIA convened group designed to support the project and the greater alignment of community development activity.

4 Board performance priorities

The Board has set 10 priority areas. These have been mapped to the Regional and DAP goals and the key result areas specified by the MoH as follows:

Regional goal	Auckland DHB Goal	Auckland DHB Key Result Areas	Board Priorities
Improved population health	Lift the health of people living in the ADHB area	Improved health status	Chronic disease management Health of older people
Improved patient experience	Performance improvement	Better quality care Increased patient safety Staff engagement	New models of care Emergency care Elective surgery Shorter waiting times for cancer treatment Clinical leadership Culture
Cost and productivity management	Live within our means	Economic sustainability	Regionalisation through collaboration Living within our means

Progress in each area is summarised in this report under three headings:

- Scope of the work programme
 - Current status
 - Expected outcome for the year
- Proceeding to plan 
 Issues being addressed 
 Target unlikely to be met 


























The information set out on the following pages summarises the projects that support the Board's priorities and identifies the current phase and status of each project. The table below summarises the status of those projects and provides a summary of progress by comparing the position with last month. A negative figure in the last column therefore indicates the number of projects that have moved beyond that phase.

The reduction in the number of projects reflects continued refinement of the project allocations and amalgamation of related projects wherever possible when work commences.

Projects	This Month	Last Month	Change
Not yet Started	0	0	0
Planning	69	77	-8
Implementation	7	3	4
Cancelled	0	0	0
Completed	0	0	0
Total	76	80	-4

Priority Status

Board Priority		Description			
1	Emergency Care	95% of patients are admitted, discharged or transferred from adult and children's EDs within 6 hours			
		<p>92% of patients admitted, discharged or transferred from Adult Emergency Department within six hours in September. Acute flow has been impacted by spikes in ED presentations (high presentation and admission days impacting ED response times) and high hospital occupancy (reducing the ability to move patients from ED in a timely manner).</p> <p>Adult HSG immediate action plan deployed in response to capacity and flow constraints and to support services 'get back on track'. This involves increasing leadership support to reduce barriers and ensuring adherence by teams to improvement solutions introduced.</p> <p>Further work is required to ensure consistent and timely escalation response both from within operational teams and the Emergency Department. Acute and elective bed capacity modeling to understand bed requirements to meet POP and acute demand underway.</p>			
Projects		Phase	On Time	On Budget	Expected Outcome
1044 - Implement primary care initiatives to reduce acute hospital presentations that could have been prevented with earlier intervention		Define			
1046 - Streamline and improve the process of referral to inpatient specialties and admission to the inpatient ward or discharge		Define			
1047 - Reduce inpatient length of stay		Improve			
1045 - Streamline Emergency Department processes to reduce the time to be seen in the Emergency Department		Define			
2	Elective Surgery	Achieve the number of elective procedures specified in the DAP			
		<p>Quarter1 production 100% of the health target. The services continue to review their production planning in order to maintain compliance. Services have scheduled some volumes into Q2 and Q3 for increased lists and outsourcing. The project activities in support of this priority are all proceeding to plan.</p>			
Projects		Phase	On Time	On Budget	Expected Outcome
978 - Increase surgical and inpatient bed capacity		Define			
981 - Improve outpatient efficiency and patient experience		Define			
983 - Implementation of Production Planning by service area		Define			

980 - Improve Pre Admission Process		Define			
982 - Reduce waiting time for patients for First Specialist Assessment and Elective Surgery		Define			
1058 - Implement the productive operating theatre programme/lean improvement programmes (TPOR)		Define			
3	Shorter waits for cancer treatment	Radiation treatment within four weeks of first specialist assessment and medical oncology within agreed DAP timelines			
	In September 100% of eligible patients were treated within the four week target timeline. As at 30 September the service has delivered to target for 522 days. MV6 is currently being replaced and is on target to be commissioned by the end of November. A programme to introduce new technologies (e.g. V-Mat & IMRT) to further reduce treatment times is now well established in the department.				
Projects		Phase	On Time	On Budget	Expected Outcome
1043 - Establish a service delivery model aligned with the recommendations outlined in the Radiation Therapy Strategic Plan		Define			
4	Health of Older People	Integrate and streamline services, one point of entry to specialists, specialised inpatient areas for stroke, dementia and delirium, co-ordination of discharge planning, improve respite care and ensure effective outreach programmes (primary and community)			
	The Regional Clinical Network has been established and is holding its first meeting in October. The network includes a wide range of stakeholders and provides the forum for considering the work programme of the various projects. The key focus is on ensuring a commonality of thinking to avoid duplication and unnecessary variation in services between districts. This will improve the mobility of service users within the region.				
Projects		Phase	On Time	On Budget	Expected Outcome
1020 - Review specialist support to Aged Residential Care		Define			
1015 - Establishment of the Regional Clinical Network		Define			
1019 - Implement pathways for Older People with Cognitive Decline		Define			
1018 - Review and evaluate capacity for respite care		Define			
1021 - Scope workforce shortages		Define			
1017 - Review rates of access to Aged Residential Care by age across the region		Define			
1016 - Services closer to home that are more flexible and responsive		Define			
5	Clinical Leadership	Leadership from bedside to boardroom, clinicians involved in all strategic and operational decisions, leadership development for clinicians and development, management and monitoring of clinical networks			
	The Clinical Leadership Group now carries out the functions previously undertaken by the Clinical Board and the appointment of				

	<p>the Clinical Leaders in each HSG is substantially complete. There have also been developments in specific service areas such as the current recruitment activity for network leaders in Radiology, OPH and Diabetes. These networks are current gathering data with diabetes and cardiac working together to secure practice and patient level information. All networks have a multidisciplinary and whole of sector focus.</p> <p>The Clinical Education and Training Unit (CETU) is undertaking a stock take of current leadership training opportunities. A workshop has been convened to discuss how CETU can support the maintenance and development of the CANMED professional competencies (including leadership) as well as medical expert competencies. It is anticipated that any training opportunities that arise will be suitable for other clinicians.</p>			
Projects	Phase	On Time	On Budget	Expected Outcome
1102 - Develop a talent identification and development programme for future clinical leaders	Define	●	●	●
1100 - Support the development of, and provide leadership to, implement regional/national multidisciplinary clinical networks, inclusive of whole of sector participation	Control	●	●	●
1099 - Develop and implement a comprehensive leadership programme for clinical leaders and senior managers	Define	▲	●	▲
1101 - Develop and implement Auckland DHB Leadership Framework	Measure	●	●	●
1098 - Continue to implement the clinical leadership model for level 2 and 3	Improve	●	●	●
6 Culture	Professionalism, clinical excellence coupled with patient service and improved communication with patients			
●	<p>The development of the new approach to risk identification, analysis, mitigation and management is well advanced and under review by the senior management team – planned roll out will follow this review and discussion with the Board. The implementation will contribute to the first of the projects below. The community engagement projects are all at an early stage of development but are supported by supported other initiatives such as the Reo Ora - Health Voice process reported last moth which can be accessed at http://www.healthvoice.org.nz . Internal culture is also supported through the new HSG structure which engages each health group in every aspects of funding and service delivery for a given population group.</p>			
Projects	Phase	On Time	On Budget	Expected Outcome
1053 - Improve Risk Mitigation Management and Root Cause Analysis	Define	●	●	●
1055 - Improve Feedback Process	Define	●	●	●
1054 - Establish an integrated complaints framework	Define	●	●	●
1051 - Continue to implement our consumer and community engagement framework	Define	●	●	●
1052 - Bereavement management framework is developed and implemented	Define	●	●	●
1050 - Introduce a staff engagement survey tool	Define	●	●	●

1048 - Develop a culture of patient safety, open disclosure, timely and empathetic communication	Define			
1049 - Develop our clinical leaders and managers to be more effective at developing culture and taking action within our management operating system	Define			
7 New Models of Care	New models of care for fast stream elective surgery, readmission prevention, Whanau Ora, health promotion, children and young persons and older people			
	The primary care work streams continue to develop well with initiatives such as minor skin lesions gaining good referrer and patient feedback in recent surveys. The projects below continue this work with longer term strategies to change and enhance both settings and the delivery of care to improve its effectiveness – they are however at the planning stage and as such there are no outcomes to report at this point. Other initiatives that have been in play for some time are providing solid gains such as the continuation of the building programme for school dental clinics and the Alliance Health + work to extend service access and configuration as well as refurbish facilities.			
Projects	Phase	On Time	On Budget	Expected Outcome
1072 - New model of care to integrate kidney disease prevention, early intervention, and chronic kidney disease management services	Define			
1071 - Renal Services will work in partnership with primary care to design, devolve, and deliver Adult Haemodialysis (AH) for patients who are unable to home dialyse	Define			
1064 - Scope low secure rehabilitation service for high and complex needs	Define			
1069 - Establish a regional mechanism to strengthen the delivery capacity of palliative care providers	Define			
1062 - Increase awareness of mental health services	Define			
1057 - Increase the number of wards in Adults, Children's, Cancer, Cardiothoracic and Mental Health services using Releasing Time to Care	Define			
1068 - Continue regional bowel tumour stream development and service improvement in care pathways	Analyse			
1066 - Implement medical oncology service improvements	Define			
1063 - Increase responsiveness to those with a coexisting problem (CEP)	Define			
1070 - Participate in the establishment of a Haematology Clinical network	Measure			
1067 - Continue regional lung tumour stream development and service improvement in care pathways	Improve			
1061 - Develop new mental health services for as an alternative to admission service young people, adults, older adults and Maori	Define			
1058 - Implement the productive operating theatre programme/lean improvement programmes (TPOR)	Define			
1059 - Performance improvement actions focused on- radiology, cardiac surgery, research, general medicine, general surgery, adult ED, operating rooms	Define			

1075 - Improve the outcomes for people with COPD		Analyse			
1073 - Agree the principles which will inform a new service design for rehabilitation services		Define			
8	Chronic disease management	Better assessment of cardiovascular risk, enhanced treatment for heart disease and diabetes, reduced waiting times for elective cardiac surgery and clinical pathways to be across the care continuum			
	<p>Progress has been maintained for the diabetes annual review with a cumulative achievement of 56%. Whilst this is 4% short of the target, the monthly improvement gives a good indication that performance is tracking towards achieving the target. We have passed the target for good diabetes management for Maori and Other and are 2% down cumulatively on the overall target at 75%. The CVD risk assessment data has not been released yet but work with PHOs and the CVD risk and management electronic tool shows an increase in assessments in the last month which is encouraging.</p> <p>There are a number of projects noted below and these are contributing towards improving performance. An example is the work the LTC coordinators are undertaking with primary care to check and validate their diabetes registry against the MoH data. This will enable a more accurate understanding the true diabetic population and as such promote improved proactive planning of care. The self management work continues for Diabetes and for generic LTC and forms the focus for work in the coming quarter. The diabetes retinal screening project is gaining momentum and with the addition of the community delivery will expand capacity significantly. The regional approach has had timing impacts on the DHB processes but the gains from a regional approach outweigh this.</p>				
Projects		Phase	On Time	On Budget	Expected Outcome
995 - Strengthen self management via links to wider lifestyle activities e.g. green prescription		Define			
990 - Report on care planning for people screened who either have diabetes or a risk assessment >15%		Define			
994 - Develop core competencies for diabetes self management courses with supported self-management specifically for Maori and other high needs groups		Control			
991 - Quality improvement coordinators support primary care to identify people who are diabetic and have not received their review (pg 41 AP)		Define			
992 - Implement a community retinal screening service		Control			
996 - Boost workforce development for self-management skill development (p. 42 AP)		Define			
989 - Evaluate 2 community-based cardiac rehabilitation programmes		Define			
993 - Raise PHO awareness re Diabetes Get Checked programme for diabetic patients -- practices encouraged to keep Get Checked in high awareness		Define			
9	Regionalisation through Collaboration	Collaboration as an overriding principle undertaken with studious intent and with a special focus on Waitemata DHB			
	healthAlliance is undertaking its programme of development work having completed the transition programme. Other areas of this				

	report have commented extensively on regional collaboration as most significant initiatives are coordinated between ADHB, WDHB and CMDHB with nominated responsibilities to avoid duplication. The integration of teams and development of common population and provider strategies is gaining good traction despite the early stage at which many of the projects are situated.			
Projects	Phase	On Time	On Budget	Expected Outcome
1129 - The stronger bilateral opportunity offered by a shared chair and Maori board membership will allow us to optimise service planning and delivery across our two organisations	Define	●	●	●
1128 - Reduce back-office costs through standardisation and consolidation of systems and processes in the regional entity	Define	●	●	●
1125 - First Do No Harm: Regional work to improve patient safety	Define	●	●	●
10 Living within our Means	Financial deficits are not acceptable under any circumstances			
●	<p>Performance for the month and first quarter was satisfactory with a positive variance to budget and a full report is included in the Audit & Finance Committee papers.</p> <p>The benefits of the projects set out below have yet to be felt as the majority of the project work is at the planning stage. Careful management on a BAU basis has kept the overall result for ADHB at better than breakeven. The key focus areas are the management of FTEs which are 13U to date and the control of volumes both in terms of avoiding over- production but also utilising facilities to capacity to limit the level of outsourcing required to hit targets.</p> <p>The two projects showing orange flags are managing issues through mitigation strategies and no project is showing a red flag.</p>			
Projects	Phase	On Time	On Budget	Expected Outcome
1116 - Strengthen collaboration within and outside the organisation	Define	●	●	●
1118 - Non Clinical: Implement new Health Alliance organisation	Analyse	●	●	●
1109 - Managing Administration and Management staff numbers within the cap	Define	●	●	●
1117 - Clinical: Review service models for cancer and cardiac and integrate with private sector	Define	●	●	●
1114 - Utilisation of new and existing clinical supplies monitored for clinical effectiveness	Define	●	●	●
1115 - Leverage national and local procurement for clinical supplies	Define	●	●	●

1112 - Deliver productivity and quality gains by HSG	Define	●	●	●
1120 - Waitemata and Auckland DHBs integrate services where there is service quality and cost opportunities	Define	●	●	●
1110 - Manage and review impact of MECA Settlements	Define	●	●	●
1108 - Disciplined management of FTE numbers, annual leave, sick leave and CME	Define	●	●	●
1119 - National contracts to transfer to NHB	Define	●	●	●
1104 - Elective volume and funding: Implementing a patient and operations planning process to ensure early visibility of variances to plan and corrective action	Improve	●	●	●
1106 - Disciplined volume and funding risk management for IDFs. Continue IDF relationship management process with key IDF customers	Define	●	▲	●
1103 - Disciplined volume and funding risk management for the Auckland DHB Population	Define	●	●	●
1105 - Acute volumes: Manage volume and cost risk through productivity improvement and BSMC initiatives	Define	●	●	●
1122 - Ensure BSMC + 3 Business cases deliver improved processes and realise the planned benefit from defined projects	Define	●	●	●
1124 - Oral Health capital expenditure programme within budget	Define	●	●	●
1121 - Manage contracts within budget , with particular focus on Community Pharmacy, Laboratories, Rest homes	Define	●	●	●
1123 - NHB new payment system eliminates transaction error	Define	●	▲	▲

 Clinical Practice Committee

Annual Report

Year ending June 2011

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Executive summary

There is reason to believe that the CPC remains in good heart. Members, all of whom are busy clinicians, manage to find the time to attend meetings; analysis is increasingly sophisticated; discussion is robust and occasionally loud; and committee decisions are generally accepted by the hospital managers with approbation. The submissions are of increasing quality, in large part due to the carefully orchestrated 'pre-meetings' that Caroline McAleese schedules before the submission evaluation meeting itself. Many wrinkles get ironed out this way, increasing the likelihood that the committee members will be able to deliver a consensus score and vigorous opinion about the best way forward. Some of the submissions reviewed have had national import and I think this has added a degree of seriousness to our deliberations – we are committed to objectivity that seeks to avoid the excesses of over-enthusiasm for innovation and the cynicism that can't wait for the wheels to fall off. We have been heartened to see our recommendations taken equally seriously by decision-makers further up the health food chain.

I think we are beginning to recognize the limitations of a hospital-based health technology assessment (HTA) committee when it comes to cost-utility analysis. We get submissions related to technologies that alter surrogate markers of improved health (blood pressure, for example) but that, within the time frame of high quality comparative trials, alter neither morbidity nor mortality substantively. The health benefits and potential cost-savings from such interventions are not simple to determine. There are times when we have clearly reached the limits of our expertise and experience and should be utilizing such experts as health economists, epidemiologists, and/or cost-effectiveness analysts. We watch with interest the entities now charged with performing on a national scale what we have been doing, for the most part, locally. These national entities, the National Health Committee and PHARMAC, will be dealing with new non-drug technologies and will render opinions and even procurement options on a national scale. We see this as a promising development. If the resources are accurately apportioned, these entities will be able to undertake more comprehensive analysis than is currently possible for us. We certainly hope for synergies in HTA because of these developments.

I'm increasingly impressed with the expertise and skills of CPC committee members and, as we approach our **100th meeting**, I'd like to thank all past and present members for their contributions. I owe special thanks to Stephen Streat, deputy chairperson, who has had to shoulder a significant portion of the workload during my not-infrequent absences and to Caroline McAleese, our manager and librarian, who keeps us all to very short accounts. The CPC is only as good as its ability to influence decision-making and, in this regard, we have always had an excellent overseer in Dr Margaret Wilsher, firstly in her role as Deputy Chief Medical Officer and now as Chief Medical Officer at ADHB. Review shows that the scores provided by the CPC seem to impact decisions about the implementation for new health technologies. While this happy state of affairs continues we are content to continue and, if appropriate, expand this work.

Stephen Munn, Chairperson, CPC, September 2011.

CPC membership

Original CPC members that remain June 2011

Name	Served to date	Submissions reviewed by end of June 2011
Stephen Munn (Chair)	6 years	14
Stephen Streat (Deputy Chair)	6 years	9
John Beca	6 years	10
Lochie Teague	6 years	9
Rhondda Paice	6 years	5
Sarah Fitt	6 years	8

Other CPC members

Name	First Meeting	Last meeting	Served approx	Submissions reviewed by end of June 2011
Andrew Holden	26 th July 2005	8 th April 2008	3 years	3
Andrew Law	26 th July 2005	9 th May 2006	1 year	0
Denys Court	23 rd August 2005	8 th Dec 2009	4 years	4
Kirsten Finucane	26 th July 2005	12 th Dec 2006	18 months	1
Peter Alison	14 th Aug 2007	25 th Nov 2008	1 year	0
Richard Sullivan	26 th July 2005	11 th March 2008	3 years	4
Barry Snow	9 th Sep 2008	n/a	3 years	4
Emma Parry	9 th Feb 2010	n/a	1 year	1
George Laking	8 th April 2008	n/a	3 years	9
Louise Webster	26 th June 2007	n/a	4 years	6
Lucille Wilkinson	8 th August 2006	n/a	5 years	6
Nigel Robertson	9 th June 2009	n/a	2 years	2

Management

Name	Served to date	Submissions reviewed
Caroline McAleese (Manager)	6 years	n/a

Statistics year on year**2005/2006**

Meetings = 17

Submissions (new technologies) and other requests = **10**

NB. Includes 1 that was subsequently withdrawn

2006/2007

Meetings = 17

Submissions (new technologies) and other requests = **9**

2007/2008

Meetings = 16

Submissions (new technologies) and other requests = **11**

NB. Includes 3 that were subsequently withdrawn

2008/2009

Meetings = 17

Submissions (new technologies) and other requests = **10**

2009/2010

Meetings = 12

Submissions (new technologies) and other requests = **7**

2010/2011

Meetings = 15

Submissions (new technologies) and other requests = **9**

2005/2011 (6 Year totals)

Meetings = **94**

Submissions (new technologies) and other requests = **56**

Made up of:

- New technologies = **39**
- Other requests = **13**
- Withdrawn submissions = **4**

6 year summary July 2005 – June 2011

The new technologies assessed to date (in alphabetical order)

1. ABO incompatible (original submission) for renal disease (transplantation)
2. ABO incompatible (re-submission) for renal disease (transplantation)
3. Avastin (drug) for diabetic maculopathy
4. Avastin (drug) clinics for macular degeneration
5. Bariatric Surgery for morbid obesity
6. Basiliximab (drug) (original submission) for renal disease (transplantation)
7. Basiliximab (drug) (re-submission) for renal disease (transplantation)
8. DBS (Deep Brain Stimulation) for Parkinson's disease
9. Endoscopic Ultrasound (diagnostic) for gastrointestinal disease
10. Expanded Anti-D prophylaxis (MoH request)
11. Genome analysis using Array aCGH (diagnostic) for developmental delay
12. Home humidification for head & neck cancer
13. ICDs primary prevention for cardiac disease
14. Kidney Lifeport Transporter for renal disease (transplantation)
15. LVAD (left ventricular assist device) as a bridge to transplantation
16. Mass Spectrometry (diagnostic) for pregnancy (trisomy-21)
17. Minimally invasive mitral valve surgery
18. Modified enzyme test (diagnostic) for cardiac disease
19. MTOP (medical termination of pregnancy) in first trimester
20. NPWT/VAC for wounds with delayed healing
21. OCT (Optical Coherence Therapy) (diagnostic)
22. ORL laser for ORL benign tumours (original submission)
23. ORL laser for ORL benign tumours (re-submission)
24. PDT (photodynamic therapy) for unresectable cholangiocarcinomas
25. Percutaneous AVR (using CoreValve) for cardiac disease
26. Percutaneous PVR (using Melody) for cardiac disease
27. Pre-filled/labelled Midazolam syringes
28. RFA (radiofrequency ablation) using HALO for Barrett's oesophagus
29. RIC AlloSCT
30. Rituximab (drug) for systemic lupus erythematosus (SLE)
31. Safety iv (intravenous) devices
32. Screening programme for LQTS (Long QT Syndrome) (diagnostic)
33. SNS (sacral nerve stimulation) for faecal incontinence
34. SFLP (selective fetoscopic laser photocoagulation) for twin to twin syndrome (TTTS)
35. Transcatheter aortic valve insertion (TAVI) – high risk surgical candidates
36. Transcatheter aortic valve insertion (TAVI) – non-surgical candidates
37. Transient elastography using Fibroscan for liver disease
38. Vitamin C – high intravenous dose
39. VNS (Vagal Nerve Stimulation) for epilepsy

The “other” requests to date (in alphabetical order)

40. Clinical Microbiology & ID Services
41. CT PET selection criteria
42. HBOT (hyperbaric oxygen therapy)
43. Palliative care FTE
44. Prosthetic hip dislocation
45. Regional primary angioplasty service
46. Service interface
47. Surgical Smoke
48. Testing - Cytogenetic (diagnostic)
49. Testing for Cu, Zn and RBC Mg (diagnostic)
50. Testing for homocysteine, Lipoprotein(a), insulin and DHEAS (diagnostic)
51. Testing for vitamin D (diagnostic)
52. Trainee interns to house officers

Withdrawn submissions (in alphabetical order)

53. 3D Mapping (diagnostic) for cardiac disease
54. Multi disciplinary team for head & neck cancer
55. Palivizumab (drug) for respiratory disease (paed)
56. Rituximab (drug) for WG (Wegeners granulomatosis)

Scored submissions and status of each 2005 - 2011

Technology or request	Final score	ADHB response to CPC advice
SNS (sacral nerve stimulation)	115	Implemented
Bevacizumab (Avastin) for DME	100	Pending
SFLP (Selective Fetoscopic Laser Photocoagulation)	100	Implemented
RFA (radiofrequency ablation) using HALO	95	Pending
Basiliximab (drug) - re-submission	90	Implemented
Kidney LifePort transporter	60	Pending
Transient elastography using Fibroscan	60	Implemented
ABO incompatible - re-submission	57	Implemented
Avastin Clinics (drug)	45	Pending
Screening programme for LQTS	45	Pending
PDT (photodynamic therapy)	45	Pending
Primary angioplasty - regional service	45	Pending
TAVI (for non surgical candidates)	40	Implemented
ICDs primary prevention	40	Pending
Outpatient Laser - re-submission	40	Implemented
RIC (reduced intensity conditioning) alloSCT	30	Pending
ABO incompatible - original	30	Rejected
LVAD (left ventricular assist device) as a bridge	30	Pending
Bariatric Surgery	30	Implemented
Endoscopic Ultrasound (diagnostic)	30	Pending
Basiliximab (drug) - original	20	Rejected
VNS (Vagal Nerve Stimulation)	20	Rejected
PAVR (using CoreValve) - original submission	20	Rejected
NPWT/VAC	20	Pending
Expanded Anti-D Prophylaxis (drug)	15	Rejected
Pre-filled/labelled Midazolam syringes	15	Implemented
Percutaneous PVR (using Melody)	10	Rejected
Rituximab (drug)	10	Rejected
Home humidification	8	Rejected
Genome Analysis using Array aCGH (diagnostic)	5	Rejected
Vitamin c high dose intravenous	0	Rejected

1. High dose intravenous vitamin C in ICU patients

Applicant: Margaret Wilsher, CMO

Reviewers: Emma Parry and Lucille Wilkinson

Date presented to CPC: 6th September 2010

Question: the evidence of efficacy (or otherwise) of high dose vitamin C in the treatment of influenza and other critical illness

Background: Considerable media interest in high dose vitamin C

CPC assessment of the likely costs vs. outcomes: n/a

CPC assessment of the evidence: no available evidence to show that high dose Vitamin C therapy was either safe or effective (in terms of reducing mortality or morbidity).

CPC Score: 0

CPC recommendation: Due to possibility of renal toxicity from vitamin C therapy and lack of information about the safety profile of high dose intravenous therapy, it was recommended that such therapy only be delivered within the context of a clinical trial.

Result: No more cases of severe sepsis with family requests for vitamin C have emerged.

2. Regional Primary Angioplasty Service

Applicant: Mark Webster

Reviewers: Stephen Munn and George Laking

Date presented to CPC: 12th October 2010

Question: The submission included two scenarios –

1. Patients with chest pain continue to be taken to a hospital in their DHB of domicile. After a diagnosis of STEMI is made there and consultation with the Cardiologist on-call for PCI at ACH they are then transferred to ACH for PCI.
2. Patients with chest pain presenting to the St. John Ambulance Service have an immediate 12-lead ECG which is electronically transmitted to the Cardiologist on-call for PCI at ACH. If STEMI is confirmed, the patient is transported directly to ACH, bypassing the hospital in the DHB of domicile.

Background: At present, most patients in all three DHBs have access to emergency PCI during working hours, but only ADHB patients have such access after hours as well. Most WDHB and CMDHB patients with STEMI who present after-hours receive thrombolysis at their own hospital. Some of these (in particular including those who do not re-perfuse after thrombolysis) are transferred to ACH for 'rescue' PCI.

CPC assessment of the likely costs vs. outcomes: There would be no additional capital costs for PCI at ACH, but in either scenario there would be additional staff costs and potential loss of revenue to the ADHB from loss of in-hours interventional cardiology sessions.

In either scenario there would be additional costs, along with cost-savings (which would be greater with the second scenario) and perhaps also some revenue loss to WDHB and CMDHB.

In the second scenario there would be additional modest capital and running costs (which should be shared appropriately among the DHBs and the St. John Ambulance Service) associated with the necessary additional information and communications technology.

CPC assessment of the evidence: There is Level 1A evidence^{e.g.1} that in patients with STEMI, treatment with primary PCI (even with an hour or so of inter-hospital transport delay) improves patient survival (probably by 2 – 3% absolute^{2,3}) compared to treatment with thrombolysis. There is strong Level III evidence^{e.g.4} that delay to reperfusion is associated with increased mortality, both short-term⁴ and long-term³. The extent of this increased mortality is probably ~1% per 30 minutes of delay⁴. There is Level III evidence that pre-hospital STEMI

diagnosis is associated with a reduction in the time between symptoms and reperfusion by PCI of around an hour⁵.

CPC Score: 45, comprising 40 for – *Submission indicates that, for the diagnostic group in question, procedure costs will be increased but patients will likely experience significantly improved overall survival rates* and 5 for – *cost \$15,000-20,000 per QALY.*

CPC recommendation: that emergency PCI should be provided at Auckland City Hospital after hours for all patients in the greater Auckland region but only if the resultant financial loss to the ADHB from both additional costs and potential revenue loss is prevented. The CPC recommends, subject to funding being obtained for this, that within-ambulance diagnosis of STEMI (including electronic transmission of ECGs) should be established as soon as possible to maximise the clinical benefit from the emergency PCI service.

Result: Pending...

3. Surgical Smoke

Applicants: Leigh Anderson, Nurse Consultant (Level 8 Operating Rooms)

Reviewers: Nigel Robertson

Date presented to CPC: 26th October 2010

Question: n/a

Background: Usage of surgical smoke evacuation devices was inconsistent in ADHB and a number of nurses had expressed concerns about the work environment, especially given the strong organisational message about second-hand tobacco smoke

CPC assessment of the likely costs vs. outcomes: It was not possible to determine the benefit derived from the evacuation of surgical smoke as there were no long term studies that examined harm reduction in a prospective and comparative manner. The current cost to ADHB of purchasing disposable smoke evacuation devices is around \$50,000 per annum. If such devices were used in every surgical case, Dr Robertson estimated that the cost would rise to over \$800,000 per annum.

CPC assessment of the evidence: a single, large (n=86,747), high quality epidemiological study looking at the risk of lung cancer in operating room nurses which found no disease-specific increased risk. Outside expert opinion on this study, from an epidemiologist, had made it clear that while there was no major apparent effect of time in the operating room on the incidence of lung cancer over a 20 year period, a smaller, specific and deleterious effect of surgical smoke could not be excluded.

CPC Score: n/a

CPC recommendation: that the issue be taken firstly to the Director of Surgery at ADHB (Dr Ian Civil) and thereafter to each of the 3 operating room committees to see if an organisation wide policy could be determined by consensus. If a consensus policy could be agreed upon, this could be implemented, audited and policed by the ADHB Occupational Health and Safety service.

Result: New '[Surgical Smoke Management](#)' ADHB guideline published August 2011.

4. TAVI: non-surgical candidates

Applicants: Mark Webster

Reviewers: John Beca and George Laking

Date presented to CPC: 14th December 2011

Question: Should ADHB provide transcatheter aortic valve implantation (TAVI) to patients with severe, symptomatic AS who would **not** be considered as candidates for standard cardiac surgical aortic valve replacement (because of co-morbidities, age, technical factors and/or frailty)?

NB. A second question about high-risk patients was reviewed at this time but was re-evaluated in May 2011 following the publication of further evidence (see TAVI: high risk surgical candidates).

Background: This was a re-submission from 2008: Percutaneous Aortic Valve Replacement (PAVR) for high-risk **or** non-surgical candidates, having only achieved a score of 24 at that time.

CPC assessment of the likely costs vs. outcomes: considerable increase in per-patient treatment cost and the high estimated cost per quality adjusted life year (well in excess of \$20,000, when based on calculations from the RCT and local costing data).

CPC assessment of the evidence: The members of the CPC agreed that there was high level evidence of both safety and efficacy when deploying TAVI in this patient group. The evidence came from a recently published, well-designed, randomised controlled trial (RCT). The technology would offer reduced mortality and morbidity in comparison to balloon valvuloplasty or conservative treatment. Preliminary data was also presented to show that patient quality of life was improved in non-surgical candidates by TAVI.

CPC Score: 40

CPC recommendation: members of the CPC did not recommend implementation of TAVI in this patient group at this time. Should subsequent studies indicate a subgroup of non-surgical candidates for whom cost-utility data was more favourable then it was agreed that the recommendation could change.

Result: See below for high-risk surgical candidates.

5. Minimally invasive mitral valve surgery (MIMVS)

Applicants: Peter Allison and Parma Nand

Reviewers: Stephen Munn

Date presented to CPC: 22nd March 2011

Question: to determine the safety and effectiveness of this in comparison to standard therapy (mitral valve surgery via median sternotomy and standard cardiopulmonary bypass).

Background: 4 cases already done at ADHB, one of which was associated with a post-operative death. One of the specific issues arising from the departmental review was whether or not MIMVS was associated with an excess incidence of post-operative stroke when compared to standard surgical approach.

CPC assessment of the likely costs vs. outcomes:

CPC assessment of the evidence: Outcomes for MIMVS are as good as standard surgery. Bypass times are likely to be longer and hospital length of stay likely to be less with MIMVS. With the available medical literature it is reasonable to conclude that MIMVS is non-inferior from a safety and efficacy perspective. Specifically, published stroke rates in RCTs and propensity analyses are not increased by using MIMVS.

CPC Score: n/a

CPC recommendation: A number of publications commented on the learning curve associated with the implementation of MIMVS. Obviously every means should be used to avoid adverse outcomes during such a learning curve in ADHB and clinical unit consensus about a strategy to achieve this seems important.

There appears to be a pivotal role for clinical governance in obtaining consensus about such innovation and in developing strategies for dealing with implementation-related complications prior to the first case being done. The CPC will endeavour to develop clear tools and guidelines for Clinical Directors so that such episodes of discord are minimized.

Result: 3 further cases (a total of 7 cases) without major complication have been performed at the time of writing. Also, the New Clinical Practice Toolkit was subsequently developed by the CPC and is to be launched October 2011.

6. Vitamin D testing

Applicants: James Davidson and Steve Absalom

Reviewers: George Laking

Date presented to CPC: 12th April 2011

Question: Should the policy for pathologist approval be extended to include vitamin D testing?

Background: Increasing requests for the measurement of Vitamin D concentrations are unrelated to suspected bone disease but due to epidemiological data showing associations between various disease states (malignancy, infectious diseases, metabolic diseases etc) and lower Vitamin D concentrations. Causality has yet to be demonstrated.

CPC assessment of the likely costs vs. outcomes: n/a

CPC assessment of the evidence: Any effect of Vitamin D supplementation as a preventative treatment seemed to be minimal or non-existent (at least from the studies reported to date). There is therefore little data to suggest that there is significant utility in testing for Vitamin D concentrations.

CPC Score: n/a

CPC recommendation: the CPC supported the recommendations made by LabPlus to restrict blood Vitamin D concentration testing.

Result: Vitamin D testing restrictions are expected to be introduced in October 2011.

7. TAVI: high risk surgical candidates

Applicants: Mark Webster

Reviewers: John Beca and George Laking

Date presented to CPC: 10th May 2011

Question: Should ADHB provide transcatheter aortic valve implantation (TAVI) to patients with severe, symptomatic AS who would be candidates for standard cardiac surgical aortic valve replacement but who would have a **high risk** of perioperative mortality and/or morbidity (based on age, risk score, technical and other factors)?

Background: See TAVI: non-surgical candidates

CPC assessment of the likely costs vs. outcomes: Although it is possible that TAVI may be cost-saving over SAVR for some patients, it is not clear that such patients can be prospectively identified from within the 'high-risk' surgical group, or that this is true for all patients in that group.

CPC assessment of the evidence: The PARTNER 'Cohort A' trial was a non-inferiority RCT comparing TAVI (n=348) with SAVR (n=351) in patients with severe aortic stenosis (judged suitable for surgery (SAVR) but with high peri-operative risk) with a primary end-point of all-cause mortality at one year. This non-inferiority endpoint was reached with 84 deaths in the TAVI group and 89 in the SAVR group.

There were somewhat different procedural outcomes – more major vascular complications (11.0% vs. 3.2%, $p < 0.001$) and (non-significantly) more major stroke (5.1% vs. 2.4%, $p = 0.07$) with TAVI and more major bleeding (9.3% vs. 19.5% $p < 0.001$) and new-onset AF (8.6% vs. 16.0%, $p < 0.001$) with SAVR but other secondary functional outcomes (NYHA class and 6-minute walk distance) were not significantly different at one year.

Median ICU stay was longer (5.0 vs. 3.0 days) in the SAVR group (significance of these data not presented) but the use of renal replacement therapy for acute kidney injury was similar at 30 days (2.9% TAVI vs. 3.0% SAVR). Re-hospitalisation rates were also similar at one year (18.2% TAVI vs. 15.5% SAVR, $p = 0.38$).

No economic analysis or other surrogate measures of resource utilisation (e.g. length of index hospitalisation) were presented.

Of note, despite a predicted surgical AVR mortality of $\geq 15\%$ being a required inclusion criterion for the trial, 30-day mortality was only 6.3% (22/351) in patients randomized to SAVR and 5.4% (17/313) in those randomized to SAVR who

actually received that treatment.

CPC Score: n/a

CPC recommendation: The CPC recommends, before TAVI commences at ADHB, that the CMO should satisfy herself that

1. Parameter guidelines are available for review (that include measures of co-morbidity, cardiac surgical risk, frailty, age etc) that identify patients who are considered appropriate for SAVR but at 'high surgical risk' and that these have been agreed to by the cardiac surgeons and cardiologists involved in case selection. The cardiosurgical conference is the ideal forum to identify patients that are both candidates for surgery and are high risk.
2. Having identified such 'high-risk' patients, that a small multidisciplinary selection committee is constituted to determine for each patient whether SAVR or TAVI is the most suitable treatment option. The composition of this committee will need to reflect at least the principal clinical services with appropriate expertise – cardiac surgery, interventional cardiology and cardiac intensive care (including a cardiac anaesthesia perspective).
3. Measures to prevent 'eligibility creep' are in place. Such 'creep' could be either by declaring non-surgical candidates to be high-risk surgical candidates or by declaring moderate or low-risk surgical candidates to be high-risk. Clear documentation of patient selection processes should help to serve this goal.
4. That an audit process is in place to record patient selection criteria, processes and outcomes (including measures of resource use and total cost and revenue) for all patients assessed for TAVI (irrespective of subsequent treatment) by the above committee.
5. There is an understanding that the results of this audit will be reviewed by the CPC one year after implementation of TAVI.

Result: A multidisciplinary selection committee has been established with 11 patients discussed and 6 accepted, at the time of writing. The first case was carried out on 12th July 2011.

8. Homocysteine, Lipoprotein(a), Insulin and DHEAS

Applicants: James Davidson and Steve Absalom

Reviewers: John Beca (homocysteine and Lipoprotein(a)), Rhondda Paice (insulin) and Lochie Teague (DHEAS)

Date presented to CPC: 24th May 2011

Question: Should the ADHB policy for pathologist approval be extended to include Lipoprotein(a) and homocysteine, Insulin and DHEA testing?

Background: There has been an increase in the numbers of requests for these tests with little apparent clinical utility.

CPC assessment of the likely costs vs. outcomes: n/a

CPC assessment of the evidence: Although high plasma homocysteine is associated with an increased risk of cardiovascular, cerebrovascular and peripheral vascular disease, the 2009 Cochrane meta analysis of 8 RCTs with over 24,000 patients showed that homocysteine lowering interventions did not reduce myocardial infarction, stroke or death by any cause. One meta-analysis has suggested possible harm in patients with high baseline homocysteine and another suggested a possible very mild benefit, especially if folate combined with B vitamins. Collectively these studies and international guidelines suggest no current role for treatment of high homocysteine (unless as part of a RCT).

Although high plasma lipoprotein(a) is associated with an increased risk of cardiovascular and cerebrovascular disease, the benefits of any therapies remain unproven.

Although serum insulin levels can help evaluate insulin production, diagnose an insulinoma and help determine the cause of hypoglycaemia, the majority of requests appear to be using plasma insulin as a marker of insulin resistance in the context of the "metabolic syndrome". However, plasma insulin levels are poor measures of insulin resistance and there appears to be no clinical benefit in measuring insulin resistance in everyday clinical practice.

Although DHEAS levels decrease markedly after early adulthood there is no good evidence that DHEA supplementation has any benefits except in patients with Addison's disease.

CPC Score: n/a

CPC recommendation: the CPC supported the recommendations made by LabPlus to restrict these tests.

Result: The restrictions on these tests were introduced August 2011.

9. Avastin for diabetic maculopathy

Applicants: Andrew Riley and David Squirrell

Reviewers: Lucille Wilkinson and Louise Webster

Date presented to CPC: 14th June 2011

Question: Intravitreal bevacizumab (Avastin) for the treatment of diabetic macular oedema (DME)

Background: Historically, laser therapy was used alone to treat diabetic maculopathy. This may preserve visual acuity to some extent, but often at the cost of a loss of visual contrast. Intravitreal steroid injection (triamcinolone) was more recently used (after judicious laser therapy) as it was often of benefit to vision in the short term. However, this treatment has significant complications (cataract and glaucoma) which require surgery and medical treatment. Recently, anti-vascular endothelial growth factor (VEGF) agents (ranibizumab and bevacizumab), which have been used extensively in the treatment of age-related macular degeneration, have been shown to be effective treatment for selected patients with diabetic maculopathy. Such treatment has more durable benefit than that of intravitreal steroid and is associated much less frequently with subsequent cataract or glaucoma.

CPC assessment of the likely costs vs. outcomes: Based on direct costs to the ADHB only (costs of drug administration and monitoring and the costs of treatment of cataract and glaucoma) shows that treatment with bevacizumab is net cost-saving over two years to ADHB compared to treatment with triamcinolone assuming a 32% incidence of prior cataract surgery.

CPC assessment of the evidence: Intravitreal bevacizumab is an established procedure which is safely performed at ADHB, most commonly for age-related macular degeneration. Bevacizumab is unlicensed for this indication and route of administration.

There is Level 1A evidence that intravitreal injection of anti-VEGF treatment (ranibizumab and bevacizumab) improves and preserves visual acuity to a clinically meaningful degree compared to treatment with intravitreal triamcinolone. These beneficial effects are durable to (at least) two years.

CPC Score: 100

CPC recommendation: that intravitreal bevacizumab should be provided for selected patients with diabetic maculopathy and that this should include explicit documented processes for patient selection and treatment along with capture of relevant clinical and financial data for later review.

Result: Pending...

Forthcoming Submissions

For the next financial year there are already 4 potential submissions:

- Renal denervation (booked for August 9th 2011)
- Watchman for stroke prevention in AF (booked for September 13th 2011)
- MALDI-TOF mass spectrometry for rapid identification of bacteria (booked for September 27th 2011)
- Ketogenic diet for medically refractory epilepsy in children (booked for 11th October 2011)
- Anti-bacterial sutures (provisionally booked for 22nd November 2011)

Horizon Scanning

Stephen Munn continues to be a member of the Health Policy Advisory Committee on Technology (HealthPACT) and has been a member since October 2005. This horizon scanning body reviews new technologies and produces HealthPACT reports which are now regularly reviewed by the CPC.

An Access database of HealthPACT reports and the CPC's assessment of them was established by the CPC Manager in 2008 and held 354 reports at the end of June 2011. The database enables 'Horizon Scanning Summaries' to be provided to the CMO on an annual basis as well as the Capital Planning and Funding Committee on request.

NB. No HealthPACT reports have been published since November 2010 so work in this area has decreased accordingly.

See attached the Horizon Scanning Summary for 2011.

7.2 Minister's Six Health Priorities

7.2 Health Target Updates











The Ministry of Health targets areas applicable to the provider arm are set out in the table below. Six of the 10 measures have been met, and in the case of radiation therapy for 522 consecutive days. Meeting the elective surgery target for the month hand quarter was pleasing and indicates that performance strategies are working.




Acute patient flow management is a focus in all departments, not just ED. The Rugby World Cup has created some spikes but the improvement strategies are working.

The cardiac bypass surgery targets have been affected by an increase in numbers last month and this is being reduced back towards target levels through outsourcing of 26 procedures in the month and a focus on increasing internal volumes.

The quit smoking targets are proving difficult to achieve. This is not a wide issue and the focus is on improving the underperforming areas.

Data in the other areas is dependent on MOH information and has yet to be received for the first quarter.

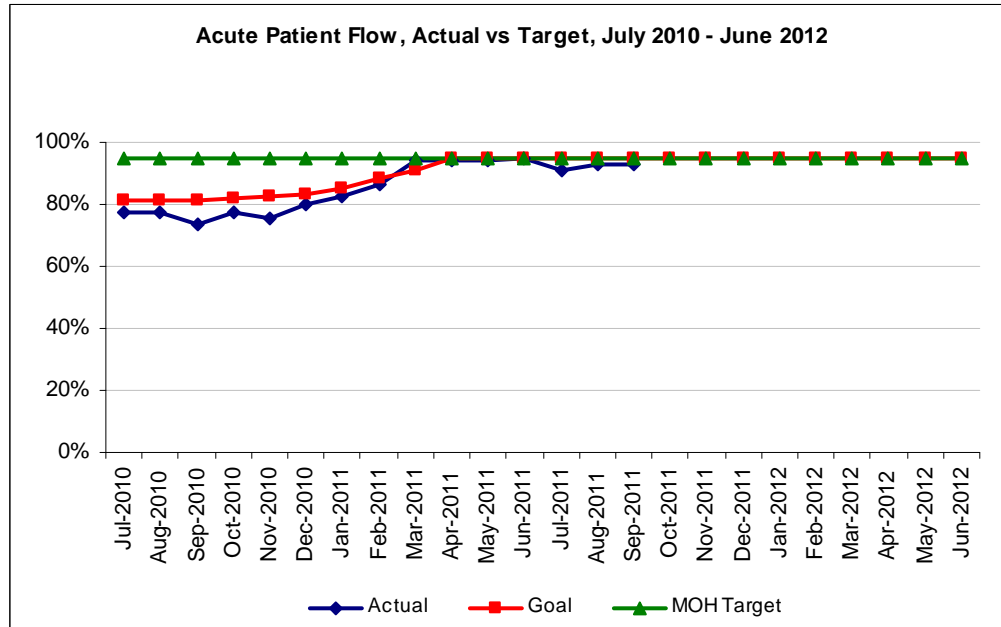
	Status	Comment
Adult acute patient flow		92% achieved against 95% target.
Child acute patient flow		93% achieved against 95% target.
Improved access to elective surgery		100% of target achieved and 101% for the quarter.
Shorter waits for radiation therapy		100% of eligible patients treated.
Increased immunisation		Q1 2011/12 results not yet available.
Better help for smokers to quit		81% achieved against 95% target
Diabetes checks		Q1 2011/12 results not yet available.
Diabetes management		Q1 2011/12 results not yet available.
Cardiovascular risk assessment		Q1 2011/12 results not yet available.
Cardiac bypass surgery		Patients waiting 114 against a target of 94 reflecting a reduction from the 121 spike last month. Volumes were below target at 60 plus 26 more outsourced.

Key to symbols	Proceeding to plan	
	Issues being addressed	
	Target unlikely to be met	

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 2012



Project Risks / Comments:

92% of patients admitted, discharged or transferred from Emergency Department within six hours in Qtr 1 11/12.

Actions continue to be taken across Adult and Children's service to respond to constraints impacting on flow.

Project: Adult Acute Patient Flow

89

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 2012

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

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)

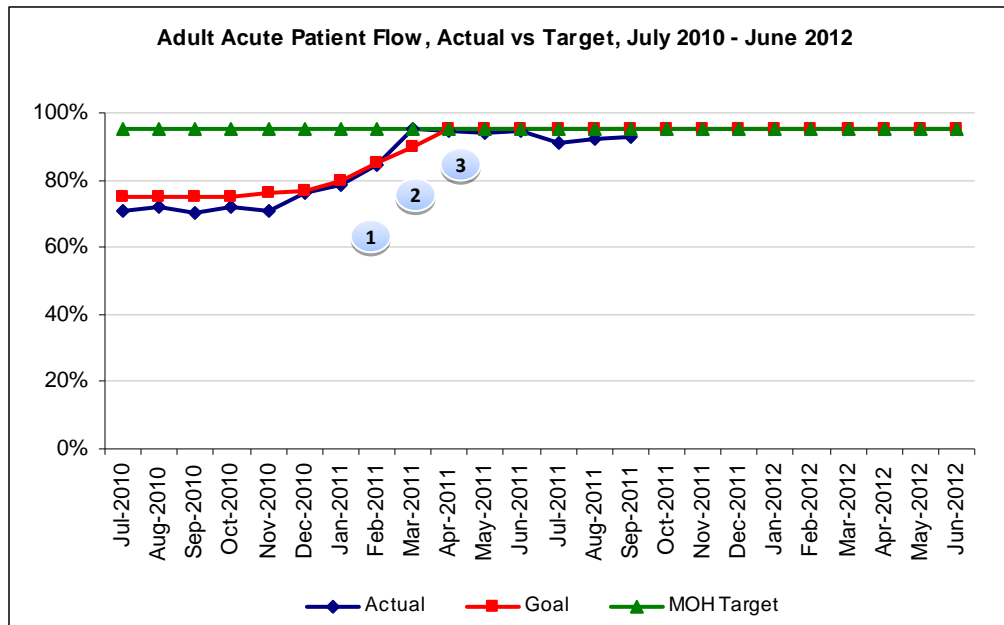
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.

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.

Adult Acute Patient Flow, Actual vs Target, July 2010 - June 2012



Project Risks / Comments:

92% of patients admitted, discharged or transferred from Adult Emergency Department within six hours in September.

Three areas for further focus include: reducing delays to ED sign on, reducing delays to inpatient specialty sign on post referral from ED, reducing access block (no beds available).

Measures underway to address these concerns include:

Finalising Adult ED escalation plan and incorporate into hospital wide plan.

Workshop review of 3 hour strategies to identify further improvement opportunities

Implement Gen med redesign

Develop acute and elective bed capacity forecasting to integrate with elective surgery POP.

Review effectiveness of breach meeting and improve.

Project: Children's Acute Patient Flow

90

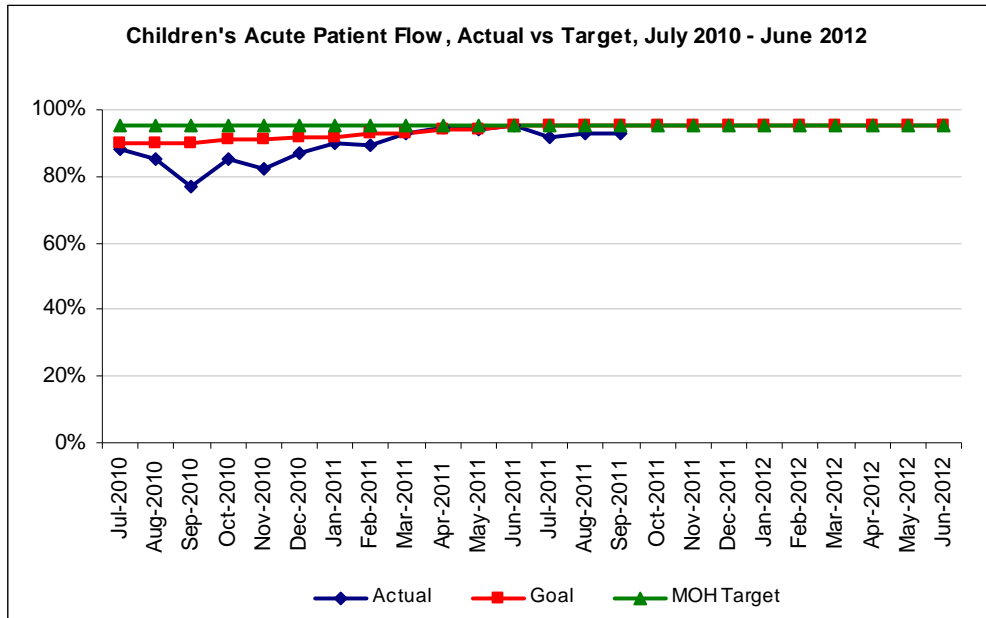
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: **30 July 2012**

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Project Risks /Comments:

September's results for Starship's Acute Patient Flow project came in at 93%, just two percentage points below our target. This performance was consistent with that of the prior month and a significant 14% above the equivalent month last year. In addition there were 11 days where we achieved 95% or greater.

A feature of September has been the somewhat inconsistent nature of Acute admissions. The random nature of presentations across each week and time of day has made management within CED and the wards more challenging. It has also led to random bed block, albeit for short periods of time as we attempt to balance the Acute admissions with our Elective lists. Our efforts with respect to Capacity Planning have proven to have been of real value within this period as while we can't remove random variation in Acute admissions we can forward project their likely effect and impact on resourcing.

Other key initiatives being undertaken to support the six hour target are:

We continue to progress the project on the 2 hour component of the patient journey. While progress continues to be slower than planned, we have strong clinical buy in to move the project forward as priorities dictate.

The use of Estimated Discharge Dates has been central to our efforts with Capacity Planning and each successive month, accuracy has been improving. Having greater predictability around discharging is not only beneficial to patient flow but is also highly desirable to the families of patients.

A further project is to be initiated on improving the discharging process and will be started in the next few weeks. Our Steering Group met recently to discuss progress. While we are generally pleased with progress made to date, there is open acknowledgement that there is still much work to be done before we can consider the process to be both robust and stable.

Improvements to date:

Improvement in the Estimate Discharge Date (EDD's) for current inpatients – steady improvement in accuracy.

Improvement in the forecasting occupancy

Immediate Actions to Lift Performance

We continue to progress the specific project we are operating on the 2 hour component. While advancement is slower than planned, we have identified five key areas for improvement and are moving these forward.

1. A new suite of reports including a breakdown of the 3-2-1 performance is now produced each Monday and is distributed to key stakeholders.
2. Ongoing focus to ensure timely discharging by improving the rounding process. General Pediatrics is paying particular attention to Nurse presence on rounds to enhance communication, particularly with parents.
3. In addition Pediatric Orthopedics has been operating a daily Rapid Round Meeting including the Multi Disciplinary Team to improve communication and agree actions for a co-ordinated discharge plan.
4. We have concluded a project on Bed Turnaround time in our Pediatric Surgical Ward and we will be replicating the project in other wards starting with Pediatric Orthopedics.
5. We continue to progress the specific project we are operating on the 2 hour component. While advancement is slower than planned, we have identified five key areas for improvement and are moving these forward as priorities allow.

Longer term projects

Starship Capacity Planning Project

Starship's website is being upgraded, information for parents regarding the use the transition lounge will be included – launch date is expected to be in October.

Project: Improved access to elective surgery

91

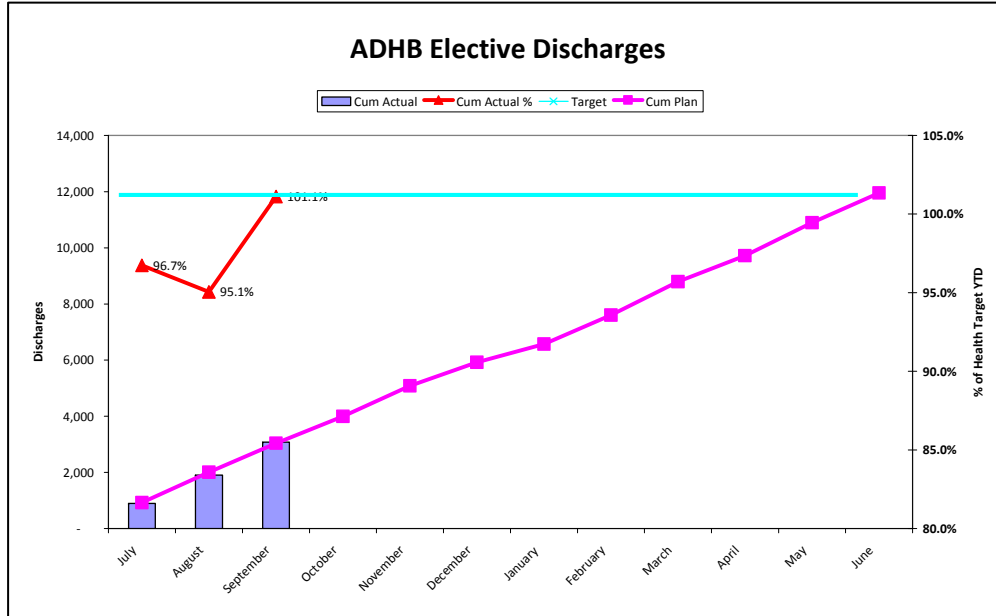
Primary Objective: Increase ADHB Elective Surgical Discharges from 11,149 to 11,950

Date of Delivery: 30 June 2012

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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



Planned activities:

1. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Continuing to review the production plan at a daily and weekly level.

Risks / Comments: (Amber)

1. Quarter 1 performance is expected to be 101% of target.
2. Month to date for October is 100% at time of report preparation.

Project: Shorter waits for Radiation Therapy

92

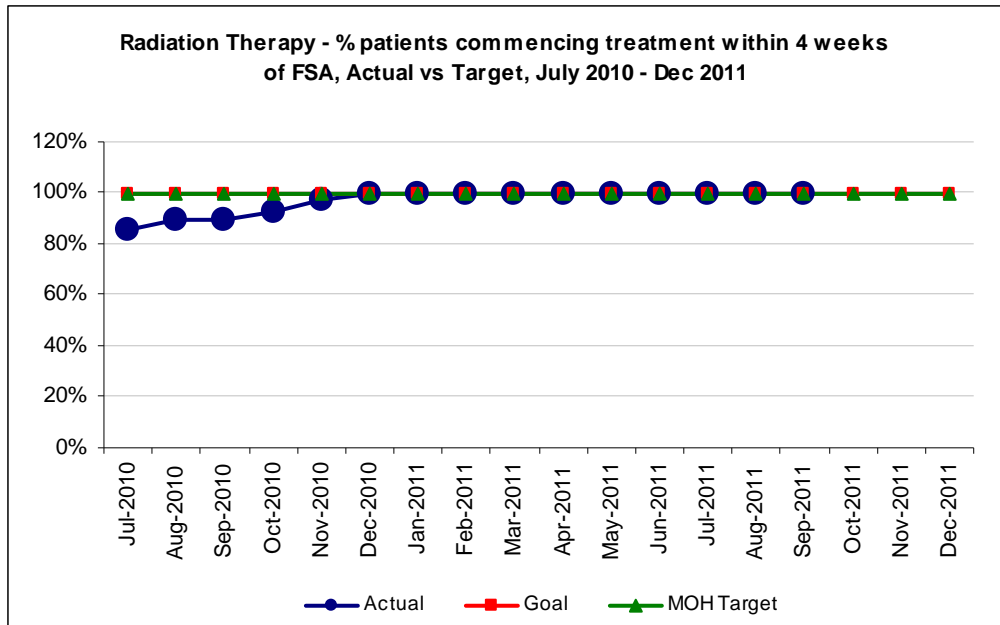
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



The service is 100% compliant for September 2011

Key risks which may impact capacity to deliver to the target in the coming months:

MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement August - December 2011. This will be mitigated by our ARO Contract.

Introduction of new technology also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment.

The HDR Brachytherapy machine was damaged mid July and following assessment by the manufacturers in Holland requires full replacement. The insurer has approved full replacement costs and a new machine is expected to arrive in November. In the interim patients are receiving LDR treatment.

Radiation Oncology Wait times – September 2011

In September 100% of eligible patients were treated within the 4 week target timeline. As at 30 September Radiation Oncology delivered to the target for 522 consecutive days.

Further improvements in progress to sustain delivery:

Replacement of MV6: Decommissioning commenced on the 22nd August until late December 2011. Evening shifts have been reinstated during this period to mitigate lost capacity

Introduction of HDR for Gynaecological patients is now being phased into the department (subject to the requirement to replace the machine – refer risks).

A public/private Model of care has been developed to enable our clinicians to treat public patients at ARO. Noting the variability in our referral flows, ARO have agreed to operate a 4 week rolling average of approx 3 patients per week from August 2011.

Introduction of new technology: The introduction of V-Mat treatment has the potential to reduce treatment times for specific tumour groups by up to 50% when fully implemented next year.

Aria project: A project is well underway to develop a full electronic record within the LINAC machine's operating system. Project end expected Dec 2011.

An "Operational team" measures 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

93

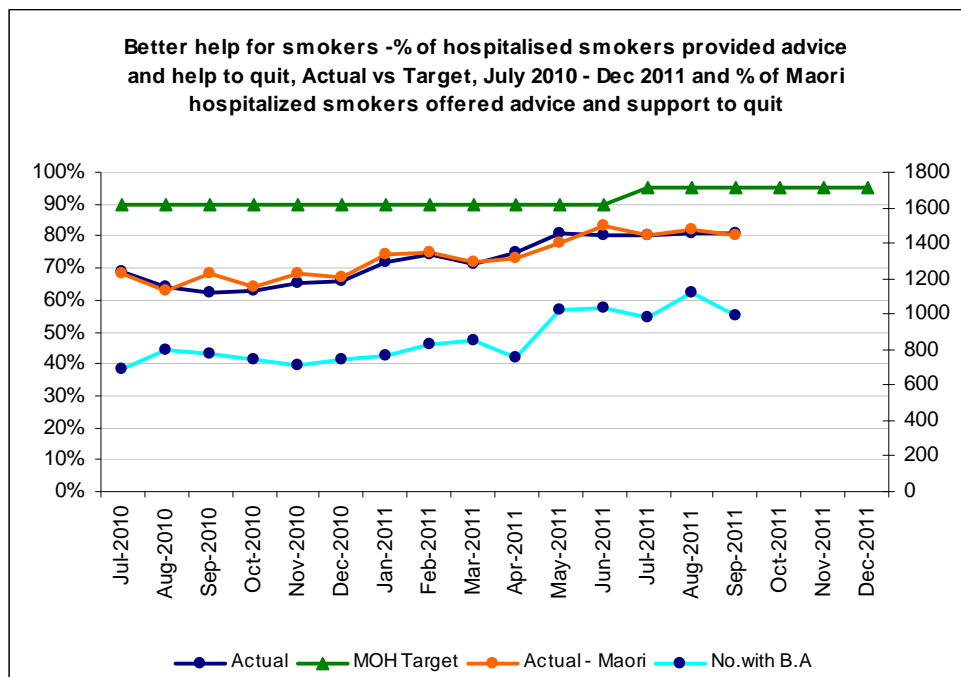
Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child

Programme Sponsor: Taima Campbell

Programme Manager: Jan Marshall

Steering Group: Di Roud, Anna Schofield, Maggie O'Brien, Stephen Child, George Laking, Jim Kriechbaum, Paul Bohmer, Arun Kulkarni, Michelle Stevens, Kristine Nicol, Bernadette Rehman, Paul Birch, Anne-Marie Pickering, Victoria Child, Jan Marshall, Kara Hamilton, Steven Stewart



Comments

Result: Of the 8810 events coded in September 1223 (14%) were identified as smokers. 81% (1124) of all smokers were given brief advice to stop smoking.

Two gains were made in late September that will show up in the October figures. The Ministry has allowed DHBs to remove the Ex smokers coded F17.1 from the smoking prevalence. A system has been set up to do this and it is anticipated this will result in an increase of 2-4%. The Greenlane Surgical Unit instituted a system to record brief advice on the day of surgery which should translate into a 1-2% increase.

The GMs Adult Health and Information Management Services and Smokefree Coordinator visited Waitemata DHB to review the systems and processes that have aided WDHB met this target. As a result we are exploring the generation of an electronic "Brief Advice Brochure" to be given with the Discharge Summary in AED. A combination of factors lead to the WDHB achievement including prioritisation of the target at all levels and high level accountability across services. Due to delays in coding WHDB instituted daily reports from Charge Nurses to GMs up to the COO monitor ward performance which resulted in sharp increase in results.

Achievements in August:

- Direct Dial Quitline phone at the Level 5 reception, fortnightly "Quit Clinics" for staff and visitors went live 27 September improve staff access and uptake of Quit Services
- Security staff stationed at Starship Hospital entrance has significantly reduced onsite smoking. Fencing erected and Smokefree boundary line in place at ACH main entrance.
- ADHB job applicants asked smoking status for statistical purposes

Immediate Actions to improve performance by 15%:

A. Focus on short stay/high volume areas to achieve 4-5%:

- Continued auditing and 1:1 coaching in AED and APU
- To reduce the "not asked/ documented" option in the Electronic Discharge Summary in AED from 27% to 10%
- Greenlane Surgical Centre recording of ABC on day of surgery to be implemented

B. Improve engagement of clinical workforce to achieve 5-8%:

- Data on target now distributed weekly to senior leadership
- Letters to Level 2 leaders with monthly results requesting support from services not meeting the target
- Best Practise Guidelines to be distributed to wards and updated weekly
- To work with Registrars to determine barriers and support mechanisms to assist junior doctors complete the ABC in clinical documents and EDS

C. Data collection systems and processes to achieve 5%:

- Smoking and Brief advice column to be added to Ward electronic whiteboards to monitor the ABC completion
- Investigation of generation of a Brief Advice Brochure with the EDS for AED
- Research – ADHB joining 6 other DHBs is participating in a ABC Outcomes survey funded by the MOH to measure the outcomes of Brief Advice given in hospitals

D. Communications – planned activities

- An NRT working Group as been established to develop an NRT promotion campaign to all clinical staff
- Quit Banner to be set up at Level four entrance

Project: Cardiac Bypass Surgery

94

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 94.

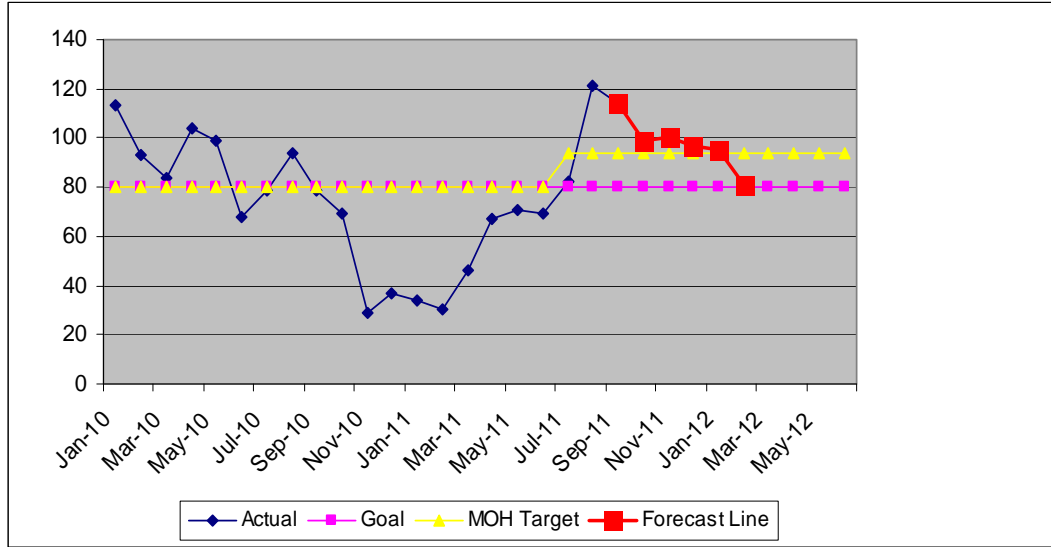
To support the national cardiac bypass intervention target, 940 bypasses should be completed in 2011/2012

Date of Delivery: 30 June 2012

Clinical Lead: Peter Ruygrok

Project Sponsors: Fionnagh Dougan

Steering Group: Marian Hussey, Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam Freeman



Monthly Performance

65 Bypass procedures were completed by the service during September. Of these completed procedures 60 are eligible to be counted against the MoH target for the Northern region population. The 5 "other" procedures are comprised of Transplants as well as other procedures involving the use of a bypass but not revascularisation of arteries or valve repair/replacement. In addition to these volumes 26 eligible bypass procedures were outsourced to Mercy Hospital during September. Outsourcing of these procedures was necessary due to the volume of patients waiting for bypass surgery. Over the last 14 weeks the accepted referral volume has markedly increased over previous years. On average three additional patients have been accepted onto the wait list during FY 2011/2012 and compared to this time last FY we have accepted 28 additional referrals. Historically the referral rate often slows through October before picking up in November and then sustaining a decrease until May. Hopefully this is the case for the coming months as this would allow the service to deal with the backlog of waiting patients.

As the graph above shows we have been able to effect a slight reduction in the waiting list throughout September, however we are still above our target maximum waiting numbers and therefore we will continue to outsource throughout October. Weekend contracts also continue with the adult congenital service making surgical resource available to assist us in completing these lists going forward. As part of the FTE approval for CIVCU we will be addressing some of the historical bed blocking issues that have historically prevented weekend contracts being fully utilised.

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
- Enhanced recovery pathway in ICU
- Scheduling workshop for productive theatres
- Releasing time to care foundation modules
- CVICU\HDU merger

Further improvements in progress:

- 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 on bypass cases
- The Productive Operating Room (NHS Programme)
 - To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- 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
- Elective patient focused team project
 - To maintain elective throughput in the service during periods of constrained production
- ICU Nursing FTE business case approved
- Weekend contract case certainty
- Rapid Rounds ward 42

Project: Diabetes

95

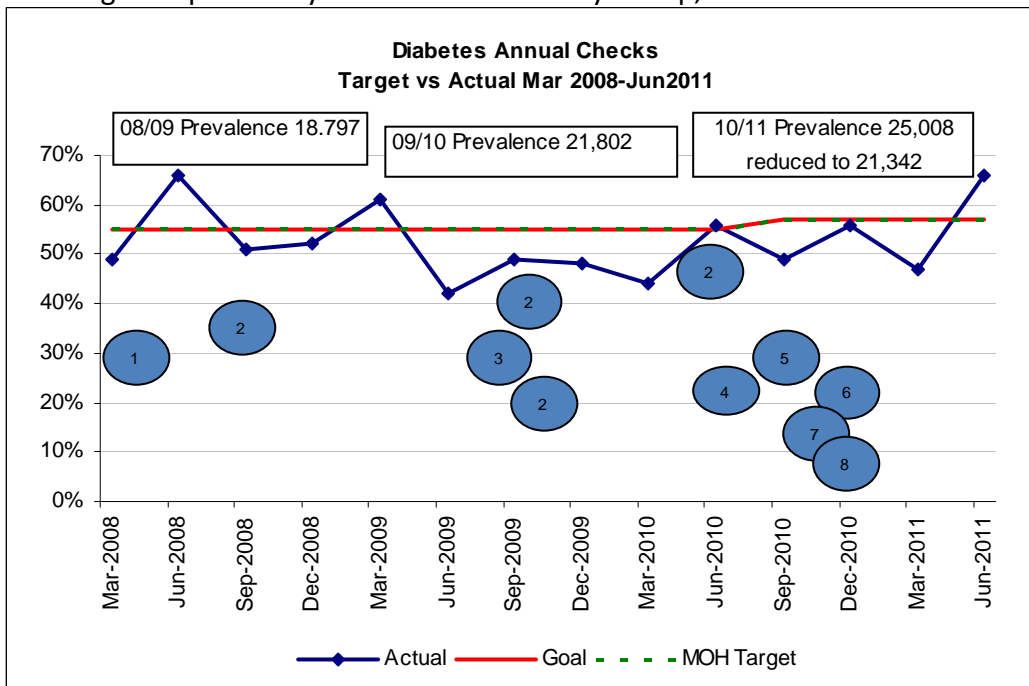
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
- 2) Practise based data (results) feedback
- 2a) Increase other feedback options
- 3) Improved understanding of IT linkages in Practice systems
- 4) Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
- 5) Routine reports to clinical advisory leadership meetings
- 6) CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
- 7) Regional shared care pathway work
- 8) Regional shared target setting and service outcomes

Project Risks / Comments:

Q4 shows a significant increase in the number of Diabetes Annual Reviews (DAR's) from the previous quarter, reaching 66% (9 % above target). Performance has been increasing steadily over the months with DAR's at 59% in April, 65% in May and 73% in June. The performance for "Other", which is where all of the underperformance has fallen, has shown a steady increase from 47% in March, to 50% in April, 53% in May and 67% in June, contributing to an overall Quarter 4 performance for Other of 57% (1% under target of 58%). Performance against target for Maori and Pacific continues to be strong, with Q4 performance for Pacific at 79% and for Maori 63% (against a target of 55%).

The Long Term Condition Quality Improvement Coordinators have visited a significant number of practices in ADHB and have gained a good understanding of systems and management of diabetes in Primary Care. They have supported and assisted practices to establish an accurate register of patients with diabetes, establish recall systems and utilise IT systems, such as Dr Info, to better manage their patients with Long Term Conditions. They have also met with a considerable number of stakeholders, including the Auckland Diabetes Centre, as part of their work to improve coordination of care between primary and secondary services.

Project: Diabetes

96

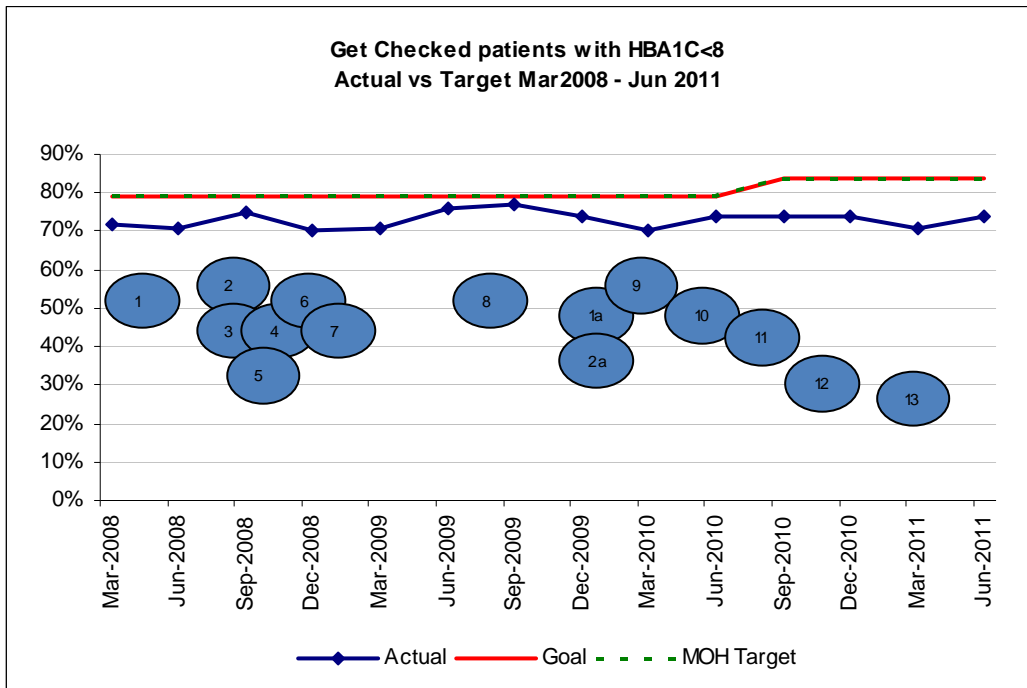
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

Date of Delivery: 79% of people with diabetes will have a HbA1c \leq 8%

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Recent and Current activities:

- 1) Increase awareness project with PHOs driving information share
 - 1a) reinforce awareness
- 2) Practise based data (results) feedback via various mediums including Health point
 - 2a) increase feedback processes
- 3) Direct Secondary Service phone support for GPs
- 4) Increased community shared clinics with secondary care
- 5) Increased SEAsian Nurse Specialist access
- 6) Widened opportunity for self management to include greater than 2 year or less diagnosed people with diabetes
- 7) Improved culturally appropriate self management courses
- 8) Improved understanding of IT linkages in Practice systems (linking PPP)
- 9) Auckland Diabetes Advisory Team – structured agreed district plan of action
- 10) Redesign the supported self management to meet needs of population
- 11) Developing shared care pathway for Diabetes
- 12) Regional shared care pathway work including clinical workshop
- 13) Implementation plan being developed for diabetes coordinators (quality improvement roles) and population audit tools for each practice.

Project Risks / Comments:

Q4 data shows an increase from the previous quarter of 71% to 74%. Diabetes management for Maori and Pacific has also improved. In Q3 this was 60% for Maori and 55% for Pacific, while in Q4 this increased to 67% for Maori and 60% Pacific.

There are a number of activities to support this component of the target, including long term condition quality improvement initiative, who will be working with practices and secondary services to improve this performance. The Diabetes Self Management Education service provider has run 15 courses between February and May, with a focus on accessibility (in terms of access and cultural competency) to our high needs populations. Additionally a generic self management course for long term conditions (based on the Stanford model) is being implemented for our Pacific populations through the HVAZ framework, with two courses having been completed as at the end of June and 4 community based staff having been trained as Master Trainers at the end of June.

Project: Cardiovascular Risk Assessment

Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

Date of Delivery: Overall goal is to have 80% of eligible population CVD risk assessed every five years.

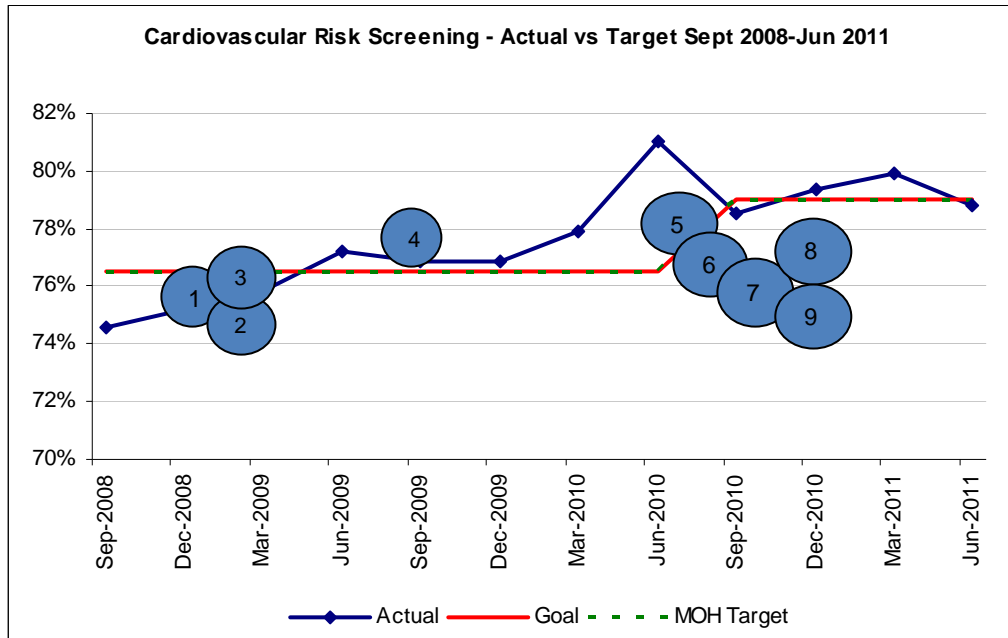
Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team

Recent and Current activities:

- 1) Support the uptake of an electronic CVD tool
- 2) Training and information system support for electronic tool
- 3) IT help line for GPs for risk assessment tool
- 4) Increase the cumulative incentive payments for achieving both good assessment and good management together
- 5) Review and reshape incentives to link with PPP targets
- 6) Enhance links to Green Rx and maximise primary care uptake
- 7) Continue to work in various workplaces to enhance CVD risk assessment for men
- 8) Link in with research looking at ways to optimise Pacific males participation in health self management
- 9) Work regionally to have similar focus on incentive goals



Project Risks / Comments:

The Q4 CVD data shows a 1.1% decrease from the previous quarter to 78.8% (this is just 0.2% under target overall). Despite this small decrease targets for both Maori and Pacific were met (74.3% and 76.1% respectively against a target of 71%). Other was 0.4% under target.

We continue to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract. The work being undertaken by the Long Term Condition Quality Improvement Coordinators (noted in the diabetes comments above) are also supporting CVD screening and management in primary care.

Project: Increased Immunisation

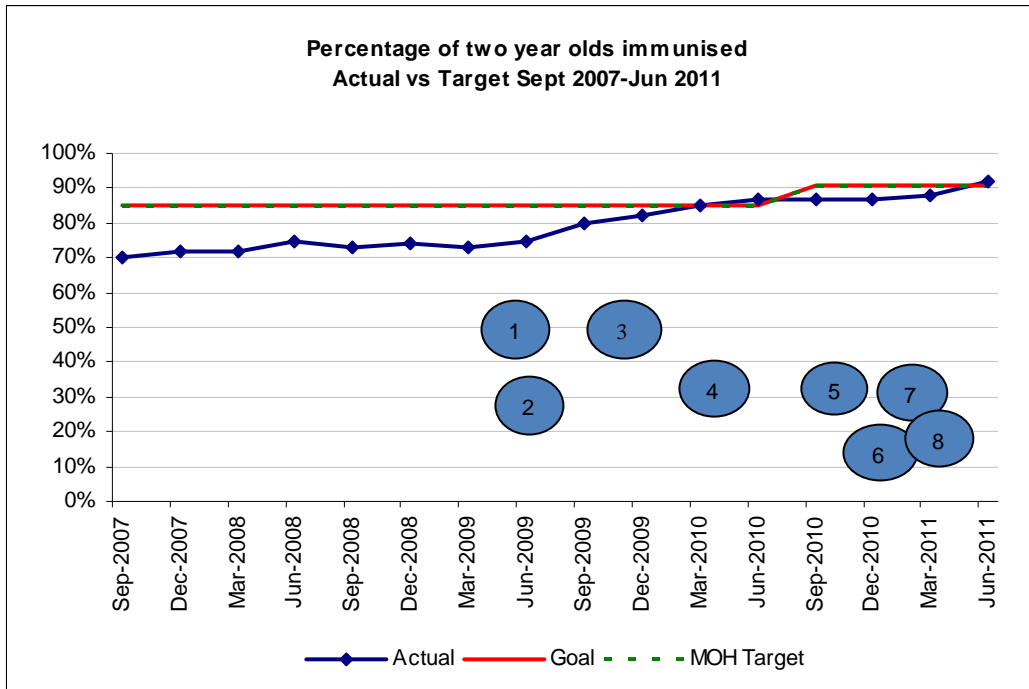
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

Date of Delivery: 1 July 2010, 1 July 2011 and 1 July 2012

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

Steering Group: Richard Aickin, Carol Stott, Aroha Haggie, Hilda Faasalele, Ruth Bijl, Alison Leversha, IMAC, Auckland PHO, Public Health, Plunket, Commissioner for Children Office, Ministry of Health

**Current activities**

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices begins with final results expected by June 2011.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct.

Project Risks / Comments:

As at 30 June 2011, ADHB's immunisation coverage (2 year olds full immunised all ethnicities) was 92% (regional target 90%, ADHB target 91%). On 30 June 2009 ADHB's immunisation coverage rate for Maori children aged 2 years was 68% (total coverage 75%). Maori coverage has now reached 88%, a 20 percentage points increase in two years. Pacific coverage was 78% and is now 95%. This achievement was the result of a huge effort by all providers, particularly general practices. It was also the result of more systematic and targeted approaches driven from ADHB Planning and Funding and the National Immunisation Register team. They were strongly supported by PHO based Immunisation Coordinators and more systematised outreach work by the Immunisation Advisory Centre based outreach team. Referrals to the outreach team nearly doubled earlier this year as the focus shifted to referring children overdue for scheduled immunisations much more quickly. This made the task of connecting with often mobile families easier. The relationship with PHO based Immunisation Coordinators has also been critical as has a district wide data analysis and improvement project. ADHB is committed to achieving the lowest possible incidence of vaccine preventable disease and to reducing inequalities by achieving the highest possible immunisation coverage across the whole population.

7.3 Management Operating System (MOS) - Presentation

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

8.1 Committee Recommendations

8.1 Committee Recommendations

Community and Public Health Advisory Committee Recommendations

Recommendation

That the Auckland District Health Board:

Notes the background and progress made to date on developing a locality approach in Auckland DHB.

Notes the linkage with concurrent primary care and community engagement activity, and the actions to align and coordinate across Auckland and Waitemata DHBs.

Background

This is a recommendation from the CPHAC following a presentation on the Locality approach for Health Service Planning to that Committee.

Maori Health Advisory Committee Recommendations

Disabled Support Advisory Committee Recommendation

PERFORMANCE IMPROVEMENT

9.1 DAP Projects Report

9.1 District Annual Plan Progress Report

The information set out on the attached pages covers progress with improvement activities ADHB has committed to in the 2011/12 District Annual plan.

All of the projects for 2011/12 have been started. The review to ensure that as many projects as possible can be consolidated has progressed well with a further 14 projects being removed from the system as a result. Most projects are still in the planning stage and are progressing to plan. There are only a limited number of projects where mitigation strategies have been required to address issues and no projects with a red flag.

	This month	Last month	Movement
Planning	110	125	108
Implementation	26	26	-9
Completed	6	5	1
	142	156	-51
Cancelled/removed	14	0	14
Total	156	156	0

94% of projects are on time, 98% on budget and 98% will deliver expected outcomes.

Status	This month	Last month	Change
On time	94%	96%	-2%
On budget	98%	100%	-2%
Expected outcome	98%	99%	-1%



Group Pack Report

Group/Committee: Board

Goal Level Summary

DAP Projects - total projects: 142

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	Green	Orange	Red		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	55	55	42	0	2	6	4	0	50	4	0	54	0	0	53	1	0	1	1	0	0
2 Performance improvement	61	61	35	5	3	13	1	0	53	4	0	56	1	0	56	1	0	4	4	0	0
3 Live within our means	26	26	22	0	1	2	0	0	25	0	0	23	2	0	24	1	0	1	1	0	0
Total #	142	142	99	5	6	21	5	0	128	8	0	133	3	0	133	3	0	6	6	0	0
Total %	100%	100%	73%	4%	4%	15%	4%	0%	94%	6%	0%	98%	2%	0%	98%	2%	0%	4%	100%	0%	0%

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

Exceptions

There are no projects that have been marked as an exception

Goal: 2 Performance improvement

Exceptions

There are no projects that have been marked as an exception

Goal: 3 Live within our means

Exceptions

10

LIVE WITHIN OUR MEANS

10.1 Finance Committee Recommendations

10.2 Finance Report

10.1 Finance Committee Recommendations

ADHB Board

Author: Ian Bell (8077)

Subject: Crown Health Funding Agency

Recommendation

That the Auckland District Health Board resolves that the signatories of persons who have been duly authorised to give notices and other communications to the Crown Health Funding Agency be updated by deleting Pat Snedden and Harry Burkhardt and replacing them with Lester Levy and Ian Ward.

Background

This will be discussed by the Finance Committee at their meeting on 1 November 2011.

ADHB Board**Author: Brent Wiseman (3869)****Subject: Oracle Upgrade**

Recommendation

That the Board:

1. *Approves a dispensation from tender.*
2. *Approves the business case for forwarding to the Regional Capital Committee and the Crown approval processes on the basis that:*
 - a) *The business case is for the purpose of migrating ADHB on to the shared services Oracle Release 12 system operated by healthAlliance (in accordance with the standardisation principle of shared services) from the current partially supported Oracle software*
 - b) *The business case comprises the components (inclusive of contingency budget) of:*
 - i. *Project Office \$201k*
 - ii. *System Functional and Technical \$1,247k*
 - iii. *Staff Backfill \$251k*
 - iv. *Infrastructure and IS Technical \$150k*
 - v. *IPM, Analytics and Barcode \$131k*
 - vi. *Change Management and Training \$102k*
 - vii. *Purchase of new Oracle Licences \$539k**Totalling up to \$2.675 million including \$0.222 million contingency budget*
3. *Notes the reprioritisation of ADHB capital expenditure budget of up to \$1.875 million over the 2011/12 and 2012/13 financial years to finance this business case.*
4. *Notes the increased annual operating costs from 2012/13 of \$0.8 million per annum estimated by healthAlliance in the business case, to be met from a reprioritisation of other planned ADHB operating expenditure.*
5. *Notes and supports that negotiation is undertaken with Oracle in order to minimise the increased license, and associated maintenance support costs, incurred by the sector.*
6. *Notes that, during detailed planning, healthAlliance will review the proposed go live date in order to ensure that the implementation and change management risks are minimised whilst not unduly jeopardising any national FMIS developments.*
7. *Requires that, concurrent with the Crown approval processes, healthAlliance finalises and provides the detailed project plan specifying project timeline, detailed resourcing and detailed costings to enable confirmation and approval by ADHB of the final budget within the above limit.*

8. *Requires that healthAlliance confirms that any operational costs currently funded by the DHBs will not be charged to the project and therefore double-funded.*
9. *Requires that healthAlliance confirms, supported by a stakeholder impact analysis, that no matters specified as being outside of project scope will require additional unbudgeted expenditure in order to achieve successful delivery of this project.*
10. *Notes that healthAlliance shall only charge for actual costs incurred and authorised within the limit of the final approved budget.*
11. *Requires that the healthAlliance Board considers and recommends for Shareholder approval whether their services are charged to the sector at cost recovery or at “commercial” charge out rates.*
12. *Approves commencement of the implementation, subject to Crown approvals and the above requirements, at a time which enables the achievement of a successful go live within the final approved budget.*

Background

This will be discussed by the Finance Committee at their meeting on 1 November 2011.

ADHB Board

Author: Ian Bell (8077)

Subject: Primary Options for Acute Care

Recommendation

That the Auckland District Health Board agrees to host the Primary Options for Acute Care contract of a Metro Auckland value of \$5,344,474 noting that ADHB's share will be \$1,416,309.

Background

This will be discussed by the Finance Committee at their meeting on 1 November 2011.

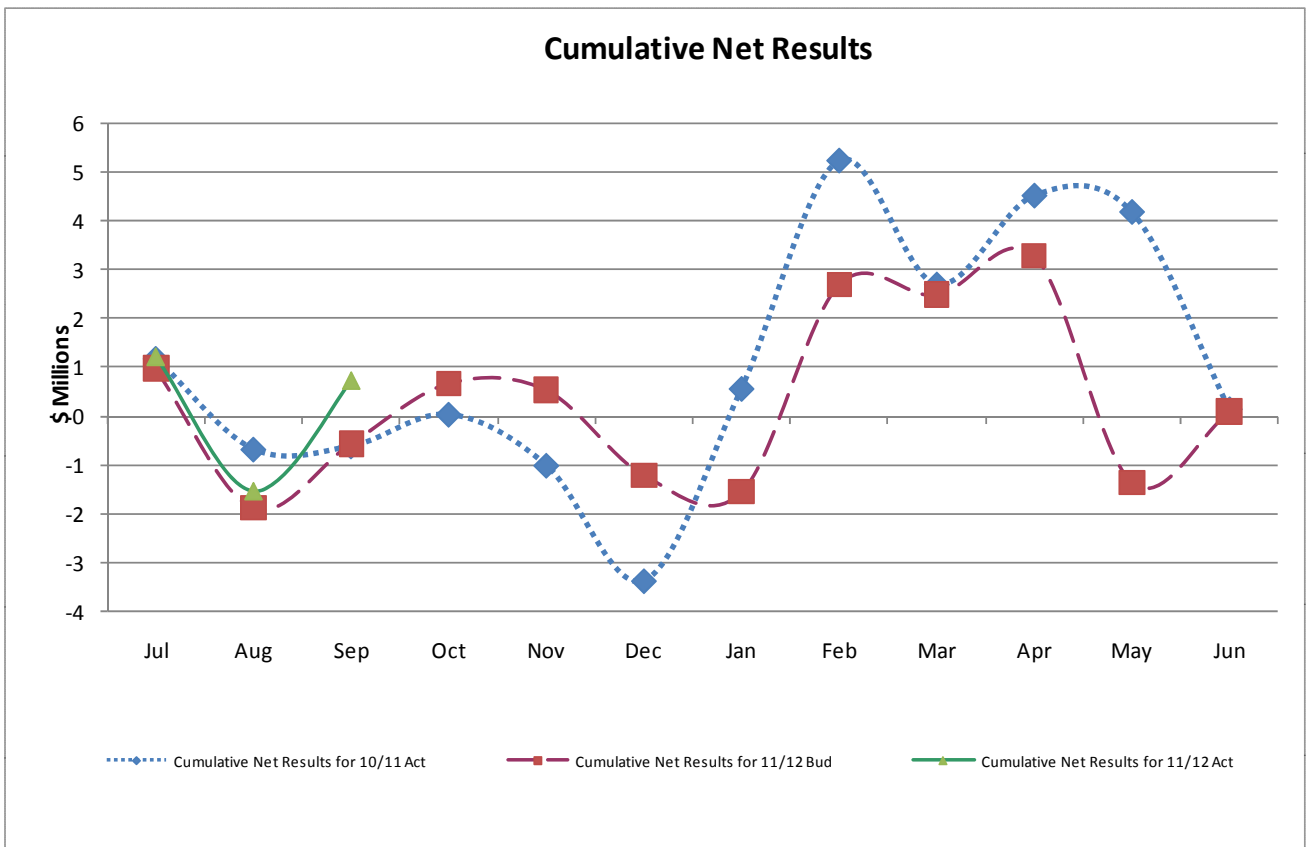
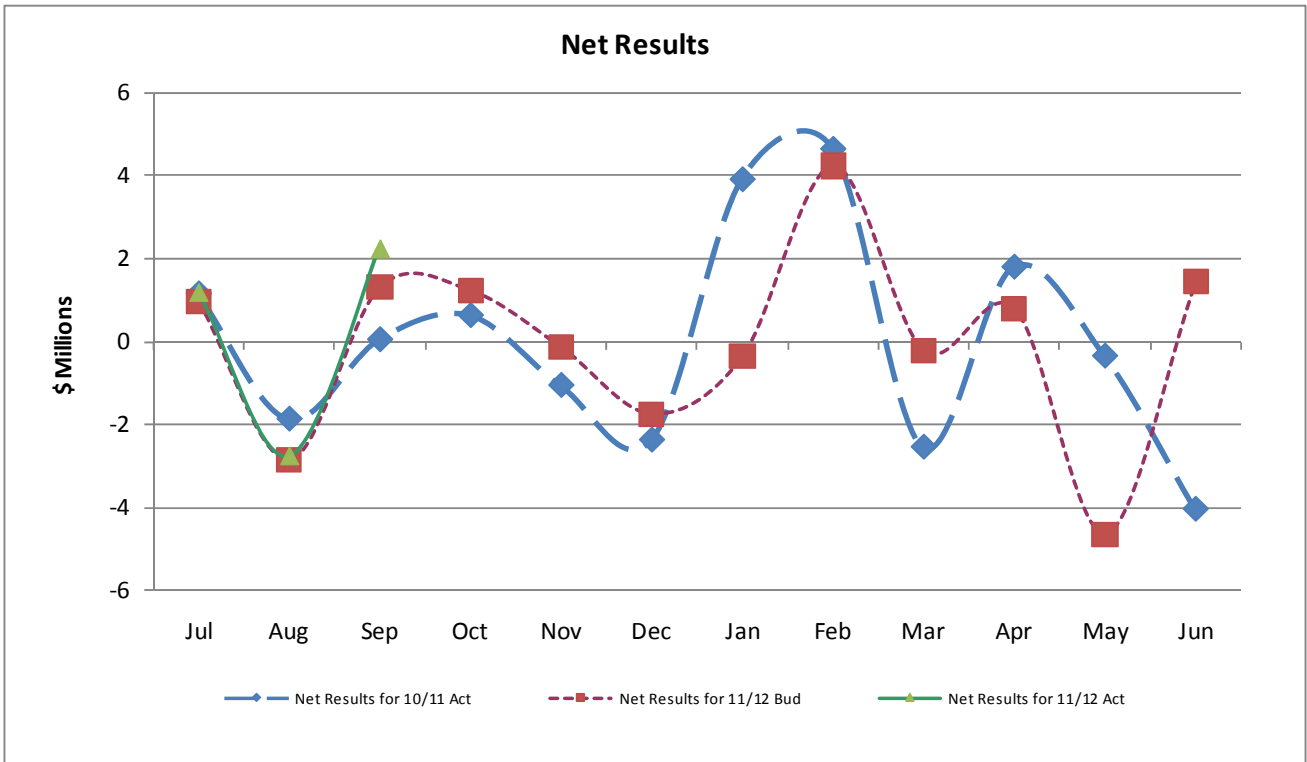
10.2 Finance Report

Auckland District Health Board

Board Financial Report

September 2011

Performance Graphs by Month & YTD



Statement of Financial Performance
Month & YTD - Sep 2011

	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
\$000s						
Income						
PBF - AKL Population	81,856	82,264	408 U	246,612	246,793	181 U
Inter District Inflows	58,683	55,265	3,418 F	170,718	165,796	4,923 F
IDF Washup Provisions	0	0	0 F	0	0	0 F
Funder to Provider Revenue	0	0	0 F	0	0	0 F
	140,540	137,529	3,010 F	417,330	412,588	4,742 F
MOH Sub-contracts	9,016	8,341	675 F	26,248	24,901	1,347 F
Other Patient Care	4,226	3,730	496 F	11,228	11,249	22 U
Services & Products	3,860	4,057	197 U	11,682	12,096	414 U
CTA	1,664	1,627	37 F	5,248	5,179	69 F
Trust & Donation Income	138	319	181 U	327	957	630 U
Financial Income	1,789	1,410	380 F	2,981	2,643	337 F
Other Income	435	594	159 U	1,349	1,708	359 U
	161,667	157,607	4,060 F	476,393	471,322	5,070 F
Expenditure						
Employee Costs						
Medical	19,092	19,436	344 F	57,278	58,234	956 F
Nursing	19,681	19,682	1 F	60,669	60,186	484 U
Technical	10,144	10,566	422 F	30,359	31,625	1,265 F
Hotel Services	835	825	9 U	2,527	2,473	55 U
Administration	6,331	6,662	330 F	19,048	20,012	964 F
Other	3,810	3,266	544 U	10,778	10,062	715 U
Total Employee Costs	59,894	60,437	544 F	180,660	182,592	1,932 F
Outsourced Services	8,111	6,207	1,904 U	21,170	18,706	2,463 U
Direct Treatment Costs	18,037	17,738	299 U	52,933	53,288	356 F
Indirect Treatment Costs	3,764	3,533	230 U	11,008	10,636	372 U
Funder Payments	46,895	46,047	849 U	142,164	139,633	2,531 U
Inter District Outflows	9,088	8,497	591 U	27,263	25,490	1,773 U
Prop, Equip, & Maintenance	3,896	3,710	186 U	11,506	11,135	372 U
Administration Costs	2,082	1,980	103 U	6,062	6,123	61 F
Total Operating Expenditure	151,768	148,148	3,619 U	452,766	447,603	5,162 U
Operating Contribution	9,900	9,459	441 F	23,627	23,719	92 U
Depreciation	3,579	3,667	87 F	10,172	10,968	796 F
Finance Costs	1,481	1,582	101 F	4,515	4,632	117 F
Capital Charge	2,583	2,896	313 F	8,221	8,680	459 F
Total Non Operating Costs	7,644	8,145	501 F	22,908	24,280	1,372 F
Net Surplus / (Deficit)	2,256	1,314	942 F	719	(561)	1,280 F

Statement of Financial Position

as at 30 September 2011

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\$'000

	Actual Sep-11	Budget Sep-11	Variance from Bud	Actual Aug-11	Var from Prev Mth	Actual Jun-11
Public Equity	573,103	574,160	1,056U	573,103	0F	573,103
Reserves						
Revaluation Reserve	331,808	353,538	21,730U	331,808	0F	331,989
Accumulated Deficit from Prior Year's Current Year's Surplus/(Deficit)	(468,224) 720	(468,308) (562)	84F 1,281F	(468,224) (1,537)	0F 2,256F	(468,367) 143
	(135,696)	(115,332)	20,365U	(137,953)	2,256F	(136,235)
Total Equity	437,407	458,828	21,421U	435,151	2,256F	436,869
Non Current Assets						
Fixed Assets	829,978	881,864	51,886U	828,498	1,480F	829,642
Derivative Financial Instruments	5,580	4,353	1,226F	5,669	89U	5,669
Investments	4,400	10,548	6,148U	4,400	0F	4,400
Total Non Current Assets	839,957	896,765	56,808U	838,566	1,390F	839,711
Current Assets						
Cash & Short Term Deposits	65,115	84,456	19,341U	71,002	5,887U	83,325
Trust Deposits	19,127	10,534	8,593F	19,067	60F	19,160
Trade & Other Receivables	70,041	57,312	12,729F	58,313	11,728F	59,230
Inventory	12,004	12,454	449U	12,022	18U	12,021
Property Intended for Resale	20,041	-	20,041F	20,585	545U	20,041
Total Current Assets	186,327	164,755	21,572F	180,990	5,338F	193,778
Current Liabilities						
Interest Bearing Loans & Borrowings	(29,175)	(5,773)	23,401U	(29,659)	484F	(23,249)
Trade & Other Payables	(136,715)	(156,164)	19,449F	(138,417)	1,702F	(149,713)
Employee Benefits	(135,040)	(127,599)	7,441U	(129,838)	5,202U	(136,320)
Funds Held in Trust	(1,099)	(1,112)	13F	(1,097)	3U	(1,093)
Loan - Associated Entities	(5,307)	15,331	20,638U	(3,916)	1,392U	(1,386)
Total Current Liabilities	(307,336)	(275,318)	32,018U	(302,925)	4,411U	(311,762)
Working Capital	(121,009)	(110,563)	10,446U	(121,935)	927F	(117,984)
Non Current Liabilities						
Interest Bearing Loans & Borrowings	(259,636)	(304,128)	44,492F	(259,627)	9U	(263,110)
Employee Benefits	(21,905)	(23,246)	1,340F	(21,853)	52U	(21,748)
Total Non Current Liabilities	(281,541)	(327,374)	45,833F	(281,480)	61U	(284,858)
Net Assets	437,407	458,828	21,421U	435,151	2,256F	436,869

Statement of Cashflows for the Year ended 30 June 2012

	Sep-11			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	152,020	163,114	(11,094)	467,933	473,385	(5,452)
Payments	(155,364)	(141,588)	(13,776)	(482,078)	(442,380)	(39,698)
Net Operating Cashflows	(3,344)	21,526	(24,870)	(14,145)	31,005	(45,150)
Investing						
Income	574	617	(43)	1,765	1,851	(86)
Capital						
Sale of Assets	0	8	(8)	0	23	(23)
Purchase Fixed Assets	(4,563)	(5,972)	1,409	(9,905)	(17,916)	8,011
Net Investing Cashflows	(3,989)	(5,347)	1,358	(8,140)	(16,042)	7,902
Financing						
Equity Injections	0	583	(583)	0	583	(583)
New Loans	0	21,000	(21,000)	0	21,000	(21,000)
Loans Repaid	0	0	0	0	0	0
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
Net Financing Cashflows	0	21,583	(21,583)	0	21,583	(21,583)
Total Net Cashflows	(7,333)	37,762	(45,095)	(22,285)	36,546	(58,831)
Opening Cash	46,069	59,805	(13,736)	61,021	61,021	0
Closing Cash	38,736	97,567	(58,831)	38,736	97,567	(58,831)

Financial Performance

- The net result for the month was a surplus of \$2.26m, a \$0.94m favourable variance against a budgeted surplus of \$1.31m. The net result year to date was a surplus of \$0.72m, a \$1.28m favourable variance against a budgeted deficit of \$0.56m.
- The result for the month is driven by higher revenue \$4.1m, higher operational costs \$3.6m and lower non-operational costs \$0.5m. Year to date the result reflects higher revenue \$5.1m, higher operational costs \$5.2m and lower non-operational costs \$1.4m.
- The month's revenue was higher than budget by \$4.1m. This was the result of:
 - a) Favourable Inter DHB revenue \$3.4m primarily driven by higher IDF revenue for PHO realignments \$1.5m (refer Funder Payments below) and for higher volumes than planned \$3.3m.
 - b) Favourable MoH sub-contracts revenue \$0.7m due mainly to higher SCI funding \$0.2m and a favourable variance in other MoH sub-contracts of \$0.2m.
 - c) Higher volumes of ACC and non residents \$0.5m
 - d) Lower external Laboratory volumes \$0.2m
 - e) Unfavourable variance in donation revenue related to lower Starship Foundation donations \$0.2m
 - f) Interest rate derivative gains \$0.4m
- The month's expenditure was higher than budgeted by \$3.1m. This was the result of:
 - a) Favourable variance in Employee Costs of \$0.5m, primarily due to lower back pay provisions. FTE are 16 above budget for the month.
 - b) Unfavourable variance in Outsourced services \$1.9m following outsourcing in Orthopaedics, General Surgery, Cardiac, Paediatric ORL to achieve ADHB population elective discharge targets.
 - c) Unfavourable variance in Direct & Indirect Treatment Costs of \$0.5m mainly in Clinical Supplies \$1.0m from a less favourable mix of volumes, Third Party Treatment costs \$0.1m, retail pharmacy materials \$0.1m and non resident bad debt provisioning \$0.1m, with favourable variances in PCT and Haemophilia Blood Products usage \$1.0m.
 - d) Unfavourable Funder Payments (including IDF Outflows) of \$1.4m due mainly to increased PHO expenditure through the realignment of PHOs. This also, in part, drives the favourable variance in Inter DHB revenue noted above.
 - e) Favourable variances in Depreciation, Interest and Capital Charges of \$0.5m driven by lower levels of capital expenditure and the devaluation of properties at last balance date.

Year to Date

- The year to date revenue was higher than budget by \$5.1m. This was the result of:
 - a) Favourable Inter DHB revenue \$4.9m due mainly to PHO realignments \$5.5m (refer Funder Payments below).
 - b) Favourable MoH sub-contracts revenue \$1.3m due mainly to higher SCI funding \$0.6m, RCLM receipts \$0.3m and Disability Support \$0.2m.
 - c) Lower external Laboratory volumes \$0.4m
 - d) Unfavourable variance in donation revenue related to Starship Foundation donations \$0.6m
 - e.) Interest rate derivative gains \$0.4m

- The year to date expenditure was higher than budgeted by \$3.8m. This was the result of:
 - a) Favourable variance in Employee Costs of \$1.9m following a lower and more favourable mix of FTEs than budgeted.
 - c.) Unfavourable variance in Outsourced services \$1.9m following outsourcing in Orthopaedics, General Surgery, Cardiac, Paediatric ORL to achieve ADHB population elective discharge targets.
 - c.) Direct & Indirect Treatment Cost variances largely offset each other. However the following variances are of note. Clinical Supplies are \$2.0m unfavourable as a result of less favourable mix of volumes. Retail pharmacy material costs are \$0.5m unfavourable, and non resident bad debt provisioning \$0.5m unfavourable. There are favourable variances in PCT and Haemophilia Blood Products usage totalling \$2.4m.
 - d.) Unfavourable Funder Payments (including IDF Outflows) of \$4.3m due mainly to increased PHO expenditure through the realignment of PHOs. This also drives the favourable variance in Inter DHB revenue noted above.
 - e.) Favourable variances in Depreciation, Interest and Capital Charges of \$1.4m driven by lower levels of capital expenditure and the devaluation of properties at last balance date.

Financial Position

- The balance of fixed assets is \$51.9m below budget principally due to the downward revaluation of land & buildings \$21.7m as at 30 June 2011, the reclassification of \$20m worth of assets, to be transferred to Health Alliance, into Property Intended for Resale and the lower capital expenditure \$5.2m.

- At month end there is an unused overdraft facility of \$36.0m.

11

GENERAL BUSINESS

12

PUBLIC EXCLUSION

AUCKLAND DISTRICT HEALTH BOARD**RESOLUTION TO EXCLUDE THE PUBLIC
FROM A MEETING OF THE BOARD****Clauses 32 and 33, Schedule 3,
New Zealand Public Health and Disability Act 2000 (“Act”)**

That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 15

The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
13.1 Confidential Board Minutes 5 October 2011	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.
13.2 Laboratory Services Update		
13.3 ER Update		
13.4 ACH Car Park Leases		

MEETING DETAILS	
Time and Date	2:00pm, Wednesday 2 November 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
Members	Dr Lester Levy (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	Jo Agnew
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Janice Mueller, Vivienne Rawlings, Ian Bell.

	Item	Page No
1 2m to 2:02pm	Karakia	001
2 3m to 2:05pm	Attendance and Apologies	005
3 2m to 2:07pm	Conflicts of Interest	007
4 5m to 2:12pm	Confirmation of Minutes 5 October 2011	015
5 3m to 2:15pm	Action Points 5 October 2011	023
6 5m to 2:20pm	Chairman's Report - Verbal	027
7 20m 5m 15m to 3:00pm	Chief Executive's Report 7.1 Chief Executive's Report 7.2 Minister's Six Health Priorities 7.3 Management Operating System (MOS) - Presentation	029 031 085 099
8 5m to 3:05pm	Lift the Health of People in Auckland City 8.1 Committee Recommendations	101
9 5m to 3:10pm	Performance Improvement 9.1 DAP Projects Report	105

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10	Live Within Our Means	109
5m	10.1 Finance Committee Recommendations	111
5m to 3:20pm	10.2 Finance Report	117
11	General Business	127
12	PUBLIC EXCLUSION	129
45m to 4:05pm	12.1 Resolution	
NEXT MEETING		
	Time and Date:	2:00pm, Wednesday 7 December 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